PART THREE

Addressing Healthy Living

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Strategies for Healthy Living

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In 2005, federal, provincial and territorial governments (F/P/T) in Canada signed on to the *Integrated Pan-Canadian Healthy Living Strategy* (HLS), "a collaborative and coordinated approach to reducing non-communicable diseases by addressing their common risk factors and the underlying conditions in society that contribute to them"(1). The *Strategy* aimed first to address subjects related to the 'obesity epidemic', specifically, healthy eating, physical activity and their relationship to healthy weights, with the recognition that other areas, including mental health and injury prevention, would need to be addressed in the future. Provinces and territories agreed to take action to reach specific 'healthy living targets' as follows:

Healthy Eating

- By 2015, increase by 20% the proportion of Canadians who make healthy food choices according to the Canadian Community Health Survey (CCHS), and Statistics Canada (SC)/Canadian Institute for Health Information (CIHI) health indicators.

Physical Activity

- By 2015, increase by 20% the proportion of Canadians who participate in regular physical activity based on 30 minutes/day of moderate to vigorous activity as measured by the CCHS and the Physical Activity Benchmarks/Monitoring Program.

Healthy Weights

- By 2015, increase by 20% the proportion of Canadians at a "normal"13 body weight based on a Body Mass Index (BMI) of 18.5 to 24.9 as measured by the National Population Health Survey (NPHS), CCHS, and SC/CIHI health indicators.

While every jurisdiction that signed on to the *Strategy*[1] accepted these targets, they often responded differently to the challenge of meeting benchmarks for healthy eating, physical activity and healthy weights. At the same time, some provinces elected to include other issues, such as alcohol and tobacco use or sexual health, as part of their efforts to promote healthy living in Canada. It is consequently the purpose of this discussion to examine selected strategies, policies and programs related to healthy living from four provinces

[1] "It should be noted that although Quebec shares the general goals of this strategy it was not involved in developing it and does not subscribe to a Canada-wide strategy in this area. Quebec intends to remain solely responsible for developing and implementing programs for promoting healthy living within its territory" (1).

as examples, with a view to assessing the extent to which sex, gender, diversity and equity emerge as critical variables for analysis and action. As we will see in this chapter, many of the strategies and related policies and programs acknowledge the importance of factoring in the determinants of health, but most do not, in fact, make provision to measure, integrate, report upon or evaluate sex, gender, diversity and equity.

Overview

This chapter is divided into four sections. The first two describe the methods used for identifying healthy living strategies, policies and programs, and the final sample used for analysis. The third section comprises a sex- and gender-based analysis (SGBA) of the *Integrated Pan-Canadian Healthy Living Strategy* as well as selected provincial healthy living strategies and related policies and programs. The fourth part of the chapter is a table of notes about if and how the core concepts of SGBA appeared and were handled in each document or website.

Methodology

This review of healthy living policies and programs is not intended to be a comprehensive cross-country, in-depth scan. There are too many policies and programs related to healthy living, too many variations on the definition of healthy living, too many different types of resources, and too many jurisdictions to allow for a thorough review. Moreover, some provincial government websites and all of the territorial government websites provide little or no information on policies and programs related to healthy living. As a result, we elected to analyze selected policies and programs of four provinces: Prince Edward Island, Manitoba, British Columbia and Ontario. These jurisdictions were chosen, in part, because three of them are located in regions represented by the Centres of Excellence involved in the study. They were also chosen because they have different socio-economic profiles as well as different histories with and approaches to working in the area of healthy living. Together, they comprise an instructive sample of healthy living policies and programs in Canada.

As with the analysis of healthy living discourse and indicators, we applied the core concepts of sex- and gender-based analysis – sex, gender, diversity and equity – in this review of documents and conversations. These concepts help us to understand who is meant to be or might be benefiting from healthy living policies and initiatives, and, by inference, who is left out or is unlikely to benefit. They also allow us to assess whether or not policies and programs attend to the needs and experiences of diverse groups of women and girls. Finally, SGBA enables us to discover if policies and programs are designed to address inequities and to promote equitable approaches to healthy living.

The review process began with a scan of healthy living strategies, specifically materials related to the *Integrated Pan-Canadian Healthy Living Strategy* published since 2004 and any provincial government documents explicitly identified as 'Healthy Living Strategies'. We then conducted a scan of provincial and federal government websites for additional information about these strategies and for related healthy living policies and programs. This task was complicated by the fact that the number and availability of documents and websites diminished between the release of the HLS and the completion of this review. For instance, the federal government published annual reports on the HLS only in 2007 and 2008, even though action towards healthy living targets were "intended to roll out over 10 years" with "ongoing monitoring and evaluation"(1). At the same time, healthy living policies and programs were sometimes moved within government and/or renamed, making them difficult to track. For example, Manitoba's healthy living policies and programs were housed in three different government divisions: Manitoba Health and Healthy Living; Manitoba Healthy Living, Youth and Seniors; and Manitoba Healthy Living, Seniors and Consumer Affairs. During these moves and departmental reconfigurations, web-based information sometimes disappeared.

During this scanning and review process, we also realized that while some documents and websites are easily recognizable because they use the term 'healthy living', others are more difficult to identify because they employ different frameworks and language to address key healthy living targets. In Prince Edward Island, Manitoba, and British Columbia, for example, provincial reports on chronic disease prevention contain a good deal of relevant information about healthy living policies and programs. Similarly, in Manitoba, the provincial Women's Health Strategy was developed with attention to healthy living. We consequently expanded our search to include policies and programs that are not necessarily tagged with the label 'healthy living', but which nonetheless target the same goals and priorities as the HLS, such as healthy eating, active living and physical activity, and obesity-reduction initiatives.

We further discovered that many government programs revolved around significant partnerships with non-governmental organizations (NGO). In British Columbia and Prince Edward Island, for example, NGO alliances for Health Eating and Active Living were integral to the development of healthy living policies and were deeply involved in the design and delivery of healthy living initiatives. Consequently, we further expanded our search to identify and retrieve relevant documents from the websites of these NGO partners and other not-for-profit agencies.

The final step in the collection of information about healthy living strategies, policies and programs involved a series of informal consultations with key stakeholders who were or had been involved in developing, delivering or reviewing relevant activities and policies. Conversations were carried out in person, wherever possible, and by telephone when face-to-face meetings were not feasible. Stakeholders were sent a backgrounder on the project and a list of questions prior to the consultations. These questions were designed to elicit information about: the range of programs and policies that have been developed since the launch of the HLS or provincial strategies; the extent to which the core concepts of SGBA were taken into

consideration in the formulation and/or implementation of various initiatives; the role of partnerships and alliances with NGOs in the design and delivery of programs; the extent to which policies and programs were deemed sustainable and; whether or not initiatives had yet been evaluated.

Sample

A scan of federal government documents and websites, provincial government documents and websites, and selected NGO documents and websites netted approximately 75 to 100 documents and websites for consideration. Closer review led to the identification of 38 documents and/or websites that were either labeled with the term 'healthy living' or were designed to address healthy living targets as set out in the HLS. We also drew on consultations with eight key stakeholders, two each from the provinces of Prince Edward Island, Ontario and Manitoba, one from British Columbia and one from the Public Health Agency of Canada.

Discussion

The documents and websites reviewed in this chapter are quite varied in nature and purpose. There are a number of frameworks that establish strategic policy directions in areas such as healthy living, healthy eating, physical activity, sport and recreation, chronic disease prevention, and women's health. The sample also includes official reports on health status and services in some of the provinces as well as descriptions of promising programs and practices. There are also a variety of web-based and print resources that outline healthy living guidelines and proffer advice to promote healthier choices for diet, exercise, body weight and, in some cases, alcohol and tobacco consumption and other dimensions aspects of health and wellness. Despite these differences, however, this collection of documents and websites (see the table at the end of the chapter) presents, with a few no exceptions, an interpretation of healthy living that includes limited or inconsistent attention to the concepts of sex, gender, diversity and equity.

Sex

Some of the documents and websites reviewed here provide information about women and men, boys and girls. The *Integrated Pan-Canadian Health Living Strategy* includes some sex-disaggregated data and the two annual reports on the HLS consistently report on rates of overweight and obesity, healthy eating and active living for males and females. Provincial reports on health status and chronic disease prevention also include some statistics on males and females, but the information is not consistently sex-disaggregated. The two provincial women's health strategies pay close attention to sex because they are sex-specific and, in the case of Ontario, government has invested in research on women's health. Most of the other policy frameworks do not address sex or sex differences. The Prince Edward Island healthy schools policies, for example, ignore sex differences in the nutritional needs of school-aged children (2,3). Indeed, every one of the PEI school policies refers to children rather than to girls and boys, male and female youth, despite the

fact that research has identified both differences and similarities in diet, physical activity and body weight for females and males.

Public education websites and descriptions of promising practices also tend not address the concept of sex in health or healthy living. One obvious exception is the Manitoba Healthy Schools website, which provides some sex-disaggregated statistics on different rates and types of healthy eating, physical activity, and sexual health behaviours among female and male students. The website notes, for example, that "soft drink consumption increases dramatically in boys between grades 6 and 10" and "older students, especially girls, tend to skip breakfast more often"(4). Unfortunately, this information does not seem to translate into programs or advice to address these kinds of differences.

While some of these documents and websites include information on sex, almost none of them consider the sex continuum in discussions of health and healthy living. In other words, sex is treated as a rigid dichotomy, in which 'male' *or* 'female' are the only alternatives. The *Manitoba Women's Health Strategy* and the *Ontario Women's Health Framework* are the only documents that mention transgender health and the critical need for improvements in services for this population. None of the materials in this sample discuss intersex individuals.

Gender

Gender is the concept most poorly represented in the documents and websites under review. It is not uncommon in statistical reports to see the term 'gender' used in place of 'sex' to identify information about males and females. Several documents we reviewed clearly fall into this trap while many others only mention gender in lists of social determinants of health, suggesting that they are also treating the terms sex and gender as synonymous. The *Ontario Sport and Physical Activity Strategy* is instructive in this regard. It notes that women face barriers to participation in sports and physical activity, but there is no discussion of the role of gender in creating or addressing these barriers. Similarly, the *Manitoba Chief Provincial Public Health Officer's Report* offers a definition of gender as socially constructed and acknowledges the need to consider gender in developing comprehensive prevention strategies, yet gender is generally mentioned in the report only as one of a list of social determinants affecting health and to identify differences in health behaviours, status and outcome between the sexes.

In some instances, the role of gender in health is acknowledged in documents and websites without being fully addressed. For example, the *Ontario Sport and Physical Activity Strategy* notes that women face barriers to participation in sports and physical activity, but there is no analysis of the source and nature of these impediments nor are their provisions outlined to ameliorate gendered barriers. This is also true for the *Integrated Pan-Canadian Healthy Living Strategy* and British Columbia's *Policy on Sport and Physical Activity*. Interestingly, the HLS includes a detailed report on results of consultations with Aboriginal organizations, in which the role of gender and the need for gender-based analysis are discussed explicitly.

Unfortunately, this consultation is consigned to an appendix while the in the rest of the document the term gender is used to signify sex differences between males and females. Similarly, a key stakeholder from PEI told us that women were targeted in some healthy living initiatives as a by-product of the focus on children. Although gender considerations would have been the driver behind this adjustment in programming, they were not acknowledged in program descriptions.

Even healthy living initiatives that were developed by or for women do not necessarily explicitly address gender. For example, a report on community projects in Manitoba quoted the organizers of a women's health conference: "We chose the topic of women's health because we know from the research that if you address women's health that will be taken in and impact the whole family"(5). While this statement clearly demonstrates the gendered nature of health, neither conference organizers nor the report's authors commented on it. Again, the main exceptions to this pattern are the women's health strategies. Each focuses on the roles of both sex and gender in health and promotes the use of sex- and gender-based analysis to better understand the needs and experiences of women and girls, and to better address gender-based inequities.

Diversity

The concept of diversity appears frequently in this sample of documents and websites. Most often, it is associated with references to ethnic, racial or cultural sub-populations, which is not surprising given that this is a dominant definition of diversity. Aboriginal peoples and immigrants or newcomers are identified most frequently in healthy living documents and websites, though in British Columbia, South Asian sub-populations are also mentioned. By and large, ethnic and cultural minority groups are mentioned in lists of populations deemed to be at risk of poor health.

Some of the policy frameworks and websites prescribe specific actions or programs to address the needs of Aboriginal peoples and ethnic minorities. For example, *Ontario's Action Plan for Healthy Eating and Active Living* notes that the provincial government is working with Aboriginal communities to develop culturally-appropriate guidelines and Health Canada has designed an Aboriginal-specific food guide (6). British Columbia also developed a suite of resources to promote healthy living among multi-cultural communities in the province and many of these are translated into languages other than English. Interestingly, even websites that aim to address the needs of culturally and ethnically diverse groups do not necessarily include culturally appropriate food choices or use photographs of people from visible minority populations.

