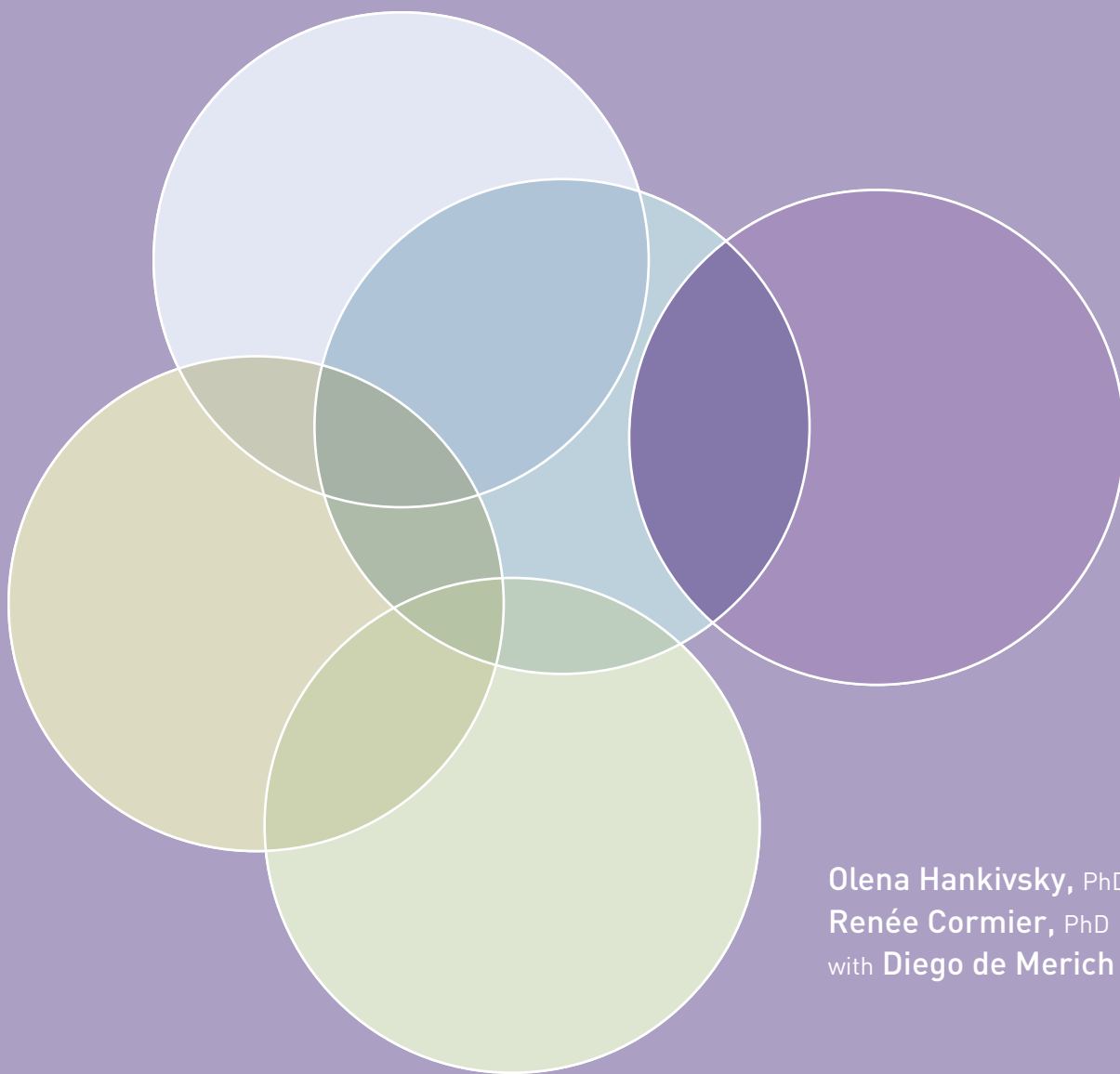


INTERSECTIONALITY

MOVING WOMEN'S HEALTH RESEARCH
AND POLICY FORWARD



Olena Hankivsky, PhD
Renée Cormier, PhD
with Diego de Merich

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WOMEN'S HEALTH RESEARCH NETWORK
VANCOUVER, CANADA

Women's Health Research Network

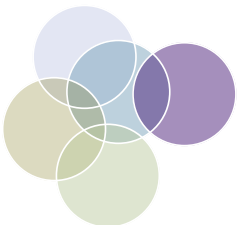
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The WHRN fosters the generation, application, and mainstreaming of new knowledge, specifically to improve women's health and women's health research. We are interested in increasing the understanding of and capacity for sex- and gender-based analyses and for integrating diverse women's health concerns into other areas of health research.

With an inclusive, multisectoral, and multi-disciplinary approach to research, the WHRN also encourages the brokerage of knowledge regarding the health of girls and women in British Columbia and Canada.

For more information about the WHRN, or about becoming a member, please visit our website at www.whrn.ca

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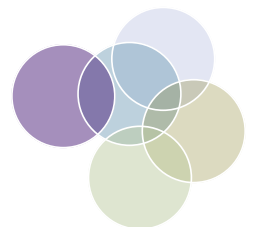
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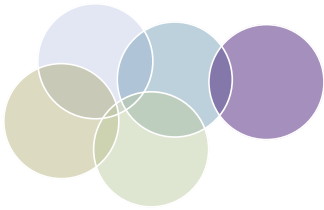
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Contents

- 1 Purpose of this Primer
- 3 What Is Intersectionality?
- 10 How Does an Intersectional Approach Differ from Other Approaches?
- 16 Why Intersectionality in Women’s Health Research and Policy?
- 19 Intersectionality and Health Research
- 32 Intersectionality and Health Policy: Some Lessons from Existing Models
- 43 Case Studies: Moving through the Research and Policy Processes Using Intersectionality
- 53 Conclusions
- 54 Appendix A: Definitions of Social Categories
- 62 References





Purpose of this Primer

While the importance of identifying and responding to diversity has been acknowledged in women’s health research and policy, approaches to date have focused on:

- (a) the singular categories of gender, social class, and race, often independently of each other or
- (b) the variables of sex and gender and the relationship between the two (Hankivsky, 2007; Rummens, 2003; Wilkinson, 2003).

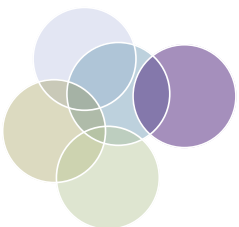
Researchers, policy-makers, and practitioners are recognizing that women’s health and experiences are shaped not only by sex and gender, but also by other factors such as race, class, culture, income, education, age, ability, sexual orientation, immigration status, ethnicity, Indigeneity, geography, and so on. Intersectionality is increasingly being adopted as a new *paradigm*¹ which seeks to counteract one- and two-dimensional approaches by bringing to the forefront the complexity of social locations and experiences for understanding differences in health needs and outcomes. For those working in the areas of gender and women’s health, intersectionality can be used for studying, understanding, and responding to the ways in which sex and gender intersect with other variables and how these intersections contribute to unique experiences of health. This perspective reveals that, while sex and gender are important considerations, one should never assume that they are the most important categories for conducting health research or for developing, implementing, or evaluating policy. In short, an intersectional framework can be thought of as the next step in the evolution of women’s health research and policy.

To date, little progress has been made in terms of developing practical guidance to health researchers and policy-makers who are interested in applying an intersectional analysis in their work. As Wilkinson has argued elsewhere, “One of the challenges of [the intersectionality perspective] is ... to articulate it effectively enough to increase its use throughout a variety of disciplines and in the study of

1 “Paradigm” is defined as a philosophical or theoretical framework preceding (1) the question of what is to be studied, (2) the kind of questions to be asked, (3) how the questions are to be structured and/or how the study is to be conducted, and (4) how the results should be interpreted, translated, and applied (Guba & Lincoln, 1994; Kuhn, 1996; Merriam-Webster Online dictionary, 2008).

a wide variety of peoples” (2003, p. 27). The **purpose of this primer** is to explore the following question: *How can health researchers, policy analysts, program and service managers, decision makers, and academics effectively apply an intersectional perspective to their day-to-day work?* While it is important to highlight that an intersectional framework can be applied to all populations, given the mandate of the Women’s Health Research Network (WHRN), this primer specifically focuses on its applicability in the context of women’s health. The primer includes the following:

- an overview of intersectionality including challenges and advantages of this approach;
- a discussion of the key assumptions of intersectionality;
- a comparison and contrast of an intersectional approach, a gender- or sex-based approach, a health determinants approach, community-based research, and Indigenous approaches;
- a discussion of the need for an intersectional approach in gender and women’s health research;
- a discussion of how to integrate an intersectional approach into health research;
- a discussion of how to integrate an intersectional approach into health policy-making;
- examples of the application of an intersectional framework to three health issues.



What Is Intersectionality?

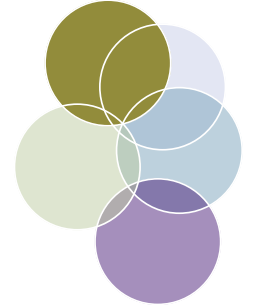
There exists no widely agreed-upon definition of intersectionality. Historically, the term “intersectionality” emerged from U.S. Black feminism, Indigenous feminism, third world feminism, queer and postcolonial theory and was officially coined by Kimberlé Crenshaw in 1989.² Broadly speaking, this perspective 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 (e.g., race, ethnicity, Indigeneity, gender, class, sexuality, geography, age, ability, immigration status, religion) as well as the impact of systems and processes of oppression and domination (e.g., racism, classism, sexism, ableism, homophobia).

Intersectionality is transforming gender studies, cultural studies, and migration studies and has started to influence the disciplines of economics, political science, psychology, geography, criminology, history, sociology, and anthropology. Researchers and decision makers working within an intersectionality paradigm share the logic that marginalizations at the individual and institutional levels create stratifications that require research approaches and policy solutions which are attuned to the interactions of these realities (Hancock, 2007). Thus, a central goal of intersectionality is the social inclusion of previously ignored and excluded populations. More recently it is being constructed in a way that is “applicable to any group of people, advantaged as well as disadvantaged” (Yuval-Davis, 2006, p. 201).

An intersectional approach, grounded in lived experience, provides the theoretical foundation for the pursuit of social justice. Unlike traditional approaches to women’s health research, which often ignores the complexities of identity formation, intersectionality has the potential to produce more accurate and useful information for making change and, in the process, helping to ensure that “existing efforts do not inadvertently disadvantage or harm any particular individual or community, or alternatively be complicit in the empowerment of another” (Rummens, 2004, p. 4). As Collins argues, an intersectional analysis is only realized “when abstract thought is joined with concrete action” (Collins, 1990, p. 29) — action that is intended to create coalitions and strategic alliances to alleviate poverty, social exclusion, marginalization, and subordination.

In short, intersectionality can be thought of as a *research and policy paradigm*

2 For a discussion of the evolution of “intersectionality” as a concept, please refer to Kathy Davis’ (2008) article entitled “Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful”.

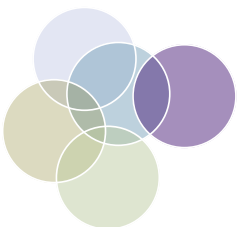


(Hancock, 2007) “for fundamentally altering the ways in which social problems are identified, experienced, and understood so as to reflect the multiplicity of lived experiences” (Oxman-Martinez et al., 2002, p. 23). At the same time, intersectionality is not prescriptive but rather can be conceptualized as “a loose set of ideas about how to undertake research [and design and implement public and health policy]” (Dhamoon, 2008, p. 3). In an attempt to move beyond a single definition of intersectionality, Dhamoon (2008) discusses “*intersectional-type approaches*” representing different dimensions of socio-political life: (1) identities of individuals or social groups, (2) categories of difference, (3) systems of domination, and (4) processes of subject formation. According to Dhamoon, “all four can encompass an examination of how subjects construct, develop, negotiate their own social locations and those of o/Others in social contexts of power. But each emphasizes something different in our understanding of subject formation and power” (2008, p. 12). The discussion below is intended to illustrate how different levels of intersectional-type analysis can be applied to women’s health research and policy.

Identities of individuals or social groups

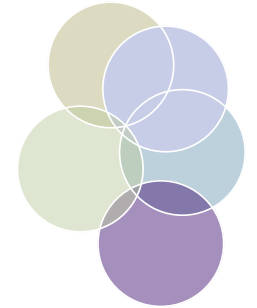
One basic assumption of intersectionality is that “different dimensions of social life cannot be separated into discrete or pure strands” (Brah & Phoenix, 2004, p. 76). Individuals’ economic, political, cultural, subjective, and experiential lives intersect to create a whole that is more than the sum of its parts. An intersectional-type approach focusing on individuals or social groups identified as “oppressed” would entail exploring the unique intersection of single dimensions of multiple axes of difference (e.g., able-bodied, working class, South Asian women). Further, systems of domination and subordination are interactive and create complex intersections (Hannan, 2001), the result of which can be a kind of “trans-identity” which is experienced at the individual, structural, and policy levels. Accordingly, this perspective is grounded in an “experience-based epistemology” (Simien, 2007), which assumes human beings experience and are shaped by interlocking forms of oppression that can change over place and time. To avoid adding or layering social locations, intersectionality can be visualized more like an oscillating net or web, where there are many spaces and shapes for renegotiation and resistance (Cole, 2008; Diamond & Butterworth, 2008).

This type of intersectional analysis is perhaps the most frequently adopted by feminist scholars and has resulted in knowledge about the lived experiences of previously neglected “other” groups such as Black women, women with



At the core of an intersectional model is the understanding that individuals occupy complex and dynamic social locations, where specific identities can be more or less salient depending on the historical or situational context.

disabilities, immigrant women, and Indigenous women. However, one of the major shortcomings of focusing on an individual's or social group's lived experience is that of essentialization. As Morris and Bunjun argue, "It is important to acknowledge multiple realities, and not to "essentialize" any group, that is, not to treat any group as if all its members are exactly the same and have the same experiences, view and priorities" (Morris & Bunjun, 2007). They further illustrate by explaining:



There are many linguistic, cultural, ethnic, religious, income, health, educational, age and political differences within the wider group "Black women living in Canada" and many different perspectives and needs. However, many researchers and organizations are still at the stage of trying to round up one Black woman whom they presume can speak for all Black women instead of seeking out the many different women in the community that can bring out different experiences and perspectives. (2007, p. 5)

Categories of Difference

At the core of an intersectional model is the understanding that individuals occupy complex and dynamic social locations, where specific identities can be more or less salient depending on the historical or situational context. Social categories such as gender, race, ethnicity, religious affiliation, and sexual orientation, are a central concept of interest in intersectional research. From an intersectional perspective, social categories are dynamic, historically grounded, socially constructed, and work at both micro and macro structural levels (Burgess-Proctor, 2006; Weber & Parra-Medina, 2003). Traditionally, social categories are seen as static and as being the *cause* of certain behaviours, but from an intersectional perspective, categories are seen as the *effect* of behaviour and are constantly constructed, deconstructed, and reconstructed (Staunæs, 2003, p. 104).

The concept of identity is frequently conflated with that of social categories of difference (Yuval-Davis, 2006). Whereas identity refers to an individual or social group's unique social location along single dimensions of multiple categories, the study of categories of difference typically entails exploration of multiple dimensions of multiple categories. McCall (2005) further speaks to the issue of social categories by distinguishing among three approaches:

- (a) Anticategorical: with the recognition that social life is too complex to be reduced to a series of categories, an *anticategorical* stance assumes a postmodern deconstruction and subsequent rejection of categories;

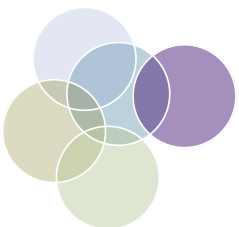
- (b) Intracategorical: the *intracategorical* approach falls conceptually in the middle of the continuum between the anticategorical and intercategorical approaches. In the intracategorical approach, the analysis consists of “a social location at the intersection of single dimensions of multiple categories” (p. 1781);
- (c) Intercategorical: directly relevant to the discussion in this section regarding the study of categories of difference is what McCall refers to as an *intercategorical* approach. An intercategorical approach entails using pre-existing categories of difference to explore inequalities within and across social groups (e.g., comparing Black women with poor White men).

An intersectional analysis assuming an intercategorical approach does not seek to add categories of analysis to one another (Brewer, 1993; Zerai, 2000) but, instead, seeks to understand what is created and experienced at the intersection of two or more axes of oppression. The study of categories of differences has been criticized for largely focusing on the race-class-gender trinity (Angus, 2008; Dhamoon, 2008; Hancock, 2007), resulting in an Oppression Olympics (Martinez, 1993) whereby social groups compete for the political and monetary support of dominant groups and at the cost of excluding “other” disadvantaged groups (Dhamoon, 2008).

