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Perceived barriers to exercise and healthy eating among women from disadvantaged neighborhoods: Results from a focus groups assessment

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Abstract

This study explored perceptions and experiences with barriers to exercise and healthy eating among women from predominately African American, disadvantaged neighborhoods. Four focus groups (n=28) were conducted between April and May 2008 with overweight or obese women (93% African American; 34.3±8.9 years; BMI 40.4±8.5). Individual, social, and environmental factors were frequently mentioned as barriers to exercise and healthy eating. Insults from strangers about their body size (e.g. from children, people at the gym), and feelings of intimidation and embarrassment about not being able to complete exercises due to their body size were described as barriers to exercise. Lack of support and pressure from family, friends, and co-workers were barriers to healthy eating; participants experienced pressure from family and friends to eat more and were told they did not need to lose weight. Participants discussed the importance of not losing their curves; this concern needs to be considered when developing weight control programs for African American women. The findings of this qualitative study guided the development of a weight loss intervention for women from disadvantaged neighborhoods.

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Keywords

Low-income; African American Women; Barriers; Physical Activity; Healthy Eating

INTRODUCTION

Physical inactivity and poor diet combined, which contribute to obesity, are the second leading cause of preventable death in the United States, behind smoking (Mokdad, Marks, Stroup, & Gerberding, 2004). Despite the known benefits of regular physical activity, a healthy diet, and maintaining a normal body weight, many women find these behaviors to be challenging. In the United States, obesity disproportionately affects African American women (Flegal, Carroll, Kit, & Ogden, 2012) and women of socioeconomic disadvantage (Mujahid, Diez Roux, Borrell, & Nieto, 2005). These women also report lower physical activity levels and less healthy diets than other women (Dubowitz et al., 2008; Kirkpatrick, Dodd, Reedy, & Krebs-Smith, 2012; Luke, Dugas, Durazo-Arvizu, Cao, & Cooper, 2011). Obesity, physical inactivity, and less healthy diets may contribute to the higher rates of disease in disadvantaged women (Roger et al., 2012).

Obesity occurs within a complex framework of interrelated factors, and the challenge of achieving and maintaining a healthy weight may be compounded by disparities in education, income, and access to supportive resources and services. To date, significant progress has not been achieved in eliminating health disparities in obesity and chronic diseases in the United States (Centers for Disease Control and Prevention, 2011). Despite the high rates of obesity among low-income, minority women, and the increased attention to eliminating health disparities, a limited number of weight loss interventions have focused on culturally tailored approaches that address their life circumstances.

Social and culturally-based preferences and the community environment influence weight-related behaviors in African Americans (Kumanyika et al., 2007). Culturally tailored programs based on input from African American women are likely to be more successful than programs developed for other groups. Developing effective and relevant weight control programs depend on assessing women's perceptions of enablers and barriers to success in their daily lives.

The African American Collaborative Obesity Research Network has called for an increased emphasis on qualitative studies that can provide insight on the "lifeworlds" of African Americans (Kumanyika et al., 2007). Often, research is based on a superficial understanding of the most significant issues from African Americans' perspectives (Kumanyika et al., 2007), and therefore issues unique to disadvantaged communities may not be considered or captured. Qualitative methods, such as focus groups, are a means for gathering in-depth information on women's experiences and challenges related to weight control, allowing researchers to 'hear the voices' of the affected community (Kumanyika et al., 2007).

A number of studies have examined barriers to physical activity among African American women. Lack of time, motivation, and knowledge; health conditions; family responsibilities; cost; and neighborhood safety have been frequently mentioned as barriers (Siddiqi, Tiro, &

Shuval, 2011). Few studies have examined barriers to healthy eating in this population (Hargreaves, Schlundt, & Buchowski, 2002; Yeh et al., 2008). The first step in developing an effective behavioral intervention for weight loss is listening to women describe their past experiences and perceived barriers related to diet, exercise, and weight management. Influential factors may include individual, social, community, and environmental factors that must be addressed for successful behavior change (McLeroy, Bibeau, Steckler, & Glanz, 1988). These types of factors present challenges, even within a supportive context.

