Gender plays a central role in people’s lives, including influencing and shaping experiences of mental and physical health. In this chapter, we do not focus on extensively reviewed sex/gender differences in health (e.g., Helgeson, 2012; Regitz-Zagrosek, 2012). Instead, consistent with conceptualizing gender as a social determinant of health (Raphael, 2009), we review theory and research on how aspects of gender as a social construct with corresponding hierarchies relate to health and well-being.

Sex and gender are intricately connected, and some would argue sex is also socially constructed (e.g., Butler, 1990). However, most often, sex is considered a biological variable consisting of genes, chromosomes, and hormones, while gender is considered a social and cultural construct consisting of a range of experiences and expectations, such as for traits, roles, feelings, and behaviors (Helgeson, 2017). There are many perspectives on gender as a social and cultural construct that are influenced by and imbedded in feminist theories and movements. We focus on several of these perspectives that are supported by empirical evidence and help to understand gender’s dynamic connection to health in ways that identify multi-level interventions to promote health, and particularly health equity.

**Gender Theories and Frameworks**

Many theories and perspectives highlight the centrality of gender norms, roles, and stereotypes, with different conceptualizations of their sources. For example, social role theory (Eagly, 1987) posits that division of labor creates norms about roles women and men fulfill. Gender roles then shape stereotypes and expectations about women’s and men’s characteristics and abilities. As another example, social cognitive theory (Bussey & Bandura, 1999) suggests that gender development is influenced by personal, behavioral, and environmental factors, and gender beliefs and roles are socialized in multiple ways. Regardless of disagreements over their sources, gender norms, roles, and stereotypes are identified as critical. Theory and research on gender stereotypes have highlighted the influence of societal conceptions of femininity and masculinity, including traits, roles, and behaviors conceptualized as typical of women/girls versus men/boys (e.g., Bem, 1974; Deaux & Lewis, 1984). These frameworks help to understand gender as a social construct with health implications.

Other theories and frameworks highlight the importance of gender-based (and other intersecting forms of) stigma, discrimination, and power. Building on stigma theory (Goffman, 1963), Chaudoir, Earnshaw, and Andel (2013) identified anticipated (i.e., expectations of rejection), enacted (i.e., discrimination), and internalized (i.e., directed at the self) stigma as mechanisms by which stigma (i.e., social devaluation of identity or attribute in context of power inequality) operates at sociocultural,
interpersonal, and individual levels to “get under the skin” and affect health. Stigma is identified as a “fundamental cause” of health disparities (Hatzenbuehler, Phelan, & Link, 2013), and gender-based stigma is one of many forms.

Another framework focused on stigma, discrimination, and power is intersectionality, which grows out of Black feminist theory and activism, and has been gaining prominence within psychology. Intersectionality highlights that people have multiple intersecting identities (e.g., gender, race, class, sexual orientation) that create unique experiences for them, experiences of individual identities are shaped by systems of oppression (e.g., patriarchy/sexism, white supremacy/racism, capitalism/classism, heterosexism), and systems of oppression are interlocking (e.g., Combahee River Collective, 1977/1995; Crenshaw, 1989). Applying intersectionality in psychology draws attention to simultaneous influences of multiple identities and forms of oppression (including gender and sexism) in shaping experiences as well as to social justice and equity as important goals (Cole, 2009; Rosenthal, 2016).

Some theories focus specifically on gender-based power. For example, the theory of gender and power (Connell, 1987) identifies the sexual division of labor, the sexual division of power, and the structure of cathexis (i.e., constraints on affective attachments) as shaping relationships between women and men. Additionally, Pratto and Walker (2004) identified four specific bases of gendered power—force, resource control, social obligations, and consensual ideologies—based in the ability to meet one’s own basic needs and confer or constrain the meeting of others’ needs. These frameworks help to understand gender-based inequality, stigma, and oppression, in combination with other intersections, which also have health implications.

Although the perspectives on gender reviewed were not necessarily developed to understand health specifically, they have been applied in various ways to the connection between gender and health. We review existing evidence on gender and health based in these frameworks, and then review intervention implications.

**Health Consequences of Gender Roles and Stereotypes**

Gender roles and stereotypes, including endorsement of traditional conceptualizations of femininity and masculinity, have important implications for health and well-being.

