BACKGROUND

From 2000 to 2010, the Bangladesh population in NYC experienced a 119% increase in size, growing from 28,269 to 61,788 individuals. Although the prevalence of diabetes among Bangladeshis has been well documented in Bangladesh, few studies have documented prevalence rates and management practices among US Bangladeshis. Several community-based samples of Bangladeshis in NYC report prevalence rates in the range of 17.25%, as compared to 10% for non-Hispanic whites. The DREAM (Diabetes Research, Action, and Education for Minorities) Project is an NIH-funded study to better understand the diabetic management practices of this particular community using a community-engaged research approach through employing community health workers (CHWs). Preliminary data collected through the interviews revealed low rates of participation in physical activity among study participants, often coupled with high rates of reported stress and anxiety.

The purpose of this study is to better understand the barriers to and facilitators of physical activity and stress management in the Bangladeshi community in order to improve and enhance an existing CHW intervention to address disparities in diabetes prevalence and management.

METHODS

IRB approval for the qualitative sub-study was obtained in August 2012; all participants provided written consent prior to study participation. Participants were purposively recruited from community-based settings using word-of-mouth and snowball sampling methods. Six focus groups were completed with a final sample of n= 67 participants (63% male, 37% female). Mean participant age was 42 years old; Mean years of residence in the US was 12. Each focus group consisted of 10-12 participants. A monetary incentive of $30 was offered to respondents in exchange for their participation. Gender-specific focus groups were conducted in-language by trained group moderators, using an instrument that had been previously piloted to ensure saliency and cultural meaning. The moderator guide included topics on obesity, physical activity, social stressors, acceptable strategies for health promotion, and motivation to participate in CHW interventions. Focus groups were audio-recorded for later translation and transcription. Transcripts were reviewed and coded by study investigators using a constant comparative approach. Atlas.ti was used to facilitate data coding and retrieval. Coding Analysis Toolkit (CAT) was used to ensure inter-coder reliability among study investigators.

RESULTS (continued)

40% of females and 50% of males did not meet recommendations for weekly physical activity based on self-report.

Gender differences and lack of access to resources had the highest frequency count for barriers to physical activity (23% and 19%, respectively), while denial/cash-in-hand and education had the lowest frequency count (4% and 4%, respectively).

“as many women they can not go outside walk like freely like others than our culture, you know, so our cultures women like most of the time they don’t try to go outside and like free like other womens, that’s the one big problem.”
- Male, on Gender Barriers to Physical Activity

“I actually think that for a few related reasons [I] cannot go to the gym because sometimes it can be seen that there is no gym for only women, that we can’t find. That’s why we can’t go. But next to my house, especially because of my work, I cannot find CHW who wants to go to a gym. Meaning that I will go outside and go to the gym, that thing I cannot do. And plus because of our Muslim country, that we will go outside and go running. These things we cannot do. Because of that, mostly in my case, those things are not done. Exercising that way doesn’t happen.”
- Female, on Lack of Access to Resources for Physical Activity

CONCLUSIONS

Qualitative results suggest a need for culturally relevant interventions that address participation in physical activity using approaches that are sensitive to key cultural, faith- and gender-based norms. Additionally, the prevalence of common stressors such as family dynamics affecting participation in physical activity illuminate the importance of enhancing education around stress management in the existing CHW intervention.

REFERENCES


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