ABSTRACT

Objective: To develop a conceptualization of cultural influence on perceptions of a rural food and physical activity policy, systems, and environmental (PSE) change project to inform public health research and practice.

Design: Basic qualitative research design, semistructured phone interviews with community health coalition members.

Setting: Five rural Southern counties (obesity prevalence > 40%).

Participants: Thirty-nine community coalition members.

Intervention: The Centers for Disease Control and Prevention High Obesity Program. PSE initiatives to increase access to healthy food and physical activity opportunities through a community coalition model.

Phenomenon of Interest: Social norms and cultural influences surrounding community members’ food preferences, physical activity behavior, and future hopes for community development.

Analysis: Abductive content analysis.

Results: Major categories on food social norms (subcategories: physical health, eating habits, and food preference), race relations, generational factors, physical activity social norms, and hopes for the community (subcategories: increased engagement, health, awareness, cohesion, and inspiration) were discussed in relation to the progress of PSE initiatives.

Conclusions and Implications: Because of community member perceptions, PSE initiatives became associated with factors beyond food and fitness, such as race relations, generational differences, and community cohesion. A focus on increased youth and church involvement, community values, relationship building, and input from diverse voices can be foundational to culturally-appropriate PSE efforts in rural settings.

Key Words: eating behavior, physical activity, culture, social norms, obesity (J Nutr Educ Behav. 2023;55:255–265.)

INTRODUCTION

Obesity is 1 of the most challenging and unyielding societal health issues of our time. Currently, more than 40% of US adults are obese, with greater prevalence among middle-aged and older adults, African Americans, people of Latino/Hispanic ethnicities, and individuals living in rural communities.\(^1\) Reason for such disparities is not entirely clear and, therefore, is difficult to address. For example, studies have demonstrated an inverse relationship between obesity and lower socioeconomic status, but the relationship is likely related not only to economics but also discrimination, lack of health knowledge, and other cultural factors.\(^2,3\)

Cultural differences and expectations, including norms around physical activity and body size, may influence obesity disparities and response to interventions.\(^4,5\) Recognizing obesity is multifactorial and complicated in etiology, many public health researchers and practitioners have shifted from focusing solely on individual education and behavior to a socioecological perspective that recognizes individual behavior is influenced by social, cultural, political, and physical environments.\(^6,7\)

Some of the largest funders of obesity-related research and public health initiatives (Centers for Disease Control and Prevention [CDC]; the US Department of Agriculture [USDA], Food and Nutrition Services; and the Robert Wood Johnson Foundation) recommend multilevel interventions to address individual
education and behavior alongside policies, systems, and environments (PSE) in which people live, work, and play.8–11 Approaches to nutrition and physical activity behaviors specific to PSE have been moderately successful,7,12 but there is much to learn about what determines if these strategies are successful across diverse communities. Policies, systems, and environmental interventions designed to address obesity within rural areas remain particularly challenging because of resource constraints and environmental factors that contribute to obesity.13 People in rural communities have less access to physical activity opportunities, nutrient-dense food, and health care. Furthermore, geographic spread, lack of public transportation, and an aging population challenge PSE strategies to address these deficits.13–15

Rural communities, while similar in their geography and population density, are quite diverse in other ways, particularly in culture. Other than adapting interventions for language and traditional foods, there is a paucity of research on how culture influences the effectiveness of health intervention strategies, particularly in rural communities in which cultural identity intersects with place identity16,17 and impacts obesogenic behavior.13 Social and cultural norms, and their relationship with the built environment, may influence whether community members use available community resources.8

Limited evidence suggests positive equity impacts of nutrition interventions when using culturally-responsive approaches. However, there is a need for additional research examining the equity impacts of culturally-responsive nutrition interventions.17 Specifically, more research is warranted on obesity and cultural factors that may moderate or interact with PSE interventions to contribute to racial, socioeconomic, and geographic obesity inequity.14,17

Culture and Public Health Practice

For this study, culture refers to localized values and beliefs of a specific group or community,19 as well as shared meaning and mental representations that comprise an overall system of ideas.20 Under this definition of culture, community beliefs, values, and concepts serve as the invisible foundation of observable behaviors and customs.21 Exploring culture from this frame enables public health professionals to move away from memorizing traits and practices related to cultural patterns of behavior and move toward understanding the worldviews that influence the behavioral decisions of members within a specific social group.22 In addition, cultural identity is not static; rather, it is dynamic and continuously changing.21

