Chapter Three:

Sex- and Gender-based Analysis as Process
Understanding the basic concepts of sex, gender, diversity and equity, as discussed in Chapter Two, is crucial to conducting SGBA. The next challenge is to learn how to use these concepts. In this chapter, we provide an overview of sex- and gender-based analysis as a process, to help you apply the concepts and learn how to conduct a SGBA.

Many guides and tools provide guidance about how to undertake SGBA by codifying the work into checklists of questions or steps. While checklists can be very helpful as validation tools – a means of ensuring that sex, gender, diversity and equity considerations have been addressed throughout the planning, policy development or research process – they can also create the impression that sex- and gender-based analysis consists of a single formula or template applied to every situation, issue or population. Our approach to SGBA, and to the development of this book, avoids formulas and templates in favour of thinking of SGBA as a process of integrating sex and gender considerations into health research, policy and practice. While the principles and concepts underpinning sex- and gender-based analysis remain constant, the application may vary depending on a variety of factors, such as the issue under consideration, what is known or assumed about a specific population and the extent to which sex and gender perspectives already inform knowledge and action. Further, the process of SGBA is iterative, which means regularly reflecting on content and process and adjusting to address gaps, inconsistencies and oversights as well as to accommodate new knowledge or insights. Iteration can therefore re-direct an analysis to include other or additional populations, to consider an issue from a novel perspective, or to tailor recommendations or interventions for specific policy and practice contexts.

In approaching sex- and gender-based analysis as a process rather than a template, we are recognizing both that the theories and practice of SGBA are continuing to evolve and that treating SGBA as a formula limits its explanatory power. Nevertheless, there are common components to every SGBA, as evidenced by the case studies found in this book. This chapter is devoted to describing these elements in detail.

Framing the Process

From start to finish, the process of SGBA is framed by a recognition that sex, gender, diversity and equity matter at every stage of health research, policy development, planning and practice. These four concepts together act as a lens or filter for evaluating descriptions, evidence, analyses and the management of
health concerns. Use of the filter enables us to anticipate and/or identify biases that contribute to health disparities and, in doing so, to create the possibility of both avoiding discrimination and redressing inequity.

Margrit Eichler and Mary Anne Burke have identified three major forms of bias that shape health research: maintaining a hierarchy; failing to examine differences and; using double standards.\(^1\) While Eichler and Burke were writing only about research, these kinds of biases can be found in every discipline and sector (i.e., government, research, NGO and private). For instance, historically, studies have excluded particular groups, such as women or people of colour, on the theory that the results of research on or with white males can be generalized to others.\(^2,3\) Such an approach involves a double standard that privileges one group – white males – over all others. We might also encounter policies, such as those classifying Indian status in Canada, that uphold existing hierarchies of power or position. In this case, the dominance of non-Aboriginal peoples in Canada, represented by the federal government, is maintained by denying to First Nations, Inuit and Métis peoples the right to define themselves. Another type of bias described by Eichler and Burke – failing to examine differences – occurs when we regard dominant and non-dominant groups of people as having the same life chances and experiences. In most societies, for example, homosexuals face far greater prejudice and discrimination than do heterosexuals and inequities are bound to arise when policies, research or practice ignore this profound difference. At the same time, we cannot treat any group, dominant or otherwise, as if everyone in it shared exactly the same outlook and experience; each of us belongs to a variety of groups and our experiences are shaped by the intersections of and interactions among these various identities or social locations. As the celebrated author and teacher, bell hooks, observed, “If I were really asked to define myself, I wouldn’t start with race; I wouldn’t start with blackness; I wouldn’t start with gender; I wouldn’t start with feminism. I would start with stripping down to what fundamentally informs my life, which is that I’m a seeker on the path.”\(^4,p287\)

According to Eichler and Burke, “Research must … always ask enough of the right questions in order to expose all three major forms of biases. Otherwise, there is the illusion that a problem has been fixed.”\(^1,(p66)\) We would argue that the same is true for planning and policy development as well as for service delivery. Applying the concepts of sex, gender, diversity and equity enables us to expose biases and can therefore go a long way towards ensuring better science, policy and planning, and – ultimately – better health for all.

