Obesity Insights Study

Black, African and Caribbean Nutrition and Weight Management in the London Borough of Lewisham 2020

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Overview

Summary of Approach and Findings

This study seeks to explore the barriers and motivations for healthy weight management in the Black African and African Caribbean (BAAC) community in the London Borough of Lewisham (LBL) in the UK. Building on existing research literature (where it exists), the study uses surveys, interviews and focus groups to capture insights from the target community. Across six key exploratory areas, nine significant themes emerged:

- Religious or traditional beliefs about food, health and body image that are in conflict with NHS guidance
- Unrealistic perceptions about what constitutes healthy body size and weight.
- Food choices and portion size are informed by culture and tradition or not well understood
- Not understanding how to manage weight using preferred foods and cooking methods
- Time, cost and accessibility create barriers to exercise
- Previous failed weight loss attempts affect future motivations
- Perceived stigma and negative associations with obesity impact weight management
- Physical and mental health challenges impact motivation and ability to manage weight
- Having 'culturally sensitive' healthcare professionals helps engagement in services.

Summary of Recommendations

Ultimately, this is about behaviour change. Therefore based on the insights gathered this study suggests the following summary-level behaviour change interventions (subject to further refinement):

1. Improve holistic nutritional and physical activity education within the community
2. Develop promotional awareness campaigns that reflect the community and their traditions
3. Provide cultural sensitivity training and support for health care professionals
4. Empower and fund community based mental health and emotional programmes to support weight management.

Introduction

The World Health Organisation (WHO) recognises obesity as one of the major global public health challenges, particularly among low-income and minority groups. The WHO identify obesity (defined by body mass index (BMI) of ≥ 30 kg/m^2) as a disease with risk factors for a large range of health conditions with significant impact on mortality (James, 2008]. More specifically, excess weight is associated with an increased incidence of cardiovascular disease, type 2 diabetes mellitus, hypertension, stroke, osteoarthritis and some cancers (Spadano et al. 1999).

Within the UK in 2011, providing care to obese and overweight people within the NHS (National Health Service) was estimated to cost £4.2 billion in direct costs with forecasts that this will more than double by 2050 if we continue as we are (Scarborough et al. 2011). However beyond the financial and physical health implications, the disease is known to have substantial impact on mental health, productivity and other social outcomes.

The Health Survey For England 2019 describes the prevalence of overweight and obese adults in England. Around two thirds of adults were identified as overweight or obese (men – 68% and women – 60%) with generally increasing trends as people age. Population inequalities were also identified with adults living in the most deprived areas more likely to be obese. This was shown to be particularly prevalent for women where 39% of women in the most deprived areas were obese, compared with 22% in the least deprived areas (Health Survey for England, 2019). In a study of 152,969 people, the Active Lives Adult Study showed that in the 12 months to November 2019, 62.3% of adults in England were obese or overweight. This is consistent with the Health Survey for England report above. However this study went on to show that Black adults showed the highest percentage of all ethnic groups at 73.6% (Active Lives Adult Survey November 2018/19 Report, 2020). Further this study suggests that despite physical activity levels before the coronavirus (Covid-19) outbreak being at a record high, there were still lower levels of activity for Black people and those from lower socioeconomic groups. Whilst data about physical activity during the pandemic is still emerging, Sport England have reported that people in higher socioeconomic groups are more likely to participate in physical activity during the pandemic (Sport England, 2020)

With respect to outcomes, a 2004 report by the Health Survey For England showed that compared to the general population; the burden of chronic diseases such as obesity, hypertension, type II diabetes and stroke are higher among Black and Minority Ethnic (BAME) people (Health Survey for England 2004: The Health of Minority Ethnic Groups, 2004).

Understanding healthy weight management in BAAC people in the UK

For the general population, there is a considerable amount of research from health, transport and environment studies all seeking to find opportunities to reduce obesity levels, improve outcomes for individuals and reduce the impact on the health care system and environment (Haskell et al. 2009 and Michie et al. 2009). Broadly they view the challenge from two main perspectives: food choices and levels of physical activity. With respect to our target population specifically, research is sparse by comparison. However several studies do provide insight on the factors which affect food choices and levels of physical activity in BAAC people in the UK.

Food choices

In 2011, the British Nutrition Foundation published a briefing paper describing the diets of minority ethnic groups in the UK. They cite seven key factors affecting food choice: income and socio-economic status, food preferences, awareness of healthy eating, religious beliefs, food beliefs, time and cooking skills and age/ generation. (British Nutrition Foundation, 2011).

Physical activity

In a systemic review of studies between 2007 and 2018, Ige-Elegbede et al (2019) investigated key factors affecting physical activity in BAME groups in the UK. The authors acknowledge the limited research available in Black communities (people of Black African Heritage), with greater research available for South Asian communities. However the six key factors identified provide helpful insights: awareness of the links between physical activity and health, interaction and engagement with health professionals, cultural expectations and social responsibilities, suitable environment for physical activity, religious fatalism and practical challenges.

Other factors – physical and mental health

Mabadiliko CIC note that in unpublished data, 85% of people who attended community-based Emotional Support Groups and Positive Self-Talk sessions described significant physical health challenges connected to their mental health. Emotional barriers like low mood, anxiety, a sense of hopelessness and social isolation impacted on people's ability to make the healthy lifestyle

changes they said they wanted to make. While Covid 19 has helped to refocus the public's attention more poignantly on health, this study represents a good opportunity to engage BAAC Lewisham residents on current and wider health matters.

These insights from the existing literature allowed this study to generate key questions for exploration and expected themes. These have been used to design our data collection approach using a 'grounded-theory approach' i.e. working from an evidence-based set of hypotheses. This approach, supported by the way we have structured our data collection approach, also allows for additional themes and insights to be identified.

Target population: The BAAC adult community in the London Borough of Lewisham (LBL), UK. Broad research questions:

1. What are the barriers and motivators for healthy weight management?
2. What support is needed?
3. What is the impact of culturally sensitive approaches to weight management support?
4. What are the appropriate behaviour change recommendations required to improve weight-related outcomes for people in the target community?

Methods

Participant eligibility

The following eligibility criteria were used to recruit participants into the study:

- Identifies as Black African or African Caribbean and;
- Is a London Borough of Lewisham resident and;
- Is 18 years old and has experience of *at least one* of the following:
  - Has accessed weight management services such as Weight Watchers, Slimming World, GCDA, Community Nutrition, Dietician, Healthy Walks or GP Exercise on Referral
  - Has a BMI over 30
  - Believes they would benefit from losing weight.

Data collection

As noted above this study uses a 'grounded-theory approach' to structure data collection. Based on the literature review described in the Introduction, a framework was designed to identify key areas of exploration and expected themes. (Table 1).

Table 1: Study Key areas for exploration and expected themes.

Key areas for exploration	Expected themes
1. Awareness and cultural attitudes	Unrealistic perceptions about what constitutes healthy body size and weight.
	Poor understanding of the links between weight and cardiovascular and other diseases.
	Religious or traditional beliefs about food, health and body image that are in conflict with NHS guidance.
2. Food choices	Food choices and portion size are informed by culture and tradition or not well understood.
3. Physical activity	The role of physical activity in weight management is not clearly understood or seen as an undesirable barrier.
4. Other motivations and barriers to healthy weight management	Perceived stigma and negative associations with obesity impact weight management
	Other motivations for healthy weight management e.g. looking good.
	Other real or perceived practical barriers to healthy weight management e.g. Previous failed weight loss attempts affect future motivations.
5. Social support (non-professional)	People with strong social support networks can be more successful at achieving weight management goals.
6. Professional support	Negative experiences with healthcare professionals can influence future attempts to access services.
	Having 'culturally sensitive' healthcare professionals helps engagement in services.