Many elements of culturally entrenched diets associated with obesity, such as those in rural areas, have significant socioeconomic and historical underpinnings.14 However, dominant conceptualizations of healthy eating practices often ignore the cultural histories and contributions of nondominant groups.19 Thus, community members may not welcome health initiatives encouraging food access and physical activity if they counter their cultural schema. Not properly integrating cultural worldviews into evidence-based interventions can lead to using interventions as a mechanism of forced assimilation to a dominant cultural paradigm,23 limiting the efficacy of the intervention across cultural groups and risking perpetuating inequality within health-promotion interventions.24

Progress with public health initiatives may also be hindered by health and body size definitions on the basis of the priority population.25 For example, in previous research, African American women identified the medical definition of an overweight body image as culturally acceptable and a healthy weight.26 Similarly, in another study, Latina women made accurate judgments about their body size and body mass index, but none perceived themselves as having a health risk, despite 58% of the sample being overweight or obese by medical standards.27 Thus, there is a conflict between biomedical standards of health and cultural standards across different communities.2

Empirical explorations of culture provide a more holistic view of the health behaviors of those who live in a specific location or identify with a specific racial or ethnic group. They also help with interventions to understand factors influencing the development of desired health changes14,16.

This research aimed to develop a conceptualization of cultural influence within a rural food and physical activity PSE change project to inform public health practice. Research questions guiding the study were as follows:

In what ways do participants describe social norms and cultural influences on eating behaviors and food preferences in the community?

In what ways do participants describe social norms and cultural influences on physical activity behaviors in the community?

How does culture influence what participants want to gain from a PSE change project and the community?

METHODS

The population of interest was participants of a CDC High Obesity Program (HOP) project in Georgia designed to increase healthy food availability and access to safe physical activity opportunities (eg, walking trails) in 5 rural Georgia counties in which adult obesity prevalence exceeds 40%.26 The CDC HOP partnerships work with land-grant universities to collaborate with local Cooperative Extension services to increase healthy food access and spaces for physical activity.27 The program is a partnership between the CDC, University of Georgia (College of Public Health, College of Agricultural and Environmental Science, College of Family and Consumer Science, College of Environment and Design, Cooperative Extension Service), and community coalitions in each of the 5 counties.27 Characteristics of each county are presented in Table 1.

All aspects of the project were community-directed through established community coalitions, defined as groups of community leaders who come together to achieve a common
goal and have decision-making power within a community-based initiative. Community coalitions were recommended as a program structure by the CDC to increase community relevance and participation in local food and physical activity interventions. Coalitions were formed in the first year of the project (2016 for 2 counties, 2018 for 3 additional counties added after the 2016 pilot project). Coalition members have been involved in project planning since the project’s inception. However, the coronavirus disease 2019 (COVID-19) pandemic caused significant meetings and project progress disruptions. Some coalition meetings were held via Zoom (Zoom Video Communications, 2020) when there was access to internet connectivity, and while projects were delayed, the CDC allowed for flexible use of funds and measures of reporting impact to account for disruptions because of COVID-19. Although originally, data collection would occur using focus groups, data were collected via telephone interviews because of limited internet availability in the counties to host Zoom focus groups.

Participant Recruitment

Individuals who participated in 1 of the 5 community coalitions at least twice between 2018 and 2020 and provided contact information (n = 79) were eligible to participate in the study. There were no exclusion criteria. Beginning in May 2020, potential participants were recruited via a telephone call by a research team member up to 4 times to participate in phone interviews lasting approximately 45 minutes. Three graduate research assistants conducted the interviews using the same semi-structured protocol. The interviewers participated in training by the project’s lead evaluation faculty member before the interviews. Thirty-nine unpaid individuals agreed to participate with all 5 counties represented. All methods and procedures were approved by the University of Georgia Institutional Review Board, which deemed the study of human subject measures exempt. Participants, all adults, provided verbal informed consent before engaging in the interview.

