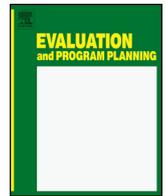




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Exploring the role of gender norms in nutrition and sexual health promotion in a piloted school-based intervention: The Philadelphia Ujima™ experience



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ABSTRACT

Perceptions of masculinity and femininity influence behaviors and can be identified in young children and adolescents (Brannon, 2004). Thus, adolescents' engagement in health risk or promoting behaviors is influenced by perceptions of masculinity and femininity and the differences in expectations, norms and responsibilities for girls and boys (WHO, 2007). Girls and boys have different needs, and gender-based interventions that consider similarities as well as differences are needed. A gender-based nutrition and sexual health promotion program was developed and piloted by the Philadelphia Ujima Coalition in a high school setting. To explore the gender differences in adolescents' perceptions of the influence of gender norms on weight, nutrition, physical activity, and sexual health and the implication of these differences in future gender-integrated health promotion programming for youth, a content analysis of student and facilitator debriefing forms were implemented for the participating schools. The content analysis was used to identify central themes, concepts gained, and overall impact of the intervention sessions. Overall, gender norms influence healthy eating practices and activity through influencing perceptions of body type in adolescents. Gender norms also influence sexual activity and decision making through influencing perceptions of beauty, masculinity, femininity, pressures and popular concepts related to sexual activity. Thus, interventions that address gender may more effectively promote health and wellness in adolescents.

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1. Introduction

Gender defines the perceived roles, expectations, responsibilities and opportunities for females and males and is influenced by familial, cultural, economic and other variables (WHO, 2007). Gender stereotypes represent beliefs about physical traits and psychological characteristics of males and females (Brannon, 2004). Furthermore, perceptions of masculinity and femininity influence behaviors and can be identified in young children and adolescents (Brannon, 2004). Thus, adolescents' engagement in health risk or promoting behaviors is influenced by perceptions of masculinity and femininity and the differences in expectations, norms and responsibilities for girls and boys (WHO, 2007). Girls

and boys have different needs and gender-based interventions that consider similarities as well as differences are needed.

In 2011, The Philadelphia Ujima Coalition for a Healthier Community was funded by the US Department of Health and Human Services Office on Women's Health to improve the health and wellness of girls, women and their families living in underserved and vulnerable communities using a community-centered, gender framework for health promotion programming. The Coalition comprised over 20 health, wellness, educational, community, social service, research and faith-based organizations who partnered to develop a collaborative network with a shared commitment to health. Using a community participatory approach to health education and promotion, the Ujima Coalition developed a gender-integrated health promotion intervention that addresses nutrition, physical fitness, sexual health and healthy relationships in a high school-based setting implemented for both adolescent males and females.

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Therefore, the purpose of this research was to explore adolescents' perceptions of the influence of gender norms on nutrition (healthy eating), fitness, and sexual health practices and the implication of these perceptions in future gender-integrated health promotion programming for youth. The lessons learned were developed to guide the implementation and evaluation of future gender integrated health promotion programming for adolescents.

2. Adolescents and obesity

Despite national attention and programming, obesity rates continue to be high (Wojcicki & Heyman, 2012). According to the Centers for Disease Control and Prevention, over one-third of youth and adolescents are either overweight or obese, with increasing risk for cardiovascular disease, high cholesterol, high blood pressure and end-stage renal disease, among other diseases (Caprio et al., 2008; CDC, 2012a; Han, Lawlor, & Kimm, 2010; Ogden, Carroll, Curtin, Lamb, & Flegal, 2010; Olshansky et al., 2005; Sweeting, 2008; Vivante et al., 2012). Moreover, obese youth are more likely to become obese adults and suffer from long-term health problems (Kaiser, 2011; Kong et al., 2012). Among youth, obesity rates are higher among adolescents compared with younger, pre-school aged children under 5 (Ogden, Carroll, Kit, & Flegal, 2012). While nationally obesity rates have continued to increase in both boys and girls, sex differences exist in prevalence trends with boys having experienced a higher rate of increase in obesity prevalence in 2009–2010 (Ogden et al., 2006, 2012). Obesity rates are disproportionately high in African-American boys and girls (Ogden et al., 2006), and other research has reported an increased risk of obesity for African-American girls (Alleyne & LaPoint, 2004; Wang et al., 2007). Locally, nearly 70% of youth in North Philadelphia are overweight or obese (PDPH-Obesity, 2010). Thus, obesity in youth is an important public health priority. There are a myriad of complex contributing factors to the high obesity rates in youth, including access to healthy food options, socioeconomic status and social, familial, behavioral, cultural and physical environmental factors that influence eating practices and physical activity levels (Wang et al., 2007). Moreover, though peer eating practices influence adolescent eating behaviors (Brogan et al., 2012), other social norms that influence adolescent behaviors, such as gender norms, may contribute to food behaviors. For instance, research on food preferences found that boys are more likely to prefer meat, fish, poultry, fatty and sugary items, whereas girls are more likely to prefer fruits and vegetables (Caine-Bish & Scheule, 2009; Cooke & Wardle, 2005; Reynolds et al., 1999). Nevertheless, the role of gender in food behaviors has been understudied.

