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Voices from a healthy life centre: a qualitative investigation of clients' nutrition and physical activity experiences

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ABSTRACT

Aims: This study aimed to investigate the perceptions and experiences of clients attending a healthy life centre in Amasya for weight management and physical activity counselling.

Methods: This qualitative study was conducted through telephone interviews with 23 individuals who had attended weight management counseling. Participants were adults aged 18 years and over who attended the healthy life centre in Amasya for weight management and were randomly selected from those who received weight management services. Semi-structured interviews were conducted to explore participants' experiences with the healthy life centre, including their reasons for applying, their access to and satisfaction with the services, and changes in their wellbeing. Using NVivo12, transcripts were analysed thematically based on grounded theory.

Results: The mean age of participants was 32.57 years (±6.1), with weight loss being a common reason for attending. The majority of participants attended a single session (n=9), and the primary sources of awareness about the center were friends (n=6) and family (n=3).The thematic analysis revealed five major themes: 1) impact on healthy living, 2) lack of promotion, 3) satisfaction, 4) reason for ceasing, and 5) suggestions for the future.

Conclusion: This study emphasises the positive impact of healthy life centres on clients' health and lifestyle behaviors, with patients reporting significant improvements in their nutritional habits and increased physical activity levels due to the counseling they received. However, the study also showed that people are unaware of the existence of healthy life centres, and that these services are not sufficiently promoted. Therefore, there is a need for the greater promotion of healthy life centres in Turkiye to improve public health.

Keywords: Health promotion, healthy life centre, qualitative research, weight management

INTRODUCTION

One of the main causes of morbidity brought on by the emergence of noncommunicable diseases (NCDs) is negative health behaviours, such as lack of physical activity, unhealthly eating habits, smoking, and excessive alcohol consumption. The World Health Organization (WHO) global plan of action encourages national governments to develop public health strategies to improve human health.[1] The burden of NCDs is a global public health problem that jeopardizes socioeconomic development.[2] In developing nations, where noncommunicable illnesses account for 71% of all causes of mortality, this figure is projected to rise to 55 million by 2030, with about 41 million fatalities globally.[3] According to the status report published by WHO for Turkiye, 34% of these deaths are due to cardiovascular diseases, 23% cancers, 7% chronic respiratory diseases, 5% diabetes, and 21% other noncommunicable diseases.[4]

A combined diet and exercise approach, more commonly known as a lifestyle intervention, has been shown in clinical trials to reverse metabolic abnormalities, reduce dependence on pharmacotherapy, and prevent the progression of diabetes and cardiovascular disease.[5,6] A growing body of literature recognises that the majority of heart disease, stroke, type 2 diabetes, and a significant percentage of cancers could be prevented through healthy dietary choices and lifestyle improvements.[7-11] Community-based interventions and public health policies are needed to combat this rising mortality rates from NCDs in preventive medicine and public health.[12] One of these policies is primary health care. Patients are more likely to modify their behaviour when professionals encourage them. Therefore, primary health care services are ideal environments for behaviour modification-based counselling.[13] Counselling patients on lifestyle change is a key

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task for primary care clinicians.[14] Considering both the direct (e.g. medical care) and indirect (e.g. sickness absenteeism or presenteeism and physical inability) cost of obesity on health systems, weight management programs which encourage people to eat a healthier diet and become more physically active could be cost effective.[15] People who have a low income tend to claim high costs as a barrier to engagement.[16] Individuals could not attend due to the cost of participation, transport and/or childcare.[17] Therefore, it is important to provide such interventions free of cost.

