Understanding physical activity participation in members of an African American church: a qualitative study

Melissa Bopp1*, Diana Lattimore2, Sara Wilcox3, Marilyn Laken4, Lottie McClorin3, Rosetta Swinton4, Octavia Gethers4 and Deborah Bryant5

Abstract

Faith-based interventions hold promise for increasing physical activity (PA) and thereby reducing health disparities. This paper examines the perceived influences on PA participation, the link between spirituality and health behaviors and the role of the church in promoting PA in African Americans. Participants (n = 44) were adult members of African American churches in South Carolina. In preparation for a faith-based intervention, eight focus groups were conducted with sedentary or underactive participants. Groups were stratified by age (<55 years versus ≥55 years), geography and gender. Four general categories were determined from the focus groups: spirituality, barriers, enablers and desired PA programs. Personal, social, community and environmental barriers and enablers were described by both men and women, with no apparent differences by age. Additionally, both men and women mentioned aerobics, walking programs, sports and classes specifically for older adults as PA programs they would like available at church. This study provides useful information for understanding the attitudes and experiences with exercise among African Americans, and provides a foundation for promoting PA through interventions with this population by incorporating spirituality, culturally specific activities and social support within the church.

Introduction

Regular physical activity (PA) participation can reduce the risk of chronic diseases and can result in many positive physical and mental health benefits [1]. African Americans experience higher rates of many forms of cancer [2], diabetes, cardiovascular disease, hypertension and stroke when compared with Caucasians and other ethnic groups [3]. Regular PA can contribute to reducing and potentially eliminating these health disparities. A large portion of the population remains sedentary or underactive despite these known benefits. In the United States, only 38.9% of African Americans are meeting the Centers for Disease Control/American College of Sports Medicine (CDC/ACSM) recommendations [4] for PA participation and another 24.8% are completely sedentary [5].

Recent research has attempted to understand the influences on PA participation for different subgroups of the population [6–10]. Since African Americans have some of the lowest rates of PA participation when compared with other ethnic groups, it is important to understand the unique influences on PA for this population in order to design programs and interventions to increase PA. The correlates of PA participation for African

1Department of Kinesiology, Community Health Institute, Kansas State University, Manhattan, KS 66506, USA,
2Department of Exercise and Sport Science, The University of San Francisco, San Francisco, CA 94117, USA,
3Department of Exercise Science, Arnold School of Public Health, University of South Carolina, Columbia, SC 29208, USA, 4Office of Special Initiatives, Health-e-AME, Medical University of South Carolina, Charleston, SC 29425, USA and 5Division of Otolaryngology, Medical University of South Carolina, Charleston, SC 29425, USA
*Correspondence to M. Boop. E-mail: mbopp@ksu.edu

© The Author 2006. Published by Oxford University Press. All rights reserved. doi:10.1093/her/cyl149

For permissions, please email: journals.permissions@oxfordjournals.org
Americans are similar to the general population for demographic and psychological influences, though differences may be apparent when examining social, behavioral and environmental correlates [6, 11–13]. Very few studies have specifically examined the perceptions and experiences of African American men, particularly regarding social, psychological, behavioral or environmental influences on PA [11, 14].

Several health promotion programs have attempted to improve health behavior among African American populations using a variety of settings including health care facilities, community centers, schools, worksites and churches [15]. It is necessary to ensure that interventions are designed to be culturally appropriate, regardless of setting, to increase the likelihood of behavior change [16]. Incorporating religiosity is a common approach to increasing cultural appropriateness in health behavior change interventions for African Americans [17, 18].

Several PA and nutrition interventions for African Americans have been delivered through faith-based organizations [19–24]. Faith-based organizations are promising for reaching African Americans because many African Americans have high levels of religiosity, are likely to attend church, use religion as a coping strategy and indicate that religion or prayer contributes to their physical health [20, 25]. African American churches often serve multiple roles in the community and are frequently the basis for social and political activities, in addition to promoting spiritual, mental and physical well-being. Although many faith-based interventions for obesity and cardiovascular disease risk factor reduction often include PA, it is typically not the major outcome of interest, and further research is needed to examine the role of the church in promoting PA.

