Health Promotion International, Vol. 30 No. 1
doi:10.1093/heapro/dau083
Advance Access published 17 September, 2014

© The Author 2014. Published by Oxford University Press. All rights reserved.
For Permissions, please email: journals.permissions@oup.com

Gender-transformative health promotion for women: a framework for action

ANN PEDERSON*, LORRAINE GREAVES and NANCY POOLE
BC Women's Hospital & Health Centre, University of British Columbia, Vancouver, BC, Canada
**Corresponding author. E-mail: apederson@cw.bc.ca*

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

SUMMARY

Gender inequity is a pervasive global challenge to health equity. Health promotion, as a field, has paid only limited attention to gender inequity to date, but could be an active agent of change if gender equity became an explicit goal of health promotion research, policy and programmes. As an aspect of gendered health systems, health promotion interventions may maintain, exacerbate or reduce gender-related health inequities, depending upon the degree and quality of gender-responsiveness within the programme or policy. This article introduces a framework for gender-transformative health promotion that builds on understanding gender as a determinant of health and outlines a continuum of actions to address gender and health. Gender-transformative health promotion interventions could play a significant role in improving the lives of millions of girls and women worldwide. Gender-related principles of action are identified that extend the core principles of health promotion but reflect the significance of attending to gender in the development and use of evidence, engagement of stakeholders and selection of interventions. We illustrate the framework with examples from a range of women's health promotion activities, including cardiovascular disease prevention, tobacco control, and alcohol use. The literature suggests that gender-responsiveness will enhance the acceptance, relevance and effectiveness of health promotion interventions. By moving beyond responsiveness to transformation, gender-transformative health promotion could enhance both health and social outcomes for large numbers of women and men, girls and boys.

Key words: framework; determinants of health; women

INTRODUCTION

Gender inequity is a pervasive global challenge to health equity (Moss, 2002). As the Women and Gender Equity Knowledge Network to the WHO Commission on the Determinants of Health has argued:

> Gender inequality damages the physical and mental health of millions of girls and women across the globe, and also of boys and men despite the many tangible benefits it gives men through resources, power, authority and control. Because of the numbers of people involved and the magnitude of the problems, taking action to improve gender equity in health and to address women's rights to health is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources [(Sen and Östlin, 2007), p. viii].

Indeed, Marmot [(Marmot, 2007), p. 1155] has also observed that: 'The differential status of men and women in almost every society is perhaps the most pervasive and entrenched inequity. As such, the relation between the sexes represents as pressing a societal issue for health as the social gradient itself.'

Despite comments like these, and others from those working on HIV/AIDS (Colgrove, 2002; Gupta, 2000; Wingood and DiClemente, 2000), gender-based violence (Barker *et al.*, 2007), and maternal and reproductive health (Boender *et al.*, 2004; Feldman-Jacobs *et al.*, 2005; Feldman-Jacobs *et al.*, 2011), the health promotion field has largely

failed to address gender inequity (Östlin *et al.*, 2006). In a review of major health promotion frameworks, Gelb *et al.* (Gelb *et al.*, 2011) identified none that incorporated gender, though the *Ottawa Charter* (World Health Organization, 1986) had noted that 'People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men' (p. 1). Most health promotion programmes and policies adopt gender-blind or gender-neutral language (Kabeer and Subrahmanian, 1996) and strategies (World Health Organization, 2010a) and some problems, such as violence against women—an extreme and widespread manifestation of gender inequality that affects the health of millions of women and girls globally (World Health Organization, 2009b, 2013)—are not yet considered core health promotion issues at all (World Health Organization, 2002). Given how addressing gender inequity could improve the health of women and girls (and men and boys), health promotion policy, research and practice need to develop evidence on the impact of gender inequity on health, establish policies that support gender equity and offer interventions that explicitly address gender inequities (e.g. End Violence Against Women Coalition, 2011). Gender-transformative health promotion interventions—ones that address both improving health and changing negative gender norms at the same time—could play a significant role in improving the lives of millions worldwide (Hankins, 2008).

This article introduces a framework for gender-transformative health promotion that builds on recent analyses of gender as a determinant of health and core principles to guide interventions. The potential value of the framework is illustrated with examples drawn from women's health promotion activities in cardiovascular disease prevention, efforts to address women and alcohol use and tobacco control.

THE NEED FOR A NEW APPROACH

Women's health researchers and advocates have long questioned the link between women's health and their social position (McDonough and Walters, 2001), how women are represented in health education and health promotion (Frank, 1995) and whether health promotion interventions are appropriately designed with respect to women (Doyal, 1995; Ward-Griffin and Ploeg, 1997; Reid *et al.*, 2007, 2012b). Even when it was new, the *Ottawa Charter* was challenged for paying inadequate attention to issues of sex and gender:

> We believe that inherent in a social approach to health is the goal of reducing inequities in health which arise from all forms of social stratification, such as class, race and gender. Too often, however, the health consequences of sex-gender inequalities remain invisible. The priorities and content of traditional health promotion programmes have often placed a further burden on women's lives by prescribing health behaviours which are unrealistic and in some instances not designed to improve women's health but instead focus on the health of the family [(Ruzek and Hill, 1986), pp. 301–302].

Despite such critiques (Daykin and Naidoo, 1995; Thurston and O'Connor, 1996; Keleher, 2004; Östlin *et al.*, 2006), health promotion interventions directed to women have, at times, relied upon inappropriate evidence (e.g. research cardiovascular disease in men (Abramson, 2009), gendered norms (e.g. assuming that all women are carers and therefore responsible for the health of the family (Heller, 1986) and/or stereotypes (e.g. that all women value attractiveness (Rothblum, 1994). These assumptions are then reflected in interventions including awareness-raising campaigns, educational bulletins or community development. For example, a 1972 poster by the American Cancer Society (see http://collections.vam.ac.uk/item/O76205/smoking-is-very-glamorous-poster-american-cancer-society/) used the phrase 'smoking is very glamorous' overlaid on the face of an ageing, unattractive woman who is smoking to not only challenge tobacco companies' use of glamour to encourage women's smoking but also to remind women that smoking is associated with premature ageing. This practice continues today: in recognition of World No Tobacco Day on 31 May 2014, the government of Queensland, Australia initiated a campaign with the tagline, 'If you smoke, your future's not pretty' featuring Miss Universe 2009 in a photo spread with the Minister of Health (http://www.health.qld.gov.au/news/stories/140529-youth-smoking.asp). Research suggests, however, that while such appeals to attractiveness remain a theme in health promotion aimed at reducing tobacco use (Grogan *et al.*, 2009), young women (and men) are actually less concerned about skin ageing than about looking mature, 'cool,' and managing their weight—attributes they associate with tobacco use.

