THE INFLUENCE OF AFRICAN AMERICAN WOMEN'S VALUES AND BELIEFS ON MODERATE INTENSITY PHYSICAL ACTIVITY: A QUALITATIVE STUDY

by

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DISSERTATION

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ABSTRACT

THE INFLUENCE OF AFRICAN AMERICAN WOMEN'S VALUES AND BELIEFS ON MODERATE INTENSITY PHYSICAL ACTIVITY: A QUALITATIVE STUDY

Routine participation in moderate intensity physical activity (MIPA) is one of the most important low-cost activities people can do for optimal health (USDHHS, 2018). Yet, for more than four decades, MIPA participation rates for AAW have been among the lowest compared to other races, and consequently, their health has been among the poorest. AAW have higher prevalence rates for obesity, heart disease, stroke, breast cancer, type II diabetes, and associated premature death. Instead of MIPA participation rates improving, they begin to decline in AAW ages 25 - 44. There is some evidence that culture, values and beliefs independently have a role in how people make decisions about being physically active. No recent evidence was found that collectively studied culture, values, beliefs, and MIPA among AAW ages 25 - 44.

An ethnographic study was conducted to explore the values and beliefs (both individual and cultural) of 12 AAW ages 25 - 44 years, and how those values and beliefs shape their attitudes, subjective norms, and perceived behavioral control for performing MIPA. The Theory of Planned Behavior (TPB) was used as the theoretical framework to explore how values and beliefs influenced MIPA decisions among AAW. Data were collected during a onetime one-to-one semi-structured Zoom interview lasting no more than an hour using open-ended questions and selected photos. Thematic analysis was used to identify common themes and patterns related to the research question, "What are AAW's values and beliefs that shape their attitudes, subjective norms, and perceived behavioral control around MIPA?"

Nine themes emerged from the data: “The meaning of MIPA,” “MIPA is devalued in the African American community,” “gym anxiety,” “social support,” “hairstyles and MIPA,” “body image,” “media representation,” “planning for MIPA,” and “effort is sufficient.” Exploring the values and beliefs of AAW that influence MIPA behavior contributed to a better understanding of how AAW prioritized MIPA, and revealed that AAW need culturally relevant MIPA education that includes their values and beliefs. Future research is warranted until disproportionate morbidity and mortality rates among this population are significantly reduced.

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"For God gave us a spirit not of fear but of power and love and self-control."

2 Timothy 1:7

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DEDICATION

I dedicate this work to my parents who are in heaven. I know that your spirit has been a guiding force and your spiritual support was a motivating factor in my completing this journey. I hope that I have made you proud.

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Table of Contents

Chapter 1

Background and Significance

African American women (AAW) are less likely than non-Hispanic White women to meet federal moderate intensity physical activity (MIPA) guidelines, will have more severe health complications as a result, and will die more often from their complications (Centers for Disease Control and Prevention, [CDC], 2019). If AAW met MIPA guidelines, their risks for morbidity and mortality rates would be reduced approximately 40% (CDC, 2019). Yet, for more than 40 years MIPA participation rates among AAW have been among the lowest of all U.S. populations (Williams et al., 2018). The lack of progress indicates that effective strategies to significantly increase participation have not been identified, and more research is warranted.

This chapter will provide an overview of the background and significance of low MIPA participation among AAW compared to other populations, how their lack of participation may be related to ethnic - specific barriers, and what culturally specific interventions may be effective in overcoming those barriers. Lastly, there will be an overview of the study's research problem and theoretical framework, followed by the purpose, research question, assumptions, and chapter summary.

Adult MIPA in the United States

Although almost any physical activity is beneficial, optimal physical and mental health benefits can be achieved when physical activities occur at moderate intensity levels (CDC, 2018). MIPA is defined as bodily movement that increases energy expenditure from 1.0 metabolic equivalent (MET) at resting, to between 3.0 and 5.9 METs (Mendes et al., 2018). MIPA activities include raking the yard, playing tennis, or taking a brisk walk at 2.5 to 4 miles

per hour. MIPA intensity may be measured using a talk test, where a person can talk during the activity but cannot sing (CDC, 2018). The value in performing routine MIPA is that adults can expect to experience improved bone health, cardiac fitness, psychological well-being, quality of life, and life expectancy regardless of age, sex, race, ethnicity, or fitness level (Fletcher et al., 2018; Tomfohr et al., 2016; World Health Organization [WHO], 2020).

MIPA Recommendations

To achieve and maintain optimal health and wellness, the U.S. government has published recommendations in the 2018 Federal Physical Activity Guidelines ([PAG], U.S. Department of Health and Human Services [USDHHS], 2018). The USDHHS (2018) advise that adults achieve at least 150 minutes per week of MIPA (typically $\geq$ 30 minutes per day, $\geq$ 5 days per week). The activities should also include muscle-strengthening of large muscles at least 2 days per week. Currently, only 24.3% of adults participate routinely in MIPA and muscle strengthening, only a slight improvement from 18.2% reported in 2008 (USDHHS, 2018). Low MIPA participation rates have also been a contributing factor in the U.S. being ranked among the top 10 unhealthiest countries in the world (U.S. National Research Council, 2013).

According to the CDC (2018), in 2017 prevalence for meeting MIPA guidelines was higher for men (28.8%) than women (20.1%), and higher for non-Hispanic Whites (26.8%) than for African Americans (20.8%) or Hispanics (18.7%). Since publication of the Heckler report on physical activity and health disparities almost 40 years ago, physical activity rates for AAW have consistently been among the lowest of all U.S. populations (Williams et al., 2018). Of the 22 million AAW in the United States, only 37% meet U.S. MIPA guidelines, compared to 38.9% of Hispanic women and 51.6% of non-Hispanic White women (Whitfield et al., 2018). Since there is a health disparity between AAW and women from other ethnic groups, more research is needed on AAW and MIPA.

MIPA Among AAW

MIPA rates for AAW are low regardless of the influence of outside factors such as socioeconomics (Agyemang & Powell-Wiley; 2013). In a self-administered survey conducted by James et al. (2014), AAW (n = 413) reported that on days they participated in MIPA, 35% participated for 30 minutes or less, 35% participated for 30 - 44 minutes, 17% for 45 - 60 minutes, and only 13% engaged in MIPA for more than 60 minutes. The small amount of time spent performing MIPA is concerning; however, a greater concern is that AAW will spend even less time performing MIPA as they age (Williams et al., 2018).

According to data collected by Williams et al. (2018), the percentage for MIPA and muscle strengthening was 34.3% among AAW ages 18-24 but declined to 29.9% by ages 25–44. It was 25.0% at ages 45-64, and only 17.6% at ages 65 and older. Demographic trends illustrated that college graduates were twice as likely as high school graduates to engage in MIPA. AAW who earned $75,000 - $99,000 participated more (37.3%) than women who earned less than $35,000 (23.4%), although participation rates declined slightly (35.2%) among women who earned more than $100,000. AAW who worked full-time (30.9%) or never married (29.4%), were more active than women who were unemployed (23.3%) or married (25.7%).

Although AAW ages 65 and older have the lowest MIPA participation rates, there are numerous MIPA studies of older AAW (Bowen et al., 2015, 2019; Kosma et al., 2017; Sebastiao et al., 2014a, 2014b; Shadyab et al., 2017) and younger AAW (Harris et al., 2018; Johnson et al., 2015; Joseph et al., 2015; Melton et al., 2016; Reese et al., 2017). However, there are fewer studies of the 25 – 44 age group. This study will focus on the 25 – 44 age group so researchers can better understand what may contribute to low MIPA rates in this age group. Understanding MIPA behavior in the 25 – 44 age group may help improve low MIPA rates among women ages

65 and older, because early identification of psychological, social, and behavioral processes may inform prevention in older groups.

Consequences of Inadequate MIPA

Evidence is conclusive that lack of sufficient MIPA is a major cause of most chronic diseases (USDHHS, 2018). A chronic disease is a non-contagious disease lasting at least three months that requires ongoing medical treatment and is known to have adverse effects on quality of life (Bernell & Howard, 2016). Alarmingly, chronic disease incidence rates are increasing as more adults regularly consume unhealthy diets, indulge excessively in tobacco and alcohol, and consistently fail to meet MIPA guidelines (CDC, 2018; WHO, 2020). The number of U.S. adults living with at least one chronic disease has reached 117 million and includes 60 million people who live with two or more (USDHHS, 2018). As a result of low MIPA participation rates among AAW, nearly 14 million women are at risk for developing at least one chronic disease (CDC, 2018).

Chronic conditions once limited to non-Hispanic White women or elderly AAW are now prevalent in AAW ages 20 - 40 (CDC, 2017). Despite efforts by the Office of Minority Health to help eliminate disparities in chronic illnesses, conditions such as obesity, heart disease, stroke, negative-triple breast cancer, and Type 2 diabetes are increasingly more prevalent among AAW than women of other races (CDC, 2017). Consequently, associated mortality rates are also more prevalent among AAW.

Morbidity and Mortality Among AAW

Obesity

In 2016, 80.6% of AAW ages 20 and older were overweight or obese compared to 64.8% of non-Hispanic White women (U.S. Department of Health and Human Services Office of

Minority Health [USDHHSOMH], 2019). According to the USDHHS (2020), weight status is categorized using body mass index (BMI) and is interpreted as underweight (below 18.5 kg/m²), normal (18.5 - 24.9 kg/m²), overweight (25.0 - 29.9 kg/m²), and obese (≥ 30.0 kg/m²). The average weight for an AA woman is 32.2 kg/m², and the death rate for AAW with a BMI ≥ 25 kg/m² is 26.8% compared to 21.7% among non-Hispanic White women (Hamdy et al, 2020; Riggs et al., 2017).

Heart disease

Almost 8% of AAW compared to 5.8% of non-Hispanic White women have heart disease (American Heart Association [AHA], 2020). Distressingly, nearly 50% of AAW ages 20 and older have some form of heart disease, which kills 50,000 AAW each year. The risks for fatality from heart disease can be reduced approximately 30% - 40% when MIPA is performed regularly (Fletcher et al., 2018).

Stroke

Regardless of age, AAW have a 47% higher risk for stroke than non-Hispanic White women (USDHHSOMH, 2020). The American Stroke Association (2020) has reported that younger AAW are 40% more likely to suffer a stroke, and experience more severe post stroke complications than women from other ethnic groups. The odds of dying from a stroke are 30% higher in AAW compared to their non-Hispanic White counterparts (USDHHSOMH, 2020).

Breast cancer

Over the past 20 years, the incidence rate for breast cancer in women has increased 0.3% annually (American Cancer Society [ACS], 2019). However, AAW have a disproportionately higher proclivity for triple-negative breast cancer and subsequent poorer outcomes than non-Hispanic White women (DeSantis et al., 2019). Of all new cases of breast cancer, 11% occur in

AAW younger than 45 (DeSantis et al., 2019). Female breast cancer is the fourth leading cause of cancer mortality in the U.S. The age-adjusted mortality rate for women of all races is 20.1% compared to 27.3% for AAW (National Cancer Institute, 2021).

Diabetes

Heart disease and insufficient MIPA increase risks for developing Type 2 diabetes two-fold among AAW compared to non-Hispanic White women (CDC, 2020). In general, the percentage of African Americans living with diabetes is 12.7% compared to 7.4% for non-Hispanic Whites. More specifically, AAW are twice as likely as their White counterparts to die from Type 2 diabetes (CDC, 2019). The importance of decreasing risks for diabetes and other chronic diseases among AAW cannot be understated. Addressing health disparities is important not only in bringing about social justice but in minimizing conditions that negatively impact mortality, morbidity, and healthcare costs for the nation.

Economic Impact of Chronic Disease

Overall, 11.1% of aggregate health care expenses are associated with inadequate MIPA and chronic diseases (Carlson et al., 2018). Preventable health care expenditures have reached 3.8 trillion dollars and unless effective interventions are identified, as the population ages, costs are expected to surpass 8 trillion dollars by 2050 (An et al., 2016; Asay et al., 2016). Most avoidable expenses stem from emergency room visits, hospital care, physician visits, pharmaceuticals, medical devices, and home-based care (An et al., 2016; Asay et al., 2016; Levine et al., 2019). In addition to burdening the healthcare system, chronic illness related absenteeism costs employers nearly 138 billion dollars annually in lost productivity (An et al.; Asay et al., 2016).

Researchers have determined that strategies to increase MIPA could, by 2023 prevent or delay over 40 million cases of chronic disease, reduce preventable health care spending by 1.1 trillion dollars annually, and improve employee productivity significantly (An et al., 2016; Asay et al, 2016; Benjamin et al., 2018; USDHHS, 2018; Williams et al., 2018). The unnecessary healthcare dollars spent on management of chronic diseases could be better spent improving health programs for the nation. Until preventable health care spending related to insufficient MIPA is eradicated, finding ways to improve MIPA participation should be a public health priority not only for AAW but for the nation.

MIPA Barriers Among AAW

When identifying solutions that improve MIPA participation among AAW, researchers must center their attention on gender - specific ethnic barriers in this population. AAW are more likely to cite family responsibilities (Im et al., 2012; James et al., 2014), personal appearance concerns (body image and hair maintenance), lack of support, and lack of MIPA exposure (Dorwart et al., 2019; Im et al., 2012) as barriers preventing routine MIPA engagement. The barriers cited by AAW may reflect their negative attitudes toward MIPA and a lower valuation of MIPA among their daily priorities. For instance, AAW have negative attitudes toward MIPA because of the negative criticism they receive for wanting to engage in MIPA (Florez et al., 2018), whereas AA men have cited lack of time, not lack of support, as a barrier to MIPA (Griffin et al., 2013).

Interventions to Increase MIPA Among AAW

Some of the strategies recently used by researchers to deliver MIPA promotion programs specific to AAW include using text messaging (Harris et al., 2018; McCoy et al., 2017), encouraging group walking (Bland & Sharma, 2017; Wilson et al., 2015), recommending use of

protective hairstyling (Huebschmann et al., 2016; Joseph et al., 2018), promoting development of weight control programs that do not alter curvy body shapes (Baruth et al., 2014), and using biblical scriptures (Joseph et al., 2017; Whitt-Glover et al., 2017).

