Understanding How Participants Become Champions and Succeed in Adopting Healthy Lifestyles: A storytelling of a community health and nutrition program at a Land-Grant University

A Dissertation

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Phalla Doung Keo

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Dedication

Of proficient individuals, Socrates said, “those who manage well the circumstances they encounter daily, and who possess judgment which is accurate in meeting occasions as they arise rarely miss the expedient course of action.” With all of this in mind, I dedicate this dissertation to seven of the most intelligent, socially competent people I know: my husband, children, and grandchildren: Loeung Khi, Chamak Khi, Lana P Khi, Jason S Khi, Kaeyo Khi Tendle, Adelynn Tran Khi, and Kyrie Keo Tendle.

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I also dedicate this to all immigrant students, especially Adult Learners without support. I believe in you, and hope you will too.

Abstract

The purpose of this study was to investigate and understand the experiences of participants who become champions and succeed in adopting healthy lifestyles. The setting was a health and nutrition educational program at University of Minnesota Extension. The main research questions were: How do participants in the Community Health Education Program become champions of the program and succeed in adopting healthy lifestyles? What can we learn about their success?

A storytelling, narrative analysis design was conducted, including interviews with program participants in 10-13 person settings. This study is important as the organization strategically supports the outreach mission of the university.

Findings included emergent themes which were organized into domains. Personal characteristics included being outgoing and passionate about what they do. The program learner domain describes their participation and engagement. This included learners' attitudes and facilitators' mindfulness that changes occur in small steps for learners. The program content domain discusses the content, including its connection to key nutrition messages based on the program implementation guidelines, the need to adapt content to fit culturally diverse learners' backgrounds, and learners' immediate needs and interests.

The program context domain suggests that context matters, including how low income families face barriers to change that are multilayered. These barriers include but are not limited to financial, health, and social exclusion; this affects the health and wellbeing of participants. Based on these findings, there are practical and theoretical implications for Human Resource Development (HRD).

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Chapter One: Introduction

This study examines the process of understanding the experiences of participants in a nutrition education program at The University of Minnesota Extension, who become champions and succeed in adopting healthy lifestyles. A champion is someone who strives to encourage others in the community to adopt strong health and nutrition practices. This study, *Understanding How Participants in a Community Nutrition Program Become Champions and Succeed in Adopting Healthy Lifestyles* (in an educational program), transcends the individual level to reach program participants from the university to the community and back to the university.

In spite of the relevance and growing literature, becoming a champion and succeeding in adopting these lifestyles continues to be problematic. Research recognizes these challenges and estimates only 10 to 30% of those graduated from the program experienced results in changes to diet and exercises.

For organizations such as the University of Minnesota Extension, gaining a greater understanding of the process by which participants become champions and succeed in adopting healthy lifestyles is a major concern because it is part of the organization's mission and can advance the work of such organizations. Extension has a long history of serving Minnesota, beginning in 1914. Being adaptive in their program in order to meet the needs of their constituents has been a key element of its success; adaptations to changing technology and other resources help to serve ever-changing communities. At that time, the extension model was forward thinking regarding the needs of local communities. As food production increased, millions worldwide have certainly

been saved from pending starvation. However, the increasing gap and disparities in the United States between the rich and the poor have widened both at the local level and in the cities. This disparity is especially the case in areas that have received a constant stream of migrants in search of a better life. Even today, Extension is addressing community food and nutrition needs. To address these needs, this study uses storytelling as a means to describe the nutrition program in Extension and explore the process of how participants become champions and succeed in adopting healthy lifestyles, especially in light of growing nutrition challenges such as growing obesity rates and unhealthy lifestyles.

The Program/Setting of the Case

Minnesota is among the healthiest states in the United States, but also ranks high in health disparities (Bruening, Neumark-Sztainer, Loth, Maclehse, & Story, 2011). These disparities are most apparent when considering minority and low-income populations. Minority communities in Minnesota face many interconnecting challenges. In 2005, 9% of the state's population lived below the poverty level and a large proportion of this population were in minority communities. Food insecurity rose to nearly 10% during the economic recession from 2005 to 2011 (Bruening et al., 2011).

The University of Minnesota is one of the largest public institutions in the country, and one of few Land Grant Universities located in an urban area. At the time of this writing, Extension is strategizing how to support the outreach mission of the University system, following the forward-thinking nature to respond to the health and nutrition needs in our changing communities.

For the past five years, Extension has delivered nearly four thousand Supplemental Nutrition Assistance Program-Education (Snap-Ed) Programs a year (Gold, Barno, Sherman, Lovett, & Hurtado, 2013), reaching approximately 70 thousand Minnesotans yearly (Lovett, Sherman, & Barno, 2011). The educational program outlined ways to improve health and wellbeing; topics included information about physical activity, increasing intake of fruits, vegetables, low fat foods, and calcium-rich foods, and making wise food shopping choices (Van Offelen, Schoeder, Leines, Roth-Yousey, & Reicks, 2011).

The Snap-Ed Educator is a paraprofessional employee in charge of program delivery, including the planning and necessary logistical details. Everyone involved in such programs is very committed to improving the health and wellbeing of families. They care about the quality of program delivery and continued improvement to better serve participants.

Problem Statement

The increase in the prevalence of overweight and obese children and adolescents is a significant health concern in United States (Medical News Today, 2004). According to a 2013 United States Department of Agriculture (USDA) study of the differences between low-income children, SNAP participants, and non-participants, 0% of all low-income children met at least 7 out of 10 dietary recommendations. This is also a problem in the South East Asian community in Minnesota. South East Asian children are joining other racial/ethnic groups in the obesity epidemic.

Taking good care of our bodies means eating foods that are healthy, along with

being physically active every day. This can be hard for families with busy lives at home, work, and school. For many, busy schedules have meant less physical activity and eating more unhealthy foods. As a result, more children and adults today are becoming overweight or obese (Doeun, 2008). Among children and adults there are significant racial and ethnic health disparities, making it important to reach our growing populations of South East Asians. Being overweight increases the risk of high blood pressure, heart disease, and diabetes. Those who are overweight with a family history of diabetes, high blood pressure, heart disease, or cancer have an even greater chance of developing these diseases.

Purpose of the Study

The purpose of this research is as follows: (a) To explore and understand the experiences of participants in a Health and Nutrition program who become champions and how succeeding in adopting healthy lifestyles happens in their communities; (b) to understand the key elements that influence participants to become champions; (c) to understand some expected outcomes from the participants' perspective, such as participants' conditions and for whom the education is most effective.

As suggested by Roger (1995), early on in this exploration there is the sense that the study is dynamic, highly organic, and context dependent. This study highlights practices among participants and organizations that want to improve their efforts in adopting healthy lifestyles in similar university extension settings.

Research Questions

Questions for this research are:

1. How do participants in the Community Nutrition Program become champions of the program and succeed in adopting healthy lifestyles?
2. What can we learn about and from their success?

The study goal is to improve our understanding of the program process and to understand how education is received by participants in the program—under what conditions and to whom the education program or intervention is most effective in contributing to intended outcomes.

Significance of the Study

This study has both theoretical and practical significance. There is a growing body of literature around educational fields, as it concerns business, with remaining competitive; this remains problematic. Any study that broadens this work is important. Much of the literature around education has reached the conclusion that we require theories, models, and a way to understand and measure the learning process. Focusing on exploring some key factors would provide understanding about how the nutrition education process happens.

In a practical sense, we live in an increasingly unequal world with extremes of wealth and poverty creating disparities. Health disparities that exist in local Minnesota communities have negatively affected the health and wellbeing of low-income families. Extension prioritizes collaborative work to address practical urgent needs. It is important that we increase our understanding of how participants become champions, of how success in adopting healthy lifestyles happens, and of those factors that contribute to long lasting effects.

This research is significant because it contributes to this understanding at a University Extension Program. Moreover, an improved understanding would help universities develop the capacities to improve this process, ultimately benefiting society.

Southeast Asian Culture Background

Culture is the term used to describe certain traits that characterize a special group of people (Gutierrez, 2002). For those of us working in the community that are involved with different ethnic cultural groups from South East Asia, it is important to understand these different cultures—what a different country is and the specific nature of each country we work with**.** The primary literature on which the curriculum is based is a combination of research pertaining to the culture, background, cuisine, and nutrition-related issues of the Cambodian, Hmong, Thai, Laotian, Vietnamese, Burmese, and Karen peoples.

Cambodian Culture and Background

Cambodia is located in Southeast Asia, surrounded by Laos, Vietnam, Thailand, and the Gulf of Thailand. The majority of people in Cambodia speak Khmer, but in recent years English has become more widely studied and spoken. Luxury is not a major concern in this culture. The basis of the Cambodian economy is rice agriculture and much of the population farms for a living. Cambodians use a combination of Western medicine, Chinese medicine, and traditional Cambodian practices in health and wellness. Although Western medicine is accepted in this country, there is a lack of professionals specializing in this type of medicine.

Cuisine. Food in Cambodia is very similar to the types of food eaten in other

areas of that region, but Cambodian food is typically less spicy. The staples of the Cambodian diet are rice and noodles. A fermented fish paste called prahok is used in almost all Cambodian cooking. A spoon and fork are used when eating, and chopsticks are only used for consuming noodle soup. A spoon is used for bringing the food to the mouth, and a fork is used for cutting up food. Knives are not used when eating because they are thought to be barbaric. A great variety of meat is eaten, such as chicken, duck, pork, and beef, but the main protein source in the Cambodian diet is fish. There are limited vegetables available in Cambodia; green leafy types are most typical, but carrots, string beans, tomatoes, and cucumbers can also be found. Fruit is readily available in this country and the display of it is a mark of abundance. Breakfasts in Cambodia are very different from American breakfasts. A typical breakfast in Cambodia would consist of noodle soup, rice with barbequed meat, or rice porridge. Lunch and dinner may be spiced broth with fish or meat and vegetables; fresh vegetables eaten with fish-based paste; or stir-fried vegetables with chopped meat. Cambodians rarely snack between meals, and hot water is often the beverage of choice.

Nutrition related diseases. Some indicators of malnutrition are birth weight, infant feeding, child growth, nutritional anemia, iodine deficiency, and Vitamin A deficiency. Infant feeding is another problem in Cambodia, leading to malnutrition. Data from the Cambodia Demographic and Health Survey (CDHS) from the year 2000 shows that 96% of women in the rural and urban areas of Cambodia breastfeed at birth and about 50% continued to breastfeed for two years. However, this data also showed that only 11% of infants started breastfeeding within an hour of birth, and 24% within one

day. According to this research, delayed breastfeeding is a current concern in this country; the sooner women begin to breastfeed, the less likely their babies are to suffer from malnutrition later in life. CDHS 2000 revealed that most infants were being introduced to other liquids and foods before the recommended age of 6 months.

Nutritional anemia is another nutrition concern. The CDHS 2000 showed an overall 63% rate of anemia in children age 6-9 months, with an especially high prevalence in children age 10-11 months. The study also found that 58% of non-pregnant women and 66% of pregnant women had anemia. According to this study, only 4% of women take an iron/folate supplement for at least 2 months during pregnancy. Iodine deficiency is a concern in this country, even though iodized salt is available. However, iodized salt is easier to find in main towns and accessibility in the remote areas is lower. Recent campaigns in the country have tried to increase awareness on this topic, and the country is working toward meeting the estimated national iodized salt requirement. Vitamin A deficiency is a problem of public health significance in Cambodia. Results from the Cambodia National Micronutrient Survey 2000 showed that vitamin A intake was very low, with less than 10% of women and children meeting their recommended daily intake.

As the previous statistics show, protein energy malnutrition (PEM) and micronutrient deficiencies are prevalent in Cambodia. Other problems include lack of availability and access to certain foods and lack of diversity in the diet. When Cambodians move to America, their nutrition problems are no longer problems of PEM and micronutrient deficiencies, but problems related to excess consumption such as

hypertension, diabetes, heart disease, and stroke. Cambodians living in America have access to unhealthy American foods and, according to a report by the Lowell Community Center, 26% of about 10 thousand Cambodians in Lowell, Massachusetts ate American meals at least once a day (Cambodian Community Health, 2010).

Hmong Culture and Background

Hmong are a small Southeast Asian minority of people from the mountains of southern China, Laos, Vietnam, Burma, and Thailand. Hmong have large extended families and are organized into 18 clans depending on ancestral lineage. The Hmong language is called Hmoob (Hmong in English) and has many dialects but the two major languages are White Hmong and Green Hmong. Hmong refugees began immigrating to the United States in 1975 from refugee camps and villages in Vietnam, Laos, and Thailand. According to the 2005 United States Census American Community Survey data, the majority of Hmong live in California, Minnesota, and Wisconsin. Although the Hmong people have been exposed to Western medicine, they have trouble understanding it. They traditionally view wellness as a balance between the body and the spirit and many Hmong practice spiritual healing.

