ANNUAL REVIEWS

Annual Review of Public Health

Advances in Gender-Transformative Approaches to Health Promotion

Jane Fisher and Shelly Makleff

Global and Women's Health Unit, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia; email: jane.fisher@monash.edu, shelly.makleff@monash.edu

Annu. Rev. Public Health 2022. 43:1–17

The *Annual Review of Public Health* is online at publhealth.annualreviews.org

https://doi.org/10.1146/annurev-publhealth-121019-053834

Keywords

gender-transformative programs, health promotion, gender norms, gender equality

Abstract

Gender is an important determinant of health, but explicit attention to gender is often missing in health promotion. We build on Pederson and colleagues' gender-transformative framework for health promotion to propose four guiding principles for gender-transformative health promotion. First, health promotion must address gender norms directly if it is to improve health outcomes. Second, it should move beyond individual change to engage explicitly with structural and social determinants of health. Third, it should address underlying gender-related determinants in order to influence health outcomes. And fourth, it requires complexity-informed design, implementation, and evaluation. We provide background on key concepts that are essential for designing, implementing, and evaluating gender-transformative health promotion: gender norms, socioecological approaches, and the gender system. We give examples of the four principles in practice, using the case of postnatal mental health promotion in Australia and sexuality education in Mexico. These four principles can be applied to health promotion efforts across contexts and outcomes to address the harmful gender norms that contribute to poor health as a part of broader efforts to improve health and well-being.

INTRODUCTION

Health promotion is defined by the World Health Organization as the "process of enabling people to increase control over, and to improve their health" (69, p. 1). The influential 1986 Ottawa Charter for Health Promotion (69) states that achieving health and well-being involves opportunities not only to modify protective health behaviors, but also to realize life goals and have the capacity to adapt to change. Prerequisites for human health include peace, food sufficiency, adequate shelter, and social justice. Political, economic, social, and cultural factors are of fundamental importance to determining health, not just individual biology. The Charter, however, does not engage specifically with gender-based risks to health and how these should be addressed as a fundamental aspect of health promotion.

Gender is a culturally determined social and cultural construct in which feminine and masculine characteristics and behaviors are prescribed. It influences self-image and individual interactions, behaviors, and aspirations. In 2001, Doyal argued that, despite major efforts to improve inequalities in health, this goal was yet to be achieved, and a new approach in the form of gender-sensitive policies that consider the importance of femaleness for women's health and health care (and of maleness for men's health and health care) was needed (16). This approach acknowledged that health is influenced by biology, including reproductive biology, but that socially constructed roles and responsibilities are major determinants.

The 1994 International Conference on Population and Development (ICPD) concluded that social and cultural factors contribute to inequalities in health and well-being, but it moved beyond this conclusion to explicitly include sexual and reproductive health and rights as central for health and health equity (66, 67). The ICPD Program of Action highlights that women's unequal access to income-generating work and a disproportionate burden of caregiving and unpaid household work together lead to inequalities in accrual of economic assets, with implications for health and well-being.

The World Health Organization Commission on Social Determinants of Health stated in 2007 that "gender relations of power constitute the root causes of gender inequality and are among the most influential of the social determinants of health" (62, p. 1). The Commission drew particular attention to the inequalities in health experienced by women. It concluded that discrimination, subordination, and exploitation restrict the rights, opportunities, and full development of all capacities of women and girls, causing disproportionate burdens of disease and social suffering (62). A 2019 conceptual model put forth by Heise et al. (28) in the *Lancet* series on Gender Equality, Norms, and Health takes the conceptualization of gender as a determinant of health further, distinguishing between two types of determinants of health: gender inequality and restrictive gender norms. "Because of the historical legacy of gender injustice, the health-related consequences of gender inequality fall most heavily on women, especially poor women; by contrast, rigid gender norms undermine the health and well-being of all people, regardless of age, sex, gender, or income setting" (28, p. 2440).

While health promotion aims to reduce health inequities, in general, the field has not addressed gender as a key driver of inequities. Ten years ago, Gelb et al. (23) identified, through a systematic search, five established health promotion frameworks published between 1974 and 2010 and reviewed how gender had been considered in them. They found that while gender had been referred to in some of these frameworks, the needs of women were limited to the consideration of biological differences. None of the frameworks had identified gender as critical to effective health promotion, and the importance of applying a gender lens to avoid victim blaming or attributing the responsibility for health to individuals was not described in any of the frameworks.

