

The George Institute for Global Health/WHO Community on Women and NCDs
Beijing + 25: Meeting the call for sex-disaggregated and gender-sensitive data

19 March 2020

The following captures the discussion in the webinar chatbox as well as the moderated Q&A session. Responses included are from the moderator, panellists, and webinar participants, and have been lightly edited. Links to useful resources are embedded in the responses, and available in the “Links” section below.

Links

- Paper showing how to use gender scores to conduct gendered analysis: <https://academic.oup.com/ije/article/36/3/612/654160>
- Covid-19: The gendered impacts of the outbreak: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30526-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30526-2/fulltext)
- Data2x - Gender and data resources related to Covid-19: <https://data2x.org/resource-center/gender-and-data-resources-related-to-covid-19/>
- Gender Advocates Data Hub, by Equal Measures 2030: <https://data.em2030.org/>
- Sex and Gender Equity in Research (SAGER) Guidelines for publishing academic research: <https://researchintegrityjournal.biomedcentral.com/articles/10.1186/s41073-016-0007-6>
- Tutorial for analysing and reporting sex differences: <https://heart.bmj.com/content/105/22/1701>
- WHO dashboard of COVID-19 data for Europe: <http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/weekly-surveillance-report>

Q & A

Questions for all panellists

How do we disaggregate data by gender, as opposed to by biological sex?

Disaggregating by gender is difficult but possible. As it is not a discrete variable, you need to develop multiple proxies to explore how gender power relations lead to differences/inequities. [Some](#) have used gender scores/scales to do this, where behavioural variables closely linked to sex are collected (such as employment in the household) to help classify the ‘femininity’ versus ‘masculinity’ of subjects. You can also use gender variables to explore how gendered power relations (differences in resources, autonomy and decision-making, etc.) lead to different outcomes. Of note, in some countries, how you define gender might generate backlash; thus, defining the gender variable can pose a challenging political as well as scientific problem.

Do you have a case study of an African country or country from global south that is putting sex-disaggregated data into proper use?

Questions for Drs. Quimby and Natasha Sobers, The University of the West Indies) who presented the following case study: sex-disaggregated data shows that women are more vulnerable to diabetes than men in Barbados, and informs gender-sensitive intervention planning

How did you assess the impact of potential barriers such as safety issues that might make it difficult for women to exercise in some communities?

We have now received funding for implementing the portion of the study that will focus on physical activity. We will modify the Stanford CDSMP program which includes exploring barriers to advice given on physical activity.

Did you assess differences in exercise, diet, and obesity outcomes among women by potential risk modifiers such as income and education level?

We didn't do this for all 31 Caribbean countries. In Barbados, we found that in women, higher education level was associated with higher fruit and vegetable consumption, more physical activity, and less diabetes.

How scalable is the Barbados diabetes control intervention to larger countries?

We are exploring this. Theoretically, it is scalable as larger cities can be subdivided into communities, not just faith-based organizations, but YMCAs, barber shops, etc. In this way, the intervention can not only be scaled, but can also systematically address disparities by being embedded in places where high-risk people already congregate.

Did the survey distinguish between type 2 diabetes in women related to gestational diabetes and type 2 not related?

The participants were all diagnosed with type 2 diabetes. None had gestational or type 1 diabetes. In addition, patients with type 2 diabetes on insulin were excluded from the study.

Questions for Isabel Yordi Aguirre, Ivo Rakovac, and Brett Craig (WHO Regional Office for Europe) who presented on approaches, challenges, and facilitators to collecting sex and gender-disaggregated NCD data: the STEPS NCD Risk Factor Survey in Eastern Europe

For the STEPS data, why would men be less likely than women to have their blood pressure measured?

In Europe, a woman may be more likely to have interactions with medical providers throughout her life course, as she accompanies her children to visits. There are also targeted interventions for women during pregnancy and for gynaecological health.

Is there any evidence to show that men and women are seeing different health workers? For example, are women more likely to see women health workers? And do female health workers have different practice patterns than male in regards to NCD care?

In the countries studied, the general practitioners are predominantly female. Men and women tend to see the same providers because they are assigned to facilities based on geographic location. Women appear to be accessing services more than men, and this could be one reason why they are receiving more lifestyle advice. But the sex of the provider and the social norms around communication between men and women could play a role. These are questions that would need further examination.

This data is really interesting and will be useful for understanding current differences in COVID -19 mortality. Have you considered how these findings might be used in this response?

No, because we do not have all the findings yet. This is a developing situation, and in this emergency phase we are focused on improving the basic capacity of health sectors. However, we have been working with different UN agencies to determine how we will look at gender and COVID-19. There have also been papers, such as [this one](#) by Wenham, Smith, and Morgan (2020).

Preliminary disaggregated data (available [here](#)) for the European region suggest a male disadvantage. Fifty-seven percent of COVID-19 cases are male, and 72.4% of deaths occur in men.

Question for Sanne Peters (The George Institute for Global Health, UK) who presented on strategies for conducting sex and gender disaggregated data analysis

Are transgendered people considered in your cardiovascular disease research?

While we would love to include transgendered people, their numbers have been too small in the studies we have completed thus far. Analyzing outcomes in transgendered people would help us clarify if the sex outcomes we identify are due to biological factors or behavioural.