

SEEKING COMMUNITY INPUT TO IMPROVE IMPLEMENTATION OF A LIFESTYLE MODIFICATION PROGRAM

Objectives: Obesity increases a person's risk for diabetes, which is becoming the most common chronic disease in the United States. Latina and African-American women in disadvantaged communities are at higher risk for becoming overweight and subsequently developing diabetes. The purpose of this focus-group study was to guide our adaptation of an evidence-based lifestyle intervention and implementation of the Community-Based Lifestyle Balance program (CLSB).

Design, Setting, and Participants: We conducted 11 focus-group discussions with 87 African-American and Latina women in disadvantaged communities, including schools, senior centers, subsidized housing communities, and churches. We also conducted informal key informant interviews with community service providers and leaders.

Results: Discussions revealed high knowledge of healthy behavior and strong interest in making lifestyle changes. However, barriers such as competing demands on these women prevented long-term practice of healthy behaviors. Women frequently expressed feelings of guilt and self-blame in their attempts and failures to make healthy changes in their daily routine. Some patterns were identified that varied by age and race/ethnicity. These findings suggest guidelines for implementing this lifestyle intervention in a variety of community settings.

Conclusions: Community-level changes such as safer streets and better access to quality grocery stores or markets, with affordable, healthy, fresh food can take years to accomplish. In the interim, CLSB can provide women with skills and strategies that can help improve their health and the health of their families. (*Ethn Dis.* 2006;16[suppl 1]:S1-79-S1-88)

Key Words: African American, Focus Group, Healthy Eating, Hispanic, Physical Activity, Qualitative Methodology, Women

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INTRODUCTION

Diabetes is rapidly becoming the most common chronic disease in the United States, with one million new cases every year and almost 200,000 deaths every year from diabetes-related complications.¹ Persons with diabetes are at increased risk for cardiovascular disease.^{2,3} Among those most at risk for diabetes and cardiovascular disease are people who are obese. In fact, the Surgeon General warns that preventable morbidity and mortality associated with obesity may soon exceed that of smoking and identifies weight as one of the 10 leading health indicators.⁴

Low-income Latina and African-American women are at especially high risk for being overweight and subsequently developing diabetes. Low-income ethnic minority women are 1.4 times more likely to be overweight than middle-income White women and 1.6 times more likely than high-income White women.⁵ The prevalence of abdominal obesity is 43% in White women, 56% in Black women, and 55% in Latinas.⁶ Latinas have rates of diabetes that are two to five times greater than in the general population and also experience higher mortality due to diabetes than White women.³ African-American women are nearly twice as likely to have diabetes as White women of similar age and more likely to

die of complications from diabetes than White women with diabetes.¹

Increasingly, self-care programs have proven to be effective in not only successfully managing diabetes but also preventing its onset.^{7,8} For example, the Diabetes Prevention Program (DPP) showed decreased onset of diabetes for those at risk through an intensive lifestyle-modification program in a group that oversampled Latinas and African-American women.⁹ This program provided interactive informational sessions, individualized nutritional as well as physical activity counseling, and gym and food stipends. Nutritionists and dieticians successfully guided participants to a weight loss of 7% and increased weekly physical activity, such as brisk walking, to an average of 150 minutes.

Other successful lifestyle-intervention programs make use of a variety of techniques, including interactive sessions in the community, mailings, and computer-based training mechanisms to facilitate weight loss and increase physical activity.¹⁰⁻¹² Most lifestyle-intervention programs occur in clinical settings and/or involve professional dieticians, nutritionists, psychologists, and exercise physiologists. Some programs offer costly incentives like health club memberships where participants then pay for membership out of pocket after the conclusion of the program.¹³

Implementation of these programs may be constrained by high material cost of professionally trained staff that makes such programs unlikely to be funded within the current healthcare system. Similarly, the high opportunity costs for low-income women to become

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involved in these programs (travel time, child care, etc) as well as potential costs for involvement in health clubs make current programs untenable in low-income and minority communities.

In recognition of these issues and with the collaboration of service providers and community members, we attempted to adapt the Diabetes Prevention Program's lifestyle modification curriculum to be suitable for implementation in low-income African-American and Latino communities. The goals of our adapted community-based lifestyle balance program (CLSB) are to support people in their efforts to lose weight and increase their physical activity. The CLSB program offers no material incentives for participation, is administered by a community health promoter (health coach) rather than dieticians and nutritionists, and is designed to be carried out in community settings and participants' homes to reduce the opportunity cost of participating. The CLSB weekly activities include eight dynamic group sessions alternating with six (or more, as necessary) individual sessions. Through this six-month program, women work together and with their health coach to meet their health goals by gradually changing eating and exercise habits. They integrate what they learn into their daily routine and leverage the group's social support by exercising together at least twice a week.

