Sex and Gender Analysis in Health Policy

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Objectives of the Presentation

1. Understand why we need sex/gender analysis of health policy
2. Understand the impact of sex/gender on determinants of health, access to health care, accessibility of health information, and health outcomes.
3. Learn about recent research using sex/gender analysis
4. Learn about sex/gender analysis tools

Why do we need sex/gender analysis of health policy?

- Women are more frequently **single head of households, primary caregivers of the family, purchasers of insurance and coordinators of health care**, education and other services for the family. (Kaiser Family Foundation Women's Health Survey)
- Differences found between women and men can and should **guide policy planning and implementation**

Sex…

Refers to the biological differences between males and females. Sex differences are concerned with males' and females' anatomy and physiology.

Every Cell Has a Sex

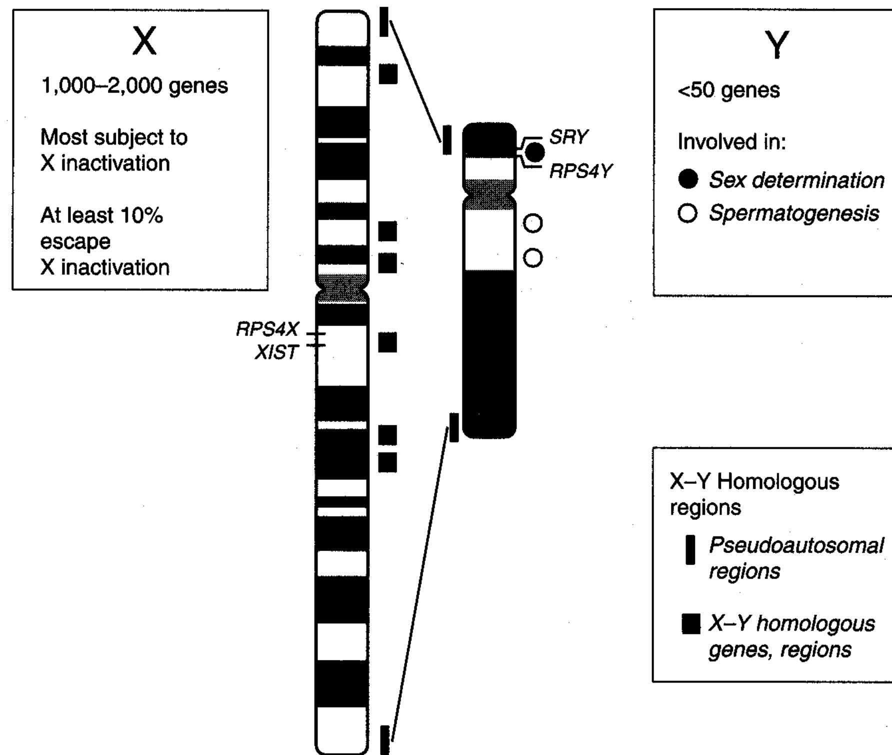


FIGURE 2-2 Comparison of gene contents and gene organizations on the X and Y chromosomes (see text for details).

IOM report 2001 p33

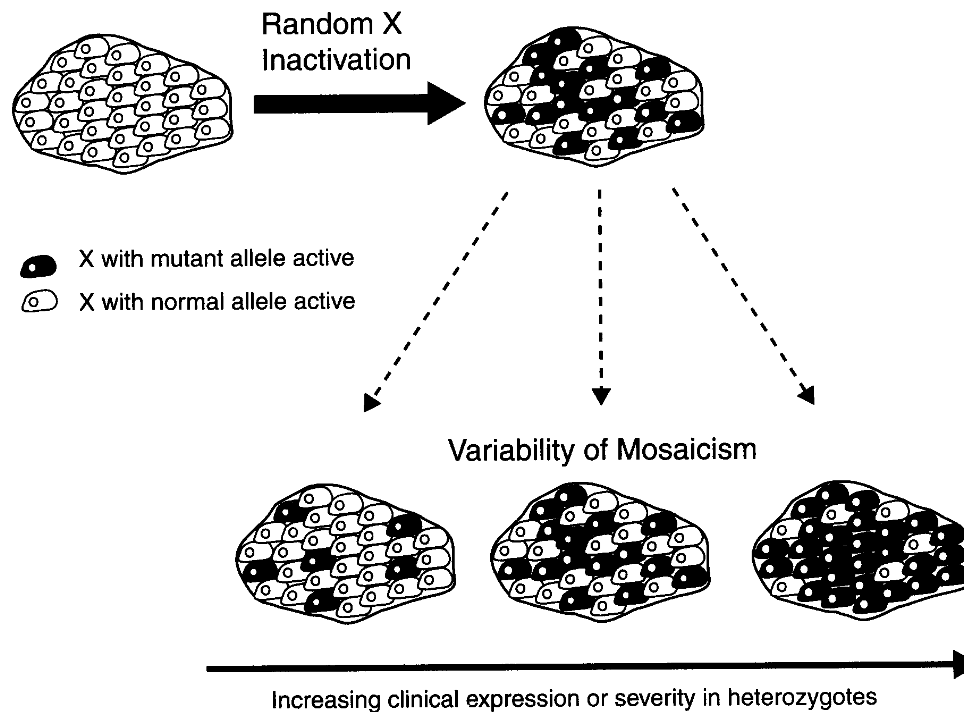
Sex Gene Variation

Female Genotype	Syndrome	Male Genotype	Syndrome
XX	"Normal"	XY	"Normal"
XO	Turner	XXY	Klinefelter
XXX	Triple-X Super-female	XYY	Super-male
XX/XXX	Genetic mosaic	XX/XY	Genetic mosaic
XX/XX	Genetic mosaic	XY/XXY	Genetic mosaic

Every Cell Has a Sex

X-Chromosome Inactivation Compensates for Differences in Gene Dosage

The twofold difference between males and females in the dosage of genes on the X chromosome is negated at many loci by the process of X-chromosome inactivation (Figure 2-3). X-chromosome inactivation is, on



IOM report 2001 p36

Gender…

Refers to the economic, social, political, and cultural attributes and opportunities associated with being male or female.

