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Promoting Health in Underserved Communities

Qualitative Findings from High School Students in South Los Angeles

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SUMMARY

Understanding adolescents' perceptions of barriers and facilitators to healthy eating, active living, and well-being is important for designing and implementing successful adolescent health promotion interventions. This qualitative study identifies prevailing beliefs, attitudes, and experiences with school- and community-based health resources among predominantly Hispanic and Black adolescents residing in an underserved community. In 2014, four focus groups were conducted (N=28) at three high schools in South Los Angeles. Barriers to healthy eating are identified inside and outside of the schools. Concerns about safety are discussed as a key barrier to mobility and limiting factors of adolescents' use of publically available physical activity resources. Participants exhibit a high level of awareness of school-based health centers offering health care services. This issue brief suggests schools can be leveraged for adolescent health promotion activities in underserved communities. Success depends on recognizing barriers in the institutional, built and social environments. Our findings suggest the importance of increasing access to school-based nutritional resources, participation in physical activity programs, and utilization of health care services.

Background

The adolescent obesity rate in the United States increased from 5% to 21% between 1980 and 2012.[1] Obesity is largely considered to be a preventable disease, and rates have increased as a result of increased consumption of calorie-dense foods and decreased physical activity. The dramatic increase in youth obesity is particularly problematic, as obese adolescents have a 75%–80% chance of remaining obese into adulthood.[2]

Racial and ethnic populations are disproportionately affected by obesity. Low-income Hispanic and African-American adolescents have higher obesity rates and worse health outcomes compared to whites.[3] Thus, these groups face a higher risk of developing type-2 diabetes[4] and numerous other physical[5,6] and mental health issues.[7] Though, diverse factors affect obesity levels—including genetic predisposition, the built environment and lifestyle choices, obesity is largely considered to be a preventable disease.

Schools offer a variety of resources that can help address the adolescent obesity epidemic, including healthy school lunches, nutrition education, and opportunities for physical activity. Some schools even have on-site community gardens or School-

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Based Health Centers (SBHC).[8] Lowering barriers to school-based health promotion resources in low-income, minority communities may help decrease existing adolescent health disparities.[9]

Purpose

The purpose of this study was to assess the barriers and facilitators to (1) healthy food, (2) active living resources, and (3) health care services in an underserved urban community. Student participants at three high schools were asked about their level of awareness and health behaviors related to health promotion resources in their school and neighborhood.

Methodology

We conducted four focus groups with 28 participants at three high schools between July and October 2014. An average of seven participants attended each group. The average age was 16 years and 32% of participants were identified as overweight or obese— a rate slightly higher than that of South Los Angeles youth (31.4%) overall.[10] The racial/ethnic composition varied by school: Site 1 had a majority of African American or black students; Site 2 had a majority of Hispanic students; Site 3 had a more even division of these groups. Overall, the majority of participants were Hispanic (Figure 1). Participants completed a pre-discussion questionnaire with health behavior and health status questions. The focus group script included open-ended questions on resource environment perceptions, barriers/facilitators, and health behaviors.

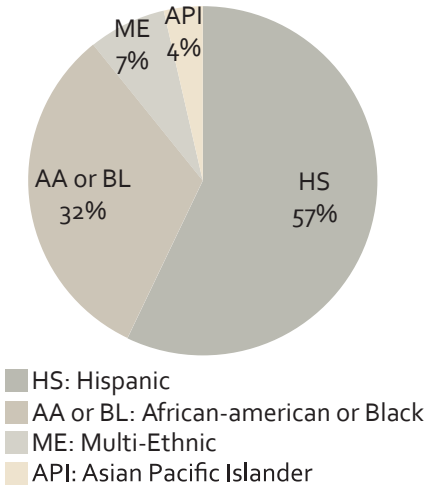

Figure 1: Race and Ethnic Composition of Participants

Key Findings

Nutrition Resource Environment:

- Food appeal and time constraints are key factors influencing student participation in school meal programs.
- Students expressed awareness of recent healthy improvements to school-based meals, and interest in additional fresh foods and opportunities to be involved with school gardens
- Students identified the high density of unhealthy food options outside of school as a barrier to healthy eating. Student food preferences were embedded in cultural and social norms, which may be difficult to change.