Results of these approaches have varied, with some researchers reporting increased MIPA (McCoy et al., 2017) and others reporting mixed outcomes (Joseph et al., 2017; Wilson, 2015) or nonsignificant findings (Bland & Sharma, 2017; Harris et al., 2018; Whitt-Glover et al., 2017). Hair maintenance (Huebschmann et al., 2016; Joseph et al., 2018) and body image (Baruth et al., 2014) studies solicited input from participants but did not report follow-up findings. The varied results of these studies and the marked health disparities among AAW indicate the need for researchers to identify innovative strategies that promote routine MIPA aimed at attenuating chronic disease disparities among this high-risk population. Culturally tailoring MIPA programs to the sociocultural norms, beliefs, values, and behaviors of AAW has been proposed as an advantageous strategy to enhance MIPA promotion efforts (James et al., 2014; Joseph et al., 2015; Joseph et al., 2017; Segar et al., 2017).

Culturally Relevant Interventions

Incorporating culture into intervention designs for AAW is believed to increase their acceptance and long-term adherence to recommendations (Joseph et al., 2018; Robinson, 2013; Whitt-Glover et al., 2017). Culture is defined as a group of shared beliefs, values, social norms, traditions, and behaviors (Kumanyika et al., 2012). Culture is a critical element in shaping health - related values, norms, beliefs, and behaviors through people's connection to their social and physical environments. Culturally informed interventions that include cultural psychosocial factors such as beliefs and values should be developed from deep structured perspectives rather

than superficially (Awad et al., 2015; Conn et al., 2013; Joseph et al., 2018; Resnicow et al., 1999; Whitt-Glover et al., 2014).

Cultural relevance involves surface and deep levels of structure (Resnicow et al., 1999). Surface structure involves matching intervention materials and messages to observable, "superficial" characteristics of a target population. This may involve using practices familiar to, and preferred by, the target audience such as recommending certain hairstyling to overcome hair maintenance barriers (Joseph et al., 2018). Deep structure involves interventions that incorporate behavior influencing psychosocial variables (Resnicow et al., 1999). According to Resnicow et al. (1999), psychosocial variables may include cultural or personal beliefs, values, norms, social history, and environmental factors specific to the population.

Beliefs and Values

Differences in MIPA participation rates are apparent between African American, non-Hispanic White, and Hispanic women, suggesting that the disparities may be related to culturally specific beliefs and values. Beliefs are tenets one holds to be true regardless of whether there is any proof of their objective truth (Frese, 2015). Individuals may have specific beliefs toward MIPA rising from their own experiences, parents' experiences, or historical events passed from one generation to the next (Ajzen, 1991).

Although a belief will develop into a value when the individual views an object as important, values are much more deeply rooted than beliefs (Frese, 2015). Both beliefs and values influence attitudes, and function as variables that predict behavioral intentions (Ajzen, 1991; Anshel, 2013; Skimina et al., 2019). Despite the importance of beliefs and values when making health related decisions, AAW may adopt the beliefs and values of their culture or parents (Rhodes et al., 2019; Skimina et al., 2019). In many cases, there is no self - reflection or

consideration given to their understanding of what their own beliefs and values are (Rhodes et al., 2019; Skimina et al., 2019).

In some cases, beliefs and values can act as barriers and motivators to MIPA participation (Joseph et al., 2018). For instance, researchers have reported that the African American culture views larger body sizes as healthy and attractive (Chithambo & Huey, 2013). The belief that a larger even overweight or obese body is more acceptable may prevent some AAW from participating in recommended levels of MIPA (Chithambo & Huey, 2013). However, other researchers have found that overweight or obese body sizes in some AAW were motivators to participate in MIPA (James et al., 2014; Segar et al., 2017). The inconsistencies in what AAW believe and value regarding the relationship between weight and MIPA participation are not clearly understood. Furthermore, despite decades of research on barriers and motivators to MIPA, most interventions have not resulted in long term increases among AAW.

Problem Statement

Routine participation in MIPA is one of the most important low-cost activities AAW can do for their health (USDHHS, 2018). Yet, for several decades, MIPA participation rates for AAW have been among the lowest compared to other races, and their health has been among the poorest. Instead of MIPA participation rates improving, they begin to decline in AAW ages 25 - 44. Assuming that AAW value their health, and that value is compelling enough to make MIPA a priority in their lives, researchers have offered a variety of recommendations to increase MIPA which have not led to satisfactory improvements (Jenkins et al., 2017; Segar et al., 2017; Whitt-Glover et al., 2014). Before designing new interventions to test, researchers need a deeper understanding of why previous interventions were not fully successful in achieving MIPA goals for AAW.

The concepts of beliefs and values are critical elements in health-related decision making because they are assumed to influence known predictors of behavior such as attitude, subjective norm, and perceived behavioral control (Ajzen, 1991; Armstrong & Mullins, 2017; Tinius et al., 2017). A qualitative exploration of values and beliefs is needed to understand how AAW prioritize MIPA within the context of their daily lives. However, no studies were found that explored the life experiences, values, and beliefs among AAW ages 25–44 and how those experiences, values, and beliefs influence their MIPA decisions. Social cognitive theories such as the Theory of Planned Behavior have been used by researchers as tools that aid in understanding a variety of physical activity behaviors among various groups (Ajzen, 1991; Huntington et al., 2020; Ruiz et al., 2021; Sur et al., 2022). It was chosen as the tool for exploring psychosocial factors and MIPA among AAW 25 – 44.

Theoretical Framework

The Theory of Planned Behavior (TPB) is one of the expectancy value models most frequently used to explain and predict human behavior across many health domains (Ajzen, 2011; Cooke et al, 2016; Grierson et al., 2015; Riebl et al., 2015; Starfelt & White, 2016; Stolte et al., 2017; Wang & Wang, 2015). The TPB was developed by Icek Ajzen, a social psychologist whose research has focused on the many factors that produce a discrepancy between intentions and actual behaviors (Ajzen, 1985). The TPB is an extension of Ajzen's earlier work with Martin Fishbein (1980) known as the Theory of Reasoned Action (TRA).

The TRA posits that volitional behavior is a function of intention (degree of readiness to perform behavior), which in turn is a function of attitude (towards a behavior) and subjective norms (social pressure to perform a behavior). Recognizing that not all behaviors fall under volitional control, Ajzen extended the TRA by adding the perceived behavioral control (PBC)

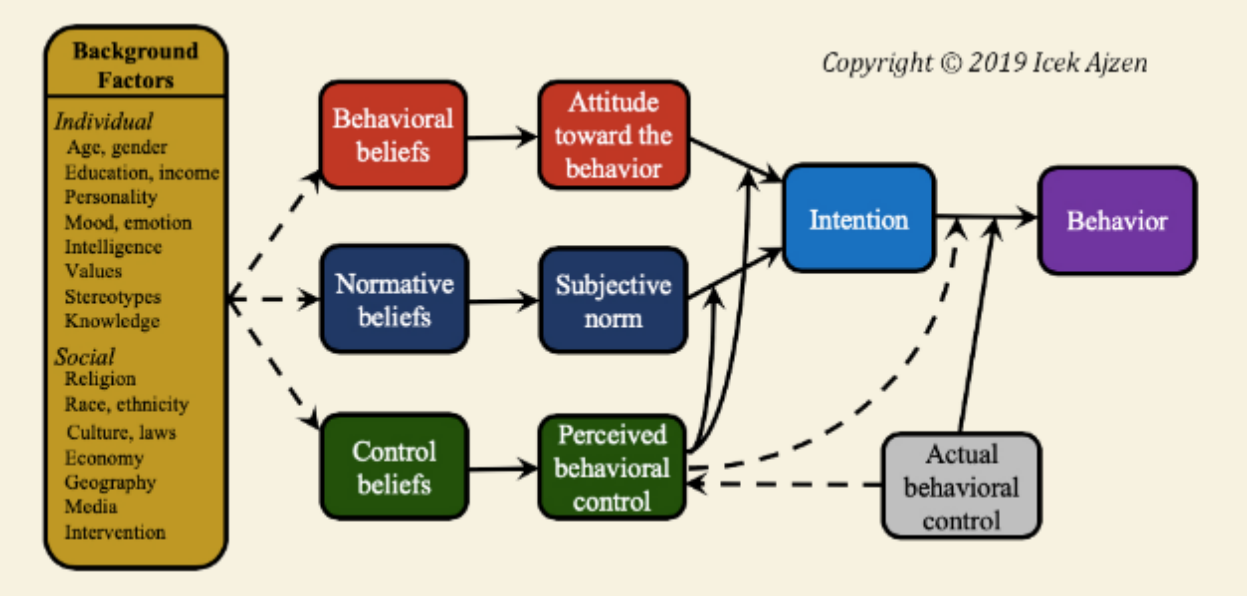
concept as an independent predictor of intention, used to explain factors outside of volitional control, and called the revised model the TPB (Ajzen, 1985).

TPB Model

The TPB model is a parsimonious illustration of the relationship between 1) background factors, 2) beliefs (behavioral, normative, and control), 3) attitude toward the behavior, 4) subjective norm, 5) perceived behavioral control (including actual control), 6) intention, and 7) behavior (See Figure 1).

Figure 1

Theory of Planned Behavior



Background Factors

Background factors are psychosocial factors assumed to influence intentions and behavior indirectly by affecting the theory's more proximal determinants. Demographic background characteristics (age, gender, education, income, race, ethnicity, and geography), personal attributes (personality traits, mood, emotion, intelligence, values, stereotypes,

knowledge, cultural beliefs), and exposure to the social environment (religion, culture, laws, media, and interventions) can be helpful to scientists by providing information about differences in beliefs (behavioral, normative, and control) across different segments of the population (Ajzen, 2020). When examining differences in beliefs, it is expected that individuals will exhibit differences in the strength of intentions to perform certain behaviors.

Which background factor to study is determined by the researcher. The researcher decides which factor or factors are believed to have the most influence on behavior-relevant beliefs (Ajzen, 2020). By including background factors in the context of the TPB, scientists can trace the extent to which these factors influence behavioral, normative, and control beliefs with respect to the behavior under investigation (Ajzen, 2020).

Beliefs

According to Ajzen (1985), the TPB posits that the psychological foundation of human action can be found in behavioral, normative, and control beliefs. Beliefs are subjective probabilities developed from individual and social background factors that use expectancy-value to make assessments about the outcome or experience.

Behavioral beliefs

Behavioral beliefs are perceived consequences of performing or not performing a behavior. TPB behavioral beliefs produce a favorable or unfavorable attitude towards the behavior and guide decisions regarding positive or negative outcomes of performing the behavior. The more positive the attitude or behavioral belief is toward a behavior, the more likely the individual will intentionally engage in that behavior (Ajzen 2020). For instance, an individual may ask, what are the benefits and consequences of this decision?

Normative beliefs

Normative beliefs are an individual's perceived beliefs about the behavioral expectations of people considered important in their lives. Normative beliefs give rise to subjective norm. There are two types of normative beliefs: injunctive and descriptive (Ajzen 2020). An injunctive normative belief is the expectation or subjective probability that a person of importance (e.g., friend, family, spouse, co-worker) approves or disapproves of the behavior under consideration. Descriptive normative beliefs involve perceptions that the person of importance performs the behavior themselves. For example, the individual considers if they will be supported or ridiculed performing the target behavior.

Control beliefs

Control beliefs are thoughts of having the ability to influence health status. Control beliefs are beliefs about the presence or absence of factors that facilitate or hinder performance of a behavior. For example, individuals will likely perform a behavior if they believe they perceive or have actual confidence in their ability to perform the behavior.

Theoretical Core Concepts

Attitude

The TPB relies on an expectancy-value to describe attitude toward a behavior. According to expectancy-value theory, a person's overall attitude towards a behavior is determined by the subjective values or evaluations of the attributes associated with the object and by the strength of these associations (Fishbein & Ajzen, 1975). If the expected outcome of behavior is something unfavorable, then the attitude toward the behavior will be negative, increasing the likelihood that the behavior will not occur.

Subjective Norm

Subjective norm refers to the perceived social pressure by peers and people of importance to engage or not engage in a behavior (Ajzen, 1991). As members of society, people typically care about what others think or believe. During their lifetime, AAW determine what types of behaviors are socially acceptable according to what important people in their lives expect. Subjective norms are determined by normative beliefs. For example, if a spouse or parent is at the top level of importance, their opinion is especially important to an individual. If the spouse or parent disapproves of an AA woman engaging in MIPA, the AA woman may feel compelled to avoid physical activities even though she may not agree with her significant others.

Perceived Behavioral Control

Perceived behavioral control (PBC) refers to an individual's perceptions about impediments to their ability to perform a target behavior (Ajzen, 1985; Bandura, 1977). Conceptually, there is no difference between perceived behavioral control and self-efficacy (Ajzen, 2020). People are expected to act on their intentions to perform target behaviors to the extent that they have control over the behavior. According to Ajzen (2020), perceived behavioral control is assumed to moderate the influence of attitude and subjective norm on intention, and actual behavioral control is assumed to moderate the effect of intention on behavior. That is, a favorable attitude and a supportive subjective norm are said to lead to the formation of favorable behavioral intentions to the extent that people believe that they are capable of performing the behavior in question.

Intention

Intention is the immediate antecedent of behavior and is an indication of an individual's readiness to perform the behavior in question (Ajzen, 1985). According to the TPB, behavioral

intentions are determined by attitude toward the behavior, subjective norm, and PBC. The stronger the intention to perform a given behavior, the more likely the behavior will occur. For instance, when an AA woman has a positive attitude toward MIPA, her social network supports engaging in MIPA, and control over performing MIPA is sufficiently strong, the likelihood that the intention will be carried out is also sufficiently strong.

Behavior

Behavior is an observable response to behavioral intention and perceptions of behavioral control (Ajzen, 1985). Performance of behavior is a result of life's events, beliefs, values, attitudes toward the behavior, and reactions by significant others, as well as facilitating or impeding factors (Ajzen, 2020). For example, bike riding for 30 minutes each day has been recommended to improve health (Dorwart et al., 2019). The individual determines that they are proficient at bike riding, has a bike riding partner, and intends to ride a bike each day. In this case, the individual is more than likely to bike ride for 30 minutes each day.

Conceptual Relationships of the TPB

The TPB model illustrates how an individual's psychosocial background experiences influence their beliefs about the positive or negative differences a behavior will make in their life (attitude), the social pressures from significant others (subjective norms), and their possession of the skills to execute the behavior (perceived behavioral control), all which influence intentions to perform the behavior. In the event the individual has no restrictions on performing the behavior, the behavior will likely occur (actual control).

