Combining Asset-Based Community Development with Women-Centred Working for Gender-transformative health promotion via the Women's Health Network in Bradford, UK

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Abstract

Women's health and life expectancy are declining in socioeconomically disadvantaged areas of England, yet gender remains marginal in health promotion and asset-based approaches are rarely examined through a gender lens. This study explored how the Women's Health Network (WHN) in Bradford, UK, integrates Asset-Based Community Development (ABCD) with Women-Centred Working (WCW) to advance gender-transformative health promotion. A qualitative design was used. Data were generated through a document review and 12 semi-structured telephone interviews with practitioners, network leaders and women participants conducted in 2020–2021. Analysis combined inductive thematic analysis with deductive application of Pederson et al.'s gender-transformative health promotion framework. Findings show that WHN combines ABCD and WCW to: build on women's strengths; position gender as a social structure rather than an individual attribute; widen health promotion to include poverty, stigma, austerity and other social determinants; and foster cross-sector collaboration between community, voluntary and statutory organisations. This model enabled women to shape service design, challenge gendered health inequalities and develop collective responses to marginalisation. The study also found that underpinning ABCD with WCW helps resist the individualised and neoliberal tendencies often associated with asset-based health promotion by foregrounding structural inequalities, trust, women-only safe spaces

and collective action. The findings suggest that combining ABCD with WCW offers a transferable model for gender-responsive, community-based health promotion in disadvantaged settings. More broadly, the study shows how asset-based approaches can be oriented towards feminist, structurally informed practice.

Keywords: women's health, gender, health promotion, assets-based community development, neoliberalism, cross-sector working

Introduction

Women's health and life expectancy are declining in England's most socioeconomically disadvantaged areas (Marmot, 2020), yet gender remains marginal in health promotion. Asset-Based Community Development (ABCD), an approach that identifies and mobilises the strengths of communities, from public and voluntary resources to local skills and social networks (Public Health England, 2018), has gained renewed attention in the UK as a mechanism for tackling health inequalities (Burkett, 2011; Foot, 2012). Evidence suggests ABCD can benefit people with long-term health conditions in disadvantaged communities (Blickem et al., 2018). However, there is limited understanding of how asset-based approaches function in practice (Cassetti et al., 2020; Harrison et al., 2019) and, in particular, how they might address gendered health inequalities.

Critics argue that ABCD risks neglecting the structural and economic determinants of health (Friedli, 2013), shifting responsibility from the state to communities in ways that reinforce neoliberal agendas (Macleod & Emejulu, 2014; Fraser, 2013). Feminist social work scholarship similarly warns against the co-option of empowerment discourses into models that promote self-responsibilisation while eroding collective

68 care infrastructures (Dominelli, 2002; Abramovitz, 1998). From this perspective,
69 ABCD can obscure the structural inequalities that feminist practice seeks to expose
70 and challenge.

71 To date, few studies have examined ABCD through a gender lens. A systematic
72 scoping review of 28 studies found that gender was absent as a category, and
73 interventions rarely targeted specific populations within communities (Cassetti et al.,
74 2020). This omission is striking given that women in the UK are more likely than men
75 to experience poverty (Women's Budget Group, 2022) and that life expectancy for
76 women in the most deprived areas is falling (Marmot, 2020).

77 This article addresses this gap by examining the Women's Health Network (WHN) in
78 Bradford, UK, a cross-sector initiative in a socioeconomically disadvantaged and
79 ethnically diverse setting. Drawing on 12 semi-structured interviews with
80 practitioners, network leaders, and women participants, analysed using Pederson et
81 al.'s (2014) gender-transformative health promotion framework, this article explores
82 how WHN positions gender as a social structure, addresses social determinants of
83 health, and fosters collective action to challenge inequalities. Analysis makes visible
84 how WHN transcends ABCD's conventional, instrumental use by underpinning and
85 integrating it with Women-Centred Working (WCW). This novel combination
86 overcomes common critiques of ABCD's individualism and its susceptibility to
87 neoliberal co-option. It is argued that WHN offers a feminist reclamation of ABCD,
88 orienting it towards collective practices that foreground structural change and social
89 justice. WHN therefore offers a unique transferable model for women's health
90 promotion in disadvantaged community settings.

To provide the necessary context for the following analysis, this section briefly defines the key terms of sex and gender before elucidating Pederson et al's (2014) gender-transformative health framework and the Women Centred Working approach. Following this, a description of the research context and methods is provided before the presentation of findings organised around the four key features of Pederson et al.'s (2014) framework. Finally, discussion and conclusion contextualise findings within the wider literature and identify transferable lessons for addressing gendered health inequalities in socioeconomically disadvantaged settings.

Sex and gender are fundamental determinants of health that interact with each other and with other social determinants including ethnicity, class, age, and disability (Pederson et al., 2014). As Pederson et al (2014: 143) argue, it is important to recognise that gender 'is not an immutable personal characteristic but rather a complex, multi-faceted social phenomenon'. Sex refers to the biological categories of male and female. Gender is a social structure which produces shared meanings about behaviours, norms, roles, relations and institutions, relative to cultures, times, and places (Connell 1987). The term 'sex-gender' illustrates the interaction between sex and gender in the context of women's health which is both a biological and social phenomenon (Pederson et al., 2014; Travis and Compton, 2001).

