# Gender Equality and Gender Norms: Framing the Opportunities for Health

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**Abstract**

The Sustainable Development Goals offer the global health community a strategic opportunity to promote human rights, advance gender equality, and achieve health for all. The inability of the health sector to accelerate progress on a range of health outcomes brings into sharp focus the significant impact of gender inequalities and restrictive gender norms on health risks and behaviours. In this paper we draw on evidence from the Series on Gender Equality, Norms and Health to dispel three myths on gender and health and describe persistent barriers to progress. We propose an agenda for action to reduce gender inequality and shift gender norms for improved health outcomes, calling on leaders in national governments, global health institutions, civil society organisations, academia, and the corporate sector to 1) focus on health outcomes and engage actors across sectors to achieve them; 2) reform the workplace and workforce to be more gender equitable; 3) fill gaps in data and eliminate gender bias in research; 4) fund civil society actors and social movements; and 5) strengthen accountability mechanisms.

**Key Messages of the Series**

- Gender norms and inequalities affect health outcomes for girls and women, boys and men, and gender minorities.
    - Gender norms and gender-related inequalities are powerful determinants of health and well-being, distinct from those caused by biological differences based on sex.
    - Due to the historical legacy of gender-based injustice, the health consequences of gender inequality fall most heavily on women, especially poor women; but restrictive gender norms undermine the health and well-being of women *and* men, *and* gender minorities.
- Gender bias and inequalities are deeply embedded in research and in the health sector.
    - Health research is biased and even discriminatory in how studies and instruments are designed and data are collected, limiting analysis and use, and perpetuating gender inequalities.
    - Health systems reflect and reinforce gender inequalities and restrictive gender norms in health care delivery and the division of labour in the health workforce, compromising the health and well-being of patients, providers, and communities.
- Research, health systems, policies, and programmes can reduce gender inequalities and shift gender norms and improve health.
    - Despite challenges, the impacts of gender norms can be evaluated by applying innovative research methods to existing survey data, thereby illustrating sex differences and gender inequalities in health, and informing policy and programme planning.
    - Gender bias in health systems can be disrupted by reducing gender inequality in the health care workforce, valuing community care providers, and mobilising civil society to hold systems accountable to the communities they serve.
    - Programmes can change gender norms and improve health outcomes by engaging multiple stakeholders from different sectors, including a diverse set of activities that reinforce each other, and fostering the active participation of affected community members.

- Laws and social and economic policies, such as tuition free education and paid parental leave, can change gender norms and improve health outcomes by markedly increasing gender equality in key domains, including education, work, and family.

- The time to act is now.
  - Despite challenges, the compelling evidence linking gender inequalities and restrictive gender norms to poor health, combined with energised and expanding social movements for gender equality, and the pressure to meet the SDGs by 2030 provides leverage for political will to promote equality and shift gender norms, not only to achieve health outcomes, but also protect human rights of all.
  - An agenda for action to promote gender equality and shift gender norms for improved health outcomes requires 1) a focus on health outcomes and engagement of actors across sectors to achieve them; 2) reforming the workplace and workforce to be more gender equitable; 3) filling gaps in data and eliminating gender bias in research; 4) funding civil society actors and social movements; and 5) strengthening accountability mechanisms.

## Introduction

We live in a complex world. The progressive agenda that demands gender equality for girls and women and gender norms that promote health and well-being for all, including gender minorities, is highly visible today. Grassroots movements, fuelled and democratised by social media, have heightened the prominence of these issues globally. Examples include ending sexual harassment in the workplace (#MeToo, #TimesUp); shining a spotlight on violence against women (#Nirbhaya in India and #NiUnaMenos in South America) and gender-related pay gaps (#EqualPay); advocating against toxic masculinities that underlie male violence (@MenEngage); and promoting lesbian, gay, bisexual, and transgender (LGBT) justice (#hrc, #WhereLoveIsIllegal).[1—8]

Simultaneously, a backlash is growing against the progressive agenda. Conservative voices continue to use arguments, often couched in cultural, economic, or religious terms, to justify discrimination against women and gender minorities, while upholding the traditional foundations of male privilege.[9,10] Co-opting the term "gender," powerful forces are pushing against hard-fought gains in human rights and health by rallying against the so-called threat of "gender ideology," a term created to indict a range of progressive views, such as LGBT rights, access to comprehensive sexuality education, and accommodation of diverse family forms.[9,11—15]

In the struggle for gender equality, this tension between progressive and conservative forces, with a two-step forward, one-step back pattern, is well known. Gains made by women's movements in the 1970s – resulting in the establishment of the United Nations (U.N.) Decade for Women (1975-85) and policy commitments made in U.N. Conferences in the 1990s – have been contested repeatedly.[16] Yet, some progress has been achieved. The World Conference on Human Rights in 1993 defined violence against women as a human rights and public health issue.[17] The 1994 International Conference on Population and Development emphasised women's empowerment and reproductive rights.[18] The 1995 Fourth World Conference on Women achieved global endorsement of a Platform

for Action embracing women's rights in education, health, the economy, political participation, and beyond.[19] These conferences underscored the systemic gender inequality that undermines the health of girls and women.[20]

