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The Experiences of African American Women Participating in Church-based Weight Loss Programs

Mangle L. Shanks
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Walden University

College of Health Sciences

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Mangle L. Shanks

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2017

Abstract

The Experiences of African American Women Participating in Church-based Weight Loss

Programs

by

Mangle L. Shanks

MBA, Jackson State University, 1978

BS, Jackson State University, 1976

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

August 2017

Abstract

While obesity is a nationwide phenomenon, African Americans – especially women – continue to be more severely affected than any other ethnic group. According to the Centers for Disease Control and Prevention, over 20% of African American women are obese compared to 15.6% of Caucasian women. The church is an important community center for many African Americans, and is often a site for health promotion programs, though little is known of the effectiveness of these programs. The purpose of this qualitative study was to study the experiences and attitudes of African American women who have gone through a church-based weight-loss program. Questions were asked about the cultural, environmental and social barriers to weight loss, and the components of effective church-based weight-loss programs. Using a phenomenological approach, this study was designed to capture new data for the development of sustainable church-based weight-loss programs. The theory of social support was used as a theoretical framework. The major themes arising from the data concerned the importance of: (a) social support on all levels; (b) the involvement of the pastor, his spouse, or other church leadership; (c) the inclusion of weight-loss participants in program design; (d) a holistic program design to meet the needs of the entire family; and (e) a culturally sensitive program. The inclusion of all these elements is recommended for future programs. The social change implication is that these recommendations could be helpful in the design, development, and implementation of sustainable church-based weight-loss programs for African American women.

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Dedication

Approximately ten years ago, I was invited to a meeting by the late Dr. Lovetta Brown to attend a community meeting in Grenada County, Grenada, MS. I thought that the information to be shared would be about how to collaborate with various organizations to promote social change unrelated to health within the community. Little did I know it was all about the prevalence of Type 2 diabetes. At this time, I was enrolled in my first quarter at Walden University, pursuing a Ph.D. in Management. After sitting through that seminar, I learned many things about chronic diseases, but most of all, I learned that “everyone does not have to get diabetes”. This changed my whole perspective on life, evoked my passion and motivated me to change my major to public health.

My career had been primarily in Business Administration, and sadly I had no knowledge of matters related to the public health arena. Prior to this meeting, if anyone mentioned public health, my first thought was the health department. Even though I was aware of various diseases such as hypertension, diabetes, cancer, heart disease, stroke and the like, I never knew these were called chronic diseases. All of my life, I was under the assumption that diabetes and other chronic diseases simply came with age, or because those diseases ran in your family, not knowing that they were strongly related to lifestyle choices and unhealthy behaviors. After starting this new relationship with Dr. Brown, I realized she was a medical doctor and Director of the Office of Health Disparities and Elimination with the Mississippi State Department of Health. It became a lasting and loving partnership until her demise. After various trainings and workshops, this relationship placed me in a position to apply for and receive two mini grants through Dr.

Brown's office, totaling \$12,000, which enabled me to conduct my first health promotion programs. Shortly thereafter, I obtained another mini grant totaling \$3,000.00 from the Office of Preventive Health from Ms. Betty Daniel, Director of the Diabetes Program. These two ladies' faith in me to promote change in my church and the community changed my life. My health promotion programs were focused on the prevention of diabetes in African Americans by promoting physical activity and better nutrition, with an underpinning goal to reduce obesity, a contributing factor of many chronic diseases according to the Centers for Disease Control and Prevention (CDC, 2014).

The aforementioned health promotion programs became springboards leading to my involvement in many other community and faith-based health promotions. All of these activities motivated me to pursue a degree in public health, which will afford me the opportunity to promote social change, by helping to improve the quality of life for individuals, families and communities through health promotion programs. I dedicate this dissertation to the late Dr. Lovetta Brown, Ms. Betty Daniel, Mrs. Dora Lee Wren, my mother. Finally, and most of all, I give the ultimate thanks to my constant companion, Jesus Christ, my Lord, my Savior and the head of my life. The sum total of my journey is embodied in the following scriptures: "I can do all things through Christ which strengtheneth me." Philippians 4:13 (KJV); "But they that wait upon the Lord shall renew their strength; they shall mount up with wings as eagles; they shall run, and not be weary; and they shall walk, and not faint." Isaiah 40:31. (KJV)

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I would like to thank my mother, Mrs. Dora Lee Wren, a retired educator for her enthusiasm, encouragement and constant push toward my completion. I would also like to thank my daughters, Tara Yvette Wren who was always there as a sounding board and to provide technical support and Tonya Denise Wren McGriggs who was always excited, inspired and encouraged about my journey.

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I would like to thank my former employer, Experience Works, Inc., for a flexible schedule that allowed me to work many hours toward this dissertation, which would have been impossible in a traditional setting. Finally, thanks to the Jackson Hinds Library System, and to the Hilton Garden Inn, Starkville, MS for providing resources that allowed me to continue my research as I traveled extensively with my job.

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Chapter 1: Introduction to the Study

Introduction

Chronic disease is at epidemic proportions in the United States. Obesity is often linked to chronic diseases such as hypertension, Type 2 diabetes mellitus, heart disease, stroke, kidney disease and cancer (Centers for Disease Control and Prevention [CDC], 2014). In the state of Mississippi, the burden of obesity and chronic disease is excessively high. In 2016, the state of Mississippi held the adverse title of the second “Fattest State in the Union” (CDC, 2016), with the state of Louisiana being the highest. As reported by the Mississippi State Department of Health (MSDH, 2016) the five most common causes of death in Mississippi in 2011--some of which were more prevalent than the United States as a whole--were heart disease, cancers, unintentional injuries, chronic obstructive pulmonary disease, and stroke. Prior to that, in 2003, over 1.8 million cases of seven chronic diseases--cancers, diabetes, heart disease, hypertension, stroke, and pulmonary conditions--were reported in Mississippi (DeVol, 2014). The MSDH (2014) also reported that in 2007, 34% of the adults in Mississippi had hypertension and of those 39% had high cholesterol levels that put them at greater risk of stroke or heart disease. This burden of chronic disease not only disrupts the well-being of individuals and their families, it also impacts the economy, with high health care costs and loss of productivity.

The causes of obesity include a combination of environmental, genetic, and individual lifestyle factors. In order to minimize or prevent the proliferation of adult obesity among African Americans (AAs), scientists concur that at a minimum, individuals must focus on a healthier dietary intake, more physical activity, and other lifestyle changes (Bacon & Aphramor, 2011). I looked at a much broader picture, to prevent the escalation of adult obesity, a constant and rigorous focus should be placed on childhood obesity.

Like other children, obese AA children and adolescents tend to become obese adults with all the morbidities associated with obesity (Story et al., 2003). The increasing prevalence of obesity among AAs increases the risk of obesity for their children. (Freedman, Khan, Serdula, Ogden & Dietz, 2006; Salsberry, Regan & Pajer 2009; Williamson & Kautz, 2009). As a result, Nsiah-Kumi et al., (2012) suggested that physicians should counsel parents on obesity health concerns for their children. They also averred that if obesity is not seriously addressed, all the children that are 11 years old will likely become the adults that are treated in 10 years for chronic disease (Nsiah-Kumi et al., 2012). Throughout the United States, obesity is fueling the escalation of many of the chronic diseases in adults, and the problem is growing; in 2014 1.9 billion adults 18 years of age and older were overweight, and of these 600 million were obese (World Health Organization [WHO], (2015).

Obesity and chronic diseases among the AA population are disproportionately higher than among other racial groups, and efforts to reduce this disparity typically require that all stakeholders work together to promote wellness (CDC, 2013). One strong entity in helping with this unmet need could be AA churches, which have been resourceful in reaching a broad population from a spiritual and social perspective, and could also help combat chronic disease (Campbell, et al., 2007).

The AA or Black church includes communities of various Christian denominations (Giger, Appel, Davidhizar & Davis, 2008). The AA church is viewed increasingly and vigorously as a resource in the reduction of obesity and chronic disease. (Baruth & Wilcox, 2013; Odulana, et al., 2013). As such, churches are ideal establishments for health promotion projects, because many AAs are in regular attendance (Campbell, et al., 2007). The AA church is a host for the population at greatest risk for chronic disease. The congregation is accessible; its members are skilled in areas needed to develop, organize and implement programs; and there is a mixture of influential individuals who can help provide empowerment, social support, and establish social networks.

Background of Study

Prior to the 21st century, the leading cause of death was infectious disease (CDC, 1999), but chronic disease has become overwhelmingly prevalent in the United States. According to the CDC (2014), chronic diseases are the primary

cause of death and disability in the United States. Diseases such as cancer, diabetes, arthritis, heart disease, and strokes are the most prevalent, costly and, preventable. The CDC (2015c) reported that chronic diseases are responsible for seven of the ten leading causes of death, along with the three leading causes of preventable death, which are: improper tobacco usage, insufficient physical activity, and poor nutritional habits.

Chronic diseases are very debilitating, but when individuals decide to self-manage any existing chronic disease it substantially reduces the severity and prevalence of the chronic disease (Cory, et al., 2010). According to Danaei, et al., (2009), a number of modifiable mortality factors related to chronic disease are due to preventable causes associated with lifestyle and dietary changes.

Authors have pointed out that prevention is cheaper and more humane than treatment. Kapustin (2010), for example, reported that 95% of all health resources are allocated for healthcare treatment, while only 5% are available for practicing prevention. This is an overarching problem that greatly affects efforts by states to gain an optimal health status. Kapustin (2010) stated that for efforts to reduce the cost of medical care and treatment there must be synergy with organizations. The organizations must have the same focus on prevention, policy, and public health to increase the percentage of dollars to spend on prevention and community health. A good example of this is found in the U.S. Department of Health and Human Services' Healthy People 2020 report, with objectives to focus

on prevention as a precursor to a health determination (Halle, Lewis, & Seshamani, 2009).

With the small percentage of health funding available for prevention, there is considerable disparity between genders within the AA community. The literature I reviewed did not provide a definitive answer why there was less focus on AA men, but programs directed toward AAs prior to 2007 focused primarily on women according to Banks-Wallace and Conn, (2002), Campbell et al.(1999), and Peterson, Atwood, and Yates (2012), and Sutherland, Barber, Harris, and Cowart (1992). Therefore, to make an impact across the entire AA community, equal access to health promotion programs by both genders that focus on the reduction of weight loss and chronic diseases is crucial.

Problem Statement

In Mississippi, the prevalence of preventable chronic diseases (cardiovascular disease, diabetes, cancer, and obesity) and their associated risk factors is higher than in any other state in the nation (MSDH), 2016). For example, in Mississippi, a southern state, the prevalence of cardiovascular disease reported in 2003 was 250,000 cases while in Montana, a western state, only 54,000 cases were reported (DeVol, 2014). Likewise, the economic cost for these cases is higher in Mississippi, at \$15.4 billion compared to Montana at \$4.0 billion (DeVol, 2014). The difference suggests that location, lifestyle and culture have a significant barrier on the prevalence of chronic disease. The cost of

healthcare associated with chronic diseases is astronomically high, and has a significant negative impact on the state's budget (MSDH, 2016).

The burden of chronic disease falls especially heavily on AAs more than any other ethnic or racial group (Debnam et al., 2012). The CDC reports that in 2013, AAs made up 13.2% of the population in the United States. This number was over 41.7 million people, with 55% of them living in the South, where the highest rate of chronic disease exists (CDC, 2015). I am convinced that continued effort should be placed on ways to reduce the prevalence and proliferation of chronic disease within in this population.

Purpose of the Study

The primary purpose of this research project was to understand the emotions, attitudes, and experiences of AA women concerning obesity, weight loss, and the effectiveness of health promotions in a church-based setting. Of interest was the discovery of factors from the cultural, social, and environmental perspectives that can influence future approaches to obesity prevention. I used a qualitative method with the phenomenological approach, using semi structured, face-to-face interviews to collect data. The data obtained from these AA women participating in my research documented their experiences as they went through a church-based health promotion program.

Research Questions

The overarching research question was: What are the experiences of African American women participating in church-based health promotion programs?

There are seven research questions as follows:

RQ1: What barriers do African American women face in their efforts to lose weight?

RQ2: What factors influence the success or failure of African American women participating in church-based health promotion programs?

RQ3: What type of social support do African American women need to help them achieve and maintain their weight loss goal?

RQ4: What verbal and written educational information helps African American women understand the relationship of weight loss to chronic disease risk and improved quality of life?

RQ5: How do African American women feel about church-based health promotion programs in comparison to other types of health promotion such as Weight Watchers?

RQ6: How do African American women feel the role of the church in health promotion programs could be expanded?

RQ7: What is the role of African American women's spiritual beliefs concerning weight loss as they go through a program?

Theoretical Foundation

According to Creswell (2013), the theory selected by the researcher guides the research pattern, the research questions, and the manner in which the researcher conducts the research. I grounded this research in the social support framework. This theory seeks to explain how individuals are able to help each other as they deal with challenging situations in their lives, such as achieving weight-loss goals by increasing physical activity and their consumption of fruits and vegetables. For example, in a study focusing on cardiovascular risk for AAs in six churches in Florida, participants reported that they would increase their intake of fruits and vegetables when “encouraged by others” or had someone they could “rely on” to support their decision to eat more fruit and vegetables (O’Neal, et al., 2014).

The role of social support appears to be a key factor to promote positive behavioral changes in health promotion (Wells & Anderson, 2011). Wells & Anderson also contend that a lack of social support negatively impacts all health outcomes. I examined the social support framework in the literature review, and used this framework to determine how program participants view this protective factor and to identify its role in the results of the program.

Nature of Study

This was a qualitative study focusing on AA women who have gone through a church-based health promotion program to lose weight. A qualitative

design using a phenomenological approach was best suited for this study because it allowed me to gather data on the in-depth experiences of these women. I aimed to compare the themes from the literature review with the themes uncovered through the face-to-face interviews to develop stronger church-based weight reduction programs in the future.

I obtained the data through face-to-face interviews, using a questionnaire containing open-ended qualitative questions. I used the results to gain a deeper understanding of the participants' attitudes and perceptions upon completion of a weight-loss program. The knowledge acquired during these interviews will translate into new knowledge for the planning and implementation of new and more effective weight loss programs focusing on weight loss maintenance and program sustainability.

Operational Definitions

African Americans: The U. S. Census Bureau (2010), reports that African Americans can be referred to also as blacks or Negros. This designation dictates a social and racial significance within society among other denominations of people.

Church-based: Of or related to any religious or spiritual references such as the Bible, praying, reading scripture. (Seale, et al 2013; Duquin, McCrea, Fetterman, & Nash, 2004; Duru, Sarkisian, Leng & Mangione, 2010)

Chronic Disease: Non-communicable diseases (NCDs), also known as chronic diseases, are not passed from person to person. They are of long duration and generally slow progression. The four main types of non-communicable diseases are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. (World Health Organization [WHO], 2014)

Culture Sensitivity: This is defined by two dimensions: surface and deep structures. Surface structure involves matching interventions materials and messages to observable, “superficial” characteristics of a target population. This may involve using people, places, languages, music, food, locations and clothing familiar to, and preferred by, the target audience. Surface structure refers to how well interventions fit with specific culture. Deep structure includes cultural, social, historical, environmental and psychological. (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1998)

Faith-based/Faith-placed: Usually related not necessarily to a church, but to organizations that focus on project or programs with the underpinning of spiritual or religious values. (Williamson & Kautz, 2009)

Health: a state of complete of physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948). The definition has not been amended since 1948.

Health Promotion: The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior toward a wide range of social and environmental interventions. (WHO, 1986)

Lifestyle: *Lifestyle* (lifestyles conducive to health) is a way of living based on identifiable patterns of behavior which are determined by the interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental living condition (Nutbeam, 1998).

Assumptions

The assumptions that underline this study were as follows: (a) all participants will understand the purpose of the study, (b) all participants are willing to participate because they were genuinely concerned about their health and would provide their answers freely and honestly, (c) the written and verbal content of the protocol are clear and easily understood by participants, (d) the questions asked are not too personal or invasive, (e) that participants who still need to lose weight may consider a behavior modification, and (f) participants are willing to discuss and share their experiences in this study because they believe it will benefit their health, family, friends and others.

Scope and Delimitations

The scope of this study was limited to AA women in the Jackson, Mississippi area who have participated in a church-based health promotion. The primary focus of the study was to understand the barriers these women face as they go through a weight loss health promotion, and to understand their experiences. In some of the literature reviewed,

there were reported barriers and some of the success of women losing weight. I endeavored to uncover other barriers and information that could be transferred into knowledge for future research. The results of this study are pertinent to this population only, and cannot be generalized to AA women living in other places.

One delimitation of this research was that only AA women were selected for the study. The participants self-reported a varied age range, and that they were either obese or overweight. The participants were dealing with one or more chronic disease or wanted to prevent the on-set of a chronic disease by participating in the weight loss health promotion.

Limitations

Several limitations existed in this study. The participants in this study were from the same geographic area and all the participants were involved in the same weight loss promotion. Since the participants in this study were from the same area it could limit the generalizability of the overall results in other church-based health promotion programs. I developed the interview instrument. Creswell, (2013) stated that a self-developed interviewing instrument is a potential weakness that may affect the validity and accuracy of the data and the quality of the data was largely dependent on my experience. (Patton, 2002a). Lastly, the final limitation is the potential emotional vulnerability that might arise among respondents.

Significance of Study

The significance of this study is that chronic disease among the AA population is continuously escalating, regardless of persistent national, state, and faith and church-based health promotions. Chronic diseases continue to proliferate and the AA community continues to suffer more than other ethnic groups (Debnam, et al., 2012). Subsequently, the data gathered from this study may provide information that will help reduce death and disability caused by chronic disease.

