

**Sex, Gender and Health Promotion: Assessing the Potential
for Health Promotion Interventions
to Address Health and Gender Inequities**

by

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ABSTRACT

As a field, health promotion has largely ignored how sex and gender contribute to one's capacity to increase control over and improve one's health—the very essence of health promotion. This dissertation urges health promoters to adopt an intersectional view of sex and gender as determinants of health and to develop interventions with explicit attention to improving gender equity. Doing so positions health promotion to improve social as well as health outcomes.

To develop this argument, I use intersectional theory to inform: an historical account of the development of health promotion and documentary review of key health promotion charters; an overview of reviews of interventions to increase physical activity, reduce smoking, and limit alcohol consumption among women; and a qualitative study of older women's involvement in physical activity.

Using criteria for gender-sensitive interventions articulated by the World Health Organization, the overview of reviews suggests that, to date, programs to address women's physical activity and substance use are more likely to be gender-specific—aimed at women—than to be gender-sensitive. Building on this limited range of health promotion programs, I outline a conceptual framework to illustrate that health promotion could reduce gender-related health inequities by transforming gender-related norms, roles, and relations. I illustrate the need for and possibilities of such a framework with examples of social marketing messages directed at women and girls.

I then present the findings of a qualitative study of older women's engagement in physical activity with a gender lens. Though aware of the importance of physical activity for

health, the women were motivated to be active to maintain their independence and function, rather than by health concerns, which can be understood as reflecting gendered expressions of resistance to the stigma associated with aging and disability—and their challenges to femininity. Informed by the framework on gender-transformative health promotion, programs could increase older women’s involvement in physical activity by aligning with older women’s priorities—stressing how being flexible, strong, and fit can contribute to women’s ability to live independently and pursue personal priorities—and simultaneously working to fight ageism, sexism, and barriers to participation.

PREFACE

This dissertation is based upon a program of work conducted over several years under the auspices of the BC Centre of Excellence for Women's Health (BCCEWH) and BC Women's Hospital & Health Centre. Specifically, I present the findings of a group of studies conducted in my roles at both institutions.

Chapter 1 introduces the thesis, including the overarching theoretical approach and the thesis components. Chapter 2 recounts the history of health promotion in Canada, a subject on which I have written and published for many years. Material for this chapter is drawn, in part, from previous writings with Drs. Colleen Reid and Sophie Dupéré, with whom I have published two book chapters on the relationship between women's health, health promotion, and intersectional theory (Reid, Pederson, & Dupéré, 2007, 2012a). This chapter also includes material written in collaboration with Karen Gelb and Lorraine Greaves (Gelb, Pederson, & Greaves, 2011) which describes an analysis of leading health promotion frameworks from the perspective of gender.

Chapter 3 is an extended version of a manuscript currently under review. This work was funded, in part, by Health Canada, through a Contribution Agreement with the BC Centre of Excellence for Women's Health in 2012-13. During that fiscal year, I lead a team of researchers to conduct a scoping review of gender-sensitive health promotion interventions related to women and physical activity, sedentary behaviour, and tobacco and alcohol use. The team who worked on the scoping review included Mei Lan Fang, Anna Liwander, Julieta Gerbrandt, and me. During the process of that scoping review, we set aside

a number of evidence reviews to be analyzed in a separate process. Following the completion of the scoping review, we prepared an article for publication and then began working on a review of those reviews, also known as an overview of reviews. Chapter 3 presents the findings of that exercise, one in which I confirmed the search criteria for the literature search, reviewed half the materials identified by the review, helped finalize the final set of reviews and completed the analysis of all the reviews related to physical activity and sedentary behaviour. Mei Lan Fang conducted the review of the reviews on alcohol and tobacco use. We completed the quality assessment and assessment of gender-sensitivity separately and then compared our results. I led the writing of the manuscript, drafting all sections; Mei reviewed and edited, confirmed or corrected information regarding the alcohol and tobacco reviews, and provided comments. I synthesized and finalized the manuscript. This chapter was written entirely on my own.

Chapter 4 presents work developed by a research team supported by the Canadian Institutes of Health Research through a Team Grant in Sex, Gender and Health Promotion. I was a named Co-Investigator on the team, known as PhiWomen (Promoting Health in Women) and was responsible for the original conceptualization of the program of work on health promotion, sex, and gender under the leadership of the then Executive Director of the BCCEWH, Dr. Lorraine Greaves. Dr. Greaves was one of the three Co-Principal Investigators leading the PhiWomen team; her Co-PIs were Dr. Jan Christilaw and Dr. Karin Humphries.

At the time we wrote the proposal for PhiWomen, I was employed as the Manager of Research and Policy at the BCCEWH. Shortly after the program of work was funded, I became a Co-Director of the BCCEWH with Dr. Nancy Poole. In both my capacities, I was

responsible for managing the day to day operations of the PhiWomen team which included generating background documents, directing research assistants, supervising literature reviews, contributing to the framework development content and strategy, reporting on progress to the funding agency, and supporting the Co-PIs in numerous ways. As the work unfolded, I contributed draft framework diagrams, presented a preliminary framework at team meetings, helped draft a book proposal to Canadian Scholars' Press to showcase the final products of the team, co-edited the book manuscript with Drs. Greaves and Poole, and wrote several manuscripts for publication in peer-reviewed journals as well as book chapters. Chapter 4 also draws on material from a chapter on power in *Making it Better: Gender-transformative Health Promotion* led by Dr. Pamela Ponc on which I am a co-author. I read all drafts of this chapter and contributed to the overall argument.

In Chapter 5, I synthesize the findings of interviews conducted at two points in time, the first set in 2000-2001 and the second in 2011. This work began when I was invited to participate as a qualitative researcher with my colleague, Lenore Riddell, to assist Dr. Karim Khan's team examining the impact of an exercise program on the health of a group of older women with osteoporosis. This work has not been previously published, though the second set of interviews were made possible with the support of the Health Canada Contribution Agreement in 2011-2012 to the BCCEWH and a final report was sent to Health Canada with the results of the preliminary analysis of the data. I conducted half the interviews in the first iteration of the study; the others were conducted by Dr. Rochelle Tucker. In 2011, I conducted half the interviews again, assisted by Rehana Nanjijuma. I completed the data analysis and wrote this chapter entirely independently. Dr. Karim Khan was the named Principal Investigator for all aspects of this work.

Chapter 6 borrows the title of a project funded by Health Canada in 2013 entitled *Rethinking Healthy Living for Women in Canada*. This report was generated by a team that I led who together conducted a series of analyses on data from the Canadian Community Health Survey related to a number of topics related to “healthy living” and women. Co-authors for this report include Dr. Barbara Clow, Margaret Haworth-Brockman, Harpa Isfeld, and Anna Liwander. The work was supported by a Contribution Agreement from Health Canada to the BCCEWH for 2012-13. In addition, Chapter 6 incorporates material previously published with Drs. Colleen Reid and Sophie Dupéré on how health promotion could benefit from engagement with intersectional theory (Reid et al., 2007, 2012a).

Throughout this work, I have benefited from the practical, logistical, and financial support of the BCCEWH and, latterly, BC Women’s Hospital & Health Centre. My work and this dissertation would not have been possible without the support, facilities, encouragement, and mentorship of countless people affiliated with these organizations.

Publications Arising from Work Presented in this Dissertation

Fang, M. L., Gerbrandt, J., Liwander, A., & **Pederson, A.** (2014). Exploring Promising Gender-Sensitive Tobacco and Alcohol Use Interventions: Results of a Scoping Review. *Substance Use & Misuse*, 49(11), 1400-1416. doi: 10.3109/10826084.2014.912225

- This paper reports the findings of a study that was the foundation for the review of reviews presented in Chapter 3. While I led this project, the other team members took the lead on writing up the findings on tobacco and alcohol use interventions and hence I am the final author on this collaborative paper.

Gelb, K. , **A. Pederson**, and L. Greaves. 2011. "How have health promotion frameworks considered gender?" *Health promotion International* November 21, 2011. doi: 10.1093/heapro/dar087

- I supervised Karen Gelb, Sirad Deria and Brenda Kent, who conducted the literature search that formed the basis for the manuscript. I participated in team meetings at which we presented the analysis of the documents. I edited the draft manuscript

initially prepared by Karen Gelb and wrote additional material. Lorraine Greaves reviewed and edited the drafts.

Greaves, L., **Pederson, A.**, and N. Poole. (Eds.) (2014). *Making it better: Gender Transformative Health Promotion for Women*. Toronto, Canadian Scholars' Press Inc.

- I co-edited this book with Lorraine Greaves and Nancy Poole. We each were responsible for writing our own chapters as well as managing the contributions of others in a particular section. I was responsible for Part 1, the section on the foundational theories and the conceptual framework on gender-transformative health promotion.

Liwander, A., **Pederson, A.** and E. Boyle. (2013). Why the Canadian Sedentary Behaviour Guidelines Should Reflect Sex and Gender. *Canadian Journal of Public Health*, 104(7): e479-e481. <http://journal.cpha.ca/index.php/cjph/article/viewFile/4108/2871>.

- This publication derives from the work that informed this entire dissertation, but particularly the chapters related to physical activity, that is, Chapters 3 and 5. The order of authors reflects the leadership that Anna Liwander demonstrated in preparing the first draft of the article and the collaboration of all team members in preparing the commentary.

Pederson, A., Ponice, P., Greaves, L., Mills, S. Christilaw, J., Frisby, W., Humphries, K., Jackson, B. E., Poole, N. & L. E. Young. (2010). Igniting an Agenda for Health Promotion for Women: Critical Perspectives, Evidence-based Practice, and Innovative Knowledge Translation. *Canadian Journal of Public Health*, 101(3): 259-261.

- This article was the first publication of the Promoting Health in Women team. I was the lead author as a reflection of my contributions to the grant proposal and project leadership. I wrote the first draft with Pamela Ponice; all other authors reviewed and approved the final draft.

Pederson, A., Greaves, L., and N. Poole. 2014. "Gender-transformative health promotion for women: a framework for action." *Health Promotion International*. doi: 10.1093/heapro/dau083.

- I drafted the manuscript as a whole, particularly the description of the framework and the background section. Nancy Poole wrote the material related to Principles of Action (also used in Chapter 4). Lorraine Greaves reviewed and edited the drafts.

Pederson, A., Poole, N., Greaves, L., Gerbrandt, J. and M.L. Fang. 2014. "Envisioning gender-transformative health promotion." In L. Greaves, A. Pederson and N. Poole. (Eds.) *Making it better: gender-transformative health promotion* (pp. 17-41). Toronto: Canadian Scholars' Press.

- This book chapter was written to explain the development of our framework for gender-transformative health promotion. I wrote the chapter, based on the article submitted to *Health Promotion International* (the journal article was published prior to the book chapter). Nancy Poole wrote the material related to Principles of Action (also used in Chapter 4). Mei Lan Fang and Julieta Gerbrandt conducted several parts of the consultation process, though it was designed and led by Dr. Greaves, Dr. Poole and me. I conducted key informant interviews, participated in discussion groups, reviewed data summarized by Julieta and Mei, and wrote the chapter as the lead contributor. Lorraine Greaves reviewed and edited the drafts, led the consultations in Australia, and supervised the work.

Pederson, A., Izadnegahdar, M., Humphries, and L.E. Young. (2014). Pioneering women-centred heart health promotion. In L. Greaves, A. Pederson and N. Poole. (Eds.) *Making it better: gender-transformative health promotion* (pp. 129-147). Toronto: Canadian Scholars' Press Inc.

- This book chapter draws on the conceptualization of gender-transformative health promotion applied to the case of cardiovascular disease in women. I was responsible for developing the chapter, particularly the section devoted to a discussion of demonstration projects on heart health promotion conducted in British Columbia.

Ponic, P., L.Greaves, **A.Pederson**, and L.E.Young. (2014). "Power and empowerment in health promotion for women." In L. Greaves, A. Pederson and N. Poole. (Eds.) *Making it better: gender-transformative health promotion* (pp. 42-57). Toronto: Canadian Scholars' Press Inc.

- This chapter was based primarily on work that Pamela Ponic conducted for her own doctoral dissertation; Lorraine Greaves was a member of her supervisory committee. My contributions were to some of the applications of the theory Pam proposed and I was part of numerous discussions, with all team members, about how to understand empowerment in contemporary health promotion for women. I reviewed and edited all drafts.

Submitted Papers

Pederson, A., & M.L. Fang. Do literature reviews on health behavior interventions address gender-sensitivity in health behaviour interventions for women? A systematic review of existing reviews

- I wrote all drafts of this manuscript, led the project as a whole, reviewed the reviews on physical activity, and coordinated all aspects of the work. Mei edited and approved all content in the manuscript and conducted the review of the reviews on alcohol and tobacco use and discussed all aspects of the gender-sensitive analysis.

Conference Presentations and Posters Presented on Work Presented in this Dissertation

Pederson, A. Understanding Older Women's Participation in Physical Activity: Implications for Health Promotion (poster). 2015 Qualitative Methods Conference, Melbourne, Australia, April 28, 2015.

Pederson, A., and Khan, K. Gender, Aging and Health: Toward an Intersectional Understanding of Older Women's Engagement in Physical Activity (poster). Canadian Association on Gerontology Conference, Halifax, Nova Scotia, October 17-19, 2013.

Pederson, A. A Framework for Gender-Transformative Health Promotion for Women. Oral presentation at the 21st IUHPE World Conference, Pattaya, Thailand August 28th, 2013.

Fang, M.L., **Pederson, A.**, Liwander, A., Gerbrandt J. Scoping Review of Gender-sensitive Health Promotion Interventions. Scoping Review of Gender-sensitive Health Promotion Interventions. Oral presentation. Canadian Public Health Association annual conference, Ottawa, June 10, 2013

Durey, R., Greaves, L., **Pederson A.** and N. Poole. Envisioning Gender Transformative Health Promotion. Plenary panel discussion at the 7th Australian Women's Health Conference, Sydney, Australia, May 10, 2013.

Pederson, A., Liwander, A., Fang, M.L, Gerbrandt, J. Gender-sensitive promising practices: Results of a scoping review (poster). 7th Australian Women's Health Conference, Sydney, Australia, May 8, 2013.

Pederson, A., Clow, B., Haworth-Brockman, M., Isfeld, H., Liwander, A. Rethinking Healthy Living for Women in Canada: Reflections on the Discourse, Evidence and Practice. Oral presentation. 7th Australian Women's Health Conference, Sydney, Australia, May 8, 2013.

Pederson, A. Strategic thinking about sex, gender and healthy living in Canada. Oral presentation. Institute of Gender and Health Advancing Excellence in Gender, Sex and Health Research, Montreal, October 29, 2012.

Ethics Approval

This dissertation incorporates data from several projects, each of which underwent their own ethical review process. The overview of reviews reported in Chapter 3 did not

require ethics review. Chapters 2 and 4 use evidence gathered covered by the PhiWomen project led by Dr. Lorraine Greaves. Chapter 5 incorporates findings from two phases of research supervised by Dr. Karim Khan. Appropriate consent forms for all data collection processes are contained in the Appendices.

PhiWomen Framework Consultation

This project was reviewed by and received ethics approval from the UBC C&W Research Ethics Board. The project title was Sex, Gender and Health Promotion: Building Evidence for Effective Health Promotion for Women. The Certificate of Approval number was CW09-0304/H09-02658.

Fear of Falling Study

This project was reviewed by and received ethics approval from the UBC Behavioural Research Ethics Board. The project was entitled, Fear of Falling: Qualitative Inquiry into the Experiences of Older Women with Osteoporosis. The Certificate of Approval number was B0-0126.

Older Women and Physical Activity Study

This project was reviewed by and received ethics approval from the UBC C&W Research Ethics Board. The project was entitled Older Women's Physical Activity and Falls Prevention. The Certificate of Approval number was CW11-0180/H11-01574.

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I have many people to thank for their contributions and support over the years. In particular, I want to single out my thesis advisor, Dr. Karim Khan, who offered his support to me long before I took him up on it and asked if I could work with him. Our supervisory relationship was such that I did not even know he was living overseas for the past few years—yet I never felt his support waver. I want to thank Karim for inviting me to find my own commitment and resolve to do this work. As someone who responds well to external demands, it has been a challenge to find the motivation, curiosity and stamina to stick with this work despite constant temptation and distractions. Thank you for reminding me that in the end, whether this dissertation was written and this degree earned would be MY choice.

I also want to thank two other people who have accompanied me on this journey as members of my thesis committee. Anne Martin-Matthews, with whom I share an unusual history, having both been students of Dr. Victor W. Marshall in earlier days, proved herself to be a thoughtful, rigorous reader. Her feedback on my draft dissertation helped me to refine

my argument, link disparate thoughts, and see the whole as more than the sum of its parts.

Thank you for taking a chance on me, Anne.

Joanie Sims-Gould was the third member of my thesis committee. Joanie, you helped me feel capable, creative, and worthy. You provided me with key ideas about how to combine the pieces of my work, offered useful, timely articles to read, and made enormously helpful suggestions on how to complete and strengthen the discussion of methods in this work. I appreciate that you were willing to work with me, Joanie, and the encouragement you offered me at every step along the way.

I've already named another mentor without whom I would not have been able to do this work: Victor Marshall. We met in 1986 in Toronto in his class on the social aspects of aging. From the start, Victor was my advocate—helping to secure a valuable contract with the federal government that launched my career; supporting my applications for scholarships; and mentoring me through my Master of Community Health degree. I did not know the first thing about being a graduate student but Victor helped me to learn not only about aging, but about writing, grantsmanship, and friendship—core elements of the scholar's life. Thank you Victor.

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Wincapaw, Natasha Jategaonkar, Shannon Pederson, and many others, particularly the Board of Directors who encouraged this work). More recently, I've been fortunate to have found similar levels of support from new colleagues and friends at BC Women's Hospital + Health Centre. I particularly want to thank Cheryl Davies and Jan Christilaw for telling me this dissertation was a priority and for their mentorship. I want to thank the members of the small but mighty Population Health Promotion team for their constant support: AJ Murray, Lana Sullivan and Shabnam Ziabakhsh. I am fortunate to work with such energetic, wise, and compassionate people. I also want to thank the students who I have had the pleasure to work with over the past few years; you have enriched me with your questions and inspired me with your enthusiasm for improving the world; thanks to Emily Falk, Charlene King, Sally Ashwell, Lisa Wone, Kimberly Charbonneau, and Madeline Chan.

I was fortunate to be supported by a series of Graduate Scholarships from the University of British Columbia over the course of my studies. The Promoting Health in Women team was funded by the Canadian Institutes of Health Research, which also supported my travel to Australia to present a poster on the work in Chapter 5. The overview of reviews was supported in part by Health Canada through a contribution to the BCCEWH.

Finally, I want to thank my life partner, Michael Barry Spruston, for truly making this possible. Until now, I have not known what it was to have unconditional support and I understand now how this has been essential to this process. I love you Barry and thank you from the bottom of my heart for all the sacrifices you made so that I could "go to work".

DEDICATION

“To absent friends and loved ones...and those who are with us now.”

This was my father’s toast at all family gatherings; I wish he and my mother were able to share in this moment with me.

CHAPTER ONE: INTRODUCTION

Health promotion is a set of strategies for positively influencing health through a range of individual, community-based, and population-level interventions (World Health Organization, 1986). Health promotion employs an array of approaches to interventions to improve health—including health education, social marketing, community development, organizational change, policy and regulation (Keleher, MacDougall, & Murphy, 2007)—though in practice, a great deal of time, effort, and resources have been invested in developing awareness-raising and health education programs. However, health promotion is not the same as health education:

Health education and health promotion are two terms which are sometimes used interchangeably. Health education is about providing health information and knowledge to individuals and communities and providing skills to enable individuals to adopt healthy behaviors voluntarily. It is a combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes, whereas health promotion takes a more comprehensive approach to promoting health by involving various players and focusing on multisectoral approaches. Health promotion has a much broader perspective and it is tuned to respond to developments which have a direct or indirect bearing on health such as inequities, changes in the patterns of consumption, environments, cultural beliefs, etc. (Kumar & Preetha, 2012 para. 6).

In Canada, health promotion interventions, mostly informed by social and psychological theories of health behaviour change, are used to address both communicable and chronic conditions, including HIV/AIDS, influenza, cardiovascular disease, some cancers, diabetes, and hypertension (DiClemente, Salazar, & Crosby, 2013). There is now significant evidence to suggest that tailored and contextualized interventions are required to address complex health problems such as chronic conditions (Smedley et al., 2000), though

political and practical constraints continue to limit health promotion activities to a narrower scope and scale (Baum & Fisher, 2014), often focused on the so-called ‘lifestyle behaviours’ (Lalonde, 1974) of physical inactivity, unhealthy eating, and smoking tobacco. Critics have also suggested that a continued focus on individual lifestyle change may unintentionally contribute to health inequities by perpetuating the advantages that certain groups have in accessing information, organizing themselves for change, and creating the conditions to support healthier living. Given that a decontextualized, one-size-fits-all approach to lifestyle change has been widely challenged (Baum & Fisher, 2014), this dissertation reflects upon how health promotion interventions could benefit from theorizing and evidence related to sex and gender (N. Jackson & Waters, 2005).

To date, the majority of health promotion programs and policies adopt universalistic, gender-blind or gender-neutral language and strategies (World Health Organization, 2010c). Interventions typically use terms such as ‘patients’ or ‘health care system users’ or ‘the urban poor’ rather than ‘low-income women’ or ‘women who experience violence and abuse’, obscuring who is actually affected by a problem or who is being studied (World Health Organization, 2010c). Yet, as an aspect of gendered health systems (Sen & Östlin, 2010), health promotion interventions may exacerbate, maintain, or reduce health inequities, depending upon the degree to which programs or policies exploit, accommodate or transform gender and gender relations (Gupta, 2000a; Sambo, 2010). There have been suggestions that 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).

To address these concerns, some researchers and practitioners have suggested that health promotion efforts incorporate contemporary theorizing and evidence about the importance of sex and gender to health (Doyal, 2001; Hankivsky, 2006; Keleher, 2004; Östlin, Eckermann, Mishra, Nkowane, & Wallstam, 2006). Significantly, this call for attention to gender in health promotion has not been limited to identifying and addressing sex- or gender-specific conditions such as reproductive or sexual health, but rather has proposed acting on gender inequity itself as a source of health risks (Östlin et al., 2006 p. 26):

There is overwhelming evidence from all fields of health research that women and men are different as regards their biology (sex differences), their access to and control over resources and their decision-making power in the family and community, as well as the roles and responsibilities that society assigns to them (gender differences). Together gender and sex, often in interaction with socioeconomic circumstances, influence exposure to health risks, access to health information and services, health outcomes and the social and economic consequences of ill-health. Recognizing the root causes of gender inequities in health is crucial therefore when designing health system responses. Health promotion as well as disease prevention needs to address these differences between women and men, boys and girls in an equitable manner in order to be effective...

Indeed, the international Women and Gender Equity Knowledge Network, one of several contributors to the World Health Organization's (WHO) deliberations on the social determinants of health (Commission on Social Determinants of Health, 2008), argued that "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 & Östlin, 2007, p. 1). In fact, the Commission itself argued that "(b)y supporting gender equity, governments, donors, international organizations and civil society can improve the lives of millions of girls and women and their families" (Commission on Social Determinants of Health, 2008 p. 16).

In this thesis, I argue that health promotion, as a field devoted to action, could learn from more dialogue and exchange with feminist scholarship by presenting intersectionality as an important theoretical contribution from women's studies that could inform health promotion as the field grapples with diversity and the persistence of health inequities (McCall, 2005; Reid et al., 2007, 2012a; Weber & Parra-Medina, 2003). Benoit and Shumka (2009) argue that sex and gender are fundamental determinants of health that shape access to education, employment, childcare, safe neighborhoods and health services—themselves determinants of health. Importantly, they also argue that other key aspects of social location such as social class, race, ethnicity, age, immigrant status and geographic location are fundamental determinants of health as well. Acting together in complex, intersecting ways influenced by power, these determinants shape access to resources and the capacity to have control over one's health. Using an intersectional analysis, which encourages reflection about what happens at the points of intersection of two or more categories, such as gender and educational status, gender and income, or gender, ethnicity, and age, can move health promotion theorizing, research and practice in new ways.

Specifically, understanding relationships among the determinants of health could inform action to reduce health inequities arising from gender norms, roles and gender relations as they shape opportunities or barriers to health. Health promotion research and practice in Canada therefore needs to take bold action, as Raphael (2008) contends, and embrace responsibility for addressing gender-related health inequities. That is, action should be taken to reduce gender-related inequities themselves, not simply expecting action on other factors to trickle down and improve gender-related inequities.

This six-chapter dissertation therefore explores the broad issue of how health promotion might be enhanced by incorporating approaches recognizing sex and gender as determinants of health into health promotion interventions for women. My aim is to expand the discussion of health promotion for women by interrogating examples of health promotion interventions, proposing a new framework for gender-transformative health promotion, and reflecting on the implications of a gender-responsive approach to older women's engagement with physical activity.

I develop the argument for and describe how health promotion has largely ignored consideration of gender to date in Chapter 2 and discuss intersectional theory as an overarching lens through which I have approached this work. In Chapter 3, I introduce the World Health Organization criteria for gender-responsiveness in health interventions proposed in 2010. Using these criteria, I report the findings of a scoping review of interventions designed to increase physical activity, reduce sedentary behaviour, enhance smoking cessation, or reduce risky alcohol consumption in women. The review documented a number of examples of gender-specific interventions but identified few interventions meeting the more rigorous standards for gender-responsiveness.

In Chapter 4, I propose a conceptual framework for gender-transformative health promotion. Building on the published literature, I summarise how health promotion interventions could be implicated in fostering, ignoring, or perpetuating gender-related health inequities by the extent to which they exploit, accommodate, or transform gender-related norms, roles, and relations. The framework is illustrated with examples of health promotion messages related to heart disease, tobacco control, and alcohol use directed at women and girls.

In Chapter 5, I try to apply gendered thinking to the particular case of older women's engagement with physical activity. Research consistently demonstrates that across age categories, girls and women are less active than boys and men in Canada, and seldom engage in physical activity of sufficient intensity and duration to derive health benefits (e.g., Bryan & Walsh, 2004). In our study, we observed that despite their awareness of the importance of physical activity, this group of older women were motivated to be active by the desire to maintain their ability to live independently, to meet their responsibilities in the household and community, to pursue personally-meaningful activities, and to avoid pain rather than by health concerns. Viewed with a gender lens, these reasons can be seen as gender-specific expressions of resistance to the stigma associated with aging, femininity, and disability. From the perspective of gender-responsive health promotion, program planners, policy makers, and health professionals might consider altering their messaging about physical activity to align with the women's priorities—stressing how being flexible, strong, and fit can contribute to women's ability to live independently and pursue personal priorities, rather than abstract goals of physical fitness.

In Chapter 6, I return to the discussion of the nature of health promotion, as a field of health care practice, policy, and research. In particular, I comment on the implications of embracing considerations of sex and gender in health promotion and suggest some approaches to practice that would improve gender equity and health. By engaging with gender norms, relations, and practices that influence exposure to risk conditions, access to health services, and the ability of individuals, communities, and groups to address the determinants of health, health promotion will increase its effectiveness, relevance, and reach.

CHAPTER TWO: LOCATING GENDER IN THE FIELD OF HEALTH PROMOTION

This chapter makes the case that gender has been of marginal interest in the field of health promotion to date, based on a review of arguments in the published literature on the value of adopting a gender perspective in the field and a document analysis of five key health promotion frameworks (see Gelb, Pederson, & Greaves, 2011). To locate this review, I outline the evolution of health promotion in Canada since the 1970s and the emergence of the concept of the determinants of health. I introduce intersectional theory as an approach to understanding sex and gender as determinants of health and explain how gender inequities contribute to health inequities.

Foundations

A Brief History of Health Promotion in Canada

Volumes have been written about the nature and practice of health promotion since the term appeared in 1974 in a Canadian federal green paper, *A New Perspective on the Health of Canadians* (Lalonde, 1974) (see, for example, Godin, 2007; Pederson, O'Neill, & Rootman, 1994; Rootman, Dupéré, Pederson, & O'Neill, 2012). Released by the then Minister of Health and Welfare, the Honourable Marc Lalonde, the report has long been known simply as the *Lalonde Report*. The *Lalonde Report* articulated a Health Field Concept consisting of four elements: human biology, environment, lifestyle, and health care organization (Lalonde, 1974). These four health fields encompass both medical and social

factors affecting health, such as the physical environment, individual and social context, biology, as well as other risk factors. Over the ensuing decades, governments, researchers, and health care providers worldwide have directed considerable attention to understand and modify aspects of lifestyles deemed to contribute to health risks—and the *Lalonde Report* has received its share of credit and critique (Labonte & Penfold, 1981).

In 1986, the WHO released the *Ottawa Charter for Health Promotion* (World Health Organization, 1986) and Canada's federal government released its own charter under the title, *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986). These documents were both significant for articulating priorities for health promotion and defining the scope of activities that could be understood as health promotion. The *Ottawa Charter*, building on an earlier formulation by the European Office of the World Health Organization defined health promotion as “the process of enabling people to increase control over, and to improve, their health”. The Epp framework adapted this concept to the Canadian context by identifying three national health challenges (reducing inequities in health, increasing prevention, enhancing capacity to cope with chronic disease and disability), three health promotion mechanisms (self-care, mutual aid, and healthy environments), and three strategies to operationalize the mechanisms (fostering public participation, strengthening community health services, and coordinating healthy public policy) (Pinder, 1994, 2007).

Subsequently, the federal government supported efforts to enhance researchers' capacity in the field (Rootman, 1989), and provincial and territorial policy makers, researchers, and activists issued their own statements advocating for greater attention to health promotion and disease prevention (e.g., Chenoy, Jackson, Hancock, & Pierre, 1989; Minister's Advisory Group on Health Promotion, 1987). Over the years, debates ensued

regarding the appropriate techniques and settings for health promotion research (Eakin & Maclean, 1992; Raphael, 2000; Stevenson & Burke, 1991), policy (M. O'Neill & Pederson, 1992) and practice (Hancock, 2001; Labonte & Robertson, 1996), the role of the state in shaping individual lifestyles (Petersen & Lupton, 1996), and whether support for health promotion was a strategy to justify cost reductions for federal contributions to health care which, in Canada, are provincial and territorial not federal responsibilities (Pederson et al., 1994).

Over the course of the 1990s, the field of population health emerged that challenged political and practical support for health promotion and its commitment to community development approaches, intersectoral action, and empowerment (Glouberman & Millar, 2003; B. Jackson, 2006; Labonte, 1995; A. Robertson, 1998). Population health popularized the phrase “determinants of health”, building on international literature demonstrating gradients in health by various markers, particularly income (Evans, Barer, & Marmor, 1994). With the advent of this larger set of determinants, the four priorities of the Lalonde Report were expanded to encompass a larger set of determinants of health. Though the specifics of what makes something a determinant of health continue to be debated (see, for example, the list in Panel 2 in Marmot, 2005), Health Canada named gender as one of 12 such determinants, in addition to health services, culture, physical environments, social support networks, biology and genetic endowment, personal health practices, healthy child development, education, income and social status, employment and working conditions, and social environments (Glouberman & Millar, 2003). This list proved to be a landmark in Canada, helping to justify several other developments, among them support for a federal program of research and knowledge translation on women’s health (the Women’s Health

Contribution Program from 1996-2013) and the establishment of an Institute of Gender and Health among the Canadian Institutes of Health Research (CIHR) in 2001—the only such organization in the world (CIHR Institute of Gender and Health, 2012). It was not until 2012, however, that the country’s Chief Public Health Officer incorporated sex- and gender-based considerations into his annual report (Chief Public Health Officer, 2012) and subsequent reports have not maintained the practice.

Sex, Gender and Their Relationship to Health Promotion

It has become common in the health field to distinguish between the concepts of ‘sex’ and ‘gender’, though there are important debates about the extent to which they are mutually constitutive, conflated, and impossibly difficult to disentangle (e.g., Clow, Pederson, Haworth-Brockman, & Bernier, 2009; Fausto-Sterling, 2005; Krieger, 2003)¹. One of the reasons that it is useful to work with both concepts is that it permits discussion of “social” and “biological” influences on health as distinct but possibly linked—though how in any given instance is an empirical question (Krieger, 2003). Broom (2008 p. 13) however, reminds us that

Sometimes relying on the dichotomy may not make much difference, but when it comes to health and other fields where the body is highly salient, a naïve commitment to the distinction may be hazardous because it suggests that some aspects of health are “purely biological” (sex) and hence exempt from signifying and socially organising processes of gender; while others are “entirely” psychological or social and thus somehow immune from the materiality of the flesh.

Accordingly, throughout this dissertation I maintain a distinction between sex and gender, consistent with current practices in Canadian health research but with a wariness about the

¹ Though English has two words, not all languages distinguish the concepts with distinct words either.

potential this choice implies for theorizing and practice (see, for example, the guidelines in place with the Canadian Institutes of Health Research regarding the requirement that all grant applicants are required to answer mandatory questions regarding their research design and the inclusion of sex and gender at <http://www.cihr-irsc.gc.ca/e/32019.html>).

According to the CIHR,

'sex' refers to a set of anatomical and physiological attributes in humans, including chromosomes, gene expression, hormone levels and function, and reproductive/sexual anatomy". Sex is used generally to categorize individuals as male, female or intersex. Sex is understood as the biological "construct that encompasses anatomy, physiology, genes, and hormones that together create a human 'package' that affects how we are labelled (Johnson, Greaves, & Repta, 2007, p. 4).

Gender, in contrast, refers to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people"². Gender "ascribes different qualities and rights to women and men regardless of individual competence or desires" (Johnsson-Latham, 2007 p. 17), reflecting culturally and historically determined prescriptions of feminine and masculine identities, traits and behaviours (Johnson, Greaves, & Repta, 2009). As a social construct, gender takes shape and changes at various levels and in differing ways—it manifests in the ways we interact, the expectations we have of ourselves and others, the careers we pursue, and the behaviours both explicitly and implicitly deemed appropriate for someone of our gender. Another useful definition of gender, provided by Ridgeway & Smith-Lovin (1999 p. 192), reminds us that gender constitutes a social structure that has meaningful consequences: "Gender is a system of social practices within society that constitutes people as different in socially significant ways and organizes relations of inequality on the basis of the difference."

² Both definitions taken from Sex, Gender and Health Research Guide: A Tool for CIHR Applicants, available at <http://www.cihr-irsc.gc.ca/e/32019.html>.

Johnson et al. (2009) suggest that it is useful to think of gender as a multidimensional construct with four levels: gender roles, gender identity, gender relations, and institutionalized gender. Each level captures different ways that gender influences aspects of our lives. For example, gender roles “reflect the behavioural norms applied to males and females in societies that influence their everyday actions, expectations, and experiences” (para. 10). Gender roles can vary between societies, over time, and between generations.

Gender identity, however, refers to “... how an individual sees themselves on the continua of female or male (or as a ‘third gender’ or ‘two-spirited’), and influences our feelings and behaviours” (para. 11). Gender identities can evolve, change, be embraced or be resisted. Gender relations, in turn,

...refer to how individuals interact with and are treated by others, based on their ascribed gender. Gender relations have a profound effect at all levels of society, and can restrict or open opportunities for individuals...Gender relations interact with our ‘race,’ ethnicity, class, and other identities (para. 12).

Gender relations can be intensely intimate and personal as well as the frameworks through which individuals and groups interact in the family, workplace, and community. Gender relations, and their manifestations at various levels of society, have been identified as important to health through the ways that they establish or limit access to opportunities, lead to or protect individuals or groups from exposures to harms, and foster capacities for decision-making, action, and engagement with health-related matters for oneself and others. Finally, a gender-relations approach reminds us that women’s and men’s interactions and the circumstances under which they do so can contribute in meaningful ways to opportunities and constraints for health practices (Schofield, Connell, Walker, Wood, & Butland, 2000). Two key settings for such gender interactions are the workplace and the family; in this

dissertation, gender relations in the family and household are made visible in Chapter 5 in the older women's descriptions of their everyday lives.

The fourth level Johnson et al. (2009) identify is "institutionalized gender", which they define as follows:

Institutionalized gender reflects the distribution of power between the genders in the political, educational, religious, media, medical, cultural and social institutions in any society. These powerful institutions shape the social norms that define, reproduce, and often justify different expectations and opportunities for women and men and girls and boys such as social and family roles, job segregation, job limitations, dress codes, health practices, and differential access to resources such as money, food, or political power (para. 13).

Naming these four dimensions of gender helps to convey the pervasiveness of its influence in every day life and to suggest the range of mechanisms, practices, and settings through which gender could influence health.

Gender Equality, Equity and Health

Broom (2008) suggests that gender inequality remains a "vexing" problem for researchers and health care providers with respect to conceptualization, understanding and its implications. Globally, it has been argued that gender equality is both a marker of and a pathway to well-being.

Gender equality ... refers to a state of affairs in which women and men enjoy the same opportunities in all walks of life. It also means the presence of a gender perspective in decision-making of all kinds and that women's interests are given the same consideration as men's in terms of rights and the allocation of resources (Johnsson-Latham, 2007 p. 17).

As such, gender equality has come to be understood as an important feature of health strategies and policies, and empowerment, understood as a process of facilitating an individual's control over their lives, has become increasingly prominent in both the health and development discourses.

Doyal (2002 p. 238) argued that

In the course of their everyday lives, women and men often face similar challenges to their health. However, there are also significant differences between the two groups. The most important starting point for explaining these differences is to be found in the realm of biology. A women's capacity for reproduction makes her vulnerable to a wide range of health problems if she is not able to control her own fertility and to go through pregnancy and child-birth safely. This gives women "special needs" which must be met if they are to realise their potential for health.

However, social differences are also important in shaping male and female patterns of health and illness. All cultures assign specific characteristics to women and to men. These include a range of responsibilities and duties as well as varying entitlements to social and economic resources. As a result, men and women in the same communities or households often lead quite different lives, exposing them to different risks and offering them differential access to health and health care...

With respect to some health outcomes, such as life expectancy, formal gender equality (sameness) is unlikely, but it has been argued that women and men should have equal opportunities for health, which may require approaches that deliberately seek to ameliorate unjust, unnecessary or avoidable disparities in the health status (PAHO, n.d.).³

Gender equity—fairness—refers to “the process of allocating resources, programs, and decision making fairly to both males and females without any discrimination on the basis of sex...and addressing any imbalances in the benefits available to males and females” (<http://www.caaws.ca/gender-equity-101/what-is-gender-equity/>). Whereas gender equality “focuses on creating the same starting line for everyone,” gender equity aims to provide

³ Health equity refers to fairness while health equality refers to sameness.

“everyone with the full range of opportunities and benefits—the same finish line”

(<http://www.caaws.ca/gender-equity-101/what-is-gender-equity/>).

The final report of the WHO Commission on the Social Determinants of Health argued that many persistent and avoidable health inequities remain between and within countries (Commission on Social Determinants of Health, 2008). The report outlined a global agenda for health equity with three overarching recommendations, none of which addressed individual health-promoting behaviours. Instead, the report recommended: (1) improving daily living conditions; (2) tackling the inequitable distribution of power, money and resources; and (3) measuring and understanding the problem and assessing the impact of action. Within these recommendations, the report argued that gender inequities are unfair, ineffective, and inefficient, and that by “supporting gender equity, governments, donors, international organizations and civil society can improve the lives of millions of girls and women and their families” (Commission on Social Determinants of Health, 2008 p. 16).

However, the WHO Commission’s report was relatively thin on specific recommendations for addressing inequities related to gender and offered a particular perspective on the relationship between gender and health, one that is not shared by all researchers in the field. The WHO framework identified gender as an intermediate factor that is shaped by other more fundamental ones such as socioeconomic status and policy as well as cultural and societal norms and values. Other scholars have argued, however, that gender must be understood as a fundamental determinant of health that structures access to key resources. Benoit and Shumka (2009) are proponents of such a view and suggest that sex and gender shape access to education, employment, childcare, safe neighborhoods and health services—themselves determinants of health. Importantly, Benoit and Shumka’s framework

identifies other key aspects of social location such as social class, race, ethnicity, age, immigrant status and geographic location as fundamental determinants of health as well. Acting together, these determinants shape access to resources and ultimately health behaviours and practices, as well as morbidity and mortality.