In Turkiye, healthy life centers (HLC) have been established in all 81 provinces to protect individuals and society from risky conditions for health, to strengthen primary healthcare services and to make these services easily accessible, and to encourage a healthy lifestyle. These facilities' target population includes both healthy people and ill people. In Turkiye, Healthy Life Centres provides solutions combating risk factors of NCDs, nutritional counselling, psycho social counselling, oral and dental health, injection services, women's and reproductive health, school health, cancer early diagnosis and screening and education, smoking cessation counselling, counselling for drug users and their relatives, infectious diseases services including control and management.[18]

Few studies have evaluated the efficacy of the services offered in HLCs because these facilities are relatively new and poorly known. In 2017, an HLC was established in Amasya, and this qualitative study aimed to investigate the views and experiences of the citizens who received services at the HLC.

METHODS

Design

This study was approved by Amasya University Ethics Committee (Date: 25.06.2020, Decision No: 89). The study was conducted in accordance with the guidelines of the Declaration of Helsinki. Written consent was obtained during phone conversations by first explaining the study's purpose, procedures, potential risks, and benefits to the participants in detail. Participants were then given the opportunity to ask questions and clarify any concerns. Following verbal agreement, a consent form was sent to them electronically, which they signed and returned via email. This process ensured transparency, informed decision-making, and adherence to ethical standards.

Qualitative research methods focus on exploring and understanding individuals' experiences, perspectives, and behaviors in depth, often through data collection methods including interviews, focus groups, and content analysis. These methods allow researchers to capture rich, contextualised insights that may not be achievable through quantitative approaches.[19-21] This study employed a qualitative research design that utilised telephone interviews to gather in-depth insights.

Telephone interviews were selected to address potential difficulties in transportation, ensuring convenience and accessibility for all participants. This method facilitated open-ended discussions, enabling the collection of rich, detailed data that provided a nuanced understanding of the research topic. The interviews were guided in a semi-structured format, allowing for consistency in questioning and the opportunity to probe deeper into emerging themes.

Subjects and Settings

This qualitative study was conducted from July to September 2020 through telephone interviews to explore the views and experiences of the services offered. Telephone interviewing was determined to be an appropriate data collection method, considering COVID 19 pandemic restrictions.

Amasya is a city located in the north of Turkiye with a population of 339.529 as of the end of 2023.[22] The participants consisted of adults aged 18 years and over who attended the HLC in Amasya for weight management. Pregnant women were excluded from this study.

Participants for the telephone interviews were randomly selected from the data received from the bioelectrical impedance scale (Tanita-BC 418). The Tanita measurements were initially used to identify individuals attending the center for weight management or physical activity, as all participants' data were recorded on Tanita-BC 418. However, no weight-related data from the measurements were utilised in the study. The only information extracted from the records was participants' telephone numbers, which were used solely for recruiting participants for the telephone interviews.

Randomisation was managed by the lead researcher using the identification numbers of the clients through an online random drawing generator. 2652 adults whose attendance frequency ranged from one to 12, were entered into the generator. When the generator provided potential participants, they were contacted, and those who volunteered to be interviewed were included in the study. The sample size was specified by data saturation when no new themes emerged from participants' experiences. In qualitative research, the goal is not to calculate sample size based on statistical power but to achieve data fullness and saturation, where no new information is emerging from additional participants.[20,21] The sample size in qualitative studies is determined by the point of saturation, ensuring the depth and richness of the data are adequately captured to address the research questions.[21,23]

All telephone interviews were conducted by a doctoral student (EDK). At the beginning of each telephone conversation, the aim of the interview was explained, and verbal consent was obtained for the interview to be recorded using a voice recording application.

Data Collection

Semi-structured interviews were conducted based on the flexible study design of a qualitative approach. An interview guide was developed based on previous literature and expert and health practitioner opinions (appendix), but the questions were not restricted to the order in the guide to allow a natural discussion. The interview guide was piloted with two participants in the target population and two experts in the health sciences to assess its clarity and comprehensiveness. No significant changes were deemed necessary, as all the questions were clear and easy to understand. This feedback was used to confirm the suitability of the interview schedule

for the main study, ensuring that it adequately captured the experiences and perspectives of the HLC attendees.

