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Perceived Benefits and Barriers to Physical Activity Among Older Latina Women[1]

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Evidence of the benefits of physical activity in the health of aging women continues to grow, but questions remain about the factors that influence these women's ability to engage in this behavior. The authors used a qualitative design to describe the social and culture-specific perceived benefits and barriers to physical activity among 143 Latina women, ages 40 to 79. Content analysis of these women's responses revealed that perceived benefits (health promotion, physical fitness, improved roles) and barriers (time constraints of women's roles, personal health, internal and external factors) function as competing elements that may explain physical inactivity. Health care providers should emphasize overcoming barriers and promote perceived benefits as clinical interventions that may pose the greatest potential to increase physical activity among aging Latina women. This emphasis holds promise as a feasible and effective primary care intervention for achieving increased physical-activity-related health benefits.

One of the most significant modifiable risk factors for many diseases is physical inactivity. From the classical work of Morris and colleagues (Morris, Heady, Raffle, & Parks, 1953) to the most recent work of Blair and associates (Sevick et al., 2000), the scientific literature has shown the significant physical and psychosocial benefits of physical activity for individuals of all ages. As a result, the 1996 Center for Disease Control and Prevention's report on physical activity and health recommended that all individuals should maintain a minimum of 30 minutes of moderate intensity physical activity on

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most days (Center for Disease Control and Prevention, 1996). Despite the known effects of regular physical activity, a large proportion of women of all ages and ethnic groups do not engage in regular physical activity. Women exercise less frequently than men, and as they age, their exercise participation decreases (O'Brien & Vertinsky, 1991). Some studies have focused on exercise in older women, but few studies include older ethnic women and how they view the benefits of regular physical activity as well as the barriers they experience (Eyler et al., 1998). The aim of this article is to describe the perceived benefits and barriers to physical activity from the viewpoint and experiences of Latina women.

PHYSICAL ACTIVITY AND WOMEN

Latina women tend to live sedentary lifestyles, and they do not engage in physical activity that promotes heart health (Burchfiel et al., 1990; Jones & Nies, 1996; Sanders-Phillips, 1994). When compared to White women, Latina women are not less informed of the benefits of physical activity (Hazuda, Stern, Gaskill, Haffner, & Gardner, 1983; Juarbe, 1997). Studies with Latina women have shown that with increased socioeconomic status, education, and acculturation, physical activity—especially exercise behaviors—increased, in particular among younger Latina women (Hazuda et al., 1983; Shea et al., 1991). Other psychosocial variables such as social roles (Wilson, 1995), social support (Suarez, Nichols, & Brady, 1993), personal internal control (Bundek, Marks, & Richardson, 1993), and perceived self-efficacy of exercise (Sanders-Phillips, 1994) have been found to be significant predictors for other health behaviors in older Latina women.

Several factors that affect women's abilities to engage in regular physical activity across all ages and ethnic groups include women's roles, lack of family support, and cultural beliefs (McAuley & Jacobson, 1991; Mobility, 1992). Some studies have been conducted to analyze the reported benefits and barriers to physical activity in women (Evans & Nies, 1997; Gillett, 1988; Johnson, Corrigan, Dubbert, & Gramling, 1990; Jones & Nies, 1996; Juarbe, 1997; Verhoef & Love, 1994; Zunft et al., 1998), and two researchers have developed scales to quantify and measure benefit and barrier perceptions (Cash, Novy, & Grant, 1994; Sechrist, Noble Walker, & Pender, 1987).

The majority of these studies have focused on younger women. Women in these studies have reported benefits such as life enhancement, increased feelings of well-being, physical fitness, improved mental health, social

interaction, body image, and overall health promotion benefits. Women have also reported many barriers to physical activity, such as social and gender-related role constraints, embarrassment, age, geographical distance to fitness facilities, cost, time limitations, and lack of spousal and family support. Older women report similar benefits of and barriers to staying physically active, but they are more likely to report benefits related to the aging process and barriers related to being old and having poor personal health (Booth, Bauman, Owen, & Gore, 1997; Lee, 1993; Zunft, et al., 1998).