The social definitions of what it means to be a woman or a man vary among cultures and change over time.

OECD, 1998

Gender

- Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organized, not because of our biologic differences (World Health Organization, 1998a).

- http://genderandhealth.ca/en/modules/introduction/introduction-whatsthedifference-Shayna.jsp?r=

- Gender varies over time and culture and is therefore changeable.
- Gender roles are those activities that are considered by a given culture to be appropriate to a man or a woman.

Through a Gender Lens: Family Health International: Research Triangle Park, NC. March 1998

Social construct & SDH: Race

What Is Race?

Race Timeline

RACE The Power of an Illusion

Has Race Always Been the Same?

American ideas about race have changed significantly over time. Since the beginning, the way we have classified and defined groups, our laws, social policies, even our scientific discoveries — have all been shaped by shifting political priorities. http://www.pbs.org/race/003_RaceTimeline/003_00-home.htm

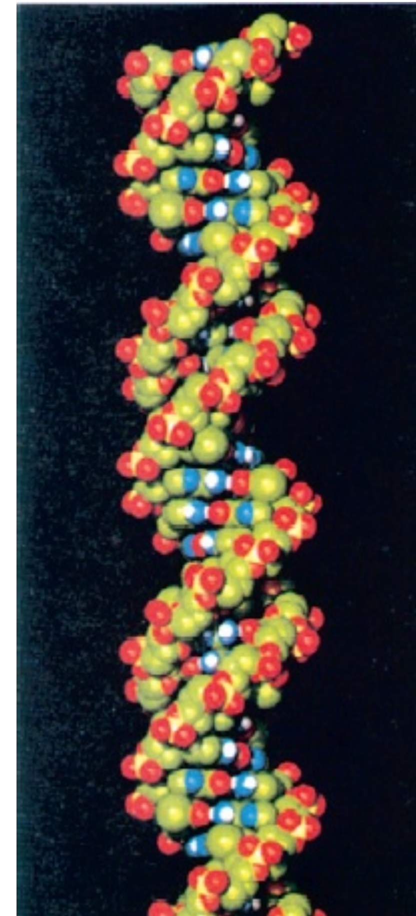
Men, Women & Populations: social determinants of health

Obviously, biological sex differences have health consequences. Yet biology is not destiny. In fact, even physiological differences in adult men and women may be socially acquired. Interactions between social and biological factors [& environment] as well as those between mental and physical health further complicate the picture.

Gender and Health: The Effects of Constrained Choices and Social Policies, Chloe E. Bird and Patricia P. Rieker, Cambridge University Press

Men, Women & Populations: Social Determinants of Health

- Epigenetics (gene expression)
- Environment



Epigenetics

Our DNA—specifically the 25,000 genes identified by the Human Genome Project—is now widely regarded as the instruction book for the human body. But genes themselves need instructions for what to do, and where and when to do it.

11.22.2006 **DNA Is Not Destiny**
The new science of epigenetics rewrites the rules of disease, heredity, and identity.
by Ethan Watters

Gender Equity & Equality

Gender Equity

Process of being fair to women and men, including using measures to compensate for historical and social disadvantages that prevent men and women from operating on a level playing field.

CIDA, 1996

Gender Equality

The state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources.

SIDA, 1997

Gender Integration & Mainstreaming

Gender Integration

Refers to strategies applied in program assessment, design, implementation, and evaluation to take gender norms into account and to compensate for gender-based inequalities.

Gender Mainstreaming

The process of incorporating a gender perspective into policies, strategies, programs, project activities, and administrative functions, as well as institutional culture of an organization.

Gender Analysis & Women's Health

– **Women's health**

– **Gender analysis**

– **Adapted from Liverpool School of Tropical Medicine *Guidelines for the Analysis of Gender and Health*, Section 2.3**

Sex/Gender Analysis

Begins to address the reason/s we have not achieved health equity and eliminated health disparities by addressing root causes.

What is Gender Analysis?

Gender analysis draws on social science methods to **examine relational differences** in women's and men's and girls' and boys'

- roles and identities
- needs and interests
- access to and exercise of power

and the **impact of these differences** in their lives and health.

How does Gender Analysis help us design and manage better health programs?

Through data collection and analysis, it identifies and interprets …

- consequences of gender differences and relations for achieving health objectives, and
- implications of health interventions for changing relations of power between women and men.

Two Key Questions

- How will the different roles and status of women and men within the community, political sphere, workplace, and household (for example, roles in decision-making and different access to and control over resources and services) affect the work to be undertaken?

- How will the anticipated results of the work affect women and men differently?

Steps of a Gender Analysis

Patterns that indicate disparities/unmet needs
– **the "what"**

Environment, access and control over resources, gender norms, activities and responsibilities, power and decision making
- **the "why"**

Look at how these gender factors constrain or support women's health.
•*Risk and vulnerability*
•*Living with ill health (burden)*
•*Programmatic responses*
- **the "so what"**

Adapted from Eckman et al., *OWH Gender-Based Programming: What does this mean?* 11/3/10

Health Insurance Exchange Stakeholder Input: Sex and Gender Implications

A Report to the NM Office of Health Care Reform
Funded through the
Federal Health Insurance Exchange Planning Grant

Gender Impacts Policy, A project of the Center for Southwest Culture

Giovanna Rossi, MSc, Project Director
Justina Trott, MD, Project Adviser

June 2011

Methodology

- **Qualitative**: Information About Women

- Four key informant interviews, seven focus groups, a policy forum

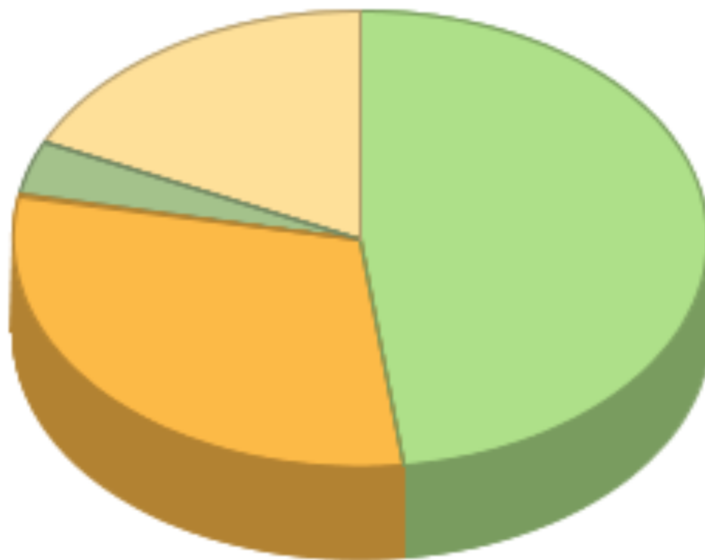
- **Quantitative**: Differences Among Men and Women