Although women themselves may face additional and/or unique challenges to exercise and healthy eating, cultural, economic, and health (i.e. obesity) factors may make engaging in these behaviors even more difficult. A handful of studies have looked at barriers to exercise and/or healthy eating among any one of these subgroups (i.e. women, African Americans, disadvantaged or obese populations); however, a very limited number of studies have examined barriers among individuals in a number of these subgroups (i.e. obese African American women from disadvantaged neighborhoods). The barriers these individuals face may be different than those faced by individuals in any one of these subgroups. To understand better the barriers to exercise and healthy eating in this group of women, a focus groups study was conducted to guide the development of a culturally tailored behavioral and social support weight loss intervention. This paper describes barriers to exercise and healthy eating identified through focus groups with women recruited from urban neighborhoods of high poverty in the southeastern United States.

METHODS

Participants & Recruitment

Overweight women living in disadvantaged neighborhoods were recruited to take part in focus groups exploring experiences with exercise and healthy eating. A community advisory board, consisting of women who lived and/or worked within the targeted neighborhoods, advised study staff on recruitment methods and materials. Participants were recruited via fliers posted at day care centers, health clinics, beauty shops, churches, social service agencies, and housing authority communities, and via word-of-mouth.

Women interested in participating contacted program staff and completed a brief telephone screening to verify eligibility. To take part, participants had to be 25–50 years old, have a body mass index (BMI) ≥ 25 kg/m², and live within one of 18 census tracts in Columbia, South Carolina with 25% or more of residents in poverty.

Sample size determination

Determining an adequate sample size for focus groups research can be based on a number of criteria, including the purpose of the study, the relative importance of achieving saturation (the number of people who need to be interviewed before redundancy of content is achieved) and range (the number of people needed to achieve most views of a phenomenon) (National Institutes of Health, 1999). This study used range as the main criterion to determine when an adequate number of participants and groups had been achieved; however, saturation was also considered. Because the overall aim was to assess the

preferences, experiences, and concerns relevant to a diet and exercise intervention for women in underserved neighborhoods (i.e. focused, formative research as opposed to open-ended qualitative inquiry), and because eligible participants and their communities were relatively homogenous with respect to socioeconomic and cultural characteristics, the sample size was smaller than that of other focus group studies, but similar to that of other studies focusing on this topic area (Eyler et al., 1998; Hoebeke, 2008; Wilcox, Oberrecht, Bopp, Kammermann, & McElmurray, 2005; Wilcox, Richter, Henderson, Greaney, & Ainsworth, 2002; Yeh et al., 2008).

Based on characteristics of the census tracts circumscribing the neighborhoods, the focused recruitment area, and the inclusion criteria, we expected women would be relatively homogeneous regarding certain attributes relevant to exercise and diet, including socioeconomic status, race, overweight/ obese, and low access to healthy food and exercise venues; however, to provide an adequate range of relevant life experiences, we screened for and purposively included women whose ages ranged from 25 to 50 years and who self-reported a range of current participation in exercise. The research team agreed that saturation was achieved for all of themes related to the barriers reported in the results below and to achieve the aim of the focus groups research.

Question development

Concepts from the researchers' proposal for the parent study (i.e. the behavioral weight loss intervention) regarding influences on dietary choices and exercise behavior provided a conceptual framework to guide question development. A complete description of the conceptual framework for this parent study has been published (Wilcox, Sharpe, Parra-Medina, Granner, & Hutto, 2001). These conceptual domains included individual, sociocultural, and environmental barriers to healthy eating and exercise, the focus of this paper. The study staff and researchers developed a pool of potential questions for the nutrition and exercise discussion guides. From the pool, two discussion guides of 11 questions for the nutrition discussion and 11 questions for the exercise discussion were selected by consensus and placed in a logical order, with follow-up probes.