Cuisine. Food in the Hmong culture is blander than many other cuisines in the Southeast Asian area. Sauces are rarely used in cooking; herbs and spices are used to give dishes flavor. In the Hmong culture, meals are eaten three times a day with little snacking in between. Staples of the traditional Hmong diet are rice, noodles, fish, meat, and green vegetables with hot chili sauces. Many of the fruits that are readily available in Southeast Asia are not available in the United States, or are prohibitively expensive. There is very

little variety in the Hmong diet and people usually eat the same types of food at each meal. Dairy is rarely eaten due to the fact that fresh milk and cheese are typically unavailable to Hmong in their native country and many Hmong people are lactose intolerant. The majority of calories in their diet come from carbohydrates and diets are typically low in fat and sweets. Broth or cold water is commonly sipped throughout meals and alcoholic beverages are rarely consumed. Hmong also grow many of their own herbs, which are used for cooking as well as for medicinal properties. Not only herbs, but also food in general is often used for medicinal purposes in the Hmong diet. For example, during the first 30 days after a woman gives birth, she only eats warm rice and chicken soup with herbs—dishes specifically prepared to help her body heal after delivery.

Nutrition related diseases. There is a high rate of iron deficiency among Hmong children in the United States. Approximately 1 out of every 4 Hmong children has anemia. Anemia in the Hmong population can result from delayed bottle weaning and excessive milk consumption. Bottle-feeding in the Hmong community can often continue after 2 years of age. The Hmong parenting style focuses on keeping the infant/child pleased and this is often accomplished by giving an infant/child a bottle.

Hmong elders often suffer from hypertension and diabetes, which they believe are caused by additives and fertilizers in the United States. Other diseases affecting the Hmong population include Chronic Obstructive Pulmonary Disease and congestive heart failure. Many Hmong also suffer from constipation and diarrhea as a result of a lack of roughage in the diet. Many of these conditions are a result of a Western diet and sedentary lifestyle. According to data from the University of California Los Angeles

School of Public Health, the likelihood of being overweight increases with each year of living in the United States after immigration. Many Hmong living in America have changed their traditional diet and now consume more sugar, salt, meat, soft drinks, cookies, pies, and cakes. Many Hmong children receive free lunch at school and are introduced to new foods that way.

Laos Culture and Background

The country of Laos is surrounded by Thailand, Vietnam, Cambodia, China, and Burma. The official language of the country is Lao, which is a tonal language of the Tai linguistic group. The written language is similar to the Cambodian alphabet. English, French, and various ethnic languages are also spoken in Laos. In Laos, the majority of the population resides in urban areas, but in the United States, most Laotian residents live in large metropolitan areas. Family is very important to Laotians and they typically live with or near their extended family. Sickness in Laos is often thought of as a spiritual problem, so chants and healing rituals are commonly used to heal people when they are ill. Massages and herbs are also used as treatments for certain conditions.

Cuisine. Laotian food is typically very spicy. The diet of Laotians tends to be low in fat and sugar. Each meal contains either rice or rice noodles. Both glutinous and non-glutinous rice is used, however glutinous rice is used more often. Glutinous refers to "sticky" rice. Meals also always include meat or fish and vegetables. Laotians typically do not use any frozen foods (meats, vegetables, fruit, etc.) so all of their meals are prepared from fresh ingredients. Many people in Laos do not have a refrigerator, and if they do they still do not store food for very long. Most families will have a garden in

which they grow vegetables and herbs. Common herbs and vegetables used in Laotian cooking include mint, lemon grass, Lao ginger, Lao eggplant, and chilies. Banana trees are also commonly grown in Laos. The bananas are eaten fresh and/or cooked when unripe. The leaves of the trees are also used for streaming and grilling other foods. Laotian breakfast often consists of sticky rice with mango, coconut, or padek (which is a type of fish preserved in brine). The liquid in which the fish are preserved is known as nam padek and is used in their cooking as well. Men in Laos will often hunt deer or other game or go fishing.

Nutrition related diseases. Major health issues in Laos include low birth weight, protein/energy malnutrition in children ages 0–5 years old, vitamin A deficiency, deficiency of B vitamins (thiamine and riboflavin), iodine deficiency disorder, anemia, and bladder stone disease. It is often seen within the Laotian population that inappropriate infant feeding practices are common. Breastfeeding is often postponed for the first few days after birth; therefore the infant is not receiving colostrum. Many infants are also often given rice at a very young age (within the first month). Anemia is very common among women, children, and older adults. Iodine deficiency is seen most in children. Prevalence of deficiency is highest in southern Laos, in rural areas, and among girls. Vitamin A deficiency is a big concern in Laos (Naphayvong, Vongvichit, Deitchler, & Knowles, 2001). Obesity rates are low in Laos; a greater percentage of the population is undernourished than obese. Food security is an issue in Laos and most of the population is not consuming 100% of their calorie or protein needs. The Laotian population in the United States has a higher prevalence of obesity, heart disease, and diabetes than the Laos

population.

Thai Culture and Background

Thailand is a country in Southeast Asia surrounded by Myanmar, Laos, Cambodia, and Malaysia. Thailand was formerly known as Siam from 1945-1949. People in Thailand follow a hierarchical structure, for example parents are superior to their children, and teachers are superior to their students. A person's education, clothes, social connections, age, and job can determine their place in a hierarchical structure.

Cuisine. Thai food has many unique characteristics but is also heavily influenced by near-by countries, such as China and India. Rice is a main staple of the Thai diet, being consumed at most meals and also made into noodles, dumplings, and desserts. Meat is also consumed at most meals and is usually beef, chicken, pork, or seafood. It is very important in Thai cuisine to have a balance of seasonings; dishes are considered most satisfying when they include sweet, sour, spicy, and salty flavors. Common seasonings are hot chilies, fish sauce, dried shrimp paste, lemon grass, coriander, basil, garlic, ginger, cumin, cardamom, and cinnamon. Coconut milk is used in a variety of dishes including curry and desserts. People in Thailand often eat three meals per day as well as many snacks. Snack carts are very popular and can often be found on streets throughout the day. Breakfast and lunch are usually simpler meals, and dinner is the largest meal with the most dishes. Eating is very important in Thai culture and is often a social event.

Nutrition related diseases. The prevalence of obesity in Thailand is increasing, in both adolescents and adults (Ackpakorn, Abbott, & Premgamone, 2007). As stated by

Langendijk, Vanwyk, Thompson, McComb, and Chusilp (2003) in a cross-sectional survey of primary school children in the Bangkok area, among 2,885 children aged 6-12, the prevalence of overweight and obese children among middle to high income families was between 28.1% and 32.3%, while in those from middle to low income families, it was 14.6%. Nation-wide surveys in 1991 and 1996 demonstrated an increased prevalence of both adult men and women being overweight and obese, with a more pronounced increase in Bangkok and the central region of Thailand. There has been a shift from mainly communicable diseases to diseases such as cancer, cardiovascular disease, diabetes, and obesity.

Vietnam Culture and Background

China, Laos, and Cambodia surround Vietnam. Its population is approximately 90 million people. Vietnamese is the official language and English is often the second language. Other languages spoken in Vietnam include French and Chinese, along with other ethnic minority languages. Agriculture is a very important aspect of the Vietnamese economy—it is a major exporter of rice, coffee, pepper, cashews, tea, rubber, wood products, and fishery products. Vietnamese Americans are the fifth largest Asian and Pacific Islanders population as of 2004.

Cuisine. Rice is worshipped in many temples in Vietnam and is the center of everything in the Vietnamese culture. It is eaten in all forms including boiled rice (eaten daily), rice porridge, steamed rice, glutinous rice cake, Banh Chung (square cake), and many more. Fish sauce is also a significant part of the Vietnamese meal. During family meals, the food is typically all combined onto one large tray and is placed in the center of

the family members. The family then all eats from the large tray of food. They will often have a small bowl of rice in front of them to mix with the rest of the food using their chopsticks—chopsticks are always used instead of silverware. Meals are often eaten in silence. Main dishes are typically eaten with leafy green vegetables and fish sauce (or other types of sauces) to dip the food into. Some examples of common dishes include sautéed vegetables, tofu, seafood-based broth with vegetables (canh), or a combination of meat/fish dishes. Wealth and poverty play a big role in cuisine for the Vietnamese. The poor are often severely lacking in their protein intake. Pho is a very popular dish in Vietnam consisting of a clear, meat-based broth and noodle soup. Dogs and snakes are sometimes eaten in Vietnam, but these are typically considered "male foods" and are avoided by women. Fertilized duck and quail eggs are popular snacks in Vietnam. Pha Lau (which includes the organs and intestines of cows and pigs) is often added to soups or eaten on their own. Eating out is more common in Vietnam than in many of its surrounding countries. Dinner is typically cooked and eaten at home, but breakfast and lunch can often be eaten out, typically by getting food from a street vender. Green tea is a very common beverage in Vietnam. Alcohol is considered a "male activity" and women in Vietnam do not typically drink alcoholic beverages.

Nutrition related diseases. Low birth weight is a nutritional problem commonly seen in Vietnam. The prevalence of anemia in Vietnam has decreased significantly since 1987 (Laillou et al., 2012); however, anemia is still a concern. Iodine deficiencies in Vietnam have decreased dramatically since salt iodization started in 1992. The prevalence of vitamin A deficiency decreased in Vietnam after the supplementation

program was implemented, which focused on giving children and mothers vitamin A supplements. Obesity rates are much lower in Vietnamese living in Vietnam than in Vietnamese Americans; however, the prevalence of obesity is shown to be increasing.

Myanmar Culture and Background

Bordered by China, Laos, Thailand, Bangladesh, and India, Myanmar is also known as Burma. Myanmar is the new official name although many still refer to it as Burma. Other ethnic groups who live in Myanmar include the Shan, Karen, Arakanese or Rakhine, Chinese, Chin, Wa, Mon, Indians and Bengalis, Jingpho, and Palaung. Burmese is the national language of the country, however many of the different ethnic groups speak other languages. English is a common second language among the educated residents, but is not commonly spoken throughout the country.

Cuisine. Rice is a staple food in Myanmar. In highland areas where rice is difficult to grow, millet, sorghum, and corn (along with some rice) are staples. A typical meal includes rice, leafy green salads, fruits, other vegetables, a soup, and curries of fish, meat, prawns (marine crustacean), or eggs. Soup is almost always served with meals; beverages aren't always served with meals, so soup is needed to help moisten foods and make swallowing easier. The four main types of soup include sweet broth, hot and spicy, sour, and bean. Curries are seasoned with turmeric, chili, fermented fish, or shrimp paste. Lentils, pickled relishes, and balachaung (fried dry prawns) are also commonly included in meals. Eating dessert with a normal meal is not common in Myanmar, but fresh fruit is often eaten after a meal. For family meals, members of the family usually sit on mats or on the floor around a low table. Food is served on a large platter from which the entire

family eats—this allows them to make their own combinations of foods. There are no "courses" during a meal; all food is served together and at the same time. Beverages that come with meals include water, juice, or green tea. Alcohol is not served with meals. Meals are usually eaten with the fingers; utensils are only used for serving the food. Typical snacks in Myanmar include chapatis (flatbread), fried insects, pickled tea, and Chinese pastries. Mohinga, which includes rice noodles served with fish soup, is a common breakfast and/or snack in Myanmar.

Nutrition related diseases. According to a Myanmar article (2006) there are several major nutritional concerns in this nation. The first is protein-energy malnutrition. In 2006, nearly 5% of children age 6 to 11 had goiters. Iron deficiency anemia is very prevalent and is a significant issue in Myanmar. In 2001, 45% of women of childbearing age had anemia. In 2002, 26.4% of adolescent girls had anemia. In 2004, 71% of pregnant women and 75% of children under the age of 5 had anemia. Thiamine deficiency is another nutrition issue in Myanmar. There are a limited amount of hospitals and doctors throughout the country, making access to health care an issue.

Definitions of Key Terms

Relevant definitions of selected key terms are addressed in the context of this paper. These key terms are acculturation, culture, health literacy, immigrants, and minority.

Acculturation: It is worth defining this term in order to better understand culture in the context of this paper. Acculturation is a process in which members of one cultural group adopt the beliefs and behaviors of another group. According to Garido,

acculturation "affects people who interact with a new culture, which produces changes in attitudes, values, behavior or identity, both at the social and personal level" (2012, p. 83).

Although acculturation is usually in the direction of a minority group adopting habits and language patterns of the dominant group, acculturation can be reciprocal—that is, the dominant group also adopts patterns typical of the minority group. Assimilation of one cultural group into another may be evidenced by changes in language preference, adoption of common attitudes, and loss of separate political or ethnic identification.

Culture: This term sounds elusive due to its complexity and broadness, yet culture is a universal phenomenon that exists in all societies. Recent culture scholars have tried to address the broadness and vagueness of the term by relating it to their respective areas of interest.

Guiso, Sapienza, & Zingales (2006) have defined culture as it related to economic development. According to Guiso et al., culture is "those customary beliefs and value that ethnic, religious, and social groups transmit fairly unchanged from generation to generation" (p. 3). Kanyinga (1992) have defined culture as an expression of monolithic ethnic/racial communities through symbols such as art, food, music, clothing, religion, or other outward forms.