**Gender Roles and Caregiving**

Caregiving for family members who are elderly and/or have health issues is shaped by societal gender roles. Generally, women are expected to be caregivers and actually do more caregiving than men (England, 2005). Using data from a national U.S. survey of adults over 50, Grigoryeva (2017) found that daughters on average spend more than double the time providing care to elderly parents than sons, and both siblings’ gender and parents’ gender influence who provides care. In a qualitative study with 28 men who were caretakers both professionally and informally for family in Canada, gender roles influenced participants’ experiences, including men tending to choose helping behaviors more consistent with the male gender role (Anjos, Ward-Griffin, & Leiper, 2012).

Women also tend to face more adverse consequences of caregiving than men. A qualitative study with 28 men who were informal caregivers in Spain found that women performed the majority of caregiving responsibilities, consistent with expectations that they would be primary caregivers (Del Río-Lozano, Del Mar García–Calvente, Marcos–Marcos, Entrena–Durán, & Maroto–Navarro, 2013). Women also seemed more consumed by the caregiving role and pushed their limits, with adverse consequences for their health and well-being, while men were more likely to seek and receive external help for caregiving, protecting their health and well-being despite experiencing stress. In another qualitative study with 36 older women in New Zealand, participants endorsed
and conformed to gender role expectations to be the caregiver for their partners, while not expect-
ing men to do the same and acknowledging that caregiving has consequences for their well-being (Williams, Giddings, Bellamy, & Gott, 2017). An international review of quantitative and qualitative research on spousal caregivers of individuals with cancer concluded that women experienced more adverse consequences of caring for their spouse than men, including for mental and physical health, quality of life, and life satisfaction (Li, Mak, & Loke, 2013). Thus, gender roles result in women doing more caregiving and experiencing more consequences of it, and gender roles also shape experiences of men who are caregivers.

**Other Consequences of the Female Gender Role for Women’s Health**

The female gender role also influences women’s health in other ways. A review of research on sexuality and breast cancer concluded that constructions of femininity and sexuality greatly affect women’s understandings and experiences of cancer and their bodies (Emilee, Ussher, & Perz, 2010). Among a sample of 1,965 people (98% women) with breast cancer in Australia, a main concern identified about consequences of breast cancer was feeling that one lacked femininity (Ussher, Perz, & Gilbert, 2012).

The female gender role also has consequences for women’s health-related self-efficacy, health behaviors, and mental health. In a sample of 100 Vietnamese American women, endorsement of feminine gender roles was positively associated with likelihood of having a clinical breast exam and self-efficacy for screening for cervical cancer among women high in acculturation, but these associations were negative among women low in acculturation (Nguyen, Clark, & Belgrave, 2014). Greater endorsement of masculine gender roles was also associated with greater self-efficacy for breast and cervical cancer screening. Among 116 young women in the U.S., greater endorsement of traditional conceptions of femininity—including self-silencing to preserve relationships and objectifying one’s body—was associated with less sexual experience and use of contraception and condoms, mediated by lower sexual self-efficacy (Impett, Schooler, & Tolman, 2006). Among another sample of 148 adolescent girls in the U.S., greater endorsement of traditional femininity was associated with lower self-esteem and greater depressive symptoms (Tolman, Impett, Tracy, & Michael, 2006). These studies suggest the societal female gender role influences women’s health, including negative consequences for health behaviors and various aspects of well-being.

**Consequences of the Male Gender Role for Men’s Health**

The dominant male gender role (also referred to as “hegemonic masculinity”) poses substantial risks to men’s health and well-being, including by reducing help-seeking and increasing risk-taking behaviors (e.g., Scott-Samuel, Crawshaw, & Oakley, 2015). For example, among 575 U.S. undergraduate men, greater gender role conflict was associated with less willingness to seek counseling for a range of psychological and interpersonal concerns, mediated by greater self-stigma related to counseling, less disclosure of distress, and more negative attitudes toward seeking counseling (Pederson & Vogel, 2007). In relation to risk-taking, a qualitative study with 11 working class white men in treatment for substance abuse in the U.S. found evidence that substance abuse, and other behaviors such as theft and use of guns, were often socialized and used to enact masculinity during adolescence (Sanders, 2011). A meta-ethnography reviewing 51 qualitative studies also concluded that many men are not comfortable with the term “depression” due to associating it with femininity and weakness, many men use avoidant strategies to cope with distress that can lead to risk-taking, and anticipated stigma related to their masculinity being threatened was an important barrier to seeking professional help (Hoy, 2012). Extending to cardiovascular health, an experiment with 285 U.S. undergraduate men found that participants who received feedback threatening their masculinity had greater vagal
withdrawal than control participants, which has been linked to cardiovascular disease and metabolic syndrome (Kramer, Himmelstein, & Springer, 2017).