Data Collection

Interviews were conducted via phone, recorded, and transcribed by a third-party transcriptionist (Rev.com). The semi-structured interview protocol included 20 open-ended questions to assess the history of the community; community member’s role in the coalition; the impact of COVID-19 on the community and the coalition; changes to physical activity opportunities, nutrition policy, and healthy food access; community acceptance; and community members’ ideal vision for what the coalition can accomplish in the next 3 years (interview protocol available on request). Interview questions were developed through the lens of appreciative inquiry; an evaluation approach focused on understanding the best of what a program has to offer or its successes in generating positive development and sustainability for the program. This approach was chosen because of the need to enhance community rapport and the desire to empower the ongoing and future efforts of the community, rather than entering in as evaluators focused on weaknesses of the program, which could have inhibited participation and response rate. Questions were developed collectively by a committee of social scientists, specifically 2 agricultural communication and program evaluation professors, 1 family and consumer sciences professor specializing in nutrition and health, and a science communication and program evaluation graduate student. Cooperative Extension educators who worked in the counties with community coalitions reviewed the interview guide before the start of the interviews for face and content validity.

Data Analysis

In place of using numerical values to quantify research findings, the current study used a basic qualitative research design on the basis of categorical thinking to generate descriptions from participant voices. Data were analyzed inductively using content analysis through MAXQDA software (version 20.2.2) to determine overall gestalt and identify categories that related to patterns in the data.

### Table 1. Demographic Information for High Obesity Program Counties Represented in Study

<table>
<thead>
<tr>
<th>County</th>
<th>SNAP Benefits&lt;sup&gt;28&lt;/sup&gt;</th>
<th>Race&lt;sup&gt;29&lt;/sup&gt;</th>
<th>Below Poverty Line&lt;sup&gt;29&lt;/sup&gt;</th>
<th>Physically Inactive&lt;sup&gt;28&lt;/sup&gt;</th>
<th>Food Insecure&lt;sup&gt;28&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Southwest)</td>
<td>25</td>
<td>White (32) Black (61)</td>
<td>33</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>2 (Southwest)</td>
<td>38</td>
<td>White (37) Black (60)</td>
<td>40</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>3 (Southwest)</td>
<td>19</td>
<td>White (42) Black (48)</td>
<td>24</td>
<td>27</td>
<td>29</td>
</tr>
<tr>
<td>4 (Southwest)</td>
<td>21</td>
<td>White (26) Black (44)</td>
<td>41</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>5 (Northeast)</td>
<td>32</td>
<td>White (37) Black (56)</td>
<td>31</td>
<td>29</td>
<td>24</td>
</tr>
</tbody>
</table>

SNAP indicates Supplemental Nutrition Assistance Program. Data included to show percentage of county populations receiving food assistance benefits.

Note: Values are presented as %. Data from The Institute for Health Metrics and Evaluation (IHME) and US Census Bureau QuickFacts for each county. URLs were not provided to retain the anonymity of the counties in the study.
Abductive coding, an iterative process involving a combination of inductive and deductive reasoning, was then used to confirm initial categories on the basis of the data and an in-depth review of the data.36 Two doctoral-level graduate students served as coders and relied on research coursework taken specifically for qualitative inquiry. Data were analyzed by the coders using open coding, followed by axial coding, in which the researchers made connections between codes derived from the open coding process.37,38

Interrater reliability was conducted to establish a code development agreement before the analysis began.39 Analysts calculated interrater reliability after coding 2 sets of identical interviews, resulting in Cohen’s kappa of 0.19 (low agreement) for 1 set and 0.70 (moderate agreement) for the other set. After meeting to determine convergences and divergences in the coding process, each analyst coded a third transcript resulting in a Cohen’s kappa of 0.63, indicating moderate agreement. In addition to the third rating being deemed adequate according to literature,40 further interrater reliability was not conducted because analysts agreed to continually update a shared codebook after full analysis began. In addition, a discussion of findings, including which codes were similar and which warranted a separate thematic category, occurred throughout the analysis process.38 Data saturation was reached by asking interview participants, who played multiple roles in the coalition, the same questions, targeting openness in data collection to allow the researchers a broader understanding of the phenomenon.41 Data triangulation also assisted in data saturation assessment, with multiple researchers coding the data, complementary to their prolonged engagement in the field.41,42 Trustworthiness for data analysis was established in accordance with Lincoln and Guba42 and Nowell et al.13 Table 2 outlines the trustworthiness methods used in this study.