Health Literacy: Martensson (2012) have said, "Health literacy comprises skills in obtaining, understanding, and acting on information about health issues in ways that promote and maintain health. Health literacy is the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions" (p. 151).

Immigrants: The definition of the term varies depending on the contextual purpose. There are three major goals of United States immigration policy, identified in a document prepared by the United States congressional budget office (CBO, 2006). These are to reunite families by admitting immigrants who already have family members living in the United States; to admit workers with specific skills and to fill positions in occupations deemed to be experiencing labors shortages; and to provide a refuge for people who face the risk of political, racial, or religious persecutions in their country of origin. These immigrants are allowed to live under different immigration statuses.

Minority: Ahmed & Buchan (2011) have defined minorities as "groups formed by individuals and families, who have left their original homeland and emigrate to another country generally for economic and, sometimes, also for political reasons" (p. 331).

A minority is a relatively small group of people—especially one commonly discriminated against in a community, society, or nation—differing from others in race, religion, language, or political persuasion.

Qualifications of the Researcher

I have resided in Minnesota for the past 34 years, but was born and raised in Cambodia. I attended Tuol Sleng High School—the complex that was used as the Security Prison 21 by the Khmer Rouge regime and is now the site of the *Tuol Sleng Genocide Museum*. This museum chronicles the effects and tragedy of the Khmer Rouge Genocide.

This history is the main reason I have come to know Minnesota as my home. My

family and I are refugees from a war that tore families apart and destroyed our country. Escaping from Cambodia to the United States gave my children and our family a new start. After settling in Minnesota in 1980, I earned a degree in nursing and worked in hospitals and hospices for 3 years. I then joined the University of Minnesota Extension Program and began teaching on the subjects of health and nutrition; I have been committed to this program for 28 years.

In 2008, I earned my Master's degree in Adult Education, and then began pursuing my dream of achieving a Doctorate of Education. I have collaborated in research studies for the University of Minnesota Extension, in both the metro area and in statewide settings, in a range of programs. I have worked with a team of Extension researchers to conduct interviews with community leaders to investigate participatory approaches to community-engaged research. In the past, I have also worked with the Vietnamese Association and Wilder Foundation to conduct interviews with Cambodian people about tobacco use. Thus, I am well acquainted with and am part of the SE Asian Minnesota Community.

The Importance of this Study

My motivation for doing this study is the need to understand how participants become successful champions of community health and nutrition programs and what we can learn from their experiences when working in a Health and Nutrition program learning environment in a community setting.

In conducting this research it was important to understand the function, purpose, motivation, and intensity of participants. Consequently, the study will use storytelling as

a basis for methodology, and a definition of social presence (Garrison & Vaughn, 2008) will allow the participants and researcher a continuous process using whatever dynamics may develop.

The Context of the Study

The University Extension Health and Nutrition Programs are designed to improve food literacy, physical activity, and healthy food access for Minnesotans, and to promote health and reduce health disparities using University resources and proven educational and engagement strategies.

Summary

This research study aims to understand how participants become champions and succeed at adopting healthy lifestyles using a narrative method, storytelling design. In this chapter, I have given the background and issues around how to understand a champion and the importance of the study. I have presented an introduction, a statement of the problem, theoretical perspectives underpinning the study, the purpose, and the research questions. In addition, I have presented definitions of key terms and relevance of the study to the field of education. In the following chapter, I will present a thorough review of academic literature.

Chapter Two: Literature Review

The following chapter presents a discussion of understanding how participants in a community nutrition program become champions at succeeding in adopting healthy lifestyles and how it is accomplished at the University of Minnesota Extension. First, this chapter will discuss the theoretical framework; second, it will give a review of key concepts, such as learning, practical learning, and Extension. The main issues, theories, and practice will also be discussed.

Acculturation is a process that affects one's behaviors, defined as the "process of cultural change as a result of contact with [the] dominant culture" (Nicolau, Van Dam, & Stronks, 2006). This process involves the westernization of the diet, which often means an increased consumption of high-fat foods, sugary desserts, red meat, and refined grains. How do these dietary changes occur? A report published in the *International Journal of Human Ecology* stated that dietary acculturation is both complex and multidimensional, and does not develop linearly from the traditional end of the spectrum to the acculturated end of the spectrum (Satia-Abouta, 2003).

Most commonly, immigrants adopt westernized food patterns for reasons of affordability, availability, and convenience (Wautier, 2012; 2013). Other factors, according to the British Diabetic Association, are the period of time within the new culture, contact with people in the dormant culture, and education levels.

Another factor contributing to obesity is the lack of activity and exercise among new immigrants. Modern technology greatly decreases the physical work to be performed in job settings (Hao & Kim, 2009). Consequently, immigrants are vulnerable to obesity

because of their increased risk for poor physical, psychological, and social health outcomes (Derose, Escarce, & Lurie, 2007).

Responding to these factors, community programs have been developed which promote the health and maintenance of immigrants' health status. These services, which provide basic education about health and nutrition, have been designed to prevent both the onset and transmission of preventable disease as well as to help maintain current health (Aday, 2001). It is important to understand that it is better for immigrants to focus on the positive aspects of healthy eating than the negative aspects (Nicolaou et al., 2006). In order to achieve the desired outcomes, these programs must promote healthy eating rather than discourage unhealthy eating.

The western diet of the United States has changed its patterns over the course of time. There has been an increase of saturated fat, refined carbohydrates, and red meat. There has also been a decrease of fruits, vegetables, and fiber. According to the Journal by the Center of Migration Studies, there are five nutrition patterns. The first and second are the hunter-gatherer styles; the third increases fruits, vegetables, and animal protein; the fourth is the western diet, a diet high in saturated fats and sugar and low in fiber; and finally the fifth is made up of efforts on the part of institutions and individuals to develop a lifestyle that increases health (Hao & Kim, 2009). In current times only the last three patterns are used. In correlation to these dietary changes there was an increase in diet causing diseases such as obesity, cardio vascular disease, and diabetes. The surgeon general stated that in 2000, the total cost of obesity in America was $117 billion—most of it coming from obesity related health problems—and in 2003, approximately 30% of

Americans were considered obese (Hao & Kim, 2009).

One's diet is mainly influenced by their culture and place of birth. Immigration to a different culture can also have a strong effect on one's diet (Nicolaou et al., 2006, p.383). The Center for Migration Studies at John Hopkins University has evidence that the obesity crisis in America would be more drastic if there was no mass of immigration (Hao & Kim, 2009). There is evidence of a correlation between the rise of the obesity epidemic and the influx of immigrants in 1965. Acculturation causes immigrants to adapt to the western culture much faster and will lead to health risks just as fast (Hao & Kim, 2009). The center for Migration Studies reported immigrants who have lived in the United States for 10 years or longer have significantly higher BMIs then those who have lived in the United States for less than 10 years (Hao & Kim, 2009). Americans are ahead of Latin American countries and far ahead of Asian countries in terms of obesity (Hao & Kim, 2009).

As stated in the 2010 American Community Survey, nearly 13% of Americans are immigrants, both legal and illegal (Camarota, 2012). Conforming to 2003 data of foreign-born people immigrated to the United States, 53% were from Latin American, 25% from Asia, and 14% from Europe (Camarota, 2012; Lentz, 2012). In keeping with the *Journal of Immigrants and Minority Health* (JoIMH), half of the total population increase between 2004-2005 was due to immigrants (Ton et al., 2011). The JoIMH stated that Asian Americans are the fastest growing minority in the United States. In 1970, there were over one million Asian Americans and in 1990 they had grown to over 7 million (Ton et al., 2011).

John L. Oliffe, at the University of British Columbia, interviewed groups of South Asian men about their culture and diet before and after moving to Canada. According to these men, their culture has very traditional eating habits that are used for social networks, social class, religion, and to show masculinity. For example, the men eat a lot of meat because meat eating is 'manly', just as drinking alcohol is manly (Oliffe et al., 2010).

Their food choice depended on their work. The majority of the men were farmers, working outside in the sweltering heat day after day. To accommodate what they burn off when working, they'd eat a lot of milk, butter, and sugary foods—foods with fat. One participant stated, "There is no other diet like it; it is a very strong diet (p.)". Every meal was homegrown. They didn't have access to a lot of 'specialty' foods until moving to Canada (Oliffe et al., 2010).

Since their diets were so traditional, they kept eating the same way when the men and their families moved to Canada, the only difference being that they were now able to afford 'specialty' foods, such as alcohol and sweets. The other change was their amounts of work. Once moving to Canada the men stopped farming which meant they ate the same amount of carbs and sugar and fats, with less than half of the work to burn those off since the winters are so long. The men described layering clothes to make them sweat and burn off what they would eat.

The majority of Asian immigrants were coming from a life of being a farmer and eating homegrown foods. Once in America they'd have access to cheap processed foods with no work to naturally burn it off and no idea as to what these foods did to their bodies

and health (Oliffe et al., 2010). Some of the more educated men understood the negative effects of the foods and during their meetings would teach the other men how to eat more nutritiously.

Other factors, according to the British Diabetic Association, were the period of time within the new culture, contact with people one has in the culture, and educational levels can be linked to a change in diet. "In Western countries, higher education level is associated with improved diet quality including lower saturated fat and red meat intakes and higher fruit and vegetable intakes" (Nicolaou et al., 2006, p.). One last factor contributing to health problems is the lack of activity and exercise. In America everything is done by technology; this greatly decreases the physical work needed to do a job (Hao & Kim, 2009).

In line with a study done by the *American Journal of Health*, there has been significant evidence that there are lower rates of obesity in first generation immigrants compared to the second and third generation immigrants, and higher rates of obesity occur the longer immigrants have lived in the United States (Bates et al., 2008). The study suggested that obesity rates would continue to increase with each generation (Bates et al., 2008). It is believed that as a child, the host culture has significant influence on the diet and plays a major factor in contributing to adult obesity. The study also states that one's demographic area plays a significant role in obesity as well (Bates et al., 2008).

Evidence shows that the majority of immigrants are healthy with excellent/good health and a low incidence of chronic disease prior to immigration to the United States (Jasso, Massey, Rosenweig, & Smith, 2004). On average, Asian Americans had a lower

obesity rate than the entire United States (Bates et al., 2008). Immigrants also tend to have a lower BMI than people born in America (Hao & Kim, 2009). Studies show that the health of immigrants often deteriorates with increased time spent in the United States, which is believed to be due to acculturation, adoption of unhealthy habits, and unhealthy living environments (Derose et al., 2007). According to the British Diabetic Association, South Asians do have a higher risk of diseases caused by diet such as obesity, diabetes type II, hypertension, and cardiovascular disease (Nicolaou et al., 2006). A study done by the Public Library of Science (PLoS) showed significant evidence that physical activity reduces the risk of communicable diseases. It also revealed evidence that if Asians exercise, they have a lower "risk reduction" compared to the white population (Waidyatilak et al., 2013).

Although some dietary changes post immigration to the United States may be positive, studies have proven immigrants to have higher rates of various health issues. For example, a study conducted on 2,488 Chinese immigrants found that compared to Chinese persons living in Asia, those in North America have higher rates of several chronic diseases including cardiovascular disease, hypertension, obesity, cancers of the breast, colon, and prostate, and type two diabetes (Satia et al., 2001; Wautier, 2012/2013).

The JoIMH conducted a study to gain data on the knowledge that Asians have about cardiovascular health. The study conducted focus groups with Chinese, Cantonese and Mandarin, Korean, and Vietnamese participants all residing in Seattle, Washington. The participants were asked to discuss signs and symptoms, risks, and prevention for

heart disease, stroke, high blood pressure, and high cholesterol. Each group's knowledge was scattered. Participants from all groups had the most knowledge about stroke; each group said that a stroke is caused by brain hemorrhage and vessel blockage. They knew that strokes caused numbness and paralysis and even death. The groups all agreed that risks for heart disease and stroke are lack of exercise and high cholesterol; high blood pressure was also a risk factor for a stroke. They agreed that poor diet was a risk factor for all four diseases. In terms of prevention all groups agreed that diet and exercise prevented heart disease and that diet prevented high blood pressure. This may sound good, but a lot of participants had false knowledge about the diseases. For example, the Vietnamese groups talked about 'frozen blood' and a lot of the groups mentioned 'thinking too much' as a risk factor for the different diseases (Ton et al., 2011).

Creating Positive Change

Creating good health requires that we add to what we already know about healthy eating and physical activity. We can then put this combined knowledge into practice and share it with our families and communities. This means taking a look at both cultural traditions and more Americanized lifestyle practices in order to learn which aspects of each can be combined to positively affect the health of the family. It also means identifying and minimizing tendencies that increase the likelihood of developing chronic diseases such as high blood pressure, diabetes, and heart disease.

