

GBA: Beyond the Red Queen Syndrome

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**Presentation at the GBA Fair
Ottawa Congress Centre
January 31, 2002**

Thank you for the invitation to participate in this important panel. I want to spend the time I have to explore two key issues related to the symposium theme of using gender based analysis as a vehicle for building knowledge for effective policy, programs, research and laws: **first**, the continuing need for gender-based analysis, and **second**, the imperative that such analyses be based on appropriate evidence. Because my own research is on the sociology of health and health care systems, and women's health, I will be drawing on examples from these areas.

For those familiar with the story *Alice Through the Looking Glass*, you will have guessed from the title of my presentation that I've decided to discuss these issues with the assistance of Lewis Carroll. So, let me begin by both thanking him and apologizing to him for using his words in ways that he most definitely never imagined.

As all of you will know, the call for gender based analysis (GBA) is not a new one. Indeed, CIDA pioneered the concept of GBA in the mid-1970s (Williams 1999). In the 1980s and 1990s, the government of Canada embraced the principles of GBA, and by 1995, it adopted a policy requiring federal departments and agencies to use GBA to inform policies and legislation. Although some in government have been focused on applying the tools and techniques of GBA for a long time – even before the formal policy was launched by the federal government – it is not surprising that this has been met with resistance in some quarters, and outright hostility in others. And in recent years, amidst a growing backlash against feminism, GBA's lustre as a equity tool has lost some of its shine. Advocates of GBA early on saw this as a strategy to identify sources and consequences of inequalities between women and men. Since many of those inequalities remain, the need for GBA continues as well, but putting such arguments forward is not always welcome. But those who do equity-seeking work – whether they are public servants engaged in policy making and analysis, or those who are working at the program level in non-governmental organizations and other institutions (including, I should say, my own sector, the post-secondary system) – know that we still need GBA to determine whether programs, policies, and laws work for equity, and it follows, whether these programs, policies and laws work for women.

For many of us who do equity work, what has been taking place in recent years

reminds us of Alice's encounter with the Red Queen in *Alice Through the Looking Glass*:

*Alice never could quite make out, in thinking it over afterwards, how it was that they began: all she remembers is, that they were running hand in hand, and the Queen went so fast that it was all she could do to keep up with her: and still the Queen kept crying 'Faster! Faster!', but Alice felt she could not go faster, though she had no breath left to say so. The most curious part of the thing was, that the trees and the other things round them never changed their places at all: however fast they went, they never seemed to pass anything. 'I wonder if all the things move along with us?' thought poor puzzled Alice. And the Queen seemed to guess her thoughts, for she cried 'Faster! Don't try to talk!' ... And they went so fast that at last they seemed to skim through the air, hardly touching the ground with their feet, till suddenly, just as Alice was getting quite exhausted, they stopped, and she found herself sitting on the ground, breathless and giddy. The Queen propped her up against a tree, and said kindly, 'You may rest a little, now.' Alice looked round her in great surprise. 'Why, I do believe we've been under this tree the whole time! Everything's just as it was!' 'Of course it is,' said the Queen. 'What would you have it?' 'Well, in our country,' said Alice, still panting a little, 'you'd generally get to somewhere else - if you ran very fast for a long time as we've been doing.' 'A slow sort of country!' said the Queen. 'Now, here, I see. **It takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!**'*

This running faster and faster to stay in the same place – the red queen syndrome – seems to be very much the definition of equity work. I think that we should move beyond this, if we can. What are the obstacles to doing so? It seems to me that there are several. First, it is not apparent that GBA or gender mainstreaming happens in a systematic way right now. Indeed, Wendy Williams has suggested that despite embracing GBA as a policy tool at the federal level and in some provinces, most policies have been developed without serious consideration of how women and men will be affected by those policies (Williams 1999). Second, too often it is assumed that calls for GBA are simply about addressing women's issues. We should be clear that the whole point of GBA is to identify if and how programs and policies affect women and men similarly or differently. It is a question to be answered. I will come back to this point momentarily. And third, because GBA is not applied systematically, asking the "equity" question(s) depends too much on the willingness and ability of individuals (usually women) at senior levels to take such work on. Equity work needs to be everyone's work, but this is – in the current environment – pretty much a pipedream. Doing this work presents tremendous challenges (even risks) for some in senior management. The challenges stem from having to do the "substantive" work and

(equally substantive!) equity work, a juggling act at the best of times. The risks are many, including but not limited to, being branded as a single issue person. (I recall some years ago a meeting with a senior administrator at my university. The President had recently released a strategic plan. Upon reading it, I had identified numerous issues of concern, some of them directly focused on gender equity. At a meeting with a member of the senior administration, I raised many of these. After more than an hour of discussion, he said with some surprise, “I thought you wanted to talk about the silence on equity in the strategic plan.” I replied, “don’t worry, I’m coming to that!”)

