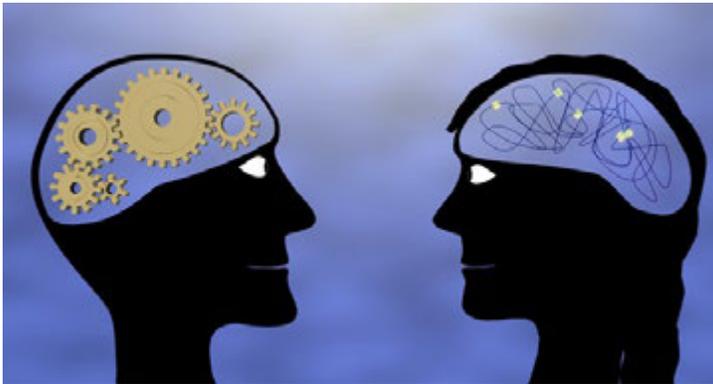


Women's Health *REPORT*

A QUARTERLY PUBLICATION OF WOMEN'S HEALTH DIETETIC PRACTICE GROUP

SEX & GENDER DIFFERENCES IN NUTRITIONAL NEEDS

By Jodi R. Godfrey, MS, RD



Note from Chair: This article is the introduction to a new area of focus for the Women's Health DPG. In 2013 we embarked on a new network relationship with the Sex and Gender Women's Health Collaborative (SGWHC). I am excited to explore this topic as we look to understand how sex and gender differences can potentially impact the field of dietetics. Jodi Godfrey, one of our members and the Managing Director for the SGWHC, begins to explore some of the research in this area in this article. We hope to provide more detailed discussions of this topic in future issues. I encourage you to review the references provided, as well as the resource list included in this issue. Finally, we recently conducted a webinar with Jodi on this topic. The recording is available through the WH DPG Web site.

Every person has a sex, and all bodies are influenced by gender. Mounting evidence and a slow but steady recognition of the real and valid influences that both biological (sex) and psycho-social (gender) factors have on health presents new challenges to dietitians. Relying on a "one-sex-fits-all" approach to nutrition ignores specific individual needs, and can hinder delivery

of the most effective lifestyle interventions and preventive strategies for women.

Embracing a sex and gender approach as part of an interdisciplinary team will advance nutrition in a climate that is evolving toward personalized patient care. This article – while not intended to be a comprehensive literature review – offers a call to action

for dietitians to incorporate sex and gender considerations into clinical practice, a goal prompted by the mission statement of the Sex & Gender Women's Health Collaborative (1).

HISTORICAL OVERVIEW OF WOMEN'S HEALTH

As far back as 1988, the Food and Drug Administration issued guidelines requiring research reporting on the safety and effectiveness of new drugs based on sex, calling attention to possible pharmacokinetic differences between women and men. Yet only 38% of studies published at the time included analysis by sex (2). More recently, the Institute of Medicine issued a report, Women's Health Research: Progress, Pitfalls, and Promise, critical of the still inadequate inclusion of women that is indicative of slower progress toward improving advances in women's health (3). The authors concluded that "Sex does matter. It matters in ways that we did not expect. Undoubtedly, it also matters in ways that we have not yet begun to imagine."

To promote a more equitable methodology across medical research and practice, Pamela Karney, MD offers a definition of women's health that recognizes the need to facilitate medical care of women in screening, diagnosis and management of conditions that:

- are unique to women;
- are more common in women;
- are more serious in women;
- have manifestations, risk factors or interventions that are different in women (4).

Likewise, it benefits registered dietitians to embrace a broader perspective of women's health – one that accounts for sex and gender differences – in order to provide the most appropriate and effective dietary guidance for all clients.

NUTRITIONAL NEEDS DIFFER BETWEEN THE SEXES

While hormones provide an obvious explanation for differences between the sexes, there are many more biological and psycho-social factors at play. From a nutritional standpoint, differences in body composition, namely adiposity versus lean mass, offers a good starting point for dietary considerations. For example:

- Caloric requirements are calculated based on body size and exercise level, but calorie needs extend beyond simple totals. Before suggesting lifestyle modifications, sex differences in

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FROM THE CHAIR Kathleen Pellechia, RD

Happy Spring! I know here in Maryland it has been cold and gloomy for far too long (and I have been inside with my children way too much). Playground – here we come!