PURPOSE OF STUDY

There is little research related to physical activity in aging Latina women. The vast majority of studies have focused on younger Mexican women and they lack information regarding the perceived benefits and barriers to physical activity. The purpose of this study is to describe older Latina women's perceptions of benefits and barriers to engage in physical activity. This article is part of a larger research project aimed at determining physical activity predictors in a sample of older Latina and White women in northern California. It focuses on the content analysis of the Latina women's responses to two open-ended questions that were asked prior to the formal structured survey.

Operational Definitions

Physical activity and exercise were defined according to the work of Caspersen and colleagues (Caspersen, Powell, & Christenson, 1985). Physical activity was defined accordingly as "any bodily movements produced by skeletal muscles that result in energy expenditure" (p. 126). Exercise was defined as a subset of physical activity, specifically, "planned, structured, repetitive, and purposive bodily movement done to improve or maintain one or more components of physical fitness" (p. 128). National origin was used as part of the screening criteria to ensure the inclusion of Latina women in the study. "Latina women" is used in this article to refer to women whose national origin is Central and South America, Mexico, Puerto Rico, or Cuba.

Benefits of physical activity were defined as women's perceptions of positive and enjoyable outcomes of this behavior. Barriers were described as those factors that were perceived as problems, challenges, or difficulties within their own gender, physical, and sociocultural realities. Benefits and barriers to physical activity were written and listed as described by each

participant. Women were encouraged to express their own feelings and asked to describe what benefits and barriers they valued and perceived to be significant from their own daily life experiences when working at home, outside the home, or during leisure-time activities.

DESIGN

We used a qualitative design to describe Latina women's perceived benefits and barriers to physical activity. Content analysis was performed to analyze the qualitative data obtained through semistructured interviews. The interviews were conducted in the language of preference (English or Spanish), with a questionnaire that had three sections. The first section is a semistructured interview that was completed before the formal structured interview and includes the questions used for the content analysis discussed in this study.

SAMPLE

We interviewed a nonprobability and purposive sample of 143 women whose national origins are Mexico, Central and South America, Puerto Rico, and Cuba who completed a self-identity screening tool to establish ethnicity. The sociodemographic characteristics of the participants are displayed in Table 1. The age of participants ranged from 40 to 79, with a median age of 55. In general, most were low income, married or living with a partner, and without college degrees. The majority of the interviews were conducted in Spanish (125, 87%) with low to moderately acculturated women. Eighty-three percent (119) were from Mexico, 14 (10%) from Central America, 7 (5%) from Cuba and Puerto Rico, and 3 (2%) from South America. Only 10% (14) worked in a professional occupation. Most were housewives (50, 35%), worked in low-paid positions (66, 46%), or as volunteers (5, 3%). Of the women who worked, either at home or outside the home, many worked an average of 7 hours per day. Seventy-six percent (108) had health insurance.

DATA COLLECTION METHODS AND PROCEDURES

Women were invited to participate in the study through contacts in local community-based organizations, in senior residential housing and activity

TABLE 1: Sociodemographic Characteristics of Older Latina Women Ages 40 to 79, Northern California 1998-1999 (*N* = 143)

Characteristic	*Frequency*	*Proportion (%)*
Age distribution		
40 to 49 years	54	38
50 to 64 years	56	39
65 to 79 years	33	23
Marital status[a]		
Single/never married	10	7
Married/living with a partner	75	53
Divorced	27	19
Widowed	29	21
Grade completed		
1-8	53	37
9-12	51	36
Some college or college graduate	28	19
Technical or vocational education	11	8
Income[b]		
< $5,000-$10,000	29	20
$10,001-$20,000	20	14
$20,001-$39,000	30	21
$39,001-$60,000	26	18
> $60,000	23	16

a. Missing data for 2 participants.
b. Two percent refused to answer and 9% were not sure or did not know the family income.

programs, and through announcements in local newspapers and senior newsletters. A telephone number, at which collect calls were accepted, was made available for interested women to give them the opportunity to ask questions about the study. If the woman agreed to participate, an appointment was made with the principal investigator or an interviewer at a time, date, and location that was convenient for the participant. Four bilingual and bicultural Latina women, skilled as survey workers, were trained to complete the surveys for this project. Each survey worker was trained in conducting the interviews and was personally monitored during the first 5 to 10 interviews by the investigator to ensure valid and reliable data collection procedures.