Application of The TPB

Low engagement in routine MIPA is a major contributing factor to high prevalence rates of obesity, heart disease, stroke, breast cancer, and Type 2 diabetes among

AAW (CDC, 2019). Participation rates are low and become even lower among AAW ages 25 – 44 (Williams et al., 2018). Some researchers have identified that AAW do not engage in MIPA because they have negative attitudes about how MIPA interferes with family responsibilities, negatively affects their personal appearance, is not encouraged by family and friends (subjective norms) and requires skills they don't think they have (perceived behavioral control; Dorwart et al., 2019; Florez et al., 2018; Griffin et al., 2013; Im et al., 2012; James et al., 2014).

However, there are personal and historical experiences (background factors) that influence attitudes, subjective norms, and perceived behavioral control. In addition, beliefs and values are critical background factors that influence health-related decisions (Skimina et al., 2019). An individual's cultural and personal values and beliefs are responsible for many of their health-related decisions because they are antecedents to behavioral, normative, and control beliefs that influence behavioral intentions (Ajzen, 2019). Also, the personal meanings of MIPA values and beliefs among AAW ages 25 – 44 are poorly understood.

Purpose of the Study

The purpose of this study is to explore the values and beliefs (cultural and individual) of AAW ages 25 - 44, and how these values and beliefs shape their attitudes, subjective norms, and perceived behavioral control for performing MIPA.

Research Question

What are AAW's values and beliefs that shape their attitudes, subjective norms, and perceived behavioral control around MIPA?

Assumptions

1. Values and beliefs of AAW ages 25 - 44 influence behavioral, normative, and control beliefs.

2. AAW ages 25 - 44 years value MIPA.
3. Behavioral, normative, and control beliefs of AAW ages 25 – 44 shape their attitudes toward MIPA, subjective norm, and perceived behavioral control.
4. AAW will respond to discussion questions honestly.

Chapter Summary

This chapter presented an overview of the trends in MIPA among U.S. adults and emphasized low MIPA participation rates among AAW. Values and beliefs were presented as key psychosocial factors with indirect influence on attitudes toward behavior, subjective norms, and perceived behavioral control. A qualitative study that explored values and beliefs among AAW was proposed and the TPB was introduced as the theoretical framework to guide the research study because of its empirical and qualitative usefulness in predicting and explaining MIPA behaviors.

Chapter 2

Review of Literature

AAW face multiple unique sociocultural barriers that prevent them from meeting federal recommendations for optimal health (CDC, 2018). Key ethnic - specific barriers cited by AAW include family responsibilities (Im et al., 2012; James et al., 2014; Jenkins et al., 2017; Joseph et al., 2017; Versey, 2014), personal appearance concerns (hair maintenance and body image), lack of support, and lack of MIPA self-efficacy (Dorwart et al., 2019; Im et al., 2012; Joseph et al., 2017). Consequently, AAW have higher rates and earlier onset of chronic conditions and disability than their non-Hispanic White counterparts (Thorpe et al., 2016). Empirical evidence has shown that routine engagement in MIPA is a low-cost, low risk positive health behavior associated with mitigating incidence and prevalence of chronic disease (Benjamin et al., 2018; Mozaffarian et al., 2015; USDHHS, 2018). However, programs designed to increase MIPA among AAW have yielded only modest increases (Jenkins et al., 2017).

Designing culturally relevant MIPA programs for AAW requires understanding ethnic variations in their attitudes toward MIPA, their social network (subjective norms), and experiences that influence their self-efficacy or perceived behavioral control (Joseph et al., 2017). According to Ajzen (2020), attitude, subjective norm, and perceived behavioral control may be influenced by beliefs and values, which can provide researchers with valuable information that may explain how these characteristics influence or fail to influence behavior.

AAW's Attitudes Toward MIPA

Family Caretaking Responsibilities

Attitudes reflect a set of beliefs, feelings, or opinions developed from past experiences that mediate a favorable or unfavorable evaluation of a target behavior (Ajzen, 2020). The

normalization of certain cultural traditions has resulted in attitudes and behaviors that unfavorably affect the health of AAW (Cislaghi & Heise, 2020). For instance, AAW place higher values on family and work responsibilities than they do on MIPA and endure internal conflicts related to the perceived competition between self-care and multiple care-giving responsibilities (Dorwart et al., 2019; Im et al., 2013; Joseph et al., 2018).

In 2018, 41% of households were headed by AAW compared to 24% headed by Hispanic women and 13% of non-Hispanic White women (U.S. Census Bureau, 2020). Among midlife AAW, MIPA was viewed as a selfish, unproductive, and self-indulgent luxury that took time away from caring for their families or working to financially support them (Im et al., 2012). James et al. (2014) reported similar attitudes among AAW ages 21 – 49 (n = 413) in a study that assessed how AAW prioritized multiple MIPA barriers. Women were allowed to choose more than one category and the following were the top nine barriers: busy lifestyle (45%), not enough time (30%), getting home too late (26%), exercise not a priority (22%), no one to exercise with (19%), expensive gym membership (15%), too much hair care (11%), no babysitter (6%), and living in an unsafe neighborhood (4%).

Prioritizing everything over self may be associated with how AAW have been socialized by the AA culture because of historical events (Woods-Giscombé, 2010). Historically, during slavery, AAW were responsible for taking care of their family and other kinship - type relationships before taking care of themselves. Since then, caregiving responsibilities of AAW have been an expectation passed down from generation to generation, performed without question, and decisions to provide care or not provide care are irrelevant (Noonan et al., 2016).

Superwoman Schema

AAW's caregiving priorities are hypothesized to be rooted in a superwoman concept partially developed from economic and social necessities to survive racism, gender oppression, disenfranchisement, and a need to eradicate historical characterizations as mammies and jezebels (Awad, et al., 2015; Sacks, 2018; Woods-Giscombé, 2010). The superwoman schema rises from cultural and psychosocial factors that dictate how AAW must focus on the needs of others while placing their own personal health at a lower priority. Assuming a superwoman role may explain why some AAW have delayed health-seeking behaviors and do not adhere to health promoting recommendations.

Woods-Giscombé (2010) explored the strong AAW role among AAW ages 19 to 72 (n = 48) and found that participants experienced internal conflicts between cultural and personal expectations. For instance, some women felt social pressure to present an image of strength because of the personal, social, and economic struggles of their foremothers. Participants also commented that they were expected to be strong and help others even when they didn't feel like doing so. Women participants believed presenting an image of strength was just part of an AA woman's life. The feelings of obligation to care for others before self were parallel to the feelings of midlife AAW (n = 21) who were interviewed by Im et al. (2012). Participants reported feeling guilty for taking time away from family or spending time away from working in order to engage in MIPA.

Im et al. (2012) recommended that health providers inform AAW that they are undervaluing their own health when they prioritize the needs of others over their own. In addition, the researchers recommended that health providers educate AAW that taking time away from familial caretaking responsibilities will improve their physiological and mental health.

Similarly, James et al. (2014) recommended health providers address the issues of busy lifestyles and time constraints by encouraging AAW to perform short workouts, use smartphone fitness apps, and perform MIPA with their family members. Likewise, Woods- Giscombé (2010) recommended that AAW seek health promotion education and counseling from their health providers.

Recommendations to access the healthcare system for health education may not present viable options for some AAW. Researchers have shown that AAW have unfavorable attitudes towards health care providers and the health - care system (Cuevas et al., 2016; Tolliver et al., 2019). Studies have shown that because of historical mistreatment of African Americans, AAW have less trust in health professionals and access the healthcare system less often than their non-Hispanic White counterparts, especially if the AA woman lacks sufficient income, education, or health insurance (Connell et al., 2019; Cuevas et al., 2016; Hausmann et al., 2020; Jamison et al., 2019; Sutton et al., 2019).

Examples of mistreatment include historical experimental surgeries performed on AAW by Dr. J. Marion Sims without anesthesia or informed consent (Wall, 2020), the exploitation of African Americans during the legendary Tuskegee syphilis experiment (Frazier, 2020), and perceptions that healthcare providers discredited symptoms reported by AAW (Cuevas et al., 2016; Tolliver et al., 2019). Therefore, it is unlikely that AAW will benefit from recommendations that mostly require using the health - care system for prevention and interventions. Historical and personal events, along with a superwoman role, are assumed to be entrenched in the value and belief systems of AAW (Noonan et al., 2016; Woods-Giscombé, 2010). How AAW normalize historical, personal, and role identification is poorly understood.

Personal Appearance Concerns

Hair Maintenance

Hair is such a focal point in the lives of some AAW that a majority of them abstain from MIPA because of the time and money spent restyling their hair afterwards, as well as the microaggressions they experience from other cultures when their hair is in its natural state (Awad et al., 2015; Hall et al., 2013; Huebschmann et al., 2016; Joseph et al., 2018; Versey, 2014). The importance of hair for an AA woman may reflect internal conflicts between her mainstream culture which prefers long, straight hair and her inherited cultural values of hair (Randle, 2015).

Historical Overview of Hair

Pre-slavery, hair was a significant indicator of social status and the type of hairstyle worn was specific to tribal identity (Randle, 2015). The hair of enslaved Africans was curly, very dry and lacked aesthetic appeal according to Eurocentric standards (Randle, 2015). As a result, the hair of enslaved Africans was forcibly shaved. To avoid future shavings, enslaved Africans began to use tools they could heat to straighten their hair. Post slavery, straight hair was more prominent and viewed among the African American community as more socially acceptable because it resembled Eurocentric standards of beauty and made White Americans feel less threatened (Randle, 2015; Robinson, 2011). Eventually, marginalized AAW adhered to the mainstream culture's hair standards to avoid persecution and to "fit in" (Walker, 2007).

The Civil Rights reforms from 1954 to 1965 yielded the Black Power Movement of the 1960's and 1970's and changed how some AAW shifted from mainstream hair standards to western African standards (Randle, 2015; Walker, 2007). Under the Black Power Movement, AAW felt empowered to embrace African American cultural definitions of beauty and reject adoption of hegemonic standards of beauty (Randle, 2015). Collectively, AAW wore natural

hairstyles as a visual symbol of shared pride, values, and beliefs, thus resisting the values and traditions of the dominant culture (Randle, 2015; Robinson, 2011). AAW engaged in the movement began to internalize new understandings of themselves and what their hair symbolized (Garrin & Marcketti, 2018).

To understand the experiences of AAW wearing natural hairstyles during the Black Power Movement, Garrin and Marcketti (2018), interviewed AAW ages 69 -76 (n=7) who were young adults during the movement. A key theme that emerged was hair negotiation. Participants reported internal conflicts between Black pride and White society's negative perceptions of being militant because of their natural hairstyling. They negotiated their hairstyles depending on their different social environments. For instance, when working in predominantly White environments, participants did not want to look "out of place" so they straightened their natural hair. Some AAW believed their straightened hair was a symbol of professionalism, while others described it as conforming to hegemonic standards of beauty (Garrin & Marcketti, 2018).

Hair Microaggressions

In 2015, Awad et al., examined beauty concerns among AA college women (n = 31) and found that racial microaggressions and political implications for the texture and styling of their hair was rooted in the mainstream White culture's value system of judging acceptable hair types among AAW. In a survey of African American and White men and women (n = 4,163), Johnson et al. (2017) found that on average, non-Hispanic White women showed explicit bias toward African American women's natural hair and rated it as less attractive and less professional than smooth hair ($p < .001$).

AAW have described feeling social pressure to straighten their hair because of the harassment they and their daughters experience from White society at school, and at work, and

within their mixed racial communities, and their social settings (Essien & Wood, 2019; Johnson et al., 2017). The pressure to straighten their hair has also been identified by AAW as the aesthetic preference of heterosexual men when choosing a mate (Capodilupo, 2015). Unfortunately, many AAW continue to avoid MIPA because of the negative effect that perspiration has on disrupting their straightened hairstyle and reverting it to its natural state (Awad, et al., 2015; Huebschmann et al., 2016; Joseph et al., 2018; Versey, 2014). In a sample of AAW ages 21 to 60 years (n = 103), Hall et al. (2013) found that AAW with hair-related concerns were 2.9 times less likely to engage in MIPA more than 150 minutes per week (95% CI,0.9-9.4; p = .08). Participants were concerned about getting their hair wet from perspiring during MIPA or from recommended water activities. The time it took to wash, dry, and restyle hair was cited as the reason 29.1% of women avoided any physical activities that caused their hair to become wet (Hall et al., 2013).

It can take an AA woman up to three hours of self-maintenance or up to six hours in a hair salon to reverse the kinkiness of hair once it becomes wet (Kwarteng, 2020). Costs to repair faux hair or restyle natural or chemically relaxed hair can cost between $200 - $10,000 (Robinson, 2012). Therefore, the additional time and expense to maintain hairstyles after engaging in MIPA may be luxuries that AAW believe they cannot afford (Im et al., 2012).

Recommendations aimed at overcoming hair maintenance barriers have largely been instructive or educational (Whitt-Glover et al., 2017). Instructions have included using a variety of protective hairstyles such as braids, cornrows, wigs, ponytails, and chemical relaxers (Joseph et al., 2017). Williams (2019) recommended that AAW seek guidance from their health care provider regarding hair maintenance barriers. However, Tolliver et al. (2017), surveyed doctors, nurse practitioners, and physician assistants and revealed that 76% of respondents have never

included a hairstyling or maintenance assessment in a discussion with AAW regarding MIPA, while only 34% of respondents felt comfortable discussing the topic of hair. No studies were found that examined if protective hairstyling effectively increased MIPA participation rates. It is not clearly understood how the value AAW place on hair is compelling enough to prevent them from engaging in MIPA.

Subjective Norm

Lack of Support for MIPA

Many behavioral change theories, including the TPB (Ajzen, 1991), highlight the importance of social factors such as social support, companionship, and social connectedness in maintaining and/or initiating behavior change. Social support is conceptualized as having family, friends, and other people to turn to in times of need (Florez et al., 2018). AAW have reported that they would engage in MIPA more often if they had support from family and friends (Awad et al., 2015; Cade, 2015; Conn et al., 2013; Dorwart et al., 2019). AAW often describe many discouraging comments from family and friends such as “Black don’t crack, you don’t need to exercise” “I love/like you the way you are,” and “Exercising is for White people” (Cade, 2015; Dorwart et al., 2019). Unlike the Eurocentric value of thinner body sizes, the AA culture values curvier and thicker body shapes, larger breasts, and more rounded derrieres (Chithambo & Huey, 2013; Ford & Pickett, 2020). The AA culture places a high value on maintaining these features and is generally not supportive of activities that make these features smaller, muscular, and less attractive (Awad et al., 2015; Conn et al., 2013; Theron & Theron, 2013).

