

Perception of Social Norms Related to Obesity Among Kuwaiti Women*

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Abstract

The purpose of this study was to explore Kuwaiti women's perception of social norms related to obesity in the area of body image, physical activity and eating practices.

The sample used in this study was an opportunity sample, drawn from all volunteer women visiting a general practice clinic in one suburb of the capital city of Kuwait, during a 30-day period. The sample size was 188 women drawn from women visiting the clinic during the 30-day period. The findings of this study suggest that social norms discovered in this study to be perceived (to exist or not to exist) by the women do not influence their level of obesity. Nonetheless, any attempt at reducing the women's level of obesity should look into influencing their social environment, i.e. ecologically.

Introduction

Williams (1960) defines norms as "rules of conduct that specify what should and should not be done by various kinds of social actors in various kinds of situations..." (p.24-25). Bierstedt (1963) defines a norm as "a rule or a standard that governs our conduct in the social situations in which we participate. It is a social expectation. It is a standard to which we are expected to conform whether we actually do so or not." (p.222). Hoebel (1966) defines a norm as "the average or modal behaviour of a given type that is manifested by a social group." (p.26). Homans (1961) defines a norm as a "statement made by a number of members of a group, not necessarily by all of them, that the members ought to behave in a certain way in certain circumstances." (p.46). Parsons (1973) defines a norm as a "verbal description of a concrete course of action....regarded as desirable, combined with an injunction to make certain future actions conform to this course." (p.75).

Norms are transmitted through the process of socialization and the latter may be viewed as a mechanism for the internalization of norms, which are reflected in a person's attitudes and values and which guide and govern a person's behaviour in the social system in question, especially in matters related to health and illness, i.e. making decisions for maintaining his health, seeking treatment or preventing an illness. An individual behaves according to his status in a given society and his role performance is defined by norms or expectations.

Norms are mainly informal and some are formal (laws with written sanctions for non-compliance). There are also religious norms (not eating pork by Muslims). Norms governing health behaviour are formal or informal. There are formal norms that define, for example, the interaction between the doctor and the patient. Certain other forms of health behaviours may have no informal character. The possible exception being the requirement to immunize against certain diseases in some countries. In Kuwait, vaccination is not required but schooling is and one cannot enter school without being vaccinated. Therefore, vaccination is indirectly compulsory in Kuwait. Since norms govern behaviour, the various roles a person carries out in a given society are defined by norms, i.e. each role is defined by norms or expectations. Illness, for example, is a physical and a social dysfunction. It has a disruptive force upon society. To avoid this disruption, society integrates sick people in a defined way by giving the sick person a status and he has to perform a role, the sick role, in that status according to the norms. He may be regarded as a conformist if he adheres to the expected behaviour, a deviant if he does not, a variant if he behaves in between. If, for example, the norm is that women are to be slim and the norm is specific about what constitutes being slim, then obese women are deviant.

Those who are neither slim nor obese are considered variants, i.e. a woman who is two kilograms overweight is neither slim nor obese but she is in between or variant.

Health education is a conformist reinforcement. If one behaves within the norms or as expected, his conformist behaviour has to be reinforced by health education so as to prevent him from being tempted (we are all the time being tempted) to lapse into nonconformity. If his behaviour is variant, then health education has to adjust it towards conformity. For example, it may be fine to overeat from time to time, at a feast or a celebration, but one must be careful that this overeating does not become a pattern or a habit and so the person lapses into deviant behaviour, then health education should and has to step in to encourage the person toward conformity. If he becomes overweight and thus deviant, he must undergo behaviour modification to change his habits of eating and he must reduce his food intake. If the norms are specific as regards overeating, then health education has a moral obligation to turn deviant into conformist behaviour.

Social norms have recently been regarded as an important area for health education to focus on. Previous models of health education concentrated entirely on personal factors (knowledge, attitudes, actions, etc.) and ignored social and environmental (ecological) factors which may play a part in influencing health behaviour. It has become increasingly apparent that man's health behaviour may be better understood if one looked at man in his natural and social habitat and examined both the internal (personal) and external (social and environmental) factors which may figure in influencing his behaviour. One such approach in health education is the ecological approach. The previous approaches which ignore man's natural and social habitat proved of limited fruitfulness in influencing the desired change in health behaviour. It is now recognised that the ecological approach is a better model of health education than previous models, in trying to solve health-related problems, because it looks at both the personal as well as the social factors which may influence health behaviour.

