How have health promotion frameworks considered gender?

KAREN GELB*, ANN PEDERSON and LORRAINE GREAVES
British Columbia Centre of Excellence for Women’s Health, Box 48, Room E311, 4500 Oak Street, Vancouver, BC, Canada V6H 3N1
*Corresponding author. E-mail: karen@clarityofexpression.com

SUMMARY
This paper provides an overview of five key internationally recognized health promotion frameworks and assesses their consideration of gender. This analysis was conducted as part of the Promoting Health in Women project, a Canadian initiative focused on generating a framework for effective health promotion for women. To date, no review of health promotion frameworks has specifically focused on assessing the treatment of gender. This analysis draws on a comprehensive literature review that covered available literature on gender and health promotion frameworks published internationally between 1974 and 2010. Analysis of five key health promotion frameworks revealed that although gender was at times mentioned as a determinant of health, gender was never identified and integrated as a factor critical to successful health promotion. This superficial attention to the role of gender in health promotion is problematic as it limits our capacity to understand how gender influences health, health contexts and health promotion, as well as our ability to integrate gender into future comprehensive health promotion strategies.

Key words: gender; gender and health promotion; framework

To date, no one has explicitly explored the presence or absence of gender in key health promotion frameworks or developed a specific women-centred health promotion framework. The analysis reported upon here was conducted as part of an ongoing and multi-component project designed to inform the larger Promoting Health in Women programme of work, a Canadian initiative focused on generating a framework for effective health promotion for women. This article identifies some conceptualizations of gender that can inform such a framework, and offers a brief overview of five key health promotion frameworks, from A New Perspective on the Health of Canadians (Lalonde, 1974) to the more recent Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005), (Canadian documents are prevalent in this review, reflecting the fact that Canada has played a key historical role in developing health promotion ideas.) and assesses the consideration of gender in their approaches.

The exclusion of gender in health promotion frameworks is viewed as a blind spot in health promotion by many feminist critics, who see gender as one of the key determinants of health (Daykin and Naidoo, 1995; Doyal, 1995; Cohen, 1998; Keleher, 2004). Women and men are different, not only biologically, but also in how they are able to act within the social structures that shape their lives and opportunities for health; this means that health promotion efforts
would benefit from greater consideration of gender (Reid et al., 2007).

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. (WHO, 2002, p.1).

Gender is a critical determinant of health, affecting 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 and Shumka, 2009). If health promotion only suggests gender-blind health promoting strategies, or focuses 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 et al., 2004). Health promotion that does not acknowledge the specific needs of women and men will not ultimately be able to provide 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 (Reid et al., 2007).

CONCEPTUALIZATIONS OF GENDER

Gender is generally understood as a social construct reflecting culturally and historically determined prescriptions of feminine and masculine identities, traits and behaviours (Johnson et al., 2007). Alongside gender, 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 et al., 2007, p. 4). Gender, being a social and cultural construct, 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.

Johnson et al. identify gender as manifesting at four levels: gender roles, gender identity, gender relations and institutionalized gender, with each level capturing different ways that gender influences all aspects of our lives (Johnson et al., 2007, pp. 5–7). Gender roles ‘are the behavioural norms applied to males and females in societies, which influence individuals’ everyday actions, expectations, and experiences’. Gender identity ‘describes how we see ourselves as female or male (or as a “third gender” or “two-spirited”), and affects our feelings and behaviours’. Gender relations ‘refer to how we interact with or are treated by people in the world around us, based on our ascribed gender. Gender relations interact with our “race,” ethnicity, class, and other identities’. Finally, institutionalized gender ‘reflects the distribution of power between the genders in the political, educational, religious, media, medical, 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’.

While conceptualizations and theories of gender, sex and diversity continue to evolve, for the purposes of this retrospective analysis it is most critical to understand simply that gender is a social construct embedded in and emerging from cultural, temporal and historical locations, and that it has various attributes generally defined as above. In the context of this review, we use the term gender in its most overarching sense, and looked for references or attention to any level of consideration either sex or gender.

METHODS

This review was informed by a wide iterative search of several databases intended to cover the spectrum of available literature on gender and health promotion frameworks. First, we searched for theoretical and conceptual literature on health promotion, and, given our ultimate aim, women’s health, and built a database. Secondly, 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. Thirdly, based on key informant information from within the Promoting Health in Women Research team and Advisory committee, we enhanced the academic literature search with a targeted review
of grey literature, to identify historical health promotion documents.

