Gender Equality, Norms, and Health 5

Gender equality and gender norms: framing the opportunities for health

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This is the fifth in a Series of five papers about gender equality, norms, and health

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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 substantial impact of gender inequalities and restrictive gender norms on health risks and behaviours. In this paper, the fifth in a Series on gender equality, norms, and health, we draw on evidence 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, academic settings, and the corporate sector to focus on health outcomes and engage actors across sectors to achieve them; reform the workplace and workforce to be more gender-equitable; fill gaps in data and eliminate gender bias in research; fund civil-society actors and social movements; and strengthen accountability mechanisms.

Introduction

Now is a politically challenging time. The progressive agenda that demands gender equality for girls and women and gender norms that promote health and wellbeing for all, including gender minorities, is highly visible. 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, transgender, and queer (LGBTQ) justice (#hrc, #WhereLoveIsIllegal).[1–8]

Simultaneously, a backlash is growing against this 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 LGBTQ 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 is well known. Gains made by women's movements in the 1970s—resulting in the establishment of the UN's Decade for Women (1975–85) and policy commitments made in UN 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, WHO's Commission on Social Determinants of Health gave further impetus to the considerable role that gender, among other social determinants, plays in determining health risks.[21] The Commission reinforced the concept of intersectionality,[22] wherein gender intersects with other social markers of power, such as race, age, and income, to create clustered relative advantage or disadvantage that gives rise to power dynamics and hierarchies among boys and men and girls and women, not just between them. The Commission's Women and Gender Equity Knowledge Network background paper[23] recognised that restrictive gender norms uphold the hierarchical system in which dominant forms of masculinity are favoured over dominant forms of femininity. As described in paper 1 of this Series,[24] a gender system is created that not only undermines the health and human rights of girls and women, but also promotes marginalisation of, and discrimination against, all those who transgress restrictive gender norms, including boys, men, and gender minorities.[24–27]

Additionally, research and advocacy on HIV/AIDS has highlighted the role that rigid notions of masculinity have on boys' and men's behaviours, including taking sexual risks, which contribute to HIV incidence.[28] Increased research on men and masculinities,[29] coupled

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 wellbeing, 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 wellbeing of women, 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 wellbeing of patients, providers, and communities

Research, health systems, policies, and programmes can reduce gender inequalities, 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 Sustainable Development Goals by 2030, provides leverage for political will to promote equality and shift gender norms, not only to achieve health outcomes, but also to protect the human rights of all
- An agenda for action to promote gender equality and shift gender norms for improved health outcomes requires a focus on health outcomes and engagement of actors across sectors to achieve them; reforming the workplace and workforce to be more gender equitable; filling gaps in data and eliminating gender bias in research; funding civil society actors and social movements; and strengthening accountability mechanisms

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with a long-standing movement on LGBTQ rights[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 and men and gender minorities, just as they are to girls and women.

The inability of the health sector to make substantial progress on some key challenges to health (such as persistently high maternal mortality in the poorest global communities,[34] the alarming incidence of HIV in adolescent girls in southern Africa,[35] higher rates of road traffic crashes and injuries in young men than in women,[36] and the disproportionately high suicide rates among LGBTQ people[37]) brings into sharp focus the major role that gender norms have on health behaviours, exposure, and vulnerability. Meeting Sustainable Development Goal (SDG) 3[38]—ie, “ensure healthy lives and promote well-being for all”—mandates that the health sector addresses gender inequalities and restrictive gender norms,[39,40] which also has the potential to leverage progress on other SDGs,[41] including SDG 5—ie, “achieve gender equality and empower all women and girls”—and vice versa.[39]

In this fifth and last paper of the *Lancet* Series on gender equality, norms, and health,[24–27] we build on evidence from the Series to dispel three myths on gender and health (Shawar YR and Shiffman J, unpublished) that stymie efforts to address gender inequalities and restrictive gender norms, and to 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

Myth: gender norms do not affect health outcomes

Reality: restrictive gender norms affect the health of girls and women, boys and men, and gender minorities in many ways.[24–27] For instance, using data from a nationally representative sample of adolescents aged 11–18 years from schools in the USA, paper 2 of this Series[25] reported 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 than women.[42] However, some dimensions of dominant masculinity and femininity can be protective of health.[24] For example, adherence to specific notions of acceptable feminine behaviour, in some contexts, is protective against harmful substance use.[43]

Myth: gender norms are entrenched and cannot be changed

Reality: although gender norms can be so pervasive that individuals might feel that they are immutable, norms are continuously negotiated, resisted, and redefined in everyday interactions.[24] Paper 3 of this Series[26] showed that gender norms can be changed to improve health.For example, in countries with policies such as tuition-free education in primary schools or 10-week paid maternity or 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. SASA!, a community-based programme in Uganda,[44] worked with traditional marriage counsellors and religious leaders from the community, as well as health-care providers and police officers from the government to increase women's ability to refuse sex and reduce 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 programme 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: gender norms are elusive and cannot be measured

Reality: although 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, papers 2 and 3 of this Series[25,26] showed 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 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 socioeconomic 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 and will further enhance understanding of the relationship between norms and health outcomes.[47]

These examples show that gender norms affect health and can be changed and measured. By dispelling these 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.

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] Paper 4 of this Series[27] shows how health-care delivery systems reinforce patients' traditional gender roles and often neglect gender inequalities in health. Services for women, for example, prioritise maternal and child health, neglecting the fact that women are at greater risk than men for specific diseases, such as some cancers and morbidities linked to ageing. Moreover, 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 so-called care roles, such as nurse, midwife, and frontline community health worker, and men disproportionately into so-called cure roles, such as physician and specialist. Furthermore, women are under-represented in jobs with incrreased pay and leadership positions.[27] Although 75% of the health workforce 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 than men to work in higher paying specialties or be offered the same opportunities for professional advancement. This type of channelling and discrimination has a cost in health outcomes because a greater proportion of female physicians in the workforce has been linked to reduced maternal and infant mortality and increased scores of universal health coverage.[27] Despite this evidence, analysis of the effect of gender norms on health systems remains neglected.[27]

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 programme units (or government ministries) to provide technical support for implementing 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]

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 (Shawar YR and Shiffman J, unpublished), academic, and therefore difficult to operationalise. The term gender has largely been interpreted in practice to be synonymous with women.[50] This limitation is routinely manifested in the health sector, where it is presumed that 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 (Shawar YR and Shiffman J, unpublished). 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 often 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 them from having a sufficient number of core staff with both sector-specific skills (eg, 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 effects 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, box-ticking exercise, partly because it lacks conceptual clarity.[53,58–61] As the theory-of-change of gender mainstreaming leading to improved 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 UN agencies has been evaluated by questions on human and financial resources for gender-related activities, with few specifics on outcomes.[64] Donors have also had a role in keeping mainstreaming focused on process 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.

