Evaluation and Program Planning 51 (2015) 8–16

Contents lists available at ScienceDirect

Evaluation and Program Planning

journal homepage: www.elsevier.com/locate/evalprogplan

A gender-based approach to developing a healthy lifestyle and healthy weight intervention for diverse Utah women

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ARTICLE INFO

Article history:
Available online 9 December 2014

Keywords:
Gender analysis
Obesity
Health behavior
Diet
Exercise
Physical activity

ABSTRACT

Utah women from some cultural minority groups have higher overweight/obesity rates than the overall population. We utilized a gender-based mixed methods approach to learn about the underlying social, cultural and gender issues that contribute to the increased obesity risk among these women and to inform intervention development. A literature review and analysis of Utah's Behavioral Risk Factor Surveillance System data informed the development of a focus group guide. Focus groups were conducted with five groups of women: African immigrants from Burundi and Rwanda, African Americans, American Indians/Alaskan Natives, Hispanics/Latinas, and Pacific Islanders. Six common themes emerged: (1) health is multidimensional and interventions must address health in this manner; (2) limited resources and time influence health behaviors; (3) norms about healthy weight vary, with certain communities showing more preference to heavier women; (4) women and men have important but different influences on healthy lifestyle practices within households; (5) women have an influential role on the health of families; and (6) opportunities exist within each group to improve health. Seeking insights from these five groups of women helped to identify common and distinct cultural and gender themes related to obesity, which can be used to help elucidate core obesity determinants.

1. Introduction

1.1. Sex, gender and health

Researchers, clinicians, and public health officials have begun to give increased attention to the role of sex and gender on health behaviors and outcomes. The term "sex" includes the biological and physiological characteristics that define men and women, while "gender" includes socially constructed roles, behaviors, activities and attributes that society considers appropriate for males and females (Johnson, Greaves, & Repta, 2009). Research that includes considerations of sex and gender has been increasing over time (Oertelt-Prigione, Parol, Krohn, Preissner, & Regitz-Zagrosek,

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http://dx.doi.org/10.1016/j.evalprogplan.2014.12.003
0149-7189/

2010); however, the terms are often used interchangeably. A gender-based analysis is a process that integrates a gender perspective into the planning, decision making and development of programs and interventions. Historically, research studies and health programs have placed a much stronger emphasis on sex differences than on the more complex interplay between sex, gender and health (Oertelt-Prigione et al., 2010).

Sex differences have been studied and documented for many health problems, including heart disease (Azad, Kathiravelu, Minoosepeher, Hebert, & Fergusson, 2011; Claassen, Sybrandy, Appelman, & Asselbergs, 2012; Lawton, 2011), hypertension (Beigh & Jain, 2012; Mounier-Vehier et al., 2012), diabetes (Sekerija et al., 2012), autoimmune disease (Oertelt-Prigione, 2012; Quintero, Amador-Patarroyo, Montoya-Ortiz, Rojas-Villarraga, & Anaya, 2012) and Alzheimer's disease (Sinforiani et al., 2010). The majority of studies of gender roles and norms and their impact on specific health conditions have been generally limited to reproductive health, domestic violence and mental health (Boileau et al., 2008; Collins, von Unger, & Armbrister, 2008; Ghanotakis, Peacock, & Wilcher, 2012; Kerrigan, Andrrinopoulos, Chung, Glass, & Ellen, 2008; Mantell et al., 2009; Paek, Lee, Salmon, & Witte, 2008; Phillips & Phillips, 2010; Wagner, Yates, & Walcott, 2012; Zuo et al., 2012). Less is known about the impact of gender on health behaviors, specifically in the area of obesity and lifestyle factors that influence healthy weight, such as diet (Costanzo, Musante, Friedman, Kern, & Tomlinson, 1999; Fagerli & Wandel, 1999; Frank et al., 2009; Gavin, Fox, & Grandy, 2011; Gray, Cinciripini, & Cinciripini, 1995) and physical activity (Butt, Weinberg, Breckon, & Claytor, 2011; Frank et al., 2009; Gavin et al., 2011; Langer et al., 2009; McLaren, Godley, & MacNairn, 2009; Sjogren, Hansson, & Stjernberg, 2011; Sjogren & Stjernberg, 2010; Slater & Tiggemann, 2011; Spence et al., 2010), although interest in these topics has increased in recent years.