Globally, girls and women perform household and caregiving as well as economic activities and hence have, on average, less leisure time than men and boys, have less access to education, have greater exposure to gender-based violence and abuse, and have ultimately have lower incomes than men—all factors which may limit girls and women from reaching their full potential for health and wellbeing (Dworkin, Treves-Kagan, & Lippman, 2013). Men and boys, on the other hand, are more likely to be exposed to conditions that put their health at risk, whether through employment, transportation, leisure pursuits, military engagement, and violence. Even in developed countries, these gender inequities persist. For example, a recent Swedish document argues that

Gender and gender power are reflected at all levels of society, where women are often responsible for health and social care provision – both at home and at the workplace – while men are able to use their greater share of leisure time to pursue careers/work and to participate in decision-making at all levels of public life (Johnsson-Latham, 2007 p. 17).

In Canada, gender inequities in health are not often named or identified as such; official recognition of this fact has been relatively slow (but see Chief Public Health Officer, 2012; Government of Manitoba, 2011; Health Canada, 1999; Johnson et al., 2009; Office of the Provincial Health Officer, 2008). In general, while women’s health compares favourably to men’s in Canada with respect to mortality, on average women experience higher rates of chronic disease and a greater burden of disability than men over their lifetime (Health Canada, 1999). Moreover, gender differences in health are dynamic. Research in British

Columbia, for example, suggested that the life expectancy of women in British Columbia was not rising at the same rate as men's, challenging the assumption that women in the province consistently outlive men (R. Fang & Millar, 2006). Yet there is emerging evidence that health care interventions—which include health promotion activities—may be more effective if they are designed with gender in mind (Boender et al., 2004; World Health Organization, 2011b). Such evidence is driving new conversations about how to improve health by, for example, fostering women's empowerment, encouraging men and boys to address negative attitudes toward girls and women, and challenging gender norms and relations (Attanapola, 2008; Barker, Ricardo, & Nascimento, 2007; Keleher & Franklin, 2008; Koenig & McCree, 2011; Nascimento, Ricardo, Barker, Santos, & Olukoya, 2010; Sambo, 2010).

These conversations have been increasingly part of the discourse of health promotion in Canada (Reid et al., 2007, 2012a; Thurston, 1998; Thurston & O'Connor, 1996). In particular, there is interest in how intersectionality could inform health promotion theorizing and practice (Reid et al., 2007, 2012a). While a full discussion of intersectional theory is beyond the scope of this dissertation, I used this theoretical lens to inform my research and to understand how gender influences health through its intersection with other determinants of health, particularly age (Calasanti, 2010; Martin, 2012).

Intersectional Theory

Intersectional theory is based on the idea that “different dimensions of social life cannot be separated into discrete or pure strands” (Brah & Phoenix, 2004, p. 76). When

attempting to understand social inequities, an intersectional analysis focuses on social relationships of power instead of focusing on access to resources. An intersectional analysis examines social experiences and how they intersect through multiple forms of oppression, and what happens at those intersections (McCall, 2005).

Intersectional theory was developed most prominently by Black feminist social scientists emphasizing the simultaneous production of race, class, and gender inequity, such that in any given situation, the unique contribution of one factor might be difficult to measure (Collins, 1989; Fonow & Cook, 1991). This approach—an alternative to earlier models that assumed that advantage and disadvantage simply accumulate to produce “double jeopardy”—suggests that the content and implications of gender and race as socially constructed categories vary as a function of each other (Mullings & Schulz, 2006). For example, whiteness and blackness are gendered, and masculinity and femininity are “raced” within particular cultural contexts. Hence it is often difficult to pinpoint how the interaction, articulation, and simultaneity of race, class, and gender, for example, affect women and men in their daily lives, and the ways in which these forms of inequity interact in specific situations to condition health (Mullings & Schulz, 2006).

Intersectional theory suggests that we need to move beyond seeing ourselves and others as single points in some specified set of dichotomies--male or female, White or Black, straight or gay, scholar or activist, powerful or powerless. Rather, “we need to imagine ourselves as existing at the intersection of multiple identities, all of which influence one another and together shape our continually changing experience and interactions” (Brydon-Miller, 2004, p. 9). Intersectional scholarship arose primarily to better understand and

address the multiple dimensions of social inequity including class, race/ethnicity, gender, sexual orientation, age, and disability.

As an analytical tool and framework, intersectional analysis can be used at both the micro and macro levels. At a micro level, intersectionality aims to understand the effects of the structural inequities on individual lives by focusing on the interplay between social categories and multiple sources of power and privilege. At a macro level it seeks to understand how multiple power systems (i.e., institutions) are implicated in the production, organization and sustainability of inequities. It provides a social structural analysis of inequity (Bilge, 2009).

What distinguishes intersectionality from a social determinants of health approach is that an intersectional analysis does not seek to simply add categories to one another (e.g., gender, race, class, sexuality) but instead strives to understand what is created and experienced at the intersection of two or more categories (Hankivsky et al., 2010). In so doing, it recognizes the multidimensional and relational nature of social locations and places lived experiences, social forces, and overlapping systems of discrimination and subordination at the centre of analysis (Hannan, 2001). In this way an intersectional analysis captures several levels of difference (Hankivsky et al., 2010).

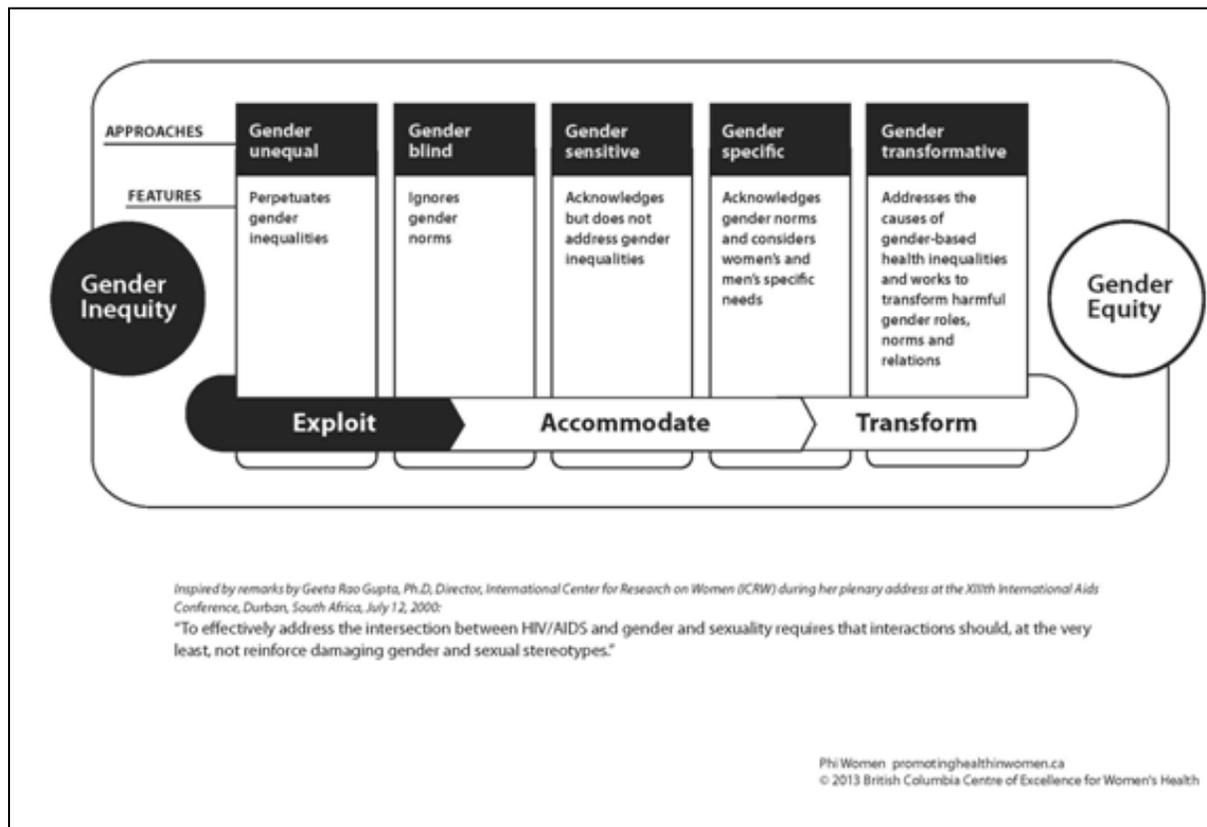
Gender and age function as social axes through which inequalities are distributed along the continuum of the life course (Calasanti, 2010). Older adults, for example, uniquely perform both age and gender according to their social location and chronological age. This is evident, for example, in the reflections of older women on their experiences of and preferences regarding physical activity, as I will take up further in Chapter 5.

A Continuum of Action on Gender and Health

Researchers and analysts are increasingly using a common framework to describe the range of possible actions that can be taken to address gender-related health inequities. Figure 2.1 illustrates a continuum of potential gender-responsive interventions. It is derived from discussions within the HIV/AIDS epidemic (e.g., (Gupta, 2000a) and emerging evidence of the various ways that health interventions relate to gender, particularly gender relations (Sambo, 2010; World Health Organization, 2010c). This continuum identifies that health interventions—which should be understood to include health promotion but also clinical practices, health research and policies—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 as a threat to health equity (World Health Organization, 2010c). What have come to be referred to as “gender-transformative” approaches are those which “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, Schuler, & Hardee, 2009, p. 8). Applied to health promotion interventions, being gender-transformative means that interventions, whether social marketing, health education, community development, organizational change, or public policies, either use content that does not exploit harmful gender norms or stereotypes or creates support to transform such norms, assumptions or practices. That is, for example, instead of taking existing gender norms as the status quo, when there is evidence that they are harmful, health promotion efforts will challenge rather than perpetuate them. This could mean using inclusive imagery and language to capture the diversity of the population; removing financial barriers to

services that limit access by those of lower income (who are more likely in most countries to be disproportionately women and girls); or working on exposing and changing attitudes toward women and girls that increase their risk for exploitation, violence and abuse.

Figure 2.1 A Continuum of Approaches to Action on Gender and Health⁴



To illustrate the value of this continuum, and its implications for health promotion research, policy, and practice, I will summarize the features of each approach as described by the WHO (2010c).

⁴ As a member of the PhiWomen team, I have permission to use this and other images developed in the process of generating the conceptual framework for gender-transformative health promotion.

Gender-unequal

Gender-unequal initiatives perpetuate gender inequalities by reinforcing unbalanced gender norms, roles and relations. Typically, one sex will be privileged over another and this leads to that sex enjoying more rights, privileges, opportunities and resources than the other, whether information, services, or opportunities for decision-making. For example, a program might only be available to people able to pay a fee; given women's generally fewer economic resources, women might not be able to access the program as easily as men.

Gender-blind

Gender-blind programs ignore gender norms, roles and relations and may therefore reinforce gender-based discrimination, biases and stereotypes. The most common argument for gender blind initiatives is that they are 'fair' because they treat everyone the same, but by ignoring structured barriers faced by some program participants, the program may contribute to inequities. Technologies may also be gender blind. For example, a report on gender inequities in science and technologies documented how car seat belts are not routinely tested using models that simulate adult women, particularly pregnant women. As a result, women, who are smaller on average than men, have been described as "out of position" drivers because the seat belts do not fit or protect them in the same way as for men (Schiebinger, 2010).

Gender-sensitive

Gender-sensitive programs acknowledge and consider gender norms, roles and inequalities but do not necessarily involve action to address them. For example, a program to reduce maternal-child transmission of HIV would likely acknowledge that women may not have the status, rights nor decision-making authority to practice safer sex, insist upon the use of condoms, or adopt safer child-feeding strategies, though they would be encouraged to do so nonetheless.

Gender-specific

Gender-specific programs acknowledge that gender norms, roles and relations exist and have an impact on access to or control over resources. This may mean targeted a program specifically at women or men, accommodating gender norms but not working to address or change them. Programs that provide child-minding and offer women-only spaces can be gender-specific but not necessarily gender transformative because they do not challenge why women are responsible for children when they need their own health care or why mixed spaces are unsafe for women. Thus, instead of addressing gender-based violence, it removes the threat of it. While obviously an important approach, gender-specific programs do not necessarily address the root causes of gender imbalances in power, resources or opportunities.

Gender-transformative

Gender-transformative approaches actively strive to examine, question, and change rigid gender norms and imbalances of power as a means of reaching health as well as gender equity objectives. Gender transformation seeks to shift gender roles and relations closer to gender equity in a given context. Gender-transformative approaches actively strive to examine, question, and change rigid gender structures and imbalance of power as a means of reaching health and gender equity objectives (Rottach et al., 2009). Since gender equity is likely never fully attained, gender transformation is an ongoing process toward it. What is transformative in one context, however, may not be transformative in another. Gender transformation involves identifying the ways that gender discrimination, inequality or oppression operates in a particular situation and taking feasible steps toward improving these conditions—even if the result would still be considered regressive by the standards of another situation (Rottach et al., 2009). Gender transformation is therefore possible in every context, from the most repressive to the most progressive.

Having clarified this continuum, I will apply it in a discussion of typical health promotion practice. I will introduce the work of several authors who have argued for greater consideration of gender within the field of health promotion and summarize the findings of a review of prominent international and Canadian health promotion frameworks to illustrate their relative gender-blindness. In subsequent chapters, I will develop a framework to illustrate how health promotion interventions could undertaken gender-transformative approaches.

Gendered Critiques of Health Promotion Interventions

Women's health researchers and advocates have long questioned the link between women's health and their social position (McDonough & Walters, 2001), how women are represented in health education and health promotion (Frank, 1995), and whether health interventions, including health promotion, are appropriately designed with respect to women (Armstrong & Deadman, 2009; Doyal, 1995; Reid et al., 2007; Reid, Pederson, & Dupéré, 2012b; Ward-Griffin & Ploeg, 1997). Two decades ago, British sociologists Daykin and Naidoo (1995) suggested that health promotion rested on and perpetuated certain aspects of gender inequities (Pederson, Ponc, Greaves, et al., 2010); echoing concerns raised a decade earlier by writers in North America:

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 & Hill, 1986, pp. 301-302)

Critiques like these argued that health promotion held women responsible for their own health as well as the health of others (including partners, children and others), ignored women's unpaid work, and employed the techniques of health education and social marketing to encourage women to adopt healthy lifestyles without regard for the individual and structural constraints of power, income, race and education—among others—that limit women's ability to take action on health issues. Moreover, health promotion interventions directed to women have, at times, relied upon inappropriate evidence (e.g., such as research

on men regarding cardiovascular disease (Abramson, 2009)), gendered norms (e.g., the assumption that all women are mothers), and/or stereotypes (e.g., that women value attractiveness above other qualities or aspirations).

More recently, researchers concerned with men's health have raised questions about the ways that dominant expressions of masculinity—so-called hegemonic masculinity—have contributed to unhealthy lifestyles among men (S. Robertson & Robertson, 2006; S. Robertson & Williamson, 2005). In contrast to the discourse about women's and girls' health, this research and theorizing has focused on the ways that discourses of masculinity contribute to men's neglect of their health, celebrate risk-taking at the expense of health, and minimize discussions of men's and boys' needs for connectedness, relationship, and meaning (Connell, 1987). Finally, scholars, activists and researchers concerned with other sexual and/or gender identities, including lesbian, bisexual, intersex, transgender and queer (among others), continue to expand the discussion of gender and health beyond the male/female or man/woman dichotomy that has dominated the field for the past 20 years. Yet apart from research into sexual and reproductive health, including HIV/AIDS prevention and management, little of this understanding has been picked up in the dominant practices, texts and frameworks of health promotion as a field.

A Gendered Review of Health Promotion Frameworks

Building on our familiarity with the literature on health promotion, a small group from the PhiWomen team conducted a formal analysis of the extent of gender considerations in key conceptual frameworks for health promotion from 1974 through 2005, a span of over

30 years.⁵ For the purposes of this retrospective analysis, we used the term gender in its most overarching sense, and looked for instances of any level of consideration of either sex or gender. In this assessment, we conducted a wide iterative search of several databases intended to cover the spectrum of available literature on gender and health promotion frameworks. We initially searched for theoretical and conceptual literature on health promotion, and, given our ultimate aim, women's health, and built a database. Then we searched for key words in our entire database of sources to identify the key health promotion frameworks that have been published in the last 40 years. Finally, we expanded the academic literature search with a targeted review of grey literature, to identify historical health promotion documents, based in part on discussions with key informants.

The primary search was carried out using select databases: Medline-OVID; CINAHL-EBSCO; Women's Studies International-EBSCO; Academic Search Elite-EBSCO and Soc Index-EBSCO. Search terms included Theory or Concept, Model or Framework, Health Promotion, Gender, Women's Health, Feminist Theory, Sex Factors and combinations thereof. This search identified approximately 9000 references which were compiled in an *Endnote*TM database. We used key word searches within this database, such as complexity, gender, women and health, women's health promotion, gender health promotion, health framework, feminism, Ottawa, and Bangkok. This step reduced our search to approximately 2000 abstracts. These 2000 abstracts were reviewed manually for relevance and based on content, key words and the presence of frameworks or models, 125 abstracts were identified as relevant. These 125 frameworks and/or models were reviewed and relevance assessed based on content, the presence of conceptual or operational models or frameworks, or

⁵ This project was undertaken by a team of researchers from the CIHR Team in Sex, Gender and Health Promotion known as PhiWomen (Promoting Health in Women). I was a co-investigator, the daily manager of the research team, and a co-author of this review.

specific attention to women, gender and health promotion, and 45 articles were identified as relevant for understanding the development of health promotion frameworks.

Although this extensive academic literature search revealed both operational and implementation-focused frameworks and models, it did not turn up any of the key historical health promotion documents foundational to health promotion (such as the *Ottawa Charter for Health Promotion* and *Achieving Health for all: A Framework for Health Promotion*). Accordingly, we conducted key informant interviews to augment the academic literature review and completed a complementary grey literature search, specifically seeking out conceptual frameworks put out by from national or international bodies. This process included extensive web searches which were reviewed in consultation with the Promoting Health in Women Research Team and Advisory Committee. Through this process, five health promotion frameworks were identified as key to the development of the field of health promotion and current health promotion framework activities: the *Ottawa Charter for Health Promotion* (World Health Organization, 1986); the federal government's Epp Report from Canada, *Achieving Health for all: A Framework for Health Promotion* (Epp, 1986); the *Population Health Promotion: An Integrated Model of Population Health and Health Promotion* model (Hamilton & Bhatti, 1996); the health field concept in *A New Perspective on the Health of Canadians* (Lalonde, 1974), and *The Bangkok Charter for Health Promotion in a Globalized World* (World Health Organization, 2005). The results of our review are reported chronologically.

Gender Analysis of Key Health Promotion Frameworks

Many authors have attributed the emergence of health promotion discourse to the release of the so-called Lalonde Report in Canada in 1974 (e.g., Low & Thériault, 2008; Pederson et al., 1994). However, the report showed a complete absence of consideration as to how sex and/or gender affects health and health behaviours. Aside from explicit discussion of men's average shorter lifespan (while overlooking other metrics, such as quality of life), health differences and health determinants were all discussed in gender-blind terms, assuming a similar level of power, control, and capacity to affect change in one's environment among all members of the populations. Indeed, 'The LIFESTYLE category, in the Health Field Concept, consisted of the aggregation of decisions by individuals which affect their health and over which they more or less have control' (Lalonde, 1974, p. 32, emphasis in original).

Just over a decade later, the Ottawa Charter for Health Promotion (World Health Organization, 1986) was released at the First International Conference on Health Promotion in Ottawa. According to the Charter, health is 'a positive concept emphasizing social and personal resources, as well as physical capacities'(p. 1). The explicit mention of social resources captures the importance of contextual and non-medical factors in influencing health. Whereas the Lalonde Report suggested that all people more or less have control over 'lifestyle' factors that influence health, the Ottawa Charter emphasized the relationship between an individual and their broader social context, and introduced the discussion of health equity:

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. 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 (World Health Organization, 1986 p.1).

However, beyond this mention that both women and men must be able to control the factors that determine health, gender was not explicitly considered within the Charter. While there was an articulation that various external factors, such as education, income and a stable eco-system, affect health, the Charter offered no assessment of the role that gender plays in relation to these external factors, nor any recognition of gender as a key determinant of health.

The Ottawa Charter did, however, mention the importance of attending to local needs: 'Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems' (World Health Organization, 1986, p. 2). This frame set the stage for understanding the importance of tailored and responsive strategies—adapting programs for different communities and cultures, different needs—and is a strong starting point that allows practitioners to account for, and respond to, the myriad social, cultural and economic circumstances—including expressions of gender and gender relations—that differentially affect women's and men's health:

Health is created and lived by people within the settings of their everyday life—where they learn, work, play, study and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members (World Health Organization, 1986, p. 3).

Achieving Health for all: A Framework for Health Promotion (Epp, 1986), was released in Ottawa in 1986 during the activities of the First International Conference on Health Promotion as Canada's response to the Ottawa Charter. While the report mentioned differential health experiences for women and men, it offered little critical assessment of the factors influencing these differences. Indeed, it made no mention of gender or how gender might factor into or affect the identified health challenges, health promotion mechanisms, or strategies for action. To its credit, the Epp Report clearly acknowledged that while it focused on issues deemed of national importance, they might be trumped by more locally-pertinent issues. Recognition that health challenges differ by region and community is a key starting point for understanding that variations in health are influenced by a range of social factors and contexts including gender. However, this assertion did not expand the dialogue on gender and diversity as influences of health at the time.

In 1994, the Federal/Provincial/Territorial Advisory Committee on Population Health released *Strategies for Population Health: Investing in the Health of Canadians* (Federal/Provincial/Territorial Advisory Committee on Population Health, 1994) detailing nine determinants of health. Notably, gender did not appear on this first list of health determinants, but by 1999, gender, culture, and social environments, had all been added (Health Canada, 1999; A. Robertson, 1998). More recently, literacy has been added as a determinant of health in Canada, in addition to education (Public Health Agency of Canada, n.d.).

With the initial release of the *Strategies for Population Health: Investing in the Health of Canadians* document in 1994 (Federal/Provincial/Territorial Advisory Committee on Population Health, 1994) and an increased interest in population health, questions were

raised about the similarities and differences between population health and health promotion (A. Robertson, 1998). As part of the broader response to these questions, Hamilton and Bhatti (1996) published *Population Health Promotion: An Integrated Model of Population Health and Health Promotion*. In this model, they sought to avoid ‘a debate over the similarities and differences’ between the two approaches, and instead aimed to ‘combine the ideas to provide an integrated Population Health Promotion Model’ (Hamilton & Bhatti, 1996, p. 1).

Hamilton and Bhatti (1996, p. 5) suggested that their model shows ‘how a population health approach can be implemented through action on the full range of health determinants by means of health promotion strategies’. They synthesized materials from the *Ottawa Charter* and *Strategies for Population Health* to lay the foundation for their action model, and constructed a three-dimensional cube-shaped model addressing the what, how and who that must be considered in actions to improve health. The importance of evidence-based decision making is emphasized, and the reality that all of these variables rest on the values and assumptions of the actors taking up any component of action is also highlighted. The main feature of the model is its articulation of how many health determining behaviours are situated beyond the traditional health sector. The model itself is not intended to be prescriptive, rather it aims to function as ‘a planning tool and a departure point for developing other models designed for specific needs’ (Hamilton and Bhatti, 1996, p. 11).

As this model was developed before gender was added to the list of determinants of health in 1999, it does not specifically weigh in on gender as it relates to health. However, in knitting together health promotion and the social determinants of health, it goes a long way to bringing gender into the health promotion conversation. This model situates the determinants

of health as the areas in which health promotion actions can be implemented. As gender has been integrated as a key determinant of health in the years since the development of this model, gender fits quite naturally in this model but this has yet to formally happen.

The Bangkok Charter for Health Promotion in a Globalized World (World Health Organization, 2005) was released in 2005 at the 6th Global Conference on Health Promotion. The Bangkok Charter locates itself as identifying ‘actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion’ (World Health Organization, 2005 p. 1), but it departs from the Ottawa Charter in that it introduces the private sector into the conversation, suggesting that building partnerships and alliances with the private sector is a required strategy for health promotion in a globalized world. Despite this significant difference in relation to the Ottawa Charter, the Bangkok Charter, like its predecessor, gives only a cursory nod to gender as a factor in health promotion, noting only that “women and men are affected differently” by challenges such as “adverse social, economic and demographic changes that affect working conditions, learning environment, family patterns, and the culture and social fabric of communities” (p. 2). With few explicit comments relating to gender and no content suggesting any understanding of how to integrate gender into health promotion, the Bangkok Charter is, for all intents and purposes, gender-blind (Reid et al., 2007).

Reflections

As a whole, this review highlights the ways in which all of these frameworks have expanded and enriched our understanding of health promotion, health promotion practice,

and best practices in health promotion. However, in reviewing these five key pieces it became clear that gender was largely neglected as a topic within the frameworks. Further, when gender was mentioned as a consideration or as a determinant of health, its complexity was not addressed, nor was it understood as a relational variable interacting with other factors and determinants of health.

Gender was never identified as critical to successful health promotion and was not assessed in relation to other variables or health determinants. The exclusion of gender in these examples of health promotion frameworks has been identified as a blind spot in health promotion by critics who regard gender as one of the key determinants of health (Cohen, 1998; Daykin & Naidoo, 1995; Doyal, 1995; Keleher & Murphy, 2004). Women and men are different biologically—which calls for us to conduct sex-based research—but also in how they are able to act within the social structures that shape their lives and opportunities for health, that is, in terms of gender. Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risk, and in differential access to and utilization of health information, care and services. These differences, in turn have clear impact on health outcomes (World Health Organization, 2002b). For example, gender affects a person's access to, and control over, financial and physical resources, education and information and freedom of movement. Gender in turn intersects with and influences all other aspects and experiences in life, including the other determinants of health, such as employment or housing (Benoit & Shumka, 2009). If health promotion interventions are gender-blind or focus solely on the biological differences between women and men's health, then the factors that relate to enabling individuals and communities to achieve good health cannot be fully accounted for

(Eckman, Huntley, & Bhuyan, 2004). Health promotion that does not acknowledge the specific needs of women and men will not ultimately be able to promote health for all. Conversely, health promotion that does attend to sex and gender influences stands to produce more effective health promotion overall, and better health promotion for women specifically.

The evidence for health interventions to incorporate an understanding of sex and gender emerged initially in the fight against infectious diseases (Vlassoff & Bonilla, 1994) and has more recently begun to be considered relevant to chronic disease (Keleher, 2004). Less attention has been paid, however, to the dominant, lifestyle practices that are usually agreed to be significant risk factors for the development of chronic disease such as physical inactivity, unhealthful eating, and smoking. In Chapter 3, I present the findings of an overview of reviews of interventions related to fostering women's engagement in physical activity and reducing substance use to see whether there is evidence of a gender perspective in the reviews or the interventions.

CHAPTER THREE: AN OVERVIEW OF REVIEWS OF HEALTH BEHAVIOUR INTERVENTIONS FOR WOMEN

Differences in gender norms and roles may result in women and men having different health care needs, experiences, and outcomes, and engaging in different health-related behaviours or practices. In 2010, the World Health Organization proposed documenting “promising practices” in gender and health (World Health Organization, 2010b p. 1) because it recognized

that inequalities women face cannot effectively be transformed without addressing broader socio-cultural, economic and political factors [which] has resulted in a growing focus on the often unequal power relations between and among different groups of women and men and the ways in which gender norms, roles and relations differentially shape life chances and opportunities for women and men over the life course.

In this proposal, the WHO described gender as a structural determinant of health that is deeply contextual within and across societies such that efforts to address gender influences on health cannot be met with one-size-fits-all solutions. Promising practices were identified as health interventions, policies and systems designed to reduce gender-related health inequities and promote gender equity (Sen & Östlin, 2010) through explicit actions to address gender norms, roles, relations, and systems (Sen & Östlin, 2007). Common elements in interventions identified as promising practices included adopting a rights-based approach; being based on a gender assessment or research to identify local needs; promoting community participation and ownership; strengthening the health system; building knowledge of and capacity to address gender equality issues; ensuring the participation of men; building-in monitoring and evaluation indicators and processes; and including plans for replication and scale up (World Health Organization, 2010b p. 3). They further categorized

interventions as “gender blind” (those that ignore gender norms and relations in their design and application), “gender-sensitive” (those that consider gender norms, roles and relations but do not propose actions based on these), “gender- specific” (those that intentionally target men or women to achieve programmatic or policy goals) and “gender transformative” (those that address gender inequalities and incorporate strategies to foster change in relationships between men and women and promote empowerment) (World Health Organization, 2010b p. 3).

To date, gender-related health interventions have been undertaken in the fields of sexual, maternal, and reproductive health (Boender et al., 2004); infectious disease, including HIV/AIDS (Eckman et al., 2004; World Health Organization, 2009b), tuberculosis (Allotey & Gyapong, 2008), and malaria (Heggenhougen, Hackethal, & Vivek, 2003), among others (Periago, Fescina, & Ramón-Pardo, 2004); as well as to address gender-based violence (Dworkin et al., 2013; Nascimento et al., 2010) and adolescent health (Keeling & Dain, 2010), including mental health (World Health Organization, 2011b). With the increased recognition of the global burden associated with non-communicable and chronic diseases (World Health Organization, 2011c), international and local health agencies, researchers and policy makers have identified a number of health-related behaviours such as physical inactivity, tobacco smoking and drinking alcohol as major contributors to morbidity and mortality (World Health Organization, 2009a). However interventions to promote physical activity and reduce the harms of tobacco and alcohol use tend to ignore the potential contribution of sex and gender to health practices, and mainstream policy statements and health promotion frameworks have paid limited attention to date to sex and gender (Gelb et

al., 2011), despite the fact that they are recognized determinants of health (Public Health Agency of Canada, n.d.).

To encourage the inclusion of sex and gender considerations in health behaviour research, policy, and practice to improve women's health, we conducted an overview of reviews (V. Smith, Devane, Begley, & Clarke, 2011) of gender-sensitive interventions related to physical activity, smoking and drinking – practices generally identified as important for chronic disease prevention. For the purposes of this overview of reviews, we defined gender-sensitive interventions according to the established World Health Organization framework for gender-sensitive interventions (World Health Organization, 2010a), namely, that being gender-sensitive entails recognizing and raising awareness of the health effects of gender differentials and addressing the conditions through which sex and gender may affect health by how they interact to create conditions, exposures, or outcomes that are different for women and men or subpopulations of women and men.

Recently, O'Neill et al. (2014, p. 57) argued that “interventions need to be designed and implemented with an ‘equity lens’ to ensure that benefits reach the most hard-to-reach segments of the population and to avoid intervention-generated inequalities.” Earlier, Jepson, Harris, Platt & Tannahill (2010) assessed reviews of the effectiveness of interventions to change several health behaviours, including tobacco use, heavy alcohol use and physical activity, but reported that they were unable to determine for whom interventions were effective because they found limited evidence to help explain the links between these health behaviours and social and economic inequalities, including those associated with gender. These arguments informed our exploration of the extent of gender-responsiveness in selected aspects of health promotion practice.

This overview of reviews is the final step of a scoping review conducted to determine the extent and nature of the literature on gender-sensitive interventions to reduce women's alcohol and tobacco use, increase physical activity and reduce sedentary behaviour (M. L. Fang, Gerbrandt, Liwander, & Pederson, 2014). During the literature search for the scoping review, we identified a number of reviews in addition to primary research studies. Given the different methods required to conduct an overview of reviews, we conducted a separate analysis of the reviews and report the findings here. The purpose of this work is to broaden the discussion of “healthy living” by introducing the concept of gender-sensitive interventions and to develop an approach to conducting an overview of reviews that operationalizes some of the criteria of the WHO's ‘promising practices’ in gender and health.

Methods

The study design was informed by previous work on the value of a gendered approach to evidence reviews (Doull, Runnels, Tudiver, & Boscoe, 2010; Welch et al., 2013), policy (World Health Organization, 2007) and research (Johnson et al., 2009). Our study was also guided by Jepson et al.'s (2010) recommendation that future systematic reviews focus on demonstrating how the effectiveness of health behaviour interventions varies by social determinants of health such as gender. The design of this overview of reviews was informed by scoping review methods (Arksey & O'Malley, 2005; Davis, Drey, & Gould, 2009) and guidance on conducting reviews of reviews (V. Smith et al., 2011). A “review of reviews” or overview of reviews involves the same steps as other reviews, namely, identifying the study objective and research question, locating sources, selecting

reviews, conducting a quality assessment, summarizing the results of the assessment, and discussing potential implications for practice and research, but may or may not include meta-analysis or combining findings (V. Smith et al., 2011). Since we completed our study, a number of articles have been published employing the overview of reviews approach including Lorenc et al. (2013) and Martineau et al. (2013), which both tried to summarize large and diverse sets of reviews.

Research objectives

This study complements the scoping review undertaken previously to gauge the nature of the literature related to ‘gender-sensitive promising practices’ in healthy living (M. L. Fang et al., 2014). The study was designed to explore whether the fields of tobacco, alcohol, physical activity and sedentary behaviour interventions have begun to consider sex, gender, diversity and equity, and to what extent those have begun to influence health promotion interventions.

Search strategy

This overview of reviews examined systematic reviews as well as other types of reviews, including summaries of best practices and recommendations from various forms of evidence reviews. In addition to the databases, search engines and content-relevant websites that were searched initially for the scoping review, six other databases were searched for additional relevant reviews: (i) Cochrane Database of Systematic reviews; (Asikainen,

Kukkonen-Harjula, & Miilunpalo) Joanna Briggs; (iii) EBM Reviews; (iv) Centre for Reviews and Dissemination; (v) Database of Promoting Health Effectiveness Reviews and (vi) NICE Evidence Database for Health and Social Care. A detailed list of databases and websites can be found in Table 3.1.

A comprehensive search of review-specific databases was conducted to identify English-language peer-reviewed publications and reports that aimed to synthesize reviews of gender-sensitive interventions to address smoking, alcohol use, physical activity and sedentary behaviour among adult women published between 2001 and 2013. Combinations of keywords related to “women”, “gender”, “intervention” and “review” were entered into the review-specific databases and, where appropriate, in the ‘title’ and ‘abstract’ fields. (The term “sex” was not included because trial searches using the term produced vast literature related to sexual health which was not the intent of the study. We did not use a separate search term for “girl*” because in our experience, search engines included did not consistently use the term and, typically, items related to girls were located within the category of women.) We had consulted with a librarian and other researchers to develop the search terms for the scoping review, which we repeated in this study and used in additional databases. Grey literature searches were conducted by entering similar keywords into search engines, databases and content-relevant websites (see Table 3.1).

Table 3.1 Complete List of Sources Searched for Overview of Reviews

Databases, Search Engines and Content-Relevant Websites	N
<i>Academic</i>	6
Medline	
PsychINFO	
CINAHL	
Web of Science	
Sociological Abstracts	
Proquest	
<i>Review Specific</i>	6
Cochrane Database of Systematic Reviews	
Joanna Briggs	
EBM Reviews	
Centre for Reviews and Dissemination	
Database of Promoting Health Effectiveness Reviews (DoPHER)	
NICE Evidence Database for Health and Social Care	
<i>Specialized</i>	10
Ageline	
Alcohol Studies Database	
Bibliomap	
Alcohol and Alcohol Problems Science Database (ETOH)	
Trials Register of Promoting Health Interventions (TROPHI)	
Turning Research into Practice (TRIP)	
Smoking and Health Database	
Adolescent Health – PAHO/WHO (ADOLEC)	
University of York Health Technology Assessment Database	
University of Laval Knowledge Utilization Database	
<i>Grey (including Government and Non-Governmental Organizations)</i>	26
BC Government	
Crown Publications	
Grey Literature Report	
Canadian Women’s Health Network	
Health Canada	
Bandolier	
The World Bank – Gender and Development	
CDC Recommends: The Prevention Guidelines System	
Statistics Canada	
National Aboriginal Health Organization (NAHO)	
World Health Organization – Women’s Health	

Table 3.1 Complete List of Sources Searched for Overview of Reviews cont.

Ontario Women's Health Network
USAIDS
Women's Health Victoria
Women to Women
Healthy Women
YWCA Canada
International Women's Coalition
Women – Health and Social Services: Aboriginal Canada Portal
BC Centre of Excellence for Women's Health (BCCEWH)
Atlantic Centre of Excellence for Women's Health
Prairie Women's Health Centre of Excellence
WomensHealth.gov
UNAIDS
Inter Agency Gender Working Group
Google

Total 48

* Note that the current search only focused on review-specific databases. Other database and websites were searched during our previous scoping review, which captured some articles that were included for this review.

Study Selection

Review articles were included if they were: (i) published between 2001-2013; (ii) focused on changing alcohol use, tobacco use, physical activity and/or sedentary behaviour as the primary outcome; (iii) could be retrieved free-of-charge online or through university library services; and (iv) were written in English (see Figure 3.1). The first three topics were chosen because of their prominence as areas of health promotion practice whereas sedentary behaviour was identified as an emerging topic of concern for health promotion research, policy and practice, particularly for girls and women (Pederson, Haworth-Brockman, Clow, Isfeld, & Liwander, 2013).

Four specific criteria were then used to operationalize the definition of gender-sensitive health promotion interventions for subsequent review, building upon the WHO discussion document on ‘promising practices’ in gender and health (World Health Organization, 2010b). Although the WHO identified a longer list of features, for the purposes of our study we considered reviews to be potentially ‘gender-sensitive’ if they met at least one of these four criteria:

1. Aimed to improve girl’s and/or women’s health outcomes;
2. Incorporated an understanding of sex and/or gender;
3. Engaged with the social determinants of girls’ and/or women’s health; and/or
4. Sought to reduce gender-related social and health inequities.

To maintain consistency with our scoping review, these criteria were the same ones used in that study (which had excluded review papers). However, this overview of reviews expands the previous work, which explicitly excluded review papers.

For each topic area (tobacco, alcohol, physical activity and sedentary behaviour), two reviewers conducted a search using the search strategy and inclusion criteria. All results were checked by a third reviewer. Titles and abstracts were reviewed to evaluate the reviews' for relevance and whether they superficially met our inclusion criteria; included reviews were fully analyzed using standard coding procedures and charting forms. Inter-rater reliability was assessed for the full-text review. Kappa statistic was calculated for a random sample of 25% of the records that were rated independently by each researcher. The inter-rater agreement for the full-text review was 0.75. Discrepancies between the reviewers’ ratings were discussed until a consensus was reached.

Data extraction, analysis and quality assessment

We developed a coding form that included items from Downs and Black's Study Quality Appraisal Checklist (Downs & Black, 1998). Of the 27 items on their Checklist, we agreed that 12 were pertinent for this overview of reviews to ensure methodological quality. To assess gender-sensitivity in the reviews, our quality appraisal form was supplemented by items inspired by Doull et al. (2010) and the WHO framework for "gender-sensitive promising practices" (World Health Organization, 2010b). Six additional questions were incorporated into the data coding form:

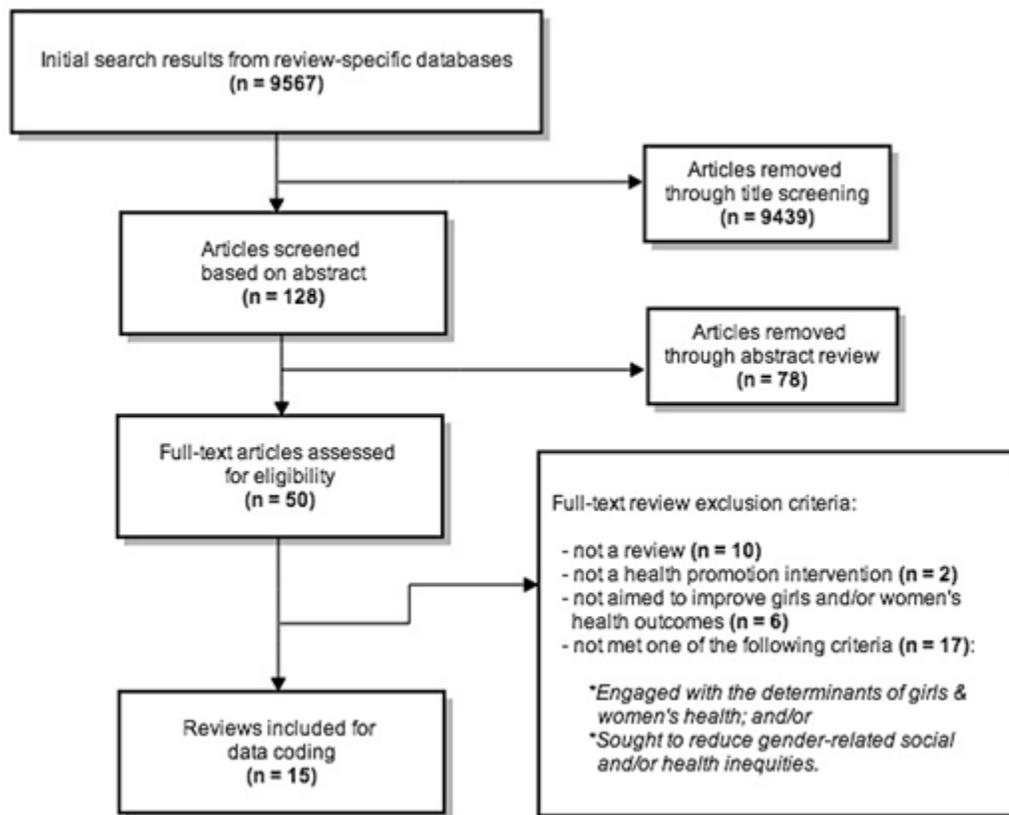
1. Did the review aim to improve girls' and women's health?
2. Did the review include gender-related terminology and language?
3. Were the terms "sex" and/or "gender" defined in the review?
4. Did the review engage with the determinants of girls' and women's health?
5. Did the review consider demographic diversity among women?
6. Did the review seek to reduce gender-related social and health inequities?