Data sources

This study takes a triangulated approach to data collection using three data sources which are all built around our data collection framework (Table 1):

1. Surveys (quantitative data): 10 structured questions delivered via Survey Monkey. The target for participant survey completion was set at 50 people.

2. 1-1 Interviews (qualitative data): Guided interview with 20 semi-structured questions delivered via videoconferencing technology (e.g. Zoom) due to Covid-19 social distancing guidelines. Age and gender demographic information was collected from interview participants. The target for interviews was set at 25 people. Interviewers were provided by Mabadiliko CIC and via our network of partners including the Lewisham BME network, S.I.R.G., Action for Community Development, African Advocacy Foundation, Bromley Lewisham MIND, GCDA and participants in the Mental Health Insight work. These partners also provided study participants from their networks, which supplemented participants recruited from Mabadiliko CIC's network. Interviewers received training via two 2-hour sessions. Session one included an overview of the study objectives and approach, information about the data collection approach, consent and GDPR requirements. Session two focused on the interview process including best practice for delivering interviews (e.g. using empathy and eliminating personal biases) and 'role-play' practice. Interviewers were provided with an interview guide to ensure standardisation across interviews (see Appendix 2). Interviewers were required to obtain signed consent forms from participants before the interview. Interviews were transcribed and provided to the Mabadiliko team (on an anonymous basis) for analysis. Non-Mabadiliko CIC interviewers were paid £50 per completed transcript.

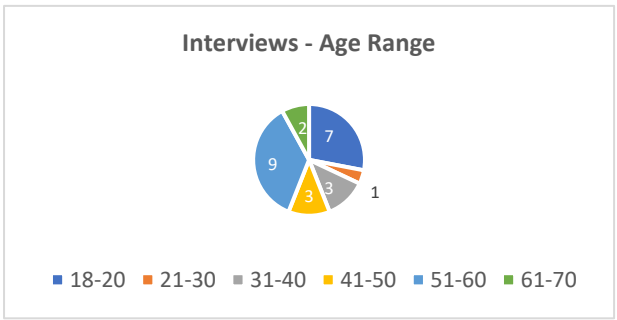
3. Focus Groups (qualitative data): 4 broad questions delivered by Zoom. In comparison to the structured and semi-structured approaches above, the focus group questions were deliberately open to allow for wider discussion and ensure we capture themes in addition to our expected themes. The focus groups were delivered by Mabadiliko CIC staff and transcribed (on an anonymous basis) for analysis. Participant consent was obtained via the interview stage.

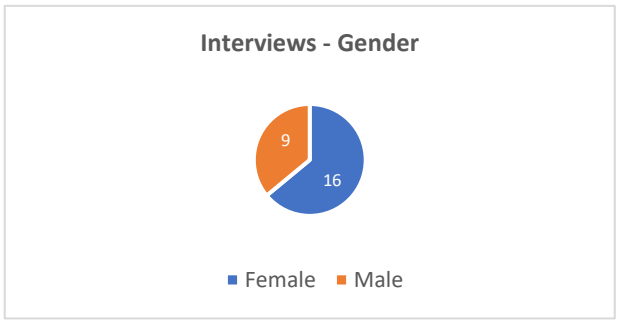
Data analysis

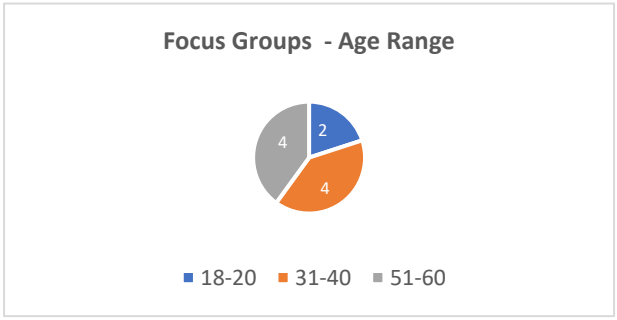
- Quantitative data – survey data was analysed using Excel to produce summary graphs for each of the 10 questions. Due to the small sample size, statistical significance was not calculated. However these results provide a useful guide **when triangulated with the qualitative results.**

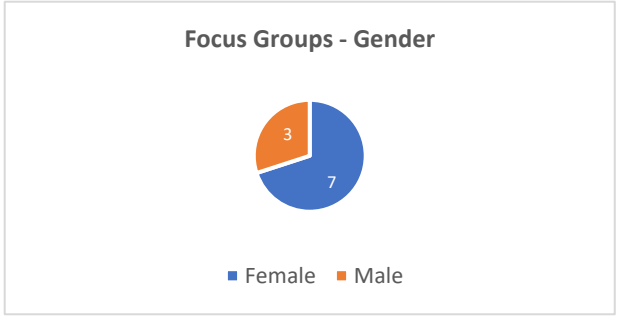
- Qualitative data – Transcripts from the interviews and focus groups were analysed using a thematic approach to manually code key words and paragraphs to themes including those generated from our hypotheses (Table 1) and new themes generated from the study itself. Where necessary themes were adapted to provide a true reflection of insights gathered. NVivo Qualitative Data Analysis Software was used to aid coding activity and help generate reporting.

Results and Discussion A total number of 68 surveys were completed. The graphs below show information about the interviews and focus groups.