Focus group facilitation

The focus groups followed a semi-structured format in which a set of open-ended questions was used to stimulate discussion. Exercise was defined as "any activity that gets your heart beating faster and makes you breathe heavier. This could be exercise you plan for, like doing a workout video or jogging, or things you do as part of your everyday life, such as working in your yard, going out dancing, or walking back and forth to work." Examples of questions from the focus group guides are shown in Table 1. A Master's level health educator facilitated the focus groups, with an assistant present to manage the audio recording and take notes. Participants signed an informed consent form, which included agreement to be audio recorded. A professional transcription company provided verbatim transcription. The university's Institutional Review Board approved the study protocol.

Although focus groups were developed and intended to capture exercise (n=2) and healthy eating (n=2) experiences separately, all focus groups discussed both health behaviors and

therefore content from all four was analyzed and summarized together. The four focus groups, each consisting of four to ten women, were conducted within a four-week period of time (from 4/24/2008 to 5/22/2008) and took place at community centers located within the recruitment area. Each focus group lasted approximately two hours, with snacks and beverages provided. Twenty dollars was provided in appreciation for attendance and to offset any expenses.

Data Analysis

For quality control, three staff persons who had conducted or assisted with the focus groups independently listened to the audiotapes and compared the recorded content to the professionally transcribed transcripts, noting errors and omissions in transcription, and then compiled the errors. Based on the staff's edits, the professional transcription company provided corrected transcripts, which staff again compared to the audiotapes and made final minor corrections. Each of these three staff persons and a graduate student assistant independently reviewed all of the transcripts and identified key themes. The conceptual framework for the proposed intervention study provided a working structure for the coding process; however, coders allowed new themes to emerge from the transcripts. Note-based coding was used to assign conceptual codes to portions of text, which were later compiled and synthesized to form higher order themes. In group meetings, the coders compared the themes they had identified, discussed areas of agreement and disagreement, considered additional themes and reached consensus. The lead researcher facilitated the final compilation of key themes with illustrative quotes. As a final validation step, a researcher external to the project independently read the transcripts and compared themes identified to that of the study team. No additional changes were made to the final summary of results. Content related to barriers to healthy eating and exercise were the basis for this report.

RESULTS

Participant Characteristics

Phone inquiries came from 89 women, 19 of whom did not meet the inclusion criteria: not residing in the poverty area (n=12), not being overweight or obese (n=3), or not in the 25 to 50 age range (n=4); 42 could not be reached for initial screening, or had scheduling conflicts or did not show up for the group as scheduled; 28 met inclusion criteria and participated in the focus groups. Of the women scheduled to participate in the focus groups, the average attendance rate across the four focus groups was 71% (range 57%–82%). Among the 80 women who inquired and reported where they had heard about the focus groups, the following sources were named: word of mouth/a friend (26%), community center (19%), a member of the community advisory board (14%), public housing authority (9%), Head Start office (6%), school (8%), social services (5%), health department (4%), and employment office (4%). One woman reported each of the following recruitment locations: restaurant, shop, community development organization, and clinic.

A total of 28 unique participants took part in the four focus groups (n=4 participants took part in both an exercise and healthy eating focus group). The sample was 93% African American. The mean age of the participants was 34.3±8.9 years (range = 25–50 years), and

the mean BMI, based on self-reported height and weight, was 40.4 ± 8.5 (range = 27.6–57.6). Of the 28 participants, 36% (n=10) reported engaging in no exercise during the past week, 32% (n=9) engaged in 60 minutes, and 32% (n=9) engaged in >60 minutes.

Barriers to Exercise

Personal Barriers—Some women cited lack of motivation as a barrier to exercise. One woman stated:

- Well, for me, it's just the lack of motivation.... I used to say time, but as I sit down and watch TV for about three hours—I have the time but I just don't want to go. Plain and simple.

Not seeing quick results was also discussed by some as a barrier:

- ...but I just couldn't see the results and I just couldn't – I wasn't satisfied.
- It seems like I'm not losing it fast enough.
- You can't stay committed because you don't see the results.