Systems of Domination and Processes of Subject Formation

In an exploration of systems of domination and oppression (e.g., racism, sexism, colonialism) and processes of subject formation and differentiation (e.g., racialization, gendering, sexualizing), the focus of an intersectionality-type analysis “is not on the intersection itself, but what the intersection reveals about power” (Dhamoon, 2008, p. 20). Central to an intersectional perspective are questions about “deprivation, privilege, discrimination, and aspirations, to permit characterizing people more fully, and as more than the sum or product of their parts” (Krieger & Zierler, 1995, p. 253). As Bogard explains, “we exist in social contexts created by the intersections of systems of power ... and oppression” (1999, p. 277). Similarly, Yuval-Davis (2006) explains that, because social positions are relational, attention to social power axes is essential.

By striving to elucidate and interpret multiple and intersecting systems of oppression and privilege (i.e., “neglected points of intersection”; McCall, 2005, p. 1780) intersectional scholars complicate our understanding of social identities and locations. This is not to say that intersectional theorists categorize persons as either



“One cannot assume the same effect or constellation each time, and hence, the investigation of the specific social, political and economic processes involved in each historical instance is important.” ~ YUVAL-DAVIS, 2006

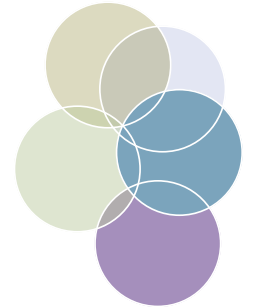
intersectionally privileged or intersectionally oppressed. Because individuals are members of more than one community and can identify with more than one social group, they can simultaneously experience both discrimination and privilege. The multiple and crosscutting social relations produce “a matrix of domination taking a ‘both/and’ form ... not a simple model of structural subordinate relations” (Daly & Stephens, 1995, pp. 206–207).

As Morris and Bunjun explain, “in order to understand how anybody has come to their current situation, we need to understand the past (history/colonization)” (2007, p. 1). In Canada, this is particularly important for both non-Aboriginal and Aboriginal peoples when considering colonialism and how the lives of Aboriginal peoples continue to be affected by generations of their families who were confined to reserves and who experienced severe abuses in the context of the residential school system. The systematic racism that Aboriginal people in Canada have experienced and continue to experience has had major consequences with poverty, substance use, violence, and mental health being serious issues within that culture (e.g., Browne & Fiske, 2001; Browne & Smye, 2002). For a more in-depth discussion of the effects of colonization in Canada, please refer to Morris and Bunjun (2007).

In addition, as pointed out by Yuval-Davis (2006), “One cannot assume the same effect or constellation each time, and hence, the investigation of the specific social, political and economic processes involved in each historical instance is important” (p. 200).

For example, while in Canada there are proportionally more men than women (roughly three to one) infected with HIV/AIDS, in the sub-Saharan region of Africa, more women than men (61 percent versus 39 percent) have HIV/AIDS (UN Programme on AIDS & WHO, 2007). The socio-cultural environment of women from the sub-Saharan region, which includes exposure to systemic patriarchy, poverty, and domestic violence, is seen as directly contributing to the high rates of infection (Osarenren, 2008; WHO, 2004); therefore a response to the HIV/AIDS epidemic involves situating the issue within a broader social context.

As can be seen from the discussion above, there are several ways to incorporate an intersectional-type analysis in women’s health research and policy. Despite the broad spectrum of approaches representing intersectional-type analyses, common assumptions underlie all research and policy that is grounded in an intersectional perspective. These are highlighted and discussed as Key Assumptions of Intersectionality in the following section.



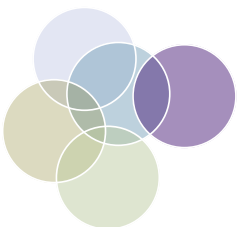
Key Assumptions of Intersectionality

Pursuit of Social Justice as Main Objective

- By “joining abstract thought with concrete action” (Collins, 1990, p. 29), the ultimate goal of an intersectional analysis is to advance an identifiable social justice issue. This action is intended to create coalitions and strategic alliances to alleviate poverty, social exclusion, marginalization, and subordination. This may involve first revealing meaningful similarities and then coming together. Thus, “opportunities for coalition building coupled with a commitment to social justice make ... the intersectional approach a crucial strategy ... and praxis” (Burgess-Proctor, 2006, p. 43).

Conceptualization of Identity and Social Categories of Difference

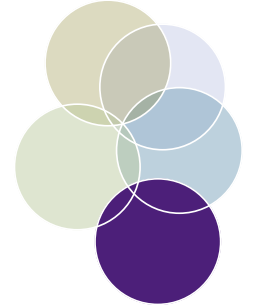
- First, individuals’ social lives are complex and dimensions of social life cannot be delineated into separate measurable elements (Brah & Phoenix, 2004). For example, being classified as male or female provides insufficient information to fully capture the complexities of lived experience. As Simien argues in reference to women, “diverse life experiences [such as] stereotyping, silencing and marginalization do not lend themselves to simple, categorical analysis based solely on gender” (2007, p. 267). Thus, social categories intersect to create unique social locations, and it is the intersection which is of concern in an intersectional analysis.
- Second, it is important not to essentialize any one group or assume that all members of a single social group share similar experiences, perspectives, and needs. For example, the group “women with disabilities” may vary considerably according to age, ethnicity, religious views, income, and geography and consequently may have very different experiences interacting with the health care system.
- Third, social categories such as race, ethnicity, gender, age, class, geography, and so on are fluid and flexible. From an intersectional perspective, social categories are dynamic, historically grounded, socially constructed, and work at both micro and macro structural levels (Burgess-Proctor, 2006; Weber & Parra-Medina, 2003). As such, the definition of social categories involves a process of construction, deconstruction, and reconstruction (Staunæs, 2003, p. 104).



An intersectional-type analysis places the importance of power and its role in creating and perpetuating the personal and social structures of discrimination and oppression front and centre in the consideration of the issue at hand.

Power as Central to an Intersectional Analysis

- First, as argued by Dhamoon (2008), “the study of intersectionality would benefit from moving away from simply analyzing social identities and such categories as race, gender, and class, and moving towards foregrounding an analysis of the interactive relationship between processes of subject formation and systems of domination” (2008, p. 20). An intersectional-type analysis places the importance of power and its role in creating and perpetuating the personal and social structures of discrimination and oppression front and centre in the consideration of the issue at hand.
- Second, systems of domination and processes of subject formation are shaped by time and place. It is essential to understand that systems of power are shaped by the “historical, social and political context and ... unique individual experiences resulting from the coming together of different types of identity” (AWID, 2004, p. 2).
- Third, intersectional theorists do not categorize persons as either intersectionally privileged or intersectionally oppressed. Because individuals are members of more than one community they can simultaneously experience both discrimination and privilege. As such, a matrix of domination (Collins, 1990; Daly & Stephens, 1995) may capture more effectively the complexity of these multiple and crosscutting social relations.



Weber and Parra-Medina (2003) provide an excellent synthesis of the broad questions that drive an intersectional analysis. They are:

- What is the meaning of race, ethnicity, class, sexuality, and other systems of inequality across the ideological, political, and economic domains of society in institutional structures and individual lives?
- How are these co-constructed systems of inequality simultaneously produced, reinforced, resisted, and transformed – over time, in different locations, and in different institutional domains (e.g., health, education, economy, religion, polity, and family)?
- How can our understanding of the intersecting dynamics of these systems guide us in the pursuit of social justice? (2003, p. 184).

How Does an Intersectional Approach Differ from Other Approaches?

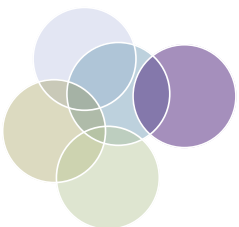
An intersectional approach differentiates itself from other approaches by how it conceptualizes social identity or categories of difference; by how it places power and the complexity of processes of domination and subordination at the centre of analysis; and by how its main objective is the pursuit of social justice through intersectoral and counterintuitive coalitions. Many other theoretical and research paradigms are complementary to an intersectional approach. In particular, gender- and sex-based approaches, health determinants approaches, community-based research, and Indigenous methodologies share some similarities with an intersectional-type approach but nevertheless can be differentiated from intersectionality along numerous dimensions. Each of these approaches will be compared and contrasted with an intersectional approach in relation to how each addresses the basic assumptions underlying an intersectional approach.

Gender-Based and Sex- and Gender-Based Analysis

Thus far, the dominant methods for identifying and responding to differences between men and women in Canada have been gender-based (GBA), gender- and sex-based analysis (GSBA), and sex- and gender-based analysis (SGBA). It is well-established that sex and gender are crucial to determining how health or diseases processes differ between men and men and among women, and they are critical to accurate interpretation and validation of research that affects aspects of women's lives (Johnson, Greaves, & Repta, 2007; NIH, 2008). A number of resources have been developed in Canada to provide guidelines to researchers and/or policy-makers on how to incorporate the concepts of sex and gender and their interaction into their work:

- *Better Science with Sex and Gender: A Primer for Health Research*, Johnson, Greaves and Repta, 2007
- *Exploring Concepts of Gender and Health*, Health Canada, 2003a
- *Gender- and Sex-based Analysis in Health Research: A Guide for CIHR Researchers and Reviewers*, Spitzer, 2004
- *Gender-based Analysis: A Guide for Policy-Making*, Status of Women Canada, 2003

A GBA/SGBA approach is similar to an intersectional approach in its recognition of the importance of categories of difference and the fluidity of these categories.

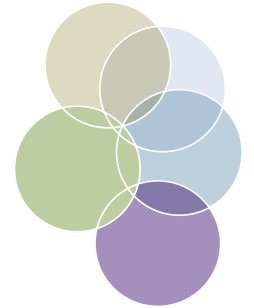


If the exclusion of sex and gender is seen to undermine the production of scientific knowledge and evidence, then the marginalization or exclusion of other variables must have the same effects on the validity and reliability of knowledge production.

For example, in the Women’s Health Research Network’s *Better Science with Sex and Gender: A Primer for Health Research*, gender is viewed as culturally shaped and historically specific (Johnson et al., 2007). However, a GBA/GSBA approach can be differentiated from an intersectional approach with respect to how social categories are addressed in relation to one another. While sex- and gender-based methodologies developed to date are also intended to be informed by a diversity analysis, primacy is generally given to sex and gender, resulting in adequate recognition of how sex and gender interact with other social categories, including race, ethnicity, socioeconomic status, sexual orientation, geography, ability, age, and migration status — all of which form hierarchies of inclusion or exclusion and have significant health implications (Hankivsky et al., 2007; CRIAW, 2006; NWAC, 2006; Hankivsky, 2005).

GBA/GSBA approaches thus differ from an intersectional approach because they use an “additive” approach to understanding health inequities. Gender and/or sex are frequently assigned primary importance, with additional variables of interest analyzed in terms of their additional explanatory power. Instead, sex and gender could be explored as mutually intersecting with other axes of discrimination. Similarly Weldon has argued, “intersectionality has been helpful in showing how thinking in terms of gender *plus* race is incomplete and obscures the experience of women at the interstices of these social relations” (Weldon, 2005, p. 5). Based on a review of women’s health research in Canada, Varcoe, Hankivsky, and Morrow (2007) concluded that “[the] sole attention to gender carries the risk of treating all women the same ... overlooking the fluid and changing nature of gender; overlooking the ways in which economics, race, ability, geography, sexuality and other influences shape and intersect with gender; and diverting attention away from differences among women” (p. 18). Indeed, one must consider that if the exclusion of sex and gender is seen to undermine the production of scientific knowledge and evidence, then the marginalization or exclusion of other variables must have the same effects on the validity and reliability of knowledge production.

Power is a central concept with intersectionality as well as with GBA/GSBA. GBA/GSBA is grounded in the assumption that, globally, power is unevenly distributed between the genders: men have more power than women. Of particular interest is the concept of *institutional gender*, which “reflects the distribution of power between the genders in the political, educational, religious, media, medical, and social institutions in any society” (Johnson et al., 2007, p. 7). Institutional gender is a central concept in a GSBA approach that examines the impact of societal norms and



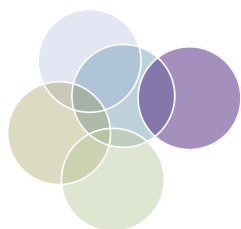
expectations in shaping men's and women's position in society, ultimately resulting in inequitable health outcomes. According to *Better Science with Sex and Gender: A Primer for Health Research* (Johnson et al., 2007), "Historically, much health research has assumed a gender-neutral or gender-blind stance, so the impetus to understand the contributions of sex and gender to health has largely arisen within the field of women's health" (p. 1). As a result, most gender-related health research to date has focused on women's health exclusively because there is a conflation of "gender" with "women" (WHO, 2001). Consequently, little attention has been paid to the impact of gender on men's health (Doyal, 2001) or to examining women's and men's health *in relation* to one another or among transsexuals (whether they have undergone surgery or not).

Health Determinants Approach

In Canada, the health determinants movement can be traced back to the landmark "Black Report" (1982), which found that socio-economic factors were of equal or greater importance to health and well-being compared to the impact of the medical health care system in Canada. In the 1990s, the Public Health Agency of Canada identified twelve determinants in health representing a myriad of social, cultural, environmental, as well as genetic and biological factors.³ Several determinants of health models have since been developed (e.g., Dahlgren & Whitehead, 1991; Link & Phelan, 1995; Raphael, 2004; WHO, 2006) differing from one another with regards to which socio-bio-cultural factors are included or excluded and in the way that these factors are interrelated.

Most recently in Canada, Benoit and Shumka (2008) have built upon previous models to propose a dynamic Health Determinants Framework which includes both sex and gender as determinants of health; stresses the intersection of key determinants; and differentiates among macro-, meso-, and micro-level determinants. Macro-level or fundamental determinants refer "to the primary importance of some determinants for shaping health outcomes" (p. 18). These include sex, gender, social class, race, ethnicity, immigrant status, geographic location, and age. Meso-level determinants refer primarily to access to key resources such as employment, education, childcare, safe neighbourhoods, and health services. Micro-level determinants

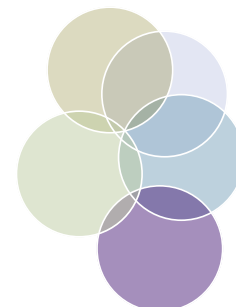
3 As of 2008, the Public Health Agency of Canada recognizes the following determinants of health: income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture.



A health determinants approach, through its recognition of multiple dynamic factors influencing the health of individuals has a primary goal similar to that of an intersectional approach: the inclusion of previously ignored and excluded populations in health research.

refer to behaviours such as smoking, diet, and exercise. In this model, macro-level and meso-level variables are thought to interact in shaping individual behaviour, ultimately determining health outcomes (p. 19).

A health determinants approach, through its recognition of multiple dynamic factors influencing the health of individuals has a primary goal similar to that of an intersectional approach: the inclusion of previously ignored and excluded populations in health research. Yet, despite the conceptual advances made in Canada through its determinants of health approach, significant health inequities persist. Among the criticism of the health determinants approach include the finite number of categories limiting which factors are contributing to differential health outcomes, the insufficient attention to the relationship among the determinants, the inadequate methods of identifying and measuring each determinant, and the lack of understanding of the wider context of structural inequities in which they are embedded (Hankivsky & Christoffersen, 2008). In short, aside from Benoit and Shumka's recent efforts, a health determinants approach does not place explicit emphasis on power, the interactions between determinants, and the oppressive effects of these relationships.



Community-Based Research

The most commonly used definition of community-based research emerged from the Loka Institute in 2008:

Community-based research is “conducted by, for or with the participation of community members ... Community based research aims not merely to advance understanding, but also to ensure that knowledge contributes to making a concrete and constructive difference in the world” (Loka Institute, 2008).

Alternative terms include “participatory research”, “participatory action research”, “action research”, “cooperative inquiry”, “participatory evaluation”, “empowerment evaluation”, among others. While these approaches may differ slightly, what is common among them is that “each is explicitly committed to conducting research that will benefit the participants either through direct intervention or by using the results to inform action for change” (Israel et al., 1998).