As regards the importance of social norms in influencing health behaviour, Keyes (1972) notes that change in behaviour "should be sought primarily through social and environmental supports and that social distance, social norms and social perceptions are important intervening variables between knowledge, attitudes and health action." (p.15). The World Health Organization (1983) regards norms as "a vital part in defining the general approach of people to illness and health as well as to treatment and prevention...." (p.19). Freeman et al. (1979) suggest that "there can be little question that social factors correlate with the incidence of a wide variety of illnesses." (p.3). Susser (1979)

notes that "factors affecting the distribution of disease in populations may be biological or environmental, and both have social implications." (p.714). Burton and Baric (1979) note that "aspects of health-directed behaviour are a part of a person's adherence to social norms..." (p.741). Susser and Watson (1971) note that "norms and values, and their material resources, govern the initial interpretation of the nature of the individual's problem, the recognition of his illness, and his participation in treatment." (p.196). Baric (1975) notes that:

"social norms represent the value system concerning health and illness in a society. An individual's behaviour will be assessed by comparing it to existing norms, and the individual will be labelled as conformist or deviant, accordingly. The internalisation of norms is reflected in a person's attitudes, routines and decisions regarding health maintenance, prevention and cure of illness and is, therefore, of great importance." (p.3).

Green (1970) notes that:

"Social pressures and social supports from reference groups are posited as the main determinants of, and intervening variables between, psychological readiness and preventive health behaviour. For the sake of brevity, social pressures and social supports can be loosely termed social norms." (p.31).

In this study, norms are explored in terms of their prevalence (statistical or social), historicity, sanctions, social support and legitimation (using the method developed by Baric, 1979). Two additional aspects of norms will be reviewed here, namely conformity and the coercive power of the norm. Each of the above terms is explained below.

The prevalence of a norm (statistical or social) indicates (just as it is in epidemiology), as Baric (1979) suggests, "the proportion of the overall population under study manifesting a certain condition, or...a perception, calculated as a percentage," (p.10). The general approach in assessing the prevalence of a norm is to ask respondents what they think that most of the people they know feel about a particular issue.

A statistical norm represents the proportion of those in a social group who express average opinions, behaviours, attitudes or perceptions regarding an issue or an expectation. A statistical norm has no element of constraint or coercive power i.e. it is not supported by sanctions nor is it legitimised. A social norm is a statistical norm that is supported by sanctions and is legitimised.

Historicity of a norm, as the term suggests, refers literally to lack of knowledge about its historicity or origins or how it started. The term also implies, according to Berger and Luckmann (1967), an action which has been typified in the "course of a shared history" (p.72) and hence the term. A norm is said to have historicity if its origin or function is not known or cannot be traced and the norm is taken for granted by the actors that it does exist, i.e. it becomes part of the actors objective reality and they conform to its expectations. Historicity, like social control, is an institutionalised action. Historicity is one

element of the coercive power (see below) of the norm (the others being sanctions, social support and legitimation).

To ascertain the historicity of a norm, respondents may be asked whether they know how the expectation started. They may either state that it has always been like that or they may recall how it started. If respondents could not recall how the expectation started, the norm is said to have historicity.

Sanctions are repercussions or reactions undertaken by a society or a majority of its members against a nonconformist mode of behaviour made by some. Sanctions concerning a given expectation implies that there may be certain repercussions for nonconformity to the expectation. Sanctions, together with legitimation, render a mere statistical norm a social one.

To establish whether a norm is supported by sanctions, respondents may be asked if there are any repercussions for nonconformity to a given expectation.

Social support can be implicit or explicit. The latter is not examined here. Implicit social support may be regarded as the expressed opinion of a person being shared with members of his family and friends. It may be measured by asking respondents whether their family and friends share or support their opinions regarding a given expectation or an issue.

Legitimation is an important attribute of a norm and it may be regarded as a means through which an expectation is given "a stamp of approval" or rendered more acceptable by certain agents or significant others. For example, health norms are legitimised by health professionals. In this study, four legitimising agents are considered, namely the mass media, the medical profession, the authorities, and important people in society. The authorities, as a legitimising agent, are used only once, regarding one of the norms explored in this study. Legitimation and sanctions are two attributes of a norm which are used in this study to determine whether the norm is statistical or social, i.e. if the norm is supported by sanction and is legitimised, it is considered as a social norm. Otherwise, it is merely a statistical norm.

Conformity is just what the term implies, i.e. "going along" or doing the expected and conforming to a given expectation.