### RESULTS

Based on the following demographic options provided to coalition members to self-classify, the participant group (n = 34) was represented as follows: 44.1% female, 52.9% male, 61.8% White, 29.4% Black/African American, 0.2% of Asian descent, 0.2% identified as White and Native American, and 0.2% preferred not to answer. Participants represented all 5 counties involved in the project (County 1, 35.9%; County 2, 7.7%; County 3, 12.8%; County 4, 15.4%; County 5, 28.2%). The interview protocol did not include a question about how many years participants had lived in their current county. However, some participants voluntarily and informally provided that information as they responded to interview questions. For those who provided such information, community membership varied and included lifelong residents (n = 3), recent residents (who moved to the community in < 10 years) (n = 10), and those who left the county and returned (n = 7).

Table 3 provides an overview of the 5 categories and 6 subcategories generated through the content analysis approach. All counties are represented in the table through sample quotes. The following sections present an overview of the categories developed through the content analysis.

#### Sociocultural Influences on Eating Behavior and Food Preferences

Three categories were identified within participant descriptions of sociocultural influences on eating behaviors and food preferences: social norms, race relations, and generational factors.
The most prominent category was social norms, broken into 3 subcategories. The first subcategory was social norms for physical health, capturing physical health and body image perceptions within the community. Participants identified a “tendency to be an obese community” (County 5, female), though the project “help[ed] the community to have healthier food and [change what] they see in their bodies” (County 3, male). Another subcategory was social norms for eating habits, which described the distancing from the community’s agricultural roots and history of cooking at home to a preference for quick service and fast food, patterns of healthy and unhealthy eating, and changes in healthy food consumption as a result of the project. Social norms for food preference described community members’ desires for certain traditional Southern produce (eg, collard greens, tomatoes, squash, and okra) despite the produce variety grown in the community gardens. Produce like kale and eggplants, not part of traditional cuisine in the communities, were underused by community members. Participants noted lack of grocery stores and availability of convenience and dollar stores shaped social norms of less nutritious foods as preferred and acceptable food:

<table>
<thead>
<tr>
<th>Categories and Subcategories</th>
<th>Representative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food social norms&lt;sup&gt;a&lt;/sup&gt;</td>
<td>“We just didn’t think about the general health needs of our whole community, as far as staying healthy. A lot of times when you see it all the time, you don’t realize it until somebody from the outside points it out to you.” (County 3, female)</td>
</tr>
<tr>
<td>Social norms for physical health</td>
<td>“Over the last 30 years, everybody’s gotten away from [growing their own food]... [community gardens and healthy cooking classes] help people get their mind back on... doing things their self and what they can do, rather than just walk across the street and pick up a bag of chips... “ (County 2, male)</td>
</tr>
<tr>
<td>Social norms for eating habits</td>
<td>“I’m not joking, you plant anything you want, but if you don’t have collards, they don’t want to come to the gardens.” (County 5, male)</td>
</tr>
<tr>
<td>Social norms for food preference</td>
<td>“We’re [the White community] more flexible... we can just go to a big grocery store. Or we’re so busy, we just open a can. [The Black community] tend[s] not to do that and they would rather have the fresh vegetables... because culture probably started it and you’ve kept that and now the access is not there.” (County 4, female)</td>
</tr>
<tr>
<td>Race relations&lt;sup&gt;a&lt;/sup&gt;</td>
<td>“Again, a lot of that goes back to generational poverty, because down here you learn to cook by what your parents or grandparents cook, and that’s how you cook and then your children learn that from you.” (County 1, male)</td>
</tr>
<tr>
<td>Generational factors&lt;sup&gt;a&lt;/sup&gt;</td>
<td>“We have a lot of sedentary people in our community.” (County 3, male)</td>
</tr>
<tr>
<td>Physical activity social norms&lt;sup&gt;b&lt;/sup&gt;</td>
<td>“If we can get our churches involved, we got a whole lot of people. Because a lot of people are going to listen to the pastors before they listen to anyone else.” (County 1, female)</td>
</tr>
<tr>
<td>Hopes for the community&lt;sup&gt;c&lt;/sup&gt;</td>
<td>“[My hope is] that we’ve lowered the rates of diabetes and that we’ve lowered the rates of preventable cancers, that we have lowered the rights of dangerous hypertension, that we have improved the quality of life for our citizenry, that we’ve not only extended the life of our citizens by making them physically healthier, but that we’ve improved the quality of their lives, that the standard of living has improved.” (County 1, male)</td>
</tr>
<tr>
<td>Increased community engagement</td>
<td>“There have just been a huge number of initiatives that have spawned ideas and probably moved individuals to be more aware of healthy options and more healthy lifestyles.” (County 5, male)</td>
</tr>
<tr>
<td>Visioning a healthier community</td>
<td>“[The High Obesity Program is] an apolitical activity that I think, can bring people from a lot of different backgrounds together in a non-controversial way, that I hope would be positive.” (County 4, male)</td>
</tr>
<tr>
<td>Increased awareness of healthy behaviors</td>
<td>“So, I feel like if people see what we’re doing here, we can be an influence on them and they’ll also want to do this.” (County 3, female)</td>
</tr>
</tbody>
</table>