Another reason this study is significant is that it highlights the power and the value of the AA church and its ability to be a change agent within the community. The church is a crucial leader and a powerful institution to aid the public health sector in the fight against chronic disease. The church has an opportunity to play a major role in health sciences from all levels of prevention such as primary, secondary, and tertiary prevention because of its direct access to this population.

The findings of this study can be replicated to help other AA women be successful in their weight loss and help churches build sustainable CBHPP programs. The findings will also provide vital information to other researchers, public health practitioners, and key stakeholders.

Significance to Practice

This study was intended to uncover relevant data concerning how AA women can decrease their obesity rate and reduce the rate of chronic disease in the AA community. Overall, any findings to reduce obesity is extremely relevant in regard to the economic

cost it has on the health care industry and significantly on the impact it has on those suffering from such disease.

Additionally, another gap is along the lines of cultural beliefs. The relevance of participant's inclusion in the beginning phase of planning a church-based health promotion program and using a holistic approach to help obtain a healthier lifestyle is paramount. The overall public health implication is that it will add to the knowledge base across the public health sector and toward the goals of future research. The new data can be simulated through church-based health promotions programs to enhance new methodologies that can promote vital changes to accomplish a healthier AA community.

Significance to Social Change

This study provided insight into the varied lifestyles of AA women. The knowledge of certain contributing factors such as their culture, social environment, and spiritual beliefs can have a significant positive impact that can contribute to positive behavior modifications. The findings concur with other findings that obesity and chronic disease are disproportionately higher among the AA community. The information gathered from these women can be useful knowledge to promote effective positive change by understanding the components needed to design and maintain sustainable church-based weight-loss programs.

The study findings uncovered the women's experiences, attitudes, and emotions concerning obesity and being overweight which have a strong impact on chronic disease. The results from the data gathered can also help to engage, empower, and educate

individuals involved in church-based health promotion programs to make healthier lifestyle choices.

Summary

Chapter 1 included the background of the study, the problem statement, the purpose of the study, the nature of study, the theoretical framework, and the gap in the literature as it relates to the lack of in-depth information on the views, attitudes, and experiences of AA women who have gone through church-based weight-loss programs. The information collected in this study uncovered barriers, cultural and environmental influences that hindered participants from achieving their weight-loss goals. Additionally, this chapter included definitions, assumptions, the scope and delimitations, limitations, significance of study, significance to practice, significance to theory and significance to social change. Chapter 2 includes the literature review, and the data that provided an overview of other studies of church-based health promotion programs that focused primarily on AA women.

Chapter 2: Literature Review

Introduction

In this chapter, I analyzed studies primarily concerning AA women participating in church-based health promotion programs (CBHPPs) designed to change behavior and thereby reduce obesity and improve health. These programs focused primarily on an increased consumption of fruits and vegetables and increased physical activity. According to WHO, the increase of chronic diseases such as diabetes, cancer, and cardiovascular diseases escalates when unhealthy foods are consumed and physical activity is limited (WHO, 2014). Lee et al., (2011) and Mozaffarian, Hao, Rimm, Willett and Hu (2011) both reported that these lifestyle factors are modifiable, and deaths related to chronic diseases can be reduced when these lifestyle changes are made.

The primary purpose of this research project was to understand the experiences of AA women concerning obesity, weight loss, and the effectiveness of CBHPPs. As I reviewed the literature, CBHPPs are viewed favorably as a conduit for better health outcomes in the literature. For example, Campbell et al. (2007) stated that, since the church can reach a wide-range of individuals at one time, the possibility to reduce chronic disease is increased when church-based programs are available. Also, Clay, Newline, and Leeks (2005) stated that the church is a place where AA can be empowered and it can be a pathway to reach this population with health promotion programs. However, there is a paucity of

research concerning participants' successful continuation of the knowledge and practices gained in the promotion after it ends. In this study, I gathered information regarding the experiences of individuals who participated in a weight loss CBHPP to determine how the program impacted their lives. In this chapter, I reviewed the literature on the general structure of various CBHPPs and the associated behavioral changes and lifestyle modifications reported.

Literature Search Strategy

The primary source of information used to obtain and select scholarly and peer-reviewed articles was the Walden University Library, which connects with multiple databases. The databases explored for this search included Academic Search Premier, SAGE, PubMed, EBSCO, ProQuest, CINAHL, MEDLINE, SAGE, Science Diet, SocIndex, and ERIC. Using these databases, I reviewed approximately 329 articles through July, 2015 to identify articles pertinent to the research. The following key phrases were searched: *weight loss programs, African American church-based interventions, African Americans church-based health promotions, faith-based interventions, chronic disease and African Americans, health disparity among African Americans, community-based health promotions, perceptions of weight loss programs among African American women, attitudes of African American women concerning weight loss programs, health interventions, and health promotions*. I also used text books to review certain methodologies, various frameworks, and specifics for the

qualitative approach known as a phenomenological research. Google Scholar was also used to identify CBHPPs.

Theoretical Foundation

The theory I used in this dissertation was the theory of social support (Barnes, 1954). Barnes, a social anthropologist from Australia, introduced the first description of social support. He conducted a “community study” and discovered that despite the cultural values of the community, many of the individuals’ decisions were influenced by communication with other personal contacts rather than those within the formal organizational structure.

Other authors explained how theories are viewed. According to Latkin (2010), a theory should guide the researcher, allow for insights in the study, and broaden its perspective. Despite the usage of existing theories in health promotion, Freudenberg et al. (1995) revealed that theories only provide a “casual” explanation and “often fall short of meeting the needs of the practitioners’ needs.” (p. 296). In this study, I used the theory of social support to construct interview questions to explore the extent to which women experience social support and to identify if it was beneficial or an unfavorable experience.

Social support is a supportive behavioral relationship categorized by emotional support that includes concern, instrumental support consist of the provision of resources, and informational support, consists of advice, and appraisal support, provides positive affirmations (Parker, Baldwin, Israel &

Salinas, 2004; Parham, 1993). The theory of social support has developed rapidly over the last 30 years with positive results (Thoits, 2011). There is a continuous need for researchers to study the social support theory further to explore how much more the usage of this framework can help provide positive results in health promotions.

Authors of a study that measured social support among AAs who had end stage renal disease (ESRD) reported positive results and pointed out that the overall quality of life of participants improved because of the social support among the patients. (Wells & Anderson, 2011). The literature reported that as the patients went through dialysis they were given a personal resource questionnaire to measure their level of perceived social support. The social support for the patients came in the form of the provision of resources (instrumental support), problem solving assistance (informational support), and physical assistance, all of which helped their overall sense of self-esteem and social well-being (appraisal support). Wells & Anderson, (2011) also noted that ESRD is very debilitating, but they believed, based on the results of the questionnaire, that the reason social support was high among the patients was because of their frequent interaction with the healthcare team that provided the support the patients needed (Wells & Anderson, 2011).

Groh, Jason, and Keys (2008) described the success with participants who were enrolled into an Alcoholics Anonymous program. They reported that social

support provided positive results in both qualitative and quantitative studies for those with harmful habits and for individuals in the recovery mode. The authors of this study reviewed 24 papers to examine the connection between AAs and the variable of social support. All forms of support such as informational, appraisal and instrumental led to the recovery of patients with their involvement of friends, family and others (Groh, et al., 2008).

Holden, et al. (2015) reported on positive results of social support for the overall general health within an Australian population; O'Neal, et al., (2014) reported an increase of fruits and vegetable intake among AA adults; Thoits (2011) reported on the positive relationship between social support and physical and mental health. Another form of social support is peer coaching. This type of social support was used in a study to help those combating the chronic disease of diabetes (Joseph, Griffin, Hall & Sullivan, 2001). In this study, an individual who had diabetes relied on the support of others who had controlled diabetes to serve as their mentors. The participants found positive results through face-to-face contact, telephone calls, and focus groups. The participants shared their problems, ideas and their efforts to change their behaviors. Coaching allowed for support of others as they endeavored to obtain self-efficacy. In this same study, the researchers found that the "Buddy Support" system which promoted the concepts of social support aided in smoke cessation.

Church-Based Weight Loss Programs

This review looked at CBHPPs targeting weight loss. There were only a few studies that examined and described the experiences of individuals participating in physical activity. The lack of physical activity escalates chronic diseases, often leading to a reduced quality of life, morbidity and mortality. After reviewing the literature I was able to identify that AA women was the primary research participants in these health promotion programs. The studies for this research are listed in the following table.

Table 1

Church-based Weight Loss Programs

Health Promotion (Acronym)	Author	Year	Health Promotion Focus
Black Churches United for Better Health (BCUBH)	Campbell et al.	2000	Nutrition
Eat for Life Trial (EFL)	Resnicow et al.	2001	Nutrition
Body and Soul	Resnicow et al.	2004	Nutrition
Healthy Body Healthy Spirit Trial (HBHS)	Resnicow et al.	2002	Nutrition and Physical Activity
The Bless Project	Williamsom and Kautz	2009	Physical Activity, and Weight Loss
PATHWAYS	McNabb et al.	1997	Weight Loss
The Doctorate of Nursing Practice Project (DNP)	Rigsby	2011	Physical Activity, Nutrition and Weight Loss
H.U.B. City Steps	Zoellner et al.	2011	Physical Activity, Nutrition and Weight Loss
Heart and Soul Program (HSPAP)	Peterson et al.	2012	Physical Activity
Sisters in Motion (SIM)	Duru et al.	2010	Physical Activity
The Genesis Health Project	Cowart et al.	2009	Nutrition, Physical Activity and Weight Loss
Project Joy	Yanek et al.	2001	Physical Activity and Weight Loss
Wholeness, Oneness, Righteousness, Deliverance (WORD)	Kim et al.	2008	Nutrition and Physical Activity
Wellness for African Americans through Churches (WATCH)	Campbell et al.	2004	Nutrition and Physical Activity
Life Project	Parker et al.	2010	Nutrition, Physical Activity and Weight Loss
Fan, Activity, and Nutrition Program (FAN)	Wilcox et al.	2010	Nutrition and Physical Activity

Programs focusing on Nutrition

Campbell et al., (1999) evaluated a study on increasing the consumption of fruit and vegetables (F&V) through The Black Churches United for Better Health Project (BCUBH) (1999). This was a 4-year project conducted among 50 rural AA churches to promote the national 5-a-day for Better Health Program organized by the National Cancer Institute (NCI) and the Produce for Better Health Foundation to increase F&V to prevent certain cancers and reduce chronic disease. (Campbell et al., 1999). There were nine other interventions funded through the NCI during this period, but the BCUBH was the only intervention that included African Americans and churches. This study on cancer and chronic disease is especially interesting because it highlights how AA are disproportionately affected by all types of chronic diseases, and how churches can be effective in helping participants improve and increase dietary intake. I observed that there was no physical activity mentioned in this study; dietary changes were made after participants were involved in gardening, modification of cooking habits and methods to include more F&V. The authors used an ecological framework and a multi-component approach, meaning that activities focused on various levels such as “individual, social networks, and community.” In this study, the theories used were the stages-of-change, social cognitive theory, social support, self-efficacy and activities based on the precede-proceed model,

which is used to identify “predisposing, enabling, and reinforcing factors related to increasing the consumption of F&V” (p. 1391-1392).

The findings from this study had commonalities with other research studies in the literature that showed that once participants are exposed to a health program, they learn how to make better choices and healthier outcomes are realized. Peterson et al., (2012) also suggested that the increased consumption of F&V in this study was directly correlated to the frequency of church attendance for members who attended more days weekly over those who attended once a month. The intervention was successful in improving the nutrition among AAs based on results of program evaluation. The authors also suggested that social support and social networks promoted the successful strategies that encouraged the increase of F&V.

The Eat for Life Trial (EFL) was an evaluation conducted by Resnicow et al., (2001) on measuring the amount of F&V consumed daily among AA. This study was conducted in Atlanta, Georgia among 14 churches (Baptist, Methodist, & AME) serving a total of 1,011 individuals within various socioeconomic groups among the congregations. All participants received baseline screenings and guidelines on the intervention.

The findings concurred with Bopp, et al., (2009) in the Health-e-AME-e-Fit program that AA consumes less than the daily recommended amount of F&V. This established finding solidified the fact that AAs are continually at risk for

reducing health outcomes due to the low consumption of healthy foods based on their cultural cooking practices and sedentary lifestyle.

This study was a motivational interviewing intervention (MI), a form of social support, in which participants were contacted by telephone to encourage their consumption of the 5-A-Day message, a reminder to eat the daily recommended amount of vegetables. For continued daily support, participants were given other information such as, but not limited to, a nutritional cookbook, a video with a spiritual premise, educational materials, and other reminders such as writing tablets and refrigerator magnets.

In this study, only self-efficacy was mentioned but social support was provided through MI. According to (Freudenberg et al., 1995) self-efficacy is the confidence level of an individual that helps them to take the right action to protect their health. In conclusion, the goal was to move participants to 5-A-Day vegetable intake; the results of this study confirmed MI helped participants to increase their F&V intake ranging from 3.45 to 4.28 servings a day. The findings also concurred with other studies that the black church is a premier place to positively impact the health of AAs through CBHPP, because the church has access to a broad population and can influence so many individuals in one setting to promote better health outcomes (Resnicow et al., 2001).

Body and Soul was a weight-loss CBHHP intervention evaluated by Resnicow et al., (2004). This intervention was collaboration between two

universities, the American Cancer Society (ACS) and the National Institutes of Health (NIH). This intervention was conducted in AA churches using foundational components of two other dietary and F&V interventions, BCUBH and EFL. The BCUBH intervention aimed at increasing F&V in rural AA churches to combat cancer and decrease chronic disease, and the EFL intervention used motivational interviewing to increase the consumption of F&V. The primary emphasis of this study was to decrease obesity in AA females within specific communities. Typically, interventions develop partnerships to obtain additional resources to assist with associated costs of the health promotion, uniquely, Body and Soul was operated and supported by church leadership and church volunteers within the congregation.

Body and Soul used the following components of BCUBH and EFL: pastoral support, environmental change activities, health education, promotional activities, and peer counseling. The theoretical framework for the Body and Soul study was based on the constructs of social support and self-efficacy. The results of the intervention showed an increase in the consumption of fruit and vegetable consumption, increase of physical activity and a reduction of the systolic decreased. According to Campbell et al., (2007) the success of the Body and Soul intervention was so paramount that National Cancer Institute recommended that whenever this research-based model is replicated using volunteers and lay counselors it can help prevent cancer disparity. The authors concluded that

CBHPP success can be realized when there is collaboration of volunteers, community partners and social support.

The Healthy Body Healthy Spirit Trial, (HBHS) was an evaluation conducted by (Resincow et al., 2002) on the consumption of F&V among AA adults in churches. Researchers used two theories to test the increase of F&V intake, self-efficacy and social support. To collect the data on SE a 10-item behavior-specific scale was used and a three-item scale was used to measure SS. This intervention took place in Atlanta metropolitan area among 16 churches. The number of AA adults recruited was 1,021 at health fairs of which 76.2% were women.

There were three groups in this intervention. Group one received educational literature from government and other relevant sources; group two received materials targeted on culture specific materials for AAs; and group three received MI and the culturally targeted material. All of the material was designed to have a focus on self-efficacy and social support toward the consumption of more F&V. The highest consumption level of F&V was 17% among group three, but it was not clear of the percent among groups one and two. The reason cited for the increase on F&V for this group was due to the “multidimensional model” that provided culture sensitivity literature, discussion on values, focus groups, participants had a trained psychologist to conduct the MI and they also talked with them about nutrition and physical activity. The authors reported that the SS

and the SE of the participants had a significant effect on the improved consumption of F&V.

Programs focusing on Nutrition, Physical Activity and Education

The Bless Project launched the “Let’s get moving: Let’s get praising” health promotion to combat Cardiovascular disease (CVD) and stroke among African Americans in a small country church in rural North Carolina (Williamson & Kautz, 2009). This project was launched solely by a congregational health nurse to bring about awareness and education of CVD and stroke using a train-the-trainer concept. The importance of physical activity and nutrition was discussed concerning combating this disease. This project was unique in that it used a combination of “faith-placed” meaning a group such as Weight Watchers (WW) meeting in churches focusing on screenings, education and the guidelines of the WW program. The “faith-based” aspect promoted spiritual focused sessions, spiritual activities such as prayers and songs. The success was measured by the number of individuals trained to educate the congregation on stroke and CVD risk factors and risky behaviors and the full participation of all church leaders and the membership.

The authors emphasized that churches must take “church ownership” of their health promotion program because it will be impossible for one nurse to keep a program alive. As noted in Project Joy, Yanek, et al., (2001) success was realized in their physical activity program when the pastors’ wife attended and a

drop in attendance when she was not present. In addition to the church being involved, the authors also emphasized the importance of developing “knowledgeable caring community partnerships” that have a health concern or a health focus. To sustain a health promotion program over time can be expensive and overpowering, causing health programs unable to continue overtime.

The Pathways health promotion evaluation, according to McNabb et al., (1997) was a 14-week church-based weight loss program that tested how effective an “active-learning” weight loss program would be for 39 obese AA women with diabetes. The 14-week program focused on reducing obesity through a “highly structured” program that provided information that was culturally sensitive. The program was led by trained lay volunteers and focused on behavior changes, eating behaviors, problem-solving techniques and physical activity. Three churches participated. Each of the three churches followed the same structure and all had facilitators and trained lay volunteers. During the intervention, the Pathways participants lost 5% of their body weight by choosing their own foods that was low in fat and increasing physical activity, while the control group gained a “modest” weight. The primary focus of the Pathways program was not to measure weight loss but to test how well participants would listen, learn and apply the techniques to have a better health outcome. The results of the study suggested that weight loss was similar or greater to other behavioral weight loss studies among AA women.

