GENDER & ADDICTION
Integrating Gender into Health Promotion Exercise

British Columbia Centre of Excellence for Women's Health

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http://promotinghealthinwomen.ca

OVERVIEW

1. Introduction to the Gender Integration Continuum
2. Gender Integration Small Group Exercise
3. Large Group Discussion

LEARNING OBJECTIVES

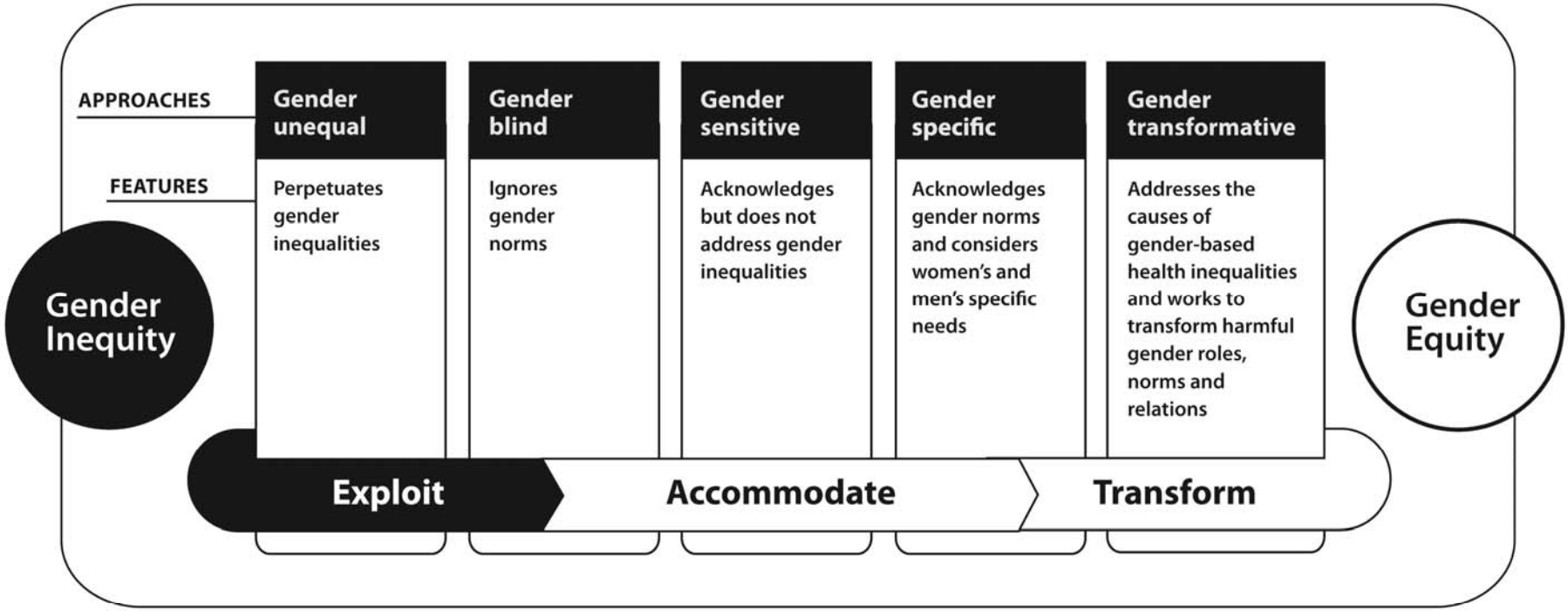
1. Increased knowledge about different approaches to gender integration in health promotion
2. Experience with using the *Gender Integration Continuum* as a tool to assess the current level of gender integration in programs and policies
3. Increased confidence in applying principles of gender transformative health promotion to your own work

Gender Integration

* Gender integration refers to strategies that take gender norms into account and compensate for gender-based inequalities.
* By assessing our current level of gender integration, we can ask **"How can we improve health as well as move towards improving gender equity?"**

Continuum of Approaches to Action on Gender and Health

A Continuum of Approaches to Action on Gender and Health



Inspired by remarks by Geeta Rao Gupta, Ph.D, Director, International Center for Research on Women (ICRW) during her plenary address at the XIIIth International Aids Conference, Durban, South Africa, July 12, 2000:

1. Gender-unequal

* **Gender unequal initiatives perpetuate gender inequalities by reinforcing unbalanced gender norms, roles and relations.**
* These approaches may consider sex and gender differences but may sustain traditional stereotypes and inequities.
* **Example:** A program may encourage women to quit smoking or reduce alcohol use due to concerns about their appearance.