Another category of diversity that appears frequently in the sample is socio-economic status. Again, this emphasis is understandable given the large body of literature linking poverty with health as well as the presence of anti-poverty initiatives in some of the provinces. Provincial health status reports provide a good deal of data that is disaggregated by income and many documents note that low income is associated with health disparities and inequities. Some initiatives to address low income are mentioned, such as improving social assistance rates and access to safe, affordable housing, but only a few initiatives seem to have been put

in place. These consist mainly of breakfast programs in the schools, although Manitoba has also developed a low-cost bicycle helmet program to promote safe cycling among children.

To greater or lesser degrees, other dimensions of diversity also figure in the documents and websites: age, ability, living in rural and remote locations, sexual orientation, etc. Provincial health reports, for example, include a good deal of data disaggregated by age and both the *Physical Activity Strategy for Prince Edward Island* and the *Ontario Sport and Physical Activity Strategy* recognize the needs of people living with a disability, among others. While many of these categories of diversity appear in lists of the social determinants of health and are identified as needing action, only some of them are addressed in policies and initiatives. There are a number of programs targeted at or geared to the needs of different age groups, most especially children and seniors. All of the schools programs and many of the websites, for instance, focus on the importance of supporting healthy living throughout childhood. One program in Ontario and another one in British Columbia are likewise designed to enhance healthy eating choices for children living in rural and remote communities. By comparison, there is virtually no provision for programs or policies that recognize or respond to the needs of sexual minority populations.

All of the documents and websites in our sample tend to treat different types of diversity as discrete rather than intersecting facets of identity and experience. In other words, policies and programs might be designed for Aboriginal people *or* women, but not necessarily for Aboriginal women. The Manitoba low-cost bicycle helmet program is a good example of this phenomenon as it is more likely to benefit urban children than those living in rural and remote communities. Similarly, several policies acknowledge that women and girls face barriers to participation in sports and other forms of physical activity, but there is no discussion of how these obstacles might be different or more severe for women and girls from visible minority or sexual minority populations.

The women's health strategies described in this review are more likely to consider the needs and experiences of different groups of women. The *Manitoba Women's Health Strategy*, for example, notes that "Manitoba's women are diverse. Gender, race, ethnicity and culture, disability, age, income, geography and sexual orientation have an impact on women's health status. All Manitoba women need access to health services that take this diversity into account" (7). The *Ontario Women's Health Framework* is the only document that uses the term 'intersectionality'. The framework defines intersectionality as the process by which "various socially and culturally constructed categories of discrimination interact on multiple levels contributing to systematic social inequality. The classic models of oppression within society, such as those based on race, ethnicity, gender, religion, nationality, sexual orientation, class, or disability do not act independently of one another, but interrelate creating a system of oppression that reflects the 'intersection' of multiple forms of discrimination" (8). While these acknowledgements of intersecting identities and oppressions represents a significant step forward, it is too early to assess the extent to which this concept can and will be used to design and deliver healthy living policies and programs.

Equity

Many of the documents and websites in this review include no consideration of the concept of equity. This is especially true of public education materials, such as the *Manitoba Healthy Living Guide* and the *go! pei initiative*. Some of the policy frameworks and healthy living initiatives, particularly those for or with schools, have adopted a 'one-size-fits-all' approach to healthy eating and active living that does not address issues of diversity or equity. Even those programs and policies that discuss the social determinants of health do not necessarily make the connection to inequity. For example, neither of the annual reports on the *Integrated Pan-Canadian Health Living Strategy* uses the word equity, despite the fact that the *Strategy* itself mentions the need to reduce health disparities, particularly for Aboriginal people and those living on low-income. In some cases, the concept of equity may be implicit in these types of discussions of health disparities, but it is difficult to be certain when the values of justice or fairness are not mentioned.

Other sources make explicit reference to the advancement of equity in health and healthy living. The reports of the Chief Public Health Officer of Manitoba and British Columbia Provincial Health Officer, for example, both include robust definitions of equity that consider both individual and structural sources of inequity. The Manitoba Healthy Living website and the *British Columbia Healthy Futures for Families* initiative similarly are unequivocal about the need to address health disparities and inequities and both acknowledge structural and well as individual factors that facilitate or hinder healthy living. The women's health strategies also identify health equity as a guiding principle in their frameworks. While it is encouraging to see these statements about equity, much of the time the websites and documents do not describe how equity will be achieved or provide examples of policies and programs that embody the principles of fairness and justice. The *Physical Activity Strategy for Prince Edward Island*, for example, acknowledges the importance of equity, but only comments that there is a need for "'creativity' in providing equitable access to physical activity for all, including the development of low-cost, conveniently-located recreation facilities" (9).

In cases where specific actions are outlined and endorsed, it is not always clear whether or not these recommendations can, have or will be act upon. One report on Prince Edward Island schools suggests that healthy foods should be priced "competitively" to make them more attractive than unhealthy foods (10), but there is no easy way to find out if this recommendation has been implemented. Similarly, several reports point to the need for increased greater government spending on programs for "at-risk" and targeted populations, including women, but there are few examples of new or expanded initiatives. Some of the most far-reaching recommendations to date have been put forward by the British Columbia Healthy Living Alliance. In a report on healthy families, the Alliance calls for significant government investment in housing, income assistance, employment programs, transportation systems, etc. and recommends that Aboriginal communities be given greater control over "health, social, education and justice policies and funding"(11). It remains to be seen whether the federal or provincial governments are prepared to take these next steps.

Discourse Meets Strategy

In an earlier chapter, we described the main features of the healthy living discourse, which include:

- a focus on individual responsibility for health – both causes and solutions;
- a tendency to blame individuals for failure to achieve or maintain health;
- an understanding of risk as an imminent threat rather than a statistical probability;
- limited attention to the social determinants of health;
- a single, universalized prescription for health and healthy living;
- an emphasis on physical rather than mental or social well-being.

In this chapter, we have seen that many provincial and federal strategies, policies and programs focus on individual change and offer a 'one-size-fits-all' approach, reflected some of the main tenets of the healthy living discourse. While none of the documents or websites explicitly blames people for overweight and obesity, unhealthy eating or sedentary behaviour, some cases they refer to individual responsibility for health, which creates the potential for blaming. Moreover, gendered expectations may also lead to blaming: in several documents women are singled out as having responsibility for the health of their children and families, which means, by extension, that they are culpable if children and families are not healthy.

Risk appears frequently in this sample of documents and websites, particularly in discussions of chronic disease prevention and vulnerable or marginalized populations. Healthy eating, active living and body weight are all identified as ways to reduce the individual risk of developing conditions such as diabetes and cardiovascular diseases. Risk is also discussed at the level of populations, with some groups in Canada, such as Aboriginal people and those living in poverty, seen as in greater danger and needing greater support or more interventions. In this sample of documents and websites, ill health is largely presented as a certainty, inevitable if action is not taken, rather than one of a number of possible outcomes.

A surprising number of documents and websites at least mention the social determinants of health, but few of them are able to suggest concrete steps for systemic change or demonstrate that governments are committed to ameliorating health disparities and eliminating health inequities. Similarly, healthy eating initiatives and nutritional policies and programs focus largely on providing information to the public, rather than advocating for regulation of the food industry. Some school-based policies prohibit certain products on school premises, particularly high-energy drinks, but again this effort focuses on limiting opportunities for individuals to make unhealthy food choices rather than improving the quality of processed foods. Without concrete plans for systemic change and without investment in these types of changes, policies and programs often default to a focus on individual behaviour change.

Finally, the emphasis on physical health is widespread in healthy living strategies and related policies and programs. For example, some of the school-based strategies promote curriculum changes, such as the revival of physical education classes, but they remain focused on the physical benefits of exercise, rather than the opportunities that sports and other types of physical activity offer for social growth, the development of support systems, and psychological well-being. Mental health is mentioned occasionally, usually in reference to future action, but social well-being is rarely acknowledged or discussed, especially as an outcome or a factor affecting choices about diet, exercise and weight.

Conclusion

Carrying out a sex- and gender-based analysis of healthy living strategies and related policies and programs has been more difficult than expected. Identifying relevant documents and websites took time and persistence because so many relevant initiatives do not bear the label 'healthy living' and because the landscape of healthy living policy and programming is changing at a rapid pace. At the same time, many of the documents under review are policy strategies or frameworks, rather than plans for or reports on specific actions. As the report of the Chief Public Health Officer of Manitoba notes, recommendations are offered "at a more general and strategic level, rather than spelling out specific policies, regulations or actions" (12). Conversely, public education websites tend to contain general or generic information about healthy living and offer few if any indications of policy positions, strategic directions for programming, or planned investments in new initiatives. As a result, it has often been difficult to assess the extent to which sex, gender, diversity and equity would or have actually been addressed.

The dearth of evaluations of healthy living policies and programs has created further barriers in this regard. Almost none of the documents and websites in our sample have undergone systematic process or outcome evaluation – or at least the results of these evaluations are not publicly available. In some cases, as with the *Manitoba Women's Health Strategy*, it is too early to assess the impact of a policy or program. But it is telling that only two reports on Canada's leading healthy living framework, the *Integrated Pan-Canadian Healthy Living Strategy*, have ever been published and the last one appeared more than five years ago. Part of the challenge also relates to the highly decentralized nature of many healthy living initiatives. While federal, provincial and territorial governments signed on to the HLS, pledging to work towards specific diet, exercise and body weight targets in each of their jurisdictions, in fact the NGO sector has taken a lead in designing and implementing policies and programs related to healthy living. Many of these organizations and alliances have been highly successful in public education and advocacy, but details about their programs – and the extent to which initiatives address sex, gender, diversity and equity – are hard to come by, even with the assistance of key informants.

The information we have been able to collect suggests that healthy living initiatives do not pay enough attention to sex, gender, diversity or equity. Clearly, this statement does not apply equally to every healthy

living strategy, policy or and program. Many demonstrate concern about the plight of the poor and the needs of Aboriginal populations. Many refer to the social determinants of health and address diversity, at least to some extent. Some pay attention to sex differences between males and females, and some evince commitment to the principles of equity and social justice. But there are few policies or programs that consistently use all four concepts – or the full meaning of all four concepts – to explain and advance healthy living in Canada.

Canadian healthy living strategies reviewed and their content related to sex, gender, diversity and equity.

Document/ Website	Author	Year	Concepts	Findings	URL
1.					
The Integrated Pan-Canadian Healthy Living Strategy	The Secretariat for the Intersectoral Healthy Living Network in partnership with the F/P/T Healthy Living Task Group and the F/P/T Advisory Committee on Population Health and Health Security	2005	Sex	The report includes some sex-disaggregated data and mentions the need to reduce the gap between women and men, boys and girls, particularly with respect to physical activity, which is much lower for women than for men. The sex continuum is not addressed and sexual minority populations are not mentioned in the strategy.	http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/ipchls-spimmvs-eng.php
			Gender	No mention is made of gender considerations, except in an Appendix reporting on consultations with Aboriginal Organizations and this information is not integrated into the main body of the strategy. There is no discussion of the gender continuum.	
			Diversity	A separate consultation with Aboriginal organizations was undertaken and reported on in Appendix B. The document also mentions the need to reduce disparities to support healthy living for Aboriginal people, but no Aboriginal-specific actions are defined. Other dimensions of diversity, such as age, geographic location, disability and education, are mentioned but are not addressed in healthy living targets or in the discussion of policy and programming.	

Document/ Website	Author	Year	Concepts	Findings	URL
				Diversity related to sexual orientation, gender presentation, spirituality, etc. are not acknowledged or addressed.	
			Equity	The report mentions the need to reduce health disparities, particularly for Aboriginal people and people with low income. Discussion of specific plans for action is minimal and typically does not address overlapping or intersecting vulnerabilities and inequities.	
			General	Short-, medium- and long-term results are often identified without assigning roles and responsibilities to meet these targets.	
2.					
The 2007 Report on the Integrated Pan-Canadian Healthy Living Strategy	The Secretariat for the Intersectoral Healthy Living Network in partnership with the F/P/T Healthy Living Task Group and the F/P/T Advisory Committee on Population	2007	Sex	The report includes statistical data for women and men on the key healthy living targets: physical activity, healthy eating, and healthy body weights. The sex continuum is not addressed and sexual minority populations are not mentioned.	
			Gender	No mention is made of gender considerations or the gender continuum.	