- A gender analysis of secondary sex-disaggregated data

Qualitative: Questions We Asked

- What barriers are there currently to health coverage for you and your family?
- Would you participate in a Health Exchange?
- What benefits are most important to you and your family?
- What additional benefits and services do you want in your health plan?
- What ways do you prefer to stay informed?
- What would make it easier for you to enroll in an insurance plan offered by the Exchange?
- What customer service tools are most important to you?
- How can an exchange be tailored to address the lives of women and girls in NM, including their responsibilities to family, work and community?

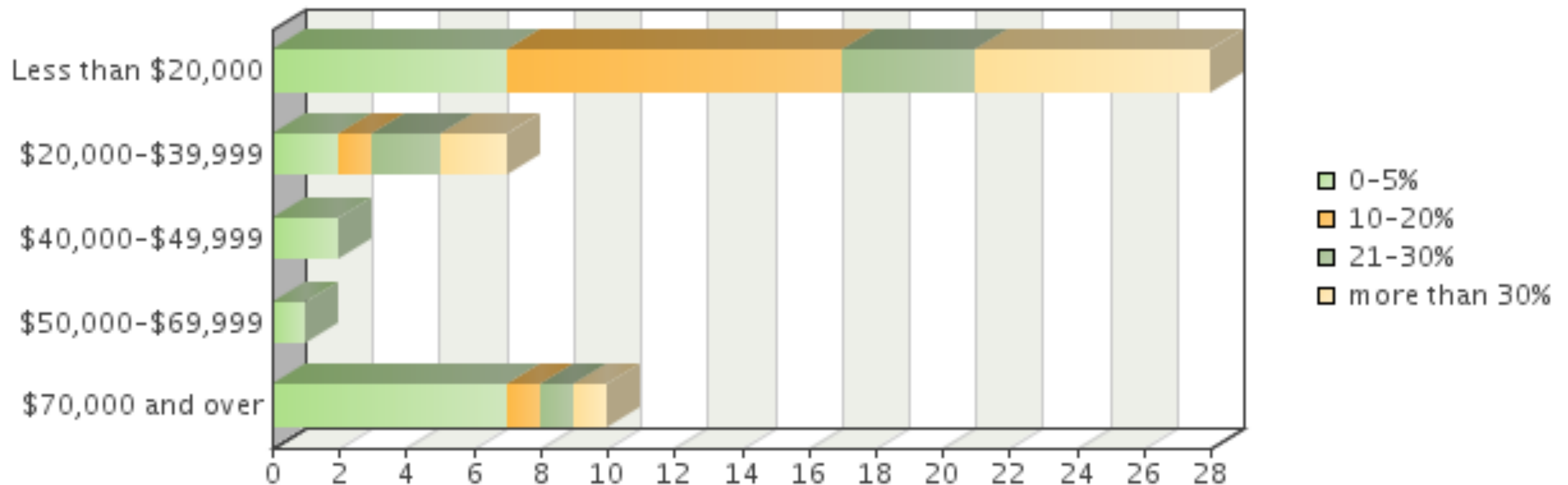
Focus Group Participants:
48% Hispanic/Latina
30% Anglo
4% Black/African American
18% American Indian



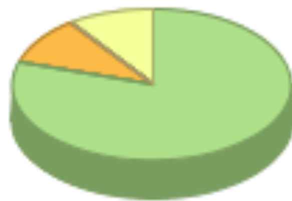
- Hispanic
- Anglo/Caucasian
- Black/African American
- American Indian/Alaska Native

The lowest household income earners (<$20,000) reported using the greatest portion of their income to pay for health care.

A significant number of high household income levels (>$70,000) reported paying 10-20% of their income to health care, with some spending more than 30% of their income on health care.