The purpose of this study was to examine the perceived influences on PA participation, the perceived link between spirituality and health behaviors and the perceived role of the church in promoting PA among African American men and women church members. A qualitative approach (i.e. focus groups) was used to obtain the views and opinions of church members in detail. The results of this study served as formative research for the Health-e-AME Physical-e-Fit program that is described elsewhere [26]).

Methods

Participants
Participants were 44 members of African Methodist Episcopal (AME) churches (24 men, 20 women), 18 years of age or older, who were classified as sedentary or underactive. Participants were members of AME churches in the Charleston or Columbia, South Carolina, areas.

Recruitment of churches and participants
Churches in the Columbia and Charleston areas were recruited to host the focus groups through pastoral contacts and established relationships with the AME health ministry. Health directors in these churches helped to identify members who would be willing to participate. Churches were in urban and rural areas and had diverse age and socioeconomic congregations.

Focus group formation
Volunteer participants from the recruited churches were screened for PA behavior with the CDC Behavioral Risk Factor Surveillance System PA module [27]. Participants who met CDC/ACSM recommendations for PA [4] were excluded from the study, while individuals who were sedentary or underactive were invited to participate in the focus groups. Groups were stratified by gender, geography (Columbia or Charleston, South Carolina area) and age (<55 or ≥55 years). Four focus groups were conducted for each gender, with two groups consisting of participants younger than 55 years and two groups consisting of participants 55 years and older. Four groups were held in Charleston and four were held in Columbia.

Procedure
Eligible participants read and signed an informed consent form and then completed a brief sociodemographic survey before the start of the focus
All participants received $20 at the completion of the focus group. The Institutional Review Board at the University of South Carolina and the Medical University of South Carolina along with the review board for the seventh Episcopal District of the AME church approved this study.

Eight focus groups were conducted between November 2002 and March 2003. Three moderators (all African American women) were trained to facilitate the focus groups. A staff member was present as the note taker in all groups. The facilitator used a moderator’s guide that was developed with the planning committee comprised of representatives from the Medical University of South Carolina, the University of South Carolina and the AME church. The facilitator asked questions about the group’s perception of barriers to PA for themselves and fellow church members; how they felt God and their spirituality related to exercise and diet; what they thought would motivate them or people in their church community to exercise; what types of activities for exercise were currently offered in their churches; what types of activities they desired to help increase PA participation; their thoughts about the proposed PA programs for the Health-e-AME program and any additional thoughts they had about PA and their church. The moderator’s guide can be found in Appendix A.

All focus group discussions were audiotaped. Transcripts of the focus groups were prepared verbatim. The text was entered into NVivo (QSR International PTY Ltd), a software program that facilitates qualitative data analysis by allowing for the coding and organization of data across themes and groups. The coding guide, developed based on a review of the groups by the coders and investigators, was organized according to a social ecological model [28] in order to capture individual, interpersonal, community and environmental influences on PA. After in-depth discussion of the codes, practice coding sessions and coding modifications, each of the transcripts was independently coded by two coders, with each person coding five or six groups. Another person was present during the comparison of codes to ensure accuracy, prevent coding drift and resolve discrepancies.

**Results**

The characteristics of the participants are shown in Table I. Themes that emerged from groups were organized into four categories: spirituality, barriers, enablers and desired PA programs. Gender differences in these themes are described. There were no clear differences by age.

**Spirituality and health**

Among women, all groups referred to scriptures describing the need to take care of one’s body, and they believed that PA and healthy eating helped one to do that. The two groups of younger women said that overeating is described as a sin in the Bible. Other ideas mentioned in only one group of younger women included asking God to give you strength to be physically active, having time to meditate or pray while being active or asking God for help to be active and eat healthy. While the two groups of younger women agreed that there were many other and more important factors that contribute to being a good Christian beyond PA and diet, they believed that being active and eating healthy contributed to making one a better Christian.