The coercive power of a norm is manifested by its historicity and its social support. The coercive power of a norm may be viewed as that power which influences or sways a person into acting or expressing an opinion in a certain way.

In summary, the four main characteristics of a norm explored in this study are historicity, social support, sanctions and legitimation. The former two contribute mainly to the norm's coercive power and the latter two contribute mainly to the norm being considered a social one, i.e. a norm which is not supported by sanctions and is not legitimised by significant others is merely a

statistical norm.

The purpose of this study was to explore Kuwaiti women's perception of social norms related to obesity. The study was designed on the assumption that a high percentage of indigenous Kuwaiti women are overweight and that is the result of the interaction of societal forces (norms, customs, and social position of women) with the personal factors (women's perception of norms). The study, therefore, undertook to establish women's perception of social norms which may be relevant to obesity in the area of body image, physical activity and eating practices.

Method

1. The sample of women

The Kuwaiti women's sample used was an opportunity sample drawn from all volunteer women visiting Qadysia Clinic in the suburb of Qadysia in Kuwait, the capital city of Kuwait, during a thirty-day period. The sample size was 188 women drawn from women visiting the clinic during the thirty-day period. The clinic was chosen because it is conveniently located in one of the oldest suburbs of Kuwait and because the clinic staff showed willingness to provide support in carrying out the study.

2. Measurement of perception of social norms among a group of Kuwaiti women was carried out by set of pretested questions concerning their perception of norms related to such areas as body image, physical activity, and eating patterns and practices, and covering such characteristics of norms as historicity, sanctions, social support, and legitimation.

Perception by the women of each of the 11 expectations surveyed was carried out as follows:-

1. **Prevalence:** by asking a woman if she thinks that people expect "this" of her.

2. **Historicity:** by asking a woman if she knows how the expectation started. If she could not recall, the expectation is said to have historicity, i.e., being a part of her objective reality. If she knows how it started, she is then asked to tell how.

3. **Sanctions:** by asking a woman if there are any repercussions for nonconformity to a given expectation.

4. **Social support:** by asking a woman if her family and friends share or support her opinion of the expectation in question.

5. **Legitimation:** by asking a woman if her opinion about a certain

expectation is approved or supported by one of the following legitimising agents:

- 5.1 Mass media
- 5.2 Medical profession
- 5.3 Authorities
- 5.4 Important people in society.

The women questionnaire contained questions about the respondent's age, marital status, level of education, occupation, type of dress (see below), and measurements of weight and height and was pretested on 36 Kuwaiti women. A small number of changes were made to a number of the questions asked to enable complete understanding by the respondents. The final version thus contained a set of questions that would elicit the responses required to achieve the objectives laid down.

The type of dress the women wore was categorised into traditional and other. Traditional dress refers to the Islamic dress which is loose-fitting and long and has long sleeves. A headkerchief is worn with it. Other dress refers to any dress that did not fit the description of the Islamic dress.

The occupations of the respondents were grouped into professional, skilled and manual in accordance with the Registrar-General's classification of occupations. A category of 'others' was added to include those who did not fit into the aforementioned categories, i.e. housewives, those in the armed forces, etc.

The questionnaires used for this study were essentially of the structured type but included a certain number of open-ended questions in addition.

The measurement of weight and height was made using standard instruments available in a clinic. The body mass index (BMI) which was the index of adiposity used in this study, was calculated by dividing the weight in Kilograms by the square of the height in meters (W/H^2).

The questionnaire used in this study to measure women's perception of social norms, was administered by two Kuwaiti female health workers in the general practice clinic of Qadysia, serving the suburb of Qadysia in the city of Kuwait, the capital of Kuwait. The health workers were trained to approach Kuwaiti women visiting the clinic for various purposes about their willingness to participate in the study. If they agree, then the study was explained to them and were shown how to fill in the questionnaire. The participants were encouraged to consult with the health workers regarding the filling in of the questionnaire.

Data analysis

The choice of the answers to the questions as well as the various variables

used in the questionnaires were coded by giving each a numerical value.

The data was analysed by using an S.P.S.S. (Statistical Package for Social Sciences) programme. The numerical values used for the answers and the variables used in the questionnaires were fed directly into the computer and a frequency distribution for them was obtained. Using the same package, the data was cross tabulated and the chi-square tests were carried out to establish a statistical test of association between certain variables. The level of significance (p) used in this study was equal to or less than 0.05.