In 2005, the World Health Organisation (WHO) Commission on the Social Determinants of Health (CSDH) gave further impetus to the significant role that gender, among other social determinants, plays in determining health risks.[21] It reinforced the concept of intersectionality[22] – gender intersects with other social markers of power, such as race, age, and income, to create clustered disadvantage that gives rise to power dynamics and hierarchies *among* boys/men and girls/women, not just between them. The CSDH's Women and Gender Equity Knowledge Network (WGEKN) background paper recognised that restrictive gender norms uphold the hierarchical system in which dominant forms of masculinity are favoured over dominant forms of femininity.[23] As described in Heise and Greene et al. in this Series, this creates a "gender system"[24] that not only undermines the health and human rights of girls/women and gender minorities, but also promotes marginalisation of and discrimination against all those who transgress restrictive gender norms, including boys/men.[24—27]

Additionally, research and advocacy on AIDS highlighted the role that rigid notions of masculinity have on boys'/men's behaviours, including taking sexual risks, which contribute to HIV incidence.[28] Increased research on men and masculinities,[29] coupled with a long-standing LGBT rights movement[30] and new movements of men for gender equality[31—33] has drawn attention to the ways in which dominant constructions of masculinity and femininity can be damaging to the health of boys/men and gender minorities, just as they are to girls/women.

The inability of the health sector to make significant progress on some key health challenges – such as persistently high maternal mortality in the poorest communities,[34] the alarming incidence of HIV among adolescent girls in southern Africa,[35] higher rates of vehicular accidents among young men

than women,[36] and the disproportionately high suicide rates among LGBT persons[37] – brings into sharp focus the significant role that gender norms have on health behaviours, exposure, and vulnerability. Meeting Goal 3 of the Sustainable Development Goals (SDGs)[38] (ensure health and well-being for all) mandates that the health sector address gender inequalities and restrictive gender norms,[39,40] which also has the potential to leverage progress on multiple SDGs,[41] including SDG 5 (achieve gender equality and empower all women and girls) and vice versa.[39]

In this final paper of the Series on Gender Equality, Norms and Health, we build on evidence from the Series to dispel three myths on gender and health and describe persistent barriers to progress. We conclude with an agenda for action to reduce gender inequality and shift gender norms for improved health outcomes.

## Dispelling myths on gender and health

Drawing from new analyses in this Series, we provide evidence to dispel myths[42] that stymie efforts to address gender inequalities and restrictive gender norms in health.

**Myth I:** Gender norms do not affect health outcomes.

**Reality:** Restrictive gender norms affect the health of girls/women, boys/men, and gender minorities through multiple pathways.[24—27] For instance, using data from a nationally representative sample of adolescents aged 11-18 from U.S. schools, Weber et al., in this Series, found that students furthest from the median of a gender-normative measure for their same-sex school peers are at substantially increased risk for several health-related adverse outcomes.[25] Boys and men adhering to norms that enforce conventional masculine ideals are more likely to use various harmful substances, including tobacco and, consequently, have higher morbidity and mortality rates than women.[43] On the other hand, some dimensions of dominant masculinity and femininity can be protective of health.[24] For example, adherence to certain notions of acceptable feminine behaviour, in some contexts, is protective against harmful substance use.[44]

**Myth II:** Gender norms are entrenched and cannot be changed.

**Reality:** While gender norms can be so pervasive that individuals may feel they are 'ordained,' norms are continuously negotiated, resisted, and redefined in everyday interactions.[24] Heymann et al., in this Series, demonstrate that gender norms can be changed to improve health. For example, in countries with policies such as tuition-free education in primary school or ten-week paid maternity/parental leave, the odds that women had sole or joint decision-making power in the household increased and improved women's and children's health, relative to countries without these policies.[26] Programmes have also been shown to change gender norms and improve health outcomes when they engage multiple stakeholders from different sectors. For example, SASA!, a community-based program in Uganda, worked with traditional marriage counselors and religious leaders from the community, as well as healthcare providers, and police officers from government to increase women's ability to refuse sex and reduced intimate partner violence. Effective programmes also include a diverse set of activities that reinforce each other and foster active participation by affected community members. For instance, an HIV-prevention program in Nicaragua improved gender-equitable attitudes by combining soap operas and peer education and Program H, in Brazil, increased support for equitable gender norms by encouraging young men to serve as active agents of change in their communities.[26]

**Myth III:** Gender norms are elusive and cannot be measured.

**Reality:** While a rich body of qualitative evidence on gender norms exists,[45,46] very few quantitative analyses of the impact of gender norms on health outcomes are available because direct measures of gender norms are absent in standard survey data.[25] However, Weber et al. and Heymann et al. demonstrate that the impact of gender norms on health outcomes can be assessed by creating proxy measures for norms using existing data. For example, researchers used geospatial hot-spot analysis with Demographic and Health Survey (DHS) data from Ethiopia to identify evidence of the norm of son preference in clusters of communities, with more care-seeking for childhood illness for boys

than for girls. Son-preference was clustered in intersecting socio-economic and religious groups in geographical sub-regions of the country, allowing for targeted interventions.[25] Innovative research to improve methods to measure normative change is underway, which will further enhance understanding of the relationship between norms and health outcomes.[47]

The examples given above illustrate that gender norms affect health and can be changed and measured. By dispelling these three myths, the health sector can address other long-standing barriers to progress on gender inequality, restrictive gender norms, and health.