Similar results were found for the men, who mentioned in three groups (one older, two younger)

---

**Table I. Participant characteristics, mean (SD) or percentages**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Men (n = 24)</th>
<th>Women (n = 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>51.08 (15.38)</td>
<td>57.45 (11.07)</td>
</tr>
<tr>
<td>Body mass index (kg m⁻²)</td>
<td>31.54 (5.79)</td>
<td>31.61 (6.1)</td>
</tr>
<tr>
<td>Household size</td>
<td>2.71 (1.33)</td>
<td>2.4 (1.24)</td>
</tr>
<tr>
<td>Marital status (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>67</td>
<td>65</td>
</tr>
<tr>
<td>Education level (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>High school graduate</td>
<td>33</td>
<td>26</td>
</tr>
<tr>
<td>Some college or college graduate</td>
<td>42</td>
<td>47</td>
</tr>
<tr>
<td>Employment status (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed full or part time</td>
<td>56</td>
<td>48</td>
</tr>
<tr>
<td>Rating of health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good or very good</td>
<td>75</td>
<td>79</td>
</tr>
<tr>
<td>Fair or poor</td>
<td>25</td>
<td>21</td>
</tr>
</tbody>
</table>
the need to take care of their bodies through healthy eating and PA, as instructed by the Bible. One younger man stated, ‘It’s a known fact in order for you to have faith you have to have a healthy mind and to exercise your mind is exercising your faith’. Men in three groups thought that PA and healthy eating contributed to an individual’s Christianity. In contrast, men in two groups (one older, one younger) suggested that there was no connection between spirituality and health, and that PA and healthy eating should be a part of everyday life and not a spiritual activity. Other ideas offered in only one group of older men included improving one’s relationship with God and biblical references to specific foods and overeating.

Barriers
Several themes emerged as barriers to PA for both men and women. Specifically, personal, social, community and physical environment barriers were themes among both younger and older men and women. Within the themes several sub-categories appeared (see Table II). Gender differences are discussed within each specific theme.

Personal barriers
Lack of time, motivation and knowledge; health problems and overall fatigue were cited as personal barriers to PA by both men and women.

Lack of time
Lack of time, which participants described as resulting from obligations to work, school, family and church, was discussed by three groups of men (one older, two younger) and all groups of women. For example, one younger man said, ‘... there’s a lot of men who work and it’s scheduling that gets them pinned. Well men, we’re taught to be the breadwinner and they’re going to try; they work to make as much money as they can. A lot of them have part time jobs from their regular jobs, and the only little time they have is not for recreation, but for just rest’. Also, one older woman explained, ‘Do it on Saturday? That’s about the only time I have to run around and try to do what I need to get done to start the week back over again, and on Sunday I’m at church so I really don’t, I don’t find the time to exercise really’.

Lack of motivation
Men and women (all groups) discussed not having willpower or desire to exercise. For example, one older man said, ‘... I used to walk seven days a week, two and a half miles per day before I went to work in the morning. But after the illness, I guess it’s like my wife says, it’s laziness. So I’ll get up in the morning with the intention of walking and I’ll look outside and it’s cloudy and I’ll say it’s gonna rain. Thank God it’s gonna rain, you know. And so that’s my excuse for not going’. A younger woman shared, ‘I have faith in God, but it’s just that – that’s the part that is tearing me apart. The faith and then I don’t have the willpower to you know, to do the exercising or to eat right’.

Lack of knowledge about exercise
Two groups of men (one older, one younger) and two groups of women (one older, one younger) discussed lacking knowledge about how to properly exercise and lacking knowledge about exercising in spite of health concerns. For example, one older woman said, ‘And that’s why a lot of people probably don’t go out, because they think it’s not safe with their health problem, but I say if they get a group together and do more walking, that’s a good exercise. Sometimes you have to educate people’. Another example of lacking knowledge came from a younger man who said, ‘And in an African American that’s rampant. Most African Americans do not know how to work out and that’s the truth’.