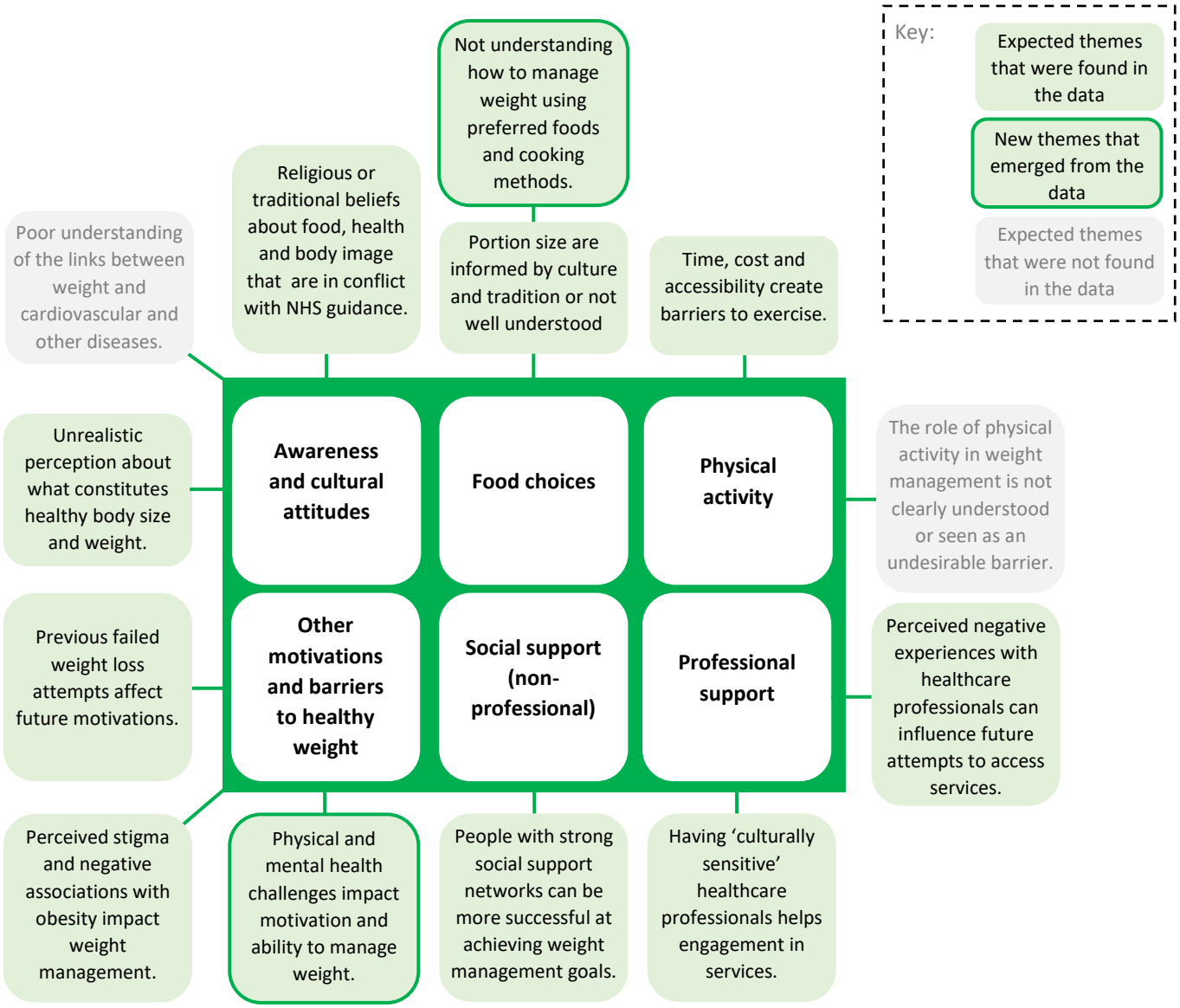






In summary, within our key areas of exploration, six of the eleven expected themes materialised as highly significant in our data. Other themes were new, refined or did not emerge in the data at all. See illustration 1 below.

Illustration 1: Key exploration areas with study themes.



As we have taken a triangulated approach to capturing data, below we have grouped the findings from all relevant survey, interview, and focus groups within each exploration area. Full data graphs are provided in Appendix 1.

Key exploration Area 1: Awareness and cultural attitudes

Two questions were relevant from the survey:

1. *Do you perceive yourself to be a healthy weight, overweight or obese?* 34% of respondents identified as knowing their BMI and classifying themselves as overweight or obese. 16% knew their BMI and classified themselves as within a normal weight. 50% of the total respondents did not know their BMI. 15% did not know their BMI but perceived themselves to be within a healthy weight range.

2. *Do you think you may be at risk of health conditions?* 74% of respondents believed that they would be at risk at their current weight or if they gained further weight.

Relevant themes from the interviews and focus groups:

1. *Religious or traditional beliefs about food, health and body image that are in conflict with NHS guidance*
   With respect to BMI, some participants felt that it was of use as a general guide, however the majority people felt that it was irrelevant, difficult to understand and most importantly not relevant to the physiology and preferred body images of the community. This was consistent across genders and age groups.

   Focus Group - I think BMI is just… language or coded language in numbers… people don't really relate to it.

   009 (Female 18-20) - I don't think the BMI is very helpful for black people. What is it based on anyway?

   012 (Female 31-40) - BMI is more or less important, I think it's a helpful guide. But I'm always sceptical about how phase metrics have been generated, my assumption is that they've been generated based on European populations. They don't account for differences in the physiology of black people like bone density and muscle density. Those things that are not unhealthy but can increase your weight on the scales. It also doesn't measure fat. So I take it as a guide.

   008 (Female 31-40) - BMI… it's a bit unrealistic.

   011 (Female 61-70) – BMI has never been an issue for me… my family were big boned…therefore I am big boned

   There were differences in ideal body sizes with concerns about being underweight as well as overweight.

   005 (Female 51-60) - In my culture big is beautiful!!!

   008 (Female 31-40) - when I have lost weight, a lot of concern, like, are you okay, checking if I have eating disorders and stuff like that.

   There is also a strong connection between food and expressions of love and bonding across genders and ages.

   021 (Female 51- 60) - Food equals family and friends. Hospitality is important to us and we need to express our love. We eat because someone made it for us and we're doing it together.

   010 (Male 61-70) - Well, if I ever introduce you to my mother, you probably would end up being twice my size, she can't let you go to without eating… I think we have a psyche as a people that eating gives us…pleasure.

2. *Unrealistic perceptions about what constitutes healthy body size and weight.*
   In the general absence of engagement with BMI metrics, participants identified varied and often subjective approaches to determining healthy body sizes and weights. This largely included the way they feel physically or mentally, or how they look in the mirror or in their clothes. This was consistent across genders and age groups.

   023 (Male 18-20) - I don't know if I'm in a healthy am weight range… I'm not sure how weight range is measured.

   011 (Female 61-70) - I know based on how I feel with my mobility.

   013 (Female 31-40) – I know from how my clothes fit.

   009 (Female 18-20) - I don't know but it's just by sight. Yeah.

Key exploration Area 2: Food choices

One question was relevant from the survey:

1. *How do you decide what food and portion sizes to eat?* 75% of respondents reported using their own judgement only.

Food choices was overwhelmingly the largest talking point for participants. Relevant themes from interviews and focus groups:

1. *Food choices and portion size are informed by culture and tradition or not well understood*
   The role of traditional food choices were reflected by almost all participants. Portion sizes were also consistently cited as being large, with no clear measurement framework. There was also a strong theme that food choices and portion

sizes were habitual and embedded during childhood. Most participants referenced the challenge of breaking out of these habits, particularly older people who tended to favour traditional foods.

004 (Male 41-50) - We are more oriented to food of our own culture such as plantain yam and jollof rice.

009 (Male 51-60) - People don't like to be told what to do but if they can be encouraged or if they can have a balance in their own life then they will see the benefits.

020 (Female 51-60) - The way that we were raised as children impacts how we eat as adults. With portion sizes, as children we tend to follow those same patterns as adults.

017 (Female 18-20) - There was no "make sure you eat salad with it" when I was younger. So now I don't even think about it.

015 (Female 18-20) - I think I've built my own eating habits, aside from cultural food.

2. *Not understanding how to manage weight using preferred foods and cooking methods*
   People struggled to translate traditional foods into healthy food choices. Many referenced the historical roots of diet trends. Across the study there were several references to cooking methods including references e.g. frying foods.

005 (Female 51-60) - Caribbean history is stooped in slavery where some traditions like eating a lot of sugar and a lot of salt have been passed down through conditions imposed on people by slavery.

005 (Male 41-50) - Lack of vitamin D lowers immunity and make you susceptible to diseases.

006 (Male 41-50) - I think the food available is not helpful, having to make choices about food they do not know can put them at risk.

016 (Female 18-20) - A lot of the preparation methods such as frying, using palm oils or using a lot of saturated fats… are very prevalent in Afro Caribbean foods.

Key exploration Area 3: Physical activity

One question was relevant from the survey:

1. *What influences how physically active you are?* 31% of respondents reported enjoying taking part in exercise with others. 19% reported enjoying exercising but not having the time. 10% reported not enjoying exercise. 15% reported a long-term health condition.

Relevant themes from interviews and focus groups:

1. *Time, cost and accessibility create barriers to exercise*
   Almost all participants referenced lack of time as a barrier to exercising. Younger people were more likely to mention study commitments. Both men and women referenced work commitments. Women were more likely to mention time constraints due to childcare. The cost of exercise was also a challenge, including the cost of gym memberships or at-home equipment as well as the accessibility of preferred types of exercise. Younger people were more likely to reference exercise with respect to weight management only, whereas older people were more likely to reference it with respect to enjoyment which started in younger years.