**Persistent barriers to progress**

Building on evidence from this Series and drawing on existing literature, we identified five persistent barriers to addressing gender inequality and restrictive gender norms to improve health.

1. Gender bias in health systems

   Health systems reflect and reinforce gender inequalities and restrictive gender norms in health care delivery and in the division of labour in the health workforce.[27] Hay et al., in this Series, show how health care delivery systems reinforce patients' traditional gender roles and often neglect gender inequalities in health. Services for women, for instance, prioritise maternal and child health, neglecting the fact that women are at greater risk than men for specific diseases, such as certain cancers and morbidities linked to aging. At the same time, evidence suggests that clinicians resist men's engagement in maternal and paediatric care, reinforcing gender norms.[27]

   The health workforce reflects prevalent gender norms by differentially valuing the contribution of men and women as health care providers. Women are disproportionately socially conditioned into "care" roles, such as nurse, midwife, and frontline community health worker, and men disproportionately into "cure" roles, such as physician and specialist. Also, women are

underrepresented in higher paying jobs and leadership positions.[27] Although 75% of the health work force is female, most women health workers are largely confined to positions with little power to change systems, organisations, or their careers, leading to work stress, job dissatisfaction, and burnout, which in turn can also result in poorer quality care of patients.[27] Even when women become physicians, they are less likely to work in higher paying specialties or be offered the same opportunities for professional advancement as men. This type of channeling and discrimination has a cost in health outcomes because a greater proportion of female physicians in the workforce has been linked to lower maternal and infant mortality and higher universal health coverage (UHC) scores.[27] Despite this evidence, analysis of the impact of gender norms in health systems remains neglected.[27]

2. Inadequate response by national governments and health institutions

National governments and global health institutions have historically addressed gender inequality through a strategy called gender mainstreaming, as endorsed by the Fourth World Conference on Women (1995).[48] Gender mainstreaming is defined as "the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes… so that women and men benefit equally and inequality is not perpetuated."[49]

The theory behind mainstreaming is that integrating gender "considerations" into policies and programmes would rectify the power imbalance between men and women and, in the health sector, result in improved health outcomes.[50,51] Mainstreaming involves the creation of an "architecture" consisting of a central gender unit (or a ministry of women's affairs) and gender focal points in all program units (or government ministries) to provide technical support for implementing the gender policy. It also includes processes for capacity building, largely through gender training, as well as the production of multiple checklists, tools, and guidance notes on how to mainstream.[50]

A robust literature assessing the theory and practice of mainstreaming across sectors points out

several limitations, including a flawed theory of change, an ineffective architecture, and processes not linked to results.[50,52]

First, the building blocks of the theory, "gender norms" and "gender equality," are perceived to be ambiguous,[42] academic, and therefore challenging to operationalise. The term "gender" has largely been interpreted in practice to be synonymous with women.[50] This issue is routinely manifested in the health sector where it is presumed there is no need for gender mainstreaming because maternal and reproductive health programmes are seen as an adequate response to "gender" in health and because the sector addresses the causes of male mortality.[50] This misconception also misses the relational context between men and women inherent in the concept of gender, and the ways in which gender norms are embedded in institutions and social interactions.[42] As a result, mainstreaming has been unable to tackle underlying gender norms, especially as they affect men's health and that of gender minorities.

Second, the architecture of mainstreaming is cumbersome and perceived to be expensive, resulting in under-resourced gender units and under-trained professionals.[50] In most institutions, resource constraints for mainstreaming prevent having a large enough core of staff with *both* sector specific skills (e.g. technical skills in health or agriculture) and deep knowledge of relevant gender gaps in the sector, as well as experience using proven approaches to close them. Instead, programme units tend to employ a minimum number of generalist gender focal points who do not have the needed skills, influence, or budget, and are overloaded with other routine responsibilities.[53] Finding health experts who understand the impacts that gender inequality and norms have on health outcomes is challenging because most medical and public health curricula do not incorporate modules on the difference between sex and gender and their differential impacts on health outcomes.[54—57]

Finally, the practice of mainstreaming has largely become a process-oriented, "tick-the-box" exercise

partly because it lacked conceptual clarity.[53,58—61] As the theory of change from mainstreaming to health outcomes was assumed, rather than established by evidence, the success of mainstreaming was measured by implementing process changes, rather than by improvements in health associated with advances in gender equality.[58,62,63] For example, since 2012, progress on gender mainstreaming of U.N. agencies has been evaluated by questions on human and financial resources for "gender-related" activities, with few specifics on outcomes.[64] Donors have also played a role in keeping mainstreaming process-oriented by requiring process-related indicators of progress. Ultimately, implementing mainstreaming across all sectors and departments resulted in "gender" becoming everyone's problem but no one's responsibility.

