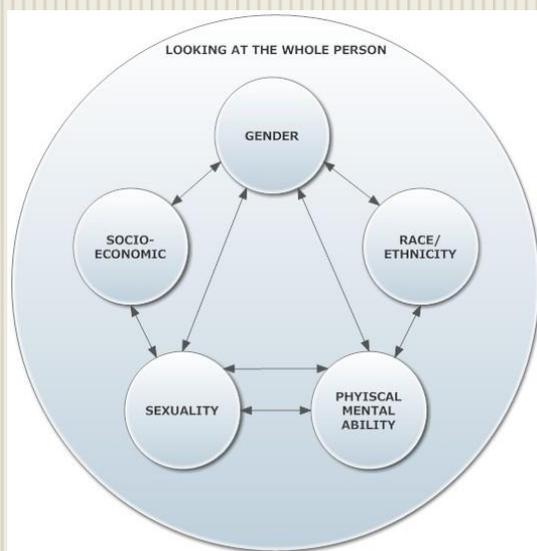




PRINCIPLES & PURPOSE MATTER:

PUTTING GENDER EQUITY & JUSTICE AT THE CENTER OF CALIFORNIA'S IMPLEMENTATION OF HEALTH IN ALL POLICIES



CALIFORNIA NATIONAL ORGANIZATION FOR WOMEN

December 1, 2013

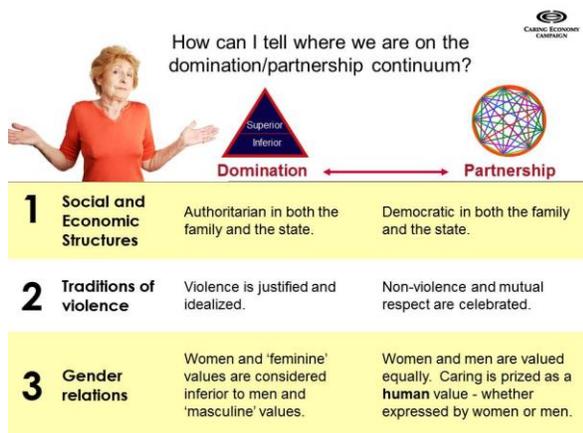
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Introduction

There are choices to be made by each reader as individuals and as leaders of social justice organizations. The easier of the two main decisions presented in this paper will be choosing human rights based principles and policies over social dominance oriented principles and policies. The harder decision will be to act on the first choice by altering relationships with people who have chosen social dominance.



This paper is written for those who value human rights based principles and policies and also value individual and organizational integrity. By integrity, I mean an inner sense of wholeness where honesty and consistency of character are demonstrated through actions in accordance with values, beliefs and principles you claim to hold. This paper is also written to show that others can have integrity coupled with a belief in social dominance and with its patriarchal masculinity and femininity.

Every choice we make moves the continuum -- which way depends on the choice

There is too much at stake, too much harm caused by silence and inaction. Too much lost by short sighted unconscious decisions that lead to

acceptance of small victories while institutionalized oppression is fortified in exchange. There is too much at stake to accept incremental change for human rights based policies and programs while massive shifts in policy are routinely advanced and implemented by social dominance oriented policy makers.¹

This paper is written to state a belief that health and education, to name two are human rights – not commodities of which we are only afforded an “opportunity” to access. This paper is written to state a belief that all human beings are born free, equal in dignity and rights entitled to equal protection of the laws and must be free from all forms of discrimination. And with that stated, this paper is written to expose the deliberate undermining of human rights based Health in All Policies for the benefit of the few.

Why Principles and Purpose Matter: Transforming Human Rights Based Social Determinants of Health into a Social Dominance Maintenance Tool

We are at the beginning of another period of massive social, economic, and political change. As we move from the industrial age into what is being called the knowledge age, we face the same challenge jobs and justice. With change however comes opportunity. Whether we are successful in creating a more equitable and just world will depend on the choices each one of us, as individuals, and as organizations, make in choosing either a dominator² or partnership³ world.

In California and in the rest of the nation, part of this period of change is the implementation of the Affordable Care Act and with it the expansion of Health in All Policies. Health in All Policies (HiAP) is an

human rights based approach to public health that identifies root causes of health disparities called social determinants of health.

What are the social 'determinants' of health?

The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

What are the drivers of health inequities?

The global context affects how societies prosper through its impact on international relations and domestic norms and policies. These in turn shape the way society, both at national and local level, organizes its affairs, giving rise to forms of social position and hierarchy, whereby populations are organized according to income, education, occupation, gender, race/ethnicity and other factors. Where people are in the social hierarchy affects the conditions in which they grow, learn, live, work and age, their vulnerability to ill health and the consequences of ill health

Whether implementation of the ACA, Health in All Policies, or any other policy, including whether state and local budgets benefit everyone in a fair and equitable manner depends on the principles used by decision-makers and policy advocates when creating, implementing and judging outcomes of these policies.⁴



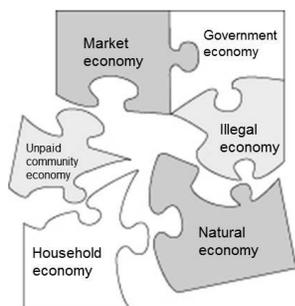
Across the world Human rights based policies are moving forward. However, the main impediments to implementation both here in the United States and across the world are social dominance oriented (SDO) corporate, religious and political leaders.⁵ The goal for these SDO individuals is to maintain the current social, political, and economic system that allows the 1% to dominate and oppress the 99%.

Social Dominance Orientation: Revisiting the Structure and Function of a Variable Predicting Social and Political Attitudes, 2012 Social dominance orientation (SDO) is one of the most powerful predictors of intergroup attitudes and behavior. Although SDO works well as a unitary construct, some analyses suggest it might consist of two complementary dimensions—SDO-Dominance (SDO-D), or the preference for some groups to dominate others, and SDO-Egalitarianism (SDO-E), a preference for nonegalitarian intergroup relations. Using seven samples from the United States and Israel, the authors confirm factor-analytic evidence and show predictive validity for both dimensions. In the United States, SDO-D was theorized and

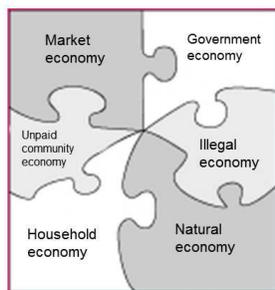
found to be more related to old-fashioned racism, zero-sum competition, and aggressive intergroup phenomena than SDO-E; SDO-E better predicted more subtle legitimizing ideologies, conservatism, and opposition to redistributive social policies. In a contentious hierarchical intergroup context (the Israeli–Palestinian context), SDO-D better predicted both conservatism and aggressive intergroup attitudes. Fundamentally, these analyses begin to establish the existence of complementary psychological orientations underlying the preference for group-based dominance and inequality.

Whether dealing with health, [sustainability](#), poverty and/or their connection to each other [an unholy alliance](#) has formed internationally between multinational corporate leaders, [the Vatican](#), and other anti-woman, anti-gender⁶ equity religiously-based leaders. This same alliance make-up is duplicated at the national and state level in the United States, including California. This white paper exposes the principles and policies being chosen right now surrounding implementation of the Affordable Care Act and Health in All Policies in California. Along with this exposure this white paper will illuminate a path towards human rights based Health in All Policies and ACA implementation.

As the paper illuminates California’s current path and the alternative, the reader will discover the devastating impacts on everyone’s individual human rights and most especially on black women and men. The choices made whether conscious or unconscious cause real life-altering damage and/or real life-enhancing advantage based on whether you are a dominant group member or not.



The old economic map



The new economic map

Image originally appeared in *The Real Wealth of Nations*, 2007, by Riane Eisler. Reproduced here with permission from Berrett-Koehler Publishers.

CARING ECONOMY CAMPAIGN
www.caringeconomy.org

Three major parts of our economy are hidden as are the values that keep them hidden. Critical analysis exposes what’s hidden.

of others, or simply chosen to remain blind or have chosen to go along to get along. This paper does not attempt to explain the choices by individuals, but to expose the systemic root causes so that those joining the effort to implement human rights based principles and policies can effectively act to move California and this country toward a partnership society.

The personal decisions by individuals in positions of power to maintain social dominance in sex/gender relations, as well as, race, ethnicity and other status categories are exposed whenever a fair minded critical analysis is conducted.⁷ For a Fair-minded critical thought process to occur there must be a process that clarifies goals, examines assumptions, discerns hidden values, evaluates evidence, accomplishes actions, and assesses conclusions. This will be uncomfortable for those individuals who have chosen personal benefit at the expense

What is a social dominance/market based health policy versus a human rights based health policy?

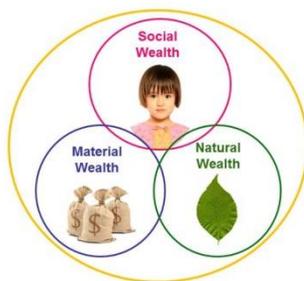
First HiAP and the ACA in California:

The Affordable Care Act leaves the choice of a human rights based or social dominant market based approach for implementing HiAP up to the individual states. California is currently on the path toward a social dominance/market based approach in spite of its reputation for being a socially progressive state.

A human rights based Health in All Policies implementation would use data from all sectors, political, social and economic to discover and then eliminate policies and/or conditions that are the root cause of health inequities based on the principle that all human beings are born free equal in dignity and rights. A social dominance/market based Health in All Policies seeks to redefine social determinants of health, how they are measured, and who is responsible from a perspective that assumes the ability to dominate and control others is a right of dominant group members.

What are the social determinants of health in a Human Rights based health policy versus a social dominance/market based health policy?

A human rights based Health in All Policies or social determinants of health places the **root causes of the condition at the center**. For example, male violence and individual corporate decisions that cause bad health consequences are the focus of policies, including behavior modification. Another example of a human rights based approach to social determinants of health is a physician understanding that risk of breast cancer includes exposure to farm pesticides, toxic chemicals, and stress, as well as, family history. A human rights based public health policy would ensure that medical histories include such questions.



Real Wealth


Caring Economy
Campaign
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A Human Rights Based HiAP equally values and counts
Real Wealth

A human rights based HiAP would ensure full access to reproductive, end of life, long term and other healthcare. A human rights based HiAP would value and place every individual's right to health at the center of all public policy, including economic, social, and political policies.

Health in All Policies is a process of social, political, and economic planning and outcome analysis that incorporates two critical human rights based concepts: 1) All Human beings are born free, equal in dignity and rights, and 2) the purpose or role of government is to create a favorable environment in which every human being may enjoy all of their rights, including but not

limited to removing advantage and disadvantage caused by social statuses such as race, ethnicity, gender and socio-economic status. These human rights based principles purpose is to provide sufficient

protection so individuals can remain free from subjugation while living with others in an interrelated world.

The first [human rights based principle](#) upon which Health in All Policies rests is:

All human beings are born free and equal in dignity and rights and must enjoy the equal protection of the law against discrimination based on their sex, age, gender, gender identity, sexuality, marital status, sexual history or behavior, real or imputed, race, color ethnicity, language, religion, political or other opinion, national, geographical or social origin, property, birth, physical or mental disability, health status, including HIV, and civil, political, social or other status.

Because political, economic, social, and legal privileges have been and continue to be granted and/or denied based upon membership in dominant status categories, historically and presently individuals experience different barriers to the fulfillment of their human rights. Substantive equality requires these barriers to be removed in order for diverse individuals to enjoy fundamental rights and freedoms on an equal basis with others.

These barriers or social determinants of health are the numerous ways that health is impacted by social statuses that advantage and disadvantage individuals, such as race, ethnicity, gender and socio-economic status. Given the above principle and purpose the goal of human rights based HiAP is the elimination of these barriers.

The second human rights based principle is the purpose or role of government and any social, political, economic or legal system given the first principle is to create a favorable environment in which every human being may enjoy all of their

The work of care and caregiving



grows our real wealth



Equally valuing care work and caregiving is equally valuing women and the work that we do

rights in order to take an active part in economic, social, cultural and political life.

In other words, one of the purposes of government is to eliminate the barriers that prevent individuals from reaching their full potential.

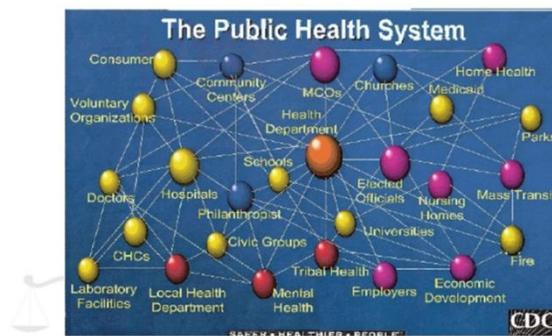
What we know from the data is that health is a prerequisite for full individual agency and freedom and, at the same time, social conditions that provide people with greater agency and control over their work and lives are associated with better outcomes. This mutually reinforcing relationship has important consequences for policy making. Consequently “a human rights perspective removes actions to relieve poverty and ensure equity from the voluntary realm of charity ... to the domain of law,” The health sector can use the “internationally recognized human rights mechanisms for legal accountability” to push for aggressive social policies to tackle health inequities, since international human rights instruments, “provide not only a framework but also a legal obligation for policies towards

achieving equal opportunity to be healthy, an obligation that necessarily requires consideration of poverty and social disadvantage.” (A Conceptual Framework for Action on the Social Determinants of Health 2010, page 13.)

The adoption of the social dominance/market based approach by the Brown Administration, among other things, leaves health in the realm of charity, rather than in the domain of law. This decision leaves our health in the hands of social dominance oriented health insurers and providers for their profit. This decision also leaves our health, especially women’s health in the hands of Catholic Directives driven healthcare corporations. Imagine the public health system shown below dominated by Catholic Bishops Controlled healthcare corporations.



OMHPPH Linking to the Network



Health and healthcare under social dominance is a commodity to be bought by those with the means to obtain it. Those who do not have the means must rely on charity care. Health and healthcare as a human right is not the foundational principle of Health in All Policies.

TrueChild Disconnect vs. Reconnect

U.S.	International
Health framework	Human rights framework
Individual focused	Community focused
American exceptionalism	Partnership w/ other countries key
Emphasis on big RCT	Emphasis on promising, replicable pilots
Research is scientific, experimental	Research is field-based, applied
Incrsg focus on school-based sexed	Incrsg focus on community-based programs
Highly political	Results oriented
Feminism equalized most inequities	Major M/F inequities remain
Ignore communal norms	Communal norms crucial
Focus on gender norms	Focus on gender equity and norms

Social dominance /market based HiAP maintains racialized public health, where health disparities are explained as biological or genetic differences thereby removing state and corporate responsibility. As you will see later in this paper racialized public health has already adversely impacted how maternal health is being addressed in California. It also allows Health Insurers to continue to charge the oppressed for failing to adequately manage the risks associated with being discriminated against.⁸ Injuries caused by violence are to be paid by the one whose bones are

broken, not by the perpetrator. Health conditions caused by personal decisions of corporate decision-makers such as air, water and soil pollution, toxins, to manipulating food with sugar, fat and salt are to be paid by the victim, not the corporation.

And last but most certainly not least reproductive, end of life and long term healthcare are commodified along with all other healthcare where only an opportunity to access is guaranteed.

Those who have the means have full access those who do not have the means do not have access. In addition to maintaining control over our bodies, especially women’s bodies, is the omnipresent need to maintain patriarchal gender norms. In addition to removing individual decisions in a corporate based structure social determinants of health reposition to focus on individual behavior of workers as the primary way of reducing healthcare costs.

Why and Who in California is attempting to implement a social dominance/market based approach to health policy: Choosing Social Dominance in Health in All Policies: Tracking the Decision to its Source

[Commission to Build a Healthier America](#)¹ included Republican Senator Bill Frist, most prominently known for leading the effort to transform the termination of catastrophic pregnancies into “partial-birth abortion” and Mark McClellan from the social dominance based [Brookings Institution](#), which asserts women’s poverty is caused by their status as single women, rather than systemic sex discrimination.

Social dominance oriented individuals do not believe all human beings are born free, equal in dignity and rights, nor do they believe human beings have a right to health, education or development. As we will see from the Robert Wood Johnson Foundation and others including the California Endowment the arguments used to persuade a social dominance oriented individual to reduce disparities is to concentrate on costs of bad health to dominant group members and to focus on policies and programs where these same dominant group members can make a profit.

For example a February 15, 2013 California Endowment Capitol Briefing Health Policy 101 slide presentation conducted by George Flores entitled [Health Happens Here: The Social Determinants of Health](#) the “Cost of Poverty in San Francisco Bay Area” shows the diminishing returns of wealth on health after \$150,000 in income. The intersection of income and health also shows socio-economic privilege, where one year in life expectancy is gained for every \$12,500 rise in annual household income and the inverse for the vast majority of the population who make less than \$150,000 a year. We will discuss slides 34 and 35 in greater detail later. For now, a read through this presentation also shows a move toward policies and programs that benefit developers and construction industry. Beginning with slide 38 are descriptions of the policies and programs created and controlled by the [Strategic Growth Council](#) and it’s [Health in All Policies Task Force](#),

which are made up almost entirely by corporate interests. With a frame of jobs and justice, the data seems to indicate that a baseline income level to strive for is the lifestyle produced with \$150,000.

