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Understanding Alaska's Gendered Policy Response to the COVID-19 Pandemic through the Prism of a Wellness Concept

COVID-GEA
Understanding the Gendered Impacts of COVID-19 in the Arctic

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Introduction

Alaska has historically been vulnerable when met with emergency situations, and the COVID-19 pandemic is no exception. The region's geographic remoteness and limited access to health resources elevate the importance of nuanced subnational and local regulations. In focusing on Alaska's gender-responsive policy measures to the pandemic, this study examines the effectiveness of Alaska's legislation using the gendered lens, focusing on one of its most at-risk demographics: women.Under the pandemic, women are disproportionately affected in terms of unemployment, domestic violence, and increased burden of responsibilities, including child/elderly care and household tasks. In addition, women working in female-dominated spheres such as healthcare and social assistance are subject to higher rates of COVID-19 contraction [1] [2].

The growing volume of literature demonstrates that a public health approach extending beyond physical healthcare is essential amid and beyond the pandemic and can also better address women's needs [3] [4]. The conceptual novelty of our study is to conduct policy analysis through a gender lens using the SAMHSA Wellness Model developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The SAMHSA Wellness Model consists of eight equally valued components—social, occupational, intellectual, emotional, physical, environmental, financial, and spiritual. Although it was initially designed to encourage recovery amongst individuals in crisis dealing with mental/behavioral health issues or substance use, it highlights the importance of a holistic approach to crisis response. Notably, this holistic approach has some similarities to the concepts of health and wellness among the Indigenous Peoples of Alaska [5]. The SAMHSA Wellness Model uses the terms 'wellness' and 'wellbeing' interchangeably to emphasize that 'health' does not solely refer to 'physical health,' as the opposite of the dominant U.S. medical model, where physical health and overall health are essentially synonymous.

Research Goal

This study aims to understand Alaska's gendered policy response to the COVID-19 pandemic through the prism of the SAMHSA Wellness Model to better understand lapses in gender-responsive crisis-time decision-making. With the analysis of Alaska's policy compendiums, this study's classification of policies in terms of their responsiveness to women's needs in the prism of the wellness model will inform a holistic understanding of decision-making trends and policy-relevant highlights for solutions to crises.

Study Area

Alaska's population is 734,182, with a female-to-male ratio of 95.8:100 (2021). Alaska is one of the Arctic regions most severely affected by COVID-19 [6]. Numerous studies have shown the disproportionate impacts of COVID-19 among Indigenous Peoples, making up approximately 18% of Alaska's population, and exceptionally higher rates of morbidity and mortality from the virus [7].The Alaskan economy, primarily based on natural resource extraction, contributes to gender inequalities. According to the U.S. Bureau of Labor Statistics, most of the higher-paying jobs in Alaska are in the oil and gas industry, which is overwhelmingly male-dominated, whereas women are overrepresented in the local government, education, and healthcare sectors (for example, women comprise 89% of childcare workers, 87% of registered nurses, and 73-94% of teachers) [8].

Figure 1. Map of Alaska. Source: Nations Online Project.

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Methodology

We created the Arctic COVID-19 Gender Response Tracker (COVID-GEA Tracker), which monitors gendered policy responses introduced by Arctic governments to tackle the COVID-19 pandemic starting from March 1st, 2020 [9]. Initially based on the UN Women COVID-19 Global Gender Response Tracker methodology, the COVID-GEA Tracker, in addition to national policy measures, is designed to aggregate COVID-19 measures implemented by various levels of governance.

The data was categorized into three policy categories that specifically address the needs of women: women's economic security (measures targeting or prioritizing women or targeting female-dominated sectors, such as childcare, health, and social services), unpaid care, and violence against women.

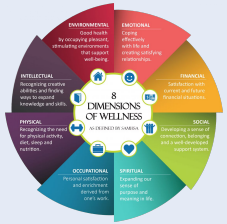

Figure 2. SAMHSA's model of wellness.

For this study, we coded Alaskan gendered policy measures from the COVID-GEA Tracker database as addressing physical, emotional, social, intellectual, environmental, occupational, financial, and spiritual health based on the SAMHSA Wellness Model (Figure 2).

Results

Based on the SAMHSA Wellness Model methodology, of the 11 state-level COVID-19 gendered policy responses in Alaska, *occupational and physical health* needs were most prominently addressed (see Figure 3), and occupational health was addressed in 40% (8 total) of gendered policies. Also, on the state level, *physical health* appeared in 25% of policies (5 total). *Environmental health* was represented through Alaska state policies addressing violence against women, appearing in 15% of policies (3 total). *Emotional health* was addressed in 15% of policies (3 total), and *intellectual health* was seen in 5% of policies (1 policy). Notably, spiritual health does not appear in any policies enacted on the state or city level.

Figure 3. Alaska state level breakdown of COVID-19 gender-responsive measures using the SAMHSA Wellness Model. *Note:* Percentages represent facets of health, not the total number of policies. More than one aspect of health can be addressed per policy.

On the municipal city/town level in Alaska, twelve COVID-19 policy responses were classified as gendered. Physical health and occupational health were the most represented facets of health (see Figure 4). Anchorage's city-level COVID-19 gendered policy response prioritized financial health, as this facet was addressed in 33.3% of their policies (2 total). After financial, physical, social, intellectual, and occupational health were all equally addressed in Anchorage's gendered policy response, appearing in 1 policy each (4 total). Fairbanks' policy response prioritized physical health, as physical health is represented in 37.5% of policies (3 total). Social and environmental health constituted 25% of the total policy response (2 policies), and environmental health was seen in 12.5% of the total health measures (1 policy). Juneau had two policies classified as gendered, and occupational health was addressed in both, constituting 66.7% of the total response (2 policies), and physical health was addressed in one of the policies, representing 33% of the health facets addressed. Nome only had one gendered COVID-19 policy response and only focused on occupational health (100%).

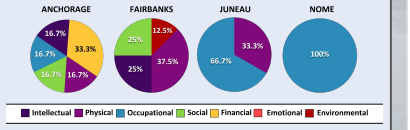

Figure 4. Alaskan municipal level breakdown of COVID-19 gender-responsive Breakdown of COVID-19 gender-responsive measures using the SAMHSA Wellness Model.

Conclusion

Women in Alaska during the pandemic were exposed to significant stressors and thus had a higher need for policies that addressed different components of wellness, including social and emotional health. Although further research is necessary, preliminary analysis suggests Alaska's gendered policy response to the COVID-19 pandemic overwhelmingly addressed physical, financial, and occupational health. The overemphasis of these categories while overlooking some areas that were of significant importance to many women in Alaska, reinforced the adherence of US COVID-19 public policies to the medical model, as opposed to a holistic approach of SAMHSA Wellness or Indigenous health models.

For future public health crises, it remains imperative for women to be taken into special consideration when forming policy responses that should address all components of wellness as defined by the SAMHSA Wellness Model.

Continuing strengthening gender-responsive governance amid and beyond the COVID-19 pandemic necessitates the improvement of gender-specific COVID-19 relevant data collection and availability, as well as the mainstreaming of gender into policies, post-COVID-19 recovery programs, and political processes. Additionally, we call for the SAMHSA Wellness Model to be used alongside the UN methodology to provide a more holistic analysis of policy responses to women's needs.

Acknowledgements

We honor the ancestral stewards of the Indigenous lands included in our study areas in Alaska. Among these stewards are the Eklutna Dena'ina, the K'enaht'ana, and the Iñupiat. We acknowledge and respect their knowledge and wisdom.

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