Chapter Eight:
Rising to the Challenge
State of the Art

In this volume, we have introduced our treatment of sex- and gender-based analysis as a process – rather than a checklist or formula – and described the core concepts that drive that process: sex, gender, diversity and equity. Our approach is further illustrated in a rich collection of case studies and commentaries, drawn from a decade of experience in policy-relevant women’s health research and knowledge exchange. We have argued – and demonstrated – that SGBA is essential for understanding and responding to health concerns of all kinds and can be applied across disciplines and sectors, programs and policies and in every type of research. Sex- and gender-based analysis encourages deeper reflection about issues, populations, sources and types of evidence and enables the development of more appropriate, efficient and cost-effective responses.

Because the process of SGBA is iterative, it raises new questions as the analysis proceeds, potentially leading to new evidence and new options for action. Indeed, the process of SGBA is fundamentally about asking questions: about data, relationships, health impact and the intersections among determinants of health – recognizing that sex and gender are fundamental influences on the identities and experiences of both women and men. It also includes asking questions about which women and men are affected by specific health conditions, the broader determinants of health, social institutions and power relationships as well as policies and practices. In this way, SGBA forces us to consider diversity among women and men, girls and boys, including differences arising from sexual orientation, gender identity, socioeconomic status, age, language, place of residence, education, historical circumstances and a host of other factors that relate to and affect experiences of health and illness, access to health care and provision of care.

Among the observations emerging from the development of this guide is the critical importance of having access to and using sex-disaggregated data. Information must be collected using the categories of male and female (at a minimum) and these data must be reported to make more comprehensive sex- and gender-based analysis possible for researchers and analysts. As we have seen, finding and getting access to sex-disaggregated data can be a challenge as well as an obstacle to undertaking an SGBA. We therefore urge data-collecting agencies, organizations that maintain datasets, governments and partners to routinely collect and report information by sex. We also hope that they will begin to explore ways to challenge the binary of male and female by developing measures of sex that are more nuanced and inclusive.

At the same time, the introductory chapters and the case studies illuminate the distinctions between the concepts of sex and gender as well as the many ways in which they overlap and interact. While sex-disaggregated data are often lacking, an additional complication for SGBA is the absence of reliable measures of “gender.” Indeed many survey tools treat sex and gender as if they are interchangeable categories and consequently report on gender differences and similarities when what is really being measured are health trends and patterns among females and males. In other words, sex-disaggregated data alone do not allow us to undertake a comprehensive SGBA. Whether or not it is possible to develop innovative methods for measuring gender remains to be seen, but in any
case we can and should use qualitative data to deepen our understanding of the differences between sex and gender as well as the subtle – and not so subtle – interplay between the biological and the social in the lives of women and men, girls and boys. Because gender, like sex, is a continuum rather than a binary, a robust sex- and gender-based analysis includes the work of conceptualizing, recognizing and analyzing multiple expressions of gender and the relationships among them.

Throughout the guide, we have emphasized the importance of moving beyond a basic understanding of differences and similarities between women and men to an appreciation of differences and similarities among groups of women and men. In other words, SGBA embraces diversity in the lives of women and men, girls and boys. As we have seen, data collection poses considerable challenges to diversity analysis. For example, many survey tools do not elicit information on “visible” characteristics, such as race and ethnicity, let alone on “invisible” characteristics, such as sexual orientation or spirituality. Even when these types of data are collected, the linkages among them may not be analyzed – referred to as cross-tabulation – or reported, making it difficult to connect the dots between diversity and health. Qualitative research can contribute to our understanding of the health of diverse populations, but more work is needed in this area, particularly for sub-populations that are conspicuously under-represented, such as indigenous Blacks in Canada. Ultimately, as with sex and gender, diversity needs to be understood as a continuum rather than as a binary of “dominant” and “non-dominant” groups.

Equity is the ultimate driver of sex- and gender-based analysis. Health inequities – like other forms of inequity – are often rooted in differences of power and privilege distributed along the fault lines of sex, gender and diversity. As many of the case studies and commentaries demonstrate, research, policies and programs that ignore these core concepts are unlikely to redress health inequities and may, in fact, deepen existing disparities or even create new ones.