As we will see programs controlled by the individuals and/or organizations listed below, whether aimed at schools and/or vulnerable communities are designed to teach “at risk” populations how to be compliant in meeting social norms, including properly adjusting to their social status and are strongly tied to gender norming⁹. The principles and policy choices being implemented by the Robert Wood Johnson Foundation, the California Endowment, Bay Area Business Council, the Brown Administration and others are steeped in the ideology of social dominance¹⁰, especially patriarchal masculinity and femininity.

In 2009 the Robert Wood Johnson Foundation's [Commission to Build a Healthier America](#)¹¹ included Republican Senator Bill Frist, most prominently known for leading the effort to transform the termination of catastrophic pregnancies into "partial-birth abortion" and Mark McClellan from the social dominance based [Brookings Institution](#) which asserts women's poverty is caused by their status as single women, rather than systemic sex discrimination. It should not be surprising, given the make-up of the RWJF commission, that they would choose to undermine the decades old and world-wide accepted human rights based approach to social determinants of health.

Given the profoundly biased committee make-up it should also not come as a surprise that the committee hired a right-wing Republican media and research firm called [Public Opinion Strategies](#) to conduct linguistic research and devise a "marketing" campaign that would convince liberals and progressives to adopt and implement social dominance oriented policies and programs.

Even with that said, I for one, was astounded at the lack of shame found within documents that

We had to talk about the topic in a way that people could understand, that was meaningful, and that didn't align the topic with any existing political perspective or agenda. ...

we were able to arrive at a frame that described the social determinants of health plainly, without political overtone.

explicitly acknowledge the unethical nature of the campaign's use of linguistically based propaganda¹² to induce agreement simply because it is effective. These types of individual decisions within a corporate-based structure have produced the vast majority of environmental degradation, factory farming, processed food manipulation and countless other oppressive behaviors that have directly impacted the health of millions. And it is exactly these types of individual decisions within a corporate-based structure that is purposefully avoided by the ["New Way to Talk About Social Determinants of Health."](#)

As shown in the documents below RWJF was not shy about the use of propaganda to ensure implementation of Health Equity did not trigger broad acceptance of human rights based policies:

["Frequently Asked Questions About the Social Determinants of Health"](#)

A: Every culture, whether defined by a country, ethnic group, industry or field, develops its own ways of seeing the world and talking about it. "Insider" language and terminology is critical, if

you're an insider. In most cases, people on the inside recognize the limitation of too much inside talk or jargon when communicating with people outside of their group. In the last several years, we have seen a rise in academics and political consultants who have taken various approaches to taking complex political issues and policies and explaining them to the public and key stakeholders in more plainspoken language. Whether conservative (Frank Luntz's Words the Work: It's Not What You Say, It's What They Hear), liberal (George Lakoff's Think Like an Elephant) or progressive (Drew Westen's The Political Brain), the approaches all recognize certain universal truths about how our minds receive and interpret information.

Regardless of your political leanings and your respect or alternatively distaste for this approach to messaging, it's hard to argue with its effectiveness. It is grounded in a firm understanding of how people think and process what they hear. As a result, we are seeing an increase in the applications of these message development and research methods across a

whole host of issues in an effort to more clearly communicate both the problems facing our country and our approach to addressing them.”

On the one hand, Americans value fairness, and the idea that wealth translates into health runs afoul of a firmly entrenched value. Similarly, messages that convey, in a visual and especially a visceral way, the idea of toxic fumes or chemicals affecting the health of kids in a particular neighborhood would today **bring to mind populist sentiments about the recklessness of big business and the failure of government** after Americans have confronted two of the biggest crises in generations, the financial meltdown that has still left nearly 10 percent of Americans out of work and the BP offshore oil spill that is decimating the Gulf Coast in ways we have not even begun to understand.

On the other hand, mentions of poverty immediately evoke victim blaming and largely unconscious prejudices, as the average American associates’ poverty with people of color. **Finding ways to speak of the impact of poverty on health without activating those networks—or activating countervailing networks related to the middle class and middle class concerns—thus becomes essential in messaging on health disparities if the goal is to influence not only public opinion but public policy.**

And within [The New Way To Talk About Social Determinants of Health](#) itself:

“This work gave us an opportunity to find a new frame for talking about the social determinants of health. Not just for people working in the field, but for policy-makers. We had to talk about the topic in a way that people could understand, that was meaningful, and that didn’t align the topic with any existing political perspective or agenda.

By working with a talented group of communicators, including Linda Loranger of Burness Communications, Allison Rosen of Chandler Chicco, Bob McKinnon of YELLOWBRICKROAD and Elizabeth Carger of Olson Zaltman Associates, we were able to arrive at a frame that described the social determinants of health plainly, without political overtone. As we started using this new way of talking not only for the commission, but also for the work in the portfolio, we gained significant traction.

We tweaked it and refined it a little, and what we ended up with was simple: Health starts where we live, learn, work and play. We started to see the messages picked up everywhere, but most importantly in media accounts of our programs and in academic literature.

*While the new framework did well in its ‘road test,’ we are an institution that prides itself on evaluation and measurement of the ideas we put forward. So we decided to test the messages more rigorously—to make sure we were getting it right—but also that we hadn’t missed an opportunity to make it better. So we engaged Drew Westen, Ph.D., of Westen Strategies and author of *The Political Brain* to help us fine-tune the messages, and build on our earlier research. Dr. Westen worked closely with our own communications staff to conduct the research that’s reflected here.” P. iii.*

The individuals involved with “The New Way” are explicit in

their desire to maintain social dominance ideology:

“The approach to messaging or “marketing” social determinants we took is rooted in contemporary neuroscience and in both a scientific and clinical understanding of the unconscious networks of associations—the interconnected sets of thoughts, feelings, images, metaphors, and emotions—that are active in the brains of persuadable audiences as they read, watch, or listen to information about social determinants of health. Introducing the notion, for example, that income level affects health immediately activates a host of associations, positive and negative, that affect the persuasiveness of the message. On the one hand, Americans value fairness, and the idea that wealth translates into health runs afoul of a firmly entrenched value. Similarly, messages that convey, in a visual and especially a visceral way, the idea of toxic fumes or chemicals affecting the health of kids in a particular neighborhood would today bring to mind populist sentiments about the recklessness of big business and the failure of government after Americans have confronted two of the biggest crises in generations, the financial meltdown that has still left nearly 10 percent of Americans out of work and the BP offshore oil spill that is decimating the Gulf Coast in ways we have not even begun to understand. On the other hand, mentions of poverty immediately evoke victim blaming and largely unconscious prejudices, as the average American associates’ poverty with people of color. Finding ways to speak of the impact of poverty on health without activating those networks—or activating countervailing networks related to the middle class and middle class concerns—thus becomes essential in messaging on health disparities if the goal is to influence not only public opinion but public policy.” P. 22.

RWJF did not spend millions of dollars, using the most sophisticated, state of the art linguistic applications to incorporate human rights based principles, **RWJF sought to reinforce social dominance oriented individuals while manipulating human rights based or partnership oriented individuals to accept policies that maintain patriarchal gender norms and with them the [Matrix of Domination](#).**

Within the “New Way” is the use of the word “access”. “Access” to education, to health and healthcare, but “access” under a social dominance/market based principle is defined as the opportunity rather than a right to health, healthcare or education. As we dig deeper into the “New Way” we will see that this social dominance/market based approach concentrates on helping people manage their “risks” caused by their social, political and economic status, rather than every human being’s right to be free from unequal social, political or economic status hierarchies.

Professor John Hope Franklin comments found in Derrick Bell’s Race, Racism and American Law demonstrate that conservative manipulation of poor whites for the purpose of maintaining wealthy elite interests is nothing new, but equally telling in this comment is the role of progressives in exposing it.

“the poor, ignorant white farmers reverted to their old habits of thinking and acting, comforted in their poverty by Conservative assurances that Negro rule must be avoided at any cost...The poor whites could say...the Negro question was an everlasting, overshadowing problem that served to hamper the progress of poor whites and prevent them from becoming realistic in social, economic, and political matters. But the effect on poor whites is best described by Tom Watson, a Populist leader, who in 1892 as a staunch advocate of a union between Negro and white farmers wrote: ‘You are kept apart that you may be separately fleeced of your earnings. You are made to hate each other because upon that hatred is rested the keystone of the arch of

financial despotism which enslaves you both. You are deceived and blinded that you may not see how this race antagonism perpetuates a monetary system which beggars both.” P. 31.

The use of the phrase personal responsibility is the current rendition of coded race-based language designed to keep people apart, while eliminating any personal responsibility for elites in decision making positions in corporations and/or elected office.

The following slide examples demonstrate that prior to RWJF’s “New Way”, Public Health Departments knew how to talk about social determinants of health from a human rights based approach:

[Virginia Department of Health: Office of Minority Public Health Policy 2007](#)



Office of Minority Health & Public Health Policy
Advancing Health Equity For All Virginians



Office of Minority Health & Public Health Policy
Advancing Health Equity For All Virginians

Health Disparities are “Differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities.”

Source: The Office of Healthy Communities, 2007. Available at www.healthyeconomies.org

VISION AND MISSION

- **Vision:** Advancing health equity for all Virginians
- **Mission:** Our mission is to identify health inequities, assess their root causes and address them by promoting social justice, influencing policy, establishing partnerships, providing resources and educating the public.



Office of Minority Health & Public Health Policy
Advancing Health Equity For All Virginians



Office of Minority Health & Public Health Policy
Advancing Health Equity For All Virginians

- **Social Determinants of Health** are those inter-related social and economic factors that influence health.
- Including, but not limited to:
 - Socioeconomic Status
 - Discrimination
 - Housing
 - Physical Environment
 - Food Security
 - Child Development
 - Culture
 - Social Support
 - Healthcare Services
 - Transportation
 - Working Conditions
 - Democratic Participation

SOCIAL JUSTICE

Social justice is the equitable distribution of **social, economic and political resources, opportunities, and burdens** and their consequences.



Office of Minority Health & Public Health Policy
Advancing Health Equity For All Virginians



Office of Minority Health & Public Health Policy
Advancing Health Equity For All Virginians

- **Health Inequities** are disparities in health that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity.
- **Health Equity** is the absence of differences in health between groups with differential exposure to those social and economic policies and practices that create barriers to opportunity.

Unnatural Causes – Is Inequality Making Us Sick?

- Health is more than healthcare
- Health is tied to the distribution of resources
- Racism imposes an added health burden.
- The choices we make are shaped by the choices we have.
- High demand + low control = chronic stress.
- Chronic stress can be deadly.
- Inequality – economic and political – is bad for our health.
- Social policy is health policy.
- Health inequalities are not natural.
- We all pay the price for poor health.

Turning White Privilege and Racial Oppression into Social Pathologies of the Oppressed

The root cause for the “bipartisan” acceptance of the “New Way” is not the use of sophisticated linguistic devices imbedded in propaganda – the root cause is patriarchal gender roles and norms. The “go to” script for social dominance oriented individuals is to turn oppression into social pathologies of the oppressed. For black boys and men the historic and on-going social, political and economic



It's a Guy Thing

The “Man Box”

We're in this box, and in order to be in that box, you have to be strong, you have to be tough, you have to have a lot of girls, you gotta have money, you have to be a player or a pimp, you gotta be in control, you have to dominate other men, and you know if you are not any of those things, then people call you soft or weak or a p'ssy or a chump or a f'ggot and nobody wants to be any of those things. So everybody stays inside the box.

Byron Hurt "Beyond Beats & Rhymes"



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oppression they suffer is made irrelevant by those implementing programs and policies that fail to address the personal responsibility of dominant group members in eliminating oppression and domination and further fail to modify the behavior of oppressive dominant group members. Rather, all that is offered are remedial aid and training so that black boys and men can learn the skills and behaviors necessary to succeed under the current social dominance hierarchy. Their reward for properly adjusting is to take their rightful place as

head of black households.

The “New Way” blueprint for gender roles is steeped in patriarchal masculinity and femininity. Following this blueprint women are and will be told that they can enter the public workforce but only as gendered males. Household duties, which are societally assigned to women will remain unpaid and are the reward for socially compliant “married” men.



It's a Girl Thing

Attributes of Trad'l Femininity

- Soft
- Weaker
- Submissive
- Deferential
- Pretty & thin
- Maternal
- Nurturing
- Emotional, sensitive
- Heterosexual!
- Social
- Quiet
- Virginal, naïve.

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Marriage is the first and preferably only path to economic security for women and is defined as the cornerstone of civil society. Any breakdown of society, such as poverty and income inequality is then stated to be caused by women refusing to submit to their assigned gender roles and/or men refusing to properly adjust to risks associated with their given social status.

Social Dominance Versus Partnership: The Critical Connection Between Gender Roles and Norms With Wealth Production & Distribution

Because we currently live within a social dominance oriented¹³ system, it is imperative that underlying social dominance/market based principles be revealed and discussed as the first step in moving toward a more just and fair world.

Patriarchal masculinity defined as the ability to dominate and control others remains the norm despite anti-bullying and harassment statutes. Patriarchal masculinity that is the need to dominate and control all others is coupled with the concomitant need not to be dominated and controlled by others, which fosters perpetual male rivalry where a “there can be only one” equation excludes almost all males from measuring up to the definition of manhood.

“Men’s feeling are not the feelings of the powerful, but of those who see themselves as powerless. These are the feelings that come inevitably from the discontinuity between the social and the psychological, between the aggregate analysis that reveals how men are in power as a group and the psychological fact that they do not feel powerful as individuals. They are the feelings of men who were raised to believe themselves entitled to feel that power, but do not feel it. No wonder many men are frustrated and angry. This may explain the recent popularity of those workshops and retreats designed to help me to claim their ‘inner’ power, their ‘deep manhood,’ or their ‘warrior within.’ The dimension of power is now reinserted into men’s experience not only as the product of individual experience but also as the product of relations with other men. In this sense, men’s experience of powerlessness is real—the men actually feel it and certainly act on it—but it is not true, that is, it does not accurately describe their condition. In contrast to women’s lives, men’s lives are structured around relationships of power and men’s differential access to power, as well as the differential access to that power of men as a group. Our imperfect analysis of our own situation leads us to believe that we men need more power, rather than leading us to support feminists’ efforts to rearrange power relationships along more equitable lines. ...



Gender Norms

- External and internal norms
- External and internal pressures, desires, rewards
 - External pressure (They’ll call me a sissy if I don’t have sex early, often)
 - External rewards (If I have sex early, often they’ll think I’m a Real Man)
 - Internal pressure (I’m a sissy if I don’t have sex early, often)
 - Internal rewards (If I have sex early, often that means I’m a Real Man)
 - Internal desires (I feel like a real man when I have lots of sex).



Why, then, do American men feel so powerless? Part of the answer is because we’ve constructed the rules of manhood so that only the tiniest fraction of men come to believe that they are the biggest of wheels the sturdiest of oaks, the most virulent repudiators of femininity the most daring and aggressive. We’ve managed to disempower the overwhelming majority of American men by other means—such as

discriminating on the basis of race, class ethnicity, age, or sexual preference. Masculinist retreats to retrieve deep, wounded, masculinity are but one of the ways in which American men currently struggle with their fears and their shame. Unfortunately, at the very moment that they work to break down the isolation that governs men’s lives, as they enable men to express those fears and that shame, they ignore the social power that men continue to exert over women and the privileges from which they (as the middle-aged, middle-class white men who largely make up these retreats) continue to benefit—regardless of their experiences as wounded victims of oppressive male socialization. ... This is the manhood of racism, of sexism, of homophobia. It is the manhood that is so chronically insecure that it trebles at the idea of lifting the ban on gays in the military, that is so threatened by women in the workplace that

women become targets of sexual harassment, that is so deeply frightened of equality that it must ensure that the playing field of male competition remains stacked against all newcomers to the game.” *College Men and Masculinities*¹⁴, p. 29-30.



Under-Resourced Environments

- Throw the ball
- Have lots of girls
- Get lots of money



“We don’t teach our boys to be men we teach them not to be women or homosexual.”

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The reaction described above is found in the policy choices of Robert Ross and the California Endowment, namely the systematic removal from funding priorities and capacity building efforts related to gender equity, women and girls empowerment, reproductive justice, as well as, providing substantial funding for men and boys of color initiatives steeped in patriarchal masculinity rather than gender transformative approaches. The “refocused” agenda is based on “market” based

health initiatives aimed to “cure” the “pathologies” in poor black and brown neighborhoods using as its blue print “*The New Way to Talk About Social Determinants of Health.*” As stated the most disturbing of these initiatives is the fatherhood programs based on Brookings Institute materials and patriarchal philosophy, which are detailed in this paper.

