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Introduction

Gender and health: Relational, intersectional, and biosocial approaches

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State of the field and the way forward

Much of the research on sex/gender and health has been dominated by two foci: 1) empirical examinations of trends and explanations for sex differences in disease incidence and mortality and 2) sex-specific disease patterns and corresponding, often differential, investments of research and policy attention to "men's health" and "women's health" needs. Though these efforts have contributed to understanding the distribution and causes of disease and mortality – and have led to dramatic improvements in allocation of resources and in attention to previously neglected health issues affecting men and women – they often do not reflect contemporary gender/feminist theory and inadvertently reinforce outmoded binary constructions of sex (male vs. female) and gender (masculine vs. feminine), as well as treat sex and gender as easily separable. Indeed, the existence of male/female differences in health outcomes is often considered self-evident and confirming these differences is often privileged over exploring similarities.

In this Special Issue, we strive to move the conceptualization of sex/gender and health away from these dominate foci with scholarship that utilizes contemporary feminist, relational approaches to gender (Connell, 2009; Ferree & Hess, 1987; Ridgeway, 2009; Schofield, Connell, Walker, Wood, & Butland, 2000), as well as prioritizing research on intersectional and biosocial approaches to gender and health (Fausto-Sterling, 2005; Hankivsky & Cormier, 2009; Hankivsky, 2011). By relational constructions of gender, we mean theory and research conceptualizing gender as a pervasive system of stratification that structures relationships and interactions between and among men and women, shapes access to resources and status, and signifies power (Connell, 1987; Scott, 1986). Gender is also conceived of as an agential process, whereby the meaning and expressions of gender are negotiated and "performed," both shaped by and reproducing of social structure (Butler, 1990; West & Zimmerman, 1987). Hallmarks of these approaches are recognition of gender as dynamic and situational, attention to differences among women and among men, and a dislodging of the assumed congruence between "sex" and "gender." In other words, the intervention we suggest is to move from rigid, false binary categories and instead to problematize and understand the construction of these categories. However, it is important to acknowledge that even in striving to undermine the reified binary of male/female categories, the gendered distribution of power and resources produces persistent differences between men and women that may have the effect of reinforcing distinctions along this axis. Each of the Special Issue papers strives to move away from essentialist ideas of sex/gender toward more constructionist/relational analyses of gender and health. Further, we also prioritized two other areas that are broadening and redefining gender and health research: 1) intersectionality and 2) biosocial perspectives.

Initially conceptualized and coined outside the field of health (e.g., Collins, 1990; Crenshaw, 1989, 1991) intersectionality is recognized across disciplines as a valuable tool for analyzing differences. Intersectionality is an approach that explores simultaneous intersections between aspects of social difference and identity (e.g., as related to meanings of race/ethnicity, Indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion) and forms of systemic oppression (e.g., racism, classism, sexism, ableism, homophobia) (e.g., Hankivsky & Cormier, 2009). And while the challenges of 'doing intersectionality' in research continue to be discussed and debated (Jordan-Zachery, 2007; McCall, 2005), in the context of health, important methods are emerging that advance the utility of intersectionality (Cole, 2009; Hankivsky, 2011; Kang, 2010; Schulz & Mullings, 2006; Weber & Fore, 2007).

Biosocial research refers to approaches, theories, and analyses that examine and/or prioritize gender and health as intersecting biological and social phenomena. Anne Fausto-Sterling's (2005) research on gender and bones is a model of biosocial research – showing how bone health is shaped by gendered and cultural norms as well as biological processes. For example, Fausto-Sterling explains how religious and cultural observances of Orthodox Jewish

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adolescents restrict physical activity and exposure to sunlight that lead to decreased spinal mineral density and therefore increased risk of osteoporosis and other bone ailments. This biosocial perspective contrasts an assumption that empirical male/female differences in health outcomes are innate and inevitable, reflecting primarily physiological phenomena or biologically-rooted behavioral "preferences," rather than the complex and dynamic interactions of social and biological processes.

Gendered health phenomena may be particularly prone to interpretations of essentialized difference: in contrast to much contemporary research addressing the patterning of health outcomes by other axes of social stratification (e.g., race/ethnicity, class, caste, etc.). Research pertaining to gender tends to regard the categories of "men" and "women" as relatively disconnected entities, "naturally" distinct in not just their biological make-up but also their gender-specific "role" socialization. As a result, in much research the social production of gendered health patterns is obscured and, specifically, the workings of social institutions, interactions, and power relations in shaping men's and women's health-relevant constraints and opportunities are not always made clear.