Fatigue
Fatigue was discussed frequently by both men and women. The major reason for fatigue in men (all groups) was due to work schedules and/or physical exertion while at work. Three groups of women (two older, one younger) discussed fatigue due to work and family obligations. For example, one younger woman said, ‘I work in a nursing home, be around patients. I work in the activity department
and I’m constantly walking and constantly on my feet and doing this and doing that’.

**Health**

Health conditions were discussed as a barrier to exercise in one group of older men and three groups of women (two older, one younger). The major issues raised were previous operations that hindered their ability to exercise and conditions such as asthma that make it more difficult to exercise. Interestingly, not having a health condition was also cited as a barrier to exercise. For example, one older man said, ‘most people they don’t have that need, you know. Nothing has hit them yet that says, you know, you need to get up and exercise. You know we’re passive about our health. Most of you and most of us have not gotten to the point yet where it’s an established need to exercise’.

**Social barriers**

*Family*

Family was mentioned as a barrier to exercise in all groups of men and three groups of women (one

---

**Table II. Summary of barriers and enablers**

<table>
<thead>
<tr>
<th>Key themes and subthemes</th>
<th>Men (groups)</th>
<th>Women (groups)</th>
<th>Key themes and subthemes</th>
<th>Men (groups)</th>
<th>Women (groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal barriers</strong></td>
<td></td>
<td></td>
<td><strong>Personal enablers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of time</td>
<td>3</td>
<td>4</td>
<td>Improved health</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Lack of motivation</td>
<td>4</td>
<td>4</td>
<td>Weight loss/appearance</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Fatigue</td>
<td>4</td>
<td>3</td>
<td>Vitality</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Health problems and lack of awareness</td>
<td>1</td>
<td>3</td>
<td>Determination/motivation/willpower</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Lack of knowledge about exercise</td>
<td>2</td>
<td>2</td>
<td>Enjoyment</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Goal setting</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Improved mental health</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Improved quality of life</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Stress relief</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Social barriers</strong></td>
<td></td>
<td></td>
<td><strong>Social support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>4</td>
<td>3</td>
<td>From church members</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Lack of social support</td>
<td>2</td>
<td>1</td>
<td>Exercise group activities</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Support from family</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Support from friends</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Want to be a role model for the family</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Family providing instruction/guidance</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Need a leader</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enjoying fellowship</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pastor support</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Physician advice</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Community barriers</strong></td>
<td></td>
<td></td>
<td><strong>Community enablers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility availability and consistence (e.g. church open for exercise use)</td>
<td>3</td>
<td>0</td>
<td>Exercise programs available at church</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Facility cost</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility discomfort</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical environment barriers</strong></td>
<td></td>
<td></td>
<td><strong>Physical environment enablers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety concerns (e.g. dogs, crime, light)</td>
<td>4</td>
<td>2</td>
<td>Having a place to walk or be active</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Outdoor places to exercise (e.g. tracks, parks, sidewalks)</td>
<td>1</td>
<td>2</td>
<td>More facilities/equipment available</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower cost for facilities</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Good weather</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Being safe while exercising</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>
older, two younger). Family obligations included caring for children or grandchildren, which could include driving them to and from work or sports, helping with homework and preparing meals. One younger woman explained, ‘One thing that prevents me now [from exercising] is my children because they’re involved in a lot and especially when working … and when I get home it’s just too late to try to think about exercise and I’m too tired’. Likewise one younger man said, ‘You know you have family, and by the time you get off work like especially people who have kids in school you have to help them with the school work or they may have other projects. They have to go to the library or you have to go meet the principal or the teacher … if you’re a single parent you have to cook dinner, you have to make sure homework is done’.

**Lack of social support**

Contrary to the previous findings, lack of social support was not frequently mentioned as a barrier to PA. The issue was only discussed in two groups of younger men and one group of younger women. For example, one man said, ‘It depends on your work schedule and probably the lack of self-motivation. Then you don’t have someone there to help push you along because it’s kind of hard to exercise by yourself even with me being in the military …’.