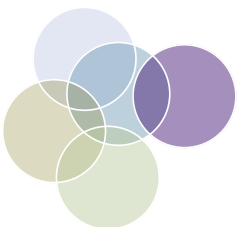
Similar to an intersectional approach, community-based research is not associated with any one methodology, but rather represents a set of underlying beliefs and principles about the research process (Wallerstein et al., 2003). A community-based research approach emphasizes collaboration, participation, and emancipatory social

justice agendas (Hall, 1993). Ultimately it is hoped that, through the participation and commitment of community members in the research process, individuals and communities can become more empowered to initiate and sustain changes in their personal and wider social lives (Wallerstein et al., 2003). In short, a community-based research approach is similar to an intersectional approach in its underlying principle regarding the pursuit of social justice as the primary goal of research. Implicit within a community-based research approach is the role of power and in particular the power a “community” has as a whole in influencing policy-makers who make decisions that impact their lives directly. In this respect, “Many community-based research studies hope to influence the public and policy-makers” (Morris & Bunjun, 2007, p. 34). Further, a community-based research approach recognizes that there are hierarchies of power within communities and differences in status among community members (Morris & Bunjun, 2007).

Indigenous Methodologies

Indigenous methods are explicitly grounded within a social justice framework and are meant to de-colonize traditional Western research linked to systems of domination such as colonialism and the oppression of Indigenous peoples in Canada. Broadly speaking, the overall goal of Indigenous methodologies is to ensure that research conducted on Indigenous issues is “carried out in a more respectful, ethical, correct, sympathetic, useful and beneficial fashion, seen from the point of view of indigenous peoples” (Porsanger, 2004). Similar to a community-based research approach, but different in its focus on Indigenous populations, Indigenous methodologies are not defined by a particular set of methods but rather a general approach to research.

Louis (2007) describes four principles underlying Indigenous approaches to research. The first is concerned with *relational accountability* whereby the researcher is responsible for nurturing the relationship with the Indigenous people involved in the research as well as “all [their] relations, be it air, water, rocks, trees, animals, insects, humans, and so forth” (Steinhauer, 2002, p. 72). The second principle is one of *respectful representation* and involves being humble, generous, and patient with the research process and the individuals involved in the process. The third principle is *reciprocal appropriation* and stresses the importance of ensuring that both the Indigenous people and the researcher benefit from the research. The fourth principle speaks to the *rights and regulations* of both the Indigenous people and the researcher, including consideration of the intellectual property rights of any knowledge produced.



Intersectionality therefore prompts Indigenous researchers to move beyond issues of colonialism, culture, and racism to consider other factors that structure systems of domination and oppression, which in turn affect social and health status of Aboriginal communities.

Intersectionality is being embraced by those conducting research with Indigenous populations as an approach complementary to an Indigenous one. For example, van der Hooghe and Kingma (2004) point out that:

The recent concept of intersectionality is helpful for assessing the complex situation of indigenous women and the discrimination they face. The position of indigenous women cannot be understood exclusively by an analysis of cultural differences ... Yet analysis and work informed by a narrow feminist perspective (which focuses on gender inequality in isolation from other forms of inequality) is equally inadequate. (p. 55)

Intersectionality therefore prompts Indigenous researchers to move beyond issues of colonialism, culture, and racism to consider other factors that structure systems of domination and oppression, which in turn affect social and health status of Aboriginal communities.

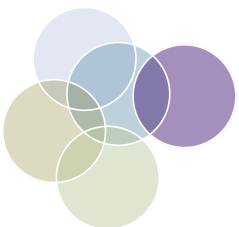


Why Intersectionality in Women's Health Research and Policy?

The traditional emphasis on a single category of identity or a small number of dominant expressions of identity has been the subject of growing scrutiny (Donaldson & Jedwab, 2003). While it is much easier to simplify research by labelling people into single or separate categories rather than multiple and overlapping categories (Morris & Bunjun, 2007), according to Wilkinson, "It has become increasingly apparent ... that this way of doing research is rather limited in its ability to accurately represent the complexity of social life" (2003, p. 27). In terms of policy and practice, government services that target only one category of identity cannot be considered inclusive (Hicks, 2003; Mwarigha, 2003). For example, even though gender is important, if it is privileged over other axes of oppression, then the social, political, and economic determinants of health will not be fully captured nor will adequate solutions to existing health disparities be found.

In the Canadian health care context, there is no dearth of studies which have outlined apparent inequities when factoring in any one additional identity marker aside from sex or gender. Within the four pillars of health research, as defined by the Canadian Institutes of Health Research (i.e., biomedical, clinical, health services and systems, and population and public health) a growing number of studies have identified clear inequities in health outcomes and access to services and health information among various groups of women (e.g., elderly, Aboriginal, sex trade workers, ethnic minorities):

- Aboriginal women in Canada, especially in rural and remote regions, report a lack of and difficult access to a variety of health services such as those related to reproductive health, domestic violence, substance use, and HIV or sexually transmitted diseases (Browne et al., 2005; Browne & Fiske, 2001; Browne & Smye, 2002; Varcoe & Dick, 2008).
- Findings from a large-scale Canadian study investigating the health care experiences of women living in rural and remote areas (Bourgeault et al., 2006) reveal a variety of issues regarding the lack of appropriate health care services and difficulties in accessing the limited services.
- In the case of Aboriginal adolescents with Type 2 diabetes, a higher than normal incidence of foot abnormalities has been noted; the highlighting of these comorbidities emphasizes a need for earlier detection and intervention within Aboriginal communities (Chuback et al., 2007).



If researchers and decision makers continue to ignore the complexity of people's lives and how the experiences of multiple locations affect life opportunities, health, and access to care, then the evidence base that is generated will reify a range of inequities.

- In a study on coronary heart disease (CHD), it was found that women and particularly women of a lower socio-economic status were less likely to receive or process information related to CHD risks, unless this information was couched squarely within a language of direct sensory experience (Angus et al., 2005).
- In a similar study related to the improvement of managing coronary artery disease (CAD), it was found that gender as well as “ethnoculturally [read: urban-rural] based components that influence people’s appraisal of their cardiac health and their decision-making” were key to more positive health outcomes (King et al., 2005).
- Women with disabilities in Canada and, in particular, older women with chronic or disabling conditions report inadequate access to and information about long-term care, hospital care, and primary health care services, including breast and cervical screening tests (Armstrong et al., 2002; Aronson, 2001, 2002; Bethune-Davies, McWilliam, & Berman, 2006; Cooper & Yoshida, 2007).
- Women in the sex trade industry in Halifax have reported a disproportionate emphasis on work-related sexual activity with little or no mention of personal sexual activity within HIV awareness campaigns, and have indicated that acceptance of sexuality and their profession by different outreach groups consistently determined whether or not they would seek out health information services (Keeping, 2004).
- Compared to Canadian-born women, immigrant and refugee women report poorer health, have a paucity of services that respond to their unique health care needs, and are less likely to use health and social services due to issues of access and a general lack of information (Grewal, Bottorff, & Balneaves, 2004; Hyman et al., 2006; Sword, Watt, & Krueger, 2006).



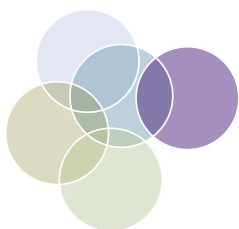
If researchers and decision makers continue to ignore the complexity of people's lives and how the experiences of multiple locations affect life opportunities, health, and access to care, then the evidence base that is generated will reify a range of inequities (Hankivsky et al., 2007). A key challenge is to move beyond the usual variables to understand the dynamics between various factors and social locations. This is especially important in the area of women's health. As Varcoe et al. note, “Inherent in the concept of women's health is the paradoxical challenge that differences among women are often greater than the differences between women and their implied binary opposite, men” (2007, p. 12).

In response, there have been calls by scholars, organizations, policy-makers, and advocates to engage in research that places multiple axes of difference as central to any investigation of health inequities (Hankivsky, 2007; Jackson et al., 2005; Reid, Pederson, & Dupéré, 2007; Spitzer, 2004). In Canada, examples of intersectionality being adopted explicitly as a theoretical concept and tool for research and/or policy have only recently begun to emerge (e.g., Benoit & Shaver, 2006; Benoit et al., 2007; Brotman & Ryan, 2004; Brotman, Ryan, & Meyer, 2006; Browne, 2007; Browne, Smye, & Varcoe, 2005; City for All Women Initiative, 2008; Clark, Hunt, & Mark, 2006; Lavoie et al., 2007; Reid, 2007; Reid, Pederson, & Dupéré, 2007; Salmon, 2007; Shoveller et al., 2007; Shoveller et al., 2004; Shumka, & Benoit, 2008; Varcoe & Dick, 2008; Vissandjee et al., 2007). Please see the Women's Health Research Network's (forthcoming) annotated bibliography of intersectional-type research and policy applications.

Intersectionality is a new paradigm for policy seeking to understand and respond to this actuality. This approach seeks to more accurately reflect the realities, including the health effects that multiple exclusionary intersections impose on individuals (Wilkinson, 2003), and this approach can change the way in which women's health is framed.

“As a method of analysis, intersectionality attempts to empirically examine the consequences of interacting inequalities on people occupying different social locations as well as address the way that specific acts and policies address the inequalities experienced by various groups.”

—(Bishwakarma, Hunt, & Zajicek, 2007, p. 9).



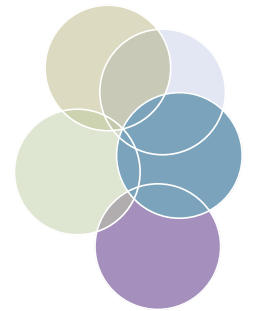
Intersectionality and Health Research

Despite the emergence of intersectionality as a major theoretical and research paradigm, discussions of how to study intersectionality and its methodologies has been limited (McCall, 2005, p. 1771). There is little empirical work that examines intersectional differences between multiple social categories. Models that move, for example, beyond the notion of a “generic” woman and that are able to measure and simultaneously investigate multiple intersectionalities are only beginning to be developed (Carter, Sellers, & Squires, 2002, p. 112).

The intersectional framework has been criticized for being overly relativistic and difficult to operationalize (Oxman-Martinez et al., 2002). Questions have also been raised about how intersectionality may transform all pillars of health research, including, for instance, biomedical and basic science research (Squier, 2007). A central challenge is that “intersectionality research requires more than simply performing separate analyses by race and gender and using traditional theories to interpret the results” (Simien, 2007, p. 271). Similarly Lorber (2006) explains, “Multiple categories disturb the neat polarity of familiar opposites that assume one dominant and one subordinate group, one normal and one deviant identity, one hegemonic status and one ‘other’” (p. 450). Wilkinson summarizes the challenge, “Researchers ... are challenged in the way they conduct their studies by examining several identity markers within their investigations. Rarely do they have the time to consider the effects of the intersection of these identity markers. Instead the goal is to isolate the ‘unique’ effects of one variable on a particular social phenomenon” (2003, p. 27).

Thus, the objective in all steps of intersectional research is “to probe beneath the single identity to discover other identities that may be present and contributing to a situation of disadvantage” (Center for Women’s Global Leadership, 2008). When intersections are typically applied in research, the three markers of gender, social class, and race or ethnicity prevail (Wilkinson, 2003). Consequently, as Wilkinson explains, “Other markers such as Aboriginal status, ability/disability, age, religion, language, immigration, and region are largely neglected despite the recognition that these markers can greatly influence individual outcomes” (2003, p. 26). Using this type of analytic framework precludes the full investigation of factors, which intersectionality explicitly takes into account, that influence health status.

The complexity of intersectionality is demanding because this approach requires analyzing the complexity of diverse influences that shape and affect health (Hankivsky et al., 2007). Analyzing multiple dimensions of life and categories of analysis is challenging (McCall, 2005). Similarly, Bishwakarma, Hunt, and Zajicek



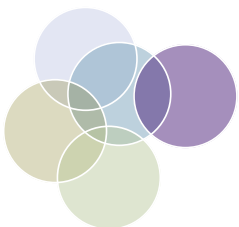
argue that “One of the most salient challenges for the intersectional researchers is how to manage the complexity of an intersectional analysis” (2007, p. 5).

Nevertheless, this approach also has much unrealized potential. It opens new intellectual spaces for knowledge and research production (Weber & Fore, 2003). And it can lead to both theoretical and methodological innovation (Simien, 2007). Hancock (2007) is among the first to make the argument that intersectionality can be envisioned as a paradigm with “a coherent set of empirical research standards” (p. 63), which underlies, informs, and guides the investigation of a research question. To demonstrate how intersectionality as a paradigm differs from other approaches, Hancock (2007) has developed the framework represented in Table 1.

Table 1: Conceptual differences among approaches to the study of race, gender, class, and other categories of difference in political science

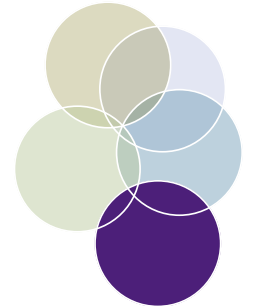
Source: Hancock, 2007. Used with permission

	UNITARY APPROACH	MULTIPLE APPROACH	INTERSECTIONAL APPROACH
Q1: How many categories are addressed?	One	More than one	More than one
Q2: What is the relationship posited between categories?	Category examined is primary	Categories matter equally in a predetermined relationship to each other	Categories matter equally; the relationship between categories is an open empirical question
Q3: How are categories conceptualized?	Static at the individual or institutional level	Static at the individual or institutional level	Dynamic interaction between individual and institutional factors
Q4: What is the presumed makeup of each category?	Uniform	Uniform	Diverse; members often differ in politically significant ways
Q5: What levels of analysis are considered feasible in a single analysis?	Individual or institutional	Individual and institutional	Individual integrated with institutional
Q6: What is the methodological conventional wisdom?	Empirical or Theoretical; Single method preferred; multiple method possible	Empirical or Theoretical; Single method sufficient; multiple method desirable	Empirical and Theoretical; Multiple method necessary and sufficient



One way to apply intersectionality early in the research process is to begin with the assumption that individuals have subjective knowledge of their own lives and the context in which they live.

As will be detailed in the following section, intersectionality explicitly embraces interdisciplinarity; it clarifies the strengths and limitations of qualitative and quantitative methods; and this approach prioritizes the use of a mix of methods to realize the demands of a multi-dimensional research analysis (Hankivsky et al., 2007; Weber & Fore, 2007).



How to Apply Intersectionality to Health Research

This section of the primer draws from a number of emerging resources, including the important work by the Canadian Research Institute for the Advancement of Women (CRIAOW), which has published an *Intersectional Feminist Frameworks Primer* (2006) and a guide on *Using Intersectional Frameworks in Research* (Morris & Bunjun, 2007). Morris and Bunjun summarize an intersectional approach to research succinctly in the following passage:

[An] intersectional perspective is important at every stage of research from project partners and advisors, designing a method for collecting information, recruiting research participants, seeking out documents and interviews with organizations which work for social and economic justice, analyzing the information you collected, then presenting and discussing the information to ... [and] evaluating the research. (p. 22)

The question remains as to exactly how to accomplish an intersectional research approach. This primer seeks to provide concrete ways in which *health researchers* can incorporate an intersectional perspective into their research design. The following sections will outline key issues to take into account when designing a health research project from an intersectional perspective. Issues related to the typical “phases” of research will be discussed, followed by key questions to consider when planning and developing a research project.

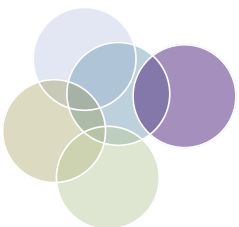
Defining the Research Question

One way to apply intersectionality early in the research process is to begin with the assumption that individuals have subjective knowledge of their own lives and the context in which they live. Researchers can use a “bottom-up” approach to research so that research is not conducted *for* or *about* women, “but, with women, and respecting the creativity, knowledge and leadership of women themselves. This doesn’t mean that everyone is going to agree. It means that everyone is really heard” (Morris & Bunjun, 2007, p. 17). An intersectional approach entails gathering

information by asking questions about how women and men live their lives, which are then built “upwards” and account for the various influences that shape women’s lives (AWRD, 2004).

Questions to Consider When Defining the Research Question

- Who is being studied? Who is being compared to whom? Why? (Lorber, 2006)
- What is the social justice issue to be addressed?
- Is this research essential?
- Is the research continuing the gaze of “othering”?
- With regards to the relationship between the researcher and the researched: How can coalitions among members of social groups with unequal political and economic power avoid reproducing existing inequality in their practice? What procedures will safeguard the voices and interests of the less powerful? How will agendas be set? How will human commonalities and differences be recognized without resorting to essentialism, false universalism, or obliviousness to historical and contemporary patterns of inequality? (Cole, 2008)
- How will researchers ensure that they are not seeing what they want to see in their research? (Weber, 2007)
- Is the research question being generated in collaboration with the researchers and the researched?
- In order to affect social change, does the research include representation from all key stakeholder groups such as policy-makers, grassroots activists, and community groups, including multiply oppressed communities?
- Will the findings contribute to furthering social justice for the researched?
- Is the research question being framed within the current cultural, societal, and/or situational context?