004 Male 41-50 - If I have money I can buy equipment to exercise at home. I get demotivated when gyms increase their prices during Covid-19.

007 (Female 41-50) - We need more Yoga and alternative health care provisions to be cheap and affordable and provided by people who understand BAME history and culture like Kemetic Yoga.

008 (Female 31-40) - Managing my time is difficult, like managing the children and work.
010 (Male 61-70) - My workload regrettably doesn't enable me to do the things that I want to do. But I think it's a case of choice at the end of the day. So you either make the time, or you don't.

Key exploration Area 4: Other motivations and barriers to healthy weight management

Three questions were relevant from the survey:

1. *How motivated and confident do you feel about losing weight?* 38% reported feeling motivated to lose weight and confident they could do it. 25% reported motivation but lack of confidence. 12% reported not feeling motivated but were confident that they could if they wanted to.

2. *Have any of the following factors negatively impacted your motivation? Please select all that apply* 24% reported not experiencing any of the factors. 24% reported low mood/depression. 23% reported unsuccessful attempts to lose wait in the past. 14% reported negative verbal comments or public embarrassment.

3. *Do you feel that any of the following are barriers to you losing weight? Please select all that apply* 34% reported the weather/ environment. 28% reported lack of time due to work or childcare management. 20% reported financial constraints. 11% reported ill-health. 7% reported problems in their relationships (friends or family).

Relevant themes from interviews and focus groups:

1. *Physical and mental health challenges impact motivation and ability to manage weight*

   For older participants in particular, across both genders, a wide range of physical health challenges were cited as barriers to weight management. Across all ages and genders mental health challenges including stress, emotional issues and anxiety were referenced. In some cases, there was simply a fear of not fitting in at public exercise spaces due to race or stigma. This appears to have been enhanced as a result of Covid 19.

   Focus Group - Yeah, because I think if you look a certain way, people don't want to go to the gym… other people might be looking on them and thinking why are you here?

   Focus Group - Having good self-esteem is really important as a motivating factor.

   005 (Female 51-60) - I fear being lonely.

   010 (Male 61-70) - I think the stresses are far greater than for Caucasian counterparts. We have far greater strain in terms of how we cope with the day to day life… we tend to work harder, housing is a problem, access to certain things can be a problem, the pressures that one has at work is a problem.

   016 (Female 18-20) - If I'm not in a good mental state that can make it difficult to exercise. Mental health is a contributing factor. If I don't wanna get out of bed I won't do it.

2. *Previous failed weight loss attempts affect future motivations*

   The majority of participants had attempted weight loss in the past which was either unsuccessful, or successful for a limited time only. Not being successful, or feeling overwhelmed by the task ahead was seen as demotivating. Having clear goals was seen as helpful addressing this motivation issue.

   025 (Male 18-20) - No matter how much I try it out and go back to the unhealthy food. So it didn't work.

   013 (Female 31-40) - What increases my ability is when I'm successful at losing weight - I see it on the scales and I receive positive feedback from family and friends.

   015 (Female 18-20) - As people we just want to see immediate results… not seeing those immediate results can then demotivate you and make you think "what am I doing, is this even having any effect?".

3. *Perceived stigma and negative associations with obesity impact weight management*

   Participant views varied with respect to the level of stigma associated with terms like 'obese' and 'overweight'. Some participants (mainly women) felt there were clear associations with shame and embarrassment. Many participants of both genders and across ages felt that the terms simply signified health issues that needed to be addressed. Some suggestions were made for alternative words, but by and large participants felt that the term wasn't important. What was important was either changing the stigma associated with the terms, or addressing the weight issue itself.

012 (Female 31-40) - I do think that they are more broadly considered to be very negative words, stigmatised words. If you're obese, you're lazy. You eat crisps all night long. So I think that they create connotations about a person's character which are not necessarily true and can be quite shaming.

004 (Male 41-50) - If the person knows the word is linked to stroke or other illness, this might increase motivation.

019 (Male 51-70) - You could dress it up in whatever language you want but it's still going to amount to the same thing.

Key exploration Area 5: Social support (non-professional)

One question was relevant from the survey:

1. *Do you obtain emotional or practical support from any of the following types of people? Please select all that apply.* 67% reported receiving it from family and friends. 14% reported receiving it from other community members. 9% did not have any of these people to discuss weight with. 5% would not feel comfortable talking about weight.

Relevant themes from interviews and focus groups:

1. *People with strong social support networks can be more successful at achieving weight management goals*
   The role of support from family friends was almost universally agreed on. Help can be provided in terms of company exercising, meal planning and eating together or simply providing encouragement or accountability. Mental health support was seen as critical and related. For women, help with childcare from the social circle was important. There were also several references to community-based support from people they trust and recognise, and can understand their challenges within the context of race, identity and culture.

   007 (Female 41-50) - Child care! Companionship and encouragement will give me more confidence to go places with them. There are no creches in gyms, early morning, evenings, and weekends.

   008 (Female 31-40) – We need more kind of exercise groups or health awareness of groups that are… similar to my culture… with… like-minded people who you know would understand the way that we eat and stuff like that.

   017 (Female 18-20) - What they could do is help me in terms of my mental health and trying to support me.

   Focus group - But if you've got a partner that's supportive, that is prepared to join you to go out exercising… eat the way that you want to eat and join you with that so that you're not on your own, that makes a difference.

Key exploration Area 6: Professional support

Two questions were relevant from the survey:

1. *How have you felt about your experiences accessing a health care professional about weight management in the past?* 29% reported not accessing support. 25% reported generally positive experiences. 16% reported generally negative experiences. 10% reported not knowing they could access weight management support from a health care professional.

2. *It makes a difference if my healthcare professional understands issues relating to my race/culture when providing weight management support.* 88% strongly agreed or agreed.

Relevant themes from interviews and focus groups:

1. *Having 'culturally sensitive' healthcare professionals helps engagement in services.*
   There was unanimous agreement that having healthcare professionals that understand the community would be significantly helpful. There were also arguments for professional support that is embedded in the community rather than accessing, for instance, GP surgeries where it is felt they either do not have enough time to help them, or simply to do not understand them.

   Focus Group: Also there is a relationship between stress and the battle with a healthier lifestyle… but yet as soon as you go to the doctor, you'll be put on anti-depressants and locked in that cycle as well.

Focus group - When you go to these classes, like Weight Watcher's, they're run by white people telling you about white diet, which is not the stuff that you're eating at home.

Focus group - But don't be just relying on the state or school or the NHS and others who generally don't have our real interests at heart… We're really causing ourselves a lot of conflict, a lot of pain. Hey, you know, if we can have clarity, clarity leads to harmony, and hopefully harmony leads to peace and a decent way for me.

Focus group – What is needed is a totally different level of understanding in terms of how our bodies work, and how we see our bodies as black people. Like going to an African-centred counsellor, as opposed to one that's a European counsellor.

005 Female (51-60) - It would help if my professional healthcare professional would understand issues relating to my race and culture and our historical experiences with food or lack of food and this co-dependency on food as a crutch, a safety net or a companion.

010 Male (61-70) - The Chinese and the Indians, they all have their own talents, their own communities, and so on. But we're just pleased to, I suppose get by, or one or two of us will make some form of success.

017 Female (18-20) - When I had my diet plan given to me, it wasn't food that was accessible in my house. It was very British centred. I couldn't get what they wanted me to eat to like. It was a very small chips and cod, and we don't eat that in my house at all.