**Community barriers**

**Facility consistency**

Consistency of the facility, and specifically the church, was mentioned by two groups of men (one older, one younger). Lack of consistency included the church not being open on a regular basis, programs being started and then not carried through for any amount of time and class instructors either not showing up or quitting. For example one man said, ‘[our church] has the problem of starting stuff but they don’t finish it’. Another issue raised was the recreation center being too crowded and therefore having to wait too long. One man said, ‘If you go by the rec center, it’s a line, and you wait and you wait so you just come back home and there wasn’t any exercise …’.

**Facility cost and facility discomfort**

One group of younger women discussed cost of joining a facility as a barrier to exercise, while one group of older women discussed not liking facilities or having them ‘too closed in’ as being a barrier to exercise.

**Physical environmental barriers**

**Safety concerns**

All four groups of men and two groups of women (one older, one younger) discussed neighborhood crime, neighborhood dogs, cars driving so close to the edge of the road that walking or riding a bicycle on the road becomes a safety issue and not having light in the evening as barriers to exercising. To illustrate concerns about safety one older woman said, ‘… people are afraid to walk in the community because of dogs or people throwing things out of the car after them’. One older man said, ‘Walking is a problem unless I walk around the yard. Like if I walk on the street, cars get close to you, you know, and I ride a bicycle sometimes and that’s another problem. The cars get too close …’.

**Outdoor places to exercise**

One group of younger men and two groups of women (one older, one younger) discussed not having sidewalks or having only limited access to walking tracks (due to children getting out of school) as barriers to exercise.

Additional environmental barriers included transportation concerns (discussed by one group of men) and hot weather (discussed by one group of women).

**Enablers**

Enablers were subdivided into several categories including personal, social support, family, community and physical environment. The results for enablers are found in Table II.

**Personal enablers**

**Perceived benefits**

Men in three groups (one older, two younger) described how physical health benefits, weight loss
and improved appearance were motivators for PA. An older man declared that PA helps to keep him young, 'Look at me, I’m in good physical condition, I’m 70 years old, but I can do what the 21 year old person can do'. In one group, younger men described improved mental health as a motivation for PA. Women in all groups also consistently described how improved physical health, improved appearance and weight loss were benefits of PA participation. The two groups of older women also mentioned a sense of vitality that came with being fit and active. For example, ‘When we learn to eat right and exercise right, we find our body lasts longer and we feel better’. Other benefits only mentioned in one group of older women included improved quality of life and stress relief.

**Other personal enablers**

All groups of women and men agreed that enjoying PA was an important enabling factor. Two groups of men (one older, one younger) and two groups of older women described how being determined and motivated, having willpower and a commitment to PA and making time for yourself a priority were enablers. Goal setting was also described as an enabler in one group, with one younger man stating, ‘The individual is going to have to set a goal for themselves and whatever makes them decide to set that goal, then they’re going to have to have dedication and commitment to making (the goal)’. Instruction and guidance about PA from a family member and having family exercise time were offered as enablers as well by a group of younger women.

**Exercise leadership**

Several groups (one younger men, one younger women, one older women) stated the need for finding someone competent and knowledgeable about PA to be an encouraging leader. One group of younger women indicated that a good exercise group with a good leader would be motivating.

**Other sources**

One group of older men suggested that enjoying the fellowship with other church members and support from the pastor, including support for the program and participation in activities, was motivating. A group of younger men indicated that meeting new people encouraged them to be active. One group of older women, one group of younger women and one group of younger men also described the importance of advice from a physician about being active.

**Community enablers**

**Church**

Men (two older, one younger) and two groups of older women said that having PA programs available at their church would help them to be more physically active. Men in three groups (two older, one younger) were interested in having PA programs at their church and using the skills and resources within the church to maintain and expand current PA programs. One older man stated, ‘Now of course you can always do it at your home, but when you have it at church, then there will be that tendency to have more than a few people doing things’. One group of older men also mentioned the need for age-appropriate programs. Two groups of older women indicated that they would enjoy having exercise classes at church.
Physical environmental enablers
Men described several features of their physical environment that would enable them to be physically active. Having a place to walk or be active was described as an enabler in all four groups, especially having a safe place to be active. Three groups of men (two older, one younger) also described the need for more recreational facilities and equipment in their neighborhood. One group of younger men believed that lower cost exercise facilities and better weather would help people to be more active.

