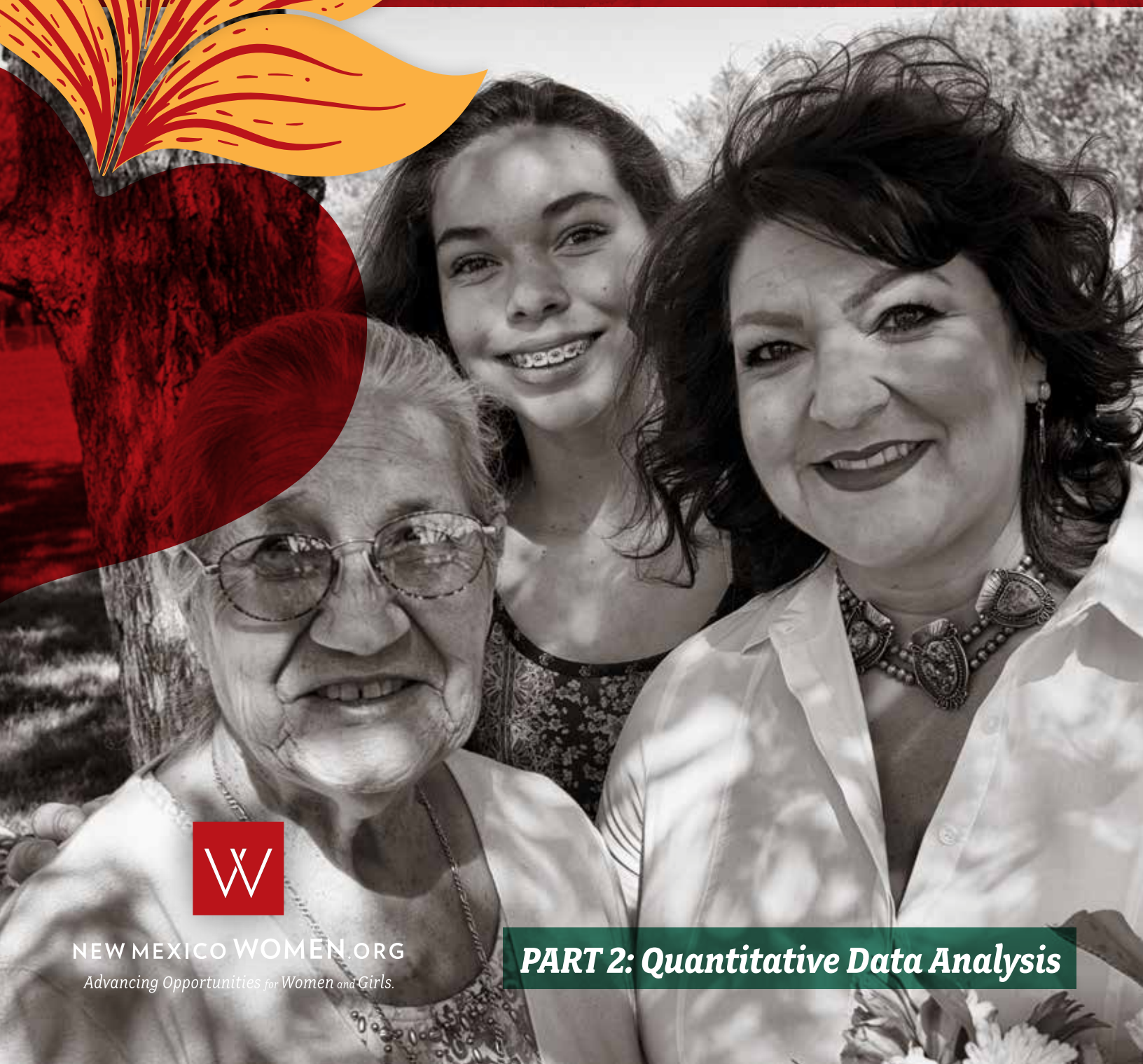
THE HEART OF GENDER JUSTICE IN NEW MEXICO:

Intersectionality, Economic Security, and Health Equity



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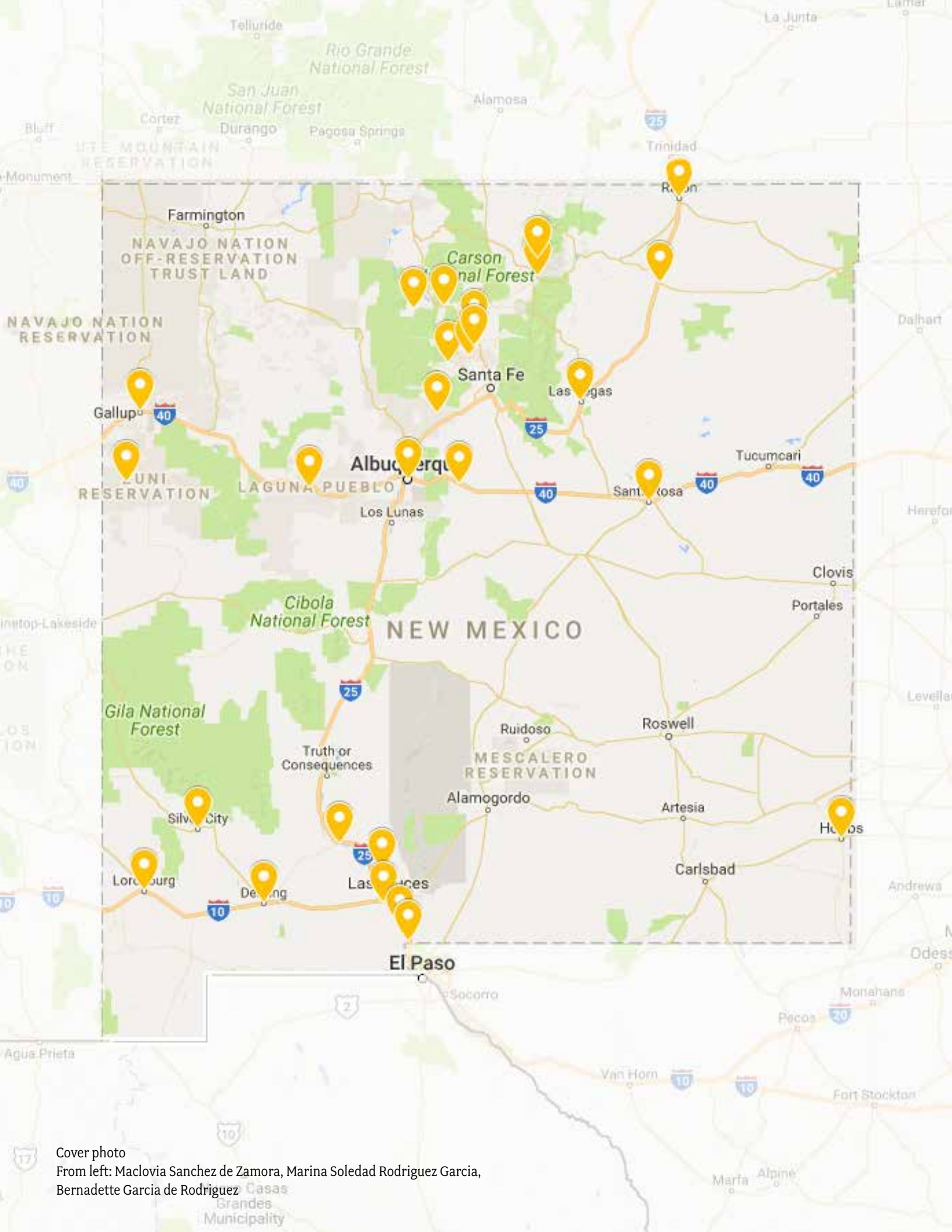
PART 2: Quantitative Data Analysis



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THE HEART OF GENDER JUSTICE IN NEW MEXICO:

Intersectionality, Economic Security, and Health Equity

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This report can be accessed online at: http://www.newmexicowomen.org/resources/.

For more information on the quantitative study and policy options, contact Lisa Cacari Stone at:
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Dedicated to the the women and girls of New Mexico whose resiliency, creativity, and beauty are a source of inspiration.

"I imagine a New Mexico where women take up more space — where women are professors, farmers, doctors, storytellers, policy makers, artists, leaders and where we get paid equally for our work. I dream of a New Mexico where girls and women don't just have choices, but where we are the architects of our own opportunities. Women hold the blueprints for structures yet unimagined, and we are the future of New Mexico." —Dr. Patricia Trujillo

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INTRODUCTION

Members of the Brave Girls Program

BACKGROUND

In the coming three years, NewMexicoWomen.Org (NMW.O) is seeking to deepen their programming at the intersection of health equity and economic security for women and girls in New Mexico. To inform their strategic plan, NMW.O contracted with the University of New Mexico's (UNM) College of Population Health and RWJF Center for Health Policy to conduct research that identifies the key intersections between health equity and economic security for women in New Mexico. In 2016, the UNM team met with the NMW.O team from June to November in order to co-develop an intersectionality equity project that combines a community- engaged component with a quantitative study. Using a Community-based Participatory Research Approach for advancing health equity policy,[1] this community-academic partnership gathered multiple forms of evidence (e.g., community voices, data, cultural representations of intersectionality) to assess the root causes of health and develop solutions. As a collaborative project, NMW.O organized and convened statewide community dialogues on intersectionality and gender equity, while the UNM team led a multi-disciplinary literature review and quantitative analysis on the intersectionality between economic security and health for women and, specifically, women of color in New Mexico. This report comprises the findings from the quantitative analysis.