Not having fun with exercise was also cited a few times as a barrier:

- ... And it's not fun either. It really isn't—not for me. Like I said, for me, I sit down and watch TV—that's more fun.

Many women talked about issues related to their body size, including others making cruel comments, being the biggest person at the gym, being intimidated by exercise, and being unable to do certain things. One woman said:

- We go to the gym and we're the biggest person there – that might stop people from wantin' to go. You want to lose the weight but you don't want to go and be like people snickerin' and laughin' 'cause your spandex is a little tight.

Another woman stated:

- For example, if I go to a school and they got a track, I don't get on the track because I'm intimidated because I don't think I can make it all the way around. It's disappointing sometimes how you can't make it all the way around. It looks so big.

Finally, women sometimes cited injuries and health conditions as barriers to exercise:

- ...but I broke three of my toes.I get frustrated now because I can't get out there and exercise and I've got another six more weeks.
-And the joints are not cooperating like they should..... now my knees hurt, and they're swelling up...

Social Barriers—The women perceived competing demands on their time and lack of energy (i.e. tired) as barriers to exercise. Many women had a job(s) and families to take care of, leaving them too tired and/or without time to engage in exercise. Women sometimes talked about the many responsibilities they had (i.e., role strain), and how such responsibilities got in the way of exercise. One woman said:

- So it's like when they [children] come home or my significant other comes home, I don't have time for exercising. If I'm like, you know, 'y'all go ahead about y'all business, let me go exercise,' then who is gonna cook dinner? Who is going to do hair for school the next morning? Who is going to get the kids ready in the tub? You know, fathers don't do the same things mothers do. Mothers have a lot on them [responsibilities] and I think that's a lot of our women problems with weight gain.

Some women also listed not having an exercise partner as a barrier to exercise:

- I had someone walking with me and as soon as she quit, I quit. You know I didn't have anyone to do it with me anymore, so I didn't go anymore.
- Well, I decided to go walking but I never finished doing it. I always wanted somebody to go with me. I didn't want to go by myself. I always needed someone to go with me.

Environmental Barriers—Women often cited aspects of the physical environment and neighborhood as barriers to exercise. They talked about safety issues, violence, dogs, unsupervised children making rude and disrespectful comments, traffic, and lack of access to facilities as barriers:

- And in our neighborhood, you walk during the daytime because if night ever falls—you better clench your pocketbook and keep movin' or you'll get robbed.
- You're scared to go outside to walk around the block because you're scared that somebody might harm you.
- But where I stay is, traffic-wise you can't walk. I mean, like she said, somebody said earlier, it's 35 [miles per hour speed limit] but they're doin' 60–65. It's not safe because of traffic where I stay.
- I'm like this is not a good area to walk in because there's strange people. Sometimes there's dogs and I am terrified of dogs. And I don't like walkin' just for the simple fact that I just see a dog and I will be very scared.
- ... And especially when it's a lot of them together [kids in the neighborhood] and they see you out there exercising, they can be real cruel. So it's—that's one of my main reasons why I don't walk because we stay in the same neighborhood and there's like a lot of kids out there and kids are real cruel these days.

Some women talked about the high cost of gym membership as a barrier to exercise:

- I mean gyms are very expensive. The membership, paying for a personal trainer, that is very expensive each month. That's \$25, personal trainer, \$5 each day. I mean that's kind of expensive.
- I would go [to aerobics class] with no problem, you know, but if I have to pay the whole—then it's like—it's either light bill or aerobic class, water bill or aerobics class, kids need tennis shoes or—what would you pick?

Barriers to Healthy Eating

Personal Barriers—The women sometimes cited lack of knowledge as a barrier to healthy eating. They talked about not knowing what to eat or how to eat or cook healthy:

- A lot of people as myself do not know how to eat healthy. I do not know how to cook healthy food or eat healthy. I don't know what's healthy for me.
- So just buying the food and then knowing what to put together to make it healthy is a problem I have for me in general.