Results

The Women Sample

Characteristics of the women sample

The 188 women in the sample were grouped according to age (Table 1), marital status (Table 2), educational level (Table 3) occupation (Table 4) and dress (Table 5).

When the various characteristics of the sample were cross tabulated with each other, several statistically significant variations were found. A statistically significant variation was found between:

1. Age and marital status ($p < 0.0001$)
2. Age and occupation ($p < 0.0001$)
3. Marital status and occupation ($p < 0.0001$)
4. Education and occupation $p < 0.0001$

Discussion and Conclusions

Discussion

The exploration of obesity among Kuwaiti women in this study was based on an opportunity sample of 188 women, drawn from a general practice clinic serving a suburb in the capital city of Kuwait, during a 30-day period and, therefore, any generalisations and/or conclusions which may be drawn from the findings are to be qualified accordingly, i.e. the study explored obesity among Kuwaiti women attending a G.P. clinic during a thirty-day period in one suburb of the capital of Kuwait.

The purpose of this study was, essentially, to explore Kuwaiti women's perception of social norms related to obesity. The study was designed on the

assumption that a high percentage of Kuwaiti women are overweight and that this may be the result of the interaction of social forces (norms, customs, and social position of women) with the personal factors (women's perception of norms).

Social norms related to body image, physical activity and eating patterns and paractices

A total of 11 social expectations were explored: two in the area of body image, three in the area of physical activity, and six in the area of eating patterns and practices. These are listed below:

- I. Norms related to body image.
 - 1) Plumpness among women and whether it is expected.
 - 2) Plumpness as a sign of health, wealth or both.
- II. Norms related to physical activity.
 - 1) Physical inactivity of women.
 - 2) Women exercising in public.
 - 3) Women exercising at home.
- III. Norms related to eating patterns and practices.
 - 1) An average family eating too much.
 - 2) A visitor to eat everything on offer.
 - 3) An average woman regularly overeating.
 - 4) Women eating too many sweets.
 - 5) Women snacking between meals.
 - 6) An average woman modifying her eating habits and dieting to lose weight when plump.

Perception of the above norms and their characteristics (historicity, sanctions, social support and legitimation) were explored by surveying a sample of women regarding their opinions concerning the aforementioned 11 norms and their characteristics.

Two of the above eleven expectations were perceived by the women to exist and these are: the norm related to exercising at home and the norm related to a woman modifying her eating habits to lose weight when plump, i.e. both satisfy the criteria of being supported by sanctions and are legitimised by the mass media, the medical profession and important people in society.

Paradoxically, neither of these two norms has an obvious influence on increasing the level of obesity among the woman since the first expectation deals with the approval of women exercising at home and the second deals with women modifying their eating habits to lose weight when plump. In fact, both

should influence the reduction of the level of obesity among the women not to increase it as, for example, the other expectations with the exception of the expectation related to women exercising in public. The latter, if it were perceived as a social norm, would also contribute to the reduction of the level of obesity among the women. Thus, the three expectations which would contribute to the reduction of the level of obesity among the women are: women exercising in public, women exercising at home and women modifying their eating habits to lose weight when plump. The latter two, as indicated above, were found to be perceived by the women to be social norms. The other eight expectations would have contributed to increasing the level of obesity among the women if they were perceived to be social norms by the women. If, for example, eating too many sweets by the women exists as a social norm and the women perceive it as such, then as far as the women are concerned it is fine to indulge in eating too many sweets since it is socially in agreement with what is expected and accepted. The same reasoning would apply to the other seven norms and these are: women being plump (expected to be, preferred to be, expected to get plumper with age, expected to get plumper after childbirth), plumpness as a sign of health and wealth, physical inactivity of women, a family eating too much, a visitor to eat everything on offer, women regularly overeating, and women snacking between meals.

In summary, two of the eleven expectations (exercising at home, and women modifying their eating habits to lose weight when plump) were perceived to be social norms by the women. One would not want the other expectations to be perceived as social norms by the women, except perhaps exercising in public, since all of the other expectations would compound the problem of obesity among the women.

Perception of social norms related to body image, physical activity and eating patterns and practices, which were represented by the eleven norms reviewed above, do not seem to contribute to the level of obesity among the women, i.e. the level of obesity among the women does not seem to be influenced by their perception of social norms discovered in this today, except, perhaps, exercising in public, which was not perceived as a social norm by the women, i.e. not being able to exercise in public may have an influence on the level of obesity among the women.