The interviews started with the following questions: "How did you first hear about the centre?" and "How did you access the centre (transportation)?". The interview then continued with the main questions, exploring the experiences of participants regarding the services, and concluded by asking their suggestions on how to improve the services. Prompts such as "Can you tell me more about this?" and "Can you tell me the reason behind your answer?" were used as appropriate to receive more depth from the responses. Telephone interviews were completed when clear patterns and data saturation emerged. Each telephone interview lasted between 6-8 minutes.

Appendix: Semi-structured Interview Guide

Introduction

Hello (the researcher introduces himself), we are interviewing you to better understand what clients think about Healthy Life Centre (HLC) in Amasya and how the services could be improved. So there are no right or wrong answers to any of our questions, we are interested in your own experiences.

Participation in this study is voluntary and your decision to participate, or not participate, will not affect the services you currently receive from the HLC. The interview will take approximately 8-10 minutes. I would like to audio record the interview with your permission; however all responses will be kept confidential. All information will be anonymised (will only be shared with research team members).

You may decline to answer any question or stop the interview at any time and for any reason. Are there any questions about what I have just explained?

May I turn on the digital recorder?

Age: Gender: Weight: Height:

How did you first get connected with HLC? (How did you hear about it? Were you referred; If so, by whom?)

What was the reason for applying the HLC? (Which services did you receive?; If attended various services, following questions will be asked for the services attended.)

When did you attend the services? (How long have you been involved?; If you cease the services, what is the reason/ reasons?)

How did you access the HLC? (Was it easy or hard?; What kind of transportation vehicle did you use?; How long did it take to access the HLC?)

How would you describe your wellbeing since receiving services from HLC? (Has your general well-being improved, declined, or remained the same? What do you think are the reasons for any changes in your health? If your health has improved, what are your thoughts on maintaining this improvement? How likely are you to follow the advice given to you?)

Can you tell me about the services that you are involved? (Was there anything you particularly liked?; Was there anything you didn't like?; What are the reasons?)

Can you tell me your suggestions about how to improve the services? (Are there any other services that you wish to be involved in future?; Why or why not?; Would you recommend HLC to a person with similar needs as you?)

Thank you very much for your time and the information you shared today.

Note: Prompts such as "Can you give an example?", "Can you please tell me more about this?" or "Can you tell me the reasons behind your answer? will be used, as appropriate.

Statistical Analysis

The recorded interviews were stored using identifying numbers (e.g., P01, P02, P03, etc.). The researcher listened to the recordings carefully and transcribed them verbatim using Microsoft Word 2020. The transcripts were analysed using a thematic analysis approach based on grounded theory using a qualitative data management software tool (NVivo12). The analysis process started by coding and labelling similar topics after reading the transcripts several times. Themes were formed using groups that included the same labels and topics. The frequency of words or phrases has also been reported to reflect the importance of a theme based on a quasi-statistical approach.

RESULTS

In total, 23 adults (20 female; 3 male) who attended nutrition and physical activity counselling were interviewed via telephone. The gender ratio of the population represents the gender ratio of adults who attended nutrition counselling over the last two years (2327 female; 325 male). The mean age of the participants was 32.57±6.1, with a minimum age of 21 and a maximum age of 42. A common reason for attendance to the counselling among interviewees was losing weight.

Interviewees' first attendance dates ranged from when the centre was first launched to when the centre was suspended due to the COVID-19 pandemic (July 2020). Of those reporting the duration of their attendance, the majority (n=9) received services from the centre only once. Other interviewees reported attending twice (n=3), three times (n=3), four times (n=1) and regularly once a month during a year (n=3).

When the participants were asked how they heard about the HLC, of those who answered this question, the majority (n=6) reported that they heard of the centre from their friends, and others (n=3) heard from a family member. A small number of participants emphasised that they attended the centre to accompany their friends (n=3) or one of their family members (n=1).