Additionally, most institutions did not make fundamental organisational changes to support mainstreaming. The WGEKN report refers to "organisational plaque," thickly encrusted with traditional, male-dominated values, relationships, and methods of work that make it difficult to alter institutional policies and norms.[23] Institutions have rarely invested in staff capacity, data collection, monitoring systems, and changes in workplace culture, human resource management, and business processes to make gender equality objectives and norms part of the institutional DNA.[50] Although the framers of gender mainstreaming viewed it as a political project for transformational change, it became a strategy which has consumed attention at the cost of tangible action to solve health problems.

3. Gaps and bias in quantitative data and health research

Much health research is gender biased and even discriminatory in how quantitative studies and instruments are designed and data are collected, limiting their value and application. As Weber et al. show in this Series, underlying gender biases are built into global surveys.[25] For instance, men are rarely asked questions on child health and care, inhibiting analysis of changes in gender norms on child health and caregiving.[25] Also, questions around family contexts and sexual

practices typically use terms such as "wife" and "husband," effectively excluding unmarried women and men and people in non-heterosexual unions.[25] Importantly, fewer men than women typically are surveyed in existing global surveys, such as the DHS, while as Heise and Greene et al. highlight, in clinical research it is women who have been systematically excluded and underrepresented.[24]

Even basic systems, such as Civil Registration and Vital Statistics (CRVS) that record statistics about major life events (e.g. maternal deaths, marriage, divorce), have data gaps that disproportionately affect women versus men.[65,66] For example, without data on maternal mortality, governments cannot effectively plan and allocate resources to maternal and child health programmes or monitor progress toward the SDGs. Additionally, lack of data on registration of girls at birth and recording of marriage limits tracking of early and forced marriage.[66] According to the World Bank, over 110 lower- and middle-income countries have deficient CRVS systems, even though major efforts are underway to strengthen and scale these systems.[67] Ironically, 34 of the 54 gender-related SDG targets require CRVS data, but much of this data is missing or coverage is low and uneven across countries.[68]

Further, global datasets are not amenable to studying how gender norms intersect with other social determinants of health (e.g. income, religion, ethnicity, race) and may be missing data for entire demographic groups, such as children 6-14 years and menopausal women.[25] Linking gender norms and health outcomes using existing datasets is often not possible because datasets with rich health-related data do not measure attitudes, behaviours, or norms and vice versa.[25]

4. Shrinking space and restricted funding for civil society action

Civil society action is a critical catalyst for setting and shaping the global agenda on gender and health and advocating for gender equitable social and health policies.

The success of the U.N. Decade for Women and subsequent world conferences, the implementation of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), and the adoption of a stand-alone goal for women's empowerment and gender equality in the SDGs was largely due to the collective action of women's organisations.[69—72] Social movements have been key to gains in gender equality and improvements in public health, such as the international women's health movement[73] and the AIDS movement within a broader LGBT health movement.[74,75] More recently, women's movements have prodded governments to redress violence against women in several countries,[76] such as Mexico[77] and India[78,79] and decriminalise abortion in Uruguay[80—82] and Ireland.[83,84] Globally, new initiatives are forming to tackle toxic masculinities[85,86] and, in the U.S., activists are beginning to argue that toxic masculinity needs to be addressed in order to reduce violence[24,29] and to advocate for policies to reduce mass shootings.[87,88] Civil society actors also implement innovative programmes that strategically shift gender norms in communities to improve health.[26,89—92] Notably, Hay et al., in this Series, demonstrated that women's self-help groups in Bihar, India challenged restrictive gender norms and increased health care access and provider responsiveness to women's health needs at the local level.[27]

Despite their role in bringing about change, the space for civil society actors to operate freely is shrinking.[93,94] Although reasons for this are context-specific,[95] globally this is due, in part, to a mix of new populist and older authoritarian forces resulting in democratic regression.[93,94] According to CIVICUS, civil society rights are now seriously restricted in 109 countries and only 4% of the world's population lives in countries where these rights are widely respected.[94] Regulatory requirements, burdensome reporting obligations, and restrictions on free speech, including anti-protest laws, systematically constrict the scope of civil society operational and programmatic activities.[93—95] Civil society organisations (CSOs) working on the protection of human rights face severe challenges, including violence, harassment, and imprisonment.[95] Civil

society action for gender equality, specifically, experiences backlash because it threatens existing power differentials and hierarchies.[96,97] For instance, the United States government's "Global Gag Rule" is an example of backlash that has a chilling effect on women's reproductive health programs in developing countries.[98]