1.2. Sex differences in overweight/obesity rates

According to the 2007–2008 National Health and Nutrition Examination Survey (NHANES) data, including measured height and weight data and involving a nationally representative sample of the United States population, the age-adjusted prevalence of obesity was 36% among women and 32% among men in the United States (Flegal, Carroll, Ogden, & Curtin, 2010). In 2007, no state had achieved the Healthy People 2010 target of reducing the prevalence of obesity to less than 15% of the population (Centers for Disease Control Prevention (CDC), 2009). In the United States, there are disparities in the rates of obesity among racial and ethnic groups. For example, data from the 2006–2008 U.S. Behavioral Risk Factor Surveillance System (BRFSS) showed that Hispanic/Latinos had a 21% greater prevalence of obesity (29%) and non-Hispanic Blacks or African Americans had a 51% greater prevalence of obesity (36%) when compared to non-Hispanic whites (24%) (Centers for Disease Control Prevention (CDC), 2009). Being overweight or obese reduces the quality of life and increases the risk for many chronic illnesses and early death (Centers for Disease Control and Prevention, 2009). In addition, obesity has staggering costs for both individuals and society. The United States spent over $190 billion on obesity-related health care in 2005 (Cawley & Meyerhoefer, 2012), and obesity was estimated to be responsible for nearly 10% of the medical spending in the United States in 2006 (Finkelstein, Trogdon, Cohen, & Dietz, 2009). These costs are expected to increase substantially if the current obesity trend continues.

There are notable sex differences in the obesity rates, with women generally having higher rates than men. The reasons for this tendency are in part biological (fat distribution, hormonal effects), but socio-cultural or gender factors also play a role (Lovejoy & Sainsbury, 2009). This circumstance is especially true among women from underserved and minority communities. Research increasingly shows correlations between being overweight or obese and chronic illnesses such as diabetes, depression and other serious medical conditions in women (Kautzky-Willer, 2011; Kautzky-Willer et al., 2010). Women have lower levels of physical activity compared to men (Belza et al., 2004; Belza & Warms, 2004) and are less likely to spend free time playing sports or participating in physical activity. Women are more likely to be involved in time-consuming care-giving activities, limiting the amount of leisure time that is available for physical activity (Belza et al., 2004; Belza & Warms, 2004). The groups that are most vulnerable to inadequate physical activity because of care-giving demands are older women who are African American, Hispanic/Latina or American Indian (Belza et al., 2004; Belza & Warms, 2004). Physical activity is often perceived as a "leisure" activity by women, who might feel less likely to engage in activities simply for the sake of being physically active (Belza & Warms, 2004). In addition, research has shown that middle aged and older adult women who are lonely report lower levels of physical activity, which suggests that social and emotional factors are important influences on women's activity levels (Hawkley, Thisted, & Cacioppo, 2009). A number of studies have identified the need to address physical activity, especially among racial and ethnic minority women (Wang, Gortmaker, & Taveras, 2011; Wang et al., 2010).

Despite public health efforts to reduce sex, gender, racial and ethnic health disparities in overweight/obesity, these differences have persisted for decades. Gender roles and norms vary among diverse cultural groups and play a substantial role in these disparities through their strong influence on lifestyle choices and behaviors. However, information is lacking about the underlying social, cultural and gender issues that contribute to the excess obesity risk among women from these cultural minority groups. Calls have been issued to implement evidence-based, gender-specific programs that aim at improving women's health (Kautzky-Willer, 2011; Kautzky-Willer et al., 2010), especially for non-Hispanic black women and Mexican-American women (Wang et al., 2011; Wang et al., 2010). For these programs to be effective, information is needed about ways to engage women, especially underserved women, in physical activity and healthy eating behaviors. Programs must incorporate ways of motivating women, altered or adjusted for environmental factors and must help women fit physical activity into their busy lives as they fulfill multiple roles and responsibilities (Belza et al., 2004). Programs should also address gender roles and norms that serve as barriers to or opportunities for healthy behaviors among women.

Because overweight/obesity is an important public health problem in the United States and disproportionately impacts women, especially those from minority and underserved populations, the Utah Women's Health Coalition (UWHC) sought to gain a greater understanding of the role of gender and culture on obesity and obesity risk factors in Utah. Our community partners expressed a similar interest in addressing these disparities. We used a gender-based analysis to examine gender-based barriers and opportunities that influence healthy behaviors. Our overall goals were to (1) gain a greater understanding of the intersection of cultural and gender issues that are associated with obesity and lifestyle risk factors among African, African American, American Indian/Alaskan Native, Hispanic/Latina and Pacific Islander women in Utah, (2) identify barriers to healthy weight among these communities and (3) identify ways to engage communities in addressing obesity and risk factors for obesity using a gender focus.

This work was undertaken to understand more about the similarities and differences that exist across diverse Utah communities when considering gender-based approaches to