Social Cognitive Behavior Theory

The social-cognitive theory of behavior change is used in the health and nutrition program (described in detail below) to explain behavior in terms of personal factors,

environmental influences, and behavioral factors, as well as the interaction between these factors. Important aspects include observational learning between participants and educators, the participants' ability to recognize their dietary and physical activity patterns, and their self-confidence in changing habits to healthier ways of living that work within their family (see figure 1). In these programs, the health and nutrition program uses a learner-centered teaching technique by focusing on the participant's unique set of knowledge and cultural traditions.

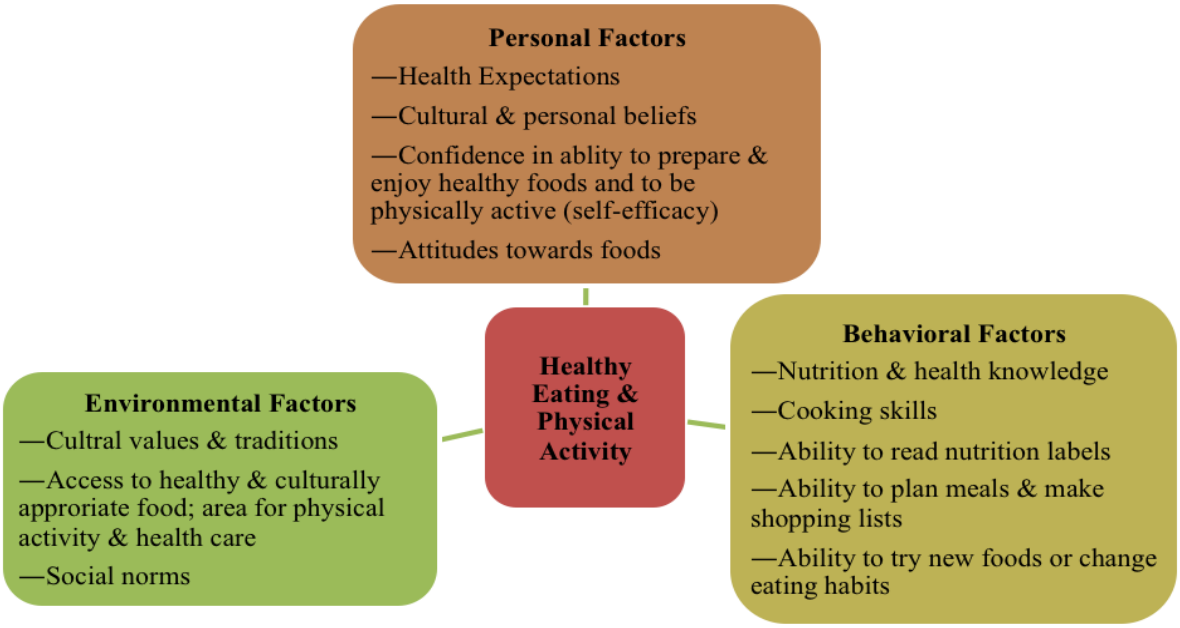

Figure 1. Factors that influence healthy eating and physical activity.

The process of learning. Knowles (1968) has stated that andragogy is " the art of science of helping adults learn" (p. 351). According to Caffarella (2002) and Caffarella and Clark (1999), it is based on five assumptions regarding how adults learn: first, as a person matures the self-concept of the learner moves toward a self-directing human being; second, an adult accumulates a growing reservoir of experience; third, the

readiness to learn is related to the applicability of the new knowledge in practice; fourth, the learners are interested in the immediate application of the new knowledge, for example problem-centered instead of people-centered; and fifth, adults are motivated to learn from internal factors rather than external ones.

Self-directed learning. Self-directed learning is learning by doing, an active process in which leaners find and use the information by their own sense of independence. This perspective has certainly impacted the development, implementation, and evaluation of educational programs that engage adults.

The purposes of this approach are: first, to enhance the ability of learners to be self-directed in the learning; second, to foster transformation as central to self-directed learning; and third, to promote emancipatory learning and social action. Furthermore, the goal of educators is to help learners in a formal or informal context to plan, execute, support, and evaluate their own learning (Houle, 1961; Tough, 1971). Self-directed learning has been applied in formal and informal educational program (Knowles, 1970).

Learning process. Strong interest and learning didactic includes skills and practice, in both cases, the learners are calling for ownership of the learning and to be an active participant of learning. From a self-directed learning approach, the role of the educator or facilitator is to help learners in a formal or informal context to plan, execute, and evaluate their own learning (Knowles, 1975; Tough, 1971). Learners know what they want to learn; they might need some scaffolding throughout the learning process but the interest and capability resides in the learners (Knowles, Holton, & Swanson, 1998).

Caffarella (2002) has suggested that education and training programs promote

three kings of change: at the individual level, the acquisition of new knowledge, building skills, and examination of personal values and belief; at the organizational level, resulting in new or revised policies, procedures and ways of working; and finally at the community and social level, allowing for differing segments of society (p. 11). These changes are part of the process; change is a process through which people and organizations move as they gradually come to understand and become skilled and competent in the use of knowledge (Caffarella, 2002).

Critical theory. Critical theory views society as a human construct (Kemmis, 2001) where the reality is altered through people's progressive understanding of historically specific processes and structures and where humans change themselves by reconstructing their society. According to this theory, the relationship of the knower and the known is subject. Subject facilitators and participants are mutually shaped by each other, and the goal is to elucidate possible paths for action that challenge and change social structures.

Critical theory is related to increased awareness and knowledge of individuals about the contradictory (frozen ideologies, power structures) of action that are distorted or hidden by everyday understandings (Mezirow, 1981). Critical theory declares that all men and women are potentially active agents of change in their social world and their personal lives; "they are subjects rather than objects, of socio historical processes, which make these social actors protagonists of history" (Comstock, 1982, p. 171). Their goal is the self-conscious practice that liberates humans from ideologically frozen conceptions of the actual and the possible.

Critical theory views society as a human construct (Kemmis, 2001) where the reality is altered through people's progressive understanding of historically specific processes and structure, where humans change themselves by reconstituting their society. According to this theory, the relationship of the knower and the known is subject—subject facilitators and participants are mutually shaped by each other, and the goal is to elucidate possible paths for action that challenge social structures.

Critical theory is concerned about an underlying social system of oppression, and that certain groups in any society are privileged over others. Their privilege constitutes an oppressive force that is more powerful when their subordinates accept their lower social status as natural, necessary, or inevitable (Friere, 1998). People with lower social status in society become accustomed to the everyday pattern of life. They understand their position in society in terms of bad luck, as part of how life is. Recognizing that the limiting situations can be changed is a key element of critical theory. People want change, but they do not know what they need, or they are afraid of the system of oppression. Although there are systems and structures that privilege certain groups, these systems were built by the people and the society, which can be modified (Mezirow, 1981).

Practical skills. Behaviorists, art/craft, and situational understanding are the three different approaches that have been discussed by Hinchliffe (2002) when talking about skills. When referring to a behaviorist approach, skill is understood as a "series of operations, capable of repetitions, with an outcome that is measurable" (Hinchliffe, 2002, p. 189). Furthermore, skills can be simple or highly complex and can demand a great

level of care and intelligence. In this approach the personal characteristics and qualities of the learners are not considered, and skills are outcome-driven instead of process-driven. The misconception about this approach is that it assumes the successful performance of a skill can be assessed in a context-independent way (Hinchliffe, 2002). Under this approach the performance of the skills will depend not only on whether particular techniques have been mastered, but also on whether the appropriate context has been understood (Hinchliffee, 2002).

The art/craft approach is based on Aristotle's contribution to instrumental reason. In this approach technique can be interpreted in terms of craft-skill, in which art/craft can be understood as "reasoned capacity to make" (Hinchliffe, 2002, p. 192). Skills can be understood as practical implementation of methods and procedures. In this approach art/craft is contrasted with luck, chance, and contingency. The idea is to have certain control and management over future contingencies. Some of the characteristics of this approach are that skills are transferable and art/craft can be used in a variety of situations with results that can be reasonably expected. Another characteristic is that it is teachable; the method can be transferred from person to person. The critics of this approach are concerned about separating "knowing how," and suggest that any display of knowledge is a combination of both (Hinchliffee, 2002, p. 193).

The third approach is situational understanding; it is directed toward an "interpretive understanding of a series of actions, oriented to production of define outcome" (Hinchliffe, 2002, p. 194). Skills contribute to see similarities and differences between settings to modify one's competencies. Skills can be seen as art, as the

integration of a series of techniques and knowledge in order to achieve some accomplishment. Practice is grounded in interpretation, so in order to improve, practice requires improving the interpretation; there is no objective interpretation; practice involves being able to respond to situation as it happens. In order to facilitate practice, it needs an agent with the appropriate capacities for facilitating situational understandings.

In situational understanding, it is important to distinguish two kinds of transfer. First, in cases where techniques are used in the same way though in different contexts; and second, in which the agent uses situational transfer (Hinchliffe, 2002). Criticism of situational transfer suggest that it is procedure which been transferred, rather than skill. On the other hand, if the procedure has been altered in some way then it must be a different process in each case, so again no transfer has occurred.

There are also arguments about the wide gap between the skill learned in a program and its use in every life. From this perspective, the program is seen as artificial, which does not teach other life skills that participants will use every day. In this context the program tries to bridge the gap between program and practice environments.

Health and Nutrition Program

In Minnesota, where approximately 10% of the state's population is living in poverty and average household incomes have dropped to a fifteen-year low, many of the state's poorest are forced to make difficult choices on a daily basis.

When families are feeling pressure from a weak job market, housing foreclosure, and the rising costs of gas and groceries, it becomes nearly impossible to focus on the importance of health and nutrition (Grumbach & Mold, 2009).

Recent study has shown that food-insecure households are significantly more likely to serve unhealthy foods such as sugar-sweetened beverages, and significantly less likely to serve healthy fruits and vegetables to their families.

With more than 500 thousand Minnesotans receiving SNAP benefits, these efforts fit neatly into Extension's century-long mission to delivery practical skills on a wide array of topics relating to health, nutrition, and family and community wellness to populations most in need. Funded in part by federal dollars for SNAP-Education (SNAP-Ed), educators provide information designed to increase the likelihood that persons eligible for SNAP will make healthy lifestyle and eating choices consistent with USDA dietary guidelines.

SNAP-Ed educators work with participants to provide education on the role of physical fitness in a healthy lifestyle, SNAP eligibility and benefits, the importance of increasing intake of fruits, vegetables, whole grains, and low fat/fat-free calcium rich foods and beverages, and wise food-shopping choices on a budget.

Minnesota is comprised of diverse populations spread across urban, suburban, and rural locales, so the SNAP-Ed program is faced with a unique challenge: how to deliver a quality program meeting the diverse need of low-income populations across the state.

The University Extension System

The Morrill Act of 1862 established the land-grant universities and the USDA. Land-grant universities, which were commonly known as 'college of agriculture and mechanical arts,' primarily focus on dissemination of agricultural and domestic or household knowledge. Prior to the passage of the 1914 Smith-Lever Act, which called for

the formation of cooperative agricultural extension to diffuse “useful and practical information on subjects relating to agriculture and home economics, and to encourage the application of the same” (Morse, 2009).

Further understanding of social cognitive behavior theory and practice is critical. It is rare that people learn things in a program that applies directly to their life. The implications for community education are important, especially for program design, implication, and evaluation. Just having information that logically implies a solution to a task is not enough. One must learn how to apply that information to a task in specific situations; that is the learning of cognitive skills.

The following chapter discusses the methodology and methods followed to undertake this study.

Chapter Three: Methodology

The research design implemented to undertake this study included a narrative method, storytelling design. In this chapter, the author first describes the rationale for the storytelling methodology. Next, the appropriateness of using narrative analysis (qualitative) to address the study question is discussed. Third, the author addresses the context and setting for this research. And finally, the strategy of sampling, data collection, and analysis process followed in this study is discussed.

Methodology

I aimed to probe and work towards an in depth understanding of meaning-making among participants who become champions and succeed in adopting healthy lifestyles of communities involved in the health and nutrition program. The main claim for the use of a story-telling narrative method is that humans are essentially story-telling entities, individually. Human society leads to stories.

Many qualitative methods could be used in this study. One such method is phenomenology. As Van Manen (2007) has indicated, phenomenology is a process in which the researcher reflects on lived experiences to understand the phenomenon under study. Phenomenology aims to come to a deeper understanding of what a person goes through as they conduct their day-to-day lives in the language of everyday life (Hultgren, 1989). There are two different approaches in phenomenology distinguished by the way the findings are used to augment specialized knowledge: The Husserl descriptive tradition and the Heidegger interpretive tradition. Sword (1999) defined qualitative inquiry as “an interactive and transformational life process in which the researcher seeks

to learn about and interpret life experience" (p. 270).

Many qualitative research methodologies are designed for collecting the research data. As Yin (1989) has argued, these approaches are well suited to study phenomenon that are somewhat ambiguous in nature. This study will use a narrative storytelling method that allows participants to fully describe their experiences. However, the stories of the participants are not examined in terms of essential themes or essences (Van Manen, 2007) as in phenomenology.