The primary search for literature on ‘Theory and Conceptual frameworks’ in Women’s Health and Health Promotion 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 \(\approx 9000\) references which were compiled in an Endnote\textsuperscript{TM} database. We used keyword searches within this database, such as complexity, gender, women and health, women’s health promotion, gender health promotion, health framework, feminism, Ottawa, Bangkok. This step reduced our search to \(\approx 2000\) 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 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 or implementation-focused frameworks and models, it did not turn up any of the key historical health promotion documents that both the Research Team and Advisory Committee knew to be foundational to health promotion (like the Ottawa Charter for Health Promotion (WHO, 1986); the Epp Report, Achieving Health for all: A Framework for Health Promotion (Epp, 1986); and the Population Health Promotion: An Integrated Model of Population Health and Health Promotion (Hamilton and Bhatti, 1996), A New Perspective on the Health of Canadians (Lalonde, 1974) and The Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005).

RESULTS: ANALYSIS OF KEY HEALTH PROMOTION FRAMEWORKS AND GENDER

Although some of these frameworks made some mention of sex, gender and/or diversity, it was rarely more than a passing nod. Although gender was at times identified as a determinant of health within these frameworks, it was not understood as a relational variable interacting with other factors and determinants of health. Further, gender was never identified as critical to successful health promotion and was not assessed in relation to other variables. None of these key health promotion frameworks acknowledged gender as a central consideration in health promotion or addressed its importance in relation to other health determinants. This limited integration of gender is problematic as it limits our capacity to understand how gender influences health, health contexts and health promotion, and consequently how women and men may respond to health promotion efforts. Moreover, although several of these frameworks mention gender, they do not discuss how to integrate gender and diversity into comprehensive health promotion strategies, such as coordinating healthy public policy or reorienting health services.

This section reviews these five key health promotion frameworks. First, we describe each one, and then examine how each addresses gender and gendered factors.

Numerous authors have attributed the emergence of health promotion discourse to the release of the so-called Lalonde Report in 1974 (e.g. Pederson et al., 1994; Low and Thériault, 2008). A New Perspective on the Health of Canadians (Lalonde, 1974), presented to the Canadian House of Commons in 1974, nudged the traditional medically based health paradigm from its historic stronghold, putting forth that improving the nation’s health requires attention
to four health fields: human biology, environment, lifestyle and health care organization (Lalonde, 1974).

When the full impact of environmental and lifestyle has been assessed, and the foregoing is necessarily but a partial statement of their effect, there can be no doubt that the traditional view of equating the level of health in Canada with the availability of physicians and hospitals is inadequate. Marvellous though health care services are in Canada in comparison with many other countries, there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology. (Lalonde, 1974, p. 18)

These four health fields encompass both medical and social factors affecting health, such as the physical environment, individual and social context, biology and other risk factors. The Lalonde Report formalized the way that Canada conceptualized health behaviours; it set the stage for understanding the social determinants of health, introduced the term ‘health promotion’ and led to many of the subsequent, key health promotion frameworks. However, there is a complete absence of consideration as to how sex and/or gender affects health and health behaviours.

For example, aside from explicit discussion about a male mortality problem, namely men’s average shorter lifespan (while overlooking other metrics, such as quality of life), mention of health differences and health determinants are 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: ‘The LIFESTYLE category, in the Health Field Concept, consists of the aggregation of decisions by individuals which affect their health and over which they more or less have control’ (Lalonde, 1974, p. 32).

Just over a decade after the initial presentation of the Lalonde Report, both the Ottawa Charter for Health Promotion (WHO, 1986) and Achieving Health for all: A Framework for Health Promotion (a Canadian document often referred to as the Epp Report) (Epp, 1986) were released. The Ottawa Charter for Health Promotion (WHO, 1986) was released at the first International Conference on Health Promotion in 1986. The Charter was put forth with a stated goal of ‘achiev[ing] Health for All by the year 2000 and beyond’ (WHO, 1986, p. 1). The document is concise and targeted, focused primarily on defining aspects of health promotion and serving as a call to action.

According to the Ottawa Charter, health is defined as ‘a positive concept emphasizing social and personal resources, as well as physical capacities’ (WHO, 1986, p. 1). The explicit mention of social resources captures the importance of contextual factors in influencing health. This illustrated progress toward further recognition of the role of non-medical factors on individual health. Whereas the Lalonde report suggests 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, as well as the notion 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 (emphasis added). (WHO, 1986, p. 1)

Beyond this passing mention that both women and men must be able to control the factors that determine health, gender is not explicitly detailed in the Charter. While there is an articulation that various external factors, such as education, income and a stable eco-system, affect health, there is 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—a critical shortcoming in developing a comprehensive health promotion framework.

The Ottawa Charter does, however, make mention of 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’ (WHO, 1986, p. 2). This 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 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. (WHO, 1986, p. 3)

Achieving Health for all: A Framework for Health Promotion (Epp, 1986) was also released in Canada in 1986, and was a Canadian-focused high-level framework. The document identifies key national health challenges—reducing inequities, increasing prevention, enhancing capacity to cope—and proposes strategies for acting on these challenges. The overarching strategies for action target high-level, population-based approaches. The three strategies identified are: Fostering Public Participation, Strengthening Community Health Services and Coordinating Healthy Public Policy.