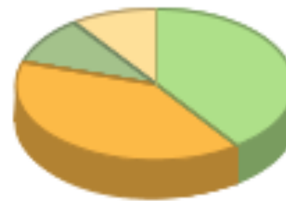


Uninsured =
Part-time
Seasonal
Self-employed



Full-time

Part-time



Self-employed

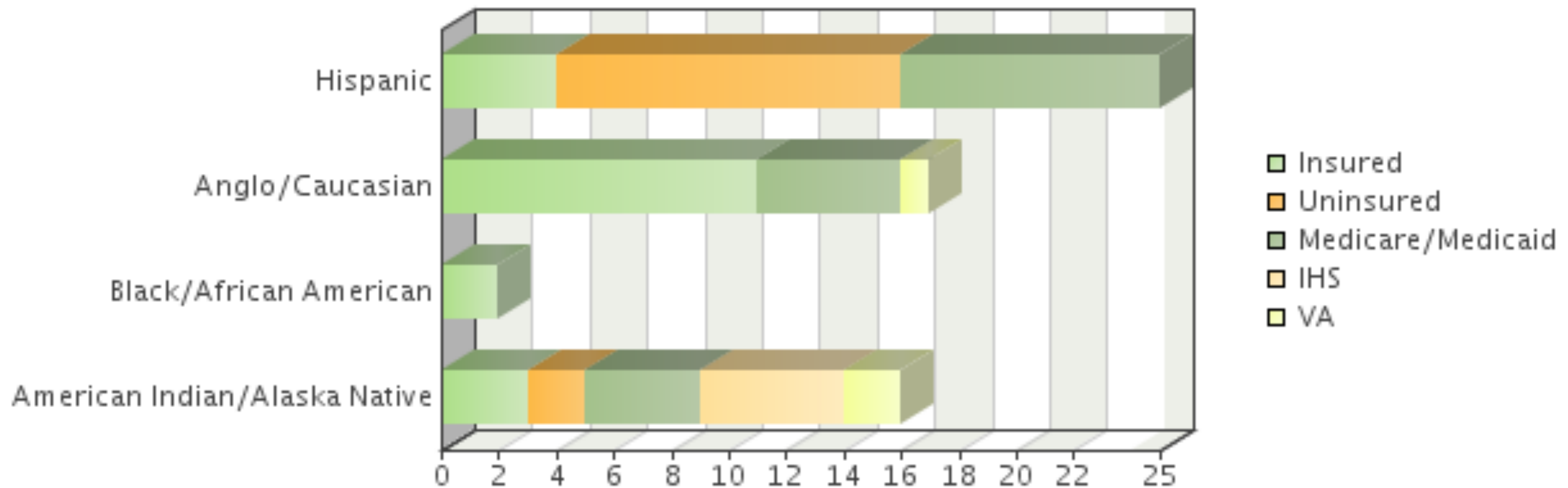
Seasonal

Unemployed

Retired

- Insured
- Uninsured
- Medicare/Medicaid
- IHS
- VA

A majority of uninsured Focus Group participants were Hispanic/Latina.



Sex and Gender Analysis of Quantitative Data

- Analyzed the data from the Uninsured Adult Household Survey, 750 people (May 2011, Research and Polling, Inc.)
- Approximately equal numbers of women and men: 49% women and 51% men

Insurance Coverage

- More women than men **had insurance** in the last 2 years, 68% compared to 56%. This is likely due to eligibility for Medicaid for pregnancy coverage and for single head of household parenting coverage.
- More women (48%) than men (34%) were **looking for health insurance**.

Affordable Care Act

- More **women** than men were **aware of ACA** – women 61%, men 58%.
- More **women** than men think the **health insurance exchange is a good idea**.
- They were also more **likely to use** the exchange than men –**very likely** to use the exchange: **52% women** compared to 40% of men.

Resource Utilization

- More **women** than men have a **regular doctor** -50% of women compared to 32% of men.
- More **men** than women seek care only if they are **very ill** –49% of men compared to 37% of women.
- More **women** than men had seen a **physician more than three times** in the last year.
- Significantly more **women** than men have seen a physician **more than 10 times** in the last year – 9% compared to 4%.

Technology

- More **women** than men **use computers** and they use them more often than men.
- The same is true for **internet** use.
- However, 13% of men and 11% of women **did not use computers at all.**

Employment

- More men than women are **employed full time** or as temporary employees (30% and 5% compared to 20% and 2% respectively for men compared to women).
- More women than men are **part-time workers** (18% compared to 12%) or **not employed** at all (48% of women are unemployed compared to 43% of men).
- Equal numbers of women and men are **self-employed** –approximately 10%.

Contributing Factors to The Differences Among Men and Women Found

- Activities and responsibilities
  - Women are more frequently **single head of households**, primary care-givers of the family, purchasers of insurance and **coordinators of health care**, education and other services for the family.
- Gender norms
  - Women's roles in diverse cultures in NM reinforce **family roles** and responsibilities, including neglecting herself to care for others.
- Access and control over resources
  - Women suffer **higher poverty rates** than men and there is a persistent **income gap** between women and men in New Mexico, especially women of color, disabled women and those living in rural communities.
- Power and decision-making
  - Fewer women are in **positions of leadership** and therefore able to influence policy. The disproportionate ratio of female to male legislators in the US and NM is also exacerbated by race/ethnicity.

Recommendations

- Cost
- Information, Knowledge and Trust
- Power Structures and Cultural Barriers
- Family Impact
- Comprehensive, Integrated and Colocated Services

Cost

- **Decrease barriers to enrollment**: enrollment should be annual and linked to income level.
- Provide a **clear comparison** of costs, benefits and services.
- Plans will need to be **affordable** based on income level, including premiums, copays, and prescriptions.

Information, Knowledge and Trust

- A health insurance exchange would need to have **trustworthy services, choice, authorization and an appeals process** from a trusted source such as an independent board.
- A health insurance exchange would need to include a strong **navigators** component with navigators who are from the communities served, well **trained, and knowledgeable**. The would need to be a respected member of health care team, included in policy and planning, and paid a salary.
- **Information** needs to be presented in different ways, including oral, print, electronic, television and radio.
- **Social skills** of the health care service providers and customer service personnel are important; build in **accountability** practices for quality of care in a centralized place.

Power Structures and Cultural Barriers

- A health insurance exchange would need to include **culturally and linguistically** appropriate services and information.
- Ensure **services to rural areas**
- Culturally relevant and **sex and gender appropriate**: sex- and gender-informed educational material
- All data should be collected, analyzed and reported **disaggregated by sex, socio-economic status, ethnicity, geographic location and age,** similar to recent requirements for all electronic data collection.
- Data collection should meet the **standards** of the recent IOM Women's Health Research report, Office on Women's Health, and Office of Minority Health and CLAS standards.

Family Impact

- **Subsidize travel** based on income.
- Bring **quality services to rural areas** via mobile unit or teleconferencing, using existing delivery systems such as schools, public health clinics, community centers and senior centers.
- Adopt a **family well being model**, which sees the family as a unit, ie. eligibility for all family members could be based on household income level. This includes "non-traditional" family structures, including grandparents as head of household and children as caregivers.
- Encourage **paid time off and flexible work schedules**, using the federal plan as a model.

Comprehensive, Integrated and Colocated Services

- Plans and providers will need to offer **integrated services** and at convenient, consolidated locations.
- **Benefits package** should include prevention, nutrition, acute care, chronic care, mental health parity, as well as acupuncture, traditional healing practices, herbal medicine along with allopathic/western medical services.
- Reproductive services are important; and **no co-pays for contraceptives.**

Sex/Gender Analytic Tools

- Transformative Research, Policy, Programs and Services
- USAID
- BIAS FREE Framework

Two Key Questions

- How will the different roles and status of women and men within the community, political sphere, workplace, and household (for example, roles in decision-making and different access to and control over resources and services) affect the work to be undertaken?
- How will the anticipated results of the work affect women and men differently?