Let me make my point through some examples. If we look at the area of health and health care, the need for a gender lens could not be more clear. Decades of research in the social sciences has confirmed that sex is the most fundamental source of differentiation among human beings (Greaves, Hankivsky et al. 1999; Grant, Ballem et al. 2000). In the area of health and health care, there are volumes of research that demonstrate the importance of sex as a determinant of health status (Doyal 2000; Doyal 2001). Consider the following list of differences that make a difference for women’s health prepared by the Society for Women’s Health Research, a US based organization (Society for Women's Health Research n.d.).

10 Differences Between Men and Women that Make a Difference in Women's Health

1. After consuming the same amount of alcohol, women have a higher blood alcohol content than men, even when you allow for size differences.
2. Women who smoke are 20 to 70 percent more likely to develop lung cancer than men who smoke the same amount of cigarettes.
3. Women tend to wake up from anesthesia more quickly than men—an average of 7 minutes for women and 11 minutes for men.
4. Some pain medications, known as kappa-opiates, are far more effective in relieving pain in women than in men.
5. Women are more likely than men to suffer a second heart attack within one year of their first heart attack.
6. The same drug can cause different reactions and different side effects in women and men—even common drugs like antihistamines and antibiotics.
7. Just as women have stronger immune systems to protect them from disease, women are more likely to get autoimmune diseases (diseases where the body attacks its own tissues) such as rheumatoid arthritis, lupus, scleroderma and multiple sclerosis.
8. During unprotected intercourse with an infected partner, women are 2 times more likely than men to contract a sexually transmitted disease and 10 times more likely to contract HIV.
9. Depression is 2-3 times more common in women than in men, in part because women's brains make less of the hormone serotonin.
10. After menopause women lose more bone than men, which is why 80 percent of people with osteoporosis are women.

The Society argues – incorrectly – for an approach they call “gender based biology,” that is, scientific research dedicated to identifying “the biological and physiological differences between men and women” (Society for Women's Health Research n.d.). The differences enumerated in

their list are not about gender at all, but rather about sex.

The differences between women and men are not only at the physiological, biochemical, or genetic levels. As social scientists have shown, there are significant differences based on gender, that is, the different roles, responsibilities and activities proscribed for women and men, based on cultural conventions and expectations. These differences relate primarily to power – the relative possession or absence of it. Gender differences are evident in most of everyday life, hence the need to consider how programs, policies, and laws affect women and men.

In the field of health and health care, gender differences are evident in health behaviours, health work, doctor-patient interactions, and are an enduring phenomenon in this society, and around the world. The importance of these differences has been recognized by federal/provincial/territorial ministers of health, and was highlighted in the *Women's Health Strategy* of Health Canada, which identifies gender as one of 12 key determinants of health (Health Canada 1999).

We could construct, based on the extensive research that has been done in recent years, an analogous table to the one prepared by the Society for Women's Health Research, only focusing on gender rather than sex differences that make a difference.