Two years later, predicated on their prior conclusions that gender inequality damages health and that existing health promotion frameworks do not address gender adequately, Pederson et al. (52) proposed a gender-transformative health promotion framework. The framework considers gendered biological, environmental, social, cultural, and economic determinants of health. It maps pathways through which health promotion can be gender-transformative to achieve health equity while highlighting the risk that health promotion programs might exploit or accommodate harmful gender norms through stereotypical depictions of women or men, which would reinforce rather than transform gender norms. The authors argued that interventions informed by the framework have the potential to improve the health of women and girls internationally.

The aim was to review the recent evidence about gender and health promotion and consider it in relation to the gender-transformative health promotion framework proposed by Pederson et al. (52).

METHODS

We have drawn on the framework for gender-transformative health promotion interventions to propose key principles that guide gender-transformative health promotion. For each of the four principles, we first summarize the related concepts presented by Pederson and colleagues. Next, we present key concepts that are fundamental for the design, implementation, and evaluation of gender-transformative health promotion and describe health promotion frameworks and programs that explicitly consider the effects of gender inequality and harmful social and gender norms on health. Then, using two published illustrative program case studies, we provide concrete examples of how each of the guiding principles has been put into practice. Finally, we reflect on implications for design, implementation, and evaluation of gender-transformative health promotion.

RESULTS: THEORETICAL FRAMEWORKS AND PRINCIPLES

Principle 1: Gender-Transformative Health Promotion Must Address Gender Norms as Part of Its Work to Impact on Health Outcomes

Pederson et al. (52) define gender-transformative health promotion as having a dual purpose to improve health and change negative gender norms. They argue that health promotion should (*a*) be disruptive in its efforts to replace harmful gender norms with positive alternative norms to promote health and (*b*) avoid health messaging that inadvertently reinforces harmful gender stereotypes, unnecessarily medicalizes issues, or blames or chastises individuals. Because gender inequality and restrictive gender norms are drivers of poor health and health inequity, all health promotion programs would benefit from incorporating considerations of gender norms in their theoretical grounding and design. Social norms influence health-related behaviors and beliefs, but guidance has been lacking on how they should be integrated into the design and evaluation of health promotion efforts. Recent frameworks by Cislaghi & Heise (9) and Heise et al. (28) detail the intersections between social norms and other determinants of health and identify ways to take these into account in health promotion.

A social norm can be defined as "a rule constructed from an individual's beliefs and evaluations: her beliefs about what others do (descriptive norm), her beliefs about what others dis/approve of (injunctive norm), and her evaluation about whether what certain others do and dis/approve of is enough reason for her to comply (reference group)" (41, p. 142).

This definition draws on foundational work by Cialdini et al. (8), which describes how social norms influence individual behaviors and beliefs through different mechanisms, including

anticipation of social sanctions, for example, expecting to be praised or accepted for complying with social norms or excluded or threatened for breaking them. While social norms and individual attitudes are different and do not always align, they have a mutual influence (9, 42).

Cislaghi & Heise (11) propose a definition of gender norms that can serve research and practice promoting gender equality in health:

> Gender norms are social norms defining acceptable and appropriate actions for women and men in a given group or society. They are embedded in formal and informal institutions, nested in the mind, and produced and reproduced through social interaction. They play a role in shaping women and men's (often unequal) access to resources and freedoms, thus affecting their voice, power, and sense of self. (11, pp. 415–16)

A growing literature describes the negative impacts of such "restrictive," "harmful," or "rigid" gender norms on both women and men (28). Men who feel pressure to comply with rigid masculine roles—for example, being aggressive, not showing emotions, not asking for help, being hypersexual, or feeling pressured to provide financially for their family—are at an increased risk for experiencing poor mental health, taking risks, being in traffic accidents, being the victim or perpetrator of violence, and sexually harassing women (28, 31). For women, norms around femininity such as being chaste, physically attractive, and overeager to please can increase the risk of all mental health problems, sexually transmitted infections, and experiencing violence (28). Programs that aim to influence gender norms by shifting power differentials to become more equal are described as gender-transformative (18, 60).

Evaluations of gender-transformative programs show that it is possible to modify harmful social norms, including gender norms (28, 34, 56). Gender-transformative programs have demonstrated reductions in complex health outcomes that are often considered intractable, including gender-based violence (1, 34), sexual risk-taking behaviors (1), and female genital cutting (15). In a review of 58 programs working with men and boys, Barker et al. (3) concluded that programs adopting a gender-transformative approach or promoting gender-equitable relationships—for example, encouraging men to play an active role in parenting or addressing gender socialization through promoting reflection on gender roles—"are more effective in producing behavior change than narrowly focused interventions" (p. 539).