A feminist masculinity conversely frees all males to be men without patriarchal social conformity and is the foundation by which our society can move toward human rights based principles and policies. For example:

By contrast, a transformed approach to violence prevention would continue to address sexual assault and would also address other prevalent forms of campus violence, including physical assaults and hate crimes. In acknowledging the gender-related nature of violence, a transformed approach would also strive to open what Allen (1993) refers to as the man box and expand the definitions of what is appropriately masculine, thus alleviating both perceived and real peer pressure that may motivate men to engage in physical and sexual aggression to affirm their masculinity. Such an approach would necessarily disassociate the heretofore ‘masculine’ traits of agency and action from violence (Pollack, 1998) in all of our social institutions, including the family, school, church, workplace, and media. Finally, a transformed approach would involve and engage students—particularly men—in meaningful ways that

emphasize ownership for activism and social change and would do so within the context of long-term and sustained prevention initiatives. College Men and Masculinities, p. 277.



Gender Transformative

Programs that...

1. Make participants aware of gender norms
2. Challenge them to think critically about them
3. Redefine them in more gender equitable ways
4. Address men as change agents, not villains, by-standers, or allies.



Geeta Gupta

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An excellent discussion of the current consequences of the “man box” and the need for gender transformative policies is Melissa Harris-Perry on November 10, 2013 discussion Jonathan Martin.¹⁵

Although the complexity of the [Matrix of Domination](#) race, ethnicity, sex, gender, sexuality, other status categories and their intersection across, between and

within statues, on the surface presents a seemingly unending combination of dominance and privilege, which lures each of us into a state of paralysis.

The key to resisting this paralysis is to keep in mind that every system has linchpins or cornerstones that hold the system or matrix together. A critical linchpin is gender roles. To illustrate the powerful effects gender roles have on how we perceive the world, ourselves, and others we will begin by asking a simple question.

Valuing Women & the Work that We Do

Why do we pay a plumber \$100 an hour and a childcare worker \$10 an hour? Why do we pay the plumber who fixes our toilet more than the person who cares and develops our children? Think about that.



The answer to this question reveals what and who we value. Value, which is the true measure of equality, is the issue of our time. This critical issue affects all of us, but most especially women of color. The value of care work and the gendered nature of care work demonstrate the stark reality of choosing a social dominance model of the male/female relationship.

In a [Woodrow Wilson International Center for Scholars](#)' paper entitled, "[Women, Migration and the Work of Care: The United States in Comparative Perspective](#)," static gender roles are assumed, namely that women are solely responsible for the "care" of their families, both children, spouse, and parents and further that such care should be provided willingly and for free.¹⁷ Men and therefore society are the recipients of that care. The expectation of care, by women for the benefit of men has been and remains a part of male social, political, economic and legal privilege.

Such a presumption means that women's pursuit of paid work and/or the refusal to provide care work for free is defined as a deficit, a drain, a societal dysfunction. Using a social dominance perspective the Wilson Scholar paper concentrates on solving the societal dysfunction of "women failing to care for their families" opting and/or choosing instead to pursue paid work.

What kinds of investments?

- Accessible, high-quality child care
- Subsidies for childcare
- Training requirements for early child care workers
- Parenting education and support programs



The complexity of the Matrix of Domination is shown in this telling quote, "First, these women are the constitutive elements of 'global care chains' that enable class privileged women to purchase care

resources from economically disadvantaged women who in turn purchase care for their children and elders from women who are even more disadvantaged in their origin countries.” *Women, Migration and the Work of Care*, p.8. There is not only a fundamental failure to address the role of male privilege in the “global care chain” but male privilege is presented as a social/cultural imperative.

It cannot be repeated too often. Taken off the table is the responsibility of men, to care for themselves and for others, including but not limited to children and elders. In turn, business, corporations, the economy itself has no responsibility for participating or paying for care work. To put the importance of valuing women and the work that we do in full view, currently women provide [\\$47 billion](#) annually in unpaid care work in California. That figure is at the current value of care work. An equal valuation with the plumber would amount to \$470 billion annually.

The current definition of care work is “multifaceted labor that produces the daily living conditions that make basic human health and well-being possible. In addition to physical, practical activities, care work involves emotional duties, such as support, the expression of affection, kindness, enthusiasm and love, in other words, a personalized relationship between employer and employee characterized by intimacy, trust, and responsibility.” *Women, Migration and the Work of Care*, p.11.



Despite the mountain of evidence regarding value of care work, such as, early education and child development on life outcomes¹⁸, care work is still defined by decision makers as unskilled or low skilled, and therefore perpetually low paid work.

The move to monetize care work – that is to put a monetary value on care work demonstrates the enormity of the redistribution of wealth that would be transferred to women, who perform unpaid care work from men who benefit from it. Monetizing care work further by applying an equal pay for equal work

standard exponentially increases the redistribution of wealth to women from men. This fundamental distribution of power, money, and value is at stake in choosing between social dominance and partnership.

A Center for Partnership Studies analysis of statistical data from 89 nations shows **the status of women can be a better predictor of everyone's quality of life than GDP.**



Women, Men, and the Quality of Life. Riane Eisler, David Loyal, and Karl Niirgard. 1995. Published by The Center for Partnership Studies. <http://www.cpartnership.org/Economics>. <http://www.economicspublicpolicy.org/essays-from-women-men-and-the-40-hour-quality-of-life>. The World Economic Forum Global Gender Gap Report 2011. <http://www.weforum.org/reports/global-gender-gap-report-2011>.

CARING ECONOMY CAMPAIGN
www.caringeconomy.org

Simply put if progressive organizations, that is Labor, LGBTQ, Women’s Rights, Environmental Justice, Social Justice, and Disability Rights organizations continue to ignore, and thereby continue to embrace a social dominance definition of masculinity and femininity, then the battles over equity, access, sustainability regarding public education, health and healthcare, economic and environmental justice will be lost.

Unity of principles and purpose is necessary because human rights based principles cannot become the foundation of our society as long as men of color accept gender and class privilege, white women accept race and class privilege and

Justice and the growth of Real Wealth are possible with the rejection of the social dominance definition of masculinity and femininity.

women of color class privilege. Only by all uniting in their rejection of social dominance orientation as the model of human relationships can we succeed in creating a human rights based partnership society.

What We Value and Who We Value as Equals Determines How We Look at Policy and Outcomes



Gender Exploitative



- > **Employ traditional gender norms**
 - o Men as aggressors, in control, etc.
 - o Women as weak, mothers only, etc.
- > **Mine existing power imbalances**
 - o Solidify them
- > **May work in short run but...**
 - o May be unsustainable
 - o Harmful long-term consequences.

This white paper utilizes all three equality approaches with the understanding that transformation includes use of both the sameness and difference concepts coupled with an anti-subjugation principle. We ask and expect the question: who benefits? to be fully and comprehensively answered when a policy or social, political or economic system is analyzed. We then proceed to form solutions based upon a human rights based intersectional gender equity principle.

Three approaches to equality: Knowing the definitions of Equality Matters



Gender Neutral



- > Gender analysis is assumed unnecessary, irrelevant
- > Assumes neutrality is acceptable
- > Ignores gendered contexts to sex, health, relations
- > Neutrality reinforces and reproduces gender injustices
- > Neutrality exploits inequalities, reinforces stereotypes.

The sameness approach highlights the necessity to include women into a world which had previously excluded them. This sameness approach is based on equality being defined as likes being treated alike. The sameness approach grants equality to women when they are like men. It does not challenge or re-examine social roles, values, or dominance.

The sameness approach is exemplified by Sheryl Sandberg, whose lean in faux feminism calls on women to be more like men at work, so women can take their rightful place as

leaders of elite social, political and economic institutions. In [Dig Deep Beyond Lean In](#), bell hooks provides an excellent analysis of this current version of 1% "feminism".



Gender Sensitive



- ✓ Accommodate gender norms but not reduce inequality
- ✓ Gender norms introduced only to reach goals
- ✓ 'Gender-by-numbers' w/ 'inclusion of women'
- ✓ No gender analysis of power, inequality, or norms
- ✓ Gender approach not culturally-relevant or sensitive.

The difference approach highlights the problem with the sameness approach, which fails to recognize that we are the same in our difference to each other. Using difference as the measure of inequality introduces hierarchy and the ability to dominate based on difference. The difference approach, which seeks to equally value difference provides a necessary component of the definition of equality, but fails to adequately deal with hierarchy and dominance.

We will see all too clearly what happens when the difference approach fails to adequately address hierarchy and dominance in health equity. Without recognition of oppression and social dominance

difference is attributed to unchangeable genetic and/or biological causes leaving supremacist beliefs unaltered.

The inadequacy of the sameness/difference model of equality is explained by Catherine MacKinnon in her analysis of *Plessy* and *Brown*, as well as, *Bradwell* and *Reed*, where MacKinnon aptly states:

“In Plessy v Ferguson, for example, where segregation with equal facilities was held to be equal, the reason given was that Blacks were different from whites, so could be treated differently (cite omitted). When Brown v. Board of Education repudiated Plessy and held that educational segregation with equal facilities was inherently unequal (cite omitted) what changed was that Brown implicitly considered Blacks to be the same as whites. At least, Black school children were potentially so. This was a substantive shift in the political and ideological ground beneath the case law, not a pure doctrinal development. What was different was now the same. Difference could still justify differentiation, presumably including exclusion and subordination as well as segregation. Being the same as the dominant group remained the quality test. The insult to Black culture inherent in the view that to be different is to be inferior, meaning properly outside the reach of guarantees of equal treatment, is an assumption that lies coiled like a snake in Brown’s ringing axiom that separate but equal is inherently unequal. This has been overlooked for the most part in the name of the benefits of integration, perhaps on the pragmatic consideration that separate Black schools were less likely to be equal to schools also attended by whites in a white supremacist society. (cite omitted) That the failure to end discrimination by whites against Blacks may signal a defect in the whole approach rather than merely its inadequate delivery, is suggested by the Court’s current deinstitutionalization of racial equality, flawlessly predicated as it is on earlier progressive precedents. (cite omitted) What did it also undoes it; differences, including products of social inequality, make unequal treatment not unequal at all. (cite omitted) Legal recognition as sovereign is thus based on neither correspondence nor distinction, but on an equal entitlement to self-determination. Yet such an argument is not regarded as an equality argument because it is predicated upon neither sameness nor difference. ...

“these are the social practices of dominance which create the gender difference as we know it. When the ‘similarly situated’ assumption is revealed as the white male standard in neutral disguise, the fist of dominance in the glove of equality, the continuity with Plessy and Bradwell beneath the victories of Brown and Reed, dominance essentialized as difference becomes first on the equality agenda rather than last.” Catherine MacKinnon, Reflections on Sex Equality Under Law, 100 Yale Law Journal 1281, P. 1288-1292.

The transformative approach recognizes that current social, economic, political, and legal norms are based on unequal gender norms. The elimination of forced gender roles allows every individual to

Gender “Transforming”

The infographic features a horizontal bar with four colored segments: red (Discriminatory), yellow (Neutral), green (Sensitive), and blue (Transformative). Above the bar, arrows point from left to right, indicating a progression. A red sun-like icon with the text 'TrueChild' is positioned above the 'Discriminatory' segment.

- ✓ Addresses gender imbalances
- ✓ Teach assertiveness, improve negotiation skills
- ✓ Integrated fully into programs, materials, policy.

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express the full spectrum of human traits. Neither gender is defined as superior or inferior, nor dominant or submissive.

What does that look like in the real world? Well, if we only use the sameness model of equality, not only are men the measure of equality, but other dominant status measures

such as race and sexuality also remain. Under the sameness model, plumbers are not like care workers, so treating (valuing) them differently is legally, politically, economically and socially acceptable. The solution is for women to become plumbers or engineers or, or, or, but as we already know because we live it every day that means women and the work that we do will remain valueless.

Masculinity defined as the ability to dominate and avoid being dominated marries gender roles to other status oppressions. The use of exclusion is embedded in the social dominance definition of male and female and therefore masculinity and femininity. To be a man is to not be a woman. Within a social dominance system race is a social/political classification where the use of exclusion is also embedded. When coupled with gender roles, race and sex/gender form group based exclusivity and social cohesion within and between dominant group members.



Gender Norms

- Define male-female relations esp.
 - Power dynamics
 - How we have sex, who does what, to whom, when
- Highly binary: promote difference and opposition
- Presented as
 - Natural (Nature's law (crying babies, math))
 - Inevitable (Boys will be boys)
 - Universal (everyone is like this)
 - Timeless (always been this way).

Gender = What society makes out of bodies & sex

The exclusivity of whiteness and masculinity combine as an extremely powerful virtually self-perpetuating force of social dominant hierarchical control. [See Cheryl I. Harris, Whiteness as Property](#). The intra-connectedness of whiteness and masculinity is necessary to allow class and/or socio-economic status differentiations within and between dominant and out-group members. Masculinity defined as the ability to dominate and control and the ability to not be dominated and controlled creates constant male rivalry and competition. The introduction of race and/or in-group/out-group status provides a method

of identifying as a dominant group member, which facilitates acceptance of the hierarchical system by less dominant members.

For example: poor and lower middle class white men are afforded privileges of whiteness despite their lack of economic dominance such as being able to walk the streets without being stopped and frisked by police. The use of exclusivity in both whiteness and maleness means by definition that there must always be a reference to blackness and femaleness.

“Inherent in the concept of ‘being white’ was the right to own or hold whiteness to the exclusion and subordination of Blacks. Because ‘identity is ... continuously being constituted through social interactions,’ the assigned political, economic, and social inferiority of Blacks necessarily shaped white identity. In the commonly held view, the presence of Black ‘blood’ – including the infamous ‘one-drop’ – consigned a person to being ‘Black’ and evoked the ‘metaphor ... of purity and contamination’ in which Black blood is a contaminant and white racial identity is pure. Recognizing or identifying oneself as white is thus a claim of racial purity, an assertion that one is free of any taint of Black blood. The law has played a critical role in legitimating this claim.” Harris, Whiteness as Property, p. 1727.

“As the law explicitly ratified those expectations in continued privilege and extended ongoing protection to those illegitimate expectations by failing to expose or to radically disturb them, the dominant and subordinate positions within the racial hierarchy were reified in law. When the law recognizes, either implicitly or explicitly, the settled expectations of whites built on the

privileges and benefits produced by white supremacy, it acknowledges and reinforces a property interest in whiteness that reproduces Black subordination.” Harris, Whiteness as Property, p. 1731.



Gender Norms

Socially-constructed expectations, norms, scripts for male-female behavior, characteristics, and roles

Other terms

- "Femininity Ideology/Masculinity Ideology"
- "Hegemonic Masculinity"
- "Hetero-normativity."



The exclusivity of whiteness and maleness causes difference to be used as the basis of determining whether equality or equal protection is applied. In other words, anyone who is not white or is not male is by definition excluded from equal protection. When supremacy or dominance is added to exclusivity evidence of difference or disparity is simply evidence or validation of supremacy. An excellent history of the evolution of race and ethnic populations in the United States, including the use of pseudo-science to

exclude populations from being part of the dominant group is *Racial and Ethnic Relations*, Ninth Edition, 2012, Joe R. Feagin, Clairece Booher Feagin.

For example in the *Mismeasure of Men*, Stephen Jay Gould pointed out that the individuals seeking to prove white male supremacy through science “*confirmed all the common prejudices of comfortable white males – that blacks, women, and poor people occupy their subordinate roles by the harsh dictates of nature.*” The use of brain size, IQ and other so-called scientific evidence of race, gender and class supremacy is not new. From Samuel Morton to Henry Goodard to Nathan Glazer, Daniel Patrick Moynihan to Charles Murray, Arthur Jansen to the Brookings Institute all use pseudo-science and pseudo-reasoning to justify white male supremacy and social dominance.

There’s Nothing New About “The New Way to Talk About Social Determinants of Health”

[The New Way of Talking About Social Determinants of Health](#), which the [Brown Administration](#) has adopted fits neatly into the above pattern of using pseudo-science to justify maintenance of the current social dominance system generally and specifically to justify the re-establishment of male, if not white male supremacy.

In *Mapping ‘Race’ Critical Approaches to Health Disparities Research*, The Politics of Framing Health Disparities: Markets and Justice, 2013, Jonathan Kahn explains how the use of market driven principles maintains social dominance hierarchies and therefore disparities in health. **Under a market or social dominance oriented system disparities in health, education, or compensation are explained or dealt with by addressing deficiencies in the person or body. Under a justice or partnership oriented system disparities in health, education or compensation are explained or dealt with by looking at social or systemic causes such as racism and sexism.**

Contemporary debates over the meaning and significance of racial disparities in health have deep roots (cites omitted). Tracing their development over the past century, particularly in relations to the legal construction of racial difference, elucidates a history of tension between

two competing frames for characterizing social understanding and responses to disparities. I characterize these frames here as a distinct binary, but they really exist as a continuum with one side or another gaining different degrees of prominence in different eras or contexts. On the one side I place 'markets,' on the other 'justice.'