Document/ Website	Author	Year	Concepts	Findings	URL
	Health and Health Security				
			Diversity	Dimensions of diversity, such as age, geographic location, disability and education, are mentioned but are not addressed in healthy living targets or discussion of policy and programming. Diversity related to sexual orientation, gender presentation, spirituality, etc. are not acknowledged or addressed.	
			Equity	The report does not address health disparities and inequities related to the social determinants of health.	
3.					
The 2008 Report on the Integrated Pan-Canadian Healthy Living Strategy	The Secretariat for the Intersectoral Healthy Living Network in partnership with the F/P/T Healthy Living Task Group and the F/P/T Advisory Committee on Population Health and Health Security	2008	Sex	The report includes statistical data for women and men on the key healthy living targets: physical activity, healthy eating, and healthy body weights. The sex continuum is not addressed and sexual minority populations are not mentioned in the strategy.	http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/ipchls-spimmvs/2008/pdf/ripchl-rspimmvs-2008-eng.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	Dimensions of diversity, such as age, geographic location, disability and education, are mentioned but are not addressed in healthy living targets or discussion of policy and programming.	

Document/ Website	Author	Year	Concepts	Findings	URL
				Diversity related to sexual orientation, gender presentation, spirituality, etc. are not acknowledged or addressed.	
			Equity	The report identifies that socio-economic status (SES), Aboriginal identity, gender and geographic location are some of the most important social determinants associated with health disparities. It also notes that food insecurity is more prevalent in certain sub-populations, including households with low incomes, households with social assistance as their primary source of income, lone parent households, renters and Aboriginal households.	
			General	The document reports on the pan-Canadian Healthy Living Strategy (HLS) by province/territory in relation to four key goals: 1. Leadership and Policy Development; 2. Knowledge Development and Transfer; 3. Community Development and Infrastructure; 4. Public Information. None of these goals has an SGBA.	
4.					
Prince Edward Island Healthy Eating Strategy	Healthy Eating Alliance	2007-2010	Sex	Data in this report are not sex disaggregated. The sex continuum is not addressed and sexual minority populations are not mentioned in the strategy.	http://www.healthyeatingpei.ca/pdf/Strategy_HEA_2007-2010.pdf

Document/ Website	Author	Year	Concepts	Findings	URL
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The strategy targets school-aged children across the Province, partnering with school health districts so the majority of the work is done through schools. Consequently the strategy takes age into consideration to some extent. Other types of diversity, such as language, ethnic/racial diversity and sexual orientation, are not mentioned or addressed.	
			Equity	This is a 'one-size-fits-all' approach that does not address health disparities and inequities related to the social determinants of health.	
			General	The strategy focuses on coordinating existing initiatives and establishing partnerships rather than launching a new set of policies and programs.	
5.					
Prince Edward Island Healthy Living Strategy	PEI Strategy for Healthy Living Steering Committee	No date	Sex	Data in the report are not disaggregated by sex. The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.gov.pe.ca/photos/original/hss_hl_strategy.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	

Document/ Website	Author	Year	Concepts	Findings	URL
			Diversity	Dimensions of diversity, such as age, geographic location, disability and education, are mentioned but are not addressed in healthy living targets or discussion of policy and programming. Diversity related to sexual orientation, gender presentation, spirituality, etc. are not acknowledged or addressed.	
			Equity	The strategy does not address health disparities and inequities related to the social determinants of health.	
			General	This strategy sets out 6 goals: 1. To slow the growth in the prevalence of preventable chronic disease in PEI; 2. To reduce tobacco use and the harm it causes to the population of PEI; 3. To increase the number of Islanders who participate in regular physical activity; 4. To promote optimal health; 5. To improve healthy eating habits that support good nutritional health; 6. To increase capacity for health promotion and chronic disease prevention. Mechanisms to achieve these goals are not identified in the strategy.	

Document/ Website	Author	Year	Concepts	Findings	URL
6.					
Physical Activity Strategy for Prince Edward Island	MacArthur Group Inc. (Consultants)	2004-2009	Sex	The strategy reports that a higher proportion of women than men do not engage in sufficient physical activity. It also notes that physical activity can have benefits for women, specifically in the reduction of osteoporosis and related fractures. As a result, the strategy recommends targeting programs for women. Differences among women are not acknowledged or addressed and sexual minority populations are not mentioned in the strategy.	http://www.gov.pe.ca/photos/original/doh_actstrat.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	This document attends to some dimensions of diversity, specifically the needs and experiences of children & youth, women, adults, seniors, and 'at risk groups', such as people living with disabilities and those who are socially and geographically isolated. Some recommendations in the document are designed to address the needs of people living with disabilities, but there is no acknowledgement of the differing needs of diverse groups of women and men.	
			Equity	The strategy includes recommendations for "creativity" in providing equitable access to physical activity for all, including the	

Document/ Website	Author	Year	Concepts	Findings	URL
				development of low-cost, conveniently-located recreation facilities. No details are given about who should assume responsibility for devising and implementing creative solutions.	
7.					
Prince Edward Island Western School Board Nutrition Policy	Western School Board of Prince Edward Island	2005	Sex	This document does not acknowledge or address sex differences in the nutritional needs of school-aged children.	http://www.healthyeatingpei.ca/pdf/WSB_School_Nutrition_Policy.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The policy does not refer to ethnic/cultural minority populations in schools nor does it address other dimensions of diversity.	
			Equity	The document addresses the need for pricing healthy foods, such as milk, so that they are as attractive, or more attractive, than less healthy foods, such as soft drinks. It also discusses the need for access to high quality nutritious foods in schools, including in vending machines.	
			General	The policy presents the need for and value of nutrition education in schools and the potential of using teachers to convey healthy eating messages to students. The policy further establishes criteria for the quality of food and beverages available in schools, including: vegetables and fruit; lower	

Document/ Website	Author	Year	Concepts	Findings	URL
				fat white and chocolate milk; whole grain products; lean meats; foods prepared with little or no fat; and foods low in salt, sugar, and caffeine. The policy prohibits energy drinks, such as RedBull™ and Rockstar™, on School Board property.	
8.					
Prince Edward Island School Healthy Eating Toolkit	PEI Healthy Eating Alliance	2005	Sex	This toolkit does not acknowledge or address sex differences in the nutritional needs of school-aged children.	http://www.gov.pe.ca/photos/original/hea_toolkit.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The toolkit provides examples of food choices, but does not discuss the food needs and/or preferences of ethnic, cultural or religious minority populations. It does not address other dimensions of diversity that might affect healthy eating, such as disability and socio-economic status.	
			Equity	The toolkit does not address health disparities and inequities related to the social determinants of health.	
			General	The toolkit is meant to provide useful information for schools as they make changes to promote healthy eating e.g. school policies, fundraising, guidelines and procedures,	

Document/ Website	Author	Year	Concepts	Findings	URL
				resources for school food programs, teacher resources, meal planning, recipes, tips The toolkit mentions the importance of being 'peanut aware'.	
9.					
PEI Eastern School District, School Nutrition: Policy Statement	Eastern School District	2011	Sex	This policy does not acknowledge or address sex differences in the nutritional needs of school-aged children.	http://www.healthyeatingpei.ca/pei-school-nutrition-policy.php
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The policy does not discuss the social dimensions of healthy eating or food needs and preferences among diverse populations.	
			Equity	The policy proposes to improve student nutrition by improving access for all students to healthy, safe, reasonably priced, attractively presented food choices. The policy further aims to reduce hunger among children living with food insecurity, through enhanced access to healthy foods within the school setting, provided in a non-stigmatizing manner.	

Document/ Website	Author	Year	Concepts	Findings	URL
			General	The policy mandates schools in the Eastern District School Board to encourage and maintain supportive environments that promote healthy food choices, both in the foods available at school and through educational programs.	
10.					
Prince Edward Island Healthy Eating Strategy	PEI Healthy Eating Alliance	2011-2015	Sex	The strategy does not acknowledge or address sex differences in nutritional needs. The sex continuum is also not addressed and sexual minority populations are not mentioned.	Draft document shared by key stakeholder – not for distribution at the time of publication of this report.
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The strategy is aimed at children and youth. The Alliance worked with French communities on the Island, but no mention is made of ethnic minority populations or Aboriginal peoples. Consideration of other forms of diversity was also absent in the strategy.	
			Equity	There is no discussion of equity, including the impact of poverty and other determinants of health on healthy eating.	
			General	The stated intention of the strategy is to ensure that healthy eating policies are in force in all elementary and consolidated schools across the province.	

Document/ Website	Author	Year	Concepts	Findings	URL
				The PEI Healthy Eating Alliance is working with school districts to develop policies for intermediate and high schools. Healthy eating tips, annual school newsletters and the School Healthy Eating Toolkit have been developed to support school communities in their efforts and based on local research.	
11.					
Evaluation of Breakfast Programs in Prince Edward Island Schools	PEI Healthy Eating Alliance	2011	Sex	The evaluation does not acknowledge or address sex differences in nutritional needs of school-aged children. Data collected in the evaluation is not disaggregated by sex.	Draft document shared by key stakeholder – not for distribution at the time of publication of this report.
			Gender	No mention is made of gender considerations or the gender continuum in the evaluation of school breakfast programs.	
			Diversity	The evaluation does not discuss the social dimensions of healthy eating nor food needs and preferences among diverse populations.	
			Equity	No mention is made of equity issues, such as disparities in socio-economic status, in the evaluation of the school breakfast programs.	

Document/ Website	Author	Year	Concepts	Findings	URL
			General	The purpose of this evaluation was to: 1. Assess the extent to which school breakfast programs in Prince Edward Island meet the KTS program standards established by Breakfast for Learning; 2. Determine whether foods and beverages offered at breakfast programs are consistent with school nutrition policies in terms of the nutritional quality of foods offered	
12.					
Healthy Living Guidelines for Early Learning and Child Care Centres on Prince Edward Island	PEI Healthy Eating Alliance	2012	Sex	The guidelines do not acknowledge or address the sex continuum.	Draft document shared by key stakeholder – not for distribution at the time of publication of this report
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The guidelines provide examples of food choices, but not those for ethnic, cultural or religious minority populations. Does not address other dimensions of diversity that might affect healthy eating, such as disability and socio-economic status.	
			Equity	The guidelines do not aim to address disparities or inequities and they offer a 'one-size-fits-all' approach to health and healthy living.	

Document/ Website	Author	Year	Concepts	Findings	URL
			General	This document is included in this review because it contains guidelines for: • Healthy eating • Physical activity and play • Tobacco free facilities • Injury prevention and sun safety • Promoting positive mental health	
13.					
PEI Promote, Prevent, Protect, Chief Public Health Officers and Health Trends	Prince Edward Island Department of Health and Wellness	2012	Sex	Some, but not all, statistics in this document are disaggregated by sex.	http://www.gov.pe.ca/photos/original/hw_cphoar2012.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	Some data are disaggregated by sex, age, education level, income. Other dimensions of diversity, such as sexual orientation or ethnicity and race, are not mentioned in the report.	
			Equity	The report refers to the determinants of health and notes that people in the lowest income quintile are the "most vulnerable economic population". Mention is also made of a needle exchange program. By and large the report points to individual behaviour change, rather than structural changes, as the solution to rising rates of obesity and chronic disease.	

Document/ Website	Author	Year	Concepts	Findings	URL
			General	This document reports on the health status of Prince Edward Islanders and on public health programs such as epidemiology, needle exchange, infection prevention and control, health trends, communicable diseases, chronic diseases.	
14.					
go! pei	Government of Prince Edward Island	No date	Sex	The sex continuum is not addressed in this initiative and sexual minority populations are not mentioned,	www.gopei.ca
			Gender	No mention is made of gender considerations or the gender continuum,	
			Diversity	The initiative mentions seniors and children in a few places and notes that “not everyone is born to have the same body type”. Otherwise there is no discussion of ethnic or racial diversity, sexual orientation, geographic location, income, or any other kind of diversity.	
			Equity	The initiative does not address health disparities and inequities related to the social determinants of health. Programs offered by go! pei are free, but they are mainly educational, addressing healthy choices rather than the structural dimensions of healthy living.	

Document/ Website	Author	Year	Concepts	Findings	URL
			General	go! pei is a community-based healthy living program that offers free physical activity and healthy eating programs for Islanders across PEI.	
15.					
go! pei Community Partner Feedback	go! pei Steering Committee	April 2011	Sex	The sex continuum is not addressed and sexual minority populations are not mentioned in this evaluation.	Draft document shared by key stakeholder – not for distribution at the time of publication of this report
			Gender	No mention is made of gender considerations or the gender continuum in this evaluation.	
			Diversity	There is no discussion of diversity of any kind.	
			Equity	As with the go! pei initiative, this evaluation does not address health disparities and inequities related to the social determinants of health.	
			General	The go! pei Steering Committee was interested in the community partners' perceptions of the of the go! pei approach to promoting healthy eating and physical activity on Prince Edward Island and what advice they may have to improve the go! pei initiative.	