The study was approved by the Committee on the Protection of Human Subjects at the University of California, San Francisco. At the time of the interviews, each participant received a copy of the informed consent in the language preferred by the respondent. If the participant was unable to read,

the consent form was read aloud and verbal consent was obtained. Each participant was given all the information that was available about the interview content and research process, and it was presented in an easy and clear manner so that the women would understand the research protocol. Women were told to be actively involved and to interact with their feelings and opinions during the interview. They were encouraged to ask questions and to voice their concerns about their perceptions of benefits and barriers to physical activity. The identity of the participants was kept confidential, and a code number was used to identify each interview packet. Each interview took approximately 2 hours, and participants received $20 compensation.

Instruments

Two open-ended questions were posed to the participants before the formal structured interview: "Please tell me in your own words, what are the benefits of being physically active and/or exercising?" and "What are the barriers you have encountered in staying physically active and/or exercising?" Women were asked to describe in their own words the perceived benefits of engaging in or maintaining regular physical activity working at home, outside the home, or during leisure time. Each response was written verbatim by the interviewer and later typed in a word processing program. The responses, which were coded according to the participants' key numbers to maintain confidentiality, were printed as a document and submitted for thematic analysis. The sentences and phrases were the units of analysis.

The last two sections of the interview consisted of the 7-day Physical Activity Recall (7D-PAR), a valid and reliable physical activity recall questionnaire (Mayer et al., 1991), and a standardized general health and sociodemographic section that includes information on fall history, walking ability, current health problems, self-reported weight, height, age, ethnicity, marital status, years of completed education, employment, income, wealth, access to health care, living arrangements, and number of years lived in the United States. The Medical Effectiveness Research Center for Diverse Communities (MERC) Self-Identity Screening Tool was used (MERC, 1997). This is a valid and reliable tool from the MERC to establish ethnicity by national origin in culturally diverse populations. We used the Marín and colleagues' (Marín, Sabogal, VanOss Marín, Otero-Sabogal, & Pérez-Stable, 1987) standardized acculturation scale to describe the acculturation level of the participants. The validity and reliability of this language-based scale have been established and discussed in detail elsewhere (Marín et al., 1987). Validation analyses of this scale have been conducted with multiple

large samples of Mexican and Central American Latinos. Cronbach's alpha reliability across different studies has been found to be between .89 and .91. In this study, the coefficient of reliability was .91.

DATA ANALYSIS

Demographic data were analyzed using descriptive statistics. Measures of central tendency were used for interval/ratio data. Nominal and ordinal data on participants' characteristics were analyzed with frequencies and proportions. Data analysis for the responses to the open-ended questions was conducted through content analysis (Krippendorf, 1980; Miles & Huberman, 1994). The analysis included the process of line-by-line open coding of each response, statement, or phrase. Two investigators coded the data independently and met several times at later dates to reconcile and perform a reliability check on the emerging themes and to complete the analysis of theme clusters and categories.

Ninety-five percent agreement was achieved for the analysis of the perception of benefits and 97% for the perception of barriers. Miles and Huberman's (1994) processes of content analysis were followed. Data reduction was accomplished by a process of selecting, simplifying, abstracting, and transforming the data to develop an initial coding scheme. This was accomplished by the grouping of codes according to their conceptual clarity. The codes were organized and compressed to display categories or clusters of themes. The last step included analysis and verification of emerging themes and their categorization into the final theme categories. The open coding themes were then listed and enumerated under each of the theme categories to describe their frequency in the analysis and to analyze these responses in the context of socioeconomic and acculturation differences.

Several steps were followed to ensure the scientific adequacy and rigor for qualitative analysis, including reflexivity (Lamb & Huttlinger, 1989), credibility, fittingness, auditability (Sandelowski, 1986), and the use of self (Lipson, 1991). The authors are bilingual and bicultural and have personal and professional experience working with aging Latina women. Credibility and auditability were enhanced by verbatim transcriptions of all statements, open coding format, and individual coding.