<sup>a</sup>Research question [RQ]1 results; <sup>b</sup>RQ2 results; <sup>c</sup>RQ3 results.
Food availability shapes food habits, behaviors, and preferences.

Race relations emerged at the nexus of race and food within the culture and history of each community and included expressions by White participants toward the Black community within the counties about food preferences and access, potentially revealing cross-racial perceptions between coalition members and noncoalition community members. Although there were non-White coalition members, for most of the county coalitions, members did not reflect the racial demographics within the county. Boundary drawing between communities through the lens of race within an interpersonal interaction in the garden was evident, such as community gardens being placed in areas that not all community members frequented or felt welcomed. Food purchase and consumption distinctions between White and Black communities were vocalized and possibly made more apparent to citizens affiliated with community garden initiatives.

Generational factors delineated perceived generational differences in eating habits, with younger individuals not eating as healthy and being more removed from their food source than older generations. Distinctions between younger and older populations’ eating habits were common. One participant described generational separations from the farm by noting,

“A lot of our younger population, they haven’t grown up where mama or grandmama go to the farmer’s market or go to the local farmer and get a bushel of peas and shell them. (County 3, male)

How individuals were taught to cook by elders was another factor that contributed to the cooking and eating habits passed down from generation to generation. Cultural practices like eating fresh tomatoes and cucumbers from the garden contributed to healthy eating behavior, whereas traditions of using fat back-to-season produce, like collard greens, contributing to unhealthy eating behavior.

Sociocultural Influences on Physical Activity

Few cultural influences were identified for physical activity, but participants described several influential social norms. They characterized their community as historically sedentary with few physical activity opportunities. For example, citizens chose to drive rather than walk, even for small distances, and those who desired to be physically active had to walk alongside busy roads or go out of town for gym access. Other participants explained that because of a lack of jobs in the county, many community members had long commutes to work each day which contributed further to reduced time to engage in physical activity. This represented an intersection between infrastructure barriers and sociocultural characteristics of the community. However, participants described the project as increasing opportunities for physical activity and changing norms, “...about a year and a half ago... people were jumping in their car to go just a block... [and now] they’re getting out and walking” (County 1, male). Participants also discussed future possibilities for activity, explaining the potential of parks as robust areas for physical activity and how the coalition focused on implementing walking trails and pathways as requested by community members.

Although there seemed to be progress in changing these social norms related to physical activity, such as walking clubs or groups participating in community yoga classes, participants also explained how the onset of COVID-19 disrupted potential physical activity opportunities, including sports tournaments, local exercise classes, and summer camps. Some community members were afraid to leave their homes, whereas others took advantage of outdoor spaces for socially-distanced exercise.

Shared Vision and Hopes for PSE Change and Community Development

Social norms and culture influenced how participants experienced the project and consequently developed hopes for the community relating to the next 3–5 years. Their hopes included increased community engagement, a healthier community, increased awareness about health-related topics, increased community cohesion, and a desire to inspire other communities. The focus for these hopes was shaped by the community’s social demographics, particularly age, race, and Southern cultural characteristics.