Sex- and gender-based analysis is neither linear nor unidirectional, but for the purposes of this guide, we have deliberately divided it into five components: issues, populations, evidence, implications and recommendations. While describing the process in this way may not capture all of its nuances and complexities, identifying and describing the five components in this manner does allow us to provide clear, insightful directions and rationale to assist in the undertaking of SGBA. Illustrations, examples, and references to specific case studies found in subsequent chapters of this guide will round out the description of sex- and gender-based analysis as process.
Defining the Issue(s)

Research, policy and planning often derive from observations or perceptions that there is a “problem” to be addressed, an issue about which we know little, or a population that is facing particular challenges. For instance, media coverage and policy initiatives of recent years have tended to focus on managing youth crime through harsher sentencing, on the assumption that youth crime is on the rise – both in volume and severity – and that imprisonment will act as an effective deterrent. Yet researchers do not all agree that youth crime is increasing nor is there much evidence to support the position that incarceration either prevents crime or rehabilitates criminalized youth.6–7 In other words, before launching into research, planning or policy development, we need to sort out why an issue has been identified as a problem and by whom: Is obesity really reaching epidemic proportions? Are we adequately prepared for emergencies? Are wait times as long as media coverage suggests? Are the foods we eat and the water we drink safe? Are we facing a crisis of care as the population ages?

To understand why and how an issue is transformed into a problem we must evaluate the source of an interpretation as well as the conclusion itself. Who says that youth delinquency is on the rise or that there is a shortage of housing? What evidence have proponents marshalled to support their positions? What other evidence exists that might suggest a different way of looking at this issue? In the same way, we need to assess the recommendations and interventions that flow from existing interpretations. If we perceive youth delinquency or obesity as a particular type of crisis, how does that shape our response? Are there alternative explanations and interventions that are not being considered and, if so, why? Finding answers to these kinds of questions, including the sources of our information or assumptions, is critical to understanding the issue at hand.

SGBA involves asking just these kinds of questions while keeping in mind the concepts outlined in Chapter Two – sex, gender, diversity and equity. What evidence do we have that wait times are excessive, and, if they are, who is most likely to wait and why? Who says that obesity is becoming epidemic, and, if they are correct, is the condition equally distributed across the population or are some groups experiencing higher rates? To what extent do our disaster management plans recognize the different strengths and needs of women and men? Does current knowledge about food or water quality include an analysis of the comparative risks for females and males, for those living in urban, rural and remote settings?

Asking more and more complex questions – as SGBA persistently prompts us to do – can provide new perspectives on long-standing health challenges. For example, the case study on diabetes in (see page 34) demonstrates the power of an analysis that takes sex, age and ethnicity into consideration. Rates of diabetes might be comparable for women and men in Manitoba, but men are more likely
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What's next after sex (Moving on to include gender)

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Something to Think About

Sex- and gender-based analysis extends throughout the research process, culminating in communication and knowledge exchange. Gender-inclusive, non-sexist writing remains controversial because there is no consensus around all aspects of this approach, but it has tremendous potential for giving voice to women and for providing direction for the evolution of language. Canada is leading the way in this field.

The way we think about femininity and masculinity, the power or prominence we ascribe to women and men in society, is often reflected in our language. Not so long ago the human race was almost invariably referred to as “mankind,” while many services and policies were identified with men or males: “manpower,” “workman’s compensation,” “ombudsman.” Words not only reflect our ideas and social values, they also reinforce them. For example, when women began to move into the medical profession, they were often referred to as “lady doctors,” thereby identifying them as unusual – a departure from the male norm.

Feminists have long recognized the power of words and have worked hard to develop and promote gender-inclusive, non-sexist language. As a result, it is now much more common to refer to the human race as “humanity,” while “he and/or she” is beginning to replace the standard “he” in sentences. But even when writers use gender-inclusive, non-sexist language to begin with, it may or may not survive the process of translation, an important consideration in countries such as Canada, which has two official languages. Similarly, in any situation where people are trying to communicate across languages and cultures, gender-inclusive, non-sexist language can be lost in translation.