For example, Awad et al. (2015) found that when AAW strongly identified with their cultural group, they adopted the culture’s support of larger, curvier body sizes. The sample of AA college women ages 19 – 25 reported being more satisfied with their larger body image and

less likely to endorse a thinner body shape than non-Hispanic White women. Participants reported that thick/toned/curvy body types were optimal (n = 31), and images of thinness were associated with being a non-Hispanic White woman (n = 4). The findings are consistent with an earlier study by Sanderson et al. (2013).

Sanderson et al. (2013) compared body image information from AA college women ages 18 - 25 from a historically Black college/university (HBCU) and a predominantly White college (PWC). HBCU women were statistically more satisfied with their weight than the PWC women ($p = .010$). PWC women valued exercise more than the women from the HBCU ($p = .828$), and there was not a significant difference in valuing thinness ($p = .229$). Researchers concluded that HBCU women were just as likely as PWC women to reject societal standards of beauty and thinness.

The cultural origins of these beliefs are debatable, but none the less, the AA culture sends messages that behaviors tending to adopt Eurocentric portrayals of beauty and thinness are betrayals to AA cultural norms (Awad et al., 2015; Noonan et al., 2016). These cultural messages are passed from generation to generation and uphold non-supportive norms of MIPA among AAW. Therefore, AAW may avoid participating in MIPA because of negative criticisms from their social networks (Florez et al., 2013; Jackson et al., 2016; Thomas et al., 2009).

Although researchers have found that some AAW value support, results supporting a positive relationship between support and MIPA are inconsistent (Harvey & Alexander, 2012; Jackson et al., 2016; Mama et al., 2015; Pekmezi et al., 2013). For instance, Florez et al. (2018) found that the absence of contact with others (social isolation), increased an AA woman's time in MIPA minutes. Specifically, a one unit increase in social isolation would increase MIPA by a factor of 2.0 ($\beta = 0.71$, $p <= 0.002$). The increase translates into nine additional minutes of daily

MIPA (average MIPA for AAW is 4.5 minutes a day). The increase in MIPA during isolation was attributed to being away from social networks that discouraged MIPA. It was not determined from the study if women engaging in MIPA had disturbances in body image satisfaction.

Researchers have recommended that AAW seek social support from their churches because most women are religious (Jenkins et al., 2017). It was recommended that AAW form walking groups at their church and walk with other women at work or in their neighborhoods (Im et al., 2013; James et al., 2013). However, researchers conducting a survey (n = 8,600; 2020), determined that compared to older generations, young African American adults are less religious, less engaged in African American churches, and less likely to say religion is an important part of their lives (Desmond et al., 2010; Mohamed, 2021). Other recommendations have included using health care providers to encourage women to identify one or two other AAW with whom they can engage in MIPA (Dorwart et al., 2019; Im et al., 2013; James et al., 2013).

More research is needed to understand differences in the value of MIPA among AAW, what influences these values, and how they were developed. For instance, why did the AAW attending the PWC value MIPA more than the AAW at the HBCU? Were internal conflicts between the cultural and personal values of participating in MIPA resolved with peer support from White students? The social network within the AA culture generally discourages MIPA among AAW, and most interventions to promote MIPA have not examined the strength of support for MIPA from AAW's social network of family, friends, and significant others.

Perceived Behavioral Control

Self-Efficacy

MIPA self-efficacy (a person's confidence in performing a behavior; Ajzen, 1985) is associated with consistent MIPA participation (Mama et al., 2015; Young et al., 2014). Dorwart

et al. (2019) identified a fear factor among AAW ages 25 and older (n =10). Participants reported avoiding MIPA because they lacked confidence performing certain activities, such as using gym equipment, feared not being fit enough to keep up with other people in the group, and feared being the only AA woman in group activities.

Researchers have shown that some AAW lack self-efficacy because of their socialization as children (Essien & Wood, 2021; Im et al., 2012). For instance, African American mothers socialized their daughters to believe that hopscotch and jump rope were viewed as feminine activities for little girls and more vigorous activities such as basketball, baseball, and wrestling were meant for little boys (Randle, 2015; Robinson, 2011). Also, AAW who grew up during segregation were socialized not to participate in physical activities with White children. In other words, African American parents understood their place in society, and certain activities were assigned to males or females, and to Blacks or Whites (Im et al., 2012; Thind et al., 2015).

Additionally, AA children were socialized to avoid activities such as tennis, volleyball, jogging, and swimming. For instance, when it was time to choose teams during gym class, White students did not choose AA students to participate in their groups because they feared the darker toned skin of the AA students would rub off. Consequently, AAW learned as children to avoid certain physical activities because they were viewed as White activities (Agyemang & Powell, 2013; Im et al., 2012). As adults, AAW feel they missed opportunities to learn certain physical activities as children, because their families could not afford to participate in sports, or they were not given an opportunity to learn to play sports as children. As young adults, they lack financial means to maintain gym memberships (Dorwart et al., 2019; Im et al., 2012; O'Brien-Richardson, 2019).

In addition to childhood socialization, media advertisements have also been instrumental in fostering racial preferences for physical activities. For instance, television commercials and Youtube promotions of physical activities are dominated by images of White adults and children. Google searches using key words such as “physical activities” “recreation centers” “learn to play tennis” “learn to swim” and “fitness centers” primarily yielded images of White adults and children. Pezmeki et al. (2013), interviewed middle - aged AAW (n = 56) in the deep south regarding their physical activity preferences. Participants reported that print, internet, and television perpetuated the image of White dominated activities such as swimming, skiing, kayaking, and golfing. As a result, AAW avoided participating in certain activities because they were categorized as activities reserved for Whites.

Studies aimed at addressing low MIPA participation rates among AAW often recommend moderate to vigorous activities such as outdoor sports (Dorwart et al., 2019) and activities done at fitness centers (James et al., 2014). However, AAW’s preferences for physical activities and confidence in performing certain activities differ from those of non-Hispanic White women, and the activities recommended by researchers typically do not reflect AAW’s values and beliefs.

Chapter Summary

This chapter presented a discussion of the influences of AAW’s value and belief systems related to their ethnic - specific MIPA barriers. Key ethnic-specific barriers discussed were their family care responsibilities, personal concerns about the negative effects of MIPA on hair maintenance and body size preferences, lack of support, and lack of self-efficacy performing MIPA. Recommendations to overcome barriers were primarily instructive and educational. Several recommendations involved AAW accessing the health care system for education and instructions related to managing their specific barriers. However, AAW do not access the

healthcare system as often as their non-Hispanic White counterparts because they generally do not trust the health care system or health care providers.

Researchers have shown that a culture's belief and value system influence MIPA behaviors. However, there are gender unique sociocultural experiences of AAW that have shaped their beliefs and values apart from the cultural group. For behavior change to occur, researchers and participants must be aware of what those experiences are. Findings from this study may enhance current literature by providing new information about the values and beliefs that AAW ages 25 – 44 rely on to make MIPA decisions when family responsibilities, hair maintenance, body size preferences, lack of support, and lack of self-efficacy are barriers.

Chapter 3

Methods and Procedures

The purpose of this study was to qualitatively explore what values and beliefs of AAW ages 25 – 44 shaped their attitudes, subjective norms, and perceived behavioral control around MIPA. In this chapter, the research design, study sample, setting, data collection methods, procedures, and plan for data analyses are described. Ethical decisions and the delimitations of the study are also discussed.

Research Design

Ethnography with photo elicitation were used in this study. As a qualitative method of inquiry, ethnography provided a systematic process for learning what values and beliefs AAW have that affected their MIPA decisions. Photo elicitation was a method used to generate memories, evoke emotion, and conversation. The photo-elicitation technique was included because previous research has shown that it has some advantages when the goal is to increase the rigor and credibility of conventional qualitative methods (Cox & Benson, 2017).

Methodology

Population and Sample

Homogenous purposive sampling was used to enroll participants. This technique was beneficial because it is used when the goal is to discover meaning in health care situations among individuals who have a shared set of characteristics (Ingold, 2017; Munhall, 2012). The sample consisted of 12 participants. Data collection ceased when saturation of themes was reached, meaning no new information was forthcoming. Data saturation is the gold standard by which purposive sample sizes are determined. It is an important component of rigor and reduces the risk

that the researcher does not have adequate data to develop a robust and valid understanding of the study's phenomenon (Constantinou et al., 2017; Polit & Beck, 2017).

Eligibility Criteria

The 12 participants were English speaking women ages 25 - 43 who engaged in MIPA less than 150 minutes per week, performed muscle-strengthening less than twice each week, were born and raised as female in the United States, and self-identified as African American or Black as their only race. Being born and raised in the United States should minimize cultural influences of African Americans from countries within Africa and the Caribbean where culture, values, and beliefs may differ (Nche, 2016). Self-identification as African American or Black only was expected to reduce influences of multicultural beliefs and values (Charmaraman et al., 2014). All participants were capable of performing MIPA without restrictions.

Recruitment

A recruitment flyer (see Appendix A) was publicly posted on Facebook and shared by other Facebook users. Facebook was useful because it is a popular online social media platform that reaches millions of diverse users worldwide (Clement, 2019). It was also advantageous to use Facebook because of an on-going pandemic that required social distancing. The flyer consisted of a link to QuestionPro where interested potential participants could review, accept or decline the consent, terms and conditions (see Appendix B). Thirty people responded to the request for participation. Six people dropped out and four were ineligible.

Procedure

Selection of Eligible Participants

Women who consented to the policy and procedures in QuestionPro were electronically directed to complete the eligibility screening survey (see Appendix C) and demographic survey

(see Appendix D). Eligible participants were contacted by the principal investigator. Using the telephone script (see Appendix E), the principal investigator contacted participants and 1) assessed them for appropriateness when answering simple questions, 2) discussed any study related concerns, 3) and evaluated their understanding of their consent, terms, and conditions. Two – four interviews were scheduled at a time to allow time between interviews to analyze data (see Appendix F). Participants were texted an invitation to their Zoom meeting.

Setting

Participants determined the location for their interview. The principal investigator conducted interviews from a private single occupied room.

Data Collection

Data were collected during a onetime one-to-one semi-structured Zoom interview lasting no more than an hour. An interview guide (see Appendix G) was utilized to allow participants to share what values and beliefs influenced their decisions round MIPA. The interview guide included open-ended questions and principal investigator selected photos to explore each participant's MIPA behaviors. The grand tour interview question was, "What was or is your first thought when you hear the words physical activity?"

Participants were shown photos of straightening combs, various body types, and AAW participating in various physical activities. Field notes were used to collect data regarding the participant's reactions to photos which sometimes evoked emotional responses. Prompts, probes, and follow-up questions were used when appropriate to gain an in depth understanding of MIPA behaviors from the participant's perspective. Data from the demographic survey was collected for analysis of sample characteristics.

Thematic Data Analysis

Audio-recorded interviews were anonymized and transcribed verbatim by the principal investigator. Thematic analysis was used to identify common themes and patterns related to the research question. Thematic analysis was an appropriate approach because researchers can make coding, theming, decontextualizing, and recontextualizing judgments about insightful, rich, and trustworthy research findings (Nowell et al., 2017). Open coding was manually performed by the principal investigator to identify topics, issues, similarities, and differences revealed through each participant's recorded interview and the principal investigator's field notes.

Triangulation of the three methods of data collection (observations, interviews, and photos) were used to maximize the validity of the analysis. The triangulation of qualitative methods substantively contributes to the rich, contextually detailed data regarding the culture being studied (Polit & Beck, 2017). Notes taken during the one-to-one interviews were analyzed to document relationships between codes and why certain labels were chosen during categorization. This process helped create an audit trail for other researchers to assess the study's trustworthiness (Cascio et al., 2019). Codes and themes were constantly compared between participants until no new codes or themes emerged. Lastly, demographic information was analyzed to describe sample characteristics.

Ethical Considerations

This study was approved by the Institutional Review Board (IRB) at the University of Texas at Arlington prior to recruitment and data collection. Participants were informed of the purpose of the study, procedures, and potential risks through written and verbal explanations. In addition, participants received contact information for the principal investigator and the University of Texas at Arlington IRB should any questions arise during or after the study period.

The principal investigator completed Human Subject Protection training within IRB requirements and prior to initiation of the study. All participants were informed through written and verbal communication with whom their information would be shared, and how all information would be anonymized and reported in aggregate format.

Confidentiality was maintained by use of code numbers instead of participant's names or other identifiers. The link to the codes were saved on a flash drive, is password protected, and kept in a locked fireproof safe. Participants were informed that there was a minimal risk that some questions could make them uncomfortable, but they were reassured that the interview would cease to allow them time for composure or to request withdrawal from the study. All participants were informed that they could withdraw from the study at any time without duress or penalty. Audio files were for transcription purposes only and were permanently destroyed as soon as transcription was completed. Transcription was performed by the principal investigator. Retention and destruction of all forms of information obtained on the participants in the course of this study was performed per University of Texas at Arlington IRB protocols.

Delimitations

The research focus was aimed at understanding low MIPA participation rates among AAW and the beliefs and values that influenced their lack of participation. Accordingly, African American men were omitted from the study. Participation in MIPA begins to decline in AAW ages 25 – 44 and therefore inquiry was limited to this age group. It was assumed that participant responses were honest and not a result of participating in a research study.

Chapter Summary

The purpose of this study was to explore what values and beliefs of AAW 25 – 44 shape their attitude toward MIPA, subjective norm, and perceived behavioral control to engage in

MIPA. An ethnographic-photo elicitation approach was used to understand the intersectionality of culture, values, beliefs, and MIPA. Participants were recruited using purposive sampling from Facebook. Data collection and thematic analysis were discussed. In addition, IRB requirements and steps taken for human subject protection were discussed, followed by a description of the study's delimitations.

Chapter 4

Findings

The final sample size was 12 AAW. Data collection stopped at 12 participants because data saturation was reached, meaning no new information was forthcoming. Interviews were conducted between October 2021 through July 2022. The interviews lasted between 30-60 minutes. The mean age of participants was 34; age range was 25 – 43 years. Participants most often reported being married (50.0%, n = 6), having a baccalaureate degree (50.0%, n = 6), and having a household income between $50,000 and $99,999. Sample characteristics are shown in Table 1.