Most institutions did not make fundamental organisational changes to support mainstreaming. The Women and Gender Equity Knowledge Network 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 that has consumed attention at the cost of tangible action to solve health problems.

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. Paper 2 of this Series[25] showed how underlying gender biases are built into global surveys. For example, 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, when used in a strictly heterosexual context, alienating people in non-heterosexual unions.[25] Fewer men than women are typically surveyed in existing global surveys, such as the

Demographic and Health Surveys, whereas as paper 1 of this Series[24] highlights, in clinical research it is women who have been systematically excluded and under-represented.

Even basic systems, such as Civil Registration and Vital Statistics (CRVS) that record statistics about major life events (eg, 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, more than 110 low-income and middle-income countries have deficient CRVS systems, although major efforts are underway to strengthen and upscale these systems.[67] Ironically, 34 of the 54 gender-related SDG targets require CRVS data, but much of these data are missing and uneven or coverage is low in many countries.[68]

Furthermore, global datasets are not amenable to studying how gender norms intersect with other social determinants of health (eg, income, religion, ethnicity, race) and might be missing data for entire demographic groups, such as children aged 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]

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 UN's Decade on Women and subsequent world conferences, the implementation of the Convention on the Elimination of all Forms of Discrimination Against Women, and the adoption of a standalone 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 making 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 LGBTQ health movement.[74,75] More recently, women's movements have encouraged 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[6,85] and, in the USA, activists are beginning to argue that toxic masculinity needs to be addressed to reduce violence[24,29] and to advocate for policies to reduce mass shootings.[86,87] Civil society actors also implement innovative programmes that strategically shift gender norms in communities to improve health.[26,88–91] Paper 4 of this Series[27] showed 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.

Despite their role in bringing about change, the space for civil society actors to operate freely is shrinking.[92,93] Although reasons for this restriction are context specific,[94] globally it is due, in part, to a mix of new populist and older authoritarian forces resulting in democratic regression.[92,93] According to CIVICUS,[93] a global alliance of civil society organisations and activists, 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. 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.[92–94] Civil society organisations (CSOs) working on the protection of human rights face severe challenges, including violence, harassment, and imprisonment.[94] Civil-society action for gender equality specifically receives backlash because it threatens existing power differentials and hierarchies.[95,96] For instance, the US Government's Global Gag Rule is an example of backlash that has a chilling effect on women's reproductive health programmes in low-income countries.[97]

Women's organisations, historically the strongest advocates for gender equality in health, receive only a small percentage of total development aid. In 2015–16, support to dedicated gender equality programming amounted to US$4·6 billion per year, representing only 4% of the Organisation for Economic Co-operation and Development's Development Assistance Committee members' total bilateral allocable aid.[98] Meanwhile, a multitude of factors limit the ability of organisations to acquire long-term local or domestic sources of funding.[99] As a result, many women's organisations rely primarily on project support. According to a survey of more than 1000 women's organisations from more than 140 countries, approximately half had never received core or multi-year funding. The survey concluded that these constraints, among others, caused women's organisations to restrict activities, reduce staff size, or close down.[100] Furthermore, donor-driven strategies that prioritise direct service provision to the exclusion of capacity building, leadership development, and women's empowerment undermine the flexibility[99,101] and sustainability of organisations that have a crucial role in setting the agenda and advocating for gender-equitable health policies.[100] Although this trend might be shifting,[102–104] these restrictions reduce the overall autonomy and increase the vulnerability of civil society.[94]

Corporate interests manipulate gender norms for profit

There are increasingly loud calls to consider the commercial determinants of health more systematically, with

a focus on so-called Big Food and Big Tobacco companies and their effect on non-communicable diseases.[105,106] 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.[107] It is well known that the cigarette industry has used gender norms in deliberate efforts to increase smoking.[42] 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] By contrast, most public health research on tobacco use has woefully lacked a gender analysis, typically analysing anti-smoking interventions by biological sex, not gender.[108] Importantly, the design and delivery of health policies and programmes often do not target gender norms to reduce tobacco use.[108]

An agenda for action

To remove the barriers we have listed and advance gender equality for improved health outcomes, national governments, global health institutions, leaders of health systems, researchers, donors, and CSOs should implement the recommendations below. Panel 1 lists the actions associated with each of the recommendations derived from analyses done for this Series.[24–27,109–115]

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, taking note of how gender inequality and restrictive gender norms affect each SDG 3 target (panel 2).[116–141] An outcome-oriented approach would include three interlinked actions: undertaking context-specific diagnostics, using the findings to inform health policies or programmes, and adopting monitoring and evaluation methods to track progress.

Consider a seemingly gender-neutral action, health-financing reform, which is essential to achieve universal health coverage (SDG target 3.8). To implement an outcome-oriented approach, one must first undertake a context-specific diagnosis by asking questions such as: who is protected under different risk-pooling systems (eg, tax-based insurance, prepaid mechanisms); how effective are the risk pools in protecting men compared with women (disaggregated by other intersecting demographic characteristics) against health shocks, while ensuring access to health care and financial protection; and are provider payment mechanisms incentivising appropriate and high-quality services for all genders? Then one can 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, geographical location, and disability.[130]

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 (eg, 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.[26]

Reform the workplace and workforce

Deliberate efforts should be made 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. These efforts 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] 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.

Fill gaps in data and eliminate gender bias in research

As a first step to address gender data gaps, CRVS systems must be strengthened at the national level, with 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, randomised controlled trials and population-based surveys must 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.[26]

Panel 1: **Summary of recommendations and actions**

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

National governments and global health institutions should:

- Conduct targeted context-specific diagnostics to identify pathways through which gender norms and inequalities differentially hinder progress on health for women and men.
- 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.
- Adopt monitoring and evaluation methods that incorporate mid-point milestones and appropriate outcome indicators to track progress towards specific health targets.
- 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.
- Support programmes to improve health outcomes that engage multiple stakeholders, 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.