Physical Activity Resource Environment:

- A majority of students reported having access to physical activity resources; yet, only 25% met the daily recommended level of exercise.
- A lower level of motivation was a key barrier for low-income adolescents. Motivation needs to be considered when designing in-school physical activity interventions.
- Worries about safety, particularly gang-related, deterred physical activity in parks and willingness to walk or bike to and from school.

Health Care Resource Environment:

- School nurses were mentioned as a primary source of medical advice. Educating nurses about SBHCs may help increase utilization.
- SBHCs should actively promote wellness resources on campus, beyond reproductive health.

Nutrition Resource Environment

Fruit and Vegetable Consumption andPreferences:

Nearly half of students believed that they "eat enough" fruits and vegetables, suggesting potential misconceptions about serving recommendations and guidelines. Students preferred fruits to vegetables, and they reported the importance of parental influence over their nutrition choices and behaviors.

School Food:

Only just over half (53.6%) of students ate lunch in the cafeteria on a regular basis, although at least 75% of them qualified for free or reduced lunch. Students expressed awareness about efforts to improve the school meals program. One student reported, "I don't eat over there, but based on what I observe, what they say around me, [the school] changed the menu; it's gotten better since last year." Students identified barriers such as long wait times, entering a pin number to get in, and inadequate stock of main menu items. Participants expressed a preference for fresh food over frozen food.

Nutrition Education:

Only one or two after-school nutrition programs were offered at each school, even though two schools had gardens on campus. Students from Sites 1 and 2 had a high level of awareness about the school garden, but they cited limited access during the school day and visibility as barriers.

Off-Campus Food Options:

Most students preferred off-campus food to that offered at school. Students highlighted the oversaturation of fast food options around their schools. One student said, "It's crazy, it's [fast food] on every corner." Students identified chips, soda, blended caffeinated drinks, and energy drinks as popular junk foods. Soda consumption was high -- 39% of students reported drinking sodas in the last 24 hours. Some unhealthy habits were embedded in the neighborhood social culture, as students frequented a street vendor outside school, and a local restaurant was identified as a popular "hangout spot."

Traditional and Alternatives Food Resources:

A large majority of students believed they have sufficient access to fresh fruits and vegetables. Most families shopped at supermarket chains and ethnic (e.g., Hispanic) grocery stores. Awareness of farmers markets varied.

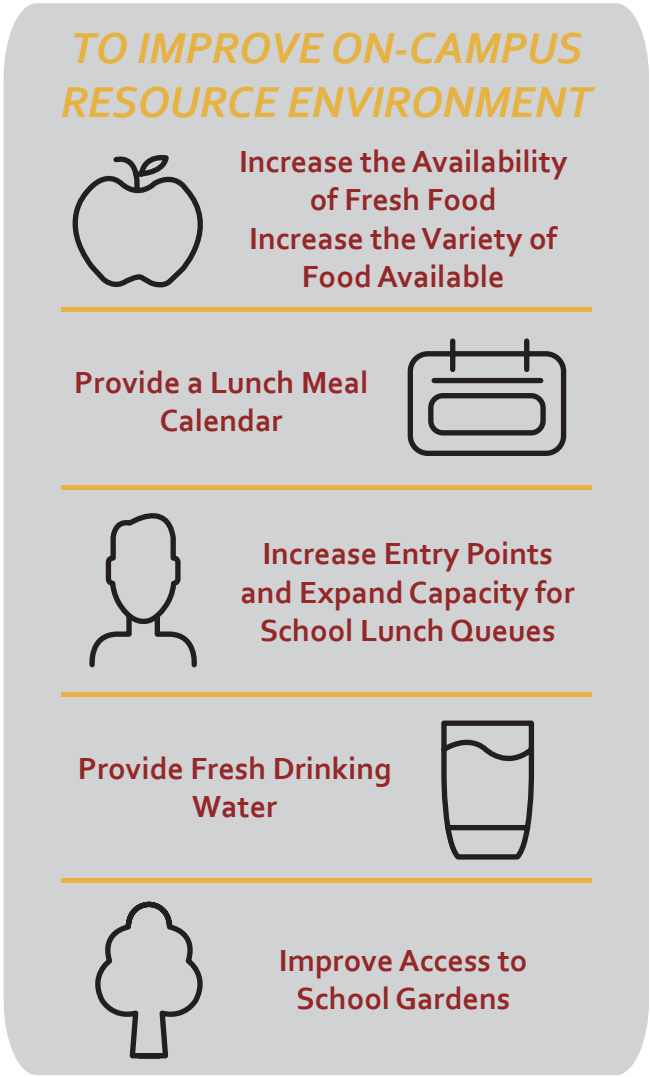

Figure 2: Recommendations to Improve the On-Campus Resource Environment (based on student recommendations)

Physical Activity Resource Environment

Although 42.9% of students reported receiving "enough physical activity levels," only a quarter reported engaging in more than sixty minutes per day. Conversely, students reported high levels of screen time and technology use.