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

Health promotion efforts during pregnancy—a time when many women are interested in optimizing their health—sometimes exacerbate women's stress by adopting messages that are shaming and blaming rather than messages supportive of both women's and foetal health (Greaves and Poole, 2005). A recent variation of such messaging depicts a pregnant woman without clothes and with her pregnant belly protruding through one of the letters of the message 'For the love of children don't drink while pregnant' (see www.fasdworld.com). More sinister are punitive legal interventions against women who drink alcohol when pregnant, such as the current legal test case in the UK attempting to criminalize women whose children have alcohol-related brain damage (Herst, 2013). Nathoo *et al.* (Nathoo *et al.*, 2013) suggest that campaigns and interventions that chastise women for substance use during pregnancy rather than support them through strategies for managing stress, accessing good nutrition and increasing social support may increase the likelihood that women avoid health care for fear of how they will be treated, rather than seek the support that non-judgemental, gender-informed health care providers might offer.

Some educational efforts actively engage in gender-based fearmongering to raise awareness of a health issue. An extreme example is a recent Canadian television campaign to raise awareness about cardiovascular disease in women that portrayed heart disease as a stalker of women with a voice-over announcing that 'Death Loves the Ladies' (see http://www.youtube.com/watch?v=GpMIKOUyZ5g). Such approaches cannot be justified: they exploit women's fears of gender-based violence to draw attention to another problem—in this case heart disease—while likening heart disease (in this case) to a predatory, potential rapist. While cardiovascular disease is a significant health problem for women, it is not equivalent to sexual assault. Exploiting women's fears in drawing such an analogy weakens the credibility of health education campaigns.

Gender has rarely been incorporated into tobacco control activities in a meaningful way (Amos *et al.*, 2012). Indeed, there are numerous examples of exploiting or accommodating gender in harmful or stereotyped ways, such as the overemphasis on women's reproductive role and its interaction with smoking (Greaves, 1996; Jacobson, 1986). Meanwhile, the tobacco industry has generated many gender-informed approaches to marketing and product development, and has a stellar history of changing gender norms with respect to smoking (Greaves, 1996, 2014; Amos and Haglund, 2000; Tinkler, 2006). Some health promotion efforts use shame to stigmatize pregnant women who smoke such as a depiction of a pregnant woman smoking with her hands covered in blood with the caption 'When you are pregnant smoking is a crime', implying that by smoking a woman is murdering her foetus (at http://www.choosehelp.com/news/tobacco/smoking-during-pregnancy-linked-to-birth-defects-like-missing-limbs-and-cleft-pallet) (see Berridge, 2013). Practices such as these help to perpetuate gender and health inequities. Fundamentally, 'the lack of translation of gender inequities in health into health promotion interventions leads to misallocated resources and weakened potential for success' [(Östlin *et al.*, 2006), p. 26]. It is time for a new approach.

Figure 1 illustrates a continuum of potential gender-responsive interventions derived from discussions within the HIV/AIDS epidemic (Gupta, 2000) and emerging evidence of the ways that health interventions relate to gender (Sambo, 2010; World Health Organization, 2010a). This continuum, based on the World Health Organization's (World Health Organization, 2011) Gender Responsive Assessment Scale, illustrates that health interventions can exploit, accommodate, or transform gender norms, systems and relations in the way that they frame an issue, use imagery and language and/or engage with gender inequity (World Health Organization, 2010a). Gender-transformative approaches 'actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender equity objectives' [(Rottach *et al.*, 2009) p. 8]; World Health Organization, 2011). Applied to health promotion, this implies developing approaches that avoid reproducing harmful gender norms or stereotypes and instead empower women and men to reach their health potential.

FRAMEWORK FOR GENDER-TRANSFORMATIVE HEALTH PROMOTION

Over a period of 6 years, we developed a Framework for Gender-transformative Health Promotion through an iterative process of literature reviews, consultation and case studies (Pederson *et al.*, 2010). Consultations included an online survey, in-person and online focus groups, and

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

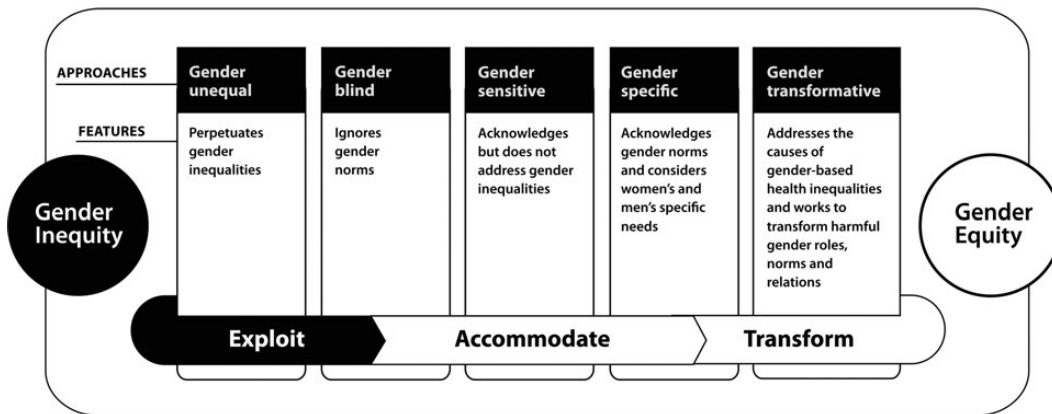

Fig. 1: A continuum of approaches to action on gender and health. Inspired by remarks by Geeta Rao Gupta, Ph.D, Director, International Center for Research on Women (ICRW) during her plenary address at the XIIIth International Aids Conference, Durban, South Africa, 12 July 2000: 'To effectively address the intersection between HIV/AIDS and gender and sexuality requires that interactions should, at the very least, not reinforce damaging gender and sexual stereotypes' (and see also World Health Organization, 2011).

key informant interviews with international experts in women's health, gender and health promotion. The Framework depicts a pathway through which health promotion could transform gender and health inequities. Its purpose is to guide researchers, policy makers and programme developers to reflect upon how gender inequity influences health and social outcomes and how gender-transformative interventions could contribute to reducing gender inequity and improving health.

