Beyond Reproductive & Maternal Health: Reframing Gender and Women's Health in Health Systems & Policy Setting

Developed in Women, Gender & Health 207:
Advanced Topics in Women, Gender and Health
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Intended Course:
This teaching example is designed to integrate seamlessly into the syllabus for MPH105: Public Health Policy & Politics (or similar public health courses on health policy), requiring no change to course grading or infrastructure. It is ideally placed in Session 1 or 2 of the course to establish a gender-based analytical lens early in the course, though it can also integrate into Session 6 on "Health Outcomes for Marginalized Populations". Session 6 currently examines interventions for marginalized populations through the lens of maternal and child health. This teaching example expands that examination toward a concrete, gendered analysis, showing students how health policy agendas are shaped by whose health needs are deemed visible, urgent, and worth addressing.

Rationale & Background for Instructor:
Public health curricula, clinical training and health policy frameworks have historically collapsed "women's health" into reproductive and maternal health. While reproductive and maternal health are undeniably important, this conflation has had measurable consequences: it has shaped research funding, clinical guidelines, and policy agendas in ways that systematically exclude or deprioritize non-reproductive women's health conditions, including cardiovascular disease (CVD), chronic pain syndromes, autoimmune disorders, and mental health. Two well-documented examples, cardiovascular disease presentation and endometriosis diagnostic delay, illustrate these issues in detail and are described in the Supplemental Materials alongside two in-class vignettes. These are not merely clinical failures; they are policy failures. The question of what is deemed "policy relevant" in health is itself a political and gendered process. Kingdon's (2011) Multiple Streams Model helps explain why: problem streams are shaped by whose suffering is rendered visible, and political streams are shaped by who has the agency and power to advocate for themselves. Women's non-reproductive health conditions have historically failed to enter the policy window.

Biological sex and social gender are distinct but interacting variables throughout the teaching example. Biological sex influences risk profiles and physiological pathways, while social gender shapes how symptoms are reported, interpreted, and invested in by researchers and policymakers. Both dimensions must be considered, consistent with Krieger's (2003) foundational framework on genders, sexes, and health, assigned as pre-reading. The in-class vignettes center cisgender women (assigned sex at birth: female, gender identity: woman), as a documented starting point, but this framing is intentionally a floor, not a ceiling. The dedicated

discussion questions in the Supplemental Materials expand the analysis to transgender men (assigned sex at birth: female, gender identity: man) and non-binary individuals (assigned sex at birth: female, gender identity: nonbinary), who share the same anatomy but face additional compounding barriers rooted in cissexism (i.e., privileging of cisgender over transgender and non-binary identities and experiences) including exclusion from research and clinical guidelines, provider bias, and delays in diagnosis and care. We invite instructors to name this expansion explicitly.

Learning Objectives for Students:

Upon completing this teaching example, students will be able to:

1. Apply Kingdon's Multiple Streams Model to analyze why historically under-researched women's health conditions have struggled to reach policy agendas, aligning with Competency #12: Discuss the policy-making process, including the role of ethics and evidence.
2. Distinguish between the roles of biological sex and social gender in shaping health outcomes and health system responses aligning with Competency #15: Evaluate policies for their impact on public health and health equity.
3. Construct a policy brief argument that applies an intersectional gender-based analysis to recommend more equitable health research or care policies aligning with Competency #9: Design a population-based policy, program, project, or intervention.

Together, these competencies support students in developing policy analysis skills that integrate evidence, gender-based analysis, and health equity perspectives into public health decision-making.

Teaching Methods:

Format: Pre-class assigned readings, in-class slide overview + small group discussion, and an optional take-home policy brief.

Estimated in-class time: ~30 minutes

1. **Pre-class preparation** (assigned the week prior)
   Students complete required pre-readings by Krieger (2003) and Warren et al. (2025), along with three recommended readings on CVD and endometriosis (see Supplemental Materials). These readings provide the conceptual vocabulary (sex vs. gender; biosocial framework, intersectionality) that underpins the in-class discussion.
2. **Mini-lecture framing** (5 minutes)
   The instructor delivers a brief slide-based framing (deck provided in the Supplemental Materials) covering:
   - The historical exclusion of women from clinical research and its downstream policy consequences
   - Two concrete examples: cardiovascular disease presentation and endometriosis diagnosis delays
   - The distinction between biological sex and social gender as distinct analytical categories
   - A prompt connecting to the Kingdon Model: "How does a health concern get onto the policy agenda, and whose concerns get left out?". The framing should name explicitly

that the vignettes focus on cisgender women as a starting point and that the discussion will expand to transgender and non-binary experiences.

3. **Small group discussion** (15 minutes)
   Students divide into at least two breakout groups, each receiving one clinical vignette (Supplemental Materials). Groups work through structured discussion questions to identify where biological sex and social gender enter the causal story, what research gaps contributed to the patient's experience, how social factors compound the patterns shown, and what a more equitable policy might look like.
4. **Full class debrief** (10 minutes)
   Groups share key observations. The instructor connects student insights to Kingdon's (2011) agenda-setting model to question whose suffering is made visible in policy, and whose is suppressed, and to Krieger's (2003) core argument: whether sex, gender, both, or neither matter for a given outcome is an empirical question, and the vignettes show what happens when that question goes unasked. The debrief also encourages connecting the cisgender-centered cases to the compounding barriers faced by transgender and non-binary individuals.
5. **Take-home policy brief assignment** (Optional)
   Students who choose Policy Option #5 for their policy memo assignment may use this teaching example as a launching point. A structured policy brief prompt, grading rubric, and instructor notes are provided in the Supplemental Materials.

References

1. Kingdon, J. W. (2011). *Agendas, alternatives, and public policies* (2nd ed.). Pearson. https://questanbridge.com/wp-content/uploads/2024/11/Agendas-Alternatives-and-Public-Policies.pdf
2. Krieger, N. (2003). Genders, sexes, and health: What are the connections — and why does it matter? *International Journal of Epidemiology,* 32(4), 652–657. https://doi.org/10.1093/ije/dyg156