Document/ Website	Author	Year	Concepts	Findings	URL
				The go! pei project is viewed as a success by community partners, mainly due to the level of participation in programs. Recommendations for improvements were generally for more funding and support for programs and volunteers, and greater resources for marketing programs.	
16.					
Manitoba Healthy Living Guide: Preventing Diabetes and Other Chronic Diseases	Government of Manitoba	No date	Sex	The document does not acknowledge or address sex differences in nutritional needs, types and amount of physical activity undertaken or needed, or; differential risks related to tobacco use. The sex continuum is also not addressed and sexual minority populations are not mentioned.	http://www.gov.mb.ca/asset_library/en/healthylivingguide/healthy_living_guide.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The document includes pictures of people from different ethic/racial groups on the website, but the description of a healthy diet is based on a Western, Euro-centric diet and does not include food from non-western diets.	
			Equity	The guide does not address health disparities and inequities related to the social determinants of health.	

Document/ Website	Author	Year	Concepts	Findings	URL
			General	This is a health promotion/public education document rather than a formal healthy living strategy, but it is part of Manitoba's activities related to the promotion of healthy living.	
17.					
Chief Provincial Public Health Officer's: Report on the Health Status of Manitobans 2010 Priorities for Prevention: Everyone, Every Place, Every Day"	Chief Public Health Officer of Manitoba	2010	Sex	Some, but not all, of the data in this report are sex-disaggregated. The sex continuum is also not addressed and transgender populations not mentioned.	http://www.gov.mb.ca/health/cppho/pfp.pdf
			Gender	The report offers a definition of gender as socially constructed and acknowledges the need to consider gender in developing comprehensive prevention strategies. Yet gender is generally only mentioned in the report as one of a list of social determinants affecting health and to identify differences in health behaviours, status and outcome between the sexes. The gender continuum is not addressed.	
			Diversity	The report provides a great deal of information on the health status of diverse populations within the province.	
			Equity	The report includes a definition of health equity and inequity and emphasizes the importance of addressing health disparities and inequities among Manitobans. Both individual and structural influences on health are acknowledged. Recommendations for	

Document/ Website	Author	Year	Concepts	Findings	URL
				addressing health inequity are not concrete. They are described in the report as "at a more general and strategic level, rather than spelling out specific policies, regulations or actions."	
			General	This document is included in the review because "healthy living" is mentioned frequently. In general, the phrase is used to refer to modifiable, individual behaviours, though there is also recognition that structural and environmental factors can affect the range of options available to individuals as well as their ability to take advantage of opportunities.	
18.					
Healthy Together Now: Chronic Disease Prevention Initiative: Manitoba Stories	Manitoba Communities and Rosetta Projects	2008	Sex	The report describes some community-based projects that are run for and by women to address smoking, diet and exercise. The sex continuum is also not addressed and sexual minority populations are not mentioned.	http://healthy.healthincommon.ca/wp-content/uploads/2011/08/Manitoba-Stories.pdf
			Gender	Although some projects are designed by and/or aimed at women, no mention is made of gender considerations or the gender continuum.	
			Diversity	Some elements of diversity are addressed in the report by virtue of the diversity of communities that contributed information on promising or best practices in relation to tobacco use, diet and exercise.	

Document/ Website	Author	Year	Concepts	Findings	URL
			Equity	Equity is addressed to some extent in the way this initiative was designed – to "provide programs in ways that community needs". But there is no explicit discussion of health disparities or inequities.	
			General	This is a report on a five-year demonstration project jointly funded by Manitoba Health and Healthy Living and the Public Health Agency of Canada to March 2010. It is a grassroots initiative to prevent chronic disease in Manitoba. Regional health authorities and government provide training, funding and support, but projects are community initiated, planned and led. This report is included in the review because the projects are designed to address three risk factors associated with chronic disease: smoking, physical inactivity and unhealthy eating.	
19.					
An Evaluability Assessment of the Chronic Disease Prevention Initiative (CDPI)	G. Braha & Associates Ltd. (Consultants)	2010	Sex	The assessment of the CDPI initiative did not include attention to sex or sex differences. The sex continuum is also not addressed and sexual minority populations are not mentioned.	http://healthy.healthincommon.ca/wp-content/uploads/2011/08/Evaluation-Executive-Summary.pdf
			Gender	No mention is made of gender considerations or the gender continuum in the assessment.	

Document/ Website	Author	Year	Concepts	Findings	URL
			Diversity	The report mentions the need for more involvement of communities, youth and elders as well as more attention to the needs of people living with disabilities and living rurally or remotely. Recommendations for further or future initiatives stress the importance of accommodating "the diversity of the population. The demographics and needs of the people being targeted for a specific program/activity need to be assessed prior to the initiative being implemented".	
			Equity	The assessment identifies the need to consider equity issues in the design and delivery of programs. These include understanding how best to promote and support lifestyle change, but also to recognize and address structural dimensions of healthy living, such as access to transportation.	
			General	The main goal of the evaluation was to identify aspects of the Initiative that worked well and what improvements were needed in order to inform the direction Manitoba Health and Healthy Living should take in moving forward with chronic disease prevention.	

Document/ Website	Author	Year	Concepts	Findings	URL
20.					
Manitoba Healthy Living, Seniors and Consumer Affairs	Government of Manitoba	No date	Sex	Most of the information on this website does not address sex differences or the sex continuum. The exceptions relate to information for pregnant and breastfeeding women. Sexual minority populations are not mentioned.	http://www.gov.mb.ca/healthyliving/
			Gender	The website does not address gender differences related to healthy living nor does it discuss the gender continuum.	
			Diversity	The website mentions seniors and youth and provides exercise and dietary guidelines and tips for these age groups. Some attention is paid to socio-economic status and to living in remote communities, but all other forms of diversity are not addressed. Images on the website do not represent the ethnically and racially diverse population of the province.	
			Equity	The website is explicit in the need to address health disparities and inequities and acknowledges structural and well as individual factors that facilitate or hinder healthy living. The province has set up a low-cost bicycle helmet program to promote safe cycling and there are a number of reports on food insecurity in Northern communities and among those living on low income in the province.	

Document/ Website	Author	Year	Concepts	Findings	URL
				While there is a great deal of advice and information to support behaviour change on this website, it is less clear what kinds of programs or policies have been implemented to address structural issues.	
			General	The website includes information on dimensions of healthy living often not included in healthy living strategies, such as injury prevention, mental health and healthy sexuality.	
21.					
Manitoba Healthy Schools	Government of Manitoba	No date	Sex	This website provides some statistics on different rates and types of healthy eating, physical activity, and sexual health behaviours for boys and girls. The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.gov.mb.ca/healthyschools/
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	Diversity is not addressed in this website or in healthy living guidelines.	
			Equity	The website does not mention equity issues related to healthy living.	

Document/ Website	Author	Year	Concepts	Findings	URL
22.					
Manitoba Women's Health Strategy	Manitoba Health, Manitoba Healthy Living, Youth and Seniors, and Status of Women Manitoba	2011	Sex	The strategy is sex-specific, notes significant sex differences in rates of disease, and mentions that improvements in services for transgender populations are needed.	http://www.gov.mb.ca/health/women/index.html
			Gender	The strategy recognizes and addresses the role of gender in health and health disparities.	
			Diversity	Recognition of diversity is one of the guiding principles of the strategy. The needs and experiences of a broad range of sub-populations of Manitoba women are discussed in the document.	
			Equity	The strategy identifies equity as a guiding principle in relation to service delivery and allocation of funds for research. Discussions of the social determinants of health throughout the document indicate that the central role of equity is largely implicit rather than explicit, but one of the stated goals is to "Address and improve health disparities especially for First Nations, Métis, and Inuit women."	
			General	Although Manitoba Healthy Living, Youth and Seniors contributed to the development of the strategy, there is limited discussion in the document of healthy living *per se* or of the key healthy living targets. Mention is made of the need to create physical activity programs and environment for women and girls, to address	

Document/ Website	Author	Year	Concepts	Findings	URL
				food insecurity among women and girls, and to strengthen violence prevention and senior abuse prevention strategies. Many of the recommendations are for programmatic and policy or structural change to ensure women's health and well-being.	
23.					
Ontario Women's Health Framework	ECHO: Improving Women's Health in Ontario	2011	Sex	This framework is sex-specific and it includes discussion of transgender populations.	http://www.echo-ontario.ca/sites/default/files/Women's%20Health%20Framework-FINAL-ENG_Web_jp2%5B1%5D_0.pdf
			Gender	The framework recognizes and addresses the role of gender – specifically women's social status and social roles – in health and health inequities.	
			Diversity	The framework provides statistics on various populations of women, including Aboriginal women, ethnic minority women, low-income women, women living rurally and in remote communities, etc. The document mentions the need for intersectional analysis.	
			Equity	One of the key goals of the framework is to reduce health disparities and inequities between and among women.	

Document/ Website	Author	Year	Concepts	Findings	URL
			General	This document was included in the review because it addresses central aspects of healthy living strategies, such as tobacco use, exercise and healthy eating.	
24.					
Ontario's Action Plan for Healthy Eating and Active Living	Ontario Ministry of Health Promotion	2006	Sex	The Action Plan does not acknowledge or address sex differences in nutrition, physical activity or body weight. The sex continuum is also not addressed and sexual minority populations are not mentioned.	http://www.mhp.gov.on.ca/en/heal/actionplan-EN.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The Action Plan acknowledges the need to address the full diversity of the population of Ontario. It names children, Aboriginal people, Newcomers, those on low-income and those living in remote Northern communities. Other dimensions of diversity are not directly addressed. According to the Action Plan, the provincial government is working with Aboriginal communities to develop culturally appropriate guidelines for healthy eating and active living.	

Document/ Website	Author	Year	Concepts	Findings	URL
			Equity	Among the stated goals of the Strategy are: Influencing the determinants of health – the social and economic factors that shape our health, and; improving the health of those most at risk and removing barriers to healthy, active living so that Ontarians have greater opportunities to enjoy good health. The strategy recognizes both individual and structural dimensions of healthy living. The government has provided funding for a variety of pilot projects aimed at children, youth and 'at risk' populations. One example is the Fruit and Vegetable Pilot Project, which is designed to enrich the diets of children in Northern communities. Much of the action plan focuses on fostering and supporting collaboration for change rather than plans for direct investment.	
			General	Develop policies and programs that promote healthy eating and physical activity.	
25.					
Active 2010 Ontario's Sport and Physical Activity Strategy	Ontario Ministry of Health Promotion	2010	Sex	Women are identified as an "underrepresented population" in sport and physical activity. The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.mhp.gov.on.ca/en/active-living/about/active2010-strategy-e.pdf

Document/ Website	Author	Year	Concepts	Findings	URL
			Gender	The Strategy notes that women face barriers to participation in sports and physical activity, but there is no discussion of the role of gender in creating or addressing these barriers. No mention is made of the gender continuum.	
			Diversity	The Strategy targets specific sub-populations: Aboriginal Ontarians, ethnic minorities, women and girls, older adults, low-income families, children and youth and Ontarians with a disability. Planned actions include working with Aboriginal and ethnic minority populations and promoting active living programs for young children and their families.	
			Equity	The Strategy acknowledges that "opportunities to participate in sport and physical activity are not afforded equally to all segments of society." Areas for action address structural as well as individual dimensions of healthy living, including: • Fostering active communities through community planning and development; • Targeting specific audiences, and; • Creating enabling environments. Most of the specific actions in the plan focus on behaviour change and supporting rather than investing in changes to infrastructure.	