Masculinity and gender role conflict also affect men with a medical diagnosis, including cancer. A qualitative study with 95 Latino and Black men in the U.S. found that receiving treatment for prostate cancer and facing the aftermath of that treatment challenged participants’ masculinity, including related to work, sex, control, strength, and independence (Maliski, Rivera, Connor, Lopez, & Litwin, 2008). Another qualitative study with 25 men on active surveillance for prostate cancer in the U.S. found that participants’ perspectives about communication with health care providers were influenced by masculine ideals, such as being stoic and denying their illness (Mróz, Oliffe, & Davison, 2013). In a longitudinal study with 66 men who had received treatment for localized prostate cancer in the U.S., greater cancer-related masculine threat (i.e., perceiving experience with cancer as inconsistent with masculinity) was associated with greater decreases in urinary, bowel, and sexual function, partially explained by decreases in emotional processing (Hoyt, Stanton, Irwin, & Thomas, 2013). This research suggests the male gender role influences men’s health, including potential negative consequences for help-seeking, risk-taking, and experiences of cancer.

**Consequences of Femininity and Masculinity for Diet and Exercise**

Conceptions of masculinity and femininity also have implications for diet attitudes and habits, including disordered eating. A meta-analysis previously concluded that femininity was positively and masculinity was negatively associated with disordered eating (Murnen & Smolak, 1997). Consistent with this meta-analysis, in a more recent sample of 178 heterosexual women and men, 132 lesbian/gay women and men, and 15 transgender women in Italy, femininity was positively associated, while masculinity was negatively associated, with symptoms and characteristics of eating disorders and body dissatisfaction (Cella, Iannaccone, & Cotrufo, 2013). Similarly, among 96 Latinx adolescents in the U.S., the association of endorsement of traditional gender roles with disordered eating and appearance concerns was moderated by gender, with a positive trend for women and negative trend for men (Lopez, Corona, & Halfond, 2013). Further, qualitative interviews with 10 young men with eating disorders in the U.K. revealed that the strong societal association of eating disorders with women delayed their own and health care providers’ identification of their eating disorders (Räisänen & Hunt, 2014).

Masculinity and femininity are also linked to exercise. For example, among 24 men diagnosed with anorexia, 21 men diagnosed with muscle dysmorphia, and 30 gym-using men from Australia, the U.K., and the U.S., adherence to traditional masculine norms was highest among those with muscle dysmorphia, and adherence to traditional feminine norms was highest among those with anorexia (Murray, Rieger, Karlov, & Touyz, 2013). Among a sample of 480 women and men in India, greater masculinity was also associated with more regular exercise (Bhattacharyya & Dasgupta, 2015). These studies suggest that for women and men, femininity has more negative implications for diet and exercise, while masculinity has more positive implications, except for potential risk for muscle dysmorphia.

**Health Consequences of Gender-Based Stigma and Discrimination**

Experiencing various forms of stigma or discrimination has well-documented connections to many adverse mental and physical health behaviors and outcomes (see Lewis, Cogburn, & Williams, 2015 for a review). This large literature includes research finding that gender-based stigma and discrimination have harmful effects on well-being.
Consequences of Women’s Experiences of Sexism

Klonoff and Landrine’s (1995) work developing the Schedule of Sexist Events with a sample of 631 women in the U.S. revealed how common and pervasive experiences of sexism are for women, with women of color found to experience greater discrimination in their lives than white women (Klonoff & Landrine, 1995). Using this measure with 255 U.S. undergraduate women and men, women who experienced high levels of sexism reported greater adverse mental health symptoms than men, including somatic, obsessive-compulsive, interpersonal sensitivity, depressive, and anxiety symptoms (Klonoff, Landrine, & Campbell, 2000). The link between sexism and psychological distress has been replicated many times. For example, a recent study with 143 U.S. undergraduate women found greater lifetime sexism and recent sexism were associated with greater distress, mediated by self-silencing (Hurst & Beesley, 2013). Another study using data from 715 Swedish women and men found that psychological distress among women was highest for those with the most traditionally gender unequal workplaces and lowest for those with the most gender equal workplaces (Elwér, Harryson, Bolin, & Hammarström, 2013).