While health promotion efforts should address social norms as one of the multiple intersecting factors that influence behavior, a focus on social norms is unlikely to create change without also addressing other factors that influence behavior, such as individual knowledge and beliefs, laws and policies at the government or institutional level, and socioeconomic and cultural characteristics of a community. Indeed, norms-focused approaches inappropriately used in isolation may discredit social norms approaches to health promotion (9, 10).

The case studies discussed in this review illustrate different approaches to addressing gender norms in health promotion, both through explicit disruption of gender norms and through careful adoption of health messages that do not reinforce harmful gendered norms and stereotypes.

Principle 2: Gender-Transformative Health Promotion Should Move Away from a Sole Focus on Individual-Level Change to also Engage Explicitly with Structural and Social Determinants of Health

Pederson et al. (52) describe the importance of conceptualizing gender as structural rather than as an individual attribute and, in doing so, acknowledge and address women's social position and harmful gender norms as determinants of health. The framework identifies gendered biological, environmental, social, cultural, and economic determinants of health.

Health promotion programs seek to address diverse socioeconomic, cultural, and social factors that influence human behavior (57). Bronfenbrenner (6) developed ecological systems theory—often referred to as the ecological or social-ecological model—to describe the multiple interrelated levels of influence on childhood development, from the immediate level of the social group, family, or school to more distal influences such as laws, cultural values, social norms, and mass media. Bronfenbrenner's approach has been adapted and applied over decades to a range of health promotion focus areas (64), including physical activity (51), prevention of alcohol abuse (65), and prevention of violence against women (2, 30).

Social-ecological models have been used increasingly to conceptualize and understand the complex phenomenon of gender-based violence. Heise's (29) influential 1998 ecological framework for violence against women presented interrelated risk factors for violence at different levels of the social ecology: the individual level (e.g., personal history such as witnessing parent-to-parent violence as a child), the immediate environment or "microsystem" (e.g., family-level factors such as alcohol use or male dominance), the broader influences on the individual or "exosystem" (e.g., unemployment or delinquent peer associates), and the societal influences or "macrosystem" (e.g., rigid gender roles, acceptance of interpersonal violence). Numerous studies have drawn on Heise's ecological framework for violence against women, resulting in a proliferation of evidence in different contexts about the causes of violence against women. This evidence base, in turn, informed Heise's (30) 2011 revised ecological framework, which details the factors that have since been empirically linked to partner violence at the individual, relationship, partner, community, and macrosocial levels. This model includes community-level social norms about the right of men to control female behavior and aspects of the gender system more broadly, for example discriminatory family laws or limited access to formal employment among women.

Heise's ecological framework has been adapted and used as the theoretical foundation for many multicomponent gender-based violence prevention programs. Rigorous evaluations have shown that gender-based violence can be prevented and indicate that programs intervening at different levels of the social ecology are more likely to be effective at measurably reducing violence than are programs intervening at only one level (48). Despite this growing evidence base, many programs maintain a focus on individual-level change, a subject of critique. For example, in the field of preventing dating violence experienced by young people, recent commentaries and editorials decry the persistent emphasis on individual-level change in violence prevention programs and remind us that programs would be more effective at changing behavior if they moved beyond individual risk factors to focus on social contexts more broadly (12, 45).

The case studies discussed below illustrate the application of approaches to considering gender as a social and structural determinant of health in gender-transformative health promotion.

Principle 3: Gender-Transformative Health Promotion Should Aim to Influence Multiple Interrelated Health Outcomes by Addressing Underlying Gender-Related Determinants

The Pederson et al. (52) framework states that "gender-transformative health promotion entails looking beyond single health concerns to how multiple factors and experiences intersect with gender in women's lives to generate conditions of risk, vulnerability or protection" (p. 146). This approach entails "understanding the common risk conditions and experiences that generate girls' and women's health challenges" and necessitates a cross-sectoral and multicomponent intervention that addresses diverse underlying risks and determinants.