In the quality appraisal, a higher score (based on one point per item if it was present in the review) indicated better methodological quality. To distinguish between low- and high-quality studies, the midpoint score of 9 was used as a guideline. Two reviewers independently assessed the quality of the included reviews. Inter-rater agreement on the quality assessment resulted in a Kappa score of 0.798 across the included reviews. The two reviewers discussed any discrepancies in ratings until a consensus was reached.

During the coding process, we found that over half the reviews included for full review for the topic of alcohol were actually reviews of treatment programs and were outside the scope of the definition of health promotion (which is focused on prevention as opposed to treatment); they were therefore excluded from the study.

Figure 3.1 provides the breakdown of results according to different phases of the review-of-reviews search strategy to encapsulate gender-sensitive health promotion interventions.

Figure 3. 1 Review of Reviews Search Strategy



Results

We identified 15 reviews published from 2001-2013 that incorporated some elements of gender-sensitivity in our areas of interest, five each in relation to alcohol use, smoking and tobacco use, and physical activity. No reviews were identified that addressed sedentary behavior, perhaps reflecting that it is a relatively new area of research.

Data were synthesized descriptively by summarizing the material extracted in the charting forms. The reviews generally summarized interventions directed at individuals (e.g., through education, counseling, home visiting, incentives or motivational interviewing), though one review examined broader tobacco interventions including pricing, advertising bans and mass media. The results are reported by target population of interest and types of the interventions sorted by each of the four health-related behaviours, paying particular attention to whether the review focused on a specific population of women and girls, and why, as well as whether what types of interventions were reviewed (see Appendix A for this detailed presentation).

In what follows, I summarized the reviews first by the three health-related practices of interest, provide a synopsis of the quality assessment conducted, and then present the analysis of their gender-sensitivity.

Summary of Reviews by Health-related Behaviour

Alcohol Use

Of the five alcohol reviews that were included in this study, three examined the literature on pregnant women, women planning a pregnancy, and/or post-partum mothers, one looked at young, adolescent girls, and the other focused on both adult women and men. A wide range of interventions to reduce alcohol use were assessed in the reviews, from classroom management training for teachers (Blake, Amaro, Schwartz, & Flinchbaugh, 2001) to brief interventions provided by nutritionists (Nilsen, 2009) to counseling sessions or motivational interviewing (Stade et al., 2009). One review examined various permutations of home visiting as an intervention to support women with alcohol or drug use problems during pregnancy and after birth (Turnbull & Osborn, 2012). One review examined trends in reporting on alcohol use (Wilsnack & Wilsnack, 2002).

The gender-sensitive characteristics of these five reviews varied considerably. In some instances, issues of gender equity or women-specific issues were discussed in the background section of the review but not picked up in the review's research question, design or subsequent reporting (Turnbull & Osborn, 2012). For example, Turnbull and Osborn (2012) acknowledged the link between social disadvantage and substance use in pregnant women and mothers, as well as risks for domestic violence, child neglect or abuse and mother-child separation, yet did not pursue these aspects of context in their review.

The most extensive discussion of gender-sensitivity was taken up in the earliest of the publications which reviewed programs directed at substance use prevention in adolescent

girls (Blake et al., 2001). For example, they concluded that "Consistent with the extant research on risk factors and protective factors, and with theories posited to explain gender differences in risk behaviors ..., those interventions that were more effective with girls tended to focus on social skills training, social influences, and social norms" (Blake et al., 2001 p. 317). Another review looked at gender-specific interventions "focused on leadership development and was intended to instill a sense of power and control over an individuals' circumstances using a life skills approach. Training in leadership, decision making, assertiveness, and refusal skills was provided" (p. 314). However, this review was very small, consisting of only four girls-only, gender-specific interventions, so the results are suggestive at best. Indeed, none of the reviews which examined interventions to reduce alcohol use involved a large number of studies or offered solid direction regarding gender-sensitive interventions to prevent or reduce alcohol use.

Smoking and Tobacco Use

Three of the five reviews of tobacco interventions were concerned with interventions for pregnant or post-partum women (W. L. Fang et al., 2004; Greaves et al., 2003; Lumley et al., 2009), while one looked at women living in low- or middle-income countries, including pregnant and post-partum women (Oncken et al., 2010), and the other was a systematic review of interventions directed at women in general that specifically excluded interventions targeting pregnant or post-partum women (Torchalla et al., 2012). This focus on pregnant and post-partum women in both the primary studies and reviews reflects continuing concern with the teratogenic effects of smoking on fetal and infant development (Oncken et al., 2010),

though there was also some evidence of a concern with understanding relapse prevention as a women's health issue rather than only a child health issue (Greaves et al., 2003).

Interventions reviewed in these studies were diverse, though there was a preponderance of psychological and educational interventions. In addition to providing knowledge and skills about smoking cessation, programs also incorporated social supports through buddy systems (see (Greaves et al., 2003)), involvement of a woman's social network, particularly her partner, in programming (M. L. Fang et al., 2014; Greaves et al., 2003) , and telephone or mail support (Torchalla et al., 2012). Lumley et al. (2009) suggest that promoting smoking cessation during pregnancy requires multiple, intense interventions involving cognitive behavioural therapy, motivational interviewing, feedback, incentives, and pharmacological therapy. Some reviews called for cultural adaptations of intervention materials (W. L. Fang et al., 2004; Torchalla et al., 2012) while others proposed that interventions be tailored to sub-groups of women, including: disadvantaged women (Torchalla et al., 2012); women in low- and middle-income countries (Oncken et al., 2010); as well as "sub-populations of pregnant smokers in particular, such as ethnic minority women, spontaneous quitters, Aboriginal women, heavy smokers and teenaged girls" (Greaves et al., 2003).

Physical Inactivity

The five reviews that examined interventions to promote physical activity targeted women with diverse demographics; populations of interest included early post-menopausal women (Asikainen et al., 2004), adult African American women (Banks-Wallace & Conn,

2002), adult Hispanic women (Perez, Fleury, & Keller, 2010), mothers with young children (Hartman, Hosper, & Stronks, 2011) and socioeconomically disadvantaged women (Cleland, Granados, Crawford, Winzenberg, & Ball, 2013). Interventions were also varied, including an assessment of various walking-based programs (Asikainen et al., 2004), culturally-appropriate forms of recreation and dance (Banks-Wallace & Conn, 2002; Perez et al., 2010) and “mother-specific” interventions in multiple settings (Hartman et al., 2011).

All the studies noted that women consistently identified lack of time, a concern for their safety, and other responsibilities as barriers to participation in physical activity. They also generally reviewed interventions to enhance leisure-time physical activity, a practice criticized for not reflecting accurately women’s preferences and opportunities for physical activity (Pederson, Haworth-Brockman, Clow, Isfeld, et al., 2013).

Perez et al. (Perez et al., 2010) reported that among adult Hispanic women, socioeconomic and cultural factors are both important predictors of physical activity participation, and physical activity of women who are poor is influenced by neighbourhood safety: "Women who live in neighborhoods and situations that preclude outdoor physical activity owing to safety, disrepair, or neighborhoods without sidewalks and parks are likely to walk outdoors less" (p. p. 357). Another review focused on socioeconomically disadvantaged women (Cleland et al., 2013), concluded that "Programs with a group delivery mode significantly increase physical activity among women experiencing disadvantage, and group delivery should be considered an essential element of physical activity programs targeting this population group" (p. 197). They noted that "The type of formats in studies that incorporated a group component generally consisted of group education meetings, practical sessions, or a combination of both, facilitated by a trained educator, health worker or

practitioner" (p. 208). These reviewers speculated that the value of group-based interventions lies in "social support" which includes instrumental support (e.g., transportation), informational (e.g., sharing of education materials), affective/emotional (e.g., inquiring on how a program is going) and appraisal (e.g., encouragement). They reported that this finding is consistent with other research, particularly for women.

Quality Assessment

Table 3.2 summarizes the quality assessment we conducted, also grouped according to topic area. Quality assessment included assessing whether the review reported the research question; databases searched; search strategy; consultation with experts; following up references in bibliographies; incorporated grey literature; involved more than one reviewer; and specified explicit inclusion and exclusion criteria. Using these criteria, we determined that most of the reviews were of medium or high quality, with those in the physical activity area receiving the highest quality assessments.

This table also indicates the quality of reviews using criteria based upon our assessment of the gender-sensitivity of the reviews. Based on these two quality assessment tools, nine of the 15 reviews met the criteria for being high quality reviews but only four were identified as gender-sensitive reviews. In relation to topic, no high quality gender-sensitive reviews in physical activity were identified though two high-quality, gender-sensitive reviews were found in each of the sets of alcohol and tobacco reviews. A detailed discussion of the gender-sensitivity assessment follows.

Table 3.2 Summary of Quality Assessment

Health Behaviour	No. High quality reviews	No. Med quality reviews	No. Low quality reviews	No. high quality gender-sensitive reviews
Alcohol Use	2	1	2	2
Smoking Tobacco	3	2	0	2
Physical Activity	4	1	0	0

Assessing Gender-sensitivity

To assess the gender-sensitivity of the reviews, we synthesized the findings of the reviews using the six questions noted earlier as dimensions of gender-sensitive health promotion interventions (based on the WHO framework). These criteria provided concrete ways to identify gender-sensitivity by documenting the reviews' aims and the reviewers' use of terms, consideration of the determinants of health, and pursuit of gender equity. Table 3.4 summarizes the results of this assessment in relation to the six questions, rather than by health behaviour, indicating how many reviews met each criteria, how many of those scored above 3 in our gender-sensitivity assessment, and which topics they addressed. Examples are provided to illustrate how the reviews were scored on these criteria.

Table 3.3 Summary of the reviews with respect to gender-sensitivity criteria

Gender-sensitive Characteristic	No. of Reviews	No. with gender score > 3	No. Health Topics	Health Topics	Examples
1. Aimed to Improve Girls and Women's Health Outcomes	15	3	3	All	As this was an inclusion criterion, all 15 reviews examined efforts to improve girls' and women's health outcomes.
2. Used Gender-related Terminology	6	5	3	All	(i) Promoting the use of gender-related concepts (Wisnack et al., 2002) (ii) Use of terms such as 'gender-based responsibilities' (Banks, Wallace & Conn, 2008)
3. Sex and/or Gender Defined in the Article	2	3	2	alcohol, tobacco	(i) Discussed the underlying biological differences between males and females that would lead one to expect different responses to exercise (Asaikainen et al., 2004) (ii) Commented on the lack of discussions of gender in published studies of substance use and identified gender-sensitive elements within some of the interventions (Blake, 2001).
4. Engaged with Determinants of Girls and Women's Health	13	8	3	All	(i) Identified aspects of social location and/or identity as relevant to health-related behaviours (Lumley et al. 1009; Cleland et al., 2012; Banks, Wallace & Conn, 2008; Turnbull et al., 2013) (ii) Gender made visible through discussions of the stigma associated with substance use among pregnant women and mothers (Stade et al., 2009)
5. Considered Demographic Diversity	11	7	3	All	(i) Emphasized the importance of cultural relevance (Banks, Wallace & Conn, 2008; Perez et al., 2010)
6. Sought to Reduce Gender-Related Social and Health Inequities	10	5	3	All	(i) Directed at women and girls living in situations of social or economic disadvantage (Cleland et al., 2012; Turnbull et al., 2013)

Did the review aim to improve girls' and women's health?

All 15 reviews examined interventions intended to improve girls' and women's health by reducing their use of alcohol or tobacco or increasing their participation in physical activity. As previously described, the reviews were diverse with respect to target population though there was a focus in the substance use reviews on studies of women who were pregnant or planning to become pregnant while the reviews of physical activity interventions targeted various sub-populations of women, including low-income or ethnic minority women. In all cases, the studies were justified on the basis of how changes in health behaviour would lead to long-term health improvements in women's health.

Did the review include gender-related terminology and language?

Six reviews incorporated gender-related terminology. For example, Banks-Wallace and Conn (2002) referred to 'gender-based responsibilities' but did not elaborate on what comprised such activities nor how they were significant in relation to the research question they were assessing. Similarly, Blake et al. (2001) referred to 'gender-specific interventions' without defining them, and Wilsnack & Wilsnack (2002) mentioned gender differences, gender norms and structures, and discussed the gendered social implications of variations in the stigmatization of drinking in different groups of women.

Other reviews included gender-related terms and concepts in the background or discussion sections of the review write-up but did not incorporate gender in any other way into the review design, analysis or reporting (Asikainen et al., 2004; Banks-Wallace & Conn,

2002; Cleland et al., 2013; Hartman et al., 2011; Perez et al., 2010) . For example, Perez, Fleury and Keller (2010) identified ‘gender factors’ as an influence on Hispanic women’s health promotion practices but did not develop this theme except to say that addressing weight concerns to encourage physical activity participation might be appropriate with Hispanic women. Wilsnack & Wilsnack (2002 p. 249) actually called for gender-sensitive measures and research but did not themselves undertake such analysis:

It is important to improve the culture- and gender-sensitivity of measures of alcohol use and alcohol problems. Cross-national research can help to explicate the complex interactions of biology and other individual- and societal-level variables that influence the drinking behaviour of women and men.

Indeed, these reviewers were among the only ones to suggest that gender be used as a comparator in the development of indicators and measures of health behaviour (specifically with regard to drinking).

Were the terms “sex” and/or “gender” defined in the review?

This question is closely related to the one above regarding the use of gender terminology but refers specifically to distinguishing between biological and social factors in health research and interventions. Greaves et al. (2003) and Torchalla et al. (2012) were the only reviewers to explicitly define ‘sex’ and ‘gender’ in their review, though other reviews used the terms without defining them (e.g., Asikainen et al., 2004; Banks-Wallace & Conn, 2002). And as noted above, several reviews also incorporated a discussion of sex and/or gender in the background section of their study (Asikainen et al., 2004; Cleland et al., 2013;

Perez et al., 2010) but few returned to this aspect of the topic in their actual review, findings, or discussion.

In reviews of smoking cessation interventions for women, including pregnant women, the reviewers paid greater attention to how sex and gender contribute to smoking initiation and what interventions might incorporate this knowledge. For example, Torchalla et al. (2012), reviewing women-specific smoking cessation programs, identified interventions that addressed women's weight concerns, taught mood and stress management, and scheduled quit dates timed to the menstrual cycle –all examples of interventions addressing both physiological and social aspects of smoking cessation.

Did the review engage with the determinants of girls' and women's health?

Similarly, to varying degrees, 13 of the 15 reviews dealt with the determinants of girls' and women's health, though usually only with respect to health-related behaviours rather than more structural factors such as women's rights, economic status, or access to benefits. However, a few reviews identified aspects of social location and/or identity as relevant to health-related behaviours, particularly social disadvantage or marginalization. Lumley et al. (2009), for example, noted that in high-income countries, "smoking has become closely correlated with entrenched social disadvantage and psychological co-morbidity" (p. 20). Banks-Wallace & Conn (2002) and Cleland et al. (2013) specifically examined how culture (i.e., African American) and socioeconomic disadvantage respectively related to engagement in physical activity programs while Turnbull and Osborn (2012), who assessed the effectiveness of home visiting programs to address alcohol or drug problems

among pregnant women and mothers, noted that substance-using women tend to be socially disadvantaged.

Gender was also made visible in these reviews was through discussions of the stigma associated with substance use among pregnant women and mothers. Stade et al. (2009), for example, recognized that "consuming alcohol in pregnancy is a socially stigmatized activity in many cultures..." (p. 10), though they did not delve into the origins of that stigma nor its sex- and/or gender-specific features.

Did the review consider diversity among girls and women?

As already noted, many of the reviews were designed to examine health behaviour interventions directed at specific groups of women and/or girls while others defined the population of interest as girls and women as a whole. Reviewers were more likely to identify the potential for differences in outcomes among various groups of girls and women than to report studies that had examined those differences. And a few reviews justified their focus on a particular sub-group of women or girls on the basis of documented disparities in health outcomes.

A number of reviews touched on the importance of cultural relevance in intervention design and implementation. For example, Banks-Wallace et al. (2002) noted that "culturally determined gender-based responsibilities are the primary personal barriers to PA." Similarly, Perez et al. (2010) focused their review on promoting physical activity participation among Hispanic women and commented that "gender, racial, and ethnic factors play an important role in health promotion behaviors of Hispanic women" and that most physical activity

interventions have reached "primarily nonminority, middle-income women and men" (pp. 342-3).

Did the review seek to reduce gender-related social and health inequities?

Two-thirds (10 out of 15) of the reviews sought to reduce gender-related social and health inequities, primarily by targeted vulnerable subpopulations of women to improve their health outcomes relative to more advantaged women. Two reviews were directed at women and girls living in situations of social or economic disadvantage (Cleland et al., 2013; Turnbull & Osborn, 2012). Other reviews targeted specific sub-populations of women, including racialized women (Hispanic and African American), young adolescent girls, and women in low- and middle-income countries. However, women who were planning a pregnancy, pregnant, in the post-partum period or mothers were most often the subject of the review.

Asaikainen et al. (2004) discussed the underlying biological differences between males and females that would lead one to expect different responses to exercise in their rationale for reviewing studies of exercise with early post-menopausal women. They then suggested that the studies they reviewed showed that women at this life stage show improvements in physiological parameters following exercise. In their discussion, however, they did not draw a connection between their suggestion that some forms of exercise are more feasible and acceptable than others without considering what accounts for those variations.

Other reviews generated findings and recommendations consistent with a gender-responsive approach but failed to use any gender-related terminology. In their review of successful postpartum smoking relapse prevention interventions, Fang et al. (2004) noted that interventions which addressed women in context by, for example, considering the smoking habits of partners, others living in the home, and close friends were more effective than those which did not. They also identified that interventions which “understand the time and financial commitment successful cessation interventions require” are more likely to be effective. These suggestions for effective interventions position women’s smoking in social context and reflect an implicit awareness of gender, yet the review did not engage deeply with these ideas.

Blake et al. (2001) were the one exception in this group; not only did they comment on the lack of discussions of gender in published studies of substance use, they identified gender-sensitive elements within some of the interventions. For example, one "gender-specific intervention focused on leadership development and was intended to instill a sense of power and control over an individuals' circumstances using a life skills approach. Training in leadership, decision making, assertiveness, and refusal skills was provided" (p. 314). These approaches are examples of gender-specific empowerment development and the reviewers’ focus on these aspects of interventions was unique among the reviews we assessed.

Discussion

This overview of reviews provides assessed reviews of interventions designed to reduce smoking and tobacco use, reduce drinking alcohol, and enhance physical activity among women to determine not only if the interventions were effective but whether they reflected an awareness of gender as an influence on women's health practices. Inspired by a proposed framework for 'promising practices in gender and health' from the WHO, reviews were characterized as gender-sensitive if they identified improving the health of girls and women as an explicit aim; employed concepts and terminology related to gender, including defining the term itself; engaged with the determinants of girls' and women's health such as income, age, and geography; sought to reduce gender-related social and health inequities; and considered diversity among girls and women.

Using these criteria, several reviews were identified as having gender-sensitivity but only two review had been designed to be so in the first place. However, the ways in which these reviews qualified as gender-sensitive were quite limited and in most cases, the reviewers themselves did not interpret their review as engaging with issues of sex and gender. Aside from aspects of culture or ethnicity, none of the reviews examined what features of women's lives contributed to the health behaviour of interest.

Most of the reviews reported on interventions targeting individual women through efforts to change health-related knowledge, motivation, and skills. Women were offered various forms of counseling and some form of social support, such as peer-mentoring, follow-up phone or mail communications, home visiting, or professional assessments. One of the physical activity reviews identified group delivery as the key to successful behaviour

change, suggesting that this may be a fruitful approach to explore further. Similarly, other reviews tended to recommend individual, gender-blind suggestions for improving women's health-related practices. For example, Cleland et al. (2013) suggested that as many women report lack of time as a barrier to engaging in physical activity, perhaps time management should be taught as part of physical activity programs. But the authors do not discuss whether teaching individual women time management skills will address the persistent barrier of lack of time that women consistently report to account for their low participation in leisure-time physical activity. A breakthrough in the physical activity/sedentary behaviour field is likely to arise from re-conceptualizing women's physical activity participation and measurement, such as through accelerometer studies of women over the course of the day, first to understand how women truly spend their time, and then to identify workable strategies for increasing physical activity (Pate, O'Neill, & Lobelo, 2008).

Notably, none of the reviews incorporated any analysis related to addressing gender-related social and health inequities except insofar as some of the reviews (and hence primary studies) examined the effectiveness of interventions for low-income or socially-marginalized girls and/or women. Addressing low-income itself as a barrier to participation, though not a conventional exercise science approach, may prove essential to increasing physical activity, for example. Similarly, since pricing is known to reduce tobacco consumption, it may have particular utility as a strategy to reduce smoking among girls and women—though there are suggestions that some women skimp on household food in order to continue to purchase cigarettes (Samet & Yoon, 2010; World Health Organization, 2007).

Most of the reviews captured interventions targeting individual women through efforts to change health-related knowledge, motivation, and skills. Women were offered

various forms of counseling and some form of social support, such as peer-mentoring, follow-up phone or mail communications, home visiting, or professional assessments. One of the physical activity reviews identified group delivery as the key to successful behaviour change, suggesting that this may be a fruitful approach to explore further. But aside from aspects of culture or ethnicity, none of the reviews examined what features of women's lives contributed to the health behaviour of interest.

For example, despite the preponderance in these reviews of individual-level interventions to motivate women to be physically active, the health promotion field as a whole has embraced the importance of enhancing opportunities for physical activity through changes to the built environment and, for women and girls, fostering social environments that are neither sexist nor homophobic and in which women and girls feel safe to learn, use their bodies, and develop confidence and skills (Pederson, Haworth-Brockman, Clow, Isfeld, et al., 2013). Innovations such as trauma-informed yoga (www.yogaoutreach.ca), a soccer league for homeless women (www.vancouverstreetsoccer.com) and the Everyone Wins Program sponsored by the Victorian Health Promotion Foundation in Australia (http://www.vichealth.vic.gov.au/Publications/Physical-Activity/Sport-and-recreation/Everyone-Wins_SSAs.aspx) are not even captured in the formal health promotion literature at this time and hence were not captured by the search processes used in this overview of reviews.

Limitations

This study had a number of limitations including the limits of searching, publication biases, and the place of grey literature in such assessments. While this overview of reviews

included grey literature, programs that are not well-documented or fully evaluated are unlikely to be captured by traditional database searches or systematic reviews. With respect to the continuum of gender-responsive interventions, the assessment criteria, which were linked to the WHO framework on ‘promising practices’, were possibly not as rigorous as the formal definition. This assessment might lead one to suggest that reviews were more gender-sensitive than perhaps they really were. Indeed, most of the reviews were centered on individual health behaviour changes rather than targeting structural and or systemic changes—which may be the very things that are required to enhance gender equity. Another the reviews were initially screened on the basis of their abstracts therefore there might have been other reviews in the initial set that undertook aspects of gender-sensitive analysis that may have been missed.

Overviews of reviews also have inherent limitations. By relying on the summarizing done by other reviewers, they are further removed than desirable from the primary data. In our case, the paucity of reviews presents a challenge for knowledge synthesis, as does the heterogeneity of the interventions; we must be cautious about drawing conclusions across the topic areas. The inclusion criteria may also have been too narrow, for example, all reviews had to be in English. Further, culturally-tailored interventions were not the primary focus of this overview of reviews. As such, there may have been many culturally-sensitive health promotion interventions that also embodied gender-sensitive characteristics that were not identified by our search strategy or data extraction. The development and implementation of a review strategy to capture culturally-sensitive health promotion interventions that consider the impact of gender on health would be a valuable future study. Finally, to be consistent with the scoping review (M. L. Fang et al., 2014), the specific approach to the concept of

health promotion excluded some studies that, while gender-sensitive, might rightly be understood as treatment interventions rather than health promotion practices. For future studies, we recommend the use of additional search criteria that are better suited to identifying interventions designed to prevent or reduce the harms associated with alcohol use, particularly those associated with fetal alcohol spectrum disorder, an area where there is considerable work focused on women and girls (Gelb & Rutman, 2011).

This leads to a challenge that affects all reviews: the limits of searching, publication biases, and the place of grey literature in such assessments. While our overview of reviews included grey literature, programs that are not well-documented or fully evaluated are unlikely to be captured by traditional database searches or systematic reviews. Yet programmers and policy makers need to be aware of such developments if innovations are to be scaled up or adapted from one context to another. As researchers, we need to be engaged with innovation that is underway in the community and how it challenges current ways of understanding, for example, physical activity interventions.

Notably, none of the reviews incorporated any analysis related to addressing gender-related social and health inequities except insofar as some of the reviews (and hence primary studies) examined the effectiveness of interventions for low-income or socially-marginalized girls and/or women. This finding suggests that there has been little uptake of this aspect of gender-responsiveness within the substance use and physical activity fields to date.

An interesting finding from this overview of reviews was the identification of a handful of articles in the early stages of the project that examined current policy initiatives to promote gender equity and/or integrate gender-sensitive health promotion interventions for tobacco and alcohol. However, these materials were ultimately excluded because they did not

actually constitute reviews. This introduces the challenge of having clear definitions and parameters when undertaking any sort of review and how to incorporate these forms of evidence.

This study had a number of other limitations. With respect to the continuum of gender-responsive interventions, our assessment criteria, which were linked to the WHO framework on ‘promising practices’, were possibly not as rigorous as the formal definition. That is, our assessment, which reduced the promising practices to four criteria, may actually suggest that the reviews were more gender-sensitive than perhaps they really were. Another limitation of this study is that we initially screened the reviews on the basis of their abstracts; there might have been other reviews in our initial findings that undertook aspects of gender-sensitive analysis that were missed using this approach. Overviews of reviews also have particular inherent limitations. By relying on the summarizing done by other reviewers, they are further removed than perhaps is desirable from the primary data and a close view of study interventions. In our case, the paucity of reviews presents a challenge for knowledge synthesis, as does the heterogeneity of the interventions included in each review. Moreover, we must be extremely cautious about drawing conclusions across the topic areas.

Conclusions

A review of reviews can help to summarize a vast body of literature and identify gaps in the field for future research. This overview of reviews offers direction for both primary studies and reviews of reviews. First, there are likely few gender-sensitive reviews because awareness of gender is limited in most interventions to reduce women’s substance use and

increase their physical activity. Until there is a larger body of research generated that explicitly attends to how gender norms, roles and relations contribute to health practices, it is unlikely that reviewers will be looking to synthesize the literature to examine the features of gender-responsive interventions. Second, there are not yet agreed-upon criteria for assessing gender-sensitivity to permit reviewers to consistently assess the quality of interventions and reviews of interventions, though the WHO (World Health Organization, 2010b) has generated an initial set for identifying ‘promising practices’ in gender and health. The work of the Cochrane Sex/Gender Methods Group offers some hope that this situation will improve (Doull et al., 2010; Runnels, Tudiver, Doull, & Boscoe, 2014).

At present, the grey literature may be a better source than the academic literature for identifying gender-sensitive interventions, suggesting that more attention is needed in research to studying grassroots and community-based programming. However, program evaluations will need to be explicit about assessing the gender-related features of interventions if they are to be useful for assessing gender-responsiveness. Sex and gender need to be examined as features of the context, content and outcomes of health behaviour interventions in order to better understand their contribution to women’s health-related practices, the barriers and facilitators of health practices, and the promotion of equity.

Finally, adopting gender-responsive approaches may also help to make it more difficult for health promotion interventions to be limited to narrow behavioural goals. Instead, health promotion interventions will need to consider ‘empowerment’ explicitly, at the individual, organizational and collective levels. As such, gender-responsive interventions are more likely to be consistent with the *Ottawa Charter* (World Health Organization, 1986)

definition of health promotion as the process of enabling people to increase control over and improve their health.

CHAPTER 4: ENVISIONING A FRAMEWORK FOR GENDER-TRANSFORMATIVE HEALTH PROMOTION FOR WOMEN⁶

To this point in this dissertation I have argued that many regard gender inequity as a pervasive global challenge to health equity (e.g., Moss, 2002). In 2000, Geeta Rao Gupta, then-president of the International Centre for Research on Women based in Washington, DC, translated this challenge for practitioners during a speech at the XIIIth International AIDS conference in Durban, South Africa:

To effectively address the intersection between HIV/AIDS and gender and sexuality requires that interventions should, at the very least, not reinforce damaging gender and sexual stereotypes. Many of our past and, unfortunately, some of our current efforts, have fostered a predatory, violent, irresponsible image of male sexuality and portrayed women as powerless victims or as repositories of infection.....Any gains achieved by such efforts in the short-term are unlikely to be sustainable because they erode the very foundation on which AIDS prevention is based—responsible, respectful, consensual, and mutually satisfying sex (Gupta, 2000, pp. 8-9).

Building on earlier work examining HIV interventions (e.g., Gupta & Weiss, 1993), Gupta argued in her speech that those offering prevention, diagnostic and treatment programs for HIV/AIDS needed to confront whether and how their efforts exploited, accommodated or transformed the gender norms, roles and relations that put men and women at risk for contracting HIV, infecting others, and/or seeking diagnostic or treatment services.

In Chapter 2, I briefly outlined some of the critiques that had been advanced regarding the neglect of gender considerations in health promotion, particularly for women (Daykin & Naidoo, 1995; Keleher, 2004; Östlin et al., 2006; Thurston & O'Connor, 1996)

⁶ Earlier versions of this chapter appeared as Pederson, Greaves & Poole (2014) and Pederson, Poole, Greaves, Gerbrandt, & Fang, (2014).

and introduced the WHO continuum of action on gender and health. I illustrated this critique with the findings of a review of prominent Canadian and international health promotion frameworks. In Chapter 3, I took up the challenge raised by this critique to examine the extent to which health promotion interventions—not just the conceptual frameworks discussed earlier—reflect gender considerations. A scoping review and overview of reviews suggest that there are few examples of gender-sensitive interventions to reduce smoking or alcohol use or increase physical activity among women in the published literature. I noted that we do see examples of such interventions in the international grey and practice-oriented literature, particularly—as per Gupta’s remarks above—in relation to efforts to address HIV/AIDS (e.g., Eckman et al., 2004), other aspects of sexual and reproductive health (e.g., Boender et al., 2004), and gender-based violence (e.g., Barker et al., 2007; Barker, Ricardo, Nascimento, Olukoya, & Santos, 2010; Nascimento et al., 2010; Usdin et al., 2005). However, despite the call for greater attention to gender in health promotion put forward by international leaders (e.g., Keleher, 2004; Sen & Östlin, 2007), to date we have not seen tremendous engagement with these issues in the mainstream health promotion literature.

In this chapter, I introduce a framework to inform gender-responsive health promotion, drawing from published literature and a consultation I helped conduct in 2011-2013 as a member of the Promoting Health in Women CIHR Team in Sex, Gender and Health Promotion. I illustrate the core of the framework with examples from cardiovascular disease prevention and suggest some of the promise of this approach for improving women’s health and fostering gender equity. The name of the Promoting Health in Women team, PhiWomen, was consciously chosen because of its association with the Golden Ratio, which is found in mathematics, art and science. Phi is understood to stand for universal harmony,

creativity and balance. The aim of the PhiWomen team was to generate a new approach to health promotion that would improve its capacity to support women's rights and improve women's health.

Expanding the remit of health promotion practice to encompass gender transformation means that health promoters will need to embrace a view of health that incorporates what Sir Michael Marmot and others have called the "causes of the causes", recognizing sex and gender as fundamental determinants of health and interrogating the links between sex, gender and other determinants of health such as income, education, occupation and the social and built environments. Only with a full recognition of the significance of sex and gender as determinants of health can health promotion contribute to more than minor changes in health outcomes; indeed, it may even exacerbate health inequities (World Health Organization, 2010c).

The Need for a Gender-Transformative Framework for Health Promotion

Health promotion, particularly through social marketing and awareness-raising efforts, has depicted women and appealed to women over the years in ways that can be understood as gender-blind, gender-exploitative, and gender-accommodating. For example, tobacco health education campaigns, such as a 1972 poster by the American Cancer Society have used phrases such as "smoking is very glamorous" overlaid on the face of an aging, 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 signs of aging and wrinkles (see

<http://collections.vam.ac.uk/item/O76205/smoking-is-very-glamorous-poster-american-cancer-society/>). Recent work indicates that the appeal to attractiveness remains a theme in health promotion literature on reducing tobacco use (Grogan, Fry, Gough, & Conner, 2009), however, it appears that young women (and men) are less concerned about skin aging than about looking mature, ‘cool,’ and managing their weight—suggesting that health education campaigns focused on facial attractiveness continue to exploit such socially manufactured aspirations while not necessarily emphasizing what young people consider important.

As another example, health promotion efforts during pregnancy—a time when many women are interested in optimizing their health and health professionals are anxious to ensure the health of mothers—sometimes exacerbate rather than ameliorate women’s stress by adopting messages that are shaming and blaming (for example, many of the messages and approaches used with respect to alcohol or tobacco use during pregnancy) rather than messages supportive of both women’s and foetal health (Greaves & Poole, 2005). A recent variation of such messaging (www.fasdworld.com) 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”. 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). Campaigns and interventions that chastise women for substance use during pregnancy rather than support them through strategies for managing stress, accessing good nutrition and increased social support may increase the likelihood that women avoid health care fearing how they will be treated, rather than seek the support that non-judgmental, gender-informed health care providers might offer (Nathoo et al., 2013).

And despite the attention paid to tobacco control over the past 40 years, gender has rarely been incorporated into its activities in a meaningful way (Amos, Greaves, Nichter, & Bloch, 2012). Indeed, there are numerous examples of exploiting gender or accommodating gender in harmful or stereotyped ways, especially with respect to women and girls, such as an 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 indeed, has a stellar history of changing gender norms with respect to smoking (Amos & Haglund, 2000; Greaves, 1996, 2014; Tinkler, 2006). Some health promotion efforts use shame to stigmatize pregnant women who smoke such as a 1973 poster from the UK's Health Education Council with the caption, "Is it fair to force your baby to smoke cigarettes?" (Berridge, 2013). Practices such as these help to perpetuate gender and health inequities rather than diminish them. Despite the fact that tobacco control persists in using gender-blind strategies (Amos et al., 2012), its comprehensive, multi-pronged approach is often touted as the most successful example of health promotion to date and as held up as a set of practices to emulate (e.g., Wen & Wu, 2012). Significantly, "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). (These kinds of illustrations, with accompanying visuals such as the videos or images of the posters, were used in presentations to initiate discussion of the need for a framework and to support aspects of the consultation process used to develop the framework.)

In contrast, there are emerging examples of social marketing and health education efforts which embrace gender-transformative principles, that is, they seek to shift gender

roles and relations toward gender-equity (Rottach et al., 2009) and engage with issues of gender in conceptualizing, analyzing, and responding to the issue (e.g., World Health Organization, 2011a; World Health Organization, 2011b). Scholars investigating issues of pregnancy and smoking, for example, produced a guide for couples that incorporated gender relations (Bottorff et al., 2006). Instead of focusing strictly on the pregnant woman as the target for smoking cessation, their research and knowledge translation initiatives directed attention to couple dynamics in relation to tobacco use to help foster understanding of both the possibilities and limits for change in their smoking practices (see <http://facet.ubc.ca/wp-content/files/Couples-and-Smoking.pdf>).

In another instance, an online campaign emerged to resist gender stereotypes and weight-bullying. This campaign was a response to a fat-shaming campaign in the state of Georgia in the United States directed at overweight and obese children (Pausé, 2014). The state ads featured, for example, a photo of a large young girl with the phrase ‘WARNING’ across the bottom of the image and a statement about child obesity such as ‘It’s hard to be a little girl when you’re not’. A counter-campaign emerged, led by Marilyn Wann, in which she revamped the images and messages:

Wann invited individuals to submit a phot of themselves and their position (a statement about what they ‘stand for’ in relation to weight/stigma/health), which were then made into a poster for the I stand campaign....The first poster, featuring Marilyn Wann, read ‘I STAND against harming fat children. Hate /= health’ (Pausé, 2014p. 77).

This campaign has proven to be very dynamic, with dozens of images of smiling, large individuals, mostly but not exclusively women, challenging the negativity, hostility and gendered nature of the original public health campaign (see, for example,

<https://www.google.ca/search?q=I+stand+campaign&biw=1474&bih=859&source=lnms&tbn=isch&sa=X&ved=0ahUKEWijqfLE8qTJAhUQ82MKHcLEA->

[MQ_AUIBygB](#)). Though controversial among some because they challenge official orthodoxies about weight and health, these ads offer distinctly different representations of people, bodies, and what constitutes health than is typical in most health promotion campaigns.

Aa third example comes from the field of HIV/AIDS, one of the domains in which I have seen the greatest use of gender-transformative approaches. As the HIV epidemic developed, recognition grew of the ways that it was fueled by gender stereotypes and gender inequalities (Gupta, 2000a, 2000b). For example, an educational ‘course pack’ produced by the Norwegian Working Group on HIV/AIDS and Gender in 2001 outlined that the risks for HIV/AIDS were gender-specific, that the effects of HIV infection were gender-specific, and that living with HIV was gender-specific (see <http://umich.edu/~spp638/Coursepack/tar-gender.pdf>). Among their recommendations, they suggested responding to this reality with efforts to empower women socially, economically, culturally, politically and sexually (see p. 24). The material also encouraged addressing men’s and boys’ attitudes toward women and girls, sexual behaviour, and reproductive choice. These initiatives would all contribute to transforming gender relations and in so doing, alter the risks, effects and consequences of HIV infection. Programs adopting this form of gender-responsive approach have been developed and evaluated, with promising results for improving positive enhancements in men’s and boys’ attitudes toward women and girls (Barker et al., 2007). Other programs have started to adapt this thinking to

preventing or reducing gender-based violence (Dworkin, Dunbar, Krishnan, Hatcher, & Sawires, 2011; Falb, Annan, & Gupta, 2015).

Much of the discourse and discussion of gender-responsiveness has occurred to date in the developing world, under the auspices of the WHO. Yet, given the need for and emerging evidence of the possibilities for gender-transformative health initiatives, our team sought to examine how to reconcile this form of thinking with the gap we had documented in gender considerations in the field of health promotion.

Developing a Framework for Gender-transformative Health Promotion

Consistent with *Ottawa Charter* principles of health promotion, the consultation strategy—as a method—embodied the tenets and assumptions of empowerment as a means of eliciting contributions from a wide range of individuals, including women, students, academics, community researchers, policy makers and health practitioners. Working with an expert advisory group of practitioners and policy makers, the PhiWomen team began working to articulate a framework for gender-transformative health promotion in 2009 through an iterative process of literature reviews, case studies, and dialogue. We began with meetings and brainstorming sessions within the research team and with our advisory group members. As ideas gelled, the consultation process comprised of in-person and online focus groups in Canada and Australia (n=36 participants), interviews with experts from Canada and Scotland (n=4), and an online survey (n=100). All processes were approved by the C&W/UBC Behavioural Ethics Research Board (See Appendices B – I).