Narrative methodology, according to Connelly and Clandine (2000), is a qualitative approach that studies "the way in which the individual experiences the world" (p. 2). As Creswell et al. (2007) have stated, narrative researchers "situate individual stories within the participants' personal experiences (their job, their home) and their cultural (racial or ethnic) and historical (time and place) contexts" (p. 244). Using narrative studies will help clear us from obscurity; as Hopkins (2003) describes, "it will bring life to the object and bring the object to life" (p. 136).

This narrative method provides details of how participants view themselves and their experiences, and how they make sense of the new healthy-eating lifestyle they adopt. Eastmond (2007) has stated that "narrative is used in much qualitative research today grounded in the phenomenological assumption that meaning is to ascribed to a phenomena through experiences and furthermore we can only know something about other people's experiences from the expression they give them" (p. 249).

The practice of narrative or storytelling is considered part of the social cultural practice in Southeast Asian. Perry (2013) has said that storytelling is a recognized

practice amongst the refugee groups, especially for those who are new to American society. Some Southeast Asians come from cultural backgrounds that place more emphasis on oral practices than on literate practices. Storytelling is a culturally appropriate method to be used by all of those who are working with or involved with Southeast Asian populations, in order to understand their experiences. Through the lived experiences of participants, educators are grounded in the ways we can learn from each other. Storytelling lights up the richness of these experiences by bringing these situations to life, allowing the listeners to reflect on the story in the context of their own beliefs and experiences.

Furthermore, current research complexities call for complete and greater understanding of the phenomena by using different methodologies: "a complete understanding of human nature is likely to require more than one perspective and methodology" (Reinhardt & Rallis, 1994). In practice, it is more common to use the strength of each methodology to have a greater understanding of the phenomena being analyzed (Patton, 2005; 1997). Utilization efforts are based on the promise that programs should be judged by their utility and actual use. It also builds on the concern of understanding how real people in the world apply learning and experience. Therefore, the priority in utilization focus is on the intended use by the intended users (Patton, 1997).

Storytelling methodology. Atkinson (as cited in Pavlish, 2007) identified the guidelines for narrative inquiry (2002). First, the research should not judge or analyze the storyteller, but focus on "establishing connection and examining the aspect of each story" (p. 29); second, the life story can stand by itself in providing an approach into human

experience; and third, each story should disclose something about life. Maxwell and Dickman (2007) have identified five basic elements for capturing and writing a successful story. These elements, which will guide my use of the storytelling method, are as follows:

1. The passion with which the story is told.
2. A hero who leads the story and allows us to see it through his or her eyes.
3. An antagonist or obstacle that the hero must overcome.
4. A moment of awareness that allows the hero to prevail.
5. The transformation of the hero and the world that naturally results.

The stories in this study are a diverse collection of personal narratives that contain well-provided data and analysis. However, the narratives in this paper are a subjective representation of how each participant chose to express their experiences. Objectivity can easily be identified and measured. The research questions that naturally develop from this premise ask: "What does this narrative or story reveal about the person and the world from which it came" (Patton, 2002, p. 115). This approach is most useful when the subjects all spoke about the same experiences and were essentially asked the same questions.

The Nominating Process

The participants in this study were adult South East Asian students who enrolled and graduated from the Health and Nutrition Program in 2014. From over 104 candidates, 10 to 13 participants were selected. Each participant was nominated because he or she was successful in a way that made him or her stand out. Program staff was asked to

nominate these standouts.

A member of staff who had taught in the program was responsible for identifying the first informant. Subsequent recruiting was accomplished by contacting the participating agencies to identify participants who had a successful story of lifestyle change after graduating from the program (Lim, 2009). This approach allowed personal involvement with the research participants, an important step in establishing trust (Lim, 2009). Trust must be established with the first informant so that he or she can introduce the researcher as a trustworthy person to other informants, encouraging them to participate in the process.

This recruitment was voluntary and no coercion was used to recruit participants for the research. The strengths and weaknesses of this approach are that selection of the participant is controlled by prospective informants (Morse, 1991). Participants did not receive any monetary compensation for their participation.

Participants for study. To restate the research question: using a storytelling method to understand how participants become champions and succeed in adopting healthy lifestyles in the community. The unit of analysis in this project is participants. Initially, 13 Asians were recruited to participate in the program. There were 5 males and 8 females selected to share their experiences after having graduated from the nutrition program. The participants' ages ranged from 18 to 67 years old and represented various Asian communities, including Cambodian, Hmong, Karen, Thai, and Vietnamese. These individuals lived in the Metro area of St. Paul and Minneapolis and all were informed that the interview would include conversations about their eating-lifestyle experiences as well

as their experiences within their current communities.

The number of participants was chosen based on Kuzel's recommendation of 6 to 8 participants for a homogenous sample (Gust, Brunce, & Johnson, 2006). Sandelowski (1995) indicated that a sample of 10 might be considered acceptable for homogenous sampling but may be too large for a narrative analysis. Therefore 10 to 13 interviewees were appropriate until meaning was established and the representation deemed adequate. In this study, champion was defined as someone who fights for, or speaks publicly in support of, their belief in positively changing healthy lifestyles within their communities. In order to plan for the possibility that not all of the participants would fit this definition of champion, three interviews were conducted.

Data Collection

After obtaining the signed consent, participants were asked to interview three times, each session lasting between 30 and 60 minutes. The initial meeting was to establish rapport and trust and allow the participants to share their stories without interference from the researcher, unless the researcher sought clarification, as stated by Rubin and Rubin (1995): "early questions should be core to the subject, but not threatening, and should deal with matters that the interviewee almost certainly knows about and ideally feels good about" (p. 131).

The second meeting was an in-depth semi-structured interview that focused on details: the clarification of respondents' stories and collecting factual and detailed descriptions of the stories they shared. The interview contained open-ended questions in clear and simple language. The keys questions for directing the conversation focused on

the participant's experiences with adaptation and how they came to balance their lifestyle between cultural and family demands and their personal goals regarding becoming healthier. Each story offered insight into one participant's experience during acclimation. Connections between stories, as well as the personal relevance of each story, were examined.

A copy of a consent form, written in clear and simple language, were shared with potential participants and included detailed information about the purpose of the study, what to expect from the study, the duration of interviews and the study, potential risks and benefits of the research, and permission to audiotape, if possible. The consent included a statement that would allow a participant to withdraw from the study at any time and a statement that all information shared during the interview would be confidential.

Interview. Interviewing was central to this storytelling and narrative research method. It created opportunities to reflect and pause with participants about what they remembered, liked, and disliked about their involvement in health and nutrition classes. Additionally, interviewing allowed participants to express certain feelings, beliefs, and opinions that might otherwise have been left unsaid or unnoticed. The goal was that participants would feel free to reveal themselves in their own words and attend to what was most important to them. Participants were free to tell their stories and conversations were allowed to flow. The questions were adjusted as the interviews unfolded so that participants were able to share their rich stories. During the interview process questions and conversations were opened-ended and free flowing, and, to a limited extent, driven

by the participants and re-directed by the researcher, in line with the practices of narrative inquiry (Gross, 2004).

Three interviews were conducted at other locations. Some participants preferred to meet at a local bookstore, a local bakery, a community center, or the participant's home. At the first session, I was able to interview 13 participants based on convenience of scheduling and each participant was asked to describe their life, foods, and food habits back in their homeland. Next, they were asked if they had faced any challenges in their eating habits since coming to United States and if there were any changes in their overall family health.

After the first interviews, 6 participants were not qualified for the second round interview and were dismissed from the project. Interviews were scheduled for the remaining 7, but one decided to withdraw from the program due to personal issues.

Before the second interview, the previous interview was reviewed to ensure no data had been missed and to identify where the participant's answers were incomplete or recorded incorrectly. In this session, the focus was on the participants' roles in the community after participation in the nutrition program, how their family experienced the change, and how their experiences influenced those outside of their family.

There were 5 participants that qualified for the third interview session. Before the scheduled interview, the previous data was reviewed and several of the collected stories were written down in order to be shared back with the participants. I had these stories in writing and planned to either read them aloud or have the participant read the story. I asked what was missing from the stories, and to verify and confirm what was stated in the

stories. At the last question, they were asked if there were any more examples that they would like to share.

Interview questions. This research focused on the different experiences participants of the Health and Nutrition program had or were exposed to that influenced their transition to becoming champions of the program. A thumbnail description of the participants included such questions as:

Demographic information

- What is your age?
- Gender?
- Where were you born?
- How long did you live there before coming to the United States?
- When did you come to Minnesota?
- Where did you get your education (both in the home country and in the United States)?

Cultural and ethnic diets before coming to the United States

- Tell me about your eating habits back in your country.
- Describe what a typical meal would consist of.
- What were the things you enjoyed eating most?
- Was western food available and did you or your family eat western food?

Changed eating habits since coming to the United States

- What were the challenges when you first arrived, in planning food for the family?
- Tell me about the changes you made in your lifestyle when you first arrived.

- How would you describe your health or your family's health when you first arrived?
- Have there been changes in your family's:
    - Weight?
    - Physical exercise?
    - Overall health?

Participating in the health and nutrition program

- What made you decide to take part in the program?
- How did you hear of the program?
- Was there one special person who inspired you to take part?
- What has been your greatest satisfaction when attending the class?
- Was it hard to make change even though you knew something was good for you?
- Tell me about how you thought about these changes as you went forward.
- Describe your first experiences at trying to change?
- What happened in the class that made you want to practice what you learned?
- Was it one special person or many things; was there an "aha" moment?

Overcoming obstacles

- What things make it hard for people in your community to make changes to the family diet? How did you manage this?
- What were the obstacles you personally had to overcome?
- Did family or others object to the changes?

Persuading others in the community

- How would you persuade a friend to go to classes?
- What would you tell them?

Checking back with the participants (triangulation)

- What is missing from these stories?
- Have I got your story right?
- Is there anything else about participating in the program that you would like to share?

Transcribing the data. All interviews were digitally recorded, after getting permission from each participant. Handwritten notes were also taken during the interviews. These notes allowed the researcher to record additional potential questions for use in future interviews with the participant, but were also to remind the researcher where the discussion was left off, if the participant decided to leave or if there was any unexpected interruption (Rubin & Rubin, 1999).

Descriptive field notes were taken during the interviews to describe the setting and actions of the participants. The field notes included anything that was shared by participants. All digitally audiotaped interviews and field notes were transcribed immediately after each interview.

Data Analysis

Data analysis in narrative research does not have one particular approach or a fixed methodology. Scholars of different disciplines have used numerous approaches to data analysis thus influencing its procedures. Priest et al. (2002) have suggested that beginner researchers should use a fixed procedure. The following 8-step procedure has

been compiled from different narrative sources (Dollard, 1949; Emden, 1998; Goodfellow, 1997; Polkinghorne, 1996; Reissman, 1993; Seidnan, 1991, as cited in Kelly & Howie, 2007):

1. Connecting with the participant's story: In this step, the researcher will listen to the interview audiotape while reading the transcript. The transcript will be read several times so the researcher will be connected and familiar with the data.
2. Attention to Dollard's criteria for life history: The researcher will pay attention to life events as narrated by the participants.
3. Chronological ordering of events and experiences: In this step, events and life experiences will be organized in chronological order.
4. Core story creation: In this step, subplots and themes will be identified. The story will be reduced to a short length.
5. Verification of core stories: The core stories will be shared with the participants for verification. Participants have the right to make changes, delete, or correct the core stories.
6. Examination of plots and subplots to identify a theme that discloses their significance: Polkinghorne (1995) indicated that in the emplotment process, the researcher "will look for connection of cause and influence among events and identification of actions that contributed to the outcome" (p. 141). Core stories will be investigated to make connections between the events that were shared by participants against the themes identified by the researcher.
7. Examination of plot structure: In this step, each core story will be examined to

identify plots and subplots, and connecting which events or experiences resulted in an outcome.

8. Emplotment of whole narratives: This final step involves reviewing the emplotment chart for each participant. Events and experiences will be recognized to show the connection that resulted in the final outcome. The emploted whole narrative is not a story but a narrative construct that gives meaning and understanding to the narrative data (Kelley & Howie, 2007).

Research Ethics

Per the requirements of the program, the research proposal was approved by an Institutional Review Board (IRB), which assures the confidentiality of the data to be obtained from the subjects. The IRB requires researchers to obtain initial informed consent of participants to protect their privacy, anonymity, and confidentiality.

As a researcher, I have established a rapport and trust within the Southeast Asian agencies and communities, so they were comfortable participating in the research project. Participation must be voluntary. My tasks were to ensure that these participants understood their rights before signing the consent form and to treat them with dignity and respect. All research participants chose a time and place that was convenient for them to conduct the interviews. They were informed that they had the freedom to terminate the interviews at any time, if they wished to discontinue. The interview would end if the participant showed any sign of discomfort or emotional distress. The participants needed to be confident that their identity would not be revealed in the research. Confidentiality was maintained by changing the participants' names to non-identifying names.