It is now more common for multicomponent programs that intervene in different ways and at different levels to be required to address complex health problems. For example, in relation

to HIV prevention (14), the DREAMS partnership is "a direct response. . .to the call for combinations or 'packages' of prevention approaches to address the multidimensional nature of HIV risk" (4, p. 12). This $385 million initiative, funded by the US government and private partners, is a "multicomponent package" that "aims to address the root causes of girls' and young women's vulnerability and improve their lives more broadly" (4, p. 2). Specifically, the program intervenes on gender inequality, poverty, sexual and gender violence, and lack of education as key components of HIV prevention for girls (61). The evaluation of this multicountry intervention intends to generate evidence about the benefits, challenges, and complexities of investing in multicomponent interventions that intervene on interrelated health outcomes and their underlying risk factors. Another example is the Dating Matters multicomponent teen violence prevention program in the United States (13). It was found that the program had an effect not only on dating violence, but also on other behaviors with similar underlying risk and protective factors, including bullying, sexual harassment, carrying weapons, and substance abuse. The program characteristics credited with this success include delivering a high dose of the intervention over an extended period as well as working across the social ecology, with students and their families, at school, and in neighborhoods (13).

The case studies illustrate how gender-transformative health promotion programs can move beyond a focus on a single health outcome.

Principle 4: Gender-Transformative Health Promotion Requires Complexity-Informed Design, Implementation, and Evaluation Strategies

Pederson and colleagues' (52) framework presents complexity as inherent to gender. "From the perspective of fostering change, it is vital to recognize that gender is not an immutable personal characteristic but rather a complex, multi-faceted social phenomenon" (p. 143). Beyond this description, however, the authors do not describe how complexity can be accounted for in gender-transformative health promotion.

In public health literature complexity is commonly considered to be an attribute of interventions, particularly those with multiple interacting components, but it is alternatively seen as a characteristic of the system in which an intervention is implemented (27, 63). Others have proposed that interventions are events that disrupt complex systems, moving the evaluation focus away from individual behavior change to system-level changes over time (49). Another facet of complexity is the mutual influence between health promotion efforts and the system in which they are implemented; for example, gender-transformative health promotion interventions aim to influence gender norms, which in turn influence intervention processes and outcomes (43).

The notion of a gender system can inform how health promotion efforts conceptualize, and ultimately address, gender as a determinant of health. The gender system reflects the different tasks and roles that are assigned to women and men in a particular context (32) and the "processes that both define females and males as different in socially significant ways and justify inequality on the basis of that difference" (58, p. 191). Gender systems are held in place by gender norms and, in most contexts, will perpetuate an unequal distribution of power and resources (28). All health promotion programs are implemented within, and influenced by, the gender system in which they are implemented. At the same time, health programs have the potential to influence the gender system in ways that contribute to a macroenvironment supporting improved health and well-being. As interventions shift norms, they are changing the gender system in which they are implemented, which can lead to unanticipated and emergent changes to the program (43).

The case studies discuss challenges accounting for complexity and consider how gender-transformative health promotion can be complexity-informed.

IMPLEMENTING GENDER-TRANSFORMATIVE HEALTH PROMOTION

Gender-transformative approaches are most usefully demonstrated in examples where the theory has been applied. We draw on two examples here: the first, a health promotion program to reduce postnatal mental health problems in Australia, and the second, a comprehensive sexuality education program to reduce intimate partner violence in Mexico.

Case Study 1: Postnatal Depression and Anxiety Prevention

Mental health problems experienced by women who are pregnant or have recently given birth are determined predominantly by social factors beyond individual control, including the occurrence of coincidental adverse life events, and the experience of past mental health problems, which cannot be modified (21, 59). However, the other major risks, which include experiencing insufficient social support and a poor relationship with the intimate partner, are potentially modifiable (21, 59).

Why should postnatal mental health programs be gender-transformative? Universal health promotion interventions for whole populations have the benefits of being less stigmatizing, able to be integrated into routine care and more likely to be used than those that are targeted (for people with current symptoms), and selective (for people at risk of developing symptoms). Individual or cluster randomized controlled trials of universal interventions to prevent postnatal depression and anxiety have included hospital-based debriefing with a psychologist (54) or a midwife listening visit (38); earlier-than-usual postnatal general practitioner consultation (24); home visits for practical and emotional care from a trained community support worker (50); an information pack, with or without an invitation to a facilitated group (55); home visits from midwives or community nurses trained to identify women's physical and mental health conditions and initiate health care (40); or information and community supports to improve access to care (39). The methodological quality of the trials was assessed in a Cochrane review as good to excellent, but the underlying theory or proposed mechanism of effect was not delineated. Apart from the intensive home visiting, none of the interventions had a beneficial impact. None of these efforts to prevent postnatal maternal mental health problems included fathers or infants, nor did they identify or address gender-based risks to mental health (19).