Document/ Website	Author	Year	Concepts	Findings	URL
26.					
Reflecting Women's Voices Echo: Improving Women's Health in Ontario Annual Report	ECHO	2009-2010	Sex	As with other ECHO documents, this annual report is sex-specific. It provides some statistics on the health status of women in Ontario.	http://www.echo-ontario.ca/sites/default/files/Annual%20Report%20Draft%20-%20Ver%2014%20FINAL%20as%20sent%20to%20MInistry%20August%2026%202010-opt.pdf
			Gender	The annual report discusses the need for strengthening the capacity for research on gendered issues and advocates for an approach to mental health and addictions that is sensitive to sex and gender considerations.	
			Diversity	The annual report discusses the need to work with and for diverse groups of women to foster and promote their health. ECHO works with a Diversity Expert Panel, but the role of the panel is unclear in the report.	
			Equity	The report discusses the importance of equity of health outcomes and access to mental health and addictions services, sexual and reproductive health care, chronic disease care.	
27.					
Evaluation of the Northern Fruit and Vegetable Pilot Program (NFVPP) Final Report	Ontario Ministry of Health Promotion	2007	Sex	The evaluation plan does not acknowledge or address sex differences in nutritional needs. Data reported in the evaluation were not sex-disaggregated. The sex continuum is also not addressed and sexual minority populations are not mentioned.	http://www.mhp.gov.on.ca/en/healthy-eating/NFVP-English-Final_EN.pdf

Document/ Website	Author	Year	Concepts	Findings	URL
			Gender	Gender is identified as a factor to consider in the impact evaluation, but the report is actually referring to physical sex – male and female. No mention is made of gender considerations or the gender continuum.	
			Diversity	No mention is made of diversity.	
			Equity	The evaluation does not address inequities related to the social determinants of health.	
			General	The primary mandate of the NFVPP was to increase the intake of fruit and vegetables of elementary school age children in a defined area of Northern Ontario. The evaluation focused exclusively on the extent to which the program changed student food preferences and behaviours.	
28.					
Healthy Futures for BC Families Policy Recommend-ations for Improving the health of British Columbians	BC Healthy Living Alliance	2009	Sex	A small number of statistics in this report are sex-disaggregated. The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.bchealthyliving.ca/sites/all/files/BCHLA_Healthy_Futures_Final_Web.pdf
			Gender	No mention is made of gender considerations or the gender continuum	

Document/ Website	Author	Year	Concepts	Findings	URL
			Diversity	The report addresses some dimension of diversity, including ethnic and racial identity, immigration status, income, and living in remote communities.	
			Equity	The report acknowledges the importance of addressing inequities related to the social determinants of health. A policy goal of the provincial government is to ensure that "rates of chronic disease and health outcomes for British Columbians of lower socio-economic status are dramatically improved, and the gap between low socio-economic status groups and those with higher socio-economic status is significantly narrowed". Recommendations for addressing the social determinants of health are far-reaching and would address structural influences on health. Acting on these recommendations would require significant government investment in housing, income assistance, employment programs, transportation systems, etc. The report also recommends greater control for Aboriginal communities over "health, social, education and justice policies and funding".	
29.					
Investing in Prevention: Improving Health and Creating	P.R.W. Kendall, BC Provincial Health Officer	2010	Sex	Much of the statistical information in the report is sex-disaggregated. The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.health.gov.bc.ca/library/publications/year/2010/Investing_in_prevention_improving_health_and_creatin

Document/ Website	Author	Year	Concepts	Findings	URL
Sustainability: The Provincial Health Officer's Special Report			Gender	The report identifies gender as a significant factor in food insecurity, poverty, life expectancy and other dimensions of health, but the term is generally used to refer to sex differences rather than the role of gender. No other mention is made of gender considerations and there is no discussion of the gender continuum.	g_sustainability.pdf
			Diversity	The report addresses many dimensions of diversity, including age, socio-economic status, education, ethnic and racial identity, immigration status and living in remote communities. Other dimension of diversity, such as sexual orientation and living with a disability, are not mentioned in the report.	
			Equity	The report has a well-articulated definition of health equity and addresses the role of the social determinants of health in creating and/or ameliorating disparities and inequities. Considerable attention is given to the impact of poverty on health. The report notes that institutional support for gender equality in BC has declined since 2001, but the discussion appears in the context of concerns about child welfare rather than the welfare of women and proposed solutions focus on ameliorating early childhood vulnerability.	

Document/ Website	Author	Year	Concepts	Findings	URL
				More broadly, the report recognizes individual and structural factors in healthy living and proposes mechanisms, including infrastructure investment, to address both. The creation of and ongoing support for the ActNow BC initiative is presented as a key governmental response to health inequities and healthy living.	
			General	The scope of proposed policy and program initiatives to support healthy living is more comprehensive than strategies focused on diet, exercise and body weight and includes: • Tobacco control; • Healthy eating and physical activity and their relationship to healthy weights; • Reduction of dietary sodium intake; • Reduction of sugar-sweetened beverages intake; • Alcohol harm reduction; • Mental health promotion and prevention of mental disorders; • Injury prevention; • Prevention of musculoskeletal diseases; • Early childhood development programs; • Clinical prevention; • Integration of healthy living and prevention services into chronic disease management, in order to prevent worsening of the condition and the development of additional chronic diseases;	

Document/ Website	Author	Year	Concepts	Findings	URL
				• A settings approach—improving the healthfulness of the settings (home, school, workplaces, communities) where people lead their lives; • Action on the social determinants of health, and; • Reduction of inequities in health.	
30.					
Promoting Healthy Living in BC's Multicultural Communities	Affiliation of Multicultural Societies and Services Agencies of BC, (**AMSSA)**	No date	Sex	The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.amssa.org/programs/multicultural-health/healthy-living-resources
			Gender	No mention is made of gender considerations or the gender continuum	
			Diversity	Educational materials on diet, exercise and body weight are available for specific ethnic and cultural communities. Healthy living materials have also been translated into a number of different languages. Other types of diversity within multicultural communities are not addressed.	
			Equity	The report recommends the importance of providing cultural competence training for service providers and increasing the diversity of service providers. Interpreters should also be provided and the three-month waiting period for access to publicly-funded health care services for immigrants should be eliminated.	

Document/ Website	Author	Year	Concepts	Findings	URL
31.					
BC's Policy on Sport and Physical Activity Sport Branch Policy	Working Group on Sport and Physical Activity	2002-03	Sex	The policy refers to men and women, but the sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.cscpacific.ca/Images/Reports/BC_Policy_final.pdf
			Gender	The policy refers to the barriers faced by women by virtue of being female. No other mention is made of gender considerations or the gender continuum.	
			Diversity	The policy addresses diversity insofar as it states that all British Columbians should have "access and ability to participate in sport and physical activity opportunities regardless of their socio-economic background, age, gender, ethnicity, geographic location or ability". Children and youth are a priority for the promotion of physical activity. The policy also promises to ensure that BC's "sport and physical activity system will recognize cultural diversity and promote mutual respect, inclusion, tolerance and understanding of different cultures". No specific actions or programs are identified to achieve these principles.	
			Equity	The policy states the gender equity and other forms of equity are important goals for the sport and physical activity in the province. No specific actions or programs are identified or proposed to meet these goals.	

Document/ Website	Author	Year	Concepts	Findings	URL
32.					
Healthy Families BC	Government of British Columbia	No date	Sex	Many of the resources on healthy living directed at women deal with pregnancy and breastfeeding. Other resources include information on sex differences in diet, exercise, alcohol consumption, etc. The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.healthyfamiliesbc.ca/
			Gender	The term gender is used to describe sex differences between males and females. The role of gender in healthy living and the gender continuum are not addressed.	
			Diversity	One item on diabetes risk refers to ethnic diversity, one item on physical activity refers to the challenges facing people living with disabilities. Most other dimensions of diversity are not addressed.	
			Equity	The social determinants of health and equity issues are not mentioned on the website.	
			General	This is a government website devoted to providing public education in areas related to healthy living, including diet, exercise and tobacco use.	
33.					

Document/ Website	Author	Year	Concepts	Findings	URL
Framework Moving Ahead From Policy to Action	Working Group on Sport And Physical Activity	2002-03	Sex	The report mentions women and girls but the sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.cscpacific.ca/Images/Reports/movinghead-policytoaction.pdf
			Gender	The report mentions that women and girls of an "under-represented population" in physical activity and sports, but no mention is made of gender considerations or the gender continuum.	
			Diversity	The report acknowledges the importance of responding to the needs and interests of under-represented populations, such as girls and women, seniors, aboriginals, low-income earners and people with disabilities. Other dimensions of diversity, such as sexual orientation and geographic location, are not discussed.	
			Equity	The report mentions the need to ensure that physical activity and sports initiatives are consistent with "gender equity and other access policies". Health disparities and inequities related to the social determinants of health are not discussed.	
34.					
BC Healthy Living Alliance Conceptual Framework	BC Healthy Living Alliance	2007	Sex	The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.bchealthyliving.ca/sites/all/files/BCHLA_Conceptual_Framework.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The document makes a passing reference to	

Document/ Website	Author	Year	Concepts	Findings	URL
				Aboriginal communities, young children, northern communities and "special populations with high needs and little involvement".	
			Equity	The document refers to the social determinants of health in a few places and mentions the need to focus initiatives on those most at risk, but equity does not appear to be a primary principle informing the conceptual framework.	
			General	Much of the discussion of healthy living focuses on lifestyle factors and behaviour change.	
35.					
BC Healthy Living Alliance Report on the Winning Legacy Initiatives	BC Healthy Living Alliance	2007-2011	Sex	The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.bchealthyliving.ca/sites/all/files/BCHLA_Report_on_Winning_Legacy_Initiatives.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	

Document/ Website	Author	Year	Concepts	Findings	URL
			Diversity	This report attends to some types of diversity within the population of British Columbia, specifically Aboriginal people, South Asians, newcomers and those living on low income. Some of the programs were targeted to specific populations. For example, Food Skills for Families had separate curricula for Aboriginal, South Asian, newcomer and low income participants. Similarly, the Farm to School Salad Bar program focused on communities in the North and Interior of BC. Other dimensions of diversity, such as sexual orientation, were not addressed in the report.	
			Equity	"Social determinants of health and health inequities were identified as key barriers to physical activity Initiatives were identified to try and address some of these barriers. For example, the *Everybody Active* initiative communities with funds to start talking about the key barriers to activity and how access could be improved for low income and vulnerable populations. The built environment was also addressed with the Built Environment and Active Transportation (*BEAT)* Initiative which provided resources, support and seed grants to local governments so they could develop 'shovel-ready' plans for improving access to active transportation.	

Document/ Website	Author	Year	Concepts	Findings	URL
36.					
The Winning Legacy A Plan for Improving the Health of British Columbians by 2010	BC Healthy Living Alliance	2005	Sex	Women are only mentioned in relation to pregnancy and breastfeeding. The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.bchealthyliving.ca/sites/all/files/BCHLA_Winning_Legacy_0.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The report mentions the importance of supporting health promotion programs for specific populations, including low income populations, pregnant/breastfeeding women, the mentally ill, First Nations People, and new Canadians. There is no other discussion of diversity in the document.	
			Equity	The document does not refer explicitly to equity, but it acknowledges the importance of the social determinants of health and emphasizes the need to address many factors, including income, social status, education, social support networks, employment and working conditions, physical environments, personal health practices, biology and genetic endowment, health services, and healthy child development.	

Document/ Website	Author	Year	Concepts	Findings	URL
				Interestingly, this document does explicitly address the importance of structural over individual barriers to healthy living: "A large volume of research reveals the vital role that socioeconomic and environmental determinants play in influencing the development of risk factors in a population. Ignoring systemic factors will severely reduce the degree that personal behaviour change will occur in British Columbia".	
			General	The report also acknowledges the gap between priority setting and action: "Setting targets is one thing: achieving them is another".	
37.					
Healthy Living in BC – The Next Generation A Policy Paper of the BC Healthy Living Alliance	BC Healthy Living Alliance	2011	Sex	The sex continuum is not addressed and sexual minority populations are not mentioned.	http://www.bchealthyliving.ca/sites/all/files/file/NextGeneration.pdf
			Gender	No mention is made of gender considerations or the gender continuum.	
			Diversity	The report acknowledges that some groups, particularly those with limited economic resources, are at increased risk of ill health, poor diet, limited physical activity and unhealthy body weights. No substantive discussion of diversity is evident in the paper.	

Document/ Website	Author	Year	Concepts	Findings	URL
			Equity	The report mentions the importance of the social determinants of health and acknowledges the reality of health inequities related to the social determinants, children and families living in poverty, the working poor, the unemployed/under-employed; those with limited education and/or low literacy, Aboriginal Peoples, new immigrants, persons suffering from social exclusion, the homeless and people with addictions and/or mental illness. There is limited discussion of specific actions and initiatives to address health inequity or other forms of inequity.	
			General	Interestingly, the paper acknowledges the complexity of dealing with increased rates of obesity: “In very simple terms many are getting too many calories and not enough physical activity. However, this is not just a matter of discipline. To make progress on this issue we need to start shifting the physical and socio-cultural environments that shape our consumption and activity patterns”. Nonetheless, much of the report focuses on the activities to support behaviour change independent of significant structural change or points to the need for structural change without discussing concrete mechanisms to achieve these ends.	