The complexities involved in translation cannot be underestimated: they may undermine the essence of the text, not only reproducing assumptions regarding sex and gender, but also creating a situation where the reader has to transcend the words to appreciate fully the author’s ideas. Let’s look at an example. Women and Health Care Reform, a working group funded through the Women’s Health Contribution Program of Health Canada, was putting the final touches to the French translation of a new plain-language English publication on women and wait times. The group asked a francophone with knowledge in sex- and gender-based analysis and non-sexist writing to review the publication. While the quality of the translation was excellent, respecting the women-centered approach of the original document, some aspects of the text were not gender-inclusive and had to be changed. For instance, the translator had elected to translate the phrase “health care professionals” as “les professionnels de la santé,” a masculine phrase for a profession overwhelmingly occupied by women, but still perceived as male-led. A better choice might have been an inclusive, neutral phrase such as “le personnel soignant,” because this term invites the reader to think of a wider range of professions and both female and male providers.

For many native French speakers, gender-inclusive and non-sexist writing is unappealing because it is often done poorly. Awkward repetitions of “he and she,” “men and women,” the masculine and feminine representation of professions, detract from the text and make for laborious reading. Even for gender-sensitive writers and translators, working in French with gender-inclusive language can prove to be a challenge. For example, when a text refers to both males and females, it is common practice to use the masculine noun form followed by the feminine noun in brackets, or following a forward slash: “patients(es)” or “patients/es.” While this approach is sensitive to the need to recognize that both females and males are involved, the practice itself reinforces the sense of female as “other,” because these notations are used in grammar to signify the dominant form of a word as well as variations – male and female.

According to French rules of grammar, adjectives are always masculinized when both sexes are represented, as in “les formateurs sont contents.” One way to avoid this would be to write “l’équipe de formation est contente.” A proximity agreement rule can also be used to circumvent this dilemma, and, with both feminine and masculine nomenclature present and the feminine noun closer to the verb, the sentence becomes “les formateurs et les formatrices sont contentes.”

Sex- and gender-based analysis raises important issues for translators as well as writers, editors and others involved in the translation of research. This discussion reminds us that the very language we use conveys important information that we sometimes take for granted based on the relationship between the rules and customs of language and the expression of sex and gender.

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than women to experience serious complications and consequences from the disease. Moreover, rates of diabetes among First Nations people in Canada far exceed the national average. Similarly, the author of a case study on measuring mental health (see page 96) discovered that because there are many ways to define “mental health” it is not easy to identify a single set of measures.

Posing more complex questions also tends to produce more complicated answers. For example, a case study, entitled “Gender and Generations: A Day at the Spa” (see page 116), begins with a discussion of access to health care services in a First Nations community and ends up grappling with formidable issues, such as the legacy of colonization, legal definitions of identity and eligibility and social relations. What starts out looking like an analysis of access to health care for First Nations people, then, is not simply a matter of health resources – human and otherwise – it is also a function of historical and political interactions. And the issue is not just how access is defined and paid for, but rather how legal definitions of identity have created differences in access to care for diverse groups of people for a variety of reasons – certainly a more complex framing of the “issue.”

As an iterative process, sex- and gender-based analysis can further lead us in new or unexpected directions as we seek to understand the initial issue. For example, while trying to account for differences in wait times for hip and knee replacement surgery among women and men, the authors of the case study (see page 68) found themselves investigating arthritis rates, perceptions of pain, diagnostic imaging and doctor-patient relationships. In this instance, the authors paused regularly to assess their research question and the evidence available to them – iteration – and in so doing pushed the boundaries of their investigation and analysis.

**Describing the Population(s)**

Addressing a research, policy or planning issue also involves an appreciation of who is affected and/or in need as well as what we know – or don’t know – about diverse populations and communities. The research commentary on the mental health of rural women (see page 140), for instance, underscores the influence of geography on access to health services. Similarly, a case study on care-giving (see page 80) demonstrates both that women provide the bulk of unpaid care-giving and that they experience more and different constraints on their time than do men involved in care-giving. Both these case studies, like others in this volume, remind us that issues play out differently in different places, at different times and for different groups of people. Interventions or policies that ignore the contexts of peoples’ lives are liable to be costly or ineffective, at best. The Compassionate Care Benefit, described in the case study on unpaid care-giving, is an excellent example of a policy that has proved disappointing because it was designed with a limited understanding of the main population needing support – women.