The emerging field of intersectionality has a history of fragmentation where individual disciplines have been working in isolation from each other, resulting in the slow progress in the acceptance of intersectionality as a viable research paradigm.

When framing the question of interest, one must consider how to prioritize persons who are to be the focus of the research. An intersectional approach involves more than collaboration between researchers and the researched. With the recognition of the complex relations of domination and subordination (Weber, 2005), it is intended to further social justice. Additionally, it is essential to recognize which identities are deemed salient in which historical, cultural, societal, or situational context may vary depending on a researcher's agenda. Researchers have an opportunity to contribute to major gaps in research simply by bringing "to the forefront the experiences and perspectives of people with less social, political and economic resources" (CRIAW, 2006, p. 29).



Literature Review

The emerging field of intersectionality has a history of fragmentation where individual disciplines have been working in isolation from each other, resulting in slow progress in the acceptance of intersectionality as a viable research paradigm (Hancock, 2007). As such, McCall (2005) has argued for the adoption of an interdisciplinary approach to intersectional research with the hope of lessening the fragmentation. Interdisciplinarity implies that researchers representing two or more disciplines unite their expertise about a topic area to address a common problem. In order to develop a more equitable and engaged scholarship and practice to eliminate health disparities, a more inclusive intellectual landscape to support alliances, dialogue, and collaboration across intersectional, critical public health, and biomedically driven paradigms must be promoted. These coalitions will involve scholars with a justice agenda who may be working from different disciplinary approaches, as well as community groups whose engagement is necessary to sharpen the critique of the status quo, to improve scholarship, and to identify paths to effective activism and change (Weber & Fore, 2007, p. 212).

An interdisciplinary approach can be incorporated into the literature review of the issue of interest. Multiple databases of literature exist and are accessible to university-based researchers and community-based researchers⁴ through major educational institutions across Canada. When conducting a background review on the topic of interest, an interdisciplinary approach would entail searching for information from databases representing a wide variety of academic disciplines and perspectives.

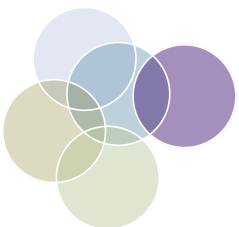
⁴ In general, community members may access in-library holdings for free, but fees are charged for borrowing services and for access to e-journals.

For example, in a review of the literature investigating the relationship between substance use and HIV, searches of the following databases representing various disciplines and perspectives resulted in multiple hits: from the biological sciences perspective (e.g., Bio Med Central, Bio One); from the health sciences perspective (e.g., MEDLINE, PubMed Central, CINAHL, and so on); from the social science perspective (e.g., PsychINFO, Humanities Index, Social Sciences Index, Academic Search Elite, Soc INDEX); from the field of geography (e.g., Agricola, Geobase); from the field of education (e.g., ERIC, Education Full Text); from the field of chemistry (e.g., Applied Science and Technology Index); from women's studies (e.g., Women's Studies International); and from political science (e.g., PAIS International, International Political Science Abstracts).

Further to accessing a variety of information from different sources, there is also a vast amount of information referred to loosely as "grey literature". Grey literature constitutes scientific and technical reports, patent documents, conference papers, internal reports, government documents, newsletters, fact sheets, theses, and dissertations which have not been published in conventional channels such as journals or books and which may be more difficult to access. While many such non-published reports are accessible through university databases and through the websites of accredited organizations (e.g., House of Commons Parliamentary Papers, United Nations Treaty Series, Ipsos News Centre, Statistics Canada, Health Canada, Canadian Women's Health Network, Canadian Research Institute for the Advancement of Women, and so on), many of these types of reports are more difficult to identify and obtain. As suggested by Morris and Bunjan (2007), an internet search using a search engine such as Google on the topic of interest may further identify unpublished reports on research in the same area. Additionally, through such a search community organizations conducting research on the same topic area might be identified and could be contacted for more details.

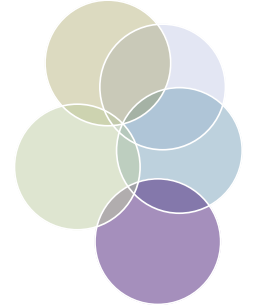
Once all of the relevant research has been identified and obtained, a critical review of the information must occur. In particular, a critical eye is needed for determining if and how diversity is addressed in the research. In general, the overall considerations should be the following:

- (1) to determine the extent to which diversity and which axes of diversity (e.g., gender, race, social class, sexual orientation, ability, and so on) are important to the topic of interest;



Individuals' lived experiences are complex and dynamic and it follows that naming categories is a process bound to time, place, and perspective. These restrictions apply not only to the people being studied, but to the researchers as well.

- (2) to determine the extent to which the relevant axes of diversity are considered and incorporated in the analyses; and
- (3) to determine the extent to which addressing diversity in the sample would have yielded different findings.



Questions to Consider When Conducting a Literature Review

- Are multiple databases representing all pillars of health research (i.e., biomedical, clinical, health services, population health) being searched?
- Have reasonable attempts been made to access “grey literature” on the topic of interest?
- Does the literature address issues of diversity among, for example, diversity between groups of women and men?

Research Design

An on-going challenge for intersectional researchers and theorists is how social categories are named and defined. For example, while identities must be named when defining the research question, stereotyping and generalizations about these identities must be avoided (Morris & Bunjun, 2007, p. 8). Hancock has suggested that, rather than abolishing categories, new conceptualizations of categories and their role in politics must be considered (2007, p. 66).

Individuals' lived experiences are complex and dynamic and it follows that naming categories is a process bound to time, place, and perspective. These restrictions apply not only to the people being studied, but to the researchers as well (Morris & Bunjun, 2007, p. 7). Further, the definition of a socially constructed category by nature is rooted in historical and contextual specificity, and the list of categories is ever-changing to account for new and emerging intersections (Thorvaldsdóttir, 2007, pp. 2, 4). See Appendix A for examples of how the definition of socially constructed categories changes over time.

Little work has been done to determine whether all possible intersections of social categories might be relevant at all times or when some of them might be most salient (Verloo, 2006). The lack of attention to some differences over others produces analyses that are not analytically sound (Bredström, 2006). This is especially the case with gender: research focused exclusively on gender can result in the marginalization

of those experiences that are not represented fully by this narrow analysis. The challenge for intersectional scholars in juggling various categories that change in meaning, importance, and salience across different times and contexts is how to address the categories simultaneously (Staunæs, 2003, p. 105). Further, a sample must be heterogeneous in order to fully explore how multiple categories intersect to form unique social locations (Lorber, 2006, p. 450), and all key concepts in a research project must be clearly defined (CIHR, 2004). More generally, an intersectional approach entails designing a research project with enough flexibility to allow for the possibility of arriving at findings that are unexpected (Bedolla, 2007, p. 238).

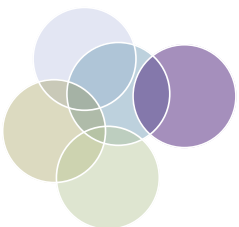
Another central concept in intersectional research is that of power and, more specifically, consideration of the experiences of the marginal compared to the privileged, including taking into account the perspective of those designing and conducting the research (Bedolla, 2007, p. 238). As argued by Weber (2006), “Thinking of race, class, gender and sexuality as power relationships enables us to understand that they are not independent but rather interdependent, mutually reinforcing systems rooted in power” (p. 37).

Questions to Consider When Choosing Research Design

- **What issues of domination and exploitation are being addressed by the research?**
- **Which are not centred, and why? Should they be?**
- **Is the issue of power at the centre of all analyses?**
- **What is the criterion for deciding the point at which policy counters domination?**

Tools of Inquiry and Analysis

With respect to choosing appropriate tools of inquiry and analytic approaches for a research project, an intersectional perspective to research design has the potential to transform traditional research methods (Hankivsky et al., 2007). Alternative methodological approaches, including ethnographic data collection, empirically established within-group profiles, and analysis strategies, are also needed (Kohn & Hudson, 2002). In the following section, the compatibility of quantitative, qualitative, and mixed methods approaches to intersectionality will be discussed.



The traditional approach to exploring issues of diversity has been to either analyze the unique contributions of individual markers such as gender or race or class or to explore simple interactions between a few identity markers.

QUANTITATIVE METHODS The empirical model consists of examining the cause and effect relationship between independent variables of interest (e.g., gender, race, social class, and so on) and dependent variables to produce macro level population data. The key challenges of a quantitative approach to intersectional research are the following:

- (1) Concepts such as gender, race, sexual orientation, ability, and so on are socially constructed and therefore new categories are constantly created and definitions are ever-changing.
- (2) Identity markers (i.e., social categories) are usually analyzed separately in order to assess their relative contribution to the phenomenon of interest frequently at the cost of examining the intersection of the independent variables and its relationship to the dependent variables of interest (McCall, 2005; Schultz & Mullings, 2006; Wilkinson, 2003).
- (3) There is a paucity of statistical methods that can explore complex intersections (Wilkinson, 2003) and, further, to explore all possible subsets of every social group of interest in a project would yield results that have little or no meaning (McCall, 2005).
- (4) Traditionally, the dominant group in a culture (e.g., White males) are used as the referent group against which every other category is compared, yielding results that are limited in their full description of how sub-groups of individuals compare to each other on the topic of interest (Vinz & Dören, 2007, p. 374).

In short, the traditional approach to exploring issues of diversity has been to either analyze the unique contributions of individual markers such as gender *or* race *or* class or to explore simple interactions between a few identity markers. However, as Simien (2007) argued, “intersectionality research requires more than simply performing separate analyses by race and gender and using traditional theories to interpret the results” (p. 271).

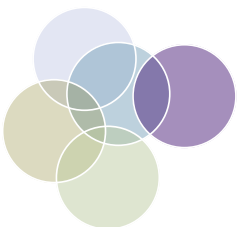
In an attempt to address how an intersectional perspective can be incorporated into a quantitative approach, Wilkinson (2003) suggested that, to explore statistical intersections, individual identity markers that are highly correlated should be combined into a single variable. Wilkinson describes an example whereby two identity markers — immigrant status and visible minority status — are highly correlated. They therefore are combined to assess how immigrants that are visible minorities differ from immigrants that are not visible minorities in relation to the dependent variable of interest — in this case, educational outcome.



Hancock (2007) has recently argued that “intersectional empiricists cannot rely on the same old data, or more precisely, data collected in the same old unitary way” (p. 66). The question remains is how to incorporate intersectionality into a quantitative design? Hankivsky et al. (2007) explored this issue by positing a randomized controlled trial embedded in an intersectional model. In such a model, “representational sampling would be prioritized, the types and number of variables would change (e.g., they capture key dimensions of inequality in any given study), and the way in which variables interact with one another would be brought to the foreground” (p. 9). Analysis of diversity would no longer entail the comparison of White males (i.e., the “norm”) to “others”, but would consist of a more descriptive, non-hierarchical statistical approach exploring differences among and between individuals of varying backgrounds (Vinz & Dören, 2007, p. 374).

QUALITATIVE METHODS Whereas one of the strengths of quantitative methodologies is the ability to test for complex statistical intersections, the strength of qualitative methods such as ethnography, neighbourhood studies, participatory action research, historical analyses, structured interviews, textual analyses of media resources, and so on allow for the in-depth study of individuals’ personal unique social locations and experiences with power and privilege. McCall (2005) has argued that qualitative research in general lends itself more easily to an in-depth investigation into the complexities of individuals’ social lives (p. 1782) and is therefore particularly complementary to an intersectional approach.

Some have argued (McCall, 2005; Schultz & Mullings, 2006) that ethnographic methodologies, including case studies and personal narratives, are “notably useful in terms of providing detailed accounts that illustrate complex social relationships and dynamics in some depth and contribute to an understanding not only of relationships between concepts, but the processes and the meanings that those processes and relationships hold” (Schultz & Mullings, 2006, p. 7). While it may not be realistic to examine or capture every possible intersection, Yuval-Davis (2006) suggests the following: “field methodology should carefully separate, and examine separately, the different levels in which social divisions operate in the communities where they work ... i.e. institutionally, intersubjectively, representationally as well as in the subjective constructions of identities” (Yuval-Davis, 2006, p. 205). Only when such contextual analysis is carried out through the use of qualitative research methods can there be an intersectional review of policy initiative and systems of implementation.



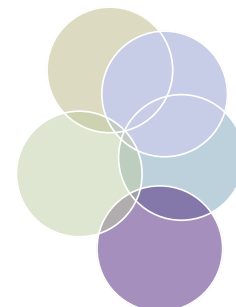
A mixed methods approach may provide the flexibility needed to ensure the applicability of an intersectional framework across a wide variety of disciplines and may help in capturing the complexity of dimensional variation among socially constructed categories.

In 2006, a special issue of the *European Journal of Women's Studies* was dedicated to intersectional scholarship. Three of the papers included in the issue described studies that used narratives as the methodological approach and where the resulting qualitative data were subjected to an intersectional analysis (Buitelaar, 2006; Ludvig, 2006; Prins, 2006). While all three papers contribute to intersectional scholarship by providing concrete examples of how an intersectional framework can be applied to research, what is still lacking is information on how intersectionality can systematically be integrated into research methodologies without relying on a strictly “methods as tools and techniques” approach to research design.

MIXED METHODS Many have suggested that an intersectional approach would involve marrying the strengths of quantitative and qualitative methods in order to fully explore individuals' lives at the macro and micro level (Burgess-Proctor, 2006; Hankivsky et al., 2007; Weber & Fore, 2007; Wilkinson, 2003). A mixed methods approach may provide the flexibility needed to ensure the applicability of an intersectional framework across a wide variety of disciplines and may help in capturing the complexity of dimensional variation among socially constructed categories such as ethnicity, gender, culture, and class and their intersections (Kohn & Hudson, 2002; Wilkinson, 2003).

According to Wilkinson (2003), the main strength of a quantitative approach is the use of larger, more geographically diverse samples from which generalizations about the population may be drawn by researchers and policy-makers. The main strength of a qualitative approach with respect to its compatibility with intersectionality lies with the ability to obtain more detailed information about individuals and their social lives, thus obtaining a deeper understanding of the intersections of diversity. Combined with data obtained through quantitative methodology “[t]he researchers can return to the quantitative information and situate the results of the qualitative study within the general framework of society and, as a result, come to a better understanding of how certain life situations and social barriers may prevent equal participation” (p. 31).

Hancock (2007) has also argued that a mixed methods approach may be most compatible with an intersectional perspective. Specifically, she argues that, in particular, fuzzy set theory may be a data collection and measurement tool that is complementary to an intersectional perspective (Hancock, 2007). Fuzzy set theory in the context of social sciences and health research is an analytic tool which measures within-group diversity and, more specifically, assesses the degree of measurement in a certain socio-cultural category such as gender, race, class, ethnicity, and so on

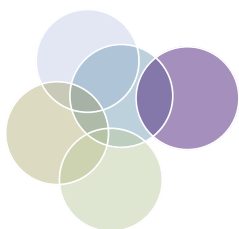


(Ragin, 2000). Traditional quantitative methods assume membership in a particular category as constituting either a “0” (not belonging) or a “1” (belonging), but fuzzy set theory assumes there are shades of grey between the anchors of the continuum and allows for membership to be assigned between 0 and 1. Such graded membership is determined and operationalized beforehand by the researcher based on a variety of contextual factors at the individual and institutional level. For example, in the case of gender, the traditional approach would be to assign an individual either as a “male” or “female”, but Tauchert (2002) has argued that a binary approach to gender is inadequate and that a broader gender continuum is necessary in order to incorporate individuals who do not identify themselves categorically as either “male” or “female” (e.g., transgendered individuals, intersexed individuals). An intersectional approach using fuzzy logic may, in this case, use a series of questions (e.g., related to genitals, sexual orientation, gender assignment at birth, and so on) to determine membership in the category of gender which may have multiple set values (operationalized beforehand) along the continuum of gender traditionally anchored by “male” and “female”.