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Health educators also conduct two home visits to engage family support in the beginning of the program and to reinforce that support at the end of the program.

INTERVENTION ADAPTATION AND COMMUNITY COLLABORATION

Community input was critical in producing a sustainable program suitable for implementation in communities with limited resources and high competing priorities. The purpose of the focus groups was to understand current knowledge, attitudes, priorities, and challenges regarding healthy eating and physical activity. We also obtained opinions about the DPP lifestyle-modification curriculum and what is needed to engage and support people in achieving health goals related to healthy eating and increased physical activity. These insights allowed for development of a program that is relevant to participant needs, strengths, and situations. Focus-group discussion was the most appropriate method for capturing this information because it allows for ideas to be shared openly without constraints of answer choices. Additionally, discussion in a group setting provides evolution of ideas and opinions as members influence each other via response and discussion.

While ideal for increased relevance and adoption of programs, full community participation in planning, designing, implementation, and evaluation is not possible because of our project's limited resources and inability to compensate people for their time. Furthermore, while community organizations share our priorities for disease prevention and agree that physical activity and healthy eating programs are needed and requested by the community, their staff is already overloaded with other immediate needs related to the survival of

current programs. For this reason, our partnership model relies on engaging community organization leaders and community members to share their experiences. With this information, our research team will design and implement a sustainable, evidence-based program. After piloting the program in the same communities as our partner organizations and focus group participants, our goal is to return to these same communities (schools, churches, community housing, senior centers) to train participants in becoming program health educators and share CLSB with an even greater number of groups. In this way, we work with community leaders toward achieving mutual health goals through an evidence-based, health-improvement intervention that is relevant to the community. Our common aim as a group of researchers and community leaders is for lasting individual and community outcomes as well as increased community capacity in an environment of lacking basic needs such as safety, housing, primary health care and employment. To date, our partner organizations remain involved as we implement the program. They continue to help us recruit participants and provide expertise in community relations. And we continue to provide this program without cost to the community and update them on our progress. Our grassroots community advisory board, involving participants from the program pilot, is another step toward community partnership.

Before conducting the focus-group discussions, we met with community organizations and learned that we have similar disease-prevention goals. Venice Family Clinic, Parents for Westside Renewal, Behavioral Health Services, Inc.'s Promotoras de Salud Project, and parents at Edison Elementary Schools helped shape the project by telling us about how to engage our priority population and what are the community priorities, strengths, and barriers. For example, from our partners

we learned that program location is an important consideration. Transportation problems, childcare issues, and other competing demands make it difficult for women to attend meetings. As such, we sought to hold focus groups and implement our program in locations where potential participants go regularly, like schools, churches, senior centers, and housing communities. In addition, we co-created the focus group discussion themes with two community partners, Parents for Westside Renewal and Behavioral Health Services, who helped to ensure appropriateness and concordance with community norms.

METHODS

With approval from the UCLA institutional review board, focus group discussions were conducted between April and July 2003. Focus group participants were recruited through community organizations including Venice Family Clinic, Parent for Westside Renewal, Behavioral Health Services Inc., San Sebastian Church, New Bethel Baptist Church, Oakwood Senior Center, and Culver City Senior Center. Leaders at these community organizations supported our efforts by distributing program flyers and talking to their friends, neighbors, colleagues, and other community members about the study. Announcements were made during the last few minutes of church services or other meetings. People who were interested in participating were asked to tell their friends about this opportunity and to share their ideas. This snowball recruitment strategy allowed us to convene focus groups that were homogeneous with respect to age (18–45 or >45 years of age), self-identified race/ethnicity (Latina or African-American), and affiliation (housing community, school, senior center, or church). For example, one group consisted of Latino women who were 18 to 45 years old and lived in public hous-

ing. All participants identified themselves as overweight or obese.

Eleven groups were conducted with a total of 87 women, 45 of whom were Latino women (six groups) and 42 were African-American women (five groups). As many as 10 and as few as five were present at each group. At the beginning of each group, a questionnaire was administered that collected the following information from each participant: date of birth, education, marital status, place of birth, length of time in the United States, health insurance, and language spoken at home. The survey also asked participants to rate their level of satisfaction with their current health-care provider and whether their doctor had ever mentioned healthy eating and exercise during an appointment.

