



# Chapter Two:

## Context and Concepts

Sex- and gender-based analysis has been discussed for two decades, but it has yet to be widely integrated into the health field among program planners and evaluators, researchers, policy makers or administrators in Canada. Recent international developments, such as the World Health Organization’s Commission on the Social Determinants of Health, and growing attention to discussions of equity and health, however, have increased the need and obligation to understand the fundamentals of sex- and gender-based analysis in order to respond to gender-related health inequities.

This chapter summarizes the key developments and commitments in SGBA and defines the core concepts of “sex,” “gender,” “diversity” and “equity.” Through describing the foundations and development of SGBA, we can see the continuing evolution of the policy and scientific contexts – from their roots in women’s health to current concerns with gender and health and health equity.

### The Roots of Sex- and Gender-based Analysis in Canada

Canada’s federal government supports SGBA and, since the late 1990s, has had formal commitments to conduct sex- and gender-based analysis. Other federal institutions, both in and out of the health field, also support SGBA. For example, federal departments such as Human Resources and Skills Development Canada and Status of Women Canada developed gender equality statements and guidelines in the 1990s while the Canadian International Development Agency (CIDA) released its *Policy on Gender Equality* in 1999.<sup>[1]</sup> In the health portfolio, the Canadian Institutes of Health Research (CIHR) included an Institute of Gender and Health among its 13 Institutes when they were established in 2001. More recently, CIHR has provided explicit support for introducing sex- and gender-based analysis into research by commissioning the creation of a guide to SGBA in research,<sup>[2]</sup> calls for research proposals to integrate sex- and gender-based analysis into their designs and support for projects examining sex and gender in health research. Each of these initiatives – and others at the provincial and regional health authority level – has increased the expectation that SGBA will be conducted and have fostered a climate of support for the practice of sex- and gender-based analysis.

The federal policy context for sex- and gender-based analysis spans nearly 40 years, beginning with the *Lalonde Report* of 1974,<sup>[3]</sup> which introduced the concept of four elements in the health field: human biology, environment, lifestyle and health care organization. Just over a decade later, Canada released *Achieving Health for All: A Framework for Health Promotion*<sup>[4]</sup> and, in partnership with the World Health Organization, the *Ottawa Charter for Health Promotion*.<sup>[5]</sup> These documents ushered in discussions of equity and health and drew particular attention to differences in health outcomes related to income, for both women

## Canadian Charter of Rights and Freedoms

### Equality Rights

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

28. Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons.

and men. During the same period, Canada signed a United Nations international agreement called the *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW)<sup>[6]</sup> and introduced the new *Canadian Charter of Rights and Freedoms* (the first part of the *Constitution Act, 1982*),<sup>[7]</sup> which prohibited discrimination on the basis of sex (in Section 15 – 1) and guaranteed equality to “male and female persons” (Section 28).

In 1995, Canada participated in the Fourth World Conference on Women, held in Beijing, China, and signed the *Beijing Declaration and Platform for Action*<sup>[8]</sup> that was developed at the conference. The *Platform* enshrined a broad definition of women’s health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Women’s health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.”<sup>[8,para 89]</sup> This definition confirmed the dual influences of biology and social context on women’s health and informed the development in Canada of a federal women’s health program supported by the Women’s Health Bureau in Health Canada as well as a *Women’s Health Strategy*<sup>[9]</sup> committed to understanding how both “sex” and “gender” are determinants of women’s health. These formal policy developments reflected the impact of the women’s health movement in Canada and around the world. In the 1950s and 1960s, a grassroots movement took shape to challenge medical authority and the social and legal constraints on women’s reproduction and reproductive health. Through landmark publications such as *Our Bodies, Ourselves*<sup>[10]</sup> in the United States and *Healthsharing*<sup>[11, 12]</sup> in Canada, the women’s health movement disputed the view that the only distinctive features of women’s health arose from their reproductive functions. Women’s health advocates argued that there was significant “medicalization” of women’s lives in which normal life processes such as puberty, menstruation, pregnancy, menopause and aging were identified as “medical” problems that required treatment, particularly the use of hormones. They further argued that important aspects of women’s lives such as caring work, economic security and women’s differential treatment by the health care system and in health research were neglected areas of women’s health. The women’s health movement remains an important source of ongoing support for women’s health research and education and has inspired improvements in care, access to services and recognition of diversity among “women” in Canada.