Consequences of sexism for women’s well-being also extend to physical health and health behaviors. For example, among 179 undergraduate women in the U.S., greater experiences of sexism in the past year were associated with greater distress, more frequent binge drinking, more cigarette smoking, and greater endorsement of smoking cigarettes to control one’s weight (Zucker & Landry, 2007). Similarly, among 754 U.S. women, greater sexism was associated with greater odds of unprotected sex through the mechanisms of psychological distress and difficult sexual situations (Choi, Bowleg, & Neilands, 2011). Further, a study with 817 U.S. women found that experiencing prejudice in health care delivery (attributed to gender or other reasons) was associated with lower adherence to cancer screening guidelines and utilization of health care when experiencing illness (Facione & Facione, 2007). Extending to direct physiological consequences, an experiment with 124 U.S. undergraduate women found that participants exposed to hostile sexism (i.e., overt, disparaging sexist beliefs) from a man experienced greater cardiovascular reactivity, including in systolic blood pressure and heart rate, than participants exposed to benevolent sexism (i.e., subtle, paternalistic sexist beliefs) from a man or not exposed to sexism, mediated by anger (Salomon, Burgess, & Bosson, 2015). Further, participants exposed to benevolent sexism from a man experienced poorer cardiovascular recovery, including in heart rate, than participants exposed to hostile sexism from a man or not exposed to sexism.

Although health consequences of sexism have not been studied as extensively as those of other forms of discrimination, such as racism, evidence supports that women’s experiences of sexism have adverse consequences for a range of mental and physical health outcomes and behaviors.

Consequences of Women of Color’s Experiences of Gendered Racism

Drawing on intersectionality, increasing research is exploring consequences of gendered racism for the well-being of women of color. Gendered racism involves discrimination unique to the intersection of one’s gender and race, and has most often referred to unique discrimination experienced by women of color (Essed, 1991). A study with 344 Black women in the U.S. found that experiences of gendered racism were common and associated with greater psychological distress (Thomas, Witherspoon, & Speight, 2008). Another study with 210 Black women in the U.S. found that those who reported greater experiences of gendered racial microaggressions (i.e., subtle puts downs, slights, stereotyping) also reported greater psychological distress (Lewis & Neville, 2015).

Other research supports the connection between gendered racism and distress, and further suggests implications for physical health outcomes and health behaviors. Two studies with Black, Latina, and white women in the U.S. (N = 135 Study 1, N = 343 Study 2) found that Black and Latina...
women experienced two aspects of gendered racism more than white women, specifically stereotype-related gendered racism (i.e., discrimination and stereotype threat based on stereotypes about Black and Latina women’s sexuality and motherhood) and birth control-related mistrust (i.e., mistrust of government and medical system related to birth control due to historical and current abuses, including forced sterilizations) (Rosenthal & Lobel, 2018). Further, the greater stereotype-related gendered racism women reported, the greater pregnancy-specific stress they reported, which is a known risk factor for adverse birth outcomes, and the greater birth control-related mistrust women reported, the lower sexual relationship power they reported, which is a known risk factor for HIV and other sexually transmitted infections (STIs). Similarly, in an experiment with 162 Black and white women in the U.S., Black women high in ethnic identification exposed to a stereotype threat condition priming their race and stereotypes about Black women experienced the greatest anxiety about seeing a doctor of all study groups (Abdou & Fingerhut, 2014). More work in this growing area is needed, but existing studies support that gendered racism has adverse consequences for the mental health of women of color, and thereby possibly also for health behaviors and outcomes.

Consequences of Transgender and Gender Nonconforming Individuals’ Experiences of Stigma and Victimization

Transgender and other gender nonconforming individuals experience stigma, discrimination, and victimization due to their gender identities and expression (i.e., cisgenderism), with consequences for well-being. A national survey including 10,528 LGBTQ students across the U.S. in grades 6 to 12 found that hearing negative remarks, experiencing verbal and physical harassment and assault, and facing discrimination in school policies based on one’s gender expression were common (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016). Transgender, genderqueer, and other gender nonconforming participants experienced a more hostile school climate than other participants. Moreover, greater victimization related to gender expression was associated with greater depressive symptoms, among other adverse personal and academic outcomes (Kosciw et al., 2016). A dyadic study (191 transgender women and their cisgender male partners) with adults found similar results. Discrimination due to being transgender for the women, discrimination due to being in a relationship with a transgender woman for the male partners, and relationship stigma (i.e., stigma targeted at relationship) were associated with greater depressive symptoms (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014). Also consistent with these findings, in an international sample of 1,207 transgender individuals 16 and older, the majority from the U.S. or U.K. (<18% from other Western and non-Western countries), the greater experiences of LGBT-related prejudice (including harassment, rejection, discrimination, victimization, and microaggressions) participants reported, the greater psychological distress they reported, mediated by anticipated stigma, internalized stigma, and rumination (Timmins, Rimes, & Rahman, 2017). Similarly, in a national U.S. sample of 552 transgender adults, anti-transgender discrimination, anti-transgender stigma awareness, and internalized transphobia were associated with greater psychological distress (Breslow et al., 2015).