Table 1

Sample Characteristics of African American Women

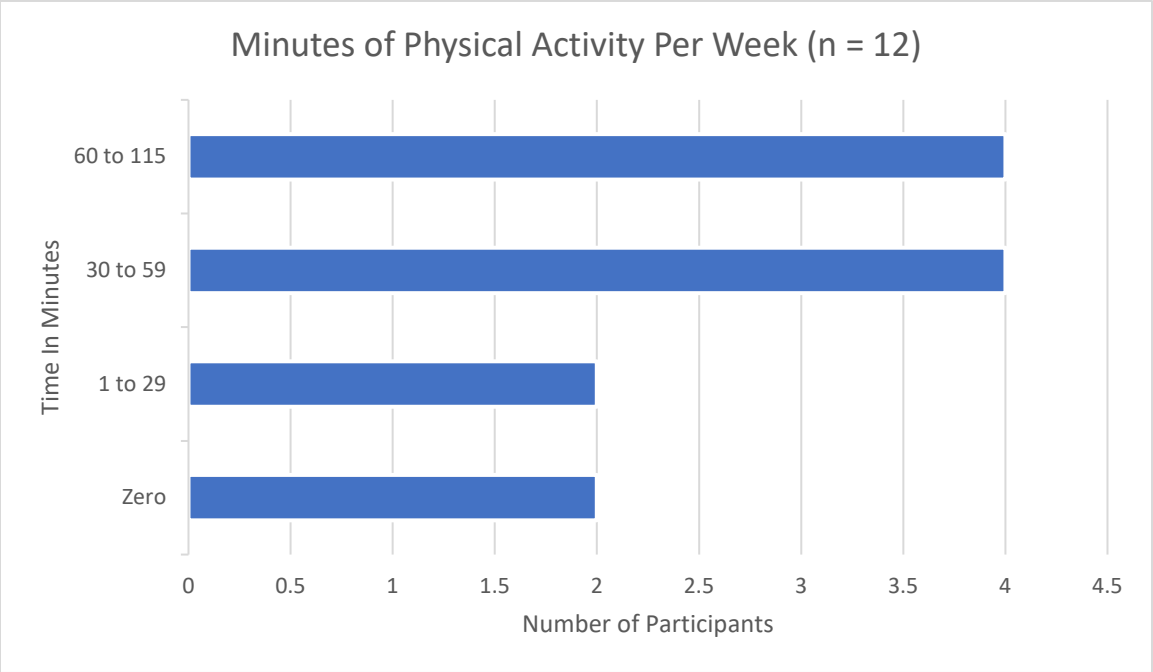
	n = 12	
	Mean	(n)%
Age (years)	34	
Marital status		
Married		(6) 50.0%
Not married		(5) 41.7%
Lives with partner		(1) 8.3%
Highest education Level		
High School		(1) 8.3 %
Associates		(1) 8.3%
Baccalaureate		(6) 50%
Masters		(4) 33.3%
Income (year)		
$30k-$49,999		(3) 25.0%
$50k-$99,999		(6) 50.0%
$100k +		(3) 25.0%

The amount of time each participant engaged in PA was collected from the demographic survey tool found in Appendix D. A review of how often participants exercised each week

indicated that two (16.67%) reported no exercise, two (16.67%) exercised between 1-29 minutes each week, while 8 (66.7%) exercised between 30-115 minutes per week. Data are illustrated in Figure 1.

Figure 1

Time Spent in Physical Activity Each Week in African American Women



Thematic Analysis

Findings extracted from line-by-line coding of transcribed interviews are presented as themes assigned to the research question exploring the values and beliefs of African American women that shape their attitude, subjective norm, and perceived behavioral control regarding MIPA. There were nine final themes in the data analysis. Themes are listed in order of presentation in Table 2.

Table 2

Physical Activity Themes Among African American Women

Theme 1	The Meaning of MIPA
Theme 2	MIPA is Devalued in the African American Community
Theme 3	Gym Anxiety
Theme 4	Social Support
Theme 5	Hairstyles and MIPA
Theme 6	Body Image
Theme 7	Media Representation
Theme 8	Planning For MIPA
Theme 9	Effort is Sufficient

The Meaning of MIPA

The first theme to emerge was how AAW described the meaning of MIPA and its role in their everyday lives. Meanings were expressed as “any type of body movement”, “exercise”, “going to the gym”, “healthy”, “something longer than 30 minutes that you could actually break a sweat or get tired from”, and “me doing the laundry, going up and down stairs carrying baskets, probably anything that’s going to get me sweating and my heart pumping a little bit faster than it would at resting level”.

Participants unanimously perceived routine MIPA participation as important and something they needed to do but described having more essential priorities such as caring for their children, working, and taking care of their households. From their perspective, those activities provided adequate amounts of MIPA.

On average participants believed the recommended amount of time adults should spend performing MIPA was 1.75 hours per week. In contrast, Federal Physical Activity Guidelines (PAG) recommend that adults engage in at least 150 minutes of moderate-intensity physical activity (MIPA) each week and should perform muscle-strengthening exercises on 2 or more days each week for optimum health. The average time the sample spent performing MIPA each week was 42.7 minutes. One woman stated, "I thought what I was doing was enough. I'm very petite. I just thought what I was doing was meeting my physical health for the week." Similarly, another participant commented,

> I'm relatively active. I have young kids and I'm moving around a lot you know what I'm saying. So, I'm not very sedentary. I am pretty active doing laundry, moving, walking, taking the kids to the park. So to me, I thought that was enough. I'm a pretty active young lady and mom.

The top priority for AAW with children is being a mom first. As a mom, African American women believe their child is a blessing, had no choice coming into the world, and therefore it's the mom's responsibility to care for them. A participant shared her viewpoint,

> I have a lot going on with the kids and work. My kids didn't ask to come here. I decided to have my kids, so it's up to me to take care of them the best way I can. And exercising I know it gives you energy, I understand that. But I also know that I feel like I don't have the energy to put into exercising and getting hot and the aftereffects of like being sore. I just don't want to deal with it.

Another mom responded that non-mandatory activities like MIPA took away valuable time with her children.

> Because as long as my children have been alive I have worked a full-time job. So I always felt like I was losing out on time with them. So anytime I'm not working, I felt that was their time, especially when they were young. As they got older, I also saw that they were very independent and didn't need me around as much, especially if they were busy with their friends or their activities. And so it was okay to take that 30 minutes or an hour for myself, to take care of myself and work out.

Participants agreed that working was a mandatory necessity to meet personal and family needs. As AAW, they believe they work longer hours and drive longer distances to obtain suitable wages more often than their White counterparts.

> You're either working for very low money, so you have to work a lot of hours, or even if you're making good money, you're commuting, traveling, you're also putting in a lot of hours. We have families, or a lot of times single parent homes where a lot of the responsibilities are on one parent. Income is a factor. A lot of times we don't have money for those extra privileges. We're just getting by, day by day or week by week.

After returning home from long workdays and longer commutes, participants reported that even though they were tired, they still were responsible for 1) caring for small children, 2) preparing and cooking dinner, 3) finishing work emails and resolving work issues, and 4) preparing for the next day. One participant shared her experience,

> I wish I could get into it [PA] more. I'm a preschool teacher so I spend a lot of my time being active at work. And I work super long hours so by the time I get home and get settled it's basically time for me to get ready for the next day. And then on the weekend since I spend so much time at work, I'm usually busy or I'm like getting rest that I missed out from the week. So, I could probably fit it in, but it's just I'm always so tired after work. It's just like, okay, no thanks, maybe try this [PA] tomorrow, and then tomorrow comes and it's the same basically.

AAW acknowledge that they may exercise less than women from other races, but believe they experience unique social issues. They perceive these social issues as greater threats to their health than not exercising as often as women from other races. Participants explained that as AAW, they are constantly under some type of race-based stress most other women do not contend with. A participant shared her perspective.

> I think there are just other societal issues that affect us on a regular basis. I think as an African American woman you are stressed about certain situations that you may be put in or you're worried about the safety of your spouse and your children because they are African American. So there's some overriding stress that kind of carries and sits with you throughout your literally everyday life. Whereas it seems if you are a non-person of color, there's a carefree less stressful life there. I think there are different circumstances regardless of your economic stature that you will carry no matter what, especially if you are an African American mom.

MIPA is Devalued in the African American Community

AAW believe the importance of MIPA was not treated as a priority throughout most of their lifetime. They recalled feeling MIPA was not an important activity emphasized by their parents, their health care providers, or during their school years. Growing up, the majority of women (n = 8) recalled that working, not exercising, was the priority for their parents. Common responses were, “none of my guardians were active,” “they never exercised, literally,” and “the activity I remember my parents doing the most was working.” Many participants recalled seeing their parents exercise if the goal was to lose weight.

Many participants believe health care practitioners do not think MIPA is important to AAW because they seldom recommend it during health encounters. One participant expressed the following: “We don’t get the care that other ethnicities get. My doctors never mentioned to me in my entire adulthood about exercising, the amount of exercise, or the time of exercise I should do.”

On average, AAW valued MIPA as 5 on a bull’s eye ring consisting of 6 priorities with the number one priority in the center ring and number six on the outside edge. Several were recently diagnosed with a chronic illness and re-prioritized MIPA from 6 to 5 (slightly more important). Although not diagnosed with a chronic illness, the remaining participants described family histories of heart disease, obesity, and diabetes. Although some participants stated they thought about the possibility of contracting similar diseases because they did not exercise, it was not an immediate concern because they perceive themselves to be healthy. One woman commented, “I don’t work out at all, and I don’t have any of that going on with me.” Another stated that she was aware not participating in routine MIPA could negatively affect her health but believed it would happen “definitely in the long term.”

As adults, some AAW have a desire to be physically active but feel they don't know how to be physically active because MIPA and sports were not highly valued during their youth. One participant explained how she wants to be more physically active but lacks confidence because PA and sports were not emphasized during her early school years or beyond high school. She stated, "I'm not that active. I've never really been into physical activity because I wasn't good at sports. I've never been into that type of thing. I wish I could get into it more."

Gym Anxiety

Working out in environments where they feel people can see them increases anxiety in most AAW. Anxiety may be higher in women who work out in the gym compared to women who work out alone. Participants reported feeling intimidated if they perceived their work out was being watched, especially by White patrons. Their perception of being watched also made them feel like they were being judged, and that increased their anxiety. They explained that their anxiety is related to not feeling competent to perform certain workouts. Additionally, AAW have a perception that most African Americans work out at home rather than in the gym. One woman shared her perception of attending a gym.

> I do think it's a privilege to be able to have a gym pass and be in all these yoga groups and groups that are surrounded with exercise and physical health, because our circumstances are a lot different in a Black community. I guess I'm somewhat inspired but on the other hand, I don't know if those spaces include us. I know it's supposed to be inclusive.

When participants were shown a photo of an African American woman working out in a gym, some women reported feeling anxious. The anxiety was associated with not knowing how to use gym equipment and the desire to portray confidence. One woman explained, "I didn't want to look like the one who didn't know what they were doing even though I didn't know what I was doing. I didn't like being stared at or watched." Another participant commented, "I worked

out with a trainer for a week. Once my week had ended, I really didn't get any more assistance, and I didn't feel comfortable asking."

Few women believed having access to African American owned gyms with more African American trainers and women would make a difference reducing anxiety or increasing gym attendance. Most women preferred working out alone and unseen. A common sentiment among women was, "I prefer there be nobody in the gym because I don't want anybody to see me making any mistakes." In most situations, gym anxiety was so prevalent, women abruptly cancelled their memberships.

Social Support

AAW reported that their social networks mostly encouraged their MIPA decisions. Most AAW believed their social network of family and friends was supportive of their decision to be sedentary or physically active. Their social networks consisted of people whose MIPA ranged from very sedentary to very active. Participants reported that the PA behaviors of their network had very little influence on their own MIPA decisions. One woman stated, "It really doesn't matter what someone else thinks. If it's something I really want to do, then I will do it." Another responded, "They don't influence me at all to be more or less physical."

Some women believed that if they saw more African Americans in their communities engaged in MIPA they would feel encouraged to engage more. African American women thought their networks supportive when they arranged virtual workouts together, showed them how to use equipment or appropriate workout apparel to wear, or showed them how to gain the most from a workout in a limited amount of time. In general, participants believe that having someone who knows what they can do, should do, and how to do it without judgement are most helpful and supportive. That person can be a friend or a trainer. One woman commented,

"Sometimes I just don't know what to do and I feel like I need guidance. I can't afford to have a personal trainer. I wouldn't mind going with somebody that's experienced because they could help me."

Some participants reported receiving negative support. One participant stated, "I don't need someone yelling at me or belittling me. Those things make me stop the exercise." In contrast, a participant who tries to work out as often as she can, stated that she routinely has to respond to comments from friends such as, "You're already small, what are you working out for?" She stated that their comments do not discourage her from working out.

Hairstyles and MIPA

The meaning of hair is very important to African American women because they believe it enhances their beauty. Wearing natural hairstyles such as afro's, dreadlocks, and braids provided a sense of self-expression of their personal style and beauty. One participant explained,

> For me it's important. I mean, I think I take value in just personal style and self-expression. So, I think hair's a way to do that. It's a way for me to feel good about myself or express myself, whatever that means at the moment.

Some participants believe their natural hairstyles are often perceived as unprofessional and unacceptable among other racial groups. They told stories of AAW being told that their hair should resemble Eurocentric (long, silky, straight) hairstyles of mainstream society. In response, AAW who wanted to feel accepted by mainstream society, abandoned their personal style and straightened their hair using chemicals, straightening combs, weaves, and extensions. A participant shared her perspective which was a common theme among participants,

> When you're talking about workplace and stuff, there's literally been people who have been told to change their hair or you can't wear your hair like that. So, part of it is like okay, for me to function and navigate society, I need to look a certain way, maybe acceptance. There is and I think this ties into it, there is a lot of Black colorism and those types of things, featurism. It's a lot of those isms within our community. So even right

> within our community it'd be like a pressure, a desire to look, or have a certain look. I mean, anything with this proximity to Whiteness is always going to be more accepted.

Consequently, women wearing straightened hairstyles often made decisions not to work out because protecting their acceptable image involved a great deal of time and money. Participants believed that most types of MIPA causes the roots of their hair to revert to its natural state resulting in damage to its straightened appearance. AAW who needed to look a certain way for work or other social environments reported postponing working out until it was time for their hair to be re-styled. The consensus among participants was that efforts to maintain a certain look were more compelling than MIPA engagement. One participant shared their sentiment,

> When I wear my hair straight, when I first get it done, it's like yeah, I'm not working out because I just got my hair straightened and I spent hours doing my hair. So, it's going to take about maybe 5 days before I go to the gym. But when I wear my hair natural, I don't care. Every time I do my hair natural, even if I do it that day I'm going to the gym.