Pederson et al (2014) identify a continuum of approaches to gender and health promotion from exploitative approaches that perpetuate gender inequalities, approaches that accommodate gender inequalities by recognising but not addressing them, to gender-transformative health promotion that 'addresses the causes of gender-based health inequalities and works to transform harmful gender roles, norms and relations'. They developed their framework for gender-transformative health promotion over 6 years through iterative literature review,

116 consultation with women and international experts in women's health and case
117 studies.

118 Gender-transformative health promotion for women is 'both an outcome and a
119 process' (Pederson et al., 2014: 144-146) that:

120 1. Works with women employing a strengths-based approach that focuses on
121 'restoring and building health rather than identifying and focusing on
122 women's deficits'
123 2. Recognises and tackles gender as a social structure rather than as an
124 individual attribute
125 3. Widens health promotion from a narrow focus on 'healthy living' to
126 consider structural factors that impact on women's health, including social
127 and economic factors
128 4. Works across sectors to link issues and combine efforts to address them

129 This article argues that WHN achieves gender-transformative health promotion
130 through its unique integration of ABCD and WCW principles.

131 Women Centred Working (WCW) was developed by WomenCentre, a Women's
132 Sector charity organisation in West Yorkshire, England. In 2003, WomenCentre
133 recognised the problem of the revolving door of services where women experiencing
134 complex issues were faced with fragmented services, not receiving the support they
135 needed, resulting in issues often escalating. In response, WomenCentre created one
136 of the first one-stop-shops in the UK for women, held out of centres in three locations
137 across West Yorkshire, where women could access integrated services.

138 Drawing on decades of grassroots working with women, the WCW project (funded by
139 the Lankelly Chase Foundation) aimed to consolidate knowledge about what

140 effective WCW looked like in practice, resulting in tangible outcomes that improved
141 tens of thousands of women's lives (WomenCentre, 2016: 3). WomenCentre (no
142 date: 2) identify the core components of WCW as:

143 1) *Focusing on women's expressed need and lived experience*
144 2) *Underpinned by understanding of women's needs and lives*
145 3) *Informed by an understanding of what works for women*
146 4) *Located within a women-only, safe and enabling environment*
147 5) *Have a holistic approach*
148 6) *Delivered with quality and professionalism*
149 7) *Delivered in a coproduced way*
150 8) *Requiring specific skill sets*
151 9) *Flexible and supportive working environment*
152 10) *Facilitating service integration and pathways*

153 Although initially developed from the perspective of a Women's Centre, WCW was
154 designed to be an approach that can be applied across sectors. It was nationally
155 recognised in the Women's Mental Health Strategy, among other reports
156 (WomenCentre, 2016: 3). Pederson et al.'s (2014) framework aligns with both ABCD
157 and Women Centred Working (WCW), given their shared emphasis on strengths-
158 based approaches, community collaboration, and holistic empowerment of women. It
159 is therefore a suitable analytic lens to apply to WHN in order to identify transferable
160 lessons for cross-sector women's health promotion in disadvantaged communities.

161 This article makes an original contribution to Asset-Based Community Development
162 scholarship by demonstrating how integrating it with gender-transformative health
163 promotion can orient ABCD towards feminist praxis. Doing so addresses the gap in

164 the literature about ABCD and gender. Significantly, WHN's foundations in Women
165 Centred Working disrupt the individualised, neoliberal logic of asset-based health
166 approaches, highlighting structural inequalities and collective solutions. Utilising
167 Pederson et al.'s framework to engage critically with grassroots, practice-led
168 approaches bridges theory and practice in a way that advances both conceptual
169 understanding and applied knowledge. This approach enables the identification of
170 mechanisms through which WHN fosters collective empowerment and structural
171 change, thereby contributing new theoretical and practical insights to both ABCD
172 literature and feminist health promotion practice. While rooted in the specific context
173 of Bradford, the findings offer globally transferable insights for health promotion
174 efforts that aim to address gendered health inequalities.

175 **The research context**

176 Bradford District ranks 21st out of 317 Local Authority Districts in England for
177 deprivation, with a 10-year gap in life expectancy between the least and most
178 deprived areas (NHS Bradford District and Craven CCG, 2021). The Women's
179 Health Network (WHN) was created in 2016 to enhance women's health and well-
180 being. The network is commissioned by the local Clinical Commissioning Groups
181 (CCGs) to deliver a minimum of 6 meetings per year and to improve women's health
182 outcomes. CCGs are responsible for commissioning most local NHS services,
183 determining the required services for diverse populations and ensuring their
184 provision. WHN focuses on seldom heard voices and promotes effective partnership
185 working (WHN, 2016).

186 The average attendance at meetings is 30 with more attending larger events. For
187 example, there were 75 attendees at the 2021 International Women's Day event.

188 The network targets events to different groups with some being oriented towards
189 professionals and others being for members of the public. Attendees tend to include
190 a core group of regulars, as well as guest speakers and less regular attendees.
191 Further information about the Women's Health Network can be found in Craddock
192 (2022).