In addition to my excitement over seeing the sun, I am even more thrilled to present this issue on Sex and Gender in Health/Medicine. This issue is the result of a collaboration we embarked on last year when we created a network relationship with the Sex and Gender Women's Health Collaborative (SGWHC). The vision of the SGWHC is: "To integrate sex and gender knowledge into medical education and practice to improve healthcare for all." One of our members, Jodi Godfrey, MS, RD, serves as the Managing Director for this group, and we are pleased to have a feature article, as well as an interview, with her about this growing field and opportunity for registered dietitians. We appreciate all of Jodi's hard work and contributions to this newsletter. Also in this issue, we are including a resource list on this topic, a House of Delegates fact sheet, and an update on the development of the 2015 Dietary Guidelines for Americans.

As we come closer to the end of this membership year, I would like to encourage you to complete our member survey at <http://bit.ly/WHDPG2014>. Every two years, the WH DPG Leadership Team produces this survey to help us better get to know our members, and to ultimately improve the services we offer. This year we are also gathering information on members' areas of expertise – not just areas of practice, but those unique skill sets each of you has and could share with fellow WH DPG members. Please take a few minutes to help us help you!



FROM THE EDITOR Heather A. Goesch, MPH, RDN, LDN

Following the long months of winter, my mind turns to spring and thoughts of refreshment, renewal and rejuvenation. It's a time to clear away the clutter, focus on what's important, and set new goals – a "spring cleaning," as it were.

For me this involves continuing education in new areas of nutrition and wellness, building connections with new contacts near and far, and ticking off boxes on my yearly bucket list. Aside from enjoyment, these endeavors provide motivation and broaden my horizons. If you ask me, more voices, more ideas, and more perspectives offer a richer, more dynamic life experience, both personally and professionally.

Our feature author for this issue, Jodi Godfrey, MS, RD of the Sex & Gender Women's Health Collaborative, is one such new voice with a new perspective. In her article, "Sex Differences in Nutrition Needs," she makes the case for utilizing a sex and gender approach to nutrition care. To help adopt such an approach in your own practice, take note of the Sex Differences in Medicine and Health resource list, and definitely don't miss the informative interview with Jodi.

Elsewhere in the newsletter you can read about our webinar series offerings, and our Member Survey (don't forget to complete yours!). You will also find the latest from the Academy's House of Delegates, updates in development of the 2015 Dietary Guidelines for Americans, and highlights from National Nutrition Month®.

This is truly a season for new growth and new perspectives – not only in the world outside our windows. Whether your spring plans are to reinvigorate your career, freshen up your personal routine, or simply tidy the top of your desk, I hope this issue gives you something to think about!

Cheers, Heather

Please feel free to contact me at whdpgpublications@gmail.com with questions or concerns.

the way calories are stored and burned could be considered (5). In addition, understanding the factors that affect energy metabolism in both women and men can culminate in better strategies to control or reverse weight gain (5).

- There is a paucity of information on the specific protein needs of men and women despite the obvious physical distinctions in lean muscle between the sexes. This could suggest differing dietary needs across the lifespan and particularly during heightened conditioning. Most women maintain a greater percentage body fat than men, despite smaller energy intake per kilogram lean mass (6% to 11% higher for every decade studied) and have a preferential use of fat as a fuel during exercise as compared to men (3). A potential reason for these findings is that the greater fat mass in women relates to more efficient fat storage during non-exercising periods (5).
- Evidence suggests that an excessive intake of protein may accelerate calcium loss, raising the risk of osteoporosis in women; while the same may promote development of kidney stones in men (6). Recent findings from Japan suggest that men who consumed the most animal protein have a 39% decreased risk of functional cognitive decline compared to men who consume the least animal protein, but a similar trend was not found among women (7). The lower lean muscle mass in women may account for these differences in protein needs.
- In addition, there are subtler differences, such as a higher level of circulating red blood cells in men, and a poorer tolerance to low levels of plasma glucose than women, according to Paul J. Flakoll, PhD, Professor of Nutritional Physiology and Director of the Center for Designing Foods to Improve Nutrition at Iowa State University, which may have nutritional implications.
- A high dietary magnesium and potassium intake may lower the risk of stroke, whereas high sodium and low dietary vitamin D appears to increase stroke risk in women but not in men (8, 9).
- Calcium is a critical nutrient to reduce the risk of osteoporosis in women, but there is insufficient evidence that dietary calcium is protective for men (6). In addition, the National Institutes of Health AARP Diet and Health Study reported supplements containing calcium were taken by 51% of men and 70% of women with findings that suggest a high intake of dietary calcium is associated with an increased risk of cardiac death in men, but not in women (10). Further studies are needed to gain a clearer understanding of the effects of supplemental calcium in health disease risk.

SEX-SPECIFIC DIFFERENCES IN DISEASE

There are known differences between men and women regarding the epidemiology and pathophysiology of many major diseases, including obesity, hypertension and stroke, diabetes, depression,

autoimmune diseases, and some forms of cancer (11, 12). While the research remains inconclusive for most conditions, substantial research has been focused on coronary heart disease with regard to sex and gender differences with practical implications for dietitians.