The work begun by the women’s movement in the 1950s and 1960s was supported and supplemented in the 1970s and afterwards by important developments in academia, particularly the fields of sociology and women’s studies. According to Sultanen and Doucet, “Ann Oakley was the first to bring a sustained analysis of the differentiation between sex and gender to the attention of the sociological community.”<sup>[13,p8]</sup> Similarly, sociologist Margrit Eichler coined the phrase “androcentric” research to refer to theories, methods and practices based upon the assumption that research conducted on men was applicable to women.<sup>[14]</sup>

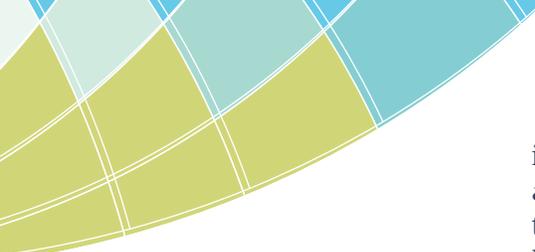
In the intervening three decades, there has been growing discussion about the extent to which health research and health practices are marked by deliberate or inadvertent gender bias.

Federal policy developments also reflected evolving international discussions. In parallel with the development of women's rights and gender equality discussions in Canada, those working in international development had similar aims to promote women, women's rights and women's health in developing countries. Initially, the approach to "Women in Development" tended to focus on creating opportunities specifically for women's economic and social development, including health.<sup>[15,16]</sup> Given high rates of infant and maternal mortality, there was a strong emphasis on reproductive and maternal health as well as on access to food, shelter and income to support women's and children's health. Important gains were made in this period, including the creation in 1981 of CEDAW.

But progress to improve the status and health of women globally remained slow. In the mid-1990s, "Women in Development" was reframed as "Gender and Development," an approach that recognized women's health was rooted in gender relations as well as in social and economic conditions.<sup>[15,16]</sup> This stance was affirmed at the United Nations Fourth World Conference on Women. As noted, the conference also affirmed the importance of health as a domain for action to improve the lives of girls and women around the world. "Gender and Development" further signalled a shift away from an exclusive focus on women to a broader focus on women *and* men, a move that was designed to broaden support for action as well as to recognize the challenges confronting both women and men in developing countries.<sup>[15]</sup> The term "gender analysis" arose in this international development context to describe the process of analyzing economic, social and health situations from the perspective of gender and gender relations. Because much early gender analysis produced information demonstrating that women had been neglected in health research and their concerns not considered

### Summary of Milestones in Canadian Federal Policy Context for Sex- and Gender-based Analysis

- 1974 – *A New Perspective on the Health of Canadians* (The Lalonde Report)
- 1981 – Canada ratified the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- 1982 – *Constitution Act and Canadian Charter of Rights and Freedoms*
- 1984 – *Ottawa Charter for Health Promotion, Achieving Health for All: A Framework for Health Promotion*
- 1995 – Canada adopted *Beijing Declaration Platform for Action*, United Nations Fourth World Conference on Women
- 1995 – *Federal Plan for Gender Equality* (1995-2000)
- 1996 – Canada-USA Forum on Women's Health
- 1996 – Women's Health Contribution Program funds Centres of Excellence for Women's Health and Canadian Women's Health Network (CWHN)
- 1994-1997 – National Forum on Health
- 1999 – Health Canada's *Women's Health Strategy*
- 2000 – Health Canada's *Gender-based Analysis Policy*
- 2000 – *Agenda for Gender Equality* (2000-2005)
- 2001 – Canadian Institutes of Health Research, Institute of Gender and Health
- 2003 – *Exploring Concepts of Gender and Health* (Health Canada)
- 2009 – *Gender Matters*, Institute of Gender and Health Strategic Plan 2009 - 2012