Definitions

- **Gender Aggravating** approaches
  - Take advantage of rigid gender norms and existing imbalances in power to achieve program objectives
- **Gender Accommodating** approaches
  - Acknowledge the role of gender norms and inequities while seeking to develop actions that adjust to and often compensate for them
- **Gender Transformative** approaches
  - Actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching gender equity objectives

Margaret E. Greene and Andrew Levack: Synchronizing Gender Strategies: A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations

Definitions

- **Aggravating:** Programs that *create, exacerbate, or exploit gender inequalities* in pursuit of educational (project) outcomes.

  This approach is harmful and, in the long run, can undermine project objectives even if achieving short-term education results.

Definitions

- **Accommodating:** Programs that *maintain existing gender dynamics and roles* to achieve project outcomes.

  While this approach is not harmful, it does not seek to reduce gender inequalities or address broader systemic factors that perpetuate inequalities and maintain the status quo.

Definitions

- **Transforming:** Programs that seek to actively change gender inequalities and to *create positive, healthy relations between men/boys and women/girls and promote gender equality* to achieve project outcomes. Transformative efforts are intentional, meaning programmers actively thought about how to advance gender equality.

  This approach attempts to promote gender equality and challenge rigid gender norms. It may help to change imbalances in power, distribution of resources, or allocation of duties between men and women and address the systemic causes underlying gender inequalities.

Integrating Gender Into Programming (Table 1)

Program goal and/or overall health objective: ______________________________

Step 1: Conduct a gender analysis of your program by answering the following questions for your program goal or objective.

A. What are the key gender relations inherent in each domain (the domains are listed below) that affect women and girls and men and boys?	B. What other potential information is missing but needed about gender relations?	C. What are the gender-based constraints to reaching program objectives?	D. What are the gender-based opportunities to reaching program objectives?
Be sure to consider these relations in different contexts—individual, partners, family and communities, healthcare and other institutions, policies			
Practices, roles, and participation **Knowledge, beliefs, perceptions (some of which are norms):** **Access to assets:** **Legal rights and status:** **Power and decision making:**			

Integrating Gender into Programming (Table 2)

Steps 2-5: Using the information you entered in Table 1, answer the following questions for your program goal/objective.

Step 2. What gender-integrated objectives can you include in your strategic planning to address gender-based opportunities or constraints?	Step 3. What proposed activities can you design to address gender-based opportunities or constraints?	Steps 4 & 5. What indicators for monitoring and evaluation will show if (1) the gender-based opportunity has been taken advantage of or (2) the gender-based constraint has been removed?

Global Forum
for Health Research
HELPING CORRECT THE 10|90 GAP

BIAS FREE

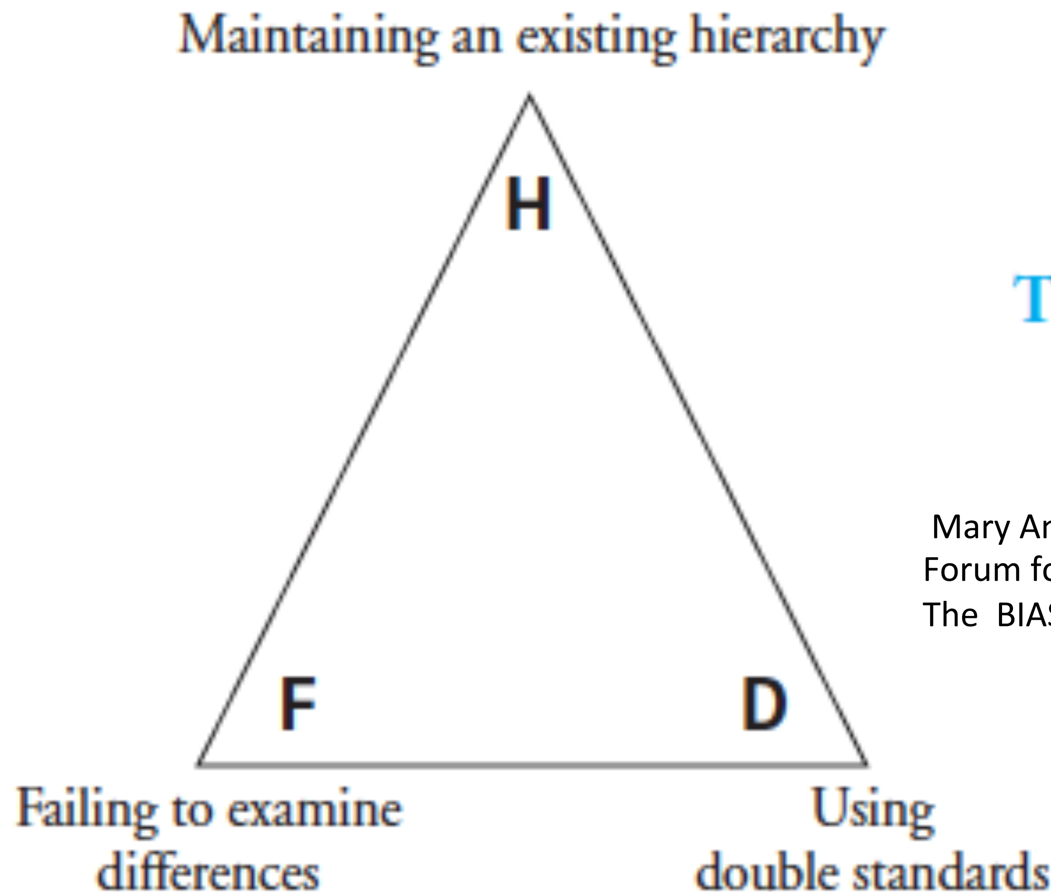
The *BIAS FREE* Framework

A practical tool for identifying and eliminating social biases in health research