In the discussion, we asked focus group participants about their knowledge regarding disease prevention, healthy eating, and exercising, as well as their current behaviors related to fitness and potential facilitators and barriers to lifestyle change. (How important is preventing disease to you? What do you do to prevent disease? How important is healthy eating? Is exercise? Are you doing anything now to improve your eating habits? To increase your physical activity? If so what? What makes it hard to eat healthy? To exercise?) We also described the CLSB and solicited feedback and opinions about the program. (What do you like or dislike about the program we described? Where would it be easy for you come to meetings? What times are most convenient? What would make it hard or easy to participate in this program?)

Notes were taken at each focus group, and all groups were audiotaped. Groups were facilitated by a bilingual moderator, and a note-taker was present at each group. The groups lasted approximately two hours each. Participants were provided dinner and a cash payment to thank them for their time and contribution. Immediately after each group, the moderator summarized

the themes and interactions of participants. Tapes were transcribed and translated.

Analysis was based on grounded theory using verbatim text as the foundation.¹⁴ Three members of the research team, including the moderator, who attended all meetings, each read three different randomly selected transcripts and separately generated similar themes. Coding of each transcript was conducted by either a doctoral or master level researcher with substantial training and experience in qualitative data analysis.

Analysis of the focus groups identified the following themes: 1) health priorities; 2) knowledge and efforts to be healthier; 3) challenges to maintaining healthy behaviors; 4) what is needed for successful behavior change; and 5) suggestions for the intervention program. The following section describes overall patterns in the opinions expressed by women. These opinions are compared and contrasted, and where possible, consensus and divergence of opinions are highlighted within and across groups. We also present information on demographic differences such as age, race/ethnicity, and family status that appear to differ in the focus groups.

RESULTS

Eleven groups were conducted, six with Latino women and five with African-American women. From the questionnaire administered before discussion, we learned that participants' age ranged from 18 to 87 years, with 25% of participants between 18–35, 42% aged 36–55, and 34% aged ≥56. Participants also varied in terms of their educational background: 47% had not completed high school, 31% were high school graduates, and 22% had completed at least one year of college. An overwhelming majority of women reported having some type of health

insurance (85%), and all reported being overweight or obese.

Health Priorities and Importance of Prevention

In our discussion of disease prevention, most participants thought that preventing disease was very important or important. Out of 87 women, only a few said that disease prevention was not important. Those women who did not prioritize disease prevention had no personal or family experience with a chronic disease or its ramifications.

Fear of disease and its complications and concerns for the future of their children were reasons for finding disease prevention important. Many said they suffer from chronic disease or know someone (family or close friend) who suffers from or has died as a result of diabetes complications or from another chronic disease. Women expressed fear about the impact of having a chronic disease, including medication costs, side effects, complicated schedules, and debilitation from disease (eg, vision loss, circulation issues, and amputation). For example, a Latina woman shared her concern about diabetes in the following excerpt: "I am afraid of diabetes. When I know that somebody dies and that they are amputating arms and legs, it scares me because you never know when you will get that disease. When the person finds out it is because they already have it. I tell my doctor to take samples because I am afraid because in my husband's family, everybody died that way. They were only left with their body from the waist up. They started cutting them in pieces. . . . I don't know if my son will one day catch diabetes. He is the grandson of the family that died in that manner." Another participant shared what her doctor told her, "'Okay, if you don't do something about it, we will have to cut your feet off.' So that in itself was a scare."

Many of our participants reported strong fatalistic beliefs that need to be

taken into account when considering preventive health services for this population. The women seemed clear about controlling what they could within strong fatalistic boundaries. In this regard, one African-American woman stated, "It is very important. Just because I believe we are all here for a certain period of time, but I would like to live that time I'm promised and I don't want it to be a preventable health issue that take me away from here." Lifestyle-change programs for this population should take into count the mention of, but also increase their capability to improve the malleable factors such as healthy eating and exercise that may lead to disease prevention.

Knowledge and Efforts to Achieve a Healthy Lifestyle

Our target population not only gave prevention high priority, but they were actively engaged in such efforts. All participants talked about their efforts to make healthy lifestyle changes. Getting regular check-ups, taking medications as indicated, getting more rest, decreasing stress levels, and quitting smoking are among the many things the women in our groups reported they were actively doing in order to prevent disease. Women also reported seeking information related to maintaining good health. Healthcare providers, television, magazines, community education sessions, and food labels were their main sources of information. As a result of this information, all groups rated healthy eating and exercise to be very important or important for their own health and that of their families. Furthermore, they were knowledgeable about healthy eating and exercise.

The women reported that they were currently making active efforts to improve their diets. Diet-related changes included doing more of the following: drinking more water; baking and steaming foods; eating more chicken, turkey, and fish; eating fresh or natural foods (fresh squeezed at home vs store-bought

or boxed juice); consuming foods with more fiber and whole grains; and incorporating variety in diets. Salads were idealized as the healthiest food. Participants were also aware that healthy eating meant limiting the consumption of fatty foods, starches, red meat, grease, sweets, soda, coffee, and fast food.