in program or policy development, there has been a tendency to equate “gender analysis” with the analysis of the situations of women and, in the case of health, to an assumption that the phrase “gender and health” really means “women’s health.” One danger of this assumption is that it can lead researchers, decision makers, planners and program managers to assume that they need attend to gender only when considering the needs of women. But many researchers have pointed out that gender pertains to both women and men and the relations between them and so is a feature of all societies and populations.<sup>[17,18]</sup> We agree. While our focus in the Women’s Health Contribution Program has been on women’s health, SGBA involves understanding the health needs and realities of both females and males, and indeed, the health implications of interactions between and among women and men, girls and boys.

Increasingly, we understand that gender inequality contributes to important health challenges for women, girls, men and boys around the world. As the international Women and Gender Equity Knowledge Network report, submitted in September 2007 to the World Health Organization (WHO) Commission on the Social Determinants of Health, argued,

Gender inequality damages the physical and mental health of millions of girls and women across the globe, and also of boys and men, despite the many tangible benefits it gives men through resources, power, authority and control. Because of the numbers of people involved and the magnitude of the problems, taking action to improve gender equity in health and to address women’s rights to health is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources...<sup>[19,p8]</sup>

Apparently the members of the WHO Commission on the Social Determinants of Health agreed, because their final report, released in 2008, concluded that differences in power, privilege and opportunity affect health, and that men and women frequently have different degrees of access to these resources for health.<sup>[20]</sup> “Gender inequality” is thus a determinant of health and actions to reduce gender inequality will improve health for both women and men.

In practical terms, efforts to improve women’s health or to identify the links between sex, gender and health inequalities have faced resistance and competition for resources. The “Gender and Development” approach advocated “gender mainstreaming” as a mechanism for encouraging action on gender issues. A gender mainstreaming approach positions gender concerns as part of every activity within research, program development and policy making, rather than segregating it as the responsibility only of “gender specialists” or those concerned with improving the status of women. By integrating gender concerns horizontally across organizations, disciplines and topic areas, it was hoped that there would be more people working on gender issues, sharing responsibility for raising awareness about and developing appropriate responses to gender concerns. Health Canada’s gender equality policy – and the related training manual *Exploring Concepts of Sex and Gender* – was introduced in 2003 to mainstream gender across every unit in the federal department.<sup>[21]</sup>

Of course, in making gender everyone’s responsibility we run the risk that it will become lost in the machineries of government, health systems, research and in civil society. Keleher<sup>[22]</sup> further reminds us that a gender mainstreaming approach needs to stay focused on the social and economic conditions that produce gendered health outcomes in the first place. Otherwise, gender mainstreaming can lead to a watering down of commitments to change the underlying causes of gender-related inequities, if it is not supported by strategic action on the practices, policies and conditions that generate gender-based inequalities in a given society. Ideally, an approach that recognizes both sex-specific concerns for women and men *and* the integration of SGBA throughout government, research and programming would seem to be optimal. This was the approach recommended by women’s health researchers during the design of CIHR.<sup>[23]</sup> With the creation of the Institute of Gender and Health within CIHR in 2001, Canada deliberately sought to sustain support for research and knowledge exchange on women’s health while nurturing the development of comparative research on women and men as well as the distinct field of men’s health.