Psychological factors such as feeling defeated, eating for other reasons than hunger (e.g. depression), being addicted to food, and finding food comforting also often emerged as barriers:

- And I think that's why a lot of people give up [on weight loss] because either they have failed or they know someone has failed, you know, and they're like 'well, what's the point in trying if I'm going to fail in the long run?'
- Because you may not know you got that problem [depression]. You been picking up and eating because you see it there, or you picking up and eating just to eat and you're not realizing and that's why I'm eating.

Social Barriers—Similar to exercise, lack of time, as well as being tired, was often perceived barriers to healthy eating, including planning and cooking healthy meals:

- So I have no time to cook a meal or sitting there trying to figure out how many calories this is or so forth. So I just grab something to fill my stomach knowing that I have to get something to eat, but at the same time it's not healthy.

As with exercise, issues with role strain and competing demands on their time were also relevant to healthy eating.

- ... your job, your kids—because you have so much to do nowadays; money is tight, you're working all the time. And like you were saying, you gotta balance things out. It's hard to balance things out when you're so busy—you're [a] mom, working, counselor, friend, all this stuff-- and by the time you, I mean you're so tired, it's like I don't feel like doin' anything.

An unsupportive social environment (i.e. family, friends, co-workers) was often mentioned as a barrier to healthy eating. The women talked about being pressured to eat more, not being supported if they were trying to eat healthfully, and being told they didn't need to lose weight, when in fact, they knew they did:

- They would be big people who encourages her to eat more all the time—telling her to eat more.
- But they'll still hand her another plate of ribs. They'll say she need to lose weight, but at the same time they're still handing her more food.

When talking about eating with co-workers, one woman stated:

- ... going to work, doing the diet plan, sitting there and I'm eating healthy, and everybody else going to Ryan's getting food and I'm like it smell good, look good, and I'm like 'okay, I'm going to set this aside today and I'm going to eat at Ryan's too with you all'...

Food as a part of socializing was sometimes mentioned as a barrier to healthy eating:

- When you go out with folks, socializing, food is a draw. If you're not sitting at your girl's or your, or your homeboy's house or whoever eating, then you go out to eat. It's a big social, big social setting." Another woman added, "It's [food] a comfort. It brings people together.

Family customs about food and eating was a barrier to healthy eating. Some participants mentioned being taught to eat everything on their plate, to fix a heavy plate, and to eat junk food and soul food.

- The reason you don't know how to eat is because that's how you was raised. Your mom taught you how to eat.
- We was raised on candy and all that junk food, all that soul food.

The food preferences and needs of kids was mentioned a few times as a barrier to healthy eating:

- I'm that person to walk, but I'm going to have some fried chicken when I get back from that walk, because I still have to provide for the family that's at home, and they're not overweight. I'm the one overweight.

Environmental Barriers—The cost of healthy food was often discussed as a major barrier to eating healthy:

- Well a lot of times the cheaper food are not the healthiest food. And I-that's why I think a lot of times that's why we don't go on the diets...
- And then you're looking at okay, well is it more important to lose weight or feed my kids?

Women were often faced with a choice of buying healthier, more expensive food, or cheaper, unhealthy food to obtain greater quantities.

- It's almost like society is punishing you for wanting to eat healthy. Fruits are way higher [cost] than chips. When you go in there to get snacks for your kids, it's like you can't –just a small case of grapes are like \$5 or \$6 but chips are 99 cents for a huge bag. And you know you gotta make the money stretch – you thinkin', okay, am I gonna do what's cheaper or am I gonna do what's healthier? And it's bad that it's that way, but you really have to think about it.
- Because you go to the grocery store, it's easier for me to pick up five pounds of chicken wings, or not even chicken wings, five pounds of thighs and legs, which is the fattiest part of the chicken than it is for me to go spend, I might only get a pound of chicken breast. You look at the quantity verses the quality and all this stuff.

Race & Culture

Race and culture-based preferences for a larger, curvaceous ideal shape influenced participants' views about weight and body size, in some cases creating conflicting feelings and potential barriers to weight loss. A number of women discussed how they did not want to lose 'the wrong parts of their body' and wanted to keep their curves. They shared that African American women embrace their curves, consider them 'normal,' and in general, do not want to be 'skinny, skinny.'