At the same time, the case studies and commentaries confirm that SGBA is crucial in all aspects of health-related work. We are not suggesting that any one piece of research or any single policy must address all forms of diversity or solve every instance of inequity. Rather, we are arguing that articulation of and attention to the core concepts of sex, gender, diversity and equity is imperative to establish why and how specific issues and populations are under consideration as well as what evidence exists and is being employed to make decisions that affect health and care. The process of sex- and gender-based analysis takes time, but it is time well spent.

**Emerging Directions**

While this guide represents the accumulated and collective knowledge and experiences of a cohort of women’s health researchers, it is also a testament to the ongoing evolution of SGBA. From its roots as a white, middle-class, urban women’s movement, based largely in North America and Europe, sex- and gender-based analysis has become more inclusive and expansive, embracing both the analysis of diversity and an understanding of global perspectives on the health and well-being of women and girls as well as for men and boys. From its initial focus on gender, SGBA has also evolved to include an analysis
of sex that transcends reproduction alone and that addresses the complex interactions of sex and gender. The emergence of new ideas and innovate methods for understanding and analyzing health – both now and in the future – create exciting opportunities to reflect upon the theory and practice of SGBA as well as to deepen its sophistication and expand its use. Currently, four areas have enormous potential to shape the future of sex- and gender-based analysis: developments in men’s health and masculinities research; expanded research and practice related to the social determinants of health; the adaptation of SGBA to the context of First Nations, Métis and Inuit communities and populations; and the application of intersectionality theory to health research.

**Men’s Health and Masculinities Research**

The field of men’s health emerged as a separate area of interest, study and practice in the 1980s.[1] Like women’s health researchers and advocates in the early days, the first generation of men’s health researchers focused on conditions that are unique to, more serious in, more prevalent among men, or that require different diagnosis, treatment or prevention than those affecting women. They also attended to conditions overlooked in mainstream literature, such as prostate and testicular cancers and mental health.[2] As with the women’s health movement, men’s health researchers and advocates responded to an absence of gender analysis. As Courtenay[3] observed, “The consistent, underlying presumption in medical literature is that what it means to be a man ... has no bearing on how men work, drink, drive, fight, or take risks. Even in studies that address health risks more common to men than women, the discussion of men’s gender is often conspicuously absent.”[p1387] Complex and illuminating theories about masculinities took shape and a body of research has been developing that demonstrates the influence of gender on men’s health.[3‑5] As Oliffe and Galdas[6] recently concluded, “There is growing evidence that the socialization of men and boys and their resulting enactment of gender (masculinities) can have a deleterious impact on their health and health behaviours. Masculinities research, which is based on this perspective, is increasingly showing that men operate using gender-specific health behaviours and experience illness that requires targeted interventions.”[p1] New frameworks that reconceptualize men’s health in light of the determinants of health, such as that of Frank and colleagues,[7] have also begun to take shape (see Figure 1).

Men’s health, like women’s health, has strengths and limitations. On the one hand, theories of masculinity expressly address power differentials and are helping to challenge the binaries of male-female and masculine-feminine as the frameworks for modeling and understanding human sexual

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**Figure 1. Health, Illness, Men and Masculinities (HIMM) Diagram**

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experience, identities and behaviours. On the other hand, while the women’s health movement has long incorporated an understanding of how women’s status relative to men influences their health, men’s health researchers have tended to shy away from engaging in an analysis of men’s health relative to women. As Connell and Messerschmidt[8] contend, “there is a tendency in the men’s studies field to presume “separate spheres,” to proceed as if women were not a relevant part of the analysis, and therefore to analyze masculinities by looking only at men and relations among men.”[p837] It would appear, then, that there is much to be gained from collaboration across the fields of women’s and men’s health. SGBA could serve as a bridge between the fields while itself being enriched by the processes of interaction and engagement.