Many women discussed their attempts to change their eating habits. Almost everyone reported struggling with portion control. Participants reported using a variety of strategies to reduce food intake or eat the right kinds of food. Behavioral strategies included: careful/complete chewing, using smaller plates, eating more meals at home rather than at restaurants, not eating late at night, not eating while reading or watching TV, keeping food out of the bedroom, and eating smaller, regularly scheduled meals. Shopping strategies that were mentioned included sticking to a set grocery store list, avoiding the isles displaying high-fat foods at the grocery store, and eliminating high-fat foods or sodas from the shopping list. Women also shared innovative eating out strategies, such as ordering half of the portion to go, requesting that no chips be brought to the table, and drinking more water.

In conjunction with healthy eating, many women reported making an effort to exercise regularly through brisk walking, running, biking, aerobics at the gym or at home using videos, exercise bikes, leg lifts, swimming, stretching, weight lifting, dancing, climbing stairs, and sports. Women regarded exercise as anything involving movement, sweat, and increased heart rate for a continuous amount of time. Women acknowledged that exercising helps people feel good, productive, energetic, and it enables easier movement. A comment that resonated among all groups was stated by an African-American woman: "When I don't exercise, I feel heavy and when I bend down, it's harder for me to get up. When I exercise I feel more flexible."

Overall Challenges

Despite the known benefits of healthy eating and exercise and current efforts to make change described above, their actual practice was inconsistent (healthy eating one day rewarded by unhealthy eating the following day) and short-lived (regular exercise a few months at most). Participants expressed difficulties in transferring their desires and knowledge into long-term practice. "I know what I am supposed to do, but to do it is another thing. It takes a lot of effort to do, and I don't make the effort to do it sometimes—a lot of times." Another participant expressed, "Everyday I get up with the thought that today I will not eat tortillas, bread, or soda, and at the first opportunity that I have, I eat a taco."

Almost everyone in the groups expressed similar frustrations. Women report that this cycle of starting and stopping lifestyle change leads to desperation and decreased motivation. "Before [a friend] and I went to the gym... then we went less and then we stopped altogether. And that is my problem, because I can't motivate myself to do it again. It's very difficult for me." This discussion of knowledge and efforts to change demonstrated that women do want to improve their health. At the same time, the barriers to healthy eating and physical activity show that many feel defeated by past failures in maintaining change.

Challenges in Healthy Eating

Participants viewed healthy eating as an ideal that was separate from their natural and usual way of life. Healthy eating was perceived as a sacrifice because it was viewed to be boring, and healthy foods were perceived to be less tasty and of limited variety. Participants reported that they rewarded their healthy practices with a day off and permission to eat high-fat favorites. They also rationalized eating high-fat foods by committing to a healthy diet tomorrow or later. Additionally,

unhealthy eating was described as becoming unlimited, because once you begin to eat the "forbidden" foods, there is no turning back. This dilemma was expressed by one participant as follows: "Because I ate a salad yesterday, now I can eat the cheeseburger. And then you think, 'So let me go ahead and have a soda.'" Another chimes in, "and the super-sized French fries." The women also reported that taste and preference lead people to fall back into unhealthy habits. "What is bad for us, we like the most. And what is good for us we don't like." Women also rationalized abandoning healthy habits with some fatalistic and self-defeating ideas, expressed variously as: "I am going to gain weight anyway, I'll eat this and eat that... I have always been fat, and my whole family is fat."

The women in our group reported that they were accustomed to eating a certain way, and those habits were hard to change. Cooking styles passed down from previous generations have shaped their food preferences and their knowledge of food preparation methods. Exemplifying this is a comment made by an African American woman, "The fatty foods are what I know how to prepare and what I like to eat." It is also the food that their families come to expect, "because you cook something bland and they say it does not taste good, and we throw it away."

Food is also central to social and family life. Meeting friends or family reunions always revolve around special foods in order to show appreciation for these relationships. "Yeah, at my family's house, they always have food. They always have just tons of food and if you don't [eat] the food, you know . . ." Hosts must offer food and visitors must accept or risk offending their family and friends. "Sometimes it is the culture too. You know, if you say 'no,' some people will get offended if you turn down whatever they are offering." Although the Latina and African-American women reported dif-

ferent food types associated with their cultural backgrounds, both reported that food was important to social relationships and culture in their daily lives.