*First, when identifying a race-based health disparity, one can locate its source or cause in human bodies or in social conditions. The former tends to biologize race, marking racialized bodies as somehow defective, weak, or diseased, often at the molecular level; examples would include characterizations of heart failure as a 'different disease' in African Americans (cite omitted), framing the resulting health disparities as due more to biology than social or historical context. The latter tends to racialize social dynamics, marking society as somehow discriminatory or unjust; examples would include many of the findings of the IOM report *Unequal Treatment Confronting Racial and Ethnic Disparities in Healthcare* that explicitly examined diverse social, historical, and economic factors as contributing to health disparities (cites omitted). pp. 25-38*

This IOM Report mentioned above was created during the Bush Administration, whose Department of Health and Human Services moved to quickly alter this IOM Report to the social dominance “market” based approach and with it continued to biologize race. The only acceptable remedies are limited to changing personal behavior of the victim through “risk management” rather than changing the personal behavior of the discriminator or oppressive system. California’s Department of Public Health created in 2006 had already adopted a social dominance approach to public health.¹⁹

Continuing with this same pattern, the California legislature in 2012, after extensive work by advocates and legislature’s health consultants produced a human rights based health equity policy and [Office of Health Equity](#). The Brown administration that had originally left out women from the health equity policy and Office of Health Equity moved well before the legislation was enacted to ensure the health equity policy and Office of Health Equity would use social dominance “market” based principle rather than a human rights based principle. See [CDPH Report to the Senate Budget Subcommittee 3 Health and Human Services, July 2012 to December 2012](#), showing how Strategic Growth Council, Let’s Get Healthy California and HiAP Taskforces interface with OHE.

Kahn explains what it means to choose a market based policy rather than a human rights based policy:

Second, having identified the source of the problem, the next step is to frame a locus of responsibility for addressing it. If the source has been located in racialized human bodies, then the tendency is to situate responsibility for addressing the problem in the individuals whose bodies are affected. This often takes the form of calls for 'personal responsibility' in taking care of oneself. ... If the source of the problem is located in society, then the tendency is to situate responsibility for addressing the problem in the polity. Mapping Race, p. 26

Third, having identified the source of the problem and located responsibility for it, the final step is to formulate an approach to solving it. Going down one tract, if you have located the source of the problem in human bodies, perhaps at the genetic level, and situated responsibility in the individuals whose bodies are affected, then the tendency is to formulate privatized, market-based approaches to address the problem. ... If you have located the source of the problem in

social conditions, and situated responsibility in the political community as a matter of justice, then the tendency is to formulate government-based policy initiatives to address the problem.

Mapping Race, p. 27

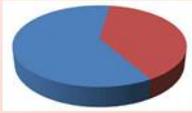


Binaries: It's about Power

Pervasive effects: Gender division of labor

- Relegated to "women's work" – lower value, recognition
- Un-under-paid nurturing: child/elder/sick care, housekeeping
- Favor male income-generating work, achievement
- Higher status, \$ for male-oriented work (programming, surgeons).

Theory of Gender & Power



Health care insurers, staunch advocates for "market-based" solutions have been and remain a powerful social dominance hierarchy enhancer. The use of social dominance oriented assumptions in insurance ratings continues to this day, especially regarding sex/gender. Race, sex, and gender norms based on white supremacist patriarchy is not gone from our society or our institutions as you will quickly see if you read on.

"At the turn of the twentieth century, Fredrick Hoffman published Race Traits and

Tendencies of the American Negro for the American Economic Association (cite omitted). Hoffman, a statistician at the Prudential Life Insurance Company, wrote the article for Prudential in response to a wave of state legislation banning discrimination against African Americans. Hoffman's aim was to establish the biological inferiority of the negro as a basis for justifying Prudential's decision to exclude African Americans from access to insurance coverage. Prudential had begun cutting back on providing insurance to African Americans as early as 1881 on the grounds that they suffered higher rates of mortality. Other insurance companies soon followed suit. State legislatures, particularly in the North, were wary of the growing power of the insurance industry and soon enacted new statutes to regulate the industry; some of these included anti-discrimination provisions. Prudential decided to resist the new laws by asserting a 'natural' biological bases for their discrimination. Leslie Ware, the vice president of Prudential declared 'We are quite sure that mortality, even amongst the best of colored lives, would not compare favorably with the mortality amongst whites' (cite omitted)."

Mapping Race, p. 28

Kahn also explains the method of transforming a human rights based policy into a market based policy:

Much of the criticism of the report targeted its focus on structural issues, arguing for concentrating more on individual behavior and responsibility. The move from 'disparities' to 'difference' aimed to shift the frame of reference from social and political to individual and biological bases for the disparities chronicled by the report. This was accomplished, in part, through, a blurring of the dual senses of the individual-social and biological-implicated by health disparities. Specifically, in terms of the initial frame of causation, the concept of 'difference' (exemplified by Satel's geneticization of racial difference with respect to BiDiI) locates the source of disparities in racialized, individual biology. Second, in terms of the frame for responsibility in addressing the problem of disparities, the critics' focus on such issues as individual behavior and access to medical care (or drugs) locates responsibility in racialized, individual social conduct. The first frame constructs a pathology of racialized bodies and has roots going back to Hoffman's Race Traits and Tendencies of the American Negro.' The second

frame constructs a pathology of racialized social behavior that has similarly deep roots but is more directly traceable to the Moynihan Report on 'The Negro Family' that suggested that many poor Black families were caught in a 'tangle of pathology' that essentially caused their social and economic problems. *Mapping Race*, p. 36



Binaries: It's about Power

- Subordinate term w/ less power
- Can't just try to equalize power
- Separate but equal narrow, binary norms won't work



To create more equitable power relationships for women and girls we need to create more equitable – less harmful – less binary gender norms!



The blurring of the biological and the social in order to pathologize entire minority groups relates more broadly to recent, conservative approaches to health disparities that address individual behavior and 'empowers' individuals by giving them increased access to 'products' (including health care and drugs) in the medical 'marketplace.' Thus, for example, in 2005, then Republican Senate Majority

Leader (and medical doctor) Bill Frist prominently called for approaches to disparities that 'promote dignity and personal responsibility' (cite omitted) While acknowledging historical and social forces that shape disparities, Frist nonetheless argues for a primary focus on programs that 'will help decrease individuals' risky behavior.' (cite omitted) he went on to say that 'the major causes of death among African Americans, for instance, are heart disease, cancer, stroke, accidents, and diabetes. Most of these are chronic diseases rather than acute illnesses, and all of these causes of death are at least arguably preventable' (cite omitted).

By prevention, Frist means action by individuals who take personal responsibility for their poor health outcomes. In this formulation, Frist acknowledged social determinants of health but then omitted them from his actual framing of the problem that located responsibility primarily in the pathologies of individuals' risky behavior.' Having individualized the problem of disparities, Frist then called for fostering 'competition' and 'empowering patients' by adopting market and consumer-oriented reforms in place of government policies to address disparities (cite omitted) Each of these remedies is firmly grounded in market-based approaches that promote individual 'choice' and 'access.' In this model, health care is cast as a consumer good, not a civil right; and health itself becomes a matter of privatized risk-management. *Mapping Race*, p. 36-37

Unfortunately Jerry Brown has embraced this approach with abandon, including adopting Frist's *New Way to Talk About Social Determinants of Health*. Joining Jerry Brown are Bay Area Business Council members Dr. Robert Ross, California Endowment CEO and Member of Board for Covered California, Tom Epstein, VP Public Affairs, Blue Shield of California, and Lloyd Dean, Dignity Health CEO, formally known as Catholic Hospital West.

Making Elected Officials Explicitly State Their Principles So We Can Act

Jay S. Kaufman states in *Ethical Dilemmas in Statistical Practice: The Problem of Race in Biomedicine*, Chapter 4, 53-66, *Mapping 'Race' Critical Approaches to Health Disparities Research 2013*.

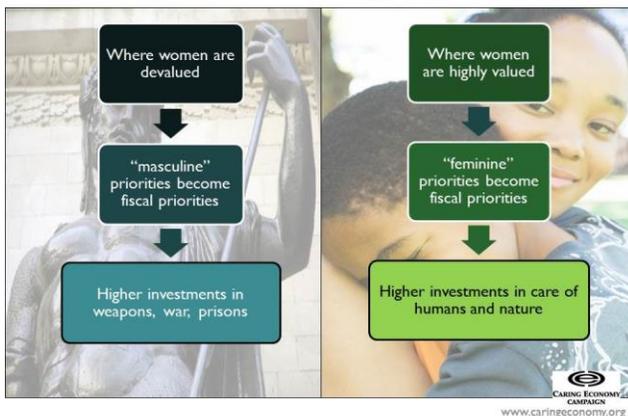
“How offended we ought to be over a given disparity is not often gauged according to any established criteria, but clearly rests on some notions of fairness and responsibility. ... If obesity is a lifestyle choice, for example, then the health problems of the corpulent are shrugged off as little more than the wages of gluttony. When seen as victims of a changing nutritional and physical environment over which they have little control, however, the same disparities in illness and death take on the hue of a moral emergency (cites omitted).” P 57

“It is with a savvy eye for these gut reactions, therefore, that political conservatives often argue against being overly concerned by racial/ethnic health disparities. It is not discrimination that explains the premature morbidity and mortality of African Americans, argue neoconservative apologists like Sally Satel, because discrimination would be an injustice. Rather, African Americans simply have innate physiologic defects that make them more likely to become sick and die young (cite omitted). Similarly, faced with overwhelming documentation of differential access to medical treatment by race, Satel argues that it is simply the case that African Americans choose to live in area of the country with inferior medical care. (cite omitted). “ P. 58.

“While the necessity of substantive knowledge is clear from both practical and philosophical positions, judgments made on the basis of such knowledge invoke beliefs, prejudices, and irrationalities from the social world that work their way inevitable and insidiously into our science. ... when people are the units of observation, the implications of simple decisions, such as who is collapsed into the cell of a table, or what is the choice of the null in a heterogeneity test, will inevitably lead to winners and losers that reflect political power, stereotypes, or other social facts. Statistics is a human endeavor, is therefore intrinsically linked to our social

conventions and institutions, both reflecting and reinforcing them (cite omitted).” P. 63.

Fiscal priorities follow gendered values



Transformative gender approaches breakdown gender and all other social dominance status hierarchies.

The necessity of having everyone involved in Health in All Policies, especially those working on health disparities is made clear in [Health Disparities and Health Equity: The Issue Is Justice](#). Equally clear, as you will see, is how the political will of dominant group members matter more than social justice.

Further Exploring the Role of Propaganda in Turning the Purpose of HiAP on its Head

The moment that social dominance oriented health insurers, providers and other interested corporations understood universal health insurance could include a human rights based healthcare

model that included health equity and anti-discrimination components – the RWJF Commission was formed to accelerate the process of altering the meaning and implementation of HiAP.

After reading the RWJF materials related to “A New Way to Talk About Social Determinants of Health,” as well as, other materials created based on this campaign, it is clear that maintaining social dominance system is its main purpose. The project for RWJF was to develop a marketing campaign designed to convince liberals and progressives to adopt and implement policies that maintain the current social dominance system.

The key for all propaganda is to appropriate the language of the principles, policies and programs targeted for co-optation. The use of algorithms to aid marketing firms in differentiating population likes and dislikes, coupled with multi-layered in person focus groups designed to linguistically map the meanings associated with words and phrases is being used to sell the adoption of co-opted principles, policies, and programs to liberal and progressive organizations.

The RWJF alterations to HiAP social determinants of health contain two main components: the first removes women from health equity and anti-discrimination definitions. The removal of women across and within other status populations, such as race, socio-economic and geographic status populations is coupled with a social dominance definition of male and female gender roles.

The second component is the locust of responsibility for the consequences of all social determinants of health, which moves from focusing on root causes or social determinants of health, such as white racial oppression and with it the causal effects of legal, social, political and economic privileges to social dominance/market based approach, which focuses on the failure of the oppressed to adjust and/or manage the risks associated with being disadvantaged.

The method for altering uniformly accepted world-wide definitions of social determinants of health was to create and then widely disseminate the “New Way” through health foundations funded by health product corporations, health insurance corporations and health provider corporations. As Anthony Iton from the California Endowment recently stated at an IOM function in Irvine California, “Money loves money.” Once widely disseminated these same funders aggressively are implementing the “New Way” policies through massive funding initiatives while simultaneously defunding reproductive justice and other gender equity transforming initiatives.

Critical analysis is eliminated and with it root causes. A complete explanation of gaps in health requires identifying what’s been called the “cause of causes.” It requires searching for broader contextual explanations that lie further upstream in the causal chain. It is the difference between individually-based risk factors and the effects of basic social conditions. In other words, risk factors must be contextualized, asking what puts people at risk of risks to be human rights based and place responsibility and obligations at the step of the cause agent.

The RFJF “New Way” propaganda uses the legitimizing myth of an individualism based on a decontextualized autonomous individual for the purpose of disconnecting the social dominance oriented behavior causing root social conditions from their effects otherwise known as social disparities in health. By maintaining the lens solely on proximate causes of individualized health condition disparities the focus of policies and programs remains on individual behavior modification of those at

Who gets to decide who is “truly in need”?
The Bay Area Business Council?
Dignity Health?

risk, rather than those causing the risk. The goal for these policies and programs is therefore to aid the “at-risk” individual in making “better” choices in adapting and/or managing the risks associated with race, poverty, etc. For example:

Social Determinants of Health: When people consistently engage in unhealthy behaviors they greatly increase the chance that they will develop chronic diseases early in life. ... Californians, therefore, must become much more engaged in improving their own health and taking personal responsibility for bringing down their own lifetime healthcare costs so that resources are preserved for those truly in need. [*Addressing California’s Healthcare Affordability Crisis, A Bay Area Council Economic Institute Report*](#), Oct 2011, p. 31-35.

Because the shift in focus prevents the search, the discussion, the knowledge of the root causes of social determinants of health individuals within a community are deterred if not prevented from mobilizing for real systemic change. What this type of language also does is shift the discussion to healthcare cost containment and cost shifting to those determined to not be “truly in need”.

California has been and remains a targeted state for the RWJF propaganda campaign since 2009-2010 because California’s Department of Public Health created in 2006 had already adopted a social dominance approach to public health.²⁰

Coupled with the aid of the [Bay Area Business Council](#) the Brown administration has continued to lead the way in implementing the “New Way Agenda.” Part of the implementation plan has been the strategic partnerships with health insurance and provider corporations, including Dignity Health, formally Catholic Hospital West. The inclusion of the Bay Area Business Council member corporations also meant the inclusion of the Brookings Institute, a social dominance oriented public policy institute that has been concentrating on gender role and gender norming enforcement as the answer to poverty.

Along with the Brown administration the California Endowment and subsequently by every other California-based/focused funder has shifted focus on race without gender, unless it’s male and in addition with an explicitly patriarchal gender roles component. The newly formed Legislative [Committee on the Status of Boys and Men of Color](#) has also focused on [policies](#) that lack a transformative gender role component, or have an explicit patriarchal gender role component. These programs also fail to focus on root causes of disparities in health. That is – real social determinants of health.

By exposing the roots of the agenda below and the dangers to everyone from the adoption of that agenda by the Brown administration, it is hoped that progressive organizations, can join together to eliminate this anti-human rights agenda from California government at all levels and from philanthropy.

Choosing Gender Norming As the Cure for Poverty

Instead of offering a living wage, middle-class jobs with defined benefit pension plans, single payer healthcare, reproductive, environmental, economic and social justice for all as solutions to health disparities, the Robert Wood Johnson Foundation, the California Endowment, and many others in government and the private sector are merely providing incentives and training for males to be heads of households, while women are targeted with disincentives to remain single. Social dominance oriented marriage, which maintains male dominant gender role is touted as the path out of poverty for women and children.



Gender Norms Are Structural

Schools, Agencies, & CBOs create, regulate, reinforce their own gender regimes...

- Approach young women as victims, helpless, vulnerable
- Reward males for boisterousness (and punish girls)
- Assume all young women want babies, families
- Tolerate gendered harassment or teasing of females
- Have men in top positions, use women as care-takers
- Segregate males/female needlessly....

Population Council

29

Right after the historic 1963 March on Washington Daniel Patrick Moynihan wrote the “The Negro Family: The Case for National Action” within which he asserted that female-headed households created a matriarchal society that undermined the role of black men. Because of diminished authority within the family, black men would abdicate their responsibilities as husbands, fathers, and providers, and the pattern would repeat from one generation to the next.