PURPOSE AND RESEARCH AIMS

The purpose of this study is to assess the intersectionality between economic security, gender equity, and health. The research method builds on the *Indicators Report: A Statistical Resource Guide to Women and Girls in New Mexico*, published by NMW.O in 2014. This report, the second in a two-part comprehensive report, complements the findings of the statewide dialogues conducted by the NMW.O team in 2016 and seeks to inform future philanthropic program planning and policymaking for advancing health equity and social justice for women and girls in New Mexico. The four overarching aims of this study are to:

1. Review the literature (peer-reviewed social and health sciences publications and grey literature/policy reports) to map the key concepts, measurements, and methods regarding intersectionality, health equity and economic security for women;
2. Develop an analytic model that measures the contextual and intersectional nature of health equity and economic security for women and girls of color in New Mexico;
3. Conduct a quantitative analysis from publicly available data to assess the relationship between economic security and health outcomes by gender, race, and ethnicity; and
4. Develop policy strategies for promoting economic security and health equity among women in New Mexico.

Weavers from Tres Manos Weaving of New Mexico

APPROACH

Our approach in this study is to apply an intersectionality equity lens for understanding the health and economic conditions for women living in New Mexico.

WHAT IS HEALTH EQUITY?

The World Health Organization framework for health equity calls for action to "address the root cause of health outcomes due to unfair disadvantages and access to social resources—social inequities due to positionality by social place/class, race, immigration status, gender and sexual orientation."[2] Rooted in human rights ethics, achieving health equity requires the valuing of all individuals equally, recognizing and rectifying historical injustices, and providing resources according to need.[3] Health equity considers the conditions (including the health system) in which people are born, grow, live, work, and age, also known as the social determinants of health.[4] These circumstances are shaped by social structures that impact distributions of power and drive allocations of dollars and other resources at global, national, and local levels.[5] Health equity ensures the conditions for optimal health for all people regardless of age, sex, gender, immigration status, disability, language, race, and ethnicity.[6] Understanding the impact of social determinants of health on diverse communities and what solutions may advance health equity and social justice is guided by an intersectionality lens.

WHAT IS INTERSECTIONALITY?

Our UNM-NMW.O team drew from the definition of intersectionality based on the collective work of feminist scholars, in particular from Patricia Hill Collins and Sirma Blige[7] and Olena Hankivsky.[8] As an analytic tool, intersectionality can help us address the complexity of problems real people face in their daily lives. Intersectionality "promotes an understanding of human beings as shaped by the interaction of different social locations (e.g., race/ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected systems and structures of power (e.g., laws, policies, state and tribal governments and other political economic unions, religious institutions, media). Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created."[9,10]

We draw upon "intersectionality" as a practical framework to assess and solve social problems impacting women and girls in New Mexico. Combining the knowledge of community leaders and researchers, we seek to advance insights into the conditions that either promote or hinder the inter-generational health, well-being, and economic status of women and girls in New Mexico. Figure 1 illustrates intersecting factors that impact the real-lived experiences of women and girls. The inner circle centers on the human spirit, body, and mind. The next concentric circle focuses on socio-demographic factors impacting health and well-being (such as income, language and race) and is followed by the third circle, which includes access to social resources (e.g., food accessibility, health insurance). The fourth circle emphasizes the social relations (e.g., homophobia/transphobia, patriarchy), and the outer most circle includes larger institutional structures (e.g., legal system, globalization) that function as oppressive or empowering forces of privilege or power.

INTERSECTING SYSTEMS OF OPPRESSION

Another major goal of intersectionality is advancing inquiry and praxis (action or practice of theory) that contribute to understanding the nature of social inequalities and developing equity-based policy in a variety of systems (e.g., education, employment, wealth, housing, criminal justice). The guiding principles of intersectionality include a focus on power, reflexivity, deep contextualization, embracing inclusive excellence, multi-level analysis for social justice, and equity.[11]

Legal scholar Kimberlè Crenshaw developed the metaphor of "mapping the margins"[12] for underscoring the ways in which conventional approaches to feminist and antiracist political organizing and policies marginalized Black women and other racially stigmatized women. In an effort to provide tools for practitioners interested in being attentive to policies and practices that can advance social justice, Crenshaw offered three concepts, which she referred to as: (1) structural intersectionality, (2) political intersectionality, and (3) representational intersectionality.[13]

Crenshaw's "mapping the margins" can be applied, for instance, to the New Mexico context in terms of the complexities of how violence is experienced and navigated differently by women in New Mexico depending on the social location of these women. Crenshaw defined the concept of structural intersectionality by referring to the reality of structural barriers women face depending on their location in society and their influence of power based on privileges (e.g., wealth, White race).[14] For example, in New Mexico, some municipalities have adopted policies that discourage women who may be in mixed status immigrant families (a family in which one or more members are undocumented) to seek the assistance of law enforcement because of fear that, while they themselves may be protected from deportation, there would be no protections for other family members who may not be documented. Structural intersectionality can also help policymakers be attentive to gaps in laws that make it challenging for Native American women who are seeking justice for surviving sexual assault, given that in many circumstances if a nontribal member is accused of violence against a tribal woman on tribal lands, the tribal government has no jurisdiction over that alleged perpetrator.

In order to shed clarity on power differentials and economic and health gender inequities in a colonized state, our multi-disciplinary research team embraced intersectionality as an analytic strategy and applied approach to address social (in)justice, as it is related to the health and economic well-being of women and girls in New Mexico. In application, these conceptual models help to deepen our understanding of day-to-day lived experiences of multiple oppressed groups that remain invisible to the general public. The "intersectional" lens guides our research and quantitative analysis.

Figure 1. Layers of Intersectionality Diagram

Members of the Brave Girls Program

DATA AND METHODS

ECONOMIC SECURITY ANALYSIS

The analysis about economic security for New Mexico women is based on the American Community Survey (ACS) five-year estimates. The ACS is an ongoing survey collected by the US Census Bureau that provides information about the demographic, social, and economic characteristics of Americans. In order to account for pre- and post-recession differences, our regression results include ACS five-year estimated averages for 2005-2009 and 2010-2014 for New Mexico.

For our analysis, we used data on New Mexico individuals 18 and older (n=146,319) and report results for the entire sample, as well as women only (n=76,030). To measure economic insecurity, we focused on variables that assessed income constraints (poverty to income ratio, poverty status), asset ownership (property ownership), and labor market outcomes (unemployment status and hours worked).

Table 1 lists these descriptive statistics for the entire sample and sample of women only.

Table 1. Definition of Economic Security Measures and Descriptive Statistics for New Mexicans
Source: American Community Survey 5-year averages - 2005-2009 and 2010-2014

DEFINITION OF ECONOMIC SECURITY MEASURES AND DESCRIPTIVE STATISTICS FOR NEW MEXICANS							
Dependent Variables	**Definition**	**All adults 18 and older**			**Women 18 and older**		
		Mean	**SD**	**n**	**Mean**	**SD**	**n**
Poverty income ratio (in %)	How many percentage points a person's income is from the poverty line. For example, a value of 200 means income is 200% of the poverty line value. A value of 50 means income is half (or 50%) of the poverty line.	289.5	165.8	142,067	281.0	166.3	74,713
Poverty line status	Identifies individuals as being on or below the poverty line value	15.8%	0.364	146,319	17.4%	0.379	76,030
Unemployment status*	Identifies individuals who have no job but are currently looking for one	7.8%	0.268	86,512	7.5%	0.263	41,516
Property ownership	Individuals who reported owning their dwelling	74.7%	0.434	146,319	75.5%	0.430	76,030
Hours worked**	Self-reported usual number of hours worked per week in the past 12 months	38.4	12.7	90,985	35.9	12.1	43,839

* These numbers include only the labor force, which is comprised of those who are and are not employed. Unemployed refers to individuals actively seeking a job. Retirees, homemakers, etc. are excluded from the labor force.

** These refer to usual hours worked per week. Individuals, therefore, could be unemployed at time of survey but reported hours worked when they were employed.

Note: SD refers to standard deviation.

We conducted a regression analysis[15] to assess the association between intersecting identities (such as being Latina and foreign born; or White, female and US born) and the economic security variables listed in Table 1. For each variable, we estimated a regression using the entire sample, as well as a regression that included women only. The results of the entire sample show how minority men and women's economic security outcomes fare relative to White, US-born males. In contrast, the results using only women compare minority women of different indigeneity status with White, US-born women. The regression analysis also examined the variables of educational attainment, marital status, presence of preschoolers in the household, and pre- vs. post-recession period in relation to economic security. The Results section describes these findings, and the Appendix[16] includes all relevant tables from the regression analysis.[17]


A healer from Kalpulli Izkalli

Table 2 includes the descriptive statistics of the independent variables for the samples of all adults as well as women only.

Table 2. Definition of Independent Variables and Descriptive Statistics for New Mexicans
Source: American Community Survey 5-year averages - 2005-2009 and 2010-2014

DEFINITION OF INDEPENDENT VARIABLES AND DESCRIPTIVE STATISTICS FOR NEW MEXICANS						
	All adults 18 and older			Women 18 and older		
Independent Variables	**Mean**	**SD**	**n**	**mean**	**SD**	**n**
Gender						
Female	52%	0.5	146,319			
Male	48%	0.5	146,319			
Race and ethnicity						
White	46.6%	0.499	146,319	46.6%	0.499	76,030
Black	1.4%	0.119	146,319	1.2%	0.109	76,030
American Indian	12.3%	0.327	146,319	12.4%	0.330	76,030
Other race	3.6%	0.186	146,319	3.7%	0.189	76,030
Hispanic	37.8%	0.485	146,319	37.6%	0.484	76,030
US born	90.2%	0.298	146,319	90.2%	0.297	76,030
Educational level						
Less than high school	56.3%	0.496	146,319	56.1%	0.496	76,030
High school diploma	27.7%	0.448	146,319	27.3%	0.446	76,030
More than high school	16.0%	0.367	146,319	16.6%	0.372	76,030
Has child under age 6 in home	15.1%	0.358	146,319	16.2%	0.368	76,030
Age groups						
Age 18-24	11.1%	0.314	146,319	10.4%	0.306	76,030
Age 25-44	29.8%	0.457	146,319	28.8%	0.453	76,030
Age 45-64	37.3%	0.484	146,319	37.6%	0.484	76,030
Age 65+	21.8%	0.413	146,319	23.2%	0.422	76,030
Single-parent household	19.0%	0.392	146,319	21.9%	0.413	76,030
Marital status						
Married	53.3%	0.499	146,319	51.1%	0.500	76,030
Divorced	21.7%	0.412	146,319	26.7%	0.443	76,030
Unmarried	25.0%	0.433	146,319	22.2%	0.415	76,030
Has a disability	10.3%	0.303	146,319	9.9%	0.299	76,030
Sample 2010-2014 period	51.6%	0.500	146,319	51%	0.500	76,030

Note: SD refers to standard deviation.

