

Enhancing Women's Health and Gender Equity in
Public Health Programmes and Policies through
Gender-based Analysis

A Collaborative Workshop: NCCDH and ACEWH



National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé



Atlantic Centre of Excellence
for Women's Health

Halifax, Nova Scotia
19-20 March 2008

**WORKSHOP ON ENHANCING WOMEN'S HEALTH
AND GENDER EQUITY IN PUBLIC HEALTH PROGRAMS
THROUGH GENDER-BASED ANALYSIS**

March 19-20, 2008

A BACKGROUND PAPER

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INTRODUCTION

This paper provides background information and perspective on gender-based analysis (GBA) as a critical tool for addressing women's health and gender equity in public health policies, programmes and practices. It begins with definitions of some of the key terms relating to gender, health and equity on the grounds that a shared vocabulary – or at least a common understanding – is imperative to collaboration, innovation and impact in these areas. In the second section of the paper, brief consideration is given to the linkages between these foundational concepts. The third section of the paper outlines the ways in which gender has a significant impact on the health of women and girls, men and boys. Section four provides an introduction to gender-based analysis as a tool for addressing gender inequities and their impact on health. Research gaps are discussed in the fifth part of the background paper, while challenges and opportunities are addressed in the sixth section. The paper closes with a framework for developing action plans to advance gender equity and the health of women and girls. The discussion is not meant to be a comprehensive review or analysis of women's health and gender equity; rather, we hope that it will serve as a point of departure for workshop participants and for future collaborations and innovations.

SECTION 1. DEFINING SEX AND GENDER, EQUITY AND EQUALITY

Discussion of gender inequity in North America resumed, in earnest, in the post-World War II era, following changes in demographics, economics, and labour force participation and increasing attention on human and civil rights around the world. The term "gender" initially served as a touchstone for foregrounding discrimination against women and for distinguishing discrimination based social norms and stereotypes from discrimination based on biological and

physiological differences between males and females. During the past four decades, however, the meanings attached to and the uses of the term “gender” have shifted, from a political rallying point *for* women, to a term applied *to* women alone, and, most recently, to a term that is in danger of losing all meaning as it is regularly confused and conflated with the term “sex” (Sen and Ostlin 2007). In this section, we will define the ways in which various terms, including sex, gender, equity and equality, are used throughout the paper and the workshop.

A. **SEX**, in common usage, refers to both sexual activity and to the biological, physiological and physical characteristics that characterize males and females. This is true across many societies and language groups (CIHR 2007)¹. Discomfort with the sexual meanings attached to the term seems to be influencing current decisions to favour data collection and statistical reporting on “gender and health” rather than on “sex and health”.² For the purposes of this paper, the term sex refers only to biological, physiological and physical characteristics that may vary between males and females. Examples of these characteristics include DNA, reproductive organs and hormonal activity as well as genitalia and secondary sex characteristics, such as body fat and hair. Increasingly, research is uncovering other differences between female and male bodies, such as brain size and functioning, as well as sex differences in the manifestations of disease and responses to medications. Whether these differences can be tied to fundamental differences between male and female bodies remains to be seen; for example, female and male brains may function differently because they are trained, rather than programmed to do so. It is also important to keep in mind that sex, as a set of characteristics, possesses an element of fluidity, depending upon behaviour; for example, anorexia or elite sports participation have an impact on the physiology and the physical attributes of the body. As a result, we must be open to thinking about the validity and significance of many kinds of differences between female and male bodies.

¹ In many languages, the term “sex” also denotes sexual activity. The WHO (2002) recommends the use of sex as defined above when discussing sexuality and sexual health.

² Many forms today in Canada, such as your school registration, ask you to identify your gender rather than your sex. Passports remain an important exception, at least for the moment. Similarly, Statistics Canada provides sex-disaggregated information on many subjects, but the titles and labels often use the term gender.