Adaptation to parenthood requires adjustments in roles and responsibilities and recognition of the changed workload (21, 59). Gender-transformative health promotion during pregnancy and early parenthood has the potential to help new parents adopt equitable roles and responsibilities and to become skilled in infant care and thereby improve mental health.

Program description. What Were We Thinking (WWWT) is a highly structured, gender-informed, interactive psychoeducational program for couples and their first baby (21). The intervention takes a new approach to the prevention of postnatal depression and anxiety by directly addressing previously neglected, relevant, and potentially modifiable risks. The intervention design is based on the premise that day-to-day interactions among a woman, her partner, and their baby can influence mental health and are promising targets for behavior change. The intervention uses a gender-informed approach to increase empathy and a shared approach to problem-solving coupled with skills building to increase confidence and reduce subjective incompetence in caregiving (see the sidebar titled The What Were We Thinking Program: Theoretical Principles and the sidebar titled The What Were We Thinking Program: Content and Structure) (21). The intervention is designed around two key areas: (*a*) the intimate partnership (About Parents curriculum) and (*b*) caring for the infant (About Babies curriculum).

THE WHAT WERE WE THINKING PROGRAM: THEORETICAL PRINCIPLES

WWWT is a highly structured, gender-informed, interactive psychoeducational program for couples and their first baby.

- Improvements in day-to-day interpersonal interactions within families are fundamental to preventing common mental disorders.
- Partner and infant behaviors can be modified to decrease those that contribute to psychological distress and increase those that promote confidence and a sense of competence.
- Women prefer to receive emotional care and practical support within their intimate relationships rather than increased care from health professionals.
- Depressive and anxiety disorders are not easily distinguished; prevention strategies should use a transdiagnostic approach.
- Readily understood, evidence-informed knowledge and opportunities for active learning and skills development should be made available at the developmental stage at which they are needed.
- A psychoeducational approach addresses plausible psychological mechanisms using education to meet salient learning needs.
- Language is crucial and needs to challenge gender stereotypes, position mothering and fathering as different but of equal importance, respect the unpaid workload, and name and normalize emotions without psychiatric labeling.
- Women's experiences of humiliation can be reduced by increasing their partners' appreciation and empathy and by reducing critical and controlling behaviors.
- Experiences of entrapment can be countered by promoting infant care as a shared endeavor in which parents with comparable competence can permit each other independent or shared leisure.
- Cognitively focused rather than emotion-focused responses to infant crying can be promoted by building skills to respond actively and effectively, rather than avoidantly.
- Occupational fatigue among parents is minimized by teaching them how to understand and promote adequate infant sleep using evidence-informed behavior management strategies.
- Together, these strategies lead to increased confidence and competence and reduced depression, anxiety, and adjustment disorders.

Sidebar adapted from Fisher et al. (21).

After giving birth, women have reduced interactions with workplaces and communities and increased dependence on their intimate partners. A relationship with the intimate partner characterized by criticism, control, and rigid gender stereotypes about roles and responsibilities can be humiliating. Conversely, if the relationship is characterized by empathy, affirmation, encouragement, and shared problem-solving, mental health can be protected and promoted (59).

While less well recognized, growing evidence indicates that dysregulated infant behaviors, including intense, unsoothable crying, waking after short sleeps, or being difficult to feed, increase the risk of their parents experiencing postpartum mental health problems. Caring for an infant and managing a household occur in a gendered social context. This occupation is repetitive, isolated, never complete, and intrinsically confining, but it is not dignified with the language and descriptors of work or understood as having health and safety risks. Rather, primary caregivers are described as "not working." Health professionals' routine questions such as "Do you work?" and "Does your partner help?" reflect a public discourse that values paid work and devalues and fails to recognize unpaid work, which is stereotyped as a female responsibility (20). There is little training in infant care skills, which are presumed to be intuitive to women. Occupational fatigue,

THE WHAT WERE WE THINKING PROGRAM: CONTENT AND STRUCTURE

WWWT has an educational framework, comprising structured, easily comprehended learning activities made available at a critical life stage when parenting-specific learning needs are high.

