A Consumer-Based Model of Physical Activity and Nutrition (Pan) Practices: the Case in a Northeastern U.S. Community

Ada Leung, Pennsylvania State University at Berks, USA
Huimin Xu, The Sage Colleges, USA
Gavin Jiayun Wu, Savannah State University, USA
James Shankweiler, Pennsylvania State University at Berks, USA
Lisa Weaver, AmeriCorps VISTA, USA

We examined the lived experiences of residents of an impoverished community in U.S. to understand the challenges in reducing health disparities among Hispanics. We identified five physical activity and nutrition (PAN) practices that stem out from the interplay of stressors and resources, namely, maintenance, assimilation, socialization, segregation, and reverse socialization.

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EXTENDED ABSTRACT
Various research studies have shown that medication, combined with lifestyle changes, including decreasing caloric intake and increasing physical activities, would delay onset of chronic health problems, such as diabetes (Katula et al. 2013; Knowler et al. 2002). Nevertheless, health disparity still persists and discrepancies in health outcomes, such as life expectancy and incidence of chronic diseases, have enlarged over time in the U.S. (Braveman and Egerter 2013). For many health indicators, people in the poorest or least educated groups, often ethnic minorities living in impoverished neighborhoods, have the worst health, but middle-class people also are less healthy than those who are at the highest social hierarchy (Marmot 2004). Although the adoption of a healthy lifestyle is the most cost-effective way in improving health outcomes, why is it not widely adopted by people of low income and education levels? The purpose of this study is to understand physical activity and nutrition (PAN) practices from the consumers’ perspective. Consumer research emphasizes on behaviors as experienced by consumers rather than relying solely on medical experts. Consumer studies adopt a “bottom-up” perspective to investigate the complexities on poverty and health (Hill and Dhanda 1999; Lee, Ozanne, and Hill 1999). This study focuses especially on the lived experiences of consumers who are most affected by this problem, namely low-income ethnic minority. Based on this study, we offer a model of household physical activity and nutrition (PAN) practices, as individual decisions on PAN practices often spill over to all of the members in the same household.

The study was conducted in the City of Reading, PA. Reading City has a population 88,000 in 2016, with about 58% of its population is of Hispanic or Latino origin. We used convenience sampling to purposely recruit ethnic minority informants from a Catholic Church. Bilingual (Spanish-English) moderators and interviewers are trained to conduct the interviews with both English- and Spanish-speaking informants.

Four focus groups (n=29) were conducted to generate consumers’ thoughts and vocabulary about their lifestyles and social lives. These informants (and their family members) were then invited to participate in depth interviews (n=25) two weeks afterwards. The participants were asked to bring 10-15 pictures about their lifestyle to the interviews, tell stories about the pictures, and elaborate how various activities fit in their lifestyle. The qualitative data were translated and transcribed in English. The informants were also asked questions about their family situation, neighborhood, health and working conditions.

We drew on Lisa Penaloza’s concept of consumer acculturation (1994) and Nakata et al’s framework of stressor-resource-behavior (2016) to guide our theoretical interpretation. Consumer acculturation refers to consumer socialization processes, such as modeling, reinforcement, and social interaction, which are central behavioral processes through which consumer skills, knowledge and behaviors were transferred by acculturation agents, including family, friends, and institutions, such as schools and churches (Penaloza 1994). Nakata et al’s approach to health-related consumption practices is to take an encompassing view of consumers’ lives, such that both their personal characteristics and their environmental situations determine their practices (Nakata et al. 2016).

Two major findings were identified from the data, interpretation, and theoretical perspectives. The first finding is that physical activity and nutrition (PAN) practices are situated in and dynamically affected by the stressors and resources encountered in consumers’ daily life. Stressors could stem from consumers’ living, working, family, and medical conditions (Braveman and Egerter 2013). The resources that the consumers could muster to engage in PAN practices are economic capital, cultural capital, interpersonal social capital (Bourdieu 1984), institutional and community social capital (Putnam, Feldstein, and Cohen 2003), and emotional capital (Froyum 2010; Reay 2004).

The second finding is that the adoption of a healthy lifestyle means engaging the in a complex, interwoven, and delicate constellation of practices: maintenance, socialization, assimilation, segregation, and reverse socialization. Therefore, the change agent needs to take residents’ stressors/resources into account when devising intervention programs to nudge community residents to engage in PAN practices.

Our investigation of stressors helps explain why it is difficult to adopt a healthy lifestyle, because a disruption in any one practice due to stressor(s) can trigger a disruption in another practice. Adoption of PAN practices is more likely if the driving forces of resources are greater than the constraining forces of stressors. As resources fuel one another in a generative way, consumers’ health outcomes are likely to improve significantly if they can wield various forms of capital effectively. For example, consumers’ cultural capital of health literacy enable them to learn about nutritious diets and physical activities, which in turn allow them to be change agents in their respective families (social capital) and community (community social capital).

For most of the informants that we interviewed, they are hopeful about the positive changes they can bring to themselves if they are given PAN related knowledge and if their community is offered more resources. Due to interconnections among PAN practices, PAN practices are often most effective when they were carried out in sync with others. Lastly, it should be added that PAN practices needed to carry out indefinitely to realize long-term effects. Research on the effectiveness of potential interventions need to measure the longitudinal effects of interventions plus their habit-forming potential so that the gains in health outcomes can be carried forward open-endedly.

Community advocates and medical professional need to understand their community members’ lived context so that they are able to design appropriate community services that encourage the cultivation of various types of capital (e.g. professional clothing drive and job fair to improve residents’ economic capital, nutritional workshops to increase cultural capital, emotional intelligence seminar to increase emotional capital), to implement projects that build on existing networks (e.g. churches, chambers of commerce, community food-bank networks), to build alliances among community agencies, and to set up an advisory board that will guide and sustain the healthy lifestyle initiative over time.

Last but not least, we investigated the health disparities among Hispanics in this research. Hispanics have surpassed African Ameri-
cans as the largest U.S. minority group in 2003 (National Research Council 2006). Hispanic segregation from the whites is lower than African American segregation, however, since immigration often reinforces ethnic enclaves, it becomes imperative to study how health disparities play out among the Hispanics (Iceland and Nelson 2008).

REFERENCES