FINDINGS

Sociodemographic characteristics and the findings from the MERC self-identity ethnicity scale are described in the Sample section. The acculturation scale mean score is 2.4 ($SD \pm 1.03$), indicating that this sample consists of a low to moderately acculturated group of women. Because most studies have reported on socioeconomic status, education, acculturation, and health behaviors among Latina women, we analyzed these factors, as well as age and found that there were no differences in benefits or barriers perceptions by socioeconomic or educational levels, or by acculturation. Three trends were noted; they were all related to perceived barriers. Many of the women who reported time and role constraints as barriers were more likely be of a slightly higher educational and income status and to work outside the home. There was no difference in the mean acculturation score of women who described time and role constraints, health, and external factors as barriers. Women who described internal factors as barriers had a lower mean acculturation score. Across all ages, women described similar barrier perceptions, but women who described health-specific barriers were more likely to be older.

Analysis and discussion of the results from the 7D-PAR is beyond the scope of this article, but briefly, 76% of the sample was physically inactive as established by national recommendations for physical activity. According to the body mass index (BMI), most of the participants (92, 64%) were overweight (22% = BMI: 26.0 kilograms/meter^2 [kg/m^2] to 28.9 kg/m^2) or obese (42% = BMI ≥ 29.0 kg/m^2) with a mean BMI of 30.5 ($SD \pm 7$). A large number of the women were diagnosed with one or multiple chronic health conditions such as arthritis (46, 32%), hypertension (37, 26%), and diabetes (16, 11%).

The categories derived from the analysis of perceived benefits and barriers to physical activity suggest that this group of older Latina women undergo a complex process when confronted with decisions to engage in physical activity. From the perspective of these women the central issues are not related to the perceived benefits but to the difficult struggles related to the multiple barriers that they experience. Both the perceived benefits and barriers functioned as competing factors that, in fact, may explain some of the reasons why this group of women is found to be physically inactive.

TABLE 2: Categories of Themes, Descriptions, and Characteristics of Perceived Barriers to Physical Activity Among Older Latina Women (*N* = 143), Northern California, 1998-1999

Perceived Barrier Theme	*Description and Characteristics*
Time constraints and women's roles	Caregiving: partners/spouses, grandchildren, other family members
	Occupational roles
	Spousal and maternal roles
Personal health	Chronic disabling illnesses: hypertension, diabetes, peripheral vascular disease, arthritis, back injury, chronic pain, orthopedic limitations
Internal factors	Lack of determination: *flojera* (sluggishness), *desidia* (neglect), *pereza* (laziness), *haraganeria* (idleness)
	Lack of motivation: tiredness, lack of energy, fatigue, chronic health problems, lack of family and spousal support, due to health, lack of energy and fatigue
External factors	Transportation, community safety, cost of facilities, weather, distance to fitness facilities

Perceived Barriers

Women attributed many benefits to staying physically active, but many described barriers that precluded their actually carrying out physical activities. Table 2 lists the most frequently reported categories of barriers with their description and characteristics. Analysis of the data generated four categories that encompassed barriers as perceived by this group of older Latina women: time constraints and women's roles, personal health, and internal and external factors.

Time Constraints and Women's Roles

The theme that captured most of the responses relating to perceived barriers to physical activities was the multiple demands of women's roles and on their time. This barrier was mentioned 46 times by the participants. Most of the responses referred to the continual and complex demands on their time as a result of their roles as women. This role had a profound impact on women's time and their ability to engage in regular physical activities. These women believe that informal caregiving, occupational, spousal, and maternal roles are barriers to physical activity. Informal caregiving responsibilities included caring for young or older children, grandchildren, or an ill or disabled partner, or caring for other family members. A 60-year-old

participant related, "There is no time. I am taking care of my grandchildren, and my husband is ill." Other time- and role-contributing factors were related to work both inside and outside the home. Women stated that their multiple responsibilities, such as working, resulted in fatigue, tiredness, and lack of motivation to maintain a pattern of regular physical activity.

Multiple role responsibilities were perceived as a significant barrier that limited the time women had to take care of themselves or to even consider a regular plan of physical activity. Some women expressed frustration and a sense of defeat in managing their time and responsibilities: "I have to watch over my grandchildren, take care of my husband, cook all day, and do housework."

In addition to work outside the home and other gender-related responsibilities, a number of women were committed to community, civic, and religious organizations. These women also expressed burdens related to their time commitments and their ability to manage time to engage in regular physical activity. A wife of a church leader who worked full-time as a nonpaid volunteer stated, "There is no time because I have many responsibilities as a church leader's wife and also at home." Lack of time due to informal caregiving roles, work, family obligations, and other volunteer roles were also mentioned as perceived barriers to engaging in regular physical activity. Feelings of fatigue, lack of energy, or tiredness were seen as an outcome of multiple roles and as additional barriers.