019 Male (51-60) - They do need to do a lot more research and have a great deal more understanding about us.

Participant Recommendations

Throughout the focus groups and interviews, participants inferred examples that could help encourage and support weight management:

- Taking a holistic approach to understanding and education about the black mind and body.
- Providing professionals and 'health champions' that look like the community in terms of race and culture (with gender being less important).
- The use of CBT and other psychological frameworks that have been successful for some in the past.
- Peer-to-peer support and increased conversation across the community including discussing the link between weight management and racism.
- Raising awareness about weight management through a range of media including animation, music, film, documentaries, exhibitions and websites

Specific recommendations were also made, broadly falling into two categories: education/ awareness and professional support.

Education/ Awareness

005 (Female 51-60) Through Animation, Music, film, documentaries, books, exhibitions, websites, apps, blogs and vlogs, award ceremonies on healthy history, etc…… lots more… all accessible to wider mainstream media and education establishments to re-educate.

009 (Female 18-20) The council and black awareness groups should have black health ambassadors; all the radio stations should give out regular public awareness messages for black people to access healthy weight services.

012 (Female 31-40) So I think promotional campaigns that are and rooted in the way that we communicate and our culture will probably grab attention more and make me think more about it.

015 (Female 18-20) advertising, we advertise in posters maybe in the community, youth clubs, having like, just that information available.

016 (Female 18-20) the media, particularly advertisements and stuff like that. I think there are a few of those on telly now, but they could be more prevalent.

0010 (Male 61-70) At the end of the day, we have to read more ourselves, we need to educate ourselves more we need to look at our health, a lot more than we do, from a holistic point of view. Realising that, yes, you know, we can do a lot. We put trust in a society that doesn't really care about us deeply.

Professional Support

> *005 (Female 51-60) The improvements from healthcare professionals, would be to find out more about my background, my culture, what I eat. Where do I get my food from? How do I cook my food? Spend more time… invest in, and believing in me, rather than just to refer me to say for example, a gym where you only have one hour with a strange person who knows nothing about you or your motivations or your emotions or anything*.
>
> *016 (Female 18-20) All doctors and healthcare professionals should know about those issues because they can give advice that is specific… Someone I know has visited a doctor for this kind of thing and because they knew what kind of food they eat they were able to offer healthy alternative, like to palm oil… they can suggest meal plans and stuff that might be more… with food that person is likely to have.*
>
> *020 (Female 51-60) It would help if the NHS understood your food and culture then they wouldn't have to spend too much time explaining or trying to go through your diet they can give you some do's and don'ts that would be good.*

General Discussion

Our study findings are not only insightful but consistent with lots of the existing literature. For example, the British Nutrition Foundation (2011) cited that some minority ethnic groups hold some conflicting traditional *e.g.* fat children are healthy and obesity is sometimes seen as a symbol of affluence and success. They also noted that older generations are more likely to follow traditional diets and less like to change habits than younger generations. They also described the level of heterogeneity in BAAC groups including summary level difference between and within people originating from Africa and the Caribbean. Across African traditional foods there can be higher consumption of starchy foods such as rice, plantain and cassava. Similar starchy foods are found across Caribbean cuisines along with higher consumption of high-sugar fruits and meats which are often heavily seasoned with salt-based products or high-fat products such as coconut cream. Both African and Caribbean communities are likely to include unhealthy cooking methods on a regular basis including the use of various high-fat oils for frying. Our studies show that in the absence of clear alternative guidance, people, particularly young people, are more inclined to opt for junk or take-out options. Further they suggest that the amount of disposable income available for families and individuals in minority ethnic groups to spend on food impacts on their dietary habits and the foods that they choose to eat. Work, study and childcare commitments (particularly for women) impacts the amount of attention that can be paid to planning and preparing healthy and affordable meals.

With respect to physical activity Koshedo et al. (2015) suggest that there is a disempowering effects of low socio-economic backgrounds on BAME people which can affect self-effectiveness, self-confidence and self-esteem. These can limit participation in health activities and result in people finding it difficult to identify and express their needs to health professionals. They suggest that this issue compounds over time and is therefore more prevalent in older generations.

There is a clear intersection noted between physical activity and mental health, wellbeing and identity. Robinson et al. (2020) reports a decline in mental health because of the COVID-19 crisis was predictive of greater overeating and lower physical activity in lockdown and that this was disproportionately affecting people with already higher BMI. The paper quotes other studies which have looked at the intersection between Covid-19, mental health and obesity. People are generally likely to report feeling more lonely, depressed and anxious since lockdown. With respect to obesity, difficulties accessing healthy food, lack of healthy eating motivation and control and lack of social support were all contributing factors.

Our 4 Behaviour Change Recommendations

Based on the insights gathered and the wider relevant research, this study suggests four summary-level behaviour change interventions. These recommendations are high-level only, and subject to further refinement (see later).

1. Improve holistic nutritional and physical activity education within the community

Although knowledge does not necessarily translate to behaviour change, awareness of healthy eating messages can impact on food choices. This information should come primarily from the community or community-based professionals rather than just GPs.

- Provide holistic support which takes into consideration nutrition, exercise, spirituality and culture.
- Develop healthy meal plans based targeted to dietary requirements, describing nutritional values based on traditional food types. It is important that educational programmes use the correct terms when understanding and educating about BAAC diets e.g. use of the terms 'plain rice' vs boiled rice.
- Embed physical activity opportunities into the everyday lifestyle of this community e.g. where they live, work and worship. This is in contrast to requiring members of the community to operate in unknown and uncomfortable spaces which might inhibit participation.
- Provide healthy weight measures that relate to the community ways of thinking e.g. levels of energy and mobility, waist/hip ratios or the ability to fit into specific clothing sizes.
- It is important to apply cultural sensitivity in the design of physical activity programmes e.g. allowing for culture or religion-specific requirements e.g. matching the gender of leaders and participates or allowing women to adopt a flexible dress code. Accommodations for those with physical limitations should also be made, particularly for older groups.
- During community engagement, understand the lifestyles and household roles of different groups and target subgroups e.g. men and women; young people, adults and older adults. Meal and exercise planning should be based on family behaviours and increasing family support.
- To increase receptiveness, involve trusted and recognised community-based professionals from the same ethnic background to relate to and speak the language of the target group.
- Deliver interventions through existing social structures of a community (e.g. schools) to reduced accessibility barriers.

2. Develop promotional awareness campaigns that reflect the community and their traditions

- Create large scale promotion campaigns to drive awareness of the links between obesity and risk factors in the traditions of the community (e.g. music, language, visual images). A range of media should be used including film, documentaries and social media content.
- Include recognisable role models to enable people to self-identify with the communications and increase self-confidence.
- Within the campaigns include details that reflect the motivational factors of this community e.g. being the best for their family, holding onto traditions but in a healthy way and looking good.

3. Provide cultural sensitivity training for health care professionals

- Deliver training for all health care professionals to provide them with skills, language and confidence to have difficult conversations about race with each other, and during interactions with the community. The training should include deep education about the wider BAAC and the sub-groups. This is critical if they are to be able to support the community with race-related weight management challenges.
- Provide additional training and support for BAAC health care professionals to increase wellbeing and engagement as well as provide tools to advocate on behalf of other BAAC professionals and the community.

4. Provide community-based mental health and emotional support programmes to support weight management

- Integrate mental health and emotional support into weight management initiatives to reduce these elements as barriers in making healthy food and activity choices. This might be achieved through fully integrated services or stand-alone/ supplementary services which are accessible to people seeking weight management support.
- Where possible, mental health and emotional support should be community-based and provided by either people from within the community, BAAC health professionals or other healthcare professionals who have a deep understanding of the combined mental health and weight management needs of the target group.
- Mental health and emotional support inputs should include options that are based on African and Caribbean-centred approaches.