193 **Methods**

194 **Research Design**

195 This study employed a small-scale qualitative research design informed by the
196 iterative processes of grounded theory, the triangulation of ethnographically informed
197 methods and participatory approaches that work with communities to evaluate the
198 Women's Health Network (WHN) in Bradford, UK.A collaborative approach was
199 adopted, with the researcher working closely alongside WHN organisers to design
200 and implement the research. Such an approach aligns with best practices in
201 participatory research, ensuring that the study remained relevant to WHN
202 stakeholders (Cargo & Mercer, 2008), providing an in-depth understanding of its
203 strengths, limitations, and transferable lessons.

204 **Positionality Statement**

205 At the time of the research, I was a Senior Lecturer in Health Research with a
206 background in sociology, holding a PhD in Sociology and a Master's degree in
207 Research Methods. My expertise in qualitative, feminist, and mixed methods shaped
208 both my interest in the Women's Health Network and my analytic approach. I
209 became interested in the network after hearing a talk by its then Chair, particularly
210 because of its success in engaging women whose experiences are often
211 marginalised within mainstream health services.

My sociological training and feminist commitments meant I was especially attentive to issues of gender, power, inequality, and structural conditions shaping women's health. However, this also created a risk that I might approach the network sympathetically or overemphasise its gender-transformative potential. To address this, I sought to remain open to complexity and contradiction in the data and used advisory group input to challenge and refine my interpretations.

I conducted the research independently, with guidance from an advisory group. My presence in feminist spaces and prior engagement with the network meant I was known to some participants, which likely supported rapport and openness, but may also have shaped what participants chose to share. Although I was known to some participants, I was not closely connected to them personally. As a white disabled woman in my thirties, I also recognise that my standpoint both enabled and constrained what I could see, particularly in relation to experiences shaped by race and other forms of marginalisation. I therefore treat the knowledge produced in this study as situated and partial, and reflexivity as an ongoing part of the research process.

Data Collection

The study was conducted over a 12-month period (2020–2021) and followed a multi-phase process. A comprehensive document review was first undertaken, including WHN reports, meeting minutes, policy documents, and relevant academic literature. This initial review informed the development of two semi-structured interview guides -one for professionals engaged with WHN and another for individuals participating in a non-professional capacity as members of the public. The interview guides were co-developed with input from an advisory board composed of key WHN stakeholders

and researchers, enhancing the validity of the data collection instrument (Patton, 2015). Questions addressed key areas such as the purpose of WHN, pathways to involvement, strengths and limitations of WHN, and its role in community engagement.

Twelve participants were recruited through purposive sampling via WHN. Recruitment was supported by CNet's EPP Lead and the then chair of WHN, who circulated an invitation to participate through the network mailing list. The study was also promoted by the lead researcher at WHN meetings and through Twitter using a poster. Because of my attendance at online monthly meetings over a two-year period, WHN members were already familiar with both me and my research. No participants dropped out.

The sample included participants from a broad range of settings, including voluntary, charitable, community, public and statutory services, and represented organisations of varying scale. For example, one participant was employed by the police, while another volunteered as the organiser of a small local exercise group for older women. The sample also reflected diversity in relation to ethnicity, disability and age.

As Bahraminejad et al. (2014) note, professional partners' experiences of participation are likely to differ according to their position within an organisation. To capture this variation, participants were recruited from across different levels of WHN's structure and membership. In keeping with the composition of WHN overall, only three participants were involved in an individual rather than professional capacity. Sample size was deemed appropriate for a small-scale qualitative study using thematic analysis (Ahmed, 2024) with data saturation achieved through iterative sampling and coding, and no new codes emerging after interview 9.

260 Due to COVID-19 restrictions, interviews were conducted via telephone by the
261 author. Each interview lasted approximately 30–60 minutes and was audio-recorded
262 with participant consent. Verbatim transcription was carried out to ensure accuracy in
263 data representation (Braun & Clarke, 2006). Audio files were permanently deleted
264 after transcription, transcripts were anonymised unless consent had been given
265 otherwise, and securely kept in an encrypted OneDrive folder. In recognition of the
266 time participants gave for participation and reflecting a feminist ethical approach to
267 research, , participants received a £20 shopping voucher; WHN organisers donated
268 their vouchers to charity.

269 **Data Analysis**

270 Data analysis was iterative, inductive and deductive. Nvivo was used to manage the
271 data. Inductive thematic analysis was employed to systematically identify, code, and
272 categorise key themes emerging from the data (Braun & Clarke, 2006). The
273 researcher engaged in an iterative process of coding, continually refining themes to
274 ensure coherence and depth. Reflexivity was integrated into the analytic process,
275 with findings regularly discussed with the project advisory board to minimise
276 researcher bias and enhance analytical rigor (Berger, 2015). For example, the
277 importance of women-only spaces became a prominent topic that was emphasised
278 by WHN members of the advisory board. Key themes were devised with the advisory
279 board, as reported in Craddock (2022). Transcripts were also shared with
280 participants for member-checking prior to analysis. This reflexive approach aligns
281 with qualitative best practices, ensuring that the findings are both trustworthy and
282 contextually grounded (Nowell et al., 2017).