The figure is to be read from the left where there is a representation of gendered social, cultural, political and economic 'determinants' interacting with biological and environmental ones to produce gendered social structures and systems. Regardless of the particular society, gender forms a metaphorical 'fault line' (Papanek and Schwede, 1988), such that structures and systems are defined by values, norms and practices that produce and are maintained by differential gendered power dynamics, which, in turn, influence differential exposures to health risks and different vulnerabilities (Sen and Östlin, 2010). Gendered roles, economic opportunities and opportunities for leadership generate and sustain these gendered social structures, which advantage some and disadvantage others in a temporal, culture-bound context (Johnson *et al.*, 2007, 2009). 'Gender hierarchy governs how people live and what they believe and claim to know about what it means to be a girl or a boy, a woman or a man' [(Sen and Östlin, 2007), p. xiii]. But from the perspective of fostering change, it is vital to recognize that gender is not an immutable personal characteristic but rather a complex, multi-faceted social phenomenon.

> Like other social relations, gender relations as experienced in daily life, and in the everyday business of feeling well or ill, are based on core structures that govern how power is embedded in social hierarchy. The structures that govern gender systems have basic commonalities and similarities across different societies, although how they manifest through beliefs, norms, organisations, behaviours and practices can vary [(Sen and Östlin, 2007), p. xii].

Gender is not a simple, binary categorical variable that can be adequately captured by sex-disaggregated data (see Kabeer and Subrahmanian, 1996). For the purposes of this paper, however, we wish to stress the social and relational nature of gender (Connell, 2012) and, most significantly, that it is not a static phenomenon: as a social construct, gender is subject to historical, cultural, generational and local expressions and manifestations and hence, can and does change.

'Health is a social as well as biological phenomenon, involving societal systems as well as individual behaviours (sic) and lifestyles' [(Travis and Compton, 2001), p. 319]. Accordingly, both sex and gender are fundamental determinants of health (Benoit and Shumka, 2009) that intersect in significant and meaningful ways with other aspects of social identity and social positioning (Hankivsky and Christoffersen, 2008) such as race/ethnicity, class, age, disability and culture

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

(Reid *et al.*, 2012a). While biological sex determines or affects some health conditions, gender socialization and power relations generate many health challenges for both women and men as manifest in multiple 'gender paradoxes in health' that change with time, giving further support to the understanding that gender and its effects can also change (Greaves, 2014; Marmot, 2007; Stuart and Soulsby, 2011a,b,c; World Health Organization, 2010b). Differences in exposures (both biological and social) and vulnerability (the ability to avoid, cope or recover from an exposure) (Sen and Östlin, 2007) account for some of the observed differences in health conditions among women and men in relation to osteoporosis, depression, HIV, tuberculosis, lung cancer, chronic obstructive pulmonary disease and blindness (Sen and Östlin, 2007). Other sources of injury, morbidity and mortality with identified sex- and gender-related roots include violence against women (Barker *et al.*, 2007), motor vehicle crashes (Pearlman and Viano, 1996), workplace injury (Messing and Östlin, 2006) and suicide (Schrijvers *et al.*, 2012). When such patterns are examined, it becomes evident that women and girls suffer the most from the persistence of gender norms, relations and structures in relation to their health (Sen and Östlin, 2007), which calls for action on gender itself as a determinant of health.

This complex set of gendered social structures and systems includes the formal health care system and the associated structures of health policy and research, which generate knowledge about and regulate people's bodies and everyday lives, as well as individual social and biological determinants and the lay world of health ideas, discourses and practice (Sen and Östlin, 2010).

Health promotion, understood to be the process of empowering individuals and communities to address the determinants of health (World Health Organization, 1986), is ideally positioned within the health field as a mechanism for challenging gender as a determinant of health. Health promotion interventions—a diverse set of communication, organizational, community and political practices that operate at multiple levels (Keleher *et al.*, 2007)—are depicted in Figure 2 as a continuum cutting across the context of health policy, research and services. Depending on the specific approach taken, health promotion interventions can exploit, accommodate or transform existing gender norms, structures and relations. If health promotion activities are gender-transformative, they should produce health *and* social outcomes that contribute to gender equity and change gender norms (Kabeer and Subrahmanian, 1996). If not, health promotion interventions likely reinforce existing gendered social structures, as signalled through a feedback loop—however unwittingly. Gender-transformative health promotion *for women* strives to improve the health and status of women by addressing gender inequities and helping women to increase control over the determinants of their health.

PRINCIPLES TO GUIDE GENDER-TRANSFORMATIVE HEALTH PROMOTION

To support implementation of gender-transformative health promotion, we envisage a planning process that engages multi-sectoral stakeholders; involves the analysis of diverse forms of evidence; critically examines current health promotion practice; identifies interventions to improve women's health and change harmful gender norms, roles and relations; and implements interventions that improve women's health and foster equitable roles for women and access to resources. This approach recognizes that gender, gender relations and gendered structures are relevant throughout all aspects of health promotion planning. A gender-transformative approach to health promotion planning also asks how interventions can be women-centred, embrace harm reduction principles, build on women's strengths and be explicitly equity-oriented.

Through our literature reviews, case studies and consultations, we identified several principles to guide gender-transformative health promotion planning. Most of these are familiar to those in the health promotion field, such as fostering empowerment, pursuing equity and reducing health disparities, being evidence-based, and being culturally-responsive and safe (Victorian Government Department of Human Services, 2008). Some, however, reflect a paradigm shift in regard to the centrality of gender and by the way they attend to the positioning of women in relation to health issues.