- B. GENDER**, by contrast, refers to a set of qualities and behaviours that are attached to females and males by societies. Expectations about these qualities and behaviours are tightly tied to prevailing ideals of masculinity and femininity, which, in turn, are rooted in the culture and history of every community (Engender Health 2007). Gender not only defines the characteristics and behaviours that are deemed appropriate for males and females, it also defines appropriate relationships between and among women and men, including economic, social, cultural, sexual and other dimensions (Status of Women Canada 1996, World Health Organization 2001). Because gender is a relational term, it does not apply only to women. Men as well as women are influenced by gendered expectations and social norms – in their relations with other men and with women. At the same time, “gender”, like the term “sex”, possesses a degree of fluidity. For instance, if we think of masculinity and femininity as existing along a continuum, we would find people situated all along that continuum, having characteristics and engaging in behaviours that are not totally in keeping with the gender norms traditionally associated with either pole of 100% feminine or 100% masculine. Gender also interacts with other determinants of health, such as poverty, ethnic identity or sexual orientation, to influence the relative power of an individual. With this definition of gender in mind, it is clear that *every* population is gendered, whether it is made up of one or the other sex or includes both sexes. As a result, any analysis, any policy, programme or practice must consider gender, including men and a range of masculinities as well as women and a range of femininities.
- C. GENDER DISCRIMINATION** involves a distinction, exclusion or restriction based on socially constructed gender roles and norms that prevent people from enjoying their full human rights (WHO 2001). In some cases, gender discrimination arises from stereotypes about sex differences between males and females: *she* has greater dexterity and fine motor skills while *he* is physically stronger. An employer hiring a dock worker may believe that a woman is simply not strong enough physically to manage heavy equipment. In other cases, beliefs about gender roles and characteristics can lead directly to discrimination. An employer looking for a bank manager may prefer to hire a man because men are assumed and expected to be emotionally restrained and logical.

- D. GENDER EQUALITY** involves men and women receiving equal treatment in laws and policies, and having equal access to resources, opportunities and services so that they can realize their full human rights and potential and can contribute to the political, economic, cultural and social life of their communities as well as receiving the benefits of inclusion and participation (WHO 2001, Status of Women Canada 1996). Gender equality does not mean treating men and women in identical ways; it involves valuing women and men equally, including their similarities, differences, needs and contributions.
- E. GENDER EQUITY** refers to the fair and just distribution of benefits and responsibilities between men and women (WHO 2001). To ensure fairness, policies, programmes and practices may have to be different for women and men to meet their immediate needs as well as to compensate for historical and social disadvantages among men and women (Status of Women Canada 1996).

2. GENDER, EQUITY AND HEALTH

For decades, feminists have used the concept of gender equality as the foundation for their demands of gender justice. Their arguments have been based on the view that, to the extent that inequalities between women and men are the product of gendered social power relations, they are inherently biased and unfair. In arguing for gender equality, many of the post-war feminists were responding to systemic discrimination in the workplace. Women were not only denied positions or promotions, they were also paid less and expected to leave their jobs upon becoming pregnant. Gender equity therefore involved women and men having access to the *same* opportunities and privileges as well as the *same* economic and social rewards.

In the intervening decades, our understanding of gender equity has evolved considerably, particularly in the field of labour relations. While we continue to demand pay equity for women and men, we also appreciate that a workplace that treats men and women exactly the same may not be equitable. Equitable access to opportunities and privileges as well as rewards in the workplace may involve the creation of different policies, programmes or practices that take into account sex and gender differences between and among men and women. Women bear babies, a sex-specific biological ability, but they are also more often and more intensively involved in

caregiving- a gendered expectation and activity. Workplace policies are equitable only to the extent that they take into account real differences among employees and strive to create fair and just outcomes in view of these differences.

Gender equity in health is further complicated by the need to understand and respond to the relationship between sex and gender. Recently, the Women and Gender Equity Knowledge Network presented their final report to the WHO Commission on Social Determinants of Health. In this report, titled “Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health, the Network defined gender equity in health as follows:

Gender equity in health cannot be based only on the principle of sameness but must also stand directly on the foundation of absence of bias. Not being able to draw on a simple universal principle such as equality complicates our task in the health field, because it necessitates an even more careful interrogation of where bias is present and how it works. We have to ensure that gender discrimination and the resulting bias do not masquerade as “natural” biological difference. The approach is based on the following principles: Where biological sex differences interact with social determinants to define different needs for women and men in health (the most obvious being maternity), gender equity will require different treatment of women and men that is sensitive to those needs. On the other hand, where no plausible biological reason exists for different health outcomes, social discrimination should be considered a prime suspect for different and inequitable health outcomes. Health equity in the latter case will require policies that encourage equal outcomes, including differential treatment to overcome historical discrimination (Sen and Ostlin 2007).

Just as in the labour market, gender equity in health involves equal outcomes for women and men. Are women as healthy as men? And if not, why? Improving health equity thus involves increasing equal health outcomes, both as a goal of public health policies, programmes and practices and as an indicator of success.

3. GENDER MATTERS IN HEALTH

Gender influences many aspects of women's and men's health, health care and personal well-being by shaping their relationships, opportunities and access to power and resources (Feindel 2001). As such, when either women or men experience gender discrimination and inequality, their health is affected (Sen and Ostlin 2007). We need to be cognizant of this reality when we undertake health research or engage in the development and implementation of public health policies, programmes and practices.