283 Secondly, a deductive stage of analysis was undertaken by the lead researcher
284 using Pederson et al.'s (2014) framework for gender-transformative health promotion
285 as an explicit analytic lens. Conducted after the initial inductive thematic analysis,
286 this involved revisiting the developed themes, subthemes, and associated interview
287 extracts and systematically comparing them with the core concepts of the
288 framework. Initial inductive coding had generated themes relating to women's
289 healthcare needs, the nature and strengths of WHN, barriers, sustainability, and
290 areas for improvement. Rather than replacing this thematic structure, the deductive
291 stage reinterpreted these findings through four framework-informed dimensions:
292 strengths-based practice, gender as a structural determinant of health, attention to
293 gendered structural inequalities beyond individual behaviour, and holistic cross-
294 sector working. Some inductive themes mapped onto more than one deductive
295 category, reflecting overlap between these dimensions in practice. This article
296 focuses on findings from this deductive stage of analysis; see Craddock (2022) for
297 discussion of the wider inductive findings.

298 **Ethical Considerations**

299 Ethical approval was obtained from Birmingham City University in February 2020
300 (Craddock /6134 /Fu /2020 /Feb /HELS FAE) with consent to publish from
301 participants. All participants were given an information sheet and gave fully informed
302 written and verbal consent. Unless consent was explicitly given, data has been
303 anonymised. Therefore, some quotations are attributed to speakers while others are
304 not to protect participants' anonymity. In line with a feminist research ethic that
305 centres women's voices, in-depth quotations are provided.

306 **Findings**

307 The following draws on data from semi-structured interviews with members of WHN
308 to demonstrate how WHN advances gender-transformative health promotion for
309 women by:

310 1) Employing a strengths-based model
311 2) Recognising and tackling gender as a social structure rather than as an
312 individual attribute
313 3) Widening health promotion to consider structural factors that impact women's
314 health
315 4) Working across sectors to link issues and combine efforts to address them

316 Rather than simply reporting participants' views, the analysis interprets how the
317 integration of Asset-Based Community Development (ABCD) with Women-Centred
318 Working (WCW) operates to address structural determinants of health and build
319 collective solidarity, thereby resisting neoliberal individualism.

320 **Employing a Strengths-Based Model to Promote Women's Health: Combining**
321 **ABCD and WCW**

322 Both ABCD and WCW invoke a strengths-based approach that involves working with
323 women in local communities to promote health, as an organiser of WHN explains:

324 *Community development at essence is starting where people are at; and*
325 *where people are at and their agendas are sometimes very different to*
326 *systems and organisations and structures. So, for me if it's really asset-*
327 *based community development then it starts from within communities, it's*
328 *that groundswell at grass roots level*

There is recognition that the motivations of organisations and service-users are often not aligned and can even be contradictory. This is especially the case within a context where public services are constrained by austerity measures and dominated by economic rationales that risk dehumanising service-users and neglecting their holistic needs.

The interviewee also positions authentic asset-based approaches as organically emerging with “that groundswell at grass roots level”. This disassociates the network from traditional hierarchal forms of organisations and presents WHN as something new and different that is rooted in local communities, rather than imposed upon them. Despite being funded by the local CCGs and comprising a range of organisations and individual members, such positioning reflects activist and social movement framings of people-led resistance (Craddock, 2020). It also obscures the amount of work that goes into creating and sustaining such networks. Given the network is organised by women, it poses questions about the invisible gendered labour involved here. To address this and prevent entrenching further gendered inequalities, WHN ensures that administrative support is paid for, providing two part time paid roles for organisers of the network.

WHN’s positioning perhaps reflects an unconscious strategy to present a welcoming setting to women who have had negative interactions with services and authorities and who are therefore, understandably, mistrustful of such initiatives. While one organiser explicitly recognised and challenged barriers that women experienced to accessing services, for others, this was not explicitly expressed but appeared to underpin WHN’s practices, as a result of the empathy of the WHN leaders towards the marginalised women they work with. This reflects the Women Centred Working

353 principle of centring and understanding the actual needs of women and is made
354 possible by having leaders with lived experiences who are embedded within the
355 communities that they work with.

356 There is a conscious effort to deconstruct hierarchical power imbalances by
357 positioning marginalised women as 'an equal partner' to professionals, who bring
358 knowledge and skills to the network:

> 359 *We're looking at asset-based approaches…understanding people's*
> 360 *outcomes and not the services […] And the value and the capacity, and*
> 361 *the skill and knowledge that is in the community and developing that. And*
> 362 *not in a way that highlights the marginalisation, but in a way that it's an*
> 363 *equal partner[ship].* (WHN organiser)

364 Both quotations shift the focus away from services and towards individual women
365 and their communities, invoking a person-centred approach that recognises women's
366 autonomy and strengths. Notably, this approach seeks to avoid "tokenism" or
367 defining women in terms of their marginalisation, demonstrating a sensitivity to the
368 lived and felt experiences of these women, in alignment with WCW principles. This
369 also reinforces the importance of inclusive and representative leadership, with the
370 founders and chairs of WHN being women with lived experiences of socioeconomic
371 disadvantage and ethnic minoritisation. Intersectional advocacy requires leadership
372 that represents the perspective of those who are multiply marginalised (Brower,
373 2024; Christoffersen, 2024; Craddock et. al., 2024).