Interventions that are explicitly women-centred, trauma-informed and which embrace harm reduction approaches are promising ways of engaging directly with how gender shapes women's health (and health inequities). Women-centred approaches acknowledge women's rights to control their own

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

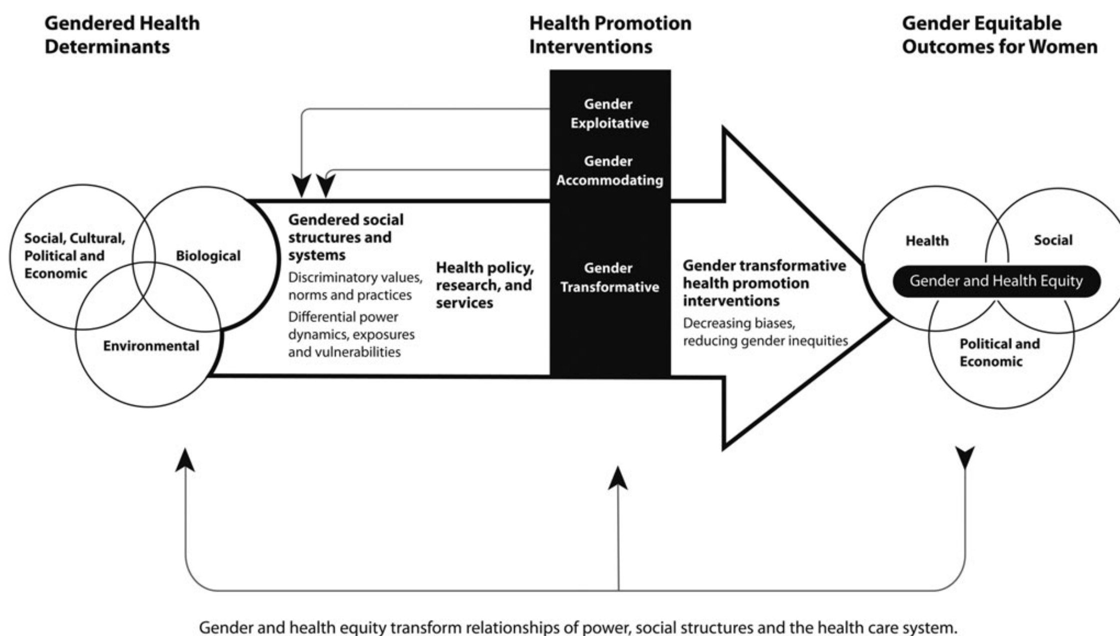

Fig. 2: A Framework for gender-transformative health promotion for women.

health, avoid unnecessary medicalization and consider women's everyday lives (Hills and Mullett, 2002); they account for women's roles as caregivers, partners and mothers and women's patterns and preferences in obtaining health care and support (Ballem and Women's Health Planning Project Steering Committee, January 2000; Greaves *et al.*, 2002; Cory, 2007). Women-centred approaches are inherently empowering and position women as agents of change in their own lives.

Health promotion interventions taking a harm-reducing stance provide pragmatic support to people by helping with immediate goals; providing a variety of options and supports for improving health; and focusing not only on narrow goals related to change in a specific health behaviour, but also on facilitating change in the full range of influences and harms associated with a behaviour (Government of British Columbia, 2005). As a principle for gender-transformative health promotion, harm reduction is closely aligned with women-centredness in its attention to empowerment and self-determination, and recognition of social context and specific, gendered influences and harms. Facilitating women finding safe housing, safety from violence, food security, income security, fair policing practices and prevention of child apprehension thus become aspects of harm-reducing, health-promoting approaches to supporting women with substance use problems (Boyd and Marcellus, 2007; Mehrabadi *et al.*, 2008; Shannon *et al.*, 2008; Poole *et al.*, 2010; Nathoo *et al.*, 2013).

In many settings, experiences of current partner violence and symptoms of past trauma are overlooked, a gender-blind approach with very serious implications through this omission and through re-traumatizing interactions (Cory and Dechief, 2007). A key element of trauma-informed health promotion is active tailoring of environments and approaches to take into account the likelihood that women will have experienced violence and trauma: this means understanding that substance use may be an adaptation or a coping mechanism (Jean Tweed Centre, March 2013). Substance use is often the focus of health promotion efforts, while the issues underlying the behaviour are typically ignored (Greaves *et al.*, 2011). Applying trauma-informed principles involves enacting health promotion through reparative, trustworthy relationships rather than through directive, power-over interventions directed toward specific behaviour change (Elliott *et al.*, 2005). Such a collaborative and relational

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

approach takes place on all levels of individual and group interactions in service delivery, including policy, leadership and organization (Harris and Fallot, 2001; Poole and Greaves, 2012).

At their core gender-transformative health promotion interventions employ strengths-based approaches focused on restoring and building health rather than identifying and focusing on women's deficits. Accordingly, gender-transformative health promotion includes secondary prevention and harm reduction and actively considers what is working well for girls and women, and what of their qualities and resources can be supported, enhanced or built upon. It challenges stereotypes of women as weak, sick and fragile by positioning women as people who can grow, thrive and recognize their own strengths (Norman, 2000; Watkins, 2002; Gottlieb, 2013). Taken together, these principles of action suggest that gender-transformative health promotion is both an outcome and a process.

TOWARD GENDER-TRANSFORMATIVE HEALTH PROMOTION

Applying the gender-transformative framework entails creativity, critical analysis and new ways of thinking. Gender-transformative tobacco control, for example, would reinvent standard thinking on prevention, cessation and policy by clearly incorporating the improvement of gender relations and gender norms in its remit (Greaves, 2014). We suggest that tobacco control advocates and programmers would examine interventions for their effectiveness in preventing tobacco use or reducing its harms, and, in the case of women, in enhancing women's autonomy as reflected, for example, in their capacity to control their exposure to secondhand smoke or their understanding of the workings of the tobacco industry (World Health Organization, 2010b; Dworkin *et al.*, 2013; Greaves, 2014).