Reform the workplace and the workforce

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

- Offer flexible work arrangements, such as part-time and work from home policies.
- Institute parental leave policies with equal time off for both parents and incentives for men to use it.
- 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.[109]
- Conduct analysis and implement actions to redress gender pay and promotion gaps (eg, implementing pay transparency).[110]
- Undertake third party certification to assess changes in workplace policies and practices.[111,112]
- Integrate modules of sex and gender-based medical concepts in medical and public health training and assess these competencies in professional accreditation licensing examinations.[113]
- 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.[114]
- 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.[115]

Fill gaps in data and eliminate gender bias in research

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

- Strengthen Civil Registration and Vital Statistics and other identification systems at the national level, by including data on marriage and divorce and other key life events.
- Make research, data collection, analyses and reporting more gender equitable.[25,26] Correct gender bias in sampling, design, and analysis of randomised controlled trials and in existing large-scale, population-based surveys; balance population-based survey sampling so women and men are equally represented and frame attitudinal and behavioural questions in an unbiased way; develop novel methods and measures to capture gender norms (both quantitatively and qualitatively) to study their link to health outcomes; collect data on gender norms and identities, including data on gender minorities; and use distinct variables on sex and gender in research.
- Transform gender and health research through key collaborations[24–27] 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; between data collectors, analysts, and policy makers to generate systems that enable evidence-based research, including monitoring of policies and programmes; across global survey data efforts to set standards for measuring gender and key sociodemographic characteristics that will allow for studies of the intersection of gender with other social determinants of health.
- 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]

Empower civil society actors and social movements

- Donors should provide reliable, multi-year and core institutional support to women's organisations and other civil society organisations that support gender and rights issues in health.
- Donors should support and promote regional and transnational civil society collaboratives and forums for developing targeted and strategic advocacy on gender and health issues.
- Civil society and people-led watchdog mechanisms should be funded to hold the health community accountable for meeting Sustainable Development Goal targets in health.
- Donors should support social movements that call for changes in gender norms.[27]

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Strengthen accountability mechanisms for national, international, public, and corporate actors

- Governments and global health institutions should invite civil society organisations to participate and provide feedback from communities and vulnerable populations.
- Donors should fund independent mechanisms for monitoring performance and suggesting remedial action.
- 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]
- Accountability mechanisms should have effective measures for remedial action.
- The health sector should partner with corporate entities to harness their marketing power for good.
- Donors should fund civil society organisations to hold the private sector accountable for the health and human rights consequences of their marketing strategies.

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.

Strengthen accountability mechanisms for national, international, public, and corporate actors

The SDGs provide an overarching accountability framework to monitor progress made by countries on gender equality and health targets.[142] 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.[143] To begin to build this web, donors should fund independent[144] 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, such as the Independent Accountability Panel[145] and Global Health 50/50 Report,[138] 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 or are often working with people most affected by gender inequalities. Already, the Global Fund for AIDS, Tuberculosis and Malaria[146] and Gavi, the Vaccine Alliance,[147] 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.[148]

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 that legal frameworks are in place to promote, enforce, and monitor gender equality and non-discrimination.[26]

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 and collective efforts between CSOs, global health institutions, and national governments to prevent harmful health outcomes.[143] One such collective effort in Vietnam[149] shows how the government, with the help of the CSO Alive and Thrive and UNICEF, banned advertising of breast milk substitutes and, along with other efforts (mass-media campaign, counselling, new policy on maternity leave), increased rates of exclusive breastfeeding, ensuring nutrition for infants during the first 6 months of life.

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.[150,151] UN Women has leveraged this new interest with corporations 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.[152] CEOs of corporations can step up to promote new, flexible gender norms for better health outcomes.

It's political

This Series presents new evidence to bolster the agenda for action to address gender inequality, norms, and health outcomes. Much of what we recommend has been said before, but 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

***Panel 2:* Examples of the impact of gender inequality and norms on SDG 3 targets**

SDG 3.1: reduce maternal mortality
Adolescent girls who are forced into marriage and early childbirth[116] and women who might delay care-seeking because they require permission from their family or husband to seek health services[117] are at an increased risk of maternal mortality

SDG 3.2: end preventable deaths of newborns and children aged under 5 years
Children born to mothers who are uneducated have a significantly lower likelihood of surviving past their fifth birthday;[118] parents might prioritise care-seeking for boys rather than girls in some settings, putting their daughters at increased risk of dying[119]

SDG 3.3: end epidemics of HIV/AIDS, tuberculosis, malaria, neglected tropical diseases, hepatitis, and water-borne and other communicable diseases
Transgender and other non-binary populations who are stigmatised and discriminated against might have reduced access to prevention and treatment services or receive poor quality of care, despite being typically at increased risk of HIV infection;[120] the use of prevention and treatment HIV services by men might be reduced if offered during fixed hours in female-dominated health services[121]

SDG 3.4: reduce premature mortality from non-communicable diseases and promote mental health
Stigma toward transgender populations might make them susceptible to stress and poor mental health outcomes;[122] the commercial exploitation of masculine norms and stereotypes has resulted in increased acceptance of tobacco and alcohol use as masculine behaviours, leading to increased incidence of lung diseases in men[123]

SDG 3.5: strengthen prevention and treatment of substance and alcohol abuse
The burden of childcare reduces women's time and ability to enter treatment programmes as compared with men; norms of masculinity that value risk taking in men result in men using substances more than women[125]

SDG 3.6: reduce road traffic accidents
Gender inequalities restrict women's freedom of movement and prevent them from being in driving-based occupations, which reduces their risk of traffic accidents;[126] many pedestrian injuries occur in men because gender norms in low-income countries make it more likely for men to be in public spaces[127]

SDG 3.7: universal access to sexual and reproductive health care services
Women's unequal access to income and information in low-income countries affects their ability to pay for sexual and reproductive health services and to negotiate the use of contraceptives with their male partners;[128] masculinity norms place men at higher risk than women of poor sexual health outcomes, which are 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[129]

SDG 3.8: achieve universal health coverage
Women in low-income countries are less likely than men to be in formal employment and therefore less likely to be covered by employment-linked health insurance schemes;[130] universal health coverage might not result in universal health care because of gender norms that restrict women's autonomous decision making and ability to seek care[131]

SDG 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 toxic workplace environments;[132] gender norms in the distribution of domestic roles result in women's increased exposure to large-particle air pollutants from cooking fuels[133]

SDG 3A: strengthen framework convention on tobacco control
Women are more likely than men to be informal ad-hoc workers in tobacco factories and thus many are exposed to the health impact of handling tobacco;[134] policies and programmes for tobacco control might be more effective in encouraging expectant fathers to quit smoking if they emphasise the positive aspects of masculinity[135]

SDG 3B: support research and development of new vaccines and medicines
Women are less likely to be enrolled in clinical trials than men, particularly in early-stage trials;[136] the work of many women in clinical trials is more likely to be undervalued and under-recognised in scientific publications and reward structures than that of men[137]

SDG 3C: support to health workforce
The global health workforce is generally led and governed by men, who occupy more than 70% of leadership positions in this field;[138] stereotypically female tasks and skills in health care are generally undervalued and underfunded[139]

SDG 3D: strengthen responses to health risks
Epidemics affecting pregnancy and reproduction (eg, Zika virus) have a substantial impact on women when they are not empowered or enabled to participate in decisions about their reproduction;[140] men's occupational roles away from the home might expose them to greater risk of zoonotic diseases (eg, Ebola virus)[141]

SDG=Sustainable Development Goals.