Related to increased community engagement, participants wanted fellow community members to see the value of change initiatives and engage with the project in meaningful ways. The need for committed volunteers and the observation that community efforts were put forth by small, homogenous groups of citizens were repeated sentiments from participants in all counties. Older volunteers (aged ≥ 50 years), who were given “an outlet when there’s nothing else to do... in a small community” (County 1, female), played a vital role in community improvement efforts. Meanwhile, youth native to the county left to raise a family elsewhere and only came back to the community to retire. Several challenges existed to community change efforts, including limited mobility of older volunteers and the lack of youth in some counties. Thus, making community change efforts relevant to younger populations was not only seen as an answer to sustaining project efforts but also to contributing to future generations that are healthier and more involved in the community.

Participants desired increased racial and socioeconomic representation within the community coalitions along with age diversity. Sociocultural factors repeatedly framed suggestions about how to increase community engagement. Participants spoke about the need to create gardens in lower-income areas and plant more crops that align with local food preferences influenced by geographic (eg, Southern dishes) and racial (eg, staple foods of the Black Community) factors. In addition, participants repeatedly alluded to the influence churches have on local culture and community involvement.
As sources of information, food access, training locations, and youth activities, churches bridged communication gaps with community members and compensated for the lack of internet access and computer skills in the counties.

Another hope expressed by participants related to visions for a healthier community. This area included desires for lower obesity rates, heart disease, diabetes, and cancer rates, along with an overall decrease in health concerns associated with body weight. Overall, participants hoped to see greater use of project initiatives (e.g., walking trails, gardens, park equipment) and increased life expectancy because of continued education and improved decision-making. Idealism for overhauling health in the community was balanced with pragmatism as members talked about how large-scale change takes time. This mental culture was mentioned several times, and participants embraced slow progress, changes not happening overnight, and the importance of starting somewhere and taking 1 step at a time in a rural community with limited opportunities.

Several participants described community-level increased awareness of healthy behaviors, specifically the observation that increased access to fresh produce through community gardens and healthier retail options significantly improved some community members’ awareness of health as a priority and introduced people to new food. Still, coalition members felt more was needed to create “a real longing to get out and [do] more, and be healthy” (County 4, male). In addition to tangible awareness, such as signs around town designating walkable miles, there was a hope that both youth and adults would be more conscious about attributing health issues to nutrition and physical activity behaviors. From the type of food served at social events to how gardening could help those with low incomes gain access to fresh produce, participants wanted health education to impact community members’ thought processes and behavior. However, participants also spoke about cultural barriers related to citizens’ resistance to change and the need to open people’s minds to the possibility that they can experience a different, healthier lifestyle.

The project also served as an impetus for improved social connection and increased community cohesion. Before the project, counties were “like a separate community” (County 4, male), with groups of people who did not actively participate or work collectively. Particularly, participants spoke of having 2 communities in 1, a White community and a Black community. A separation of racial and social groups was represented in descriptions of neighborhoods and places of worship. The history of the communities and their economic statuses impacted current population dynamics. One participant (County 4, male) connected these historical aspects to health observations by sharing, “...there’s still a lot of a hold over in terms of [a] very segregated community, not well integrated, and all that has an effect on people’s health and their lifestyle.”

Analytic codes for race in the community, race separation in town, and race and health described the influence of race on coalition participation. For some communities, the same, mostly White, small group of citizens were involved in project initiatives. Although some shared how members of the Black community assisted in many ways and were represented within the coalition, other participants thought Black community members might feel left out of larger HOP initiatives. Potential solutions to increase outreach and engagement with Black community members included more direct efforts to reach out to that particular community and integrate influential leaders within the project to get more Black community members involved in coalition work. This was especially true in counties in which Black citizens comprise most of the population.

However, participants spoke about their progress with community collaboration and goals for community change. For some communities, the project did more than help citizens with food and fitness; it served as an opportunity for racial groups to build stronger connections by coming together in ways they may not have done previously:

With this project going on, we seem to be having more Whites and more Blacks working together...more closely than we had in the past, and I think that’s a great thing and one of the best things that came out of it so far. (County 4, male)

All participants saw relationship building and the unique communal features of small, rural settings as avenues to break down silos, enhance communication, increase community engagement, and ignite change within and across county lines.