2. Gender-blind

* **Gender-blind programs ignore gender norms, roles and relations and may therefore reinforce gender-based discrimination, biases and stereotypes.**
* The most common argument for gender blind initiatives is that they are 'fair' because they treat everyone the same, but by ignoring structured barriers faced by some program participants, the program may contribute to inequities.
* **Example:** Many teen pregnancy/STI prevention programs do not acknowledge how gender may influence behaviour change; while these programs may "do no harm", they may unintentionally support current inequities and miss an important opportunity to address a determinant of health that would increase the impact of the program.

3. Gender-sensitive

* **Gender sensitive programs acknowledge but do not address gender inequalities.**
* While sex differences and gender norms and roles are considered, they do not necessarily involve action to address them.
* **Example:** A program to reduce maternal-child transmission of HIV would likely acknowledge that women may not have the status, rights nor decision-making authority to practice safer sex, insist upon the use of condoms, or adopt safer child-feeding strategies, though they would be encouraged to do so nonetheless.

4. Gender-specific

* **Gender-specific programs acknowledge gender norms and considers women's and men's specific needs.**
* Recognize that gender norms, roles and relations exist and have an impact on access to or control over resources. This may mean targeting a program specifically at women or men, and accommodating gender norms but not working to address or change them.
* While obviously an important approach, gender specific programs do not necessarily address the root causes of gender imbalances in power, resources or opportunities.
* **Example:** Programs that provide child-minding and offer women-only spaces can be gender-specific but not necessarily gender-transformative because they do not challenge why women are responsible for children when they need their own health care or why mixed spaces are unsafe or deemed unsuitable for women.

5. Gender-transformative

* **Gender transformative health promotion focuses on the dual goals of improving health *as well as* gender equity.**
* Acknowledges different norms and roles for women and men and their impact on access to and control over resources
* Considers women's and men's specific needs
* Includes ways to transform harmful gender norms, roles and relations
* **Example:** Programs to promote sexual and reproductive health that engage men and women in identifying and challenging harmful notions of masculinity and femininity

What about boys and men?

* Gender transformative initiatives recognize how **gender inequity also negatively affects the health of boys and men**

  E.g.

  - Addressing high rates of mortality from car accidents in teen boys (which may be related to peers expectations that young men should be "bold" risk-takers)
  - Tobacco control activities that recognize how a country's lung cancer mortality rate for men continues to grow as smoking is considered an attractive marker of masculinity

* **Gender transformative health promotion is interested in improving outcomes for all: women, men, girls and boys.**

SUMMARY: Gender-responsive Continuum for Assessing Programs and Policies

1. GENDER UNEQUAL	*Perpetuates gender inequality by reinforcing unbalanced gender norms, roles and relations * Privileges men over women or women over men * Leads to one sex enjoying more rights, privileges and opportunities than the other
2. GENDER BLIND	* Ignores gender norms, roles and relations * May reinforce gender-based discrimination * Ignores differences in opportunities and resource allocations between women and men * Often constructed on the principle of being 'fair' by treating everyone the same
3. GENDER SENSITIVE	* Considers gender norms, roles and relations but offers no remedial action to address them * Does not address inequality arising from unequal gender norms, roles or relations
4. GENDER SPECIFIC	*Acknowledges different norms and roles for women and men and their impact on access to and control over resources *Considers women's and men's specific needs *May intentionally target a specific group of women or men to achieve policy or program goals or to meet their needs *May make it easier for women and men to fulfill duties assigned to them based on their gender roles *Does not address underlying causes of gender differences
5. GENDER TRANSFORMATIVE	* Acknowledges different norms and roles for women and men and their impact on access to and control over resources * Considers women's and men's specific needs * Addresses the causes of gender-based health inequity * Includes ways to transform harmful gender norms, roles and relations * Promotes gender equality * Fosters changes in power relationships between women and men

Reflection/Group Discussion

* In your work related to addiction, what sex and gender issues do you see?
* How, if at all, has gender influenced the development of interventions to prevent and treat addiction? Have certain approaches been developed primarily for men only or women only or for specific populations (e.g., men with experiences of trauma, Indigenous women, girls)?
* Do you believe that these approaches have been successful in addressing differences between men and women, e.g., in engagement, treatment outcomes?

SMALL GROUP EXERCISE
~ Facilitator Instructions ~

1. Divide the audience into small groups of approximately 3-5 people.
2. Assign two program examples to each group.
3. Ask the group members to:

   (i) Determine where on the gender integration continuum they would place each example (i.e., gender-unequal, gender-blind, gender-sensitive, gender-specific, gender-transformative)

   (ii) Explain their reasoning

   (iii) Suggest ways that the program could move further along the continuum, i.e., "How could this program become more transformative?"