Coronary Heart Disease

Coronary heart disease (CHD) remains the primary cause of death among women in the United States (13). In fact, more than one-half million women die of CHD annually, exceeding the number of deaths in men, and the next seven causes of death in women combined (13). When a woman has a heart attack, she is twice as likely as a man to die within the first 60 days, and twice as likely to have a second heart attack. Simply put, CHD in women has been underestimated, underdiagnosed and has perpetuated less aggressive treatment (14, 15, 16). For example, in a study of individuals with Type 1 diabetes, women were less likely to receive statins and aspirin, and had a worse metabolic status than the men (16).

One new area of study here may be fundamental biological differences in blood vessels that contribute to ways CHD develops, progresses, and responds to treatment between women and men. The tiniest blood vessels, the microvasculature, appear to have a greater role in CHD in women where plaque accumulates more profusely, especially in younger women (11).

Despite the groundbreaking findings of the Framingham Heart Study – the first and most extensive research on the causes of heart disease and stroke within a community since 1948 – substantial evidence suggests that the Framingham Risk Score fails to identify CHD risk in a large number of women. Even to age 80, more than three-quarters of women are considered “low risk,” while women under the age of 50 are three times more likely than men to die after a heart attack or coronary artery bypass surgery (17).

The relevance becomes clearer given that women experience significantly higher total- and high-density lipoprotein (HDL) cholesterol in comparison to men (18). In obese women, low-density lipoprotein (LDL) cholesterol levels are higher than in men, whereas triglyceride levels are higher in men, particularly among those with poor glycemic control (18). This presents an obvious opportunity to offer sex-specific nutritional guidance.

There are lasting implications for women who are less likely to be referred for cardiac rehabilitation and are more likely to drop out of formal activity programs. Gender differences offer compelling insights into the forces that affect women’s responses. For example, they have competing social demands and are frequently responsible for caregiving (often on multiple fronts), thereby putting off their own needs; whereas other women believe they can return to their baseline activity without any formal support (19). Even more, research suggests that women are often uncomfortable participating in programs with a predominantly male enrollment, while others do not want to participate due to little experience with exercise programs prior to receiving a CHD diagnosis (19).

Cardiovascular differences extend to gender factors, too. In addition to caregiving demands, other psychosocial influences, such as depression, anxiety, inadequate social and economic resources, and adversities occurring early in life arise with higher frequency in women than in men, and have been directly linked to greater negative heart disease outcomes (13-15). For example, while marriage largely reduces risk of CHD in men, the stress of marriage increases risk in women (14, 15, 31). In spite of this, lifestyle interventions have been effective to reduce the risks associated with CHD in women to delay onset of heart disease, improve morbidity and mortality, and enhance overall quality of life across the lifespan.

In these instances, dietitians can be instrumental in encouraging women to participate in cardiac rehabilitation in addition to following individually tailored dietary advice. When planning a nutrition intervention for women with CHD, risk factors that must be considered include hypertension, hypercholesterolemia, obesity, physical inactivity, and metabolic syndrome (19).

Hypertension

Dietary sodium is strongly correlated with higher blood pressure levels. Significantly reducing sodium intake can often achieve a reduction in blood pressure comparable to the effects achieved by antihypertensive medication (20). Since the risk factors associated with metabolic syndrome – a condition more common among women – correlates with salt sensitivity, a more aggressive sodium reduction effort in women is warranted (16, 20, 21).

Overweight and Obesity

Obesity is another prominent, contributory factor raising the risk for hypertension in women due to a host of factors, including neurohormonal activation, intra-abdominal pressure, and renal glomerular disease (22). Achieving recommended blood pressure goals can markedly reduce morbidity and mortality in women who are obese (14).

Chronic hypertension contributes to serious morbidity and mortality among women, with even greater risk for pregnant women, including increased likelihood of acute renal failure, pulmonary edema, preeclampsia, and stroke. According to the Centers for Disease Control and Prevention, overweight women who are able to attain a healthy weight through daily exercise and a heart-healthy diet can lower incidence of hypertension by 50% (23). Since women appear to be more sodium-sensitive than men, it behooves dietitians to apply this knowledge in dietary care planning for women (20).

The increasing prevalence of obesity may affect both sexes, but there are greater challenges for women (6). The reasons, while multifactorial and not specifically clear, result in differences in body composition and are driven, in part, by differing food preferences (23, 24, 26). Current investigations indicate changes in myriad hormones, insulin resistance, and metabolic response to exercise that affect body weight differently in women and men (5, 23, 25). It appears that women are more efficient at conserving energy and storing it as fat (23-27). This ability to increase fat mass without substantial increases in energy intake points to the existence of metabolic adaptations that may contribute to the gender difference in obesity and comorbid diseases (5, 23, 26).