Study evaluation

Positives

- The data collection approach was built on and corroborated against existing scientific literature. When published this study adds to the wider research body about the BAAC community; a research area which is significantly underrepresented.
- The study takes a community-based participatory research approach i.e. the study is led by a community-based organisation (Mabadiliko CIC) working directly with the community itself. This allows existing insights and relationships to be leveraged in the study design, analysis and recommendations.
- All participant targets for surveys, interviews and focus groups were met or exceeded. Our participants came from a wider range of age groups, allowing us to compare and contrast insights.
- This study was designed by a Qualified Behaviour Change Practitioner. This enabled a rapid analysis of the results within the time and resources available using an evidenced-based approach.

Challenges

- We planned to have a number of pre-selected partner organisations help with recruitment into the survey and interviews. Ultimately, only 50% of the original partners were able to recruit participants. Mabadiliko CIC was able to reach out to a wider network for support which allowed us to meet our targets. However this created additional work and a time delay in completion of the interviews.
- Interview participants were invited to take part in focus groups. Initial volunteering was lower than expected. This was mitigated by my direct recruitment which enabled us to achieve our goal, however this created additional time pressure when organising the focus groups and completing the analysis activity.
- This study would have benefited from having more male participants.
- The existing study scope did not allow for detailed intervention design or development of an evaluation approach.

Suggestions for refinement of recommendations – detailed intervention design and evaluation plan.

As noted above, fundamentally this study is about behaviour change. As recommendations are considered for implementation (i.e. recommendations provided within this report or from any other commissioned research and insight studies), we strongly suggest providing resources to ensure detailed intervention design using an evidence-based behaviour change model. Examples include the MINDSPACE frameworks developed by the Behavioural Insights Team UK (Dolan et al., 2012 and Behavioural Insights Team, 2014). However, we would recommend using the Behavioural Change Wheel approach (Michie et al. 2014) which emerged from the Health Psychology field and provides a systematic approach to intervention design and evaluation. Further, key to the success of any behaviour change programme is a robust approach for evaluation. Following the detailed design of interventions, we recommend taking a co-creation approach to develop (and deliver) a robust plan to evaluate outcomes on the target community.

General points

- This study, along with other reviews, have identified gaps in in the weight management research for BAAC people (as well as other public health challenges). We recommend wider research to investigate the barriers and facilitators of physical activity among adults and older adults from African descent. This should use the community-based participatory research approach, where members of the community or representative organisations such as Mabadiliko CIC are directly involved in the research and intervention design process.
- In the design and implementations of any intervention, it is important to remember that the BAAC community is not homogenous. Interventions will need to be targeted for various sub groups as one size will not fit all.
- Commissioners should continue to collaborate with other agencies or groups to increase the funding for research and intervention design. This must also include appropriate funding to evaluate the success of outcomes.

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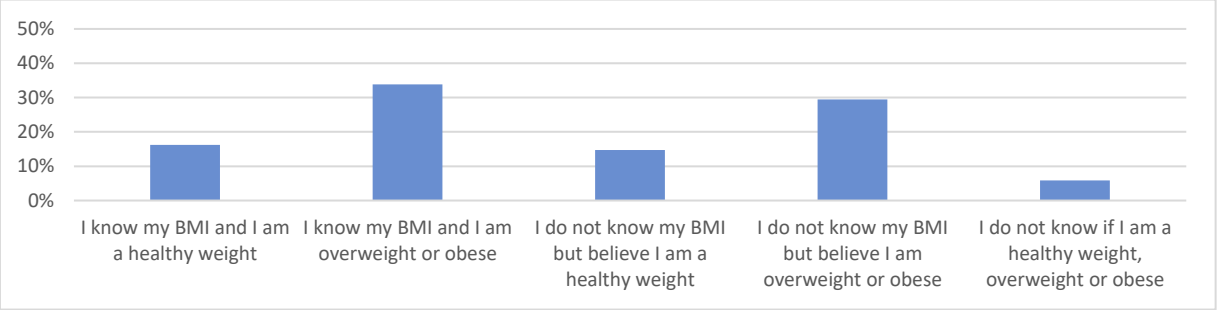
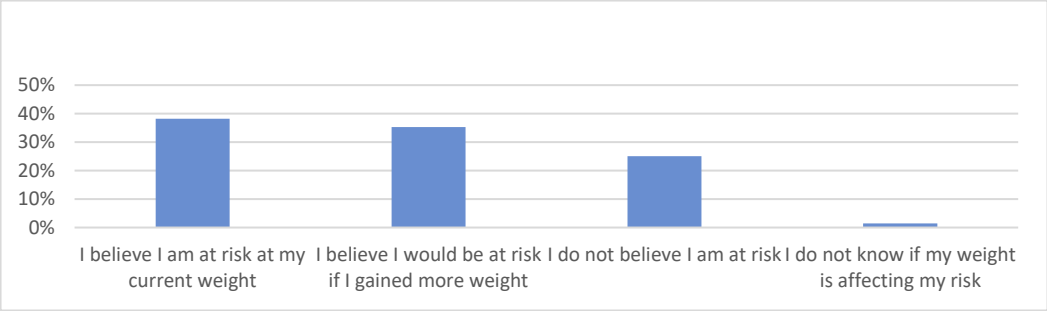
Appendix 1 – Full Survey Data

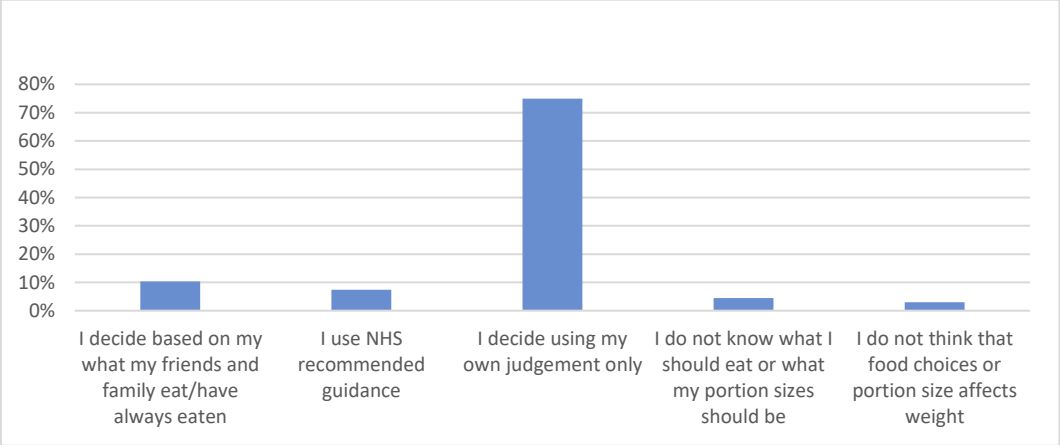
Do you perceive yourself to be a healthy weight, overweight or obese?