Participants' personal information, including interview notes, transcript, field notes, and digital recording, were stored in a locked cabinet. All data would be destroyed after the completion of the research.

Summary

This study effort is important at this juncture, as University of Minnesota Extension strategically supports the outreach mission of the University. The goal of this study is to further understand how participants become champions and succeed in adopting healthy lifestyles in their communities. The methodology followed is storytelling, using narrative analysis methods and involving constituents in a participative way. The critical consideration for the author to select these methods is because of the alignment with study aims, which fits with the selection of the method to carry out.

The interviewer questions-protocol aims to responds to a "why" or "how" type of inquiry. Furthermore, a storytelling method is included in the study because it increases confidence in the results. In this particular study, the author considers it feasible to have 13 interviews that seem realistic in this program. Participative interviews are appropriate because the researcher plans to use them in results of the study. This also builds on the concern of how real people in the real world apply study findings and experiences to study processes. The intent of the study is that within this experimenting its realization will depend on the shared commitment of participants' experiences to engage in active reality testing by all those involved in the program.

Understanding how participants become champions and succeed in adopting healthy lifestyles from within this program is critical to the processed components such

as extension agent capacities (skills, attitudes, education, and values). Also critical is our understanding of how outcomes are carried by participants, under what conditions they seems to be applied, and for whom the education program was most effective in contributing to intended outcomes.

Chapter Four: Results

This study focuses on understanding how participants become champions and succeed in adopting healthy lifestyles. A community nutrition program complements the study. In this study, I will identify individuals who describe how they changed their lifestyles to become champions and the factors that influenced that change. I will expound upon four specific themes in greater detail: (a) Asian resettlement and challenges; (b) before and after participation in nutrition class; (c) challenges and motivation of the changes; (d) community champions.

I encountered few twists and turns in the process of capturing the stories of personal life changes in the communities. My informants and contacts identified and yielded ten positive responses from potential participants. From this group I was able to conduct in-depth interviews with five of the participants who met the criteria of being champions: those who succeed in adopting healthy lifestyles in their communities. To preserve the privacy of the participants, all names of individuals used in the study are fictional. Participants were interviewed three times: first, about their ethnic cultural diets before they came to the United States; second, about the changes they made after arriving; and third, about whether there were any changes in their overall family health.

Participants' lifestyles changed when they arrived in the United States and took part in the nutrition program. For them this was a life-changing experience that fostered positive feelings and impacted their families. The interviews provided understating as to how participants became champions and became successful at adopting healthy lifestyles by looking into their interests and motivations.

In this chapter I will describe the personal stories of my participants by focusing on their lifestyle changes. I am using my participants' own words to describe their experiences as I tell their stories; I will use *italics* to quote from the following personal stories. I will then briefly present the findings of the study. Chapter 5 will focus on how these findings are supported by previous research and implications for practitioners.

I was able to interview thirteen participants in the first session; six participants were not qualified for the second interview and were dismissed from the project. Interviews were scheduled for the remaining seven but one participant decided to withdraw from the program due to personal issues. The personal stories of my five participants focus on their life stories before coming to United States and after they arrived. The narratives of the first session are presented below.

Ms. Mango

First interview. Ms. Mango is a warm, open, and positive woman. She grew up in Lao and has lived in the United States for 13 years, receiving her GED diploma from St. Paul public school. She described that her childhood in Lao was an easy life because she did not have to work. As an oldest child she learned to cook, do the grocery shopping, and take care of her sibling from an early age.

> *Well, as I remember we ate rice/sticky rice every meals; without rice it was not a meal for us. Since I am the oldest girl, I had to help my mother out on prepared meals, look after my younger sibling, frequent trip to the market. The food that I like to eat the most was grills fish with tamarind source that my mom made with variety vegetables like cucumbers, lettuces, and mints. We grow our own*

vegetables in the back yard. We had Mango trees, coconut trees, and banana trees.

Arriving in the United States was a big change for Ms. Mango and her family. The language barrier, transportation, and food are often the most daunting when families arrive in the United States with little or no pre-arrival knowledge of the place. Ms. Mango mentioned that her family ate American food more since it was easy to find in the fast food places and they had less time to cook.

We did not visit Dr. Office when we were not sick, I don't know what to tell you about healthy or not back then, but I know I was skinny when I first come to U.S., but not anymore. I found out I have high fat in my blood and my mom had too much sugar in the blood.

After she had been here for more than 10 years, her family's health had changed:

I worked two jobs. I had no times to exercise and cook. I sometime pick up fast food on the way home for my family.

Second interview. I then interviewed Ms. Mango about her experience in the United States and in nutrition class.

My friend Noy called about cooking classes that will offer at Lao center for 8 sessions to learn about healthy food. I like the classes very much; teacher let us involved: prepared, discussed, and shows us how to cook healthy food. I learned how important our body needs foods; some foods are bad for you, food you don't need to eat too much, easy way to do exercise, and have fun with your family. At the end of class each week, she let you planned your own goal and share in the

class for the next session. I learned a lot from these classes; couple things that help me to change my mind were when teacher show pictures of block artery, how much sugar in can of pop. She is my inspiration to practice eating healthy.

In addition to her cooking experience prior to taking the nutrition class, Ms. Mango felt the classes taught her about basic health concerns and needs, preparing her to eat healthier. It was a great satisfaction for her to attend the class, but it was difficult for her to make changes even though she knew changes would help her family. As she went forward with the changes for her family, she was not happy with the changes she made. The first change she made was reducing the soda pop in the house by providing less cans of pop each week, allowing the family to drink more water and 100% juice at meal times. Her second change was reducing salt in food. Each time she cooked she added less salt. For example, instead of two teaspoons of salt she put in 1¾ teaspoons, and the next time, 1½ teaspoons, and so on.

The "take home goal" every week made her want to practice what she learned and she couldn't wait to return to class to share her successes. Her teacher inspired her and was a big influence in making changes to her lifestyle. She described her teacher as friendly, knowledgeable, and available. She was there to help students succeed. She was a role model for students.

Every week I was looking forward to go to class, to learn new topic to try new cooking and tasting foods that we made. However, in Lao community it was difficult to talk to people about changing their diets. This was especially true of the elder women: they would not want to hear advice from the younger generation.

Ms. Mango's main challenge was time: time to shop and time to prepare food. She learned from her class about planning a weekly menu. Seeking the involvement of a family member in this planning made her life easier.

> *It was the happy day for me when I approached my family at dinner time at the kitchen table to plan the menu for the whole week, their reaction and question was what is you trying to do? I explain to them that was a part of my nutrition class that I am taking and I need all of you to help me by involved in this activity.*

Since then, her family has kept the routine of planning a family meal every week. She said it was not easy to change but you need to keep working until you reach your goal. Ms. Mango was an advocate for her community; she promoted the healthy cooking class by telling stories to people in her community about how her family diet had changed and the outcome of those changes.

Mr. Fish

First interview. Mr. Fish is from Vietnam. He currently works for his church and has lived with his family in St. Paul for 30 years. He reported that he had been a fish man in Vietnam with his father since he was 15 years old. He was raised in a family of seven children growing up near the ocean. His story is similar to Ms. Mango's.

> *What I remember the most about food eating back in Vietnam was I eat rice seven days a week three times a day. Without rice it was not called meals. My mom makes good fish soup, fish congee, grills fish, and cook rice with banana leaf.*

When his family arrived in Minnesota, it was very hard for them to adjust to the new country, especially since they had been raised near the ocean. Asian foods and stores

were hard to locate since his family had no transportation. The language barrier was also an obstacle. Western food was introduced to his family by his pastor and church members when they arrived. He received his GED from St. Paul public school and worked as a church counselor.

Mr. Fish described that his family was healthy back home because all they ate was rice and fish and they walked from place to place. *"Life is changed after arrived in Minnesota; I work in the building now and no more on the boat every day for me. Also I like to eat McDonald and ice-cream."* After he had lived here for all those years, the overall health of his family had changed significantly—especially weight gain.

Second interview. At his church, Mr. Fish heard a co-worker talking about a cooking class that would be offered once a week at the church by University of Minnesota extension. He was the last one to sign up for the class because he needed to discuss taking time off with his supervisor. Mr. Fish had been eager to learn because he saw the potential for him to change his eating habits. He was happy that he was able to participate. He liked the way teacher laid out the sessions, telling them what to expect in each week. He learned how to share and help each other solve problems.

He remembers to mention food safety and hands-on cooking of healthy cultural food. "*My sisters, my mom, and my wife are in charge of the kitchen at our house and I cannot wait to show them what I learned."*

Mr. Fish told me that it was hard for him to change his family diet because he did not have experience with cooking and his family made fun of him when he came up with suggestions regarding food to cook or eat. To change his family's eating habits, Mr. Fish

took his learning experience from class and taught his family about healthy food and physical activity each week. Many things like the benefits of hands-on cooking and how much fats, salts, and sugars are in the food that ate every day made him want to change the way his family ate eat foods.

He said it was hard for people in his community to understand how the foods you eat every day affect you. After he attended the class, Mr. Fish was a role model for his community. He always brought a healthy lunch to work to show off to his co-worker.

He freely acknowledged that his teacher was the one that motivated him to make changes. *"My teacher was much supported, and she makes me feel that I need to make changes to be better in life."*

Ms. Noodle

First interview. Ms. Noodle's parents were immigrants from Cambodia, arriving in the United States in 1983. At 5 feet 4 inches—an average height by American female standards—Ms. Noodle was considered to be tall among Cambodian women. Her family moved from Colorado to Minnesota 15 years ago. She got her education in the camp in Thailand and had 2 years of college in the United States.

> *I still remember going through my childhood back in Cambodia. My mom always reminded us on how important rice is, we have to have rice in every meal, and rice is a God mother of food for our people, also she kept telling us about in Pol Pot regime rice is value than gold. The foods that I like the most was sour soup with pineapple, tomatoes, hairy melon, chicken and three kinds of mints, I ate with rice.*

It was not easy for the family when they first arrived in the United States. The language barrier, finances, and lack of transportation and access to Asian grocery stores were big challenges for her family, as they were for all refugees and immigrants. "*It was very difficult for my parent more than us kids when we got here, especially when they cannot speak English and cannot eat American food."*

She described that back home people ate food because they were hungry and drank water because they were thirsty. Her family still cooks and prepares cultural food every week. She can tell that they had been putting on more weight since coming to America.

Second interview. Attending nutrition classes was her choice because she wanted to learn about healthy eating and physical activities. She also enjoyed the classes as a time to socialize with friends. *"My friend Darya was my inspiration to join the classes."* Darya was her best friend from high school. She had also taken a nutrition class and now had moved back home with her mother and worked with a non-government organization.

Ms. Noodle mentioned that most of the classes included hands-on activities and visual pictures. Fat tubes displayed the amount of fat in foods. She saw how much sugar was in a can of pop and how much salt was in food—these were jaw dropping for her. She said the teacher was a big encouragement for her, with her friendly smile. She was very knowledgeable and that made all the difference. "*Supported and understood where we coming from were a plus for a good teacher in the community."*

The change from white rice to brown rice was a challenge for her family, but Ms. Noodle leaned from class to serve both white rice and brown rice and switch slowly. She

learned the most important steps were goal setting, practicing with family and teaching what she'd learned, and discussing what worked and what did not work. She learned from hearing about the other students' experiences and said the teacher motivated people to change. *"The ways my teacher presented in class it makes me feel like I wanted to change even though I know change it hard but I can do it."*

Changing the eating habits was the hardest for her community people. After completing the nutrition training Ms. Noodle became an advocate for her community and helped her people to understand the importance of diet and exercise. She also became a recruiter for the nutrition class.

Mr. Yogurt

First interview. Mr. Yogurt is a Karen (pronounced Kah-Ren) from Burma who came to America to pursue a better life. He arrived in Minnesota in 2007 with his family and has lived in the United States for 8 years. He now lives in St. Paul. He was in a camp in Thailand for 15 years and received his high school diploma there. He is a freelance interpreter for his community.

> *Oh well, I was grown up in the mountain before escaped to camp Thailand. In the mountain we grow rice on the hills by burned trees in forest to make rice fields for planted rice. Those living on the hills were hunters (animals, birds, insects, and fish).*

He liked to eat Karen rice soup with all kinds of vegetables and meat back in the mountains. It was a big change for him and his family when they first arrived in Minnesota: the language barrier, financial situation, transportation, and availability of

Karen food in the camp. Malnutrition was a problem for all refugees. His family was considered healthy when they first arrived, but after living here for a while his mother developed diabetes, high cholesterol, and high blood pressure.

Second interview. Mr. Yogurt decided to attend a nutrition class because he wanted to learn about healthy food for his family. *"I wanted to learn about eating healthy food and physical active since my mom had diabetes and high cholesterol."*

Hands-on cooking was a great experience for him because most men from his country do not cook. It was hard to change his family's eating habits but he had to do it because he knew it would serve them well in the future. He took his nutrition class seriously by being involved with his family, preparing meals, and cutting down on unhealthy snacks. He introduced his family to brown rice, fruits and vegetables, less salt and sugar, and eating smaller portion sizes.