Participants also talked about having a limited amount of food when they were children. Some reported that they recalled eating very quickly when they were young—with the perception that they had to get their share of food before others took it. This fast eating remained a lifelong habit even though food scarcity was no longer an issue. Another common food idea from participants' upbringing was the ingrained expectation to never waste food. As adults they cleaned their plates and their children's plates, even when it resulted in overeating. A Latina woman stated, "When I was growing up, it was like you eat everything on your plate. Don't you waste it. You need to eat everything. So what my kids don't finish, it's like I can't waste a good piece of chicken. Let me eat it."

The women in our groups reported that their family roles influenced their eating. As women, they noted that they were responsible for taking care of the home, and were charged with overseeing the welfare of their spouse, children, and extended family. They reported skipping meals in order to fulfill their responsibilities, with the result that they often felt hungry and deprived towards the end of the day, when they overate to compensate. Women also turned to food for comfort. They reported using food to reduce anxiety and worries related to their family relationships or conflicts happening at home or in the community. Being overly busy at work and at home was another pattern that was reported to result in irregular and unhealthy eating. "I don't eat for hours until when I get hungry and then I am eating three cookies and then suddenly I'm just eating without thinking. And later I just eat too much."

The women also reported that logistical and economic factors played a role in their eating habits. They

expressed the view that healthy foods are more expensive at restaurants. Women also reported that fresh produce can be difficult to obtain in their neighborhoods. Many women claimed that they were very busy and lacked sufficient time to prepare healthy foods. However, to counter this point, one woman mentioned that vegetables are cheaper than meat. In addition, most women expressed a humorous self-awareness about their failure to commit appropriate time to their health. They said there always seemed to be time to watch television but little time to plan and prepare meals.

The women in our groups also felt that overall availability of unhealthy food diverts them from their healthy eating. "I was not hungry . . . when I got to work and smelled the coffee and they had donuts. I ate again." Cues encountered in their neighborhoods and on television and radio serve as temptations to eat unhealthy foods. The combination of taste preference, low cost, wide availability, and convenience make highly processed, high-fat, fast food an easy choice for many women.

Some mentioned that eating gives them something to do when they are bored or nervous. A few women mentioned cooking for others as part of their job. Because they have no control over what they cook for an employer, they found themselves often around unhealthy food, which makes not eating difficult, even though they are not hungry. Some women described food as an addiction. One African-American woman stated, "I am addicted to soda." Even though participants know they should try to avoid or eat less of certain foods, they expressed a lack of control over eating habits, stating that "food is a drug too."

Most participants felt that they received vague health messages from their health providers, with no recommended action plan or a lack of specific information to help them implement a plan. Messages such as, "Eat

healthier!" "Stop eating fatty foods!" and "Exercise!" leave women with questions about how, when, where, and how much they need to do in order to be healthy. Participants expressed not knowing enough or having concerns about the accuracy of health-related messages. For example, they mentioned confusion related to all the fad diets glorified in the media. Most agreed with a statement from one African-American woman, "One day it is bad to eat meat and broccoli, and then a few weeks later it is good to eat it."

Challenges in Exercising Regularly

Participants acknowledged facing numerous challenges in following a regular exercise regimen. Among the various reasons participants reported not exercising regularly included not liking exercise, unrealistic expectations, no support, competing demands, and safety.

Participants discussed their dislike of exercise. Some women mentioned feeling embarrassed when exercising and out of place at the gym. They said that age- and/or sex-appropriate exercise groups were hard to find. They felt that television and magazine advertising portrayed only athletic women. One woman said, "Fat women are not admitted everywhere." They were excited to hear about the program for overweight women. They expressed comfort in the idea that such a program would encourage them and not intimidate them.

Other barriers to regular exercise that women discussed were work and exhaustion. They talked about returning home tired from work and/or home responsibilities and falling into the sedentary pattern of watching television to relax. Being sedentary at home is not a problem for the women who have active, physical jobs during the day. One Latina woman shared her story about cleaning houses all day, walking

up and down stairs, cleaning windows, and running to the store. After work she talked about returning home on a packed bus and preparing dinner, after which, all she could do was rest.

Unrealistic expectations have led some participants to stop their past efforts to exercise. Many participants appeared to expect results too quickly. When immediate changes were not noticed, they abandoned their efforts. The benefits do not seem to outweigh the "suffering" during exercise. Older participants did not like the aches and pains after exercising, and said they found it hard to get used to the movements. Older participants also mentioned feeling ridiculous even when exercising alone, because they were not accustomed to the movements or were afraid of falling. Some women also mentioned that they were unable to exercise because of past injuries or feared the impact of exercise on back or joint pain.