- As a black woman you don't want to be seen without curves. You want to keep your curves.
- Sometimes when you start exercisin' you start losin' the wrong parts and that's kind of frustratin' too. So I pick and choose which exercises I do.
- I do have some friends who won't exercise because they don't want to lose their chest or their butt because you don't want to be stick thin.
- I think bigger girl is in so I even have some smaller friends that overindulge just because they want to be bigger. I have friends who are like a five or six [size] and they're like 'God I would love to be your size.' And their makin' themselves eat fat foods and just tryin' to really put the weight on. They kinda want to be bigger.

DISCUSSION

Physical inactivity and poor diet combined are among the leading preventable causes of death (Mokdad et al., 2004), and are modifiable, even for women with economic, social, and psychological barriers to change. To develop effective intervention programs, it is important to understand the barriers women perceive and encounter that will make change difficult. Barriers to healthy eating and exercise vary across gender, race, and financial status (Bopp et al., 2007; Griffith, Gunter, & Allen, 2011; King et al., 2000; Siu, Giskes, & Turrell, 2011; Wilcox et al., 2005); however, few studies have examined barriers among individuals who are a part of many of these subgroups simultaneously (e.g., overweight or obese African American women from low-income neighborhoods). To develop effective and tailored programs in this specific population, it is critical to understand the life circumstances of intervention participants who are adversely affected by health disparities.

Participants described personal, social, and environmental barriers to exercise and healthy eating and confirmed the findings of studies with similar African American and/or disadvantaged women in other settings (Bopp et al., 2007; Bragg, Tucker, Kaye, & Desmond, 2009; Chang, Nitzke, Guilford, Adair, & Hazard, 2008; Eyler et al., 1998; Hoebeke, 2008; James, 2004; Wilbur, Chandler, Dancy, Choi, & Plonczynski, 2002; Wilcox et al., 2005; Wilcox et al., 2002; Yeh et al., 2008). The consistency of findings suggests that these factors should be addressed in behavior-change interventions aimed at increasing exercise, improving dietary habits, and controlling weight in culturally tailored intervention programs.

Issues related to body size were frequently mentioned as barriers to exercise. Such barriers may be particularly relevant to overweight/obese women. A number of women talked about

being the biggest one at the gym and the cruel comments and/or snickers they received while exercising at the gym or in the neighborhood. The comments came from adults and children alike, and deterred them from going to the gym or exercising in their neighborhood, as they were embarrassed. Others talked about being intimidated by exercise; their body size may not have allowed them to do the things they wanted to do (e.g., walk a full lap around the track). Similar barriers have been found in other studies with low-income women. Hoebeke and colleagues (2008) found that low-income women who were overweight felt self-conscious about their looks when they exercised in front of others at a class. Similarly, Wilbur and colleagues (2002) found that low-income African American women feared being teased if they exercised in public because they were not fit, and such teasing would be devastating for their self-esteem. These anticipated insults and disappointments can impede initial attempts at behavior change, thereby short circuiting progress, behavioral mastery, and enhanced self-efficacy that reinforce behavior change and maintenance over time.

Findings from this qualitative study suggested that these women in poverty faced a number of challenges that might inhibit their ability to eat healthfully including role strain, unemployment or multiple jobs, single parenthood, financial hardship, and inadequate food supplies ("making things stretch"). The women in this study also discussed food addiction, eating for comfort and in response to emotions (i.e., eating for reasons other than hunger) as barriers to healthy eating. Being stressed, bored, depressed, or eating simply because it felt good were discussed as reasons for eating high quantities of unhealthy foods. Similar findings have been reported in the other limited studies that have been conducted. For example, Chang and colleagues (2008) found that low-income overweight and obese White and African American mothers used large portions of high-fat, high-calorie foods to cope with daily stress, negative emotions, and/or boredom. Further, having little money to feed their families and stressful daily lives were also reported as barriers to healthful eating (Chang et al., 2008). A recent review by Garip and Yardley (2011) also found that eating for reasons other than hunger, such as emotional and habitual eating, have hindered weight management attempts among overweight and obese adults (note: the review included men and women).