The Doctorate of Nursing Practice Project (DNP) (Rigsby, 2011) conducted a 12-week, lifestyle modification program for 36 AA participants in a church in southwest Alabama to improve hypertension. The purpose of this program was to promote physical activity, increase F&V, provide education on CVD, and to improve the control of high blood pressure (HBP). The author reported that 100% improved their physical activity, 96% had reduced high blood pressure, 40% improved their F&V intake, 94% had increased knowledge of HBP and its risk factors, and 55% experienced weight loss. The percentage of women in this study was 80.56%.

The author attributes the success of this project to the involvement of the pastor and the congregation. The participants promoted a continuance of the same program to start a community-based program so they could maintain their success and spread it throughout the community. The pastor also started an intervention for the entire community by establishing a physical fitness and health awareness program.

H.U.B. City Steps was a community-wide walking program using a CBPR approach. The evaluation of this behavioral health intervention was organized to reduce hypertension by increasing physical activity and reducing CVD among AAs in Hattiesburg, MS. (Zoellner et al., 2011). There were 269 participants enrolled in the health promotion of which 85% were women. The project used SS, MI and community involvement to accomplish the goals of increased physical

activity, selection of healthier food choices and to test the effectiveness of the walking program in the reduction of high blood pressure. The project was designed using cultural sensitive literature, peer coaches, health educators and community partnerships. The data at three-months was only sufficient enough for the authors to notate that the adherence to participants self-monitoring was better than the attendance at the education session and that HBP showed a significant decrease. According to Zoellner et al., (2014) the blood pressures continued to improve among the AA community at the six-month follow-up. The authors noted that this intervention was the first CBPR approach to measure the effectiveness of a lifestyle intervention on HBP and related results.

Programs focusing on Physical Activity

The Heart and Soul Program, (HSPAP) was a twelve weeks intervention aimed at increasing physical activity among AA women in a CBHPP evaluated by Peterson et al., (2012). This project focused on empowering the participants to be supportive of each other as they strived to achieve better health outcomes. One of the overarching elements that resonated in this project to ensure its success was developing partnerships on every front. Therefore, to attain this goal, the study was initiated in the church but it developed a “community-focused approach.” This program followed suit with other CBHPP by using scripture, prayer, spiritual messages in church bulletins and pastors sharing health messages in sermons to help change negative behaviors. While the expected outcome of this project for

participants was to increase physical activity, social support was viewed as the pathway that would help to sustain any goal accomplished by the participants.

The authors explained that the project was staged in a predominately AA church to increase physical activity to combat cardiovascular disease (CVD) among AA women. It was expressed that the propensity of AA men and AA women to be disproportionately affected by chronic diseases such as cardiovascular disease was very high. Social support was viewed as the theoretical framework along with the social comparison theory. This theory postulates that the relationships between individuals strengthen social support and builds self-esteem.

One unique element of the HSPAP was that it was originally tested on Caucasian women in a clinical trial and the authors only stated the physical activity for the Caucasian women was moderate. On the other hand, authors of the CBHPP version of HSPAP concluded that this study is a model that could be replicated and modified to promote and increase physical activity among AAs (Peterson, 2011).

Sisters in Motion, (SIM) (Duru et al., 2010) was a church-based health promotion hosted between three churches in Los Angeles, CA to promote physical activity among 62 AA women, at least 60 years old, who had a sedentary lifestyle. The intervention consisted of a control and intervention group where both were aware of the protocol because it was thoroughly explained at

enrollment. Over the eight week period, the intervention group met in small group sessions coordinated by a trained research assistant building on the social support framework for the activities. This group reported more success over the control group which was attributed to the multi-component factors, such as scriptures, prayers, goals, competition and a resource guide.

The project was designed using evidence-based practices to assist older adults in a physical fitness program. The Community Health Activities Model Program for Seniors (CHAMPS), Modified Physical Activity Questionnaire, pedometers and other baseline information were used to collect the data for this project. The intervention group reported an overall increase in steps by 7,457 more than the control group and a decrease in the systolic blood pressure. While this was a brief study, the outcomes suggest that this intervention could provide considerable improvement of health outcomes for a sedentary population leading to a better quality of life.

Programs for Nutrition and Physical Activity

The Genesis Health Project, (Cowart, et al., 2010) was a community-focused promotion between Syracuse University and AA churches in Syracuse New York. The pastors were engaged to help organize and pilot test phase one of a health promotion that would be cultural sensitive to promote a healthier congregation by reducing obesity. The program focused on nutrition, education, and a physical fitness program. The overarching goal was to promote

empowerment for the participants to retain accomplished health outcomes. The outcome of the project suggested that health promotion with AA churches can be successful. The authors suggest that churches must consider the following factors when designing a CBHPP: the support of the pastor, developing of cultural sensitive program, engagement of participants in motivational and interactive projects, promote social support through “exercise buddies” and incorporate fellowship and spiritual activities such as prayer and scriptures.

Project Joy was a nutrition and physical fitness program evaluated by Yanek et al., (2001). The focus of the program was on dietary changes and physical activity. Project Joy was a CBHPP that launched a cardiovascular risk health intervention in three AA churches with a total of 529 women in 16 churches. There were three groups studied one in each church. These researchers used a community-based participatory approach to identify among several strategies the most successful intervention to test the impact on CVD risk among AA women 40 and older. All participants in the interventions received the baseline screenings, health assessment and program guidelines. The standard behavior intervention included a general discussion on physical activity and nutrition. The social cognitive theory (SCT) approach used to measure self-efficacy. Weekly sessions on physical activity and nutrition were lead by health educators while lay leaders received training to further conduct future sessions. At each session 30 minutes of physical activity was performed and cooking

demonstrations were conducted. These sessions were very interactive and appealing to the participants. The spiritual intervention had the same sessions as the standard behavioral, but spiritual components were added such as prayer, scriptures and constant encouragement from the pastor.

In addition, other spiritual motivation such as gospel music during physical activity, calls from volunteers, a newsletter from the pastor and spiritual media messages within the congregation were included. The self-help control intervention provided resource materials from the American Heart Association (AHA) and women were offered retreats and free screenings only. This intervention was not as successful because the women wanted more direct interaction. The authors conclusively agreed that there were noteworthy improvements in the CVD risk profiles; the spiritual and standard interventions had the same outcome while the self-help noted no significant change after the one-year follow-up. The authors thoroughly agree that this study was more impactful to the participants because multiple barriers and risk factors were assessed. The authors stated that participants in this study achieved the results in a shorter time period than some participants who participated in other programs for a much longer time period.

Albert Bandura's social learning theory was used in this study. Bandura suggest that when the framework is used self-efficacy of the participants increase

because people learn from each other by listening and observing. (Bandura, 1989). The findings concurred with findings in previous studies reviewed, in that CBHPP can change negative health behaviors and improve health outcomes among AAs. According to Yanek et al., (2001) if the entire population of AA who attended the church received the spiritual intervention it would significantly be at less risk for CVD.

The Fan, Activity, and Nutrition (FAN) Program was a 15-month intervention evaluated by Wilcox et al., (2010). This project focused on physical activity, dietary changes and considered the importance of the environment and church policy in the development of a CBHPP. The project also included process evaluation, a sustainability and dissemination plan. CBPR is infrequently used in CBHPPs but helps to involve the community, stakeholders and identify other resources that are beneficial to the health promotion. To ensure the success of the promotion pastors, cooks, and church members were trained and engaged continuously to promote support throughout the congregations. The authors used a social ecological framework that would be sensitive to the culture of the participants and guide the project. The findings were that when physical activity is used as a primary outcome along with emphasis on dietary changes, a decrease in the consumption of saturated fats, an increase in F&V and whole grains, the risk factors for cancer, obesity, cardiovascular diseases and blood pressure are significantly decreased, in return, reducing chronic diseases. The authors

acknowledged the success of other interventions during their term like Eat for Life, Body and Soul and BCUBH, all of which increased F&V consumption. The findings concurred with the findings with previous studies that interventions among AA in CBHPP can reduce chronic disease among the AA population.

The WORD (Wholeness, Oneness, Righteousness, Deliverance) was an 8-week CBHPP pilot study for a weight-loss intervention to combat obesity in a rural AA church, evaluated by Kim et al., (2008). Obesity continues to be the underpinning of many chronic diseases. According to Yeary et al., (2014) the loss of weight provides positive effects toward reducing chronic diseases by lowering the risk factors perpetuated by obesity. Halle, Lewis, and Seshamani (2009) noted that chronic disease is most obtrusive for AAs with 48% suffering from such diseases as compared to 39% of the general population. According to the authors “seven out ten AAs ages 18 to 64 are obese or overweight, and AAs are 15% more likely to suffer from obesity than whites.”

Kim et al., (2008) aver that the Black church has been used as sites to conduct successful health promotions to reduce chronic diseases through physical activity and dietary interventions, but there has been paucity of studies to evaluate weight-loss interventions. According to Yeary et al., (2014) The WORD was the first intervention endeavored to sustain weight-loss within the AA church-based community. The primary expected health outcome of The WORD intervention

was to increase dietary intake, promote physical activity and promote weight loss adherence in the AA community (Kim et al., 2008).

The WORD leadership team was professionally trained and certified for four weeks in every component using the lay health advisor model (Eng & Hatch, 1991), which is most appropriate in a church environment. Strategic training was provided, but not limited to, physical activity, portion size, eating out and calorie counting. The WORD recruited 15 participants out of 30 AA churches (Black Protestant, AME Zion, Holiness and Pentecostal) from the lower Mississippi Delta on the Arkansas side, which is home to the highest levels of chronic disease nationwide and the highest obesity rate than other counties in the state (Yeary et al., 2014).

In this study, all participants completed a health assessment, received baseline screenings and follow-ups across the life of the project. For the treatment participants, The WORD intervention used all of the faith and spiritual components and messages used by other CBHPP to ensure success. The intervention also used variation from the diabetes prevention program, which required smaller group sessions and was led by the trained members of the congregation (Yeary et al., 2014). One other unique component about this project is that a Community-Based Participatory Approach (CBPR) was used, which means there was collaboration with community partners, but members of the church were involved in the design, implementation and all aspects of the project

that promoted ownership of the intervention within the congregation. In conclusion, this study was more innovative in that it used CBPR, hosted small group sessions, and focused on sustainability of weight loss (Kim et al., 2008) to help participants reduce obesity.

The Wellness for African American through Church (WATCH) was evaluated by (Campbell, et al., 2004; Campbell, et al., 2007). This health promotion was designed to help prevent colorectal cancer (CRC), improve dietary habits and physical activity among 587 AA women in 12 churches in North Carolina. The 287 participants in the study who received newsletters and videotapes effectively increased their F&V intake and had improved physical activities. This study's approach is important to AAs because they experience a higher rate of disability and death from CRC than other populations.

A final study CBHPP, the Life Project was a 10-week intervention to combat obesity among rural AA women evaluated by Parker et al., (2010). The participants in this study was concerned about evading a chronic disease, therefore, the focus was prevention. The intervention focal point centered on dietary intake, blood pressure and physical activity. Like Project Joy, this intervention had both spiritual and non-spiritual components. The only difference in the spiritual intervention is that scriptures were added during each session. The authors confirmed that the same intervention can work successfully among AAs in both rural and urban areas. Significant weight loss was reported in both

interventions, but further enrichments for the spiritual intervention was mentioned. In conclusion, the findings in this study aligns with previous studies in that CBHPP is capable and vital to helping AA reduce risk factors that lead to obesity and chronic diseases

Non-Church-Based Weight Loss Programs

Other than CBHPP and CBPR weight loss programs there are other types of weight loss program such as do-it-yourself or self-help programs, telephone-based programs, commercial programs, worksite and internet programs, clinical and non-clinical programs. The overarching factors of weight loss programs fluctuate between physical fitness, dietary and lifestyle changes. The primary goal of weight-loss programs is to help participants lose weight, achieve weight-loss maintenance and provide support needed for adherence.

A study conducted by Castro, Pruitt, Buman, and King (2011) was a telephone-based physical activity intervention designed to reduce obesity among mid-life AA. The participants were of various socioeconomic and ethnic backgrounds. The TEAM (Telephone Advice and Mentoring) study took place in the San Francisco Bay area over a 12-month period among 181 individuals to measure behavior changes in regards to food intake and physical activity. The primary focus for participants was to lose weight to combat obesity, lower the risk for CVD, cancer and diabetes. The intervention was administered between three arms: (1) the trained volunteer peer mentors offered telephone advice on physical

activity, (2) another was led by paid professional staff on physical activity (3) and the final arm was led by staff offering telephone advice on nutrition.

At baseline, participants completed the Community Healthy Activities Model Program (CHAMPS) Questionnaire, which measures the rate of moderate to intensity physical activity and it also validated self-management. The standard Active Choices Program was a self-management tool used to validate and structure questions around physical activity during the face-to-face communication with the participants. Participants was also instructed on all components of the intervention and given a “graded treadmill test” to measure the range of participants’ heart rate. The TEAM trial used two theories, the social cognitive theory which guided participants’ behavior to support their self-management skills for adherence toward physical activity and self-efficacy skills, and the transtheoretical model that assisted the interventionist toward measuring the readiness of the participants at various stages.

The authors concluded that the peer led mentors’ success was equivalent to the success of the professional staff delivering the physical activity and nutrition interventions which also led to the success of the participants. The success of the peer volunteers was contributed to them being well trained and having good listening skills. The value of this finding establishes a cost-benefit that could be financially beneficial in the operation of other health promotion programs when volunteers are trained properly. The authors cited that the element

of program fidelity added to the success of the program, in that both the volunteer mentors and staff followed the intervention guidelines and completed all the necessary data to quantify the deliverables at each session.

In the TEAM intervention program fidelity was stressed to ensure its' success. Noonan et al., (2009) avers that fidelity is extremely important to the success of any intervention or health promotion. The author states the fidelity component in programs ensures that the deliverables are presented as designed to achieve the desired outcome. The author further contends that when the program deliverable are not met it tarnish the outcome of the intended goals and objectives of the intervention. The author concludes that fidelity is directly correlated with high program effectiveness and that fidelity assessments should be implemented in the program structure and processes.

Lutes et al., (2008) evaluated the Aspiring for Lifelong Health trial (ASPIRE) focused was on weight-loss and nutrition. The authors examined how modest strides in cooking patterns, portion size, healthy nutrition and physical activity could significantly reduce obesity. In this trial, the authors suggested that since most participants regain their weight after a health intervention they should focus on lesser behavioral modifications that could be effective in leading to better outcomes for weight loss maintenance.

This trial consisted of 59 participants of mostly mid-aged Caucasians, men and women, who were randomized into three treatment groups. All treatment

groups received baseline screenings such as body mass index, weight, and stamina measurements instruments for aerobic fitness, waist circumference and strength training to evaluate the effective measurement between the groups.

The authors in this study concluded that the weight-loss from the Aspire group was noteworthy in comparison to the other treatment groups based on the approach taken. The success of this group relied on the efficacy of the individuals and the manner in which the intervention mixed the “traditional and non-dieting approaches” (p. 352). They were asked to challenge themselves and set their own goals by reducing portions sizes, increasing physical activity gradually, consumption of more F&V and whole grain foods, eat healthier snacks and beverages and reduce meat products and foods that have high fat content. Participants received weekly support as they met briefly with the lifestyle coach.

The authors concluded that such an intervention has great potential to be replicated by promoting the “small changes” approach. This approach was proven in the research to produce sustainable and promoted maintenance of weight-loss over time when this approached is adhered.

Themes identified in Church-Based Health Promotion Programs

There were various outstanding factors that stood out in the literature that affect the outcome of health promotion programs in churches. Some of the factors were the participants’ lack of knowledge of the effects of obesity on a chronic disease; the

implementation of too many components and the role of social support from family and friends. Some of the other factors are defined in more detail as follows.

Role of Pastors, Pastor's Wives, Church Leadership and the Congregation

Commonalities resonated throughout the literature concerning the potential success of health promotions involving AAs within churches. While there were various effective factors, one of the most prominent was the extent to which the pastors, their wives and other level of leadership were involved. This was evident in the health promotions mentioned such as the FAN, Body and Soul, Project JOY, Health-e-AME, Heart and Soul Physical Activity Program and the Genesis Health Project (Wilcox, et al., 2010; Resnicow, et al., 2004; Yanek, et al., 2001; Wilcox, et al., 2007; Peterson, 2011; Ford, 2013; Harmon et al., 2013; Catanzaro, et al., 2006; Clay et al., 2005; Baruth et al., 2007b; Cowart et al., 2009).

All these researchers agree that the pastor plays a valuable and major role through their on-going support, constant encouragement and counseling. The power of the pastor and the authority that comes with this position provide influence that can be used positively to impact better health for the congregation. Pastors are referred to as “gatekeepers” (Markens, Fox, Taub & Gilbert (2002) (p.806); Ford (2013) (p.511); Harmon et al., (2013) (p.44); Parrill & Kennedy (2011) (p.152). Ford insists that it is relevant to have pastors included at the onset of the health promotion. The pastor sets the tone for the direction of the church

through leadership and counseling. Baruth, Wilcox & Saunders (2013b) support that pastoral support is viewed as an “integral” (p. 204), role needed for health promotion programs to be successful within the church. Williams, Glanz, Kegler & Davis, (2009) considered it necessary to identify the perceptions of the pastors and its membership to ensure harmony before the start of a health promotion. Harmon et al., (2013) avers that the eating habits of the pastor should be known prior to beginning a church-based health promotion.

The influence of other church leadership such as deacon and pastors’ wives upon health promotions is very limited in the literature. In one study, it is duly noted according to Clay, Newlin & Leeks, (2005) that the participation of deacons, pastors’ wives and other women in the Sisters in the Spirit health promotion to improve breast screening, there was a 100% response from the women that they would have a mammogram if asked by the pastor, the pastors’ wife or a deacon’s wife. In Project Joy, when the pastors’ wives participated in physical fitness activities attendance increased (Yanek et al., 2001). This is a positive indicator that the influence of these women can be used to promote healthier behaviors.