Some participants did not feel supported in their physical-activity goals. Some workplaces, for instance, are not conducive to any physical activity. An African-American woman explained, "Now we have to sit at our computer to take our break. On your break you only get 15 minutes. Now what can you do in 15 minutes? Mind you now, because when you clock out, that starts your 15 minutes. If you go to the bathroom, there are only three stalls and you've got 20 women in the bathroom, that's half of your break right there. So what else can you do?" Some women reported feeling unsupported by their families. Many find walking alone boring and do not have friends or family to accompany them. They need positive reinforcement, which they do not get from their family and friends. Some women are unable to exercise at home because of space constraints. However, they expressed that they did not have the option of going outside to exercise for safety reasons. This was especially true for

older women, who reported being considered “easy prey” for unwanted attention. Women reported that gym memberships were not an option because of cost and limited availability in their neighborhoods.

Many women reported that competing demands, such as work and family responsibilities, do not leave time for exercising. Women reported that they were responsible for cooking, cleaning, and disciplining children at home, even if they also worked, which left them little time to take care of themselves. In fact, a few women said that if they go out, they feel guilty, even if they have completed all their tasks at home.

The women also reported that stress and depression, lack of health care, and personal motivation present barriers to an overall healthy lifestyle. Various sources of stress for these low-income Latina and African-American women included fear of being driven out of their homes/neighborhoods because of gentrification, safety concerns, unemployment, and death in the family. The resulting stress and depression cause some to seek solace in food. A Latina woman shared her story, “I lost interest in looking good. I was so depressed. It was stressful. My husband passed away 10 years ago, and I started eating and eating. I began to feel a need to eat pieces of bread and just thinking about what I am going to eat.” Some were unable to leave their home and be more active. “I stay in the house and don’t do anything. I don’t talk to anybody. I watch television and I just keep gaining and gaining weight. I’m conscious of the fact that this is my problem but to leave there, it is very difficult.” For women with adolescent children, the stress at home is even greater. Their problems grow with rebellious teenagers. As parents, they may not have any control of their children’s activities outside the home. In addition, women reported limited knowledge about accessible health care or trustworthy

healthcare providers. These beliefs—even if they contradict the fact that most of the women in the groups have health insurance—appear to dissuade women from more actively seeking out advice or information from healthcare professionals about how to manage weight, stress, or depression.

Almost all participants claimed to lack personal motivation to eat healthy and exercise. One woman stated, “I am somewhat lazy. . . . I don’t have strong willpower.” This was also rephrased as lack of self-love. “I began to gain up to twenty pounds. I acquired a complex that I would tell myself I did not have to look good for anybody anymore. You stop loving yourself. That is why I think that it is our own carelessness, because we should take care of ourselves.” Being overweight appears to be a “chicken and egg” cycle, in which depression may be the cause or the result of being overweight. Either way, the cycle of eating, not exercising, and not taking care of oneself has taken its toll on the women in this study.

The participants in this study possessed a desire to lead a healthier lifestyle, but they often did not get past that desire to realize commitment in daily practice. Women mentioned purchased books, videos, and exercise equipment. However, in many cases, the equipment was abandoned, unused or used for other purposes (eg, for hanging clothes or as a door stop, while videos are watched not while exercising, but while eating). Women expressed that the link between knowledge and practice is in attaining the motivation and commitment to change their daily lives. “Because you certainly try—every day actually. Everyday you say, ‘Today I am not going to eat this because I know it can make me sick.’ Or you say, ‘Today I didn’t walk. Tomorrow I am going to.’ It is always for tomorrow. So what would interest me is to see something that instructs you how to do it and help you make the commitment to do it.”

Feedback about the CLSB Program

Nearing the end of each focus group, we described the CLSB program to the women. Overall, the participants were interested in trying the program. They expressed the feeling that the program would address the issues they felt were preventing them from taking better care of their health. Specifically, women said the program would help increase their motivation to engage in healthy eating, provide opportunities for exercising, and provide support in the form of fellow group members and a health coach. The program’s weight-loss and exercise goals were in line with participants’ personal goals. The variety of fun activities, slow gradual changes, and focus on sustainability also attracted the women to the program. Participants also saw the program as an opportunity to have personal time away from the home and children. This also gives them a chance to talk to others with similar interests and challenges.

Certain parts of the program received mixed reviews. While some preferred the group to meet other people, others said that they would not like to share “dirty laundry” with other group members. Some participants did not like individual meetings with the health coach in their homes. They would feel self-conscious and judged by the health coach. Some thought the home visit could provide insight into how changes in lifestyle can be made effectively. They admitted that keeping a journal of eating and exercise habits would be challenging, especially when eating out. Further, a few feared that they might be judged on their writing abilities. However, most thought that the self-awareness would be an important part of change. Additionally, being weighed at every session might be discouraging.

