



Chapter Four:

Considering Sex

In this first set of case studies, we see that the process of sex- and gender-based analysis can begin by using information that is separated for the categories of male and female – referred to as “sex-disaggregated” data. Health surveillance and health administrative data are usually collected by sex – and other determinants of health – and held in provincial or national databases. But getting access to these data through reports or public websites can be difficult as well as costly and may take some persistence. The case study on systematic reviews reveals the extent to which health research does not include sex as a significant variable. Ensuring that data are not only *recorded*, but also *reported* by sex will improve the potential for undertaking SGBA across sectors and disciplines.

Once we have sex-disaggregated data in hand, we can begin to ask questions about how the issue or condition affects males and females. For example, the case study on transport accidents uses sex-disaggregated data to uncover differences in risk between women and men, and then, because transport accidents are much more common among men, it shifts to a consideration of the particular risks facing males. Similarly, the case study on diabetes indicates that rates of diabetes are comparable for women and men, but the health outcomes are worse for men than for women living with diabetes.

At the same time, two case studies – on diabetes and methyl mercury exposure – underscore the importance of attending to which females and males are under consideration in a given analysis. These case studies demonstrate the greater vulnerability of Aboriginal women and men, both to illness and exposure to environmental contaminants.

Further sex- and gender-based analysis need not be limited to comparisons between females and males. Because sex and gender operate in everyone’s lives, SGBA prompts us to ask questions about how gender roles, identities and relations operate even when only one sex is the focus of inquiry. The case study on methyl mercury exposure and the commentary on statin use both focus on women, but in doing so they expose significant biases in our approaches to regulatory policy and health education.

Finally, this chapter illuminates the ways in which SGBA contributes to a more rigorous assessment of the evidence used to make decisions about treatment, prevention and policy. When research does not include or report upon sex as a variable, we cannot be certain that interventions and treatments will be appropriate for women and men, boys and girls.