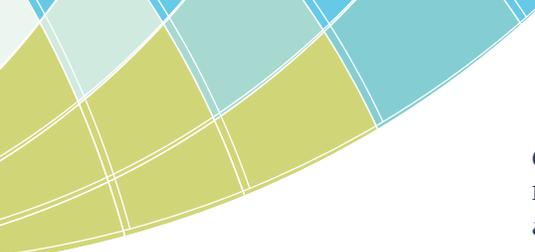
### Clarifying Concepts

In this iconic *The New Yorker* magazine cartoon, two women outside a café are discussing the end of a relationship: “Sex brought us together but gender drove us apart.” The cartoon not only identifies two of the core concepts of SGBA – “sex” and “gender” – but it likewise demonstrates the multiple meanings attached to these terms with the potential for confusion as well as humour. The word “sex” can, as it does in the cartoon, refer to the physical allure of another person and the pleasures of sexual activity, but it is also used to describe an individual as male or female. Additionally, it is a term that can be used to portray relationships between women and men, as in “the opposite sex.” Similarly, the word “gender” has multiple meanings. It is increasingly being used on official



*“Sex brought us together, but gender drove us apart.”*

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documents of all kinds, replacing the term “sex,” to identify an individual as male or female. But in this cartoon, the term “gender” refers to the different roles and responsibilities assigned to women and men, and the challenges they pose to negotiating relationships. While sex and gender are intimately connected in people’s lived experiences and in our understanding of other people, it is critical to distinguish the concepts of “sex” and “gender” as well as how they are, or should be, used in health research, program planning and policy making.

## Sex

“Sex” refers to the biological characteristics that distinguish males and females in any species. In humans, sex differences begin with the chromosomal patterns that distinguish males and females—with males usually having one X and one Y chromosome and females having two X chromosomes. From these fundamental genetic differences, other sex differences in humans arise, including variations in body size and shape, the proportion of fat to muscle, which hormones are circulating in the body or at what levels and different reproductive organs. Subtle differences in biochemical pathways, hormones, metabolism and the size of body tissues between females and males may explain some of the known differences in susceptibility to specific diseases or health conditions, such as lung diseases and arthritis. Physical and physiological differences between women and men may also account for divergent reactions to treatments or secondary prevention strategies, such as daily dosing with Aspirin™ for cardiovascular health.

Although we generally think of sex as comprised of only two categories, male and female, “maleness or femaleness exist and are expressed along a continuum.”<sup>[24,p4]</sup> Body hair, a secondary sex characteristic, is a case in point. While we generally think of women as having less body hair than men, many women and men do not fit this stereotype. Similarly, muscular development in both women and men is affected by exercise and diet, but some women are able to develop their musculature to a greater extent than some men due to differences in genetics.

Even at the cellular level, the distinction between female and male may not be clear or fixed. For example, some individuals may have an extra X or Y chromosome (XXX, XXY, XYY), yet appear to be either typically male or female with respect to their external genitals and overall appearance. Similarly, there are individuals who have sex chromosomes, genitalia and/or secondary sex characteristics that are “non-standard,” neither exclusively female nor male. These variations in chromosomal make-up and secondary sex characteristics challenge the use of only two categories of analysis when we talk about sex. As the Intersex Society of North America observes, “nature doesn’t decide where the category of “male” ends and the category of “intersex” begins, or where the category of “intersex” ends and the category of “female” begins. Humans decide.”<sup>[25,para6]</sup> The value of a fluid and flexible understanding of “sex” is that it more accurately represents human experience, but especially the needs and challenges facing individuals who do not identify with the categories of female and male. Moreover, it encourages us to learn more about just how sex matters when it comes to health and other aspects of human existence.

While sex is obviously important in reproductive health, research is increasingly demonstrating that sex is also pertinent to health for other reasons. From the cellular level up, sex affects human biology. As Johnson, Greaves and Repta

note, male and female bodies may respond differently to substances such as alcohol and tobacco as well as over-the-counter, prescription or illicit drugs due to differences in metabolism, blood chemistry and body fat composition.<sup>[24]</sup> For instance, women may be at higher risk from exposure to environmental contaminants because these chemicals tend to concentrate in body fat and women, statistically, have a higher ratio of fat to muscle than do men. There are also sex-specific differences in some diseases that arise from the effects of hormones. Prior to menopause women typically experience lower rates of heart disease than men because women's higher levels of estrogen provide protective effects.