Body Image

AAW believe physical looks are highly valued in the African American community. Many think attractiveness is associated with having a body shape like the musical icon Beyonce or Instagram models who have small waists, larger hips, and larger derrières. They believe African American men are most attracted to and prefer AAW with Beyonce and Instagram model body types. According to some participants, these images of beauty are driven by the "rap" culture and their videos, television and concert appearances, and their social media platforms.

Women who believe certain workouts will result in them appearing too thin like White women or too muscular like Serena Williams will not do MIPA. "If Black women are too thin then they look like White women," "I don't like being compared to White women," and "We like bigger body sizes and too much physical activity will make Black women look too thin or too

muscular." Further influences on what African American women believe included the following statement,

> I have seen and read comments that the African American culture is not supportive of physical activity for African American women because of the effects on their body. Let's take for example, Serena Williams and tennis with her being very fit and physical. They have mentioned that her body shape is manly. Yeah, more manly comments when women are physically fit.

Participants think most AAW do not work out to be healthy, because being "in shape" means having a thin waistline, large derrière, and large thighs. Accordingly, women who gain weight and become "a little thicker" are not inclined to exercise because they consider their thicker body shape and size are acceptable and beautiful according to the African American culture.

> My body size is slimmer up top and then bigger legs and butt. In terms of weight, because of the pandemic I'm probably a few pounds more heavier than I like. But I do find myself like, okay, well, if you do get a little thicker, that's fine because of our culture, having a bigger butt kind of fits into what's acceptable if you will.

Many AAW believe that the need to look like Beyonce or Instagram models is so compelling for some AAW that rather than exercise, they undergo unhealthy surgical procedures that have resulted in disfigurement and death (e.g. fat injections in the buttocks). Inevitably, post-surgical women feel MIPA is only needed to maintain their iconic body shape. Some participants believe this trend is daunting and that it is time for the African American culture to look beyond a certain look and begin discussions regarding healthy behaviors.

> To me it's sad because everybody's kind of looking alike, and getting work done to have that body type. People are getting cement in the body to get the big butt and then they're going to get the stomach chopped out type thing. Work out to be healthy and embrace that part of it.

Furthermore, there is a belief among some participants that the African American culture is undergoing a shift in how it values overall physical appearances. Previously, larger women

who did not look like Beyonce or an Instagram model were fat shamed. The shift in the culture's values suggests it is now taboo for African Americans to criticize overweight women and make them feel uncomfortable. One woman described the re-valuing of physical appearance by stating,

> There are certain people, I'll give you the example of Lizzo who has a show on Amazon called "Big Girls." If you judge her based on her large size, you would be deemed the one who is being unaccepting of body types. There's a positivity, especially around larger or plus size body shapes and it's very taboo to tell anyone otherwise. So there is a positivity movement right now no matter how large you are or how unhealthy you may look. I think even just overall as an African American female, anyone commenting negatively on someone's body type, whether it's small or large is very taboo.

Media Representation

AAW are discouraged from engaging in certain sports and outdoor recreation because of the insufficient number of role models. AAW who can identify with role models for MIPA feel more inspired to participate in those activities. They are hesitant to endorse advertisements for gym memberships and outdoor activities such as golfing, skiing, and jogging when the role models are predominantly White men and women. A participant shared this thought,

> I think when I see golfing I think of Tiger Woods, and I think by seeing him it may make you think, okay, well it can be. Any sport should be for anybody, but a lot of times you see White men and then you see White women. But yeah, it's not typical to see Black people golfing. On the norm it's not something you do in the Black community.

Another participant who played golf once said, "I feel intimidated because there aren't many of us playing. I got the stares. You got to be on point because you're definitely the only one out there." In contrast, when shown an image of people skiing, one participant recalled an experience at a ski lodge where several African Americans were in attendance. She shared her feelings,

> Oh my goodness, let me tell you. I have been to Black ski week and it's amazing. It's great. It's amazing seeing Black people on the skis and on the slopes and everything. But overall, it's a White thing. We know White people do this [ski]. White people have the privilege to have snow clothes and skis and all that. We don't have that. Geographically, White people live up there in the mountains and snow.

Planning For MIPA

AAW feel very confident that they could incorporate MIPA into their busy lifestyles if they wanted to. Participants believe the 2019 COVID pandemic has had a negative impact on MIPA among AAW. Participants believe social distancing caused by the pandemic has added to their burden of how to plan time to work out because their children are forced to temporarily home school. With more families working from home and homeschooling, AAW feel they have less time for MIPA because there are many more distractions at home. One participant stated, "I need to get out of the house to really get it in because at home it's just too many distractions and kids. Now I don't have a scheduled time to work out in the house."

Many participants felt planning for MIPA was one of their greatest challenges. They described solutions as 1) prioritize MIPA, and 2) identify the best time of the day for them to schedule it. Some believed they would have more success increasing their MIPA participation if they scheduled MIPA as part of their day. One participant commented, "I didn't shy away from physical stuff, but I didn't have a routine or a schedule like this has to be done just like I need to work. I didn't prioritize it in that way." Regardless of barriers to increase MIPA, AAW believe they are in total control of executing a plan to work out at least one hour, three times a week for the next three months if they wanted to.

Women who tried to work out before everyone awakened or before going to work complained of feeling less rested, tired, or sore before starting their day. Ultimately, most AAW explained they did not like feeling mentally and physically exhausted after working out, and decided it was better to have energy to take care of their children, household, and work responsibilities. One participant commented that,

> I have so many things I have to do during the day. My physical activity causes you to exert energy, then you use up that energy, then how do you accomplish everything else you have to do during the day?

Effort is sufficient

Most AAW believe their lifestyles do not allow them time to work out for 150 minutes each week as recommended by Federal Physical Activity Guidelines (PAG). They largely reported being satisfied and feeling accomplished with any amount of MIPA that they could incorporate into their busy schedules. One participant said,

> I really have to put in an effort to be active. But it is what it is. I do feel like as AAW we lead really busy lifestyles. We're working and we're taking care of the household. I'm not going to stress myself to death about it. If I can only work out on Saturday and Sunday, I'll just be like, okay, that's the best I can do this week. At least I put up an effort to do something. I just try to do the best I can.

Another participant added that she puts forth an effort to be physically active because there is an expectation from her spouse that she attempt some effort. She stated,

> He prefers, not that I'm this little woman or this tiny woman or anything like that, but that he at least can see an effort of there being some MIPA and an effort to not just gobble up food and not care. So I think because that's his preference that it does make me feel like I at least need to show that I'm interested and make some sort of an effort in staying…. I don't have to be fit, but he just at least likes to see an effort.

Many of the participants perceived efforts to eat healthy were more important than efforts to be physically active. Women were asked how they felt if they were unable to meet PAG recommendations, most respondents reported feeling satisfied with their efforts to at least do something. One respondent said she had no regrets because she knew meeting PAGs were not possible. She added,

> I believe it's more so about self and self-confidence. I mean, I still feel confident in the things I eat. And as far as my physical activities, that can substitute a daily workout. I just don't have time. I work fulltime, go to school fulltime, take care of my children fulltime, and help take care of my sick father. When do I have extra time to work out?

Faith-based women also believed efforts to be healthy were more important than efforts to exercise because of their beliefs that the body is a temple of God and people should be aware of what they put into their temple. One participant explained,

> I mean, knowing the whole healthy temple, this is God's temple. I have a tendency to think not so much about exercise, but about food and water, and vitamins. There's always some fresh fruits and veggies involved and tons of water. So those are the things that I found that I can better control. I try to balance it out, not so much as exercise, but by eating and drinking.

Chapter Summary

This chapter presented findings from data collected from 12 AAW participants. After line-by-line coding, 9 final themes emerged from the data. They were 1) the meaning of MIPA, 2) MIPA is De-Valued in the African American community, 3) Gym Anxiety, 4) Social Support, 5) Hairstyles and MIPA, 6) Body Image, 7) Media Representation, 8) Planning for MIPA, and 9) Effort is Sufficient. Study findings included direct quotes from participants which were discussed in the chapter.

Chapter 5

Discussion

The purpose of this study was to explore the values and beliefs that influence the attitudes, subjective norms, and perceived behavioral control among AAW toward MIPA. This chapter includes the interpretation of major findings compared with previous studies regarding MIPA, values, beliefs, and culture. The study limitations, conclusions, nursing implications, recommendations for future research, and the chapter summary are discussed.

The Meaning of MIPA

AAW in this study believe that physical activity means any type of bodily movement, like going to the gym or using the stairs to perform household chores. This definition is consistent with the World Health Organization's (WHO, 2020) definition that physical activity is any bodily movement produced by skeletal muscles that results in energy expenditure. Participants believe their routine daily activities are adequate to meet physical activity needs. Technically that belief has merit, however, this study did not assess the intensity, frequency, and duration of their daily activities, which are characteristics used to determine which activities meet MIPA recommendations. For optimal health, Federal Physical Activity Guidelines (United States Department of Health and Human Services [USDHHS], 2018) recommend that adults engage in 150 minutes of MIPA each week and include two days of muscle strengthening. Participants acknowledge they were unaware of recommendations and low MIPA participation rates among the sample (43 minutes per week) are consistent with previous MIPA studies in AAW (Okunrintemi et al., 2019; Williams et al., 2018; Whitfield et al., 2018).

There are two top priorities reported by AAW that are barriers to MIPA participation. Most women with children reported children as their top priority and single women reported

employment as their top priority. None of the parents in this study were stay-at-home moms so it is reasonable to assume that working to take care of their children is a priority for single and married women as well. Single women reported employment as important to support their lifestyle. Participants reported working long hours, traveling long distances to work, some were in school, some were home schooling their children or taking them to school, preparing meals, and trying to get some rest after a long day. Participants say they are too tired at the end of the day to engage in MIPA. Im et al. (2012) and James et al. (2014) found the same barriers when they investigated MIPA among AAW.

Participants report that they value their role as a mom, and spending time with their children is very important to them, more important than gym time. They believe any time spent away from their children is "lost time." Participants acknowledge that MIPA is important, but it is not as important as spending time with their children (parents) or resting (single participants). Unless participants re-prioritize the value of MIPA, increased MIPA is unlikely to occur. Some participants report that, unlike their White counterparts, AAW live every day worrying about the safety of their African American children and spouses because of current, intense social crises. Dormire et al. (2021) reported that AAW live with a profound fear that their children or spouse may be killed, and they fear they may fail at keeping them safe. Some participants say that living with this fear everyday has more profound negative consequences on their health than not meeting MIPA recommendations.

MIPA is De-valued in the African American Community

Most AAW report that their parents did not prioritize or encourage MIPA during childhood. Participants say that the behaviors their parents primarily modeled were going to

work (employment) and resting. They never saw their parents engaged in MIPA or discussed its importance even after being diagnosed with a chronic disease. Employment and resting were the two primary behaviors they observed in their parents. This finding aligns with previous findings that parents are key role models for establishing MIPA behaviors in their children (Keyes & Wilson, 2021). This de-valuation of the importance of MIPA may be a contributing factor to why some AAW are not motivated to increase MIPA until being diagnosed with a chronic disease, even when there is a family history of cardiac disease, stroke, or adult-onset diabetes.

Some AAW learned the importance of MIPA in high school and others did not. Participants who learned the importance of MIPA continued to engage in MIPA during college, while other participants who didn't learn its importance do not engage in MIPA after graduating from high school and report less confidence being physically active as an adult. This finding supports previous findings by Keyes and Wilson (2021), that adults demonstrate similar behaviors to their parents. Similarly, Essein and Wood (2021) found that lack of self-efficacy in adults is associated with their previous socialization as children.

Healthcare providers are essential stakeholders who have an obligation to improve the quality of life for their patients. However, AAW commented that their healthcare providers never discuss MIPA nor its importance during healthcare encounters. Some participants believe the lack of education is racially motivated. This finding is similar to other researchers who found African Americans were not receiving the same quality of health care that their White counterparts received (Hall et al., 2015; Tolliver et al., 2019). In addition, there is some published evidence that healthcare professionals lack the knowledge, skills, and confidence to have regular conversations about physical activity (Reid & Caterson, 2022).

Gym Anxiety

Feeling uncomfortable, watched, and judged in predominantly White gyms is a barrier for going to a gym. AAW who lack self-confidence performing MIPA do not feel comfortable working out in the gym. Participants pretend to know how to use gym equipment, but most feel intimidated asking for help from both African American and White staff. Few participants feel less intimidated asking African American staff for assistance. This feeling of not wanting to portray an image less than confident may be part of a superwoman schema researchers have identified (Woods-Giscombé, 2019). The superwoman schema posits that AAW feel pressure to always act strong and resilient for fear of being found lacking somehow. Although more research is necessary to understand the superwoman schema, health care providers should include assessments of mental health issues in this population.

Social Support

AAW believe that social support does not significantly impact their decisions to be physically active. This is somewhat contrary to the published literature that claims social support increases the likelihood of MIPA. For example, Awad et al. (2015) and Dorwart et al. (2019) found that AAW were more motivated to engage in MIPA when their support networks encouraged them to be physically active. Most participants in this study feel supported by their family and friends when those social circles allow them to make their own decisions to be physically active or not without pressure or judgement. For a majority of participants, how active or inactive their support circle was does not influence their MIPA participation.

Participants feel motivated to be physically active when they 1) see other AAW being physically active, 2) have someone who can improve their performance and self-efficacy, 3) know what to do and do not feel like they are wasting their time, and 4) when they join family

and friends. Support occurs when personal decisions regarding MIPA are respected without judgment. The attitudes toward social support for AAW may be evolving and more research is needed to understand its evolving role.

Hairstyles and MIPA

A key finding when discussing appearance is that hair is very important to AAW whether it is worn straightened or natural. Participants' feel beautiful when they wear their natural hair, particularly among other African Americans, and they feel accepted in mainstream society when they wear it straight. Participants feel social and economic pressure from outside the African American Community to straighten their hair. Women with chemically straightened hair face difficult physical activity decisions since straightened hairstyles can last several days or weeks but can be ruined after being physically active once.

Participants with straight hairstyles unanimously deferred MIPA until it was time to wash their hair. Protective hairstyles like braids, cornrows, and twists have been recommended but also appear ethnic. The finding that hair is a barrier is supported by previous research (Hall et al., 2013; Huebschmann et al., 2016; Joseph et al., 2018). AAW feel social pressure to straighten their hair in mainstream work environments but there is little information to see if that belief is consistent in Black-owned organizations. Also, more research is needed to understand the feelings AAW may be suppressing because their own values are suppressed.