Mary Anne Burke
Margrit Eichler

www.globalforumhealth.org

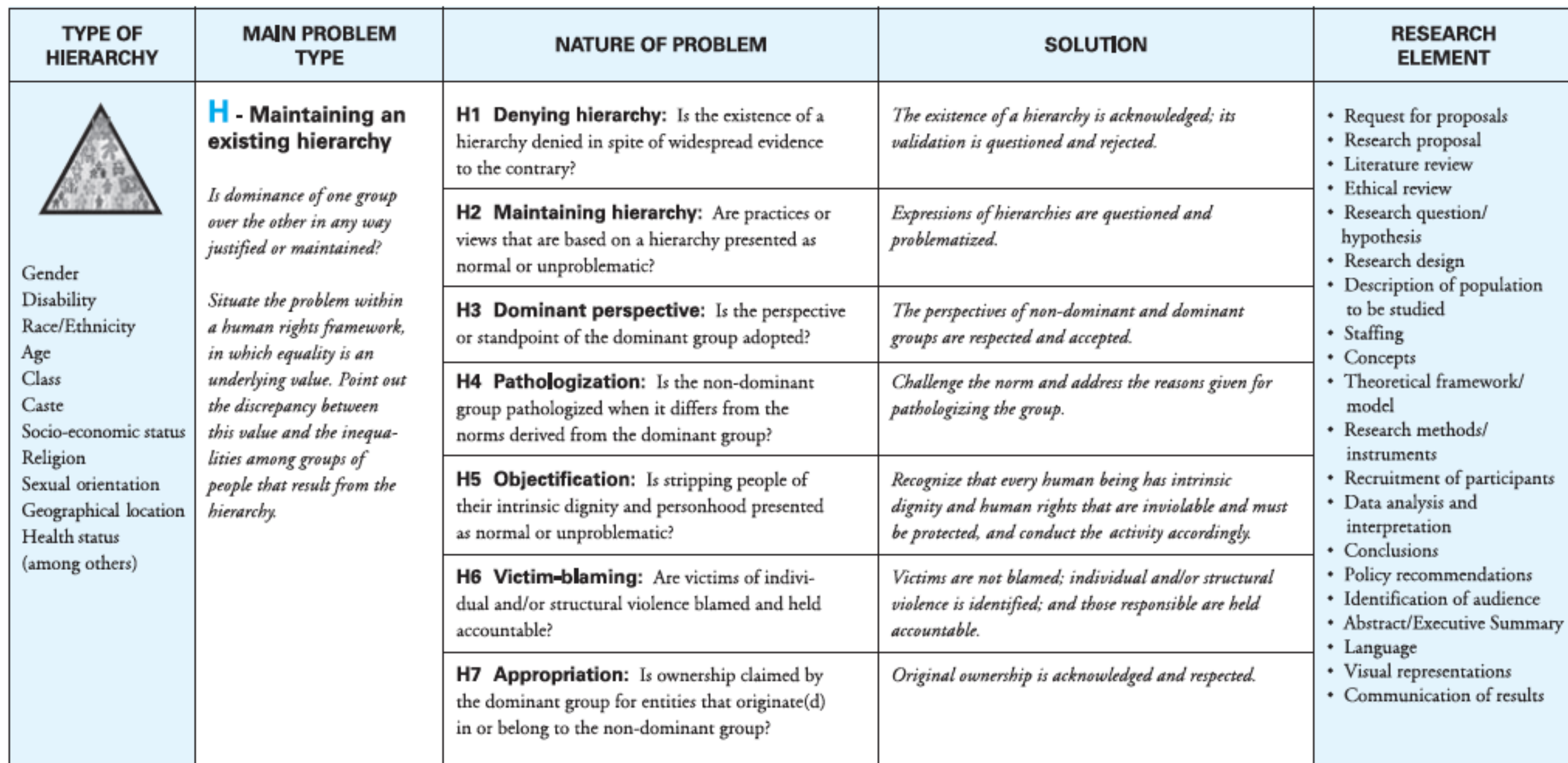
The BIAS FREE Framework



The Bias Triangle

Mary Anne Burke & Margrit Eichler, Global Forum for Health Research,
The BIAS FREE Framework , 2006