Another implication of gender-transformative health promotion is that the outcomes of interest expand to include social and economic outcomes. In the field of HIV/AIDS, for example, this translates into a concern with addressing gender norms related to male risk-taking, health services usage and gender-based violence (Sambo, 2010) and acting to address women's poverty, education and legal protections within a broad framework for HIV/AIDS initiatives (World Health Organization, 2009a). Indeed, improving women's social and economic position is central to addressing gender-based inequities across the globe.

Second, gender-transformative health promotion entails looking beyond single health issues to how multiple factors and experiences intersect with gender in women's lives to generate conditions of risk, vulnerability or protection. Gender-transformative approaches are more likely to involve working cross-sectorally, recognizing the limits of fostering change one issue at a time, competing for scarce resources and the limits of individual control over the determinants of many health issues. For example, a multi-sectoral collaborative of researchers, mental health clinicians, shelter providers, police, community housing coalition advocates and government policy analysts have been voluntarily meeting for 2 years in communities of practice to learn about and design gendered health promotion and system change approaches to improve the response to women's homelessness and mental health issues in the three northern territorial capital cities in Canada (Bopp *et al.*, August 7, 2012).

Understanding the common risk conditions and experiences that generate girls' and women's health challenges calls for combining efforts to link issues. This is why trauma-informed approaches are inherently egalitarian and potentially transformative: by creating circumstances of safety for *all* program participants, everyone can tolerate, stay and benefit from services they need. Trauma-informed substance use programmes assume widespread experiences of trauma and adjust treatment goals and protocols accordingly by not employing punitive or authoritarian approaches (Bloomenfeld and Rasmussen, 2012; Urquhart and Jasiura, 2012).

Gender-transformative health promotion must tackle gender as an element of social systems and structures, not merely an individual attribute. This may mean addressing the gender wage gap; the participation of women in leadership; or the investment in research funding on women-specific health concerns. These actions expand the definition of what constitutes health promotion, moving it from a set of interventions directed at individual behaviour change to a set of initiatives, policies and programmes that work to strategically enhance women's lives and health (Moser, 1989; Keleher, 2007; Mackenzie, 2007).

Most of the activities that are identified as health promotion for women continue to be focused on a narrow range of 'healthy living' efforts focused on achieving healthier weights through physical activity and healthful eating,

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

and preventing or reducing tobacco and alcohol use (e.g. PEI Healthy Eating Alliance, 2007). In contrast, gender-transformative chronic disease prevention efforts would attend to emerging evidence on women's challenges in achieving 'healthy living' (Pederson *et al.*, 2013), including how socio-economic status shapes the opportunities for purchasing and preparing healthful meals, how gender relations contribute to women's use of smoking to control their appetite and manage weight and/or how women's experiences of physical activity often reflect the norms of a male-centred sport and recreation culture (Liwander *et al.*, 2013). Working with women to identify the opportunities for change and adopting culturally-appropriate forms of learning, sharing and change may mean disrupting norms of professional practice, where expertise resides, how change happens, and what is important to women (Ziabakhsh *et al.*, 2013). Transformative heart health promotion campaigns would then tackle issues of weight bias and stigma as part of how to encourage healthy weights without perpetuating gender stereotypes (Puhl and Brownell, 2003), support healthful eating through ensuring adequate financial resources for nutritious food (Power, 2005) and/or encourage governments to engage with gender and culture in the design and operation of physical activity interventions (Frisby, 2013).

Through attending to gender as a facet of social life that generates opportunities as well as constraints, health promotion interventions are a potentially valuable resource for gender equity. Moreover, by insisting that gender is among the 'causes of the causes' (Bynum, 2008), gender-transformative health promotion can enhance health and social outcomes for large numbers of women and men, girls and boys (Rottach *et al.*, 2009).

CONCLUSIONS

Our Framework for Gender-Transformative Health Promotion poses a challenge to researchers, programmers and policy makers: it calls for placing renewed and critical attention on health promotion's *Ottawa Charter* roots to address the conditions that create health. By replacing harmful gendered practices with positive opportunities for health, gender-transformative health promotion could improve the lives of both women and men. Health promotion *can* actively address and change those interventions that ignore or accommodate gender norms, relations and structures and perpetuate harm by fostering risk-taking, silencing debate or depriving people of decision-making power. Health promotion can foster gender-related empowerment, sustain gender-related legal and ethical standards and sanctions and redress gendered biases that limit human agency. The challenge is clear: by acting deliberately on gender inequity in health promotion research, policy and practice, the field may finally move gender from the margins to the centre of health promotion praxis.

ACKNOWLEDGEMENTS

The authors would like to thank the rest of the members of the Promoting Health in Women project team for their contributions to this framework and the many individuals around the world who provided feedback on earlier versions of the framework (www.promotinghealthinwomen.ca).

FUNDING

This manuscript was prepared with support from the Canadian Institutes of Health Research through funding support to the CIHR Team in Sex, Gender and Health Promotion (Grant No. GTA91806).

REFERENCES

Abramson, B. (2009) Women and health: taking the matter to heart. In Armstrong, P. and Deadman, J. (eds), *Women's Health: Intersections of Policy, Research, and Practice*. Women's Press, Toronto, pp. 53–60.

Amos, A. and Haglund, M. (2000) From social taboo to "torch of freedom": the marketing of cigarettes to women. *Tobacco Control*, **9**, 3–8.

Amos, A., Greaves, L., Nichter, M. and Bloch, M. (2012) Women and tobacco: a call for including gender in tobacco control research, policy and practice. *Tobacco Control*, **21**, 236–243.

Ballem, P. and Women's Health Planning Project Steering Committee. (January 2000) Women's Health Planning Project final report. Vancouver/Richmond Health Board, Vancouver, BC.

Barker, G., Ricardo, C. and Nascimento, M. (2007) *Engaging men and Boys in Changing Gender-Based Inequity in Health: Evidence From Programme Interventions*. World Health Organization, Geneva.

Benoit, C. and Shumka, L. (2009) *Gendering the Health Determinants Framework: Why Girls' and Women's Health Matters*. Women's Health Research Network, Vancouver.