Body Image

African American cultural values impact AAW's decisions to be physically active. Participants feel that acceptance of various body shapes and sizes within the African American culture impacts their decisions to be physically active. The attitude within African American culture is that an acceptable body shape is self-defined and AAW have the freedom to endorse

any body shape and size they desire without judgement. These findings are consistent with previous findings that AAW don't feel pressure about their body image because more AAW value character qualities above physical appearance (Hughes, 2021). However, the most desirable body shape reported by participants is an hourglass figure with a small waistline, large hips, large thighs, and large derrieres. The African American community's acceptance of various body shapes may cause confusion for some women when making decisions about MIPA that may further impact the health outcomes in this population. AAW reported that, in the past, they worked out to lose extra pounds, but they don't now because plus-sizes are more acceptable.

Women who endorse an hourglass figure may have more favorable attitudes towards cosmetic enhancement than they do MIPA because surgery enhances their physical appearance in a shorter amount of time. Social media has played a major role in popularizing the desired silhouettes and, subsequently, has increased interest in Brazilian butt lifts. This surgery has been the fastest growing cosmetic surgical procedure over the past decade and increases risks for mortality (Pazmino & Garcia, 2022). Social media has also had an impact on AAW's attitudes regarding surgery because more deaths and physical disfigurements are reported on social news outlets.

Media Representation

AAW are less likely to participate in physical activities that are perceived as predominantly White. Participants reported rarely seeing African Americans performing physical activities or playing sports. Underrepresentation of African American role models is an obstacle for increasing MIPA in AAW. Photographs of AAW playing golf, downhill skiing, using gym equipment, and riding a bike are not motivators to engage in those activities. AAW perceived most organized sports as 'White' except they associated Tiger Woods with golf. They associated

Tiger Woods with golf but because media re-enforces images of White men and White women playing golf, participants still considered golf a White activity even though there are other successful African American golfers such as Harold Varner III, Cameron Champ, and Joseph Bramlett. Activities advertised as diverse and inclusive are motivators for some AAW to participate. One participant, who perceived skiing as a White activity, was motivated to ski during an event hosted by a Black ski club. These findings are consistent with previous findings that media underrepresentation of African Americans negatively impacts their decisions to engage in those sports or physical activities (Pekmezi et al., 2013).

Planning for MIPA

AAW acknowledge prioritizing PA is one of their greatest challenges. Outside of working, childcare and household responsibilities. AAW believed they have no extra time to engage in MIPA. In addition, AAW who had structure prior to the 2019 COVID pandemic now feel it is more difficult to find time in their schedule to engage in MIPA. Previous studies have also found that time constraints are barriers to planning MIPA among AAW (Dorwart et al., 2019; Joseph et al., 2017). AAW reported that when they prioritize MIPA and identify the best time to schedule it, they can find time to engage in MIPA. Above all, AAW believed they have total control over planning for MIPA and feel confident that, with planning that they could increase MIPA to 150 minutes each week.

Effort is Sufficient

AAW acknowledged that MIPA is not a priority. Clinicians, instructing AAW to perform PA, may not be realistic if the women do not understand the complex relationship between MIPA, pathophysiology of diseases that are prevalent in this population, and how to prioritize PA. Participants reported that their philosophy is that diet is more important than MIPA in

improving their health. Diet is something they feel they have more control over than being able to incorporate MIPA into their daily schedules.

Limitations

The findings of this study must be considered in relationship to the study's limitations. First, the sample is a purposive convenience sample that is relatively homogeneous with respect to socioeconomic status. Qualitative findings of this study are limited to AAW between ages 25-44 years. Another limitation is that data collection occurred during a global pandemic which may impact participant responses. For example, participants affected by social distancing may have responded differently if they had the ability to work out undisturbed at home, in groups or at fitness centers. Lastly, researcher presence during data collection may have affected participant responses. This study found that AAW do not like feeling watched and judged and methods of data collection could be redesigned to block the participant's image from the interviewer, so participants may be more forthcoming. Data were collected via Zoom meetings where participants were able to visualize the researcher. Responses may have been modified to project an interpretation that the participant was strong and competent, characteristics of the superwoman schema.

Practice Implications

Nursing is the largest U.S. healthcare profession with over 4 million registered nurses (U.S. Bureau of Labor Statistics, 2022). Registered nurses on all levels are at the forefront of delivering quality patient education aimed at improving patient outcomes. Key nursing positions that provide frequent opportunities for nurses to bridge healthcare and MIPA education include school nurses, telehealth nursing, community-based and retail nursing, hospital and primary care nursing.

Physical activity education programs for AAW should be designed with consideration given to their values and beliefs (cultural and individual). Findings from this study indicated that some values and beliefs toward MIPA are risk factors for developing chronic diseases. Thus, efforts to reduce risks should focus on behavioral changes at value and belief levels that re-structure how AAW prioritize MIPA.

A belief shared by AAW was that MIPA became more important after diagnosis of a chronic disease. Healthcare discussions should include the value of pathophysiology and its underlying effects on body systems prior to the onset of symptoms or diagnosis. Healthcare encounters that address MIPA participation should begin with a clear explanation that optimal health is achieved and sustained when PA occurs at moderate intensity levels or higher. (CDC, 2020). Additional findings from this study provided evidence that AAW are very busy, highly value their children, are not encouraged to spend time away from them, and have learned to devalue the importance of MIPA throughout their lifetime. School nurses are in key positions to use information from this study to provide school – based education and design time sensitive MIPA programs that meet Federal Physical Activity Guidelines for both parents and children. Interventions by school nurses have the potential to have significant impacts on a great number of parent-child groups and can be implemented promptly.

Participants expressed concern and disappointment that the importance of MIPA reducing risks for chronic diseases was not provided by healthcare providers. This issue creates opportunities for nurses to review current policies and replace or create policies that promote best practices and hold providers accountable for the delivery of care that is equitable. Nurses staffed at insurance companies can advocate for policies that include lower reimbursement rates

to providers who do not routinely include interventions that promote MIPA or address ethnic – specific psychosocial anxieties that prevent MIPA participation.

Long term best practices may be achieved by nurses who advocate for national, state, local, and organizational health policy changes. For instance, nurses can influence organizational tolerance policies not only where they work but also in private, public, and government institutions regarding hair discrimination. Hair is very important to AAW, and personal appearance discrimination continues to emerge as a significant barrier to MIPA participation among AAW that causes them mental anxieties. Nurses can advocate for legislation that promotes both physical and mental wellbeing among AAW. For instance, The Creating a Respectful and Open World for Natural Hair (CROWN) Act is a legislative measure moving through Congress that addresses hair appearance discrimination. Nurses can use findings from this study to lobby that the CROWN Act bill adequately addresses the needs of AAW, and similar bills address cultural competencies necessary to improve health among AAW and reduce health disparities.

Social media is very important in the daily lives of AAW but has not been effective providing positive role models or public service messages that differentiate physical activity (PA) from MIPA which includes muscle strengthening. There are a myriad of nurse-focused organizations such as the American Nurses Association and the National Black Nurses Association that can partner with philanthropic organizations such as the Robert Wood Johnson Foundation to promote culturally relevant messaging. These partnerships may be valuable when addressing health-related educational needs of AAW. For example, funding from philanthropists would allow African American nurses and nurse consultants to collaborate on the development of health promoting social media commercials, time sensitive online exercise programs, and print

media aimed at AAW and created by AAW. Exercise education should include the purpose of improving health and raise awareness that routine MIPA participation should not significantly alter body shape and that "efforts" to work out are not sufficient to achieve optimal health. An advantage of online programs is that they are accessible at the convenience of the individual, performed without feeling watch or judged, and can occur when AAW are home with their children.

Implications for Future Research

Findings from the current study contribute a better understanding of the values and beliefs AAW rely upon to make decisions regarding MIPA participation. More qualitative research is needed to provide stronger evidence regarding how values and beliefs affect the physical activity behaviors among AAW. Research should include exploring MIPA related values and beliefs in AAW ages 18 – 24 to determine if interventions should commence earlier in this population. It would be helpful to identify which activities are perceived to be enjoyable and help AAW to value those activities. Results from this study suggests that recommendations to utilize gyms or join neighborhood walking groups may not be sufficient because some AAW experience anxiety working out in gyms and are intimidated when working out in front of other people.

However, gyms and neighborhood walking groups provide ample opportunities for AAW to engage in MIPA and future qualitative research should examine if AAW value African American owned gyms, the support of African American trainers or African American members, and if that value is compelling enough in promoting long-term MIPA participation. More evidence regarding this phenomenon can support the inclusion of exercise related mental health assessments as part of insurance reimbursement or gain funding for more Black owned fitness

centers from philanthropists. In addition, more research is needed to understand the perceptions of AAW to always portray images of strength and competence (superwoman schema) even when those perceptions may have adverse effects on their health.

Furthermore, more research is needed to identify the role of social support among AAW. Positive social support is linked to promotion of increased MIPA participation, and a greater sense of mental well-being (Dorwart et al., 2019; Flórez et al., 2018; Woods-Giscombé et al., 2019). Results from the current study suggests that social support networks for AAW are evolving into a neutral role, where support systems do not make judgements on an AAW's decision to be physically active or sedentary. Both qualitative and quantitative research is needed to determine if the neutral stance taken by support networks has a positive or negative impact on MIPA.

Conclusions

In conclusion, to my knowledge, this was the first qualitative study to explore what values and beliefs (cultural and individual) AAW rely on that inform their attitudes, subjective norms, and perceived behavioral control around MIPA in women 25-44 years of age. The TPB provided a theoretical framework for exploring and understanding culturally related antecedents that indirectly impacted AAW's decisions for MIPA. The health crisis of AAW has been studied for more than four decades with little impact on health disparities within the African American female population.

AAW's values and beliefs are indirectly associated with low MIPA participation. To understand the influence of values and beliefs, an ethnographic study was performed. Thematic data analysis identified nine major themes. Significant themes associated with AAW's values and beliefs that emerged during semi-structured interviews were: 1) The Meaning of MIPA, 2)

MIPA is Devalued in the African American Community, 3) Gym Anxiety, 4) Social Support, 5) Hairstyles and MIPA, 6) Body Image, 7) Media Representation, 8) Planning for MIPA, and 9) Effort is Sufficient.

Limitations were presented and include to issues with generalizability, the COVID-19 pandemic, and researcher presence. Nursing implications were focused on nursing education to clinical nurses, patients, consumers, and insurance companies, and was followed by a discussion of additional research needs to conduct more qualitative studies to understand the relationship of AAW's values, beliefs, MIPA, self-efficacy, and superwoman schemas. AAW live within a complex structure of psychosocial and sociocultural pressures that influence MIPA decisions that often do not contribute to their well-being. Unless viable solutions are identified, low MIPA rates most likely will continue, chronic disease incidence rates will continue at disproportionate rates, and unnecessary healthcare costs will continue to drain private and public healthcare budgets. Ultimately, these results will be useful when developing culturally relevant interventions for AAW that result in long-term routine engagement in MIPA and improved health outcomes among this population.

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APPENDIX A

RECRUITMENT FLYER

VOLUNTEERS NEEDED TO TALK ABOUT YOUR BELIEFS AND VALUES TOWARD PHYSICAL ACTIVITY

Principle Researcher: Shannon Whitehead MSN/FNP-Doctoral Candidate (Nursing)

University of Texas at Arlington

NO PHYSICAL ACTIVITY OR EXERCISE IS REQUIRED DURING THIS STUDY

Research Study Title: The Influence of African American Women's Values and Beliefs on Moderate Intensity Physical Activity: A Qualitative Study

What? A onetime 60-to-90-minute audio-visual recorded interview

Why? To understand how values & cultural beliefs influence African American women's (AAW) attitudes toward physical activity because:

- As physical activity ↓ Chronic illness (obesity, heart disease, stroke, breast cancer, diabetes) ↑

You Are eligible if:

- English speaking
- Born and raised in the USA
- 25-44 years old
- African American/Black Female (as your only race)
- Engage in less than 2.5 hours of moderate physical activity/week
- Have access to the internet

If interested in participating, call me for more information (469) 305-1663 or click below to be directed to a confidential information page: https://africanamericanwomenandmipa.questionpro.com

Your Participation is CONFIDENTIAL- Thank you very much!

APPENDIX B

CONSENT FOR MINIMAL RISK STUDIES WITH ADULTS

The University of Texas at Arlington (UTA)

Consent for Minimal Risk Studies with Adults

My name is Shannon Whitehead. I am the principal investigator (PI) asking you to participate in a UTA research study titled, "The Influence of African American Women's Values and Beliefs on Moderate Intensity Physical Activity: A Qualitative Study"

Previous researchers have indicated that African American (AA) women engage in moderate intensity physical activity (MIPA) less often than women of other races. MIPA are physical activities that make you breathe harder when doing them. Lower MIPA participation is associated with higher rates for obesity, heart disease, stroke, breast cancers, and type II diabetes in AA women. Solutions increasing MIPA among AA women have not been effective, and not much is known about how African American women make decisions about MIPA. This study will give AA women a chance to describe their experiences in their own voices.

This research study is about exploring what value African American women place on MIPA and what beliefs influence their decisions to engage or not engage in MIPA.

You will not be asked to perform any physical activities during this study. You are only asked to consent to:

- Being interviewed by the PI during a 1-time, one-to-one 60–90-minute recorded audio-visual conference using a tool such as Zoom or Microsoft Teams.
- Provide eligibility information.
- Provide demographic information.
- Allow publication or presentation of data collected in aggregate (group) format. We may publish or present the results, but your name will not be used. While absolute confidentiality cannot be guaranteed, every effort is made to protect the confidentiality of your records as permitted by law.

Some questions are related to cultural experiences and there is a minimal risk that you might feel uncomfortable discussing your experiences. Shall that happen, you may:

- Request to discontinue the interview or ask for time to gain composure.

Participation is voluntary, refusal to participate will involve no penalty or loss benefits to which you may be entitled, and at any time during the study, you may withdraw without fear of duress, punishment, or penalty.

- There is no compensation for participating in this study.

For questions or concerns about the study, you can contact:

- Shannon Whitehead MSN/FNP, RN (469) 305-1663 (Principal Investigator)
- Donelle Barnes PhD (817) 272-0108 (Faculty Advisor)
- UTA Research Office at 817-272-3723 or regulatoryservices@uta.edu (Complaints/Rights)

If interested in continuing with this study, please provide your consent by clicking the consent icon below.

☐ I confirm that I have read, understand, and agree to the above policy and procedures for participation in the above name research study.