Mr. Yogurt felt that the nutrition class helped him and his family do well at healthy eating and physical activities. He was showing his mother how to do her exercises at home for thirty minutes each day. Mr. Yogurt found great satisfaction attending the class. He knew that it would be difficult for him to make changes but he knew that the changes would do well for his family. At first his family would not cooperate with his ideas of changes but after a while they began to get accustomed to the changes.

The first change he made was to serve brown rice mixed with white rice at each meal. Second, he reduced the salt added during cooking. Third, he provided more fresh fruits for snacks and drank more water. He mentioned that his nutrition teacher inspired

him to change his lifestyle. *"She is my role model for eating healthy. When she teaches she make me felt I got it, I wanted to changes. She is open and shares her experience with students, and understands where I came from."*

In his community he was able to tell stories to people about how his family's diet had changed. He explained to his friends and community what he'd learned about nutrition and how great the class was. He encouraged his friends and community to attend the classes.

Ms. Papaya

First interview. Ms. Papaya's parents came from Lao but they are Hmong. They lived on the border of Thailand and Lao. Ms. Papaya herself was born in Lao and lived there for 18 years. She received her education in Lao and the United States.

Back home her family ate mostly sticky rice, rice, meat (chicken, beef, fish, and pork), and some fruits and vegetables. She liked to eat sticky rice and papaya salad with beef jerky. It was hard for her and her family when they first arrived here due to the language barrier, lack of transportation, their financial situation, and the lack of Asian foods in American grocery stores. The family made changes by looking for food that was similar to Hmong food in American grocery stores. After living here in the United States for some time they noticed their health had changed negatively; for example, weight gain and developing health issues.

Second interview. It was her decision to take the nutrition class because she wanted to learn how to prepare healthy food for her family. All her friends kept talking about how helpful the nutrition class was for them and suggested she should participate in

the next session. Her friend, Samsy, was her inspiration: *"Every time we had potluck for our get together Samsy always bring healthy food and brown rice for us to try and led us go for a walk or dancing for exercise for a day."*

Ms. Papaya said nutrition class was eye opening for her, motivating her to change her lifestyle regarding healthy eating and exercising. She also said it was very hard for her to change or give up food that she had enjoyed for a long time, but she knew she had to work harder for her health and her family's health. Her plan was to cut down on the sticky rice intake that her family liked to eat and replace it with brown rice, provide less pop at her house and replace it with water and 100% juice, and eat smaller amounts of meat.

She wanted to practice what she had learned in class because of the ways her teacher presented, taught, and demonstrated the ideas (how much sugar in a can of pop, fats, sodium game). The teacher was very open and let students be involved in hands-on cooking, discussions, and problem solving, and encouraged the classmates to help each other with their weekly goal-setting. Ms. Papaya described that her teacher was the one that motivated her to make changes to her lifestyle.

> *My teacher was very open, calm when come to discussion in class about our goal each week. She always gave us the opportunity to present what worked what did not worked about our goal and let students learn/help each other in that issue. I proud of myself, when know that I can do it and my teacher will supported me in making the change for my own good.*

It was very hard for people in her community to change when it came to food.

To be successful, you had to keep trying, not give up, and show the outcome of changes for you or your family. It took time for her family to get comfortable with change. When she met with friends she told stories about her family's lifestyles changes after taking the nutrition class and how great the teacher was in dealing with community people.

Resettlement and Challenges

The participants' resettlement resulted in them having to overcome numerous challenges. Immigrants come to the United States from many different countries as well as from varied social, cultural, educational, and language backgrounds. They tend to live in smaller and more heterogeneous groups of refugees, thus their integration into new communities is very difficult. The key challenges include cultural adjustment, attitudes and patterns of their new communities, their language and communication skills, and economic self-sufficiency.

Participants had to adjust to life in the United States while they dealt with their often traumatic past experiences. They also faced serious nutrition risks before arrival in the United States, including undiagnosed chronic disease and lack of knowledge about healthy food. When arriving in the United States they were confronted with a lot of cheap, fatty, unhealthy foods and an entirely new way of life.

Upon arrival, all participants typically had very limited finances that led to difficult choices at the grocery store. They may have had no transportation and may have been in unfamiliar surroundings. They were engaging in their own country's lifestyles and communities—centered on family and friends from the same community. Many of them have struggled with their place in their new communities. Responsiveness of self-

help and increased confidence in their life situation seems to be enhanced when they experience a component of the change they perceive in themselves.

Before and after participation in nutrition class. It is clearly a connected and integral part of the story that when asked about keeping healthy back home the participants did not think it was important; no one paid attention to foods or healthy lifestyles. But when asked the same questions about living in the United States their answers changed. Since participating in the nutrition program, healthy food was considered key to a healthy life. For example, 5 participants mentioned they wanted to change from eating white rice to brown rice and limit unhealthy snacks, pops, fatty foods, sugar, and salt. A few tried to add exercise into their daily routine. They gained an opportunity to examine change in their lives. Their responses were more about the individual's ability to cope with changes and actions than them in the past and present.

Challenges and motivation of the changes. Regarding the decision to attend nutrition class, Ms. Papaya, Mr. Yogurt, and Ms. Noodle were self-referred; Ms. Mango and Mr. Fish followed a friend. All agreed that it was difficult to make changes to their own and their family's eating habits and lifestyles, even though they knew it would be good for the future. Participants said they learned a lot from the nutrition class and experienced great satisfaction from the opportunity to practice what they had learned. They had never before been given the chance to express themselves like they were in the interviews—this seemed to be a defining aspect of the participants' experiences.

When considering whether or not a specific person had motivated them to change their lifestyles, all of the participants credited their teacher.

Ms. Mango: *My teacher is a role model for me to changes my lifestyles from unhealthy to healthy. She delivery her presentations with enthusiasm, energy, passion and I interested in the materials.*

Mr. Fish: *Many thing that I learned from my teacher but one thing that struck me the most is her personality. She very interested in my concern and my background and believed in me to change my lifestyle.*

Ms. Papaya: *The take-home practice of hands-on activities, goals setting, and let me know the next topic make me looking forward for next week class*.

Mr. Yogurt: *Each week before class dismissed, my teacher help me/students in the classroom to set up to our goal that is challenging for me/students in view of my experience to take home to practice with our family and report back the results to the class next week.*

Ms. Noodle: *My teacher let me choose my goal topics each week to take home to practice with my family and she reassures me it is not easy to changes*.

As Wang and Han (2001) have said, when students are given choices to select assignments that are close to their personal interests, their motivation to do work should increase. The point of this story theme is that the teacher was creating an open and positive atmosphere that helped students feel they were valued community members. The teacher helped students find personal meaning in the materials they used in class by assigning tasks of their choice and giving them positive feedback that encouraged their belief that they could do well and succeed.

When thinking about change, especially community change, there are important tasks involving leaders of the family and community. Persuading people in their community to learn about healthy lifestyles was frustrating for them. All five participants expressed that they wanted to help their community members understand the importance of a healthy lifestyle. It is a story circle: when one hears another's story and experience within that shared storytelling, individuals realize they are not alone in their challenges and changing lifestyles. All of the participants in my study voiced concerns about the negative influences by people from their community who did not understand or practice healthy lifestyles. To overcome that issue, they turned to their desire to serve the community; this motivated them to focus on becoming champions of healthy lifestyles. All participants discussed how they were always learning and keeping their eyes open to new ideas in order to engage community members.

Community Champions

In this theme, community champions demonstrate how they were involved with the experiences of participants outside of the classroom, and how this enhanced the sense of accomplishment and wellbeing among within each community. Many community champions commented that they were misunderstood and often rejected by community members. To fulfill the commitment of helping to foster change within their community, champions often form strong bonds with the leaders of organizations, community, and family. All five participants were champions and succeeded in adopting healthy lifestyles. This promoted empowerment and skill building that extended beyond the nutrition class into other areas of participants' lives.

The champions from this study focused on their own communities due to a lot of barriers that they were faced with such as language, confidence, lack of education, and knowledge of nutrition and foods. The community champions were able to break these barriers as they could speak their own language as they passed on what they had learned from their participation in the nutrition classes. They were able to build confidence between individuals by being from the same community and speaking the same language. They were the gate keepers and role models; they were trusted to share knowledge and experiences with the community members. In turn, the communities recognized the value of their contributions.

Summary

In this chapter, I elaborated on four finding themes of my study: (a) all my Asian participants face the challenges and experiences to the life in the new country and they had to work hard to support and adjust to their changed lifestyles; (b) it is clear that all wanted to change lifestyles for themselves, their family, and their community; (c) lifestyle changes were not easy for everybody but all had shown that they would not give up—the study shows that the teacher was the role model and motivation for them to change their lifestyles; (d) all five participants were champions for their own communities even though they knew how difficult it was to change people's habits.

In the upcoming chapter I will discuss the need to adopt content to fit culturally diverse participants and I will provide my conclusion.

Chapter Five: Discussion and Conclusion

The underlying purpose of this research was to understand how participants become champions at adopting healthy lifestyles. This research undertaking was designed to learn from participants' experiences, in their own words. The idea was to then analyze their stories, noting when they spoke of common goals and life experiences that led to their success. This chapter will provide a summary of the study, relate the findings, and suggest possible directions for future programing.

Given the high rate of health issues found in refugees and immigrant communities after they arrived in the United States, I became interested in learning more about this problem and especially about how certain people learned to adopt more healthy lifestyles, becoming champions within their communities. I wondered if their stories would provide insight into why and how they changed their lifestyles, even when other members of the same community were not.

Findings

Participants' experiences are crucial. For some participants their lived experiences enabled them to adapt healthier lifestyles due to busy work lives. The stories of the participants were riveting as they described their participation in the nutrition classes. These champions had succeeded in adopting healthy lifestyles and in becoming healthy-living advocates for their communities. As I read and evaluated their captivating stories I was interested in how their experiences, ethnicity, background, and changing attitudes toward lifestyle had resulted in positive changes for their family and community.

They learned from people within their community or family members who had faced health challenges, for example childhood obesity, diabetes, high blood pressure, and heart disease. Anything that helps them redefine their lives and pushes them to improve is beneficial, and watching these struggles allowed them refocus and take action. They respond well when provided with examples of how others have changed their lifestyles; this allows them to take the first steps away from fear and toward positive change themselves.

The participants included Khmer, Hmong, Lao, Karen, and Vietnamese people. All of the participants were refugees and immigrants from Asia and spoke at least one language other than English, but all participants were able to communicate clearly in English.

The method I used was narrative analysis of the story telling by each participant, allowing the story to be recorded in a naturally occurring setting and then analyzed for themes that were both general and specific.

To understand how change happens for participants, content alone would not be enough. One would have to (a) understand the participants' motivations for attending the classes; (b) shed light onto the relevant discussions; and (c) try to convey this information in a way that highlights how the learning process is experienced by the participants.

A conceptual component is also necessary in order to understand how participants create and interpret health information in a meaningful way. The teacher needs to be connected to participants and understanding of their realities in order to motivate engagement and participation. This engagement is valuable for the participants. The

evidence from participants shows a positive effect between changing their lifestyle and behavioral changes. The evidence is even stronger regarding health outcomes.

The first guiding research question was: How do participants in the Community Health Education Program become champions of the program and succeed in adopting healthy lifestyles? This study has found that a supportive relationship between educators and participants leads to stronger outcomes regarding participants' learning. From the participants' stories I have learned that key factors to positive outcomes are: (a) the teacher-participant relationship; (b) the support of the participant's family and community; (c) education about negative food habits, such as fat, sugar, and salt content; (d) the way knowledge is conveyed, for example, hands-on learning seemed to be very important. Using the interview questions concerning "before and after arrival in the United States," the analysis of the participants' changing behavior showed improvement in accordance with their changing lifestyles.

a) The teacher-participant relationship: The relationship among the teacher/educator and the participant is crucial. Acknowledgement, an equal relationship, and friendliness (approachability) all play a critical role in programming. It opens a connection for the message that is practical and empowering. This mirrors what is suggested in education literature.
b) Support of participant's family and community: Participants learn best when engaged directly with family and community on incorporating knowledge to enhance learning. They possess tremendous experiential knowledge of subject matter and the ability to identify culture and histories.

c) Education regarding negative food habits such as fat, sugar, and salts: Unhealthy food habits can negatively affect learning. For example, skipping breakfast can negatively impact the ability to learn. A diet high in junk food and sugary sodas can link to childhood obesity. Participants also learned by recognizing and understanding visual pictures shown in the classes.

d) Hands-on learning: According to the interviews, this method of learning is very important. Participants mastered change effectively by practicing what they learned in classes and sharing that knowledge with their families at home.