Document/ Website	Author	Year	Concepts	Findings	URL
38.					
Further Advancing the Health of Women and Girls: Report on the Women's Health Strategy for British Columbia, 2004-2008	British Columbia Centre of Excellence for Women's Health and BC Women's Hospital and Health Centre	2009	General	The British Columbia Women's Health Strategy pre-dates the Integrated Pan-Canadian Health Living Strategy and as this document reports on the BC women's health strategy, it does not mention healthy living nor does it focus on key healthy living targets. A new Women's Health Strategy for the province is in development.	http://www.health.gov.bc.ca/women-and-children/womens-and-maternal/provincial-strategy.html

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Promising Gender-sensitive Healthy Living Interventions for Women

Ann Pederson and Anna Liwander

Most healthy living strategies in Canada have been gender neutral or even gender blind, that is, they adopt universal, "one size fits all" initiatives. However, as we have demonstrated in this report (and in past research), it is important to attend to sex and gender for more effective health promotion and the benefits of conducting a sex- and gender-based analysis (SGBA) have been established and SGBA is now mandated by policies in many jurisdictions (1-6). The value of SGBA was most recently affirmed in the 2012 Chief Public Health Officer's (CPHO) Report, *Influencing Health—The Importance of Sex and Gender*, where it was argued that "A sex- and gender-based approach is part of systematically planned interventions that are consistent with population health approaches" (7).

In this chapter, we introduce the concept of promising gender-sensitive interventions in healthy living and provide some examples of promising interventions in which sex- and gender-based analyses have been integrated into the planning, development and/or implementation of strategic actions related to healthy living.

Promising Interventions in Healthy Living

In the last few years, there has been a call for best or promising practices in chronic disease prevention and health promotion (8, 9) and it has been argued that "evidence-based practice is an important public health goal" (9). While in clinical medicine best practices have often been assessed through the use of randomized controlled trials (RCTs) and there are standardized practices for evaluating and synthesizing evidence (10-12), the complexity and context-specific nature of health promotion interventions makes promising interventions in this field less easily defined. In a report for UNAIDS, de Bruyn proposed that best practices in health promotion be defined as follows:

> "Best practices comprise examples of programmes, projects and activities that have been shown to contribute towards making interventions successful. They do not represent "perfection;" rather, they are part of a process of applying knowledge, improving it and documenting the experience to be shared with others." (13)

In Canada, interest in best practices in health promotion has been demonstrated, in part, through the *Canadian Best Practices Portal* developed by the Public Health Agency of Canada (PHAC) (14). The Portal includes a compendium of interventions related to chronic disease prevention and health promotion that have

been evaluated, shown to be successful, and have the potential to be adapted and replicated by other health practitioners working in similar fields. The resources in the Portal are aimed to help practitioners reach their public health planning, chronic disease prevention and health promotion goals, and to "increase the proportion of decisions made by the intended populations of interest using best available evidence" (15). In the Portal, best practices include:

> "Population / community-based interventions spanning a variety of approaches (i.e. policy, programs, media, etc...) aimed at health promotion, disease prevention and management related to chronic disease that have been informed by and result in evidence of effectiveness to inform decision-makers in practice, policy and research within a variety of settings (i.e. health, education, workplace, urban, rural, etc.) and populations (i.e. male and female across the lifespan, Aboriginal, families, etc...)" (14).

These two quotations suggest that best practices in health promotion should be understood as context-dependent, evidence-informed and population-specific. In keeping with this view and the preliminary nature of the evidence available on gender-sensitive interventions in healthy living, we use the term 'promising' rather than 'best' practices in this chapter.

Gender-sensitive Promising Practices

The health promotion field is starting to document the importance of attending to gender in health promotion interventions (16-22). *Gender-sensitive interventions* take gender into account and consider, for example, the different social roles of men and women that lead to women and men having, respectively, different needs, health behaviours and outcomes. Gender-sensitive interventions adopt a holistic view of health,embrace a social justice approach (23) and "reflect gender-related and diversity-related influences on behaviour, social attitudes and practices" (24).

What is significant about this approach to health promotion is the explicit recognition that improving health entails more than addressing risk factors and health behaviours. Because this understanding of health promotion is enmeshed with a determinants of health perspective and founded on explicit values of social justice and equity, it raises "the responsibility for health promotion to take concerted efforts to tackle health and social inequities" (25). From the perspective of improving women's healthful living, this means understanding the origins of health in social and economic terms, not just biological ones, and it means engaging with questions of enhancing gender equity.

Where traditional health promotion approaches have stressed individual or community empowerment to act on the determinants of health, they have not always recognized gender as a determinant of health and therefore, actions were not necessarily taken to address gender-related inequities themselves (17). This means that issues of gender and gendered power relations, particularly as they shape domestic and intimate

relationships, were not necessarily considered when health promotion interventions were developed (26). Recently, however, both women's and men's health advocates have begun to attend to gender and gender relations as aspects of health promotion. For example, Reid and colleagues argue that "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" (27).

Gender-sensitive promising practices in health which have emerged in the context of addressing maternal-child health and preventing the transmission of HIV/AIDS have shown that not all approaches are equally effective (28). Drawing from discussions in the field of HIV/AIDS prevention (28), we have generated a continuum of actions on gender and health (Figure 1).

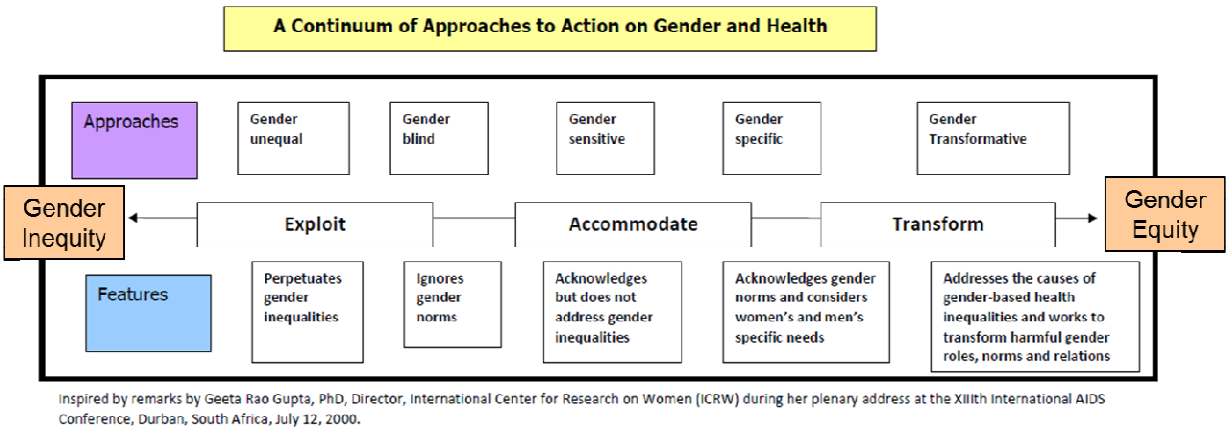

Figure 1. A continuum of approaches to action on gender and health.

This continuum is grounded in an understanding that, "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" (28). In so doing, the continuum recognizes that interactions—and interventions—can exploit, accommodate or transform gender relations by the way that they recognize, ignore or address gender-related power and its impact.

"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" (28).

For example, programs that develop health promotion messages or programs that build on a concept of femininity as 'passive' and masculinity as 'active' are reproducing norms and stereotypes that may serve to limit access to knowledge, resources, services and skills that are vital to health. In contrast, programs and services can be designed to empower girls, boys, women and men to have access to knowledge in safe, supportive, respectful

dialogue and avoid using stereotypes to inform messaging, programming or policy which are stigmatizing, shaming or marginalizing. In this way health actions can contribute to the promotion of gender equity and related social aims.

Although there is not yet a systematic approach to what some are calling "gender transformative" health promotion interventions, some principles of practice are beginning to emerge (29-31). In 2010, the Department of Gender, Women and Health at the World Health Organization (WHO), in collaboration with UNAIDS, started developing a *Gender and Health Promising Practices Series* to document pioneering initiatives that employ gender mainstreaming methods to reduce gender-based health inequities in different health areas (16). As part of this process, eight common elements of what they termed "best practices in gender and health" were identified:

1. Adopt a rights-based approach;
2. Are based on a gender assessment or research to identify local needs;
3. Promote community participation and ownership;
4. Strengthen the health system;
5. Build knowledge of and capacity to address gender equality issues;
6. Ensure the participation of men;
7. Have built in monitoring and evaluation indicators and processes; and
8. Include plans for replication and scale up (16).

UNESCO has published a guide to the essential characteristics of HIV prevention that identifies that interventions should be gender-responsive and culturally appropriate (32). Importantly, the guide recognizes that the aim is to promote the equal valuing of women's and men's contributions in the home, community and society. The guide proposes that interventions embrace 'gender responsive programming', that is, challenging bias, discriminatory practices, ideas and beliefs and attempting to change them as part of programs, policies and interventions (32). Similar language can now be found in the grey literature of several development agencies and in health programming related to reproductive and sexual health and, to a lesser extent, tobacco control (33-37).

The work on the *Gender and Health Promising Practices Series* at the WHO was discontinued with the closing of the Department of Gender, Women and Health and we have yet to see a publication that documents such promising practices very far beyond the field of HIV/AIDS prevention. What follows in this chapter are some examples of initiatives that we hope will help make these principles concrete and relevant in the context of interventions to promote healthy living for women in Canada.

Promising Gender-sensitive Healthy Living Interventions for Women

Elements of Gender-sensitive Promising Practices in Healthy Living

The academic and grey literature have just begun to document gender-sensitive approaches in healthy living, notably—for the purposes of this report—women's use of tobacco (38-41), alcohol use (42-44), physical activity (45, 46), as well as in relation to gender-based violence (47). In a preliminary scan of the literature on sex, gender and promising practices in health promotion and healthy living, as well as in discussions with health promotion leaders, program developers, and colleagues among the Centres of Excellence for Women's Health (BCCEWH), we identified a few current examples of interventions which we believe have the potential to increase the health of women in Canada. These examples have been selected because they target girls or women explicitly; incorporate an understanding of sex and/or gender (including gender norms, gender relations and gendered social institutions); engage with the determinants of girls and women's health (not just individual-level health behaviours); and/or seek to reduce gender-related social and health inequities. It is not intended to be an exhaustive list of gender-sensitive interventions and these examples "do not represent 'perfection' rather, they are part of a process of applying knowledge, improving it and documenting the experience to be shared with others" (13).

Examples in this chapter were selected because they:

- Target girls and/or women explicitly;

- Incorporate an understanding of sex and/or gender;

- Engage with the determinants of girls and women's health; and/or

- Seek to reduce gender-related social and health inequities.

Although the examples in this chapter can be considered gender-sensitive, they are also women-specific. The initiatives embrace the view that women's health is grounded in the context of their lives – in the social, economic, educational and political context in which they live, work and play (19). Women's health is a product of gendered social systems that shape their opportunities for health and their exposure to health-damaging agents, conditions and environments (48). Social norms about the roles women play in the household, in the workplace, and in the community contribute to women's economic security, as well as their access to resources and information – and in turn, their health (49).

Adopting a gender-responsive approach is likely not only to improve health outcomes but has the potential to be more effective than conventional programming. As Östlin and colleagues argue, "health promotion policies that take women's and men's differential biological and social vulnerability to health risks (as well

as their unequal access to power) into account are more likely to be successful and cost-effective compared to policies that are not concerned with such differences" (17).

Examples of innovative programs related to the topics in the profile section of this report can be found in be found in the respective chapters and are not repeated here. Instead, in the remainder of this chapter, we provide descriptions of six promising interventions underway in Canada that are closely aligned with the principles of the WHO GWH guidelines.

"Health promotion policies that take women's and men's differential biological and social vulnerability to health risks (as well as their unequal access to power) into account are more likely to be successful and cost-effective compared to policies that are not concerned with such differences" (17).

These were identified through a combination of personal experience, referral, environmental scanning and literature reviews. Several of them are associated with research underway at the BCCEWH, particularly through a nationally-funded research team entitled *Promoting Health in Women* (PhiWomen). PhiWomen is a multi-disciplinary team of scholars, practitioners and policy makers who are critically engaged with several of the programs described in this chapter, as well as theorizing about how health promotion can be a resource for action to improve the status of women at the same time as it tackles health problems.[1] It is important to stress that the interventions highlighted here are not meant to represent an exhaustive list of all activities underway in this country that are (a) related to women and healthy living or (b) fulfill our criteria for promising practices. Rather, our intent is to stimulate discussion of gender-sensitive promising practices, building on what we have learned from international activities, and to suggest their particular value for improving healthy living for women in Canada. Finally, triggered by the literature search undertaken to prepare this chapter, and discussions with colleagues working on incorporating SGBA within the context of systematic reviews (50), we are completing a scoping review of promising practices related to four healthy living topics explored in this report: alcohol use; tobacco use; physical activity and sedentary behaviour.[2] The scoping review will help to describe what is known about gender-sensitive promising practices in healthy living in relation to those topics and should identify a number of additional interventions worthy of closer examination.