Personal Health

Many participants (41) referred to their personal health as the most significant barrier to maintaining a regular program of physical activity. These women mentioned a variety of chronic disabling illnesses that influenced their ability to stay physically active. A number of responses dealt with physical limitations related to diseases such as arthritis, circulatory problems, or back injuries. For example, "I do not have good circulation in my legs, and I cannot bend my knees because I have a back injury."

Some of the answers related to personal health barriers revealed a general lack of understanding of the role of physical activity and medical conditions. These participants believed that they neither should nor were allowed to engage in regular physical activities due to their medical diagnosis. For instance, a 74-year-old woman who was recently diagnosed with atrial fibrillation stated, "I have atrial fibrillation, so I try not to overdue my physical activity." Another woman who had a diagnosis of essential hypertension stated, "I cannot exercise because of my health. I have hypertension, and that's my barrier to exercise." In another example, a 51-year-old woman

who had had arthritis for several years perceived that the greatest barrier to staying physically active was her arthritis.

A number of respondents were also affected by physical disabilities or chronic illnesses that were mentioned as the most important or only barrier to engaging in regular physical activities. For example, "My barrier is my disability. I have had a disability for 3 years. I cannot sit or stand for long periods of time." Some women recalled turning points in which their disability became their barrier to staying physically active. As one said, "I have a work-related injury, and all of my physical activities stopped since that time." With the exception of daily activities, this group of women perceived poor or ill health as the greatest barrier to engaging in regular physical activities to promote health.

Internal Factors

The third most frequently mentioned theme was related to a sense of internal personal control. Thirty-six women mentioned lack of determination and motivation as barriers to engaging in regular physical activities. The participants frequently used the word *flojera* (sluggishness) as a personal internal factor that led to lack of determination. Flojera refers to a feeling of overall inactivity that could be the result of fatigue, tiredness, or a general sense of physical and emotional inertia. The term, also used as a synonym for laziness, is associated with lack of perseverance and persistency for personal actions: "It is the flojera and tiredness after work."

Women also used other personal adjectives such as *haraganeria* (idleness), *pereza* (laziness), and *desidia* (neglect) to describe how these personal characteristics influence their ability to engage in physical activities. For example, "Laziness, lack of decision, and determination are barriers. One thinks that one is going to do it tomorrow, and then you do not do it at all." Many participants mentioned that they were not motivated to make a decision to exercise. This lack of motivation was mentioned as a personal factor that was a barrier to engaging in physical activity. Poor health, lack of energy, fatigue, lack of family and spousal support, and tiredness were all factors that led to the lack of motivation. When reflecting about this issue, a 57-year-old woman stated, "We do not have the discipline to make time to exercise. It is not one of our priorities."

External Factors

Participants also mentioned several external and environmental factors that affect their ability to stay physically active. Lack of transportation, cost, geographical distance to appropriate public or private fitness facilities, lack

of community safety, and weather were mentioned 13 times as barriers. For example, "I do not have any physical problems, but I do not drive, and I do not have transportation to go to places where I can exercise." Other participants often lived in small rooms with their family members, in shared residential facilities, or in apartment complexes. Many felt that they had limited space for engaging in physical activities or other types of aerobic exercise. One woman mentioned, "The barrier is the space. The house is too small and I do not have the appropriate space to exercise."

Perceived Benefits

A unique finding in this sample is that the statements on perceived benefits of physical activity were mostly focused on how such activity improves the roles of Latina women in the context of the family. Although women perceived many benefits from staying physically active, the majority (73%) were physically inactive according to the physical activity recall scale. The most important perceived benefits for taking part in physical activity or in regular exercise are listed in Table 3.

Three specific themes emerged from this question: health promotion, improved gender roles, and physical fitness. We found that many Latina women engaged in regular physical activity for the perceived benefits to health promotion and their influence on gender-related roles. They did so to gain more energy to meet their responsibilities and to improve their quality of work as caregivers, working women, spouses, and mothers. The focus of Latina women was directed at improving family roles rather than for health promotion or physical fitness as a personal gain.