On-Campus Sports and Exercise Programs:

Physical activity programs offered on school campuses were largely cited as resources, while several students participated in organized sports and on teams for physical activity.

Just over half eat lunch in the cafeteria regularly, although three-fourths qualify for free or reduced lunch.

Off-Campus Physical Activity and Exercise Opportunities:

A majority of students (71.5%) believed someone could easily exercise in their community, particularly when considering street quality and local parks. Students were generally aware of private gyms and local fitness classes, including free Zumba classes, but there was low utilization of these resources. Top barriers to physical activity were identified as lack of motivation (39.3%), transportation (25%), and time (21.4%). (See Figure 3.) One student captured the group sentiment in saying, "If you have the time for it [physical activity], like it's hard if you are a lazy person."

Just under half (42.9%) of students reported they felt somewhat unsafe to use community resources. Gangs were commonly cited as a threat. Several students recalled violent or uncomfortable personal experiences within their community. One student expressed, "When I walk home from school, I won't say it's completely safe, 'cause I did walk home recently and there was a group fight and someone pulled a gun out, and I almost got hit by a car trying to leave. Other than that it is safe." Students repeatedly mentioned public parks as unsafe locations due to the presence of gangs.

Critically, students mentioned feelings of unease and discomfort when walking to and from schools, and offered illustrations of their adaptive coping strategies (e.g., walking in groups). These findings suggest perceptions of safety may undermine decisions to pursue physical activity within the community.

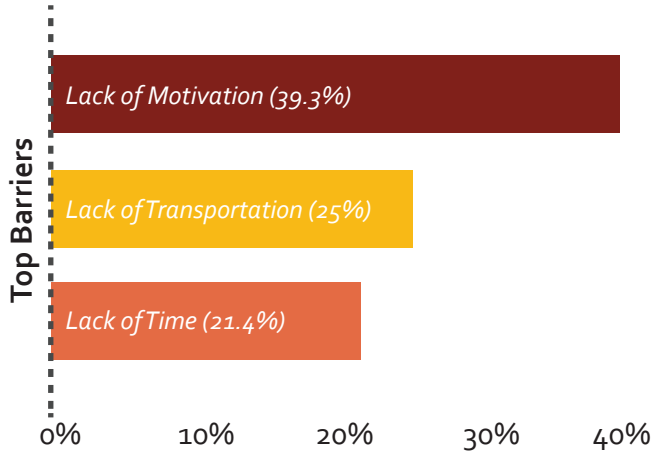

Figure 3: Top Barriers to Physical Activity (Self-reported)

Health Care Resource Environment

School-Based Health Centers (SBHCs):

Students demonstrated knowledge of the purpose and available services of the SBHCs. While over 50% of participants identified school nurses as their primary source for school medical care, just under half (42.8%) reported having visited a SBHC. Those who had visited the SBHC reported high levels of satisfaction, suggesting potential benefit from higher utilization rates. One student commented, "It was great, they actually help you, and it's really confidential." While students were aware of the services the centers offered, none had received information about physical activity or nutrition

programs at the SBHC. Students tended to rely on teachers and peers for health information, emphasizing the importance of word-of-mouth promotion.

Just under half report visiting SBHCs; those who had, report high levels of satisfaction.

Implications for School Health

Nutrition Resource Environment:

The unhealthy food environment outside schools that compete with healthier foods on campus is difficult for students to ignore. Improvements to the off-campus nutrition resource environment, such as the Healthy Kid Zone, are critical to devising strategies to address barriers to healthy food. The following recommendations can help to increase access to and consumption of school lunches.

Improvements in on-campus foods might include:

- Prominently displaying lunch menus and minimizing lunchtime queues. Increasing fresh vegetable and fruit consumption through creative ways of preparing and presenting healthy foods (e.g., smoothies).
- Teacher-based nutrition education and interventions can promote healthy food consumption.