At the same time, it is clear that women are more likely than men to experience gender discrimination in society as well as in the health care system (Greaves et al. 2000). Over the past two decades, we have learned a great deal about women's health and gender equity, which can be used to inform our understanding of public health and our efforts to achieve equal outcomes for women and men.

We need to appreciate that certain diseases or conditions affect women exclusively, are more prevalent in women or affect women differently than men (Greaves et al. 2000). As mentioned earlier, women alone go through gestation, childbirth and breastfeeding and the reproductive work women do is responsible for a large majority of their interaction with the health care system. At the same time, women and men are prone to different diseases or at different rates. For example, women are more likely than men to suffer from depression, stress, chronic conditions such as fibromyalgia and arthritis, and death resulting from intimate partner violence (Public Health Agency of Canada 2003). Conversely, men are more subject to brain injuries, some forms of cancer and suicide (Public Health Agency of Canada 2003). Furthermore, the same disease or condition may look quite different in a male patient than a female one. Research on cardiovascular disease has dispelled the myth that heart attacks are experienced universally as crushing chest pain and weakness or pain in the left arm. A woman in the midst of a heart attack is more likely to experience pain radiating into the upper chest and neck, as well as nausea and sweating. Similarly, both women and men contract HIV, but the disease manifests itself differently in male and female bodies. Different patterns in health and illness, as well as different outcomes among men and women suggest that both sex and gender are contributing factors in health status.

Furthermore, it is vital to understand the ways in which sex and gender intersect with other determinants of health to contribute to discrimination and inequity. Women are not a homogeneous group any more than men are. As a result, we need to recognize the action and interaction of multiple factors. Alongside gender, other determinants of health such as socio-economic status, race, religion and sexual orientation are strong predictors of poor health for both women and men (Feindel 2001). Because women are more likely than men to hold low-paying, part-time jobs, they are also more likely to experience ill health and other forms of disadvantage (Walters, 2003; Public Health Agency of Canada 2003). GPI Atlantic reports that one in six Nova Scotian women live below Statistics Canada's low-income cut-off- a low income rate that is 50 percent higher than that for men (by far the widest low-income gender gap in the country). Single mothers and unattached elderly women have the highest poverty rates, with 70 percent of Nova Scotian single mothers living below the low-income cut-off (Dodds and Colman 2001). Overall in Canada, 20 percent of women are poor and 70 percent of all people living in poverty are women (Greaves et al. 2000). In such cases, determinants of health other than gender may play a decisive role in health and well-being. But it is also true that when we control for other determinants of health, gender often takes on greater significance. For example, an impoverished Aboriginal woman is likely to be the least well off and the least healthy, by comparison with Aboriginal men as well as non-Aboriginal women and men.

4. GBA AS A TOOL TO ADDRESS GENDER INEQUITIES IN HEALTH

In 1995, Canada was among the 189 countries that signed the Beijing Platform for Action at the 4th United Nations International Conference on Women. The Beijing Platform for Action is an agenda for gender equity. Its main goal is to remove all obstacles to women's active participation in public and private life through ensuring an equal share in economic, social, cultural and political decision making. To achieve this goal, the signatories committed to supply resources, enact policies and implement programmes that provide equal benefits for men and women and attempt to transform unequal relations between and among women and men. Gender-based analysis (GBA) is the analytical tool and process adopted by the 189 countries as the best strategy to achieve gender equity.

Gender-based analysis is both an analytical tool and a process. GBA is a conceptual approach to research, policy and programming that helps foreground the role that gender plays in shaping women's and men's social, economic and political experiences. It facilitates critical thinking on how relations between and among women and men contribute to unequal access to resources and power (Burger 2005, Saulnier et al. 1999). Gender-based analysis is also a process. Ideally, GBA is integrated into every piece of research, policy, and programming from the beginning to the end. When it is applied midway through the process, it may be more challenging to produce a robust analysis or to implement important changes. But whenever it is applied, early or later, GBA is a valuable process for highlighting the needs of both women and men.

In health fields, gender-based analysis is a powerful tool for developing equitable health policies and programmes that provide equal benefits to men and women. It moves away from blaming women or implying that women need to change if they hope to achieve equity to adopting a framework that considers the systemic barriers women face and identifies the need for social change (Saulnier et al. 1999). When gender is used as a lens to examine health, it also draws out the salient intersections between gender and the other determinants of health, such as income, culture or education (Sen and Ostlin 2007).