The choice of methods, particularly the use of focus groups, was informed by a need for detailed feedback on the framework as well as the opportunity that group discussions have for generating critical feedback (Kitzinger, 1994, 1995). In particular, we wished to access as wide an audience as possible and to do so in a timely manner that did not limit us to those individuals who were physically able to attend a session in Vancouver or Melbourne, the two prime study locations, or one of the conference presentations. Online focus groups facilitate the participation of those who are less likely to be vocal during a face-to-face session, enable rapid engagement of participants anywhere there is a high-speed internet connection, and permit anonymous engagement thereby potentially eliciting honest, critical feedback (Liamputtong, 2011).

The consultation process was iterative, each step building on the one before. In April 2012, team members conducted a focus group in Melbourne with experts from across the state of Victoria (15 people attended). Participants were shown a draft framework in a powerpoint presentation and the subsequent discussion was recorded by two note takers and summarized for the team in writing (See Appendix B for the presentation to Melbourne consultation group.)

Four expert interviews were conducted following the focus group in Melbourne, from June 15 – August 15, 2012. Each was completed by phone, recorded in real time, transcribed verbatim, and analyzed. A standard, semi-structured interview guide was used as different team members conducted the interviews (I did one of the four). Key informants were selected based on their educational background and their expertise through working and teaching in the field of health promotion and/or gender studies. One hour, semi-structured, in-depth interviews were conducted with four key informants. With their consent, the interviews were

recorded, transcribed, and analyzed. For the data analysis, a thematic analysis was conducted using NVivo 8. The interview transcripts were coded using a set of ten pre-set codes, followed by second layer of analysis which involved extracting and summarizing of the key points. Participants were asked to review the draft framework and to offer their thoughts regarding the strengths and limitations of the framework, including the stated objectives; their assessment of who would be most likely to use it; how to make the tool user-friendly; whether it guided users to understand gender-transformative health promotion for women; what challenges we would face in introducing the framework to the field; and their advice for developing it further (see Appendix C for interview guide, Appendix D for consent form, and Appendix E for the consultation brief circulated to all participants, regardless of the form of data collection).

Focus group web-meetings were conducted over a one month period in September, 2012. Focus group questions were developed using similar questions as had been put to the key informants. A list of potential user organizations was compiled and email invitations were sent out to a wide range of potential participants consisting of policy makers, health-care professionals, local decision makers, service providers, community organizations, consumer advocates, researchers, educators and health-care payers. Five web-meetings were scheduled, averaging four participants per group. In total, there were twenty-two participants for the five web-meetings. Again, upon the receiving the participants' consent, the interviews were recorded, transcribed, and analyzed. This phase was supported by a YouTube video explaining the framework in 6 minutes (see Appendix F for video script, still available to view at <https://www.youtube.com/watch?v=9wzkg51iaKw>).

An online survey was widely disseminated to five women's health and health promotion list-serves for one week from September 21st-28th, 2012 (see Appendix G for survey instrument and Appendix H for consent form). Social media, such as Twitter, were used to advertize the survey and recruit participants. The survey questionnaire consisted of a series of open and closed ended questions, and was based on the questions used for the key informant interviews and focus groups, to maintain consistency. The online survey also used the same YouTube video to introduce the framework. Initially, the survey was scheduled to run for two weeks, however, due to the fairly rapid response, the desired sample size of 100 was reached in a week.

Five online focus groups were also conducted in September 2012 using WebEx, a synchronymous web-based meeting technology, to support discussion and participation. Participants were sent the background document in advance to orient them to the process and to illustrate the early drafts of the framework (see Appendix I for focus group script). Then they were shown the video and invited into a discussion of the framework following a standardized interview guide comprised primarily of the open-ended questions used in the key informant interviews and online survey.

Participants in the online survey and focus groups were asked whether there was a need to incorporate gender into health promotion; whether health promotion approaches for women should adopt a gender-transformative approach; whether a conceptual framework and planning tool would be useful; and whether the draft tool that they reviewed could help direct changes needed to advance effective health promotion for women.

All qualitative data were transcribed, coded and analyzed using NVivo software (Bazeley, 2007) for responses to the survey and focus group questions, and while quantitative

descriptive data identifying the types of respondents, and their involvement in health promotion were analyzed using SPSS software. The qualitative responses to the survey and focus group questions were then coded and grouped by themes to summarize the advice received.

In late fall, the findings of the consultations to date were shared at the Institute of Gender and Health conference in Montreal and asked for feedback. We continued revising the framework through the winter and presented the final version in May 2013 at the 7th Australian Women's Health Conference in Sydney at a plenary session and later that year, at the 22nd International Union of Health Promotion and Education (IUHPE) conference in Pattaya, Thailand. Each of these processes provided us with opportunities for discussion and validation of our approach and purpose in developing the framework. (Since then, the framework has been published in *Health Promotion International* (Pederson, Greaves, & Poole, 2014) and in a book chapter (Pederson, Poole, Greaves, Gerbrandt, & Fang, 2014)).

Results

Data came from the four health promotion and women's health or gender and health experts from Canada and Scotland who were interviewed, the 36 people who participated during in-person and online focus groups in Canada and Australia, and the 100 surveys respondents.

A total of 271 people started the online survey with 100 completing it. A substantial number of people stopped with process once they reached the video; accordingly, we wondered if this meant that some people who were interested in the project were unable to

view the video for technical reasons or that they had understood enough by that point to have determined they were not interested in continuing. Of the 100 people who completed the survey, the vast majority of the respondents (85%) to the online survey reported having had experience working in the health promotion field while even more (88%) reported working in the women's health or gender and health field. In response to an an open-ended question in the online survey, one respondent wrote:

Health promotion practitioners are finding that they need an equity lens of some sort to figure out how to address the needs of diverse populations and not increase disparities between populations. It should help people look at the structures and barriers that women and girls face, and develop health promotion plans that reduce or address those barriers and structures (Survey Respondent).

This respondent clearly articulated a desire for analytic and practical tools for health promotion to address issues of equity and diversity.

Overall, consultation participants—including academic researchers, policy makers, health promotion practitioners, students, and health care providers—agreed that a framework would be useful for increasing awareness about gender transformation as a health promotion approach and helping to guide action: “Health promotion is missing a big piece of making women healthy if it is not working towards greater gender equality”. Respondents encouraged us to articulate our theoretical foundations and to make clear how we understood gender as a determinant of health that is profoundly intersected by other determinants, as illustrated by the next quotation:

If you get that the economic influences intersect with gender to keep the problem in place then you're going to be able to easily see the logic of the fact that, you know, simply putting up another women's shelter is not going to be—not going to be a long-term solution to ending violence against women.

The respondents also urged the research team to explicitly incorporate the determinants of health into the framework, to consider issues practicality and feasibility, and urged consideration of how to build capacity for gender-transformative practice. They also urged us to generate a tool that could illustrate that the approach could be incorporated in a variety of health promotion initiatives, particularly policy interventions. We were also asked to identify clear outcomes and to suggest relevant indicators to support evaluation of the framework and its impact.

Despite this support, participants in all of the consultation processes raised questions about the usefulness of the framework as a guide for practice and as a tool to influence policy makers. Some people thought that a framework would be more useful to researchers than practitioners or policy makers and some felt that expanding the aim of health promotion to foster gender equity was too ambitious. We also observed that the phrase “gender transformative” was sometimes understood as referring to practices associated with sexuality such as sex-change surgery or gender transitioning. One respondent wrote, “Why can’t we keep sexual orientation personal?” In a related vein, respondents urged transparency in terminology and to clarity in defining key concepts and terms.

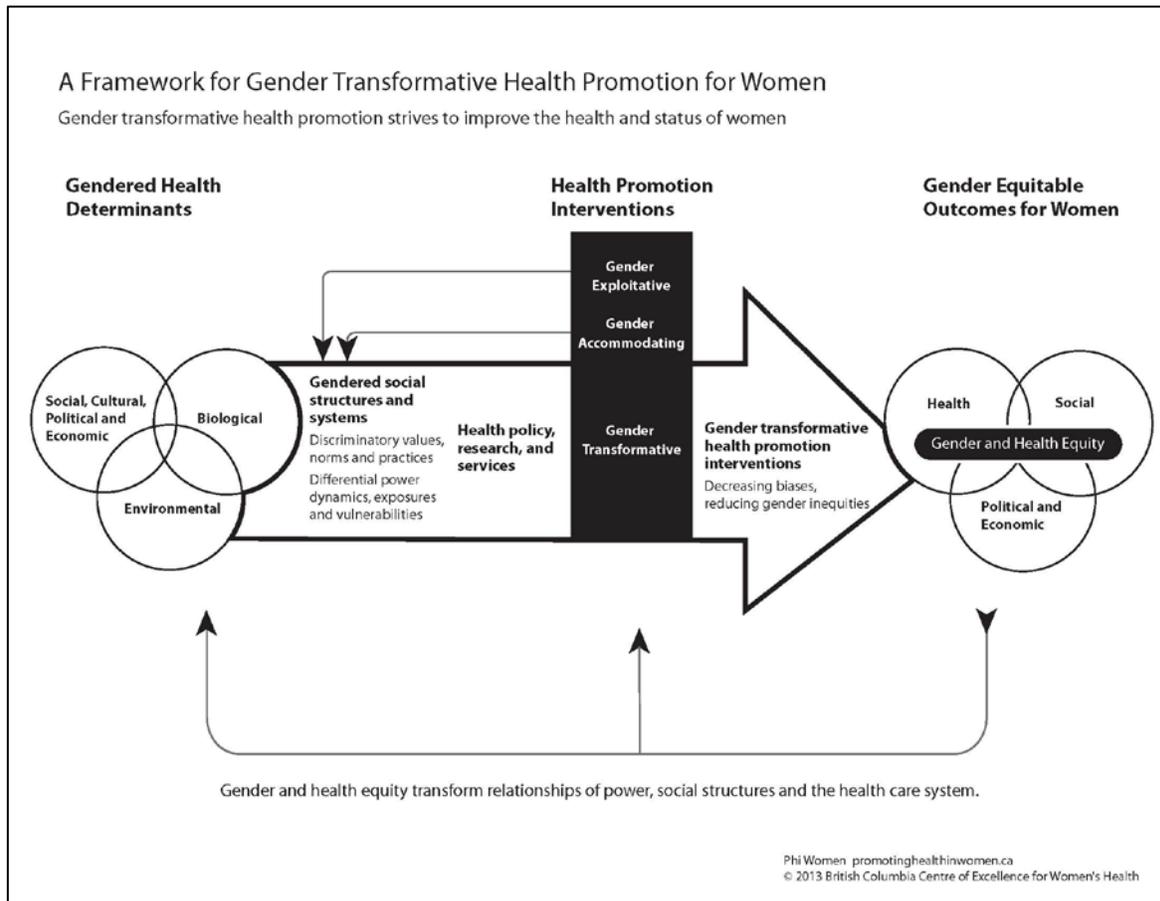
A Framework for Gender-transformative Health Promotion

Figure 4.1 illustrates our Framework for Gender-transformative Health Promotion. The framework is intended to illustrate the ways in which health promotion interacts with multiple factors to either improve health and social outcomes for women or, through a feedback loop, maintain or even exacerbate health systems and social structures that are

based on and foster biased and discriminatory norms and practices. The Framework represents a synthesis of these processes and depicts a pathway through which health promotion could transform gender and health inequities. Its purpose is to guide researchers, policy makers and program 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.

In this representation, each section affects the one(s) to its right. On the left is a representation of gender structures and systems, which affect everything from relationship roles and economic opportunities to power structures and personal choices. These in turn affect the health context affecting what happens in policy, research and practice, as well as individual social and biological determinants. Finally, these determinants produce outcomes that include both direct health outcomes for women as well as socio-political outcomes (e.g., distributions of power and resources) which ultimately all contribute to health inequity. Health promotion is diagrammatically depicted as a continuum cutting across all these contexts and effects. Health promotion approaches taken can either reinforce existing gender norms, structures and relations or transform them. If health promotion activities are gender-transformative, they produce health and social outcomes that contribute to gender equity.

Figure 4.1 A Framework for Gender-Transformative Health Promotion



Gupta’s provocative question of the role of health promotion and disease prevention efforts in sustaining or challenging aspects of cultural and social norms as expressed through gender and gender relations forms the core of the framework for gender-transformative health promotion. Variations on this continuum have been incorporated into a number of publications of the World Health Organization, including, for example, a discussion paper on gender, women and primary health care renewal (World Health Organization, 2010c). The continuum permits us to envision the characteristics of interventions from those which contribute to fostering gender inequities by maintaining or exploiting harmful gender norms or assumptions to those which support gender equity by acting to explicitly transform gender

norms, roles and relations. Moreover, we can see in the framework diagram that there is a feedback loop from health promotion activities that are exploitive or accommodating back to a health and social system that is discriminatory and biased and hence likely to iterate and exacerbate rather than reduce gender and health inequities.

The framework is intended to convey that gender operates at every level of health, structurally and/or systemically, via outright discrimination or tacit biases affecting women in a range of social positions. The pervasiveness of gender as a determinant of health grounds the need for health promotion strategies that are gender-informed and that specifically consider the needs and experiences of women (Keleher, 2004). Moreover, we position gender in the context of other social determinants of health such as socioeconomic status, age, ethnocultural identity, location, etc. in order to develop health promotion strategies that will be meaningful for diverse groups of women (Reid et al., 2012a). Every step in the framework assumes an awareness of the role of gender in producing health outcomes and is intended to orient the user toward those particular effects in the type of health issue or health promotion strategy at hand.

The framework was influenced Sen and Östlin's (2010) discussion of the social determinants of health which identifies social determinants—both processes and systems of social stratification—as varying with gender. Together, these produce a set of discriminatory values, norms, practices and behaviours and lead women and men to have different types of vulnerabilities to diseases, injuries and disabilities, and to experience different levels and types of exposures to health risks and conditions. These are affected by biases within the health system and health research—but also contribute to producing those biases. Through complex interactions, these factors produce two sets of outcomes: health outcomes (e.g., life

expectancy, health status, mental health) and social and economic consequences (e.g., level of education and income; relationship status; place of residence; membership in valued social networks and so on). Both women and men, as well as intersex and transgendered people, are affected by the gendered structural determinants, but with different outcomes.

As Sen and Östlin describe,

...some girls are fed less, educated less, and more physically restricted than boys in their families or communities and women often have lower-paid, less secure and informal employment. Girls and women are often viewed as less capable or able, and in some regions are seen as repositories of male or family honor (sic) and the self-respect of communities...Restrictions on their physical mobility, sexuality, and reproductive capacity are perceived to be natural; and in many instances, accepted codes of social conduct and legal systems condone, and even reward, violence against them... (p. 5).

In turn, girls and women may have differential access to healthful living conditions, health formation and health care, which affects not only health status itself but is reflected in women's economic and social standing.

As described previously, an intersectional lens implies that gender is understood to interact with other dimensions of social location and experience. This in turn implies that researchers, policy makers and health promoters must be cautious in generalizing about all women or men and should attend to how gender interacts with such factors as income, education, and age to influence identity, experience and opportunities. Gender and culture crosscut all other social determinants of health and gender connects biological and psychological differences with social and relational experiences (Keleher, 2004). This relationship predicts women's health and social outcomes, driving and delineating pathways of inequity, especially in those, such as socioeconomic circumstances, that manifest in women's lower levels of income across the lifespan and in women's relatively subordinate

positions of power and lower levels of decision-making—in the governance of political arenas, workplaces or families.

In this framework, both gender and sex are defined as continuous and fluid variables, open to redefinition in various temporal and cultural settings (Johnson et al., 2009; Krieger, 2003). We take this position because assuming gender is a dichotomous, categorical variable can lead to the further assumption that *all* women are different from *all* men, yet women themselves are a homogeneous group. One danger of such an assumption is that it can lead to conceptualizing women's needs and interests as those that fit the needs of the dominant group in any given context. By not examining within-population differences, some groups of women may be marginalized. It is critical that health promotion therefore identifies and is sensitive to the fact that while most women experience some level of gendered inequality and inequity, women may experience those inequalities differently depending upon their age, experiences of racialization, socioeconomic status and so on (Reid et al., 2007, 2012a).

Traditional population and public health interventions, like much of health research and practice, both neglected women and/or treated women as aggregate groups. It is important to acknowledge that women's health and social identities are defined by other elements of social inequities such as race-ethnicity, age, sexuality, disability, culture and religion; the interplay between these dimensions places some women in more vulnerable positions than others (Hankivsky et al., 2010). An intersectional analysis, by focusing on social relationships of power instead of focusing on differences in resources, encourages researchers and program developers to examine social experiences and how they intersect at multiple forms of oppression (McCall, 2005).

The framework also reflects some of the major tensions in the field such as the long-standing debate over the appropriate level at which to intervene—the individual versus structural—and the influence of neoliberalism and its focus on individual responsibility for health and health promotion that aims at changing individual knowledge and behaviours, rather than addressing powerful social, cultural and economic conditions that shape the opportunities for health (Petersen & Lupton, 1996).

For example, while discourse on social responsibility clearly contends that health is shaped by social conditions (P. Ponc & Frisby, 2010), the dominance of activity related to health behaviour change has tended to infer that health is the responsibility of the individual rather than society through government, regulation, and social conditions. Although health promotion scholarship has long made the argument to consider how structure and agency affects health behavior, health promotion interventions continue to largely target health behaviors and the related individual characteristics of those are most at risk of diminished health who are often the poor and underserved (Raphael, 2006, 2004).

The framework also necessitates having a theory of power. As noted at the end of Chapter 3, this framework embraces the WHO definition of health promotion as the process of enabling individuals and communities to increase control over and improve their health (World Health Organization, 1986). This definition has long been understood to imply that ‘empowerment’ as the core mechanisms for changing individual and community health (P. L. Ponc, 2008). ‘Empowerment’ has been variously defined though Wallerstein (Wallerstein, 1992; Wallerstein & Bernstein, 1988) has been particularly influential. In a now-classic article, she proposed that empowerment be understood as “a social-action process that promotes participation of people, organizations, and communities to wards the goals of

increased individual and community control, political efficacy, improved quality of community life, and social justice” (Wallerstein, 1992 p. 198).

Power, the central aim of empowerment, is about having mastery and control; it involves a relationship, is everywhere, between individuals, groups, in the state and its institutions (Ferreira & Castiel, 2009). Power is not a “an object, a thing, but a relationship” and it is not “an attribute of individuals and communities, but an expression of the relationship between two entities” (Ferreira & Castiel, 2009 p. 70) . Hierarchical structures, systems and norms are dictated by individuals who hold the power, typically those who possess socially desirable traits. Gender relations, to varying degrees, involve unequal and unjust power dynamics depending upon the particular context (Reid et al., 2007). Dominant health promotion discourses, exemplified for example by the Bangkok Charter discussion in Chapter 2 which referred to women and men as unequal and different, may contribute to the trivialization of challenges experienced by women as a result of gendered social structures and systems.

In this sense, and for the purposes of this framework, empowerment is understood as a collective of social process that aims to increase control and transition power back to those that have less power or who are powerless (Ferreira & Castiel, 2009; Sadan, 1997). Empowerment requires the integration of micro, meso and macro level interrelations between the individual, community and society to achieve a structural system that allows for equitable participation and engagement in decision-making processes (Sadan, 1997). However, “individual empowerment does not consider or challenge the social determinants of health and ... does not constitute full empowerment in the sense of transforming the relations of power” (Woodall, Warwick-Booth, & Cross, 2012 para. 7).

Having outlined the components of the framework and its core conceptual foundations, let us consider how it might work in practice. First, I outline a set of principles which were articulated to accompany the framework (Pederson, Greaves, et al., 2014; Pederson, Poole, et al., 2014) and then a planning tool that was derived to align with those principles and the framework's theoretical commitments.

Principles to Guide Action

Through literature reviews, team meetings, and discussions with practitioners, researchers and policy makers throughout the consultation, a set of eight principles was derived to inform gender-transformative health promotion. The principles are both background values that inform the use of the framework and criteria for checking that the outcomes generated by the framework are likely to be gender-transformative and positive for women. These principles are intended to ensure that health promotion programs are meaningful for women of diverse backgrounds and that the outcomes promote positive encounters with the health and social services systems. The principles are listed in their order of importance to ensuring that actions are effective and gender-responsive. The principles are that to be gender-transformative, health promotion interventions should be: evidence-based; equity-focused; action-oriented; women-centred; culturally safe; trauma-informed; oriented toward harm reduction; and strengths-based. Each of these is described further below.

Evidence-based

Health promotion interventions must be based upon research evidence of all kinds, including knowledge derived from clinical, policy and program work, as well as from women's experience and traditional, indigenous ways of knowing (Currie & Wiesenberg, 2003). Inclusive and collaborative approaches to research are essential to generate evidence and information for program and policy design, and to support the synthesis of these forms of knowledge to create effective, women-centred interventions (see, for example, Moya, 2002; Poole, 2008; Rycroft-Malone et al., 2004).

Equity-focused

Health promotion should aim to foster equity by recognizing how social, cultural and economic conditions can affect access to resources and power and therefore health (Baum & Harris, 2006). Interventions should seek to reduce disparities in health that result from systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity (Iyer, Sen, & Östlin, 2010). Sometimes, this means that tailored approaches are required in health promotion to achieve the reduction of inequities in health (see, for example, Browne et al., 2012).

Action-oriented

Action and change are central to the women's movement and women-centred research (Greaves, 2009; Reid, Tom, & Frisby, 2006; Ruzek & Hill, 1986). Health promotion is therefore action-oriented, in alignment with consciousness raising groups in the 1970s, the Action Agendas during the UN Decade for women, and current efforts to challenge the negative effects of economic globalization, end violence against women, and resist the erosion of women's rights (see, for example, Kirby, Greaves, & Reid, 2006; Miles, 2013; Reid et al., 2006).

Women-centred

Women-centred health promotion recognizes that women's health is important in and of itself, in addition to being linked to fetal, child, family and community health (Barnett, 2000). Women-centred health promotion and care involve women as informed participants in their own health care, and improve women's overall health and safety (Bottorff, Balneaves, Sent, Grewal, & Browne, 2001; Hills & Mullett, 2002). Women-centred care acknowledges women's rights to control their own reproductive health, avoids unnecessary medicalization, and takes into account women's roles as caregivers, and their patterns and preferences in obtaining health care (see, for example, Ballem & Women's Health Planning Project Steering Committee, January 2000; Cory, 2007; Greaves, Poole, & Cormier, 2002).

Culturally-safe

Around the world, health promotion interventions must grapple with recognition of the influences of colonization and migration on women's identities and health (Smye & Browne, 2002). Health promoters need to be aware of their own cultural identity, socio-historical location in relation to service recipients, as well as of their attitudes and ways of conceptualizing health, wellness, and parenting (Browne et al., 2009). Respect for women's cultural location and having one's values and preferences taken into account in any health promotion encounter is important, as is accommodation of a woman's interest in culturally-based healing (see, for example, Aboriginal Nurses Association of Canada, 2009; Hanson, 2009).

Trauma-informed

Experiences of gender-based violence and trauma are fundamentally linked to women's physical and mental health (Wall, 2014). In many settings, experiences of current partner violence and symptoms of past trauma are often overlooked; and interactions with service providers can in themselves be re-traumatizing (Williams & Paul, 2008). Importantly, trauma-informed systems and services do not depend on disclosures of trauma but rather take into account the influence of trauma and violence on women's health (The Jean Tweed Centre, 2013); understand trauma-related symptoms as attempts to cope; and integrate this knowledge into all aspects of service delivery, policy, and organization (see, for example, Harris & Fallot, 2001; Poole & Greaves, 2012; Varcoe, 2008).

Harm Reduction-oriented

According to the Centre for Addictions and Mental Health, harm reduction refers to “any program or policy that aims to reduce the harmful consequences of substance use without requiring the cessation, or even necessarily the reduction, of drug use” (Centre for Addiction and Mental Health, 2002). Harm-reducing initiatives are pragmatic; they help women with immediate goals, provide a variety of options and supports for improving health, and focus not only on attaining goals related to change in a specific health behaviour (such as abstinence from tobacco use), but rather on facilitating change across the full range of influences and harms associated with that health behaviour (see, for example, Mehrabadi et al., 2008; Shannon et al., 2008).

Strengths-based

A strengths-based approach is not deficit-oriented (Chan, Chan, & Ng, 2006). It explicitly recognizes the positive efforts and factors in people’s lives that can be built upon to further improve health (Francis & Chong, 2015). It includes secondary prevention and harm reduction and actively considers what is working well for girls and women, and what resources can be supported, enhanced or made available to them. A strengths-based approach challenges stereotypes of women as weak, sick, and fragile, and instead regards women as individuals who can grow and thrive and recognize their own strengths (see, for example, Gottlieb, 2013; Norman, 2000; Watkins, 2002).

While several of these principles reflect core health promotion values and practices, they have been reinterpreted here to ensure that there is also a gender component to them. Together, they are intended to support the development of gender-transformative health promotion interventions.

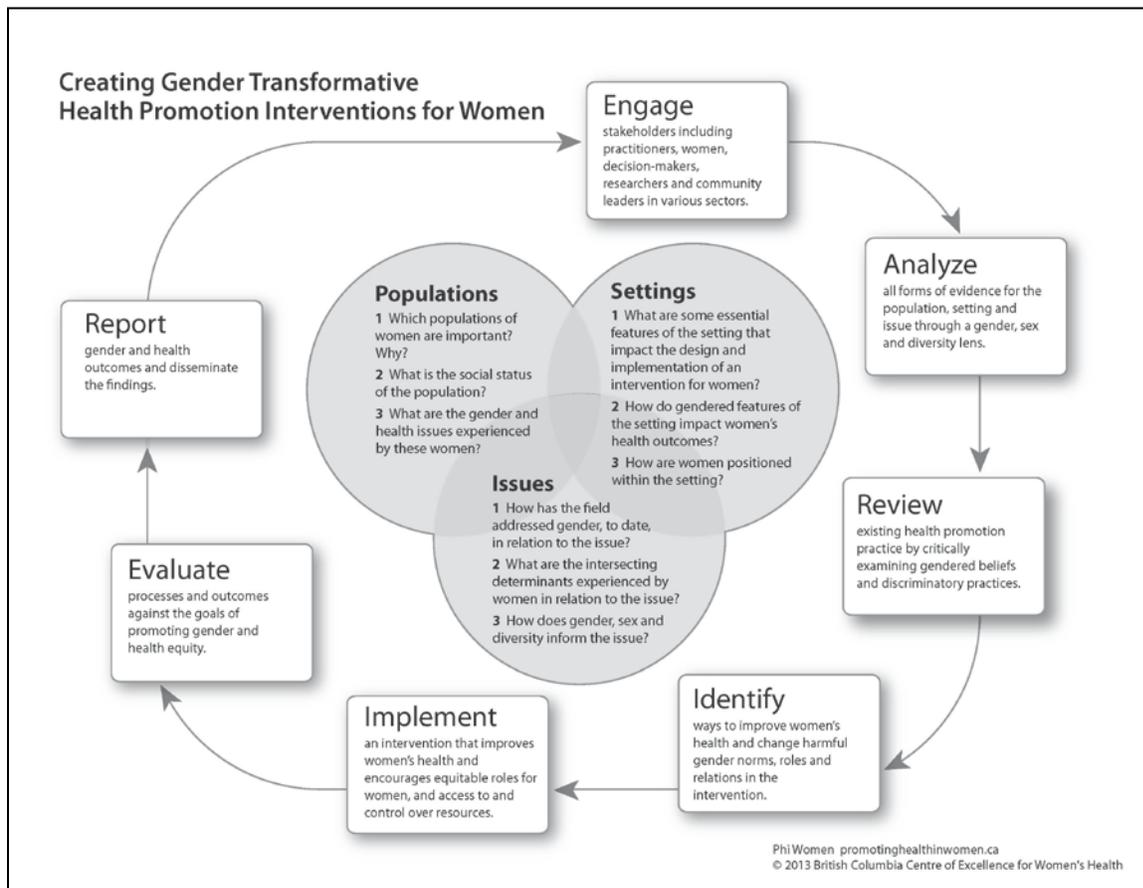
Translating the Framework into Practice

The practical application of the framework were a consideration from the start of the PhiWomen project. Moreover, participants in the consultation workshop in Melbourne, Australia, in April 2012 explicitly encouraged the team to consider how researchers, policy makers and health promotion program developers would apply the framework in practice. Building on the literature and our intentions related to this framework, the team generated a set of guiding principles (Pederson, Poole, et al., 2014) to inform the development of gender-transformative interventions, as illustrated in Figure 4.2 below.

This illustration takes as its starting point what Frolich and Poland (2007) identified as three entry points for health promotion interventions—‘at risk’ populations, settings, and issues—each of which embodies distinct assumptions about what shapes health, health outcomes and potential solutions. This planning tool poses questions to the user about the population, setting, or issue of interest with a gender and women-specific lens. The purpose of the questions is to facilitate a full characterization of the population of interest, their circumstances, and the state of knowledge in relation to women and gender in relation to the particular issue. These questions were inspired by a framework to guide the development of interventions published by Poland et al. (2009) which used a set of nested questions to

stimulate thinking and planning. (This paper was a significant resource in the development of the framework as it encouraged the team to examine the historical, theoretical and practical context of health topics with respect to how they had considered issues of women and gender including tobacco use, housing, physical inactivity, and violence against women.)

Figure 4.2 Creating Gender-Transformative Health Promotion Interventions for Women



These core questions are framed within a planning cycle, each step of which is also interpreted through the lens of women's health and gender norms, roles and relations. Theoretically, one could enter this planning process at any stage, but the most common starting point would be engaging with key stakeholders who are interested in and/or responsible for a particular health issue. Consistent with the view that health promotion practice should be evidence-based, review and evaluation steps are explicitly named in the planning cycle. (For additional discussion of this planning tool, see Poole et al. (2014)).

Conclusion

In 2007, the Women and Gender Equity Knowledge Network, one of the networks established to contribute to the WHO Commission on the Social Determinants of Health, argued that gender inequality is among the most influential of the social determinants of health and that

(b)ecause 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 & Östlin, 2007 p. 1).

And Östlin et al. (2006 p. 26) warned that despite continually emerging knowledge of the impact of gender on health inequities, it has not translated into effective programs and policies, leading to "misallocated resources and weakened potential for success...". Health promotion activities that do not appropriately engage with the social and environmental issues that affect health, including gender, is not likely to be able to adequately address the key pressures on health in general and on women's health in particular.

This chapter has only been able to provide an introduction to the framework we developed. As a team, we determined at the outset that a comprehensive discussion of the framework, including its history, theoretical foundations, practical applications, and implications for knowledge translation would require a book-length treatment. Such a book was prepared over the course of 2013-2014 and subsequently published as an edited collection, *Making it better: gender-transformative health promotion* (Greaves, Pederson, & Poole, 2014). Though the ultimate impact of the framework therefore remains to be seen, at this juncture, we have achieved our aim of articulating how health promotion as a practical endeavour might embrace a concern for gender equity, incorporate evidence regarding gender as a determinant of health, and adopt an approach to planning that incorporates the perspectives of the women intended to be served by the program or policy.

Still, a gender-transformative approach will have to redress the tendency in health promotion to focus on women largely in their reproductive and care-giving roles and instead embrace a comprehensive view of women's health that recognizes how women's lives produce their health. With respect to interventions, we will need to question universalistic, one-size-fits-all approaches, and devise, tailor and implement approaches that take gender, other determinants of health and their interactions into account. A gender-transformative approach to health promotion will also pay close attention to the tone and nature of messaging that is used to engage and inform women. Instead of messages deliberately or inadvertently playing to women's fears, sexualizing women, or treating women as a homogeneous group, gender transformative health promotion helps put power—as knowledge, as choice, and as opportunity—into women's hands. In Chapter 5, I explore some of the possibilities of this approach using physical activity as a case example.

CHAPTER 5: EXAMINING THE MEANING OF PHYSICAL ACTIVITY FOR OLDER WOMEN WITH OSTEOPOROSIS WITH A GENDER LENS

Fostering greater physical activity among older women with osteoporosis could have significant health and social benefits. According to Osteoporosis Canada, an estimated one in three women and one in five men will suffer from an osteoporotic fracture during their lifetime.⁷ Physical activity reduces the risk of fractures and falls (Li, Chen, Yang, & Tsauo, 2009), yet women over 65 in Canada report low rates of physical activity for leisure or transportation and most women obtain physical activity through household labour and walking rather than deliberate exercise (Sun, Norman, & While, 2013). Patients diagnosed with osteoporosis are encouraged to engage in weight-bearing, balance and strengthening activities to reduce their risk of falling and fracture and to promote bone strength (Papaioannou et al., 2010). Together, these findings suggest that older women with osteoporosis are unlikely to be sufficiently physically active to achieve health benefits but should be engaging in regular physical activity.

Though scholars in leisure studies have recognized the importance of gender as a determinant of women's recreational physical activity for two decades (e.g., Shaw, 1994), using gender analysis to help explain or influence women's participation in physical activity is very recent (Duin et al., 2015). Yet there is agreement that social norms persist regarding appropriate physical activities for the different sexes (Physical Activity Strategy, 2012) with sport remaining largely socially constructed as a male domain (Schell & Rodriguez, 2000)—though this may be changing among younger generations of women (Duin et al., 2015). Women's strong preferences for activities such as walking, dancing, and gardening may

⁷ See <http://www.osteoporosis.ca/osteoporosis-and-you/osteoporosis-facts-and-statistics/>

indicate that some sports and physical activities are still regarded as male domains with limited social and physical space for female participation (Davison, Cutting, & Birch, 2003; DiCarlo, 2015; Gilbert, 2001; Robbins, Pender, & Kazanis, 2003). Ideals of the female body and what it means to be “feminine” among diverse groups of women (Versey, 2014), as well as issues of safety (Napolitano & Marcus, 2000), may also limit women’s participation in physical activity (Duin et al., 2015; Roper & Halloran, 2007).

Efforts to increase physical activity rates have included both encouraging individual women to increase their physical activity by increasing their leisure-time participation in recreation and sport and changing the social and physical organization of work, school, and the household. Individually-oriented approaches have largely failed to increase overall physical activity levels to date (Brownson, Hoehner, Day, Forsyth, & Sallis, 2009; Heath et al., 2006; Humpel, Owen, & Leslie, 2002; Saelens, Sallis, & Frank, 2003) and many studies have identified a long list of barriers to physical activity among women, as well as a few enablers. Duin et al. (2015) are among the few to have conceptualized these factors as aspects of gendered social structures.

This chapter explores the engagement of older women living with osteoporosis in physical activity with a gender lens. Data are drawn from a study involving semi-structured interviews conducted in two phases ten years apart with a small group of older women who participated in a clinical trial of a community-based group falls prevention, strength and balance program (Carter et al., 2002). Our aim was to understand how these women, all of whom had been sufficiently motivated to volunteer to participate in an exercise program, managed living with osteoporosis, a condition for which exercise is recommended. In particular, we were interested in whether participation in the tailored exercise program

influenced women's long-term engagement with physical activity, what facilitated or impeded their involvement in physical activity, and what they perceived might be done to enhance their level of physical activity.

Our ultimate aim in this work was to identify possible ways to enhance the participation of older women in physical activity that is appropriate to their age, health status, and lifestyle, and to address the documented gap in women's physical activity participation, despite well-publicised, long-standing activity recommendations such as Canada's Physical Activity Guidelines for Older Adults (see http://www.csep.ca/CMFiles/Guidelines/CSEP_PAGuidelines_older-adults_en.pdf) and women's familiarity with the importance of exercise.

Theoretical Approach

As the women in this study were aged 65 years and older, it was important to adopt an intersectional stance to ensure that gender's interactions with age and aging were considered in the study design and data analysis. Mielewczk and Willig (2007 p. 831) argue that a focus on health practices necessarily leads to consideration of identity because "the various practices we engage in, their meanings and functions, are involved in the constitution of our (social and self) identities and any change in such practices is likely to have implications for our experience of ourselves as social actors and as selves." Lyons (2009) contends that gender—both in terms of identity and gender relations—too is enacted or performed in daily life and through daily practices, including health-related behaviours such

as smoking, drinking, exercising, meal preparation, and so on. And Broom (2008) reminds us that health practices are social as well as individual. As Lyons (2009 p. 397) elaborates,

Decisions people make about what actions to engage in to 'be healthy' are infused by ideas about appropriate masculine and feminine behaviour, and ... 'this suggests that the doing of health is a form of doing gender' (p. 12). Engaging in health behaviours are themselves forms of social practice which construct the person; furthermore, social order is negotiated, produced and reproduced through such practices ... Men's and women's lives are socially organised in ways that affect their health behaviours through patterns in employment, social roles and activities, and economic resources... Thus, health behaviour is a social practice through which gender identities and gender hegemony are continuously (re)constructed.

Using the examples of healthful eating and drinking alcohol, Lyons explored how gender is performed through health practices and identified three critical aspects of gender that require conceptual elaboration and empirical examination. The first was the notion that gender is relational, that is, that masculinities and femininities are constructed and to varying degrees enacted in relation to one another, typically organized as opposites. With respect to femininities, she (Lyons, 2009 p. 397) argued that

Performing ideal femininity involves viewing the body as vulnerable, attending to self-care, seeking professional health advice and help, and being concerned with diet and nutrition. Furthermore, femininity is linked to being the carers and custodians of other people's health (men, children, families) via women's 'natural' helping abilities ... although evidence shows that these responsibilities have their own health costs.... Ideal femininity is not all good for health, however. The emphasis on beauty and slenderness and the pursuit of the 'thin ideal' ... have serious consequences for disordered eating patterns, including extreme dieting....

The second issue Lyons' raised was that of understanding that masculinities and femininities are embodied, that is, gender is lived in and through the body, expressed through bodily activities, and shaped by how changes over time. Again, we tend to see the construction of masculine and feminine bodies in terms of opposites, with masculine bodies

represented as “hard, dry, invulnerable, strong, powerful, dominating and active” while feminine bodies are “represented as soft, leaky, vulnerable, weak, messy and passive” (p. 405). Increasingly, Lyons argues, the bodies valued in Western society are those which are regarded as active, fit, young, sexually attractive and healthy-looking. Many people engage in health-related practices, including eating, drinking and exercise, to attain this body ideal—but many more people engage in these practices and fail to achieve the ideal, openly resist the pressure to attain these aims, and/or feel guilt and shame at not living up to these shared cultural expectations (Petersen & Lupton, 1996).

The third issue Lyons observed was that masculinities and femininities are local, contingent, and intersectional (p. 394). From a gender perspective, “...health behaviours need to be understood in the context of men’s and women’s interactions on both personal and institutional levels” (Bottorff, Oliffe, Robinson, & Carey, 2011, para. 3) because health is affected by both gendered social structures and the micro-dynamics of gender identity (Johnson et al., 2009). “Gender, defined as the socially prescribed and experienced dimensions of masculinity and femininity in society, is evident in the diverse ways individuals engage in health behaviours” (Bottorff et al., 2011, para. 3). Even in single sex studies such as this one, gendered norms, understandings, and practices can be visible in the ways that study participants talk about themselves, their lives, and their activities, because, as a social structure, gender and gender relations are both constructed and reproduced through social interactions, including routine talk and everyday behaviours.

Lyons (2009) argues from her study of gender and practices of eating and drinking that studies should examine gender as relational, recognizing the ways that femininities and masculinities are typically constructed as opposites. She also stressed that researchers attend

to the ways that gender is embodied, and locally, historically and culturally contingent, that is, intersectional.

Calasanti and King (2015) remind us that intersectionality is fundamentally about understanding “relations of inequality between groups” (p. 193) and examines “institutionalized activities that maintain inequality” (p. 193). In the context of examining age and gender, for example, we might begin with noting differences in the life chances, circumstances and health practices of women and men, but then recognize that there are also differences between women themselves.

Men have lower life expectancies than women...and one may note their higher rates of cigarette smoking or alcohol use in a study of gender and health, but intersectionality must tie these behaviors to power-based relations among groups: not just women and men, but also groups distinguished by such other inequities as race, class, age, and sexuality.

Social *inequalities* comprise relations in which some groups lose authority, status, and wealth, and are stigmatized by others, and in which those disparities in life chances are justified as natural, divinely ordained, and/or rational and thus beyond dispute (pp. 193-194, italics in original).

Age/aging can be understood as a system of inequality: one’s status as an aging person varies, in part, on how one ages—how age is inscribed upon the body, marking time in the skin through colour, texture and markings—as well as upon one’s gender. Calasanti and King suggest that elite old men enjoy a different status than other men, and that many women acquire their status because of their relationship to men. This translates into a hierarchy among women, one that is complicated by age, as younger women enjoy a privileged status in the social, sexual, and relationship market relative to older women. An intersectional approach to aging theorizes the effects of relations of gender inequality on

ways that people experience aging in terms of such things as bodily changes, labour market relations, and caregiving responsibilities.