This Special Issue seeks to explicate these social processes by highlighting how gender as a relational, intersectional, and biosocial construct shapes health. Though there is considerable overlap between these three domains, each emphasizes particular conceptual and empirical issues that merit attention. Together they further disrupt persistent essentializing tendencies in much gender and health research, underscore new ways of thinking about gender complexities, and highlight the ongoing need for capturing intersections of biological factors and other forms of social differences – including but not limited to gender and sex.

Features and limitations of the Special Issue

A number of specific features and limitations of the Special Issue warrant mention. This Special Issue originated through the Gender and Health Working Group (2008–2010) of the Robert Wood Johnson (RWJ) Health and Society Scholars Program at Columbia University. This working group consisted of approximately 30 scholars from Canadian and New York area universities with training in a range of disciplines including sociology, political science, public health, medicine, and chemistry, who came together to discuss current issues and future priorities in gender and health scholarship. We felt this type of discussion could contribute to the development of gender and health research if concretized in exemplary scholarship and made available to a wider audience through a venue such as this Special Issue. To facilitate a successful and cohesive Special Issue – and to further our intellectual exchange around our three focal areas – we hosted a two-day international conference to "workshop" candidate papers for the proposed Special Issue. The conference was held at Columbia University in July of 2010 and was funded by the Robert Wood Johnson Health and Society Scholars Program and the Institute for Intersectionality Research and Policy at Simon Fraser University. Authors received extensive feedback at the conference and the 20 papers included in this Special Issue underwent an internal blind review process before being submitted to *SSM*'s standard peer review.

In selecting and soliciting papers for the Special Issue, we strove to include research and authors of diverse geographical and cultural contexts. Our hope is for this collection of papers to help bridge some of the conceptual and empirical divides in gender and health scholarship between the Global North and South. Nonetheless, we would have liked an even greater breadth of geographic diversity. Our constraints in achieving this goal reflect broader structural barriers to reaching beyond the English-language dominance of international scholarship. Similarly, the greater than anticipated number of conceptual papers relative to empirical studies reflects ongoing limitations of data availability to apply the insights of theoretical advances to the empirical research. Despite these limitations, our compilation of articles has noteworthy strengths beyond the important theoretical and conceptual advances offered by our three focal areas. For example, the papers reflect a range of methodological approaches (including qualitative, quantitative, and mixed methods approaches) showing the breadth and depth of tools available to study gender and health. In addition, the papers highlight the critical importance of exploring gender and health within the context of life course timing, race/ethnicity, socioeconomic status, micro-, meso-, and macro-level structures, as well as *within* groups of men and *within* groups of women.

Below we organize the specific discussion of papers by the three foci (relational, intersectional, and biosocial perspectives) for ease of presentation. However, this is not meant to suggest that these foci are wholly distinct or that the papers described in each section are only representative of that focal area. Further, we organize the papers within each section by key themes and "take home messages." We hope this organization helps draw readers' attention to some of the overarching theoretical and methodological contributions of the Special Issue. Papers within the journal are simply ordered alphabetically by first author's last name; the order does not reflect categorizations or prioritization of substantive areas. We now turn to descriptions of the papers and how they advance scholarship through engaging with relational, intersectional and biosocial approaches to gender and health.

Gender as relational

In seeking to highlight scholarship deploying a relational approach to gender, we intentionally eschewed papers that focused simply on "men's health" or "women's health," or differences between them, without explicitly interrogating the dynamic workings of gender that produce observed health outcomes. We also sought papers that advance understanding of health practices, outcomes, and policies by applying a relational gender lens *and* inform gender scholarship by leveraging insights from health outcomes as the literal embodiment of inextricably linked social and biological processes. The papers in this Special Issue therefore illustrate several broadly applicable insights about the workings of gender that reflect a relational approach.