Conclusions

The findings of this study suggest that 86 (46%) of the 188 women surveyed were either overweight or obese. There was consistent correlation of body weight with social factors such as age, marital status, and occupation, i.e.

the obese women were older, divorced/widowed, and those who did not have a job.

Social norms discovered in this study to be perceived by the women do not seem to influence the level of obesity among them, except perhaps exercising in public, which was not perceived as a social norm by the women, i.e. not being able to exercise in public may have an influence upon the level of obesity among the women. However, walking is accepted socially as a form of exercise in public for women. Exercising at home and dieting to lose weight when plump were both found to be perceived as social norms by the women. However, judging from the level of obesity among the women, the majority of those who were overweight or obese neither exercised nor dieted to lose weight.

Apparently, it can no longer be suggested that obesity is basically an abnormality of the individual. Rather, it can be regarded, not infrequently, as a natural reaction by an individual to perceived expectations found in his/her social environment. The low physical activity of the women, for example, may be attributed to their reaction to expectations concerning the unacceptability of their exercising in public. Moreover, even though exercising at home is socially acceptable, most of the women do not exercise at home. They may either find it confining, since they spend most of their time indoors, or may perceive it to be incongruent with routine domestic activities.

Since health education, through the ecological model, is to move away from influencing individuals through the mere transmission of knowledge towards influencing them through their social environment, it must start by influencing government policies and emphasising the role of the women's social networks in the effort of reducing, arresting or eliminating the problem of obesity among the women. The specifics of this effort are given below.

It is unlikely, in a Muslim society like Kuwait, that health education/promotion can change the norm concerning women exercising in public but it can influence government policies to ensure that certain areas be created that are acceptable for women to use for exercise in public. The government, incidentally, has already reserved one sea-front club for women to use solely for exercise.

Even though dieting to lose weight was perceived to be socially acceptable, not many women, apparently, practised it. It is possible that many of the women find dieting painful, as it requires a great amount of self-discipline. Health education should attempt to influence government policies concerning food bought by the public by suggesting that the government should encourage the development, by food manufacturers, of low calorie foods which retain high nutritional value, are tasteful, safe, and reasonably priced. Such foods would be likely to reduce the stigma of a dieting and render it less painful

and more satisfying.

Not only are the presently available foods in Kuwait bland, but they are also expensive, which makes dieting even more difficult and painful. In addition, health education should emphasise the importance of the role of the women's social networks in successful dieting, by making them aware of the problem, its associated risks, and of the need for their support. This is likely to reduce the pressures of isolation which often accompanies dieting.

Few can deny the power of the mass media, especially television, in effecting changes in knowledge, and raising awareness of attitudes, skills, and norms. Since the media are controlled by the government, health education should attempt to influence programming policies so as to include programmes which would develop favourable approaches towards health behaviour, exercise, sensible eating patterns etc. and to change the character of food advertising which entices people to overeat. It should legitimise, through these programmes, that being thin or slender is healthy. It should project the physical limitations of the obese and the potential risks from a variety of obesity related diseases and state that obesity is usually the result of overeating together with a low level of physical activity. It should promote being slender as the desirable shape. One possibility, for example, would be to eliminate television series which show women stars that are plump or obese and replace them with those showing more slender ones. It may also be helpful to project more often important women in society who are fit and healthy, i.e. to make use of the concept of significant others for imagery and role models. Some of the women are likely to model themselves on the stars or on important women in society whilst enjoying one of their most important forms of entertainment. They could also be a source of dietary knowledge.

Table 1
Women grouped according to age (n-188)

Age	Number	Per Cent
Under 20	22	11.7
20-34	114	60.6
35 and over	52	27.7
Total	188	100

Table 2
Women grouped according to marital status (n-188)

Marital Status	Number	Per Cent
Single	66	35.1
Married	104	55.3
Divorced/Widowed	18	9.6
Total	188	100.0

Table 3
Women grouped according to educational level (n-188)

Education	Number	Per Cent
Elementary	5	2.7
Intermediate	32	17.0
Secondary	34	18.1
Higher Education	107	56.9
No Education	10	5.3
Total	188	100.0

Table 4
Women grouped according to occupation (n-188)

Occupation	Number	Per Cent
Professional	90	47.9
Skilled	70	37.2
Others	28	14.9
Total	188	100.0

Table 5
Women grouped according to dress (n-188)

Dress	Number	Per Cent
Traditional	107	56.9
Other	81	43.1
Total	188	100.0

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