In this chapter, I take up these issues with respect to the accounts the study participants gave of themselves in relation to physical activity as older women with osteoporosis. By telling me about physical activity, the women were telling me about themselves, including what they want us to see them as being like and how they think they should appear to me. They were also illustrating the dominance of contemporary discourses of health and its equation with youthfulness, vigor, and beauty.

Current Evidence on Older Women and Physical Activity

Evidence consistently correlates physical activity with health benefits in general (Khan et al., 2012) and for women specifically (Reid, Dyck, McKay, & Frisby, 2000; Wen & Wu, 2012). It is also well documented that more men are physically active than women in Canada; for example, the Canadian Fitness & Lifestyle Research Institute reported in early 2015 that, based on 2013 data from the Canadian Community Health Survey (CCHS), that 55% of men and 51% of women over age 20 reported being physically active in their leisure time (Canadian Fitness and Lifestyle Research Institute, 2015). Using 2006/2007 CCHS data, we found that older women (age 65 and older) were the least physically active as a group of all age categories (Pederson, Haworth-Brockman, Clow, Isfeld, & Liwander, 2013; Sun et al., 2013). Similarly, based on 2009 Canadian Community Health Survey data, Milan and Vézina (2011) report that physical activity declined among both women and men over 65 as they aged, but fewer women were active or moderately active than men in every age cohort

(see <http://www.statcan.gc.ca/pub/89-503-x/2010001/article/11441-eng.htm>). Specifically, 43.8% of women 65-74 years were classified as active or moderately active, compared to 53.3% of men. From 75-84 years of age, 30.6% of women were classified as active, compared with 46.9% of men. At age 85 years and older, only 19.4% of women were considered active or moderately active, compared to 32.55 of men. While there are important reasons to debate how physical activity is measured and its ability to capture women's activity levels (the CCHS reports on leisure-based physical activity, see Forsey & Haworth-Brockman, 2008), there is nevertheless agreement that many older women are insufficiently physically active to achieve health benefits according to the standards set by the Canadian Physical Activity Guidelines for Older Adults (Tremblay et al., 2011).

Investigations in developed countries have enumerated a number of barriers to physical activity, particularly leisure-time physical activity, such as lack of interest, fear for their personal safety, insufficient resources, time constraints, pain, lack of companionship, lack of transportation, lack of knowledge of how to exercise, lack of self-discipline, self-consciousness, personal caregiving responsibilities, and so on (see, for example, Crombie et al., 2004; Jeannae M. Dergance et al., 2003; McArthur, Dumas, Woodend, Beach, & Stacey, 2014). Analyses of diverse groups of women suggest that other factors also pose impediments to engaging in physical activity. For example, among some African American women, maintaining one's hairstyle can be sufficiently complex, time-consuming, and expensive to preclude exercise (Versey, 2014)—suggesting the role of cultural and gender in understanding women's health practices. Among older women in particular, researchers have reported diverse barriers to regular physical activity including health problems, weather, lack of time, laziness and other activities (Korkiakangas, Taanila, & Keinänen-

Kiukaanniemi, 2011), a preference for household work over leisure-time physical activity (Plonczynski, Wilbur, Larson, & Thiede, 2008), a sense of hopelessness (Plow, Allen, & Resnik, 2011), lack of awareness regarding facilities and programs as well as how to exercise, gender socialization, and logistical challenges (see details in Bundon, Clarke, & Miller, 2011).

Researchers have also identified a number of facilitators of physical activity engagement among older adults, including its ability to facilitate women being able to “do what I want to do” (Clarke, Khan, McKay, Zyla, & Liu-Ambrose, 2005) and a desire for independence (Paterson & Warburton, 2010), improvements in functional capacity, weight loss, and enhanced sense of body control (Stathi, McKenna, & Fox, 2010), and improvements in mental and physical wellbeing (J.M. Dergance et al., 2003).

For example, Ward-Griffin et al (2004) conducted a phenomenological study of what they describe as community-dwelling seniors’ perceptions of falling, fear of falling, safety and identity and observed that the participants in their study, who were both women (n=7) and men (n=2), experienced a dynamic tension between “exercising precaution” and “striving for independence”. The study participants reported using a combination of strategies, often simultaneously, to balance these two opposing forces. These strategies involved psychological, social and environmental practices. Exercising precaution involved depending on help, resisting activities, eliminating hazards, selecting safe spaces, and assigning blame (deflection, minimizing). Striving for independence involved having confidence, minimizing the impact of a fall, resisting confinement, running the risk, and accessing resources to facilitate independence. On balance, these older adults employed more strategies associated

with exercising precaution than striving for independence, though they were also concerned about the impact of a fall on their independence and ability to independent living.

These findings suggest that involvement in physical activity is complex, requires an understanding of the context of women's lives, and may vary by setting (rural versus urban), age cohort (specific generational experiences of physical activity), and gender (e.g., expectations of gender appropriate activities, demands of gendered roles, and opportunities for involvement).

Methods

This project was informed by feminist qualitative methodology (DeVault & Gross, 2012; Hesse-Biber, 2012) and interview methods (Rubin & Rubin, 2011) in the context of a randomized clinical trial to test the effectiveness of an exercise intervention (Carter et al., 2002) The clinical trial that provided the opportunity for this study involved 93 women, of whom 24 were interviewed by two researchers in 2000-2001 and then again, a decade later, in 2011(See Appendices J-M). We re-interviewed as many of the women as possible to learn about their experiences living with osteoporosis, aging, and physical activity participation. The second set of interviews paid close attention to any changes that the women reported having occurred between the two interviews, their current level of involvement in physical activity, and their overall health and functioning. An important aim of the second phase of the study was to ascertain the impact that the women's involvement in the falls prevention trial had on the women's subsequent physical activity. Of the original 24 women, we were

able to locate 17; of those, 10 women were sufficiently well and willing to engage in another interview. During this period, the women aged (from being 65-74 to 74-84), experienced changes in their health status, and underwent a number of personal changes.

Participant Recruitment

Women were recruited to the clinical trial through letters from the hospital at which they had received a positive bone densitometry test indicating they met the clinical criteria for having osteoporosis, were between 65-74, English-speaking, were not engaged in more than 8 hours of moderate to strenuous physical activity a week, and had no pre-existing conditions which would preclude them from undertaking a supervised physical activity program. The opportunity to participate in the qualitative study was presented to potential participants in the clinical trial by a research assistant not involved in the study; potential participants left their names with her and were subsequently contacted by the study researchers to confirm their interest, review the consent procedures, and schedule the first interview. Participants were invited to elect to be interviewed in a location of their choice; all but two chose to have us interview them in their own homes. The other two were interviewed in a suitable private office at the hospital.

For the second study, following Kosma et al. (2004), we used multiple channels to recruit study participants, as approved by the University of British Columbia /Children's and Women's Health Centre of British Columbia Research Ethics Board (UBC C&W REB) (See Appendix I). First, the women were mailed an information package and consent form; if they were willing to be part of the study, they were invited to contact the researchers.

Invitations and consent forms were mailed to 23 women who were previously enrolled in the original study. Follow-up phone calls to women were made within 1- 2 weeks of receiving the invitation to ensure receipt, to explain the research purpose and consent process as well as answer any questions. Ten women out of the 23 (44%) original study participants met the recruitment criteria and enrolled to participate. Thirteen women were 'lost to follow-up' and/or declined for the following reasons: ill health and inability to participate (6), disinterest (3), recent family member's death or ill health (2), unreachable by telephone/mail (2). Several women provided verbal consent over the telephone and their written consent was obtained on the day of their interview. Of the 24 women in the original study, 7 could not be located at their former address (the letter was returned).

The clinical trial excluded women who had medical indications against participating in an exercise program, who had entered into menopause less than 5 years previously, who were more than 130% of their ideal body weight, or would be absent from the study community for more than 4 weeks during the 20-week trial (Carter et al., 2002). In the follow-up study, we recognized a number of additional factors that might make it difficult for women to participate. Specifically, older women who had physical or mental impairments were excluded. These impairments included co-morbid conditions which affected their mobility, speech or cognitive understanding of the meaning of informed consent. As co-morbid conditions are experienced by many older women, we allowed women to self-identify their co-morbid conditions and decide for themselves whether these would affect their participation in the study.

Data Collection

We chose to use semi-structured interviews (Demicco-Bloom & Crabtree, 2006) for this study because we were interested in using the findings to complement questionnaire data collected by the clinical trial team and to have comparable data from each of the women (Bernard, 1988). Moreover, we were interested in the women's experiences, observations, and reports on the exercise intervention as well as trying to inform gaps in understanding of women's knowledge of osteoporosis and our interest in promoting appropriate health-related behaviours, we also used the interviews to explore what the women knew about the disease, how they were initially diagnosed, and the various practices they undertook as a result of knowing they had been diagnosed with low bone mineral density (Rubin & Rubin, 2011). Finally, we chose to use semi-structured interviews so that the interview format would elicit topics the women thought were important that we had not necessarily identified ourselves.

Interview schedules were constructed by the team members and piloted with women with osteoporosis who were known by the researchers. Pilot interviews were used to refine the questions as well as to train the interviewers. For the 2011 study, the interview schedule was constructed following a review of the original study materials from 2001-2001, a review of the literature on women's involvement in physical activity, discussions with health care providers who offer specialized physiotherapy, nutrition, medical and nursing care to women (and men) with osteoporosis, and observation of a public education session on osteoporosis provided by the health care team at a Canadian hospital. Two pilot interviews were conducted to familiarize the researchers with the interview procedures and questions.

Participants were interviewed in their homes, according to their preference. Meeting women in their homes allowed interviews to be scheduled at the convenience of the women and in a familiar place. The setting also afforded the interviewers the benefit of contextualizing participant's accounts and life experiences. We generated participant profiles after each interview based on observing the women in their homes as well as our recollections of the conversation. These participant profiles provided a means of recording invaluable information about each participant's context, some of which was not verbalized during the actual recordings. They also allowed interviewers to better understand how living with osteoporosis and participating or not participating in physical activity is influenced by a woman's particular circumstances.

The women were asked to show the interviewers where they cooked, and the researchers took advantage of being in the study participants' homes to look at their washrooms for grab bars, raised toilets or shower chairs, and ask about help with garden chores, laundry, and driving when it was apparent that these were part of their lives. In the interviews themselves, we asked the women about what had changed for them in the 10 years since we had interviewed them previously. I was particularly interested in changes due to health conditions, the loss of life partners, moving residence, retirement, new family members, and so on. The women were also asked about how they were managing their osteoporosis, specifically their use of medication, physical activity, and diet, and any actions taken to prevent falls such as the use of mobility aids, grab bars in the washroom, or removal of scatter rugs. We also asked if they had experienced any falls and what impact falling had had on their daily lives, exercise habits, and health. A lot of the interview consisted of asking

about the women's lifetime patterns of physical activity, primarily as a leisure-time activity (see Appendices J – L).

Interviews varied in length. The interviews in 2000-2001 each ranged from 40 – 70 minutes on average but the interviews in 2011 were all considerably longer, ranging from 90 to 120 minutes. However, when one considers that there were two interviews in the early phase of the study and only one in the second, it becomes clear that the total length of time spent with each participant was approximately the same.

Data Management and Analysis

We followed a multi-step, interpretive process to analyze the data for both sets of data, informed by framework analysis (Gale, Heath, Cameron, Rashid, & Redwood, 2013; J. Smith & Firth, 2011). All interviews were recorded and then transcribed verbatim by professional transcribers. To ensure the quality of the transcription, the research assistant reviewed all transcripts against the original interview recordings and corrected any errors. This process ensured accuracy as well as familiarity with the data. Next, all transcripts were read by the researchers in their entirety to capture the overall story of the woman's life. Initially, we each reviewed the transcripts from the women we had each interviewed but eventually it became clear that to complete the analysis I would need to thoroughly review all the interviews. We summarized the interviews through what we referred to as participant profiles a mechanism for committing aspects of the interview to memory but also to initiate interpretation. As framework analysis uses a matrix approach to coding, this facilitated us generating both individual accounts for each woman and a coding scheme to use

comparatively among them. We generated an individual profile of each participant by reading the three interviews in sequence and writing an account of each woman. These narrative summaries were a critical tool for moving past the purely descriptive categorizing that the code-based analysis produced. We included demographic information, health status and current participation in physical activity, age, and estimated socio-economic status based on the woman's home and neighbourhood in the profile of each interview participant. We inquired in the interviews about whether the women lived alone, had children, managed pets, had help with housework, and how they spent their time as part of the interviews.

We then developed a coding scheme derived from both the interview guide and the topics that arose in the interviews, a combination of deductive (e.g., health history, exercise history, demographics) and inductive (e.g., fear, aging, pain, personal philosophy, time, social support) coding. The coding list was reviewed repeatedly by both researcher and research assistant and a coding dictionary to justify the codes was prepared (see Appendix N). All interviews were coded in NVivo 8 using the coding scheme and summaries were generated across the codes by one of the researchers. The cross-case coding categories arose both inductively and deductively. For instance, we generated a continuum of women's engagement in physical activity in order to capture the variation among the sample using categories that emerged from the data. We coded "fear of falling" however based on our initial curiosity about its contributions to exercise and managing osteoporosis concerns.

One way that we increased the rigour of the study was by working as a team, comparing thoughts and analyses on regular basis. We wrote memos and offered illustrations to convey our interpretations. We also conducted an additional set of interviews with health care providers familiar with women such as those in our sample. Though not specifically

concerned with the individual women in our sample, these interviews served as a form of data triangulation (Creswell, 1998; Lacey & Luff, 2009) by permitting us to explore our initial findings with health care providers who work to promote the health and well-being of women living with osteoporosis. In particular, we were interested in the nature of the barriers and facilitators to physical activity that the health care providers could identify and any suggestions they might offer on how to encourage safe, appropriate physical activity among women with low bone density (see Appendix N for the interview guide for health care providers). This round of interviews was also completed because the second phase of the research project was funded explicitly as policy research and was intended to generate practical suggestions to inform policy and programming for older adults.

I have summarized the data about physical activity into barriers and facilitators as well as describing the women's current (and previous) involvement in physical activity. Findings were interpreted with close attention to the gendered nature of the ways that physical activity was or was not part of their daily lives.

Results

Study Participant Demographic Profiles

By virtue of the inclusion and exclusion criteria for the original community-based intervention study in 2000, all the women in this study had to disclose whether they undertook 8 or more hours of vigorous physical activity a week prior to their enrolment in the study; this criterion was employed to enhance the sensitivity of the measurement to changes

arising from the exercise program if there were any (Carter et al., 2002). Given this limitation, it is perhaps not surprising that the women in both the original and more recent studies were not generally physically active. Moreover, by the time of the 2011 study, all of the women were between 74 – 85 years old, had a confirmed diagnosis of osteoporosis, had been living with the condition for a minimum of 10 years, were sufficiently skilled in speaking English to participate in an interview, and were sufficiently competent to provide informed consent. Table 5.1 summarizes the profile of the participants.

In 2011, the mean age of the study participants was nearly 80 years (79.4), with the women ranging in age from 76-87. Most were middle-income or higher, though one (H. Sparks, all references to participants use a pseudonym), was notably less well off than the others. All of the women continued to live relatively independently, but two had moved to supported housing; one woman lived in a seniors' assisted living residence and the other in a seniors' apartment building. Half lived in apartment-type dwellings, half in houses. Half of the women still lived with a male partner; the others were either widowed or divorced. All of the women lived in or near a large city in Western Canada.

Table 5.1 Demographic Profiles of Study Participants

Participant Pseudonym	Age	SES	Marital status	Living arrangement	Residential Setting	Former occupation
Tricia Armstrong*	78	Middle	divorced	independent	assisted living apt.	travel agent
Arlene Baker	87	Higher	married	with spouse	house	Library technician
Kellie Chapman	77	Upper middle	widowed	independent	apartment	nurse & nutrition consultant
Lisa Hollis	78	Middle	divorced	independent	apartment	nurse & teacher
Isabelle King	83	Higher	married	with spouse	house	homemaker
Rebecca Kwong	77	Higher	married	with spouse	house	homemaker
Sharon Michaels	77	Higher	married	with spouse	house	homemaker
Melissa Moon	80	Middle	widowed	independent	house	realtor
Jessie Roberts	81	Middle	married	with spouse	apartment	health administrator
Heather Sparks	76	Middle-lower	divorced	independent	seniors apartment	home-based sales

Summary of Study Participants' Participation in Physical Activity

The women varied in the extent to which they were physically active. Melissa, for example, described herself as housebound as a result of a recent incident in which she twisted her ankle, but even when she was not laid up by her foot, she was no longer doing much in the way of walking. She did no deliberate physical activity whatsoever, though she responded to the presence of the interviewer and her questioning with vague comments about needing to exercise more, perhaps going to an exercise class again, etc.. However, this might

be best understood as a social desirability response because she had not enjoyed the exercise class she'd been in years earlier, found exercising boring, and only participated because she'd been randomized into the exercise arm of the study. As best we could assess, she had not done more than minimal activity for years. She had borrowed a shopping cart from the local supermarket as a makeshift walker to help her get home from the store and had decided that she'd hang on to it as it was handy. Jessie, like Melissa, talked about exercising again, but admitted that she'd had such a difficult time with emotional and physical challenges and sufficient demands to provide caregiving that she wasn't likely to become physically active again anytime soon.

At the other extreme, Tricia walked laps of the courtyard in her apartment building in the warm weather and did laps in the hallways in the poorer weather, while Heather was still traipsing about town with a knapsack conducting her beauty products business on foot and public transit. Rebecca performed exercises most mornings, following a television program of them, went to a fitness class at the local community centre twice a week, and walked outdoors when she had someone to walk beside her. In between were a number of women who were active as the weather, their health, and their support systems permitted. For example, Isabelle had had a series of health crises over the past few years that had resulted in significant weight loss, time in hospital, and pain; she had begun walking again with the help of walking sticks to support her being out of the house on her own but otherwise depended on the company of her husband or a friend to walk. She had joined the walking program at the local mall, which had a seniors' program, and went there once a week to walk with others. But where she had formerly done her own gardening and housework and walked up to 8 miles with a friend for recreation, she was now reduced to short walks around the

neighbourhood or shopping mall, and relied on assistance with the heavier house cleaning and garden work.

In 2011, the most common form of physical activity reported by the study participants was walking: nine of the 10 women reported walking as something they deliberately did for “exercise.” However, the women varied in their capacity for walking as well as the extent to which they walked. While one woman described running her home-based beauty product business on foot, using a combination of walking and public transit to deliver her goods to her customers, others described only being able to walk with the aid of walking sticks or the physical support of a partner or friend to help them balance. Hence, even though all the women reported that they walked and enjoyed walking, they were not necessarily referring to precisely the same activity. Nine of the ten women spoke about their participation in other forms of physical activity in addition to walking; only one woman reported walking as her exclusive form of physical activity. The women’s participation in various forms of exercise is summarized below to show the range and type of activities within the sample. See Table 5.2 for a summary of the patterns of the women’s involvement in physical activity.

Table 5.2 Summary of Study Participants' Patterns of Physical Activity

Sedentary	Light Activity	Moderate Activity	Vigorous Activity
- activity is incidental, random, not deliberate	- occasional walking, housework, may need help and support	- physical activity as a resource for maintaining function, independence, not being disfigured by osteoporosis - not necessarily going to classes but regular walking	- deliberate (planned) engagement in regular, intense physical activity e.g., Zumba class
e.g., Melissa, Rebecca	e.g., Sharon, Isabelle, Jessie, Lisa, Kellie	e.g., Tricia Heather	e.g., Arlene
- housebound except with support, limited mobility at home - may be indifferent or aspiring	- motivated but not necessarily able to be as active as they want - often invoked previous history of being active ("I could be active again if not now") - physical activity contingent, intermittent - may express some yearning to be active (or reflect social desirability of "value" of physical activity) - don't want to be a couch potato	- making things happen for oneself "those who make things happen and those who asked what happened" - taking pleasure in being mistaken for being younger than they are	- physical activity identity: "physical activity is part of who I am, what I do, how I spend time" - more likely to express pleasure in physical activity than other women
<p>Common Themes:</p> <p>"Personal responsibility to stay healthy"</p> <p>Osteoporosis is not the central feature of my identity</p> <p>Critique of the "couch potato"</p>			

Reasons for Participating in Physical Activity

The women in the study gave various reasons for participating in physical activity. Some were motivated by their personal health history, including experience of falling, and wanted to protect against further occurrences, and most agreed that exercise—especially walking—was ‘good for you’. Other reasons for participating were transportation (walking as a way to get about town), wanting to be outside in nature, help with managing pain and discomfort, improvements in appearance, and because it “feels good.” These comments were what the women said in answer to direct questioning about their reasons for engaging in exercise and physical activity. Taking the interviews as a whole, however, it became clear that engaging in physical activity—even walking 10 blocks a day as Sharon dutifully did—was one of several strategies the women employed to define and defend themselves as capable of living independently.

Maintaining Independence

In the early interviews, we asked the women what they knew about osteoporosis and what they thought of when they heard the term. The women uniformly shared an image of someone with "osteoporosis" as a "hunched over, frail, ugly, little old lady." This is clearly a stigmatized and denigrated image of both aging and women. When asked what they worry about in relation to osteoporosis, they said they wanted to avoid becoming the "ugly" image of a dependent person who cannot do anything for herself. This response illustrated the effort the women put into maintaining or re-establishing their independence.

The women made a number of points during the interviews that can be understood as ways of demonstrating their functionality, independence, and competency. For example, they reported that they do all their own shopping, cooking and cleaning. More frail women or one who has moved into an assisted living facility, make scaled back versions of these same reports. While a woman may not do her own vacuuming, she still does her own cooking, laundry, and light housekeeping. However, all but one woman report that they no longer vacuum - it is too painful to take the posture associated with vacuuming. The fact that all the women raised this fact in routine talk suggests they took for granted that this was "women's work" and hence a woman who was not performing this task warranted an explanation and justification.

The women were keen to maintain their independence. Only one had moved into a form of assisted living and even there she made a point of demonstrating that she was not in need of medical assistance but rather had moved in to counter being lonely and depressed. She made an effort to demonstrate to the interviewer how she was strong, capable, and more physically active than every other resident in the facility, despite not being the youngest. Melissa, who really was unable to live independently, eventually acknowledged that near the end of the third interview, she preferred the idea of having someone come to live in her home than to moving into a supported living arrangement. She wanted to be near her possessions, which she had acquired, in part, through overseas travelling, and she liked her home. A couple of women had moved between the first and second set of interviews, usually due to the burden of costs and living on a fixed income, as well as recognition that they might not be able to manage the stairs any longer or the size of their home.

Being Active

Significantly, while "being active" was highly valued, this did not always refer to being physically active. In fact, engaging in physical activity was seen as a support for being "active" in the more general, everyday sense. The women commented on the importance of doing things to both be active and to facilitate being active. They understood "active" as being mentally, physically, and socially engaged. To be 'active' was a positive quality; the opposite was to be disengaged, passive, and/or still. Being inactive was perhaps best expressed as someone who was sitting watching television.

Two women (Isabelle, Tricia) spoke about deliberately undertaking activities to "stimulate" their minds. If the women were physically active, as Heather and Tricia were, they saw themselves as exceptional. Isabelle and Sharon made an effort to demonstrate how 'active' they were despite their limitations. There was clearly, therefore, a normative, positive value placed on the concept of 'being active.' Being active was similar to being 'busy'—having responsibilities, commitments, and a schedule.

The women also liked having valued roles. Volunteering was particularly important to this group of women. Each spoke of different volunteer activities they were engaged in. One of the ways that Sharon and Isabelle showed their health and relative youthfulness was in visiting older people, particularly those in care facilities. Tricia, perhaps the most active volunteer of this group, did recycling, canvassed for charitable organizations, and had a role as a fire safety coordinator in her residence. Indeed, she showed the interviewer a photo of herself that had appeared in a local newspaper in which she was honoured for those activities. Another woman, who was lost to follow-up, mentioned that she helped other people with

their taxes; this volunteer role was an extension of her previous employment role and she stressed that she wanted to be able to 'help' others in this way.

Despite the class and ethnocultural diversity in the group, the women in this sample saw "being busy" as very important and as benchmark for measuring their independence and value. In the early interviews, two of the women were still employed, while another was so busy caring for her grandchildren she insisted that the interviewer manage the interview in 15 minutes because it was the only time she has to spare. Two women were still managing all of their own housework, including washing outdoor windows standing on ladders. Several women did volunteer work, two visited "seniors", while another provided support to a thrift shop. They enjoyed playing card games, socializing with friends, being part of a seniors' writing group, taking courses, and going for walks. In the later interviews, the scale of activity had lessened somewhat but not the value of being "busy". None of the women were providing child care to grandchildren any longer, as the children were all older, but they were also less able to manage the work. The last woman who was still working was about to give up her home-based beauty product business because she was being expected to use a computer, something she had not mastered and cannot afford to purchase.

As the women described it, they gradually gave up key household tasks. First they gave up vacuuming, a task that was not only tedious but usually painful for these women because of their osteoporosis and something that their medical providers advised them to forgo. After the vacuuming has been relinquished, the women variously reported giving up other tasks, starting with ironing, then shopping independently, or changing light bulbs that required standing on stools or ladders, or picking up grandchildren or pets.

Walking remained the preferred activity by far but the vigor with which women walked, where they walked, and how far they walked diminished by the time of the later interviews. One woman, Isabelle, who had easily walked eight miles with a friend on a regular basis in 2000, was just learning to walk again independently after four years of serious illness that had kept her largely housebound. To go out now, she either relied on having company to support her or using walking poles. Kellie reported regularly using a cane. Rebecca, on the other hand, said she never walks alone any more. Only Heather, who prided herself on walking everywhere with a backpack to deliver products to her customers, was still highly mobile. Thus the meaning of physical activity changed over time among the women in this sample, as did their responses to what facilitated or impeded it. Thus the women offered the interviewers a view of “positive” aging that comprised being active, helping others, and appearing youthful (within limits).

Resistance to Aging

Virtually all the women agreed that exercise improved their mobility, strength, and flexibility and often reduced their pain. Several of the women had lower back pain (two had what they called “nurses’ back” from years of lifting and turning patients) and all commented that an appropriate level of physical activity reduced their pain. Yet most of the women did not do much in the way of physical activity by the time of the third interview, either at home or at a fitness facility. However, all the women but one walked and claimed that they loved to walk. Indeed, most of them perceived themselves as fast walkers, so fast that they needed to walk alone because their friends or family could not keep up with them.

While a couple of women were deterred from walking by cold or rain (Regina, for example), most of them were willing to walk regardless of the weather. Most of the women talked about two kinds of walking: functional walking (to get to the store or visit the doctor) and recreational walking (walking for pleasure and exercise outdoors).

At the same time that walking was a source of pleasure and perceived exercise, the women were worried about falling. They worried about tripping over curbs and tree roots, avoided dogs and places where children crowded on the sidewalk, went to the mall early to avoid the crowd, and tried to travel on transit at times when there would be few people carrying large knapsacks that might bump them. They were anxious about getting on escalators, learned where the elevators were in the places they frequented, and occasionally used walking aids such as a cane or walking sticks. One woman had purchased walking sticks while another had her husband make her some from her sons unused ski poles. But the women were reluctant to use the walking sticks and cane sometimes because they didn't want to appear unusual. Only one woman claimed she didn't care what people thought of her when she used her cane, but nevertheless admitted sometimes she didn't feel like using it. In general, the women saw using such supports as markers of aging, and they did not want to be considered old.

Aging was clearly a stigmatized and denigrated status. Even as these women aged, they worked to varying degrees to avoid unnecessary markers of their age. Lisa, for example, mentioned a friend who would not use a cane to support her when out walking: "Yeah, oh I've got a friend, she's 90 and she won't use her cane, and she's had some terrible falls. I said 'Use your cane.' 'No, I don't want people to think I'm old.'"

In another instance, Heather challenged the interviewer to guess her age, delighting in the way that the interviewer hesitated and then insisting that she ‘work it out’ based on the year of her birth. She relayed several stories of people not believing she was the age she was. These tales of the mismatch between perceived and actual age seemed to rely upon a couple of elements: the extent to which she walked in her daily life and the reported speed with which she walked. Thus she and some of the other women established their credentials as “young for their age” through invoking a stereotype of older people as slow moving.

These women were aware of themselves aging. They sometimes assumed that mobility difficulties they had, pains they experienced, and changes that they witnesses in their bodies were natural, inevitable aspects of aging rather than the result of disease processes. This sometimes meant that they did not question what they were experiencing or they normalized the declines they noticed.

The women were conscious of not wanting to look their age, revelling in stories of being mistaken for being younger than they were, and taking steps to disguise the most salient markers of age such as hair colour. This is one of the reasons they expressed dismay about their diagnosis of osteoporosis—they feared it would mean that they would become the ugly, bent, old woman they had in their mind’s eye.

The women made explicit comparisons of themselves with others, usually to confirm that they were doing better than they were. Some of the comparators were in terms of ability to walk quickly or whether they were a lighter or smaller than others. Tricia, for example, said, “I’m pretty agile. I walk quicker than anybody around the lake! I have some walking partners and they walk too slow.”

Often the comparator was whether the other people were as ‘active’ as they were, both mentally and physically. Esther, one of the participants in the first set of interviews, was critical, for example, of her son-in-law’s mother:

I don’t want to be like an old woman. You know, my son-in-law’s mother – she is younger than me. I always ask her to call me. She says ‘no, no.’...She is a White Canadian. Now she cannot walk very good....She is two years young than me....I want to be active. I want to be healthier, and hopefully, I can still help some people, you know, income tax, some people.

The women also commented on the importance of doing things to both be active and to facilitate being active. They understood “active” as being mentally, physically, and socially engaged. To be ‘active’ was a positive quality; the opposite was to be disengaged, passive, and/or still. Being inactive was perhaps best expressed as someone who was sitting watching television.

Moreover, their assessments of themselves and others were highly contextualized and linked to lifecourse expectations such as what ageing women should look like, whether they met those criteria or not, whether they acted their age or not in terms of their physicality. The ability to walk quickly distinguished them from others who were less mobile, agile and independent. Walking briskly, regularly and with purpose were highly valued markers of health and wellbeing. Some, who were no longer able to walk alone or very far, expressed regret about this loss of strength and harkened back to a time when they were could walk more easily – invoking cultural norms about independence, autonomy, physical strength as markers of youthfulness and vigor.

Managing Osteoporosis

As virtually all of the women in the study understood osteoporosis to be a condition that arose from dietary inadequacies, their strategies for addressing the condition were largely dietary. While they generally preferred not to take prescription medication, they all reported taking calcium supplements, usually in combination with vitamins, though they did not see this as "taking pills." Being a "pill taker" was associated with another aspect of aging and dependence—being "one of those little old ladies taking a pill for everything". Some of them believed that taking calcium was as valuable as taking bisphosphonates in terms of enhancing bone density—and they certainly found it easier to tolerate. While several of the women found the daily regimen for a drug like Fosamax annoying because it disrupted their routine of starting the day with a cup of coffee, a few found it intolerable due to discomfort. One woman, who was a nurse, believed that she developed gastro-esophageal reflux disease from taking it and even flew home from a vacation due to the extreme discomfort and distress she experienced while taking it.

Resisting a Negative Identity

Being "a pill taker", as described above, was to be avoided. Sometimes this was a result of direct experience of unpleasant or medically contra-indicated side effects, but often it was merely a preference. It was like a badge of honour not to rely on medication to be healthy. Kellie, in the first interview, reported: "I stay away from pills, and as soon as I can get rid of Fosamax and Didrocal, I will be very happy, because I am not a pill taker." In the second interview, following a bout of esophageal reflux which she attributed to taking

Fosamax, she spoke dismissively about taking bisphosphates: "...you know, it burns a hole in your esophagus sometimes, and hell, I don't need that. So I let my bones get a little bit more brittle, I'll fall over, and (laughter)... The Actonel is supposed to not have so many side effects, but I think I will stop using it altogether and just get some decent calcium. I'm tired of these different pills. Soon I'll be like all the little old ladies with (name of pharmacy) bags of pills and take it for whatever reason...I don't want to be in that situation." The women did not associate taking supplements, such as calcium and vitamins, as "pills". With the development of an infusion that could be administered annually (e.g., Reclast), which some of the women were on at the time of the third interview, the requirement to be a 'pill taker' to deal with osteoporosis may have lessened. For people like Sharon and Kellie, for example, who found that they suffered terrible heartburn from bisphosphonates, this was a very positive development. However, this technical development does not change the way that being a pill taker is a stigmatized identity, another marker of vulnerability and age.

Facilitators of Physical Activity

Asked what helped them with exercising, this group of older women had relatively few suggestions. Sharon noted that having walking sticks for support helped her walk while Rebecca mentioned that having her spouse to accompany her on walks was very supportive. While Isabelle preferred to walk with friends, this was becoming increasingly difficult as friends died, moved away, or became incapacitated. Another woman felt that her faith helped her to be motivated whereas another felt that it was proximity to a community centre and walking trails that helped. In general, however, the women were somewhat at a loss to offer

suggestions as to what would help them be more active as they continued to age and possibly decline.

Barriers to Participating in Physical Activity

On the other hand, the study participants generated an extensive list of barriers to participation. These ranged from physical challenges such as frailty, fatigue, recovering from illness or injury, and a sense of weakness to lack of companion (e.g., for dancing) to having other priorities for how to spend time. The women noted that life events, such as a bereavement, vacation, or relocation disrupted physical activity routines and made it more difficult to establish them again. They also noted that having other chronic conditions besides osteoporosis such as osteoarthritis, diabetes, or cancer limited their energy or interest in physical activity. In addition, some of the women reported being afraid of injury, specifically falling, as a reason to be cautious about physical activity. One woman had had a series of car accidents over her life and these were sufficiently debilitating that she felt her ability to engage in physical activity was seriously impaired.

Women also identified aspects of the physical fitness experience itself as a barrier to engaging. Jessie Roberts, for example, commented on her experiences with weight training classes; her original experience was positive because she went to a seniors-specific class and recognized noticeable improvement in her strength. But later, when she tried to return to the gym at a time that was not designated for seniors she found it uncomfortable to be in a largely male environment. When Jessie was asked if she attends the gym in her local community centre she responded, “It’s a – they have seniors on Monday, Wednesdays and

Fridays....That's when I went. And it was hard at first because you didn't – but then I got into it, and I was, I felt good doing it. So I did it for quite, I should have kept it up, I'm sorry I didn't. But things happen in your life, there's a lot of things, you know. And it wasn't easy to try to get back in. I've gone back once and didn't feel comfortable, you know.” Further, “But the accessibility..., like I, I went once at, not when seniors was on and I felt so awkward because you get all these muscle guys [laughs] you get different people in there, so you don't feel as comfortable. And then with the seniors, when I went back it felt crowded, too many. I, again I didn't feel comfortable. I, I felt like I had to be instructed to start again and I just never got back into it. It's hard.”

Kellie Chapman also thought that weight-training would be a good exercise option for her but felt it was expensive and difficult to initiate: “I also took some weight bearing classes because I felt that in that course as well, because I felt I needed to gain some more strength, and like now I've got no muscles whatsoever, so I need to restart doing something...And I don't know what to do because I'm afraid, because I'm not . . . well-versed in that what to do best and to go to a weight-trainer – they're all very expensive.”

Women also mentioned that physical activity opportunities were not always accessible, whether as a function of cost, travel, or location. Several women reported that getting to a fitness facility was difficult due to driving and/or parking; one woman had to give up her driving license and another relied completely on other people to drive her places, thus limiting her opportunities to exercise.

Finally, the women in this study offered accounts of their health and physical activity participation based on their personal histories, life experiences, where they grew up (e.g., farm, Europe, countryside), and what they understood to be the randomness of illness and

injury (“things happen”). Though they felt some responsibility to take steps to be healthy and regarded others critically if they could be described as a “couch potato,” they did not necessarily feel that they had the personal, practical, financial, and emotional resources to engage in physical activity at this particular life stage.

Discussion

This study identified some aspects of the meaning of physical activity in a small group of older women living with osteoporosis. Despite their awareness that physical activity would likely help them maintain balance, flexibility, and strength, most of the women engaged in only limited leisure-time physical activity, and reported declining use of physical activity for transportation. As the women aged and their strength deteriorated, so too did the extent to which they were able to complete their own housework, the most common source of physical activity among women. Though the women were aware that exercise was part of managing their health, they saw being “active” as an important expression of their relative youth, healthfulness, and ability to manage independently.

These findings are consistent with those reported by others (Jeannae M. Dergance et al., 2003; Paterson & Warburton, 2010), particularly Clarke et al (2005), who studied a similar population of older women and found that the women’s ability to engage in meaningful activities was central to their definition of health, wellbeing, and quality of life: “Rather than being able to engage in extreme sports or undertake physical marvels, health entailed having sufficient physical abilities and independence in order to be able to lead the life one desired without the assistance of others” (Clarke et al., 2005 p. 49). The women in

our study used their level of activity as a marker of their ability to be independent and self-sufficient, despite various constraints they experienced as a result of pain, disability, energy, or limited resources. Asked to define what it means to be healthy, the women in Clarke et al.'s study said it was 'being able to do the things I want to do'. "[T]he meanings the women attributed to the word 'healthy' largely pertained to the ability to maintain an active and rewarding lifestyle" (Clarke et al., 2005, p. 48). It also meant being independent and able to fend for oneself; being unhealthy was associated with dependence and inactivity. Other research has documented similar findings regarding older women's valuing physical activity as a support to maintaining independence (Bowen, Eaves, Vance, & Moneyham, 2015; Bundon et al., 2011; Korkiakangas et al., 2011).

In their claims of being active, the women in this study consistently expressed what gerontologists have referred to as the "busy ethic." First proposed by Ekerdt (Ekerdt, 1986), the "busy ethic" refers to a moral code that legitimates retirement to the extent that it is "earnest, occupied, and filled with activity" (p. 239). Though this construct has been criticized for being Western, androcentric and ageist (Liang & Luo, 2012), it was nevertheless a shared value among the women in this group—despite variations in ancestry, income and current living arrangements. Ekerdt suggests that the "busy ethic" function as a way to "symbolically defend retirees against aging" (p. 241) through the way it creates continuity between mid-life and retirement because mid-life is understood as a time of tremendous, meaningful activity. "Adherence to the busy ethics can be a defense—even to oneself—against possible judgments of obsolescence or senescence" (p. 241). Yet

(t)he threat of the busy ethic ideal is that it subtly coerces older adults to subscribe to a lifestyle that may not suit their situation. For instance, the busy ethic stems from the work ethic, and so cohorts of women who did not work outside the home may not feel the need to convey an image of 'busyness'.

Instead, they may delight in not being busy with their traditional roles of cook, housekeeper and care person to small children (Phillips, Ajrouch, & Hillcoat-Nalletamby, 2010) (pp. 64-65).

Our data did not indicate that homemakers were less likely than women who had worked for pay to endorse or espouse the busy ethic—suggesting that it is a pervasive value that transcended differences among these women.

Further, the women’s conceptualization of “being active” as referring to more than their level of physical activity is worth noting. While exercise scientists and physical activity advocates may want to ensure that “being active” is not conflated with being “physically” active, the accounts of these women suggest that this may sometimes be the case and that they value “activity” that is more than the expenditure of energy, practicing balance, and improving strength and flexibility. From a policy perspective, this understanding aligns with discussions about the value and limits of concepts such as “successful” and “active” aging (Foster & Walker, 2014).

Understanding that gender is performed through daily activities (Hunt, McCann, Gray, Mutrie, & Wyke, 2013; Lyons, 2009), we can understand that the women’s descriptions of how they adapted their performance of household tasks like ironing, vacuuming, cleaning, and making meals as strategies they employed to fulfill social expectations of their role as adult women, still capable of living on their own. The women resisted facets of the aging identity which might warrant changes in their living arrangements such as moving into assisted living and saw osteoporosis as a potential threat to their autonomy and independence.