APPENDIX C

ELIGIBILITY SCREENING

1. What is your 10-digit telephone number including area code. (e.g. (XXX) XXX-XXXX). I will use this number to phone you about the interview.

2. What is your age in years?

3. What is the amount of time in minutes that you spend each week performing moderate intensity physical activity or exercise (you can talk but cannot sing when performing these types of activities).

4. Where you born and raised as a female in the United States?

   Yes ☐

   No ☐

5. Do you read and write English proficiently?
   Yes ☐
   No ☐

6. Is African American or Black your only race/ethnicity?
   Yes ☐
   No ☐

7. Do you have access to the internet (to use a video conference tool like Zoom or Microsoft Teams?
   Yes ☐
   No ☐

8. Are you able to use a video conference tool like Zoom or Microsoft Teams without difficulty?
   Yes ☐
   No ☐

APPENDIX D

DEMOGRAPHIC SURVEY

1. What city do and state do you currently live in?

2. What is your annual income in dollars?

3. What is your highest level of school completed?
    a. Less than high school
    b. High school degree or GED
    c. Some college but no degree
    d. Associate degree
    e. Bachelor's degree
    f. Master's degree
    g. Doctoral degree

4. What is your current relationship status?
    a. Not married
    b. Living with a partner
    c. Separated
    d. Divorced
    e. Widowed
    f. Married

APPENDIX E

TELEPHONE SCRIPT

Protocol Title: The Influence of African American Women's Values and Beliefs on Moderate Intensity Physical Activity: A Qualitative Study

Hello, my name is Shannon Whitehead. I am a PhD student from the University of Texas at Arlington School of Nursing and Health Innovations.

I am contacting you because: you completed the demographic surveys in QuestionPro and have consented to participating in my study.

I am interested in learning about the cultural experiences, values, and beliefs regarding and physical activity among African American. Your participation in this phone call and research study is completely voluntary.

My study has been approved by the University of Texas at Arlington's Institutional Review Board, which is concerned with the safety of research participants. May I continue?

Just to confirm, you understand the research procedures and risk, and agree to voluntarily participate in the study? *The telephone call will politely end at any time the participant withdraws her consent to continue*.

- You are between the ages of 25 – 44
- The amount of time in minutes that you spend each week performing moderate intensity physical activity or exercise is _____ (whatever the potential participant recorded)
- You were born and raised as a female in the United States
- You read and write English proficiently
- You self-identify as African American or Black as your only race/ethnicity
- You have access to the internet to use a video conference tool like Zoom or Microsoft Teams
- You can use a video conference tool like Zoom or Microsoft Teams without difficulty

If any answer is "no" or the amount of time performing MIPA/exercise is greater than 150 minutes per week, I will thank her for her time and politely end the call.

I would like to tell you about what I will be doing with the information you give me. May I continue? Continue if permission is granted, or politely end the call.

If you join the study, any information collected may be seen by my research faculty. I will make every effort to ensure that your information is kept private and used only for the research study that we are discussing. The information may be written in a publication as a group of responses. Individual information will remain unidentifiable.

If you do not agree to continue with this phone call or the Zoom interview, it will not affect you in any way.

(If the person says "No, "I will thank the person for her time and politely end the call)

Your personal information will not be kept if you choose not to enroll in the study or if you do not qualify to be in the study.

We have completed the telephone screening portion of our call.

- Do you have any questions?
- Do you think you would like to participate in this research study?

If the answer is yes, an interview time will be added to the Weekly Interview Appointment schedule. If there are no more questions, the telephone call will politely end.

ID no._____

APPENDIX F

WEEKLY INTERVIEW APPOINTMENT SCHEDULE

Week of _____

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
0800							
0830							
0900							
0930							
1000							
1030							
1100							
1130							
1200							
1230							
1300							
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1530							
1600							
1630							
1700							
1730							
1800							
1830							

APPENDIX G

SEMI-STRUCTURED INTERVIEW GUIDE WITH PHOTO ELICITATION

Grand tour: What is your first thought when you hear the words "physical activity?"

Physical Activity- Attitude

1. Tell me about your current experiences with being physically active where the activity made you slightly out of breath. For example, do you walk, run, work out at the gym, or what?
    a. Prompting: During the last 7 days on how many days did you do a physical activity where you were slightly out of breath?
    b. Probe: How do you feel when you do physical activity? [Probes: Tired? Invigorated? Happy? Disgusted? Healthy?]
2. Thinking about those activities, about how much time did you spend doing those activities each day you did them?
3. In your opinion, how much time do you think adults should spend each week doing physical activities that make them slightly out of breath?
4. If you wanted to start being physically active regularly, what would you do?
    a. Alternative: A: (If you wanted to increase the amount of time you are physically active, what would you do?)
    b. What would be your biggest challenge?
    c. What are some ways for you to overcome these challenges?

Hair:

5. What are your feelings when you look at this photo?

PHOTO OF AN ENSLAVED AFRICAN WOMAN WITH KINKY HAIR

6. How important is your hair to you?
7. How much time do you spend styling your hair for work (school)?
8. When you are meeting girlfriends, how much time do you spend styling your hair?
9. When you are meeting male friends, how much time do you spend styling your hair?
10. How does your hair style affect how you do physical activity or what you do?
11. What feelings do you have when you look at this photo?
12. What thoughts do you have when you see this photo?

PHOTO OF AN AFRICAN AMERICAN WOMAN STRAIGHTENING A CHILD'S HAIR

13. In the following scenario, you are invited to a friend's house for a party. She designs bathing suits and has one she designed for each of her friends. She invites everyone to get in her swimming pool.
    a. What is your reaction?
    b. Why or why not?

14. What are your thoughts when you look at this photo?

PHOTO OF AN AFRICAN AMERICAN CHILD AND A STRAIGHTENING COMB BEING HEATED ON A STOVE

15. When you look at these images, which hairstyle do you like the most? The least? Why?

PHOTO OF A WOMAN WITH AN AFRO-STRAIGHT	PHOTO OF A WOMAN WITH BLOND HAIR	PHOTO OF A WOMAN WITH DREDS	PHOTO OF A WOMAN WITH STRAIGHT HAIR	PHOTO OF A WOMAN WITH AN AFRO-KINKY

16. When you think about African American men and women, what are some of the things you've heard them say about African American women's hair?

17. How do you think that you have been influenced by any of these beliefs when you think about your own hair?

Subjective Norm-Support

18. Some people think being physically active is easier when the people around them are supportive and encouraging.
19. Tell me about the people close to you, who encourages you to be physically active?
20. When you think about the people in your life, who are the people you feel discourage you from being physically active ?
    c. Prompt: how does that make you feel?

21. When you want to work out, what are some things your family, friends, significant others say to you about working out? Prompt: what do they say about the type of activity you plan to engage in?

22. If someone close to you was giving you advice on how to be more physically active where the activity made you breathe harder, what would you want them to say?
23. Was being physically active part of your childhood?
    d. What types of activities were you engaged in?
    e. Why did you choose those activities?
24. What are your thoughts when you look at this picture?

PHOTO OF A GROUP OF AFRICAN AMERICAN WOMEN WALKING

25. When you think about African American men and women, what are some of the things you've heard them say about being physically active?
26. How do you think that you have been influenced by any of these beliefs when you think about your own attitudes toward being physically active?

Subjective Norm- Body Image

Body size

27. When you look at these images, what would be your preferred or acceptable size? Why?

PHOTO OF A CURVACEOUS AFRICAN AMERICAN WOMAN	PHOTO OF A SMALL SIZE AFRICAN AMERICAN WOMAN	PHOTO OF A PLUS SIZE AFRICAN AMERICAN WOMAN	PHOTO OF A MUSCULAR AFRICAN AMERICAN WOMAN

28. Do you believe your opinion is like how the African American culture would rank these body sizes?
29. Does your body type influence your decision to work out?
30. Which of the body size images in your opinion is closest to your body size?

PHOTO OF A CURVACEOUS AFRICAN AMERICAN WOMAN	PHOTO OF A SMALL SIZE AFRICAN AMERICAN WOMAN	PHOTO OF A PLUS SIZE AFRICAN AMERICAN WOMAN	PHOTO OF A MUSCULAR AFRICAN AMERICAN WOMAN

31. What do you think White women believe is an acceptable body size?

32. In what ways if any, do you believe African American women might be judged more harshly (hair, body size, skin color).
    f. Do you have any examples?
    g. Probe: think about Serena Williams, Lizzo, Stacey Abrams

33. What messages from society do you believe you receive about being an African American woman?

34. When you think about African American men and women, what are some of the things you've heard them say about African American women's body sizes and shapes? [too big, too small, too muscular].

35. How do you think that you have been influenced by any of these beliefs when you think about your own body shape?

Perceived Behavioral Control

36. How confident are you that you could work out at a gym?

PHOTO OF AN AFRICAN AMERICAN WOMAN WORKING OUT IN A GYM

37. What types of physical activities do you believe you can successfully perform?

38. What are your thoughts when you see the following images?

PHOTO OF AN AFRICAN AMERICAN WOMAN GOLFING

PHOTO OF PEOPLE DOWNHILL SKIING

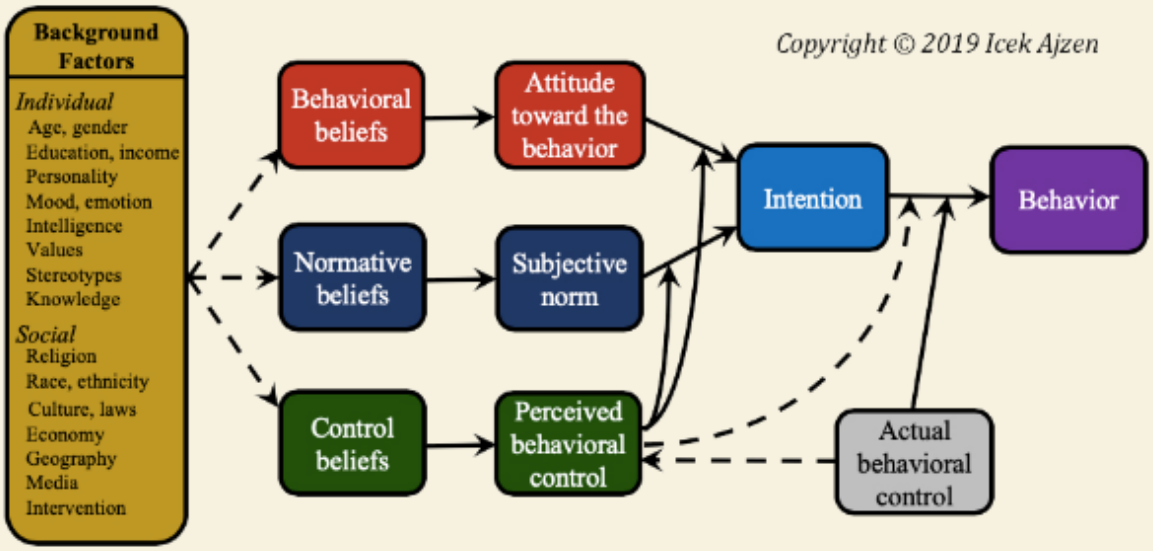
PHOTO OF AN AFRICAN AMERICAN WOMAN BIKE RIDING OUTDOORS

This concludes our discussion, is there anything that we have not discussed today or anything else that you would like to share before we end?

APPENDIX H

PERMISSION TO USE TPB MODEL

Theory of Planned Behavior With Background Factors*



APPENDIX I

UNIVERSITY OF TEXAS at ARLINGTON INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY OF TEXAS ARLINGTON | OFFICE OF RESEARCH ADMINISTRATION REGULATORY SERVICES

11/10/2022

IRB Approval of Administrative Modification

PI: Shannon Whitehead
Faculty Advisor: Dr. Sharon Wilson
Department: Nursing - Undergrad
IRB Protocol #: 2022-0081.1
Study Title: *The Influence of African American Women's Values and Beliefs on Moderate Intensity Physical Activity: A Qualitative Study*

Effective Approval: 11/10/2022

The IRB has approved the above referenced submission in accordance with applicable regulations and/or UTA's IRB Standard Operating Procedures. The IRB Team approved this modification that qualifies for administrative review. The approved administrative modification is limited to:

- Changing Faculty Advisor from Dr. Sharon Wilson to Dr. Donelle Barnes

Principal Investigator and Faculty Advisor Responsibilities

All personnel conducting human subject research must comply with UTA's IRB Standard Operating Procedures and RA-PO4, Statement of Principles and Policies Regarding Human Subjects in Research. Important items for PIs and Faculty Advisors are as follows:

- **Notify Regulatory Services of proposed, new, or changing funding source**
- Fulfill research oversight responsibilities, IV.F and IV.G.
- Obtain approval prior to initiating changes in research or personnel, IX.B.
- Report Serious Adverse Events (SAEs) and Unanticipated Problems (UPs), IX.C.
- Fulfill Continuing Review requirements, if applicable, IX.A.
- Protect human subject data (XV.) and maintain records (XXI.C.).
- Maintain HSP (3 years), GCP (3 years), and RCR (4 years) training as applicable.

UNIVERSITY OF TEXAS ARLINGTON | OFFICE OF RESEARCH ADMINISTRATION REGULATORY SERVICES

10/21/2021

IRB Approval of Minimal Risk (MR) Protocol

PI: Shannon Whitehead
Faculty Advisor: Dr. Sharon Wilson
Department: Nursing - Undergrad
IRB Protocol #: 2022-0081
Study Title: *The Influence of African American Women's Values and Beliefs on Moderate Intensity Physical Activity: A Qualitative Study*

Effective Approval: 10/16/2021

The IRB has approved the above referenced submission in accordance with applicable regulations and/or UTA's IRB Standard Operating Procedures.

Principal Investigator and Faculty Advisor Responsibilities

All personnel conducting human subject research must comply with UTA's IRB Standard Operating Procedures and RA-PO4, Statement of Principles and Policies Regarding Human Subjects in Research. Important items for PIs and Faculty Advisors are as follows:

- **Notify Regulatory Services of proposed, new, or changing funding source**
- Fulfill research oversight responsibilities, IV.F and IV.G.
- Obtain approval prior to initiating changes in research or personnel, IX.B.
- Report Serious Adverse Events (SAEs) and Unanticipated Problems (UPs), IX.C.
- Fulfill Continuing Review requirements, if applicable, IX.A.
- Protect human subject data (XV.) and maintain records (XXI.C.).
- Maintain HSP (3 years), GCP (3 years), and RCR (4 years) training as applicable.