The women reminded us that the program must be sensitive to participants’ daily circumstances and challenges. Ill children, meetings and other commitments, and family problems

could prevent some women from coming to every session. Women encouraged us to find a way for participants to make up sessions they were unable to attend. For women with young children, they wanted us to offer childcare during sessions. Participants also agreed that groups should be as similar as possible in age, language preference, and race/ethnicity. Information and activities should be tailored to people's needs in exercise levels, food preferences, and language. In addition, offering the program in a safe location close to home is important to minimize the challenges in attending meetings.

Participants agreed that the most important issues for a successful program include sessions during convenient times; homogenous groups (being with women "like them"); and safe location close to home or a place they frequent on a regular basis such as schools, churches, or community centers. One participant mentioned that she would likely not be interested in a program offered in a clinic setting because of her initial thoughts that it would be boring. Consistency of program and knowledgeable health coach were also mentioned as important components. Participants offered the opinion that the program must follow through on the set guidelines as explained to participants. From the beginning, the program must be well defined in terms of who can participate, activities, and time commitment. Entertaining and informative activities, advanced notice of events, and clear schedule of meetings are important to engage participants and gain trust in the program. A knowledgeable, motivating, and trustworthy health coach must be available in order to engage women in surmounting the difficulties in making lifestyle changes. One African-American participant stated, "Personally, I would need to know I am coming to see a professional who knows what they're doing and knows how to get me steered back in the right direction for me to be motivated and

come every week and invest an hour of my time." Women felt that the coach must be able to devote time to each participant, relate to participants, and provide reliable new information. The coach must also be able to motivate, be non-judgmental, and genuinely care about participants. Being able to refer psychological issues around dangerous eating and exercising habits to professionals may also be important.

Difference Between Groups

Participants under 45 years old expressed more interest in preventing diseases that they have seen in their friends and family. They were interested in losing weight and exercising for aesthetic purposes such as looking good in fashionable clothes. On the other hand, groups over 45 years old expressed more concern about managing diseases through diet and exercise rather than medications. They also felt that disease was an immediate threat; that is, with age their susceptibility to disease increases. Illustrating this point, a Latina woman stated, "I think that after 40 and so many years, a woman needs to begin to pay attention to the things that cause sickness. You no longer have a headache, and not take it into account. No . . . you have to think about why you have a headache. Because we know that at a certain age, disease can come much more easily and they are more difficult to cure. It takes longer for a person to feel better . . . and we begin to depend on it [medication]."

Most barriers to healthy living were similar across the age groups, except for one major difference. An emphasis on physical limitations, such as muscular aches, comorbidities, no teeth for chewing hard vegetables, was prevalent in the older groups. For the younger group, the barriers were around busy schedules disrupting eating and exercise schedules. The more mature group also mentioned not having the information available to them when they were younger. At their age, making changes now is even more

difficult. Both groups reported experiencing heavy family demands and responsibilities.

In general, Latinas and African-American women expressed similar knowledge, challenges, and need for support to implement behavior change. However, the Latinas and African-American women differed drastically in their style of discussion and willingness to share with the group and address the research team. In the Latina groups, the research team seemed to be automatically accepted as experts. The participants asked questions about what they should do and about disease prevention. They sought support and approval of the moderator in their conversation. They shared very personal information about their feelings and family problems quite freely with the whole group. Many arrived late and were amenable to staying late.

In contrast, the African-American women groups questioned the research team about procedures, motives, and validity of the program. "If this is a healthy program, why are chips and salsa offered?" "Who are you and who is funding this program?" "Why are you doing this?" "What are the qualifications of the health coach?" Personal issues about negative interactions with medical providers, drinking, smoking, and depression were brought up by participants but they declined to elaborate further. Instead, some participants approached the research team after the session to further explain their comments because they did not want to "air their dirty laundry" in the group. This group was also concerned about time and was eager to finish the program when their two-hour commitment had passed.

DISCUSSION

Overall, participants expressed a high knowledge of healthy eating and exercising, and all participants expressed

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interest in increasing exercise and healthy eating. This finding is very different from those of a needs assessment conducted three years ago by a health promotion program in one of the Latina communities, in which community members had little interest and awareness about healthy lifestyles.¹⁵

Even with this growing interest and knowledge, most participants experience challenges in maintaining lifestyle change. Other qualitative studies point to similar barriers and enablers to healthful behaviors found in this study, including personal, social, and environmental factors.¹⁶⁻²⁴ However, in this study we found that another powerful barrier to behavior change was self-blame for not doing what they were "supposed" to do. Healthy eating and physical activity seem to be an unattainable ideal because of the vicious cycle of attempts and failures, making each new try more difficult. Furthermore, healthy eating and physical activity are perceived as sacrifices, not a way of life, not enjoyable, suffering. In the end, participants blamed themselves for their lack of motivation. However, given the situation, healthy lifestyle changes may be impossible to sustain especially in their high-stress environment.