Out-of-school nutrition programs can engage students' families and expand reach into the community.

Physical Activity Resource Environment:

Decreasing barriers to active living requires confronting intrapersonal and environmental barriers.

- Creative marketing can portray physical activity programs as fun.
- Physical activity programs can be more appealing (e.g., playing music during activity), and diverse activities (e.g., dance or kick-boxing) can be offered.
- While school personnel are unable to alter community social environments, existing coping strategies can be utilized and built upon (e.g., encouraging walking or bike clubs), and students can organize groups to promote a safe and clean environment (e.g., vandalism cleanup programs).
- Safety personnel can be located at busy intersections to address safety concerns. Ultimately, using a model—such as a Coordinated School Health Program (CSHP), designed to assess the school health climate—could promote healthy eating and physical activity in school environments. [11] The CSHP identifies structures, such as a district wellness policy and a school health coordinator, and school-specific features to coordinate health promotion and prevention services. [12] Adopting these recommendations could lead to increased utilization of health promotion resources on high school campuses and improved health for at-risk students in low-income communities.

Health Care Resource Environment:

Increasing utilization of SBHCs requires first increasing awareness of SBHCs in both the student population and the school nurse population. School nurses are already viewed as a primary source of medical advice and should partner with SBHCs to ensure all student health care needs can be met. SBHCs, along with school nurses, should work together on an integrated referral network to improve student health outcomes.

- School nurses should play a key role in connecting students to SBHCs to increase utilization
- SBHCs can fill a health care gap for students and serve as a wellness promotion entity on campus
- An integrated referral network can link SBHC patients to other health promotion resources, such as physical activity and nutrition programs
- School nurse and SBHC providers should be educated about health promotion resources and activities on school campuses.

ACKNOWLEDGEMENTS

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Endnotes

1. Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of childhood and adult obesity in the United States, 2011-2012. JAMA. 2014;311(8):806-814. doi: 10.1001/jama.2014.732.

2. To cite, if used: http://activelivingresearch.org/case-study-los-angeles-unified-school-district-physical-education-implementation-plan

3. Lifshitz F. Obesity in Children. Journal of Clinical Research in Pediatric Endocrinology. 2008;1(2):53-60. doi:10.4008/jcrpe.v1i2.35.

4. Wang Y, Beydoun M. The Obesity Epidemic in the United States—Gender, Age, Socioeconomic, Racial/Ethnic, and Geographic Characteristics: A Systematic Review and Meta-Regression Analysis. Epidemiol Rev. 2007;29:6-28.

5. Koplan JP, Liverman CT, Kraak VA, eds. Preventing Childhood Obesity: Health in Balance. Washington DC: Institute of Medicine of the National Academies; 2004.

6. Sorof JM, Lai D, Turner J, Poffenbarger T, Portman RJ. Overweight, ethnicity, and the prevalence of hypertension in school-aged children. Pediatrics. 2004;113:475–482.

7. Wing YK, Hui SH, Pak WM, Cheun A, Li A, Fok, T. A controlled study of sleep related disordered breathing in obese children. Arch Dis Child. 2003;88(12):1043–1047.

8. American Academy of Child and Adolescent Psychology. Facts for Families: Obesity in Children and Teens. http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Obesity_In_Children_And_Teens_79.aspx. Published March 2011. Accessed December 16, 2014.

9. Lofink H, Kuebler J, Juszczak L, Schlitt J, Even M, Rosenberg J, et al. 2010-2011 School-Based Health Alliance Census Report. Washington DC: School-Based Health Alliance; 2013.

10. Baranowski T, Cullen KW, Nicklas T, Thompson D, Baranowski J. School-based Obesity-Prevention: A Blueprint for Taming the Epidemic. Am J Health Beh. 2002;26(6):486-493.

11. Kolbe L, Kann L, Patterson B, Wechsler H, Osorio J, Collins J. Enabling the Nation's Schools to Help Prevent Heart Disease, Stroke, Cancer, COPD, Diabetes, and Other Serious Health Problems. Public Health Rep. 2004;119(3):286-302.

12. Stoltz AD, Coburn S, Knickelbein A. Building Local Infrastructure for Coordinated School Health Programs: A Pilot Study. J Sch Nurs. 2009;25(2):133-140. doi: 10.1177/1059840509332281.