

Implications for Policy to Support Healthy Weight for Women

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ABSTRACT

Worldwide, obesity rates have more than doubled during the past three decades. Women experience twice the obesity prevalence as men, and women of color, with less education, and in lower income levels disproportionately affected. Obesity and its comorbidities result in considerable economic burdens for the individual and society. Given the widespread prevalence of obesity, the potential effect on individual and population health, and associated costs, policy solutions targeting obesity prevention and interventions must be explored.

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Worldwide, obesity is identified as a health epidemic. Since 1980 global rates of obesity have doubled, and more than 1.4 billion adults age 20 years and older are classified as overweight (body mass index [BMI] greater than or equal to 25). Of these, nearly 300 million women meet the definition of *obesity* and have BMIs greater than or equal to 30 (World Health Organization [WHO], 2014a). At present, approximately 65% of the world's populations lives in countries where being overweight and obese result in more deaths than being underweight (WHO, 2014a). In all WHO delineated regions, women are more likely to be obese than men with roughly double the obesity prevalence. Women in the region of the Americas are more likely to be overweight than women living in other regions, and approximately one half of these women are obese (WHO, 2014b).

This global trend toward obesity is reflected in the United States, where more than two thirds of adults were overweight in 2011, and more than one third of those adults (34.9%) were obese (Levi, Segal, St. Laurent, & Rayburn, 2014). Today, two states (Mississippi and West Virginia) report adult obesity rates greater than 35%, 20 states have rates greater than 25%, and all states have rates greater than 20% (Levi et al., 2014). Although the prevalence of obesity is similar among men

and women, some groups are disproportionately affected. African American (47.8%) and Latino (42%) adults are more likely to be obese than their White (32.6%) adult counterparts (Levi et al., 2014). Among African American adults, women are more likely to be obese than men (56.6% compared to 37.1%, respectively) (Ogden, Carroll, Kit, & Flegal, 2012). Although male obesity prevalence is similar at all income and educational levels, obesity prevalence in women increases as education and income levels decrease (Ogden, Lamb, Carroll, & Flegal, 2010). This finding is particularly concerning given that women's poverty rates remain substantially below those of men and are greatest among women of color (Robbins & Morrison, 2014).

Given the significant number of individuals battling obesity globally, the potential effect of obesity on individual and population health, and significant associated costs, policy solutions that target obesity prevention and interventions must be explored. Currently, a patchwork of local, state, and national obesity-related policies exist regarding health care access, food security, improved physical activity, and other interventions. The Patient Protection and Affordable Care Act of 2010 (ACA) presents an opportunity to frame a national response to being overweight and obese that may

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serve to bridge existing policies to form a more coordinated effort. The purpose of this article is to present an overview of obesity-related factors with implications for women's health, discuss policy targeting social determinants that contribute to the obesity epidemic, and explore the framework of policy solutions presented within the ACA.

Women's Health and the Burden of Obesity

Obesity significantly affects women's health across the life span. In the life course perspective theory, health is considered an integrated continuum where a complex interplay of biological, behavioral, psychological, social, and environmental factors contribute to health outcomes across the course of a person's life. Life course perspective provides a framework to better understand and explain the burden of obesity as it relates to women's health outcomes and the associated cost and quality of care (Health Resources and Services Administration [HRSA], n.d.).

Early Programming

Based on the life course perspective, early experiences, such as childhood obesity, can influence an individual's current and future health, may result in expression of a specific disease or condition, or may signal future vulnerability (HRSA, n.d.). For example, obese children are at greater risk for becoming obese adults (Centers for Disease Control and Prevention [CDC], 2012). Although evidence suggests that obesity rates are stabilizing for children and adults, approximately 10% of children become obese as early as age 2 to 5 years, approximately 20.5% of children are obese by adolescence (age 12–19 years), and 6.5% of children age 12 to 19 years are severely obese (Ogden et al., 2012; Skinner & Skelton, 2014). Although the percentage of male high school students who are obese surpasses that of female students, the percentage of students who are overweight is similar for both genders. Rates of obesity and overweight among female Black and Latina students exceed those of White students (Levi et al., 2014).

Incremental lifetime medical costs attributable to obesity are estimated at \$19,000 more for a child who is obese at age 10 than for a 10-year-old child who is normal weight (Finkelstein et al., 2008). Policy initiatives aimed at improving women's health outcomes should consider strategies to decrease childhood obesity as a prevention effort. Although the short-term cost of obesity for a 20-year-old may be relatively modest, the costs associated with continued obesity increase exponentially because obesity promoted diseases become more prevalent as the individual ages (Finkelstein et al., 2008).

Critical or Sensitive Periods

Although adverse events or exposures affect health at any life stage, in the life course perspective theory it is suggested that the effect is more significant at critical or sensitive periods, such as pregnancy (HRSA, n.d.). The burden of obesity-related mortality and morbidity extends to mothers as well. Since 1990, maternal mortality in the United States has nearly doubled. Of approximately four million U.S. women each year who give birth, about 52,000 experience severe complications, and 500 to 600 women die of these complications. Of these maternal deaths, approximately one half are preventable. Leading causes of maternal deaths include thromboemboli, obstetric hemorrhage, and severe hypertension or preeclampsia, all of which have been linked to obesity (National Maternal Health Initiative, 2014; United Nations Fund for Population Activities, 2012).

Approximately 40% of women enter pregnancy overweight or obese, which has significant implications for pregnancy outcomes (Magerison Zilko, Rehkopf, & Abrams, 2010). The risk of miscarriage in obese women is estimated to be 25% to 37% greater than among women who are nonobese. Obesity is linked to a higher incidence of polycystic ovary syndrome (PCOS), an endocrine imbalance that affects fertility (Guelinckx, Devlieger, Beckers, & Vansant, 2008).

Cumulative Impact

Although individual exposures or experiences may have minimal effect on health trajectory, in the life course perspective theory it is indicated that sustained exposure to multiple stressors may have a cumulative effect on health (HRSA, n.d.). For instance, obesity is associated with approximately 20% of cancers in women (Robert Wood Johnson Foundation [RWJF], 2014), including

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