While the pastor, pastors’ wives and other leadership of the church are vital to the success of the health promotion program, the congregation plays a major role, since technically they are the subjects of study. The membership must be willing to participate and adhere to the guidelines of the promotion in order to

achieve a healthier lifestyle modification (Rigsby, 2011; Williamson, 2009). The church has been identified as a focal point to reach many AAs at one time to promote better outcomes.

Role of Lay Health Educators

I recognized other factors that was frequently mentioned in the literature was lay health educators, used interchangeably as lay health advisors, lay health advocates or peer leaders as used in Project Joy, Body and Soul and The WORD health promotions. These are individuals that are within the congregations who can be trained to assist their peers with behavior modifications. These individuals can be extremely effective because they may have experienced similar situations as the health promotion participants and can be seen as people who care and understand and looked upon as examples.

According to English, Merzel, & Moon-Howard, (2010) lay health advisors provide a sense of social support. Pennington et al., (2013) adds that using lay health advisors is important in that they are cost-effective, and many churches do not have a large budget to operate health promotions. This concept is demonstrated in The Bless Project, FAN, and SIM health promotions. This speaks to the fact that training peers to be lay health advisors is beneficial. Bopp et al., (2009) emphasized the importance of pastoral support and lay advisors toward the success of health promotions. An emphasis was placed on using these individuals to help ensure success in health promotions with a strong premise on training, which resonated as another key element focused on in the

Healthy-AME-e, WATCH, FAN, PATHWAYS, TEAM Trial, H.U.B. City Steps and The Genesis Project health promotions.

Role of Culture, Empowerment and the Environment

In the FAN health promotion, culture characteristics were used to guide the promotion throughout the duration of the project. On a broader scale, FAN focused on changing structural and environmental behaviors of the congregation and church policy (Baruth & Wilcox, 2013). Participants of ethnic and racial backgrounds often deal with issues that may hinder their participation in a health promotion; therefore, programs should be designed with cultural sensitivity and empowerment (Tucker et al., 2014). Cowart et al., (2010) avers that it is imperative that health promotion programs for AAs be designed with cultural sensitivity. For example, AAs may view asking questions about income too private and even when screenings are done it must offer areas of privacy. Other studies that reference the importance of cultural sensitivity include HSBS, H.U.B. City Steps, and DNP. According to Di Noia et al., (2013) dietary interventions aimed at combating chronic disease among AA need to be designed and implemented around the culture characteristics to be more effective. The DNP project led to the empowerment of the church and the membership once they were trained and took ownership in the maintenance of their health (Rigsby, 2011).

Environmental factors were sparsely mentioned in the literature reviewed as a component of the health promotions. Body and Soul, BCUBH and the FAN

health promotions only made inference of environmental factors. The environment in which you live, work, play and frequent can influence your dietary choices if communities have greater access to fast food restaurants rather than grocery stores where you can make healthier food choices. The built environment is also important and supports the success of individuals where they can walk and have access to other recreational activities. According to Ball et al., (2006) there is still more research needed concerning environmental factors and their effects on nutrition and physical activity. The researchers suggest that a broader scope of the environment should be examined on every front including family and policy environment.

Spiritual Components

In the BCUBH, Project Joy, Heart and Soul, Eat for Life Trials, HSPAP, DNP and The Bless Project, all of these health promotions desired to help change negative behaviors in participants. These health promotions included some type of spiritual component such as praise worship, prayer, spiritual songs, reading of the scripture and spiritual messages from the pastor, on bulletin boards, newsletters and announcements as part of the project. Spiritual themes in a health promotion seemed to help participants have long term positive effects on healthy lifestyle modifications (Seale et al., 2013). Participants' perceptions on their faith and their belief in God helped them with their struggle to become healthier is both positive and empowering. Duquin et al., 2004 used scripture and responsive

readings in an intergeneration health promotion to generate a discussion for the participants to discuss and express issues that would help them to come to resolutions and focus on everyday living. Duru, et al., (2010) commented that the SIM promotion participants had group prayer and scripture readings and how the scriptures applied to their overall well-being and physical activity.

In a few other studies, some non-spiritual components that the authors contribute the level of success attained were the frameworks of community capacity building, social support and motivational interviewing reported success early in the intervention (Zoellner et al., 2011). In both spiritual and non-spiritual components, they provide more than a single foundation, but together form a cohesive platform manner to build a much stronger program structure that can help successful outcomes. The Eat for Life trials, HBHS, BCUBH, HUB City Steps also used MI to counsel participants.

Partnerships and Community Involvement

Partnerships can be developed to gain a greater reach and obtain additional resources needed to help with a health promotion (Wilcox, et al., 2010; Zoellner et al., 2014; Phillips-Caesar, et al., 2015). In the H.U.B. Steps “Get Healthy Hattiesburg” initiative a partnership was collaborated between the mayors’ office and the University of Southern Mississippi to reduce cardiovascular disease and increase physical activity. The WORD and FAN used a CBPR approach by developing an academic and community partnership to establish a more

collaborative effort within the community. The HSAP promotion developed outside partnerships that aided its success and BCUBH established coalitions internally and externally. Body and Soul developed a partnership with a university, a health agency and the National Institutes of Health to help reach their goals. According to Guta, Flicker & Roche (2013) some health promotions have lacked a sense of success without the dynamics of developing meaningful partnerships that would increase and improve public health research. In a study to promote dietary changes to promote the attainment of a better quality of life in several communities in the Lower Mississippi Delta (LMD), a partnership was formed between six universities, cooperative extension services and other community organizations (Kennedy et al., 2011). The Bless Project used a faith-based approach and a “faith-placed” approach, the usage of a commercial organization focusing on weight-loss such as a local Weight Watchers group and the Department of Human Services to assist them to meet the goals of the project.

Small Changes Approach

The “small changes approach,” which was mentioned in the FAN and ASPIRE health promotions, allows participants to set their own goals to lose weight over time, rather than the traditional guidelines of weight-loss health promotion programs. Participants received support through phone calls, small change strategies and educational materials. Results of the ASPIRE promotion noted that using this approach participants maintained their weight-loss after the

12-month follow-up (Damschroder, et al., 2014). The concept of promoting small changes over a longer period of time promotes a greater impact in health promotions when participants are dealing with multiple behaviors (Baruth & Wilcox, 2013). The Small Changes and Lasting Effects (SCALE) Trial used CBPR to obtain a greater reach and engagement, and the “small changes approach” to promote better eating habits and increase physical activity among AAs and *Hispanics using the “small change approach” found that adherence outcomes for participants was significant enough to lead to other health promotions interventions using this concept (Phillips-Caesar, et al., 2015).

Psychological Factors

Though there is ample information in the psychological literature about the role of shame in obesity, the women in the studies reviewed above rarely spoke about shame, guilt or body image. According to Burmeister et al., (2013) individuals seeking to lose weight face many obstacles such as environmental factors, the stigma of being overweight or obese and food addiction. The authors in this study sought to identify the relationship between low weight-loss and food addiction and found that participants who are overweight or obese are dissatisfied with their body image, have lower willpower to manage weight and that shame was moderately high.

James et al., (2012) avers that AA women continue to have shorter lives due to chronic disease related to obesity. Despite the plectra of health promotion

programs, there is still not a definitive answer as to why there is not an overwhelming success rate in the reduction of obesity among AA women. The authors in this study suggested that many health promotion programs are too general, and not culturally focused on certain views of AA women such as body image and other traditions.

Program Participants' Attitudes and Concerns

Drayton-Brooks & White (2004) reports that some participants' attitudes toward the attainment of a healthier lifestyle can be positive or negative. In this research, some of the participants felt really good about their efforts, and expressed an overall sense of the value of good health, and having the knowledge of what it takes to become healthier, but at the same time expressing the inability to transform that knowledge into healthy behaviors. Some of the participants believed that prayer was the answer to their success, while others felt regardless of what they did, some diseases was automatic and that they were going to be affected at some point in their lives and that losing weight would not make a difference in their lifestyle. They expressed that they will not live any longer and that eating fast food is quicker and easier.

Peterson (2011), in the Heart and Soul health promotion, cited the perceptions of participants on the value of physical activity from childhood through the adult years. The participants remarked that, as a child, physical activity was fun, but as an adult, they did not want to sweat or after a long day of

work they were simply tired. Participants acknowledged the benefits of physical activity such as having fewer health issues and the prevention of a chronic disease, but yet having a lack of motivation; they stated barriers such as not having enough time, the responsibilities of the family and being too tired at the end of a work day to be physically active. On the other hand, it was discovered that some believed through prayer, scripture and the support of others it could help them become more concerned about healthier outcomes. According to Kim et al., (2008) in the WORD promotion it was also found that faith through the scriptures and prayers were keys to the success of participants in a health promotion, along with having others to provide encouragement.

Cowart et al., (2009) Genesis Health Project, described the attitudes of participants as they endeavored to lose weight and conform to a healthier lifestyle. While the participants in this project reported barriers such as timing, physical disabilities, daily exhaustion, and lack of motivation, they also had strong desires to become healthier and to obtain overall wellness both physically and mentally. Some of the participants cited that the project helped them learn how to take better care of themselves; other expressed the importance of the being able to fellowship with others and reduce weight at the same time and; for others, it was encouraging and gave them hope for a longer life.

Baruth, Sharpe, Parra-Medina & Wilcox (2014) looked at some of the attitudes shared in a focus group by AA women concerning their experiences for

the lack of exercise and unhealthy eating from a personal, social, environmental perspective. The women referred to the lack of motivation, embarrassment from body size, time, family responsibilities, lack of support from friends, family, co-workers who are not interested in becoming healthier.

Henderson, et al., (2001) noted that it is important to mention that some participants have referred to not having the right environment or safe places to perform physical activity is an important factor to be considered in developing a weight-loss program. Also in this same research which included a focus group spoke to the role of the community “It Takes a Village” concept as a provider of recreational facilities for physical activity. It is suggested that this approach should be widely considered by researchers, health educators, policymakers, and public health advocates. The focus groups revealed that some participants scope of physical activity was viewed as chores around the home; there was a lack of education about physical activity observed; neighborhoods were not conducive or safe for physical activity; people were not able to socialize; and in some cases the financial cost to afford a membership to a health facility was not feasible.

In many cases, the lack of communications among different racial and ethnic groups can be a barrier in general and even so among health educators. One participant in the Heart and Soul study stated that often times while health educators want to provide valuable information they fail to understand what individuals already know, what they are interested in learning or even if they

understand that the behavior exist (Drayton-Brooks & White, 2003). According to Peterson, (2011) the lack of precise communication has been identified by other researchers as a barrier leading to better health outcomes.

Program fidelity (PF) was introduced as being a key to the success of health promotion programs. Rohrbach et al., (2010) report that fidelity in the implementation stage can produce stronger programmatic results when a comprehensive training program is instituted in a health promotion program. Fagan et al., (2008) posit that the implementation of the high fidelity component in the infant stage of health promotions programs promotes sustainability over time.

Noonan et al., (2009) further contend that fidelity should be introduced in the composition phase of the intervention. He avers that it is imperative that careful consideration is given in the selection of key decision makers to ensure every facet of the health promotion along with the usage of SMART (specific, measurable, attainable, realistic and timely) objectives often requested in health promotion requests for proposals to measure continuous progress.

Evaluation of Methodology in Literature Review

Various factors such as poor dietary choices and sedentary lifestyle lead to obesity and are the primary contributors to the poor health among AAs. Also, chronic diseases are more prevalent among individuals of racial and ethnic groups.

Halle, Lewis & Seshamani (2009) explained that these groups experience an inexplicably elevated pace of disease also due to the lack of insurance and appropriate access to optimal health care. The authors reported that the data shows obesity undergirds many chronic diseases, in which AAs are more susceptible to and will experience more mortality, from cancer, diabetes and new incidence rates of HIV/AIDS

In the literature review, the authors concurred and provided empirical evidence that two behavioral strategies that were effective in reducing chronic diseases during the cycle of the interventions were the increase of physical activity and the decrease of unhealthy food. The program evaluators suggested that interventions that contained at least three components such as physical activity, dietary change and social support tended to help participants be more effective in reaching their weight-loss goals during the life of the project. To ensure that some success is achieved, it is evident through the literature that certain factors are implemented in the planning phase when structuring an AA health promotion. The factors that lead to success in these health promotions are attributed to the inclusion of trained peer health educators, prayer and scripture, church leadership especially pastors, pastor and deacon wives; developing community partnerships, consideration of the environment, culture sensitivity advocating small changes.

A major limitation in the literature review in terms of methods was that the bulk of the studies were quantitative in nature. There were only few studies that itemized participants' expressions in a qualitative manner concerning their attitudes, experiences, emotions and perceptions concerning weight-loss, while others only provided an overall qualitative analogy.

Another limitation was that the interventions were primarily on AA women and only a few studies referenced environmental and cultural factors. These factors can negatively affect the successful outcome when they are not included in the planning and developing stage of the health promotion.

There continues to be gaps in the literature and it is significant that leadership in churches is embracing health promotion at a faster pace. The most successful faith-based studies in churches are strongly influenced by pastors. One interesting finding in the scholarly-based literature was the influence of pastors' wives has in church-based health promotions (Yanek et al., 2001). By using the influence of pastor wives, it could greatly increase the strength in church-based health promotions.

The literature reviewed in this research related to health promotions primarily among AA women in church settings. These studies were principally reviewed to the point of saturation for health promotions among this population to determine if the effectiveness of an intervention in a church setting would promote better health outcomes, by decreasing the prevalence of chronic diseases

such as diabetes, high blood pressure, cancer, cardiovascular disease, stroke and obesity through health promotions. These studies focused on increasing physical activity and the consumption of fruits and vegetables, improving nutrition, decreasing of sodium intake and the attainment of better weight control. While there were numerous studies identified in the literature around this phenomenon there were only a few participants' comments noted on their experiences concerning the health promotion. There was no recent study found over the last five years that provided in-depth details on the experiences, attitudes and perceptions shared by the participants.

Summary

The primary goal of this research project was to understand the experiences, emotions, attitudes of individuals concerning obesity, weight-loss and the effectiveness of church-based health promotions. The knowledge gained through this research study will be qualitative and help to reveal gaps in the literature. According to Denzin and Lincoln (2000) the qualitative approach is of a more innate nature that will allow the researcher to gain more in-depth details about a particular phenomenon.

Health promotion in churches has increased but there is not yet a comprehensive replica of a health promotion intervention or program that solidifies a perfect model. The results of this research study will be shared with participants, stakeholders, health-focused community organizations and churches endeavoring to reduce obesity and reduce chronic diseases through health promotions to align with the goals of Healthy People

2020, by decreasing obesity through increasing physical activity and the consumption of more F&V in an effort to practice prevention (U. S. Department of Health and Human Services, 2010).

The challenge with weight-loss programs is helping individuals to sustain the weight over time. The health promotions reviewed provided only short-term evaluations and only one promotion had a sustainability component. Since there was no long-term program evaluations it is impossible to determine the continuing success of the program or its' participants. Therefore, this research endeavored to uncover factors that will add value to future health promotions programs. The principle factors cited in the literature as affecting the outcome of health promotion programs in churches are: program design and program fidelity; participants' motivation and empowerment; spiritual components and cultural sensitivity; partnerships and community involvement; support from family and friends; trained program organizers; and support of pastors and their wives and other church leadership. A major limitation is paucity of information on the experiences of AA women going through CBHPP weight loss programs. I discovered the need for comprehensive qualitative research to study and uncover the experiences that can lead to weight-loss, weight-loss maintenance and the decrease of chronic diseases within the AA community. The information from this research can be shared with other sectors, researchers, and health educators to design more effective health promotions for AAs.

Chapter 3: Research Method

Introduction

In this chapter I reviewed the qualitative method and phenomenological approach that I used to collect the data on the attitudes and experiences of AA women as they go through a church-based weight loss program. The reason I used the phenomenological approach was because Creswell (2007) stated that this avenue “adds a voice” to the study. The literature does not report recent qualitative studies over the last 5 years; therefore, this implies that there may be rich new data to be uncovered through the interview process.

Research Design and Rationale

I conducted a cross-sectional, qualitative study based on interviews with a purposive and homogenous sample of AA women who have been part of a church-based weight-loss program. According to Palinkas et al. (2013), using this method allows researchers to conduct in-depth studies and reach a point of saturation when no new information arises from the interviews. Palinkas et al. further stated that a small sample size is sufficient for this method and will be a fair representation to draw inference regarding the phenomenon being studied.

I used a qualitative and phenomenological approach to guide the research to obtain a broader understanding of the issues, barriers and cultural behaviors faced by this ethnic group. During the interview process, I used a questionnaire designed for qualitative research to gain valuable information and evaluate the

effectiveness of a church-based program. The overarching research question in this study was: What are the experiences of AA women participating in church-based health promotion programs. There were seven research questions as follows:

RQ1: What barriers do African American women face in their efforts to lose weight?

RQ2: What factors influence the success or failure of African American women participating in church-based health promotion programs?

RQ3: What type of social support do African American women need to help them achieve and maintain their weight loss goal?

RQ4: What verbal and written educational information helps African American women understand the relationship of weight loss to chronic disease risk and improved quality of life?

RQ5: How do African American women feel about church-based health promotion programs in comparison to other types of health promotion such as Weight Watchers?

RQ6: How do African American women feel the role of the church in health promotion programs could be expanded?

RQ7: What is the role of African American women's spiritual beliefs concerning weight loss as they go through a program?

Role of the Researcher

As the principal investigator for this research study, I contacted women who have gone through a local city-wide weight-loss program in Jackson, Mississippi, called Medical Mall in Motion (MMIM). This program targeted local churches and charged each church to develop individualized weight-loss programs that lasted for a period of 10 months. I was responsible for conducting the interviews, selecting and developing the most appropriate instrument and the protocol to obtain the information needed to answer the research questions, disseminating and collecting the questionnaires, and interpreting the data for this qualitative study. I designed the interview questions, and audio taped the interviews with the permission of each participant. I asked all of the questions in the same manner to observe the willingness or the hesitancy feedback from each individual on the same question. I made sure that the data collected reflected an accurate accounting of the participants' experiences and not to insert personal biases.