Differences in fat mass may be explained, at least in part, by more estrogen receptors in subcutaneous deposits of women, which may explain why women have greater subcutaneous gluteal and femoral deposits of fat (26). Postmenopausal women experience an increase in waist to hip ratio and greater visceral adipose accumulation that can be partially reversed upon administration of estrogen. However, the influence of sex hormones on adiposity is one small part of the hormonal picture.

Our understanding of obesity extends beyond sex hormones to the function of adipocytes as an endocrine organ, which regulates adiposity and metabolism (27, 30). Fat cells release hormones that, in individuals at a healthy weight, modulate body fat. However, with excess weight gain adipocytes enlarge, leading to dysregulation in the adipose tissue, and ultimately inflammation. Adipose tissue secretes a large number of proteins – more than 50 known adipokines – that control various metabolic functions; the most familiar are adiponectin and leptin (24, 27). Both play critical roles in energy balance as influenced by the sex of the individual. Adiponectin appears to have a role in the development of atherosclerosis and the inflammatory response, which seems to promote obesity; while leptin regulates appetite. When there are lower levels of insulin and leptin in overweight women, appetite is stimulated, leading to increased fat stores. This does not seem to be the case in men (27).

Physiological differences in adiposity are impacted differently with regard to physical activity, too (3). Beneficial effects of exercise on CHD risk is less significant in women than men, with a smaller increase in HDL and less weight loss resulting from similar physical activity. It appears that physical activity may be a more effective tool to promote weight loss in men than women (30). However, methods to promote successful weight loss in both sexes require further study. In the meantime, strategies that take into account the individual's biology, rather than just body weight or energy intake will help assure better patient-centered outcomes.

Cancers and Obesity

Women who are obese are at a higher risk for several types of cancers as compared to men who are obese (28). One study, using National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) data, estimated that 34,000 new cases of cancer in men (4%) and 50,500 in women (7%) are associated with obesity. Several possible mechanisms may explain the association of obesity with increased risk of certain cancers in women:

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our vision

“Optimizing the future of women’s health at all ages.”

- Fat tissue produces excess estrogen, which is associated with increased risk for breast, endometrial, and other cancers, as well as increased inflammation;
- Increased levels of insulin and insulin-like growth factor-1 (IGF-1) are often elevated in obesity, which may stimulate the development of some cancers;
- Fat cells produce adipokines, which may promote cell growth (28).

In considering dietary recommendations for obese women, the findings from a study of Mexican American women illustrates the necessity of considering both culture and sex differences (29). Mexican American women are more likely to meet the fruit and vegetables guideline of at least five portions daily, while men are more likely to meet physical activity guidelines of 150 minutes weekly (29). These differences in lifestyle outcomes reflect the necessity of a sex and gender approach in formulating appropriate behavior change strategies to improve body weight and reduce disease risks associated with obesity.

Two Sides to Diabetes

Contrary to type 2 diabetes, which is usually characterized by obesity and increasing age, the literature on the potential sex and gender differences in type 1 diabetes appears more related to CHD risk factors and metabolic control than to differences in glucose homeostasis. Women with type 1 diabetes have higher total cholesterol and triglyceride levels, but lower HDL levels – both of which are predictors of CHD in women (12). In contrast, sialic acid and fibrinogen were strong predictors of CHD only in men with type 1 diabetes (18). What, if any, significance these differences may have in long term management remain to be elucidated.

Women who develop diabetes prior to the menopausal transition appear to lose any CHD advantage likely due to a higher rate of micro- and macrovascular complications (11). Obesity and dyslipidemia increase the development of long-term complications in women, yet are less likely to be treated, according to intervention guidelines (11). Therefore, differences in treatment may contribute to this sex-specific difference in cardiometabolic risk. A continuing need for improvements in the treatment of individuals with diabetes is particularly striking for women (18).

SUMMARY

Registered dietitians are well positioned to help women make appropriate adjustments to lifestyle behaviors to improve health outcomes, focusing on dietary variables that affect lipid levels, hypertension, and diabetes, as well as sufficient physical activity. The recommendations must be rooted in an understanding of sex differences both in the manifestation of diseases and in changes that are modifiable for women, rather than broad guidelines based on a “what’s good for him is good enough for her” mentality (22).

In the era of personalized medicine, it is time for dietitians to adopt a sex and gender approach to dietary management. Tailoring nutrition recommendations to the specific needs of women will assure that individual dietary guidance for health prevention, as well as disease progression, is achieved.