This group of women shared a common view of osteoporosis as a potentially disfiguring and disabling condition that they were anxious to avoid. Asked what the work

conjured up for them, they uniformly referred to an aged, ugly, old woman with a hunched back. This finding is consistent with a study of senior Danish women's ideas about osteoporosis (Reventlow & Bang, 2006, p. 322) in which women reported that osteoporosis evoked the image of "a woman with a bent body and a collapsing back." Yet none of the women in our sample were yet hunched over in the way that they imagined a woman with osteoporosis would be, despite some history of spontaneous spinal fractures and some falls. Like the Danish women, the women in our study described osteoporosis as a silent condition that was identified in either routine or dramatic ways, depending upon an individual woman's experience. Unlike the women in the Danish study, however, the women in our study did not invoke family history or genetics as an explanation for their development of osteoporosis. Instead, they associated it with dietary insufficiencies, particularly during childhood. As a consequence, the women reporting taking calcium and vitamin supplements and/or to ensuring that they ate a calcium-rich diet as a way to try to reduce further deterioration in their bone density. And despite their involvement with the exercise trial, the women did not generally understand exercise as a strategy for maintaining bone health. Moreover, the majority of them reported that having osteoporosis had not been a major source of distress in their life to date. Other chronic conditions, particularly ones that they understood to be potentially lethal, such as cancer or heart disease, were both of greater concern to them as medical problems and as conditions which limited their daily lives.

From the perspective of intersectional analysis, this study illustrates the gendered nature of aging and the stigma associated with aging for women. Several of the women made disparaging remarks about themselves, their bodies, or the appearance of other women, displaying both ageism and sexism in their denigration of who are visibly old, particularly

those who are disfigured by a condition such as osteoporosis. Calasanti and King (2015) suggest that these findings fall under the

rubric of intersectionality because the ways in which people mark or perceive their bodies as 'old' vary with gender, race, class, and sexuality. For instance, women, accorded status in part for their sexual attractiveness to men, appear to be old at younger ages than men. Such women's sense of selves *as* women rest on attractiveness...

Among younger women, physical activity is sometimes used as a bodily regimen to help attain or maintain an acceptable physical image, but for older women, physical activity may not hold the same promise of avoiding or repairing the body's changes. Given Western gender relations, the daily health practices of women are deeply influenced by their routine efforts to maintain membership in a valued social group, one that is gendered and age-graded, namely, the sexually attractive woman (likely heterosexual) (Calasanti, 2010; Calasanti & King, 2015).

On the other hand, an intersectional approach reminds us not to essentialize categories such as "older woman" and assume uniform experiences. In this study, for example, we saw significant variation in, for example, the mobility of women who were approximately the same age. With more demographic data or a larger sample, we might have been able to deeply explore the associations between income level or class, civil status, age and physical health, to see how partnerships, for example, foster access to or resources for physical activity.

The importance of this study derives in part from the perspective that we were able to obtain by revisiting the women a number of years after the original contact. By returning to interview the women after a decade, we were able to observe some aspects of how the women aged and the place of osteoporosis in their experience. During this period, the sample

aged (from being 65-74 to 74-84), experienced changes in their health status, and underwent a number of personal changes. Our aim was to understand how this small group of women, all of whom had been sufficiently motivated to originally volunteer to participate in an exercise program, were living with and managing a chronic condition that might impair their mobility but for which exercise is part of recommended self-management. In particular, we were interested in whether participation in the tailored exercise program had an influence on the women's engagement with physical activity, what facilitated or impeded their involvement in physical activity, and what they perceived might be done to enhance their level of physical activity.

Though we started the second phase of this study thinking we would learn how to support older women to be physically active, we actually learned about the utilitarian nature of physical activity for this group of women. From the perspective of interventions to promote physical activity in older women, then, we are in agreement with Xue et al. (2012), who suggest that it is particularly important to encourage light-to-moderate physical activity among older women as “most of the decline in physical activity in older women was due to a decrease in walking and doing household chores rather than regular exercise” (Xue et al., 2012 p. 542). Interventions to support walking (Giles-Corti & Donovan, 2002; Xue et al., 2012) and maintaining daily activity in the household would likely be both acceptable to the women and align with their priority to remain active and independent. However, the lifelong marginalization of physical activity in most women's lives is so normalized that physical activity is not conceived of as sufficiently relevant to or inherently valued for older women and thus is also marginal to policy makers and programmers—with the possible exception of those concerned with health care costs.

The design of this study and the small sample size make it difficult to generalize from these findings. It is possible that the women in this sample gave more attention to physical activity in the discussion of their everyday lives than other women of the same demographic profile might have. Just as several participants in the early interviews claimed to be ineligible for the study because they were not afraid of falling (a comment invoked by our name for the project as “Fear of Falling”), it is likely that the women in this study emphasized the importance of physical activity, especially in the second round of interviews, because they knew we were interested in the topic. Moreover, the sample was drawn from a group of women who had volunteered for a community-based trial of a physical activity program, which might make them an unusual group in the first place. However, the consistency of these findings with other studies suggests that these data capture some common aspects of the experience of older women living with osteoporosis, and their experiences of aging, physical activity, and identity.

These findings raise questions about the nature of health promotion interventions to facilitate physical activity among women with osteoporosis. On the surface, the data suggest that women could be encouraged to participate in physical activity if it was clear that doing so would help facilitate their goals of independence, appearing relatively youthful, and avoiding pain. Messages about and interventions for this target group would stay away from associations with sports and formal exercise in favour of physical activity providing functional capacities, fostering a youthful appearance, and being incorporated into everyday life. This approach aligns with gender norms and expectations regarding women’s roles and priorities but it does not challenge the gendered organization of physical activity, the division

of labour in the household, or women's concerns about attractiveness (see Pederson, Greaves, et al., 2014).

A gender lens recognizes that involvement in physical activity is a function of complex, gendered, situated health practices (Hunt et al., 2013). From this perspective, recommendations for interventions to address women's lack of physical activity do not focus only on improving women's knowledge of physical activity and personal motivation for being active. Rather, interventions need to be redesigned to address how they might stop reproducing gendered patterns of physical activity. This might include addressing societal messaging about women and physical activity; enhancing women's opportunities for physical activity that are safe, acceptable and appropriate; creating built and social environments for everyday physical activity to incorporate movement into paid work, caregiving, transportation, and leisure; and actively challenging gender norms about physical activity. Finally, although older women are influenced by socio-cultural norms and practices, they are also active agents who engage in the construction and reconstruction of their identities and social worlds (Shaw, 2001; Wearing, 1995). From this perspective, personal and cultural practices and understandings of aging and leisure are linked to power relations; through leisure older people can resist, negotiate, and perpetuate stereotypes of aging and gender—such as when older women resist the idea that strength training is only for young men.

Burgoyne (2015) conducted semi-structured interviews with 12 older adults, including 8 women and 4 men, discharged from a medically-supervised group exercise program to explore the barriers and facilitators to maintaining physical activity engagement. She found that post-program engagement varied widely, from 2 – 48 months following the completion of the supervised program and identified four themes that supported physical

activity engagement: personal drive; social connections and support; program content, structure and instructor skills and personality; and program accessibility (i.e., convenience, affordability, relevance, timing, transportation). Significantly, she also documented that the participants in her study felt that health care providers and fitness or physical activity instructors should stress the benefits of physical activity even after a medically-supervised program is completed, and that health care providers must continue to provide support for engagement in physical activity.

Program and Policy Implications

Reflecting on the analysis offered by Foster & Walker (Foster & Walker, 2014) regarding the two concepts, I would encourage Canadian policy makers to seriously examine the value of the “active aging” concept and its implications for policy. In contrast to the American notion of “successful aging,” with its emphasis on productivity and individual health, “active aging” embraces a broad conceptualization of activity espoused by the World Health Organization as “continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physical active or to participate in the labour force” (World Health Organization, 2002a p. 12). This definition is more gender-sensitive than perspectives which emphasize aging as primarily concerned with transitioning from labour force participation to leisure. As such, it encourages multisectoral policy-making. That is, interventions to promote active aging should not be limited to labour force policy but also foster opportunities for education, volunteering, social inclusion, and skills development (Foster & Walker, 2014). Such an approach to policy making is consistent with the

understanding espoused by the WHO that health is a resource for living, not an end in itself, and health promotion is the process of enabling individuals and communities to increase control and improve their health (WHO-EURO, 1984; World Health Organization, 1986).

Notably, the WHO framework on active ageing (World Health Organization, 2002a) does introduce both gender and culture as “cross-cutting” determinants of active ageing. While culture is understood to shape the way people age, gender is described as a “lens” through which to consider the appropriateness of various policy options and how they will affect the well being of both men and women” (p. 20). The text then describes the marked gender differences in labour force participation and caregiving that currently characterize many societies and individual lives. Further, it identifies what they label as the “feminization of ageing” as a challenge facing most countries:

Women live longer than men almost everywhere. This is reflected in the higher ratio of women versus men in older age groups.... While women have the advantage in length of life, they are more likely than men to experience domestic violence and discrimination in access to education, income, food, meaningful work, health care, inheritances, social security measures and political power. These cumulative disadvantages mean that women are more likely than men to be poor and to suffer disabilities in older age. Because of their second-class status, the health of older women is often neglected or ignored. In addition, many women have low or no incomes because of years spent in unpaid caregiving roles. The provision of family care is often achieved at the detriment of female caregivers’ economic security and good health in later life (World Health Organization, 2002a, pp. 39-40).

Surely understanding that this is the pattern of current aging would lead policy makers to insist upon gender analysis during the policy making process, including establish gender-specific policy aims and evaluating policy implementation using gendered criteria?

The WHO framework is notable for another reason. Unlike other policy frameworks, the WHO Active Ageing policy acknowledges issues of violence and abuse in the lives of

older people, as well as the ageist attitudes and gender inequities that perpetuate it (see p. 29).

Taking this a step further, I would suggest that an intersectional approach to active aging would lead to creative, flexible policy options. By its very nature, intersectionality challenges the notion that “one size fits all” and instead sheds light on variation—not just at an individual level, but at the intersection of important processes such as gender, age, race and class. Given that older people do not age in identical ways and therefore some people will experience health challenges and disability regardless of “healthy lifestyles,” it might be valuable to think of bundles of policy options rather than single policies. Just as households may currently choose among various schemes when electing to take their Old Age Pension to reflect their individual and household circumstances, other policies could permit choice and variation to facilitate engagement, participation and “being active” as women and men prefer. Foundational to all of these policies would be human rights policy to eliminate and protect against ageism, as well enactment of provisions to foster gender equality.

Conclusions

This project was informed by theorizing on gender and health behaviour (Lyons, 2009; Lyons, Emslie, & Hunt, 2014) which have incorporated discussions of hegemonic masculinities and femininities (Connell, 1987; Schippers, 2007). There is increasing evidence of the importance of both sex (as biology) and gender (as social factors) in understanding male and female differences in health, including bone health and disease (Fausto-Sterling, 2005). Viewed from the perspective of sex and gender, women’s lack of involvement in

physical activity may be less an individual behavioural choice than the outcome of a complex set of contextualized and gendered health practices that shape the ways that women live their everyday lives, constraining their opportunities for leisure as well as their priorities for health (Duin et al., 2015). “By focusing on enabling individuals to ‘do what they want to do’ as the goal of interventions, health care practitioners may better understand the motivations and perspectives of older adults while also being sensitive to the changing physical and social realities of growing older” (Clarke et al., 2005 p. 57).

A gender lens recognizes that women’s involvement in physical activity is a function of complex, gendered, situated health practices. From this perspective, recommendations for interventions to address women’s lack of physical activity would not focus simply on improving women’s knowledge of physical activity and personal motivation for being active. Rather, interventions would be redesigned to acknowledge women’s priorities or, ideally, to address how they might stop reproducing gendered patterns of physical activity. For example, awareness-raising campaigns to promote physical activity might address societal messaging about women and physical activity to continue the changes that have occurred over the previous three decades regarding women’s involvement in physical activity as normal. Programmers and policy makers might enhance women’s opportunities for physical activity that are safe, acceptable, social, and appropriate by creating built and social environments for everyday physical activity to incorporate movement into paid work, caregiving, transportation, and leisure; and actively challenging gender norms about physical activity by continuing to celebrate women’s events, creating mixed sex events whenever possible, and advocating for the media and international sports federations to devote adequate resources to the development of girls’ and women’s sports.

With respect to promoting physical activity, research suggests that group physical activity provides valued opportunities for socializing and support as well as physical activity. Burgoyne's (2015) study participants commented that they were more likely to engage in physical activity if they were committed to a registered group experience rather than trying to do it at home on their own. Participants also said that they didn't always know 'where to go' and lacked information about opportunities, programs and services. Accordingly a gendered approach to programming would take into account how women/men prefer to obtain health information, such as physical activity guidelines, from whom, where, and when. This might mean, for example, "(p)roviding programs or services that assist and encourage [older adults] to remain engaged in household and outdoor [physical activity], such as cleaning or gardening, may be beneficial in maintaining or increasing [physical activity] engagement among [older adults]" (Burgoyne, 2015 p. 71).

Notably, though the women subscribed to the "busy ethic" that has been seen as embedded in discussion of "successful aging" as articulated by Rowe and Kahn (1987), they were generally unable to fulfill other criteria associated with the construct. As women living with documented low bone density, these women were already identified as potentially frail, "at risk" or "unsuccessful agers". They challenged this potentially denigrating label, however, by pointing out and disparaging others who were in poorer health, who were less independent or functional, or who were not as engaged in being "busy". Whereas the intent of this study had been to understand women's engagement in physical activity, the main finding of this inquiry was the priority they placed on doing the things they wanted to do that. These women were mostly not interested in physical activity per se but rather the extent to which physical activity could help them meet that overarching goal.

This chapter aimed to shift the discussion of older women's lack of engagement with physical activity by focusing less on physical activity and more on how women's engagement in physical activity may be shaped by (and ultimately changed by) gender and gender relations. Such an approach aligns with suggestions that gender-neutral policies, programs, and projects in fields such as childhood obesity may contribute to observed gender differences in health behaviours and health outcomes (Simen-Kapeu & Veugelers, 2010; Sweeting, 2008).

CHAPTER SIX: RETHINKING WOMEN AND HEALTHY LIVING

It is the understanding that “(h)health inequalities are produced by social inequalities” (Raphael & Bryant, 2015 p. 245) that underlies my thesis that addressing gender inequalities can reduce health inequalities. To the extent that those inequalities are unfair and unjust, such health inequalities are inequitable. Hence, addressing gender inequalities themselves can produce health and gender equity. As a health field devoted to action to empower individuals and communities to increase control over and improve their health, health promotion is positioned to adopt greater responsibility for improving gender equity than it has to date.

Kumar and Preetha (2012 para. 1), writing from India, have suggested that health promotion is “more relevant today than ever in addressing public health problems” given the “triple burden of diseases” confronting health systems, policy makers and providers worldwide, namely: the as-yet-unfinished battle with communicable diseases; new, emerging and re-emerging diseases; and the rise of non-communicable chronic diseases. They also acknowledged that health is influenced by numerous factors outside the health system, including food consumption patterns, demographic changes, work and working conditions, family life, globalization, schools and the learning environment, as well as culture and the social fabric. Yet this contemporary statement of support for health promotion nevertheless failed to seriously explain or discuss how it is that culture and the social fabric contribute to health—nor how these influences might be changed. This kind of discussion remains the norm in most health promotion texts and practice settings, which focus less on changing social structures and patterns than on physical and material living and working conditions. Though essential, such practices cannot address those aspects of health-damaging conditions which are shaped by gender, in all its dimensions.

Closer to home, in late August 2015, Statistics Canada released one of its regular *Health Reports* describing a cohort analysis of avoidable mortality among First Nations adults in Canada (Park, Tjepkema, Goedhuis, & Pennock, 2015). This report detailed that from 1991-2006, First Nations adults in Canada had more than twice the risk of dying from avoidable causes than non-Indigenous adults. Both men and women were at greater risk, with First Nations men having just over twice the risk of non-Indigenous men, while First Nations women had nearly 2.5 times greater risk (though overall First Nations men had greater avoidable mortality than First Nations women). Moreover, the patterns of avoidable mortality by disease varied by cause, with men more likely to die from (in order of risk) alcohol and drug use disorders, unintentional injuries, and diabetes mellitus, while women were more likely to die from alcohol and drug use disorders, diabetes mellitus, infections, and unintentional injuries. These gendered breakdowns enable us to see that First Nations women and men have both different risks from non-Indigenous men and women in Canada, but also from each other. In turn, such findings should inspire action that engages with these between-group and within-group differences.

This dissertation has tried to grapple with the issues raised by both these examples: a largely gender-blind health promotion world and evidence of significant gender-related health inequities. To do so, I have documented the gender-blind nature of health promotion as a field over time and traced the growth of calls for greater attention to issues of gender by health practitioners and researchers. I have demonstrated that though the World Health Organization has proposed documenting pioneering practices in gender and health interventions, there has been little attention to this approach in some of the mainstream areas of health promotion, namely, tobacco control, alcohol use, and physical inactivity. Not only

will researchers need to identify the lack of attention to gender concerns at the level of specific interventions, but knowledge synthesis methods remain to be developed that can reliably and meaningfully report evidence of gender-sensitive interventions.

Moreover, knowledge translation efforts will need to embrace lessons from the field of sex, gender and health research. A few authors (Oliffe, 2012; Poole, 2012) have begun to explore this topic. Poole, for example, suggests that knowledge translation practices should echo knowledge generation approaches by embracing participatory, feminist, action-oriented aims that deliberately seek to expand the range of participants in knowledge exchange and empower less-powerful actors. She has developed and tested a system of virtual communities of practice (vCOP) which facilitate interaction among individuals across physical and social locations as a tool for engaging practitioners, in particular, in discussion with researchers and policy makers. To date, these vCOP have generated a diverse set of tools to inform practice related to substance use, mental health and gender. In a different vein, Oliffe proposes that when research investigates gender relations and their influence on health practices (Bottorff et al., 2011), interventions should take those relations into account and address them explicitly. For example, in investigations about mothers, fathers and prenatal smoking, Oliffe and his colleagues identified patterns of smoking relationships and focused their knowledge translation efforts, in part, on sharing the models with women and men of parenting age to enable them to understand how smoking was part of their relationship, not simply an individual behaviour (Bottorff et al., 2006).

One way that the field might move forward is to deliberately develop health promotion with gender in mind. To that end, I've proposed a framework for developing gender-transformative interventions, informed by international discussions of gender as a

determinant of health. Applying a gender lens to older women's physical inactivity, I then tried to demonstrate how health promotion interventions might differ if they addressed the structural, practical, and personal barriers women report to being more active. Together, these materials are intended to support a call for rethinking women and healthy living.

What might this look like? As a start, changing gender roles, relations and practices to reduce discriminatory assumptions, language and practices—changed for the better—would become one of the explicit goals of health promotion activities. Combining the empowering core of health promotion with a commitment to transform gender—including aspects of gender norms, roles, relations and institutions that are harmful, diminishing and/or used to justify inequalities between and among women and men—will not only improve women's health, but also women's status, thereby responding to the calls for gender equity as a route to achieving health. This might entail rethinking depictions of women and men, girls and boys in health and physical activity program materials to ensure that the diversity of people is visible. It might mean offering gender-segregated and gender-specific programming to ensure the participation of women and girls from communities which prohibit exposure of the body to nonfamilial men and boys as well women and girls who have are simply reluctant to be visible engaging in physical activity. It might mean combining the Olympics such that the “real” ones and the Para-Olympics are one event and eliminating gender-testing for all participants. It may mean expanding the availability of offerings for girls and boys so that they can develop body awareness, skills and confidence at an early age—and then use them as they see fit for dance, play, sports, meditative practice or work. It means reducing barriers to participation through eliminating fees at public facilities. It could mean enhancing access to physiotherapy and other supports that are no longer covered by provincial health insurance

plans but are covered by private plans—which by virtue of men’s greater participation in the workplace means that more men than women will have access to these providers. The point is not to be prescriptive but to open up the range of available options through challenging gendered and age-graded assumptions about who people are, what they want, and what they can accomplish. This applies equally to men and to women (Oliffe, 2012).

Program developers and policy makers also need to know whether a program “works”, under what conditions it works and for whom. Although there is not yet a systematic approach to what we and others are calling “gender transformative” health promotion interventions, some principles of practice are beginning to emerge. As discussed at the outset, international agencies such as the World Health Organization (World Health Organization, 2002b, 2009b, 2010b, 2010c) and UNESCO (Sambo, 2010) have been at the forefront of this work, suggesting that promising practices should, at a minimum: adopt a rights-based approach; be based on a gender assessment or research to identify local needs; promote community participation and ownership; strengthen the health system; build knowledge of and capacity to address gender equality issues; ensure the participation of men; have built in monitoring and evaluation indicators and processes; and include plans for replication and scale up. None of the programs reviewed over the course of this research meet many of these criteria, let alone all. Yet, there may be opportunities to embrace some of these elements within programs and policies sooner rather than later. For example, research continues to accumulate that is describing the interactions of sex and gender and their effects in the context of tobacco use (Greaves, 2014), violence (Barker et al., 2007), HIV and reproductive health (Caro, 2009), and injury (Duckham et al., 2013)—to name but a few areas.

Indeed, while we posit that advances in the field of women's health can be instructive to health promotion and critique health promotion's slow uptake of theories and concepts, the field of gender and women's health has been marred by some limitations. While theoretical advances are sophisticated and complex, there remains a tendency to essentialize the category of "woman", to see gender as primarily affecting women, and to ignore or pay scant attention to men and masculinities. As well, there are those who would argue that some women's health advocates give too much primacy to gender over other key social determinants of health (Hankivsky et al., 2010)—or fail to recognize and acknowledge this as a limitation in their work.

As previously noted, health promotion could continue to learn from more dialogue and exchange with feminist scholarship by presenting intersectionality as an important theoretical contribution from women's studies and other fields that could help health promotion grapple with diversity and the persistence of health inequities (McCall, 2005; Reid et al., 2007, 2012a; Weber & Parra-Medina, 2003). Using an intersectional analysis to design research and interventions could increase the theoretical rigour and enhance health promotion practice and policy, both within and beyond women's health. Moreover, we need to "situate research and practice within a theoretical framework of context-specific categorizations of bodies by gender, age, and other dimensions of inequality" (Cairney, 2000) (p. 732) as we seek to improve the lives of elders, including older women.

Gender must be understood as a fundamental determinant of health that structures access to key resources (Benoit & Shumka, 2009) such as education, employment, childcare, safe neighborhoods and health services—themselves determinants of health. But gender must be understood to interact with social class, race, ethnicity, age, immigrant status and

geographic location as fundamental determinants of health as well. Acting together, these determinants shape access to resources and ultimately health behaviors and morbidity and mortality. Understanding the relationships among the determinants of health and what happens at the intersections of two or more categories such as gender and age is important for action to reduce health inequities. It is critical that actions be taken to tackle gender-related inequities and their consequences both directly and indirectly in order to reduce the health inequities which are a consequence of them. That is, action should be taken to reduce gender-related inequities themselves, not simply expecting action on other factors to trickle down to improving gender-related inequities. Health promotion research and practice in Canada therefore needs to take bold action (Raphael, 2008); theoretical innovations to improve knowledge and praxis, such as the uptake of gender-responsiveness, are needed to enable us to embrace the complex interplay of health determinants and to understand how they intersect and mutually reinforce each other.

Gender-transformative health promotion rests on a number of tried and tested principles—reinterpreted with a gender lens. These were derived from multiple fields of practice but particularly the fields of substance use and violence against women. These principles can be used to inform program design as well as how providers should relate to program participants. They imply a very different form of health promotion practice than has arisen from the social-cognitive theories that dominated the field in its early days.

Gender-transformative health promotion promises to challenge the use of stigma, shame, and gender stereotypes to promote health and, in so doing, can contribute to fostering mental as well as physical health. Evidence is mounting that it is possible to address the root causes of gender inequality, to challenge assumptions of the nature of gender relations, and to

use these processes to reduce the risk of communicable diseases such as HIV/AIDS (Eckman et al., 2004; World Health Organization, 2009b), tuberculosis (Allotey & Gyapong, 2008), and malaria (Heggenhougen et al., 2003), as well as non-communicable health challenges such as gender-based violence (Dworkin et al., 2013; Nascimento et al., 2010). Programs aimed at the empowerment (Wallerstein, 2006), particularly of girls, show promise of helping to reduce violence and early marriage (Amin & Chandra-Mouli, 2014; Horton, 2015); such programs are especially promising when complemented by programs working with men and boys (Dworkin et al., 2013). While some programs continue to rely upon messages derived from hegemonic masculinity or enhanced femininity, a critique is emerging that this is harmful and indeed unethical (Fleming, Lee, & Dworkin, 2014). Indeed, much work remains to be done to demonstrate a new set of ‘promising practices’ that align with the ones proposed a few years ago (World Health Organization, 2010b).

In a previous discussion, a number of implications of applying an intersectional approach within health promotion were identified, many of which would apply to gender-transformative health promotion itself (Reid et al., 2007, 2012a). For example, an intersectional analysis shifts our focus from “immutable” individual characteristics (e.g., sex, ethnicity) to “mutable social realities” (e.g., those that can be changed through an intervention). With an intersectional lens, gender, ethnicity, and age are to be understood not as strictly biological categories but also social ones (Krieger, 2003). We will be wary of essentializing “populations,” and generalizing about “all women,” recognizing instead the importance of understanding differences and inequalities among and between women.

An intersectional, gender-responsive approach shifts the focus of research and interventions from individual behaviours to social structures—or at least to those behaviours

in context. A gender-responsive approach pays attention to the structures, institutions, ideologies and practices that sustain rigid, harmful gender norms through relations of power and privilege. This involves taking action on the “causes of the causes”, that is, the social policies, assumptions, and practices that perpetuate gender-related inequities in income, employment, education, work, and caregiving, while adopting ecological and multisectoral approaches to interventions.

Gender-transformative health promotion invites us to pay attention to social processes, social dynamics, and the role of power in producing and sustaining social inequities. It also encourages the researcher-practitioner to connect her or his personal and political identities, and to become aware of her or his own power and privilege. Adopting a reflexive practice can help prevent health researchers and practitioners from unknowingly perpetuating, sustaining, and reinforcing harmful stereotypes—including those related to sex and gender.

This dissertation can help to open up new lines of inquiry with respect to women’s health and health promotion. Its core argument—that health promotion research, policy and practice would be strengthened with a gender-responsive approach—would, however, be strengthened by rigorous research and evaluation of programs and policy initiatives intended to identify and address gender-related health inequities. These complex interventions require significant commitment, time and resources to develop, conduct and evaluate. As such, for the ideas outlined here to influence the field of health promotion, we will need to pursue demonstration project funding opportunities, develop appropriate evidence synthesis tools and indicators, and further the dialogue about such research. The test of this approach lies in

empirical research—demonstration projects, interventions studies and knowledge syntheses—as well as its reception by practitioners, policy makers and program participants.

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APPENDIX A: SUMMARY OF THE REVIEWS IN THE OVERVIEW OF REVIEWS

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
Alcohol	Blake (2001) A Review of Substance Abuse Prevention Interventions for Young Adolescent Girls	Young adolescent girls	Interventions varied, including classroom management training for teachers; social decision-making education for elementary school students; classroom-based sessions on social influences and cognitive development; curricula to address smoking prevention or cardiovascular risk reduction; mass media campaigns; interactive drama sessions; health education including peer group resistance training; activity booklets; and parental support.	<p>- “those interventions that were more effective with girls tended to focus on social skills training, social influences, and social norms; interventions that provide social skills training to improve interpersonal communications or negotiation and improve peer pressure resistance skills or self-efficacy might be more appealing to girls than to boys (Graham et al., 1990; Santi et al., 1994).”</p> <p>- One "gender-specific intervention focused on leadership development and was intended to instill a sense of power and control over an individuals' circumstances using a life skills approach. Training in leadership, decision making, assertiveness, and refusal skills was provided" (p. 314).</p> <p>- Four girls-only, gender-specific interventions were identified: all relied on social influence or social learning theory models and three of them provided either life skills or social resistance skills training. Most of the published interventions to date have not addressed or mentioned the issue of gender</p>	<p>"Consistent with the extant research on risk factors and protective factors, and with theories posited to explain gender differences in risk behaviors ...those interventions that were more effective with girls tended to focus on social skills training, social influences, and social norms" (p. 317). "</p> <p>- Relatively few investigators examined the differential effectiveness of programs by gender, considered the role that gender might have in shaping risk behaviors or integrated the risk factors and protective factors unique to girls in the design of the interventions being delivered.</p> <p>- A number of factors contribute to the lack of published gender-specific studies in the literature. First, most of the early substance use prevention programs were implemented in schools—a setting in which substantial logistical constraints exist to delivering gender-specific programs. Second, as was discussed in the literature, and as was discussed by Amaro et al. (2001), relatively few theoretical models have been developed to explain fully the differential substance use patterns, risk factors, and protective factors that are seen between adolescent boys and girls</p>

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
				other than to include gender as a covariate in outcome analyses.	
Alcohol	Stade et al. (2009) Psychological and/or educational interventions for reducing alcohol consumption in pregnant women and women planning pregnancy (Review)	Pregnant women and women planning a pregnancy	Psychological and educational (not pharmacological) interventions during pregnancy or 12 months before conception for women planning pregnancy. Studies provided advice on alcohol reduction through counselling sessions or motivational interviews with follow-up support from self-help manual or letter. Psychological interventions include cognitive-behavioural therapy (CBT), brief psychodynamic psychotherapy, interpersonal psychotherapy, and supportive counselling or therapy	Gender-sensitive characteristics of the interventions were not noted. However, the authors recognized that "consuming alcohol in pregnancy is a socially stigmatized activity in many cultures, and results based on self-reported behaviour may exaggerate the positive effects of interventions' (p. 498). Eligible women were followed up with an alcohol assessment (labelled a 'diagnostic interview'), which was conducted together with a partner selected by the woman. The partner could be the woman's spouse, father of the child, or any other supportive adult who would be knowledgeable about the woman's health habits. Following the assessment interview, the couples were randomized to either a 25-min brief intervention or to a control group (which received no further care) situations.	"The main conclusion of this review is that overall there is very little evidence about the effects of educational and psychological interventions aiming to reduce alcohol consumption in pregnancy, and in particular, on the effect of such interventions on the health of women and babies" (p. 11)."The evidence from the limited number of studies suggests that psychological and educational interventions may result in increased abstinence from alcohol, and a reduction in alcohol consumption among pregnant women. However, results were not consistent, and the paucity of studies, the number of total participants, the high risk of bias of some of the studies, and the complexity of interventions limits our ability to determine the type of intervention which would be most effective in increasing abstinence from, or reducing the consumption of, alcohol among pregnant women."

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
				The effects of the brief intervention were significantly enhanced when a partner participated (Chang et al., 2005).	
Alcohol	Turnbull et al. (2013) Home visits during pregnancy and after birth for women with an alcohol or drug problem (Review)	Pregnant and post-partum women with substance use problems	This review examined various permutations of home visits as an intervention to support women with alcohol or drug use problems during pregnancy and after birth. "Home visits that commenced during pregnancy and/or after birth by teams or individuals consisting of doctors (obstetricians, general practitioners or paediatricians), nurses (midwives, drug and alcohol workers or early childhood nurses), social workers, counsellors or trained lay people. Included studies that detailed timing of visits, frequency of visits, the type of home visitors, the interventions and co-interventions. Home visits may have included outreach visits to non-healthcare	The reviewers recognized that mothers with "drug addictions frequently have a history of poor antenatal and postnatal care and tend to be socially disadvantaged" though there was no discussion of how or why. The aim of home visiting initiatives is to link pregnant women and mothers with health and social services with the goal of reducing the harms associated with substance use while fostering a positive developmental context for the child. There was acknowledgement that there might be an impact of domestic violence, child neglect or abuse and the risk of subsequent mother-child separation. "Home visiting services may take a non-judgmental and supportive role or amore directive approach in which the goals are to monitor the families' compliance with standards of parenting care and ensure the infant's welfare...." (p. 3).	"There is insufficient evidence to recommend the routine use of home visits for pregnant or postpartum women with a drug or alcohol problem. Further large, high-quality trials are needed" (p. 2).

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
			facilities".		
Alcohol	Wilsnack & Wilsnack (2002) International Gender and Alcohol Research: Recent Findings and Future Directions	women and men	(i) Develop standard reporting units of alcohol consumption that considers sex (e.g. biological breakdown) and gender differences (varied drinking patterns and behaviours between men and women); gender norms and structures in different cultures; gendered social implications such as stigmatisation of drinking in different groups of women (differentiated by education, employment and status); (ii) Policy implications for gender and alcohol use	(i) considers gender and alcohol use in various contexts such as culture, geography, education, employment (ii) considers sex and alcohol use in terms of biological breakdown (iii) considers gender, norms, roles and responsibilities on patterns and amount of alcohol use (see page 246)	It is important to improve the culture- and gender-sensitivity of measures of alcohol use and alcohol problems. Cross-national research can help to explicate the complex interactions of biology and other individual- and societal-level variables that influence the drinking behaviour of women and men (p.249)
Alcohol	Nilsen et al. (2009) "Brief alcohol intervention	Pregnant women	Brief intervention has been described as a patient-centred approach that focuses	Eligible women were followed up with an alcohol assessment (labelled a 'diagnostic interview'), which	This overview presents a convincing evidence base with regard to the effectiveness of delivering brief intervention in antenatal care and many other healthcare settings.

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
	to prevent drinking during pregnancy: an overview of research findings"		on changing risk behaviour (p. 498). Brief intervention has been used in the alcohol literature to encompass a wide range of activity in addressing alcohol-related risk and misuse, from a single 5-min session of simple advice delivered by a generalist healthcare provider (e.g. a physician or a nurse in primary healthcare) to much longer consultations and multiple sessions accompanied by repeated follow-ups delivered in specialist settings (Kaner et al., 2007). (i) brief intervention group received a 1-h motivational interview (Handmaker et al., 1999) (ii) 45-min brief intervention (Chang et al., 1999) (iii) 25 minute couples brief intervention (Chang et al., 2005) (iv) brief intervention group, which consisted of 10–15-min sessions of advice delivered by trained nutritionists	was conducted together with a partner selected by the woman. The partner could be the woman's spouse, father of the child, or any other supportive adult who would be knowledgeable about the woman's health habits. Following the assessment interview, the couples were randomized to either a 25-min brief intervention or to a control group (which received no further care) situations. The effects of the brief intervention were significantly enhanced when a partner participated.(Chang et al., 2005).	

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
			(2007 by O'Connor and Whaley)		
Tobacco	Fang et al. (2004) Smoking Cessation in Pregnancy: A review of postpartum relapse prevention strategies	Pregnant women who smoke	Brief motivational interviews; screening/assessment by health care providers; counselling; telephone support, mail, or digital follow-up; support/encouragement; social marketing/media messaging. (i) Most research on smoking cessation and pregnancy has attempted to maintain cessation during pregnancy. Programs that support women during this time protect the health of the unborn baby as well as the pregnant mother. Several programs keep high-risk women from smoking during pregnancy but do not track whether the women remain smoke-free after the baby is born (Windsor et al., 2000; Ershoff et al; 1989; Scott et al., 2000). (ii) The focus of most studies was not specifically on prevention of relapse, but rather on	"Programs that successfully reduce postpartum relapse rates, even though they are specifically designed to reduce prepartum smoking rates, are those that include the smoking habits of partners, others living in the home, and close friends; support women with positive encouragement rather than negative nagging; understand the time and financial commitment successful cessation interventions require; encourage women's social networks to support her; take place throughout pregnancy and through early childhood care; and distinguish between women with concrete plans for not relapsing and those who have not thought out possible challenges" (p. 271). "Authors note that successful interventions embody these characteristics: (i) Lillington (1995) reported that culturally appropriate, low-literacy materials are useful in delaying relapse or maintaining cessation. (ii) The general opinion is that	"Although there is much information on the rationale and strategies for smoking cessation for pregnant women, fewer studies exist on how to prevent relapse..... Programs should incorporate stresses particular to postpartum women, should be part of routine health care, and should involve the woman's social support network, including her partner, to maximize effectiveness." (p. 264).

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
			<p>maintaining cessation throughout pregnancy and beyond. These programs were often offered in tandem with broader social service programs (Dolan-Mullen et al., 2000; Donatelle et al., 2000)</p>	<p>clinical and social intervention cessation programs that would be most effective are those that address the needs of the individual woman, address her social network, and are incorporated into routine health care. (iii) The programs should also include personal interaction with clinicians and/or support staff (Cinciripini et al., 2000) (iv) Address a woman's social sphere by increasing community awareness about why women who are pregnant should not smoke,(Cnattingius et al., 1992) encouraging a woman's social network to support her with positive encouragement rather than negative nagging (Solomon et a., 2000; Edwards et al., 1998 Haslam, 2000) "</p>	
Tobacco	Greaves et al. (2003). Expecting to quit: a best practices review of smoking cessation interventions for pregnant and	Pregnant and postpartum women who smoke	"(i) Quit Guides: Many interventions used some form of take-home, patient-focused guide to quitting, usually incorporating some skill building, tips on reduction and cessation and advice. (ii) Counselling: Many interventions included	"Recommended interventions from review (p.30): Information; tailored information (Windsor Guide); social support (buddy); incentives (Donatelle et al., 2000); Information; tailored information (Ershoff et al., 1989, 1990; Mullen et al., 1990); Information; tailored information (Windsor Guide);	"There is no available evidence to judge exactly which components work best in relation to the others or, if appropriate, in which particular balance or combination. More importantly, there is no clear evidence to date that indicates which sub-populations would benefit from which components and in which balance or combination" (p. 44). While there have been no shortage of attempts, effective smoking cessation programs and interventions for pregnant and postpartum girls and women are scarce. For sub-populations of pregnant smokers in particular, such as ethnic minority women, spontaneous quitters, Aboriginal

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
	postpartum girls and women		<p>some form of counselling, however brief, delivered by a range of practitioners from obstetricians to peers. (iii) Buddy Support: Many interventions encouraged the identification and involvement of a “buddy” for the pregnant woman to assist with providing social support during the cessation process. (iv) Partner counselling/social context: Some interventions included identification of the smoking patterns of the partner and friends and family as key aspects of the assessment process. (v) Information: Many interventions included some education about pregnancy and smoking in the form of pamphlets or videos. (vi) Nicotine Replacement Therapies: Pharmacological components existed in some interventions to complement other approaches. (vii) Human Follow-up:</p>	<p>counselling (Hjalmarson et al., 1991); Information; tailored information (Windsor Guide) (O’Connor et al., 1992); Information; tailored information; social support; counselling; incentives (Walsh et al., 1997); Information; tailored information (Windsor Guide); counselling (Windsor et al., 2000). From the wider literature in women’s health, women-centred care, and teenaged girls and women’s smoking and substance use, it is possible to name several approaches or perspectives that could either be applied immediately to the field of tobacco cessation with pregnant smokers, or that could be integrated into future intervention development and research. Best practices approaches (p.45): (i) Tailoring - increased emphasis on the specific characteristics of sub-groups of smokers who have special features or experiences affecting their ability to quit. (ii) Women-centred Care - an assessment of women’s diversity that demands an understanding in the context of health. It also prescribes a holistic or comprehensive view of, and approach to,</p>	<p>women, heavy smokers and teenaged girls, tailored strategies are all but absent. Recommendations include shifting the focus of interventions to include women’s health as motivation for cessation, increased tailoring of interventions, and the incorporation of harm reduction, stigma reduction, and a woman-centred approach into clinical practice.</p>

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
			<p>Human follow up was incorporated into several interventions, with a view to sustaining the impact of the other components and offering encouragement. (viii) Other Follow-up: Other forms of follow up were a distinct component, including paper-based communications to assess the effect of the intervention. (ix) Incentives: Both financial and symbolic rewards were incorporated into some interventions. (x) Feedback about Biological Changes: Ultrasound images, stress tests, or other biological data were delivered back to the pregnant woman to illustrate the effects of smoking on the fetus. (xi) Groups: Some interventions included support groups or group counselling to deliver and/or sustain the intervention."</p>	<p>health, including mental and physical health considerations. (iii) Reducing Stigma - integrate awareness of stigma into the four As (ask, advise, assist, arrange follow up) when dealing with pregnant smokers. (iv) Relapse Prevention - ultimate intervention is to either begin by using the woman's health as the motivation or intervene postpartum to shift the motivation from the fetus to the woman herself. (v) Harm Reduction - all measures would be taken to reduce the harm to the woman and the fetus from the effects of smoking. More specific to tobacco, an emphasis on smoking reduction during pregnancy and postpartum would become a focus in programming. NRTs should be integrated more fully into interventions as a way of reducing the level of nicotine and lessen the harmful effects of smoking cigarettes. (vi) Partner/Social Support - it is necessary to acknowledge the presence of smokers in the lives of pregnant smokers and to determine the dynamics of those relationships (vii) Social Issues Integration - consider issues of poverty, income adequacy, unemployment, and</p>	

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
				low education cluster to create survival pressures on pregnant smokers; consider entire context of social and economic factors is considered and a similarly wide range of solutions and aids is offered"	
Tobacco	Lumley et al. (2009) Interventions for promoting smoking cessation during pregnancy	Pregnant women who smoke	A range of intervention types were examined including: cognitive behavioural therapy, education and motivational interviewing; interventions based on the stages of change model using various media; feedback on foetal or maternal health status; rewards or incentives for smoking cessation; pharmacotherapies; other, such as hypnosis, home visits.	In the discussion, the reviewers noted that in high-income countries, "smoking has become closely correlated with entrenched social disadvantage and psychological co-morbidity" (p. 20). This was not visible in the reports on the studies. They did report the effectiveness of high intensity with other forms of support including follow up and reminders, home visits, personal contacts, incentives or provision of pharmacological therapy (p. 45)	"Smoking cessation interventions in pregnancy reduce the proportion of women who continue to smoke in late pregnancy, and reduce low birthweight and pretermbirth. Smoking cessation interventions in pregnancy need to be implemented in all maternity care settings. Given the difficulty many pregnant women addicted to tobacco have quitting during pregnancy, population-based measures to reduce smoking and social inequalities should be supported" (p. 2).