Additionally, women's organisations, historically the strongest advocates for gender equality in health, receive only a small percentage of total development aid. In 2015-2016, support to dedicated gender equality programming amounted to USD 4.6 billion per year, representing only 4% of OECD Development Assistance Committee (DAC) members' total bilateral allocable aid.[99] Meanwhile, a multitude of factors limit the ability of organisations to acquire long term local or domestic sources of funding.[100] As a result, many women's organisations rely primarily on project-support. According to a survey of almost 750 women's organisations from over 140 countries, approximately half had never received core or multi-year funding. These constraints cause women's organisations to limit activities, reduce staff size, or close down.[101] Furthermore, donor-driven strategies that prioritise direct service provision, to the exclusion of capacity building, leadership development, and women's empowerment, undermine the flexibility[100,102] and sustainability of organisations that play a critical role in setting the agenda and advocating for gender equitable health policies.[101] While this trend may be shifting,[103—105] these restrictions reduce the overall autonomy and increase the vulnerability of civil society.[95]

5. Corporate interests manipulate gender norms for profit

Calls to consider the commercial determinants of health more systematically, with a focus on "Big Food" and "Big Tobacco" companies and their effect on non-communicable diseases, are on the rise.[106,107] To promote alcohol consumption and increase profits, the corporate sector influences lifestyle choices and subsequent health outcomes by manipulating gender norms and exploiting people's desire to be popular, attractive, and modern.[108] It is well known that the cigarette industry has utilised gender norms in deliberate efforts to increase smoking among boys/men and girls/women,

resulting in high rates of lung cancer.[43] In targeting men, tobacco use was linked with positive notions of masculinity, such as independence and freedom; in targeting gender minorities, tobacco use was linked with defiance and solidarity; and for women, tobacco use was linked with norms of independence and increased agency.[24] In contrast, public health research on tobacco use does not include gender analysis. In fact, evaluations of anti-smoking interventions are only analysed by biological sex, not gender. Importantly, the design and delivery of health policies and programmes do not target gender norms to reduce tobacco use.[109]

## An agenda for action

To remove the barriers listed above and advance gender equality for improved health outcomes, national governments, global health institutions, health systems leaders, researchers, donors, and CSOs should implement the recommendations below. Panel 1[24—27,110—116] lists the actions associated with each of the recommendations derived from analyses conducted for this Series.

1) Focus on health outcomes and engage actors across sectors to achieve them.

National governments, global health institutions, and health systems should measure the success of their efforts to address gender inequality and restrictive gender norms by the achievement of specific health outcomes. This approach should prioritise meeting the SDG 3 targets. Panel 2[117—142] illustrates some of the ways in which gender inequality and restrictive gender norms affect each SDG 3 target. An outcome-oriented approach would include three interlinked actions: conducting context specific diagnostics, using the findings to inform health policies or programmes, and adopting monitoring and evaluation methods to track progress (Panel 1).

For example, consider a seemingly gender-neutral action, health financing reform, which is essential to achieve UHC (SDG target 3.8). To implement an outcome-oriented approach, first, undertake a context-specific diagnosis by asking questions such as: who is protected under different risk pooling systems (tax-based insurance, prepaid mechanisms, etc.); how effective are

the risk pools in protecting men compared to women (disaggregated by other intersecting demographic characteristics) against health shocks, while ensuring access and financial protection; and are provider payment mechanisms incentivising appropriate and high quality services for all genders? Second, use answers to these diagnostic questions to design public financing systems that, for example, respond to women in informal employment with no access to employee-based insurance and publicly-financed social insurance with affordable premiums. Finally, develop appropriate outcome indicators for tracking progress toward universal coverage that are sex-disaggregated and stratified by age, race, ethnicity, income, geographic location, and disability.[131]

To achieve the health SDGs, the health sector needs to work collaboratively with other sectors that address the social determinants of health.[26] This Series shows that policies that increase gender equality in sectors outside of health (e.g. tuition-free education, paid maternity leave) improve health outcomes. Similarly, programmes that address gender inequalities and norms are more likely to improve health outcomes when they engage multiple stakeholders from different sectors, use a diverse set of activities that reinforce each other, and engage affected communities (Panel 1).[26]

2) Reform the workplace and workforce

There should be deliberate efforts in health institutions at all levels to remove "organisational plaque"[23] and create a workplace environment that prioritises and rewards tackling gender inequality and restrictive gender norms. This must include measures to create an inclusive and diverse workplace and break the "men cure, women care" paradigm through gender equitable recruitment, promotion and career advancement, and retention policies.[27] Additionally, academic institutions must begin to build a pipeline of medical and public health professionals who are trained to understand the difference between sex and gender and respond to the impact of gender

inequality and restrictive norms on the health workforce and health outcomes, including but not restricted to sexual and reproductive health, as well as the care of patients and communities. Specific measures are described in Panel 1.

3) Fill gaps in data and eliminate gender bias in research.

As a first step to address gender data gaps, we recommend strengthening CRVS systems at the national level, with particular emphasis on recording and reporting complete data for gender-related SDG targets. Given that six of the SDG 3 gender-related targets require CRVS data, the health sector should lead other sectors in a collaborative effort to ensure that countries prioritise functioning CRVS systems with increased coverage and quality of data. To make research more gender equitable, we recommend that randomised controlled trials and population-based surveys reduce gender bias in sampling, design, and reporting.[25] Fostering collaborations to build bridges across the health and social sciences, as well as between researchers and policy-makers is necessary to generate meaningful evidence.[24—27] Similarly, rigorous mixed methods evaluations are needed to know what works to address gender inequality and restrictive gender norms and how (Panel 1).[26]

4) Empower civil society actors and social movements.