Because SGBA encourages us to ask questions about who is involved and who is affected, it is especially powerful for exposing gaps in data, literature, research, policy and planning. Are we talking about both females and males or a single sex? Does our data set include information about transgendered individuals or groups? Do we have evidence about females and males of all ages or for adults
or children only? Do we have information about females and males from diverse ethnic and socio-economic backgrounds? The answers to these kinds of questions define the parameters of our analyses and conclusions. For instance, the case study on housing (see page 104) examines the core housing need of specific groups of women and men in Manitoba: those on low income, renting or owning their homes, women living with disabilities as well as Aboriginal, non-Aboriginal and immigrant women. Because the study includes a variety of clearly-defined groups of people, it leads to more robust conclusions about who is adversely affected by housing shortages. If the authors had instead used data that are aggregated – combined across race, class, gender and other social locations – they would not have learned about these sub-population differences with the result that their conclusions and recommendations would not necessarily be valid or able to address inequities. In other words, by explicating the populations affected by an issue, we can avoid the biases described by Eichler and Burke.

Unfortunately, much information on sub-populations in Canada is simply not available, making it difficult to understand, let alone address differences or similarities based on sex and gender, race and ethnicity, sexual orientation and gender identity, age, class and other determinants of health. Nonetheless, undertaking a gap analysis of affected and engaged populations is important even when data are lacking because it triggers iteration – a review of the original research question or policy intervention – and validation or adjustment of the process. For example, the contribution on systematic reviews (see page 44) points out the ways in which a highly-respected approach to analyzing and synthesizing health data can lead to erroneous or incomplete conclusions if it does not involve a routine assessment of sex and gender in clinical trials and other health research.

Assembling the Evidence

Part of defining issues and describing populations for study or action involves finding out what data are available. And as with understanding issues and populations, we need to approach evidence thoughtfully, assessing its strengths and limitations and asking if it utilizes or speaks to the core concepts of sex, gender, diversity and equity.

The process of SGBA can and should involve many different kinds and sources of evidence and information, from case studies and interviews, to surveys and statistical analyses, to media coverage and local consultations. Often quantitative data – numbers – are the type of evidence preferred by policy makers and health care professionals and they can contribute significantly to our understanding of the impact of sex, gender and other determinants of health. Many case studies in this volume demonstrate the explanatory power of data that identify differences between and among females and males. A case study on transport accidents (see page 50), for instance, reveals that males in Belize are much more likely than females to be involved in transport accidents while another case study in
the same chapter reveals that women face greater health risks than men from exposure to methyl mercury (see page 60). Quantitative data can also help us to distinguish among the experiences of diverse groups of women and men. The case study on HIV/AIDS (see page 136) demonstrates that among women and men in Canada, First Nations peoples face the greatest risk of infection in Canada while injection drug use and heterosexual intercourse have become the most common modes of transmission. Awareness of population differences, which are often captured well by quantitative data, is critical for avoiding biases and for developing effective interventions, appropriate policies and rigorous research.

As mentioned earlier, it can be challenging to find evidence that is gathered or reported for females and males as well as across a diversity of social locations. Canadian health surveillance and survey tools, for instance, routinely collect information that distinguishes between females and males, but that information may be combined or “aggregated” for reporting purposes. Moreover, administrative datasets – those that track hospital and physician services in each province – do not routinely include information about race, ethnicity, socio-economic status and many other determinants of health. New tools for locating sex-disaggregated data have begun to emerge in recent years, including The Source, a data portal housed at the British Columbia Centre of Excellence for Women’s Health. Nonetheless, considerable effort and resources may still be required to get access to existing data that are disaggregated by various social locations and when these data do not exist, new research may be needed.