VARIABLES EXAMINED FOR NEW MEXICO WOMEN'S HEALTH AND ECONOMIC SECURITY

The analysis of women's health and its link to economic security used data from the Behavioral Risk Factor Surveillance System's (BRFSS) data. BRFSS is an annual telephone survey conducted by the Centers for Disease Control and Prevention (CDC) that collects data on health behaviors, risk factors, and health status of US residents.[18] With the exception of fruit and

vegetable intake, which was collected only in 2009, the remaining variables (obesity status, depression, diabetes, reproductive and heart health, and health insurance coverage and utilization) were studied using the 2011 to 2015 BRFSS samples from New Mexico.

From the BRFSS data, we chose measures that could describe health outcomes and access to health care (see Table 3). Access to health care was measured by the variables of: insurance coverage, having had a checkup in the past two years, having a personal health care provider, and not seeing a doctor in the past 12 months due to prohibitive cost. For the descriptor of access to women's reproductive health, we examined the variables of: having had a mammogram in the past two years (for women over age 40) and having had a pap smear within the past three years (the clinically recommended period of time).

Regarding health, we examined the variables of: obesity status, having been diagnosed with depression, having been diagnosed with diabetes, and having being diagnosed with a heart attack. Given the role of nutrition and food security in health, we also included consumption of fruits and vegetables as a variable, which is measured in the BRFSS as consuming less than 5 fruits or vegetables in a day. Table 3 includes all the summary statistics for these measures.

Table 3. Measures of Health Care Access and Health Outcomes Descriptive Statistics for New Mexicans
Source: Behavioral Risk Factor Surveillance Systems (BRFSS) - 2009 to 2015

MEASURES OF HEALTH CARE ACCESS AND HEALTH OUTCOMES DESCRIPTIVE STATISTICS FOR NEW MEXICANS				
Health and Access to Health Care Descriptors	**Variable**	**Mean**	**SD**	**n**
Obesity status and nutrition	Obese (BMI ≥ 30)	26.3%	0.44	62,831
	Eats less than 5 fruits or vegetables per day*	74.9%	0.434	8,461
Depression	Diagnosed with depression (major or dysthymia)	20.9%	0.406	43,055
Diabetes	Has ever been diagnosed with diabetes	12.5%	0.331	65,241
Access to reproductive health	Had a pap smear within the past 3 years	73.6%	0.441	12,459
	Over 40 and had a mammogram within past 2 years	69.2%	0.462	13,890
Heart health	Has ever been diagnosed with heart attack	5.7%	0.232	65,241
Insurance coverage and utilization	Insured by any health plan	86.1%	0.346	65,026
	Had a checkup within past 2 years	79.4%	0.404	65,241
Access to primary care and cost as a barrier	Has personal health care provider	78.3%	0.412	65,122
	Did not see doctor in past 12 months due to cost	14.5%	0.352	65,137

* This data was collected only in 2009.

Note: SD refers to standard deviation.

In order to assess the role of economic security in health outcomes (listed in Table 3), we classified independent variables by individual demographic characteristics (such as race, marital status, age, gender) and socioeconomic descriptors (income, employment status, home ownership, and education). In order to account for individual behavior on health, we also included measures of health habits (exercise, drinking, and smoking). Table 4 includes the descriptive statistics of these variables.

Table 4. Independent Variables Descriptive Statistics

Source: Behavioral Risk Factor Surveillance Systems (BRFSS) - 2011 to 2015

INDEPENDENT VARIABLES DESCRIPTIVE STATISTICS			
Independent Variables*	**Mean**	**Standard Deviation (SD)**	**n**
Female	59.4%	0.491	65,241
Race:			
White	77.9%	0.415	65,241
Black	1.4%	0.116	65,241
American Indian	9.2%	0.289	65,241
Other race	9.0%	0.286	65,241
Hispanic	33.4%	0.472	65,241
Has some form of health insurance	86.1%	0.346	65,026
Educational level:			
Less than high school	12.0%	0.325	65,241
High school graduate or GED	27.2%	0.445	65,241
Some college or more	60.9%	0.488	65,241
Age:			
Age 18 to 24	4.8%	0.214	65,241
Age 25 to 44	22.0%	0.414	65,241
Age 45 to 64	41.6%	0.493	65,241
Age 65 or older	31.6%	0.465	65,241
Lives in urban area or MSA**	26.1%	0.439	65,241
Marital status:			
Married	52.0%	0.5	64,833
Divorced	15.8%	0.365	64,833
Widowed	12.2%	0.327	64,833
Never married	14.1%	0.348	64,833
Income:			
Under 25 thousand annually	36.2%	0.481	57,010
25 to 34 thousand	12.7%	0.332	57,010
35 to 50 thousand	14.5%	0.352	57,010
50+ thousand	36.6%	0.482	57,010
Employment status:			
Employed for wages	38.4%	0.486	64,895
Self-employed	9.3%	0.291	64,895
Out of work for more than a year	2.8%	0.165	64,895
Out of work for less than a year	2.7%	0.163	64,895
Home ownership: Owns home	75.6%	0.43	42,567
Health habits:			
No drinking in the past 30 days	52.4%	0.499	65,241
Smoked daily in the past 30 days	11.0%	0.312	65,241
Exercised within the past 30 days	75.3%	0.431	63,246

* Not all categories add up to 100% since small frequency categories were omitted from the table.

** MSA stands for Metropolitan Statistical Area. This is a measure used by the US Census Bureau to identify areas with high population density.

The data in Table 4 was collected between 2011 and 2015. Each year, BRFSS collects data from a different sample of individuals, among whom very few are minority women. To overcome this limitation, we pooled the annual samples. This yielded a larger sample for all groups of interest (by race and gender). With a larger sample size, we could provide better estimates (such as the mean and standard deviation) for groups for whom annual sample sizes were too small. This is the case for American Indian and African American women, for instance.

ANALYSIS OF NEW MEXICO WOMEN'S HEALTH CARE ACCESS AND HEALTH OUTCOMES

To analyze health care access and health outcomes (listed in Table 3), we used regression analysis.[19] This allowed assessing the role of socioeconomic variables (such as home ownership and employment status) in the health outcomes. For instance, we could assess how being unemployed was linked to the likelihood of being uninsured, given that (by means of the regression analysis) we had accounted for race, age, etc. In examining health outcomes, we included insurance coverage and having a personal health care provider as explanatory variables, given the role of access to health care in timely diagnoses. In addition to reporting the regression estimates, we illustrated our key findings with graphs for key groups, using pooled unweighted data (for years in which the variable was available). The purpose of these graphs is to provide a visual representation of the key findings of this study. The Appendix that accompanies this report[20] includes the complete output from our regression analysis results of the economic security variables and socioeconomic determinants of health and health outcome variables (see Tables 5 through 33).

Weavers from Tres Manos Weaving of New Mexico

Weavers from Tres Manos Weaving of New Mexico

RESULTS

FINDING 1

Socioeconomic determinants of women's health include: income inequalities, economic insecurity, intersections of race and place of birth, and number of household-earning parents.

1.1 Race and place of birth play a role in economic insecurity for New Mexico women (measured by lower income, living under the federal poverty level, and being unemployed). Figure 2 illustrates economic insecurity is most prevalent among American Indian, Hispanic, and Black women. This vulnerability is also evident when comparing before (2005-2009) and after (2010-2014) results of the Great Recession (which began in 2008) (see Tables 5 to 11).[21]

Figure 2 shows that, compared to White women, American Indian women are more than twice as likely to be poor. Adjusted probabilities from regression results (Table 8)

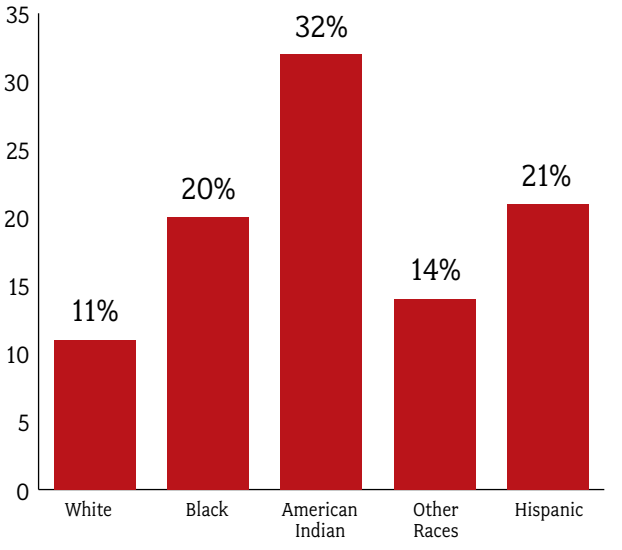


Figure 2. Percent of Adult Women in New Mexico Living in Poverty, by Race/Ethnicity

Source: American Community Survey (ACS) - 5 year averages - 2005-2009 and 2010-2014

reveal that, when compared to White men, American Indian men and women, along with foreign-born individuals, are 2 to 5 times more likely to be poor (see also Tables 14 & 15).