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<http://bit.ly/WHDPG2014>

We want to know how the DPG can better serve its membership! **Thanks!**



Jodi R Godfrey MS, RD

Tell us about your professional background and career path.

All told, I have 30 years of health and medical communications experience, beginning with public relations agencies and then moving to non-profits. After completing my master's degree in Nutrition & Health Communications from Boston University and the dietetic internship at Lahey Clinic Medical Center in Burlington, MA, I began my registered dietitian career as a contributing editor to the *Journal of Women's Health*. I authored a monthly feature column "Conversation with the Experts," addressing all aspects of medical care. At this time I was also program director for the annual Congress on Women's Health, a continuing education program for physicians and the allied health professions.

Currently I am Managing Director of the Sex & Gender Women's Health Collaborative (SGWHC), the lead dietitian at Youth Consultant Service, a nonprofit organization that provides behavioral treatment for children in residential facilities across New Jersey, and a consulting editor to the peer-reviewed journal *Childhood Obesity*. For the latter, my goal is to identify best practices in schools across the country and look for controversial topics to explore (e.g., offering chocolate milk, or expansion of vegetable offerings). My personal insights on food and nutrition are also shared on my blog, Feeding Kids and You (<http://feeding-kids.wordpress.com/>).

Tell us how you came to be in the role of Managing Director at SGWHC, and what the position entails.

During the time my column in the *Journal of Women's Health* was in publication, its focus was on medical conditions, though I aimed to find a nutrition link to explore when interviewing the specialists. As the column was being phased out, the journal's deputy director connected me with the American Medical Women's Association and the American College of Women's Health Physicians, who were looking for someone to lead production of a web-based educational forum focusing on the evolving science of women's health. The position was a natural fit for me given my program development and communications experiences, as well as my skills as a dietitian, in evaluation of research and working within the medical community to forge partnerships aiming to promote a broader definition of women's health.

As Managing Director, I have advanced the vision of the SGWHC working group and produced the first and only online repository of evidence-based resources that offer a sex and/or gender approach to health care. In order to expand our reach, I worked to form alliances with medical institutions and organizations vested in women's health. Among these groups is the WH DPG, which became an official partner of the SGWHC about a year ago.

How do you employ your skills as a registered dietitian in your current position?

My work on behalf of the SGWHC requires that I identify and share any new clinical findings that reflect sex and gender differences, and communicate new content to our website subscribers and partnering organizations. This is accomplished by posting

new content, writing blog posts, issuing e-blasts through our newsletter service, sharing information through social media (@GoWomensHealth on Twitter, LinkedIn, Facebook), and seeking opportunities to advocate for our mission -- "Establish a universal understanding that a sex and gender perspective is integral to an evidence-based approach to medical care." The growing body of evidence on differences in nutritional needs of women and men prompted me to pitch the idea of preparing an overview and webinar for my own practice group, so that dietetics professionals would join the forefront of care in applying a sex and gender sensitivity to the delivery of nutritional care.

What resources do you find most helpful in your daily work, particularly those you might suggest to those interested in embracing the sex and gender perspective in our own work?

First and foremost, I hope that dietetics professionals will begin to reframe their approaches to dietary counsel and presentation of nutrition messages by integrating a sex and gender sensitivity to research and clinical practices. The best resource for those who specialize in women's health is to visit <http://sgwhc.org> and (1) subscribe to the e-blasts to receive bimonthly updates on programs and key studies; and (2) use the search tool to find new studies that feature nutrition related content.

How do you feel about the research in the area of sex and gender-specific nutrition?

The impact of nutrition on disease onset and progression remains poorly understood, even more so for the subtleties between men and women. We must reconsider individual needs in the evolving world of patient-centered care to include implications based on sex, as well as cultural and socioeconomic factors. Trying to get effective healthy eating messages out to the public when competing with the marketing forces of our mighty food industry makes our effectiveness all the more challenging. However, the single most important challenge for registered dietitians must be on reversing the trajectory of obesity beginning in utero and among infants and toddlers. I also believe we should encourage families to make vegetables and legumes a cornerstone of their diets, and promote regular activity for all individuals. Both of these practices are essential to achieving long-term health for the next generation. Our effectiveness will depend upon whether we tailor our recommendations appropriately to meet the specific needs of women and men. Registered dietitians must continue to seek effective strategies for weight management so as to reduce the risk of noncommunicable, chronic diseases, which I believe should include a whole foods-based approach to nutrition education.

If you had one or two "most important" things you want dietetics practitioners to learn from your research experience, and/or from how you directly utilize a sex and gender perspective in practice, what would it be?