PROGRAM EXAMPLES
GENDER & ADDICTION

EXAMPLE #1 : SmokeFree Women (USA)

SmokeFree Women (http://women.smokefree.gov) was developed to reach and engage female smokers to provide smoking cessation information about topics that are often important to women with the goal to increase and support quit attempts. Examples of some of the interactive tools on the site are quizzes, a live chat feature, a quit guide smartphone application, and various social media components including Facebook and Twitter. Some of the resources include:

* Self-quizzes about important subjects like depression, withdrawal, and relationships
* Link to SmokefreeMOM, a mobile text messaging program that provides 24/7 tips, advice, and encouragement to help pregnant women quit smoking
* Local and state telephone quitlines (general population)
* National Cancer Institute's national telephone quitline
* Publications, which may be downloaded, printed, or ordered

EXAMPLE #2: Whiskyjack Treatment Centre (Manitoba, Canada)

In the mid 1990's media attention raised concern about widespread solvent use on First Nations Reserves across Canada. As a result, Health Canada established six First Nations youth treatment centres. The Whiskyjack Treatment Centre program offers 22 beds for residential treatment services of which 12 beds are dedicated to solvent abuse and 10 beds for other addictions. The program is designed to accommodate First Nation Youth, ages 11 to 17. The program is based on providing effective holistic healing for youth and their families within a safe environment of respect, trust and love. The program is offered continuously throughout the year for female and male clients with both programs operating simultaneously but separated by gender. The program emphasizes an empowerment approach, single gender group sharing, and specific traditional teachings.

EXAMPLE #3: Tobacco Free Nurses' Registered Nurses Referral to Quitlines-Helping Smokers Quit (RNQL-HSQ) Program (USA)

Tobacco Free Nurses began in 2003 and was the first national program in the US to focus on helping nurses to stop smoking and on providing nurses the education and resources they need to help their patients quit smoking. The RNQL-HSQ Program involves nurses from four hospitals in Kentucky and four in Louisiana who receive free education and resources in tobacco cessation to help their patients quit. The program includes a webcast, web-based resources, a trifold folder including a pocket guide for helping smokers quit, and a card from the Kentucky telephone quitline. The project is premised on the idea that, as the largest group of healthcare professionals, nurses are in a key position to help all patients receive the health benefits of quitting smoking. Key ideas in the training include:

* Even a brief intervention of no more than 3 minutes can be effective.
* Getting help with quitting during hospitalization is effective, especially if this support continues after discharge including support from a telephone quitline.
* To help smokers quit, every healthcare provider is urged to implement an intervention, referred to as the 5As (Ask, Advise, Assess, Assist, Arrange)

EXAMPLE #4: Caron Treatment Centers (USA)

For young men between the ages of 20 and 25, alcohol treatment and drug rehab programs through the Caron Pennsylvania network (www.caron.org) address both chemical dependency and mental health concerns. The programs recognizes that young men of this age often struggle to establish their own identity. This can occur as a result of "feeling caught" developmentally between adolescence and young adulthood. The inpatient treatment program offers a personalized addiction treatment plan in a gender separate, gender specific and age specific environment, based on a 12-Step program. Men participate in individual, group and family therapies, therapeutic activities, informative lectures, and continuing care planning. Through group process, the program addresses male-specific issues such as: sexuality, cross addiction, entitlement and narcissism, anger, ego, rage and control, compulsive behaviors, and resentments.

EXAMPLE #5: Canada's Low Risk Drinking Guidelines, Éduc'alcool (Quebec, Canada)

When Canada's Low-Risk Drinking Guidelines were released in 2011, the non-profit organization Éduc'alcool (http://educalcool.qc.ca) promoted the new national guidelines through an extensive awareness campaign. Central to the campaign was information about how the guidelines differed for men and women. The guidelines suggest a limit of 2 drinks at a time for women (10/week) and 3 drinks at a time for men (15/week). Éduc'alcool developed posters with messages such as "It's not sexist, it's science" and "Men Can Take More." Another set of posters targeted men with the tagline "You wouldn't go to a job interview wasted, would you?" and women with the tagline "You wouldn't show up drunk on a first date, would you?"