Most youth and adolescents do not adhere to the recommendations provided by the Dietary Guidelines for Americans for important foods, such as fruits, vegetables and whole grains (CDC, 2010a, 2010b, 2012b). Moreover, fruit and vegetable consumption has been demonstrated to reduce adiposity in children, but fruits and vegetables are the least likely to be consumed in adequate amounts by youth (Davis et al., 2007). Obesity in youth has also been associated with breakfast skipping, fast food consumption and increased portion sizes (Davis et al., 2007). The use of the nutrition facts label is associated with healthier eating practices; however, adolescents traditionally often do not utilize the nutrition facts label to make food choices (Wojcicki & Heyman, 2012). Health promotion efforts targeted at obesity reduction are often focused on food choices, eating practices and physical activity, but decision-making skills and emotional cues to eating are also important contributors to eating practices (Riggs, Sakuma, & Pentz, 2007). However, differences in how gender norms, roles and expectations influence decision-making skills, and the emotional aspects of eating practices are understudied.

Gender differences in food choices and physical activity levels are influenced by social and cultural factors that dictate norms,

roles and behaviors (Sweeting, 2008). Differences in gender norms, roles and expectations also influence the causes and consequences of obesity for girls and boys (Kinston, Miller, Loader, & Wolff, 1990; Wisniewski & Chernausk, 2009). Girls, for example, are more likely to have reduced physical activity and poor body image related to obesity and to being overweight (Sweeting, 2008; Wang et al., 2007; Wingood, DiClemente, Harrington, & Davies, 2002). Perceptions of femininity and masculinity influence food choices, as research in young adults has indicated that young women are more likely to avoid high fat foods, eat fruits and vegetables, diet and report a greater significance of eating healthy based on social norms that promote such behaviors in young women (Wardle et al., 2004).

Thus, health promotion interventions addressing obesity and nutrition in adolescents should consider differences in how gender norms influence eating practices and perceptions of healthy weight. The role of gender norms and expectations in eating practices and perceptions of a healthy weight should be addressed in health promotion programs targeted at preventing and reducing adolescent obesity. Gaps remain as 'gender-blind' health promotion programs often exclude the role of gender norms, roles and expectations in program planning and evaluation efforts (Greaves, 2011; Núñez, Robertson-James, Reels, Weingartner, & Bungy, 2012).

2.1. Adolescents and sexual behaviors

The Centers for Disease Control and Prevention (2007) reports that persons between the ages of 15–24 account for nearly 50% (or 9.1 million) of all new STDs acquired each year. According to 2010 national data for gonorrhea and chlamydia, African Americans are more affected by gonorrhea than any other racial group (CDC, 2010a, 2010b). In addition, the rate of chlamydia is highest among young black women aged 15–19 (CDC, 2010a, 2010b). Research has demonstrated that untreated STDs are prevalent in African-American communities, increasing the risk of infection with each sexual encounter (CDC, 2011). Alarming, Pennsylvania ranks 7th in the U.S. in cases of HIV infection diagnosed among all age groups and 8th in the number of reported AIDS cases among young people ages 13–19 (Sexuality Information and Education Council of the United States (SIECUS), 2010). The AIDS Activity Coordinating Office found that 47% of youth from Philadelphia STD clinics who have HIV had a previous history of gonorrhea, chlamydia and/or syphilis (PDPH, 2011).

Effective and comprehensive health education and promotion efforts to address sexual health in adolescents are needed. Though information on sexually transmitted diseases (STDs), such as human immunodeficiency virus (HIV), is often taught in school, contraceptive options, sexual negotiation, attitudes and knowledge related to sexual activities are not routinely included in school-based health education (Sexuality Information and Education Council of the United States (SIECUS), 2010). Failure to consistently address these and other important contributors to sexual health decisions and practices has negative consequences for adolescents and the prevention of sexually transmitted infections.

Social, cultural and gender norms influence sexual attitudes and behaviors in adolescents and should be addressed in health promotion programs (Wilson & Wiley, 2009). However, challenges remain in the comprehensiveness of sexual health programs delivered in schools. For example, a study by Renju et al. (2010), which evaluated teacher-led, peer-assisted adolescent sexual and reproductive health (ASRH) education, found that the most sensitive sexual and reproductive health topics (i.e., how to say no, how to use a condom, pregnancy and puberty, gender norms, sexual myths and temptations) were not well covered in the class sessions. Consequently, challenges exist in implementing effective comprehensive sexual health education that addresses recommended

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