Questions to Consider When Choosing Tools of Inquiry

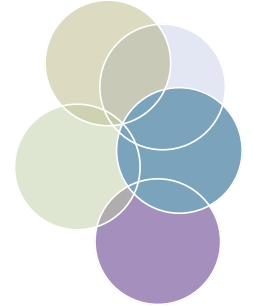
- Are the key concepts of interest clearly defined?
- Is the tool suited to collecting data that is disaggregated by gender, race, ethnicity, and other identities?
- Can highly correlated individual identity markers be combined into one in order to explore statistical intersections?
- Is the tool suited to collecting micro or macro data or a combination of both?
- Is the sample representative of the experiences of a diverse group of people for whom the issue under study is relevant?

KNOWLEDGE TRANSLATION According to the CIHR, knowledge translation can be thought of as “a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the healthcare system” (Tetroe, 2007, p. 1). This includes a range of considerations from how knowledge is created through to how the new knowledge



If we hope to develop a more equitable and engaged scholarship and practice to eliminate health disparities, we must also promote a more inclusive intellectual landscape to support alliances, dialogue, and collaboration.

is transformed into action. As stressed by Morris and Bunjun, “Action research does not end until the recommendations of the report have been adopted” (2007, p. 39). A clearly thought-out knowledge translation plan is critical to intersectional scholarship. From an intersectional perspective, there is a wide range of stakeholders in the research process; therefore a knowledge translation plan must target various audiences in terms of how they will inform the research process, how they will take part in the research and dissemination activities, and how they will use the findings. Morris and Bunjun (2007) suggest three key stakeholder groups in the knowledge translation process: (1) individuals who took part in the research (i.e., the research participants); (2) relevant social justice communities; and (3) policy-makers and service providers. A fourth stakeholder group to be considered includes other researchers who are working in similar areas of concern.



Questions to Consider When Developing a Knowledge Translation Plan

- Who are the key stakeholder groups and are they represented through all phases of the research and policy-making process?
- Are research findings being communicated in a manner that is consistent with an intersectional perspective?
- Are all the key stakeholders involved in all phases of the knowledge translation plan, ranging from knowledge creation to dissemination through to knowledge uptake and evaluation?
- How will the knowledge translation plan be monitored and evaluated?

Conclusion

If we hope to develop a more equitable and engaged scholarship and practice to eliminate health disparities, we must also promote a more inclusive intellectual landscape to support alliances, dialogue, and collaboration across intersectional, critical public health, and biomedically driven paradigms. These coalitions will involve scholars with a justice agenda who may be working from different disciplinary approaches, but may also involve community groups whose engagement is necessary to sharpen the critique of the status quo, to improve scholarship, and to identify paths to effective activism and change (Weber & Fore, 2007, p. 212).

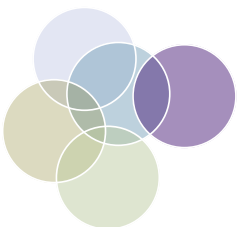
Intersectionality and Health Policy: Some Lessons from Existing Models

The goal of intersectional policy process analysis is to identify and address “the way specific acts and policies address the inequalities experienced by various social groups” (Bishwakarma, Hunt, & Zajicek, 2007, p. 9). It explicitly recognizes that to address these layered inequalities, a one-size-fits-all approach will not work (CRIAW, 2006; Hankivsky, 2005; Parken & Young, 2007). And because intersectionality emphasizes the “dynamic interactions between individual and institutional actors [it] provides a more comprehensive examination of policy success and failure” (Hancock, 2007, p. 74).

However, as in the area of research, little progress has been made to include intersectionality in public or health policy (Bishwakarma, Hunt, & Zajicek, 2007; Manual, 2006; Patel, 2001; Wilkinson, 2003). For example, although various bodies within the United Nations system have recognized the idea of intersectionality, no specific policies have been developed to address intersectional inequalities (CWGL, 2006). One notable exception is the United Kingdom, where emerging equality registration is prompting progressive work to develop policy models that are able to address multiple grounds of inequality. In Canada, as in most other countries, with a few key exceptions (CRIAW, 2006; EGALE, 2002; Hankivsky, 2005; OHRC, 2001), intersectionality remains a relatively unknown and underdeveloped concept in policy discourse and application.

Given this context, methods for integrating intersectionality in policy are in their very early stages of development. The complexity and relative “newness” of the intersectional approach makes it challenging for policy application. Moreover, even when the importance of diversity is noted and even when recommendations are made to include an intersectional approach in policy, decision makers tend to espouse one-dimensional approaches, such as gender mainstreaming or gender-based analysis. As a number of scholars and activists (Verloo, 2006; CRIAW, 2006; Hankivsky, 2005) have argued elsewhere, these approaches cannot be adapted to address multiple inequalities.

Applying intersectionality differs from conventional policy designed to target certain populations and which typically deals with single identity markers such as gender, immigrant status, and Aboriginal status (Hicks, 2003, p. 5, cited in Wilkinson, 2003, p. 26). From an intersectional viewpoint, targeted policies are often as ineffective



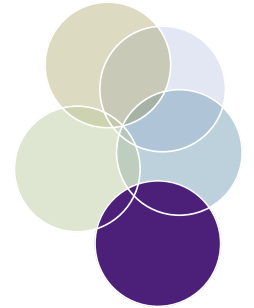
“Intersectional work goes deeper to examine the limits of policy-making designed to assist target populations who should theoretically benefit from either racially-targeted or gender-targeted public policy but in reality benefit from neither.” ~ HANCOCK, 2007

as general policies in that both fail to address multiple identities and within-group diversity. As Hancock explains, “intersectional work goes deeper to examine the limits of policy-making designed to assist target populations who should theoretically benefit from either racially-targeted or gender-targeted public policy but in reality benefit from neither” (2007, p. 66).

Moreover, an intersectional policy analysis differs from efforts to get at issues of diversity by starting with one identity category, such as gender, to which others are added. These analyses assume unitary categories that are based on a uniform set of experiences (Hancock, 2007; Hankivsky, 2007) which can be simply brought together to understand differences. This type of “additive approach” is typical but inadequate for “getting at the layered interrelationships between wider social inequalities and individual experience of discrimination” (Parken & Young, 2007, p. 27). And, importantly, it may lead to “competition rather than coordination among marginal groups for fringe levels of resources rather than systemic reform that could transform the entire logic of distribution” (Hancock, 2007, p. 70).

Efforts to move beyond “one-dimensional” and “additive” policy analyses have included equality mainstreaming, diversity mainstreaming, intersectional feminist frameworks, intersectional public policy analysis, and multi-strand mainstreaming. These “multi-pronged, multi-dimensional” (CRIA, 2006) approaches reject binary thinking in policy. Nevertheless they share the logic that meaningful attention to diversity changes the policy questions that are asked, the kind of data that is collected, how data is collected, and how it is disaggregated. They are concerned with evaluating the efficacy of policy initiatives in addressing the problems faced by different intersecting identities (CWGL, 2006). In sum, they have the potential to “change the way in which policy analysis is undertaken and resultant policy is developed, implemented and evaluated” (Hankivsky, 2005, p. 994).

To date, two distinct approaches have been developed specifically to apply intersectionality to public policy. The first is focused on re-conceptualizing the typical policy cycle which is based on the premise that policy “proceeds in distinct stages from policy formulation to implementation” (John, 1998, p. 204). It can be broken down and analyzed in the context of its constituent parts. The second takes a different approach, which begins with the examination of a policy field and then proceeds through various stages, ending with monitoring and evaluation. These two approaches are detailed below and provide a starting point for further developing and debating intersectional policy analysis and, in particular, its application in health policy.



Approach 1: Applying Intersectionality to a Typical Policy Cycle

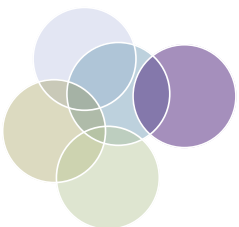
The first approach draws predominantly from the work of Bishwakarma, Hunt, and Zajicek (2007) in which the authors strive to systematically integrate intersectionality in the policy-making process using a typical policy cycle. Their premise is that “since governing bodies, both national and international, as well as different non-governmental organizations, have a vested interest in developing social policies leading to inclusion of the most marginalized groups, they must integrate intersectionality at all phases of policymaking process” (Bishwakarma et al., 2007, p. 1). The authors draw on a conceptual policy framework adopted from Dunn (1994) to develop questions and criteria for an intersectional analysis in four stages of policy-making.

In their proposed framework or model, they argue that an intersectional policy process analysis should include an examination of each stage of policy process to determine the extent (if any) to which the intersectional approach is needed and, if it is, whether it is included (Bishwakarma et al., 2007, p. 9). Moreover, they argue that, to be done effectively, “representatives of intersectionally-defined target populations should be included proportionately in the policy process, including the implementation and evaluation stages” (Bishwakarma et al., 2007, p. 21). This helps to avoid what Phillips (1995) has described as policies that are worked out *for* rather than *with* politically excluded constituencies.

Bishwakarma, Hunt, and Zajicek present a practical guide, which they themselves apply to the case study of education in Nepal. Their approach consists of four stages of policy-making, as detailed below. Each stage integrates key questions and issues for consideration, which we have expanded upon using other emerging methods and examples, and which demonstrate the advantages of the intersectionality perspective for informed policy-making.

PHASE 1. AGENDA SETTING (PROBLEM STRUCTURING): At this stage the problem is defined, drawing the attention of the policy-makers to a problem that requires governmental action. The problem then morphs into a policy issue.

Because so many key stakeholders, with various knowledge, biases, and understandings of inequalities, are involved in agenda setting, it is critical to understand who defines when, where, and why certain policy problems become important and which do not. The first stage also entails establishing whether a



Decision makers should consider the foreseeable impacts on members of vulnerable and marginalized. At times, this may require the collection of more information and the undertaking of intersectional research.

defined policy problem is experienced differently by various social groups and, therefore, requires an intersectional approach to problem definition (Bishwakarma et al., 2007, p. 9). This involves probing beyond a single identity to examine what other identities may be interacting to create a situation of disadvantage (CWGL, 2006). It should be determined “who is currently winning or losing in the policy field” (Parken & Young, 2007, p. 78) because “who is at issue matters just as much as what is at stake” (Hancock, 2007, p. 65). In the process, an intersectional approach resists any group generalizations and focuses on layered interrelations between social inequities and within category diversity.

This step may involve taking into account a historical account of the issue as well as a situational analysis of the problem. The historical account may involve considering the effects of colonialism, nation building, and economic globalization (CRIA, 2006). The situational analysis is a comprehensive diagnosis that focuses on the interaction of both individual and institutional factors (Hancock, 2007, p. 71) that can illuminate systems of domination and individual experiences of discrimination.

It entails determining what categories of experience are prevalent in the context of this policy. And it also leads to determining whether a current policy addresses certain disadvantages but creates competition and discrimination for others. As the Centre for Women’s Global Leadership (2006) asks, “Does a policy initiate addressing racial discrimination and economic opportunity for one group of women create further tensions with other racial or ethnic women creating a competition and hierarchy of minorities that serves to perpetuate the domination of a majority group?”

PHASE 2. POLICY FORMULATION (ALTERNATIVES AND RECOMMENDATION):

Official proposals or alternatives are developed for dealing with policy issues and a policy proposal or alternative is adopted by a form of government (legislative majority, agency directors, or court decisions).

The second phase must determine if the official policy proposals address the problem through an intersectional perspective. Informative questions in such an exercise include: What kind of program or policy is envisioned? What are the desired or intended results? (Bishwakarma et al., 2007, p. 8) Importantly, decision makers should consider the foreseeable impacts on members of vulnerable and marginalized groups. At times, this may require the collection of more information and the undertaking of intersectional research, as detailed in the previous section,



since there is a paucity of data and information in general that illustrates the simultaneous operation of various dimensions of inequality.

In proposing policy options, Bishwakarma, Hunt, and Zajicek (2007) also acknowledge that some might argue national policies cannot be written to include every group within the short narratives of policy frameworks. However, the question becomes whether the status quo and/or general or homogenous policies address the specific consequences of oppression for the different groups of “disadvantaged” people (p. 19). Their point is that, while the challenges of intersectionality are numerous, a more complex view of social reality in policy formulation is required.

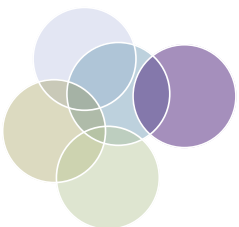
PHASE 3. POLICY IMPLEMENTATION (MONITORING): An adopted policy is carried out by an administration unit(s) through mobilization of finances and resources in compliance with the policy.

This phase involves evaluating if an adopted policy is implemented by an administrative unit(s) or relevant government department in compliance with the intersectional nature of the problem as well as policy. Evidence of the intersectional nature of policy regarding its implementation would include, among other things, the targeted population’s membership (and membership responsibilities) within the implementing agency or administrative unit (Bishwakarma et al., 2007, p. 10). This of course highlights the importance of maintaining extensive and meaningful inclusion of affected key stakeholders throughout the policy process.

PHASE 4. POLICY ASSESSMENT (EVALUATION): Governmental units determine whether all relevant policy actions are in compliance with the statutory requirements of the policy and whether policy objectives have been achieved.

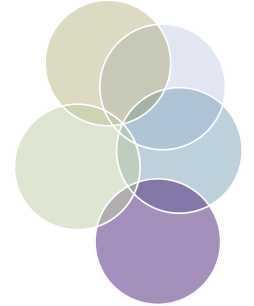
Upon completion of these four phases, Bishwakarma, Hunt, and Zajicek (2007) explain that a decision needs to be made whether policy objectives have been achieved given the intersectional nature of the problem. That is, they argue, we need to take into account baseline conditions and compare the results gained through the evaluation and assessment stage following policy implementation in order to assess whether the policy objectives have been achieved.

Applying intersectionality to a policy cycle requires a certain rigidity which recognizes each stage as having “a distinctive characteristic and mannerism and process that give the individual stage a life and presence of its own” (John, 1998, p. 21). It is important to note that this policy model is often seen as flawed inasmuch as it



Evidence of the intersectional nature of policy regarding its implementation would include, among other things, the targeted population's membership (and membership responsibilities) within the implementing agency or administrative unit.

exaggerates the tidiness of a process that is altogether more complex, fluid, and nuanced. For example, the linear description of the stages is inaccurate, since the process often reveals many elements of the stages in different order; or it might reveal that the model is far too top-down in nature and fails to factor in the interaction of multiple, differing, or competing policy cycles which have an impact on the cycle under analysis and on its formulation and implementation (Sabatier, 1999, p. 7). Ultimately, however, the model does allow for some clarity about how to begin to integrate intersectionality within the policy process.



Approach 2: Multi-Strand Project: Commissioned by the National Assembly for Wales and the Equality and Human Rights Commission

This project was developed in response to the new “six strand” Equal Treatment legislation covering gender, ability, race, sexual orientation, age, and religion (in training and education) in the United Kingdom and the need to develop a road map for a cohesive and integrated approach to promoting equality. The requirement to move beyond siloed approaches and to design and adopt “an approach that can incorporate and manage the differences in origin and outcomes between strands” (Parken & Young, 2007, p. 26) was at the foundation of this path-breaking work. As the authors explain “our research began from the premise that what was required was an inclusive method capable of promoting equality through policy design, informed by evidence. We have created a multi-strand approach, which avoids ‘strand’ issues but values the different knowledges and approaches of ‘strand’ voices” (Parken & Young, 2007, p. 29).

The authors situate the multi-strand approach by explaining that:

(W)e consciously avoided beginning with one strand and adding others. Neither did we begin from a theme of issue and look for connections across ‘strands.’ We began with investigating a policy field — social care, and then focused on the situation of carers — asking who are Wales’ carers by quantitatively and qualitatively using the ‘strands’ to who they were and what inequities they may be subject to. (p. 28)

The multi-strand approach thus differs from the first example in that it begins with an investigation of a policy field (not “proofing” an existing or new policy). It then proceeds to gather evidence of inequality with the aim of creating new policies that are able to address identified inequalities. Accordingly, this approach “does not

begin with 'strand issues' or existing policies, which have their own way of framing debates. This method prevents the distinctions between forms of inequities from being lost and provides for an inquiry that would capture both individual and group disadvantage" (Parken & Young, 2007, p. 28).

The multi-strand model presented in Figure 1 has four distinct stages: mapping, visioning, road testing and monitoring, and evaluation. It involves a range of expertise — policy, equality, and human rights — and it is intended to engage with all relevant stakeholders. It is "based upon the collection, collation, analysis and synthesis of equality evidence for all equality 'strands' and human rights and those outside of 'strands'" (Parken & Young, 2007, p. 50). According to Parken and Young, "It works to promote equality in a positive, proactive and creative way" (2007, p. 50).