The first intervention we describe, *Girls' Empowerment Groups*, aimed to identify best practices in health promotion with girls and to develop tools to support facilitators in girls' empowerment groups. The second example relates to *Women-centred Tobacco Interventions* and how to deliver smoking cessation and relapse prevention interventions. Third, we present an innovative resource, *Couples and Smoking*, which addresses

[1] For more information: www.promotinghealthinwomen.ca

[2] Results will be available in mid-2013.

relational influences on smoking during pregnancy and brings men and partners into the discussion of smoking practices and strategizing to reduce or quit smoking. This is followed by the *Hearth Health Promotion Initiative* in British Columbia which focuses on women-specific factors in heart health promotion. The last two examples, *trauma-informed physical activity* and *gender-based violence in health programs*, include interventions that are based on understandings of trauma and violence, with particular focus on prioritizing women's safety, collaboration, and cultural and situational appropriateness. These latter principles are important features of gender-sensitive programming for women.

Girls' Empowerment Groups

As we have seen earlier in this report, there are gender-specific influences that effect girls' healthy living, including their use of tobacco, alcohol, their engagement in physical activity, body weights, experiences of violence, sexual behaviour, and so on. These influences require gender-specific responses.

In 2011/2012, the BC Centre of Excellence for Women's Health (BCCEWH) and the Girls Action Foundation (GAF) collaborated to develop tools and resources to support leaders working with girls in offering programming that addresses girls' healthy living issues (2). The Girls Action Foundation is a national non-profit organization based in Montreal, Canada that fosters and supports programs across the country that build girls' and young women's skills and confidence and inspire action for change. Girls' group programs linked to the GAF address local issues facing girls and young women and pay particular attention to marginalized groups, including girls and young women living in Northern communities, racialized groups, immigrant women, low-income women and those living in rural regions (42). The girls' empowerment programs involved varied by setting, context, population and/or target issue(s), yet had the common elements of acknowledging girls' experiences, providing a safe space for them to express themselves, enhancing their social support networks, and building their self-esteem.[3] They also recognize the importance of girls' diversity in terms of race, socio-economic status, ability, sexuality, gender identity, religion, culture, Aboriginal identity, refugee, immigrant or other status.

The Girls' Empowerment Programs vary by setting, context, population and/or target issue(s), yet have the common elements of acknowledging girls' experiences, provide a safe space for them to express themselves, enhance their social support networks, and build their self-esteem.

Leading up to the recent collaboration between the BCCEWH and GAF, a literature review on promising practices for girls was prepared and focus groups with girls and interviews with program facilitators were conducted; together these materials provide the evidence base for the educational tools. The results of the one-year study suggest that *Girls' Empowerment Groups* were successful in improving girls' self-esteem, which was

[3] The findings from this phase of the collaboration can be found at http://promotinghealthinwomen.ca/wordpress/wp-content/uploads/2012/08/I-love-it-because-you-could-just-be-yourself-Full-Report.pdf

"associated with improved decision-making and ability to resist social pressures to engage in risky health behaviours such as drinking and smoking" – important factors in empowering girls. The girls appreciated the opportunity to participate in girls-only spaces where they could discuss topics that would normally be considered taboo, such as sexuality, substance use, eating disorders and suicide, and to obtain accurate information about these issues. The girls' groups provided them with opportunities to build friendships with other girls, and share what they were going through, which was helpful in building self-confidence (2).

Building on the findings about what works in promoting girls' health from the perspectives of the girls and the facilitators, three backgrounders have been developed for group facilitators on the topics of: (1) *Girls, Smoking and Stress*; (2) *Girls, Alcohol and Depression*; and (3) *Girls, Physical Activity and Culture*. These backgrounders present current resources for facilitators on what is known about girls' tobacco and alcohol use and links to stress and depression as well as what is known about girls' physical activity. They provide information on the health impacts of early tobacco and alcohol use and heavy drinking as well as suggestions on how to start conversations about smoking, drinking and physical activity. The backgrounders also recommend materials that the facilitator might want to share with girls about smoking and drinking, and suggestions on how to create fun, safe and culturally appropriate physical activity programs for girls. These documents are designed to increase facilitators' understanding of these complex health issues and to promote critical engagement with these issues by girls in the safe context of girls' groups.

Girls' groups linked to the GAF employ a holistic, empowerment model that incorporates principles and practices from strength-based, popular education, media literacy, and civic engagement approaches (51). The GAF model and other emerging frameworks for girls' health promotion, such as that advocated by the VALIDITY project team at the Centre for Addiction and Mental Health in Ontario (52) promote a move from issue-specific interventions, towards health-determinant-oriented approaches that address interconnected factors and conditions that affect girls' health. The three backgrounders provide practical resources for girls' group facilitators that avoid narrowly focused approaches to discussion of alcohol, tobacco and physical activity, and are consistent with the holistic, empowerment oriented GAF model.

Women-centred Tobacco Interventions

Smoking is an important preventable cause of mortality and morbidity for women in Canada. While many women succeed in quitting smoking with generalized or mainstream interventions, many do not. Promising approaches for gender-specific tobacco interventions for pregnant women have not yet been fully developed, implemented or evaluated and there is a lack of emphasis in the literature on how to prepare women to quit and support this decision within the larger context of their lives. To address this gap, researchers at the BCCEWH reviewed and synthesized the literature on: a) sex- and gender-related influences in tobacco use and addiction; b) evidence-based clinical guidelines on treating tobacco dependence and preventing relapse; and c) best practices in the delivery of women-centred care to provide the foundation for a women-centred approach to tobacco dependence treatment and relapse prevention.

From this synthesis, principles of women-centred tobacco interventions were derived and utilized to prepare a practical guide, entitled *Liberation!* for use by a wide range of practitioners to start conversations about quitting smoking with women (40). The four principles derived from the literature and which are the foundation of the *Liberation!* guide include:

1. *Women-centred care for tobacco is tailored* - Tobacco cessation interventions that are tailored specifically for women support a woman's readiness to quit and allow her to have choice and control over the intervention components, including the use of pharmacotherapy.

2. *Women-centred care for tobacco builds confidence and increases motivation* - Working with women to identify gender specific barriers and opportunities for change helps build confidence and motivation, ultimately improving their chances of meeting smoking cessation goals.

3. *Women-centred care for tobacco integrates social justice issues* - Women-centred care acknowledges other priorities such as housing, food security, and caregiving roles and how these challenges may be related to smoking behaviour.

4. *Women-centred care for tobacco is holistic and comprehensive* - Women-centred care integrates support/treatment for trauma, mental health recovery, substance use, or other important health concerns which the woman identifies; valuing women's health for its own sake. (40).

This women-centred tobacco intervention was built on Motivational Interviewing (an evidence-based communication style to support change) and describes three phases for providers to consider and enact in their work with women smokers – engaging, guiding and planning. The guide links this evidence-based, paced approach to key elements of women-centred care, to produce practical ideas on 'how' to have these important conversations with women. Experts in women's health and smoking cessation, health care practitioners and women who smoke were then involved in providing input on the desirability and acceptability of aspects of the approach.

The *Liberation!* guide recognizes the numerous factors that influence women's experience with smoking and success at quitting. It helps practitioners and women address physiological and biological factors influencing smoking (i.e., level of dependence, menstrual cycle, genetics, mental health and substance use), as well as psychosocial factors (i.e., stress, lack of support, experiences of trauma, stigma). It explores options for use of Nicotine Replacement Therapies or not, gradual reduction versus complete cessation, and brief or longer-term support. The emphasis of this guide is make doable, these complex conversations as research shows that clinical interventions as brief as three minutes can increase quitting rates significantly among current smokers and recent quitters, and that quitting smoking for even a short

period of time, can have profound, liberating effects on a woman's physical and psychological well-being (40). The guide is being shared with local, provincial, national and international audiences of service providers, researchers and policy makers. It is also being taken up by service providers working with women and with people training those working in tobacco control.[4]

Researchers with the BCCEWH have also conducted a 'best or better practices' review of strategies for pregnant and postpartum women who smoke. Pregnancy is often identified as a key opportunity for health promotion for women because expectant mothers are concerned not only with their own health but also of promoting the health of the fetus. It is important that interventions designed to promote the health of the fetus not ignore the implications for the mother and ideally interventions are framed, conceptualized and delivered in ways that promote the health of both mother and her developing child. It may be challenging in such programming, however, to avoid employing stereotypical depictions of women, their bodies, and their lives during this particular life process, given normative cultural assumptions about mothering, pregnancy and infants. Tobacco use during pregnancy is one area that has received explicit sex- and gender-based analysis in recent years. The report *Expecting to Quit* summarizes the findings from best practices designed to support smoking cessation among pregnant and postpartum girls and women (38).[5]

Both *Expecting to Quit* and the *Liberation!* guide take a women-centred approach to smoking cessation and recognize that these need to be tailored specifically for women and their circumstances. They recognize the numerous factors that influence women's experience with smoking and success at quitting including biological factors and social factors, and emphasize the collaborative and dynamic nature of real-life interventions.

Tobacco Interventions for Couples in the Context of Pregnancy

An innovative resource has been developed by researchers associated with the Investigating Tobacco and Gender (iTAG) and the Families Controlling and Eliminating Tobacco (FACET) research team which are led by researchers at the University of British Columbia.[6] This resource, *Couples and Smoking*, is an interesting example of gender-informed health promotion because it pays explicit attention to relational influences on smoking during pregnancy and it brings men and partners into the discussion of smoking practices and strategizing to reduce or quit smoking (53).

Pregnancy is often a time when couples start to think about changes in tobacco use by one or both partners (38). Smoking cessation for pregnant women and new mothers is often temporary, with many women relapsing after childbirth (54, 55). It is important, therefore, to continue to gain understanding of the

[4] For more information: http://www.coalescing-vc.org/virtualLearning/section4/documents/Liberation-HelpingWomenQuitSmoking.pdf

[5] For more information: http://www.expectingtoquit.ca

[6] For more information: www.itag.ubc.ca and www.facet.ubc.ca

difficulties women experience in reducing or stopping smoking, in order to develop new approaches to supporting smoking cessation.

The research underlying the *Couples and Smoking* booklet set out to learn about couples' everyday routines that might influence smoking cessation. Twenty-eight women who quit or reduced smoking for pregnancy and their male partners were interviewed following delivery and at three to six months postpartum. Interviews focused on: pre-pregnancy smoking practices; interactions regarding tobacco use before, during and after the woman's pregnancy; conflicts over smoking; and efforts to minimize environmental tobacco smoke.

The end product of the research is a model of smoking in couples based upon the couples' behavioural patterns the study participants described. The researchers found that couples usually develop one of three types of Tobacco Related Interaction Patterns (TRIPs): accommodating, disengaged, and conflictual. The three patterns differ with respect to the interaction between a couple regarding smoking, whether both partners smoke or not. The accommodating pattern "describes couples who treat smoking as acceptable and find ways to create opportunities to smoke" while the disengaged patterns "describes couples who treat smoking as an individual choice and usually smoke separately from one another" if they smoke. The conflictual pattern refers to couples "for whom smoking creates tension in their relationship and sometimes arguments" (53). These three interaction patterns can influence women's efforts to reduce or stop smoking in different ways and understanding them can help her navigate how she wants to deal with smoking during her pregnancy, a time when many women feel compelled to quit smoking.

The power of this approach to addressing smoking during pregnancy is that it takes the interaction between a woman who smokes and her partner as the focus of attention and assists women to understand how the couples' pre-existing interaction pattern around smoking may affect how they deal with her smoking her pregnancy.

A self-help booklet describing TRIPs for use by pregnant women who smoke and their partners was subsequently developed (53). The booklet helps women and their partners learn how routines, habits, and ways of interacting influence smoking, an important first step in changing smoking behaviours. It can be used along with other resources to support women and their partners in reaching their cessation goals (53).[7] Concretely, the guide identifies patterns which may generate tension or conflict and thus can help protect a woman's physical and emotional health and empower her to act.

"Couples and Smoking" moves past the concept that it is only the woman who must change if she is to address her smoking during pregnancy.

[7] For more information: http://www.hcip-bc.org/resources-for-practice/documents/CouplesandSmoking.pdf

This approach to addressing smoking moves past the concept that it is only the woman who must change if she is to address her smoking during pregnancy and it does so by illuminating patterns, offering couples skills, and working to ensure that a woman and her partner engage around this health issue in respectful ways.