It has three interlinked components:

1. Primary care from a maternal and child health nurse trained in WWWT program theory and implementation;
2. Attractively illustrated program materials in accessible plain language, including worksheets for each learning activity and a short book; and
3. An in-person seminar offered at 6–8 weeks postpartum in the form of small-group sessions for about five couples and their babies in a short single-day or half-day program. The sessions have two sections:
   - About Babies includes learning activities about infant temperament, crying, and fussing; recognition of tired cues and sleep needs; and establishment of feed–play–sleep routines of daily care and safe, sustainable settling strategies (known collectively as infant behavior management).
   - About Parents includes learning activities about differences between how parenthood had been imagined and how it is being experienced; recalling the difficult and pleasing aspects of the baby's birth; recognizing, naming, and renegotiating the unpaid workload fairly in nonconfrontational ways; acknowledging the disenfranchised losses of parenthood as well as the gains; identifying experiences within parents' families of origin that they wish to duplicate or to relinquish; and identifying gaps in support.

Adult learning strategies include group discussion, individual tasks using print materials and discussions among partners, practice in problem-solving and negotiation, hands-on supported practice in infant wrapping and settling, short talks, and practical demonstrations.

Sidebar adapted from Fisher et al. (21).

well recognized as a health risk among shift workers, is rarely considered in explaining diminished problem-solving and emotion regulation among mothers of infants (33, 46, 47). We therefore sought to influence gendered roles and expectations around caregiving and in the intimate partnership by training maternal and child health professionals to integrate WWWT in the usual first-time parents' groups (see the sidebar titled The What Were We Thinking Program: Theoretical Principles and the sidebar titled The What Were We Thinking Program: Content and Structure).

Results. A cluster randomized controlled trial of WWWT was conducted in six local government areas, which administer maternal and child health services in Melbourne, Australia. Twenty-four maternal and child health centers (MCHCs) were allocated randomly to usual care and 24 to usual care plus WWWT. All primiparous women in the MCHCs who had a baby under the age of four weeks and who had sufficient English fluency were eligible to participate. They completed individual telephone interviews when their babies were one month and six months old. In the intervention arm, women, their partners, and babies were invited to a WWWT group. In intention-to-treat analyses, which included all eligible women regardless of participation in the intervention, investigators found that there were significantly lower rates of mild to moderate symptoms of anxiety and that self-rated health (an indicator of occupational fatigue) was significantly better. The proportion of women experiencing diagnosed depressive, anxiety, or adjustment disorders was lower in the intervention arm than in the control arm, but this difference was not statistically significant. However, per-protocol analyses, which compared the group that received

the full three-component intervention (in-person seminar as well as materials and care from a trained nurse) with the usual care control arm, revealed that the full intervention was effective in reducing prevalence of depression, anxiety, and adjustment disorders compared with usual care; however, the partial intervention (materials and care from a trained nurse) was not.

Opportunities to learn about renegotiating roles and responsibilities equitably and minimizing critical or coercive behaviors in interactions with the intimate partner were found to be relevant and useful by 82% of women and 71% of men. The intervention led to significant behavior change in couples whose relationships were functioning optimally in the early postpartum period. Nearly 90% of women and men said that it had been useful to learn about how to soothe and settle their babies. Couples whose babies were unsettled in the early postpartum period were significantly more likely to apply infant behavior management strategies to promote sleep and establish sustainable routines of care and to be using recommended safe sleep practices than were those whose babies had been settled in the early postpartum weeks. Overall, more than 95% of women and men said that the program would be useful to all parents.

How this case study illustrates a gender-transformative approach.

Principle 1: Gender-transformative health promotion must address gender norms as part of its work to impact on health outcomes. WWWT is explicitly gender-transformative in positioning women's unpaid caregiving and household work as requiring recognition and explicit renegotiation after the birth of a baby, a period when reversion to traditional gender norms is common. The program challenges harmful stereotypes that assume that women are responsible for and intuitively skilled at this work and instead positions this work as a highly skilled activity for which new skills and knowledge are required, thereby creating positive alternatives to harmful norms.

Principle 2: Gender-transformative health promotion should move away from a sole focus on individual-level change to also engage explicitly with structural and social determinants of health. WWWT positions postpartum mental health problems as being socially determined rather than being an illness intrinsic to an individual. Training for primary health care providers involves introducing this new way of thinking and assisting practitioners to become aware of their gender stereotypes and how these are expressed automatically in clinical questions and their behaviors.

Principle 3: Gender-transformative health promotion should aim to influence multiple interrelated health outcomes by addressing underlying gender-related determinants. WWWT intervenes on unsettled infant behavior, and the intimate partnership, to improve mental health. It does so by contextualizing these experiences within a gendered social context and addressing the underlying social norms that contribute to poor health and well-being outcomes.