According to its authors, the multi-strand approach has the capacity to:

- identify the underlying (sometimes complex) sources of inequality;
- be citizen-focused, taking into account the whole person, and not just a single aspect of identity or experience;
- maintain the distinctions between the origins of inequality between "strands" and provide an integrated method of working that will enable resources to be targeted towards reducing the greatest inequalities;
- enhance the forms of democratic participation that recognize the equal worth and dignity of all "strands".

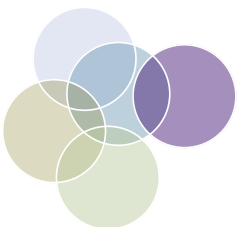
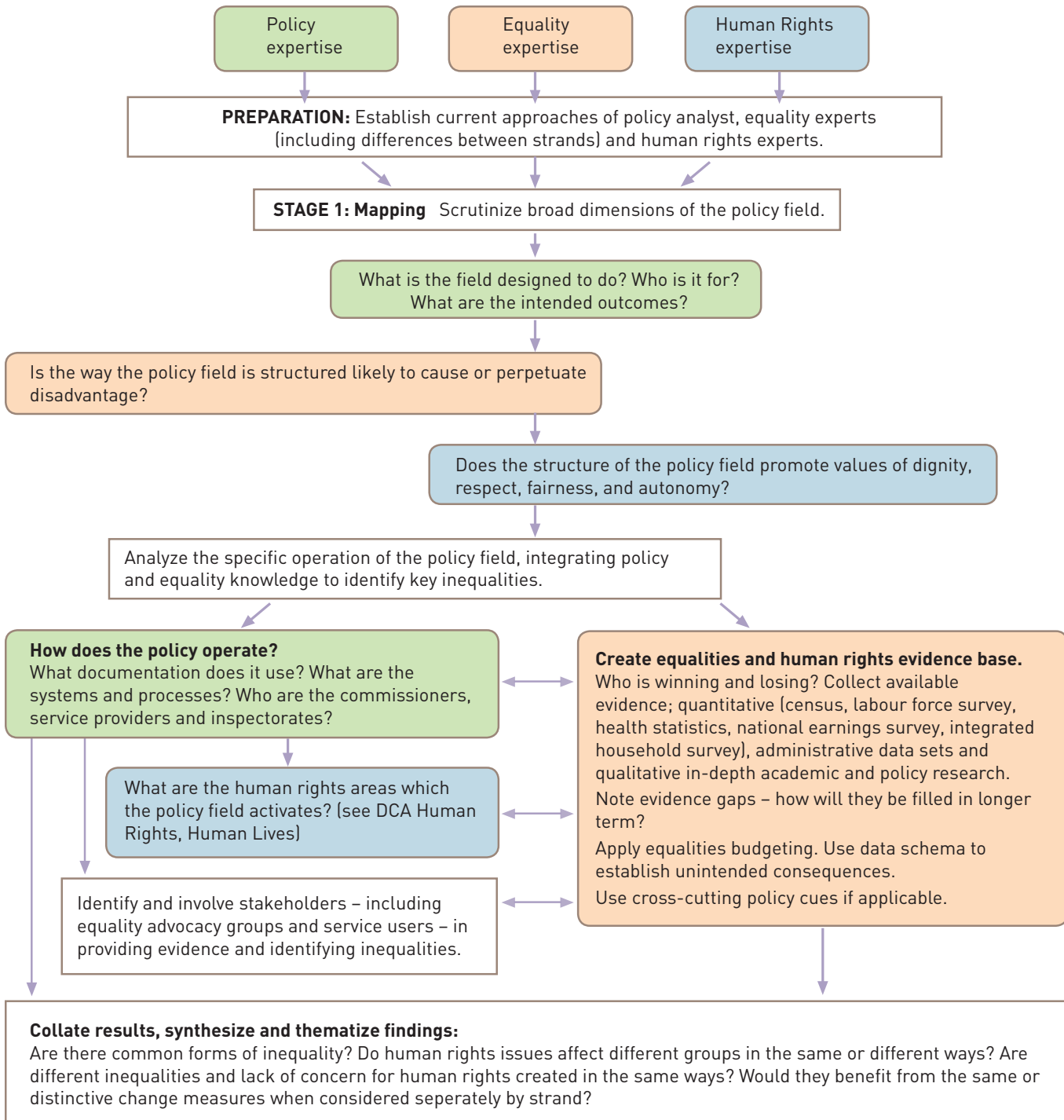


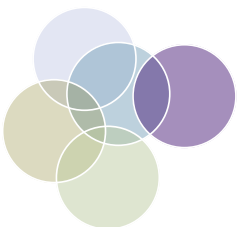
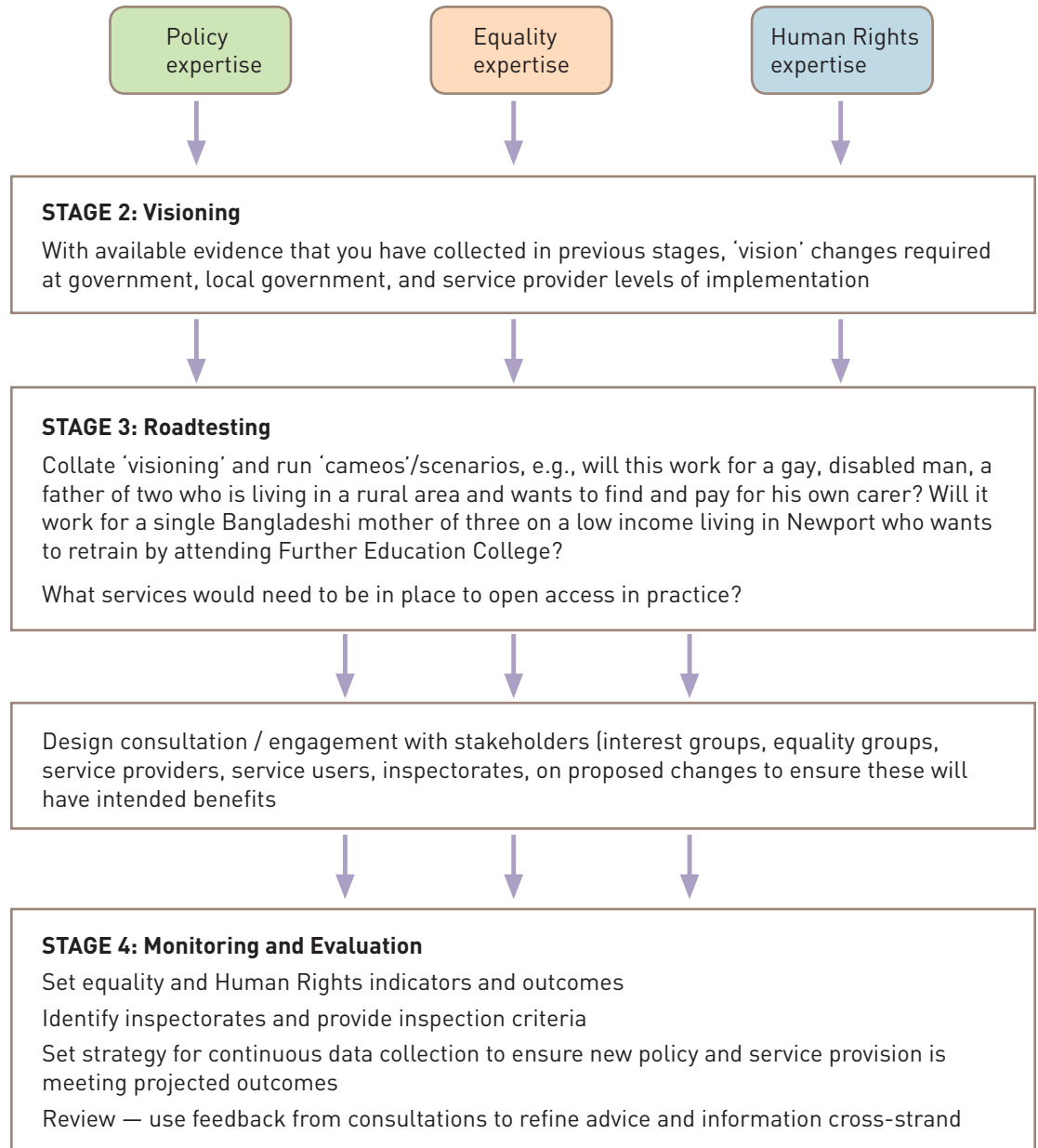
Figure 1. The Multi-Strand Model

Source: Parken & Young, 2007. Used with permission

PREPARATION AND STAGE 1



STAGES 2, 3, and 4



Policy-makers will need to draw on a solid base of research evidence, have access to appropriate data, secure appropriate human and economic resources, and be able to engage in ongoing intersectoral debates that include both policy and equity knowledge from a range of stakeholders.

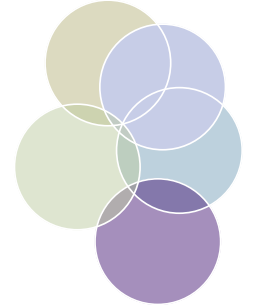
Conclusion

Moving towards applying intersectionality in a systematic and effective manner will require political will and cannot be realized or managed on a purely administrative level (Parken & Young, 2007). This is because, intersectionality challenges the status quo in public policy, which is focused on finding simple solutions that are politically feasible and work within existing institutional frameworks and timeframes (Manuel, 2006). There is no doubt, that given its attention to multiple identity markers, “an intersectional approach is likely to lengthen the time needed to craft, enact and implement legislation” (Manuel, 2006, p. 195). Successful integration of intersectionality also requires appropriate training because “multi-strand working requires ‘strand’ advocates to be trained in the different forms of inequality and different approaches to remedy in play between ‘strands’” (Parken & Young, 2007, p. 8). Intersectionality also presents “a challenge of creating complex alliances across intersecting inequalities” (Bishwakarma et al., 2007, p. 25) for the development of public policies.

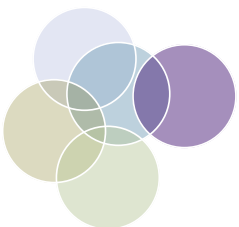
To move towards effective integration, policy-makers will need to draw on a solid base of research evidence, have access to appropriate data, secure appropriate human and economic resources, and be able to engage in ongoing intersectoral debates that include both policy and equity knowledge from a range of stakeholders. And, in the end, those who engage with this work will need to be aware of issues of power in that those groups who currently benefit from policy initiatives may be resistant to the changes that may be brought about by intersectional policy-making.

Nevertheless, “the policy prescriptions and discourse arising from such an analysis will be truer to people’s actual lived experiences and therefore more effective and better able to target the actual location of oppressive forces at work in society” (Bedolla, 2007, p. 246). Similarly the Canadian Research Institute for the Advancement of Women has asserted that such approaches “unravel how social categories of difference intersect in constantly changing ways in order to crack open oppressive dialogues, structures and practices” (CRIAOW, 2006, p. 10). The challenge now is to further develop the application of intersectionality in policy and in health policy more specifically.

In the final analysis, intersectionality “specifically addresses the limitation of single-explanation approaches in public policy that have failed to capture the complexity of disparities across groups” (Manuel, 2006, p. 189). By bringing to the foreground the various background dimensions that interact to create layers of inequality, a more

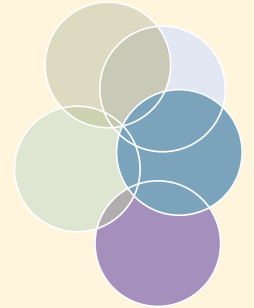


complete and sophisticated analysis can be developed, one that better captures the ways in which public policy is experienced by various groups of women and men who may experience multiple forms of discrimination (Hankivsky, 2005). Policy-makers may be persuaded to incorporate this approach into their work if they understand that it has the potential to lead to more effective, more responsive, and therefore, more efficient policy decisions. Intersectionality does therefore provide, as Hancock (2007) so succinctly puts it, “the best chance for an effective diagnosis and ultimately an effective prescription” (p. 73).



Case Studies: Moving Through the Research and Policy Processes Using Intersectionality

The following case studies provide, from an intersectionality perspective, often-overlooked facts and crucial insights into the various dimensions that constitute the social context of health, the structure of the health care system, including issues of access and quality of care, the role of power within national and international contexts in the construction of health inequities, and the necessary directions in health research and policy to move these various priority areas in health forward in a way that is consistent with an intersectionality framework. Three women's health issues will be explored in the following sections: violence against women, cardiovascular disease, and HIV/AIDS.



CASE 1

Violence Against Women

Background

- Violence against women occurs on a continuum, beginning with female foeticide and ending with homicide, and includes infanticide, incest, sexual harassment, interpersonal violence, and trafficking.
- Research and policy on violence against women has used a one-size-fits-all approach. The traditional approach has generally been “to emphasize the common experiences of battered women in the interests of forging a strong feminist movement to end woman abuse” (Sokoloff & Dupont, 2005, p. 41).
- Claiming that violence is experienced and affects all women in the same way falsely assumes that gender is the primary or single factor in determining violence. Violence against women is not a “monolithic phenomenon” (Oxman-Martinez et al., 2002).
- Intersectionality requires moving beyond single factor descriptions of violence against women. It requires the emphasis of “both individual and structural analyses of race, class, and gender inequality and marginalization in culturally diverse communities” (Sokoloff & Dupont, 2005, pp. 59–60).
- Intersectionality allows for the existence of both victimization and agency among women who experience violence (Sokoloff & Dupont, 2005).

General Context

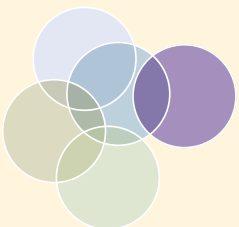
- Research is sparse on prevalence, frequency, and severity of violence against women and violence against women is difficult to document, especially in immigrant and ethnic minority populations in Canada and other jurisdictions (Bent-Goodley, 2007; Oxman-Martinez et al., 2002).
- Current measures do not assess the impact of race, ethnicity, gender, sexual orientation, nationality, religion, age, ability, and culture on outcomes (Bent-Goodley, 2007, p. 95).

Help-seeking Behaviours

- Women of colour often turn to informal service providers (i.e., friends, faith-based communities) to receive services before reaching out to formal providers (i.e., mental health service providers, the criminal justice system, or other health professionals (Bent-Goodley, 2007).
- Immigrant and refugee women are less likely to access a shelter or transition house (Oxman-Martinez et al., 2002).
- Women of colour are often encouraged to keep the business of the family within the family (Bent-Goodley, 2007).
- Women of colour often feel ambivalent about using the police and the criminal justice system (Oxman-Martinez et al., 2002).
- Visible minority and immigrant women often express a preference for interventions that are focused on the collective good (Oxman-Martinez et al., 2002).

Institutional Barriers

- Women of colour experience several stereotypes and labels, especially from health care professionals, that discourage them from seeking help (Bent-Goodley, 2007).
- Mainstream front line interventions are based on a dominant (e.g., eurocentric and middle-class) cultural construction of help (Oxman-Martinez et al., 2002). For example, although mainstream shelter workers in Canada often view violence as a masculine natural trait, Native women and women of colour identify poverty, racism, and colonialism as affecting men's behaviour (Oxman-Martinez et al., 2002).



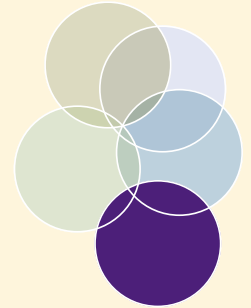
- Language barriers among recent immigrants and refugees but also among long-standing citizens who do not use mainstream languages undermine the effective access and use of available antiviolence services (Oxman-Martinez et al., 2002).

Systemic Domains

- Social and economic structures such as capitalism, globalization, imperialism, and armed conflicts create conditions for violence against women (e.g., rape, transnational trafficking of poor and migrant women).
- High prevalence of poverty has a significant impact on how violence is experienced (Bent-Goodley, 2007).
- Many women experience greater risk of violence because of immigration status (Bent-Goodley, 2007).

Research and Policy

- Research with marginalized populations requires methods that are participatory and based on a community action model. It is also critical to keep in mind that there are many differences within groups of women (e.g., Aboriginal women, immigrant women) and that women within such groups do not speak with one voice (Sokoloff & Dupont, 2005).
- Participating communities in research projects should experience benefits from the results of studies (Bent-Goodley, 2007).
- Research requires interdisciplinary collaboration to find solutions to address the complexities of violence against women (Bent-Goodley, 2007).
- Research should test programs, services, and practices that can help to resolve violence against women within diverse frameworks (Bent-Goodley, 2007).
- Structural solutions (e.g., economic and food security, affordable housing, social security) are required to help alleviate the risks and effects of violence against women (Sokoloff & Dupont, 2005).
- As policies may have differential effects of differently situated women, equity should be ensured in the development and evaluation of policies (Bent-Goodley, 2007).