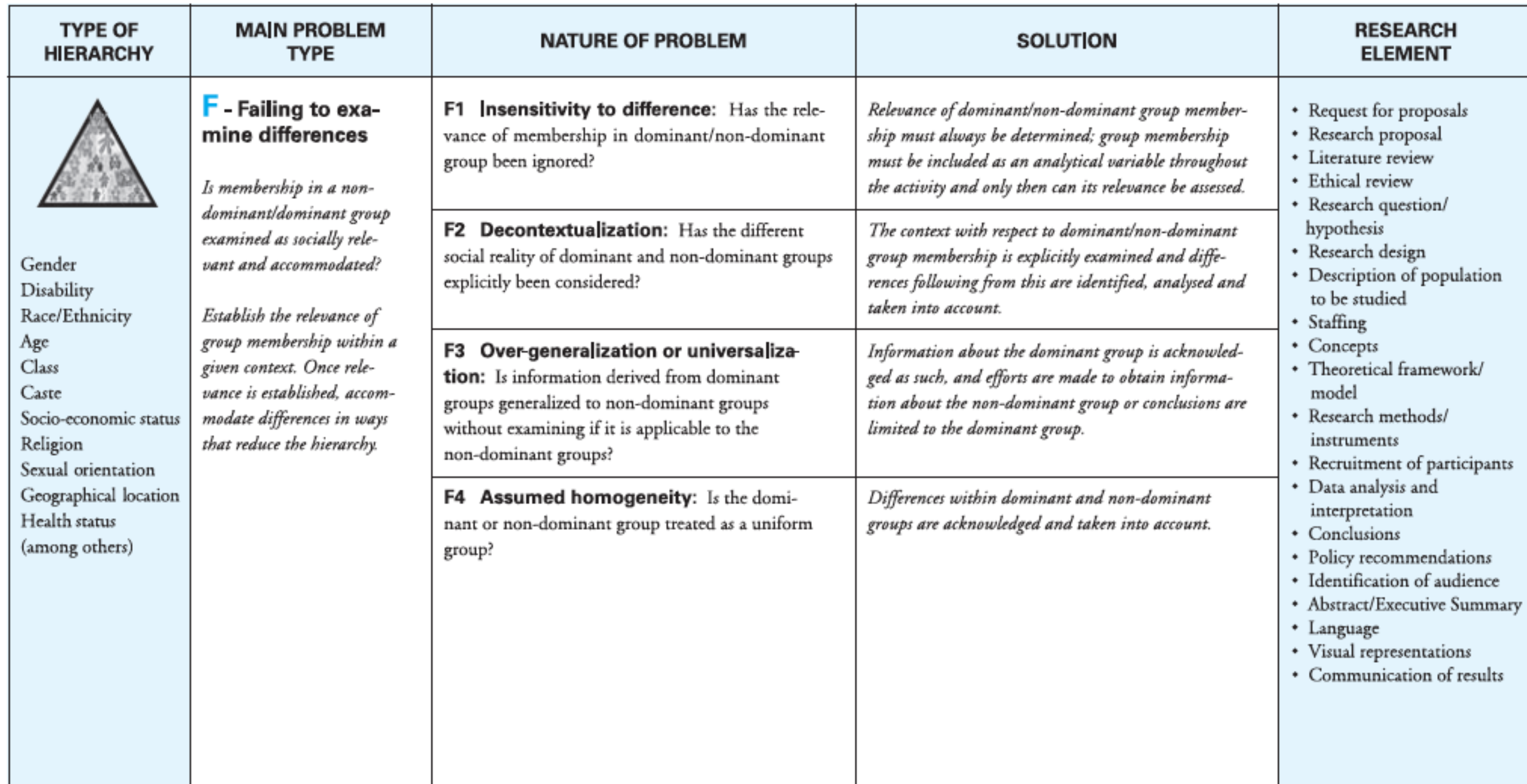
BIAS FREE Framework



THE *BIAS FREE* FRAMEWORK
for Research

TYPE OF HIERARCHY	MAIN PROBLEM TYPE	NATURE OF PROBLEM	SOLUTION	RESEARCH ELEMENT
Gender Disability Race/Ethnicity Age Class Caste Socio-economic status Religion Sexual orientation Geographical location Health status (among others)	**H - Maintaining an existing hierarchy** *Is dominance of one group over the other in any way justified or maintained?* *Situate the problem within a human rights framework, in which equality is an underlying value. Point out the discrepancy between this value and the inequalities among groups of people that result from the hierarchy.*	**H1 Denying hierarchy:** Is the existence of a hierarchy denied in spite of widespread evidence to the contrary?	*The existence of a hierarchy is acknowledged; its validation is questioned and rejected.*	• Request for proposals • Research proposal • Literature review • Ethical review • Research question/ hypothesis • Research design • Description of population to be studied • Staffing • Concepts • Theoretical framework/ model • Research methods/ instruments • Recruitment of participants • Data analysis and interpretation • Conclusions • Policy recommendations • Identification of audience • Abstract/Executive Summary • Language • Visual representations • Communication of results
		H2 Maintaining hierarchy: Are practices or views that are based on a hierarchy presented as normal or unproblematic?	*Expressions of hierarchies are questioned and problematized.*	
		H3 Dominant perspective: Is the perspective or standpoint of the dominant group adopted?	*The perspectives of non-dominant and dominant groups are respected and accepted.*	
		H4 Pathologization: Is the non-dominant group pathologized when it differs from the norms derived from the dominant group?	*Challenge the norm and address the reasons given for pathologizing the group.*	
		H5 Objectification: Is stripping people of their intrinsic dignity and personhood presented as normal or unproblematic?	*Recognize that every human being has intrinsic dignity and human rights that are inviolable and must be protected, and conduct the activity accordingly.*	
		H6 Victim-blaming: Are victims of individual and/or structural violence blamed and held accountable?	*Victims are not blamed; individual and/or structural violence is identified; and those responsible are held accountable.*	
		H7 Appropriation: Is ownership claimed by the dominant group for entities that originate(d) in or belong to the non-dominant group?	*Original ownership is acknowledged and respected.*	