The Income to Poverty Ratio[22] (IPR) variable measures how far above or below the poverty line individuals are. We estimated the average[23] IPR for women by race. Results show that White US-born women have an IPR of 325 points (on average, their household income is 3.25 times higher than income at the poverty line). In comparison, foreign-born Hispanic women have an IPR average of 174 points, and for US-born American Indian women this score is 183. In other words, the IPR averages for American Indian women and Hispanic foreign-born women are almost half of that of White US-born women. This finding is also supported by regression results available in Tables 13 and 15.

The Great Recession increased this disparity. Estimates of the average IPR among American Indian women declined by 13% in the 2010-2014 post-recession period compared to 2005-2009 period. For White women this decline was only 4.6%. Women who identified as Other Race saw the second largest drop with a decline of almost 8%.[24] These numbers represent a decline in household incomes and demonstrate that American Indian women and those identifying as Other Race are at higher risk of being poor.

The Role of Unemployment in Economic Insecurity

Another measure of economic insecurity was unemployment. Regression results show the risk of being unemployed in New Mexico is 1.5 to 1.6 times higher for American Indian and Black women than for non-Hispanic White women (see Figure 3 and Table 10). For foreign-born women, the risk of unemployment is 1.2 times higher than US-born women (Table 10). Alongside this risk of unemployment, American Indian women employed in the labor market actually work more hours during a usual workweek than White women, while their average earnings in wages are 33% less per year.

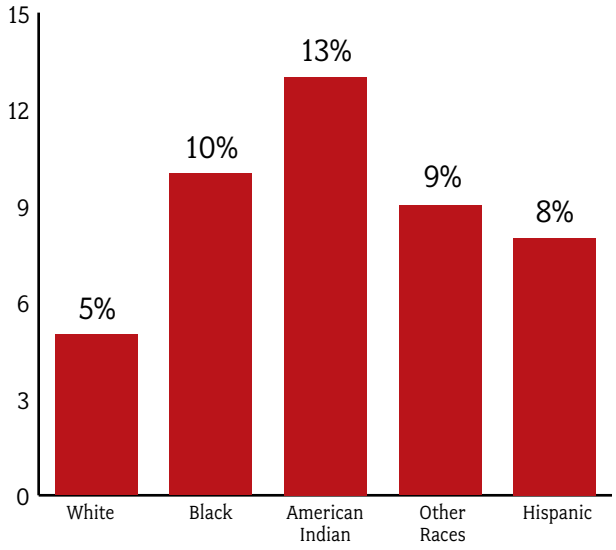


Figure 3. Unemployment Status of Women, by Race/Ethnicity
Source: American Community Survey (ACS) - 5 year averages - 2005-2009 and 2010-2014

The Effect of Single-parent Households on Women's Economic Security

1.2 Being in a single-parent household puts adult women's economic security at risk, and that risk is even greater when children of preschool age (five or younger) are present in the household. Regression results reveal that in New Mexico, unmarried women are over 4 times more likely to be poor than married women (Table 8). Women with children five or younger are 1.8 times more likely to be poor than women who do not have preschoolers in their household (see Figure 4 and Table 8). When we analyzed women in single-parent households who also have children under the age of six, we found they are over 4 times more likely to be poor than two-parent households without preschoolers.

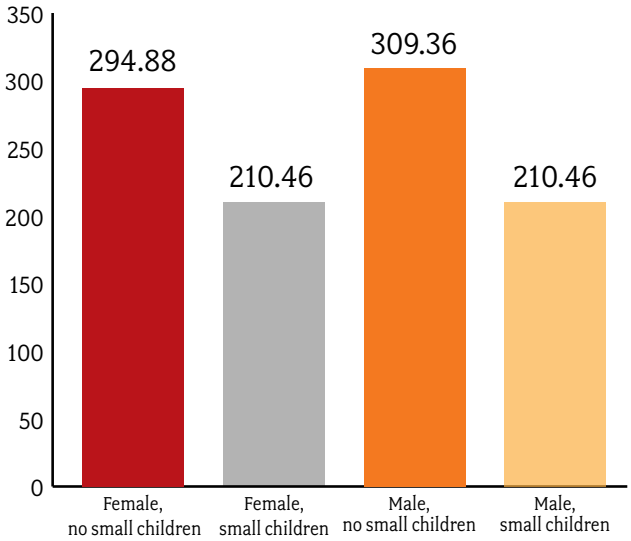


Figure 4. Income to Poverty Ratio (IPR) Averages for Women and Men with and without Young Children
Source: American Community Survey (ACS) - 5 year averages - 2005-2009 and 2010-2014

Regarding income, women in single-parent households with young children have an IPR 27% lower[25] than the average IPR of women within two-parent households and no young children.[26] These women in single-parent households with young children are much more likely to have income below the poverty line than women without young children[27] (see Table 8).

Home Ownership for Parents of Young Children

Regression results reveal that long-term asset ownership is also lower for women who live in a household with children age five or younger, since they have a lower likelihood of owning property (over 38% lower compared to women in households without young children) (Table 9). This negative association is also illustrated in Figure 5 for women with young children.[28] Regarding employment as a source of regular income, women with children of preschool age are employed for fewer hours per week relative to women who do not have young children[29] (Table 11).

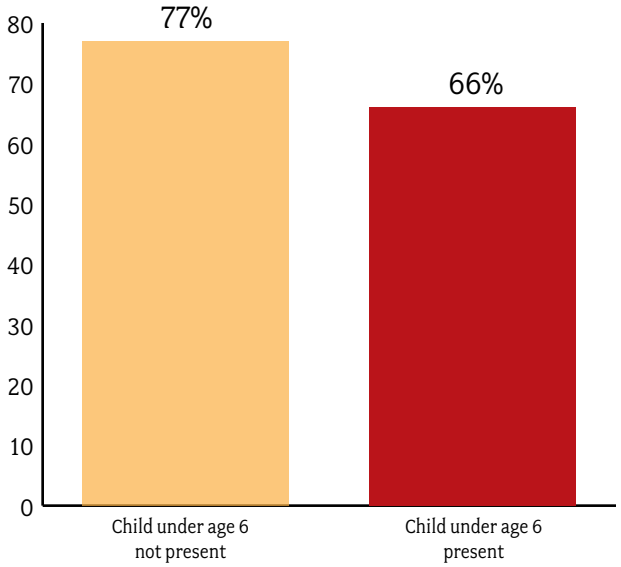


Figure 5. Percent of Women with and without Small Children Who Own Their Homes

Source: American Community Survey (ACS) - 5 year averages - 2005-2009 and 2010-2014

FINDING 2

Race, ethnicity, income and insurance coverage matter for access to primary care, as well as reproductive and behavioral health services.

2.1 Race and ethnicity are closely linked to having access to insurance coverage, health care services, and preventative reproductive health screenings. Regarding access to care, American Indian and Hispanic women face the greatest challenges. Figure 6 shows that only 67% of American Indian women have a personal health care provider. Adjusted probabilities from regression results (available in Table 25) show that, compared to White women, American Indian women are half as likely to have a personal health care provider.

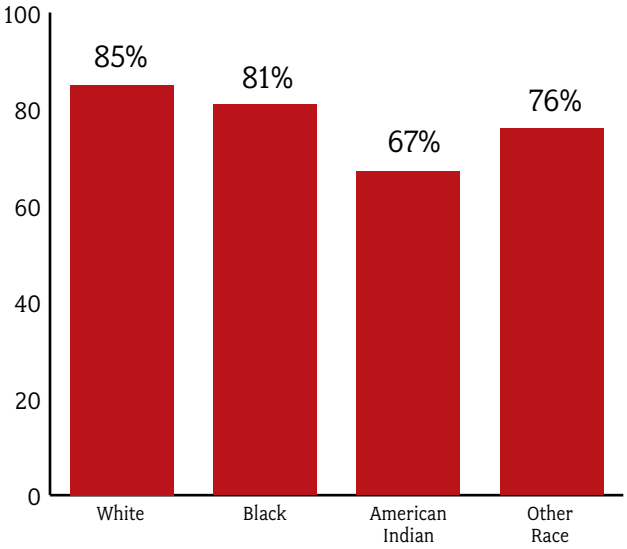


Figure 6. Percent of Women Who Have a Personal Health Care Provider, by Race

Source: Behavioral Risk Factor Surveillance System (BRFSS). 2011-2015. Unweighted averages.

Insurance Coverage by Race and Ethnicity

Figure 7 shows the distribution of health insurance coverage by race and ethnicity among women throughout the 2011 to 2015 period. American Indian and Hispanic women stand out due to lower levels of health insurance coverage. In spite of this, the time comparison shows that, for all groups, the proportion of insured increased after the implementation of the Patient Protection and Affordable Care Act (see Figure 7). Regression results (available in Table 23) confirm these findings: Hispanic women are over 25% less likely than White women to be insured, though the probability of being insured for all women was 2.2 times higher in 2015 than in 2011.