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.

Contributors

GRG led the design, analysis, and writing of the paper. GRG, NO, CG, and KC collected and organised the evidence and contributed to framing, analysis, and writing of the manuscript. SHa, KB, YRS, JS, CAB, and RM helped to frame and write early drafts of the manuscript. LH, MEG, AMW, GLD, JH, SHe, AR, KH, and JK reviewed the manuscript and provided analysis. All authors helped to develop the recommendations, reviewed successive drafts of the paper, and provided input. GRG, NO, CG, KC, and GLD prepared the final version of the paper, which all authors approved.

Steering Committee of *The Lancet* Series on Gender Equality, Norms, and Health

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References

1 O'Neil A, Sojo V, Fileborn B, Scovelle AJ, Milner A. The #MeToo movement: an opportunity in public health? *Lancet* 2018; **391:** 2587–89.
2 Time's Up. Time's up: the clock has run out on sexual assault, harassment and inequalities in the workplace. 2018. https://www.timesupnow.com/home (accessed Dec 13, 2018).
3 Bakshi G. The 'Nirbhaya' movement: an Indian feminist revolution. GNOVIS. 2017. http://www.gnovisjournal.org/2017/05/02/the-nirbhaya-movement-an-indian-feminist-revolution/ (accessed Dec 13, 2018).
4 Goñi U. Argentina's women joined across South America in marches against violence. 2016. https://www.theguardian.com/world/2016/oct/20/argentina-women- south-america-marches-violence-ni-una-menos (accessed Dec 13, 2018).
5 Equal Pay Today! Campaign. Support equal pay. http://www.equalpaytoday.org/ (accessed Dec 13, 2018).
6 MenEngage Alliance. What we do. http://menengage.org/about-us/what-we-do/ (accessed Feb 18, 2019).
7 The Human Rights Campaign. Explore. 2018. https://www.hrc.org/explore (accessed Dec 13, 2018).
8 Where Love Is Illegal. Where love is illegal: documenting and sharing LGBTI stories of discrimination and survival from around the world. 2018. http://whereloveisillegal.com/ (accessed Dec 13, 2018).
9 Corrêa S, Paternotte D, Kuhar R. The globalisation of anti-gender campaigns: transnational anti-gender movements in Europe and Latin America create unlikely alliances. 2018. https://www.ips-journal.eu/topics/human-rights/go/98/article/show/the-globalisation-of- anti-gender-campaigns-2761/ (accessed Nov 25, 2018).
10 Halperin-Kaddari R, Freeman MA. Backlash goes global: men's groups, patriarchal family policy, and the false promise of gender-neutral laws. *Can J Women Law* 2016; **28:** 182–210.
11 Assis MP, Ogando AC. Bolsonaro, 'gender ideology' and hegemonic masculinity in Brazil. 2018. https://www.aljazeera.com/indepth/opinion/bolsonaro-gender-ideology-hegemonic-masculinity-brazil-181031062523759.html (accessed Feb 18, 2019).
12 Assis MP, Ogando AC. Gender ideology and the Brazilian elections: Bolsonaro represents a hegemonic, masculine, and violent form of inhabiting the world. 2018. http://www.publicseminar.org/2018/11/gender-ideology-and-the-brazilian-elections/ (accessed Feb 18, 2019).
13 Corrêa S. Gender ideology: tracking its origins and meanings in current gender politics. 2015. https://blogs.lse.ac.uk/gender/2017/12/11/gender-ideology-tracking-its-origins-and-meanings-in-current-gender-politics/ (accessed Feb 18, 2019).
14 Kováts E. The equality paradigm exposed: why emancipatory politics came under fire and what we can do about it. In: Henkel F, Piplaš D, eds. Political trends & dynamics: gender politics in southeast Europe. Sarajevo, Bosnia: Friedrich-Ebert-Stiftung, 2018: 8–11.
15 Vigoya, MV. The controversy surrounding gender: a central question of (sexual) politics in Colombia. 2016. https://sxpolitics.org/the-controversy-surrounding-gender-nodal-question-of-sexual-politics-in-colombia/16218 (accessed Feb 18, 2019).
16 Bunch C. Beijing, backlash, and the future of women's human rights. *Health Hum Rights* 1995; **1:** 449–53.
17 UN Human Rights Office of the High Commissioner. Vienna Declaration and programme of action: adopted by the World Conference on Human Rights in Vienna on 25 June 1993. 1996. https://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx (accessed Feb 18, 2019).
18 UN Population Fund. Programme of action adopted at the International Conference of Population and Development Cairo, 5–13 September 1994: 20th anniversary addition. 2014. https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf. (accessed Feb 18, 2019).
19 The Fourth World Conference on Women. Beijing Declaration and platform for action. http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf (accessed Feb 18, 2019).
20 UN Human Rights Office of the High Commissioner. Women's rights are human rights. 2014. https://www.ohchr.org/Documents/Events/WHRD/WomenRightsAreHR.pdf (accessed Feb 18, 2019).
21 Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization, 2008.
22 Bilge S. Intersectionality undone: saving intersectionality from intersectionality studies. *Du Bois Rev* 2014; **10:** 405–24.
23 Sen G, Östlin P. Unequal, unfair, ineffective and inefficient: gender inequity in health—why it exists and how we can change it. 2007. https://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf (accessed Sept 15, 2018).
24 Heise L, Greene ME, Opper N, et al. Gender inequality and restrictive gender norms: framing the challenges to health. *Lancet* 2019; published online May 30. http://dx.doi.org/10.1016/S0140-6736(19)30652-X.
25 Weber AM, Cislaghi B, Meausoone V, et al. Gender norms and health: insights from global survey data. *Lancet* 2019; published online May 30. http://dx.doi.org/10.1016/S0140-6736(19)30765-2.
26 Heymann J, Levy JK, Bose B, et al. Improving health with programmatic, legal, and policy approaches to reduce gender inequality and change restrictive gender norms. *Lancet* 2019; published online May 30. http://dx.doi.org/10.1016/S0140-6736(19)30656-7.

