



## Using gender-based analyses to understand physical inactivity among women in Yellowstone County, Montana



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### ARTICLE INFO

#### Article history:

Available online 9 December 2014

#### Keywords:

Physical inactivity

Gender analysis

Gender and health promotion

Gender framework

### ABSTRACT

Physical inactivity contributes to many health problems. Gender, the socially constructed roles and activities deemed appropriate for men and women, is an important factor in women's physical inactivity. To better understand how gender influences participation in leisure-time physical activity, a gender analysis was conducted using sex-disaggregated data from a county-wide health assessment phone survey and a qualitative analysis of focus group transcripts. From this gender analysis, several gender-based constraints emerged, including women's roles as caregivers, which left little time or energy for physical activity, women's leisure time activities and hobbies, which were less active than men's hobbies, and expectations for women's appearance that made them uncomfortable sweating in front of strangers. Gender-based opportunities included women's enjoyment of activity as a social connection, less rigid gender roles for younger women, and a sense of responsibility to set a good example for their families. The gender analysis was used to gain a deeper understanding of gender-based constraints and opportunities related to physical activity. This understanding is being used in the next step of our research to develop a gender-specific intervention to promote physical activity in women that addresses the underlying causes of physical inactivity through accommodation or transformation of those gender norms.

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### 1. Introduction

The World Health Organization's *Manual for Integrating Gender into Reproductive Health and HIV Programs* (2009) defines gender as "the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women (p. 8)." When examining determinants of health and designing community health interventions, it is important to take into consideration the surrounding culture and context in which health occurs, and this includes gender.

Many of the factors that affect health have a basis in societal biases that perpetuate stereotypes, gender roles, or discriminatory policies that adversely affect individuals' lives. In a gender-based approach, data are analyzed with the awareness that the biases and gender roles into which we are socialized also need to be examined (Brittle & Bird, 2007; Khosla & Barth, 2008; Parker, 1993). "While theories about gender have been well developed and debated in the social sciences for at least two decades, the notion of gender as being distinct from sex is still a relatively new concept in medical discourse and research" (Johnson, Greaves, & Repta, 2007, p. 1). Much of the existing gender-based literature focuses largely on traditional women's issues such as reproductive health or gender-based violence (Inner Spaces Outer Faces Initiative, 2007; Parker, 1993; Commonwealth Secretariat and Maritime Centre of Excellence for Women's Health, 2002; Interagency Gender Working Group, 2009; Greene, 2012; Ostlin, Eckermann, Mishra, Knowane, & Wallstam, 2006). This article aims to illustrate that broader community health issues, such as

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physical activity, may also benefit from gender-based program planning and analysis.

Regular physical activity is associated with enhanced health, including reduced risk of cardiovascular disease, stroke, type 2 diabetes, cancers, osteoporosis, depression, and fall-related injuries (Warburton, Nicol, & Bredin, 2006; U.S. Public Health Service, 1996; World Health Organization, 2007, 2008, 2010). Though most individuals are aware of the benefits of physical activity, most men and women in the United States do not engage in the 2008 Physical Activity Guidelines for Americans. These Physical Activity Guidelines (U.S. Department of Health and Human Services, 2008) include at least 150 min a week of moderate-intensity or 74 min a week of vigorous-intensity aerobic physical activity or an equivalent combination of moderate- and vigorous-intensity aerobic activity. Furthermore, when data are examined by sex, health disparities emerge with women reporting significantly less leisure-time physical activity than men (Adachi-Mejia et al., 2010; U.S. Public Health Service, 1996; Doldren & Webb, 2013; Ransdell, Vener, & Sell, 2004; U.S. Department of Health and Human Services, 2000). The authors seek to demonstrate how data garnered from the framework of gender-based analysis using the Gender Analysis Framework of the Liverpool School of Tropical Medicine [hereafter referred to as Gender Analysis Framework] (Gender and Health Group, Liverpool School of Tropical Medicine, 1999) can be used to gain a deeper understanding of the barriers to, and opportunities for, physical activity that can be used to develop a gender-based health intervention to increase leisure-time physical activity for women.