Essential Readings

Crenshaw, K. (1995). Mapping the margins: Intersectionality, identity politics and violence against women of colour. In K. Crenshaw, N. Gotanda, G. Peller & K. Thomas, (Eds), *Critical race theory: The key writings that informed the movement* (pp. 357-383) New York: New York Press.

Bent-Goodley, T. B. (2007). Health Disparities and Violence Against Women: Why and How Cultural and Societal Influences Matter. *Trauma, Violence and Abuse*, 8(2), 90-104.

Oxman-Martinez, J., Krane, J., Corgin, N., & Loisell, L. (2002). *Competing Conceptions of Conjugal Violence: Insights from an Intersectional Framework*. Montreal: Centre for Applied Family Studies, McGill University. Immigration & Metropolis.

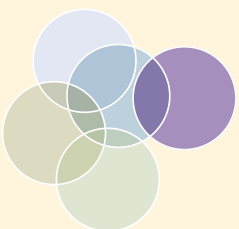
Sokoloff, N., & Dupont, I. (2005). Domestic Violence at the Intersections of Race, Class, and Gender: Challenges and Contributions to Understanding Violence Against Marginalized Women in Diverse Communities. *Violence Against Women*, 11(1), 38-64.

CASE 2

Cardiovascular Disease

Background

- Cardiovascular disease (CVD) is comprised of a range of health conditions and illnesses, including myocardial infarction, ischemic heart disease, valvular heart disease, peripheral vascular disease, arrhythmias, high blood pressure, and stroke and is the number one killer of all Canadians (Statistics Canada, 2006).
- Traditionally, CVD has been considered a White man's disease, resulting in a lack of information about the risk factors, diagnosis, treatment, and prevention of CVD in women and vulnerable groups of men and women (Health Canada, 2003b).
- While CVD mortality rates are similar for males (31 percent) and females (33 percent), recent evidence suggests that deaths related to CVD are significantly higher among some vulnerable sub-groups in Canada, including First Nations and Inuit populations (Health Canada, 2007), refugees (DesMeules et al., 2004), South

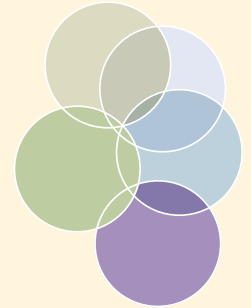


Asians (Gupta, Singh, & Verma, 2006; Sheth et al., 1999), and individuals who are less educated, as well as among women living in northern, remote, and rural communities (WHI, 2006).

- As recently as 2007 (Pilote), there were calls to explore sex and gender differences in order to further our understanding of the cause, treatment, and prevention of CVD in Canada at the cost of downplaying or ignoring the contribution of other factors such as ethnicity, education, geography, income, and so on, thus essentializing the experiences of women and men.
- In recognition of the interrelationships among the many complex levels of influence on CVD, in combination with the increasing diversity of the Canadian population, intersectional-type analysis “can be instructive in starting the process of both identifying and better understanding the factors, relationships and processes that are essential for advancing the evidence base around CVD” (Dhamoon & Hankivsky, 2008, p. 16).

Social Processes as Risk Factors for CVD

- Significant variation has been established in CVD along the lines of age, sex, ethnic group, and geographic areas (Anand et al., 2001; Franzini & Spears, 2003; Tanuseputro et al., 2003).
- Even controlling for traditional risk factors, people living in lower income areas are more likely to be obese, smoke, and be physically inactive and to develop CVD compared to those in well-off neighbourhoods (Diez-Roux et al., 2001; HSF, 2006).
- Rural populations, especially Aboriginal persons living in rural areas, have higher risks of CVD compared to individuals living in urban centres (Monsalve et al., 2005).
- In an analysis of National Population Health Survey data, Wong and Wong (2003) found that immigrant women tended to have worse CVD risk factors than non-immigrant women (regardless of race or birth country).
- In a study examining data from the National Health and Nutrition Examination Survey III, Young, Cunningham, and Buist (2005) found that, in addition to being less educated and reporting non-White ethnicity and lower levels of income, health, and social support, lone mothers were more likely to be current smokers, be overweight or obese, and were more likely to have experienced a CVD event (MI, CHF, or stroke) compared to partnered mothers.



Institutional Barriers to Care

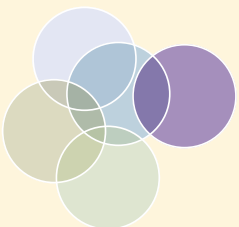
- South Asian ethnicity has been shown to be an independent predictor of poorer outcome after coronary bypass grafting (Brister et al., 2007).
- In a large review of literature exploring racial or ethnic differences in cardiac care, Lillie-Blanton and colleagues (2002) found that there were significant differences in care along ethnic or racial lines even after adjusting for clinical and socioeconomic factors.
- In the United States, research has demonstrated that African Americans and Latinos receive poorer treatment in the health care system than Whites (Weber & Fore, 2007, p. 197).
- African Americans are less likely than Whites to undergo costly invasive cardiovascular procedures & Hispanics were less likely than Whites to have received catheterization and PTCA (angioplasty) (Ford, Newman, & Deosaransingh, 2000).

CVD in the Global Context

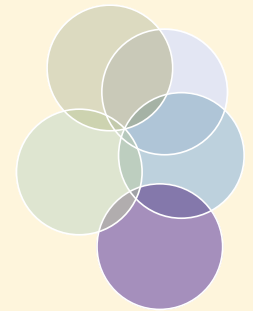
- In their examination of CVD, Yusuf and colleagues have observed that “social and economic transitions have resulted in major changes in population demography, industrial structure, income levels, expenditure patterns, education levels, family structures, eating habits and physical activity” (Yusuf et al., 2001b, p. 2862). The authors highlight why space is an important intersection by further explaining, “with urbanization ... there is a decrease in energy expenditure (through less physical activity) and a loss of the traditional social support mechanisms. In addition to increased migration of individuals from rural to urban areas, rural areas are themselves also being transformed. For example, increased mechanization in agriculture and increased use of automobile and bus transportation in rural areas are leading to a decrease in physical activity” (Yusuf et al., 2001a, p. 2751).

Research and Policy

- To improve the breadth and depth of CVD research, there is a need to contextualize health disparities within a matrix of domination by exploring risk factors beyond ethnocultural affiliation and gender, to fully explore the relationships among the relevant variables, and to avoid essentialist characterizations of difference (King et al., 2007; King et al., 2006).



- CVD research should adopt a “bottom-up” approach which is based on the notion that individuals have subjective knowledge of their own lives and the context in which they live and that they are in the best position to define their own “health problems” (Dhamoon & Hankivsky, 2008).
- CVD research and policy focuses traditionally on the prevention, detection, and management of major risk factors which are usually targeted at the individual level (e.g., smoking, alcohol, physical inactivity, obesity, nutrition), firmly placing individuals at blame for their own health problems while ignoring macro-level processes (e.g., inequity in access to care) which shape the development and outcomes of CVD (Dhamoon & Hankivsky, 2008). As such, an intersectional approach would situate CVD research and policy within the current cultural, societal, and institutional contexts.
- As Magnusson has argued, “Globalization creates ... new *process challenges* to an effective response to national health problems” (2007, p. 3). A key feature of an intersectional-type approach with regards to the development of a population-wide CVD strategy would involve the coordination of all relevant global actors (Dhamoon & Hankivsky, 2008).



Essential Readings

Dhamoon, R., & Hankivsky, O. (2008). *Why the Theory and Practice of Intersectional-Type Approaches Matters to Health Research and Policy*. Paper for presentation at the Annual General Meeting of the Canadian Political Science Association, Vancouver, B.C. 4-6 June, 2008.

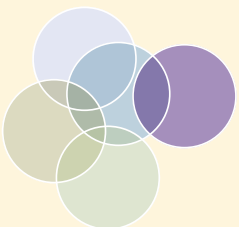
King, K., Thomlinson, E., Sanguins, J., & LeBlanc, P. (2005). Men and women managing coronary artery disease risk: Urban-rural contrasts. *Social Science & Medicine* 62, 1091-1102.

Weber, L., & Fore, M. E. (2007). Race, Ethnicity, and Health: An Intersectional Approach. In H. Vera & J. R. Feagan, (Eds.), *Handbooks of the Sociology of Racial and Ethnic Relations*. New York: Springer US.

CASE 3 *HIV/AIDS*

Background

- When considering the HIV/AIDS epidemic in Canada, early on the disease was seen as primarily affecting males who had sex with males, with AIDS being perceived as the “gay men’s disease”.
- Recent data indicates that the proportion of women infected with HIV has more than doubled from 11.3 percent between the years 1985 and 1996 to 27.8 percent in 2006, and the number of women with AIDS has quadrupled from 6.1 percent in 1994 to 24.2 percent in 2006 (Centre for Infectious Disease Prevention and Control, 2007).
- Rates of infection are also increasing among other vulnerable populations such as Aboriginal people, inmates, injection drug users, at-risk youth, and immigrants from countries where HIV is endemic (Public Health Agency of Canada, 2006).
- In Canada, rates of HIV infection among Aboriginal women are increasing disproportionately compared to all other populations in Canada. Additionally, Aboriginal women are infected on average at a younger age compared to non-Aboriginal women, and they are more likely to be infected through intravenous drug use compared to non-Aboriginal women (Health Canada, 2004).
- Women, and in particular women who are multiply disadvantaged (e.g., drug users, sex trade workers, immigrants, refugees, living in poverty, Aboriginal), are at greater risk for sexual assault and interpersonal violence, increasing exposure to HIV (BC Ministry of Health, 2007).
- Early feminist research in the area of HIV/AIDS focused on the “gendered” and “sexual” nature of the disease; but recently there have been calls to explore HIV/AIDS from an intersectional perspective with the recognition that gender and sexuality cannot be separated from other axes of identity, including race, class, age, religious affiliation, immigrant status, and so on (Amaro & Raj, 2000; Bredstrom, 2006; Hankivsky, 2005).
- HIV/AIDS is beginning to be acknowledged as a “socio-economic” phenomenon rather than a purely medical one (Williamson, 2004). Consequently an intersectional approach to the study of HIV/AIDS-related issues would permit an analysis of how systems of discrimination, oppression, and power have an impact on the prevention, incidence, detection, and treatment of HIV/AIDS.

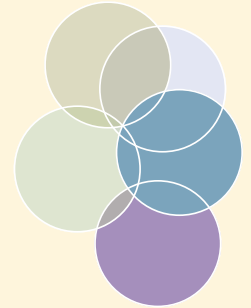


Disparities in Access to Care

- In Canada, geographic location is related to access to HIV care. For example, people living in the Maritimes do not have a drug reimbursement program and therefore have the poorest access to medication; whereas individuals with HIV from wealthier provinces such as Alberta, Ontario, and Quebec have better access to HIV/AIDS care and treatment (Louise Binder on AIDS and Women, 2006).
- Individuals from British Columbia receive the least expensive HIV/AIDS drugs and must pay to access more costly (and effective) drugs thereby creating a further disparity between low income individuals (who frequently have other axes of vulnerability, e.g., immigrant, woman, Aboriginal) and wealthier, more privileged individuals (Louise Binder on AIDS and Women 2006).
- Immigrant and refugee populations in Canada often living in poverty frequently cannot access Canada's health care system due to their lack of legal status in Canada and additionally report problems negotiating the complicated health care system (Lawson et al., 2006).
- First Nations women living with HIV/AIDS in Canada report significant barriers based on gender, race, and class to accessing a broad range of services and, in particular, culturally sensitive services (Ship & Norton, 2001).
- In Canada, research suggests that First Nations people living with HIV/AIDS, particularly Aboriginal women, experience more barriers to health care or drugs crucial to their treatment, resulting in a delay in the start of their treatment and ultimately having an impact on life expectancy after initial diagnosis compared to non-Aboriginal people with HIV and AIDS (Jackson & Reimer, 2008).
- According to a large-scale study in the United States, HIV-infected persons were less likely to receive highly active antiretroviral therapy (HAART) if they were African American or Hispanic; lacked health insurance or had public insurance; were exposed to HIV through intravenous drug use; or had less than a college education (Anderson et al., 2006).

Stigma and Discrimination

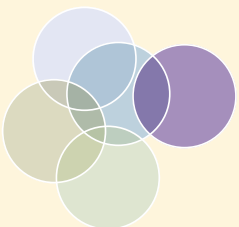
- Historically, there is a moral meaning attached to HIV/AIDS due to its association with groups that are blamed as being responsible for the HIV/AIDS epidemic in North America such as intravenous drug users, homosexuals, and sex trade workers (Treichler, 1999; Williamson, 2004).



- Stigma and discrimination has been identified by the Joint United Nations Program on HIV/AIDS as a major barrier to HIV/AIDS prevention and care (UNAIDS, 2002).
- Persons living with HIV/AIDS report double, triple, or even multiple layering of stigma if the mode of infection is also stigmatized (e.g., drug use); if they belong to certain cultural groups (e.g., Aboriginal) or gender (i.e., female) or social class (i.e., “poor”); or if they suffer from another illness that is also stigmatized (e.g., mental illness) (Collins, von Unger, & Armbrister, 2008; Mill et al., 2007; Ship & Norton, 2001).
- HIV/AIDS is frequently associated with groups that are already marginalized; consequently stigma serves to further stigmatize marginalized groups, increasing their vulnerability to infection and ultimately contributing to greater class, gender, and racial inequalities in society (Williamson, 2004).

Research and Policy

- Knowledge about the role of stigma and discrimination with regards to its impact on marginalized populations is crucial in addressing HIV prevention, diagnosis, and access to care. Antistigma programs targeted at marginalized groups are essential in ensuring that those who need help access the care and treatment they need (Williamson, 2004).
- In order to fully address HIV/AIDS within marginalized groups in Canada, it is essential to examine the intersecting variables of race, cultural identity, geographic region, disease stage, gender, age, and mode of transmission.
- An intersectional-type analysis is critical in ascertaining the role of oppression — that is, political, economic, and social power processes — based on axes of discrimination (e.g., gender, race, ethnicity, religion, age, sexual orientation, geography) in fully understanding women’s risk for and experiences with HIV/AIDS care (Amaro & Raj, 2000; Hankivsky, 2005; Msimang, 2003).
- In recognition of the powerful effects of oppression in women’s lives, it has been argued that the prevention of the spread of HIV infection globally should be addressed through the inclusion and empowerment of women and other marginalized communities “to gain control of their bodies, social identities and future lives” (Williamson, 2004, p. 4).
- With its exploration of the socio-economic and cultural aspects of sexual behaviour, the root causes of poverty, gender inequality, and racism, as well as the role of globalization in the HIV/AIDS epidemic, HIV/AIDS research and policy



must be framed as “...a health issue, as a human rights issue, and as a sexual and reproductive rights issue” (Msimang, 2003, p. 113).

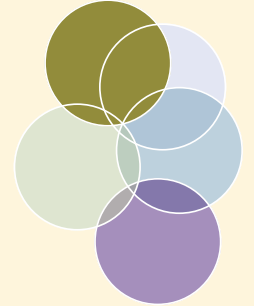
Essential Readings

Amaro, H., & Raj, A. (2000). On the Margin: Power and Women’s HIV Risk Reduction Strategies. *Sex Roles*, 42(7/8), 723-749.

Jackson, R., & Reimer, G. (2008). *Canadian Aboriginal People Living with HIV/AIDS Care, Treatment and Support Issues*. Ottawa: Canadian Aboriginal AIDS Network.

Mill, J., Austin, W., Chaw-Kant, A. J., Dumont-Smith, C., Edwards, N., & et al. (2007). *The Influence of Stigma on Access to Health Services by Persons with HIV Illness*. Edmonton, AB: University of Alberta.

Williamson, K. (2004). *AIDS, Gender and the Refugee Protection Framework*. Working Paper Series. Oxford, UK: International Development Centre, University of Oxford.



Conclusions

In sum, intersectionality reveals the need for more complexity and inclusion in research and policy design. Kobayashi argues this is a priority in the Canadian context, “Policy and research that calls attention to the salience of multiple diversity markers, including sexual orientation, geographic region, disability and their intersections is needed to ensure that disparities are reduced and equity is promoted and ultimately achieved not only in health care but in all aspects of Canadian society” (2003, p. 98).