At the same time, quantitative data cannot address every research question or policy issue. The explanatory power of statistical evidence may be limited by the tools used for data collection. The case study on mental health indicators (see page 96), is a perfect example of the challenges associated with using existing survey data; while the statistics illuminate some basic patterns in mental health disorders among females and males, they do not necessarily tell us why these patterns exist or how these disorders are experienced by women and men as well as for different groups of men and women. As the author of the case study, Cara Tannenbaum, notes, “distress” is recognized as a significant predictor of mental illness, yet “very few surveys measure distress per se.” It may be possible to compensate for these kinds of limitations by taking a creative approach to the data. For example, in this case study, the researchers identified other measures of mental health – including self-reported symptoms and diagnoses, physician visits and prescription medications – as “proxies” or substitutes for distress. While this method gives us more information about patterns of depression and anxiety, it does not help us understand the ways in which women and men identify mental health issues, make sense of them or decide to treat them. Nor does this information illuminate differences in the medical management of and community response to mental health disorders among women and men. Tannenbaum concludes that we need to refine and expand existing databases to facilitate a thorough sex- and gender-based analysis.
While we agree that new survey tools and reporting protocols would go a long way toward enabling researchers, planners, policy makers and health care providers to both understand and address the core concepts of sex, gender, diversity and equity, we also realize that such changes will not happen quickly or easily. In the meantime, we have other types of evidence at our disposal that can assist us in undertaking a robust sex- and gender-based analysis. Qualitative data – records and experiences captured in words and pictures rather than in numbers – are especially useful for explaining why a particular health issue has arisen and how it is affecting different groups of people. The case study on disaster and emergency planning (see page 86), for example, includes an array of quotations from women who have lived through emergencies of various kinds, and their words help to illustrate the ways in which disasters are experienced differently by women and men. Similarly, in the case study on care-giving (see page 80), we learn from a series of interviews and focus groups with diverse groups of women that though they share certain experiences, they also face particular challenges based on their ethnicity, socio-economic status, sexual orientation and age. Specifically, older women reported that they have less energy and stamina for care-giving while immigrant women found it difficult to navigate the health care system.

Qualitative evidence comes from many different sources, such as individual interviews, group discussions, observation, documents and media coverage. It can also come in a variety of forms, including stories, personal testimony, letters, internet blogs, images, etc. The case study on prescription drug advertising to consumers (see page 152), for instance, includes an analysis of advertising content and placement: not only do drug advertisements appear more frequently in “women’s” than “men’s” magazines, but the advertisements themselves build on and reinforce gender stereotypes about specific health conditions, such as depression. People’s accounts of their experiences as patients,
providers and decision makers in health care are important resources for policy makers, planners and providers as they work to develop interventions that meet the needs of the population.

As with quantitative evidence, it is important to appraise the merits and limitations of qualitative evidence. Is the research trustworthy? How well does it speak to the core concepts of sex, gender, diversity and equity? We also need to appreciate that while words and images provide a different perspective on health and illness, they do not necessarily tell the whole story any more than numbers do. As with quantitative data, we need to consider who is asking the questions as well as who is answering them. If we interview doctors and not patients – or vice versa – we have only found some of the answers to our questions. As the commentary on mental health demonstrates (see page 140), if we ignore rural perspectives in our analysis of mental health and addiction services, we have only a partial portrait of the needs of people in Canada. Moreover, though qualitative data typically provide rich detail on a subject, the words and experiences of a few people cannot be generalized to larger groups.[8] The project reported on in the care-giving case study, for instance, serves as an important corrective to broad generalizations about unpaid care-giving based on survey data, but we cannot assume that the evidence provided by fourteen female caregivers in Nova Scotia adequately captures the experiences of all caregivers in Canada.

Ideally, an analysis will draw on both qualitative and quantitative evidence. The iterative quality of SGBA is especially useful for incorporating various types and sources of evidence because it helps us to see which aspects of an issue are addressed and which are overlooked as well as which populations are included and which are missing. As gaps in knowledge are identified, we are prompted to look for further or different evidence and to re-evaluate the original research question or policy inquiry. The case study on obesity and safety (see page 124) as well as the case study on wait times for hip and knee replacement surgery (see page 68) are especially useful for demonstrating the ways in which sex- and gender-based analysis moves back and forth between questions and evidence.