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
Tobacco	Torchalla et al. (2012) Smoking cessation programs targeted to women: a systematic review	women excluding targeted pregnant or postpartum women	<p>Diverse interventions including (i) Behavioral strategies to prevent weight gain</p> <p>(ii) Medications to prevent weight gain</p> <p>(iii) Cognitive strategies to reduce weight and body image concerns. (iv) Strategies to reduce and cope with negative affect (v) Coping skills training and/or stress management training re: general life stressors, (vi) Cognitive-behavioral strategies to identify and manage situations and triggers. (vii) Medication to reduce the rewarding effects of nicotine (viii) Scheduling the quit date to be timed to the menstrual cycle</p> <p>(ix) Peer lay counselors who shared features with the target group</p> <p>(x) Socioculturally adapted materials and components (xi) Brief motivational counselling</p> <p>(xii) tailored/gendered</p>	<p>(i) Coping skills training and/or stress management training that addressed general life stressors, interpersonal stress and the challenges of balancing family and work. (ii) Scheduling the quit date to be timed to the menstrual cycle</p> <p>(iii) Peer lay counselors who shared commonalities with the target group (e.g., language, culture, attitudes, and beliefs). (iv) Socioculturally adapted materials and components. (v) Brief to moderate motivational interventions (one-time counseling plus supportive telephone calls or post-visit reminder letters). (vi) Additional material: tailored/gendered self-help booklet, tailored/gendered video/poster exposure, mailings and/or telephone calls only without any face-to-face interaction.</p>	Further attention should be devoted to identifying new settings for providing smoking cessation interventions to women from disadvantaged groups. Women-specific tobacco programs help women stop smoking, although they appear to produce similar abstinence rates as non-sex/gender specific programs. Offering interventions for women specifically may reduce barriers to treatment entry and better meet individual preferences of smokers. Developing approaches that fully account for the multiple challenges treatment-seeking women face is still an area of research.

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
			self-help booklet, tailored/gendered video/poster exposure, mailings and/or telephone calls only without any face-to-face interaction.		
Tobacco	Oncken et al. (2010) Prenatal tobacco prevention and cessation interventions for women in low- and middle-income countries	women living in low, middle income countries	Increasing unit price for tobacco products Advertising bans in most or all available media Mass media combined with other interventions (e.g. in schools) Reducing client expense for cessation therapies Systems interventions (screening systems, provider training, coverage of treatment) Clinical interventions (e.g. physician or nurse	(i) Intra-treatment social support (Fiore et al., 2008); effect of physician advice to pregnant women to encourage their husbands to quit smoking in order to limit their SHS exposure; (ii) the intervention included educational materials on simple strategies to help husbands quit and brief reminders at subsequent visits (Loke & Lam, 2005)	In order to prevent high levels of tobacco use among women in LMICs (similar to many high income countries), research needs to test and measure the impact of interventions to prevent tobacco uptake and to aid in cessation in this population. Given the particular risks for adverse effects on pregnancy and birth outcomes of tobacco use and SHS exposure, efforts should be targeted specifically to pregnant women. Research and implementation of effective strategies for pregnant women in LMICs must occur in context with the global tobacco control efforts of the FCTC and MPOWER strategies.

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
			advice, or counseling) Pharmacotherapy Relapse prevention		
Physical Activity	Asaikainen et al. (2004) Exercise for Health for Early Postmenopausal Women: A Systematic Review of Randomised Controlled Trials	Early postmenopausal women	Four types of interventions were found: 1. Exercise training through walking 2. Walking combined with resistance training 3. Other aerobic activities 4. Other aerobic activity combined with resistance training. Some interventions were supervised, others were home-based. Monitoring was conducted through exercise diaries, telephone contact and newsletters.	Sex is identified as relevant in the discussion of the underlying biological differences between males and females that would lead one to expect different responses to exercise and therefore a need to study women independently. In the background discussion, sex/gender differences are explained as possible due to women's experience of menopause and associated physiological and anatomical changes. While detailed implications for clinical practice with respect to sex/gender are not offered, the reviewers note that certain interventions are more feasible and acceptable but not really "why" or "for whom". The review encourages clinicians to provide exercise advice to	Early postmenopausal women are not a commonly-studied group but women of this age/life stage show physiological benefits from a combination of aerobic and resistance exercise. Walking was the most common and most feasible form of exercise and can be performed without supervision at home. Short bouts of walking can be incorporated into daily routines and the effects of accumulated exercise are similar to those for continuous exercise for improving aerobic exercise and body composition, and possibly glucose levels and BP. They note that other forms of physical activity should be studied such as nordice walking, yoga, dance, golf and tennis as they may be preferred by some women as well as suitable home-based alternatives.

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
				postmenopausal women.	
Physical Activity	Banks-Wallace & Conn (2008) Interventions to promote physical activity among African American women	African American adult women	Four studies used interventions designed exclusively to increase physical activity; the remaining studies targeted both diet and physical activity. Most interventions involved weekly education/motivation sessions or supervised exercise sessions. Settings include churches, hospital, or centre. Most studies incorporated strategies to be culturally-relevant; strategies included factors related to delivery of interventions including the setting, scheduling, ethnicity of the programmer, use of incentives, messaging, and/or recruitment. Only one study actively examined the impact of culturally-relevant behavioural strategies.	Awareness that large body size may be culturally acceptable among African American women prompted investigators to stress the health benefits and sense of well-being associated with weight loss over thinness as cultural ideal. The reviewers state "there is a need for both interventions geared toward discrete subpopulations of African American women and studies that have sufficient sample size to adequately assess within group differences affecting adoption of activity." (p. 331). In the discussion section, the reviewers note that "(h)ousehold chores and work-related activity are major sources of physical activity among women in general and African American women in particular" (p. 333), yet established research efforts typically focus on leisure-time exercise. They also note that "(c)ulturally determined gender-based responsibilities are the	This review did not critically examine aspects of sex/gender as they relate to the participation of African American women in exercise or dietary interventions; they did attempt to assess cultural relevance but few reviews provided sufficient detail to clarify the criteria for cultural relevance. The reviewers suggest that African American women can and do increase their physical activity in response to interventions, however, the inconsistent and modest findings suggest that further research is needed to find interventions that successfully engage more women and also increase the amount of physical activity among the women who do increase their activity.

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
				primary personal barriers to physical activity among African American women" (p. 333) and that therefore "(e)ffective interventions must explicate culturally consistent strategies for diminishing or working around barriers to physical activity" (p. 333).	
Physical Activity	Cleland et al. (2012) Effectiveness of interventions to promote physical activity among socioeconomically disadvantaged women: a systematic review and meta-analysis	Socio-economically disadvantaged adult women	Examined a number of facets of interventions to determine effectiveness, including: physical activity measure; mode of delivery; delivery channel; setting; duration; use of theory; theory employed; number of behavioural techniques employed; mean participant age; and risk of bias. All types of interventions-- individual, social, environmental, policy-- targeted at socioeconomically disadvantaged women were included. Some were class-based, others home-based; some involved education (e.g., classes, self-help booklets) combined with fitness sessions, others behavioural counselling and fitness;	In the background to the review, the authors document differences between women and men across the lifespan, noting that women are less active than men and there are clear socioeconomic inequalities in leisure-time physical activity participation: those with lower levels of education, income and living in socioeconomically disadvantaged areas demonstrate the lowest levels of physical activity. The reviewers also note that women's physical activity participation may also influence the activity levels of others; for instance, mothers have been shown to have more influence on children's physical activity behaviours than fathers. The actual review did not document any gender-sensitive characteristics per se, in part because they were not able to extract information on social	"Programs with a group delivery mode significantly increase physical activity among women experiencing disadvantage, and group delivery should be considered an essential element of physical activity programs targeting this population group" (p. 197). "The type of formats in studies that incorporated a group component generally consisted of group education meetings, practical sessions, or a combination of both, facilitated by a trained educator, health worker or practitioner" (p. 208). They speculate that the value of the group-based interventions lies in "social support" which includes instrumental support (e.g., transportation), informational (e.g., sharing of education materials), affective/emotional (e.g., inquiring on how a program is going) and appraisal (e.g., encouragement). They report that is finding is consistent with other research, particularly for women.

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
			, motivational sessions (e.g., computer-tailored health messages, goal setting, telephone support, motivational interviewing); medical screening (e.g., blood pressure; bone density; glucose). Interventions were diverse and included cycling, aerobic classes, walking, dance, team sports and games, swimming, weight training, and pram walking.	support fro the included studies. They also noted that only one study incorporated any support/strategies for teaching time-management "despite lack of time being identified commonly and consistently as a barrier to physicl activity, including among those experiencing socioeconomic disadvantage" (p. 209).	
Physical Activity	Hartman et al. (2010) Targeting physical activity and nutrition interventions towards mothers with young children: a review on components that contribute to attendance and effectiveness	Mothers with young children	Reviewers were interested in what they describe as "mother-specific" intervention components, that is, anything "adapted to the situation of mothers with young children" (p. 1365). Mother-specific features included: embedding the intervention in a routine visit for child health; conducting the intervention in a community-based facility and providing child care for a nominal fee; offering joint mother-child activities; repeating the session at	In the background to the review, the authors note that the transition to motherhood may explain observed weight gain among new mothers compared to non-mothers and suggest this is in part due to low levels of physical activity. They note that this transition involves social, biological and occupational changes in women's lives.	Some studies examined reasons for non-attendance and identified some mother-specific reasons including lack of child care and scheduling conflict, as well as work or school conflict, transportation difficulties, sickness, limited mobility, and lack of interest.Embedding the intervention in routine visits for child health care seemed to increase attendance rates. Discussion about overcoming practical barriers and making plans to do so also seems to increase participation. They suggest that changing dietary practices is easier for mothers than changing physical activity practices.

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
			<p>various times; scheduling the intervention at mothers' preferred time; linking the intervention setting and timing to voucher pick-up; actively aiming to overcome maternal social isolation (e.g., pram walking). Other elements of the interventions involved counselling; education; exercise training; cognitive behavioural interventions; print materials; video; correspondence; telephone contact; and pedometers for monitoring progress.</p>		
Physical Activity	Perez et al. (2010) Review of Intervention Studies Promoting Physical Activity in Hispanic Women	Hispanic adult women	Interventions generally targeted sedentary Hispanic women, who were overweight. Interventions were individually, family or community-focused. Interventions included physical activity classes with home-based telephone support; education and problem-solving; walking programs; low-impact salsa or merengue dancing; social support; goal-setting; and hatha	In the background section, the authors note that "gender, racial, and ethnic factors play an important role in health promotion behaviors of Hispanic women" and that most physical activity interventions have reached "primarily nonminority, middle-income women and men" (pp. 342-3). "...women-specific programs may particularly attract women who may otherwise not seek any treatment" (p. 49). With respect to the interventions themselves, the authors	Reviewers noted that socioeconomic and cultural factors are both important predictors of physical activity participation, observing, for example, that physical activity of women who are poor is influenced by neighbourhood safety. "Women who live in neighborhoods and situations that preclude outdoor physical activity owing to safety, disrepair, or neighborhoods without sidewalks and parks are likely to walk outdoors less" (p. 357). They also suggest that cultural tailoring has been insufficiently implemented and studied but is likely important. They suggest that their review indicates that "best practices" for physical activity interventions with Hispanic women involve Hispanic women in the planning and development of the intervention to ensure that it is appropriate, feasible and effective.

Health Behaviour	Source	Population of Interest	Types of Interventions	Gender-sensitive Characteristics	Main Conclusions
			<p>yoga. Settings included elementary schools, home, university campus, and/or community facilities. Culturally-relevant components included Spanish-language educational materials; bilingual instruction; social activities with culturally relevant food/snacks; a lay health worker; a community advisory group; and Latin dance.</p>	<p>suggest that it is addressing weight concerns that made these interventions gender-sensitive.</p>	

APPENDIX B: MELBOURNE FRAMEWORK CONSULTATION GUIDE

Slide 1

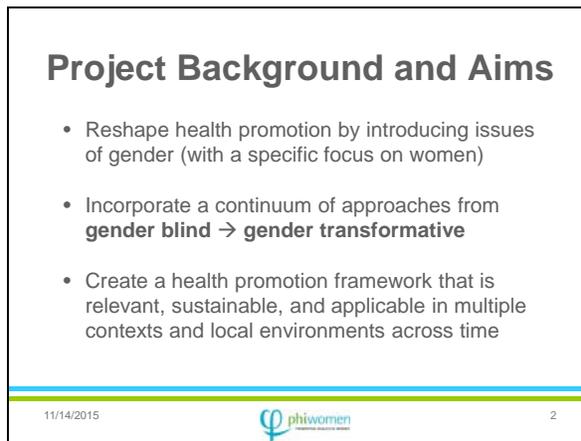


Stakeholder Consultation:
Developing A Women's
Health Promotion Framework

BCC Centre of Excellence for Women's Health
Vancouver, British Columbia, Canada

11/14/2015  1

Slide 2

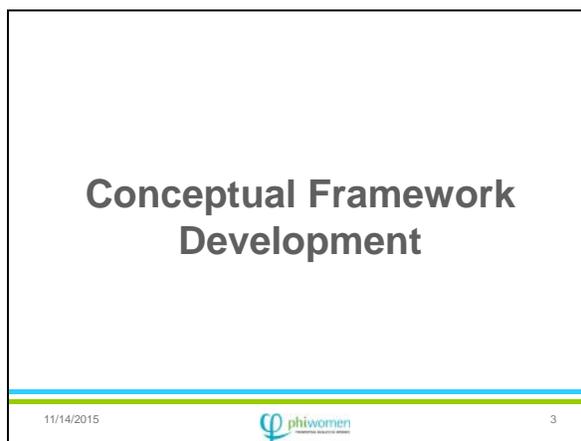


Project Background and Aims

- Reshape health promotion by introducing issues of gender (with a specific focus on women)
- Incorporate a continuum of approaches from **gender blind** → **gender transformative**
- Create a health promotion framework that is relevant, sustainable, and applicable in multiple contexts and local environments across time

11/14/2015  2

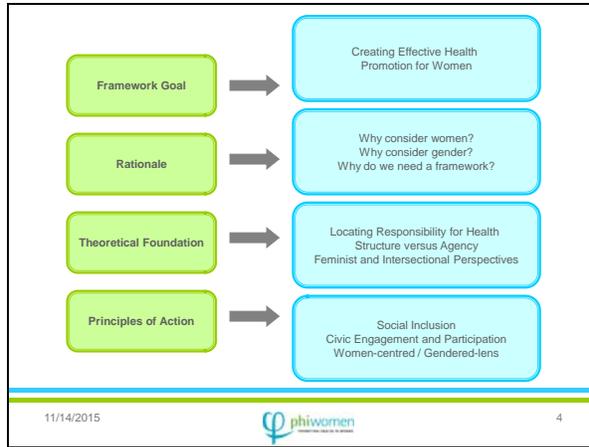
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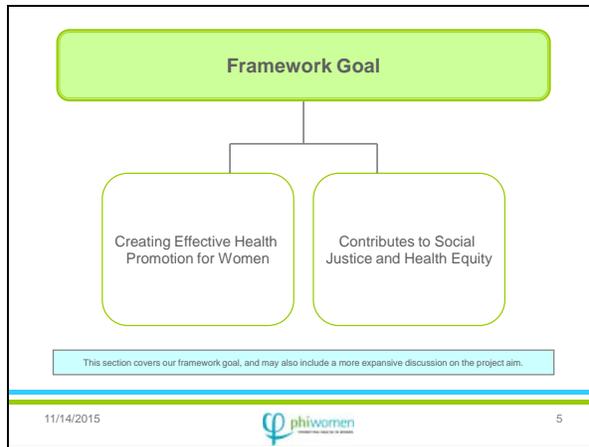
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Development**

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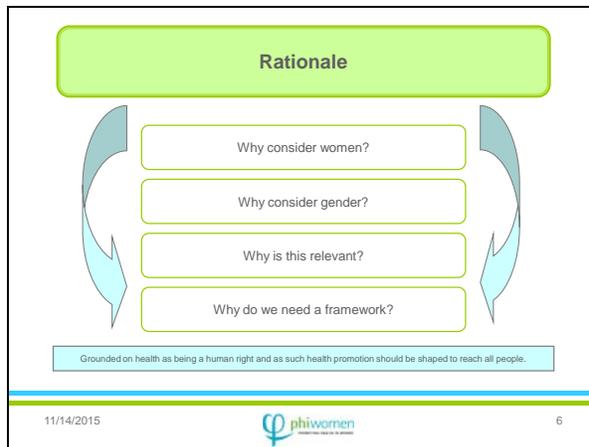
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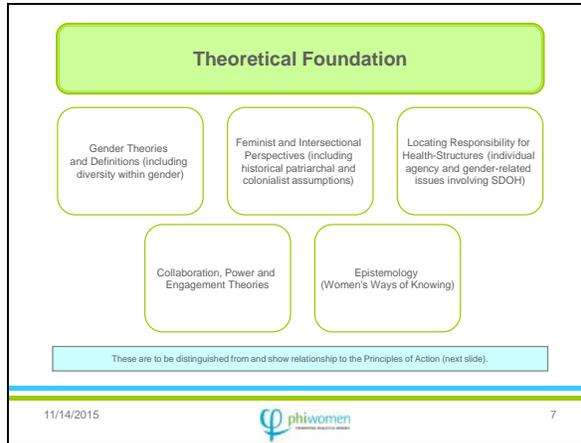
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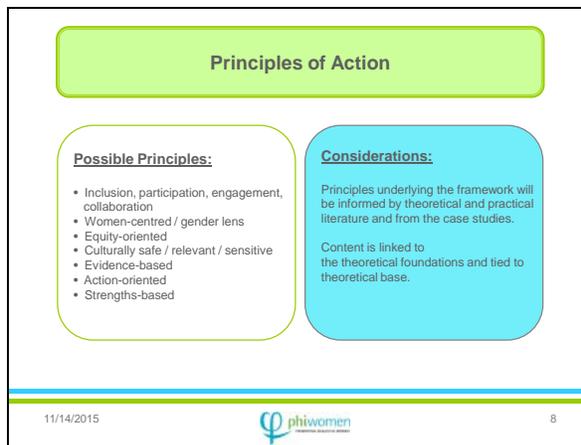
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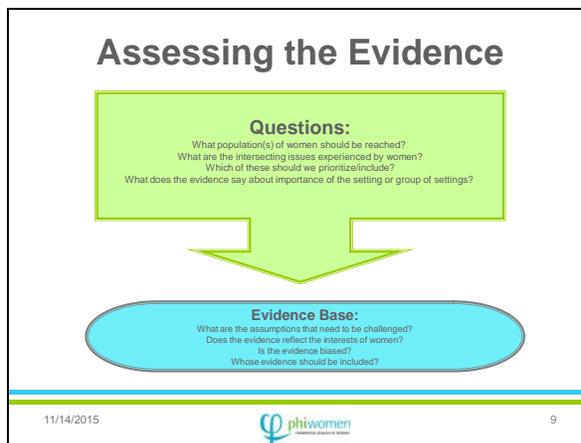
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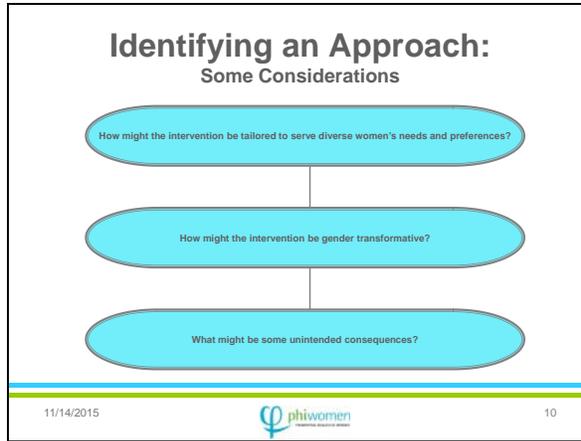
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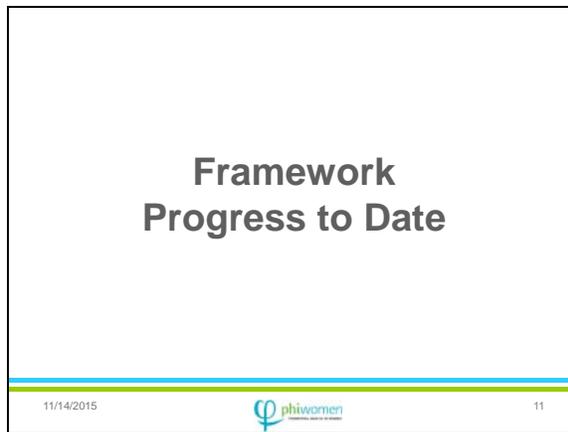
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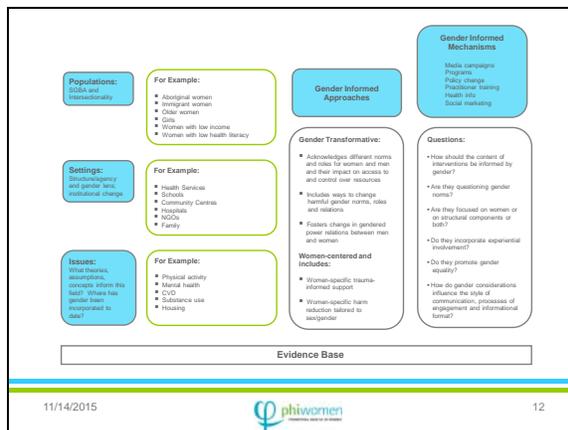
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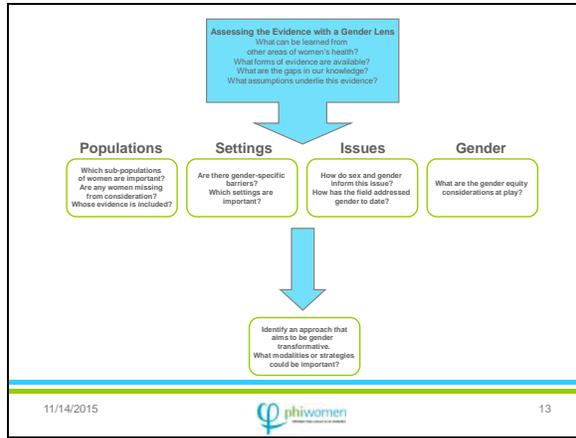
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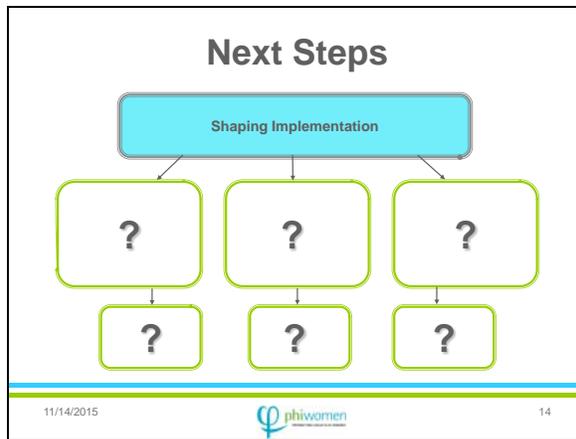
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Slide 13



Slide 14



Slide 15



Slide 16

Discussion
Stakeholder Feedback

- What do you think are the general strengths and limitations of the framework?

11/14/2015  16

Slide 17

Discussion
Stakeholder Feedback

- How could this framework guide the development of action at multiple levels (i.e. individual, community, national, policy etc.)?

11/14/2015  17

Slide 18

Discussion
Stakeholder Feedback

- How would you ensure the framework is user-friendly?

11/14/2015  18

Discussion

Stakeholder Feedback

- Do you think this framework is gender-transformative (i.e. transforming unequal gender relations to promote shared power, control of resources, decision-making, and support for women's empowerment in future health promotion strategies and initiatives)?

APPENDIX C: FRAMEWORK CONSULTATION EXPERT INTERVIEW GUIDE



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FRAMEWORK CONSULTATION Interview Guide

I) Introduce PhiWomen and the Framework:

- **Suggested formulation:** *This project is being undertaken by PhiWomen, an interdisciplinary research team based at the BC Centre of Excellence for Women's Health and is funded by the Canadian Institutes of Health Research (CIHR), Institute of Gender and Health (IGH). Together, with assistance from an expert advisory group in Canada, and Australian partners, PhiWomen aims to develop a women-centred health promotion framework.*
- *The purpose of the framework is to help stakeholders in a variety of sectors influence health promotion policy, practice and research by encompassing issues of sex, gender, diversity, and equity.*
- *The goal of the framework is to assist the stakeholders in working towards transforming gender as it is currently experienced or imposed in various settings. Gender transformation is a relative concept that seeks to shift gender roles and relations closer to gender equity in a given context.*
- *The backgrounder document and framework diagrams that we have provided offer an introduction to the theoretical grounding of the framework as well as a brief overview of how we envision the framework be used through applying gender transformative approaches.*
- *Some examples of gender transformative approaches include: 1) Challenging the distribution of resources and wealth as well as the allocation of duties between men and women (in different settings such as the workplace, school, home etc.); 2) Addressing differential power relationships between women and people of the community in positions of power (such as health and/or social service providers, government and/or traditional leaders, employers etc.) and; 3) Recognizing the multitude of social factors that work together to determine women's position and acknowledge these when developing new programs and policies.*

II) Mention the consultation we have completed and explain why this interview is important.

- **Suggested formulation:** *In April, we conducted a focus group with 14 key stakeholders in the areas of health promotion and women's health in Melbourne, Australia. Now we wish to have more in depth conversations with a few experts to get the best possible feedback on the development of this framework. Next steps will include multiple consultations in the form of web-meetings with a variety of stakeholders.*

III) Ensure confidentiality, and explain how you will protect their privacy.

- **Suggested formulation:** *Everything you say to me will remain anonymous. We will not keep a record of your name with the data and we will remove any identifying information from the transcripts and report of this consultation.*

IV) Request permission to audiotape the interview and take notes.

- **Suggested formulation:** *It is important to capture exactly how you say things, so I would like to start recording our conversation. Is this OK with you?*

Begin recording.

Expert Interview Guide
Version I 8/27/2015
1 of 3



Interview Questions:

1. To begin, what do you think are the general strengths and limitations of this framework?
2. What are your thoughts on the objectives of the framework?
 - Prompts: Are they timely, useful, and/or feasible?
3. Who can you see most likely using this framework and why?
 - Prompts: What resources and level of expertise would you need in order to use this framework?
4. How can we ensure the framework is user-friendly?
 - Prompts: Is it clear and easy to follow? Are the names of the steps clear and sufficiently explained? Do we need to further clarify a certain section or concept? Do the questions about issues, settings and populations make sense?
5. Does the framework successfully guide the user in thinking about and incorporating gender transformative health promotion approaches for women?
6. In your opinion, what is the main challenge in introducing gender transformation into the area of health promotion for women?
7. How can this framework be further developed to help address that challenge?
8. Is this anything else you would like to add or anything you would like to comment on that we haven't touched upon but you think is important?

Interviewer: Please remember to add any relevant notes (on pg. 3) and any questions you may have that are specific to this particular key informant's areas of expertise.

For the next phase of the consultation we will be conducting focus groups with a variety of stakeholders interested in health promotion. Can you recommend a contact that would be a good resource to consult with about this framework moving forward?

Do you have any questions or comments before we end the interview?

V) Thank the expert interviewee.

- **Suggested formulation:** *Thank you so much for your time. Once we finalize the framework we will be sending you a synopsis of the results. We look forward to continuing to improve the framework and appreciate your feedback.*

VI) Briefly write a memo stating your initial thoughts and any post-reflections of the interview.

VII) Send the audio file and memo to Julieta.



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British Columbia
Centre of Excellence
for Women's Health

Interviewer Notes:

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APPENDIX D: EXPERT CONSULTATION CONSENT FORM



Phi Women Project: International Stakeholder Consultation for the Development of a Women's Health Promotion Framework

Project Description

The Phi Women Project aims to solicit your feedback on an international women's health promotion framework developed for the purposes of shifting women's health promotion initiatives to effect individual level improvements in health along with empowerment, in the context of social responsibility and gender equity. This framework has been developed collaboratively by a small team of multidisciplinary, multi-pillared researchers, trainees and practitioners in Canada.

We invite you to share your input in a web-meeting to help ensure that the key principles and strategic directions outlined in this framework will be relevant and helpful in multiple contexts and local environments. Your contributions will help guide the Project Team in revising and finalizing the framework. **We anticipate that the web-meeting will last 90 minutes. The web-meeting will be audio-taped and transcribed.** A thematic analysis and narrative summary will be conducted on the consultation findings. These will be incorporated in the dissemination materials (i.e. report, book, peer-reviewed publication) as a part of the method development process.

This project is being led by
Excellence for Women's Health (BCCEWH) in Vancouver, Canada
This project is funded by the Canadian Institutes of Health Research
(CIHR) – Institute of Gender and Health.

Informed Consent

In order to publish the framework development process and the final version of the framework, we received ethics approval to conduct this International Stakeholder Consultation process from the University of British Columbia, Office of Research Services. The Research Ethics Board aims to protect the rights of research subjects and participants. This requires that you provide consent in order to partake in the web-meeting consultation process by signing on the line below. Your participation is completely voluntary. You are free to stop participating at any time during the meeting, even after you have provided your consent.

Potential Harms

There are no known harms associated with your participation in the web-meeting.

Potential Benefits

Your participation will generate important feedback to assist in the development process of an international framework for promoting women's health.

Confidentiality

Confidentiality will be respected. Any information that is obtained during the consultation will be kept confidential. Knowledge of your identity is not required. You will not be required to



write your name or any other identifying information on research materials. Transcribed data will be maintained in a secure location. Only the Phi Women Research Team will have access to the information. These will be stored in locked filing cabinets, and saved in password-protected computers at the BC Centre for Excellence in Women's Health.

Should you have any concerns about your involvement in this project, you can contact the Principal Investigator or the Research Subject Information Line in the UBC Office of Research Services (toll-free) at 1-877-822-8598 or by e-mail to RSIL@ors.ubc.ca. Questions about the processes and procedures of the web-meeting can be directed to the Principal Investigator, or to the Research Assistant or by email

If you would like a copy of this consent form, please print this page, or contact

Your signature on this form will signify that you have received a document which describes the project details, whether there are possible risks, and benefits, that you have received an adequate opportunity to consider the information in the documents describing the project, and that you voluntarily agree to participate in the web-meeting.

Signature

Date

APPENDIX E: BACKGROUNDER FOR FRAMEWORK CONSULTATION



Understanding Health Promotion Approaches in the Context of Gender and Women's Health Backgrounder

Why a framework on health promotion for women?

The health promotion field has been built upon some key documents and strategic frameworks over the past 40 years, such as the Ottawa Charter for Health Promotion (WHO, 1986) and the Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005). However, a close examination of these documents indicates that they are gender blind (Daykin & Naidoo, 1995). That is, they fail to acknowledge crucial differences in opportunities and resource allocations between women and men by ignoring gender roles, norms and relations (WHO, 2010). This is despite gender being a long-recognized, and important, social determinant of health (Benoit & Shumka, 2009; Health Canada, 1999; IGWG, 2004; McGibbon, 2012; Sen & Östlin, 2010; WHO, 1998). Gender roles, norms and relations shape the lives of both women and men through the process of conforming to expected behaviours and characteristics, exposures to risk conditions, experiences of discrimination and access to health services. However, the impact of gendered relations and institutional arrangements often result in an unequal distribution of power, rendering girls and women experiencing health inequities (CSDH, 2008; Iyer, Sen, & Östlin, 2008). The expression of this inequity could take many forms, including lower income for women, poorer nutritional intake, less access to education for girls, lack of autonomy and decision-making power on their reproductive issues, and more exposure to violence and abuse (Sen & Östlin, 2007). Working together in synergy, the multitude of effects that stem from gender inequity contribute to poorer health outcomes for women (Sen & Östlin, 2010). Consequently, a health promotion framework that explicitly addresses these processes and results, with emphasis on improving the social and health needs of women is required (Gelb, Pederson, & Greaves, 2011).

What will gender mean to health promotion?

Recognizing gender as a determinant of health is a critical first step in understanding women's health and their specific health needs (CSDH, 2008). Gender not only determines a set of opportunities for girls and women by prescribing roles, behaviours and assumptions, but it also sets up various processes such as discrimination and stigmatization that limit girls' and women's access to health care and social supports (Sen & Östlin, 2010). Nevertheless being gender aware is only a first step, and seeking gender equity a first goal. Most importantly, we must work towards *transforming* gender as it is currently experienced or imposed in many settings by creating changes that lead to more autonomous and powerful choices for girls and women regarding their health (Rottach, Schuler, & Hardee, 2009; WHO, 2010). This entails unearthing gendered practices and patterns that may be invisible or unchallenged, such as, who drives a family car, or who decides what contraception is used by a couple. Dominant gendered practices and norms determine who will get to eat first at a family meal, or who will have the educational opportunity to train to become a doctor or nurse. Ultimately, it affects how much control women have over their own health and well-being.

Who is the framework for?

This Framework is intended to assist a wide range of audiences. Health promotion practitioners, community organizations and health care services will directly benefit from assessing their activities or plans in light of the principles and suggestions offered in the Framework, and adjusting accordingly. Policy makers and program planners will also benefit from anticipating and ameliorating the impact of gender on women's health, so that they can propose policies and programmes that are more efficient and effective. Women and women's advocates will benefit by being able to frame their concerns and questions, and by generating evidence with researchers on all aspects of the issues in the Framework.



Principles

The principles are both background values that inform the use of the framework and criteria for checking that the outcomes generated by the framework are likely to be gender-transformative and positive for women. The principles are drawn from promising practices in health promotion and women's health. They are intended to ensure that health promotion outcomes are meaningful for women of diverse backgrounds and that the outcomes promote positive encounters with the health system.

Theories

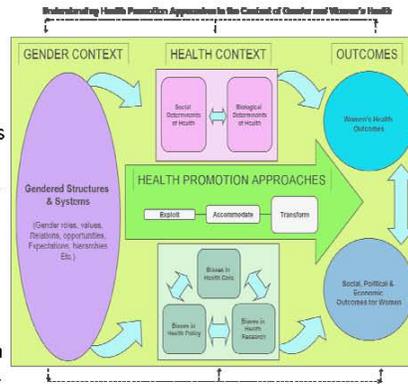
The framework is embedded in theoretical foundations, which are larger ways of thinking about gender relations and women's experiences. They are drawn from various disciplines, including feminist theory, philosophy, intersectionality and cultural theory (Barker, Hulme, & Iversen, 1994; Hankivsky et al., 2010; Kelly, 2008; Ridgeway, 2009; Risman, 2004; Reid, Pederson, & Dupéré, 2012). Together, the theoretical foundations provide a rationale and strategy for gender-transformative health promotion. While the Principles provide specific guidelines for enabling health promotion strategies that better serve women, the theories are the background assumptions that justify undertaking this work.

Gender in the context of the social determinants of health

This framework proceeds from an understanding of gender as a critical social determinant of health, which interacts with all the other social determinants to produce different health experiences for individual women and men (Sen & Östlin, 2010). Gender operates at every level of health, structurally and/or systemically, via outright discrimination or tacit biases affecting women in a range of social positions (Sen & Östlin, 2010). The pervasiveness of gender as a determinant of health grounds the need for health promotion strategies that are gender-informed and that specifically consider the needs and experiences of women (Keleher, 2004). Moreover, it is necessary to understand gender in the context of other social determinants of health (such as socioeconomic status, ethnocultural identity, location, etc.) in order to develop health promotion strategies that will be meaningful for diverse groups of women (Reid et al, 2012). Every step in the framework assumes an awareness of the role of gender in producing health outcomes and is intended to orient the user toward those particular effects in the type of health issue or health promotion strategy at hand.

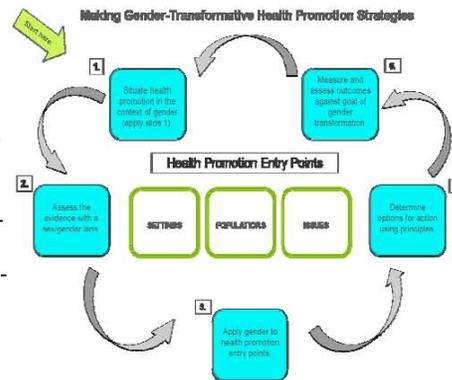
How to use the Framework?

The Framework sets out concrete steps for rendering health promotion gender-transformative. The crux of the framework is captured in two diagrams. The first, “Understanding health promotion approaches in the context of gender and women’s health,” illustrates the ways in which health promotion interacts with multiple factors to produce health and social outcomes. Each section affects the one(s) to its right. On the left is a representation of gender structures and systems, which affect everything from relationship roles and economic opportunities to power structures and personal choices. These in turn affect the health context affecting what happens in policy, research and practice, and also individual social and biological determinants. Finally, these determinants produce outcomes that include both direct health outcomes for women as well as socio-political outcomes (e.g. distributions of power and resources) which ultimately contribute to health inequity. Health promotion is diagrammatically depicted as a large arrow cutting across all these contexts. These health promotion approaches taken can be described as exploitative, accommodating, or transformative with respect to gender. Health promotion can advance health outcomes while reproducing harmful gender roles, however, it can also transform gender in order to achieve better health outcomes.



Gender transformation is a *relative* concept that seeks to shift gender roles and relations closer to gender equity in a given context. Gender transformative approaches actively strive to examine, question, and change rigid gender structures and imbalance of power as a means of reaching health and gender equity objectives (Rottach, et al., 2009). Since gender equity is likely never fully attained, gender transformation is an ongoing process toward it. What is transformative in one context, however, may not be transformative in another. Gender transformation involves identifying the ways that gender discrimination, inequality or oppression operates in a particular situation and taking feasible steps toward improving these conditions – even if the result would still be considered regressive by the standards of another situation (Rottach, et al., 2009). Gender transformation is therefore possible in every context, from the most repressive to the most progressive.

The second diagram, “Making Gender-transformative Health Promotion Strategies,” is a tool based on the first, descriptive diagram and the other components of the framework. Gender transformative health promotion is an ideal, and there can be situation and culturally specific barriers to achieving it. However, this tool specifies five steps that assist the user in working towards achieving gender transformative health promotion: 1) situate the health promotion idea in the context of gender (using the first diagram as a guide); 2) assess the evidence with a sex and gender lens; 3) apply the sex/gender analysis to the traditional health promotion entry points (settings, populations and issues); 4) determine options for action using the Framework’s principles; and 5) measure and assess the outcomes using the understanding of gender transformation provided in the framework. More detailed questions are provided through hyperlinks for each step. The cycle is iterative and although intended to be followed from step 1 to step 5, users of the Framework can focus on the steps that will provide the most value for them.