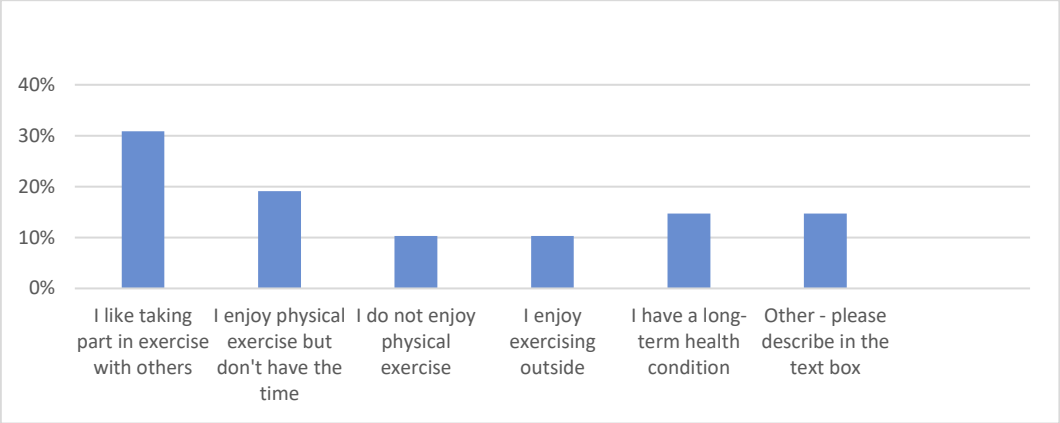
Do you think you may be at risk of health conditions?



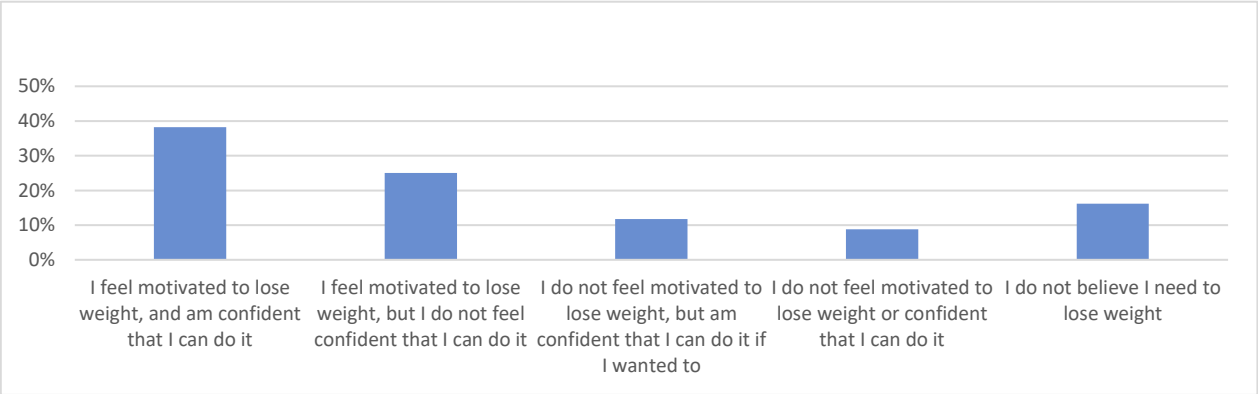
How do you decide what food and portion sizes to eat?



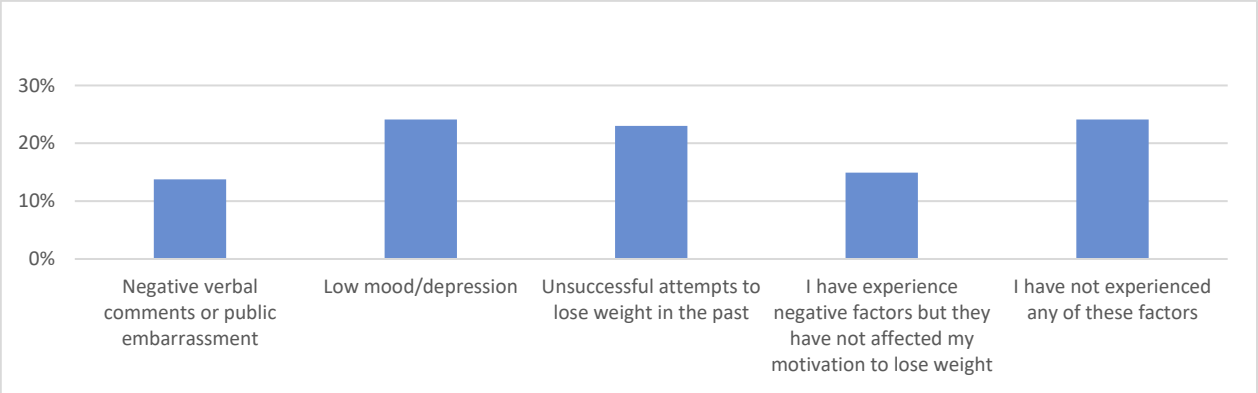
What influences how physically active you are?



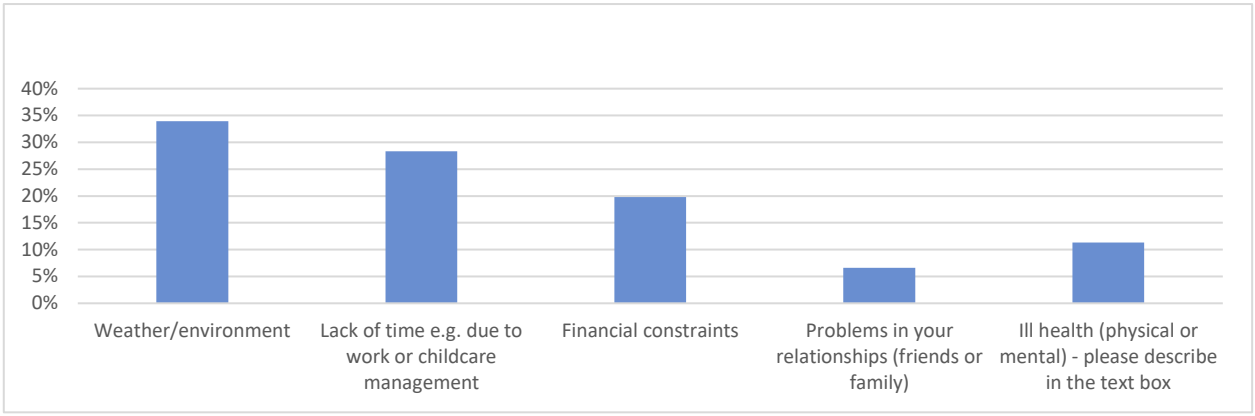
How motivated and confident do you feel about losing weight?



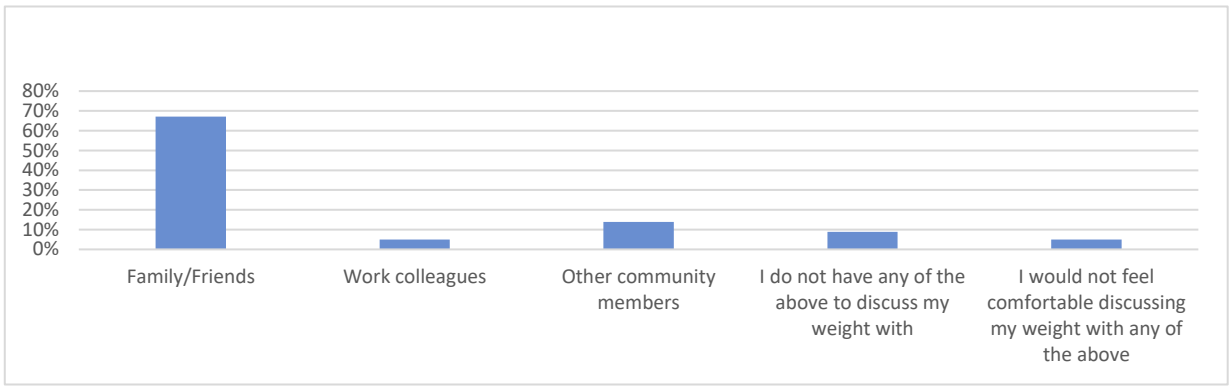
Have any of the following factors negatively impacted your motivation? Please select all that apply.