Males and females may also differ in their susceptibility to disease. For example, a growing body of research suggests that women's bodies may be more vulnerable than men's bodies to the effects of tobacco and other forms of smoke. For example, studies suggest that female smokers may have increased susceptibility to chronic obstructive pulmonary disease.<sup>[26,27]</sup> While the biological mechanisms to explain these observations are far from certain, Sin and colleagues suggest it is plausible that women may suffer earlier and more severe effects from cigarette smoke because toxic substances accumulate and persist in the lungs and/or because their bodies respond strongly to the toxins.<sup>[27]</sup> Other researchers are investigating how differences in occupational and environmental exposures may also differ for women and men and in part reflect biological differences in susceptibility to the effects of inhaled pollutants.<sup>[28]</sup>

While it is not clear whether some of the observed differences in susceptibility are related to body size -do small men and large women face different rates of lung disease than average-sized males and females?- or whether they are genuinely sex-linked differences, findings such as these raise interesting questions about the potential for sex-specific variations in disease and illness that must be addressed in future research.

## Gender

“Gender” consists of the socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes.<sup>[29]</sup> In other words, gender both describes and prescribes what it means to be female or male at a given time, in a given society. While we tend to think of sex as determined exclusively by nature or biology, gender undoubtedly has a “profoundly social character ... [It is] a complex, and powerfully effective, domain of social practice.”<sup>[30,p18]</sup> Understanding and analyzing the impact of gender on health – and life in general – can consequently pose serious challenges because social processes are both complex and changeable. Today's views on femininity or masculinity, for example, are not the same as they were a generation ago, nor do these terms mean the same thing in Western culture as they do elsewhere in the world. Nonetheless, we cannot avoid grappling with this concept because, as mentioned earlier, gender is a reality in every society, for every population and individual.

Like sex, gender has been typically treated as having two distinct categories – maleness (or masculinity) and femaleness (or femininity) – but, again like sex, this binary division does not adequately capture the range of human experience or the expressions of self and identity that gender encompasses. For one thing, few – if any – individuals fulfill the ideals of masculinity or femininity

and most of us do not aspire to or achieve one ideal to the exclusion of the other. As Connell observed, “we must acknowledge that sometimes masculine conduct or masculine identity goes together with a female body. It is actually very common for a (biological) man to have elements of “feminine” identity, desire and patterns of conduct.”<sup>[30,p16]</sup> In other words, most of us experience or exemplify gender as a continuum of characteristics and behaviours rather than as mutually exclusive categories.

At the same time, some people reject the categories of female and male altogether or refuse to identify as one or the other and some individuals identify as both female and male. In some cases, people refer to themselves as “transgender,” a term that denotes their identity as male or female is – wholly or in part – different from their biological sex. Further, in some indigenous cultures, there is a concept of the “two-spirited” person, which has been used to identify people with a same-sex orientation as well those who are transgendered.<sup>[31]</sup> It is important to

note that this concept is usually quite distinct from the notion of a gender continuum in that it implies the coexistence of coherent but distinct female and male identities within the same individual.

According to Sultanen and Doucet, “Much of the history of Canada in the twentieth century, as elsewhere, has been about experimenting with and testing new paths of male and female experience.”<sup>[13,p2]</sup> Johnson and colleagues suggest that it is useful to distinguish among different facets of female and male experience, specifically gender identity, gender roles, gender relations, and institutionalized gender.<sup>[24]</sup> By exploring these different aspects of gender and their interactions, we can more easily track the “experiment” and gain insight into the ways in which gender contributes to important differences between and among women and men in financial security, reproductive and sexual health, mental health, experiences of violence and paid and unpaid caring work.<sup>[22]</sup>

### Something to Think About

Identify a characteristic or behaviour that is commonly associated with your sex. Are you a woman who likes to cook or works with children? Are you a man who loves sports or is employed in the financial world?