APPENDIX A

Definitions of Social Categories

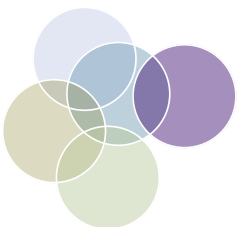
These examples of how the definition of socially constructed categories changes over time were written by Diego de Merich, Research Associate with the Institute for Critical Studies in Gender and Health.

Ethnicity

It could be argued that the principal determinants of ethnicity make its definition two-fold. Commonly, it is “used in reference to population groups or categories that are characterized by a shared nationality, culture, or language” (Rummens, 2003, p. 87). On the other hand, as an identity, it is primarily a construct of *self*-definition and self-concept measured by how connected an individual feels to a specific ethnic group. Critical here is knowledge about one’s own ethnic group, its customs, traditions and history, rather than on knowledge of other people’s ethnic group. As a sense of belonging (and exclusion), according to Martha Bernal and George Knight, the development of ethnic identity in children, rests upon five key components:

- (1) *Ethnic self-identification*: requiring an individual or “own-ethnic group” category with attendant “social cues”;
- (2) *Ethnic constancy*: knowledge that these ethnic cues will be constant or permanent across time and place;
- (3) *Ethnic role behaviours*: participation in the roles and behaviours which have been predetermined as elements of that ethnic identity;
- (4) *Ethnic knowledge*: personal knowledge of the customs, traditions and language of a particular culture; and
- (5) *Ethnic feelings and preferences*: preference for those very cues, customs and roles incorporated within that ethnic identity (Bernal & Knight, 1993, p. 34).

In recognizing a certain flexibility of the term ethnicity, as well as a tendency to conflate the term with race and culture, it is generally agreed that the most appropriate determinants and boundaries of ethnic identity, rest within each ethnic group member. Otherwise, there is a sociological problem where group membership is ascribed to by the researcher rather than self selected (Dein, 2006, p. 70).



Culture

In contrast to the concept of *ethnicity*, Frances Henry defines culture as the “totality of the ideas, beliefs, values, knowledge, and way of life of a group of people who share a certain historical, religious, racial, linguistic, ethnic or social background” (quoted in Rummens, 2003, p. 87). In this sense, culture is very much *experiential*, linked as it is on the actualization of racial, national, religious, or other group values, traditions, and cues. At the same time, as mentioned above, it is sometimes used in an essentialist manner and interchangeably with race or more often with ethnicity. For the ease of social or health research, it seems, a “fact file” approach is often used which requires a specific list of attributes pertaining to a specific cultural grouping to be developed. The danger with this approach, argues Dein, is principally the stereotyping and racism that this essentialism can engender. As he puts it:

Culture becomes reified, something which is static not as something dynamic and negotiated ... This approach neglects historical factors which influence cultural narratives and mystify the social production of culture. Fact file approaches neglect the power relations, which continuously destabilise cultural practices (Dein, 2006, p. 71).

In the Canadian context, it should be worth noting that there is also a recognition that *culture* is not only to be applied conceptually to non-dominant populations, but also in a broader understanding that we all “carry with us our personal cultural identities which impact the way we interact” with one another (Collins & Arthur, 2007, p. 31).

Note, however, that in the case of both *ethnicity* and *culture*, meanings are not only self-directed but are sometimes imposed externally.

Race

Nowhere is the essentialist approach more evident than in the various constructions of *race*. Here, the tendency is for the literature to define race specifically in contrast to ethnicity, with the two seen as “discrete, homogeneous, fixed categories of difference, with race functioning primarily as a signifier of biological difference and ethnicity as signifying cultural difference and heritage” (Dein, 2006, p. 71). And yet aside from the physical characteristics incorporated into a “fact file” on race, the identification with a socially constructed racial identity involves, much like culture and ethnicity, knowledge of the social and historical contexts within which that “race” is situated. From the psychological formation of notions and self-identification with *race*, terms such as “discrimination, marginalization,



alienation, segregation, hegemony and internalized racism (constructing one's identity vis-à-vis the hegemonic culture of the socially oppressive other) are among the concepts of interest in this domain" (Potts & Watts, 2003, p. 69).

Sex

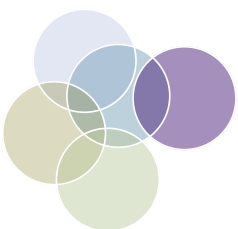
In a similar essentialist vein, Health Canada in a number of publications defines sex in its most clinical fashion as "the biological characteristics such as anatomy (e.g., body size and shape) and physiology (e.g., hormonal activity or functioning of organs) that distinguish males and females". These biological characteristics are seen to occur at the molecular, cellular, or organ level and are the result of a complex interaction of hormonal, environmental, and genetic factors (CIHR, 2006). In this sense, *sex* may be thought to be free from social construct and yet it is difficult to see how in this dyadic, either-or conceptualization of *sex*, an *intersex* person, for example, may be viewed or classified without some ascription of social values, norms, or preferences being involved in the identification process. As Blizzard (2002) points out, the definition of *intersex* is that of an individual displaying characteristics of both sexes, and yet these "characteristics" are rarely defined. So, as a result, "the interpretation may be physical, mental, in personality, or in other ways" (Blizzard, 2002, p. 616) — ways which are decidedly less "clinical" than the definition above.

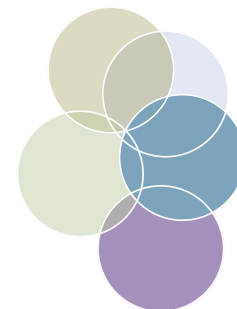
Gender

In contrast to the medical understanding of *sex*, Health Canada recognizes gender as "an array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to two sexes based on a differential basis" (CIHR, 2006). As Girda Siann notes, while *sex* has traditionally been limited to the biological differences between males and females, *gender* "is the manner in which culture defines and constrains these differences" (Siann, 1994, p. 3). In this sense, *sex* is recognized to be immutable or fixed, while *gender* and especially the ascriptions of terms such as "masculine" and "feminine" are not, given their socially constructed, time-, place-, and culture-dependent nature.

Sexual Orientation

In the connection between *gender* and *sexuality*, their cultural significance and their historical roles as ontological identifiers, Siann (1994) argues that:





The notion that humans have an innate sexual urge that propels them towards sexual activity is one we are all familiar with. It is a belief which is characteristic of all societies although the manner in which individuals feel able to give expression to their sexuality varies across societies and across time. This is because all societies prescribe and codify sexual activity and in this way legitimize some sexual practices and not others. (p.10)

In this sense, “sexuality as practice” serves as a useful bridge between essentialist notions of *sex* and social constructions of *gender* and *sexual orientation*. Sexual orientation is seen to run somewhere along a continuum which incorporates homo-, hetero-, bi-, and trans-sexual classifications. Given the very private nature of sexuality, it seems, the appropriateness of each of the above terms may vary within the life cycle of an individual, but is also very much related to a question of self-identification. The difficulty for researchers, aside from the obvious experiential nature of sexuality in contrast with an identity or self-identification which may or may not incorporate those experiences, becomes evident in a common methodological conundrum. As Savin-Williams (2008) has argued, the difficulty rests in the simple process of categorization. How exactly is sexual orientation to be defined? By “who one has sex with? Who one is attracted to? How one [self] identifies? Should options be categorical (gay, lesbian, bisexual, heterosexual) or dimensional (1–7 scale from exclusively heterosexual to exclusively homosexual)? Sexual behavior, sexual attraction, and sexual identity questions do not always solicit similar populations, and individuals might have aspects of one attribute but not exclusively so” (Savin-Williams, 2008, p. 136). Much like gender, *sexual orientation* cannot be said to be essentialist or immutable as a category of identity.

Age

In the most essentialist or biological of definitions, *age* here would be defined as the chronological measure of the physical aging process which, by convention, is counted in calendar years. Of more significance to the social researcher, however, are questions of how a person’s chronological identity may or may not determine her ability to access certain services or to participate fully in community life. The effect of this creeping chronologization of life over the past century, according to Uhlenberg (2000), has meant that:

(I)n a variety of ways the state, work organizations, and schools seized upon age as a criterion for determining who was entitled to and who was disqualified from participating in particular activities or programs. Age

barriers thus produced a standard life course that is separated into three boxes: education for young people, work for adults who are not old, and leisure for the old. (p. 262)

An analysis of these artificially constructed barriers, according to him, allows us to better evaluate the extent to which a given society is age-integrationist or age-segregationist.

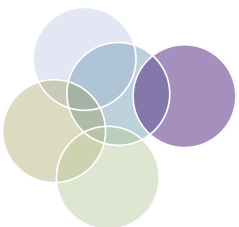
Dis/Ability

In 1980, the World Health Organization prepared the *International Classification of Impairments, Disabilities, and Handicaps* (ICIDH), in which disability was defined as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (WHO, 1980). One of the principal difficulties with this taxonomy, however, comes from the causal relation which is implicitly created, whereby *disability is defined as* “resulting from an impairment” and *handicap* as “resulting from an impairment or disability”. As Simeonsson and colleagues (2000) argue, this linear progression “implies a fixed sequence, with medical factors determining outcomes [and with a] negative and pathology-oriented language reflecting a disease-based framework” (p. 115).

In response to this, the WHO in 2001 developed its International Classification of Functioning, Disability, and Health (ICF), in which it “acknowledges that every human being can experience a decrement in health and thereby experience some degree of disability. Disability is not something that only happens to a minority of humanity. The ICF thus ‘mainstreams’ the experience of disability and recognizes it as a universal human experience” (WHO, 2001). Other researchers, in writing *disability as dis / ability* have opted to emphasize an original dichotomy and its implicit framing of disability as “lack, something to be fixed, just as illness is understood in this binary frame as lacking health” (Diedrich, 2007, p. 244). In emphasizing this binary logic, Diedrich explores the possibility of undermining and overturning its restrictive system of classification.

Religion

As Harrison (2006) points out, while there is generally no difficulty in recognizing certain traditions or concepts as being religious in nature, there is very little agreement as to what *religion* actually *is* (p. 133). As such, she proposes three useful categories of definition: intellectual, affective, and functional definitions of religion.

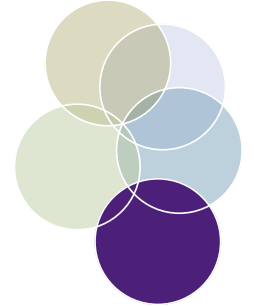


The first is the understanding of religion as a belief in some particular object (a belief in a God or many gods). The second relates instead to the individual practice of religion (through prayer, religious ceremony, and through an emotional attachment to a religious belief system). This understanding involves “a way of *experiencing reality* rather than a set of doctrinal formulations” related to one’s religion (Harrison, 2006, p. 135; emphasis added). Finally, the functional definition of religion appears the most essentialist, ascribing to religion the requirement of specified purpose. Anthropologist J. G. Frazer’s simplistic definition of religion, therefore, is the “propitiation and conciliation of powers superior to man” (quoted in Harrison, 2006, p. 136).

Finally, in a similar functionalist vein, and with consequence in political discourse and policy-making in the United States, many conservative commentators there have also opted for a strictly functionalist understanding of religion. This is done not to emphasize the importance of religion, but to bemoan the fact that *secular humanism* has become the “new” religion. In response, however, some consensus would indicate that “whatever else a religion is, it at least needs a supernatural component, and as such, secular humanism, which is a naturalistic ethical outlook on life, can not be a religion, even if it functions in some of the ways religion does” (Grothe, 2007, p. 65). Ultimately, then, and as with many of the definitions listed above, the most useful definition to the researcher will most likely be the more experiential of the three types, while still recognizing religion as a shared set of moral values and beliefs, most often underpinned by a supernatural claim, and organized or codified as sacred text, ritual, or mystic experience.

Class and Socio-Economic Status

Class here is frequently understood to mean socio-economic social stratification. Class is very much a product of time and historical, economic, and social conditions, rather than a static ontological category. The determinants of class may include education, income, education, family background, and language, among others. Socio-economic status, in contrast to the concept of class, represents a linear scale measuring an individual’s or group’s income or social position relative to others. The categories of socio-economic status are frequently identified with markers such as “poor”, “working poor”, “working class”, “middle class”, and “upper class”, with the last three clearly requiring boundaries of income brackets so as to make sense of the categorization. Class can be understood in terms of questions of mobility and class permeability. Kingston (1996), in analyzing intergenerational class closure, for example, shows that class is not necessarily a stable concept over time, as particular



class “attributes” (both advantages and disadvantages) do not necessarily carry forward to subsequent generations (Kingston, 1996, p. 323). In the context of health care, or access to health services, one’s class can preclude certain health outcomes. For example, a recent global study has found that when factoring in socio-economic position (SEP) and education levels, incidence of certain types of cancer (lung and colorectal) were greatly increased among individuals of a lower SEP (de Kok et al., 2008, p. 1132).

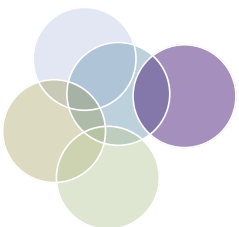
Education

Related closely to class and socio-economic position, *education* is understood here as formal instruction and is traditionally sub-categorized as primary, middle, high school, or higher or university education. It can be, although is not generally associated in the literature with vocational training. Given the artificially constructed associations with *age* identified above, education has traditionally been seen as related to the earlier stages of development in the life cycle. Currently, however, as these socially constructed barriers are brought down, the concept of life-long learning has taken hold. One recent study demonstrates how the promotion of life-long learning orientations is dependent upon targeting specific areas of the learning process in traditional-aged undergraduate students and upon positive diverse peer interactions. By “increasing student motivation, creating spaces for students to reflect, talking about issues related to social justice, engaging in discussions with each other and with faculty, and experiencing some cognitive dissonance”, a more life-long learning orientation was said to easily develop (Mayhew, Wolniak, & Pacarella, 2008, p. 353).

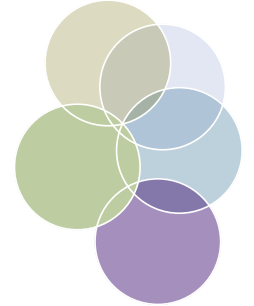
Geography

One of the most necessary geographical distinctions — and most relevant to a country as vast as Canada — used in health research is that of rural versus urban geography. “Rural”, “urban”, “ecosystem”, “habitat”, “regional”, and “community”, are all identifiers which help to signify place and an understanding of belonging to a particular geographical space. As Twohig (2007) points out, “the idea that place matters for health services and health outcomes is not a particularly novel notion” (p. 5). There is recognition of the need for research into the regional variations in epidemiology but also in health outcomes.

There are many other examples, not immediately obvious, of how geography may impact policy decisions in ways that even race or culture may not. For example, a recent study of mortgage lending discrimination, has argued that individual racial



discrimination is often confused with geographical discrimination. Here, rates were made higher in geographical areas where concentrations of a particular ethnic minority (Latinos) was higher, but members of that same ethnic minority living in “non-concentrated areas” received better lending rates from the same financial institutions (Yezer, 2006, p. 202). Also, from a sociological perspective, and specifically in reference to identity-formation, Sarup (1996) makes the argument that for Aboriginal peoples “the history of colonial servitude is inaugurated by [a] loss to an outsider of *the local place*, whose concrete geographical identity must thereafter be searched for and somehow restored” (p. 150; emphasis added). It becomes clear, then, that the physical place within which an individual is situated can have a very real impact upon any construction or notion of identity and life outcome.



Language

In outlining the boundaries between the concepts of “language”, “communication”, and “language community”, Pupavac (2006) succinctly outlines how:

Language is communication. Language involves relationships. We develop language through the communications of those around us. A common language represents a shared form of communication developed in society with others. Those speaking in the same language logically constitute a language community. (p. 61)

Language then, is an important means by which identity can be formed, but it is also a very powerful method of exclusion or inclusion (implicit unilingualism in the United States or explicit bilingualism in Canada). A recent study in Italy, for example, has shown a strong correlation between language and identity formation among groups of South Asian immigrants in Sicily. Here, Rizzo (2008) suggests that an “Indian-Anglo-Italian hybrid variety has been built upon a process of relexification during which Asian immigrants translate their local language into English by keeping the syntactic structure of their native language [e.g., Urdu or Hindi] in the English sentence and by adding a mixture of Sicilian-Italian words” (p. 49). The fluidity of these language structures, it would appear, demonstrates a notion of cultural identity which is also very much in flux or transition (both for the host and the immigrant populations and those using sign language).

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