These group discussions provided us with rich information for adapting a lifestyle modification intervention shown to be effective in a research setting to our community settings. In the focus group discussion, we learned that disease prevention was rated very important by most participants, mostly

those with family and friends with chronic disease. Such personal experiences with disease can help them and others understand health consequences and prioritize healthy behaviors, including disease prevention, and may prove to be successful in engaging a larger group of people with different health priorities. Including the importance of health not just for themselves but also for the whole family may also increase participants' motivation.

We also learned that many women have high knowledge about healthy eating and physical activity. However, because fad diets and trendy recommendations (all meat, no carbohydrates) confuse people and are so prevalent in the media, we will include a review of the basics of healthy eating and physical activity. Providing information to fill the gaps and continued support can also help build confidence in their own knowledge and ability to make change. Information on portion sizes and delicious healthy alternatives to high-fat foods or ingredients as well as opportunities for safe and enjoyable group exercise were some of the needs mentioned in the discussions that the program will address.

Through the focus group discussions, we were made aware of the real challenges to making lifestyle changes. This understanding helps us to frame our program message in a more effective way and focus our approach to change. Program messages can include: 1) understanding that change is difficult but small steps make it doable; 2) implement changes that are enjoyable, not sacrifices; and 3) changes are not for now or the next six months but a way of life. In addition, this information can help health coaches think about relevant strategies and seek appropriate resources available in the community (such as free physical activity opportunities and inexpensive, convenient, healthy fast food options).

To deal with the challenge of maintaining the practice of healthy behaviors, our program will focus on

parts of the intervention regarding skill building and strategies to increase sustainability of healthy habits that women believe they can incorporate into their daily life. Sharing new skills in cooking, self-monitoring, problem solving, and stress and time management can provide the tools women need to make behavior changes and gain a sense of control, however small, over their situation. Additionally, incorporating specific changes into the daily routine as norms not as ideals is important for success. Individualized and attainable intermediate goals can help increase self-efficacy and motivation. These incremental changes allow the body time to change without discouraging participants as has happened in their past attempts to incorporate healthy behaviors into their daily routine.

Many also mentioned that being accountable to another person would help motivate them to action. As such our health coaches will not only help women incorporate healthy activities into their daily routine but also follow up on plans and strategies used. As sustainability of behavior change is important to our program, this follow up will decrease gradually in the second three months of the program when results from behavior changes have been seen and their own motivation and self-esteem can help sustain healthy behaviors.

In addition, we learned from the focus groups that for the younger group, the purpose and motivation must go beyond the superficial desire to look good in clothes toward a deeper desire to improve health for long-term lifestyle change. For the older group, we need appropriate physical activities given not only physical limitations but also to dispel perceptions that they look silly. For the Latina group we must work to turn participants' efforts to please the health coach into efforts to discover challenges and strategies to overcome them. For the African-American group,

we must focus on earning community trust and credibility through sharing our knowledge and maintaining a reliable program schedule. As trusted and reliable people, health coaches have the opportunity to support women in their efforts to translate knowledge to action with lasting and real outcomes. Our aim is for health improvement that lasts a lifetime and the framing of healthy eating and exercising as a way of life, not an unattainable ideal or a sacrifice.

This individual focus on health improvement can support women as they face the challenges in their environment. An important challenge and future direction is to find ways to make changes in the environment to support healthier lifestyles, such as safer streets for walking and parks for playing as well as having affordable fresh fruits and vegetables available in all communities. Such changes take a long time to become reality. In the meantime, women can benefit from obtaining the tools and skills necessary in making personal lifestyle changes in the face of their own reality.

ACKNOWLEDGMENTS

We would like to thank the support of our community partners whose time and effort made this study possible: Venice Family Clinic, Parents for Westside Renewal, Behavioral Health Services, Inc.'s Promotoras de Salud Project, as well as community leaders at various churches, senior centers, schools, and public housing communities. We also acknowledge the contributions of the UCLA/Drew Project Export Research Core: Arleen Brown, MD, Mayer Davidson, MD, Carol Mangione, MD, and Peter Mendel, PhD. The work for this paper was supported by UCLA/Drew Project Export (NCMH020MD 000148 and P20 MD000182), Resource Centers for Minority Aging Research/Center for Health Improvement of Minority Elderly (RCMAR/CHIME; NIH/NIA 3P03AG021684), and NIH grant 5P30AG021684-02, and the UCLA/RAND Center for Research

on Quality in Managed Care (NIMH MH068639).

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