Now identify a characteristic or behaviour that is usually linked with a sex that is not your own. Are you a stay-at-home father or a man whose favourite colour is pink? Are you a woman who speaks her mind or repairs cars for a living?

How do people around you react to you when your activities, behaviours or personality fit and do not fit with gender roles prescribed for your sex?

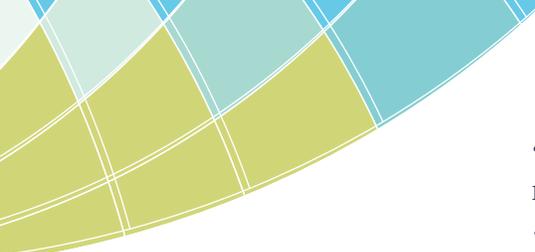
First, let us consider the meaning of “gender identity.” “Our gender identity describes how we see ourselves as female or male (or as a “third gender” or “two-spirited”), and affects our feelings and behaviours.”<sup>[24,p6]</sup> Gender identity is not the same as sexual orientation – one can identify as female and be sexually attracted to women, men, neither or both. Rather, gender identity encompasses one’s sense of being a “woman” or “man” and most people develop a gender identity within the context of societal prescriptions about the appropriate expression of gender for their biological sex (as female or male). In other words, as we learn to think of ourselves as female or male, we also learn what behaviours, emotions, relationships, opportunities and work are considered appropriate for women and men.

This brings us to the second aspect of gender, “gender roles.” Gender roles are the means by which we express or enact our gender identity, they are “the behavioural norms applied to males and females in societies, which influence individuals’ everyday actions, expectations, and experiences. ... from how

we dress or talk, to what we may aspire to do, to what we feel are valuable contributions to make as a woman or a man.”<sup>[24,p5]</sup> Sometimes gender roles are thought of as complementary, with male or masculine individuals contributing one set of skills and characteristics to society and female or feminine individuals supplying another. Often women and men are seen as entirely distinct kinds of people, with characteristics that are not only different, but competing or even irreconcilable. Whether we think of female and male as complementary or competing, however, they are inevitably linked to one another. As Connell and Messerschmidt remind us, “Gender is always relational, and patterns of masculinity are socially defined in contradistinction from some model (whether real or imaginary) of femininity.”<sup>[32,p848]</sup>

Because gender is relational, it is critical to understand the meaning and workings of “gender relations,” the third facet identified by Johnson and her colleagues. The phrase, “gender relations,” refers to “how we interact with or are treated by people in the world around us, based on our ascribed gender.”<sup>[24,p7]</sup> If, for example, we believe that males should be active and outgoing while females should be quiet, gentle and accommodating, we are likely to react negatively to a shy little boy and a boisterous little girl. Similarly, an assertive woman might be called “aggressive” while a man who enjoys knitting might be labelled a “wimp.” Although these aspects of gender roles might seem relatively insignificant, gender relations can and do translate them into discrimination and disadvantage. For instance, historically women have been excluded from high paying and high prestige jobs on the grounds that they are “too emotional” or “have no head for business.” Indeed, gender relations often seem to work to the advantage of men while disadvantaging women. In most societies, women are less likely than men to have access to benefits and resources, such as wealth and power, and they are more likely than men to suffer hardships, such as violence and discrimination. But women are not alone in suffering the negative effects of gender stereotypes. Gay men, for example, have long experienced violence and prejudice at the hands of straight men and women because the dominant masculinity in Western society is “emphatically heterosexual.”<sup>[33,p102]</sup> Because gender is relational, we need to consider both the variety and hierarchy of gender roles and identities when we explore the links between gender and health.<sup>[31]</sup>