**Gender and the Determinants of Health**

While some countries, governments and organizations recognize gender as a determinant of health – as Canada does – it is often merely included in a list without being described or linked to the other determinants of health. Recently, however, the WHO Commission on the Social Determinants of Health presented a conceptual framework that organizes the determinants of health and locates gender in relation to other determinants (see Figure 2).[9] The WHO model suggests that social and individual factors, including material circumstances, social cohesion, psychosocial factors, personal behaviours and biological factors, interact with the health care system to produce the distribution of health and well-being in any given society. These factors are, in turn, influenced by a person’s social position, which is a function of his or her education, occupation, income, sex and gender, ethnicity and/or race. The framework also recognizes that there is a feedback loop between health and well-being and social position because health is also a resource for being able to engage in social life, including education and occupation, and also because some health conditions, such as mental illness, carry stigma that can affect an individual’s social position. Finally, the model proposes that the socioeconomic and political contexts in which we live – specifically the nature of governance and policy as well as the cultural and societal norms and values that characterize communities and countries – influence social position and are, in turn, affected by the distribution of health and well-being. This model is a significant advance on a simple list of determinants of health that ignores the significance of interplay and intersection among the determinants. But it is also noteworthy that sex is absent from the model, raising questions about whether there is an understanding or due attention to the distinctions between the biological and the social. Moreover, gender is located in the framework as an aspect of social position, rather than an overarching or pervasive influence on health, comparable to policies and economic contexts. In other words, in the WHO model, gender appears to be central without actually being pivotal.
A new publication by the Women’s Health Research Network in British Columbia proposes an alternative conceptual model (see Figure 3). Benoit and Shumka describe sex and gender as “fundamental determinants of health” on the grounds that they influence other determinants of health. Sex and gender – along with class, race, ethnicity, immigrant status, age and geographic location – determine a person’s access to key resources, such as employment, education, childcare, safe neighbourhoods and health services as well as individual behaviours, choices and opportunities, such as smoking, nutrition or diet and exercise patterns – all of which affect morbidity and mortality. In this model – as opposed to the WHO framework – both sex and gender are named and they are understood as foundational to health and well-being rather than as only significant. While the diagram itself suggests that the influence of various macro, meso and micro determinants flows only in one direction, the framework does capture the interplay of influences on health. As Benoit and Shumka maintain, “Our model is dynamic in that it can be amended over time and according to location to include emerging fundamental determinants of interest to researchers, such as sexual orientation or access to clean water for those living in less-privileged areas of the globe.”
The point of this discussion is not to spark a debate over which model is better. What is exciting and important from the perspective of the development of SGBA is that alternative models can generate innovative empirical research and practical interventions. Moreover, the test of either of these – or other – frameworks will be how well they are able to account for sex- and gender-based differences in health outcomes and health-related behaviours. This emerging work reflects the vibrancy of current discussions of sex, gender and health underway in Canada and around the world as well as promising theoretical and empirical research directions.

Aboriginal-specific GBA

Another development we are seeing in Canada concerns the relevance and/or adaptation of sex- and gender-based analysis for Inuit, First Nations and Métis communities. Women in Métis, First Nations and Inuit groups have been exploring the potential for SGBA to respond to the particular social contexts, traditions and histories of Aboriginal communities. For example, Native Women’s Association of Canada (NWAC) and Pauktuuit, Inuit Women of Canada have initiated discussions about the need for culturally relevant SGBA, building upon the support for substantive equality outlined in Canada’s Charter of Rights and Freedoms (see Chapter 2). Both organizations have emphasized the need for explicit attention to the historical and contemporary experiences of First Nations, Métis and Inuit women in research, policy development and program planning. In particular, NWAC has called for attention to the impact of colonization, western-style capitalism, globalization, nationalism and paternalistic approaches to development that characterize current policies and programs. Both organizations in turn suggest that SGBA needs to be modified to embrace the

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*a “Aboriginal” is an umbrella term which can be used to refer to First Nations, Inuit and Métis peoples collectively, as described in the Constitution of Canada. However, the authors recognize and acknowledge that the experiences and SGBA-related work are distinct for Métis, Inuit and First Nations populations and organizations.*
cultural, historical, linguistic and other unique features of Inuit, First Nations and Métis women if it is to redress the particular forms of inequalities and inequities they experience.