Lack of social support and social pressures have been reported as barriers to healthy eating (Chang et al., 2008) and weight management (Garip & Yardley, 2011). The women in this study talked specifically about the pressure from family and friends to eat more. This negative influence may be especially strong in African American communities, as food and the context of eating traditional foods is important to the African American cultural identity. Pressure to eat more may be the result of jealousy, intentional disruption, or greater desirability of a larger body size among African American women (Kronenfeld et al., 2010; Latner, Stunkard, and Wilson, 2005).

Body ideals are typically larger in African American women than other racial groups. (Gordon et al., 2010; Powell and Kahn, 1995). African American women find a curvaceous body type more attractive than a slender body (Overstreet, Quinn, and Agocha, 2010). Women in this study described not wanting to lose the 'wrong parts' of their bodies, the importance of keeping their curves, and that being a big girl was 'in.' Such concerns may deter African American women from exercise. Such culturally-rooted ideals need to be

considered when developing a weight control program; desirable outcomes other than a thin body may be stronger motivators. Weight loss and a healthy, curvaceous body are not mutually exclusive with sufficient exercise and healthful, enjoyable food.

The findings of our study should be interpreted in the context of some recognized limitations. Focus group research in public health is conducted with an applied purpose, in contrast to other qualitative research, such as extensive ethnographies that explore social and cultural phenomena in depth. We used focus group methods to conduct a formative assessment of the preferences, experiences, and concerns relevant to a diet and exercise intervention for women in urban, underserved neighborhoods in a southeastern city, with the applied purpose of developing the intervention plan for a randomized controlled trial. Further, findings reported here focused on particular domains that may have affected success in behavior change and weight loss, specifically individual, social, and environmental barriers to healthy eating and exercise. Therefore, these results cannot be considered an exhaustive exploration. Additionally, participation rates among women scheduled to attend focus groups were modest, varying from 57% to 82%. We are unable to determine how women who failed to participate may have been alike or different from the women who did participate, thus loss of scheduled participants may have introduced an unknown amount of bias. Finally, this small sample from a single geographic location of African American women from a low income neighborhood may not be generalizable to other overweight, low-income African American women throughout the United States, but they do confirm findings from other samples of African American and disadvantaged women.

Our study examined and uncovered barriers to exercise and healthy eating among women who may encounter challenges from multiple avenues, including culture, economics, and health. The findings from this study were similar to the findings of studies examining barriers among African American women, low-income women, or overweight or obese individuals. Unfortunately, overweight or obese, African American women from disadvantaged neighborhoods may experience a culmination of all of the barriers that have been reported by any one of these subgroups. Public health efforts aimed at improving the health of low-income, African American women, who have disproportionately higher rates of obesity, lower levels of physical activity, and poorer dietary habits are warranted. This qualitative study offers valuable insight into the exercise and healthy eating barriers a vulnerable population may face, and should be considered in the development and implementation of subsequent weight loss interventions for African American women from disadvantaged neighborhoods.

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Table 1

Select Questions from the Focus Groups Interview Guide

Question	Probes (if needed)
Exercise	
1. Many women have good intentions to exercise but have trouble doing it. For you, what gets in the way of doing exercise, if anything?	And what about _____? <ul style="list-style-type: none"> • Your family responsibilities • Your job-your schedule, what you do at work • Your thoughts or feelings • Your relationships with family and friends • Your neighborhood
2. Have any of you ever made a decision to exercise more (as an adult)? What happened after you made that decision?	What were some of the challenges to getting started, if any?
Healthy Eating	
1. How many of you have ever decided you were going to make some changes to lose some weight or just make changes in the way you were eating? What was that like for you?	What influenced your success or lack of success?
2. Let's say "Linda" is ready to start losing weight, and she's going to change the way she eats. What are reasons that it might be hard for her to change what she eats?	