5. RESEARCH GAPS

There are significant gaps in women's health research outside the traditional focus of reproductive and sexual health. The historic exclusion of women from clinical trials means there are huge gaps in knowledge about how common diseases and conditions, like cardiovascular disease and diabetes, affect women. In turn, this lack of knowledge raises questions about the effectiveness of established treatments and preventions for women. For example, in 2005 a 10-year study revealed that aspirin, a long prescribed and widely advertised method to prevent heart attacks, does not prevent first heart attacks or heart disease in women, but does reduce the risk of stroke (Peck 2005). In men, the effect is reversed: aspirin prevents the risk of heart attacks, but not of strokes (Peck 2005).

At the same time, research on men's health is only now emerging as an important area of inquiry as are questions about the role of gender in men's health. For example, a study of mental health

in Manitoba revealed that while women experience much higher rates of depression than do men, that men are more likely than women to commit suicide (Donner 2003). We can speculate that this difference may be tied to gender expectations that make it difficult for men to seek help or to gender norms that predispose males towards more violent mechanisms, such as guns, for suicide. But we do not have empirical evidence to account for this difference between women and men and, in Canada, there is limited research being done in this area. These examples highlight the importance of research that includes both women and men and research that takes into account gender as well as sex.

There is an urgent need to expand research on the role of gender in women's health, as it has long been neglected. For example, HIV/AIDS infection rates among young, heterosexual women in Canada have substantially increased in recent years compared to their male counterparts. Research indicates that an increase in HIV infection rates among women is closely linked to gender-based issues such as power imbalances in sexual relationships, intimate partner violence, socio-economic status and access to health care services. More work on the intersection of gender and other social determinants is also needed, including the ways in which changes to family structures, income levels, job security and the availability of public services affect the health of women (Walters 2003).

Finally, we need new measures to track and evaluate the role of gender in health as men and women may conceptualize health differently (Walters 2003). Sex disaggregated statistics alone do not provide researchers and policy makers with the full picture. New quantitative measures must be created and tested to generate accurate data on gender. Researchers must also recognize the importance of qualitative data to draw out the complexities of gender and create a well-rounded picture.

6. CURRENT CHALLENGES AND OPPORTUNITIES

Many challenges arise when addressing gender inequity and women's health. The over-arching challenge of this area is changing long-standing, deep rooted beliefs on gender roles in our communities, our institutions, our workplaces and our societies. This takes time, energy, political will, leadership and education. Research shows that political will is key to the success

of integrating gender into policy, research and programming in governmental and non-governmental agencies (Moser 2005, Rees 2005, Veitch 2005). Senior management must not only provide training and education opportunities for their staff, but must make gender equity and women's health an organizational priority. This requires a comprehensive framework that integrates analytical tools, such as gender-based analysis, into research, policy and programming. However, change does not end with research, policy and programming. Organizations committed to gender equity and women's health must collaborate with community-based organizations to develop, monitor and ensure the effectiveness of policies and programmes.

7. NEXT STEPS

Achieving gender equity and advancing women's health are laudable and necessary goals for our communities, but the path to this goal may seem so arduous as to be nearly impossible. The World Health Organization's Women and Gender Equity Knowledge Network (Sen and Ostlin, 2007) has proposed a framework to address gender inequity in health and public health. The Network has outlined seven key strategies aimed at exposing, challenging and changing systemic gender inequality.

1. Challenge gender stereotypes and adopt multilevel strategies to change harmful norms and practices.
2. Reduce the health risks associated with being a man or a woman by tackling gendered vulnerabilities.
3. Improve the health system by making it more accountable and accessible to women.
4. Increase the health care system's awareness and proper handling of women's problems as producers and consumers of health care.
5. Take action to improve the evidence base for policies by changing gender imbalances in the content and the processes of health research.
6. Mainstream gender equality and equity in organizations and empower women for health by creating supportive structures, incentives, and accountability mechanisms.
7. Support women's organizations that are often the front lines of women's health care.

8. CONCLUSION

Gender inequality affects the health of many women in Canada and, as we are increasingly aware, it also undermines the health of men, albeit in different ways. Since the 1970s, Canada has been a leader in the field of social determinants of health. But gender and culture were the last to be added to Health Canada's list of social determinants, giving the impression that they were afterthoughts to the larger discussions about what makes people sick and healthy. Canada's participation in the World Health Organization's initiatives around the social determinants of health as well as the creation of the Public Health Agency of Canada, the National Collaborating Centre on Determinants of Health and the Centres of Excellence on Women's Health provide both resources and opportunities to move again into the vanguard, supporting research, policy, programming and practice that embody gender equity and that will improve women's health. By investing in gender equity and women's health, we will not only be showing leadership, but also contributing to the well-being of women, men, children, families, and communities across Canada.

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