The single most important takeaway message for dietetics professionals is to commit to viewing women's nutritional needs as influenced by much more than our reproductive hormones and organs. It is essential to adopt dietary strategies with a broader appreciation for the myriad factors that affect women, including how they might respond physiologically, emotionally and socially to foods and physical activity. Only then can we begin to achieve a more targeted approach to nutritional advocacy, and achieve success at promoting ideal eating habits for our clients.

The 2015 Dietary Guidelines are expected to be released in the fall of 2015. The first status report published in the *Women's Health Report* in October 2013 included basic information about the 2015 Dietary Guidelines, updates on development of the Dietary Guidelines Advisory Committee (DGAC) and its future plans, and discussion from the DGAC's first meeting.

Since then the DGAC held two additional meetings, and developed five subcommittees to begin the "systematic review" of all new evidence since 2010 to ensure that the 2015 Dietary Guidelines make appropriate recommendations based on significant research.

A brief overview of each subcommittee (SC) is below. (For more information on the subcommittee assignments, please visit http://www.health.gov/dietaryguidelines/DGAC_Subcommittees_508.pdf.)

SC 1: Food and Nutrient Intakes, and Health: Current Status and Trends, Chair: Marian Neuhouser

The purpose of this SC is to identify the current eating behaviors and nutrient intakes of Americans, and to pinpoint the current prevalence and trends of the most common nutrition-related chronic diseases.

SC 2: Dietary Patterns, Foods and Nutrients, and Health Outcomes, Chair: Anna Maria Siega-Riz

The Dietary Patterns, Foods and Nutrients, and Health Outcomes SC is researching the "exposure of interest" of certain foods and dietary patterns and the "outcomes of interest," including nutrition- and diet-related diseases, most of which are preventable.

SC 3: Diet and Physical Activity Behavior Change,

Chair: Rafael Pérez-Escamilla

This SC is looking closely at the physical activity behaviors and dietary recommendations of Americans, including adherence to the recommendations, motivation to comply, and barriers. An additional responsibility is to research successful intervention programs that improve adherence.

SC 4: Food and Physical Activity Environments, Chair: Mary Story

The Food and Physical Activity Environments SC will answer questions such as, "How does environment play a role in an individual's capability to make healthy lifestyle choices related to physical activity and eating?"

SC 5: Food Sustainability and Safety, Chair: Mim Nelson

The final SC will assess how our food is produced, as well as ways to improve overall human health and safety to improve the "health of the planet."

The five subcommittees were introduced and made initial presentations at the second DGAC meeting January 13-14, 2014. The third meeting, held on March 14, 2014, continued discussion of the new guidelines with presentations from various food and nutrition experts, as well as from each SC. The "Invited Expert Presentations" included:

- *Effective Prevention of Obesity in Healthcare Settings: Barriers and Opportunities*, by William H. Dietz, Consultant, Institute of Medicine

- *Effective Strategies and Delivery Approaches to Changing Diet and Activity for Weight Control*, by Deborah F. Tate, Gillings School of Global Public Health, University of North Carolina Chapel Hill
- *Restricting Trans Fat Use in Foods: the New York City Experience*, by Sonia Angell, Centers for Disease Control and Prevention
- *The Contributions of Food Science to Help Americans Achieve the Dietary Guidelines—Future Opportunities and Challenges*, by John Ruff, Institute of Food Technologists

The next meeting will be held sometime in the spring or summer of 2014. The DGAC will continue to review the scientific evidence, and welcomes comments from the public at <http://www.health.gov/dietaryguidelines/dga2015/comments/>.

References

Subcommittee Source: <http://www.health.gov/dietaryguidelines/2015-binder/meeting2/subcommittees.aspx>

More specific info about subcommittees: http://www.health.gov/dietaryguidelines/2015-binder/meeting2/docs/workGroupPresentations/Millen%20DGAC%20meeting%20_Intro%20to%20SCs_final_1.14.14_2-27-14.pdf

Meeting 2 notes: <http://www.health.gov/dietaryguidelines/2015-binder/meeting2/mtgMaterials.aspx>

Meeting 3 notes: <http://www.health.gov/dietaryguidelines/2015-binder/meeting3/mtgMaterials.aspx>

GOT CASE STUDIES?

The *Women's Health Report* is looking for contributing authors to share case studies for our future publications.

Please contact Editor Heather Goesch at whdpgpublications@gmail.com if you'd like to contribute.

SEEKING TESTIMONIALS FROM MEMBERS

The *WH DPG* is looking for members to provide testimonials about working in women's health, and on membership in the *WH DPG* for its new website.