To harness the power of social movements, we recommend that donors fund civil society actors with flexible and multi-year funding. Civil society actors also need the space to organise and mobilise their constituencies for better health outcomes in the communities that are most affected by gender inequalities and restrictive gender norms.

5) Strengthen accountability mechanisms for national and international, public and corporate actors.

The SDGs provide an overarching accountability framework to monitor progress made by countries on gender equality and health targets.[143] However, such an expansive and ambitious framework with interlinked goals, requires a "web of accountability" that engages multiple stakeholders from multiple sectors to hold each other mutually accountable for addressing gender inequalities and restrictive gender norms.[144]

To begin to build this web, donors should fund independent[145] and transparent accountability mechanisms that take a comprehensive approach to monitoring and reviewing performance against the SDG targets and have effective mechanisms for remedial action. Even existing exemplars in global health, for example, the Independent Accountability Panel[146] and Global Health 50/50,[147] lack the capacity specifically for remedial action.

CSOs should be given a formal role to comment on reported results and provide feedback because they represent and/or are often working with those most affected by gender inequalities. Already, the Global Fund for AIDS, Tuberculosis and Malaria[148] and Gavi, The Vaccine Alliance,[149] among others, include CSO representatives on their executive boards. Recently, the Joint WHO-CSO Task Force recommended that CSOs be engaged in assessing WHO's performance in upholding the principles of gender equality, health equity, and human rights.[150]

To ensure that governments meet the health outcomes included in SDG 3, they should also be held accountable for advancing SDG 5 which commits governments to ensure legal frameworks are in place to promote, enforce, and monitor gender equality and non-discrimination.[26]

Additionally, an inclusive accountability web should include mechanisms to hold corporate entities accountable for egregious profit-driven marketing tactics and media content that perpetuate restrictive gender norms and stereotypes. Donors should fund both independent "watchdog" organisations, as well as collective efforts between CSOs, global health institutions,

and national governments to prevent harmful health outcomes.[144] An example of such a collective effort in Vietnam shows how the government, with the help of a CSO, Alive and Thrive, and UNICEF banned advertising of breast milk substitutes and, along with other efforts (mass media campaign, counseling, new policy on maternity leave), increased rates of exclusive breastfeeding, ensuring nutrition for infants during the first 6 months of life.[151]

The health sector should also partner with key players in advertising and the media, who are willing to take advantage of this moment in time when restrictive gender norms and gender inequality are being publicly questioned.[152,153] U.N. Women has leveraged this new interest among corporates to bring together leading advertising and marketing firms in a collaborative public-private partnership, the Unstereotype Alliance. This initiative promotes gender equitable, non-stereotypical marketing messages to improve health.[154] CEOs of corporations can step up to promote new, flexible gender norms for better health outcomes.

**It's political**

The Series presents new evidence to bolster the agenda for action to address gender inequality, norms, and health outcomes. Ironically, much of what we recommend has been said before. Yet, progress to date has been episodic and slow. The reason for the inertia and active opposition to gender equality is that changing the balance of power requires more than technical fixes – it requires political will. Leaders and decision-makers in health must act on this evidence to overcome the barriers that impede progress.

The ingredients to mobilise the political will necessary to promote gender equality and shift gender norms exist today. These include the pressure on countries to achieve the SDGs by 2030, energised social movements fighting for women's rights and gender equality all over the

world, ongoing activism by advocates for the rights of gender minorities, and the emergence of new champions working to challenge harmful aspects of masculinity and to engage men more fully in the struggle for gender equality. Social media provides the potential to scale these efforts. Despite challenges in the global political arena, this context provides a foundation for health sector leaders to seize the moment and exercise their political will to promote gender equality and shift restrictive gender norms, not only to achieve health outcomes, but also to protect the dignity and human rights of all.

**Panel 1. Agenda for action**

**1. Focus on health outcomes and engage actors across sectors to achieve them**

a. National governments and global health institutions should:

i. Conduct targeted context- specific diagnostics to identify pathways through which gender norms and inequalities differentially hinder progress on health for women and men.

ii. Use the diagnostic findings to implement health policies or programmatic interventions based on available evidence of what works, and advocate for social and economic policies that more broadly promote gender equality and changes in gender norms.

iii. Adopt monitoring and evaluation methods that incorporate mid-point milestones and appropriate outcome indicators to track progress towards specific health targets.

b. National governments should promote policies, such as tuition-free education and paid maternity leave to shift gender norms and improve health. Laws and policies that promote greater gender equality in work, education, and family roles contribute to improved health outcomes, and can lead to increased life expectancy across genders.[26]

c. Programmes to improve health outcomes should engage multiple stakeholders from different sectors, include a diverse set of activities that reinforce each other, and foster active participation by affected community members and key actors who enforce gender norms, including parents, teachers, peers, and the media.[26]