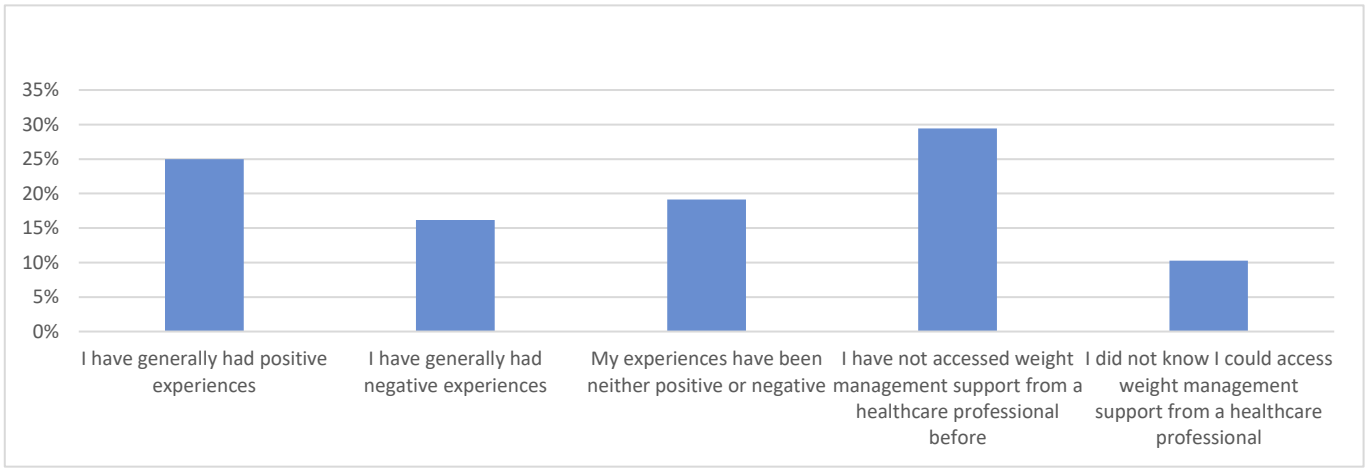
Do you feel that any of the following are barriers to you losing weight? Please select all that apply.



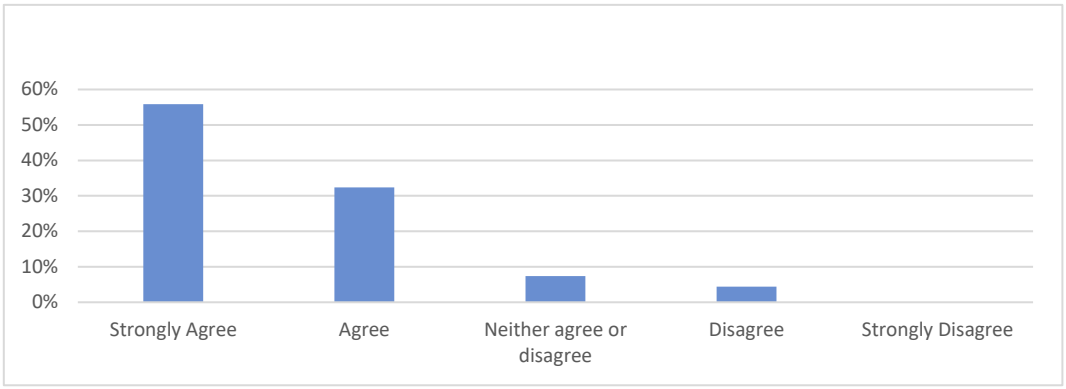
Do you obtain emotional or practical support from any of the following types of people? Please select all that apply.



How have felt about your experiences accessing a health care professional about weight management in the past?



It makes a difference if my healthcare professional understands issues relating to my race/culture when providing weight management support.


60%
50%
40%
30%
20%
10%
0%
Strongly Agree
Agree
Neither agree or disagree
Disagree
Strongly Disagree

Appendix 2 – Interview Guide

Interviewer Name:

Participant ID:

Interview format (e.g. Zoom), date, start time and end time:

Consent form completed and received by interviewer? (Y/N):

Interviewer Opening remarks:

- Thank you for agreeing to participate in the interview phase of the Obesity Insights Study. My name is <insert> and I work for <insert >
- As you will have read in the consent form, this study has been commissioned by Public Health Lewisham and is being delivered by Mabadiliko CIC with the support of various partner organisations.
- The purpose of the study is to help Public Health Lewisham better understand the perspective of Black African and African Caribbean (BAAC) adults about existing barriers and motivations for maintain healthy weight.
- In this session I will ask you some questions which build on the survey you have already completed so that we can understand in more detail the key focus areas of the study.
- The session should take between 60 and 90 minutes during which I will work through the questions in an interview guide. It is important that I work through the questions in the correct order. If we start to discuss an answer that relates to a later question, I may ask you to pause so that we can we come back to your answer.
- This interview is being recorded to allow me to transcribe it when we have finished. As we work through the interview you may notice me taking notes. These are purely to help me remember key points from the conversation that I can refer to when I listen to the recording. I will also share the questions on the slide.
- All of your data will be anonymous and deleted when the study is completion. You are free to withdraw from the study at any time without providing a reason. Is the information I have just described clear?
- *Interviewer proceeds with interview – see page 2 for Semi Structured Interview Guide.*
    - Feel free to ask 1-2 probing questions including clarifying that they have understood the question.
    - Make sure you can hear the interviewees are audible for the recording
    - Give them time to answer, be ok with the silence!

Interviewer Closing remarks:

- We have now completed the interview, I would like to thank you again for your participation.
- In terms of next steps, your interview, as well as other interviews completed in this study, will be transcribed and analysed by the team. Ultimately our analysis will form a recommendations report for Public Health Lewisham.
- As a reminder, all of your data will be anonymous and deleted when the study is completion. You are free to withdraw from the study at any time without providing a reason.
- We will also be running further focus groups which will complete the final phase of our information gathering. The focus groups will last between 1.5 – 2 hrs. Would you like to register interest in taking part in a focus group?
- Do you have any questions before we conclude the session?

Semi-structured Interview Guide

Theme	Questions	Observations – including non-verbal
Self-awareness	• Do you feel that you need to lose weight? • How do you decide/know if you are in a healthy weight range? • How important is it to you to know your BMI? Include a BMI definition for the team. • Why do you think diabetes, obesity, high blood pressure, stroke, heart disease high cholesterol are prevalent in the Black community? • How do you think we could raise awareness of links between weight these health problems?	
Food choices	• What are your culture's/ community's attitudes towards food choices and portion sizes? • How does your culture's/ community's attitude affect your own food choices and portion sizes?	
Physical Activity	• When you are making decisions about whether or not to exercise, what sorts of things influence your decisions?	
Psychological factors	• When you hear the words "overweight," or "obese" what different kinds of things come to mind? • How do you think the descriptions increase or decrease motivation to lose weight? • Are there any other descriptions that would be better than "overweight," or "obese"?	
Behavioural Capability	• What increases and decrease your motivation to manage your weight? • Have you ever tried to manage your weight in the past? What has made you successful or unsuccessful? • What increases or decreases your confidence in your ability to manage your weight?	
Social Support (non-professional)	• Do you people in your social circle think you would benefit from losing weight? • What support do you believe your social circle could provide if you decided you wanted to lose weight?	
Professional Support	• Have you ever had help from a healthcare professional or weight loss programme to lose weight? • What improvements could be made to the support provided by health care professionals? • Does it help when your healthcare professional understands issues relating to your race/culture?	
Practical Considerations	• Is there anything else that affects your ability to manage your weight like time, finances or physical capability.	