Heart Health Promotion for Women

Heart disease is the primary cause of mortality among women in Canada and women have unique social, economic, psycho-social and biological factors that put them at risk for heart disease and that require attention (49, 56). With support from the Provincial Health Services Authority's (PHSA) Population and Public Health Primary Prevention Projects fund, BC Women's Hospital & Health Centre (BC Women's) and the BCCEWH have undertaken a project to explore the features of women-specific heart health promotion interventions.

Between 2010 and 2013, health promotion practitioners in British Columbia conducted four demonstration projects within a new or existing primary care settings in the Lower Mainland of the province, as a first step toward establishing a heart health program for women. These small scale, community-based health education and promotion programs worked with women to identify their priorities with respect to heart health, adapted educational content to be culturally relevant, addressed barriers to accessing physical activity and healthy food (through subsidized leisure-access passes, a community garden, and women-only gym times), and created safety for vulnerable women through the timing, location, and pacing of the program offerings. Staff members who were facilitating the programs came to see themselves as "co-learners" in the process and surrendered some of their usual practices and instead shared their own stories and struggles. Women were not weighed or measured if they chose not to be, and clinical discussions were held in private or in group discussions as the women themselves dictated. Meals and childcare were provided as standard features of the programs because the women they serve are often low income and/or food insecure and most had children. Children were included in activities when appropriate, as were partners, but for women who experienced violence in their relationships, safety was also created through a combination of women-only and shared space. In short, in numerous ways, these programs sought to give women information about how to reduce their risks for heart disease through practical skills, increased knowledge and social support and to address structural changes such as access to recreational facilities, link women to community resources, and develop community gardens to provide food. They built on trust-building and harm reduction approaches to smoking cessation, relationship-building, and financial skill-building as opposed to scare tactics and judgment.

Initial evaluations of the women-specific, gender-sensitive heart health promotion programs demonstrate that women in the four sites had gained new knowledge and were more confident in their understanding of how they could address the risk factors for heart disease through healthier eating, physical activity and smoking cessation. Longer-term follow-up data will help determine what impact the programs have over time. In addition, the demonstration projects have inspired discussion among health services planners and the leadership in chronic disease prevention in the province to consider how to expand this approach across the continuum of heart health interventions (such as to cardiovascular rehabilitation programs) and to other health authority services.The project teams, researchers and evaluators have also been developing the *Elements of a Gender-sensitive Framework for Promoting Heart Health* (57) based upon the experiences of these four projects and their ongoing review of literature on heart health promotion. Though not finalized, this initiative has prompted discussion about how conventional heart health promotion programming has been largely directed at men and how some recent media messages about women and heart health have exploited gender stereotypes in order to elicit women's attention.

Initial evaluations of the Heart Health Program suggest that women had gained new knowledge and were more confident in their understanding of how they could address the risk factors for heart disease.

Trauma-informed Physical Activity

Physical activity has important positive effects on both physical and mental health for women (45, 58-64). Yet, as we have demonstrated earlier in this report, many women find it challenging to engage in levels of physical activity that are sufficient to promote health and marginalized women, in particular, face many barriers to participation in sport, recreation, and physical leisure (65, 66). This includes women who are racialized, disabled, elderly, mothering, rural-dwelling, living on low income, or a combination thereof, who tend to have low activity levels and face multiple and overlapping barriers to being physically active (61, 67-71).

Critical perspectives on physical activity and health promotion suggest that physical activity strategies must also go beyond dominant approaches aimed at individual behaviour change and take women's social contexts, embodied experiences, and daily lives into account (19, 72). This also means taking violence and related forms of trauma such as homelessness or problematic substance use into account (2).

Violence and trauma can generate a 'disconnection' from one's own body that inhibits women from engaging in physical activity (73). The notion of 'trauma-informed' health care and promotion is an innovative strategy that focuses on creating interventions that are based on understandings of trauma and prioritize women's safety, collaboration, and strengths (74). While this work has shown promise in the fields of mental health and substance use (75-77), there has been minimal uptake in the field of physical activity. To date, the only known application has been within yoga (78). In fact, it is the incorporation of yoga into trauma treatment programs that likely initiated the exploration of ways that yoga itself could be transformed

into a more health-promoting activity by minimizing aspects that some people find problematic such as controlled breathing, having one's eyes closed, and being touched to correct a position.

The notion of 'trauma-informed' health care and promotion is an innovative strategy that focuses on creating interventions that are based on understandings of trauma and prioritize women's safety, collaboration, and strengths (74).

Researchers with the BCCEWH, in partnership with ProMOTION Plus, have been working for three years to conceptualize how physical activity program offerings could be more welcoming and appropriate for marginalized women (79).[8] Broadening the "trauma-informed" approach espoused by some yoga practitioners (described below) to other forms of physical activity is a promising direction. As dominant forms of sport and fitness tend to be gendered, racialized, homophobic, body-centric, and otherwise oppressive (80), they are also potentially re-traumatizing activities.

Yoga Outreach[9], a volunteer-run charitable organization in Vancouver, works in transition houses for women who have been abused and uses innovative trauma-informed teaching to create opportunities for women that are safe and empowering, as well as being free of cost.Yoga Outreach staff match volunteer yoga teachers to organizations such as correctional facilities, safe and transition houses for women, mental health institutions, substance use recovery centers, and women's centers (81). Staff develop curricula and training workshops that are tailored to particular participants groups, such as people with concurrent disorders or youth at risk. The approach to yoga is based on the recognition that many marginalized individuals have experienced ongoing trauma in their lives and may suffer from post-traumatic stress. A safe environment is created by using non-violent and invitational language from teachers, refraining from personal touch or assists, and a welcoming room. Yoga Outreach's focus is to encourage participants to safely re-connect with their bodies and re-develop the ability to choose what type of movement feels right for them. These principles of trauma-informed yoga are similar to those of trauma-informed care generally: choice, safety and action (personal communication with Delanie Dyck, Executive Director, September 22, 2011) (82).

Currently, researchers at BCCEWH are conducting a qualitative inquiry into whether practitioners in the field of physical activity and the women-serving communities are able to find common ground and together develop an approach to promoting physical activity (beyond yoga) that might be welcoming to women, particularly those who report experiencing physical activity programs as intimidating, stressful, and/or unsafe. This work could benefit anyone with a trauma history but it may be particularly useful for working with girls and women, many of whom find physical activity and recreation programs to be in settings that are uncomfortable.

[8] This work is being led by Dr. Pamela Ponic. A discussion paper prepared by the team is available at http://www.bccewh.bc.ca/publications-resources/documents/DiscussionPaper-PhysicalActivityforMarginalizedWomen2011.pdf

[9] For more information: http://yogaoutreach.com

Addressing Gender-based Violence in Health Programs

Gender-based violence (GBV), as discussed elsewhere in this report, is a pervasive problem for women in Canada and a barrier to women being able to live healthfully. International agencies such as USAID have begun to identify opportunities for the health sector to prevent and respond to GBV, recognizing that the solutions to gender-based violence are—like most aspects of healthy living—numerous and require multisectoral action (83). Some programs to address GBV explicitly involve men and/or boys and are directed at changing attitudes and values regarding girls and women (83). Moreover, violence against women is a function of gender norms and social, economic, legal and structures that perpetuate and legitimate gender inequalities. Programs to address gender-based violence can both address the health issues arising from violence such as injury and trauma, but they can also address the root causes and assumptions that support gender-based violence in the first place. Programs with these characteristics are designed to transform gender relations, not merely accommodate them.

The guiding principles of GBV programming align with those of trauma-informed care described above: (1) ensuring survivors' safety; (2) doing no harm; (3) maintaining confidentiality, ensuring informed consent, preserving privacy and creating protections against disclosure; (4) ensuring cultural and situational appropriateness; (5) employing a human rights and public health perspective; and (6) engaging in multisectoral action at multiple levels. Quality programming also entails appropriate documentation, data collection and program evaluation (84).

In Canada, many hospitals and health services provide programs and services directed at preventing and/or ameliorating the effects of violence against women. Programs such as the *Woman Abuse Response Program* at BC Women's Hospital & Health Centre in Vancouver, may provide direct services to women or support health care workers to work with women with abuse and violence histories through training and the provision of resources. In recent years, debates about universal screening versus case identification have been debated in practice and in the literature as service providers work to establish the most appropriate ways to respond to women who come into services and who may be experiencing violence. Using the program at BC Women's Hospital as an example, program documentation stresses a growing understanding that women experiencing violence often also have mental health issues and that women may use substances like tobacco, alcohol or others to help cope with their experiences. Such a vision has led program staff to stress the importance of working across sectors to ensure that women are provided with the supports they need and one service, such as a transition house, does not undermine a woman's capacity to make change by, for example, refusing to provide shelter to someone who is an active substance user. This way of working requires that health care providers work with experts in other fields and understand how they can work to maximize a woman's safety during health care. Health services researchers are studying how emergency services and primary care could be modified to incorporate similar principles of care.[10]

[10] For more information: www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/default.htm

The Future: Gender Transformative Health Promotion

Though certainly not intended to be an exhaustive listing of programs and activities underway in Canada, the interventions described above begin to suggest some common principles that may be important to support women in more healthful ways of living. In particular, the principles of trauma-informed care, which offer guidance about creating programs and policies that do not rely on a woman disclosing whether she is experiencing violence but create the conditions for her to be safe regardless, may be valuable in designing policies, programs and services for women (74). Finding ways to create safe places for women to learn, to change and to develop new skills involves more than providing pamphlets and media messages. It includes working across sectors in prevention activities and learning from colleagues who understand marginalization, gender inequity and the impact of violence and trauma on women's lives. It is clearly also important to embrace the established principles of effective health promotion regarding the importance of participatory approaches, empowerment and engagement, as the foundation for action. But it is also vital to work in context—to recognize the diversity of women and the limitations of easily transferring interventions from one setting to another without critical thinking and advice from key stakeholders, particularly program participants. Finally, these examples stress the importance of addressing the constraints and barriers that limit women's ability to act so as to provide better opportunities for health rather than assuming that individual women have all the resources necessary to improve their own health, a critique for health promotion that has been noted in the past.

As noted earlier, Östlin and colleagues have argued that gender-informed health promotion policies "are more likely to be successful and cost-effective compared to policies that are not concerned with such differences" (17). At this stage, we lack the evidence to confirm whether they are correct, but the examples in this chapter suggest that there are interesting experiments and innovations underway in a number of fields which may lead us to programs, policies and actions that seriously consider issues of gender equity (and diversity) within their overall approach. The goal however, is not just to acknowledge issues of sex and gender as part of programs but to work on reducing gender-related inequities and the harms associated with them. In short, the goal is to create and engage in gender transformative practices, including gender transformative health promotion.

As the work of PhiWomen and others continues, it is also important to remember that the construct of 'best practices' is not likely to ever fully apply to the field of gender-sensitive health promotion—both because of the context-specific manifestations of gender and gender relations and because of the contested nature of evidence and the evolving nature of definitions of the 'good life'.

Summary

Health promotion interventions do not necessarily lend themselves well to the narrow definition of 'best practices' commonly used in clinical medicine. Nevertheless, program developers and policy makers need to know whether a program "works", under what conditions it works, and for whom. The concept of 'promising practices' is therefore useful as it embraces a spirit of innovation but also sees the importance of evaluation in determining whether an intervention is worth sharing and adapting in other circumstances. In this chapter, we have introduced the concept of gender-sensitive interventions as a potential approach to improving the effectiveness of policies and programs aimed at improving the health of girls and women with respect to healthy living. These programs appear to be rare and can be difficult to identify as there is no systematic inventory available in Canada and to date there are no internationally agreed upon standards or elements for gender-sensitive practices. Although there is an emerging knowledge base regarding such programs, policies and practices, the field can still be considered in its infancy and much work remains to be done to compile evidence of what works in relation to bringing a gender lens into health promotion and healthy living interventions.

The lack of evaluation of programs in general, and of the gender transformative elements of programs more specifically, may hinder the identification of examples of promising practices and the development of this work. The closing of the Department of Gender, Women and Health at the World Health Organization has also meant the redirection of some energy away from this field at the global level. A forthcoming paper on a scoping review of the academic and grey literature of gender-sensitive healthy living interventions in tobacco, alcohol, physical activity and sedentary behaviour may provide some initial steps in expanding the documentation of examples of promising practices as well as contribute a set of common elements. Subsequent review by researchers, program planners and policy makers with expertise in girls and women's health and gender-based analysis might be a way to generate a consensus on the elements.

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