**2. Reform the workplace and the workforce**

Leaders in health systems, global health institutions, national governments, and the corporate sector should reform:

The Workplace[110]

a. Offer flexible work arrangements, such as part-time and work from home policies.
b. Institute parental leave policies with equal time off for males and females and incentives for men to use it.
c. Establish systems to prevent and respond in a timely way to sexual harassment and abuse of power in health institutions and systems and measures to protect the dignity of patients and staff.
d. Conduct analysis and implement actions to redress gender pay and promotion gaps (e.g., implementing pay transparency).[111]
e. Undertake third party certification to assess changes in workplace policies and practices.[112,113]

The Workforce

a. Integrate modules of sex and gender-based medical concepts in medical and public health training and assess these competencies in professional accreditation licensing examinations.[114]
b. Promote on-the-job learning for health sector experts in national governments and global health institutions, with a learning-by-doing model that focuses on the "how," such as UNICEF's GenderPro.[115]
c. Establish an accredited, practical, global gender and health capacity-building platform that includes a roster of gender and health experts available to provide on-site technical support to build expertise and an open-source knowledge bank, such as the Prevention Collaborative, which builds capacity on prevention of violence against women.[116]

**3. Fill gaps in data and eliminate gender bias in research**

Global health institutions, national governments, donors, and researchers should:

a. Strengthen Civil Registration and Vital Statistics (CRVS) and other identification systems at the national level, by including data on marriage and divorce and other key life events.

b. Make research, data collection, analyses and reporting more gender equitable:[25,26]

   i. Correct gender bias in sampling, design, and analysis of randomised controlled trials and in existing large-scale, population-based surveys;

   ii. Balance population-based survey sampling so women and men are equally represented and frame attitudinal and behavioural questions in an unbiased way;

   iii. Develop novel methods and measures to capture gender norms (both quantitatively and qualitatively) to study their link to health outcomes;

   iv. Collect data on gender norms and identities, including data on gender minorities, and use distinct variables on sex and gender in research.

c. Transform gender and health research through key collaborations:[24—27]

   i. Across the fields of health sciences, social sciences, and humanities to build the bridges needed to ensure effective use of survey data on outcomes and policies and programmes;

   ii. Between data collectors, analysts, and policy makers to generate systems that enable evidence-based research, including monitoring of policies and programmes;

   iii. Across global survey data efforts to set standards for measuring gender and key socio- demographic characteristics that will allow for studies of the intersection of gender with other social determinants of health.

d. Conduct rigorous and mixed method evaluations to learn what works to change gender norms and reduce gender inequality, and how interventions bring about this change.[26]

**4. Empower civil society actors and social movements**

Donors should:

a. Provide reliable, multi-year and core institutional support to women's organizations and other civil society organizations that support gender and rights issues in health.
b. Support and promote regional and transnational civil society collaboratives and forums for developing targeted and strategic advocacy on gender and health issues.
c. Fund civil society and people-led watch-dog mechanisms to hold the health community accountable for meeting SDG targets in health.
d. Support social movements that call for changes in gender norms.[27]

5. **Strengthen accountability mechanisms for national and international, public and corporate actors**
   a. Governments and global health institutions should invite CSOs to participate and provide feedback from communities and vulnerable populations.
   b. Donors should fund independent mechanisms for monitoring performance and suggesting remedial action.
   c. Accountability measures should regularly measure and monitor action steps taken by governments, including passage and implementation of laws, policies, and programmes that advance gender equality.[26]
   d. Accountability mechanisms should have effective measures for remedial action.
   e. The health sector should partner with corporate entities to harness their marketing power for good.
   f. Donors should fund CSOs to hold the private sector accountable for the health and human rights consequences of their marketing strategies.

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758 **Panel 2. Gender Inequality, Norms, and the SDG 3 Targets**
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| **SDG 3 Target** | ***Example of gender inequality and its impact on target*** | ***Example of gendered norms, expectations, behaviours, and their impact(s) on target*** |
|---|---|---|
| **3.1: Reduce maternal mortality** | Adolescent girls who are subject to forced marriage and early childbirth are at increased risk of maternal mortality.[117] | Women who require family/husband's permission to seek health services may delay care-seeking leading to increased risk of maternal mortality.[118] |
| **3.2: End preventable deaths of newborns and children under 5** | Children born to illiterate mothers have a significantly lower likelihood of surviving past their 5th birthday.[119] | Parents may prioritise care-seeking for boys rather than girls in some regions of the world.[120] |
| **3.3. End epidemics of AIDS, TB, malaria, neglected tropical diseases, hepatitis, water- borne, and other communicable diseases** | Transgender and other non-binary populations who suffer stigma and discrimination may have reduced access to services or receive poor quality of care, even though they are typically at higher risk of HIV.[121] | HIV services offered during restricted opening hours or in female-dominated sexual and reproductive health services may mitigate against men's access, resulting in lower use of prevention and treatment services.[122] |
| **3.4: Reduce premature mortality from non-communicable diseases (NCDs), promotion of mental health** | Stigma towards transgender populations may make them vulnerable to stress and poor mental health outcomes.[123] | Commercial exploitation of masculine norms and stereotypes has resulted in higher acceptance of (and expectation of) exposure to tobacco and alcohol as "masculine" behaviours – leading to higher rates of NCD outcomes in men.[124] |
| **3.5:Strengthen prevention and treatment of substance and alcohol abuse** | Women may be less likely to enter treatment programmes than men – for example due to the inequality of the burden of childcare.[125] | Gender norms result in large differences in substance use between men and women - with men using substances more than women.[126] |