10 Gender Differences that Make a Difference in Women's Health

11. Men and women engage in different risk-taking behaviours related to their traditional gender roles, and as a result men have a greater propensity for risk-taking behaviours that may have serious and lethal consequences (Harrison 1978). Women are not risk-averse, however, as evidenced by higher rates of smoking particularly among young females, for example (Statistics Canada 2001).
12. Women are much more likely to engage in health protective behaviours, including accessing health screening (e.g., breast self-examination, pap smear screening, regular check-ups) (Miles 1991).
13. Women are the fastest growing risk group for HIV/AIDS, yet HIV/AIDS is mostly an invisible epidemic among women. The primary routes of transmission for women are heterosexual activity (64% of cases) and intravenous drug use (11% of cases). There is some evidence to suggest that gender factors may influence women's risk of the disease. There is also evidence to suggest that the efficacy of treatments may be affected by both sex (e.g., drug metabolism) and gender (e.g., lifestyles) (Health Protection Branch 1998).
14. Women and men do not receive the same (or similar) care, even for the same conditions (Lorber 1997). American studies show women are less likely to receive high-tech services, and tend to receive less aggressive care for conditions such as heart disease and cancer (Clancy 2000).
15. According to the National Population Health Survey, stress levels among women have been on the rise between 1985 and 1991. The rates in Nova Scotia show the most dramatic change – in 1985, women's stress rates were 12% below men's; by 1991, women's stress rates were 29% above men's (Amaratunga 2000).
16. Suicide rates are significantly higher in the Aboriginal population compared to other Canadians. The Royal Commission on Aboriginal Peoples found that suicide among Aboriginal girls to be eight times higher than the national average (Royal Commission on Aboriginal Peoples 1996).
17. Depression is far more common in women, and many researchers attribute this to women's status in society (Astbury, Dennerstein et al. 1993).

18. Violence is considered to be a major public health issue. Women (wives) are more likely than men (husbands) to be murdered; women are significantly more likely to be victims of sexual assault (Jiwani 2000).
19. It is estimated that women constitute 80% of those who provide care, whether or not that care is paid, and whether it is provided in institutions or at home. There are significant differences in the nature of caring work provided by women and men, with women more likely to be involved in the provision of personal care and the management of caring (Armstrong, Amaratunga et al. 2002).
20. Poverty, a key determinant of health and longevity, is more common in women. It is associated with many of the leading causes of sickness, disability and death (Townson 1999).

To date, most biomedical and clinical research has been conducted on men, and thus it has been taken for granted that humans are male. Only because of legislation in the US (but not in Canada) are women now routinely included in clinical studies. Even still, the United States General Accounting Office (GAO) reported in May 2000 that there has been no change in the frequency of analysis of research results by sex, much less gender (U.S. General Accounting Office 2000). This trend is not limited to the US context. A research team headed by Dr. Donna Stewart published data in 2000 that reveals identical trends in Canada, based on a review of research studies and clinical trials at the University of Toronto (Stewart, Cheung et al. 2000). This speaks to a very slow rate of change, even with legislation and accountability frameworks mandating change. It also highlights the enormous demand for capacity building, and education about sex and gender analysis.

We are stymied not only by an unwillingness to consider how gender affects experiences, but also by how we might measure gender and the consequences of programs and policies. More often than not, when we consider the differences between women and men, we treat sex like any other variable. Another problem is that programs and policies, and the research that informs them, are totally gender neutral or gender insensitive. Women have, to a very large extent, been “overlooked, ignored or subsumed” (Rosser 1994) in studies into the provision of health services and the effects of health care reform on providers and recipients of care. Consequently, it is difficult to ascertain exactly what consequences flow from policy changes. Gender insensitivity can happen in a few ways. We might fail to see if gender (not just sex) matters in how we measure things, and in how we analyze things. Let me deal with these in reverse order.

The Analysis Problem: According to Pat Kaufert, the problem in health care research is less often one of exclusion than one of making the women invisible (Kaufert 1999). This is often done in the course of data analysis, particularly in research of a more epidemiological nature. For example, consider the research from the Manitoba Centre for Health Policy and Evaluation (MCHPE). Research at this centre (but certainly not only at this centre) only rarely examines the differences in health experiences between women and men (Metge, Black et al. 1999). The majority of studies report age and sex-standardized findings using a population-based health information system (Brownell and Hamilton 1999; Brownell, Roos et al. 1999; Brownell, Roos et al. 1999; DeCoster, Chough Carriere et al. 1999; Roos and Shapiro 1999). While it is true that standardization or adjustment of population-based data has the virtue of calculating a single rate that adjusts for each age and sex group of a standard population, thereby resulting in improvements in the comparability of rates of different populations, such global statistics do not permit us to see the specific ways in which health experiences (whether we are talking about mortality or utilization) manifest differently in the various subgroups of a population. We need sex-disaggregated data (Horne, Donner et al. 1999) if we are to begin to understand the

gendered nature of health and illness experiences, including those related to health care utilization.