While the report does make mention of differential health experiences for women and men, it does little by way of critically assessing the factors influencing these findings. Indeed, it makes no mention of gender nor addresses how gender might factor into or affect the identified health challenges, or strategies for action. To its credit, the Epp Report does clearly acknowledge that while it has chosen as its focus issues deemed of national importance, they may well be trumped by more locally pertinent issues (Epp, 1986, p. 2). 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 (Table 1). Gender did not appear on this first list of health determinants, but by 1999 both gender and culture, along with social environments, had all been added (Robertson, 1998; Health Canada, 1999). Since then, the list of 12 determinants of health has remained largely consistent, with the only change being the addition of literacy alongside 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 (Robertson, 1998). As part of the broader response to these questions, Hamilton and Bhatti (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 and Bhatti, 1996, p. 1).
Hamilton and Bhatti (Hamilton and Bhatti, 1996, p. 5) explain 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. A critical next step, however, would be to examine how gender in all of its manifestations acts as a determinant of health and interacts with the other factors in this model.

The most recent charter for health promotion from the World Health Organization, the Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005), was released in 2005, at the 6th Global Conference on Health Promotion. The Bangkok Charter self-describes as identifying ‘actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion’ (WHO, 2005, p. 1), and it goes on to detail these. The Bangkok Charter departs from the Ottawa Charter dramatically 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 gross departure from the Ottawa Charter in relation to private sector involvement in health promotion, the Bangkok Charter is much like the Ottawa Charter in that it pays only a cursory nod to gender as a factor in health promotion. Other than a brief mention that ‘women and men are affected differently’ (WHO, 2005, p. 2) by the determinants of health, the Bangkok Charter is noticeably lacking on content pertaining to women or gender considerations. 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).

CONCLUSION

A brief review of five key health promotion frameworks highlights the ways in which all of these frameworks, from the Lalonde Report (Lalonde, 1974) onward, have progressed our understanding of health promotion, health promotion practice and best practices in health promotion. However, in reviewing these five key pieces, it is clear that gender has been overlooked, to varying degrees, in most instances. When gender was mentioned as a consideration, or as a determinant of health, its complexity was not addressed, and it was not understood as a relational variable interacting with other factors and determinants of health. Further, gender was never identified as critical to successful health promotion and was not assessed in relation to other variables or health determinants. Where we are seeing gender addressed within health promotion is in the practice and implementation literature. Concretely, considerations of sex and gender and their relationship to health promotion have been taken up in the fields of reproductive and sexual health, particularly within the fields of maternal-child health and HIV/AIDS (Eckman et al., 2004; Feldman-Jacobs et al., 2005). However, gender does not appear as a foundational consideration—not as a lens through which we see other aspects of health and health promotion, or as an interactive variable or factor in health—in health promotion frameworks on an
international level. This critical omission of gender as a central consideration to conceptualizing health promotion is detrimental. It has limited, and continues to limit the scope of development of the field, as well as our capacity to fully address and understand the ways in which gender acts as a critical determinant of health, influencing both health and health experiences, research and practice.

However, despite this significant lack of attention to gender and in health promotion frameworks, the situation is not without promise. There are several who have, and continue to critically examine, discuss and promote gender in health promotion work (Daykin and Naidoo, 1995; Thurston and O’Connor, 1996; Keleher, 2004; Ostlin et al., 2006; Reid et al., 2007). This body of literature, developed in response to this vacuum, identifies many useful approaches such as backing away from individualizing and victim blaming in health promotion practice, and looking to the broader social structures and contexts that influence health to draw from in developing more effective health promotion particularly for women. Further, there is also a growing body of literature that discusses the complexity of gender and intersectionality (Reid et al., 2007; Hankivsky and Christoffersen, 2008; Reid et al., in press), investigating myriad processes and factors that converge to affect the health of women and men, which will also contribute to adding needed depth to health promotion and health promotion frameworks.

It is clear that in order to create a health promotion framework that will be effective for women (or for men) gender in all of its manifestations and in its interactive and intersectional potential with other factors will need to be incorporated. As this has not occurred to date in major Canadian and international health promotion frameworks, it is urgently required. While these key frameworks omitted gender, there were significant concepts and some incremental steps embedded in them that have both highlighted the absence of, and set the stage for a robust treatment and inclusion of gender and related concepts to evolve an effective health promotion approach for women. Our subsequent work is exploring all of these concepts and approaches examining how these various theoretical perspectives can help inform the development of a framework for health promotion for women.

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