If interested, please email info@womenshealthdpg.org.

HOD Fact Sheet

House of Delegates

Spring 2014

“‘Google’ is not a synonym for ‘research’.”
— Dan Brown,
The Lost Symbol

During the House of Delegates dialogue session on *Nutrition Services Delivery and Payment: The Business of Every Academy Member* (October 18 and 19, 2013), the need for outcomes data to support increased reimbursement for nutrition services of the registered dietitian nutritionist (RDN) and dietetic technician, registered (DTR) emerged as a theme. We must use research to demonstrate how RDNs and DTRs improve the nation’s health through food and nutrition in order to advocate for increased reimbursement.

An example of the power of published outcomes research on the role of the RDN was the January 2013, publication in *Managed Care Magazine* that concluded “MNT [Medical Nutrition Therapy] is a valuable adjunct to health management programs that can be implemented for a relatively low cost. MNT warrants serious consideration as a standard inclusion in health benefit plans”¹. The study was a project of the Dietetics Practice Based Research Network and was “the first to evaluate a policy decision by an insurance company to provide coverage for MNT”¹. The Academy Nutrition Services Coverage Team has used the article in several ways to help members with reimbursement issues, such as: including the article in advocacy materials distributed to the Public Policy Panel members at the 2013 Public Policy Workshop, sharing it with numerous affiliates to support their advocacy work around the Essential Health Benefits package for their states and also with Reimbursement Representatives and other Academy members who are working on expanding coverage for MNT services with private insurance companies.



As instrumental as the *Managed Care* article has been, one article is not enough. Collecting and utilizing outcomes data in all practice areas is imperative to the advancement of the profession, as seen with the Centers for Medicare and Medicaid Services’ (CMS) decision on Intensive Behavioral Counseling for Obesity. Without sufficient outcomes data on the effectiveness of RDN specific interventions, reimbursement by CMS for services is difficult to achieve.

Research is frequently acknowledged as the basis of our profession. Members frequently apply and discuss research in practice but they are less likely to contribute to new nutrition and dietetics related research. The question is why all the interest but minimal contribution?

Mega Issue Question:

How do we mobilize members to commit their time, talent and resources to research?

Meeting Objectives:

Participants will be able to:

1. Increase members’ awareness of Academy research resources.
2. Recognize various ways members are utilizing and contributing to research.
3. Develop a plan to empower members (at all practice levels) to use, participate in and/or conduct research to benefit the profession and the public.
4. Identify ways that members can build a professional culture that encourages and embraces research.
5. Advocate for resources to conduct research.

The Academy has made a significant effort to encourage and educate members on the importance of research, standardized language, and evidence based practice.

Academy Resources	Description
Research Website	Provides quick access to Academy Research resources, philosophy and framework, and the Academy Knowledge Center. http://www.eatright.org/research/
Academy's Health Informatics Infrastructure	Online tool that promotes efficient and accurate use of the Nutrition Care Process and the corresponding International Dietetics and Nutrition Terminology, helps members track and report on patient outcomes, and collects RDN-impact data for use in public policy and quality improvement research.
Evidence Analysis Library	The Academy of Nutrition and Dietetics Evidence Analysis Library (EAL®) aggregates existing literature on relevant nutrition and dietetic topics housed within an accessible, online, user-friendly library. http://andevidencelibrary.com
Dietetics Practice- Based Research Network	The Dietetics Practice-Based Research Network (DPBRN) is a network of nutrition and dietetics professionals and students with varying specialties and areas of expertise who are interested in studying and improving patient care. DPBRN conducts, supports, promotes and advocates research in practice-based settings by bringing practitioners and researchers together to identify research that is needed in practice settings, design top-class research, obtain funding and carry that research out in real-life practice settings. DPBRN is a free benefit of membership in the Academy. http://www.eatright.org/members/DPBRN/
Nutrition Care Process	The Nutrition Care Process (NCP) is a holistic, systematic approach to providing high quality nutrition care. Use of a care process provides a framework for the RDN to individualize care, taking into account the patient/client's needs and values and using the best evidence available to make decisions. http://www.eatright.org/ncp/
International Dietetics and Nutrition Terminology	The International Dietetics and Nutrition Terminology Reference Manual is available in print and electronically. Using standard terminology allows RDNs in all settings to use the same words to describe things resulting in more precise and effective documentation and communication. Standardized terminology is essential for electronic health records and billing forms. Standardized language will also facilitate legislative efforts. Each term has a reference sheet that defines the term and important information regarding use of the term. http://www.eatright.org/shop

What HOD Needs from You

Talk with your delegate(s) about this issue in advance of the Spring 2014 HOD Meeting (May 3-4, 2014).