Gender is made not born

Several papers highlight the fluid and negotiated nature of gender identity and expression, and how these actively constructed meanings of gender have important implications for health. Hansen's (2012) examination of Puerto Rican evangelist street ministries describes how the deliberate *re*-definition of masculinity is an integral strategy in ministry-based drug addiction treatment. As a path to overcoming drug addiction, alternative masculinities are invoked to offer socially and economically marginalized men sources of esteem and identity that are not otherwise available through engagement in the formal economy. As described in Hansen's paper, masculinity is manifold, dynamic, and instrumental. Variants of masculinity not only coexist but also evolve over time among individuals, enacted in ways that both reflect and reinforce social hierarchies. Gender is also deployed as a deliberate social intervention, whereby Pentecostal ministries explicitly promote masculine identity reformulation as integral to addiction recovery. Another example of the health implications of performed masculinity is Muñoz-Laboy's et al. (2012) ethnographic investigation of the gender regimes of formerly incarcerated Latino men in New York City. The study illuminates the workings of masculinity at

the margins; men disadvantaged by class and race/ethnicity and further alienated from the formal labor force by incarceration histories perform an idealized masculinity that entails "knucklehead" behavior at the expense of their own health and that of others.

Hansen's and Muñoz-Laboy's contributions build on and extend a growing body of critical scholarship over the past several years that has applied gender theory to the multiple and hierarchical nature of masculinities to health (e.g., Courtenay, 2000). Far less common in the realm of health is a similarly relational approach to gender and femininities. In this sense, the contribution by Jewkes and Morrell (2012) is path breaking. Jewkes and Morrell interrogate how young women mobilize diverse femininities in negotiating sexual and romantic relationships in South Africa. In analyzing women's narratives of intimate heterosexual relationships, Jewkes and Morrell foreground women's agency in pursuit of their own sexual and emotional agendas and demonstrate how women's actions to affirm femininity, in the context of structural constraints and inequalities, exacerbate their risk for HIV. The research also importantly shows how the femininities deployed by women, some of which invoked the discourse of empowerment, do not fundamentally destabilize men's power or the prevailing gender order. In many ways, in fact, they serve to legitimize and reinforce patriarchal power structures.

Gender is inescapably embedded in and constitutive of social structure

Several papers tackle the critical interface between gender and social structure very explicitly. For example, in her ethnographic investigation of local applications of a national age of consent law in Uganda, Parikh (2012) illustrates how a macro-level structural intervention intended to address gendered HIV risk has the unintended (but foreseeable) consequence of reinforcing gender as well as age- and class-based social hierarchies. In the midst of conflicting and contested local notions of acceptable adolescent female sexuality, strategic deployment of legal sanctions against sexual relations with girls under 18, as dictated by the highly normative "Defilement Law," are used in effect to simultaneously reaffirm patriarchal control of female sexuality and reproduce structural inequalities among men.

Connell (2012) reviews the case for relational approaches to gender in health research and practice that by definition understand "gender as embodied social structure." In her contribution she conceptualizes the need to extend theorizing of gender and health to a broader world scale, accounting for the complexities of gender structures globally (especially by recentering and prioritizing less developed contexts) and the ways in which gendered health production increasingly takes place within transnational arenas.

Sex/gender differences research need not reify the binary

Connell articulates the definition of and limits to the "categorical thinking" that underpins much "gender and health" research and policy – that which is organized around explaining and addressing presumed socially- and/or biologically-rooted dichotomies. In empirical quantitative health research, even efforts to draw on relational gender theory to elucidate gendered health production have been hampered by data availability and therefore reliance on crude categories of "woman" and "man" as proxies for gendered social experience. As Connell notes, in much of this research, "gender" is often operationalized only as the differences between these categories and, as described above, the focus on such binary distinctions tends to essentialize difference. However, when studies explicitly examine specific types of gender performance among categories of people, they have the potential to elucidate and destabilize apparent dichotomies rather than reify them. Several papers in this Special Issue utilize categorical comparisons but reflect a relational approach by illustrating the complexity and fluidity of differences among and between men and women.

For example, two papers in this issue investigate the gendered performance of care work and explore the resulting group differences in health practices and outcomes. In examining the role of gendered expectations of mothers to disproportionately bear the burden of feeding their children at the expense of their own health, Martin and Lippert (2012) demonstrate how such expectations produce inverse associations between income and obesity among women but not men. By differentiating women and men in terms of their location in highly gendered social roles (e.g., parenting), they find that, in the context of economic deprivation and food insecurity, mothers are more likely than child-free men and women and fathers to be overweight or obese and to gain more weight over the follow up period.