Analyzing the Implications

With the issues and populations clearly defined and the best available evidence in hand, we are now prepared to consider the ways in which sex, gender, diversity and equity influence – or should influence – health status, health policy and planning, health care delivery and health research. The case studies and commentaries to follow illustrate this component of the SGBA process through the analysis of various issues. But two case studies in particular – one on tobacco (see page 146) and the other on HIV/AIDS (see page 136) – validate our view that SGBA is a process rather than a formula because the same analytical approach applied to different issues and populations expose different implications for future program delivery and policy directions. On the one hand, the SGBA of smoking epidemics and international tobacco control policies indicates the importance of prevention efforts tailored to women’s needs and realities, because the dominant approach to tobacco control has been a “one size fits all” approach that has not served women well. On the other hand, the SGBA of HIV/AIDS suggests the need for policies and programs that recognize women’s diversity and the fact that females are found in almost every “at-risk” group identified and targeted by governments and other agencies. By treating HIV/AIDS as a danger only to
particular groups of people and by ignoring the role of sex and gender, existing policies and programs effectively segregate HIV prevention and treatment from society as a whole and do not address the differential risks of exposure for diverse groups of females and males. The SGBA case study on HIV/AIDS consequently recommends mainstreamed rather than targeted policies and programs. These conclusions diverge because they are specific to the issue and the context: they reflect the different histories of the tobacco and HIV/AIDS epidemics, the politics of intervention, the biology of addiction, infection and disease and the ways that gender, diversity and power shape both sexual behaviour and tobacco use.

At the same time, analyzing the implications of sex, gender, diversity and equity may take you in unexpected directions. For example, the case study on obesity in children, mentioned earlier, revealed a surprising relationship between obesity, bullying and gender. As a result, the SGBA process moved our thinking about interventions from a focus on physical activity and nutrition alone to one that includes violence prevention and the creation of safe places and spaces.

As with the other components of the SGBA process, analysis has to be approached thoughtfully. Although many of the biases described by Eichler and Burke can be reduced or eliminated by appropriately defining issues, identifying and engaging populations and assembling evidence, we cannot assume that these measures alone will produce balanced, inclusive and equitable conclusions or recommendations. Analyses also have to be undertaken with the core concepts of sex, gender, diversity and equity in mind as well as with an awareness of potential blind spots.

Let’s consider for a moment how we might approach the relationship between race and health. In many of the case studies and commentaries, reliable evidence identifies higher rates of illness among ethnic-minority populations, such as Aboriginal peoples and people of colour, than in the general population or as compared with the Caucasian majority in Canada. If we assume that such differences can be attributed to the strengths or limitations of individuals in these populations, we would be guilty of bias – victim blaming and pathologizing to use the language of Eichler and Burke. Similarly, if we assume that only some people within these populations are capable of responding to or rectifying these differences, we would also be guilty of bias – denying agency. Even with the best evidence and the best intentions, it is still possible to fall prey to stereotyping, overgeneralization, using double standards, exaggerating differences, ignoring similarities and a host of other biases.

According to Eichler and Burke, it is imperative to “always ask enough of the right questions in order to expose all three major forms of biases.”[1,66] They have developed a list of 20 “right questions,” but many other lists exist as well and some of these are referenced in the resource list at the end of the volume. As mentioned at the beginning of this chapter, these sorts of checklists can be very helpful as validation tools, enabling us to verify that we have avoided biases...
and addressed the core concepts of sex, gender, diversity and equity. We would suggest that iteration is also integral to steering clear of biases because it helps us to assess our own assumptions – how we are framing the issues, viewing the populations and assembling the evidence – and to adjust our analysis accordingly.

**Structuring the Recommendations**

Having come to some interpretation and conclusions about sex, gender, diversity and equity, it is time to develop recommendations. While it might seem like a simple task to make recommendations based on new findings, we need to bear in mind that research, program and policy development and service delivery all exist in specific contexts – social, political, economic, historic, geographic and so on. When developing recommendations from an SGBA, it is important to recognize the obstacles and threats as well as the strengths and opportunities afforded by these contexts. Similarly, conclusions are presented to specific audiences and the ability of policy makers, planners, practitioners and others both to absorb and respond to recommendations is determined by the environments in which they work. Policy makers, for example, tend to be constrained by relatively short timeframes – usually tied to election cycles – budgetary limitations and the directions of political leadership. Consequently, multiple, long-term and costly recommendations – as well as those that involve fundamental changes in social policy or attitudes – may not be feasible or attractive for policy makers. Health care providers, in contrast, may be reluctant to act upon analyses that are new or innovative rather than established and may not, therefore, respond positively to recommendations for novel directions in treatment or innovative models of care.