Principle 4: Gender-transformative health promotion requires complexity-informed design, implementation, and evaluation strategies. The evaluation of WWWT noted that some participants did not attend the intervention because the father did not want to participate. Other research has similarly highlighted the need to develop further strategies to effectively engage men in health promotion interventions (17). Gender norms around fathers' involvement in maternal child health services may have impeded program success for some participants. In this way, the gender system can be a barrier to the program, even while the program aims to impact the social norms that uphold the gender system. Program design for gender-transformative programs should consider the

complexities of designing a program that shifts the very norms that are simultaneously acting as a barrier to program engagement and of accounting for this issue in program theory and evaluation.

Case Study 2: Gender-transformative sexuality education

Adolescence is a period of rapid emotional and social development (5, 7) and a time of gender socialization, when "gendered attitudes and behaviours intensify" and some potentially harmful behaviours, such as violence, risky sexual behaviors, and substance abuse, begin to emerge (35, p. 36). Gender-transformative health promotion for young people aims to reshape harmful gender norms in ways that promote gender equality at an early age, with the potential to influence health and well-being into adulthood.

Why should sexuality education programs be gender-transformative? Sexuality education programs typically focus on improving health outcomes, such as reducing rates of HIV, sexually transmitted infections, and unintended or mistimed pregnancies (22, 36, 37). Recent guidelines, however, advocate for an empowerment approach to sexuality education, which incorporates content about gender and power to promote equitable relationships (25, 68). Haberland (26) conducted a comprehensive review that identified 22 studies of sexuality education and HIV prevention programs published between 1990 and 2012. On the basis of the published literature and by examining curricula, Haberland categorized 10 of these programs as including content about gender and power dynamics in intimate partnerships and 22 as excluding these topics. When classified in terms of rigorous evidence of effects on pregnancy and sexually transmitted infections, "the programs that addressed gender or power were five times as likely to be effective as those that did not; fully 80% of them were associated with a significantly lower rate of [sexually transmitted infections] or unintended pregnancy. In contrast, among the programs that did not address gender or power, only 17% had such an association" (26, p. 31). Haberland suggested that by incorporating gender and power, sexuality education can not only influence traditional public health outcomes but also contribute to egalitarian and nonviolent intimate partnerships (26).

Program description. A comprehensive sexuality education program was developed and implemented by Mexfam, a Mexican community-based organization. Drawing on international guidelines, the intervention was updated in 2016 to address partner violence prevention. The intervention used a gender-transformative approach, engaging diverse strategies to encourage critical reflection about gendered social norms and partner violence (44). Participatory activities in a group setting focused on norm-related topics that were relevant to participants' lives, and open dialogue between participants and facilitators provided a space to share and discuss, and critically debate, personal beliefs and experiences. Two-hour sessions were delivered weekly over 10 weeks by professional health educators to groups of 20 participants aged 14–17. The intervention was implemented at a public technical secondary school in the southern part of Mexico City with students from lower- to middle-income families. Session topics included sexually transmitted infections, sexuality and gender identity, unintended pregnancy, partner violence, and relationship skills. Participants were also provided with information about how to seek support for sexual health or for cases of partner violence and were informed of their right to seek health services.

Results. An evaluation of the intervention in Mexico showed the pathways through which the course appeared to influence the health and well-being of participants (44). The first pathway is through supporting shifts in beliefs about and understandings of gender and violence. For example, participants learned to identify types of violence that can occur in relationships, they began to

question whether excessive jealousy and controlling behavior were signs of love or rather forms of violence, they described beginning to accept their own sexuality, and they reduced homophobic commentary in class. The second pathway is through encouraging communication about sexuality, relationships, and violence. As participants became more comfortable talking openly about these topics during the course, they also began to discuss these topics with family members, partners, and peers—a step along the pathway to assertive communication in future relationships. The third pathway is through preparing participants to recognize and address unhealthy or violent behaviors in romantic relationships. Participants said they intervened in partner violence around them, began to address controlling behavior in their own relationships, left violent or controlling relationships, and felt more prepared to seek support in case they experienced partner violence. The fourth pathway is through promoting care-seeking behavior. Participants reported seeking information and referrals from the health educators who facilitated the course and accessing health services during and after the intervention, suggesting that the course addressed some of the barriers often encountered by young people in need of sexual and reproductive health and violence-related services and support.