27 Hay K, McDougal L, Percival V, et al. Disrupting gender norms in health systems: making the case for change. *Lancet* 2019; published online May 30. http://dx.doi.org/10.1016/S0140-6736(19)30648-8.
28 Evans J, Oliffe JL, Gregory D, Frank B. Health, illness, men and masculinities (HIMM): a theoretical framework for understanding men and their health. *J Men's Health* 2011; **8:** 7–15.
29 Greene ME, Robles O, Pawlak PM. Masculinities, social change, and development. World Development Report 2012: Gender Equality and Development Background Paper. 2011. http://siteresources.worldbank.org/INTWDR2012/Resources/7778105- 1299699968583/7786210-1322671773271/Greene-et-al-masculinities.pdf (accessed Dec 13, 2018).
30 Morris BJ. History of lesbian, gay, bisexual, and transgender social movements. https://www.apa.org/pi/lgbt/resources/history.aspx (accessed Dec 13, 2018).
31 Promundo. About us. https://promundoglobal.org/ (accessed Dec 13, 2018).
32 DATE SAFE Project. Making an impact since 2003. 2017. https://www.datesafeproject.org/about-us/ (accessed Dec 13, 2018).
33 ReThink. Our story. https://we-rethink.org/ (accessed Dec 13, 2018).
34 World Bank Group. Maternal mortality ratio (modeled estimate, per 100,000 live births). 2018. https://data.worldbank.org/indicator/SH.STA.MMRT (accessed Nov 26, 2018).
35 Brown K, Williams DB, Kinchen, et al. Status of HIV epidemic control among adolescent girls and young women aged 15–24 years—seven African countries 2015–2017. *Morb Mortal Wkly Rep* 2018; **67:** 29–32.
36 WHO. Road traffic injuries. 2018. https://www.who.int/news-room/fact-sheets/detail/road-traffic-injuries (accessed Nov 26, 2018).
37 WHO. Suicide. 2018. https://www.who.int/news-room/fact- sheets/detail/suicide (accessed Nov 26, 2018).
38 UN. Transforming our world: the 2030 agenda for sustainable development. New York: United Nations, 2015.
39 Manandhar M, Hawkes S, Buse K, Nosrati E, Magar V. Gender, health and the 2030 agenda for sustainable development. *Bull World Health Organ* 2018; **96:** 644–53.
40 UN Women. Turning promises into action: gender equality in the 2030 Agenda for Sustainable Development. 2018. http://www.unwomen.org/en/digital-library/publications/2018/2/gender-equality-in-the-2030-agenda-for-sustainable-development-2018. (accessed Nov 26, 2018).
41 Fritz AK, Heise L. A moment of convergence: STRIVE and the Sustainable Development Goals. Washington DC: International Centre for Research on Women; London, UK: London School of Hygiene & Tropical Medicine, 2018.
42 Hawkes S, Buse K, Yoon SY. Gender-responsive tobacco control: evidence and options for policies and programmes, report summary. https://globalhealth5050.org/wp- content/uploads/2018/09/Report-Summary-Gender-and-Tobacco.pdf (accessed Nov 26, 2018).
43 Brady J, Iwamoto DK, Grivel M, Kaya A, Clinton L. A systematic review of the salient role of feminine norms on substance use among women. *Addict Behav* 2016; **62:** 83–90.
44 Kyegombe N, Abramsky T, Devries KM, et al. The impact of SASA!, a community mobilization intervention, on reported HIV-related risk behaviours and relationship dynamics in Kampala, Uganda. *J Int AIDS Soc* 2014; **17:** 19232.
45 Lundgren R, Burgess S, Chatelois H, et al. Processing gender: lived experiences of reproducing and transforming gender norms over the life course of young people in Northern Uganda. *Cult Health Sex* 2019; **21:** 387–403.
46 Basu S, Zuo X, Lou C, Acharya R, Lundgren R. Learning to be gendered: gender socialization in early adolescence among urban poor in Delhi, India, and Shanghai, China. *J Adolesc Health* 2017; **61:** S24–29.
47 Cislaghi B, Heise L. Measuring gender-related norms: report of a meeting, Baltimore Maryland, June 14–15, 2016. London: Learning Group on Social Norms and Gender-based Violence of the London School of Hygiene & Tropical Medicine, 2016.
48 UN. Report of the Fourth World Conference on Women. New York: United Nations, 1996. http://www.un.org/womenwatch/daw/beijing/pdf/Beijing%20full%20report%20E.pdf (accessed Nov 26, 2018).
49 UN Economic and Social Council. Coordination of the policies and activities of the specialized agencies and other bodies of the United Nations system. 1997. http://www.un.org/womenwatch/osagi/pdf/ECOSOCAC1997.2.PDF (accessed Nov 26, 2018).
50 Brouwers R. Revisiting gender mainstreaming in international development: goodbye to an illusionary strategy. ISS Working Paper—General Series 556. The Hague: International Institute of Social Studies of Erasmus University Rotterdam, 2013.
51 WHO. Strategy for integrating gender analysis and actions into the work of WHO: WHO gender strategy. 2009. http://apps.who.int/iris/bitstream/handle/10665/44044/9789241597708_eng_Text.pdf (accessed Nov 26, 2018).
52 Ravindran TS, Kelkar-Khambete A. Women's health policies and programmes and gender-mainstreaming in health policies, programmes and within health sector institutions. 2007. https://www.who.int/social_determinants/resources/womens_health_policies_wgkn_2007.pdf (accessed Feb 16, 2019).
53 Mehra R, Rao Gupta G. Gender mainstreaming: making it happen. In: Buvinic M, Morrison AR, Ofosu-Amaah AW, Sjoblom M, eds. Equality for women: where do we stand on Millennium Development Goal 3? Washington, DC: IBRD/The World Bank, 2008: 311—35.
54 Dhawan S, Bakir M, Jones E, Kilpatrick S, Merz CN. Sex and gender medicine in physician clinical training: results of a large, single-center survey. *Biol Sex Diff* 2016; **7** (suppl)**:** 37.
55 Henrich JP, Viscoli CM. What do medical schools teach about women's health and gender differences? *Acad Med* 2016; **81:** 476–82.
56 Miller VM, Flynn PM, Lindor KD. Evaluating sex and gender competencies in the medical curriculum: a case study. *Gend Med* 2012; **9:** 180–86.
57 Miller VM, Rice M, Schiebinger L, et al. Embedding concepts of sex and gender health differences into medical curricula. *J Womens Health* 2013; **22:** 194–202.
58 Lamprell G, Braithwaite J. Mainstreaming gender and promoting intersectionality in Papua New Guinea's health policy: a triangulated analysis applying data-mining and content analytic techniques. *Int J Equity Health* 2017; **16:** 65.
59 Milward K, Mukhopadhyay M, Wong F. Gender mainstreaming critiques: signposts or dead ends? *IDS Bull* 2015; **46:** 75–81.
60 UN Women Training Centre. Training for gender equality twenty years on. 2015. http://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2015/paper_trainingforgenderequal ity20-b.pdf (accessed Sept 15, 2018).
61 Wong F, Vaast C, Mukhopadhyay M. Conceptualizing professional development for gender trainers: a working paper developed for UN Women Training Centre and KIT. 2016. https://www.kit.nl/wp-content/uploads/2018/10/Conceptualizing-Professional-Development-of-Gender-Trainers-review-and-mapping-report-May-2016.pdf (accessed Sept 15, 2018).
62 Theobald S, Tolhurst R, Elsey H, Standing H. Engendering the bureaucracy? Challenges and opportunities for mainstreaming gender in Ministries of Health under sector-wide approaches. *Health Policy Plan* 2005; **20:** 141–49.
63 Operations Evaluation Department African Development Bank Group. Mainstreaming gender equality: a road to results or a road to nowhere? Tunis, Tunisia: African Development Bank, 2012. http://idev.afdb.org/sites/default/files/documents/files/2012%20-%20Mainstreaming%20Gender%20Equality-A%20Road%20to%20Results%20or%20a%20Road%20to%20Nowhere%20-%20Synthesis%20Report.pdf (accessed Sept 15, 2018).
64 UN Women. Promoting UN accountability (UN-SWAP and UNCT-SWAP). http://www.unwomen.org/en/how-we-work/un-system-coordination/promoting-un-accountability (accessed Feb 16, 2019).
65 Oomman N, Mehl G, Berg M, Silverman R. Modernising vital registration systems: why now? *Lancet* 2013; **381:** 1336–37.
66 Data 2X. Civil registration, vital statistics, and gender. 2014. https://www.data2x.org/wp-content/uploads/2017/11/CRVSgenderdimensions_June2014.pdf (accessed Feb 18, 2019).
67 World Bank Group, WHO. Global civil registration and vital statistics: scaling up investment plan 2015–2024. 2014. http://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/CRVS%20Scaling-up%20plan%20final%205-28-14web.pdf (accessed Feb 18, 2019).