BIAS FREE Framework

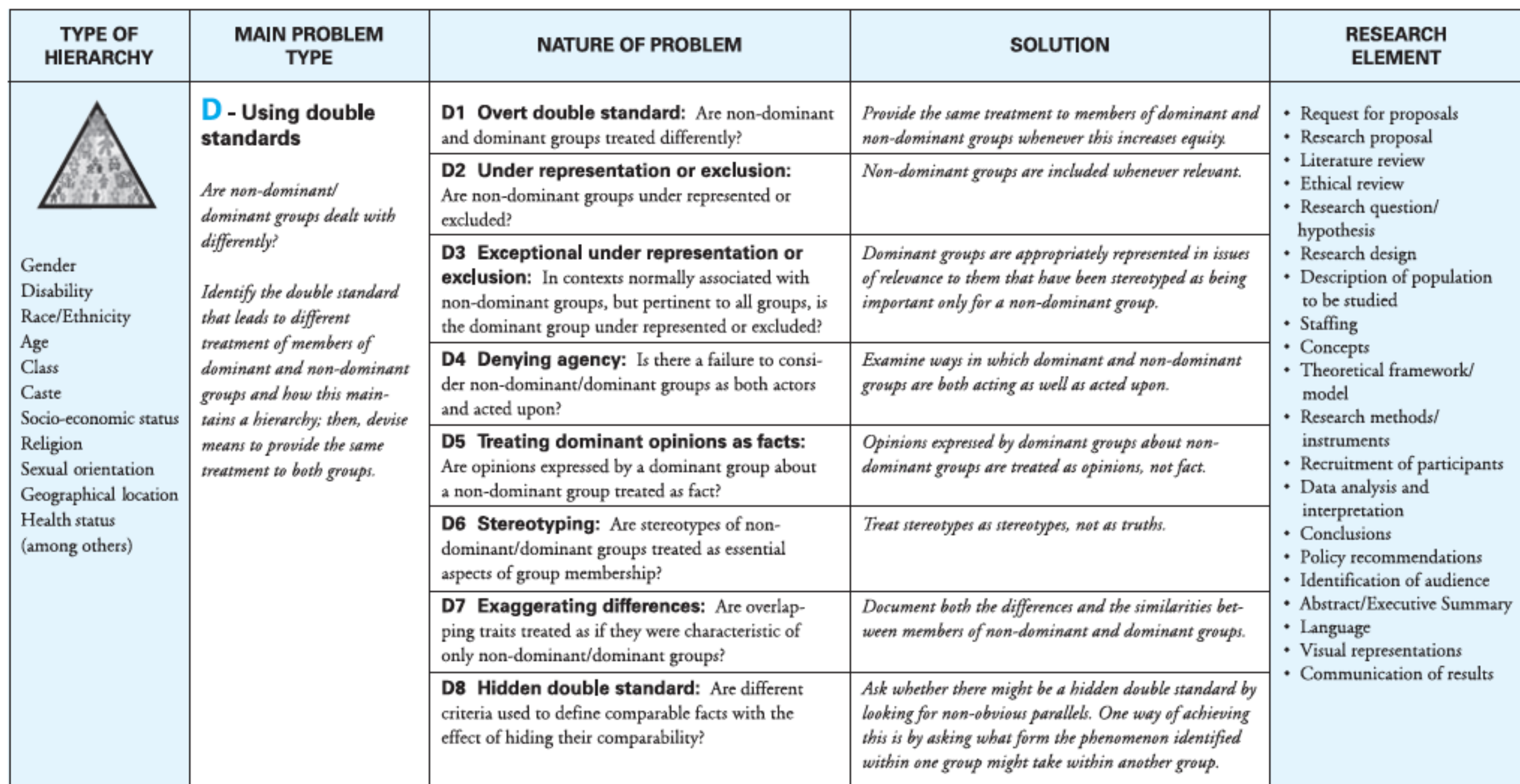


for Research

TYPE OF HIERARCHY	MAIN PROBLEM TYPE	NATURE OF PROBLEM	SOLUTION	RESEARCH ELEMENT
Gender Disability Race/Ethnicity Age Class Caste Socio-economic status Religion Sexual orientation Geographical location Health status (among others)	**F - Failing to examine differences** *Is membership in a non-dominant/dominant group examined as socially relevant and accommodated?* *Establish the relevance of group membership within a given context. Once relevance is established, accommodate differences in ways that reduce the hierarchy.*	**F1 Insensitivity to difference:** Has the relevance of membership in dominant/non-dominant group been ignored?	*Relevance of dominant/non-dominant group membership must always be determined; group membership must be included as an analytical variable throughout the activity and only then can its relevance be assessed.*	• Request for proposals • Research proposal • Literature review • Ethical review • Research question/ hypothesis • Research design • Description of population to be studied • Staffing • Concepts • Theoretical framework/ model • Research methods/ instruments • Recruitment of participants • Data analysis and interpretation • Conclusions • Policy recommendations • Identification of audience • Abstract/Executive Summary • Language • Visual representations • Communication of results
		F2 Decontextualization: Has the different social reality of dominant and non-dominant groups explicitly been considered?	*The context with respect to dominant/non-dominant group membership is explicitly examined and differences following from this are identified, analysed and taken into account.*	
		F3 Over-generalization or universalization: Is information derived from dominant groups generalized to non-dominant groups without examining if it is applicable to the non-dominant groups?	*Information about the dominant group is acknowledged as such, and efforts are made to obtain information about the non-dominant group or conclusions are limited to the dominant group.*	
		F4 Assumed homogeneity: Is the dominant or non-dominant group treated as a uniform group?	*Differences within dominant and non-dominant groups are acknowledged and taken into account.*	

BIAS FREE Framework

for Research



TYPE OF HIERARCHY	MAIN PROBLEM TYPE	NATURE OF PROBLEM	SOLUTION	RESEARCH ELEMENT
Gender Disability Race/Ethnicity Age Class Caste Socio-economic status Religion Sexual orientation Geographical location Health status (among others)	**D - Using double standards** *Are non-dominant/ dominant groups dealt with differently?* *Identify the double standard that leads to different treatment of members of dominant and non-dominant groups and how this maintains a hierarchy; then, devise means to provide the same treatment to both groups.*	**D1 Overt double standard:** Are non-dominant and dominant groups treated differently?	*Provide the same treatment to members of dominant and non-dominant groups whenever this increases equity.*	• Request for proposals • Research proposal • Literature review • Ethical review • Research question/ hypothesis • Research design • Description of population to be studied • Staffing • Concepts • Theoretical framework/ model • Research methods/ instruments • Recruitment of participants • Data analysis and interpretation • Conclusions • Policy recommendations • Identification of audience • Abstract/Executive Summary • Language • Visual representations • Communication of results
		D2 Under representation or exclusion: Are non-dominant groups under represented or excluded?	*Non-dominant groups are included whenever relevant.*	
		D3 Exceptional under representation or exclusion: In contexts normally associated with non-dominant groups, but pertinent to all groups, is the dominant group under represented or excluded?	*Dominant groups are appropriately represented in issues of relevance to them that have been stereotyped as being important only for a non-dominant group.*	
		D4 Denying agency: Is there a failure to consider non-dominant/dominant groups as both actors and acted upon?	*Examine ways in which dominant and non-dominant groups are both acting as well as acted upon.*	
		D5 Treating dominant opinions as facts: Are opinions expressed by a dominant group about a non-dominant group treated as fact?	*Opinions expressed by dominant groups about non-dominant groups are treated as opinions, not fact.*	
		D6 Stereotyping: Are stereotypes of non-dominant/dominant groups treated as essential aspects of group membership?	*Treat stereotypes as stereotypes, not as truths.*	
		D7 Exaggerating differences: Are overlapping traits treated as if they were characteristic of only non-dominant/dominant groups?	*Document both the differences and the similarities between members of non-dominant and dominant groups.*	
		D8 Hidden double standard: Are different criteria used to define comparable facts with the effect of hiding their comparability?	*Ask whether there might be a hidden double standard by looking for non-obvious parallels. One way of achieving this is by asking what form the phenomenon identified within one group might take within another group.*	