Other recent studies further support that stigma transgender individuals face has adverse consequences for health behaviors and suicidality. For example, qualitative interviews with 32 transgender men in the U.S. revealed that avoiding cervical cancer screening was one way some men coped with discrimination experienced both in health care settings and more generally (Alizaga, 2017). A focus group study with 48 transgender women in Peru also found that multi-level stigma contributed to their HIV risk (Perez-Brumer et al., 2017). Similarly, among 78 transgender women sex workers in the Dominican Republic, greater stigma predicted less condom use (Budhwani et al., 2017a). Extending these findings to substance use, among 149 U.S. transgender women, greater transphobic discrimination predicted greater odds of binge drinking (Arayasirikul, Wilson, & Raymond, 2017), and among 243 transgender women in the Dominican Republic, greater stigma was associated
with greater odds of drug use, including cocaine specifically (Budhwani et al., 2017b). Similarly, in a national survey of 4,115 U.S. transgender adults, those who reported greater major and everyday transphobic discrimination were more likely to report drug/alcohol abuse, smoking, and having attempted suicide (Miller & Grollman, 2015). Further supporting the connection to suicidality, a study including 816 transgender and gender nonconforming adults in Canada and the U.S. found that gender identity-based discrimination, rejection, victimization, and non-affirmation, as well as internalized transphobia, negative expectations, and non-disclosure of one’s gender identity, were associated with greater suicidal ideation (Testa et al., 2017). A recent systematic review also concluded that interpersonal and structural discrimination and victimization were important predictors of suicidal ideation and attempts among transgender individuals (McNeil, Ellis, & Eccles, 2017).

In this emerging area of research, evidence supports that transgender and gender nonconforming individuals’ experiences of stigma and victimization have adverse consequences for mental health outcomes, health behaviors, and suicide, suggesting there may also be adverse consequences for other health outcomes.

**Health Consequences of Gender-Based Power and Violence**

Much of the work already reviewed (e.g., gender roles, sexism) is connected to gender-based power, and some research has particularly focused on how gender-based power affects health, such as for women’s HIV risk. With a focus on the U.S. context, Wingood and DiClemente (2000) applied the theory of gender and power to understanding women’s HIV risk. Specifically, the sexual division of labor (e.g., poverty, low education, unemployment, lack of health insurance), the sexual division of power (e.g., abuse, sexually oriented media, limited access to HIV education, limited self-efficacy), and the structure of cathexis or affective attachments and social norms (e.g., having an older partner, wanting to have children, gender norms and beliefs, depression) have documented connections to HIV risk for women (Wingood & DiClemente, 2000). Current research continues to utilize and find support for this theory. For example, a recent analysis of dyadic data from 522 Black and Latina women in the U.S. and their main male partners found that structural power was indirectly associated and interpersonal power in the relationship was directly associated with women’s HIV risk (Rinehart et al., 2018). Rosenthal and Levy (2010) also reviewed extensive international research supporting that the four bases of gendered power identified by Pratto and Walker (2004) play critical roles in women’s (and men’s) HIV risk. Specifically, force (e.g., abuse, violence), resource control (e.g., poverty, education, institutional influence), social obligations (e.g., caretaking responsibilities, commitment to intimate relationships), and consensual ideologies that support gender inequality (e.g., sexual norms and scripts, femininity and masculinity, homophobia, benevolent sexism) have documented associations with women’s HIV risk. Rosenthal and Levy (2010) highlighted that although men tend to have greater power than women, gendered power dynamics also increase men’s HIV risk; further, intersections with other forms of power and inequality, such as race- and class-based, also influence HIV risk (also see Wingood & DiClemente, 2000). The connection between gendered power and HIV risk continues to be replicated. For example, a recent analysis of data from 16,540 women living in Kenya, Malawi, Nepal, and Nigeria found that multiple aspects of women’s autonomy related to lower HIV risk (Mengo, Small, Sharma, & Paula, 2016).