Similarly, Reczek and Umberson (2012) explore qualitatively how engagement in "health work" – the practices that sustain the physical and mental health of others – is differentially distributed, producing a well-documented "gender gap," which is often invoked as an explanation for differences in the health returns on marriage and co-habiting relationships for men and women in heterosexual unions. Highlighting the contingent and relational nature of gender dynamics, the authors show how the gendered distribution of health work is differentially distributed across straight, gay, and lesbian couples. Asymmetry in the performance of health work by gender was evident disproportionately among heterosexual couples. By dislodging the conflation of "male" and "female" with corresponding gendered expectations, the paper works to de-essentialize this distinction.

Intersectionality

The gender and health field recognizes the importance of diversity. Yet most conventional gender and health research is limited to considering categories such as sex and gender, or looking at gender in addition to other categories – usually race and/or class – without fully considering and analyzing full contexts, interactional effects with other social locations and influences of power inequities. Intersectionality theory explicitly encourages investigations of numerous intersecting inequalities (including but not limited to gender), not only at the individual level but also at structural levels. By employing intersectionality in their work, researchers in this issue illustrate innovative approaches for examining identity, equity and power and demonstrate the value added of this approach for producing more nuanced and complicated knowledge about the causes and potential remedies to health inequities.

Intersectionality does not marginalize gender – it conceptualizes gender as a fluid, intersecting form of inequality

The intersectionality-informed qualitative and quantitative research highlighted in this issue show that gender is not an essential, stand alone "variable" in health research, but takes meaning in relation to other categories (Shields, 2008). In so doing, the contributions in this volume illustrate how and why "the intersectionality perspective brings to the fore the complexity and contingency of social inequities" (Bates, Hankivsky, & Springer, 2009, p. 1).

For example, Markens (2012) illustrates why the full complexity of global surrogacy and concomitant cultural assumptions regarding reproductive practices and women's health/bodies/gametes can only be captured by research that focuses on gendered interactions with class, race and nation. Weber and

Hilfinger (2012) advance understandings of post-disaster health inequities by demonstrating how gender, race and class shape power relationships among government/corporate alliances, front line disaster recovery workers and disadvantaged residents in Mississipi Gulf Coast communities post-Katrina. Importantly, their paper situates the individual experiences of front line workers within broader social structures of privilege and power to demonstrate the extent to which macro-level social inequities produce and maintain health inequities. Sen and Iyer (2012) investigate intersections of gender and economic class to create nuanced understandings of the experiences and power among different subgroups within households to access health care for long term ailments in 60 villages in Karnataka, India.

Intersectionality is producing methodological innovations

As evidenced by the contributions to this Special Issue, gender and health scholars are not only recognizing the significance of intersectionality, they are using this perspective in their research to ask new and different questions about the multiple contexts and processes that shape human experiences and health. A number of the papers featured here especially stand out in terms of their methodological contributions to the field. To begin, a significant amount of intersectionality scholarship tends to focus on the experiences of the most marginalized populations and/or how their experiences compare and contrast with those who are most privileged. As intersectionality theory reminds us, human beings experience different degrees of penalty or privilege depending on their social location (Dhamoon & Hankivsky, 2011). Two of the papers in this collection further this important theoretical insight by investigating 'middle groups.' Sen and Iyer use an innovative quantitative method to analyze middle groups in a multi-dimensional socioeconomic ordering to illustrate how such groups leverage their advantages and counter their disadvantage to secure health treatment. Weber and Hilfinger present qualitative findings about the experiences of front line disaster workers (who are situated between disadvantaged populations they serve and powerful alliances that control access to essential resources) to show how social relations of power and control contribute to health and social inequities, especially among groups such as the front line workers, who have certain access to power and privileges.

Moreover, a significant gap within intersectionality health scholarship is its lack of attention to the biomedical paradigm. By examining how intersections of gender, race, class and nationality interact with the biological aspects of sex/gender to affect conceptualizations and evaluations of global surrogacy, Markens' paper makes important headway in terms of showing how intersectionality can influence understandings of the biological. In examining how social structures and processes interact with the biological she also builds important conceptual and empirical bridges between intersectionality scholarship and biosocial approaches highlighted in this issue.