The Measurement Problem: That said, even additional studies that involve the calculation of sex-specific statistics remain limited in their capacity to capture why and how sex/gender matter in the study of health and health care (and in other areas of investigation and public policy as well). It is simplistic to treat the biological variable sex as if it can capture the full array of social, political, and economic forces that both structure and produce (ill) health for women and men, or explain the effects of policy changes on individual providers and recipients of care. Indeed, it is important for researchers to examine not just sex as a demographic characteristic that, for example, affects susceptibility to disease, need for surgery, or likelihood of accessing health care. We also need studies on the influence of gender, and this involves examining relationships of power, and subordination and superordination. Most of our measures are totally inadequate.

In research on health system performance, the limited range of indicators used provide an incomplete picture, if not a misrepresentation, of the effects of health care reforms. This is true in general, and in particular when it comes to experiences in which there are known gender effects or differences. And it is probably useful to remember that it will be difficult to say much about gender effects if we don't ask the question or include appropriate measures.

In an environment guided by evidence-based decision-making, the "best" evidence is usually defined as that which is "objective," quantifiable, and replicable. As a consequence, many studies of health care focus on data collected through quantitative methods. The data of choice seems to be population-based administrative data. More often than not, "qualitative research is often relegated to supplementary roles in the generation of evaluation of evidence, such as planning or explaining quantitative research" (Rychetnik and Frommer 2000).

To illustrate the limitations of administrative data, consider the February 1999 report by the MCHPE on hospital bed closures in Winnipeg. Brownell and Hamilton report that 727 beds were closed in Winnipeg hospitals in the period between 1992/93 and 1997/98, an amount totalling 24% (Brownell and Hamilton 1999). What were the effects of this hospital downsizing? Brownell and Hamilton report that hospitals cared for the same volume of patients with fewer beds by delivering care in different ways (e.g., by shifting care from inpatient to outpatient settings). As well, they report that the quality of care (measured rather crudely by hospital readmission rates) and the health of Winnipeggers (also measured rather crudely by premature mortality, that is, deaths before age 75) were unaffected by the bed closures. A recently published report by researchers at the Centre for Health Services and Policy Research in British Columbia reached similar conclusions about the effects of hospital downsizing on elders' health care utilization and mortality rates (Sheps, Reid et al. 2000). These researchers conclude that there have been minimal adverse effects associated with the reduction in acute care services, that the reductions in acute care services coincide with public policy goals of (and citizen preferences for) shifting care "closer to home," and that longer term hospital stays are being reserved for those who are sicker. In an editorial regarding the Sheps et al. study, Roos contends that all of the headlines about hospital downsizing and bed closures exaggerate the effects of this type of health care reform (Roos 2000).

I would argue that the impact of health care reforms, and in particular the shift of health care from institutions to the community and the home, have – for the most part – gone unexamined. These reforms, which continue apace as governments have cut their financial commitments to the health care system, affect everyone, but I believe that there is evidence to suggest that they

affect women more than men. Women are on the frontlines at home and in institutions. If caring work is transferred home, then women by and large will have to assume those responsibilities in addition to, or perhaps in place of, their other responsibilities in their families and in the paid work force. Similarly, health reforms have had a number of consequences for professional nurses and paraprofessional workers in the health care system, the majority of whom are women. The effects are potentially far-ranging, including work intensification, injuries, and burnout. But by all counts, the gender effects of health care reform have been entirely ignored. Without answers to these (and similar) questions, we cannot even begin to assess the effects of health care reforms such as hospital downsizing.

Several implications flow from these observations, not the least being that we need to understand the various aspects and consequences of health care policy through a gender lens – that is, to identify how and why the experiences differ for women and men. Too few studies do this at present.

Chambliss has pointed out, “no one has the luxury of a gender-free view of the world, and there is plenty of evidence that the genders see the world differently” (Chambliss 1996). This is the heart of the matter. Most policy research ignores sex/gender, is silent on its significance as a determinant, or treats sex/gender as if it is less important than other characteristics such as socioeconomic status. I would argue that we need to determine not that gender matters so much as that it doesn’t matter before we dismiss the criticisms that many feminist researchers make about what gets measured and how. At the very least, we need to ask questions such as the following: are sex and gender important here? how are sex and gender effects measured? Until we do so, we are making policy decisions blinded to the possibility that sex and gender do matter – to women, and to men. We may be advancing policies in ways that disadvantage some segments of the population. And we’ll keep running – like Alice and the Red Queen – but getting nowhere fast.

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