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

Berridge, V. (2013) *Demons: Our Changing Attitudes to Alcohol, Tobacco and Drugs*. Oxford University Press, Oxford, UK.

Bloomenfeld, J. and Rasmussen, T. (2012) The evolution of trauma-informed practice at the Jean Tweed Centre. In Poole, N. and Greaves, L. (eds), *Becoming Trauma Informed*. Centre for Addiction and Mental Health, Toronto, ON, pp. 135–145.

Boender, C., Santana, D., Santillan, D., Hardee, K., Greene, M. E. and Shuler, S. (2004) *The 'so What?' Report. A Look at Whether Integrating A Gender Focus Into Programs Makes A Difference in Outcomes*. Interagency Gender Working Group & USAIDS, Washington, DC.

Bopp, J., Carry, C., Duncan, L., Fuller, L., Hache, A., Henderson, C. *et al.* (August 7, 2012). Repairing the holes in the net: responding to the mental health needs of northern homeless women. *Paper presented at the 15th International Congress on Circumpolar Health*, Fairbanks, Alaska.

Boyd, S. C. and Marcellus, L. (2007) *With Child: Substance use During Pregnancy, A Woman-Centred Approach*. Fernwood Publishing, Halifax, NS.

Bynum, B. (2008) The art of medicine: the McKeown thesis. *The Lancet*, **371**, 644–645.

Colgrove, J. (2002) The McKeown thesis: a historical controversy and its enduring influence. *American Journal of Public Health*, **92**, 725–729.

Connell, R. (2012) Gender, health and theory: conceptualizing the issues, in local and world perspective. *Social Science & Medicine*, **74**, 1675–1683.

Cory, J. (2007) *Women-Centred Care: A Curriculum for Health Providers*. Vancouver Coastal Health Authority, BC Women's Hospital and Health Care, Vancouver, BC.

Cory, J. and Dechief, L. (2007) *Safety and Health Enhancement (SHE) for Women Experiencing Abuse: a Framework for Health Care Providers and Planners*. BC Women's Hospital, Woman Abuse Program, Vancouver, BC.

Daykin, N. and Naidoo, J. (1995) Feminist critiques of health promotion. In Bunton, R., Nettleton, S. and Burrows, R. (eds), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle, and Risk*. Routledge, London, UK, pp. 59–69.

Doyal, L. (1995) *What Makes Women Sick: Gender and the Political Economy of Health*. Macmillan Press Ltd, London, UK.

Dworkin, S. L., Treves-Kagan, S. and Lippman, S. A. (2013) Gender-transformative interventions to reduce HIV risks and violence with heterosexually-active men: a review of global evidence. *AIDS & Behavior*, **17**, 2845–2863.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S. and Reed, B. G. (2005) Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, **33**, 461–477.

End Violence Against Women Coalition. (2011) *A Different World is Possible: Promising Practices to Prevent Violence Against Women and Girls*. End Violence Against Women Coalition, London.

Feldman-Jacobs, C., Olukoya, P. and Avni, M. (2005) A summary of the 'so what' report: a look at whether integrating a gender focus into programmes makes a difference to outcomes. IGWG and WHO, Washington.

Feldman-Jacobs, C., Yeakey, M. and Avni, M. (2011) A summary report of new evidence that gender perspectives improve reproductive health outcomes. USAID and IGWG.

Frank, J. W. (1995) Why 'population health'? *Canadian Journal of Public Health*, **86**, 162–164.

Frisby, W. (2013) The politics of taking action: women, poverty and leisure access policy. In Freysinger, V. J., Henderson, K. A., Shaw, S. M. and Bialeschki, M. D. (eds), *Leisure, Women and Gender*. Venture Publishing, State College, PA, pp. 409–424.

Gelb, K., Pederson, A. and Greaves, L. (2011) How have health promotion frameworks considered gender? *Health Promotion International*, **27**, 445–452.

Gottlieb, L. (ed.) (2013) *Strength-based Nursing Care: Health and Healing for Person and Family*. Springer, New York.

Government of British Columbia. (2005). *Harm Reduction: a British Columbia Community Action Guide*. Victoria, BC. http://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf (last accessed 2 September 2014).

Greaves, L. (1996). Smoke Screen: Women's Smoking and Social Control. Fernwood, Halifax.

Greaves, L. (2014) Can tobacco control be transformative? Reducing gender inequity and tobacco use among vulnerable populations. *International Journal of Environmental Research and Public Health*, **11**, 792–803.

Greaves, L. and Poole, N. (2005) Victimized or validated? Responses to substance-using pregnant women. *Canadian Women's Studies Journal*, **24**, 87–92.

Greaves, L., Poole, N. and Cormier, R. (2002) *Fetal Alcohol Syndrome and Women's Health: Setting a Women-Centred Research Agenda*. BC Centre of Excellence for Women's Health, Vancouver, BC.

Greaves, L., Poole, N., Okoli, C. T. C., Hemsing, N., Qu, A., Bialystok, L. *et al.* (2011) *Expecting to Quit: a Best Practices Review of Smoking Cessation Interventions for Pregnant and Postpartum Girls and Women (Second Edition)*. British Columbia Centre of Excellence for Women's Health and Health Canada, Vancouver, BC.

Grogan, S., Fry, G., Gough, B. and Conner, M. (2009) Smoking to stay thin or giving up to save face? Young men and women talk about appearance concerns and smoking. *British Journal of Health Psychology*, **14**, 175–186.

Gupta, G. R. (2000) Gender, sexuality and HIV/AIDS: the what, the why and the how. Plenary address at the XIII international AIDS conference. *Paper presented at the XIII International AIDS Conference*, Durban, SA. http://siteresources.worldbank.org/EXTAFRREGTOPGENDER/Resources/durban_speech.pdf (last accessed 2 September 2014).

Hankins, C. (2008) Gender, sex, and HIV: how well are we addressing the imbalance? *Current Opinion in HIV and AIDS*, **3**, 514–520.

Hankivsky, O. and Christoffersen, A. (2008) Intersectionality and the determinants of health: a Canadian perspective. *Critical Public Health*, **18**, 271–283.