The gender-transformative sexuality education program was able to move beyond typical sexuality education topics aimed at pregnancy and sexually transmitted infection prevention to also support young people in engaging in less violent and more equitable relationships, which ultimately can contribute to improved health and well-being.

How this case study illustrates gender-transformative health promotion.

Principle 1: Gender-transformative health promotion must address gender norms as part of its work to impact on health outcomes. This gender-transformative sexuality education program in Mexico explicitly aims to disrupt harmful gender norms. It does so by engaging young people in group activities and discussions to identify and question the harmful social norms that shape their environment. The course promotes critical reflection about rigid gender roles and presents gender-equitable beliefs and behaviors to replace harmful ones.

Principle 2: Gender-transformative health promotion should move away from a sole focus on individual-level change to also engage explicitly with structural and social determinants of health. Health promotion is a "process of empowering individuals and communities to address determinants of health" (52, p. 144). The sexuality education program described here did so by emphasizing the role of gender inequality and gender norms as factors that influence individual beliefs and behaviors and consequently impact on health and well-being. The course engages directly at the individual, classroom, and school levels. The intervention also appears to have an indirect influence beyond this realm, with participants informing partners and family members about course topics, engaging in bystander behaviors to discourage homophobic commentary and partner violence, and encouraging peers and family members to leave violent relationships or seek sexual and reproductive health services (44).

Principle 3: Gender-transformative health promotion should aim to influence multiple interrelated health outcomes by addressing underlying gender-related determinants. By addressing underlying gender-related risk and protective factors, the intervention was able to contribute to interrelated health outcomes that improve health and well-being. The course developed capacity among young people to communicate comfortably about sexual health and relationships, provided tools to prevent or address partner violence in their community or in their own relationships, and promoted health-seeking behavior.

Principle 4: Gender-transformative health promotion requires complexity-informed design, implementation, and evaluation strategies. Programs that engage gender norms require evaluation methods suited to detect shifts in social norms and personal beliefs (53) in addition to the health outcomes traditionally measured in evaluations. The evaluation of the sexuality education program in Mexico examined how the program disrupted the system in which it was implemented (43). Applying complexity concepts such as unpredictability, emergence, and context dependency to the analysis helped investigators consider how the social aspects of complexity influenced the intervention, which then allowed for examination of how the intervention influenced both individual and group processes. The study concludes that a social complex adaptive systems approach is useful for evaluating gender-transformative health promotion efforts, though this approach is still being refined (43).

CONCLUSION

Gender is an important determinant of health, rigid gender norms are harmful to health and well-being, and these require recognition of and explicit attention in health promotion. Overall, Pederson and colleagues' (52) gender-transformative framework for health promotion remains of intrinsic importance but is yet to be fully realized as many health promotion initiatives are still gender blind. We build on the framework by proposing four guiding principles for gender-transformative health promotion. First, health promotion must address gender norms as part of its work to impact on health outcomes. Second, it should move away from a sole focus on individual-level change to also engage explicitly with structural and social determinants of health. Third, it should be designed to influence multiple interrelated health outcomes by addressing underlying gender-related determinants. And fourth, it requires complexity-informed design, implementation, and evaluation strategies. We have provided examples of these principles in practice, using the case of postnatal mental health in Australia and sexuality education in Mexico. We suggest that these four principles cut across contexts and should be applied to gender-transformative health promotion efforts regardless of whom they are implemented by, the socioeconomic or political context, and the health outcome being addressed. Gender-transformative health promotion can modify harmful gender norms and improve health and well-being for all.

DISCLOSURE STATEMENT

The authors are not aware of any affiliations, memberships, funding, or financial holdings that might be perceived as affecting the objectivity of this review.

ACKNOWLEDGMENTS

We acknowledge the organizations that implemented the case study programs. We are grateful to Cardinia Shire Council, Frankston City Council, Hobsons Bay City Council, Monash City Council, Moreland City Council, and Mornington Peninsula Shire Council for their collaboration in implementing the trial of the What Were We Thinking program. J.F. is supported by the Finkel Professorial Fellowship, which receives funding from the Finkel Family Foundation. Fundación Mexicana para la Planeación Familiar (Mexfam) implemented the comprehensive sexuality program in Mexico and partnered with International Planned Parenthood Federation Western Hemisphere Region (IPPFWHR, now called Fòs Feminista) and the London School of Hygiene and Tropical Medicine to evaluate the program. This article builds on the lessons from that collaboration.

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