The Assembly of First Nations (AFN) has also been among the organizations to explore the application of sex- and gender-based analysis. In a recently developed series of documents, AFN proposes a Gender-balanced framework. The Framework introduction explains that the gender-balanced approach “integrates the First Nations historical and cultural context and perspective to provide for more responsive and effective policy and legislative development where First Nations are concerned. The First Nations worldview requires a balanced approach to all aspects of life between men and women, boys and girls as well as the recognition and consideration of those who engender both male and female, to ensure that everyone is included in the sacred circle of our Nations.”[14,p4]

From the perspective of the evolution of SGBA, these various adaptations are evidence of the continuing need to look seriously at culture, colonization, ethnicity and race and their links to – and implications for – gender, gender identity, gender relations and institutional gender. They expose the historical and cultural specificity of any one view of sex and gender and enlarge the conversation from a consideration of sex and gender to one that links them to other important aspects of social life. Work on SGBA in the context of Latin America is raising similar questions about adapting an analytic method that was developed primarily in Europe and North America to parts of the world with very different histories of gender relations and terminology. Intersectionality theory, described below, extends this thread further again.

**Intersectionality**

According to Siltanen and Doucet,[1] diversity is “a key analytical challenge facing those interested in the analysis of gender today … how to find a way to address the specificity of experiences of gender while at the same time attending to broader commonalities and configurations that have social and political significance.”[p187] In other words, we need to ask how we get at the ways in which sex and gender intersect and interact with other significant dimensions of identity and difference, such as visible minority and immigrant status, heterosexuality and ability. Intersectional theory developed in response to these pressing questions, gaining prominence in the 1990s when sociologist Patricia Hill Collins utilized the concept in her work on Black feminism.[1,15] Since its emergence from United States (US) Black feminism, intersectional theory has been further influenced by “Indigenous feminism, third world feminism, and queer and postcolonial theory.”[16,p9]

While there is no single agreed-upon definition of intersectionality, the theory posits that people’s experiences are simultaneously the product of how they identify themselves, how they are seen by others, and how they interact with others. Because intersectional theory seeks to understand how these aspects of self and society interact, it challenges theories and practices that privilege single categories, such as race or gender, in explanations of human experience, including health.[1] As Hankivsky and Cormier[16] observe, “this perspective moves beyond single or typically favoured categories of analysis (e.g., sex, gender, race
and class) to consider simultaneous interactions between different aspects of social identity … as well as the impact of systems and processes of oppression and domination …”[p3]

On the one hand, intersectionality has been described as a successful theory because it offers feminist theorists a framework for addressing thorny intellectual and political debates about privilege and disadvantage, both past and present.[see 17] It also prompts researchers to think beyond the categories of race, class, sex and gender to look at broader social forces, such as globalization, colonization and oppression. On the other hand, intersectional analysis has been critiqued because it sometimes waters down attention to politically, historically and culturally significant social divisions, as it tries to focus attention on the complexity of social experience. Sultanen and Doucet quoted Stasiulis who also pointed out the difficulties of determining “which social relations in the seemingly dizzying array of differences should be accorded particular salience or significance …”[1,p.179] Moreover, though some progress has been made in the development of guidelines and techniques for applying intersectional analysis, such as the work of the Canadian Research Institute for the Advancement of Women (CRIA W), this work is still in the very earliest stages of development.[1,18]

Intersectional analysis represents an important opportunity to deepen the sophistication of SGBA by introducing a new order of complexity. It brings social theory to the forefront of discussions about health and encourages us to reassess heath research methods and, models as well as health policies and practices in light of those theories. For example, intersectional analysis prompts us to think about the workings and impact of social processes, such as marginalization and racialization, rather than focusing on static social states or locations, such as Black and White. In the process it reminds us forcibly that the determinants of health are dynamic and changeable and that specific facets of human experience or individual identity may be more or less significant from one illness, issue or context to the next.

**The Challenge of Achieving Equity and Health**

In recent years, we have witnessed an unprecedented shift in discussions about health disparities, from a focus on biological or behavioural vulnerabilities and access to health services to an emphasis on power and privilege, including access to a broader array of resources, such as education and wealth as well as political and social opportunities. While this shift began with a focus on the effects of socioeconomic status on health, it has evolved to include new approaches to social epidemiology and health research. For example, the final report of the WHO Commission on the Social Determinants of Health[9] identifies gender inequity as a key driver of health and other disparities and urges action to redress imbalances of power and privilege between and among women and men. Our position throughout this guide is that sex- and gender-based analysis as an iterative process is essential to uncovering and reducing disparity and inequity. We need to rise to this new challenge of integrating gender concerns within broader discussions of equity and health such that sex, gender and diversity, which shape all societies, are fully integrated into research and policy making.
References