Violence is an important aspect of gendered power that affects health. Globally, women and girls experience many forms of gendered violence that harm their health and well-being, which is identified as a human rights issue (Kusuma & Babu, 2017; Oran, Khalifeh, & Howard, 2017). As examples, intimate partner violence (e.g., Wong & Mellor, 2014), sexual violence (e.g., Dartnall & Jewkes, 2013), and sex trafficking (e.g., Konstantopoulou et al., 2013) endanger women and girls around the world, with a range of direct and indirect adverse consequences, including trauma and mental illness, substance abuse, sexual and reproductive health challenges, injury, and death. Thus, gender-based
power imbalances, including those based in violence, have adverse consequences for the health and well-being of women and girls.

**Intervention Implications**

As the preceding review demonstrates, health psychology should move beyond simply focusing on sex/gender differences in health to understand dynamic ways that various aspects of gender, as a social and cultural construct with corresponding hierarchies and inequities, shape health and well-being. This dynamic understanding of gender as a social determinant of health has implications for multi-level interventions and health care provision.

Interventions targeting women and girls have increasingly incorporated empowerment strategies to improve health and well-being, including addressing gender norms and stereotypes. For example, an intervention for women in the U.S. addressing gender norms and scripts in addition to other HIV risk reduction strategies empowered women’s relationships with men, including improving women’s confidence to discuss condom use with partners (Dworkin, Exner, Melendez, Hoffman, & Ehrhardt, 2006). Another intervention for women in rural South Africa including microfinancing as well as training related to HIV and sexuality, gender norms, and intimate partner violence, decreased intimate partner violence and increased empowerment two years later (Kim et al., 2007). Similarly, a systematic review found that interventions focused on community empowerment to reduce HIV risk among women sex workers in low- and middle-income countries successfully increased condom use and reduced HIV and other STIs (Kerrigan, Fonner, Stromdahl, & Kennedy, 2013). Finally, an intervention including addressing gender-specific barriers and empowering women in the U.S. to exercise increased physical activity longitudinally (Segar, Jayaratne, Hanlon, & Richardson, 2002).

Gender-focused interventions have also targeted men and boys around the world. A review of interventions for men and boys aimed at promoting gender equity, including in health, concluded that “gender-transformative” interventions—aiming to transform gender roles and promote gender equity—were most effective in changing attitudes and behavior (WHO, 2007). Dworkin, Treves-Kagan, and Lippman (2013) also concluded from a review of international research that gender-transformative interventions with men reduce intimate partner violence, improve gender equity-related attitudes, increase condom use, and reduce risk of HIV and other STIs. Masculinity norms are also sometimes used to appeal to men in health interventions, although this strategy has been critiqued for reinforcing gender norms (Fleming, Lee, & Dworkin, 2014).

Reducing gender-based stigma and discrimination is another important avenue for intervention. Consistent with critical, feminist, and intersectional perspectives in psychology, this can include supporting social movements to reduce societal sexism, cisgenderism, and other intersecting forms of oppression, as well as considering activism as an intervention strategy (e.g., see Rosenthal, 2016). For example, feminist identity and beliefs have been associated directly with greater body satisfaction (Borowsky, Eisenberg, Buchianieri, Piran, & Neumark-Sztainer, 2016) and indirectly with greater condom use self-efficacy and sexual satisfaction (Schick, Zucker, & Bay-Cheng, 2008). Similarly, womanism (form of feminism focused on intersection of gender and race for women of color) was found to buffer sexual minority women of color from adverse consequences of sexism for distress (DeBlaere & Bertsch, 2013). Aiming to reduce gender-based stigma and discrimination can also include training health care providers to better understand health consequences of discrimination and reduce the influence of implicit stereotypes and biases on provision of care, drawing on existing research on how to reduce sexism and cisgenderism (e.g., Ansara, 2012; Becker, Zawadzki, & Shields, 2014). Educational settings are also important places for intervention, such as sexual assault prevention programs and policies at colleges and universities (e.g., Vladutiu, Martin, & Macy, 2011). Kosciw et al. (2016) emphasize the need for schools to make changes to support transgender and gender nonconforming youth, including supportive clubs, teacher trainings, inclusive and affirming
curricula, and policies to prevent and address gender expression-based discrimination. These examples demonstrate how dynamic understandings of gender as a social determinant of health can help us to intervene at multiple levels to promote health equity and the well-being of all people.

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