Intersectionality is a challenge to status quo gender research and policy

Many of the intersectionality-informed contributions to the Special Issue, including papers by Hankivsky, Tolhurst et al. and Sharman and Johnson, identify key impediments to progress in the field such as the challenge of bridging the gulf between theory and methods, and issues of pragmatism which often override the demands of developing research approaches and methods to interrogate multifaceted health issues. Many of the papers, however, explicitly recognize that intersectionality necessitates significant changes to the status quo in gender and health research and policy. For example, Sharman and Johnson (2012) note that fundamental structural changes in funding agencies such as the Institute for Gender and Health (the world's only funding organization of its kind) may be necessary in order to make space for intersectionality within the landscape of gender, sex and health research. Tolhurst et al. (2012) similarly argue that gender mainstreaming – an internationally recognized strategy for promoting gender equality in health policy – needs to be completely reframed by the politics of intersectionality to address gender as an intersecting component of wider social inequalities. Hankivsky (2012) demonstrates the wide-ranging benefits of de-centering gender in health research and policy and discusses the significant implications of such shifts for the field of gender and health. And Rosenfield's (2012) paper actually disrupts the status quo by demonstrating why intersectional approaches that integrate cultural and structural factors are essential to fully understanding how stratification shapes mental health. Despite progress in the field of intersectionality, an important cross-cutting argument in all the papers dealing with intersectionality is that much more work is required conceptually and methodologically to fully develop the potential of this perspective in health research and policy.

Biosocial approaches

One challenge in applying a gender relations perspective to gender and health is the need to adequately theorize and engage with the intersection of biological *and* social aspects of health for men and women. There has been little gender and health research that adequately incorporates biology and the social environment, let alone from a gender relations perspective. This type of biosocial approach to gender and health has the potential to revolutionize our understanding of health for men and women – not only for health differences and similarities between males and females, but also for understanding variations and consistencies within all humans. The articles in this Special Issue make important contributions toward advancing this relational biosocial approach to gender and health research in a range theoretical, empirical, and practical ways.

Excellent relational biosocial gender and health research is doable

One implication of scant research using a biosocial approach is that there are few models to follow and it is difficult to determine *how* to examine the dynamic interaction of biology and the social environment in shaping health outcomes. This difficulty was highlighted in Sharman and Johnson's perspective from inside a gender and health funding organization. However, strides are being made to help build the foundation for future researchers – both through example and through structured guidance.

In this Special Issue, we not only include papers that have successfully conducted relational biosocial gender and health research – as described in detail in the next section – we also include a paper that develops a theoretical frame and good practice guidelines to help researchers conduct this type of relational biosocial gender and health research. Springer, Mager Stellman, and Jordan-Young (2012) begin by articulating and rigorously supporting two central tenets of relational biosocial research – first, sex is not a biological mechanism and second, sex and gender are entangled and need be modeled as such. The authors then proceed through a step-by-step flowchart for how to actually conduct relational biosocial gender and health research, helping demystify the process by creating easy to follow and well-explicated guidelines. Further, the authors include extensive examples from cardiovascular disease throughout the paper to specifically illustrate each

of the points they raise. Papers such as Springer et al.'s (2012) are a critical and necessary next step in moving this field forward.

A biological difference does not mean a biological cause

Another key contribution of the biosocial research in this Special Issue is to specifically and concretely demonstrate that the presence of a biological health-related difference does *not* necessarily indicate a biological cause. Health outcomes, particularly physical health outcomes, by definition have a physical manifestation or presentation. These physical presentations can frequently be linked with a biological process or predictor. In the case of gender and health, this is often articulated in a way that attributes male/female differences in outcomes to male/female physiology. One key problem with this logic is the assumption (or even assertion, in some cases) that this physiological difference is innate – or at least not socially determined. The articles in this Special Issue blow apart this assumption by repeatedly showing the multiplicative ways that gender can shape physiology.