374 WCW is positioned as the foundation for ABCD which is described by WHN's
375 previous Chair as '*a kind of follow on from Women Centred Working'*. WHN's co-
376 chair reinforces that WCW is the cornerstone upon which ABCD builds:

377 *So the ethos for me, is kind of firstly about being women led, and being a*
378 *safe space for women essentially. And having that kind of approach,*
379 *that…we want to look at involving communities in their care and having a*
380 *bit more of a dialogue and a bottom-up approach, as opposed to that top*
381 *down approach, that generally happens.*

382 WHN applies WCW's principle of being led by women, for women (WomenCentre,
383 2016). Again, we see emphasis placed on a bottom-up, grassroots approach with
384 women positioned as equal partners to professionals, entering a two-sided dialogue
385 with women as co-producers rather than just service-users. Underpinning ABCD with
386 WCW thus enables WHN to achieve the first feature of Pederson et al.'s (2014)
387 framework for gender-transformative health promotion for women - working with
388 women using a strengths-based approach rather than focussing on women's deficits.

389 As the quotations above are from the perspectives of WHN's organisers, it could be
390 assumed that they are more likely to reflect the ideal of what WHN aims for rather
391 than the reality of what happens from the perspective of local women. However, data
392 from individual members reveals that this ethos is enacted, providing women with "*a*
393 *real sense of ownership when they are listened to*". An individual member of WHN
394 explains how the network works across sectors and with women as co-producers of
395 services:

396 *Domestic abuse services were being recommissioned a couple of years*
397 *ago. They used the Women's Health Network as a big part of the*
398 *consultation process. It was being co-commissioned by NHS and Bradford*
399 *Council. So we were part of the consultation. But then we did another*
400 *workshop around service design, so that all women involved could have*

401 *that voice in what the services should look like, how accessible they were,*
402 *where they should be. It gives women a real sense of ownership when*
403 *they are listened to.*

404 Emphasis is again placed on the agency of women in contrast to the disempowerment
405 that labels such as 'marginalised' can often bring (Craddock, 2022). Working across
406 sectors enables this holistic approach to women's health promotion, informed by a
407 focus on women as active, valued, co-producers of services rather than passive
408 service users, embodying principles of ABCD and WCW.

409 **Recognising and Tackling Gender as a Social Structure Rather Than as an**
410 **Individual Attribute**

411 Combining ABCD with WCW results in foregrounding gender as a social structure,
412 rather than as an individual attribute. Pederson et al. (2014: 143) assert that gender-
413 transformative health promotion must work 'to transform harmful gender roles, norms
414 and relations'. WHN attempts to do so by moving women's health topics from the
415 private sphere to the public sphere, bringing to light and challenging gendered
416 oppression. This is achieved by participatory workshops about gendered stereotypes
417 and their impacts alongside awareness raising, for example, via public menopause
418 cafes which create safe women-only spaces for open discussion. This echoes
419 feminist consciousness-raising and provides peer support, another key principle of
420 WCW (WomenCentre, no date). WHN's co-chair states:

421 *We've brought forward issues like menopause […] We've brought forward*
422 *things around, you know, just women feeling shame, or things like*
423 *stereotypes and conversations. So because we've brought all of that*
424 *forward and acted, you know, tried to do something about it*.

425 As a result of participating in WHN, individual members demonstrate an increased
426 understanding of the implicit gendered norms that inform medicine, which result in
427 women's bodies and issues being misunderstood or dismissed. An individual
428 member explains:

429 *There's still very little menopause awareness training for GPs. Women are*
430 *either being fobbed off, told 'it's your time of life, you should expect it, go*
431 *away'. Or they've been given antidepressants, they're told 'it's just anxiety,*
432 *you're being overanxious'. The GPs are not aware of the range of*
433 *symptoms, the sort of ways they can present and they're still relying on*
434 *just anything to get that patient out of the waiting room.*

435 This also reflects the socioeconomic pressures public services face in the context of
436 continued austerity measures and worsening health, where quick turnaround of
437 patients is valued over genuine person-centred care. Gendered stereotypes about
438 women are demonstrated with the notion that women are more likely to complain,
439 less likely to experience serious health problems, and that complaints can be
440 attributed to anxiety. Women's concerns about their health are often dismissed,
441 illuminating medical gaslighting and misogyny (Ng et al., 2024; Chan et al., 2023).

442 Rather than internalise this dismissal as being the individual woman's fault,
443 participating in WHN enables members to connect such issues to wider structural
444 problems such as medicine's neglect of women's health:

445 *women's health, women's bodies, I feel, as though …there isn't much*
446 *light on them, there's not much information around them, there's not*
447 *much knowledge around them. And there isn't, for me, as much*
448 *research and investigation into that. If you look at, in terms of things like*

449 *medication, trials, just from my knowledge, and please correct me if I'm*
450 *wrong, but a lot of them are kind of, they're created by middle aged white*
451 *men, or tested upon middle aged white men. And I don't feel that*
452 *women's health kind of thing, has come that far. So if you look at some*
453 *of the things like menopause, things like painful periods, endometriosis,*
454 *all of these things, there's very much…there's not much light on them, I*
455 *find. There's not much knowledge around them, and that stigma that's*
456 *attached to that, I think that's a massive thing.*

457 Indeed, the National Institute for Care Excellence (NICE, 2017) has only recently
458 produced guidance on managing endometriosis, a condition that affects 1 in 10
459 women and takes almost a decade to diagnose. Their core recommendation is to
460 listen to women, suggesting that the act of listening to women has not been common
461 practice within healthcare. The need to inscribe this within clinical guidelines
462 highlights the gendered inequalities women face in accessing appropriate healthcare
463 and the continued persistence of damaging gendered norms and oppression.