We might ask ourselves why it is that a relatively small group of people – white, heterosexual, affluent, urban men – seem able to accumulate wealth, power and privilege while the majority do not enjoy all the benefits of society, or at least not to the same degree. This brings us to the fourth dimension of gender, “institutionalized gender.” Institutionalized gender refers to the ways in which key social institutions, such as the media, our education and health care systems, the courts and the religious and political establishments, frame gender experiences, roles and relationships. “These powerful institutions shape the social norms that define, reproduce, and often justify different expectations and opportunities for women and men and girls and boys, such as social and family roles, job segregation, job limitations, dress codes, health practices, and differential access to resources such as money, food, or political power.”<sup>[24,p7]</sup> Because most cultures value aspects of maleness more highly than those of femaleness, women are more likely to experience structural inequalities in opportunities and access to resources, including the basic necessities of food, shelter and security. Advocates for women’s rights have, especially in the past, tended to hold men solely responsible for this subordination of women, but



“women are central in many of the processes constructing masculinities – as mothers; as schoolmates; as girlfriends, sexual partners, and wives; as workers ... and so forth.”<sup>[32,p848]</sup> In other words, women and men together construct and perpetuate dominant gender roles and gender relations. Change thus requires an understanding of the perspectives and realities of both women and men and SGBA is an important process for contributing to positive and informed action for change.

### *Diversity*

At its most basic, “diversity” refers to variations or dissimilarities between and among people. It is often used to denote observable differences, such as visible ethnic variations in a population and distinctions in age or location of residence. But diversity also includes differences that are not always evident, such as sexual orientation, education and religious or spiritual persuasion. In the context of SGBA, diversity involves understanding that while every individual develops gender identity, enacts gender roles and experiences both gender relations and institutionalized gender, the nature of that experience is specific, “particular to a certain time and place, and social, cultural, economic and political situation. ... [and] because gender differences and inequalities in a particular place combine with the effects of other forms of social division such as class and ethnicity, not all women or all men experience gender-related health problems or issues in the same way.”<sup>[35,p3]</sup> For example, while it is no longer unusual for women in Canada to be involved in paid employment, some cultural traditions within Canadian society make it impossible for women to work outside the home without risking their safety and the respect of their communities. Similarly, while most men in Western societies continue to fulfill an economic role in their households, the creation of paternity leave provisions in public policy reflects changes in the social role of men as fathers and the increasing acceptance of them as nurturers and carers.

Given the variety and specificity of human experience, it is critical that we refrain from generalizing about *all* women or *all* men when we discuss sex and gender as determinants of health. Sex and gender are only two of numerous determinants of health – including socio-economic status, age, sexual orientation, race, ethnicity, geographic location, education, physical and mental ability – all of which act and interact to affect health and care for an individual.<sup>[18]</sup> Understanding all of the social dimensions that comprise the life of a person or group of people – what social scientists sometimes refer to as “social location” – thus requires examining the complexity of lives and the intersecting aspects of identity, location and experience that shape health. When we are studying the health of First Nations, Inuit or Métis people in Canada, for example, we need to be aware of the impact that colonization, segregation on reserves, displacement off the land, residential schooling, loss of language and racism may have had on individuals and communities. We may also need to understand the ways that gender relations function in a particular First Nation community as well as how the members of the community understand their identities. This information will further need to be considered within an overall understanding of the complex legal position of First Nations people in Canada and of the implications of jurisdictional arrangements on access to services, financial support and care.

Our health research begins with the variables of sex and gender because we recognize that “women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ.”<sup>[36,p2]</sup> Moreover, differences in health may arise from structural differences between women and men in access to the basic resources for health like food, safety and shelter as well as in gendered practices that limit girls and women around the world or put the health of boys and men at risk through violence, injury and risk-taking. But sex- and gender-based analysis involves more than simply understanding the differences or similarities *between* women and men; its purpose is also to illuminate the differences *among* groups of women and men. As a result, SGBA moves from initial questions about women’s and men’s health to consider how other variables or determinants of health affect different groups of women and men.