## 2. Background

The Alliance, an affiliated partnership of two tertiary care hospitals (Billings Clinic and St. Vincent Healthcare) and Yellowstone County's health department (RiverStone Health), founded the Healthy By Design Coalition, a cross-sector coalition working in Yellowstone County, Montana. The mission of the Coalition is to create a community that embraces a culture of health and well-being.

The Coalition previously focused community health solutions on the community at-large without using a gender lens or without taking gender into account. Health solutions for the community were based on a 2006 Community Health Assessment and generalized to the entire population, which, as determined through identified disparities based on sex, may not adequately address the needs of women and girls. As a result, the Healthy By Design Coalition's Women and Children Subcommittee was formed. The Subcommittee represents various agencies serving women and children in Yellowstone County, including two hospitals, the health department, Montana State University-Billings, YMCA, Big Brothers/Big Sisters, and Montana Amateur Sports. The study was initiated in 2011 by the Subcommittee with funding support from the U.S. Department of Health and Human Services Office on Women's Health.

## 3. Methods

The Gender Analysis Framework (Gender and Health Group, Liverpool School of Tropical Medicine, 1999) was used to conduct the gender analysis. The framework consists of three parts: (1) identifying who gets ill, including when and where; (2) identifying factors affecting who gets ill; and (3) identifying factors affecting responses to poor health. The established framework was translated into a focus on wellness instead of illness. The steps to conduct the gender analysis were adapted to include examination of sex-disaggregated data related to wellness behaviors. Factors that had the potential to influence engagement in physical

activity were examined. The World Health Organization publication, "Gender Analysis in Health: A Review of Selected Tools," examined 17 widely used gender tools and noted a limitation of the framework, "while the guidelines provide tools for analysis, they do not address, in concrete terms, how one might actually institutionalize the use of such tools" (p. 58). However, the broad scope of the analysis tools allowed the adaptation of the framework for a gender-based analysis of wellness behaviors, which was used in the present intervention.

Three parts of the Framework were identified: Part 1: patterns of ill health, identifying who gets ill, when and where; Part 2: factors affecting who gets ill; and Part 3: factors affecting responses to ill health. The steps associated with each part of the Framework included the following:

- Step A: Examine sex-disaggregated quantitative data—identify existing patterns for women's health.
- Step B: Examine why the identified patterns exist—identify factors affecting who gets ill, including socially constructed roles, behaviors, activities, and attributes.
- Step C: Examine how the identified gender factors either constrain or support women's health.

### 3.1. Step A: Examination of sex-disaggregated quantitative data

The Alliance sponsored a Community Health Assessment (CHA) in Yellowstone County, Montana, in 2011. The purpose of the 2011 CHA was to identify primary health-related issues that affect county residents. Professional Research Consultants (PRC), a marketing research organization providing services exclusively for the healthcare industry, was contracted to conduct the CHA. PRC developed the final survey instrument, the sampling plan, administered the CHA survey, and conducted the data collection and data analysis. The study population for the CHA included all residents of Yellowstone County in Montana. The county was defined by zip code ([www.usps.com](http://www.usps.com)).

The survey instrument used for the CHA was based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) and included customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was similar to the previous 2006 Community Health Assessment (CHA) used in the region, allowing for data trending over time. The survey consisted of 201 questions that were largely nationally normed by asking the same question in other communities contracted with PRC. Questions not nationally normed were specific to the geographic region and identical to questions on the 2006 CHA, which was also conducted in Yellowstone County (, p.6).

The survey was administered by telephone to a random sample of 400 individuals aged 18 and older in Yellowstone County. A total of 213 men and 187 women participated in the phone survey. Telephone interviews took approximately 20 min. To accurately represent the population studied, PRC randomly sampled the population and adjusted the results of the random sample to match the geographic distribution and demographic characteristics of Yellowstone County (post-stratification) to minimize any naturally occurring bias.

Data from the CHA were analyzed to determine health issues for the community at large. After the community-wide analysis, data from the 2011 CHA were segmented by sex and analyzed to determine the nature and extent of sex-based disparities (Appendix A)<sup>1</sup>.

<sup>1</sup> Complete findings from the 2011 Community Health Assessment are available upon request to the authors.

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