The following five broad themes emerged from the thematic analysis: 1) impacts on healthy living, 2) lack of promotion, 3) satisfaction, 4) reason for ceasing, 5) suggestions for the future.

Impacts on Healthy Living

Among many interviewees, there was the perception that the services in HLC Amasya had favourable impacts on their lifestyles, as indicated; "In fact, I learned once again how to eat…. I maintain (the behaviours that I gained from the nutrition counselling). Sometimes I gained some weight, then

I tend to lose that weight when I applied her (the dietitian) eating advice." (P08). However, a minority of the participants mentioned that they did not put the advice given by the experts in the centre into practice, as one interviewee said: "Unfortunately, it did not have any impact on my lifestyle in only one session. If I continued, it would probably have an impact." (P19).

A new subtheme emerged in discussions of impact on individuals' lifestyles: weight loss. Several participants (n=7) expressed their experiences with weight loss.

For example, one interviewee said: "I reached my target weight." (P13), and another reported: "Before, I was unable to lose weight. I lost weight thanks to her (the dietitian)." (P07).

Lack of Promotion

An interesting theme to emerge was the centre's failure to publicise its services. The participants were unanimous in that many people living in Amasya were not aware of the existence of this centre. When asked whether the participants attended physical activity counselling when it is available, one participant said: "No, I did not. Personally, I did not even know about it." (P08).

Satisfaction

With respect to satisfaction, pleasure was a sense amongst all interviewees. In one case, the participant thought that the group physical activity session was great (P02). Another interviewee quoted; "It was a very good opportunity for us." (P03). This view was agreed with the statement that the services provided in this centre were almost the same as private centres but were free. Some interviewees reported that they recommended the services in the HLC Amasya to the people around them.

One concern was expressed regarding the accessibility of the centre, as reported; "The centre is far from my house, I wish there was another near to my area." (P21). This view was echoed by another interviewee who said "I wish there were more centres in the locations where everyone could go." (P10).

Reason for Ceasing

Reasons expressed by the interviewees for not continuing to attend the services included reaching the target weight, a busy schedule and moving from the city (Amasya). In addition to these reasons, the COVID-19 pandemic was mentioned by many interviewees for ceasing attendance.

Suggestions for Future Improvements

The interviewees were asked for their suggestions and expectations regarding the HLC. Their views included:

- The number of centres should be increased.
- The services in the centre should be publicised more effectively through social media and leaflets.
- There should be more practitioners (dietitians and physiotherapists) in the centre.
- The clients should be given more detail about their measurements, such as an abdominal fat percentage.
- Group sessions, including walking and running for different gender and age groups, should be organised.

DISCUSSION

This study explored the effectiveness of nutritional and physical activity counselling provided by HLCs, a component of primary healthcare services. To the best of our knowledge, as the first qualitative study in Turkiye to document participants' experiences with HLCs, this research provides novel insights into their impact to the existing literature. Quantitative research has consistently demonstrated the benefits of counselling in primary healthcare settings. For example, Zynk et al.[24] found that nutritional and physical activity counselling for patients with obesity significantly improved health outcomes. Similarly, Reynolds et al.[25] reported that tailored counselling interventions in primary care settings led to better management of chronic conditions.

Despite these positive outcomes, our study also identified challenges related to the COVID-19 pandemic, that led to the suspension of services. The temporary disruption in HLC services impacted program continuity, but did not diminish overall participant satisfaction with the counselling received before the pandemic. This mirrors the findings of other studies that have assessed the impact of pandemic-related interruptions on healthcare services globally.[26,27] Studies have reported reduced access to services for patients with chronic and rare diseases,[28] and an increased workload for healthcare providers.[29]

The participants in our study appreciated the free nature of HLC services, which aligns with recent evidence that cost-free health interventions can enhance participation and satisfaction. Studies by Dhillon et al.[28] and Murayama et al.[29] found that removing financial barriers significantly improves the uptake and effectiveness of health programs. While removing financial barriers can increase service utilisation, it may also increase workloads for health staff and affect their remuneration.[30] Coordinating health financing and human resource policies is essential to address these challenges and ensure sustainable improvements in healthcare access and outcomes.