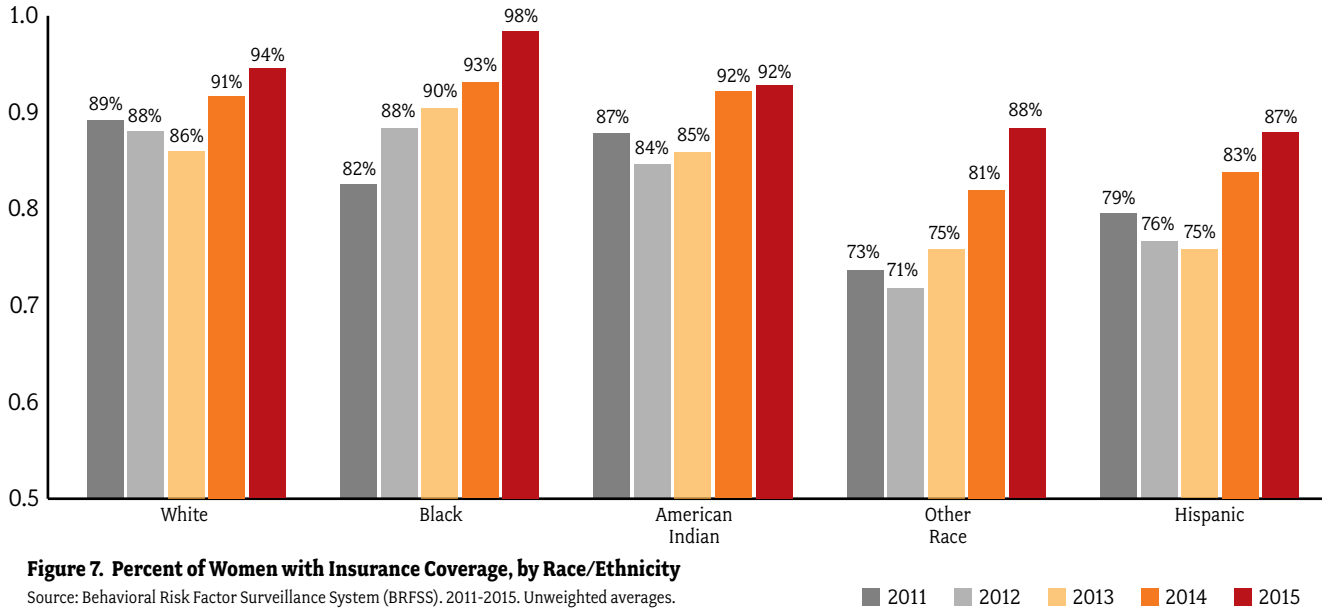


Figure 7. Percent of Women with Insurance Coverage, by Race/Ethnicity

Source: Behavioral Risk Factor Surveillance System (BRFSS). 2011-2015. Unweighted averages.

Prohibitive Cost of Doctor's Visits

Figure 8 shows the relationship between income and not seeing a doctor due to prohibitive cost for women. Whereas 28% of women with an annual household income under 15 thousand dollars did not see the doctor due to prohibitive cost, this occurred among only 6% of women with household income over 50 thousand dollars a year. The probabilistic regression analysis from Table 24 confirms these findings. Specifically, results indicate that, compared to women with household incomes under $25 thousand per year, those earning an income between $35 to $50 thousand dollars are half as likely to not see a doctor due to prohibitive cost, and those earning $50 thousand or more are over 70% less likely to do so. Furthermore, Table 24 also shows Hispanic women are 20% more likely than non-Hispanic women to not see a doctor due to the cost.

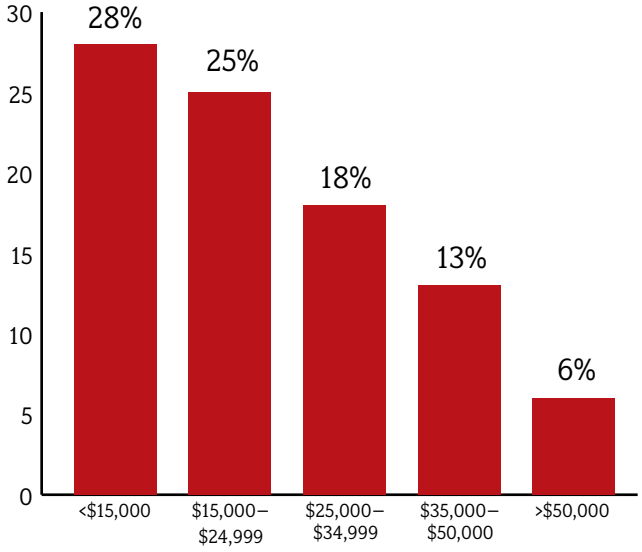


Figure 8. Percent of All Women Who Did Not See a Doctor Due to Prohibitive Cost, by Annual Income Levels

Source: Behavioral Risk Factor Surveillance System (BRFSS). 2011-2015. Unweighted averages.

Access to Reproductive Health Services

Regarding access to reproductive health services, Figure 9 shows that 61% of women earning less than $15 thousand per year get a mammogram compared to 76% among those earning $50 thousand per year or more.

Hispanic women (compared to non-Hispanic) are more likely to have had a mammogram and pap smear (Table 31). American Indian women are more likely to have received a mammogram compared to White women (Table 31). Overall, however, rates of pap smears declined between 2012 and 2014 for all women (Table 31). Women earning $50 thousand or more per year are 1.6 times more likely to get a pap smear and 1.7 times more likely to get a mammogram than women earning less than $25 thousand per year (see Figure 9 and Table 32). Health insurance coverage makes women almost three times more likely to get either test.

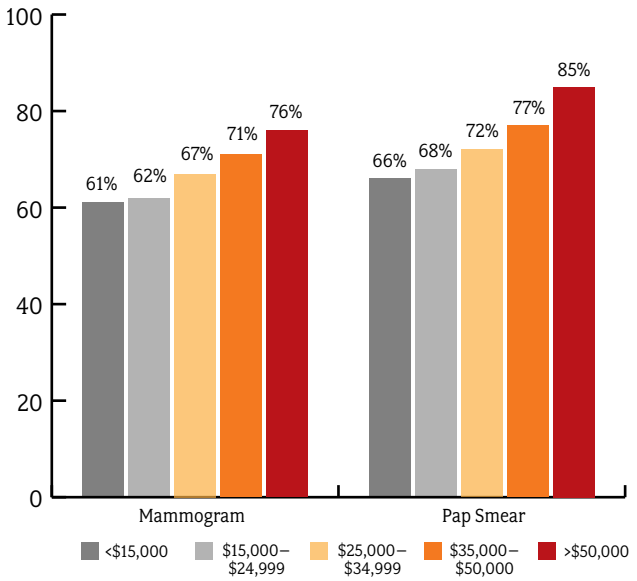


Figure 9. Percent of Women Who Had a Mammogram in Past 2 Years, and Percent Who Had a Pap Smear in Past 3 Years, by Annual Income Levels

Source: Behavioral Risk Factor Surveillance System (BRFSS). 2011-2015. Unweighted averages.

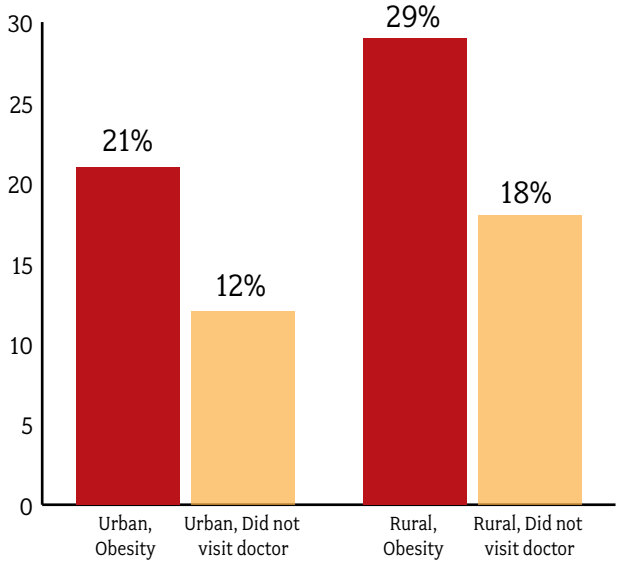


Figure 10. Urban and Rural Differences in Obesity and Not Seeing a Doctor Due to Prohibitive Cost

Source: Behavioral Risk Factor Surveillance System (BRFSS). 2011-2015. Unweighted averages.

Urban and Rural Differences

Figure 10 shows that women living in rural areas are more likely to have a higher prevalence of obesity and are more likely to not see a doctor due to prohibitive cost. The regression analysis shows that, compared to non-urban women, women living at or near metropolitan areas are nearly 20% less likely to be obese (Table 28), 21% more likely to have had a mammogram (Table 31), 18% less likely to not see a doctor due to prohibitive cost (Table 24), and 25% more likely to get a doctor's check-up within a two-year period (Table 27). This is true even after accounting for income, education, insurance status, and property ownership (through the regression analysis).

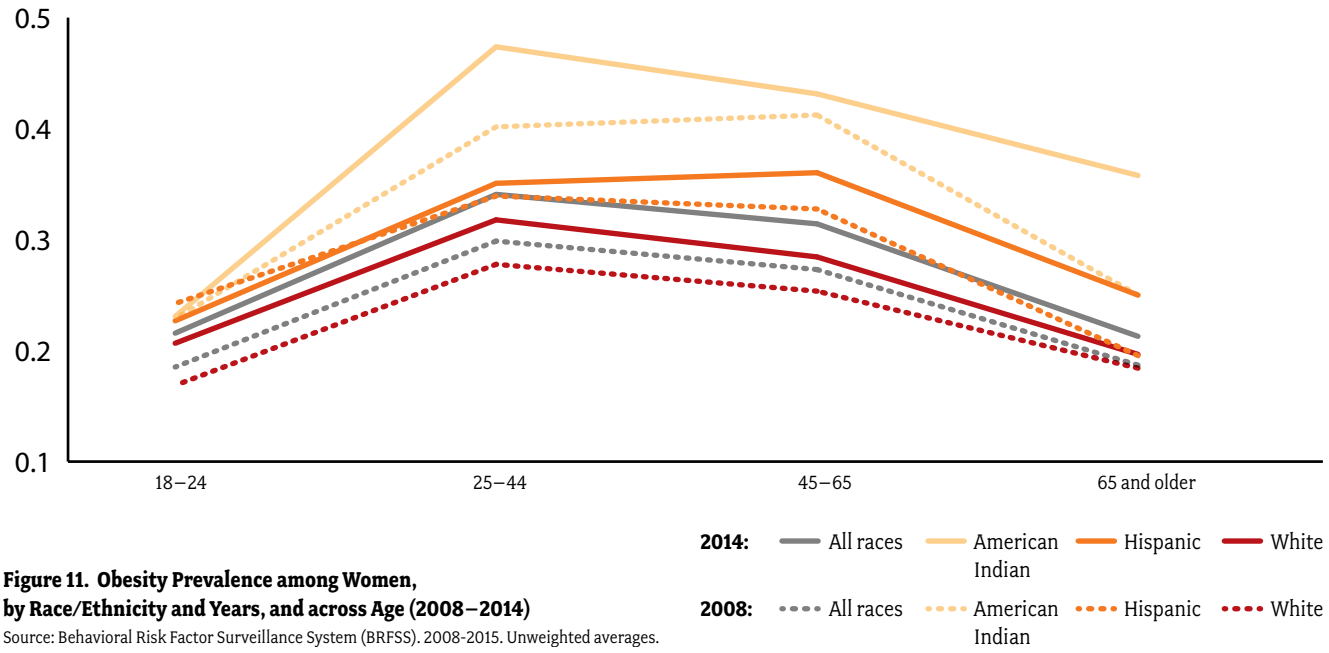


Figure 11. Obesity Prevalence among Women, by Race/Ethnicity and Years, and across Age (2008–2014)

Source: Behavioral Risk Factor Surveillance System (BRFSS). 2008-2015. Unweighted averages.