The second guiding research question was: What can we learn about their success? This study shows the following: (a) because of the uniqueness of each community and nature of the study I learned that community people would listen to their own people's stories and try to adopt or do the same when they saw how great the outcomes were; (b) teachers or educators were teaching or showing how important changing lifestyles were, but not all took the knowledge of their learning in class and applied it to their own situation, until they heard the story from a person who had a successful outcome; (c) story-telling was very popular and successful within the community—in this case the organizations or University Extension should consider including more people from these specific communities on their staff.

Responding to these factors, community programs have been developed which promote the health and maintenance of immigrants' health statuses. These services that provide basic education about health and nutrition have been designed to prevent both onset and transmission of preventable disease as well as to help maintain current health

(Aday, 2001).

As suggested by Nicolaou et al. (2006), in order to achieve desired outcomes, these programs must promote healthy eating rather than discourage unhealthy eating. Jere Brophy (1987) has said motivation to learn is a competence acquired "through general experience but stimulated most directly through modeling, communication of expectations, and direct instruction or socialization by significant others (especially parents and teachers)." Given the lack of role models in Southeast Asian communities, people were listening and following people's stories of healthy lifestyles from within their ethnic group. As stated by Roger E (1962), "adoption is an individual process detailing the series of stages one undergoes from first hearing about a product to finally adopting it."

Previous research supports the findings gleaned from the stories of this study's participants. The importance of the teacher participant relationship is referenced time and again by the interviewees. It is not an overstatement to say that a relationship helped students learn and master the new habits and skills that they will need. It is tremendously important to have a good teacher or mentor to give you encouragement and direction along the way. The teacher/educator can change a student's life and there are an endless amount of stories attesting to the benefit of a strong relationship. The greatest teachers, educators, and most influential role models are able to connect with students and reach out to them on multiple levels.

Ms. Mango: *My teacher is a role model for me to changes my lifestyles from unhealthy healthy. She delivery her presentation with enthusiasm, energy, passion*

and I am interested in the materials. Teacher worked with me to write down my goals for example: I will change my eating habit from white rice to brown rice in one month and exercise 30 minutes to one hour on Tuesday, Thursday, Friday, and Sunday. She also help made calendar for kept track of my goals and if I missed my goals I have my plan to work on Monday and Wednesday.

Mr. Fish*: Many thing that I learn from my teacher but one thing that struck me the most is her personally. She is very interested in my concern and my background and believed in me to change my lifestyle. I had too many goals that I wanted to work with but teacher taught me to start up with one goal/activity and have a plan for how I will deal with troubles when they occur. My goal is to cut down high fat, sugar, salt snack and to eat healthy snack in one month and my plan to deal with when I have a craving for unhealthy snack, I will eat fresh fruits or dried nuts and fresh cut vegetables.*

These relationships are crucial to a successful program and successful champions; the support of participant's family and community is also indicated in these previous studies, for example, Wallerstein & Bernestein (1988) said that participation of people in group action and dialogue efforts directed at community targets enhances control and beliefs in the ability to change people's lives.

Education about negative food habits, such as fat, sugar, and salt were found to be important, although Aday suggested it would be more effective to focus on the positive rather than negative aspects of healthy eating. The way knowledge is conveyed, for

example hand-on learning, also seemed to be important. To change behavior, one must direct the head of the household and community leaders to motivate the family member and make them aware of what needs to change and feel they need to make those changes. Many people know these facts, but knowing was not enough; to get on the far side of knowing you have to give them clear direction and explain why change is needed. In order to encourage change it is better to be positive than negative. For example, it is better to make positive suggestions, such as, "When you're at the grocery store instead of buying soda pop get 100% juice, because your family members will drink whatever is around" than to simply tell them to "eat or drink healthy" or "don't buy soda pop."

> Ms. Papaya: *The take-home practice of hand-on activities, goals setting, and menu planning before shopping also, let me know the next topic make me look forward for the next class. My family had refuse to follow my ideas of change and complain about food had no taste.*

> Mr. Yogurt: *Each week before class dismissed teacher help me /students in the classroom to set up our goal that is challenging for me/students in view of my experience to take home practice with our family and report back the results to the class.*

I found out that the interviewees were struggling when they approached family members about their plan to change their family's eating habits. Members were not cooperative and refused to follow the plan, due to a lack of understanding. Topics on how to make family members understand were brought up in class discussions and the teacher

was prepared to help the students with this topic.

When changing structures within the way of life: first, make it easier for family members; second, progress gradually and carefully from one stage to the next—show them your plan or menu and reason for change; third, work and connect with family members and people in your community. Through this study, I became aware that slow change was more successful: to help people change to eating healthier, some community champions served half white rice and half brown rice, gradually moving to serving just brown rice within a month. Providing fresh fruits and vegetables for snacks in their house was another plan to cut down on sugary, fatty, and salty snacks. Making 100% juice and water available for family members to drink around the house was an effective way to cut out high sugar options. Another idea was to add tofu to soup and the ground meat they were using in foods such as meatballs, baked eggrolls, and spring rolls. That small change effected a big change.

In summary, it seems likely that the family's eating experience is a major factor in successful changes—their attitude toward foods, and their relationship with food. Diet related diseases among South East Asians strongly suggests a need to adopt diets lower in fat, salt, and sugar in addition to including more physical activity. However, such changes would be contrary to some traditional South East Asian cultural practices. Cultural attitudes about where and with whom certain foods are eaten also emerged as a hurdle toward healthy lifestyles.

The way the classes were taught is crucial. In the next section I will review the recommendations for practitioners and make recommendations for future research.

Recommendations

There is growing interest about the integration of research and practice in health promotion intervention. In this study, the nutrition program can improve families' health and wellbeing, by motivating participants and delivering practical cultural information, which in turn will lead to participants' wellbeing in diverse communities. This will have a positive social effect on these communities. Given the lack of role models in each community, Asian people are more likely to listen to the leaders and follow their own countrymen.

Here are my recommendations:

1. Teachers' and educators' cultural background made a large impact in the classroom setting, whether it was a community center or public school. As evidenced by the stories told, the teachers' personal experience, how the participants viewed their role as cultural representatives, and their language and traditions impacted their daily life.
2. Implement standards evidence based curriculum and a more community learner-centered approach. The lesson learned is related to the confidence and experience of the teachers, educators, and facilitator to deliver the program.
3. Top down programming at the level of participants and join professional community cultural training.
4. Integrate culturally specific activities to promote physical activities.

5. Provide nutrition education using specific Southeast Asian foods and develop strategies for overcoming communities' and family members' preferences for unhealthy foods versus healthy Southeast Asian foods.

Limitations of the Study

The limitations of this study are three fold. First, there are few studies and current literature that address understanding how participants become champions and succeed in adopting healthy lifestyles in the context of non-profit organizations. The second limitation has to do with the scope of the study. This study focused only on Southeast Asia. The findings and recommendations may be different for different groups. The third limitation was that adult participants were the sole focus of this study, limiting its relevancy to others, for example teens, young adults and elders.

Future Research

There is an interest in understanding how participants become champions and succeed in adopting healthy lifestyles as a process that bridges research and practice in applied real life of participants and health science. At the same time, there are few studies and little evidence to draw from in order to provide guidance to this study effort. Studies similar to this one, focusing on implementation, are needed to identify other factors and compare and contrast the work of multiple organizations. There is a need to conduct more research, focus on others regions, and to focus on other age groups.

Knowledge of implementation programs could help determine a baseline and further studies could identify changes that occurred in order to fully understand how the knowledge transfer process happens in these growing communities. Successful programs

could be studied for further insights into how change happens. In order to develop suitable nutrition interventions we must study the unhealthy behaviors which are influencing the eating habits of these communities with the goal of improving long term health outcomes for South East Asians.

New Beginning

I still strive to be one of the Asian female leaders in my community. Through this study I have gained a great deal of knowledge and insight about Southeast Asian community champions, and as a leader I am today a changed person from when I began this study in 2010. This has been a study of hope for both my participants and myself. This study of positive deliberation and future action has been most motivating. I am ready for new beginnings as an Asian American woman who aspires to be a leader in the community.

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Appendix A: Interview Protocol

Interview Process

Demographic information

- What is your age?
- Gender: M/F
- Where were you born?
- How long did you live there before coming to the United States?
- When did you come to Minnesota?
- Where did you get your education? (Both in the home country and in the United States)

Cultural and ethnic diets, before coming to the United States

- Tell me about your eating habits back in your country.
- Describe what a typical meal would consist of.
- What were the things you enjoyed eating most?
- Was western food available and did you or your family eat western food?

Changed eating habits since coming to the United States

- What were the challenges when you first arrived in planning food for the family?
- Tell me about the changes you made in your lifestyle when you first arrived.
- How would you describe your health or your family's health when you first arrived?
- Have there been changes in your family's:
    - Weight?
    - Physical exercise?
    - Overall health?

Participating in the health and nutrition program

- What made you decide to take part in the program?
- How did you hear of the program?
- Was there one special person who inspired you to take part?

- What has been your greatest satisfaction when attending the class?
- Was it hard to make change even though you knew something was good for you?
- Tell me about how you thought about these changes as you went forward.
- Describe your first experiences at trying to change?
- What happened in the class that made you want to practice what you learned?
- Was it one special person or many things; was there an "aha" moment?

Overcoming obstacles

- What things make it hard for people in your community to make changes to the family diet? How did you manage this?
- What were the obstacles you personally had to overcome?
- Did family or others object to the changes?

Persuading others in the community

- How would you persuade a friend to go to classes?
- What would you tell them?

Checking back with the participants (triangulation)

- What is missing from these stories?
- Have I got your story right?
- Is there anything else about participating in the program that you would like to share?

Appendix B: IRB Exemption

The IRB: Human Subjects Committee determined that the referenced study is exempt from review under federal guidelines 45 CFR Part 46.101(b) category #2 SURVEYS/INTERVIEWS; STANDARDIZED EDUCATIONAL TESTS; OBSERVATION OF PUBLIC BEHAVIOR.

Study Number: 1502E63381

Principal Investigator: Phalla Keo

Title(s):
Understanding How Participants in a Community Nutrition Program Become Champions and succeed in Adopting Healthy Lifestyles

This e-mail confirmation is your official University of Minnesota HRPP notification of exemption from full committee review. You will not receive a hard copy or letter.

This secure electronic notification between password protected authentications has been deemed by the University of Minnesota to constitute a legal signature.

The study number above is assigned to your research. That number and the title of your study must be used in all communication with the IRB office.

Research that involves observation can be approved under this category without obtaining consent.

SURVEY OR INTERVIEW RESEARCH APPROVED AS EXEMPT UNDER THIS CATEGORY IS LIMITED TO ADULT SUBJECTS.

This exemption is valid for five years from the date of this correspondence and will be filed inactive at that time. You will receive a notification prior to inactivation. If this research will extend beyond five years, you must submit a new application to the IRB before the study's expiration date.

Upon receipt of this email, you may begin your research. If you have questions, please call the IRB office at (612) 626-5654.

You may go to the View Completed section of research Central at http://eresearch.umn.edu/ to view further details on your study.

The IRB wishes you success with this research.

Consent Form

Understanding How Participants in a Community Nutrition Program Become Champions and Succeed in Adopting Healthy Lifestyles

You are invited to be in a research study of the understanding how participants in a nutrition program become champions and succeed in adopting healthy lifestyles in twin cities, Minnesota. You were selected as a possible participant because your name was identified through a local community organization. I ask you that you read this form and ask any questions you may have before agreeing to be in the study.

This study being conducted by: Phalla Keo, a Doctoral student at the University of Minnesota

Background Information

The purpose of this study is: To understand what the meaning of the experiences of champions is and succeed in adopting the healthy lifestyles and how does their succeed impact their personal lives, families and their adaptation to the community where they lives.

Procedures:

If you are agree to be in this study, I would ask you to reflect on your own experience as a champion succeed in adopting healthy lifestyles and to tell your story and give examples in a 1- to 3 hours interviews answering the questions of the research based on your reflection. The interview will be recorded.

Risks and benefits of being in the study

The study has a possible minimal risk: You may feel invasion of privacy. However the information you provide while telling your story will be private and anonymous and no names or relationship to any organization will be released.

The benefits to participants are: To contribute to provide information to Community Nutrition to understand the experiences of Champions and succeed in adopting healthy lifestyles to develop programs and provide services to community and their family.

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only researches will have access to the records. (*If tape recordings or videotapes are make, explain who will have access, if they will be used for education purposes, and when they will be erased.)*

Voluntary Nature of the Study:
Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with University of Minnesota or the Community organization which provided me your name. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and questions:
The researcher supervising this study is: Dr. Rosemarie Park. You may ask any questions you have now. If you have questions later, **you are encourages** to contact her at Room 410 E WullH
86 Pleasant St. S.E Minneapolis, MN 55455, Phone : 612-626-6267, email: parkx002@umn.edu

If you have questions or concerns regarding this study and would like to talk to someone other than researcher, **you are encouraged** to contact the Research Subject' Advocate line. D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; 612-625-1650.

You will be given a copy of this information to keep for your records.

Statement of Consent:
I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature: _____

Date: _____

Signature of Investigator:_____

Date: _____