I also conducted the research in a manner in which the participants were not harmed or intruded upon (Creswell, 2013). I contacted all participants in this study personally to ensure the success of this project. I protected the confidentiality of all participants, and their information was handled using every ethical consideration possible to reduce any conflict of interest. I ensured the

credibility by making sure the recordings were clear, taking quality notes and listening precisely.

Methodology

Participant Selection Logic

A purposeful sample was drawn of AA women who lived and attended church in the Jackson, Mississippi metropolitan area. The criteria for participation included:

- African American women
- Ages ranging from 18-70
- Overweight or obese (self reported)
- Currently living in the Jackson, Mississippi area
- Diagnosed with a chronic disease (e.g. hypertension; self-reported)
- Participants who have participated in at least one church-based weight program

These women came from diverse backgrounds and attended a variety of Christian institutions, such as Apostolic Pentecostal, Baptist, Methodist and Non-Denomination churches.

Instrumentation

Prior to starting the interviews, I used a small group of experts to test the interview instrument for validity, reliability, functionality and content. The interview instrument was found to be sound and appropriate and no adjustments

were needed. After these interviews were concluded the data collected from these participants were discarded.

The instruments used to collect data and guide this research were: Appendix A, the screening interview questionnaire; Appendix B, recruitment letter; Appendix C, recruitment flier; Appendix D, Demographic Questions ; Appendix E, Health Questionnaire ; Appendix F, Interview Questions; and Appendix G, Medical Mall in Motion Recruitment Guidelines.

The first instrument I used was the recruitment flier (Appendix C) and the recruitment letter (Appendix B), which was presented to the specified churches to obtain the sample size needed for the research. Next, I mailed the informed consent form to prospective participants. The instrument used to determine the eligibility of the prospective participants was the screening interview questionnaire (Appendix A). I asked each participant to complete the demographic and health questionnaires before the interview started. (Appendix D and E) in order to capture descriptive data. Appendix F provided the in-depth, open-ended interview questions that I used to generate qualitative data. According to Creswell (2013), the best protocol for this type of study is an interview.

I used a tape recorder to capture the data verbatim from each person. To prepare for the success of each interview the tape recorder was checked to ensure that it was in good working condition prior to each meeting. Extra tapes and a backup tape recorder were available to collect the data.

As the researcher I was responsible for all instruments. My goal was to capture the deep essence and experiences of each participant by using active listening skills. This required me to report any biases in relation to the data and collect data on the observed emotional state and body language of each participant.

Recruitment, Participation and Data Collection

After I obtained approval from Walden's Institutional Review Board (03-03-16-0121784), participants were recruited from among AA women who have gone through a CBHPP. The primary recruiting pool for this research targeted participants from the MMIM CBHPP, sponsored by the Jackson Medical Mall Foundation (JMMF). I had established a collaborative working relationship with the JMMF through other community health promotions.

I obtained approval from the JMMF to contact the churches. The MMIM health promotion was conducted from January, 2012 to December, 2012 across the city of Jackson, Mississippi. The first two months of the health promotion was a planning period. The activities for this health promotion lasted 10 months among 32 churches, with 410 participants (See Appendix G). At the conclusion of the MMIM health promotion, a total weight loss reported among all the participants in the various churches was approximately 3,500 lbs. The focus of the promotion was to reduce obesity to help decrease the rate of chronic diseases such as hypertension, diabetes, cholesterol, stroke, and cancer in the Jackson,

Mississippi metropolitan area. The MMIM provided some incentives for the project at various meetings; the churches that participated in this health promotion designed their own programs to assist participants in losing weight.

I explained to all participants that they would be requested to sign an informed consent form. A minimum of 11 participants were recruited and advised that the interviews would last approximately 2 hours. When a participant agreed to a confidential interview, they received information of the time and location to meet with me in a conducive and safe environment that would facilitate the best results for a private interview.

Prior to each interview, the participant was contacted in ample time to confirm the meeting and a follow-up call the day of the interview. It took 6 weeks to collect the data. After all interviews were completed, I analyzed the data to depict the themes and the data that arose from the interviews. I categorized all data to protect anonymity of each participant.

I collected the data through a one-on-one, face-to-face, semi-structured interview. Participants were expected to share their experiences, tell their stories, and answer open-ended questions that would be helpful to uncover new data to help improve CBHPP. Each interview began with a brief discussion around the central research question. After which, I followed-up by asking each person the same interview questions to obtain the vital information needed for this research.

Data Analysis

In order to secure this data, I planned, organized, and developed a system to secure and store information. I generated a spreadsheet to document the reoccurring themes that arose from each interview. The data collected from the screening interview, transcribed interviews, in-depth face-to-face interviews, field notes, including observation notes, and the transcripts of the participant story were coded manually. I categorized the data so it could be easily retrieved for information and analysis. I devised a coding system that would identify each person and provide information systematically for easy retrieval. I used the data collected from the demographic and health questionnaires to generate a spreadsheet of descriptive statistics.

Trustworthiness

Credibility

I realize that credibility will be established based on my integrity as a researcher. It is important that ample amount of time was spent with each participant to ensure all details of the research received adequate consideration to answer the research question. I expected to reach the point of saturation after interviewing 10-12 participants, as new themes unfolded it would add rigor to the research. I was careful not to interject any bias due to personal experiences of participating in a church-based health promotion program. According to the

literature, a researcher should report all results, not just the positive, but the negative as well (Ulin, et al., 2005).

Transferability

The results of this study will enable the reader to understand and recount the in-depth experiences shared by the participants. I do not expect that the data from such a small purposeful sample of 10-12 participants will be generalizable to larger populations, but they do open up new variables like the participation of the pastor or other church leader that could be examined in subsequent larger scale studies. According to Polit and Beck, (2010) the Principal of Proximal Similarity supports generalization when the population studied has relatable characteristics, such as the same chronic disease. These authors contended that it is for future researchers to identify potential transferability of the concepts reported in a piece of research.

Dependability and Conformability

To establish dependability, I provided the appropriate amount of time for each individual and used the same questionnaire. The semi-structured interview questions were the same and the exact procedures and techniques were used with each participant. Conformability must be initially established by the researcher developing an “audit trail” as suggested by Ulin et al. (2005) to examine those processes which will lead to the conclusions drawn in this study. I established trustworthiness by allowing participants

the opportunity to review the written transcript of their interview in order to validate and strengthen the credibility of their story.

Ethical Procedures

All ethical practices were followed starting with Walden's IRB approval. It is imperative that all information is kept confidential when dealing with human subjects. The initial letter of consent explained to each participant the process that I would take and that their participation is voluntary. Each person was informed that they can excuse themselves at any point during the interview for reasons deemed necessary. No participant was forced to participate in this research. Any information collected such as name, ages, date of birth and gender was deleted from all transcripts. To further protect the identity, pseudonyms were used during the coding process so that I would be privy to this information. I have a high standard for confidentiality; therefore, I ensured the privacy for all participants in every aspect of the data collection. For extra precaution all of the participants' information will be locked in a secure cabinet where I have the only access.

Summary

This chapter discussed the in-depth approach, the process and procedures that were followed for collecting and analyzing data to answer the research questions; including the procedures for recruitment, the eligibility for participation, the data collection process, data analysis plan, and how trustworthiness will be ensured. In Chapter 4, the results of the research findings are presented, including a description of the

research setting, the demographics of the participants and a summary of the themes identified.

Chapter 4: Research Findings

Introduction

I designed this phenomenological study in order to understand the experiences and attitudes of AA women who participated in a church-based health promotion program aiming at helping reduce chronic disease through weight-loss and dietary changes. I obtained the data needed for this study, through semi-structured interviews, which allowed the participants to share their points of view more openly rather than in generalizations. This setting also allowed me to dig deeper with probing questions during the interview.

The overarching research question in this study was: What are the experiences of African American women participating in church-based health promotion programs?

There are seven research questions as follows:

RQ1: What barriers do African American women face in their efforts to lose weight?

RQ2: What factors influence the success or failure of African American women participating in church-based health promotion programs?

RQ3: What type of social support do African American women need to help them achieve and maintain their weight loss goal?

RQ4: What verbal and written educational information helps African American women understand the relationship of weight loss to chronic disease risk and improved quality of life?

RQ5: How do African American women feel about church-based health promotion programs in comparison to other types of health promotion such as Weight Watchers?

RQ6: How do African American women feel the role of the church in health promotion programs could be expanded?

RQ7: What is the role of African American women's spiritual beliefs concerning weight loss as they go through a program?

During the interviews, I made sure that all questions were asked in the same manner to each person so that the information provided would be consistent.

Prior to starting my official interviews, I tested my instrument on two individuals to ensure that the questions were clear, understandable and appropriate. After these two sessions, the instrument was finalized.

In Chapter 4, I present the perspectives of AA women in a church-based health promotion program and the results of this research. The chapter includes the demographics and characteristics of the research participants and the recurring themes extracted from the data to answer the overall research question. I will also describe the process used for data collection and data analysis.

Sample of African American Women

All of the women in this study had participated in the 2012 MMIM church-based health promotion program. This health promotion was implemented in more than 40 Mississippi churches to help reduce weight and thereby combat obesity and other chronic

diseases. The MMIM provided the entry and exit guidelines for the churches, monthly incentives, along with a financial incentive awarded to the top three churches that had the highest weight-loss at the end of the health promotion. While this effort by the MMIM was focused toward reducing obesity, it was not designed to help participants meet a specific weight-loss goal, nor maintain weight-loss; any goal to reach a desired weight was left up to each individual church health promotion program. The MMIM emphasized that all guidelines would be designed by each church. Meetings were held once a month every month, at which speakers provided information, education, and motivation to help keep the teams engaged in the weight-loss challenge. All the churches reported the weight-loss of participants for the full 10 months of the program to the MMIM.

Data Collection

I conducted all interviews one-on-one and face-to-face. I collected data from 10 participants. To ensure that all data were collected accurately, I used a tape recorder and took notes on each question. To avert technical issues, I also brought an extra tape recorder. While there were some needed adjustments during data collection process, none of this movement altered or influenced the success of the interview sessions. I collected the data over a period of 6 weeks, averaging at least two interviews a week. The length of time for each interview ranged from 1½ hours to 2 hours. Participants were willing to be contacted again to verify the accuracy of the data, to make any corrections or revisions to the interpretation of the information shared during the interview, if needed. After reviewing the data for analysis, I discovered that additional information was needed from

research participants to obtain more in-depth information to answer the research questions thoroughly. After I contacted the participants again, nine of the 10 participants willingly shared more details to aid in further exploration of the research. After I interviewed all participants, I achieved data saturation.

Data Analysis

The participants provided detailed information concerning their experiences after participation in a church-based health promotion program. I reviewed notes, tapes, and each participant answer to the same questions and searched for similar and different responses from the participants. From this review, I was able to identify the statements categorically; words and phrases provided recurrent and emerging themes. The overall goal of this analysis was to make the association between the data gathered and the research questions.

As a result of the data analysis, the following themes were identified: (a) AA women believe food was portrayed as a survival tool, (b) AA women believe that planning is not a priority in terms of personal health, (c) AA women feel that there is a lack of knowledge between how physical health affects other areas of our lives, (d) AA women feel that health promoters need to develop holistic programs to encompass the family, and (e) AA women feel that church leaders have not been role models for healthy living.

Evidence of Trustworthiness

Credibility

I spent sufficient time with each person to obtain the necessary information needed to answer the research questions. I was careful not to interject any bias due to personal experiences of participating in a church-based health promotion program. The point of saturation was met after interviewing 10 participants. To add more rigor to the study, I conducted further research with nine of the 10 participants to discover more details and depict more themes. I reported all results, both positive and negative concerning their failures and successes concerning their weight loss experiences.

Transferability

The data collected in this small purposeful study can possibly be transferable to a larger study with similar circumstances in a geographic area having similar church-based weight-loss activities and a similar framework and methodological approach. The participants shared their lived experiences, individually and collectively, and what they believed to be true about the local weight-loss programs in AA churches. The exact quotes from the participants helped to ensure transferability.

Dependability and Conformability

I spent appropriate time with each individual to ensure dependability, and I used the same questionnaire and semi-structured interview questions, along with the same procedures and techniques during the interview process. I developed a system to track all the details and sequences of all activities throughout the entire project to monitor the

process in the research in order to draw a conclusion in the study; through these steps conformability was established. Upon completion of the interview, participants in this study had the opportunity to review my transcript, which validated and strengthened the credibility of their responses, so that trustworthiness could be realized.

Setting

I collected the majority of the data in a private room on the campus of the Greater Bethlehem Temple Apostolic Faith Church, centrally located in the city of Jackson, MS. I conducted all interviews in a setting that was conducive to safety and comfort for each participant. I conducted one interview in the privacy of one participant's home.

One participant contacted me the day of the interview to change her time to a later time in the day because she had a job interview. I was able to honor her request, using another private room in a different location on the same premises. Another participant asked if I would come to her home because she suffered from asthma and at this time she was not permitted to leave due to some external environmental concerns. I conducted this interview in the privacy of her home in a professional manner and followed the same protocol as all other interviews. She was home alone. I offered all participants fresh fruit, a health bar, a pecan roll, and water.

Results

Demographic Data

A purposeful sample of 11 women was recruited and 10 participated. These women came from various religious denominations, but participated under the same

guidelines of the MMIM health promotion within their congregations. The education status of the participants varied with two completing high school, three with some college and five that completed college. The marital status of the women also varied, two never married, four are divorced, three are married and one is a widower. Other demographic and personal characteristics of the sample are shown in Table 2.

Table 2.

Demographic Characteristics of Research Participants

Age Range	Participants #
36-45	3
46-59	3
60-72	4

Church Affiliation	Participants #
Apostolic	4
Baptist	1
Methodist	3
Non-Denomination	2

Table 2 shows the ages of the participants and their religious associations. The participants' ages ranged from 36-72. The demographic data revealed that participants came from various walks of life, with varied religious backgrounds.

Table 3.

Personal Health Characteristics of Research Participants (n=10)

Height	Weight	Normal	BMI	Obese/Overweight
5'0"	203	95- 128	39.6	Obese
5'3"	275	104-141	48.7	Obese
5'3"	155	104-141	27.5	Overweight
5'4"	168	108-145	28.8	Overweight
5'4"	87	108-145	32.1	Obese
5'4"	190	108-145	32.6	Obese
5'4"	220	108-145	37.8	Obese
5'4.5"	205	109-147	34.6	Obese
5'7"	215	118-159	33.7	Obese
5'8"	165	122-164	25.1	Overweight

Table 3 shows the data reported by the participants on height, weight and obesity status, and the calculated body mass index (BMI; CDC, 2015). The calculated BMI for most of these women was high and therefore suggested a health risk, according to the CDC's BMI guideline. Three participants were overweight and seven were obese.

Table 4.

Health Characteristics of Research Participants

Health Conditions	# of Participants
Pre-Hypertension	2
Hypertension	5
Type 2 Diabetes	2
High Cholesterol	3
Sleep Apnea	2
Osteoarthritis	2
Other	4

Table 4 outlines the variety of chronic diseases the participants reported as health conditions that they deal with on a daily basis.

Interview Data

The participants were asked about their own experiences while participating in the MMIM health promotion. Their experiences or attitudes were similar. They felt that the program provided outstanding information but was not in-depth enough to ensure successful weight-loss of the participants. Some of the participants did not feel the program met their needs in their individual churches because it was not well-organized and the lack of involvement from the church was sufficient to keep them engaged. Some of the participants stated that they recalled some emphasis was placed on the importance of weight-loss, but do not recall the correlation of weight-loss in its relationship to a chronic disease. All of the participants' beliefs about the goal or intent of church-based health promotion programs were positive. The participants felt that the responsibility of the church in health promotion should be a priority and on-going efforts should be made to help its congregants become healthier in every aspect. The answers shared by these AA women provided a wealth of information that have given insight to their barriers to weight-loss, factors that influence success or failure in church-based health promotion programs and the importance of social support.

RQ1: What barriers do African American women face in their efforts to lose weight?

The participants cited a variety of barriers that AA women face in their efforts to lose weight. Some of these barriers are strongly tied to their upbringing. In order to survive food was imperative and the lack of appropriate nutrition would lead to poor health.

Theme 1: Some women were raised to see food primarily as a survival tool.

Some of the women stated that in their upbringing food was viewed as a way to survive without regard to its nutritional value or its focus on health, for example:

“There was always food on the table, in the refrigerator, in the cabinet and the freezer. Sometime it was not what I wanted to eat but there was always food, but we were told eat everything on your plate.” (P3).

“In the 1940’s and 1960’s, we considered food as a survival. We were taught to plant vegetables in the spring and can it in jars for the winter; also we preserved our meats, such as pork and beef in the smokehouse.

This was country life, but in the city we lived paycheck to paycheck.