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| **3.6: Halve road traffic accidents** | Women are less likely to be in road accidents because social inequalities restrict their mobility and prevent them from being in driving-based occupations.[127] | Pedestrian injuries may reflect gender norms of who occupies public spaces – in some settings a large proportion of pedestrian injuries are found among poorer men walking to work, but this may vary in other contexts.[128] |
| **3.7: Universal access to sexual and reproductive healthcare services** | Women's unequal access to income and information affects their ability to pay for the cost of sexual and reproductive health services and to negotiate the use of contraceptives.[129] | Norms of masculinity may place men at higher risk of poor sexual health outcomes associated with having more sexual partners, being more likely to have sex under the influence of drugs or alcohol, and being less likely to seek information and care.[130] |
| **3.8: Achieve universal health coverage** | Health insurance schemes may mitigate against the participation of women (e.g. less likely to be in formal employment, or less likely to have available funds) – similarly less access to family resources may lead to barriers to out of pocket expenditure on health care services.[131] | Universal coverage may not equate to universal access, and women may have lower access due to a number of factors including restrictions on women's autonomous care-seeking.[132] |
| **3.9: Substantially reduce environmental pollution and contamination** | Gender inequalities in participation in formal employment mean that men are more likely to be exposed to harmful/toxic workplace environments.[133] | Gender norms in distribution of domestic roles result in women's increased exposure to large particle air pollutants from cooking fuels.[134] |
| **3A: Strengthen framework convention on tobacco control** | Women are more likely to be informal piece-meal workers in rolling *beedis* (a popular and cheap form of cigarettes in India), exposing them in larger numbers to the health impact of handling tobacco.[135] | Gender-sensitive policies and programmes may be more effective (e.g. emphasis on positive aspects of masculinity may encourage expectant fathers to quit smoking).[136] |

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| **3B: Support R&D for new vaccines and medicine** | Women are less likely to be enrolled in clinical trials, particularly in early stage trials.[137] | A large proportion of women's work in clinical trials is more likely to be under-valued and under-recognised in publications and reward structures.[138] |
| **3C: Support to health workforce** | The global health workforce is generally led and governed by men, with over 70% of leadership positions occupied by men.[139] | "Female" tasks and skills in the health workforce are more generally undervalued and underfunded.[140] |
| **3D: Strengthen response to health risks** | Epidemics affecting pregnancy and reproduction (e.g., Zika) have a significant impact on women when they are not empowered or enabled to participate in reproductive decision-making.[141] | Men's occupational roles away from the home (e.g. in logging industry) may expose them to greater risk of zoonotic diseases (e.g., Ebola).[142] |

**Contributors:**

GRG, as the lead author, led the conceptualizing of the paper and the research necessary to develop the supporting arguments. GRG, NO, CG, and KC worked closely to frame, plan, draft, write, and revise the manuscript. NO conceived the format of "myths" on gender in global health. She also gathered information on corporate sector engagement on gender norms and health through informal informational interviews and document review. CG provided the critique of gender mainstreaming and conceived of several recommendations addressing gender in health institutions. KC performed literature reviews, annotated bibliographies and summary research reports on several illustrative examples to support the overall arguments and recommendations made in the paper. NO, CG, KC, S. Hawkes, YRS, JS, KB, CAB, GLD, and GRG provided critical input in developing the recommendations. S. Hawkes, YRS, JS, KB, and RM reviewed drafts of the manuscript and provided comments. S. Hawkes and KB wrote and revised the initial drafts of the paper. KB participated in a one-day face-to-face meeting on the scope of the paper, co-authored one section and one table, and reviewed, commented and contributed to a succession of drafts. LH, MEG, AW, JH, KH, AR, and S. Henry provided analyses and case studies, as well as shared findings and provided inputs to support the development of the recommendations and key messages. S. Hawkes created the table on how gender inequality and restrictive gender norms impact SDG 3 (Panel 1). YRS and JS completed analysis of the challenges to addressing gender in global health organizations. RM provided analysis on the limitations of gender mainstreaming and building technical capacity on gender. CAB provided a

summary of components of successful grassroots movements. LH, MEG, AMW, JH, KH, AR, SH, and JK reviewed drafts of the manuscript and provided comments. GLD was the Principal Investigator of the Lancet Series on Gender and Health and provided critical input on framing and recommendations, as well as helped to edit the manuscript.

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