Health Promotion

Ninety-one percent of the participants mentioned that a regular pattern of physical activity led to personal health promotion benefits. In particular, women mentioned that these health benefits (a) led to a sense of improved overall physical health, (b) helped in the management of disease and in illnesses prevention, and (c) promoted mental health.

Women mentioned that physical activity maintained or improved their health by promoting heart health and improving the quality of life. The following quotes reflect the perceptions of many of these participants: "Physical activity is good for you. It is good to maintain the circulation of the heart. It is good for your health." "Exercising is good for weight maintenance, to improve the health of your heart, and to maintain normal cholesterol levels."

TABLE 3: Categories of Themes, Descriptions, and Characteristics of Perceived Benefits to Physical Activity Among Older Latina Women (*N* = 143), Northern California, 1998-1999

Perceived Benefit Theme	*Description and Characteristics*
Health promotion	Overall physical health: heart health, improved quality of life and sleep quality, longevity and staying younger/reducing aging, increased energy and enhanced feelings of well-being
	Management of disease and illnesses prevention: Symptom management, that is, pain
	Promote mental health: improved mental alertness and mood, reduced stress, and better mental disposition
Improved roles	Family roles: for the future of children and family; passing health legacy to children, improved caregiving for children and family
	Working role: improved physical aptitude and quality of work
Physical fitness	Health and physical performance: physical stamina, weight management, physical agility, body strength, endurance, mobility, muscle toning

In addition to these health promotion benefits, participants described how physical activities enhanced their energy and overall feelings of well-being. A 41-year-old woman stated that the greatest benefit she received from exercising was the energy and strength that resulted as an outcome of staying physically active: "The benefit of staying physically active is improved circulation. Your muscles are strengthened, you feel good, and you can then have more energy." A 61-year-old woman stated, "When I exercise I feel better, less 'rusty,' more active, healthy, and with energy." Women who were actively participating in regular physical activity were able to state multiple benefits that resulted in overall feelings of well-being and better quality of life, including improved patterns and quality of sleep: "The benefit is that you are healthy. I feel good. It gives me happiness and total vitality. When I do not do anything, I do not feel good. I have no energy."

Several women also felt that regular physical activities are extremely important for a healthy aging process, to reduce the signs of aging, and to look younger: "When you stay physically active, you do not age as fast. You can be free of many illnesses, including arthritis and muscular diseases, and you can walk better when you get to an old age."

A small group of women mentioned that regular physical activities were strategies in managing diseases such as arthritis, hypertension, and cholesterol. For example, a 56-year-old woman related, "Exercise helps me with my high blood pressure, with my heart problems, and with my diabetes." In particular, pain was mentioned as a symptom that could be improved and managed with physical activity: "When I exercise, I feel more relaxed. I feel that my leg pain is improved, and I can become more active. When I exercise, I can control my diabetes much better." A few respondents also mentioned the ability to prevent other illnesses as one of the benefits of physical activity. For instance, a 53-year-old woman stated, "When I exercise, I am in better health. Exercise keeps your circulation going. I can prevent arthritis or stiffness of the body."

Some women mentioned the positive outcome on their mental health as a benefit of staying physically active. The most commonly mentioned mental health benefit was mental alertness. The participants also mentioned such other benefits as stress reduction, enhanced mental motivation, mood improvement, and mental disposition to engage in daily living or role-related responsibilities. For instance, some women who work at home or outside the home stated that a benefits of exercising was their ability to reduce stress at work: "I feel mentally and physically good when I exercise. My mind feels clear, and I use this time to pray and meditate. It gives me a great start to my day."

Improved Roles

Twenty of the participants mentioned perceived benefits related to improved gender-related roles. By staying physically active they were able to maintain or improve their roles as mothers, spouses, or family members. This particular group of women perceived that the benefits extended from those that produced a personal gain to those that extended to their children and families: "I exercise to improve my health and for my children." One woman in particular felt that by exercising she was able to pass this health behavior and "legacy" to her children; she said, "Exercise makes you healthy. You feel better and you motivate your children to exercise." Women also perceived that staying physically active improved their roles as caregivers to their children, grandchildren, or family members. For example, "I stay physically active to have more energy to help my family" and "The benefit is to feel well. I feel useful because I can still take care of my grandchildren and take them to places." Women also perceived that their occupational roles were performed with much more agility and stamina if they exercised regularly. They often stated that exercise improved the

quality of their work and enhanced their physical potential. A 58-year-old woman stated, "When I exercise, I have more energy to do my work."