Christopher Jencks wrote at the time, “Moynihan’s analysis is in the conservative tradition that guided the drafting of the poverty program (in whose formation he (Moynihan) participated during the winter of 1963-64). The guiding assumption is that social pathology is caused less by basic defects in social systems than by defects in particular individuals and groups which prevent their adjusting to the system. The prescription is therefore to change the deviants, not the system.” Stephen Steinberg *Turning Back: The Retreat from Racial Justice in American Thought and Policy*, pg. 108.

In 2013, in The [Moynihan Report Revisted](#), produced by the conservative Urban Institute²¹, states,

*The Moynihan report argued that the black family, ‘battered and harassed by discrimination, ... is the fundamental source of the weakness of the Negro community.’ More specifically, Moynihan viewed the large disparity between the shares of black and white children born into and raised in single-parent households and the disparity in black and white marriage rates as the key factors impeding black economic progress and social equality. **Over the past five decades, the statistics that so alarmed Moynihan in the 1960s have only grown worse, not only for blacks, but for whites and Hispanics as well.** ... That the decline in traditional families occurred across racial and ethnic groups indicate the factors driving the decline do not lie solely within the black community but in the large social and economic context. Nevertheless, the consequences of these trends in family structure may be felt disproportionately among blacks as black children are far more likely to be born into and raised in father-absent families than are white children.” Pg . 3-4*

The male breadwinner role, for example, has long been viewed as essential for sustaining a successful marriage. Couples with traditional views of marriage and gender roles will be more likely to form stable unions than couples with nontraditional views, and religious institutions are believed to reinforce such views.

This treatise on male dominance goes on to point out what social dominance oriented individuals feel is another alarming trend:

*“Figure 9 also shows that black women are more likely to complete college than black men, and that gender differences hold true for whites. **That represents a significant shift over the past and has implications for trends in employment and earnings by gender. The improving labor market status for women relative to men likely influences individuals’ decisions about family structure and fertility.** (emphasis added) At p. 11*

It seems that the only gender-based analysis that exists is the harm caused to men and children from the move toward women and girls’ equality and empowerment.

What is also striking about the Brookings Institute’s work regarding marriage and family is the explicit nature of their social dominance intent. Marriage as currently constituted where women perform household, child, elder and spouse

care for free and in addition to any “paid” work benefits men and the society they control; therefore, women should happily take on these unpaid tasks for the sake and welfare of the community. With community defined as men.

Over the past five decades, the statistics that so alarmed Moynihan in the 1960s have only grown worse, not only for blacks, but for whites and Hispanics as well. ...

That represents a significant shift over the past and has implications for trends in employment and earnings by gender. The improving labor market status for women relative to men likely influences individuals’ decisions about family structure and fertility.

Found in the Brookings institute materials are the findings that newly immigrant Mexican Americans marry at a higher percentage than African Americans and Whites. The materials go on to state that due to marriage and other family support poverty does not impact Mexican households as much as others, especially African Americans where the “culture” of single mothers is prevalent. For Brookings alleviating poverty through access to early education, higher wages, quality healthcare, and elimination of other adverse social conditions, such as environmental degradation are not on the table.

What is on the table is the use of government and private social institutions to limit resources available to women so that marriage is the only option available for economic security. The creation of unequal power dependency relationship is appropriate because according to Brookings the government has the right to act in preventing mal-adaptive cultural traits like single motherhood and therefore

has the additional right to coerce women to reject female autonomy.

*Sociological theory emphasizes the importance of social norms and values in shaping family behavior. **The male breadwinner role, for example, has long been viewed as essential for sustaining a successful marriage. Couples with traditional views of marriage and gender roles will be more likely to form stable unions than couples with nontraditional views, and religious institutions are believed to reinforce such views.** Demographers, by contrast, emphasize the importance of age, race and ethnicity, sex ratios, and prior family characteristics in shaping future relationships. And, finally, psychological theory sees relationship skills and the characteristics associated with such skills—for example, mental health and the ability to manage conflict—as important determinants of relationship quality and union stability.* [The Future of Children: Fragile Families](#) Pg 24

An example of the use of social coercion to enforce social norms as a significant part of “market” based or “New Way” is found in the Brown Administration’s plan championed by Bob Ross. Instead of working to give boys and girls the tools to escape societally imposed gender boxes and form their own self-identity, the Brown Administration and Bob Ross have chosen to double down on patriarchal masculinity and the massive social control that goes along with it. Below is the Brown Administration’s social dominance oriented [community health model](#). The California Endowment didn’t just seek partnership with Dignity Health, in creating implementation plans [The Community Centered Health Homes: Bridging The Gap Between Health Services And Community Prevention](#), February 2011, includes Catholic Health Initiatives, a Catholic healthcare conglomerate spanning across states east of the Mississippi.²²

TABLE 1. THRIVE community health factors

PLACE



1. What's Sold & How It's Promoted is characterized by the availability and promotion of safe, healthy, affordable, culturally appropriate products and services (e.g. food, books and school supplies, sports equipment, arts and crafts supplies, and other recreational items) and the limited promotion and availability, or lack, of potentially harmful products and services (e.g. tobacco, firearms, alcohol, and other drugs).



2. Look, Feel & Safety is characterized by a well-maintained, appealing, clean, and culturally relevant visual and auditory environment; and actual and perceived safety.



3. Parks & Open Space is characterized by safe, clean, accessible parks; parks that appeal to interests and activities of all age groups; green space; outdoor space that is accessible to the community; natural/open space that is preserved through the planning process.



4. Getting Around is characterized by availability of safe, reliable, accessible, and affordable methods for moving people around. This includes public transit, walking, and biking.



5. Housing is characterized by the availability of safe and affordable housing to enable citizens from a wide range of economic levels and age groups to live within its boundaries.



6. Air, Water & Soil is characterized by safe and non-toxic water, soil, indoor and outdoor air, and building materials. Community design should help conserve resources, minimize waste, and promote a healthy environment.



7. Arts & Culture is characterized by a variety of opportunities within the community for cultural and creative expression and participation through the arts.

EQUITABLE OPPORTUNITY



8. Racial Justice is policies and organizational practices in the community that foster equitable opportunities and services for all. It is evident in positive relations between people of different races and ethnic backgrounds.



9. Jobs & Local Ownership is characterized by local ownership of assets, including homes and businesses, access to investment opportunities, job availability, and the ability to make a living wage.



10. Education is characterized by high quality and available education and literacy development for all ages.

PEOPLE



11. Social Networks & Trust is characterized by strong social ties among all people in the community – regardless of their role. These relationships are ideally built upon mutual obligations, opportunities to exchange information, and the ability to enforce standards and administer sanctions.



12. Participation and Willingness to Act for the Common Good is characterized by local leadership, involvement in community or social organizations, participation in the political process, and a willingness to intervene on behalf of the common good of the community.



13. Norms/ Costumbres are characterized by community standards of behavior that suggest and define what the community sees as acceptable and unacceptable behavior.

Place does not include what and/or how products are produced – i.e. salt, sugar, fat manipulation

Women & children being safe in their homes & on the street should be measured

Transportation needs should both take into account current gendered transportation patterns & seek to remove gendered & other status barriers

Human Rights are not on the agenda, especially the human rights of women and girls of color

This is the most disturbing category, where community is defined as a coercive force of social control including, but not limited to gender norms & gender roles

The People section explicitly states that a healthy community is one that has the ability to enforce standards and administer sanctions against people who fail to meet community standards of behavior. There is no mention, let alone acknowledgement of individual human rights to self-determination and equal protection.



Gender Norms Are Highly Regulated

What are you called when you cross gender lines?

Male

Female

Punk

Tomboy

Queer

Dyke

Nelly

Butch

Sissy

Queer

Fag

Ostracism → Shame → intimidation → Economic
Discrimination → Violence

In addition to the enormous problems associated with social sanctions connected to gender norming and/or gender conforming for both heterosexual and LGBTQ men and women; social sanctions and community norms are also class specific where middle and low socio-economic groups are targeted while the affluent and corporate decision-makers are exempt from sanctions.

What is equally disturbing about Community Centered Health Homes is the exponential growth of Catholic and

other religiously based healthcare systems. I use the word systems because these entities intend to control healthcare across the entire life of human beings. The current prospect of Catholic and other anti-woman religiously based healthcare systems growing at an exponential rate is dangerous enough for women and girls; their dominance in public health places women and girls in grave danger of losing recognition of their human rights.

Real World Consequence of the Brown Administration's Adoption of the NEW WAY: Throwing Black Women Under the Bus

The material attached to the NEW WAY is disturbing enough, but nothing illustrates the power behind the forces adopting the New Way like the transformation of Paula Braveman's work at the University of San Francisco's Center on Social Disparities in Health since the UCSF became a contract partner within the new Office of Health Equity (OHE).

Hyperlinked below is Paula Braveman's 2007 power-point presentation entitled, "The unsolved mystery of racial disparities in infant health: Do we know enough to act?"

Braveman answered yes to this question in 2007, specifically pointing out the pseudo-science mentioned above and explicitly calls for action on social determinants of health that impact pregnant women, especially African-American women.

In contrast to the 2007 power-point presentation, is Braveman's 2013 presentation to the California Department of Public Health's Office of Health Equity Advisory Committee, where the causes of African-American pre-term and low birth weight health disparities are labeled unknown.



Born too early, too small

- Infant mortality
- Serious disability
 - Cognitive
 - Emotional-behavioral
 - Physical
- Family burden
- Economic costs
 - Medical care
 - Special ed.
 - Social services
 - Productivity lost



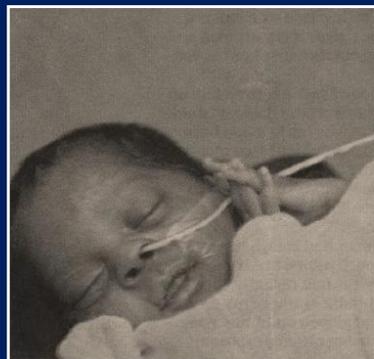
(NY Times 2/27/07. Photo : Dilip Vishwanat. Article: Nicholas Bakalar)



CENTER ON SOCIAL DISPARITIES IN HEALTH
University of California, San Francisco

What if the causes are not known?

- **African-American newborns are 2 or more times as likely as White newborns to be**
 - born too small (low birth weight)
 - born too early (premature)
 - And these predict infant mortality, childhood disability, and adult chronic disease
- **The causes are not known**
- **Can we call this unfair?**



Social determinants of health, such as violence, racism and the physiological damage caused by stress is not mentioned or addressed in this slide presentation. The substantive change in the 2013 presentation is at the heart of the real purpose behind the use of the NEW WAY– to do nothing to reduce health inequities.

Paula Braveman has demonstrated innumerable times over the course of her career that she believes in human rights based principles:

[2003 Defining equity in health](#): *“For the purposes of measurement and operationalization, equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage. Equity is an ethical principle; it also is consonant with and closely related to human rights principles. The proposed definition of equity supports operationalization of the right to the highest attainable standard of health as indicated by the health status of the most socially advantaged group. Assessing health equity requires comparing health and its social determinants between more and less advantaged social groups. These comparisons are essential to assess whether national and international policies are leading toward or away from greater social justice in health.”*

[Health disparities and health equity: concepts and measurement 2006](#): *“There is little consensus about the meaning of the terms "health disparities," "health inequalities," or "health equity." The definitions can have important practical consequences, determining the measurements that are monitored by governments and international agencies and the activities that will be supported by resources earmarked to address health disparities/inequalities or health equity. This paper aims to clarify the concepts of health disparities/inequalities (used interchangeably here) and health equity, focusing on the implications of different definitions for measurement and hence for accountability. Health disparities/inequalities do not refer to all differences in health. A health disparity/inequality is a particular type of difference in health (or in the most important influences on health that could potentially be shaped by policies); it is a difference in which disadvantaged social groups—such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination—systematically experience worse health or greater health risks than more advantaged social groups. ("Social advantage" refers to one's relative position in a social hierarchy determined by wealth, power, and/or prestige.) Health disparities/inequalities include differences between the most advantaged group in a given category—e.g., the wealthiest, the most powerful racial/ethnic group—and all others, not only between the best- and worst-off groups. Pursuing health equity means pursuing the elimination of such health disparities/inequalities.”*

2009 [“it’s The Skin You’re In”](#): [African-American Women Talk About Their Experiences of Racism](#). An Exploratory Study to Develop Measures of Racism for Birth Outcome Studies

Blumenshine P, Egerter S, Barclay CJ, Cubbin C, Braveman PA. [Socioeconomic disparities in adverse birth outcomes: A systematic review](#). Am J Prev Med 2010 Sept; 39(3):263-72

[2010 Social conditions, health equity, and human rights](#): *“The fields of health equity and human rights have different languages, perspectives, and tools for action, yet they share several foundational concepts. This paper explores connections between human rights and health equity, focusing particularly on the implications of current knowledge of how social conditions may influence health and health inequalities, the metric by which health equity is assessed. The role of social conditions in health is explicitly addressed by both 1) the concept that health equity requires equity in social conditions, as well as in other modifiable determinants, of health; and 2) the right to a standard of living adequate for health. The indivisibility and interdependence of all human rights--civil and political as well as economic and social--together with the right to education, implicitly but unambiguously support the need to address the social (including political) determinants of health, thus contributing to the conceptual basis for health equity. The right to the highest attainable standard of health strengthens the concept and guides the measurement of health equity by implying that the reference group for equity comparisons should be one that has optimal conditions for health. The human rights principles of non-discrimination and equality also strengthen the conceptual foundation for health equity by identifying groups among whom inequalities in health status and health determinants (including social conditions) reflect a lack of health equity; and by construing discrimination to include not only intentional bias, but also actions with unintentionally discriminatory effects. In turn, health equity can make substantial contributions to human rights 1) insofar as research on health inequalities provides increasing understanding and empiric evidence of the importance of social conditions as determinants of health; and, more concretely, 2) by indicating how to operationalize the concept of the right to health for the purposes of measurement and accountability, which have been elusive. Human rights laws and principles and health equity concepts and technical approaches can be powerful tools for mutual strengthening, not only by contributing toward building awareness and consensus around shared values, but also by guiding analysis and strengthening measurement of both human rights and health equity.”*

[What is Health Equity: And How Does a Life-Course Approach Take Us Further Toward It?](#)

“Although the terms "health equity" and "health disparities" have become increasingly familiar to health professionals in the United States over the past two decades, they are rarely defined. Federal agencies have often defined "health disparities" in ways that encompass all health differences between any groups. Lack of clarity about the concepts of health disparities and health equity can have serious consequences for how resources are allocated, by removing social justice as an explicit consideration from policy agendas. This paper aims to make explicit what these concepts mean and to discuss what a life-course perspective can contribute to efforts to achieve health equity and eliminate health disparities. Equity means justice. Health equity is the principle or goal that motivates efforts to eliminate disparities in health between groups of people who are economically or socially worse-off and their better-off counterparts--such as different racial/ethnic or socioeconomic groups or groups defined by disability status, sexual orientation, or gender identity--by making special efforts to improve the health of those who are economically or socially disadvantaged. Health disparities are the metric by which we measure progress toward health

equity. The basis for these definitions in ethical and human rights principles is discussed, along with the relevance of a life-course perspective for moving toward greater health equity.”

Specifically, Braveman states in *What is Health Equity: And How Does a Life-Course Approach Take Us Further Toward It?*,

Many of us who try to understand and address health disparities have been drawn to consider a life-course approach as we confront gaps in the knowledge gained from research focused on exposures occurring relatively close in time to health outcomes. As noted earlier, the persistent two-to threefold disparity in low birth weight and preterm birth between Black and White newborns, for example, is not explained by the known risk factors for adverse birth outcomes, which are typically measured around the time of pregnancy or not long before. (cite omitted) The roles of economic and social factors – such as stressful experiences resulting from low income and/or racial discrimination- in racial disparities in birth outcomes have not been conclusively established. A number of studies have, however, revealed a larger racial disparity in birth outcomes among college-educated or high-income women than among poor women, and relatively good birth outcomes of Black immigrants from the Caribbean or Africa. (cite omitted) This and other evidence strongly suggest that economic and social factors are involved.

[2013 PowerPoint](#)



What are “health disparities/inequalities”?

- Differences, variations: descriptive terms
- Most official U.S. definitions refer only to differences between unspecified groups
- But we really mean: Health differences that are unfair (in a particular way)
- M. Whitehead: unfair, avoidable, and unjust
- But ideas of fairness, avoidability, and justice vary

Ideas of fairness, avoidability, and justice vary? Really?

What happen?

Jerry Brown, Bob Ross and Lloyd Dean adopting “The New Way to Talk About Social Determinants of Health is What Happened.

Lastly, Braveman in [Health Disparities and Health Equity: The issue Is Justice](#) stated, “Previous official approaches to defining health disparities in the United States have avoided being explicit about values and principles, perhaps for fear of stirring political opposition, because of genuine differences in values or because of the prevailing ethos that enjoins researchers to avoid the realm of values that might compromise the integrity of their science. Scientists, like all others should be guided by ethical and human rights values. The first decade of the 21st century has ended with little if any evidence of

progress toward eliminating health disparities by race or socio-economic status. It is time to be explicit that the heart of a commitment to addressing health disparities is a commitment to achieving a more just society.” Unfortunately for the people of California that commitment has not occurred.