Questions for your members to consider:

- What are you already doing in regards to research?
- How do you see yourself/yourself contributing to research in the future?

Delegate contact information is available at www.eatright.org/leaderdirectory. The backgrounder is available at www.eatright.org/hod > Spring HOD Meeting Materials.

Denise Andersen MS RDN LD CLC
WH DPG HOD Delegate

1. Bradley D, Murphy G, Snetslaar L, Myers E, Qualls L. The Incremental Value of Medical Nutrition Therapy in Weight Management. *Managed Care*. 2013; 40-45.





Dietetic Interns and Gail Frank, DrPH, RD, CHES, Internship Director (far right), at one of their four informational tables during the nutrition fair. The 'Spice Up Your World with Flavor and Nutrition' table showcased a global map identifying herbs and spices for different regions of the world.

To celebrate National Nutrition Month®, the dietetic interns at California State University Long Beach in cooperation with members of Students Active in Community Health (SACH) – a student organization of nutrition, health science, community health, and physical therapy members – prepared practical tips to “Enjoy the Taste of Eating Right!” These tips were presented at a free nutrition fair for other students held on St. Patrick’s Day, March 17, 2014.

Dressed in green ‘veggie’ tops and black pants, the twelve interns shared information about:

- *Using spices for flavor, instead of salt* – presented samples of different herbs and spices for favorite multi-ethnic dishes;
- *Choosing the best fluids* – used equivalent bags of sugar to illustrate the amount in sodas, fruit-flavored drinks and coffees;

- *Balancing meals* – showed appropriate portion sizes and misconceptions using ‘My Plate’ as a guide; and
- *Saving money while making healthy choices* – discussed the amount of money saved when you prepare salads with fresh vegetables on your own instead of buying a ready-made one, as well as when you cook rather than purchase fast food.

The members of SACH posed nutrition and food quiz questions, and discussed the correct answers with participants. Fresh fruit, water, and fruit bars were given as treats. Dozens of students visited the fair between classes, taking advantage of the opportunity to learn truthful nutrition information showcased by their peers. As Courtney Dair, one of the dietetic interns, explained, ‘being smart about nutrition will help you live and feel better!’ And Ali Milligan, SACH President, encouraged students to ‘think and drink smart.’



MEMBERSHIP UPDATE – FREE WEBINARS By Maria Bournas, MS, RD, LDN

Our annual webinar series is underway again! The WH DPG is offering another set of free webinars to members. Participation is a great way to share knowledge and information on innovative and varied practice areas.

We kicked off the series in February with a session presented in conjunction with the PHCNPG, in which Phyllis Stell Crowley, MS, RD, CD, IBCLC discussed how to manage common breastfeeding concerns of new mothers. In early April Susan Allen, RD, CCN helped us sort through cutting edge information on supplements to support women’s health. Most recently Jodi Godfrey, MS, RD, in conjunction with her feature article, spoke about embracing a sex and gender approach in order to provide optimal nutrition care for women.

Keep an eye out for future webinars, including our next offering -- Exercise in Diabetes During Pregnancy -- from Melissa Ortiz, MA, RD, CDE on Thursday 15 May.

Webinars are 1 hour in length and offer 1 CEU, pending approval from the Academy of Nutrition and Dietetics.

We are already starting to plan the 2014-2015 webinar series. If you have ideas for topics, or are interested in being a presenter, please send an email to whdpgmembership@gmail.com.

Webinar recordings are available on the WH DPG website, and can be accessed through the Member Section.

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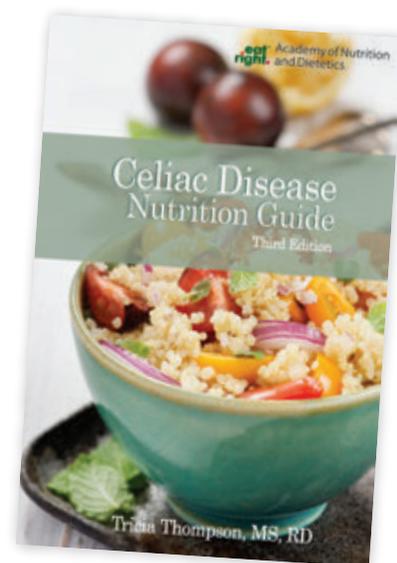
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Celiac Disease Nutrition Guide, Third Edition

Fully updated to include new FDA gluten-free labeling rule information, this is the essential guide for people diagnosed with celiac disease, dermatitis herpetiformis, or non-celiac gluten sensitivity. It outlines how to follow a gluten-free diet, identify food products and medications that might contain gluten, shop for gluten-free products, and more.



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