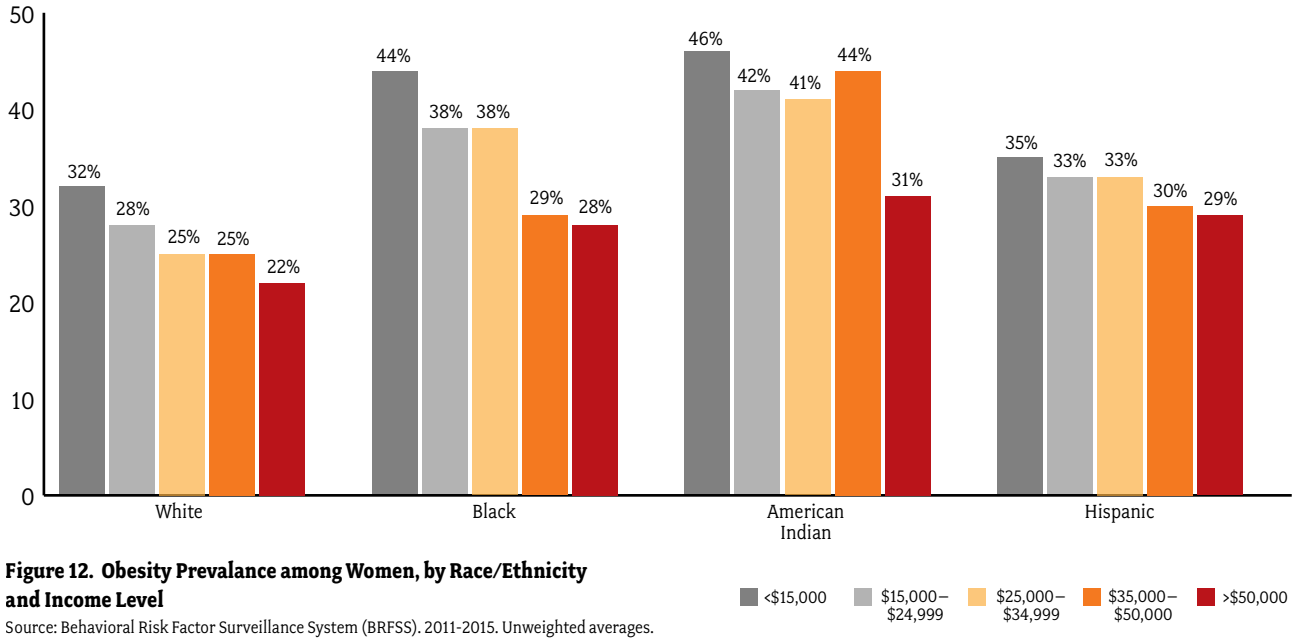


Figure 12. Obesity Prevalance among Women, by Race/Ethnicity and Income Level

Source: Behavioral Risk Factor Surveillance System (BRFSS). 2011-2015. Unweighted averages.

Factors Associated With Rates of Obesity

Women in the age range of 30 to 50 years have the highest prevalence of obesity compared to women in their 60s and above (see Figure 11). There are also differences in obesity by race. For instance, American Indian women are 1.6 times more likely than White women to be obese (Table 28).

Higher income, as would be expected, is linked to a lower prevalence of obesity; however, for American Indian women this is the case only among the higher income range (those earning $50 thousand or more) (see Figure 12). Furthermore, home ownership and education (both high school and higher levels of education) are also linked to lower likelihoods of obesity (Table 28). Finally, American Indian women have the highest prevalence of obesity rates across all income levels (see Figure 12).

Exercise and Diet

2.4 The impact of exercise on obesity is smaller for low-income women. Exercise in the past 30 days (a very low threshold for physical activity) decreases the likelihood of obesity by over 40% (Table 28). Since exercise and socioeconomic status could be associated, a regression was included for women that accounted for exercise across different levels of income. We found exercise is effective in reducing rates of obesity across most of the income spectrum, but this effectiveness is substantially larger for the wealthier group (annual income of $50 thousand or more). Among this group, regression results show exercise reduces the probability of obesity by nearly 40%, compared to 28% among the group earning $25 to $35 thousand per year.[30]

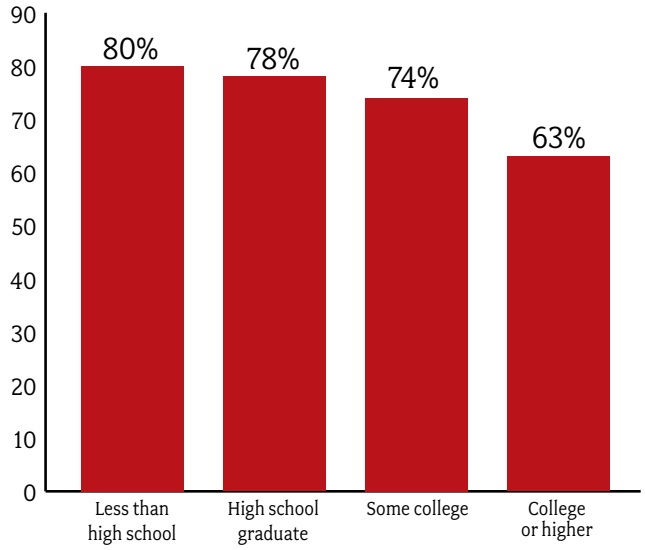


Figure 13. Percent of Women who Eat Fewer than 5 Fruits or Vegetables a Day, by Educational Level

Source: Behavioral Risk Factor Surveillance System (BRFSS). 2011-2015. Unweighted averages.

2.5 Education is associated with whether individuals have a healthy diet. Figure 13 shows that only 63% of women with college or higher education eat fewer than five fruits or vegetables per day compared to 80% missing this nutrition

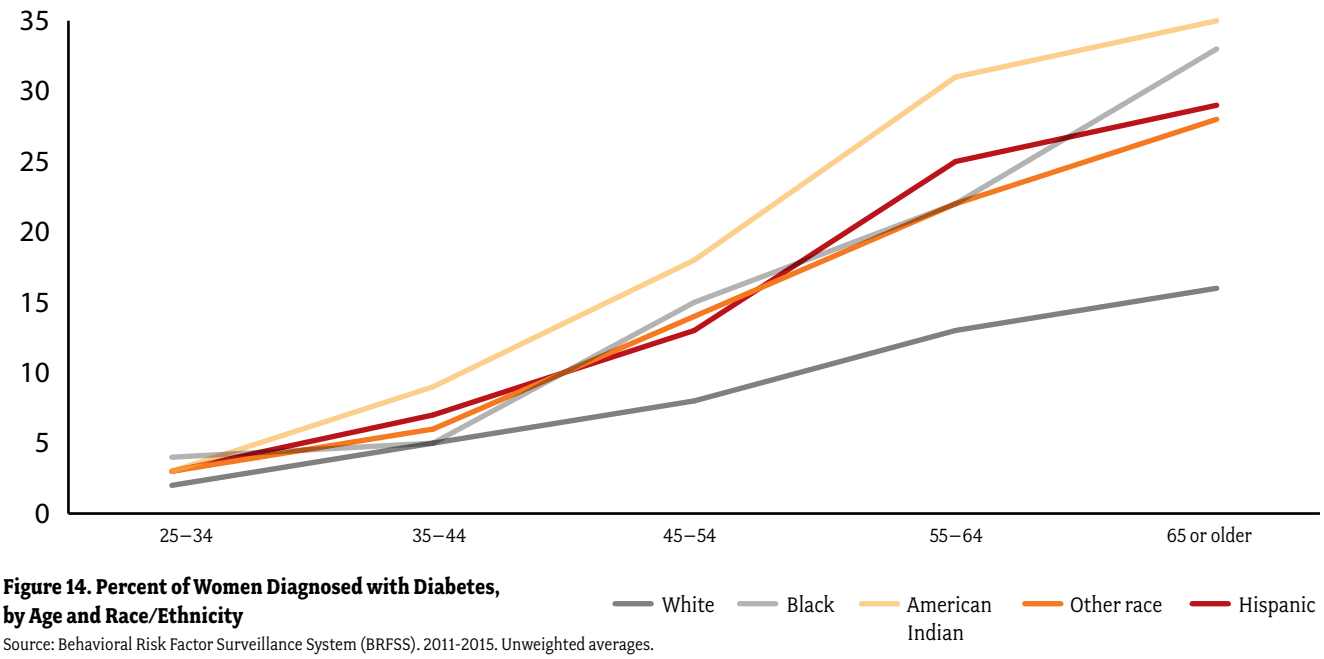


Figure 14. Percent of Women Diagnosed with Diabetes, by Age and Race/Ethnicity

Source: Behavioral Risk Factor Surveillance System (BRFSS). 2011-2015. Unweighted averages.

mark among women with less than a high school education. Regression results, which account for other demographic and socioeconomic factors, show that college-educated individuals are nearly 40% more likely to eat fruits or vegetables than those with less than a high school education (Table 29). In contrast, Hispanic women are over 30% less likely to eat fruits or vegetables than non-Hispanic women.