In [Overcoming Obstacles to Health in 2013 and Beyond](#), the RWJF Commission to Build a Healthier American continues to ignore sex/gender based oppression and places sex as a category that cannot be modified.

Many factors influence health. Age clearly matters; most people can expect to be less healthy at age 80 than they were at age 20. Sex matters, too—for example, men don’t experience medical complications related to childbirth and rarely have breast cancer. Genes also can matter; some occur more often among people with ancestors from certain parts of the world. But individuals have no control over their age or over the sex and genetic make-up with which they were born, despite increasing recognition of how our physical and social environments shape the expression (or suppression) of our genes to affect health. At pg 30

Token Spending On Gender & Reproductive Justice Masks Decision to Double Down on the Gendered Matrix of Domination

Nowhere in any of the materials are institutional discrimination mentioned, how it impacts health and how to eliminate it. Nowhere in any of the materials are the principles, concepts and analysis of Mapping “Race” found, even though the book was produced as part of Robert Woods Johnson

Foundation Center for Health Policy at the University of New Mexico.



Project H/Project M

- Engage young men as well
- Address power imbalances
- Address internal & external gender norms
- Address healthy, pleasurable sex, feelings and relationships
- Encourages participants to:
 - Think critically about gender codes
 - Change external social norms.

Gender and Health is missing despite having journal publication of Gender and Health: Relational, Intersectional, and Biosocial approaches in June 2012 Social Science & Medicine and despite [Dr. Justina Trott’s](#) work in New Mexico to provide comprehensive and integrative health care and research for women.²³

In addition to the above referenced devaluing of women, especially women of color is that both the RWJF and the California Endowment²⁴ is the enormous

spending disparity between market based policies, including the use of patriarchal masculinity for men and boys of color programs and justice or human rights based policies, including women’s health and gender norms funding. The spending disparity is so substantial that the miniscule amount of money spent on women’s health, especially women of color can only be labeled a token.

The choice between a human rights based public health perspective and the NEW WAY is as clear as it is stark in the outcomes that the choice produces. Principles matter. Whether the decision makers

believe all human beings are born free, equal in dignity and rights or whether those decision makers believe that some human beings are more equal than others matters.

It matters whether that principle is stated and it most certainly matters whether that principle is adhered to throughout the public policy process. The elimination of the NEW WAY is warranted by just the one effect shown above, but there are many more policies currently happening and even more that loom on the horizon.

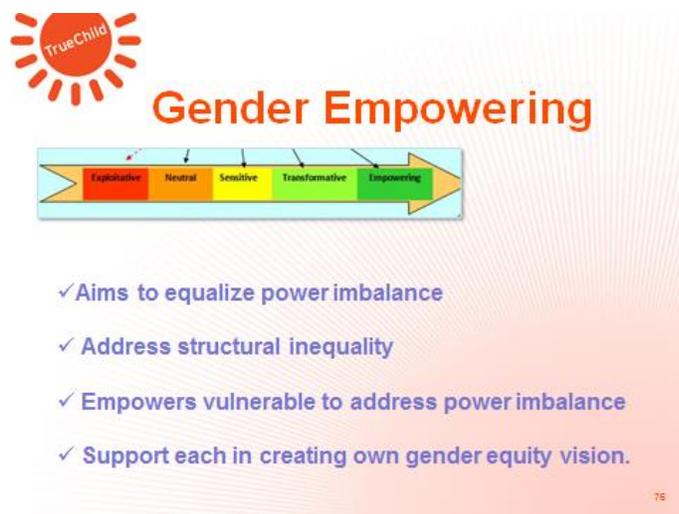
The rejection of human rights based Health in All Policies and the adoption of individually based choice/responsibility reinforces legitimizing myths that will maintain health disparities while allowing social control through behavior modification schemes, cost shifting and discipline based on lack of compliance and/or unsuccessful modification.

In order to cut through the propaganda designed to trigger an uncritical positive response, we must concentrate on root causes. The use of critical analysis exposes the matrix of domination and further provides the means for the dismantling of that matrix - the linchpin that holds the system together. That is why this white paper concentrates on the linchpin that holds the system together – gender roles.

Respecting, Acknowledging, and Following the Advice of Black Female Feminist Scholars

The choice to adopt the “New Way” continues an inexcusable lack of acknowledgement and consultation with African American, Latina, Asian-Pacific Islander, and Indigenous women scholars by Bob Ross, other philanthropic leaders, as well as, state and local government leaders. Dorothy Roberts, Kimberlé Crenshaw, Patricia Collins, Cheryl Harris, [bell hooks](#), [Melissa Harris-Perry](#), Angela Davis and many others²⁵ should not just be acknowledged, but regularly consulted by anyone who asserts they are

attempting to address health disparities especially in the black community.



The diagram features a sun icon with 'TrueChild' written inside. Below it, the title 'Gender Empowering' is written in large orange letters. Underneath the title is a horizontal arrow pointing to the right, divided into five colored segments: red ('Explicative'), orange ('Neutral'), yellow ('Sensitive'), green ('Transformative'), and dark green ('Empowering'). Below the arrow, there are four bullet points in blue text, each preceded by a checkmark. The background of the diagram is a light pinkish-orange gradient.

- ✓ Aims to equalize power imbalance
- ✓ Address structural inequality
- ✓ Empowers vulnerable to address power imbalance
- ✓ Support each in creating own gender equity vision.

Without such consultation all too often as is the case with the California Endowment adoption of social dominance oriented policies, especially patriarchal masculinity occurs to the direct detriment of men and boys of color, especially Black men and boys. Instead what is needed from philanthropic leaders is gender transformative philanthropy -- starting with a vision of feminist masculinity.

“What is and was needed is a vision of masculinity where self-esteem and self-love of one’s unique being forms the basis of identity. Cultures of domination attack self-esteem, replacing it with a notion that we derive our sense of being from dominion over another. Patriarchal masculinity teaches men that their sense of self and identity, their reason for being, resides in their capacity to dominate others. To change this males must critique and challenge male domination of the planet, of less powerful men, of

women and children. But they must also have a clear vision of what feminist masculinity looks like²⁶. How can you become what you cannot imagine? And that vision has yet to be made fully clear by feminist thinkers male or female.

As is often the case in revolutionary movements for social justice we are better at naming the problem than we are at envisioning the solution. We do know that patriarchal masculinity encourages men to be pathologically narcissistic, infantile, and psychologically dependent on the privileges (however relative) that they receive simply for having been born male. Many men feel that their lives are being threatened if these privileges are taken away, as they have structured no meaningful core identity. That is why the men's movement positively attempted to teach men how to reconnect with their feelings, to reclaim the lost boy within and nurture his soul, his spiritual growth.

No significant body of feminist literature has appeared that addresses boys, that lets them know how they can construct an identity that is not rooted in sexism. Anti-sexist men have done little education for critical consciousness which includes a focus on boyhood, especially the development of adolescent males. As a consequence of this gap, now that discussions about the raising of boys are receiving national attention, feminist perspectives are rarely if ever part of the discussion. Tragically, we are witnessing a resurgence of harmful misogynist assumptions that mothers cannot raise healthy sons, that boys 'benefit' from patriarchal militaristic notions of masculinity which emphasize discipline and obedience to authority. Boys need healthy self-esteem. They need love. And a wise and loving feminist politics can provide the only foundation to save the lives of male children. Patriarchy will not heal them. If that were so they would all be well. ...

A feminist vision which embraces feminist masculinity, which loves boys and men and demands on their behalf every right that we desire for girls and women, can renew the American male. Feminist thinking teaches us all, especially, how to love justice and freedom in ways that foster and affirm life. Clearly we need new strategies, new theories, guides that will show us how to create a world where feminist masculinity thrives." bell hooks, *Feminism is for Everybody: Passionate Politics*, 2000, p. 70-71.

In 2004, bell hooks also wrote *The Will to Change: Men, Masculinity, and Love* and in *We Real Cool: Black Men and Masculinity* bell hooks stated:

Young black males, like all boys in patriarchal culture, learn early that manhood is synonymous with the domination and control over others, that simply by being male they are in a position of authority that gives them the right to assert their will over others, to use coercion and/or violence to gain and maintain power. Black boys who do not want to be dominant are subjected to forms of psychological terrorism as a means of forcing them to embody patriarchal thinking. Shaming and rituals of disregard, of constant humiliation, are the tactics deployed to break the boys spirit. ...



Gender Justice

- ✓ Aims for full realization of human rights for all genders and gender expressions
- ✓ Intersectional – honors many masc & fem nuanced by history, culture, social class
- ✓ Works on diff levels to change structures & systems of oppression (legal, social, etc.).



Even though the welfare of boys began to receive more attention in this nation as boys particularly murder, the violent acting out of white boys tends to be viewed as a psychological disorder that can be corrected, while black boys who act out tend to be viewed as criminals and punished accordingly. Conservatives responses from diverse black communities began to talk about

black males as an endangered species. By choosing an animal analogy they embraced racist/sexist iconography that had historically depicted the black male as a beast. Then they focused attention on the need to ‘civilize’ unruly black boys through strict discipline at home and in schools, thus revealing the extent to which they internalized racist/sexist thinking about black masculinity, and paid no meaningful attention to the psychological well-being of black boys. If a black boy obeys authority, is quiet, and does his homework, he tends to be viewed as psychologically whole simply because he is not a problem. We Real Cool p. 82-83.

In addition to the above works, there are numerous works regarding masculinity and gender roles that should equally be respected, acknowledged and followed including but not limited to [white ribbon](#) campaign.²⁷

The Need for a Racialized-Gendered Social Determinants of Health Framework

Nancy López, in *Contextualizing Lived Race-Gender*, demonstrates an intersectional gender analysis:

“First, I argue that in order to understand the historic and ongoing health disparities among racially stigmatized groups, we must anchor our analysis in an examination of what I term ‘lived-race-gender’ and the ‘racialized-gendered social determinants of health.’ The racialized-gendered social determinants of health is a framework that interrogates intersecting systems of stratification at multiple levels. Including the micro/individual level or what I call lived race-gender, the meso/institutional level, for example neighborhoods, schools or other local social contexts, and the macro/structural level of society, including state and federal policies and political economic structures at the national and global levels.” Mapping ‘Race’ p. 181-182

The literature on the social determinants of health is anchored in unpacking how the vast majority of disease and illness is due to social forces or fundamental causes in society in the form of social policies and political decisions that create conditions of poverty and inequality. (cite omitted) ‘The challenge is to understand how position in the social hierarchy is related to health.’ (cite omitted) The ‘social determinants of health’ paradigm stands in stark contrast to the popular biomedical model that presumes that individual-level genetic or biological differences are the fundamental cause of health disparities by race. The biomedical model has been the cornerstone of the medical training that medical doctors are exposed to; however, the social determinants of health paradigm is beginning to gain traction.” Id. p. 183.

...the racialized-gendered determinants of health framework simply acknowledges that there are social forces that result from intersecting racialized and gendered social hierarchies at the individual/micro level, the institutional/community/meso level and the societal/structural level that have implications for health outcomes and disparities. ... Given that everyone is

simultaneously racialized and gendered in a given society, whether these racialized and gendered inequalities translate into cumulative unearned social advantages or cumulative disadvantages in either a particular social setting or over the life course requires empirical scrutiny and meticulous contextualization of pathways of embodiment.” Id. p. 187.

The added stresses faced by women of color, and Black women in particular, may be part of the puzzle of why even middle-class Black women give birth to children with lower birth weights than their White counterparts, as pregnancy is a site of racialization. (cites omitted) As discussed by Geronimus (this volume), the studies of the birth outcomes of Arab-named women in California after 9/11 were far more negative than before the terrorist attacks to the United States and the increased surveillance. (cite omitted) What is so compelling about this finding is that the genetic or biological makeup of these women did not change, but the social forces surrounding their lived race-gender experiences took a turn for the worse as they were subjected to new race-gender microaggressions (cites omitted). Id 189

Regardless of what level of race data one is collecting, one should aim for transparency by specifying how one is linking individual level to institutional level and structural levels of inequality. (cites omitted) One should also aim to engage the simultaneity and connections between ‘race’, gender and class inequality. Id 191

Part of this data collection requires that researchers, scholars, and policy makers engage in self-reflexivity by embodying themselves and consistently asking themselves how their own lived race-gender and social class locations as well as their academic training shapes their understandings of inequality. This transparency about positionality as well data collection and analysis can provide the missing link for dismantling racial discrimination across institutions and in turn contribute to ending health disparities. Id 195

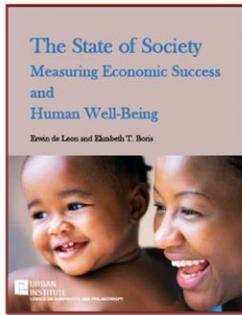
To take seriously that ‘race’ is a multilevel social construction would mean that health disparities researchers would examine structural racism and systemic racism, and map racialized power and privilege dynamics and hierarchies as manufactured through formal and informal practices in all our social institutions (cites omitted). Rather than accept biodeterministic models that assume that human disease and experience are a function of innate genetic or biological phenomenon, we need to map the constellation of contexts, whether situations, environments, and social structures that overlap and produce inequality. Id 299-200

Structural and systemic racism, including acceptance of biodeterministic models that assume that human disease are innately genetic or biological cannot be exposed and then eliminated without the transparency that a racialized-gendered approach to social determinants of health affords.

Without “Racialized-Gendered Approach To Social Determinants Of Health Women And Girls Are In Danger Of Losing Recognition Of Their Human Right To Control Their Body And To Be Free And Equal.

The acceptance of the “New Way” especially regarding California’s implementation of the Affordable Care Act is a not so stealth war on women. Since Catholic Hospital West, now Dignity Health’s CEO Lloyd

What kinds of measures?



The State of Society report is available at www.caringeconomy.org

New economic measures **must:**

1. Include the economic value of caring and caregiving work
2. Pay attention to marginalized populations
3. Recognize that the status of women predicts the nation’s quality of life and economic success



Dean is a member of the Bay Area Business Council, Governor Brown’s Strategic Growth Council and therefore the Health in All Policies and Let’s Get Healthy California Task Forces it is not surprising that gender equity and women and girls empowerment are not pursued in this state. Making gender equity and women and girls empowerment even more unlikely is Dignity Health’s partners, Blue Cross and Blue Shield, health insurers that have a business model that seeks to exclude women or charge women more for the same policy as men. Blue Cross and Blue Shield is

the national health plans that exclude abortion.

Health Insurers and health providers haven’t missed a beat with the election of Jerry Brown.

Measuring Real Wealth and Human Well Being is What California should be measuring.

Comfortably in control of every facet of health and economic policy we have witnessed a Department of Public Health that is deaf, dumb, and blind to women’s health and to their human

rights. Jerry Brown’s California Department of Public Health, including the Office of Health Equity does not listen to the community stakeholders who presented human rights based gender inclusive HiAP Strategic plans for mental health²⁸. Further, unlike other states such as Oregon²⁹, Brown’s Public Health Agenda does not include maternal health. In addition, Brown’s Public Health Department fails to meet with outside women’s health/rights groups choosing only to meet with the [Public Health Institute’s Center for Research on Women and Families](#).

Since [PHI is a strategic contractor](#) for the Department of Public Health, such contact does not qualify as meetings with stakeholders. Unsurprisingly, those contacts have secured only the retention of PHI’s Women’s Health Survey; however, this study is woefully inadequate in quantity and quality of data on women’s health to even remotely satisfy the legal mandate to include women across, between and among status populations.

Demonstrating the anti-gender equity bias currently present the CDPH explicitly states that the data collected from the Women’s Health Survey will only be used to compare women to women, not women to men. What this means, for example, is the disparity between women and men regarding outcomes for heart attacks will not be measured or studied for root causes of the disparity. The legal mandate doesn’t state that Jerry Brown gets to decide which status populations are important and which status populations are not important enough to collect data and then move to eliminate disparities. Most

notably advocates for infant and maternal health are not strategic stakeholders despite the known need.³⁰

Social Dominance Oriented Market-Based Principles Merge With Catholic Directives: Dignity Health's Expansion Trumps Individual Human Rights

Right now in California and other states Lloyd Dean, Dignity Health's CEO is executing an ambitious expansion plan for the Catholic Healthcare provider that seeks to compete with Kaiser. That means a 40% share of the healthcare market. In this state, Dignity Health and every other healthcare provider is not required to disclose the services they do not provide. All that is required is that health insurers include a notice in their policy coverage information.

The state of California does not track maternal mortality as a key indicator, nor does the state require adequate data collection regarding safety, quality and access to reproductive healthcare, or palliative and other end of life care.