Three of the papers (Cheslack-Postava & Jordan-Young, 2012; Fausto-Sterling, Garcia Coll, & Lamarre, 2012a, 2012b) demonstrate how early childhood socialization interacts with, and directly influences, neurological development to shape behavioral and cognitive health disorders such as autism. Fausto-Sterling's two papers tackle the issue broadly by reviewing the literature on sex differentiation in the first three years of life and then applying a dynamic systems perspective to understand the gendered embodiment of these differences. Fausto-Sterling and her colleagues repeatedly show how different types of early childhood male/female differences with biological associations are fundamentally shaped and altered by a dynamic, gendered developmental context in a way that can have profound health effects into adulthood. Autism is one particular childhood neurological outcome ripe for a gendered biosocial analysis, and Cheslack-Postava and Jordan-Young provide this intervention by conceptualizing "gender as a pervasive developmental environment" that partially causes the well-established higher rate of autism among boys relative to girls. This paper has the potential to reshape how scholars understand the long-standing puzzle of higher rates of autism among boys by demonstrating that two specific aspects of gender as a pervasive developmental environment (gendered parental interaction and gender bias in diagnoses) potentially account for the majority of the male/female difference in autism prevalence.

Brain reorganization theory is also subject to sophisticated gendered biosocial analyses in Jordan-Young's (2012) paper on congenital adrenal hyperplasia (CAH). Jordan-Young uses CAH to debunk the routine assumption that high prenatal androgen exposure permanently "masculinizes" the brain – a theory used to explain a wide range of health-related outcomes and psychosocial development. More broadly, her paper uses CAH as a case study to demonstrate a core principle of biosocial research – that physiological phenomena (e.g., height–weight ratio or mood deregulation) have specific meanings and effects within a particular gender regime and must be seen as a simultaneous product of biology and the social environment.

Finally, two papers (Frisco, Weden, Lippert, & Burnett, 2012; Martin & Lippert, 2012) demonstrate that assumed physiological mechanisms are insufficient explanations for the link between obesity and women's childbearing and childrearing. Frisco et al. argue that social and historical contexts (i.e. population prevalence of obesity) shape gendered social processes associated with female attractiveness on the marriage market such that obese women have reduced childbearing during "leaner" historical times – regardless of physiological connections between obesity and fecundity. Martin and Lippert document that the social role of "mothers" as protectors and feeders of their children (rather than biological metabolic changes associated with childbearing) can lead food insecure women to gain weight by engaging in behaviors (i.e. delaying or skipping their own meals to ensure their children have sufficient food) that may harm themselves but ensure adequate nutrition for their children. These papers demonstrate the importance of examining gendered social relations and biological processes as key mechanisms for relationships that are often understood as primarily biological.

Biosocial approaches require taking biology, as well as the social environment, seriously

A third key theme emanating from these papers is that biosocial approaches to gender and health require seriously engaging with biological processes as well as thoroughly explicating social mechanisms. Related to the themes above – if a biological process is implicated in a biosocial understanding of gendered health it is essential to explicitly identify, theorize, and explore this *process* rather than simply noting a biological difference and asserting a biological cause. This is a key point outlined in the paper by Springer et al. and the critical importance of this is demonstrated throughout the biosocial papers. Fausto-Sterling and colleagues note this issue throughout their paper and Jordan-Young specifically highlights the logical flaws and biological impossibilities of "brain organization theory" when the plausible biological mechanisms are seriously interrogated. Further, as demonstrated in each of the papers, and articulated by Springer et al. it is critical to explore the biological mechanisms not only in the context of a gendered social environment but also attentive to other potentially influential factors such as life course stage.

Conclusion and future directions

While the approaches highlighted in this Special Issue do not capture the full breadth of the rapidly changing field, they do represent significant shifts in thinking that have far reaching consequences. The collection of empirical and theoretical papers engage a variety of methodological approaches and signal the growing challenges in thinking through, and responding to, the range of biological and social factors that interact to influence health inequities. Specifically, they demonstrate the need for researchers to continue interrogating the categories of their analyses, including but not limited to sex and gender. They make clear the importance of relational thinking, moving beyond binaries, and capturing the contexts in which people's lives are experienced. In some instances, they challenge assumptions that gender, regardless of how it is conceptualized, is always the primary axis through which to understand specific health experiences, conditions or even access to health services.

Together, this body of work represents another 'defining moment' in gender and health research. It focuses on issues and features models that chart new paths for researchers, decision makers and advocates engaged with explaining gendered patterns in health and working toward health equity. In sum, this Special Issue is intended to inspire deeper and extended discussions that will better discern the complexities in the field and continue the process of integrating new approaches and frameworks for gender and health research. We hope that one outcome of this compilation is to increase institutional, economic, and political support and opportunities for additional theory-advancing, interdisciplinary, international, and applied projects on gender and health.

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