Factors Associated With Prevalence of Diabetes

2.6 Age, race, ethnicity and economic factors are related to the prevalence rates of diabetes among women. Figure 14 shows that over one-third of American Indian women 65 or older have been diagnosed with diabetes, compared to only about 15% of White women in the same age group. Furthermore, regression results (available in Table 32) show that women over 55 years of age are over 20 times more likely to be diabetic than women between 18-24 years of age. It is important to note that the prevalence of diabetes among younger women is still a valid concern, as women in the age range of 25-44 are 2 to 6 times more likely to be diabetic than women 18-24 years of age (Table 32). Regarding race, Black women are 1.7 times more likely than White women to be diabetic, American Indian women are 2.3 times more likely, and Hispanic women are 1.9 times more likely than non-Hispanic women to be diabetic (Table 32). Finally, socioeconomic factors are statistically significant, as expected, but nonetheless staggering: whereas earning $35-50 thousand annually reduces the likelihood of diabetes by 24%, earning $50 thousand or more annually reduces it by almost twice as much. This is the case even after accounting for (through regression analysis) home ownership and employment status (Table 32).

Women diagnosed with diabetes, in many instances, lack access to primary care. Figure 15 shows that, among American Indian women who are diagnosed with diabetes, 23% report that they do not have a primary care provider. This is almost twice the rate compared to non-Hispanic White women (12.1%). Many Black women with diabetes also lack access to a primary care provider (20.2%), followed by Hispanic women (18.8%).

Behavioral Health Conditions and Influences

2.7 Socioeconomic conditions and access to healthcare are linked to behavioral health conditions among women. Women with higher incomes (earning $50 thousand or more annually) are 28% less likely to be diagnosed with depression (Table 30) and half as likely to have had a heart attack than women earning less than $25 thousand per year (Table 33). The inequalities persist, with depression being less prevalent for women who own their home versus those who do not, and women

whose highest level of education was finishing high school compared to those who did not graduate from high school (Table 30).

Insured women are 30% more likely to be diagnosed with depression (and presumably receive treatment) than uninsured women (Table 30). Women with a personal health care provider are 54% more likely to be diagnosed with depression (Table 30) and almost twice as likely to be diagnosed with having had a heart attack as women without a health care provider (Table 33). These results hold even after accounting for (through regression analyses available in Tables 30 & 33) socioeconomic differences, revealing the importance of having health insurance and a personal health care provider on receiving treatment for health ailments.

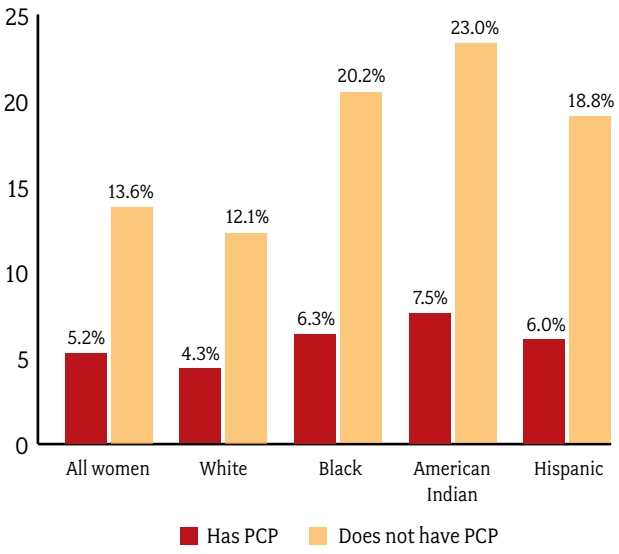


Figure 15. Percent of Women Diagnosed with Diabetes, by Access to Primary Care Providers (PCP) and Race/Ethnicity
Source: Behavioral Risk Factor Surveillance System (BRFSS). 2011-2015. Unweighted averages.


Healers from Kalpulli Izkalli

Members of the Brave Girls Program

POLICY CONSIDERATIONS

Our quantitative analysis of the link between economic security and health found that women of color with lower incomes experience more vulnerabilities compared to non-Hispanic White women with higher incomes. In considering the root causes of women's health, we recommend these findings be shared with community stakeholders who have vested interests in advancing the economic security and health equity for diverse women living in New Mexico.

Following principles of equity, we suggest policy interventions should be guided by a community-engaged process that draws from alternative ways of knowing in combination with scientific evidence. Intersectionality, as an applied tool, embraces feminist, decolonized and de-racialized pedagogies as a means for shifting and equalizing power. Additionally, advancing and valuing diverse ways of knowing is necessary for achieving social justice and for interrogating multiple systems of privilege/advantage as well as oppression/disadvantage.[31] The benefit of bridging alternative ways of thinking with scientific evidence is fostering deeper understandings of structural inequities. Engaging with communities to develop policy interventions is a promising approach for disrupting the interdependent forms of privilege and oppression (colonialism, imperialism, racism, homophobia, "ableism," and patriarchy).

As a baseline for stimulating further public dialogue, we conducted a review of evidence from both peer-reviewed and policy literature and reports (e.g., PubMed, Lexus Nexus, NewMexicoWomen.org, Cochrane, National Conference of State Legislatures, World Health Organization/EPINET). Based on the review of evidence, we propose three broad policy strategies as a way to support future public dialogues and the development of meaningful policy interventions for and by the communities most impacted by inequities.

POLICY STRATEGY 1

Tackle the social determinants of women's health by developing rules, norms, and institutional capacities that value women and equalize power and gender relations within the home and community, as well as publicly.

Results from a project in the European Union (EU) that assessed gender policies demonstrate that important structural models are social determinants of women's health inequities.[32] One of those models consists of "gender policy regimes" that "entail a set of rules, norms, and institutions about gender relations that influence the construction of policies" in each country of the EU.[33] These regimes also referred to a form of governmental rules that were determined by cultural norms leading to policies that reflect the values of the society with regards to a woman's place in and outside the home. These ruling governments were characterized in two ways: 1) dual earner/dual career countries that championed policies and institutions which allowed for gender equity in labor; and 2) familial-based countries that still ignored the unpaid labor of women in the household, leading to uneven division of labor and smaller numbers of women in the workplace.[34]

POLICY STRATEGY 2

Engage with communities in developing policies that promote women's political representation, advance employment opportunities, promote equal incomes, foster family unity, and promote gender-equitable use of time in the labor force and at home.

Research on gender policies in Europe analyzed gender related policies that influence social and health equity in five ways: 1) policies to promote political representation, 2) employment policies, 3) policies to promote equal incomes, 4) family policies, and 5) policies to promote gender-equitable use of time.[35] Policies that promote gender health equity were formulated in order to potentially change the gendered division of labor. One example of this is parental leave for both parents because it leads to more gender equal time use. Also, this can lead to an increase in women's time in the paid labor force, which is generally seen as a contributing factor to both men and women's well-being.[36] This research study identified single mothers as being among the most vulnerable and at risk for poor health. Some of the structural recommendations that were highlighted as having the most benefit for advancing health equity for women were redistributive and welfare policies such as income maintenance, education and training, social housing, promoting female employment, and work-family balance.[37] Additionally, access to family planning resources, policies that help mothers remain in the labor force, balancing employment and family demands, and informal work-family practices, may yield important benefits for single household mothers and their families.[38] Ultimately, the authors recommended policies that support women's participation in the labor force and reduce their burden of care, such as increasing public services and economic support for families and entitlements for fathers. These types of policies are related to lower levels of gender inequality in terms of health.[39]

One intervention analyzed was the concept of economic solvency. Because poverty, health inequality, and intimate partner violence are all circularly connected, economic solvency is usually suggested as a means of removing some of the barriers to women's health equality. However, economic solvency remains loosely defined and abstract. Gilroy, Symes, and MacFarlane's (2015) intervention describe it as, "for women, economic solvency is a long-term state that occurs when there is societal structure that supports gender equity and external resources are available and can be used by a woman who has

necessary human capital, sustainable employment and independence."[40] While their definition still remains imprecise and the authors acknowledge this limitation, their goal was not to identify structural barriers to women's health inequality but rather to pose a foundational framework that solidifies some of the language used in assessing structural interventions towards health equity.

POLICY STRATEGY 3

Invest in and build capacity for partnerships aimed at advancing gender and economic equity for women and girls in New Mexico.

One way of applying the approach of participatory or community-driven development is the adaptation of the capacities and vulnerabilities approach (CVA) as a gender analysis tool.[41] Because "understanding the gender-related capacities and vulnerabilities of a resource-poor community is necessary when considering health and healthcare at the individual and community levels," adapting the CVA allows researchers to "examine these emerging problems and drawn-out social issues in relation to health from the perspective of complex long-term community-based challenges that bring insecurity and uncertainty to a particular community."[42] This approach supports community-based research that considers the contextual structural realities leading to a lack of access to health care and health care inequity, while also allowing researchers and community members to identify the assets or capacities possessed by the particular community in question. The CVA focuses on gender as a contributing factor to an issue and ensures that relevant gendered nuances can be identified and assessed while accommodating for and preserving local cultural identities.[43]

We recommend that the existing network of community-based and grassroots organizations working with girls and women in New Mexico be activated to develop long-term sustainable policy action. According to a policy analysis conducted in December 2016,[44] many grassroots organizations are proponents for targeting the structural violence and economic factors that impact women, especially women of color. For instance, Women Building Community (WBC) was a prominent voice for reproductive justice efforts and funded economic opportunities for women.[45] WBC led to the founding of NewMexicoWomen.Org (NMW.O), which is a program of New Mexico Community Foundation. NMW.O has used research-based evidence as a means to prioritize the many needs and assets of New Mexico's diverse women and girls. Other organizations such as Young Women United, Tewa Women United, and the Southwest Creations Collaborative have been champions for policy proposals to invest in social and gender justice for women of color.[46] For example, in 2010 many of these organizations came together to host a fundraiser in support of continued economic grant funding for women. Researchers with the University of New Mexico and Northern New Mexico College have documented the role of institutional racism and sexism and the resulting adverse consequences on the health of women of color.[47] The researchers' recommendations have highlighted the need for increasing economic opportunity for women, engaging and mentoring more women into political leadership positions and targeting violence against women.