464 Notably, this participant is hesitant to make knowledge claims, qualifying statements
465 with 'I feel', 'just from my knowledge', 'please correct me if I'm wrong' to minimise
466 their claim to legitimacy or universality. This could reflect the inevitable power
467 imbalance between researcher and participant, where the participant might be
468 careful not to overstep into the researcher's perceived area of expertise. However,
469 given that I had attended many meetings of WHN and was familiar with most
470 participants, it is perhaps more likely to be symptomatic of gendered ways of
471 speaking, where women have been socialised to use more tentative speech forms
472 than men (Lakoff, 1973). Despite challenging gendered oppression in the content of
473 her speech, the form of this participant's speech reveals the insidious nature of such

474 gendered norms. This further emphasises the value and need for WHN's work
475 challenging gendered norms.

476 Moreover, this participant highlights how ethnicity and class intersect with gender to
477 produce oppression, with medical knowledge being based not only on men, but on a
478 small section of privileged white men who produce universalised knowledge and
479 'truths' based on their own, limited experiences. The participant identifies a further
480 consequence of the omission of women's bodies from medical knowledge – there is
481 stigma relating to women's health problems. Stigma was famously defined by
482 Goffman (1963: 3) as an 'attribute that is deeply discrediting'. We have seen how
483 women's health problems are often discredited by medical professionals and that
484 this is a gendered phenomenon.

485 Findings suggest that WHN not only builds on women's existing strengths but also
486 fosters critical consciousness regarding gendered oppression. This aligns with
487 Freire's (1970) concept of critical pedagogy that informed feminist consciousness
488 raising wherein marginalised groups (here, women) develop agency through
489 collective reflection and action. WHN's strengths-based approach, is enhanced by
490 the creation of women-only safe spaces for open dialogue. Participating in WHN
491 raises women's awareness of underlying gendered norms that negatively impact on
492 women's health, such as those related to women and mental health, women's
493 bodies, and the medical profession. This enables participants to collectively confront
494 gendered stigma and recognise the structural roots of inequality, achieving the
495 second element of Pederson et al.'s (2014) framework.

496 **A Holistic Approach: Widening Health Promotion to Consider Structural**
497 **Factors that Impact Women's Health**

498 WHN encourages a broadening of health promotion from narrow understandings of
499 'healthy lives', which place the responsibility on the individual and mask structural
500 inequalities, towards a holistic appreciation of the multiple structural disadvantages
501 that impact negatively on women's health. As shown in the previous section, there is
502 recognition of how axes of ethnicity, poverty, and gender intersect to compound
503 health inequalities. WHN's previous Chair explains:

504 *Our focus, as an organisation, is around tackling inequality and I think the*
505 *communities that we're most interested in hearing from and connecting*
506 *with and understanding are those who suffer the worst health inequality.*
507 *So, that generally means we're talking about poverty, so we're talking*
508 *about women in the most deprived wards of our district. We're talking*
509 *about women from minority ethnic communities who are often living in*
510 *difficult situations and in poverty. We're talking about women who might*
511 *be survivors of domestic abuse or sexual violence. So, we're talking about*
512 *women who, for a whole spectrum of reasons, are, because of their life*
513 *experiences and life situations, experiencing barriers to good health.*

514 In recognition of the structural factors that negatively impact women's health, WHN
515 vocally resists austerity policies that result in the cutting of funds for public services,
516 reaffirming the necessity of public services for community health promotion.
517 Interactions in the community enabled by physical settings create opportunities to
518 connect services, reinforcing a holistic approach to health:

Community centres are often one of the first places women will go because they already attend a coffee morning or they take their kids to youth group there, they've already got that trusted relationship with staff there. And they will talk about their problems and then accept that support, oh, you need to see your GP about that, you need to do this. So there needs to be much better investment in the voluntary community centres because it can have a massive impact on health.

WHN builds on gendered critiques of austerity that reveal the disproportionate impact of public spending cuts on women (Craddock, 2020) and seeks to challenge this by strengthening public services as a core element of healthy communities. WHN, therefore, widens understandings of health to consider structural issues that impact negatively on women's health such as austerity policies, poverty, and intersecting axes of oppression. Moreover, they work across sectors to address these issues.