Beyond recognition for progress, research participants hoped that change efforts in their community would inspire other communities. Participants’ desire to positively influence other communities was rooted in an awareness of what their particular community offered. They knew their strengths, weaknesses, and culture:

When you’re a small town, you don’t enter into a lot of the things that the major cities have because you just don’t have the people or the facilities. And [you] don’t have the problems a lot of times either. So it works out well. (County 5, female)

Helping visitors and nonresidents of the county see what the community has to offer may encourage them to return and take advantage of those offerings and/or move to the community, possibly enhancing the sustainability of the community’s future. However, despite the small size and low population density, “that’s the way a lot of people in the town want to keep it” (County 5, female). The culture citizens valued and what they hoped others saw relates to factors such as the relaxed, slower-paced, low-crime atmosphere of their towns. Overall, the culture of the rural communities simultaneously exhibited areas of significant strength and potential barriers to behavior change.

**DISCUSSION**

The cultural and social norms represented within community coalitions that undergirded a nutrition and
physical activity PSE change project were explored. The findings implied the project goals evolved when diverse community voices were involved. Specifically, the initial goals of the intervention were designed to increase healthy food availability and access to safe physical activity opportunities. However, by inviting the perspective of community volunteers from different counties, the project unexpectedly became associated with goals pertaining to factors beyond nutrition and physical activity, such as race relations, generational differences, and community cohesion. If no input was garnered from asking community members open-ended questions, it is likely that information about cultural aspects related to nutrition education and exercise resources, which only the community members would know, would be unknown to outside researchers associated with the project. Not actively engaging multiple voices in a culturally-affirming way may present barriers to the evolution of a health initiative.

An interviewee’s race, age, and connection to their current county influenced their view of project goals and effectiveness. Diversity also played a part in the demographic makeup of each county, showing that counties close in geography are not homogeneous. Thus, the desired project outcomes varied because each location had a different history.

Although all community coalitions aimed to create a healthier community through PSE changes, how their social and cultural norms were expressed in their daily lives influenced their hopes for the project and their initiatives. For example, individuals who explained social norms of living in a community relationally and economically separated by race expressed hopes that the project would bring people together and help them work toward common goals side-by-side in a way that had not happened previously. Overall, recognizing community diversity, in general, and within community coalitions, is important in framing subsequent evidence-based interventions to avoid forced assimilation to a particular cultural paradigm.17,23

Social and cultural norms played a major role in the food choices and eating patterns in each community. As supported by prior research,18 participants described how Southern food culture was a primary driver of food patterns. Here, Southern food culture relates to types of food traditionally eaten in the southeastern region of the US and the social norms attributed to eating, such as an abundance of food offered to guests as an act of hospitality. In addition, thematic findings indicated food pattern differences between people of different ages and racial identifications. Race relations were a category that highlighted how different food might be preferred by different community groups. Participants also related food preferences to access and how specific groups could not eat their preferred foods, such as fresh vegetables.

Participants described generational eating habit differences, indicating youth had less knowledge about nutrition and agriculture because of limited access to fresh produce and food preparation techniques that have changed over time. Similar to previous research findings focused on promoting awareness and adoption of health interventions in rural settings,44,45 youth engagement and community members hailed church influence as pillars for sustained community vitality.

Results related to social norms surrounding physical activity were associated with a lack of access to exercise opportunities, compounded with what were described as sedentary communities. The social norm was a sedentary lifestyle, but this seemed more related to a lack of access to exercise spaces and equipment rather than a cultural lack of value for physical activity. The project did seem to elicit changing social norms around physical activity in that participants began to observe community members choosing to walk instead of driving short distances. However, the momentum for increased physical activity was stalled by the onset of COVID-19.

Findings also emphasized that relationship building within rural communities was critical for successful program implementation and collective action. With optimism about different parts of the community coming together expressed, participants noted the contribution of the HOP project to community cohesion and improved race relations. They also expressed how change happens slowly and recognized that small steps could lead to progress over time, further indicating the building of cross-cultural relationships before taking broad, fast-paced steps to promote change. Such observations about the slowness of change in rural communities related to the cultural norms of the communities by referring to localized beliefs19 and shared mentality.20 In addition, while participants had personal motivations for participating in project initiatives, they recognized the need to motivate the community in a way that promoted awareness and collective interest in project activities. Pride in their community was 1 of the strongest motivators for change; participants understood what their communities had to offer, and this understanding motivated their actions and visions of the future. Within rural areas, compounding factors, such as history, nostalgia, and community pride, impact the direction and capacity for behavior change.14,46 Therefore, examining how the cultures of a rural area impact the development and adoption of health-promotion interventions is critical for increasing behavior change.17,47 The Figure presents a framework for the sociocultural influences of food and physical activity on the shared vision for development in the rural communities involved in the project.