Let’s consider briefly the contexts of the case study on obesity in children (see page 124). This piece of work began as a project for the annual Atlantic Summer Institute (ASI) on Healthy and Safe Communities that aims to promote community capacity and community development by exploring the linkages between the social determinants of health and the root causes of crime and victimization. The Institute leaders were looking for an issue that would help to demonstrate concretely the overlap between health and safety and decided upon childhood obesity. When this case study was presented to participants at the ASI – most of whom came from diverse government departments and community organizations – the response was very positive. The case study helped them to rethink the ways in which issues were typically framed as health or safety issues, but not both. It also helped them to appreciate that if an intervention did not address both health and safety dimensions of obesity in children, it could unintentionally cause harm.

A few months later, we presented the same case study to a more homogeneous group of public health practitioners and health promotion policy makers and their response was quite different. They recognized the connections between health, safety and obesity, but felt that their work contexts would not allow them
to respond to safety or other determinants of health because policy and practice were focused on promoting active living and healthy eating. The recommendations that obesity initiatives need to include an understanding of safety and other determinants of health were, consequently, not as well-received.

Similarly, the case study on transport accidents in Belize (see page 50) illustrates the importance of knowledge exchange between researchers and their audiences in the development of recommendations. The case study was originally developed for the Pan-American Health Organization and presented in a workshop involving biostatisticians, epidemiologists and policy makers from Belize and neighbouring Caribbean countries. While the authors had thought to discuss hazardous employment for men and the possible need for better health and safety education to reduce men’s transport deaths and injuries, they learned from the policy and program staff in attendance that more pressing issues involved the need for improved roads, better traffic regulation enforcement and tighter regulation of driving qualifications.

We are not suggesting here that the context should drive the SGBA process. Regardless of the final destination of the analysis, we must pay attention to the core concepts of sex, gender, diversity and equity if we hope to conduct better science, develop better policies and practices and ensure better health for everyone. Instead, we are pointing out the importance of identifying the best audience for recommendations and understanding what kinds of information they need to act as champions for change. Awareness of the context for a specific SGBA is important, because it can establish a timeframe for the analysis, suggest parameters for the inquiry, locate appropriate audiences for the recommendations and determine the best method for presenting recommendations aimed at addressing and reducing health inequities.

**Conclusion**

In this chapter and the previous one, we have described the ideas and approaches involved in undertaking an SGBA in the areas of health research, policy and planning. We have examined the core concepts that serve as the foundation for sex- and gender-based analysis as well as the ways in which these concepts are integrated into the process of SGBA. While a comprehensive understanding of concepts and methods is crucial for undertaking a rigorous SGBA, concrete examples are invaluable for moving from theory to practice. In the chapters that follow, we have assembled nearly two dozen case studies and commentaries that illustrate the richness and diversity of the SGBA process. These examples are drawn largely from member organizations of the Women’s Health Contribution Program – a funding program managed by the Bureau of Women’s Health and Gender-based Analysis, Health Canada – and they represent more than a decade of experience in policy-relevant women’s health research and knowledge exchange.

The case studies are organized into four chapters that are designed both to appeal to readers with different levels of experience and expertise with SGBA and for readers working in different sectors and/or agencies. Chapter Four, Considering Sex, explores the importance of recognizing similarities and differences between and among sexes through the use of both quantitative and qualitative data. Chapter Five, Emphasizing Gender, focuses on the ways in which gender roles and stereotypes as well as sex differences contribute to health and illness.
Chapter Six, Regarding the Determinants of Health, highlights the intersections of sex and gender with other determinants of health, such as race and age, and pushes past medical definitions of health to consider the health implications of environments of many kinds – physical, economic, historic, social, etc. Chapter Seven, Addressing Policy, examines the relationship between policy and health, underscoring the importance of SGBA for the development and implementation of inclusive, equitable and effective policy.

References