Community partnerships and nonprofit advocacy organizations and coalitions have played a prominent role in targeting structural violence, specifically interpersonal and domestic violence,[48] including: Alianza-National Latino Alliance for the Elimination of Domestic Violence, Coalition to Stop Violence Against Native Women, New Mexico Coalition against Domestic Violence, New Mexico Coalition of Sexual Assault Program, and New Mexico Office of Juvenile Justice & Delinquency Prevention. Due to their work, gender issues have gained attention in the political arena and among state legislators and congressional leaders, who have taken a stance on combating domestic violence. For example, during his 2014 campaign, New Mexico Senator Tom Udall supported the Violence against Women Reauthorization Act to assist with prosecuting non-natives who harm native women.[49] These networks and policy strategies represent a modest movement among nonprofits, academics, foundations, and politicians to advocate for health equity and gender justice.

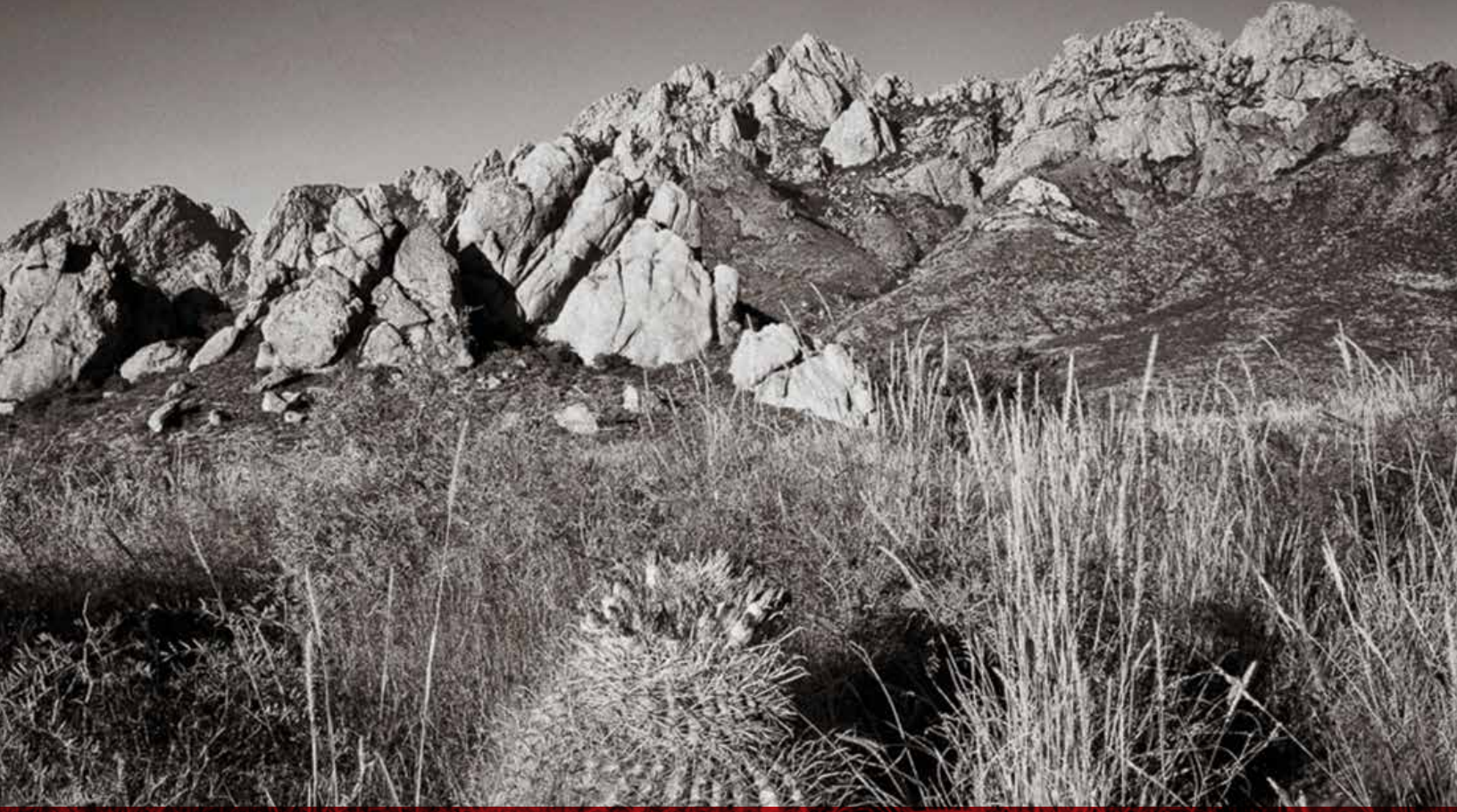
Weavers from Tres Manos Weaving of New Mexico

CONCLUSION

Results from our study highlight that socioeconomic inequality, race, ethnicity, insurance coverage, and place in societal structure matter for gaining access to primary care, as well as reproductive and behavioral health services. In order to tackle these inequities and achieve gender justice, together we must understand the interaction of different oppressive structural forces on women's health (e.g., race/ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion).

Our results are helpful in developing future funding and policy strategies in New Mexico. Central to achieving gender equity and social change, is establishing credible evidence for decision-making by foundations, governments and community organizations. To achieve gender justice in New Mexico, funding should be directed to organizations led by women and/or serving women and girls living in low income communities, as well as geographically, racially, and culturally diverse communities across New Mexico.

Funders should adopt a social and gender justice lens and leverage their access to other foundations, funders, and donors to influence the conversation around the need to invest in social and gender justice work. It is also important to increase funders' and donors' understanding of the social determinants of health and economic equity mentioned above. With a commitment to bidirectional learning and dialogue, communities can play a central role in educating funders on the intersectional, layered, and nuanced histories and realities shaping communities' lived experiences and efforts.



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15 Both poverty income ratio and hours worked were analyzed using ordinary least squares since we were dealing with continuous variables. Poverty line, employment status, and property ownership are binary outcomes, so we used logistic regression and report Odds Ratios. All regressions report robust standard errors and correct for potential clustering at the household level.

16 Due to the length of the Appendix of the full data analysis tables, the Appendix is available as a separate document on NMW.O's website and upon request.

17 For the analysis of intersectionality, we controlled for interaction terms of race/ethnicity and US born status. This analysis only allows for an unadjusted comparison of means between these groups since no other controls were included. As before, all regressions report robust standard errors and correct for potential clustering at the household level.

18 Centers for Disease Control & Prevention. Behavioral Risk Factor Surveillance System. 2016; https://www.cdc.gov/brfss/data_documentation/index.htm. Accessed December 9, 2016.

19 We used Logistic regression model for our binary outcomes with robust standard errors. We present odds ratios instead of coefficients.

20 Due to the length of the Appendix of the full data analysis tables, the Appendix is available as a separate document on NMW.O's website and upon request.

21 To assess the role of economic security in the outcomes of interest we classified our independent variables by individual demographic characteristics (such as race, marital status, age, gender), socioeconomic variables (income, employment status and home ownership status, and education), and, in order to account for individual's behavior on health, we accounted for health habits (exercise, drinking and smoking).

22 The Income to Poverty Ratio measures how many times higher or lower household income is relative to the poverty line. An Income to Poverty Ratio of 200 means that a person lives in a household with income that is 200%, or twice as large as the poverty line. If it is 50 it means this person's household income is half of the poverty line, or 50% of the poverty line.

23 All references to averages are simple averages, unadjusted through regression analysis to account for any other factors.

24 Individuals who classified themselves as multiple races or did not identify with any race were coded as other race and were mostly self-identified as Hispanic (88% of those under Other race also identified as Hispanic in the American Community Survey and 82% in the pooled Behavioral Risk Factor Surveillance System).

25 This is the result of comparing the average IPR for women in single parent household vs. the average IPR of women in two parent households.

26 IPR for adult women who do not live in single parent household is 310. This means their income is, on average, 310% of the poverty line. The coefficient in the regression for women in single parent household with young children was -85. The ratio between these two shows how much lower (percentagewise) IPR is for women with children of preschool age.

27 Results from Table 7 also show that women who are unmarried AND have pre-school age children have an IPR 85 points above that of married women without young children. This result ought to be interpreted carefully since single mothers might reside with parents. That means that when estimating the IPR, the ACS uses household income of all adults in the household, not just the single mother's income.

28 Results from Table 9 show single-parent households to be more likely to own a home. Since data also suggests that home ownership is highly prevalent in New Mexico's low-income areas and that many young single mothers live with relatives, we assume that reporting of home ownership in the ACS reflects family ownership, as opposed to individual ownership.

29 It is worth noting that the picture of unemployment among minorities is quite complex. For instance, women are, in general, more likely to be employed (i.e., look for a job and find it) than men. According to our findings, women in NM are almost 10% less likely to

be unemployed than men. Working hours per week, however, are affected for mothers of young children.

30 The reference category was those not exercising earning $25,000 or less per year.

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