We were told to eat all you can so you want be hungry, you ate to survive.” (P5)

“Growing up, food was definitely a survival tool hands down. My mother provided for my siblings and I all of the essentials needed for survival. Food is a part of survival, but necessary to sustain life.” (P10)

Theme 2: A few women were taught about healthy food in childhood. A few of the participants had heard some conversation about the nutritional value of food in their upbringing, but as they grew into adulthood this knowledge did not impact their lives. Below are some of their responses:

“For me, food was viewed as nourishment to stay healthy.” (P2)

“As a child, food was portrayed as important to have energy and a good mind. My mother taught us how to take care of a garden and made sure we had our three meals when possible, daily. She also wanted to make sure that meals included yellow and green vegetables, as much as possible.” (P6)

“I was taught as a child that a meal should consist of one item from each of the major food groups. Unhealthy food was portrayed as a treat and was not a daily occurrence.” (P7)

Theme 3: Food habits are set in childhood. Several participants mentioned that a lack of education or a lack of knowledge on how to diet and what is the proper nutrition; along with not having a role model from guidance. They also felt that being healthy begins in childhood. Several comments follow:

One participant referred to a barrier being related to as “generational” she explained that people do what they see others do and it is passed down from one generation to the next. (P6)

Another participant stated that “In my home, as a child food was always portrayed as a celebratory event, we ate until we were full as ticks. In the movie “Big Mama House” it reminded me of how I grew up. In the movie the family would eat Sunday dinner and all kinds of food were lined up on the table. So for every event in our household, regardless of the event, we ate lots of food. We loved food.” (P8)

RQ2: What factors influence the success or failure of African American women participating in church-based health promotion programs?

The AA women in this sample stated that they were hindered in their success for weight-loss at the church based health promotion program due to a lack of motivation, being overwhelmed with other priorities, struggling with the side effects of medications that cause weight gain, suffering with mobility issues, and feeling discouraged by other church members who did not show up for the meetings. Two major factors were expressed, the lack of planning and having role models. The participants also felt that the factors that influence success can also negate failure.

Theme 4: Planning is a major key to successful weight-loss and maintenance.

Participants commented that planning is a powerful tool to be successful in your weight-loss journey. In terms of taking care of your personal health it is very important that planning is instituted to promote healthy behaviors. The majority of the women cited planning must be a major individual goal. One participant explained that “you must have a plan.” She had a teenager in sports that kept her busy, but she found that getting the car

loaded prior to the time allowed her to do other things and while at the soccer field she would walk while other moms just sat in their cars. Another participant stated that “if you don’t plan to eat or cook you will grab anything.” Participants also explained that women have lots of responsibilities and the busy life style hinders their ability to stay on course with a weight-loss plan. Other participant’s comments:

“Due to having busy lifestyles, planning meals (healthy meals), is not at the top of the list. Most women just make sure they are eating something to satisfy the hunger pains.” (P1)

“I feel that planning is a priority for one’s personal health and a longer healthier life. I always have a plan A & B and sometimes plan C.” (P2)

“Growing up our meals was not planned but I learned when I became a wife and a mother that it was economical to plan meals.” (P6)

“Planning is viewed as a necessity but usually is at the bottom of the priority list” (P7)

“I would tend to agree with this, especially for me and my life, and in the lives of women in my life. Planning time for personal health was not a priority, nor considered necessary.” (P8)

Theme 5: Having a role model helps in weight-loss. A few of the participants thought back on what they saw in terms of role models for health and one stated that the only role model she recalled was looking at individuals who were models for the department store Gayfers and another cited seeing Caucasians as the only role models.

Another suggested that a modern day role model is needed to provide the necessary encouragement and to share his or her story which will help to inspire others. Overall, all of the participants felt that church leadership should be role models for its congregation. The overall consensus is that the church leadership should play a major role in every aspect of its member's lives to help them have better life outcomes. Participants mentioned while the church has a role to play, it is incumbent upon the individual to have personal responsibility.

RQ3: What type of social support do African American women need to help them achieve and maintain their weight loss goal?

Theme 6: All types of social support are beneficial in achieving and maintaining weight-loss. The participants felt that understanding the needs of each woman as an individual is important as each person is different and that one-on-one support is needed in most cases for that individual to be successful. The women all agreed that having social support from others was an important key to their success in weight loss and weight maintenance. All of the participants agreed that having someone to connect with, to talk and share with, and to encourage them, provided that needed on-going motivation.

All of the AA women in the study further stated the following in terms of the need for social support:

“ A strong support group, where you would have a buddy system, receive phone calls, meet together, and identification of each individual needs. (P2)

“We need an accountability partner, along with family encouragement and participation.” (P11)

“Surround yourself with like-minded people and be discreet and be careful of your circle of friends; you need someone to help you know how to eat and think about different foods; you need family support, neighbors, co-workers, in all of your circles. (P8)

“It takes a village” for this weight loss journey and it is key in achieving this goal. Some people with disabilities need to lose weight. There should be someone to help identify resources to help them with their struggle to lose weight.” (P9)

“Strong support from the pastor and other leadership of the church and teachings on the value of health is very important.” (P3)

Theme 7: Program participants wish to be consulted on program design.

Participants agree that other structural and environmental supports are necessary to help ensure weight lost.

“Programs should be designed with built-in components that will reach outside of the length of the program to help participants maintain their weight- loss.” (P5)

“Survey participants to see what they want or need and offer incentives to help motivate program participants” (P4)

“Ensure accessibility to the space allocated and make sure that all the equipment works” (P6)

“Do not have long programs but promote small changes opposed to really big ones” (P2)

“Have meetings weekly and not monthly” (P3)

“Have participants with similarities of issues and concern meet together” (P8)

“Include prayer and scripture” (P9)

RQ4: What verbal and written educational information helps African American women understand the relationship of weight loss to chronic disease risk and improved quality of life?

Theme 8: Participants felt that African American women lack knowledge about how physical health affects other areas of their lives. In this study it was a general consensus among the participants that some, but not all, AA women lack knowledge about how physical health affects other areas of their lives. Most of the women agreed that for many women the information needed, verbal and written, sometimes have conflicting information and it leaves them with questions. These women felt that some information provided during health promotions may not come from reputable sources. They shared that you should only rely on information that come from

approved, evidence-based organizations such as the CDC, WHO, American Diabetes Association, American Heart Association, Academy of Nutrition and Dietetics, American Cancer Association and other approved government organizations or websites.

Some of the women were comfortable with the information they have received and felt that they should share the information they have with family members at various events like family reunions to help others. Some of the women felt “it’s not the information that is the problem it’s “the mindset” of the individuals.

Other women felt that while the information is often disseminated, verbally or written, it can be overwhelming and when it falls into the hands or on the ears of people that cannot interpret it properly, because of the medical jargon, this causes confusion among those seeking to have better health outcomes. The women felt it would be better for each person to be selective in receiving the information pertinent only to their condition, and that it should be short and to the point, and after which you should seek education by a professional for that condition. Another participant added that when a speaker presents information they should be open to getting emails from their audience just in case something was misunderstood in their presentation. Other comments are as follows:

“Food nutrition and its impact on the body are not taught enough in school or at home. We usually learn what food (unhealthy) does for and to the body after we have packed on the weight or had a serious health issue like a heart attack.” (P1)

“There is limited knowledge but we recognize that if we are not healthy we are not strong enough to care for other family members and to live our dreams. Women need to and must be proactive in learning all we can to promote overall good health.” (P2)

“I do not believe we really understand how poor physical health will affect us. Example: when we are in poor physical health, it is difficult to carry our spiritual assignments. When we are in poor health we are susceptible to depression and anxiety. We spend more money and lose productivity when we are in poor health. (P7)

“There is a lack of knowledge how your physical health relates to or affects all other areas of our lives. We sometimes just don’t see how taking a walk outdoors can alleviate depression, some may know that it can help improve our overall health but we just don’t follow through (P8)

RQ5: How do African American women feel about church-based health promotion programs in comparison to other types of health promotion such as Weight Watchers?

Theme 9: African American women want health promoters to develop holistic programs that encompass the entire family. The AA women in this study noted that churches should seek to build holistic health promotion programs that encompass the entire family. Participant responses are as follows:

“I agree that programs should be culturally sensitive and attractive enough for women and their families to have a desire to participate.”

(P2)

“I agree, the program must look at the body as a whole.” (P3)

“There is usually a conflict of interest when it comes to caring for family and caring for self. Holistic programs that include family concerns would help eliminate this conflict. (P7)

The women in the research agreed that the church-based health promotion is the best option, for the following reasons:

“There is no cost. If the church has a gym or family life center participants can benefit from it. It is more personably and it promotes fellowship. Everybody is on the same path and have the same goals. It is motivational with everybody getting together.” (P6)

“We can incorporate some of the techniques used by Weight Watchers, but why pay money at Weight Watchers and the church is free. We are with people we know.” (P2)

“Secular programs are good, but we can use their model and add scriptures to see our self in the place of God’s will.” (P8)

“Church-based is better it speaks to the entire person (social, spiritual, physical, emotional, other), while secular programs are aimed at diet only and sometimes fitness.” (P7)

“Weight Watchers is set-up basically for financial benefits or their reputation.

RQ6: How do African American women feel the role of the church in health promotion can be expanded?

The AA women in this study felt that the church is a major resource to help reduce chronic disease and that church leaders have not been the role models for healthy living.

Theme 10: For African American women, the church is a major resource.

The church is viewed as the bedrock of the AA community and it is held upwards as a pillar of hope for many. Most of the AA women in this study feel that the church is the center of the community and that it should be the place where they can go to find help in every area of our lives. The women in this study reported that the church is the key to many social ills that plague the AA community, including chronic disease. However, many of them reported that the church is not taking the active role it should on health promotion, as well as some other social issues faced in the AA community.

When asked what the role of the church in health promotion should be, these women had a lot to say, for example:

One participant stated “talk is cheap, we say one thing but we do something else... the church should be a model for the entire community in every aspect, the church promotes that our bodies are the temple of God but is not responding to the entire call.”

Another participant feels “there should be more conversation about health issues and teachings about how to get off medications using healthcare professional speakers”. Another said that the role of church is to reach out and connect to others in the community and other churches, to provide a stronger support system for any project we are trying to accomplish. Another felt that the church can be a supporter of health by providing healthy food choices and more talk about health. Yet another participant stated that “the church is our staple and health promotion is major.” Another added that if a church is going to provide health promotion it needs to focus on “maintenance,” to help the person after they have reached their goal. These women felt that the pastor should promote diet, nutrition, exercise and deal with health issues, and that the church should develop a model that works, and share it with other churches and denominations through fliers, church announcements and bulletins, but most of all “get it off of the table and put it in front of pastors and the congregation.” These women provided many other comments on what the role of the church should be in health promotion:

“It has been revealed in health studies that attending church, being involved with prayer partners and the belief in God has helped many

overcome or helped them to deal with various health issues. Prayer reduces stress which helps the body to heal.” (P1)

“The church can be a link to provide workshops to provide medical and nutritional information as well as exercise programs to help reduce chronic disease.” (P4)

“The church can help reduce some chronic disease by developing proper meal planning and cooking classes. The church need to set-up and encourage physical fitness classes at least twice per week.” (P5)

“We depend on the church to help us have a closer walk with God, so we trust the church also to help us understand whatever is going on with us. This is done through seminars and health and wellness ministries.” (P6)

Theme 11: African American women report that church leaders could have been better role models for healthy living. When these women were asked about the role of the church leaders being role models they responded:

“We see it all the time, the oversight, the preacher and many obese choir members. When various occasions come up southern cuisine is served adding to the problem. Healthy eating and exercise should be promoted in the church by the leaders and then congregation will follow. (P1)

“I truly agree leadership plays a major role. Sometimes we have those in the church pulling away from ideas when they have the power to impact many lives.” (P2)

“I believe that as we receive more knowledge about health, those in leadership positions should have more concern about their personal health, but traditionally, I do not think leadership has taught the importance of physical health.” (P7)

“I personally agree with this. I don’t think the church as a whole has done a very good job at relating your physical health to your spiritual health, or describing how the two go hand in hand for overall health and wellness, holistically. (P8)

“Many times the leaders in church positions do not make healthy living relevant; therefore, it does not expose the followers to it.” (P10)

RQ7: What is the role of African American women’s spiritual beliefs concerning weight-loss as they go through a program?

Theme 12: African American women believe that religious beliefs are compelling factors for success in every aspect of life. Many AA women have strong religious beliefs toward there being a higher power that is able to help them out of whatever situation they may encounter. Even with this sense of optimism for that spiritual force that is able to deliver and sustain, it appears that in the fight against chronic disease the women have not been able yet to conquer and defeat obesity, but they still have hope.

All of the women in this research believe that their body is the temple of God and that it should be treated as such, holy unto God and that they should glorify him through their body.

“The body is the temple and we must take care of it; how effective can we be spiritually if we can’t stand, if we can’t worship, being too heavy on our feet and having aching knees?.” (P10)

“It is a sin to overeat and that our bodies are the temple of the Holy Ghost and we should want to treasure it so that we can do Gods’ work.” (P4)

“While we have spiritual beliefs “we have not yet made the spiritual connections between our health and our bodies” (P7)

“When you are unhealthy it hinders your church activities, you can’t praise, you too tired, you too heavy, you can’t jump or run, just wave, and you know that you need to make a change.” (P5)

Summary

The participants in this study were all AA women living in the Jackson, MS metropolitan area. These women participated in the same community-wide weight-loss program, MMIM, through their own individual churches. I met with each participant in a private setting to conduct a one-on-one interview to obtain their perspective on their weight-loss journey from their participation in a church-based weight-loss program. Participants in this study had various perceptions about the experience of trying to lose

weight in a church-based program. Some thought the MMIM was a ‘great program’, while others thought the program should have done more with the churches to help participants have extended and successful outcomes. In particular, they recommended (a) weekly meetings rather than once a month with the churches; (b) a program representative visiting each church and talking more about health, (c) weekly incentives, and (d) a shorter time span than 10 months.

Some of the research participants also had issues with their individual church MMIM projects. They felt that some of them were not trained, and did not have the communication skills or personality to create the right environment to promote success. Some reported that the pastor, his spouse or other leadership played no role to support the project. A few others reported that the pastor played a minimum role in the health promotion. In another church the pastors’ wife played a major role as a team leader. All of the participants shared that in order for a church-based health promotion program to be successful the pastor, his spouse and other leadership will need to be involved. Many participants reported that despite the short comings of the MMIM project, it did make them more aware and self conscious about their health. One participant stated that she continues to do some of things learned while going through the program.

Overall, the participants agreed that their childhood and cultural experiences and environment around their eating traditions of families, at home, church gatherings, holidays and special events has helped to perpetuate their present unhealthy behaviors. It is duly noted, that the participants in this study firmly believed that better health

outcomes are perpetuated on an enhanced role of the church concerning health promotion, social support, and health education and personal responsibility concerning chronic disease prevention and management.

In conclusion, this research finding posits that the weight-loss barriers provided by the AA women in this study are strongly influenced by their cultural experiences of their childhood along with some life experience in their adult lives. These factors have significantly impeded their attitude and behavior toward their weight-loss journey. Some of the other factors mentioned were socioeconomic status, environmental, cultural and mental factors. Some noted having issues with the side effect of medication and health issues, lack of family support and transportation and body image.

While these women faced many barriers, they feel confident that if a well-organized church-based health promotion program was developed within their church, coupled with a strong social support system, aligned with trained healthcare professionals, positive support from the pastor and leadership, it would help them become successful in their weight-loss goal and maintenance endeavor. With these support factors in place, the women attitudes and behaviors toward eating healthier foods and increasing physical activity to combat obesity and other chronic disease will be more apt to change.

In Chapter 5 the following will be discussed: interpretation and findings, limitations of the findings, recommendations for future research, implications for positive social change and conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological study was to understand the experiences and perceptions of 10 AA women as they participated in a church-based health promotion program. Overall, my primary goal for this study was to gain a deeper insight of these AA women attitudes and perceptions as they tried to reach their desired weight loss goal to fight obesity and other chronic diseases through a church-based health promotion. My other goal was to determine how effective the health promotion program would be in helping them to reach their desire goal.

The AA women in this study struggled with several preventable chronic diseases, including obesity. According to the MSDH (2014), the prevalence of preventable chronic diseases such as obesity is higher in Mississippi than any other state in the United States. I observed according to the literature that obesity has become an increasing public health concern (Wand & Ramjee, 2013). In order to combat obesity, individuals must choose a healthier diet and must have a regular routine physical activity regiment. Obesity is a global pandemic because of its presence in almost all countries (Swimburn, et al., 2011).

The 10 AA women in this study all lived in the Jackson, Mississippi metropolitan area. These women came from various backgrounds with diverse socio-economic statuses, education levels, ages, marital statuses, church affiliations, and personal and health characteristics. The aim of the church-based health promotion program that these

women participated in was to reduce obesity. The perceptions of the women in this study suggested that their obesity had both external and internal contributing factors.

Many quantitative studies have explored the phenomenon of obesity, but few have addressed the experiences of AA women going through church-based weight reduction programs. In the previous chapter, the main findings were summarized into the following twelve themes:

Barriers faced by African American women in their efforts to lose weight

- 1: Some women were raised to see food primarily as a survival tool.
- 2: A few women were taught about healthy food in childhood.
- 3: Food habits are set in childhood.

Factors influencing African American women in church-based health promotion

- 4: Planning is a major key to successful weight loss and maintenance.
- 5: Having a role model helps in weight loss.

Social support African American women need to help them with weight loss

- 6: All types of social support are beneficial in achieving and maintaining weight loss.
- 7: Program participants wish to be consulted on program design.

Information and knowledge on weight loss, chronic disease and quality of life

- 8: These women lack knowledge on how physical health affects other areas of their lives.

Preference for type of weight-loss program

- 9: African American women want holistic programs that encompass the entire family.

How the role of the church in health promotion can be expanded

10: For African American women, the church is a major resource.

11: Church leaders should be role models for healthy living.

The role of African American women's spiritual beliefs in weight loss

12: Religious beliefs are compelling factors for success in every aspect of life.

These findings revealed that the main reasons why these women struggled with their weight and continued to be obese or overweight were a lack of social support, lack of planning, lack of holistic health promotions, and the lack of the church focusing on health.

In this chapter, I interpreted the findings from the interviews and provided more detailed information on the major themes that helped to answer the overall research question: What are the experiences of AA women participating in church-based health promotion programs?