The Ministry of Health established HLCs in 2018 to improve public health through accessible health-related counselling.[18] However, our study revealed that inadequate promotion of these centres limits public awareness and utilisation. Research indicates that while awareness of primary healthcare centres is generally high among rural populations, the utilisation of their services remains low.[31,32] To improve primary healthcare centre utilisation, researchers recommend regular assessments of patient satisfaction, collaborative efforts between primary healthcare centre staff and communities, and public awareness campaigns through information, education, and communication activities.[31,32] Enhancing the promotion of HLCs through public service announcements, social media campaigns, and community outreach could address these challenges and improve service utilisation.

Patient satisfaction, a key quality indicator in healthcare, was notably high in the present study. Research on patient satisfaction in healthcare settings has consistently shown high levels of contentment with counselling services. Patients value comprehensive care that addresses their specific needs, as seen in cancer patients' positive experiences with interprofessional

complementary and integrative healthcare counselling.[33] Patients with asthma reported satisfaction with primary care counselling, particularly when it was client-oriented and supported self-care adherence.[34] Similarly, patients at a nurse practitioner-led clinic reported high satisfaction with services, especially appreciating the lifestyle counselling that led to positive behavioural changes.[35] Across these studies, patients valued the comprehensive nature of counselling, the expertise of healthcare professionals, and a personalised approach to addressing their health concerns.

Limitations

A limitation of this study is that only telephone interviews were used for data collection. This was because there was a lockdown in Turkiye due to the COVID-19 pandemic and it was not possible to conduct face-to-face interviews, which may have resulted in missing non-verbal expressions, mutual relationships, or trust between participants and the researcher. Future research could benefit from incorporating diverse data collection methods, including in-person interviews, to capture a more comprehensive view of participant experiences. Another limitation of this study is the absence of detailed demographic data, including range, economic status, and education level, which could have provided valuable context for understanding the participants' experiences, perspectives, and behaviors. These factors can influence individuals' responses and may have added depth to the analysis. Future studies may benefit from including such demographic variables to enhance the comprehensiveness and applicability of the findings. Additionaly, lack of gender balance in this study may limit the generalisability of the findings and introduce potential bias in understanding the experiences and perspectives of different genders. While we made efforts to capture diverse viewpoints, the underrepresentation of males may have resulted in an incomplete understanding of their experiences. Future studies should aim for a more gender-balanced sample to ensure a broader and more representative perspective on the topic.

CONCLUSION

In conclusion, this study provides valuable insights into the effectiveness of nutritional and physical activity counselling provided for HLC in Turkiye. This study highlights the positive impact of HLCs on clients' health and lifestyle behaviours. Patients reported improved nutritional habits and increased physical activity levels as a result of the counselling provided by HLCs. Nevertheless, the study also indicated that HLCs are not sufficiently promoted and that patients are not adequately informed of the availability of these services. Therefore, there is a need for increased promotion of HLCs and collaboration between nutritional and physical activity counsellors and primary healthcare physicians. This study contributes to the growing body of research on the importance of primary healthcare services in promoting healthy behaviours and improving public health. Despite the limitation of using only telephone interviews due to the COVID-19 pandemic, the findings of this study suggest that HLCs can be a valuable resource for individuals seeking to improve their health and wellbeing.

ETHICAL DECLARATIONS

Ethics Committee Approval

The study was carried out with the permission of Amasya University Ethics Committee (Date: 25.06.2020, Decision No: 89).

Informed Consent

All patients signed and free and informed consent form.

Referee Evaluation Process

Externally peer-reviewed.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

Financial Disclosure

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Author Contributions

All of the authors declare that they have all participated in the design, execution, and analysis of the paper, and that they have approved the final version.

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