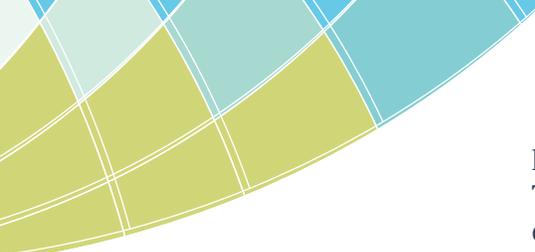
### Equity

Through the exploration of differences and similarities among and between women and men, girls and boys, SGBA helps to identify and offer solutions for health inequities. “Health inequities” are defined as differences in health outcomes that are deemed to be unfair, avoidable and changeable.<sup>[37]</sup> In other words, when an individual or group suffers more illness or more severe illness as a result of poverty or discrimination, for example, they are experiencing health inequities. It is well documented that social hierarchies affect who gets ill and the consequences of illness,<sup>[38,39]</sup> including who is able to access formal health care, who gives and receives care at home, and who experiences the long-term personal, social and economic impacts of illness. Gender, social class, age, ethnicity and religion – among other things – play a significant role in determining who is most likely to become ill and who is least likely to have resources to cope with illness:

Gender intersects with economic inequality, racial or ethnic hierarchy, caste domination, differences based on sexual orientation and a number of other social markers. Focusing just on economic inequalities across households can seriously distort our understanding of how inequality works and who actually bears its burdens. .... Studies tell us the poor are worse off in terms of both health access and health outcomes than those who are economically better off. But they don’t tell us whether the burden of this inequity is borne equally by different caste or racial groups among the poor. Nor do they tell us how the burden of health inequity is shared among different members of poor households. This poses a challenge for policy to ensure equity both across and within households.<sup>[19,p2]</sup>

Achieving gender health equity requires that women and men, girls and boys have equal opportunity and access to the conditions and services that enable them to achieve good health.

In Canada, as previously noted, gender equality is guaranteed through the Constitution, under Sections 15(1) and 28 of the *Canadian Charter of Rights and Freedoms* and by the many international human rights agreements that Canada



has signed. But we also distinguish between formal and substantive equality. The legal concept of “formal equality” requires that people in the same or similar circumstances be treated the same. Historically, treating people “equally” in this sense was understood to mean giving women and men the same opportunities, services and programs. The movement to achieve “equal pay for equal work” is an example of formal equality. But sometimes different treatment may be required to achieve fairness and justice when differences between people cause disadvantages and inequality. This brings us to the legal concept of “substantive equality,” which focuses on the importance of insuring not only equality of opportunity, but also equality of outcome. “Affirmative action,” a policy designed to address historic and systematic exclusion of women and other groups from high income and high status employment, is an example of an approach aimed at substantive equality.

By recognizing that many differences in health among and between women and men may arise from modifiable factors, SGBA is a resource for developing and assessing tailored responses to gendered health inequities: “Taking action to improve gender equity in health is one of the most direct ways to reduce health inequities and ensure effective use of health resources.”<sup>[19,p2]</sup> These actions will need to address the underlying factors that generate gender inequity, both within and outside of the health sector, particularly gender power relations and the ways they influence social norms, practices and institutions.

## Conclusion

In recent decades, Canada has moved steadily towards a deeper appreciation of the role of sex and gender in health and in health inequities. We now have policies that not only enable, but *require* the use of sex- and gender-based analysis in the development of health programs and strategies, in the use of public monies and in the funding of health research. The four core concepts of SGBA – sex, gender, diversity and equity – are critical to further advances in this area: together they create a framework for exploring and understanding people’s experiences of health and illness, and evaluating the extent to which our responses are equal, fair, effective and efficient.

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