Working Across Sectors to Link Issues and Combine Efforts to Address Them

Gender-transformative health promotion requires cross-sectoral working to address the complexity of issues women face (Pederson et al., 2014). WHN's membership includes public services, statutory services, and charity organisations, alongside individual women. Several participants suggest that WHN breaks down barriers between the statutory and voluntary sector (Craddock, 2022). ABCD involves mapping assets in local communities, reaching out to and connecting them. This quotation from an individual member explains part of this process and highlights the value of contacting a diverse range of groups:

543 *So, I think what they did was contact, perhaps use a directory, contact lots*
544 *of different organisations, asking them to take part, and of course, it was*
545 *great to include social landlords, charities, health providers, all that,*
546 *community centres.*

547 Here we see the application of both cross-sectoral working and WCW's principle of
548 having a holistic approach to women's health.

549 A CCG commissioner who was involved in funding WHN, explains the vital role that
550 WHN plays in bringing together groups that would otherwise go unheard, with WHN
551 acting as a facilitator of conversations between grassroots groups and NHS
552 organisations.

553 *So, if I think of some of the really small organisations that get involved in*
554 *Women's Health Network, that probably weren't round the table three*
555 *years ago; if I'd have tried to engage with those groups of people and*
556 *those community workers or volunteers three years ago and I'd have*
557 *turned up and said, 'I'm the head of engagement for the CCG and I want*
558 *to know what you think about X, Y and Z', they wouldn't have known who I*
559 *was and they wouldn't have trusted me […]*

560 *But because those groups are involved in the Women's Health Network,*
561 *they…we have a relationship and we can work through the Women's*
562 *Health Network, to say to them, 'we are the CCG and this is what we do*
563 *and this is what we need to know about and what can you tell us?' And it*
564 *facilitates the conversations.*

565 Representation of smaller community groups who have experience of women's
566 everyday lives provides a valuable vantage point for the strategic level and ensures

567 that decision-makers take account of the needs and experiences of women and their
568 communities (WomenCentre, no date; 2016). These community outcomes link into
569 organisational outcomes; the duplication of services is minimised which saves
570 money, leading to change at an institutional level (WomenCentre, 2016). This can
571 help to tackle the issue of women facing multiple disadvantages having to navigate
572 complex systems of siloed separate services, by instead adopting an intersectional
573 approach that widens access to services for women and streamlines service
574 delivery. Framing this work in the neoliberal language of cost-saving and efficiency
575 ensures that WHN receives the funds required to do such work, which allows
576 organisers to tackle structural inequalities in the hostile environment of continued
577 austerity.

578 Discussion: Lessons for Gender-Transformative, Community-Based Health 579 Promotion

580 This article demonstrates how underpinning Asset-Based Community Development
581 (ABCD) with Women Centred Working (WCW) produces gender-transformative
582 health promotion. Rather than focusing on individual responsibility, WHN redirects
583 attention to structural inequalities and collective solutions. It therefore challenges the
584 neoliberal, individualised framing often associated with asset-based approaches by
585 grounding its work in women-centred principles. The model offers a participatory,
586 cross-sector approach that centres women's lived experiences, knowledge and
587 needs in socioeconomically disadvantaged settings. In doing so, it addresses the
588 structural roots of women's marginalisation while elevating relational, collective and
589 contextually situated responses (Dominelli, 2002).

590 Although asset-based approaches have gained traction in community health, there
591 remains limited understanding of how they function in practice, especially in relation
592 to gender (Cassetti et al., 2020). Responding to this gap, this article uses Pederson
593 et al.'s (2014) gender-transformative health promotion framework as an explicit lens
594 for analysis, answering Fisher and Makleff's (2022) call for examples of its practical
595 application. Building on feminist scholarship that conceptualises gender as a
596 structural force shaping health outcomes (Connell, 2012; Hankivsky, 2012), it
597 highlights how WHN embodies the four key features of Pederson et al.'s (2014)
598 gender-transformative health promotion framework. WHN adopts a strengths-based
599 approach (1); challenges gender as a structural determinant of health (2); shifts
600 focus beyond individual behaviour to gendered structural inequalities (3); and works
601 holistically across sectors (4). These elements reflect the complex, intersectional
602 realities of women's lives and demonstrate the framework's real-world utility.

603 **Recognising and Challenging Gender as a Social Structure in Health**
604 **Promotion**

605 WHN's work aligns with feminist critiques of individualised health interventions by
606 emphasising power, agency, and social structures (Sen & Östlin, 2008). Creating a
607 safe women-only space is central to fostering openness and relationality. This is
608 because many women have experienced gender-based violence. Worldwide, more
609 than one in four women experience domestic abuse before fifty (Sardinha et al.,
610 2022). Therefore, service providers need to have a specific skill set that incorporates
611 awareness of the prevalence of gender-based domestic violence and its impacts.
612 This requires sensitivity, empathy, and working with women from a trauma-informed
613 position (WomenCentre, 2016; Pederson et al., 2014). WHN's work on domestic
614 abuse services, co-designed with women and service providers, exemplifies this

615 approach. It shows how trauma-informed, cross-sector collaboration can respond to
616 women's holistic needs and foster sustainable trust. By challenging harmful gender
617 norms and enabling women to shape services, WHN addresses the structural drivers
618 of poor health while strengthening community agency.