Further erosion of gender equity and anti-discrimination protections has been caused by the granting of expansive access to Healthcare Corporations and Foundations to decision making positions in state government, including but not limited to seats on councils and taskforces related to strategic planning for health and overall economic development, such as the new GoBiz, the Strategic Growth Council, the Health in All Policies and Let's Get Healthy California Taskforces. Fair and equitable representation by bargaining units is also undermined when labor organizations submit to Catholic Directives and/or Statement of Common Values.

Catholic Directive driven ACOs are partnering with Blue Cross and Blue Shield, major health insurers is more than a little troubling. Blue Cross, the leading health insurance carrier switching to an Accountable Care System model has teamed up with Dignity Health in California, which has led to retired state employees through CalPERS being denied access to reproductive and end of life care.³¹ The impact of this recent partnership cannot be understated.

As stated, because the Accountable Care model depends on health performance measures, whether the chosen performance measures are comprehensive enough to adequately ensure equity and non-discrimination is of paramount import in creating a constitutionally defensible ACO system. That is why one of the substantial adverse effects of increased market share and therefore power in Sacramento is the effort by providers to exclude sex/gender from performance measures, which can be used to both determine payment, used by consumers to judge quality, and equally important used to determine health equity.

The Accountable Care System's efficacy depends, however, on whether the chosen performance measures are comprehensive enough to adequately ensure equity and non-discrimination if your goal is improving the health of everyone.

It is evident from the work and documents produced by these councils and taskforces that the elimination of sex/gender from health data, including health disparities data collection and disparity elimination mandates, eliminating sex/gender as a social determinant of health within HiAP

implementation, as well as elimination of sex/gender in economic strategic planning is a prime objective.

Failing to Adequately Assess and Protect Access to Full Reproductive Healthcare

Women and men's ability to actualize their rights and freedom of choice in accessing family planning services and make and have their end of life decisions respected from and by any medical provider is dependent upon not only whether they are told of this right when entering a medical facility that refuses to provide such care, but whether they have sufficient alternative providers made available to them.

The Office of Statewide Health Planning and Development (OSHPD) should be charged with ensuring sufficient supply of healthcare providers to meet the need, including but not limited to full reproductive healthcare and end of life care. It is unclear whether the OSHPD understands that religiously based corporations, especially healthcare and long term care providers do not have a right under the law to expand market-share at the expense of women and men's health and rights.

In addition to access, the state has a duty to ensure quality of care. Healthcare providers no matter their affiliation do not have a right to provide inferior substandard service and most certainly they do not have the right to be exempt from quality assessment and/or to falsely advertise to health consumers regarding the scope of services and the quality of services provided. It is equally unclear whether Department of Public Health, including but not limited to OSHPD understand their concomitant duties regarding healthcare quality.

The California Hospital Association and the Association of Health Insurers fought to defeat AB 411, which expands HEDIS/EAS performance measures to include race, ethnicity, sex/gender³², sexual orientation, and sexual identity. Prior to this bill, Dignity Health, along with other Healthcare corporations pulled out of the California Hospital Assessment and Reporting Taskforce³³. Governor [Brown vetoed AB 411](#), stating "nothing in current law prevents the Department of Health Care Services from requiring its external quality review organization to provide more detailed data by geography, race, ethnicity, or other demographic attribute. If the department sees a need or benefit that justifies the costs of procuring this additional data, I am confident that they will procure it." Governor Brown believes he alone should have the power to decide whether and which status groups deserve health equity.

Let's be clear. At the same time that Blue Cross is partnering with Dignity Health to create and expand Catholic Directive Driven ACOs they and others in the industry are actively lobbying at the state and federal level to limit data collection as to both quality and access.

In 2011-2012 budget trailer bill, eliminated the Office of Women's Health while creating the Office of Health Equity. As enacted, the Department of Public Health is mandated to eliminate health disparities. Of particular note is that original bill failed to include sex/gender, in other words, the mandate to eliminate health disparities failed to include women and girls. Since inclusion of women within the mandate to eliminate health disparities, neither budget allocation nor effort has been made to implement this mandate.

With the implementation of the Patient Protection and Affordable Care Act (PPACA) the conscious acts to exclude sex/gender, when PPACA itself mandates disaggregated data collection that includes sex/gender is both indefensible and illegal.

What magnifies the importance of performance measures and data reporting is its use in conjunction with health consumer information websites. Although the state mandates that health plans, including Medi-Cal inform covered persons the extent of excluded services and the names of the health providers in their network that limit services, Dignity Health and other religiously affiliated healthcare providers remain free to omit these limitations on their websites and other materials.³⁴ The failure of this state to mandate truth in advertising for healthcare facilities and the failure to provide [reproductive health performance data](#), including maternal act to lure women into sub-standard healthcare facilities that devalue their lives.

The substantial harm caused to women from the intentional exclusion of performance measures related to maternity and other reproductive healthcare; as well as, excluding sex/gender within other healthcare performance measures such as diabetes or cardiovascular disease is unconscionable, especially in the age of electronic medical records. Such intentional exclusion of data constitutes a violation of women's fundamental rights to equal protection under the law.

Consistently refusing to collect and report sex/gender data, including but not limited to creating forms, data collection systems and ultimately performance measures from that data, which fail to disaggregate by sex becomes discriminatory acts in themselves.

The failure to ensure adequate competition between healthcare providers exacerbates cost and supply issues rather than alleviate them. For example, there is a known shortage of abortion providers in California, as evidenced by the Rand³⁵ study. This study formed the basis of the clinical trial and current legislation (AB154), which expands nurse practitioner's scope of practice to include first trimester abortions, so that more providers are capable of meeting the expected demand.

The unfettered expansion of Catholic Directives driven ACOs frustrates meeting the access and quality healthcare needs of California's women and girls by severely limiting the ability of physicians and nurse practitioners to enter the market. The entry costs for physicians and nurse practitioners to meet demand for segregated health services is already cost prohibitive and forcing additional entry costs of being "outside" of ACO networks is impracticable. The barriers to entry for new independent outside network reproductive health and end of life care providers is cost prohibitive and is antithetical to a patient centered care model facilitated by an ACO.

In the recent St. John's merger documents Dignity Health's Horizon 2020 expansion strategic plan is outlined, including an organizational model that allows control over physicians and other medical personnel. Dignity Health details an example of this strategy that was deployed in the Sacramento area in California where CalPERS "partnered" with Blue Cross, Dignity Health and Hills Physicians group that "covered" 41,000 "lives" otherwise known as human beings.

Without notice or thought to the individual human rights of its members CalPERS' board members eliminated access to self-determined end of life and reproductive health care for CalPERS members. Although under Medicare rules CMS dictates that notice must be provided to medicare recipients prior

to acceptance of hospice care by the individual, notice without the ability to choose out of network providers at that moment makes notice meaningless. It should also be noted that not even this inadequate notice is mandated for reproductive health care services.

Further the State of California continues to allow misleading, if not false advertising by Catholic directive driven health care providers. For example there are billboards and T.V. ads that state Dignity Health doctors listen. The full sentence should be Dignity Health Doctors Listen to the Catholic Bishops in deciding what healthcare you will receive. In Sacramento T.V. ads for Hills Physicians urges viewers to demand Hill doctors in their insurance plan, but fail to tell those very same viewers that Hill physicians are Catholic Bishop controlled physicians.

Equally disturbing in the St. John's merger documents is the "Indication of Interest in Saint John's Health Center" letter showing that the UCLA Health System is in an "alliance" with Ascension Health and Daughters of Charity Health System, who together submitted a joint response to the "Confidential Information Memorandum in connection with Saint John's Health Center." This document states that

This partnership will include St. Vincent Medical Center, St. Francis Medical Center, and UCLA's community based ambulatory care centers under a structure that will integrate management, operations and clinical activities. This partnership is designed to promote community health, improve clinical care, and advance the long-term financial stability of our collective health missions. Given the critically important role of Saint John's and its physicians in providing care, we would be very excited to have Saint John's become part of this arrangement. As an integral component of a collective provider network, we would collectively advance and expand the role of Saint John's in providing important healthcare services in our community. In addition, through Ascension Health's involvement, Saint John's would remain a Catholic Hospital. *SJHC-SCLHS's Application for AG Consent re Affiliation with Providence – Notebook 1 of 4, p. 276.*

In addition to the above disturbing insights into Dignity Health, UCLA Health System and Ascension Health System is the apparent competition from Providence Health System, which is fully controlled by the Catholic Bishop Directives rather than Dignity Health's "Statement of Common Values."

In Southern California it appears that there are two Catholic Directive Driven Healthcare systems vying to dominate the market with Kaiser being the only secular alternative now that UCLA appears to be making "arrangements" with Catholic healthcare. What is also apparent is the move to merge in anticipation of building expansive healthcare systems that serve middle class, as well as lower socio-economic individuals.

The first merger to show this pattern was the recent Orange County, California Hoag Hospital/Saint Joseph's Hospital affiliation agreement in 2012/2013 where almost immediately so-called "direct" abortion were banned at Hoag Hospital.

California NOW and our allies have been working with the California Attorney General to modernize the hospital merger statutes and regulations, which among other things will address the massive health care systems that implementation of the Affordable Care Act are encouraging. During the last hospital merger expansion in the late 90s Sheila Kuehl introduced legislation to protect our fundamental rights to reproductive healthcare – [AB 525](#) Kuehl 2000.

Taking Action: Stating Our Principles Including Choosing Human Rights Based HiAP

California NOW intends to introduce legislation in the upcoming session to finish and improve upon AB 525, including but not limited to adding end of life care protections, accounting for the dangerous consequences of Catholic Directives and other religiously driven Accountable Care Organizations and/or Community Centered Health Homes, and ensuring adequate data collection and oversight.

The 2013-14 California legislative session includes the following issues of great concern to women and girls:

- Whether reproductive health clinics will be included in the definition of Qualified Health Clinics;
- Whether women/men will have the ability to go outside their insurance network for reproductive and other services not provided by their plan;
- Whether full scope pregnancy benefits will be available; and,
- Whether sex/gender and other status groups will be included in Health Quality Data Collection.

Right now the Brown Administration is against all of the above. That's why California NOW will be sponsoring legislation establishing health as a human right in California and specifically mandating that all healthcare providers inform potential patients regarding the services they do not provide; and further make it the obligation of the State to provide comprehensive reproductive and end of life care throughout the state.

No longer will maternal mortality be off the list of quality indicators. No longer will healthcare refusals be unexamined for patient safety. No longer will citizens be denied healthcare information because religiously operated health corporations formed a monopoly in geographic regions of this state.

And no more will we tolerate the Department of Public Health's adoption of the "New Way" so the state can do nothing to improve maternal and infant health outcomes, especially in the African American community.

The impact on reproductive health services, as well as, end of life directives cannot be competently assessed without verifiable data. Quality cannot be measured without data. Access cannot be measured without data. Cost to taxpayers cannot be assessed without data.

Currently the Office of Statewide Health Planning and Development neither lists quality indicators broken out by sex/gender nor are any of the twelve mortality indicators related to pregnancy. The OSHPD also fails to collect data regarding palliative care and end of life directives. There are no prevention related quality indicators for reproductive healthcare. The only data readily available on the website shows volume and utilization of cesarean and vaginal births. This despite recent evidence of substantial health issues related to the Catholic Bishops' Directives³⁶.

A brief look at the data forms reporting quality and access information fail to contain any useful data in assessing impacts, disparities, safety, quality or access regarding any health service related and/or impacted by religious directives. Such information gaps include end of life care.

The realities of the impacts of end of life directives were wholly ignored. Not only are the rights of patients to make decisions about their care substantially interfered with if not completely negated and ignored, but the costs of prolonging life becomes a profit center for religiously affiliated institutions with those profits coming from the taxpayer and insured.

The refusal to use human rights based principles extends to economic policy, where women and the work we do are not on the agenda.

Taking Action Part II: Healthcare Is Not the Only Economic Sector On The Social Dominance Menu

Governor Brown has not only handed off California's healthcare sector to health insurers and providers, but the rest of California's economy. California Forward's CEO shows who's in charge of California's economy:

Meanwhile, the [2013 California Economic Summit](#) which will be held next month in Los Angeles, claiming to bring Californians representing sixteen regions from across the state gather to consider how to improve the state's ability to create more middle-class jobs and compete more effectively in the global economy.

"To restore the California dream we need quality jobs," said Jim Mayer, CEO of California Forward, which partners with the California Stewardship Network on the California Economic Summit project. "We value the participation of GO-Biz and the many other state agencies participating in the 2013 Summit. We look forward to a lasting relationship that enables state officials to be informed of regional priorities to create jobs, restore upward mobility, and advance environmental sustainability."³⁷

Speaker John Perez, as an afterthought tried to put in place principles and limits on the powers that GO BIZ has to manipulate California's economy, but once again, Governor [Brown vetoed AB 53](#), stating that deciding what economic sectors are important to Californians should solely be in his hands, which means in the hands of predatory multinational corporations.

In the end there is a decision to make- we either believe all human beings are free, equal in dignity and rights entitled to equal protection of the law or we don't. There is no middle ground regarding this principle.

The need for human rights based approach to Health in All Policies, including data collection, analysis and oversight, which includes gender across, between and within other status populations, is critical. Given the current assault on recognition of our human rights to health, healthcare and education those areas will be given priority attention through the described legislative agenda and the following additions:

- Introduce legislation to dedicate Oil Severance Tax to among other things, Early Childhood Development, Childcare and Health in All Policies data collection and analysis.
- Creation of a website and smart phone application that shows Catholic and other religiously based healthcare facilities and affiliated doctors and insurance partners, alternatives in a geographic radius and actions that can be taken individually and collectively to ensure comprehensive reproductive and end of life care is available to every Californian.
- Challenge the California Endowment and all other philanthropic organizations to both abandon the “New Way” and fully incorporate and fund gender transformative programs and policies, including but not limited to capacity building and HiAP.
- Create and offer training programs for government and non-government workers in human rights based intersectional gender equity program/policy creation and outcome analysis.

It will take a united effort to right the ship of state and move it toward a human rights based Health in All Policies. We hope you and your organization will join us in that effort.

¹ *Let me give you a word on the philosophy of reform. The whole history of the progress of human liberty shows that all concessions yet made to her august claims have been born of earnest struggle. The conflict has been exciting, agitating, all absorbing, and for the time being putting all other tumult to silence. It must do this or it does nothing. If there is no struggle there is no progress. Those who profess to favor freedom, and yet deprecate agitation, are men who want crops without plowing up the ground. They want rain without thunder and lightning. They want the ocean without the awful roar of its many waters. This struggle may be a moral one, or it may be a physical one; or it may be both moral and physical; but it must be a struggle. Power concedes nothing without a demand. It never did and it never will. Find out just what people will submit to, and you have found the exact amount of injustice and wrong which will be imposed upon them; and these will continue until they are resisted with either words or blows, or with both. The limits of tyrants are prescribed by the endurance of those whom they oppress.* Frederick Douglas

² Dominator model consists of ranking of one half of humanity over the other. See Riane Eisler, *The Chalice & the Blade* (1987) “The root of the problem lies in a social system in which the power of the Blade is idealized – in which both men and women are taught to equate true masculinity with violence and domination and to see men who do not conform to this ideal as too soft or effeminate.”

³ Partnership model consists of a principle of linking rather than ranking, difference, especially male and female difference is not equated with either inferiority or superiority. Id.

⁴ <http://siteresources.worldbank.org/INTWDR2012/Resources/7778105-1299699968583/7786210-1315936222006/Complete-Report.pdf>

⁵ PNAS, Paul K. Pitt, Daniel M. Stancato, et al, [Higher Social Class predicts increased unethical behavior](#), Jan. 26, 2012.

⁶ Those who ask, ‘What will a focus on college men mean for enduring efforts to ensure the fair, respectful, and equitable treatment of women,’ should be labeled gender realist, not skeptics. Although our focus in this chapter is on men, our greater plea is for the closing of gendered outcomes gaps in postsecondary education. We

simply want to make clear that men have gender too. Thus, the ongoing quest for gender equity should also be inclusive of them and responsive to their challenges. ... The one-sided mishandling of gender occurs in most social spaces, including college and university campuses. For instance, student activities, resources, and courses offered on 'gender' are almost always about rape and sexual assault, empowering and protecting the rights of women, and illuminating consciousness of women's experiences around the world. Though each is undeniably essential they are examples of how gender is misused as a substitute for women. For sure, we are not arguing for a reduction in or the elimination of women's courses and initiatives; in fact, we feel there should be more. But we are advocating a two-sided treatment of gender for two important reasons: (1) It needs to be more widely understood that men have gender too; and (2) because gender is relational, the status of women cannot be improved without a corresponding emphasis on tending to the social forces that misshape men's attitudes and behaviors and helping them develop productive masculinities." *College Men and Masculinities: Theory, Research, and Implications for Practice*, 2010, Shaun R. Harper and Frank Harris III, editors. p. 5.