Women in three groups (one older, two younger) described the importance of having a nice place to walk or be active as an enabling factor. One group of younger women also described good weather, and having access to equipment as enablers to PA.

Desired church PA programs
Programs
Participants were asked to describe what types of PA programs they would like to have at their church. Among men, the most frequently listed programs were walking programs (all groups), sports (all groups), aerobics (one older) and classes specifically for older adults (one older). Women from all groups said they wanted walking and sports programs at their church. Other activities mentioned only once by women included weights or resistance training (older women) and a weight-loss contest (younger women).

Characteristics of programs
One older man suggested ideas for age-appropriate activities, ‘You can target the younger group with sports and music, get the middle-aged people with walking, and then have the older people doing walking and gardening’. Older men from one group stressed the importance of networking with other churches for successful programs. Men in two younger groups suggested that contests (walking, sports or weight loss) would be a good way to increase interest in PA. Women in two of the groups (one older, one younger) had suggestions for making the programs successful including having programs for people of all ages, doing group activities, using prizes to motivate people, holding programs at convenient times and having a good leader to motivate the group. For example, ‘I think if we had a real good instructor that can help us out and show us, we would have a dining hall full of people trying to do exercises’. Some other ideas mentioned in only one group of women were using Christian music during activities, holding programs especially for parents, getting support from key church leaders (i.e. the pastor and his/her spouse), having PA at church functions and increasing awareness of existing programs. Women also stated that educational activities would be valuable, especially those focused on nutrition and health conditions.

Discussion
Interventions to promote PA are more likely to succeed if they are ethnically sensitive and culturally tailored [16]. This study furthers our understanding of obstacles to PA participation African American adults face, as well as enablers for increasing PA in a faith-based setting. Additionally, this study includes the perspectives of African American men, an understudied group.

Although some PA barriers and enablers found in this study are not unique to the African American population, others appear very distinctive for this population. Religion has a prominent place in the African American culture [25], and the church institution promotes spiritual, mental and physical well-being; therefore, examining the perceived link between religion and PA is crucial to expand our knowledge on promoting PA in a faith-based setting. Specifically, our results indicate that some women in the African American community seek to gain strength from God to be physically active. Furthermore, women in our study believe that both PA and healthy eating help maintain a healthy body, which is referred to in scripture. Some participants (both men and women) thought that PA and healthy eating contribute to being a better Christian. The results of this study indicate that
spirituality, the church and social connections within the church are meaningful areas to incorporate when designing interventions for the African American population. Previous faith-based health promotion interventions targeting African Americans have used spirituality or religiosity to varying degrees. Furthermore, many of the interventions that incorporated spiritual messages into the program were successful [19, 21, 24, 29, 30]. Evidence from other studies has shown that African Americans, especially women, spirituality is often closely tied with health and should be considered when developing interventions targeting health behaviors [31–33]. A major purpose of conducting these focus groups was to inform the development of our intervention, the Health-e-AME Faith-based PA initiative. The ideas and themes that were discovered in these focus groups provided a strong foundation for developing this intervention. For example, use of scriptures and spirituality was integrated into all of our health messages, the specific programs offered resulted from the preferences voiced in these focus groups and barriers and enablers were addressed in trainings and in intervention materials. Thus, the result was a culturally tailored program designed reach a larger portion of AME members (for more details regarding the program, see [26]).

Consistent with the social ecological model [28], several social, cultural and environmental themes emerged as both barriers and enablers in the present study. Although lack of time is a common barrier to the majority of adults, regardless of race, participants tended to view this barrier (competing demands on one’s time) through a cultural lens in our focus groups. For example, a consistent theme was the responsibilities to family that has been consistently documented in an African American population [34–36]. Although only women described the need to have activities available for the entire family, both the men and women described obstacles that arise due to family obligations and responsibilities. For that reason, interventions that include the entire family or consider familial influences may be vital in order to have an effective PA program for the African American population.