Physical Fitness

Twenty-one women in the study mentioned improved physical fitness as one of the benefits of regular physical activity. Among others, this group of women mentioned improved physical agility and weight management as benefits that improved their overall health. For instance, a 47-year-old woman stated, "Exercise is good for everything, including your mental and physical health. But as you get older, you have to maintain your flexibility and manage your weight."

Although less frequently, the respondents also listed benefits that are attributes of physical fitness such as physical agility, body strength, endurance, mobility, muscle toning, and stamina: "I stay physically active because of stamina, to feel better, and for muscle toning."

DISCUSSION

Over the past two decades, evolving scientific knowledge in the published literature has focused on describing socioeconomic differences rather than physical activity perceptions among Latina women. Our interviews indicate that despite the high prevalence of physical inactivity, this group of low to moderately acculturated older Latina women were very articulate in identifying health promotion, physical fitness, and improved gender roles as benefits of physical activity. These benefits are similar to those reported by women in other studies, but there are several cultural differences when compared to White women and women of other ethnic backgrounds in the United States and other countries. For instance, in studies with African American (Jones & Nies, 1996) and other non-White women (Booth et al., 1997; Cash et al., 1994), the authors reported personal enjoyment, entertainment, and social interactions as primary benefits of exercising. In our study, none of the women stated these as personal benefits. Participants perceive little or no time for social interactions outside the home and family because of their multiple role responsibilities. As has been reported previously in the literature with Latinos, this perception may also be the result of issues related to familism (Marín & VanOss Marín, 1991). Latina women in this sample may have focused on benefits that promoted a sense of respect and pride in family and extended family interactions rather than on those that result from interactions outside the family unit. In addition to health

promotion, the perceptions of benefits of older Latina women were directed at improving their roles in the context of the family, which is far more important to them than personal or individualistic gains. In this group of low to moderately acculturated older Latina women, these values are strongly guarded and may differ from those that may be reported by younger and more acculturated samples of Latina women.

As opposed to the results of other studies (Booth et al., 1997), this sample did not report being outdoors as a benefit of physical activity. Being outdoors may not be perceived as a benefit because physical safety and weather barriers hindered women from enjoying outdoor physical activities. Many participants reported a preference for engaging in physical activities at home to avoid exercising outdoors.

With the exception of old-age perceptions, the barriers reported are similar to those in other studies with ethnically diverse women. In particular, the findings are comparable to those reported in a recent qualitative study on minority women (Asian American/Pacific Islander, Black, Hispanic, and American Indian), in which lack of time stemmed from taking care of the family, children, spouses, and grandchildren (Eyler et al., 1998). In Eyler's (1998) study, and in others conducted in European countries, up to 20% of women perceived that they were too old to exercise (Zunft et al., 1998). In our study, women did not mention old age as a barrier. Many felt that walking and doing household chores alone were ways of being physically active; consequently, they did not perceive their age as a barrier to engaging in regular exercise or to staying physically active.

The trend noted on barrier perceptions related to time and role constraints may be explained by the fact that women with higher educational levels are more likely to work outside the home. They may therefore be more likely to perceive time and role constraints as physical activity barriers rather than internal or external control barriers.

There are several limitations to this study. The results of this study are limited by a sample that includes a wide range of ages, and not all findings can be discussed in the context of perceptions and differences between age groups. The tendency noted for older women to describe more personal health-related barriers could be explained in the context of aging and declining health. Aging women develop chronic illnesses and experience physical and psychosocial implications that may be perceived as barriers to physical activity. Many older women in this sample had chronic illnesses, and they were more likely to describe personal health barriers rather than time and role constraints or internal or external factors.

We described the perceptions of a group of Latina women who were low to moderately acculturated and of low educational and socioeconomic status in northern California. Generalizability from this study may be limited and interpreted in the context of socioeconomic, ethnic, and acculturation characteristics. The findings, however, indicate the need for culturally relevant nursing interventions focused on time- and role-constraint barriers and health education to promote physical activity.

NOTE

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