⁷ Such a process requires intellectual humility, empathy, integrity, perseverance, courage, autonomy, confidence in reason, and other intellectual traits. Without those essential intellectual traits, what often results is clever, but manipulative and often unethical or subjective thought and analysis.

⁸ Talking about gender rating in health insurance: Blue Shield spokesman Tom Epstein said at the time, "Our egghead actuaries crunched the numbers based on all the data we have about healthcare" and found that women were more accident-prone than men and more likely to break bones or get sick. "It's all about the statistics," he said. <http://articles.latimes.com/2009/jan/28/business/fi-insure28>
Gender rating still allowed in Long Term Care Insurance (California NOW Comments on Long Term Care available upon request) Talking about defeating Assembly member Monning's bill (AB 189) that would have barred discrimination in wellness programs: <http://premieraccountsblog.com/2013/06/two-wins-for-wellness/>

⁹ Search the California Endowment Website on boys and men of color, especially [sandsandbrother](http://www.boysandmenofcolor.org/) there is no mention let alone links to masculinity and gender norming, see links:

<http://www.boysandmenofcolor.org/resources/> ; <http://allianceforbmoc.org/>;
<http://blackmaleachievement.org/AboutUs>

This failure is despite the California Endowments knowledge of the success of such programs, like those listed below: http://www.futureswithoutviolence.org/section/our_work/men_and_boys_coaching_leadership/ , <http://www.acalltomen.com/> , Bullying & Harassment <http://truechild.org/PageDisplay.asp?p1=6280>; see also, School Pushouts & Dropouts <http://truechild.org/PageDisplay.asp?p1=6285>; Health & Wellness for Black Girls <http://truechild.org/heinz>; Gender-Based Violence <http://truechild.org/PageDisplay.asp?p1=8720>; see also, http://www.popcouncil.org/publications/books/2010_ItsAllOne.asp , <http://http://www.promundo.org.br/en/online-store/publicacoes-loja-virtual/program-h-manual/> , <http://www.promundo.org.br/en/sem-categoria/program-m-materials/> , <http://www.engenderhealth.org/our-work/major-projects/gender-matters.php> , <http://www.mencanstoprape.org/Launch-the-Strength-Campaign/> , <http://www.scenariosusa.org/films/curricula/masculinity-curriculum/> , <http://www.mvpngnational.org/>

¹⁰ High Social Dominance orientation and high in-group identification equals more discriminatory acts against out-groups. Social dominance orientation: A personality variable predicting social and political attitudes. *Journal of Personality and Social Psychology* 67, no. 4: 741-763. Social Dominance Orientation is the desire that one's in-group dominate and be superior to out-groups. Pratto, Felicia, James Sidanius, Lisa M. Stallworth, and Bertram F. Malle. 1994.

¹¹ Also on the Commission was a representative of SEIU-UHW, a health union that has signed on to the [Catholic Bishops' Statement of Common Values](#) and has been active in subjecting health workers to discriminatory wellness outcome penalties.

¹² "Propaganda is the deliberate, systematic attempt to shape perceptions, manipulate cognitions, and direct behavior to achieve a response that furthers the desired intent of the propagandist." See, Garth Jowett and Victoria O'Donnell, *Propaganda and Persuasion*, 4th ed. Sage Publications, p. 7. See also, Richard Alan Nelson, *A Chronology and Glossary of Propaganda in the United States* (1996) pp. 232-233, "Propaganda is neutrally defined as a systematic form of purposeful persuasion that attempts to influence the emotions, attitudes, opinions, and actions of specified target audiences for ideological, political or commercial purposes through the

controlled transmission of one-sided messages (which may or may not be factual) via mass and direct media channels.

¹³ Social Dominance Orientation is the desire that one's in-group dominate and be superior to out-groups. Pratto, Felicia, James Sidanius, Lisa M. Stallworth, and Bertram F. Malle. 1994. Social dominance orientation: A personality variable predicting social and political attitudes. *Journal of Personality and Social Psychology* 67, no. 4: 741-763.

¹⁴ *College Men and Masculinities: Theory, Research, and Implications for Practice*, 2010, Shaun R. Harper and Frank Harris III, editors.

¹⁵ <http://www.msnbc.com/melissa-harris-perry/mhp-syllabus-november-10>
<http://www.msnbc.com/melissa-harris-perry/watch/dolphins-scandal-offers-fresh-look-at-hazing-62771267740>
<http://www.msnbc.com/melissa-harris-perry/watch/nerdland-looks-at-the-nfl-bullying-scandal-62733891856>
<http://www.msnbc.com/melissa-harris-perry/watch/does-football-change-our-idea-of-masculinity-62733891855>
<http://www.msnbc.com/melissa-harris-perry/watch/incognito-an-honorary-black-person-really-62732867925>
<http://www.msnbc.com/melissa-harris-perry/watch/nfl-hall-of-famer-dorsett-diagnosed-with-cte-62737475633>

¹⁶ All slide pictures, unless otherwise marked contained in this paper are from the <http://www.caringeconomy.org/> or TrueChild.org

¹⁷ John Stuart Mill stated aptly in *The Subjection of Women*, "their masters require something more of them than actual service. Men do not want solely the obedience of women, they want their sentiments. All men except the most brutish, desire to have, not a forced slave but a willing one, not a slave merely, but a favorite." John Stuart Mill, *Subjection of Women*, in *Essays on Sex Equality*, The feminist Papers: From Adams to de Beauvoir, 201-202 (Alice S. Rossi ed., 1970).

¹⁸ <http://news.stanford.edu/news/2013/september/toddler-language-gap-091213.html>; see also, <http://nieer.org/sites/nieer/files/yearbook2012.pdf>; see also, <http://www.nga.org/files/live/sites/NGA/files/pdf/2013/1310NGAEarlyLiteracyReportWeb.pdf>

¹⁹ California's public health community provided fertile ground for the 2009 RWJF New Way Agenda because the ground work for transforming a human rights based HiAP had already been taking place. In 2003, a document entitled [Health For All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities](#), developed by The California Campaign to Eliminate Racial and Ethnic Disparities in Health by transforming the human costs of discrimination and other social dominance oriented behavior into factors that influence the frequency and severity of injury and illness. RWJF's "New Way of Talking About Social Determinants of Health" was adopted by the California Endowment, as well as, PolicyLink and SEIU-UHW, both of which were board participants in the RWJF commission that created the "new way."

²⁰ California's public health community provided fertile ground for the 2009 RWJF New Way Agenda because the ground work for transforming a human rights based HiAP had already been taking place. In 2003, a document entitled [Health For All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities](#), developed by The California Campaign to Eliminate Racial and Ethnic Disparities in Health by transforming the human costs of discrimination and other social dominance oriented behavior into factors that influence the frequency and severity of injury and illness. RWJF's "New Way of Talking About Social Determinants of Health" was adopted by the California Endowment, as well as, PolicyLink and SEIU-UHW, both of which were board participants in the RWJF commission that created the "new way."

²¹ The Urban Institute, performs research and writes reports for the Robert Wood Johnson Foundation

²² Illustrating the comfortable relationship between the California Endowment and Bill Frist in [June 2013 George Flores](#), Co-Chair Program Manager for the California Endowment cites Bill Frist's Bipartisan Policy Center at a work shop on the ACA. The [Bipartisan Policy Center](#) advocates for photo identification to vote, diluting political party affiliation and organizing, in addition to social dominance/market based health policies.

²³ [RWJF Joins Major Initiative to Aid Boys and Men of Color](#)

[RWJF Fellow Wins Women's Health Leadership Award](#) University of New Mexico Health Policy Center Fellow honored for pioneering work in 'sex and gender medicine.' When people think of women's health, they tend to think of "bikini medicine"—health care for the parts of the body related to women's reproductive systems, says

Justina Trott, MD, FACP, a senior fellow at the [Robert Wood Johnson Foundation \(RWJF\) Center for Health Policy at the University of New Mexico](#).

Gender and Health

Relational, Intersectional, and Biosocial Approaches

June 2012 Publisher: [Elsevier B.V.](#) Publication: [Social Science & Medicine](#)

Author(s): [Springer KW](#), [Hankivsky O](#), and [Bates LM](#)

In the past, research on sex/gender and health has not incorporated a conceptualization including contemporary feminist, relational approaches to gender, nor has it prioritized research on intersectional and biosocial approaches. This special issue of *Social Science & Medicine* contains papers exploring these approaches, which emerged from a conference originating from the Gender and Health Working Group (2008-2010) of the *Robert Wood Johnson Foundation Health and Society Scholars Program* at Columbia University. The July 2010 conference featured papers that conference participants read and discussed for inclusion in the special issue.

The papers are divided into three foci:

- Gender as relational
 - Gender is made not born.
 - Gender is inescapably embedded in and constitutive of social structure.
 - Sex/gender differences research need not reify the binary.
- Intersectionality
 - Intersectionality does not marginalize gender, but conceptualizes gender as a fluid, intersecting form of inequality.
 - Intersectionality is producing methodological innovations.
 - Intersectionality is a challenge to status quo gender research and policy.
- Biosocial approaches
 - Excellent relational biosocial gender and health research is doable.
 - A biological difference does not mean a biological cause.
 - Biosocial approaches require taking biology, as well as the social environment, seriously.

Gender and health is a rapidly changing field. This article highlights the ways this collection of papers, engaging a variety of methodologies, expand the field of gender and health..

[TRI-CAUCUS CONVENES HEALTH DISPARITIES SUMMIT IN ALBUQUERQUE](#)

Rep. Lucille Roybal-Allard (D-CA) News Release

Sep 06, 2013 - Today, Congresswoman Lucille Roybal-Allard along with Members of the Congressional Tri-Caucus (Congressional Hispanic Caucus, Congressional Black Caucus, and Congressional Asian Pacific American Caucus) joined the University of New Mexico to convene a health disparities summit. The summit, "Practices and Policies that Promote Health Justice" focuses on racial and ethnic health disparities and the disproportionate burden of poor health and early death faced by minority populations throughout the United States. Attending the conference were over 400 policy experts, community members, tribal leaders, researchers, students, and advocates who gathered in Albuquerque to discuss the status of health equity in the United States.

"Health disparities are the product of historical injustices. Because of this, health disparities are morally wrong and unacceptable. No one's life expectancy should be determined by the color of their skin, or the zip code in which they are born or currently live," said Congresswoman Roybal-Allard.

In cooperation with members of the Tri-Caucus, the University of New Mexico organized the event and assembled six expert panels to discuss some of the most pressing issues in minority health including access to care, mental health, and health care for immigrant families. The two-day conference provides an opportunity for policymakers, health policy experts, scholars and advocates to coordinate action and develop policies for the elimination of health disparities at the local, state, and national level.

In his opening remarks, Dr. Gabriel R. Sanchez, the Interim Executive Director of the Robert Wood Johnson Center for Health Policy at the University of New Mexico said, "eliminating health disparities is one of the most pressing challenges for American society. Despite the many obstacles that lie ahead, the elimination of health disparities is something that can and must be done."

In addition to Congresswoman Roybal-Allard, other elected officials who are participating in the summit included Congresswoman Lujan Grisham (NM-1), Congresswoman Negrete McLeod (CA-35), Congresswoman Grace

Napolitano (CA-32), Congresswoman Eddie Bernice Johnson (TX-30), Congressman Ben Ray Lujan (NM-3), and Congressman Joaquin Castro (TX-20).

²⁴ The California Endowment did join in the creating of the [California Council on Gender, a project of Truechild.org](#) in 2011, which produced "[Challenging Restrictive Gender Norms: A Key to decreasing partner violence in at-risk communities](#)" and in 2013 the Movement Strategy Center received a substantial grant for the Brown Boi Project, which is using transformative gender and masculinity norms to improve self-esteem and overall social and emotional health of boys of color at a middle school in East Oakland. This funding is a significant improvement from the 2009 Rand Study [Reparable Harm: Assessing and Addressing Disparities Faced by Boys and Men of Color in California](#), which was produced for the California Endowment. This study relies on information from the Brookings Institute, which is examined extensively in the next section. It is clear from the exposure to gender equity principles that TrueChild and other grantees have introduced to the California Endowment is having a positive impact.

²⁵ <http://www.theroot.com/views/15-black-feminist-books-everyone-should-read>; Mapping "Race" Critical Approaches to Health Disparities Research, Edited by Laura E. Gómez and Nancy López, 2013 (Extensively quoted in this paper) is an excellent start in beginning to understand ethnicity, especially the diversity found within Latino/a and Asian-Pacific Islander communities.

²⁶ Here is a good example of what feminist masculinity looks like: <http://www.upworthy.com/7-cowardly-words-from-a-totally-sexist-stranger-sparked-this-courageous>; see also, men speak out: Views on Gender, Sex, and Power, Shira Tarrant, 2nd Ed, 2013;

²⁷ *College Men and Masculinities: Theory, Research, and Implications for Practice*, Shaun R. Harper (Editor), Frank Harris III (Editor) 2010; see also, <http://www.whiteribbon.ca/>, <http://www.mencanstoprape.org/The-Men-of-Strength-Club/>, <http://www.opensocietyfoundations.org/voices/redefining-masculinity-save-black-boys>; Harper, S. R., & Kuykendall, J. A. (2012). Institutional efforts to improve Black male student achievement: A standards-based approach. *Change*, 44(2), 23-29. ; [Masculinity, School Dropouts & Zero Tolerance Policies, TrueChild.org](#)

²⁸ [California Draft Wellness Plan](#) concentrates almost exclusively on patient personal behavior, rather than social determinants of health. See also, CDPH, California Reducing Disparities Project Reports: http://www.cdph.ca.gov/programs/Documents/African_Am_CRDP_Pop_Rept_FINAL2012.pdf; http://www.nativehealth.org/sites/dev.nh.edeloa.net/files/native_vision_report_compressed.pdf; http://www.eqcai.org/atf/cf/%7B8cca0e2f-faec-46c1-8727-cb02a7d1b3cc%7D/FIRST_DO_NO_HARM-LGBTQ_REPORT.PDF; http://www.ucdmc.ucdavis.edu/newsroom/pdf/latino_disparities.pdf; <http://crdp.pacificclinics.org/resources/crdp/document/crdp-api-population-report-our-own-words>

²⁹ <http://transformationcenter.org/wp-content/uploads/2013/10/1-prenatal-care-metric-explanation.pdf>; <http://transformationcenter.org/wp-content/uploads/2013/06/Prenatal-Care-Guidance-Document-October-2013.pdf>

³⁰ <http://www.cdph.ca.gov/programs/mcah/Documents/MO-MCAH-Bulletin-MQI-MaternalMorbidity-7-12-2012.pdf>; <http://www.cdph.ca.gov/programs/mcah/Documents/MCAH-OBHemorrhageToolkit.pdf>

³¹ [CalPERS saves \\$37 million as medical groups coordinate healthcare, September 05, 2012 Los Angeles Times](#)

³² Sex/gender was not included in the original legislation.

³³ The California Hospital Assessment and Reporting Taskforce (CHART) formed in 2004 to enable a standardized, statewide "report card" on hospitals. CHART has since adopted more than 70 performance measures to assess the quality of hospital care. More than 240 California hospitals, representing 85% of the state's acute

care admissions, have voluntarily participated by reporting performance data to CHART and agreeing to have that data displayed on CalHospitalCompare.org.

However, the reporting landscape has changed markedly since the launch of CHART. In late 2011, the California Hospital Association's board of trustees voted to withdraw the organization's support from CHART. They noted declining value to users, costs of data collection to hospitals, and the belief that the Centers for Medicare and Medicaid Services' Hospital Compare website obviated the need for a state-based reporting effort. In particular, CHA was disappointed that two key goals of CHART — consolidating the data requested of hospitals by commercial plans and financially rewarding strong performers — were never realized. Finally, the hope that consumers would opt to have elective procedures at higher-rated hospitals proved impractical due to insurance network restrictions on choice. <http://www.chcf.org/publications/2012/03/quality-reporting-crossroads#ixzz2ZstZEEJq>

³⁴ The Perinatal Diagnostic and Treatment Center (PDTC) helps women with high-risk or complicated pregnancies. The skilled staff including two affiliated perinatologists - physicians specializing in high-risk pregnancy - work together with your obstetrician to provide monitored care for the health of both you and your unborn baby. The PDTC also works in conjunction with CHOC Children's at Mission Hospital Neonatologists. Since 1995, we have delivered over 500 healthy newborns to high-risk mothers. <http://www.mission4health.com/Our-Services/Mission-Maternity-Center/Perinatal-Diagnostic-and-Treatment-Center.aspx>

³⁵ Rand Study [Nurse Practitioners and Sexual and Reproductive Health Services](#)

³⁶ [Below the Radar: Religious Refusals to Treat Pregnancy Complications Put Women in Danger](#), National Women's Law Center; see also, [Do religious restrictions influence ectopic pregnancy management? A national qualitative study.](#)

³⁷ See caeconomy.org

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