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APPENDIX F: VIDEO SCRIPT

YouTube Video Link: <http://www.youtube.com/watch?v=2LwzQyoZtHk>

INTRODUCTION	
1. BCCEWH Website Screenshot	“Hi there, my name is Mei and I am a researcher at the BCCEWH.
2. Title and Intro Image	Thanks for taking the time today to review our framework for effective health promotion for women. I work with a team of researchers called the Promoting Health in Women team.
3. PhiWomen Website Screenshot	In this brief YouTube clip, we want to tell you a little bit about the project and to introduce you to a conceptual framework and a planning on how to we can better develop health promotion activities for women.”
4. Women and Children Picture	“So where did this framework come from? Just over a year ago, we brought together a team of researchers and health promotion practitioners and asked them how they think about gender. We asked them what kind of framework or tool would be helpful for them in their work. Out of these conversations, we developed a conceptual framework and planning tool to help health promotion practitioners, community organizations and health care service providers in thinking about the impacts of sex, gender, diversity and equity in their work.
5. Work in Progress	“As we introduce you to these tools, please keep in mind that this is a work in progress. Because it is a work in progress, your thoughts and comments are very valuable

INTRODUCTION	
	to us.”
6. International	“Individuals and organizations in multiple countries are currently reviewing the conceptual framework and planning tool. Think about how the key principles and strategic directions described would be relevant and helpful to you in your work environment.”
7. Asian Girl Picture	“Thanks in advance for taking the time to help our team revise and finalize this framework.”

PART I: CONCEPTUAL FRAMEWORK	
8. Entire conceptual framework	“Here is an image of our conceptual framework called, ‘incorporating gender into health promotion for women.’ The overall goal of this framework is to show how health promotion interacts with multiple factors to produce health and social outcomes. Each section of the framework affects the section to its right.”
9. Gender Context Image	“The section on the left represents gendered structures and systems, which affects everything from relationship roles and economic opportunities to power structures and personal choices. This refers to the gender context of your organization, community and country. This might refer to issues such as whether women have equal access to education and employment opportunities, how much control women

PART I: CONCEPTUAL FRAMEWORK	
	have over their own health such as choices about contraception and how their health is affected by their other roles, for example, partner, mother, or caregiver.”
10. Centre Image and Health Context minus Arrow	“The image next to the gender context, is health context. Health promotion activities are affected by individual, social and biological determinants of health. This includes biological determinants such as age and genetics and social determinants like income and access to healthy food. The gender context also affects what happens in policy, research and health care. Gendered relations and institutional relations often results in unequal distribution of power, making it difficult girls and women to achieve optimal health. This could include pharmaceutical studies that are only conducted on men or health care services that do not consider the impact of migration and colonization on health and policies that do not consider how women are different, for example, younger women have different health needs than older women.”
11. Gender and Health Context Image	→ blink health context
12. Right Image: Health Outcome	“To the right of health context is the outcome section. This refers both to direct health outcomes to women as well as socio-political outcomes for women. Health outcomes can range from life expectancy and maternal mortality rates to mental wellness and the prevalence of chronic illnesses such as (diabetes, cancer and heart disease), sociopolitical outcomes

PART I: CONCEPTUAL FRAMEWORK	
	such as exposure to gender-based violence, equal access to health care services and the availability of culturally appropriate services.”
13. Gender, Health and Outcome Image	→ Blink outcome
14. Health Promotion Arrow Image	“Lastly in our conceptual framework, health promotion itself is depicted as a large arrow cutting across all of these contexts. Health promotion approaches can be exploitative, accommodating or transformative. We are concerned with health promotion approaches that are gender transformative that focus on promoting both women’s health and gender equity.
15. Insert whole slide again Picture of the whole thing from left to right	We hope that when you look at the overall conceptual framework that you can see the importance of incorporating a gender lens into health promotion.

PART II: PLANNING TOOL	
16. Whole Image of Planning Tool	“During our consultation process, we heard about the need for a tool to help practitioners move towards gender transformative health promotion. This tool has five steps to help individuals and organizations create and implement health promotion programming for girls and women.”
17. Step 1 Image	“The first step is to think about how gender affects health promotion. We think that the

PART II: PLANNING TOOL	
	conceptual framework that we just described is a good starting place.”
18. Step 2 Image	“Step two requires that you look at the area that you are working in with a sex and gender lens. For example, if you are concerned with obesity in your community, is there any research that describes different trends and influences between men and women or between girls and women or between different groups of women in your community. Has there been an opportunity to gather input from women in the community on what they perceive to be the key issues? There are lots of different ways of conducting gender-based analysis and this might look different in every organization or community.”
19. Step 3 Image	“Step three is applying a gender analysis to the health promotion entry points, settings, populations and issues. Often, health promotion, we start our planning from one of these three entry points. How does a gender lens, clarify your understanding of these entry points?”
20. Step 4 Image	“The fourth step is to determine options for action. Once again, the conceptual framework can be helpful in identifying gender transformative health promotion opportunities.”
21. Step 5 Image	“Lastly, is important to measure and assess outcomes of various health promotion activities, in light of the goal of gender transformation.”

PART II: PLANNING TOOL	
22. Overall Image of Planning Tool	“This tool is intended to be iterative meaning that, you can move back and forth between steps. We hope that this tool can be helpful in anticipating and addressing the impact of gender on women’s health so that health promotion programs and policies can be more efficient and effective. It can also be a tool to guide planning and consultation with key stakeholders in your particular area of work.”
23. Have slide with logo, funder, and Centre’s website.	“Thanks for taking the time to review the conceptual framework and planning tool. Your important is valuable and vital to the development of the health promotion framework for women. Please keep in touch so that we can keep you updated on this important work.”
24. Website Image	“If you would like to learn more about the work of our Centre, please feel free to contact or visit us on the web at: www.promotinghealthinwomen.ca or www.bccewh.ca ”

APPENDIX G: ONLINE FRAMEWORK SURVEY LETTER OF INVITATION



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THE UNIVERSITY OF BRITISH COLUMBIA



August 24, 2012

Invitation to participate in an e-survey on a draft framework For effective health promotion for women

We would like to invite you to complete an online survey on a draft framework for effective health promotion for women. The purpose of the framework is to help stakeholders in a variety of sectors influence health promotion policy, practice and research by encompassing the issues of sex, gender, diversity, and equity. We need your input to ensure that the key principles and strategic directions outlined in the framework will be relevant and helpful in multiple contexts and local environments.

The draft framework is being collaboratively developed by a group of researchers in Canada who are part of a Canadian Institutes of Health Research Team in Sex, Gender and Health Promotion (Promoting Health in Women, PhiWomen). The PhiWomen team was established to integrate gender and equity considerations into health promotion activities in order to improve the health of women and girls. We are currently engaged in a multi-step consultation process to generate feedback on the framework so as to ensure that it is useful to potential users and serves the needs of different stakeholders.

To date, we have held an initial consultation process with a group of key informants in Australia and Canada who were experts in health promotion and women's health and we have revised the framework based on that input. We are now embarking on the second phase of the consultation process which is to conduct an online survey. We plan a third review phase for the summer and fall which will involve web-based focus groups. The results of the consultation will be synthesized and used to develop a final framework that will be broadly disseminated in 2013.

As a survey participant, we are inviting you to participate in a 10-15-minute survey. If you would like to participate as a key informant on the framework, please click on the link below. The e-survey will be available until September 30th, 2012.

<http://fluidsurveys.com/surveys/bccewh/developing-a-health-promotion-framework-for-women/>

Thank you for taking the time to consider being a key informant as part of our review process to refine the framework. Your input is greatly appreciated.

Sincerely,

(Principal Investigator), On behalf of the Sex, Gender and Health Promotion
Project Team Senior Investigator, British Columbia Centre of Excellence for Women's Health
Phone: _____
Email: _____

Letter of Invitation – E-Survey
Version I 8/27/2015
1 of 1

APPENDIX H: ONLINE SURVEY

Provisios for PAA Admendment (H09-02658-A008) Web Survey Consultation

This document includes all the questions and text currently in the E-Survey.

DRAFT E-SURVEY: PhiWomen Framework Online Consultation September 13, 2012 Version

1. Project Information

THANK YOU FOR YOUR INTEREST IN REVIEWING A CONCEPTUAL FRAMEWORK AND PLANNING TOOL FOR EFFECTIVE health promotion for women! We expect that this survey will take approximately 10-15 minutes of your time to complete. You are part of an extensive international consultation process that will be synthesized and used to develop a final women-centered health promotion resource for dissemination in 2013.

The Promoting Health in Women Team (PhiWomen), funded by the Canadian Institutes of Health Research, was established to integrate gender and equity considerations into health promotion activities in order to create more effective health promotion for women. We have developed a conceptual framework and planning tool to promote effective health promotion for women and we are currently engaged in a multi-step consultation process to generate feedback on it so as to ensure that it is useful to potential users and serves the needs of different stakeholders.

Purpose

The purpose of the conceptual framework and planning tool is to help stakeholders in a variety of sectors influence health promotion policy, practice and research by engaging with the impacts of sex, gender, diversity, and equity in their work. The purpose of the e-survey is to seek feedback on the usability and feasibility of the conceptual framework and planning tool. In order to orient you to the progress of our work, we have created an online instructional YouTube video.

We invite you to share your input on the conceptual framework and planning tool to help ensure that the key principles and strategic directions outlined; will be relevant and helpful in multiple contexts and local environments. Your contributions through this survey will help guide the PhiWomen team in revising and finalizing the conceptual framework and planning tool. We anticipate that the **survey will take approximately 10-15 minutes to complete.**

2. Providing Consent

Informed Consent

Ethics approval has been received from the University of British Columbia Office Of Research Services (REB) to conduct this stakeholder consultation process. The REB aims to help protect the rights of research subjects and participants. This requires that you provide consent to partake in the survey process by clicking the box below. Your participation is

completely voluntary. You are free to stop completing the survey at any time, even after you have given your consent. **Please note, if you do not select the "SUBMIT" button at the end of the survey, the information from your survey will not be collected.**

Please be aware that the 'Fluid Surveys' tool is being utilized to collect information in the survey. All information will be collected and stored in Canada. There is no intention to collect your personal information unless you voluntarily decide to provide it at the end of the survey so that you can be acknowledged as a reviewer in the framework appendices, or to receive a copy of the final framework.

As with any website, the Fluid Survey web server will automatically collect the IP (Internet Protocol) address of the computer you are using, and because the IP address is an identifying number, it is deemed to be personal information. Although IP addresses do not directly identify you, individuals using that computer may be identified with the cooperation of the Internet Service Provider. For these reasons, we cannot completely ensure confidentiality of your answers.

Should you have any concerns about your involvement in this project, you can contact the Principal Investigator or the Research Subject Information Line in the UBC Office of Research Services (toll-free) at 1-877-822-8598 or by e-mail to RSIL@ors.ubc.ca. Questions about the survey process or general information about PhiWomen and the framework can be directed to the PhiWomen team (Ph: +1 604-875-2633; info@promotinghealthinwomen.ca).

If you would like a copy of this consent form, please print this page, or contact the PhiWomen team at the email above.

Do you give consent to complete this survey having read the material above?

Yes No

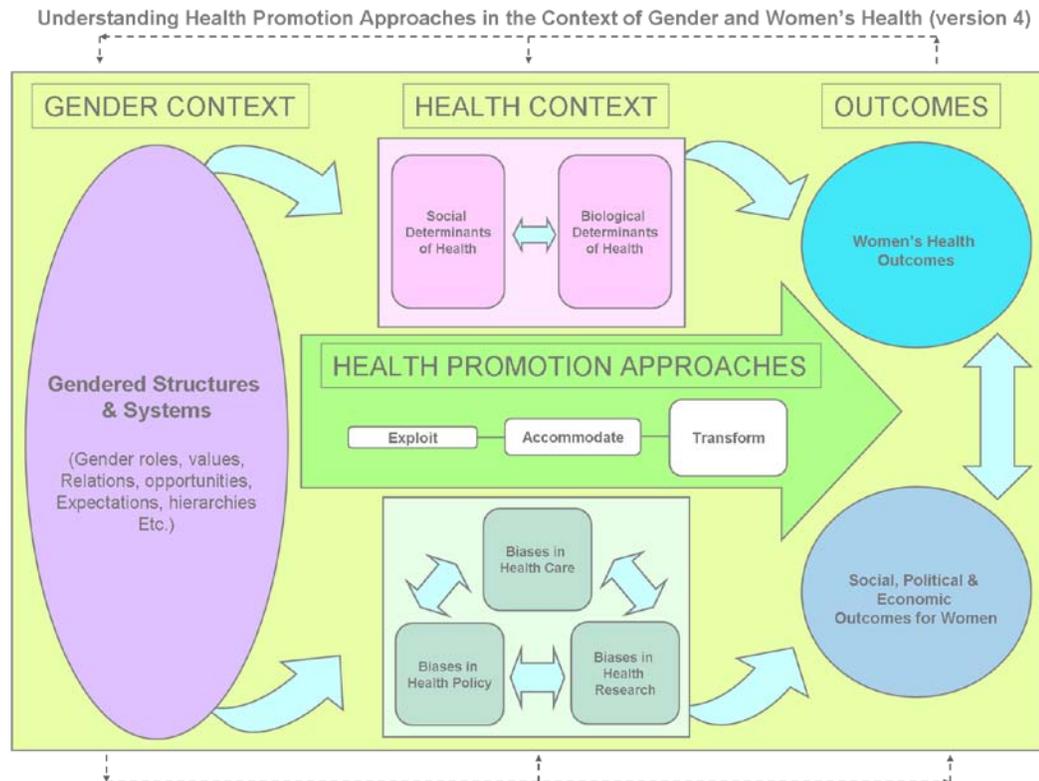
3. Instructions For Survey Completion

PLEASE NOTE:

- Before beginning the survey, please view (in FULLSCREEN mode) the 7 minute informative YouTube video: <http://www.youtube.com/watch?v=JN7S-gp-1fi>
- Information provided in the YouTube Video is also available as readable text in the survey for your reference
- To see the progress of your survey, refer to the status bar at the top right corner which displays in percentage how much of the survey you have completed and approximately how much is left
- If you need to change an answer, you may click the "back" button to the previous page and re-select your answer

- You can skip through the questions you do not wish to comment on by clicking on the "Next" button at the end of each page, however, you must click the "SUBMIT" button at the end of the survey to be included in this review process.
- If you wish, the survey may be saved and completed at a later time

4. Conceptual Framework (3 Questions): Incorporating gender into health promotion for women



Despite gender being a long-recognized, and important, social determinant of health, health promotion often fails to acknowledge crucial differences in opportunities and resource allocations between women and men by ignoring gender roles, norms and relations. However, the impact of gendered relations and institutional arrangements often result in an unequal distribution of power, rendering girls and women less able to achieve optimal health. The expression of this inequity takes many forms, including lower income for women, poorer nutritional intake, less access to education for girls, lack of autonomy and decision-making power on reproductive issues, and greater exposure to gender-based violence and abuse. Working synergistically, these effects can contribute to poorer health outcomes for women. A health promotion framework that explicitly addresses these processes with emphasis on improving the social and health needs of women is required.

“Understanding health promotion approaches in the context of gender and women’s health” illustrates the ways in which health promotion interacts with multiple factors to produce health and social outcomes. Each section affects the one(s) to its right. On the left is a representation of gender structures and systems, which affect everything from relationship

roles and economic opportunities to power structures and personal choices. These in turn affect the health context affecting what happens in policy, research and practice, and also individual social and biological determinants. Finally, these determinants produce outcomes that include both direct health outcomes for women as well as socio-political outcomes (e.g., distributions of power and resources) which ultimately contribute to health inequity.

Health promotion is diagrammatically depicted as a large arrow cutting across all these contexts. These health promotion approaches taken can be described as exploitative, accommodating, or transformative with respect to gender. Health promotion can advance health outcomes while reproducing harmful gender roles, however, it can also transform gender in order to achieve better health outcomes.

(Q1) Do you think that there is a need to incorporate a gender lens into health promotion?

Strongly Disagree Disagree Agree
Strongly Agree

Our framework is centered on *gender transformation* and seeks to shift gender roles and relations closer to gender equity in a given context. Gender transformative approaches actively strive to examine, question, and change gender structures and imbalances in power as a means of reaching health and gender equity objectives. Since gender equity is likely never fully attained, gender transformation is an ongoing process toward it.

(Q2a) Are you familiar with the term “gender transformation?”

No Yes, somewhat Yes, completely

(Q2b) Please provide any additional thoughts, comments or suggestions.

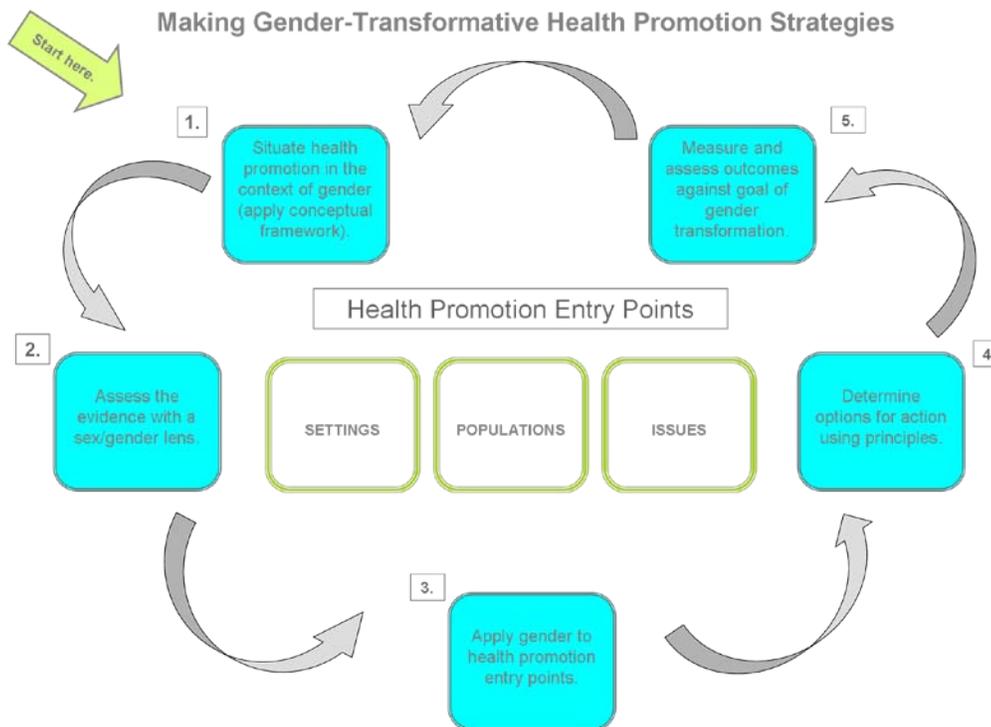
(Q3a) Do you think that health promotion approaches for women should be built on **transforming gender** as it currently stands?

Strongly Disagree Disagree Agree
Strongly Agree

(Q3b) Please provide any additional thoughts, comments or suggestions.

5. Planning Tool (4 questions): “Making Gender-transformative Health Promotion Strategies”

“Making Gender-transformative Health Promotion Strategies,” is a tool based on the conceptual framework. Gender transformative health promotion is an ideal, and there can be situational and culturally specific barriers to achieving it. However, this tool specifies five steps that assist the user in working towards achieving gender transformative health promotion: 1) situate the health promotion idea in the context of gender (using the conceptual framework above as a guide) 2) assess the evidence with a sex and gender lens; 3) apply the sex/gender analysis to the traditional health promotion entry points (settings, populations and issues); 4) determine options for action using the conceptual framework’s principles; and 5) measure and assess the outcomes using the understanding of gender transformation provided in the conceptual framework. The cycle is iterative and although intended to be followed from step 1 to step 5, users of the planning tool can focus on the steps that will provide the most value for them. The core content of the planning tool is schematically represented in the following diagram:



(Q4) Do you think the planning tool is a useful tool in assisting users in working towards achieving gender transformative health promotion?

- No Yes, somewhat Yes, completely

(Q5) How useful will the conceptual framework and planning tool be in supporting your work?

- Not useful Somewhat useful Very useful

(Q6) When you have planned or enacted health promotion programming for girls and women, have you begun your planning from the entry point of an issue, a setting, a population or some combination of them?

(Q7) How can we ensure the framework is useful and user-friendly?

6. Potential Impact

This framework is intended to assist health promotion practitioners, community organizations and health care service providers. Policy makers and program planners may benefit from anticipating and ameliorating the impact of gender on women's health, so that they can propose policies and programs that are more efficient and effective. Lastly, women and women's advocates could benefit by being able to frame their concerns and questions, and by generating evidence with researchers on all aspects of the issues in the framework.

(Q8) In your view do you think there are opportunities for adopting this framework and planning tool in your work?

- No Yes, somewhat Yes, definitely

(Q9) How do you anticipate using them? Please check all that apply.

- Direct policy development or changes

- Direct practice/patient care
- Direct future research
- Program Planning
- Educational/training purposes
- Research /evaluation
- Other (please specify): _____

(Q10) From your personal or organizational perspective, do you think that the framework and planning tool can direct the changes needed to advance effective health promotion for women?

- No Yes, somewhat Yes, definitely

(Q11) Do you think this framework might be helpful to health promotion practitioners? Why or why not?

7. Please Tell Us about Yourself

We would like to know the characteristics of those who provide feedback as it will help us better understand the information we receive during this review process.

(Q12) What is your role? (Please check all that apply)

- Health care provider
- Researcher
- Educator
- Policy maker
- Program planner
- Program manager/director
- Advocate/patient group representative
- Other (please specify): _____

(Q13) Where do you work? (Please check all that apply)

- Private health care practice

- Hospital or health clinic/centre
- Health authority
- Not-for profit community organization
- Provincial/territorial government
- Research institution
- University /college
- Self-employed
- Not currently employed or retired
- Other (please specify): _____

(Q14) In what country do you reside?
→ DROPDOWN LIST OF COUNTRIES

(Q15) Do you have experience working in health promotion?

- No Yes

(Q16) Do you have experience working in women's health and/or with gender issues?

- No Yes

8. Reviewer Acknowledgement

If you would like to be involved in further discussions about the framework please add your name and email address to the space below.

Help Spread the Word!

The framework is currently being reviewed by individuals and organizations in multiple countries. Please forward the draft framework and the link to this survey to anyone that has an interest in health promotion and/or women's health and might be interested in being an additional reviewer.

Thank you!

THANK YOU FOR BEING A REVIEWER OF THIS CONCEPTUAL
FRAMEWORK AND PLANNING TOOL!

Your input is valuable to us and vital to the development of a Health Promotion Framework for Women. The results of the survey will be synthesized and used to finalize the framework. All survey participants for whom we have an e-mail address will receive a copy of the final framework.

If you were forwarded the survey link and would like to be added to our e-mailing list, please include your e-mail address in the space provided below, or contact us at info@promotinghealthinwomen.ca.

APPENDIX I: CONSULTATION WEB-MEETING GUIDE



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA



FRAMEWORK CONSULTATION Web-Meeting Guide

- I) Welcome and Introduction of PhiWomen
First of all I would like to welcome you to our web-meeting. We appreciate your time and expertise and thank you for assisting us in this endeavour. We will begin by giving you a brief background to the project using some PowerPoint slides, then we will show you a 7 minute video explaining the framework and finally we will be asking for your opinion on the framework.
- **SLIDE 1:** *This project is being undertaken by PhiWomen, an interdisciplinary research team based at the BC Centre of Excellence for Women's Health and is funded by the Canadian Institutes of Health Research (CIHR), Institute of Gender and Health (IGH). Together, with assistance from an expert advisory group in Canada, and Australian partners, PhiWomen aims to develop a women-centred health promotion framework.*
 - *The background document and framework diagrams that we have provided offer an introduction to the theoretical grounding of the framework as well as a brief overview of how we envision the framework be used through applying gender transformative approaches.*
 - **SLIDE 2:** *The Framework has 3 main objectives. (Read objectives). We also offer a definition of gender transformation and the source of that definition is noted on this slide. Gender transformation is an important aspect of the framework as we will see once we dive into it. So before we begin the discussion we wanted to show you a short video that introduces the framework. (SHARE DESKTOP THEN PLAY VIDEO).*
 - **Stop sharing desktop to go back to PowerPoint**
- II) BEGIN DISCUSSION
- *Before we begin recording, I just wanted to remind you that everything you say here will remain anonymous and we ask that you do not discuss names outside of this meeting. We will not keep a record of your name with the data and we will remove any identifying information from the transcripts and report of this consultation. We also would please ask that you do not widely distribute the framework materials yet as they are still in draft form and will be changing. Marie please begin recording the conversation now.*

Begin recording.

Interview Questions: (Slides 13-17)

1. To begin, what do you think are the general strengths and limitations of this framework?
2. How can we ensure the framework is useful?
 - Prompts: Is it clear and easy to follow? Are the names of the steps clear and sufficiently explained? Do we need to further clarify a certain section or concept? Do the questions about issues, settings and populations make sense?

Web-Meeting Guide
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3. Does the framework successfully guide the user in thinking about and incorporating gender transformative health promotion approaches for women?
4. Who can you see most likely using this framework and why?
 - Prompts: What resources and level of expertise would you need in order to use this framework?
5. Is this anything else you would like to add or anything you would like to comment on that we haven't touched upon but you think is important?

For the next phase of the consultation we will be conducting an e-survey which will be circulated to a variety of stakeholders interested in health promotion. We will be sending that link out and asking you to please circulate it to your colleagues and contacts in the health promotion or women's health field.

Do you have any questions or comments before we end the meeting?

V) Thank the web-meeting participants.

- **Suggested formulation:** *Thank you so much for your time. Once we finalize the framework we will be sending you a synopsis of the results. We look forward to continuing to improve the framework and appreciate your feedback. We also just want to remind you to please return a signed copy of the consent form if you already haven't done so. Thanks again and have a great rest of your day. Good bye.*

APPENDIX J: FEAR OF FALLING INTERVIEW 1 GUIDE

Study Objectives

1. To understand how fear of falling affects the lives of older women with diagnosed osteoporosis;
2. To explore the effect of an exercise intervention on women's fear of falling;
3. To assess the effect of social support on women's fear of falling.

Study Questions

1. How did you learn you had osteoporosis?
2. What do you know about osteoporosis? What is the nature of this condition?
3. What causes osteoporosis?
4. How did you feel about being diagnosed with osteoporosis?
5. What has been the impact of osteoporosis on your life?
6. Do you do anything differently now that you know you have osteoporosis? What sorts of things? Why?
7. When you think about osteoporosis, what comes to mind? What is your picture of someone with osteoporosis?
8. With respect to having osteoporosis, what is your biggest worry? Why? How do you deal with this worry?
9. What actions have you taken to deal with this worry?
10. Are you doing anything differently because of osteoporosis? What? Why?
11. Would you describe yourself as afraid of falling since you learned you had osteoporosis? How afraid are you? How do you live with this fear?
12. Do you take medication for your osteoporosis? What?
13. Do you take female hormones? For how long? Why?

Demographic Questions

1. How old are you?
2. What is your current marital status? Etc.
3. Do you work? Did you before you retired? What did you do?

4. Do you live alone or with someone? If so, with whom do you live?
5. Do you have family and/or friends to help you out? Who are they?

APPENDIX K: FEAR OF FALLING INTERVIEW 2 GUIDE

Review of FOF Study Objectives

1. To understand how fear of falling affects the lives of older women with diagnosed osteoporosis;
2. to explore the effect of an exercise intervention on women's fear of falling;
3. To assess the effect of social support on women's fear of falling.

New Objectives

1. To understand women's experiences of an exercise intervention designed for osteoporosis;
2. To learn how women cope with osteoporosis on a daily basis.

Interview Questions

1. What has changed in the last four months in your life? (could include going to OsteoFit or not)
2. If you did OsteoFit, how did you find OsteoFit?
3. Did you think it was beneficial? In what way?
4. Did you have any problems with OsteoFit? If so, what were they?
5. What were your experiences of the measurement sessions at Vancouver Hospital over the course of the study?
6. What are your plans for the future with regard to managing your osteoporosis?
7. Have you heard anything new about osteoporosis management over the past four months?

APPENDIX L: FEAR OF FALLING FOLLOW-UP INTERVIEW GUIDE

Introduction

We last spoke many years ago as part of a study we were doing about the effectiveness of the Osteofit program. Today we would like to follow-up on that discussion and learn about how you have been living since we last spoke and, in particular, what role physical activity has played in your life.

Sample interview questions

1. What has changed in the last 10 years in your life? (This could include going to OsteoFit or not, may include age-related changes, loss of spouse, change of residence, health challenges, new family members)
2. What would you say has been the impact of osteoporosis on your life? We are interested in the little every day things as well as any major effects if you think it has had any (pain, fracture, fear of falling, hesitation in planning, moving to a one-level dwelling, not doing stairs, etc.)
3. Thinking back over the past few years, how have you been managing your osteoporosis? Do you take medication (for pain, for Osteoporosis itself, other medication), exercise, eat in a particular way, make any alterations in your home (stair rails, remove scatter rugs, bathtub grab bars, etc.)?
4. Do you remember the Osteofit program? Did you continue on with it after the study ended? Why or why not? If you did, for how long? Why?
5. If you are not involved with Osteofit, have you been doing any other sort of physical activity? What, where, how often? Why? How long have you been doing this? Do you expect to continue? Or take up physical activity again?

6. If you are not doing any sort of physical activity, can we talk about why that is? Are there things that make exercising difficult for you? Can you think of anything that would help you to exercise?

7. One of the other things that we'd like to know more about since we last spoke with you is your experience with falls. Do you recall having any falls? Can you describe them for me? Would you describe yourself as afraid of falling? Do you do anything to manage this fear? Has being involved in exercise (if you have been) been helpful in managing your worries about falling? How? Is there anything else that helps?

8. What are your plans for the future with regard to managing your osteoporosis?

APPENDIX M: INTERVIEW CONSENT FORM FOLLOW-UP STUDY

UNIVERSITY OF BRITISH COLUMBIA



*Department of Family Practice
Faculty of Medicine
Suite 320 – 5950 University Boulevard
Vancouver, B.C. Canada V6T 1Z3*



PARTICIPANT CONSENT

PHYSICAL ACTIVITY AMONG OLDER WOMEN WITH OSTEOPOROSIS

Principal Investigator:

This research is being led by _____ and Investigator at the BC Centre of Excellence for Women's Health (BCCEWH) in Vancouver, BC

Co-Investigator:

_____ Department of Family Practice & Bone Health Research Group at the Centre for Hip Health and Mobility at the University of British Columbia (UBC).

Funded by: Health Canada

Purpose of the study:

This study will explore the factors which enable some older women to be physically active and the barriers that others confront in trying to engage in physical activity. We will be talking to older adult women living with osteoporosis to understand your experiences of physical activity and inactivity, if you've experienced personal and social benefits from continuing to engage in physical activity, and what has supported or hindered your involvement. Accordingly, we will develop ideas for new approaches to encouraging other women with osteoporosis to be physically active regularly. The study goal is to find ways to enhance the likelihood women with osteoporosis will participate regularly in physical activity to promote their health and well-being by understanding women's experiences of physical activity and inactivity over time.

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Participants:

You are invited to participate in this study if you participated in the previous research study 10 years ago called “Fear of Falling: A Qualitative Inquiry into the Experiences of Older Women with Osteoporosis”, that was associated with a clinical trial evaluating the strength and balance effects of Osteofit, a community-based exercise program developed and administered by the Osteoporosis Program of BC Women’s Hospital & Health Centre. Two dozen women who participated in the previous research will be invited to participate in this study. To participate in this study, you must also be a fluent English speaker and be in adequate physical and mental health to consent to your own participation.

Procedures:

As part of this study, you are invited to participate in one 60-90 minute interview at a location of your choice including your home, a nearby café, community center or at the hospital (Children’s and Women’s Health Centre of British Columbia). You will be asked to share your experiences and thoughts about participating in physical activity over the long-term as a women living with osteoporosis. Your interview will include a few background questions about your age and living situation to help us understand your experiences. Your interview will be recorded, and a research team member may take notes about what you say. Your contributions will inform the development of information for the Osteofit website aimed at supporting older adults in enhancing their management of osteoporosis.

Benefits:

While sharing your experiences of physical activity we hope that you will benefit from an opportunity to reflect and that other women living with osteoporosis may benefit from what we learn from women in this study. At the end of the study we will provide a fact sheet tailored towards those living with osteoporosis which will be developed from what we learn in this study. This information will also be made available online through the Osteofit website.

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Risks:

There is the potential risk that by participating in the interview and providing information on your physical activity experiences that you may experience challenging feelings as you think about your health and what living with osteoporosis has been like for you. If necessary and desired, you will be referred to counselling or other support resources in your community.

Remuneration/Reimbursement:

To thank you for participating you will receive a gift card to a supermarket in the amount of \$30, in lieu of an honorarium. This is to cover the costs of your time and any inconvenience arising from your participation. If you prefer for your interview to take place at the hospital (BC Women's Hospital & Health Centre), we will reimburse your transportation costs, including parking and mileage, bus fare or taxi costs, and ask you to submit receipts.

Confidentiality:

If you agree to be part of this study, your identity will be kept strictly confidential. All of your information from the interview will be identified using a coded participant number. All interview data will be kept in a locked filing cabinet and digital audio files and text files will be stored on a password protected computer. Only the research team will have access to this information. You will not be identified by name in any reports of the study. After five years, all audio files will be erased and digital audio files will be destroyed.

Contact for Information about the Study:

If you have any questions about this project, please feel free to speak with the project Research Assistant,
email _____ You may also contact the Principal
Investigator _____

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Contact for Concerns about Your Treatment in the Study:

If you have any concerns about your treatment or rights as a research subject, you can contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or toll-free at 1-877-822-8598, or email (RSIL@ors.ubc.ca).

Consent:

Should you choose to participate, please note that your participation is completely voluntary. You are free to withdraw from the study at any time, even after you have given your consent. There will be no consequences if you decide to withdraw from the study at any time in the process.

I have read the information above and I agree to give permission to participate in the Project:

Name (please print)

Signature

Date

A signed and dated copy of this consent form will be left with you, and a copy will be provided to the Investigator.

BC Centre of Excellence for Women's Health
CHILDREN'S AND WOMEN'S HEALTH CENTRE OF BC
VANCOUVER, BC



APPENDIX N: CODING DICTIONARY

Category	Parent	Suggested sub-codes
	Accidents	<ul style="list-style-type: none"> • Car accidents and resulting injuries • Excludes falls/near falls
Demographics	Age	<ul style="list-style-type: none"> • Exact age (if available)
Activities	personal and self-care activities	<ul style="list-style-type: none"> • Massage • Rest
Activities	social and community activities	<ul style="list-style-type: none"> • Care giving • Volunteering – including church • Participation in other research • Travelled independently • Travelled with people
Advice	Advice to others Esp. re: living with Osteoporosis	<ul style="list-style-type: none"> • Osteofit classes • Walking, moving • Nutrition and diet
Aging	Aging reflections	<ul style="list-style-type: none"> • on self, family, friends, others aging
	Balance	<ul style="list-style-type: none"> • Imbalance and in/stability • Management of balance issues
Personal history	Cognition and memory	<ul style="list-style-type: none"> • impairments • Of events and dates • Of illnesses and changes • Strategies to aid memory/loss
Personal history	Daily living activities ~ mobility	Includes activities which may indicate mobility: <ul style="list-style-type: none"> • Cleaning • Cooking • Lifting • shopping • Changing light bulbs • Transportation – driving • Transportation – train/bus • Technology - computers
Aging	Death and dying	<ul style="list-style-type: none"> • death of family member • death of friend • death of others
Demographics	Occupational role - past	<ul style="list-style-type: none"> • Retired (occupation)
	Environment changes	<ul style="list-style-type: none"> • Home • Walking supports
	Falls	<ul style="list-style-type: none"> • Falls and near falls

Category	Parent	Suggested sub-codes
		<ul style="list-style-type: none"> • Un/related to Osteoporosis • Connections to balance and stability
Demographics	Family	<ul style="list-style-type: none"> • immediate • extended • family origin, inc. immigration
Fear	Fear	<ul style="list-style-type: none"> • Fear in general • Fears for safety • Fear of activities • Fear of events
	Fractures	<ul style="list-style-type: none"> • Un/related to falls • Un/related to Osteoporosis
Demographics	Friends	<ul style="list-style-type: none"> • neighbors, acquaintances, close friends
	Future plans	<ul style="list-style-type: none"> • moving residence • exercise • volunteering
Health care	Health care experiences	<ul style="list-style-type: none"> • experiences with doctors • physiotherapists, chiropractors, RMTs • specialists
Health experiences	Health status	<ul style="list-style-type: none"> • beliefs, attitudes & feelings about health and wellness changes • smoking • knowledge about health issues
Identity	Identity ~ attitude can be gleaned	Includes social and exercise aspects of identity such as: <ul style="list-style-type: none"> • Independence • active • lucky, fortunate • advocate • identify with illness
Demographics	Income - SES circumstances	<ul style="list-style-type: none"> • Spouse working • Characteristics of home • Transportation • Benefits (medical/pharmacare)/pensions
Demographics	Living situation ~ life changes	<ul style="list-style-type: none"> • Lives with spouse/partner • Lives alone • Lives in apartment/multi-storey • home/assisted living

Category	Parent	Suggested sub-codes
		<ul style="list-style-type: none"> • moved from/to residence
Demographics	Marital status	<ul style="list-style-type: none"> • Single, divorced or widowed • Married
Nutrition and diet	Nutrition	<ul style="list-style-type: none"> • Nutrition and diet routine • supplements • Concerns • Advice to others
Osteoporosis	Osteoporosis	<ul style="list-style-type: none"> • fear, falls & fractures related to Osteo • pain/tiredness related to Osteo • Understanding & other info on Osteo
Osteoporosis	Osteoporosis history ~management, excluding nutrition and PA	Includes knowledge of Osteoporosis status currently, its effects and management of osteoporosis excluding nutrition and PA : <ul style="list-style-type: none"> • Diagnosis & bone density scans • Family history • clothing • height changes & posture • Medication • Daily management
Osteoporosis	Osteoporosis status – current ~management, excluding nutrition and PA	<ul style="list-style-type: none"> • Follow-up bone density • clothing • height changes & posture • Medication • Daily management
Other illness	Other illnesses	<ul style="list-style-type: none"> • Chronic and acute illnesses • Health concerns • injury – other than falls
Pain	Pain	Pain and pain management: <ul style="list-style-type: none"> • osteoporosis related • fall related • fracture related • related to another illness • pain attribution • practitioners providing care
	Pets	<ul style="list-style-type: none"> • cat, dog...
Personal philosophy	Philosophy of life ~ beliefs, attitudes	<ul style="list-style-type: none"> • people • life - hence may overlap with religion

Category	Parent	Suggested sub-codes
Physical Activity	Physical Activity	<ul style="list-style-type: none"> • Why exercise • Setting • advice to others • physical inactivity(ex: 'sitting,' not doing much)
Physical activity	Physical activity	<ul style="list-style-type: none"> ○ Child codes • walking • Osteofit classes • Other exercise – home/classes
Religious and Cultural practices	Religious and Cultural practices	<ul style="list-style-type: none"> • Attends church • Meditates • Reads religious text • Belief in God/higher power
Social support	Social support ~ received for daily activities, spending time	<ul style="list-style-type: none"> • Family • Friends • Neighbours • Care-givers
Time	Time	<ul style="list-style-type: none"> • Present and past • Experience of time • Having sufficient time to do things
Tiredness	Tiredness	<ul style="list-style-type: none"> • Tiredness un/related to pain • Tiredness un/related to in jury • Tiredness un/related to aging • Tiredness un/related to mobility

APPENDIX O: INTERVIEW GUIDE FOR HEALTH CARE PROVIDERS

Introduction

Today, we would like to invite you to draw from your experience of working with older women with Osteoporosis. We are interested in how older women living with Osteoporosis are able (or not) to engage in relevant physical activity. We have spoken with women living with Osteoporosis individually and now seek to better understand strategies to promote physical activity among this particular group of older women.

Sample interview questions

1. What is your role in the health care program for women with osteoporosis? In what capacity do you interact with women who have osteoporosis? How long have you been in this role?
2. Osteoporosis management includes a certain amount of self-care. What advice do you give to women, from your particular area of responsibility and expertise, about living with and managing having osteoporosis?
3. From your experiences of working with women with osteoporosis, what do you know about the barriers they experience in engaging in physical activity?
4. From your experiences of working with women with osteoporosis, what facilitates their involvement in physical activity?
5. What strategies do you use, in your particular capacity, to support women's self-care of osteoporosis, especially with respect to physical activity?
6. Can you suggest any other strategies that would help women to be physically active in safe and appropriate ways?