**IMPLICATIONS FOR RESEARCH AND PRACTICE**

A conceptualization of cultural influence on the perceptions of a rural food and physical activity PSE change project was developed. As a research exploration, it unearthed several implications for public health research and practice. The results support future investigations into the role schools and religious institutions play, as community partners, in bringing diverse voices to the project.
In addition, religious leaders may provide support and message for health interventions within specific communities. Research could also investigate the limitations of religious involvement within community-based health promotion, not to further marginalize specific community members. Although cultural characteristics can affect participation in physical activity, such influences were not identified in this study’s data. Thus, there is an opportunity for future research to examine connections between culture and physical activity more directly.

Limitations to the current study include only interviewing members of the community coalitions. Because of self-selection for involvement, the perspectives of those interviewed are inherently limited. Herein lies an opportunity for future research to include results triangulated with interviews or surveys with a broader range of community members to more holistically investigate sociocultural influences on rural community PSE vision for development. A broader range of community members could include the 45 eligible individuals who chose not to be interviewed and those who do not serve in the capacity of a community coalition member. Because of the nature of qualitative research, the results of the study are not generalizable beyond the current population. Therefore, future research is encouraged to validate the presented framework in other rural communities. In addition, the findings presented here are descriptive categories, as an extensive exploration into deeper meaning-making processes of the participants was beyond the scope of the current study. Scholars interested in continuing this research using qualitative methodology can use other methods to provide more interpretive data. For example, a thematic analysis will yield deeper analytical insights about overarching patterns across data and categories, deepening our understanding of the topic. An additional limitation is that recruitment began fairly soon after the COVID-19 pandemic and associated social distance and lockdown protocols were initiated in Georgia, which may have impacted participants’ choice to be interviewed.

In practice, external project leaders, community volunteers, and community members on the receiving end of project outcomes may view the same community initiative and its success differently. To avoid competing commitments, capturing the visions of community members when working in community-engaged research may ensure a program design is flexible enough to adapt to the citizens’ voices and needs, including cultural identities. As supported by the findings of this study and past literature, encouraging community change requires
the engagement of multiple voices. Therefore, public health researchers and practitioners are encouraged to intentionally engage broader audiences to increase the efficacy of health projects, as the diversity of voices may present culturally-appropriate means of improving food access and physical activity. Engagement can involve evaluative approaches to better understand community members’ goals and perspectives of their community and the specific public health project. Garnering community member feedback at all stages of implementation (before, during, and after) could create a well-rounded approach to engagement.

Scholars and practitioners are encouraged to explore what community values and how that information relates to mindset, motive, and behavior changes. A focus on values helps project leaders remember that access alone does not promote the project or community goals; awareness, knowledge acquisition, and adoption of new practices are key. In addition, allowing more time to establish relationships and shared values around project goals may be necessary, given the communal culture of smaller rural towns. With fewer people assuming roles in community projects, relationships are important in establishing a foundation for long-term community investment in health initiatives. To gain participants’ trust, health practitioners working in rural areas must balance the slow-moving nature of progress and relationship building with demonstrable change. Rural residents may be particularly hesitant to change their behavior on a cultural level and resist acculturating to new norms presented to them by outsiders. Therefore, understanding how to view project initiatives and goals through a culturally-responsive lens may increase the impact of health-promotion interventions and help practitioners view cultural differences as a potential asset rather than a barrier.

Overall, health practitioners are encouraged to explore the cultural expressions and social norms of a community and adapt project goals and methods accordingly to ensure that PSE projects promote health equity. Aside from knowledge about health information, what one believes about themselves and how they perceive social reactions in their environment impacts decisions about their health. Thus, understanding sociocultural, physical, industrial, and historical elements must be considered to understand community identity and development holistically. Doing so may increase the sustainability of health-promotion interventions while simultaneously building trust among collaborative partners and improving the effectiveness of community-based program evaluation.17

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