Interpretation of the Findings

In this research, I utilized a phenomenological approach to extrapolate the themes for this study. The primary purpose of this research project was to understand the emotions, attitudes, and experiences of AA women concerning obesity, weight loss, and the effectiveness of health promotions in a church-based setting. Of interest was the discovery of factors from the cultural, social, and environmental perspectives that may influence future approaches to obesity prevention. I examined the experiences of AA women as they matriculated from the MMIM, a church-based health promotion program.

During the data analysis process, I recognized major themes aligned with those in the literature review as noted in Chapter 2. There were commonalities that resonated throughout the review and some of the same factors that were prevalent in those studies were reiterated during the interviews. Both the previous literature and this study found that AAs struggle with weight-loss to attain optimum health and that obesity continues to escalate within the AA community.

The mission and vision of the MMIM was aligned with those of past church-based weight-loss programs such as: (a) William and Kautz, 2009, McNabb et al., 1997, Yanek et al., 2001, Zoellner et al., 2011, Parker et al., 2010, and (b) church-based programs that focused on physical activity and nutrition such as: Campbell et al., 2000, Resnicow et al., 2001, Resnicow et al., 2004, Resnicow et al., 2002, Rigsby, 2011, Peterson et al., 2012, Duru et al., 2010, Kim et al., 2008, Campbell et al., 2004, and Wilcox, et al., 2010. The target of these programs was to reduce obesity among the AA community by promoting healthier lifestyles.

The following research questions were asked to each participant concerning their attitudes and experiences overall and during the MMIM CBHPP at their individual churches. The discussion is organized by research questions.

Barriers faced by African American women in their efforts to lose weight

My research revealed some of the basic barriers to weight loss cited in the literature (Bopp, et al., 2007; Cowart, et al., 2010; Kim et al., 2004; Peterson, 2011), such as: (a) lack of social support from friends and family, (b) lack of time due to other life

responsibilities, (c) lack of money to continuously buy healthier foods, (d) the challenge of breaking habits tied to cultural eating behaviors (e) fatigue along with the lack of motivation to maintain a physical activity regiment (f) the lack of commitment and self-control (g) the everyday stressful life circumstances (h) childhood relationship with food and (i) the lack knowledge of the effects of food choices and consequences.

Food was viewed as a survival tool. Some of the participants stated their cultural upbringing and food patterns continue to give them a perspective on how food is consumed now and even in their adulthood. According to Blixen et al., (2006), the practice of what and how people eat has been passed down through generations. One participant noted that “as you learn better you should do better regardless of how you were brought up.” As noted in Chapter 4, several alluded to the instructions given by their parents to eat all of the food set before them and to clean their plate. As noted in the study by Kim et al. (2008), one participant spoke about “not wasting food, but eat it all”. Overtime, dietary patterns can become addictive and are linked to eating disorders that are associated with dieting behavior in the early years that can promote obesity (Gerhardt et. al., 2011). One participant stated that food was viewed as “rewards in moments of celebration or comfort in times of sorrow.” Kumanyika, et al., (2007) stated that food is often used to deal with the daily issues of life and the stress it evokes. While it is known that food provides nourishment to the body, it was also noted by Hargreaves, Schlundt and Buschowski (2002) that certain food choices we make impact our emotions,” both positively and negatively.”

Food was viewed as a source of health. It was evident in this research that the women were aware of chronic diseases because all of them were battling with some type of chronic conditions. It was not evident that all of them knew that some of the conditions they had could have derived from the lack physical activity, cooking patterns, and the lack of knowledge regarding good nutrition and the education concerning how certain foods affect your overall health. In a study conducted by Kim et al., (2008), one participant stated that eating is not the problem; but its' knowing how to eat and when to eat. The study furthered cited how peer pressure affects behavior in a social setting. It is noted in the literature that the food choices of many AAs consist of high fat and sugar, frying and a low consumption of fruits, vegetables and whole grains foods, which contributes to chronic health conditions (Baruth, et al., 2011; Cowart et al., 2010; Yanek et al., 2001; Christie et al., 2010; Resnicow et al., 2004; Resnicow et al., 2001; Rigby, 2011). Baruth et al. (2011) further stated that a poor diet and the lack of physical activity are among the leading causes of death in the United States.

The participants in this study were aware that they needed to eat healthier but acknowledged their lack of skills in healthier meal preparation. In the study by Kim et al., (2008), one of the major barriers the participants faced was the lack of knowledge about healthy cooking. In the literature I observed that AAs have the potential to make changes to their eating plans by cooking the foods they enjoy using alternative methods, which can yield better health outcomes over a span of time. (Cowart et al., 2010; Parker et al.).

Overall, the research participants were well aware of the eating patterns, behaviors, and challenges faced by AAs and their desire to attain and maintain a better quality of life by making better food choices to help reduce obesity and chronic disease. Nevertheless, the women in this study expressed their disappointment about being overweight or obese and their apprehension regarding continued patterns and their inability to become successful in their weight loss goals. One woman spoke of being ashamed of her size and always wearing bigger clothes so that her real size did not show.

Some of the other women expressed feelings of being disappointed, uncomfortable, disgusted, angry, miserable, and unhappy at various times. One woman was self-accepting and content where she is and is no longer attempting to lose weight. In a study conducted by Baturka et al. (2000), the researchers stated that some AA women yield to a strong cultural pressure to accept who they are, make the best of their appearance and be happy with what God gave them.

Factors influencing African American women in church-based health promotion

My research revealed the following themes relevant to this research question. There were two primary themes identified and discussed in Chapter 2 of this research.

Planning is an important tool for successful weight loss and maintenance. The literature supports the idea that, in order to have success in weight-loss and maintenance, planning is a key mechanism (Hargreaves et al., 2010; Fitzgibbon et al., 2005). These authors further contend if there are endeavors to lose and maintain weight, certain strategies must focus on types of food and meal planning, holiday planning, eating out,

and family and social gathering. (Hargreaves et al., 2010; Fitzgibbon et al., 2005).

Ironically, while all of the participants agreed planning was an effective tool and key to their success, only one person had continued to focus on changing her weight by using this strategy. It is evident that to be successful there must be a certain mindset and time allocated to achieve any desired goal.

In terms of planning, one participant suggested the following: (a) learn individual self care strategies after certain life's issues are experienced such as divorce, (b) set personal goals, she called them events, for example, she stated that most people lose weight as they prepare for a wedding, therefore, create events that foster weight loss. She further contended that to remain motivated or have self-control read information that provides some type of inspiration.

The literature introduces a plethora of habits that must exist on a continuous basis to lose and maintain weight-loss, such as: (a) self-efficacy, (b) positive attitude, (c) social support, (d) self-monitoring, (e) locus of control, (f) stress coping mechanisms, (g) motivation, (h) continuation of physical activity (i) and healthy dietary choices (Elfhag & Rossner, 2005). The research shows that among women who are overweight and regain their weight, very few of them use social support strategies and have an exercise routine, and many eat based on their emotions (Kayman, Bruvold & Stern, 1990). In comparison to women in general, AA women have a tendency to regain the weight (Parker et al., 2011).

Secondly, role models are helpful in weight-loss programs. Most participants in this study reported that having a role model is a positive and powerful premise in the attainment of any desired goal, especially in weight-loss. Interestingly, none of the women had experienced a childhood role model who could have helped them challenge or refocus their mindset on a healthier lifestyle as they grew. The literature posits that role modeling starts in childhood, be it negative or positive (Prochaska & Velicer, 1997). There is considerable evidence that an epidemic of childhood obesity is directly linked to obese adults (Whitaker et al., 1997). Primarily parents have the first role in the etiology and prevention of weight control and for raising healthy children so that they do not become overweight or obese. Parents are charged with the food choices for their children and whether they will model healthy or unhealthy behaviors (Golan & Crow, 2004; Lau, et al., 1990).

In this study, many of the participants alluded to the fact that the church should be where the ideal role models should exist in all facets of life, since it is the center of the AA community (Peterson et al., 2012). Other participants commented that we cannot blame the church for our actions, but we must take personal responsibility for our own health outcomes once you learn how to better take care of yourself.

Social support African American women need to help them with weight-loss

As fore stated, there are many components to successful weight-loss, such as planning, goal setting, and taking personal responsibility, and with social support being a key factor to ensure the engagement of AA women to promote better eating habits,

physical activity and to have overall better health outcomes (Bracy et al., 2014; Eugeni et al., Mama et al., 2015).

All types of social support are beneficial in health promotion. The first theme is that any kind of social support is beneficial in weight-loss. All of the women agreed that social support is very beneficial to them on an individual basis as well in a support group when joining a CBHPP. Overall, the women indicated that having family and friends to encourage them and to have someone to communicate with on-going and to fellowship with for physical activity to support their journey would be extremely valuable.

Many of the health promotion programs discussed in Chapter 2 noted social support as one of the main factors that sustain a health promotion program (Campbell et al., 2000; Resnicow et al., 2001; 2004; Duru et al., McNabb et al., 1997; Peterson et al., 2012; Wilcox et al., 2007; Cowart et al., Yanek et al.). When social support is included in CBHPPs, positive and favorable results are realized in health behavior changes, especially for physical activity with women (Peterson et al., 2012).

In other kinds of health promotion – e.g. with Alcohol Anonymous and with individuals receiving dialyses – social support has also been found to be helpful, because each member of the group was experiencing similar situations (Groh et al., 2008; Wells, et al., 2011). In the study by Resnicow et al., (2004) successfully increasing fruit and vegetable consumption required social support through one-on-one counseling and telephone calls from professional within the church such as social workers, teachers, nurses and psychologists. Cowart et al., (2010) mentioned “personal connectedness”

between the participants and program leadership was critical in reducing obesity and promoting a healthier lifestyle. This was confirmed by Peterson et al., (2011) in an evaluation of the HSPAP program, which was designed to increase physical activity, social support by partners, family and friends, and other women in the program, through emails, encouraging prayers, phone calls, spiritual messages and pastoral support helped the participants to maintain an active lifestyle, increase self-esteem, and improve health.

Finally, Yanek et al., 2001 health promotion was designed to improve cardiovascular disease (CVD) health among AA women. As a result of social report from the lay health leaders, the pastors and other the women reported significant improvements in waist circumference, systolic blood pressure, dietary energy, fat and sodium and weight-loss. The authors suggested that this health promotion can be replicated and improve health outcomes for CVD.

This research is grounded in the social support framework. As fore stated, this construct seeks to explain how individuals are able to help each other as they deal with challenging situations in their lives such as achieving weight-loss goals. According to Kegler et al., (2012), social support is rich in church settings and can be used as an advantage point to promote healthier lifestyle changes. Another component of weight-loss is weight control. As noted in this research the participants strongly acknowledged that social support is perceived as a vital part of successful weight-loss efforts and adherence. The role of social support appears to be a key factor to promote positive behavioral changes in health promotion (Wells & Anderson, 2011). Since the church

serves as a buffer against so many of the social ills of life, the framework of social support in weight loss is expected to be beneficial in the environment of a church-based health promotion weight loss program.

The second theme was that weight-loss participants need to be involved in the planning, designing and the organizing of the health promotion program. Kumanyaka, et al., (1991) speaks to the importance of the program content and the program characteristics that will promote the success or failure. The participants in this research suggested that participants must have a voice in the overall design of the program. This also speaks to the planning and goal setting on behalf of the promotion organizers. Program fidelity, which ensure that the appropriate time has been given to every aspect of the health promotion to ensure success, was emphasized in Chapter 2 as a major component that promote the success or failure of a program (Rohrbach et al., 2010; Fagan et al., 2008; Noonan et al., 2009). One example can be seen in Cowart et al., 2010. From a leadership perspective the pastors, the ministers, and individuals from the various churches were trained and discussed the .goals, roles and responsibilities, after which the participants were involved and everyone followed through with the health promotion. At the end of the project, the participants did not want it to end. It was noted in the literature that the “personal connectedness and the program ownership empowered successful outcomes.

The TEAM (Castro, et al., 2011) health promotion, a 12-month telephone advice and mentoring study encouraged physical activity, stressed how program fidelity is

essential to program success. The inclusion of program fidelity in planning would help lead to a greater investment and loyalty by the participants, wherewith, leading to increased success and better outcomes overall for the program and participants. The MMIM participants further contended that it is crucial that each participant is assessed for needs in terms of participation and that all the structural and environmental supports are in place. They also had concerns that any health promotion should have spiritual components, offer incentives, promote small changes, and include a weight lost maintenance plan and that the building is accessible for activities. The literature review revealed that when the congregation become emotionally attached to the health promotion and take ownership, the promotion can yield better outcomes. For example, Williamson et al., 2009, overall objective was to reduce risk factors for stroke. During a Sunday morning the pastor introduced the health promotion to the congregation and the church gravitated to the idea. When the church members accepted leadership roles it allowed them the opportunity to shape and design the program to fit their specific needs.

Cowart, et al., (2010), health promotion was designed to reduce obesity because of its associated risk to chronic disease. The program planners developed a Pastors' Health Council and the pastors pledge their commitment to the program. After which all six pastors was trained on delivering health messages and they became models of health by helping to develop the health promotion program and engaging their congregations to embrace healthier lifestyles. They recruited lay health advisors in the church and used the train-the-trainer model and helped to design the program to the specific needs of their

congregation. The design of this program provoked ownership, motivation and empowerment. It is evident from the research study and the literature review that program fidelity and the program design is vital to the success of any health promotion.

Information and knowledge on weight loss, chronic disease and quality of life

When asked about information, the majority of the participant felt that they were on information overload, especially during health promotion programs. They felt that so much information is available but it needs to be tailored, catered and disseminated differently to meet specific and individual needs, so that each person could have a better understanding how to use the information best for their health situation. They also stated the different presenters have different education levels, tone, presentation styles and that they are not familiar with their audience and this sometimes presents a problem to participants in understanding and evaluating the information.

Timely and accurate information is paramount in health promotion. This is the only theme to arise from this question. In Chapter 2, it was evident in the health promotions that the type of information received was crucial to the success of the program. Health promotion programs suggested and discussed that the information provided should be culturally sensitive. (Shaikh et al., 2011; McNabb et al., 1997; Zoellner et al., 2011; Cowart et al., 2009; Wilcox et al., 2010). To ensure that participants are receiving evidence-based information health promoters should be resourceful and everyone involved should be adequately trained. Each health promotion

should have appropriate educational activities, offer resource guides, tailored printed materials, learning activities and specific disease discussions. (Lancaster, et al., 2014).

The women in this research expressed their disappointment with speakers doing the MMIM, not speaking on their level of understanding and using words they did not comprehend and without having an opportunity to ask questions. The women also expressed that there is enough information available on all the diseases but they lack the opportunity to have information more specified on their conditions. Finally, they were concerned whether all the printed materials were accurate and if the websites was reputable.

Preference for type of weight-loss program

AA women want holistic health promotions that encompass the family. This was the only theme to arise from this question. All the participants agreed that the church-based health promotion would be best in developing a holistic approach toward weight loss. The various components of such an approach have been reported in the literature, for example: *spiritual components* (Campbell et al., 2000; Duru et al., 2010, Resnicow et al., 2004, 2001; Shaik et al., 2011; Peterson et al., 2012; Yanek et al.,; Kim et al., 2008; Parker et al., 2010); *cultural sensitivity* (Shaikh et al., 2011; Resnicow et al., 2001, 2004; Cowart et al., 2009; Zoellner et al., 2011); *training provided by lay facilitators or educators* (Mcnabb et al., 1997; Campbell et al., 2000; Campbell et al., 2004; Peterson et al., 2012; Zoellner et al., 2011; Yanek et al., 2001; Cowart et al., 2009, Wilcox et al., 2007; *pastoral and church leadership influence* (Duru et al., 2010; Campbell et al., 2000;

Yanek et al., 2001; Rigsby, 2011; Cowart et al., 2009; Wilcox et al., 2007 ; *small change approach* (Wilcox et al., 2010; Lutes et al., 2008., Cowart et al., 2009); *faith-based and faith-placed concept* (Williamson & Kautz, 2009; Parker et al., 2010) and *program fidelity* (Zoellner et al., 2011; Yanek et al., 2001). Only one of the church-based promotions reported in these studies had all of these components. In each case, the authors reported that these components were instituted to encourage success, but the level of success varied between participants during the life of the project. The participants in my study were concerned with *pastoral leadership* and a *faith-based concept*, but they added a new one: a program that would encompass the entire family and meet their needs on various levels of life.

The participants stated that the church-based program could be easier to develop for families which could provide some of the social support needed within the home, hence improving their experience and improving relationships with their spouse and children. The other comments focused on being with other people that you are familiar and comfortable with and those who are trustworthy. The participants acknowledged that church-based program should be designed to fit their culture; they suggested that scriptures, prayers and songs could be instituted and that they could have some input to the design and the overall program operations. While church-based was the preference do to no cost or low cost, they were open to other concepts from programs such as Weight Watchers that could be beneficial.

In the SIM health promotion (Duru, et al., 2010) suggested that CBHPP would be more effective due to its “reach” and ability to offer a spiritual-based program. The Bless Project, (Williamson & Kautz, 2009) focused on reducing CVD. This promotion was a prime example as it mixed faith-based components with faith-placed components of the Weight Watchers program to educate the congregation on risky behaviors. This project also focused on the involvement of the members in the health promotion, as well as, (Coward et al., 2010) a focus on reducing obesity. According to Duquin, et al., (2015) the curricula for health promotion programs should be developed with a holistic approach to ensure that all the dimensions (physical, emotional, social/interpersonal, intellectual, environmental and spiritual) are covered to ensure successful outcome for the participants. The authors suggested with such a curriculum this will help to strengthen the family, ensure self-efficacy, and promote healthy behaviors and lifestyle changes; consequently, preventing or reducing chronic diseases.