Harris, M. and Fallot, R. D. (2001) *Using Trauma Theory to Design Service Systems*. Jossey Bass, San Francisco, CA.

Heller, A. F. (1986) *Health and Home: Women as Health Guardians*. Canadian Advisory Council on the Status of Women, Ottawa.

Herst, D. (2013, March 2) Pregnancy and drinking could be criminalized. http://guardianlv.com/2014/02/pregnancy-and-drinking-could-be-criminalized/ (last accessed 2 September 2014).

Hills, M. and Mullett, J. (2002) Women-centred care: working collaboratively to develop gender inclusive health policy. *Health Care for Women International*, **23**, 84–97.

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

Jacobson, B. (1986) *Beating the Lady Killers: Women and Smoking*. Pluto Press, London.

Jean Tweed Centre. (March 2013) *Trauma Matters: Guidelines for Trauma-Informed Services in Women's Substance Use Services*. Jean Tweed Centre, Toronto, ON.

Johnson, J. L., Greaves, L. and Repta, R. (2007) *Better Science with Sex and Gender: a Primer for Health Research*. Women's Health Research Network, Vancouver, BC.

Johnson, J. L., Greaves, L. and Repta, R. (2009) Better science with sex and gender: facilitating the use of a sex- and gender-based analysis in health research. *International Journal for Equity in Health*, **8**, 94–102.

Kabeer, N. and Subrahmanian, R. (1996) *Institutions, Relations and Outcomes: Framework and Tools for Gender-Aware Planning*. Institute of Development Studies, Sussex, UK.

Keleher, H. (2004) Why build a health promotion evidence base about gender? *Health Promotion International*, **19**, 277–279.

Keleher, H. (2007) Reframing health promotion. In Keleher, H., MacDougall, C. and Murphy, B. (eds), *Understanding Health Promotion*. Oxford University Press, Melbourne, pp. 29–46.

Keleher, H., MacDougall, C. and Murphy, B. (2007) *Understanding Health Promotion*. Oxford University Press, Melbourne, Australia.

Liwander, A., Pederson, A. and Boyle, E. (2013) Why the Canadian sedentary behaviour guidelines should reflect sex and gender. *Canadian Journal of Public Health*, **104**, e479–e481.

Mackenzie, C. (2007) Guidebook 4: health promotion as a gendering practice. In Keleher, H., MacDougall, C. and Murphy, B. (eds), *Understanding Health Promotion*. Oxford University Press, Melbourne, pp. 107–110.

Marmot, M. (2007) Achieving health equity: from root causes to fair outcomes. *The Lancet*, **370**, 1153–1163.

McDonough, P. and Walters, V. (2001) Gender and health: reassessing patterns and explanations. *Social Science and Medicine*, **52**, 547–559.

Mehrabadi, A., Craib, K. J., Patterson, K., Adam, W., Moniruzzaman, A., Ward-Burkitt, B. *et al.* (2008) The Cedar Project: a comparison of HIV-related vulnerabilities amongst young Aboriginal women surviving drug use and sex work in two Canadian cities. *International Journal of Drug Policy*, **19**, 159–168.

Messing, K. and Östlin, P. (2006) *Gender Equality, Work and Health: a Review of the Evidence*. World Health Organization, Geneva, Switzerland, pp. 57.

Moser, C. (1989) Gender planning in the Third World: meeting practical and strategic needs. *World Development*, **17**, 1799–1825.

Moss, N. E. (2002) Gender equity and socioeconomic inequality: a framework for the patterning of women's health. *Social Science & Medicine (1982)*, **54**, 649–661.

Nathoo, T., Poole, N., Bryans, M., Dechief, L., Hardeman, S., Marcellus, L. *et al.* (2013) Voices from the community: developing effective community programs to support pregnant and early parenting women who use alcohol and other substances. *First Peoples Child & Family Review*, **8**, 94–106.

Norman, E. (2000) Introduction: the strengths perspective and resiliency enhancement—a natural partnership. In Norman, E. (ed), *Resiliencey Enhancement: Putting the Strengths Perspective into Social Work Practice*. Columbia University Press, New York, pp. 1–18.

Östlin, P., Eckermann, E., Mishra, U. S., Nkowane, M. and Wallstam, E. (2006) Gender and health promotion: a multisectoral policy approach. *Health Promotion International*, **21**, 25–35.

Papanek, H. and Schwede, L. (1988) *Women are good with money-earning and managing in an Indonesian city*. *Economic & Political Weekly*, **XXIII**(44).

Pearlman, M. D. and Viano, D. (1996) *Automobile crash simulation with the first pregnant crash test dummy*. *American Journal of Obstetrics and Gynecology*, **175**, 977–981.

Pederson, A., Ponic, P. L., Greaves, L., Mills, S., Christilaw, J. E., Frisby, W. *et al.* (2010) Igniting an agenda for health promotion for women: critical perspectives, evidence-based practice and innovative knowledge translation. *Canadian Journal of Public Health*, **101**, 259–262.

Pederson, A., Haworth-Brockman, M. J., Clow, B., Isfeld, H. and Liwander, A. (eds). (2013) *Rethinking Women and Healthy Living in Canada*. BC Centre of Excellence for Women's Health, Vancouver.

PEI Healthy Eating Alliance. (2007) Prince Edward Island Healthy Eating Strategy 2007-2010. Charlottetown, PE: author. www.healthyeatingpei.ca/pdf/Strategy_HEA_2007-2010.pdf (last accessed 2 September 2014).

Poole, N., Urquhart, C. and Talbot, C. (2010) Women-Centred Harm Reduction, Gendering the National Framework Series (Vol. 4). Gendering the National Framework. BC Centre of Excellence for Women's Health, Vancouver, BC.

Power, E. M. (2005) Determinants of healthy eating among low-income Canadians. *Canadian Journal of Public Health*, **96**(Supp. 3), S37–S42.

Puhl, R. M. and Brownell, K. D. (2003) Psychosocial origins of obesity stigma: toward changing a powerful and pervasive bias. *Obesity Reviews*, **4**, 213–227.