68 Center for Excellence for CRVS Systems. Knowledge briefs on gender and CRVS: harnessing CRVS systems for the gender-related SDGs—opportunities and challenges. 2019. https://crvssystems.ca/sites/default/files/inline-files/CRVS_Gender_1.3_Harnessing%20CRVS%20Systems_e_WEB.pdf (accessed Feb 21, 2019).

69 Desai M. Gender, health, and globalization: a critical social movement perspective. *Development* 2004; **47:** 36–42.

70 Hempel M. Reproductive health and rights: origins of and challenges to the ICPD agenda. *Health Transit Rev* 1996; **6:** 73–85.

71 Moosa Z, Kinyili HM. Big plans, small steps: learnings from three decades of mobilising resources for women's rights. *IDS Bull* 2015; **46:** 101–07.

72 Dhar, S. Gender and Sustainable Development Goals. *Indian J Gend Stud* 2018; **25:** 47–78.

73 Nichols FH. History of the women's health movement in the 20th century. *J Obstet Gynecol Neonatal Nurs* 2000; **29:** 56–64.

74 Enoch J, Piot P. Human rights in the fourth decade of the HIV/AIDS response: an inspiring legacy and urgent imperative. *Health Hum Rights* 2017; **19:** 117–22.

75 UNAIDS. The essential role of civil society. In: 2006 report on the global AIDS epidemic: a UNAIDS 10th anniversary special edition. http://data.unaids.org/pub/report/2006/2006_gr_en.pdf (accessed Feb 18, 2019).

76 Weldon LS, Htun M. Feminist mobilisation and progressive policy change: why governments take actions to fight violence against women. *Gend Dev* 2013; **21:** 231–47.

77 Beer C. Left parties and violence against women legislation in Mexico. *Soc Polit* 2017; **24:** 511–37.

78 Chaudhuri S, Fitzgerald S. Rape protests in India and birth of a new repertoire. *Soc Mov Stud* 2015; **14:** 622–28.

79 Addlakha R. Discursive and institutional intersections: women, health, and law in modern India. *Int J Sociol*, 2014; **24:** 488–502.

80 Anderson CF. Decriminalizing abortion in Uruguay: women's movements, secularism, and political allies. *J Women Polit Policy* 2017; **38:** 221–46.

81 Pousadela, I. M. Social mobilization and political representation: the women's movement's struggle for legal abortion in Uruguay. *VOLUNTAS* 2016; **27:** 125–45.

82 Wood S, Abracinskas L, Correa S, Pecheny M. Reform of abortion law in Uruguay: context, process and lessons learned. *Reprod Health Matters* 2016; **24:** 102–10.

83 Shaw D, Norman WV. A tale of two countries: women's reproductive rights in Ireland and the US. *BMJ* 2018; **361:** k2471.

84 Li A. From Ireland to Northern Ireland: campaigns for abortion law. *Lancet* 2018; **391:** 2403–04.

85 Promundo. Manhood 2.0. https://promundoglobal.org/programs/manhood-2-0/ (accessed Feb 18, 2019).

86 Haider S. The shooting in Orlando, terrorism, or toxic masculinity. *Men Masc* 2016; **19:** 555–65.

87 Fessler L. Activist Shaun King says toxic masculinity is at the root of gun violence, war, and terrorism. 2018. https://qz.com/work/1409018/hhw4-shaun-king/ (accessed Feb 18, 2019).

88 UNICEF. Technical note: coordinated strategy to abandon female genital mutilation/cutting in one generation. New York, NY: UNICEF, 2007.

89 Ambramsky T, Devries K, Kiss L, et al. Findings from the SASA! study: a cluster randomized controlled trial to assess the impact of community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC Med* 2014; **12:** 122.