619 Trust-building is central to this process, it is the 'vital ingredient'. In the context of
620 peer support for women who experience multiple disadvantages, Gilbert (2025: 11)
621 suggests that trust building invokes a feminist ethics of care that 'necessitates that
622 relationships within these women's spaces are encompassing mutual respect,
623 empathy and compassion'. Trust is cultivated not only through empathy and safety
624 but also through women's visible impact on service design, reinforcing their agency
625 and contribution (WomenCentre, 2016; Gilbert, 2025; Harrison et al., 2019).

626 **Feminist Reframing of ABCD: The Role of Women-Centred Working**

627 This article advances scholarship on ABCD by illustrating how it can promote
628 gender-transformative health when paired with a WCW approach. While ABCD has
629 been critiqued for insufficiently addressing structural inequalities (Friedli, 2013;
630 Macleod and Emejulu, 2014), WCW provides a necessary feminist lens, ensuring
631 that gender is considered as a social structure. This integration challenges traditional
632 deficit-based approaches that overlook the role of gender and social determinants in
633 shaping health disparities (Morgan et al., 2016). Instead, WHN's intersectional
634 approach takes account of how gender, ethnic minoritisation, and poverty interact to
635 negatively impact on women's health outcomes.

636 Crucially, WHN foregrounds the role of well-funded, accessible community
637 infrastructure in promoting women's health. This underscores the need for ABCD to
638 engage politically, not just practically. The WHN model thus offers critical insight for

women's health promotion in austerity contexts, showing how grassroots, cross-sector organising can foster collective care and resistance. Therefore, as Burkett (2011b: 573) asserts, 'we should not overlook [ABCD's] radical possibilities' as responses to neoliberal times. Similarly, Roy (2017: 455) draws on community development practitioner discourse to contend that:

Rather than unwitting tools of neoliberalism, they considered their work to be about mitigating the worst effects of poverty and social vulnerability in ways that enhance collectivism and solidarity, concepts that neoliberalism arguably seeks to disrupt.

It appears that the discourse of neoliberal capitalism can be used as a trojan horse that ushers in solidarity and collectivism. WHN's experienced organisers are fluent in the language of neoliberal capitalism and utilise it in how they describe their strategic priorities for funding applications and evaluations. They have learnt the rules of this specific game, or field (Bourdieu, 1986), and can play it successfully, while maintaining collectivist values. This knowledge becomes a form of embodied cultural capital. Other groups wishing to utilise similar strategies should work closely with individuals and organisations who have such capital and can support others to learn the rules of and strategically navigate this game. What is distinct in the case of WHN, is how it brings to the fore structural issues of gendered health inequalities by underpinning ABCD with WCW. This is particularly important in the context of women's worsening health outcomes and life expectancy in socioeconomically deprived areas.

Implications for Policy and Practice

662 Policy frameworks must move beyond individualist, biomedical and deficit-focused
663 models. WHN demonstrates that addressing gendered health disparities requires
664 long-term investment in participatory, community-led models that foreground
665 structural inequality (Cornish et al., 2014; Mathie and Cunningham, 2003).
666 Embedding ABCD and WCW principles in public health policy could offer more
667 inclusive, sustainable responses to women's health needs, especially in deprived
668 settings. To succeed, such initiatives must be trusted, long-term, and genuinely co-
669 produced rather than tokenistic. They should be underpinned an understanding of
670 the priorities identified by service-users and engage in a continual dialogue with
671 them rather than one-off consultations. Having organisers with both lived experience
672 and cultural capital who are embedded within local communities is one strategy to
673 achieve this.

674 **Limitations and Future Research**

675 This article presents findings from a single UK case study. Future research should
676 examine how ABCD and WCW operate in diverse settings and explore their long-
677 term effects. Comparative studies across socio-cultural contexts would enhance
678 understanding of the model's transferability and impact.

679 **Conclusion**

680 Gender-transformative health promotion is urgently needed in light of ongoing
681 gendered health inequalities and declining life expectancy for women in the most
682 deprived areas of the UK. This article contributes original insight by demonstrating
683 how ABCD, when underpinned by WCW, can offer a feminist, community-driven
684 model that addresses systemic inequalities.

685 By shifting the focus from individual responsibility to collective action and structural
686 determinants, WHN challenges the dominant neoliberal orientation of asset-based
687 health initiatives. The findings show how health interventions can be both embedded
688 in and resistant to neoliberal systems, creating space for more relational,
689 participatory, and just forms of care.

690 This study contributes to feminist health and social work scholarship by providing a
691 concrete example of gender-transformative health promotion in practice. WHN's
692 model offers a replicable framework for practitioners, researchers, and policymakers
693 seeking to address women's health inequalities in disadvantaged contexts,
694 demonstrating that sustainable transformation is possible when communities are
695 empowered to lead the way.

696 **Declarations**

697 **Ethical approval**

698 Ethical approval was obtained from Birmingham City University in February 2020
699 (Craddock /6134 /Fu /2020 /Feb /HELS FAE)

700 Consent to participate

701 All participants were given an information sheet and gave fully informed written and
702 verbal consent.

703 Consent to publish

704 All **participants gave consent to publish.**

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707 **Declaration of Interest:**

708 The author reports there are no competing interests to declare.

709 **Data Availability Statement**

710 The data that support the findings of this study are available from the author upon
711 reasonable request.

712 **Clinical trial number: not applicable**

713 **References**

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