EXAMPLE #6: 'Soul Buddyz' Media Project (Soul City, South Africa)

South Africa has the highest rates of gender-based violence of any country in the world and 70% of domestic violence cases are linked to alcohol use. Soul Buddyz (www.soulcity.org.za) is a multi media "edutainment" vehicle for children aged 8-12 years old (boys and girls) designed to promote their health and well-being, consisting of television and radio dramas and school books. Launched in January 2011, the fifth series of the Soul Buddyz television programme focused on violence prevention and specifically the role of alcohol as a catalyst for violence. The scripts were developed through child participation workshops that asked children to map, draw and write about their perceptions of masculinity, alcohol and substance abuse. Children outlined the ways in which alcohol and substance abuse influence their upbringing, for instance how alcohol and violent behaviour by their fathers or brothers is evidence of their masculinity. Soul Buddyz Clubs have been set up across the country to help children, who have been inspired by the television series, become active agents for social change in their communities and in their own lives. The Clubs have attracted 130,000 children in almost 6 500 clubs countrywide.

EXAMPLE #7: Calgary Drug Treatment Court (Canada)

The first Drug Treatment Court was started in 1989 in the United States. Drug treatment courts combine addiction treatment and justice system processing by a multi-disciplinary team. The Calgary Drug Treatment Court (http://calgarydrugtreatmentcourt.org) began in May 2007 as a pilot project and provides a holistic or wrap around approach integrating Justice, Law Enforcement, Health Services, Housing, Employment, Treatment and Rehabilitation services. Due to research showing that over 90% of women who suffer from addictions have experienced a history of abuse or trauma and that a woman's criminal history is often a very different journey than that of a man, the CDTC offers a women's program that is uniquely designed for women and led by women. In 2010, approximately 75% of the program client were male and 25% were female (although attending in smaller numbers, women have been significantly more likely to complete the program than men). In order to make the program more accessible, the program has expanded to include a Day Program which offers both mixed-education classes and gender specific group components. Overall, the approach of drug treatment courts is one of appropriate flexibility in adjusting program content, including incentives and sanctions, to better achieve program results with particular groups such as women, indigenous people and minority ethnic groups.

EXAMPLE #8: 16 Step Groups (USA and Canada)

The 16-step Empowerment Model (http://charlottekasl.com) offers a holistic, wellness approach for overcoming addiction, trauma and depression, regardless of gender. It has been adopted throughout the Unites States and Canada. The 16-step model addresses issues of cultural diversity and internalized oppression stemming from sexism, racism, classism, and homophobia. In this model, the concept of "codependency" is understood as a form of internalized oppression, rather than an addiction to security, in a cultural context as well as an individual problem. In surveys sent to both male and female members of 16-step groups asking for responses, respondents most often listed: improving self-esteem; helping them believe in their own wisdom; giving them permission to be creative; expressing and validating their personal beliefs and feelings; and helping to be more courageous as being the positive effects of a 16-step group. The 16-step model encourages people to use this or any other model as a springboard to find their own voice.

Summary – Gender Integration Continuum

* There may be differences in how various programs are classified on the continuum – remember, this is simply a tool to help us further our thinking
* At a minimum, health promotion activities should strive to "do no harm" in terms of gender norms and relations. (There is no viable rationale for designing a project that deliberately exploits gender inequality).
* Sometimes, programs will have unintended outcomes (good or bad); gender blind programs are more likely to cause unintentional harm or to miss opportunities to enhance program outcomes because they have not considered gender at all
* Programs may opt to conform to existing gender norms in order to enhance outcomes or as an interim step to 'buy time' until a better solution can be reached, but the goal is to move towards more transformative programming
* Transformative elements can be integrated into ongoing programs without having to start over again

Summary – Gender Transformative Health Promotion

* There is no ‘how-to’ manual for doing gender transformative health promotion. Gender transformative health promotion may include challenging traditional gender norms, promoting critical thinking, supporting women's economic empowerment, engaging men in women's health issues, advocacy, addressing power imbalances between health care providers and patients, etc.
* Gender transformative health promotion requires strategy, creativity, critical thinking, and use of the available evidence base

Reflection/Group Discussion

* What existing projects and activities are you currently involved with?
  * How would you classify them along the gender continuum?
  * How can they be further developed to become more "gender transformative"?
* Considering the examples discussed today, which approaches might be transferable to your own work? What else might be considered?

Notes for Facilitators

* You may want to create a handout from the example slides to distribute to each group. Ideally, each group will have program examples from more than one category of "gender blind," "gender specific," etc.
* Alternately, you might consider giving common examples to two or more groups – some groups may classify the examples differently and this may result in interesting discussion.
* Remember that in some cases that there is no "correct" answer for the examples. Participants will have alternate contexts or scenarios that influence their interpretation of the project's intention and design and will make assumptions based on limited information. Provide space for diverse answers and encourage participants to explain their assumptions and decision-making process.

Acknowledgements

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