90 Kyegombe N, Starmann E, Devries KM. 'SASA! is the medicine that treats violence'. Qualitative findings on how community mobilisation intervention to prevent violence against women created change in Kampala, Uganda. *Glob Health Action* 2014; **7:** 25082.

91 Doyle K, Levtov RG, Barker G, et al. Gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: findings from a randomized controlled trial. *PLoS One* 2018; **13:** E0192756.

92 Green D. Closing civic space: trends, drivers and what donors can do about it. 2019. https://oxfamblogs.org/fp2p/closing-civic-space-trends-drivers-and-what-donors-can-do-about-it (accessed Feb 18, 2019).

93 CIVICUS. Democracy for all: beyond a crisis of imagination findings and conclusions from a year-long initiative. https://www.civicus.org/documents/reports-and-publications/reimagining-democracy/democracy-for-all-en.pdf (accessed Feb 18, 2019).

94 Aho E, Grinde J. Shrinking space for civil society—challenges in implementing the 2030 agenda. FORUMSYD. 2017. https://www.forumsyd.org/sites/default/files/2018-03/Shrinking-Space%20-%20Challenges%20in%20implementing%20the%202030%20agenda.pdf (accessed Feb 18, 2019).

95 Rao Gupta G. Progress toward gender equality: backlash and resistance. 2018. https://unfoundation.org/blog/post/progress-toward-gender-equality-backlash-resistance/ (accessed Feb 18, 2019).

96 Global Fund for Women. Stemming the tide of the biggest threat to women's rights. https://www.globalfundforwomen.org/violence-against-women-threaten-rights-middle-east (accessed Feb 18, 2019).

97 Cousins S. Abortion: US global gag rule is having "chilling effect" on sexual health service providers. *BMJ* 2018; **363:** k4886.

98 Organisation for Economic Co-operation and Development. Aid in support of gender equality and women's empowerment. http://www.oecd.org/dac/stats/aidinsupportofgenderequalityandwomensempowerment.htm (accessed Nov 26, 2018).

99 Guttentag M, Renior M. Facilitating financial sustainability: understanding the drivers of CSO financial sustainability. 2018. https://www.issuelab.org/resources/30588/30588.pdf (accessed Feb 18, 2019).

100 Arutyunova A, Clark C. Watering the leaves, starving the roots: the status of financing for women's rights organizing and gender equality. Toronto, ON: Association for Women's Rights in Development, 2013.

101 Broome J. 2018 Ariadne forecast: for European social change and human rights funders. http://www.ariadne-network.eu/wp-content/uploads/2015/03/Ariadne2018Forecast.pdf (accessed Feb 18, 2019).

102 King M. Why Melinda Gates is investing $20M in the global women's movement. 2017. https://www.forbes.com/sites/michelleking/2017/10/11/why-melinda-gates-is-investing-20m-in-the-global-womens-movement/#45d9020a47f3 (accessed Sept 15, 2018).

103 UN Regional Information Center for Western Europe. #SheDecides conference raises 181 million euros for women and girls. 2017. https://www.unric.org/en/latest-un-buzz/30497-shedecides-conference-raises-181-million-euros-for-women-and-girls- (accessed Sept 15, 2018).

104 Bhushan A. Canada's turn to feminist international assistance: by the numbers. 2017. http://cidpnsi.ca/canadas-turn-to-feminist-international-assistance-by-the-numbers/ (accessed Sept 15, 2018).

105 Kickbusch I, Allen L, Franz C. The commercial determinants of health. *Lancet Glob Health* 2016; **4:** e895–96.

106 Hawkes S, Buse K, Kapilashrami. Gender blind? An analysis of global public-private partnerships for health. *Global Health* 2017; **13:** 26.

107 Jung AR, Hovland R. Targeting gender: a content analysis of alcohol advertising in magazines. *Health Mark Q* 2016; **33:** 221–38.

108 Hawkes S, Buse K. Gender-responsive tobacco control: evidence and options for policies and programmes. 2018. https://www.who.int/fctc/cop/sessions/cop8/Gender-Responsive-Tobacco-Control.pdf (accessed Feb 18, 2019).

109 Bohnet I. What works: gender equality by design. Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 2016.

110 Advisory, Conciliation and Arbitration Service and Government Equalities. Gender pay gap reporting: overview. https://www.gov.uk/guidance/gender-pay-gap-reporting-overview (accessed Nov 26, 2018).

111 The Global Business Certification Standard for Gender Equality. Why edge certification? http://edge-cert.org/ (accessed Sept 15, 2018).

112 Gender at work. About us: building cultures of equality & inclusion. https://genderatwork.org/about-us/ (accessed Dec 13, 2018).

113 Ludwig S, Oertelt-Prigione S, Kurmeyer C, et al. A successful strategy to integrate sex and gender medicine into a newly developed medical curriculum. *J Womens Health* 2015; **24:** 996–1005.

114 GWToday, George Washington University. Global women's institute and UNICEF to partner on gender education, credentialing programs. July 20, 2018. https://gwtoday.gwu.edu/global-women%E2%80%99s-institute-and-unicef-partner-gender-education-credentialing-programs (accessed April 25, 2019).

115 The Prevention Collaborative. Introducing the Prevention Collaborative. http://www.svri.org/forums/forum2017/Satellite/ThePreventionCollaborative.pdf (accessed Dec 13, 2018).

116 Raj A, Boehmer U. Girl child marriage and its association with national rates of HIV, maternal health, and infant mortality across 97 countries. *Violence Against Women* 2013; **19:** 536–51.

117 Aziz S, Kumar Mitra D, Omar Rahman M. Identifying factors associated with low maternal health care seeking behaviour in Bangladesh: does women's autonomy matter? *Women's Reprod Health* 2017; **4:** 115–25.

118 UN Educational, Scientific and Cultural Organization. Education counts: towards the Millennium Development Goals. SP, France: UNESCO, 2011. https://unesdoc.unesco.org/ark:/48223/pf0000190214 (accessed Dec 1, 2018).

119 Treleaven E, Toan PN, Le DN, Diamond-Smith N, Partridge C, Le HT. Gender disparities in child health care seeking in northern Vietnam. *Asian Popul Stud* 2016; **12:** 312–30.

120 Scheim A, Santos G, Arreola S, et al. Inequities in access to HIV prevention services for transgender men: results of a global survey of men who have sex with men. *J Int AIDS Soc* 2016; **19:** S2.