How the role of the church in health promotion can be expanded

AA women feel the church is a major resource for health promotion. The black church is revered in the AA community and viewed as the most important social institution that preserves the “black ethos” and is a pipeline to deliver “social welfare” (Levin, 1984; DeHaven, et al., 2004). It is widely noted in the literature review that the AA church has been identified as a primary source of reaching the AA community on multiple levels, inclusive of health promotion to reduce obesity and other chronic diseases, because of church’s’ ability to influence or impact behaviors (Campbell, et al.,

2007b; Christy et al., 2010; Baruth et al., 2011; Cowart et.al., 2010; Peterson, 2011; Parker et al., Duru et al., 2010; Yanek et al., 2001; Resnicow et al., 2001; McNabb et al., 1997). As noted in Chapter 4, in the eyes of the women in this research, the overall consensus confirms this view. The church is an esteemed institution and it should set an example in every aspect of our life, from cooking to counseling. The women in this study stated that they look to the church to help solve problems and matters of every sort, and matters of health should be on that list. In Project Joy (Yanek et al., 2001), it was observed that regardless of the intervention in which participants were placed, all participants' results was significantly improved due to the church based affiliation. The analysis of The WORD program, Kim et al., (2008), was evident of this finding. These authors postulated that the participants who were in the group intervention with the spiritual components had greater results than the other group.

The second theme was that AA women reported that pastors, preachers, overseers and other church leaders have not been positive role models for healthy living. The women in this sample felt that the role of the church could be expanded if the leadership of the church would become proactive and involved in health promotions. At least one participant cited that while she feel the church should take on this role, but it in reality it comes down to each person taking personal responsibility as they learn what is necessary to have a better health outcome.

Peterson (2001) reported that a lack of positive role models, along with ineffective social support, were the main factors that decrease the success for participants

in weight-loss health promotions. The pastor role in the church is paramount, but the influence of the pastors' wife and deacon wives has not been fully explored. According to Duru et al., (2010), health promotion to improve breast screenings, it was noted that the presence of the pastor wife and deacon wives was beneficial to its success with the increase of attendance. It resonated throughout the literature review, that the engagement of church leadership is vital to successful health promotions outcomes. It was noted that when pastors and their wives was involved more participation was realized such as in these studies. (Baruth et al., 2011; Christie et al., 2010) Yanek et al., 2001; Wilcox et al., 2007; Peterson, 2011; Cowart et al.)

In a church-based health promotion to reduce colorectal cancer (Lumpkins, Coffey, Daley & Greiner, 2013) all the pastors interviewed agreed that the church should take the leading role to communicate and promote risk and prevention information to accomplish effective health promotions in the church. Subsequently, in another study, when pastors was asked about their perspective of research at the church, they believed that the church is a promising venue for health promotions, but they would move cautiously to identify any "potential conflict" as they speak in regards to respect to the church values, the ability to develop trust, and time spent away from the pulpit which is the pastors primary duty and to ensure that a clear understanding of the health promotion is established. (Smith et al., 2010).

The role of African American women's spiritual beliefs in weight loss

AA women believe that religious beliefs are compelling factors

for success in every aspect of life. This is the only theme that resonated from this question. All of these women have deep religious beliefs that God will work for them in every aspect of their lives, even weight loss. As in Williamson et al., 2009, the theme of hope was prevalent and displayed through their praise and worship during meetings, by believing that God is the bread of life, by believing that the body is the temple of God and by displaying what they believe by participating in “Go Red Sunday.” This action was embodied and embedded in their faith to obtain success in this health promotion. They believed that their body is the temple of God. Despite their continuous struggles, they are encouraged that they will overcome and conquer their goal. They believed in the Bible and that scriptures, meditation and social support among like-minded positive individuals can help them as they move forward toward meeting their goals to obtain better health outcomes.

Subsequently, Parker et al., 2010, focused on reducing obesity, they aver while churches are important for health promotions and health benefits was realized for both the spiritual and non-spiritual group, the reading of the scriptures did not have a big impact. Thus, in the literature review, the spiritual component was prevalent and responsible for the success of the program participants in (Rigsby, 2011; Peterson et al., 2012; Resnicow et al., 2004., Yanek et al., 2001; Campbell et al., 2000). All of these promotions mentioned that they included prayer, spiritual songs and scriptures. This is also emphasized by Odeluna et al., (2013), who hold that the church has a responsibility toward its congregants to provide health promotions, and that emphasis on the Bible and

the beliefs of participants, provides a foundation for reducing obesity and chronic disease in the AA community.

Limitations of Findings

Some limitations existed in this study. First of all, this was a purposeful and homogeneous, sample of women from the same geographic area and involved in the same weight loss promotion program. This limits the generalization of the overall results because of various demographics characteristics of each individual that could have affected their overall health status. Secondly, the sample size was small with only 10 participants, but it was large enough to reach a point of saturation. Conversely, in a qualitative phenomenological study this number is valid once a point of saturation has been reached (Marshall et al., 2013).

Another limitation was the self-developed nature of the researchers' interviewing instrument, which could have affected the validity and accuracy of the data (Creswell, 2013). Since all the data were self-reported there was also a question of bias or lack of accurate reporting of events due to possible memory recollection (Brutus et al., 2012).

Recommendations for Future Church-Based Weight Loss Programs

During this research, I discovered that these AA women who previously participated in the MMIM CBHPP were open and willing to discuss their feelings and offer recommendations on how their experiences can be enhanced in future CBHPPs and how CBHPPs can be designed and developed to obtain optimum results and increase the success ratio of participants and possibly sustainability of the program.

The participants recommended that in CBHPP programs, (a) participants need to be included in the planning and design of the program, (b) the pastor and his spouse, along with other church leadership should be involved and be role models, (c) programs should be designed using a holistic approach focusing on the entire family, and being attentive to physical functionality of participants and their overall health conditions, (d) relevant, evidence-based written and verbal information for specified chronic diseases should be provided, (e) speakers' presentations should be timely and easily understood, (f) culturally-sensitive spiritual components should be included and (g) the program should have a strong social support component. While this study was limited to one CBHPP, some of the findings may be applicable to other programs developed for AA women in similar geographic areas.

Recommendations for Future Research

The literature reviewed revealed that the majority of the studies conducted among AA women concerning, weight loss, nutrition, and obesity are of a quantitative nature. Since the qualitative research is sparse on this subject matter, it is concluded and highly recommended that this research design be conducted on a broader scale with AA women to give credence to this phenomenon and provide a platform for them to share and discuss their lived experiences in CBHPP.

Additionally, the phenomenological approach will be beneficial in adding more scientific knowledge and rigor to the research field about obesity, weight-loss and chronic disease among AA women.

Implications for Positive Change

The findings of this study could promote positive change when the results are revealed to other public health advocates and the organizers and practitioners of CBHPP. It has been concluded that obesity is preventable, and these women have struggled with being obese and overweight for long periods of time. The results of this study can help to provide health education, awareness and improve the knowledge gap concerning their beliefs, culture and attitudes concerning health promotions. The data gathered can help to improve and organize culturally relevant church-based health promotion programs and promote success for participants as they matriculate toward their goals using key components as listed in the conclusions to organize a successful CBHPP.

This study is limited in generalization due to the small sample of AA women but can have some implications for women across socio-demographic backgrounds. Research shows that women of racial differences, AA and Caucasian, share some of the same reasons for participating in a health promotion, such as concerns for health, attending special events, appearance, self-esteem and becoming physically fit. (Striegel-Moore, et al., 1996; Bixen et al., 2006). Some of the same values, beliefs and attitudes about obesity and weight-loss exist among the racial differences. While AA women seem to have less success than Caucasian women, which is possibly contributed to lower social pressure, all of them have the need for social support and the design for programs that are culturally sensitive (Northweher, 2004; Fitzgibbon et al., 2012).

It is concluded that as participants continue to gain knowledge concerning obesity and its effects on their physical health and its relationship to chronic disease, this can help to reduce the prevention and continued proliferation of chronic disease and promote a better quality of life within the AA community. Overall, this study could have a significant positive impact on the health of future generations.

Conclusions

This study described the lived experiences of AA women, as they went through a local church-based weight-loss within their community to combat obesity. It is evident that education on obesity and being overweight is imperative, with both short and long term strategies for prevention. Despite these women continued desire to lose weight, the majority of them continue to live sedentary lifestyle and make unhealthy food choices. The themes that resonated throughout the discussions were: (1) planning is a major key to successful weight lost and maintenance; (2) effective role models can be an asset; (3) on-going social support is critical; (4) participants in the health promotion need to help with program design; and (5) health promoters should develop holistic and culturally sensitive programs. It is observed that if these components are introduced to a health promotion it can help to bring some resolve to combating obesity and help to promote social change on a higher scale.

It is concluded in this study that churches – and especially pastors, pastors' wives or another woman in a spiritual leadership role and generally, overall church leadership – can be that major conduit to help contribute to reducing obesity and help

individuals develop better eating habits to attain and maintain better health outcomes when they are involved in the health promotion,

The overall findings confirm that the women in this study have strong interests in weight-loss to gain a better quality of life and that they are willing to participate in a CBHPP, if they are included in the structure and organization of the program to ensure sustainable results. The key findings in this study was revealed in relationship to uncovering the barriers, identifying needed social supports, understanding of educational information, spiritual beliefs that are of importance and the significance of the role of the church in health promotions programs and its relationship to their success. The information derived from these discussions can provide evidence-based information that can help improve obesity policies, health literacy, health disparities, inadvertently, reducing chronic disease and the financial healthcare burden.

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Appendix A: Screening Interview Questionnaire

Date:

Name:

Phone Number:

Race:

Age:

Overweight/Obese: Yes or No

Do you live in the Jackson Metropolitan Area: Yes or No

If no, where do you live? City: _____

Do you have a chronic disease? Yes No Don't Know

Did you participate in the Medical Mall in Motion Program in 2012? Yes or No

If yes, how long did you participate? _____

Please answer the following questions:

Are you pregnant? Yes No

Do you feel you are emotionally disabled? Yes No

Do you feel you are mentally disabled? Yes No

Appendix B: Recruitment Letter to Prospective Participants

Dear Prospective Participant:


My name is Mangle L. Shanks and I am a doctoral student in the Public Health Doctoral Program (Community Health Emphasis) at Walden University of Minneapolis, MN. I am seeking to obtain the experiences and attitudes of African American women concerning obesity, weight loss and the effectiveness of church-based weight loss programs. Much of the data gathered will help provide insight into how future church-based weight loss programs should be designed to help combat obesity.

If you would like to participate, you will have a face-to-face interview with me to discuss topics that are related to the study. The discussion could take approximately two hours. For your participation, you will receive a \$20.00 Walmart gift card for your spent time and travel cost incurred. Refreshments will be provided for your enjoyment.


Once your acceptance has been confirmed, you will be contacted to schedule a date, time and place for the meeting. You will also be contacted within 24-hours of the meeting for a final confirmation. If for some reason you are unable to attend please advise immediately so that the allotted time may be filled by someone else. I look forward to gaining your perspective on these important issues.

Appendix C: Recruitment Flier

Research Study Recruitment



"Our First Wealth is Health"
Ralph Waldo Emerson



Recruiting participants for a research study entitled:
"The Experiences of African American Women Participating in Church-based Health Promotion Programs"

Target Population
African American women who participated in the Medical Mall in Motion Health Promotion from January, 2012 - October, 2012

Your contributions will help with the following:

- *Assist health promotion participants to achieve better outcomes
- *Build stronger health promotion programs in churches
- *Reduce risk factor associated with chronic diseases

Contact Information:
Mangle L. Shanks, Researcher
(601) 927-9756
mangleshanks@gmail.com

Appendix D: Demographic Questions

1. Age (years) _____
2. Weight _____ / Ideal Weight Goal:
3. Height ft. _____ in. _____
4. Do you have a family physician? Yes _____ No _____
5. If yes, how many times a year do you visit? _____
6. Do you have health insurance? Yes _____ No _____ If so, what type?
 _____ On your job _____ Medicaid/Medicare _____ Affordable Care Plan
 _____ Other _____

7. What is your Employment Status? (please check all that apply)
 - Employed: FT _____ PT _____
 - Self-Employed _____
 - Unemployed for more than one year _____
 - Unemployed for less than a year _____
 - Retired _____
 - Homemaker _____
 - Disabled _____
 - Student _____
 If employed, what is your occupation? _____

8. What is your Marital Status?
 - Married _____
 - Divorced _____
 - Widowed _____
 - Separated _____
 - Never Married _____

9. What was your highest level of Education?
 - Highest Grade Completed _____ GED _____ or 12th _____
 - College 1-3 (some college/technical school) _____
 - College 4+ years (college graduate) _____

10. What is your religious affiliation? _____

11. Do you have close friends? Yes_____ No_____
12. Do you have close family relationships? Yes_____ No_____
13. Do you have children/grand-children living at home? Yes_____ No_____ If yes, how many?_____

Appendix E: Health Questionnaire

1. Please check all of the health problems that you currently have or have experienced within the past 5 years:

- | | |
|---|---|
| <input type="checkbox"/> Hypertension/High Blood Pressure | <input type="checkbox"/> Gall Bladder Disease |
| <input type="checkbox"/> Pre-Hypertension | <input type="checkbox"/> Coronary Heart Disease |
| <input type="checkbox"/> Type II Diabetes | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Pre-Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Overweight/Obesity |
| <input type="checkbox"/> Other: _____ | |

2. Health Status - (circle one) - In general, my health is:

Excellent Good Fair Poor

3. How many days a week do you engage in at least 30 minutes of a planned physical activity? _____

4. Are you still trying to lose weight? Yes___ or No___

5. If yes, how? _____

Based on: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (2005)

Appendix F: Interview Questions

Questions Related to Weight Loss Barriers

Looking back at your attempts to lose weight in the past ...

1. How did the time you had available during the day affect your ability to lose weight?
2. How did stress affect your ability to reach your weight loss goals?
3. What was the role of self-control or motivation in reaching your weight loss goals?
4. How does social support, such as having a partner to encourage you or to exercise with you, influence your weight loss and weight maintenance?
5. What role did economic support make, such as having the money for exercise equipment or gym membership?
6. What were the environment issues, such as not having safe places to walk or exercise in your neighborhood that have been a deterrent to your weight loss or maintenance?
7. What other factors affected your ability to achieve your weight loss goals?

Research Questions Related to Cultural Factors

8. How does the influence of your mother or other family members or friends, affect your attitudes and behaviors toward overweight and obesity?
9. How does frequent participation in social activities and events, where food may be consumed, affect your ability to lose weight?
10. What education did you receive as a child about physical fitness and body weight?
11. What education did you receive about nutrition or being overweight as a child?

Research Questions Related to Church-Based Weight Loss Programs

12. Please describe any church-based weight loss programs you have participated in.
13. How long ago did you participate?
14. Did you lose weight? _____ Yes or _____ No
15. Did you maintain the weight you lost? _____ Yes or _____ No
16. If no, why do you feel you regained the weight?
17. How did your eating habits change as you went through this program?
18. How did your physical fitness habits change as you went through this program?
- 19.. What other barriers did you encounter in realizing your weight loss goal?
20. What role did the pastor or deacon or their spouse play in the program?
21. What role should a pastor or deacon or their spouse play in church weight loss programs?
22. In what ways did you feel the weight loss program organizers had the skills and abilities needed to implement the program in a manner that would bring about success?
23. What role did your religious or spiritual beliefs or church attendance play in achieving your weight loss goals?
24. What were the long-term effects of your participation in the weight loss program?
25. What was missing from your weight-loss program that would make it more successful?
26. Is there anything else you would like to share about church-based weight loss programs?

Research Questions Related to Attitudes and Emotions

27. What is your ideal body image, size and shape?
28. How did your size contribute to your attitude and behaviors about being overweight?
29. How did self-esteem - how did you feel about yourself - affect your ability to lose weight?
30. What was the intended goal to measure or ensure your success?
31. Please describe your feelings or emotions about not being the right weight.
32. Please describe your feelings or emotions when you try to lose weight.

Partial Source: Leslie (2005).

Appendix G: Jackson Medical Mall Foundation (JMMF)

Medical Mall in Motion Church Weight- Loss Competition

MISSION: The mission of the Medical Mall in Motion church weight loss competition is twofold:

- 1.) To foster a holistic approach to healthy living and -
- 2.) To foster a holistic approach to maintaining healthy lifestyles.

Our purpose is to provide an avenue for a friendly competition amongst churches that encourages the essence of teamwork and accountability, thus working together to achieve one common goal:

Transforming Lives Physically, Mentally, and Spiritually

VISION:

Our vision is to fight obesity and all its ailments (high blood pressure, high cholesterol, diabetes, stroke, cancers, etc.) by uniting all citizens of Mississippi for one common purpose, starting with the churches. United we will stand and shift Mississippi from the most obese state to one of the more healthy states.

Competition Information:

- Registration Fee = \$50 per church
- Churches must have a point of contact and/or team leader
- Program is 10 months long (kick off is in Jan 1st 2012 – Oct 31st 2012)
- Churches are to form their own teams; teams can be a minimum of 10 members.
- Each church team is responsible for its own work out plan/schedule. Partnering with one of our strategic team members will help facilitate this process.
- We have partners with 8 fitness centers that your church team may consider using (Tougaloo Wellness & Fitness Center, Walter Payton Recreation and Wellness Center, Courthouse, Y.M.C.A., Quest Fitness, Jackson Roadmap, MBA, & Unique Life Fitness)
- The church team leader will be responsible for reporting their monthly reports to the Medical Mall Foundation.
- The winning church will receive an award of \$5000.
Deadline to have church team completed will be the days of the official weigh in (December 28th - 29th)
- The strategic team will provide monthly progress reports to all the participating churches.
- Church team leader and /or representatives must attend our monthly Medical Mall in Motion meeting (**4th Monday of every month at 6pm in the Community Meeting Room**).
- Each church team **MUST** maintain their registered team members.
- **AFTER** the official weigh-in of your team, no one can be added to the team
- **For additional information, please contact program coordinators, Mr. Don Watson or Mr. C. Erskine Brown at 601-982-8467.**