Reid, C., Pederson, A. and Dupéré, S. (2007) Addressing diversity in health promotion: Implications of women's health and intersectional theory. In O'Neill, M., Pederson, A., Dupéré, S. and Rootman, I. (eds), *Health Promotion in Canada: Critical Perspectives*. 2nd edition. Canadian Scholars' Press, Toronto, ON, pp. 75–89.

Reid, C., Pederson, A. and Dupéré, S. (2012a) Addressing diversity and inequities in health promotion: The implications of intersectional theory. In Rootman, I., Dupéré, S., Pederson, A. and O'Neill, M. (eds), *Health Promotion in Canada: Critical Perspectives on Practice*. Canadian Scholar' Press, Toronto, ON, pp. 54–66.

Reid, C., Pederson, A. and Dupéré, S. (2012b) *Addressing Diversity and Inequities in Health Promotion: the Implications of Intersectional Theory*. Canadian Scholars' Press, Inc., Toronto.

Rothblum, E. D. (1994) I'll die for the revolution but don't ask me not to diet: Feminism and the continuing stigmatization of obesity. In Fallon, P., Katzman, M. A. and Wooley, S. C. (eds), *Feminist Perspectives on Eating Disorders*. The Guilford Press, New York, NY, pp. 53–76.

Rottach, E., Schuler, R. and Hardee, K. (2009) *Gender Perspectives Improve Reproductive Health Outcomes*. PRB for the IGWG and USAIDS, Washington, DC.

Ruzek, S. and Hill, J. (1986) Promoting women's health: redefining the knowledge base and strategies for change. *Health Promotion [Oxford, England]*, **1**, 301–309.

Sambo, C. (2010) *UNESCO's short guide to the essential characteristics of effective HIV prevention*. United Nations Educational, Scientific and Cultural Organizations HIV and AIDS Intersectoral Platform, Paris, France.

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023

Schrijvers, D. L., Bollen, J. and Sabbe, B. G. C. (2012) The gender paradox in suicidal behavior and its impact on the suicidal process. *Journal of Affective Disorders*, **138**, 19–26.

Sen, G. and Östlin, P. (2007) Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health: Why it Exists and how we can Change it. Final Report to the WHO Commission on Social Determinants of Health, Women and Gender Equity Knowledge Network. World Health Organization, Geneva.

Sen, G. and Östlin, P. (2010) Gender as a social determinant of health: evidence, policies, and innovations. In Sen, G. and Östlin, P. (eds), *Gender Equity in Health: The Shifting Frontiers of Evidence and Action*. Routledge, New York and London, pp. 1–46.

Shannon, K., Kerr, T., Allinott, S., Chettiar, J., Shoveller, J. and Tyndall, M. (2008) Social and structural violence and policing in mitigating HIV risk of drug-using women in survival sex work. *Social Science and Medicine*, **66**, 911–921.

Stuart, K. and Soulsby, E. (2011a) Reducing global health inequalities. Part 1. *Journal of the Royal Society of Medicine*, **104**, 321–326.

Stuart, K. and Soulsby, E. (2011b) Reducing global health inequalities. Part 2: Myriad challenges. *Journal of the Royal Society of Medicine*, **104**, 401–404.

Stuart, K. and Soulsby, E. (2011c) Reducing global health inequalities. Part 3: Collaboration and funding. *Journal of the Royal Society of Medicine*, **104**, 442–448.

Thurston, W. E. and O'Connor, M. (1996) Health Promotion for Women: A Canadian Perspective. Position Paper for the Canada-U.S.A. Women's Health Forum: Preventive-Health Promotion Strategies, Ottawa, ON.

Tinkler, P. (2006) *Smoke Signals: Women, Smoking and Visual Culture in Britain*. Berg, London.

Travis, C.B. and Compton, J. D. (2001) Feminism and health in the decade of behavior. *Psychology of Women Quarterly*, **25**, 312–323.

Urquhart, C. and Jasiura, F. (2012) Collaborative change conversations: Integrating trauma-informed care and motivational interviewing with women. In Poole, N. and Greaves, L. (eds), *Becoming Trauma Informed*. Centre for Addiction and Mental Health, Toronto, ON, pp. 59–70.

Victorian Government Department of Human Services. (2008). *Integrated Health Promotion: a Practice Guide for Service Providers*. Melbourne. http://www.health.vic.gov.au/healthpromotion/integrated/kit.htm (last accessed 2 September 2014).

Ward-Griffin, C. and Ploeg, J. (1997) A feminist approach to health promotion for older women. *Canadian Journal on Aging*, **16**, 279–296.

Watkins, M. L. (2002) Listening to girls: a study in resilience. In Greene, R. R. (ed.), *Resiliency: an Integrated Approach to Practice, Policy, and Research*. NASW Press, Washington, DC, pp. 115–132.

Wingood, G. M. and DiClemente, R. J. (2000) Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior*, **27**, 539–565.

World Health Organization. (1986) Ottawa Charter for health promotion. *Can J Public Health*, **77**, 425–430.

World Health Organization. (2002) Two reports from WHO focus on action: against violence & promoting healthy life. *International Midwifery*, **15**, 9–10.

World Health Organization. (2009a) *Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs*. World Health Organization, Geneva.

World Health Organization. (2009b) Promoting gender equality to prevent violence against women. World Health Organization, Geneva.

World Health Organization. (2010a) *Gender, women and primary health care renewal: a discussion paper*. World Health Organization, Geneva, pp. 51.

World Health Organization. (2010b) Gender, women and the tobacco epidemic. In Samet, J. M., Soon-Young, Y. (eds), World Health Organization, Geneva.

World Health Organization. (2011) *WHO gender mainstreaming manual for health managers: a practical approach*. World Health Organization, Geneva.

World Health Organization. (2013) *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva, p. 50. http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf?ua=1 (last accessed 2 September 2014).

Ziabakhsh, S., Prodan-Bhalla, N., Middagh, D., King, C. and Jinkerson-Brass, S. (2013) Seven Sisters Healthy Heart Project Evaluation: Full report. BC Women's Hospital & Health Centre and BC Centre of Excellence for Women's Health, Vancouver. p. 117.

Downloaded from https://academic.oup.com/heapro/article/30/1/140/2805697 by guest on 14 February 2023