121 Chikovore J, Gillespie N, Mcgrath N, Orne-Gliemann J, Zuma T. Men, masculinity, and engagement with treatment as prevention in KwaZulu-Natal, South Africa. *AIDS Care* 2016; **28:** 74–82.

122 White Hughto JM, Reisner SL, Pachankis JE. Transgender stigma and health: a critical review of stigma determinants, mechanisms, and interventions. *Soc Sci Med* 2015; **147:** 222–31.

123 Hawkes S, Buse K. Gender and global health: evidence, policy, and inconvenient truths. *Lancet* 2013; **381:** 1783–87.

124 Greenfield SF, Brooks AJ, Gordon SM, et al. Substance abuse treatment entry, retention, and outcome in women: a review of the literature. *Drug Alcohol Depend* 2007; **86:** 1–21.

125 Seedat S, Scott KM, Angermeyer MC, et al. Cross-national associations between gender and mental disorders in World Health Organization world mental health surveys. *Arch Gen Psychiatry* 2009; **66:** 785–95.

126 Sorenson SB. Gender disparities in injury mortality: consistent, persistent, and larger than you'd think. *Am J Public Health* 2011; **101:** S353–58.

127 Sengoelge M, Laflamme L, El-Khatib Z. Ecological study of road traffic injuries in the eastern Mediterranean region: country economic level, road user category and gender perspectives. *BMC Public Health* 2018; **18:** 236.

128 Ewig C, Gastón AP. Inequality and the politics of social policy implementation: gender, age and Chile's 2004 health reforms. *World Dev* 2012; **40:** 2490–504.

129 Reidy D, Brookmeyer E, Gentile K, Berke A, Zeichner B. Gender role discrepancy stress, high-risk sexual behaviour, and sexually transmitted disease. *Arch Sex Behav* 2016; **45:** 459–65.

130 Witter S, Govender V, Ravindran TKS, Yates R. Minding the gaps: health financing, universal health coverage and gender. *Health Policy Plan* 2017; **32:** v4–12.

131 Ravindran T. Universal access: making health systems work for women. *BMC Public Health* 2012; **12:** S4.

132 Stergiou-Kita M, Mansfield E, Colantonio A, Moody J, Mantis S. What's gender got to do with it? Examining masculinities, health and safety and return to work in male dominated skilled trades. *Work* 2016; **54:** 721–33.

133 Gordon SB, Bruce NG, Grigg J. Respiratory risks from household air pollution in low and middle income countries. *Lancet Respir Med* 2014; **2:** 823–60.

134 Hu T, Lee AH. Women in tobacco farming: health, equality and empowerment. Public Health Institute, 2016. https://www.phi.org/uploads/application/files/cp6dgyk4gsyx1jn3uvzfftd61ohb6sagj5i9x1sw1y8c7vzm39.pdf (accessed Dec 1, 2018).

135 Shanahan P, Elliott D. Evaluation of the effectiveness of the graphic health warnings on tobacco product packaging 2008—Executive Summary. Australian Government Department of Health and Ageing, Canberra, 2009. http://www.tobaccolabels.ca/wp/wp-content/uploads/2013/12/Australia-2009-Evaluation-of-the-Effectiveness-of-the-Graphic-Health-Warnings...Executive-Summary-Govt-Report.pdf (accessed Dec 1, 2018).

136 Prakash V, Mansukhani N, Helenowski I, Woodruff T, Kibbe M. Sex bias in interventional clinical trials. *J Women's Health* 2018; **27:** 1342–48.

137 Roberts I. Women's work in UK clinical trials is undervalued. *Lancet* 2018; **392:** 732.

138 Global Health 50/50. The Global Health 50/50 report: how gender responsive are the world's most influential global health organisations? 2018. https://globalhealth5050.org/wp-content/uploads/2018/03/GH5050-Report-2018_Final.pdf (accessed Dec 1, 2018).

139 Tijdens K, De Vries DH, Steinmetz S. Health workforce remuneration: comparing wage levels, ranking, and dispersion of 16 occupational groups in 20 countries. *Hum Resour Health* 2013; **11:** 11.

140 Davies SE, Bennett B. A gendered human rights analysis of Ebola and Zika: locating gender in global health emergencies. *Int Aff* 2016; **92:** 1041–60.

141 WHO. Addressing sex and gender in epidemic-prone infectious diseases. France: World Health Organisation, 2007. https://www.who.int/csr/resources/publications/SexGenderInfectDis.pdf (accessed on Dec 1, 2018).

142 Williams C, Hunt P. Neglecting human rights: Accountability, data and Sustainable Development Goal 3. *Int J Human Right* 2017; **21:** 1114–43.

143 Smith J, Buse K, Gordon C. Civil society: the catalyst for ensuring health in the age of sustainable development. *Global Health* 2016; **12:** 40.

144 Hunt P. SDG Series: SDGs and the importance of formal independent review: an opportunity to lead the way. 2015. https://www.hhrjournal.org/2015/09/sdg-series-sdgs-and-the-importance-of-formal-independent-review-an-opportunity-for-health-to-lead-the-way/ (accessed Sept 15, 2018).

145 Independent Accountability Panel. Independence. https://iapewec.org/about/independence/ (accessed Nov 26, 2018).

146 The Global Fund. Board. https://www.theglobalfund.org/en/board/ (accessed Dec 13, 2018).

147 Gavi, the Vaccine Alliance. Board composition. https://www.gavi.org/about/governance/gavi-board/composition/ (accessed Dec 13, 2018).

148 WHO. Together for the triple billion: a new era of partnership between WHO and civil society. 2018. https://civilsociety4health.org/app/uploads/2018/12/WHO-cso-report.pdf (accessed Dec 13, 2018).

149 WHO. Viet Nam breastfeeding campaign normalizes practice, improves rates. 2016. https://www.who.int/news-room/feature-stories/detail/viet-nam-breastfeeding-campaign-normalizes-practice-improves-rates (accessed Feb 21, 2019).

150 Adrian Hodges Advisory Ltd. Opportunities for women: challenging harmful social norms and gender stereotypes to unlock women's potential. Scanplus, London: Unilever, 2017.

151 Stanley-Becker I. Gillette ad takes on 'toxic masculinity' in #MeToo-era rebrand, provoking a backlash. 2019. https://www.washingtonpost.com/nation/2019/01/15/gillette-takes-toxic-masculinity-new-ad-rebranding-metoo-era-inviting-backlash (accessed Feb 20, 2019).

152 Unstereotype Alliance. About the Unstereotype Alliance. http://www.unstereotypealliance.org/en/about (accessed Sept 15, 2018).

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