Facility accessibility and availability is a barrier for PA in African American communities [37]. Additionally, providing a safe and comfortable setting is important when planning interventions for African American communities [38]; the church is a natural setting for meeting this need. Participants in the current study consistently described how having PA programs held at the church would facilitate PA among their congregations. However, participants also described difficulties in sustaining instructors and building time into the busy church schedule. Furthermore, the importance of having a good leader for the activities was consistently mentioned as something that would be helpful. These results indicate that including the church as a partner in promoting PA is a potentially viable mechanism, and presents an excellent opportunity for reaching underserved populations. However, several logistical challenges may need resolving for these interventions to be successful such as sustaining programs over time, space and resource needs and supportive leadership.

Men and women mentioned the environment as a major influence on PA. Not having a safe place to walk was addressed as a deterrent to being physically active. Besides having a safe and convenient place to walk, having facilities with equipment and an affordable fee would help increase PA, indicating the potential for community-based interventions to improve environmental supports for PA participation. The influence of the environment on PA behavior for African Americans has not been extensively studied; however, these findings are consistent with a previous qualitative study investigating exercise among older African American and white women [39].

Although this study provides insight into PA participation among African American men and women, there are a number of limitations. First, although common in qualitative research, this was a small volunteer sample of AME church members. Members who were interested in volunteering may differ from those who did not volunteer on variables such as attitudes and interest in health and PA along with possible sociodemographic differences and, therefore, may not be a representative sample.
Related, the small sample size is a limitation, though the results are consistent with other literature in this area addressing PA participation among African Americans [14, 40]. Secondly, the results of this study may not generalize to other religious denominations or ethnic groups outside of the southeastern United States. However, it is noteworthy that ~25% of African Americans living in South Carolina are affiliated with the AME church, thus representing a sizable portion of the African American population in this state. Further, we included individuals in this study that were either sedentary or underactive. Including regularly active participants may have provided additional insight regarding what facilitates PA in this population.

**Conclusions**

Among African Americans, the role of family is highly valued and greatly influences the ability or inability to exercise [38]. This study also highlighted the desire for PA to be available in the African American churches. PA programs being offered in the church foster the unique relationship between religion or spirituality and health (PA and nutrition). Therefore, interventions providing a variety of PA choices with a spiritual base that are available to the entire family in a convenient and safe place, such as the church, are important to African Americans. This study provides useful information for understanding the attitudes and experiences with exercise among African Americans that could assist in the development of culturally specific and spiritually tailored interventions for this population.

**Acknowledgements**

This project was supported by a grant from the US Centers for Disease Control and Prevention, CCR421476-01. We wish to thank Bishop Henry Allen Belin Jr (retired), the Right Rev. Preston W. Williams II and the Presiding Elders of the seventh Episcopal District and Health Directors of the AME Church for their support and assistance with this project. We are very appreciative to all of the individuals who have volunteered their time to attend the program training and implement the PA programs in their churches, as well as to their pastors for supporting the program objectives.

**Conflict of interest statement**

None declared.

**References**

Physical activity among African American church members


Received on October 19, 2005; accepted on September 14, 2006

Appendix A. Moderators guide

Note: probes are not listed here.

1. ‘We would like to hear about the things that get in the way of exercise for you and people in your church community.’
2. ‘How does your faith in God and your spirituality relate to exercise and diet? That is, what is the connection?’

3. ‘What are the main things that would help or motivate you and people in your church community to exercise?’

4. ‘What types of activities, if any, does your church currently do to encourage its members to be more physically active?’

5. ‘We are working with the AME churches to develop programs to try to increase physical activity and exercise among adult members. A main purpose of the discussion today is to get your ideas for making these programs a success. What do you think your church could do to help its adult members be more physically active?’

6. ‘We are considering several types of programs that could be offered to AME churches, and would like your thoughts about how interested you and members of your church would be in each.’

7. ‘Are there other things related to physical activity and your church that I didn’t ask you about tonight that are important for me to know?’