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The Lancet Commission on Gender and Global Health



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Gender inequalities drive inequities in health and well-being. From determining our chance of being born¹ to the predominantly male-led delivery of our funerals,^{2,3} gender interacts with, and frequently amplifies, other inequalities such as race or poverty in shaping our entire life experience. The global goal of equality on the basis of gender is an integral part of other global struggles for inclusive, rights-based, respectful, equitable systems, structures, and communities.

Gender is a social construction—influencing, and in turn influenced by, the distribution of power and resources, divisions of work and labour, distinctions between production and reproduction, and expectations and opportunities available to all people in all societies.⁴ Gender intersects with other social factors to drive health inequities.⁵ This is evident in the COVID-19 pandemic in which severity of illness and death rates are higher in men than in women but women face heightened vulnerabilities because they form the bulk of front-line health and care workers, and bear the greatest burden of domestic violence, household and child-care responsibilities, mental health, and economic impacts of the pandemic.⁶

Gender is embedded within and across organisations, systemic structures, and institutional norms, including in science, medicine, and health.⁷ Deep-seated gender biases were documented in *The Lancet's* 2019 theme issue on advancing women in science, medicine, and global health, #LancetWomen,⁸ which explain, for example, the persistent imbalance between the 70% of health workers who are female and the 70% of health-care leadership who are male.⁹ Gender is a cross-cutting issue with an impact on the health and careers of women, men, transgender people, and people with non-binary identities everywhere.

The global health system has been aware of the relation between gender and health for decades, and scholarship in the area is widespread. In the 2019 *Lancet* Series on gender equality, norms, and health, the role of norms as a bridge to improved

equity and health was highlighted.¹⁰ By taking a gender lens to sexual and reproductive health and rights, policies and programmes are likely to have a greater impact than those that remain “gender-blind”.¹¹ And evidence shows that intersectional approaches in global health can uncover the interlocking disadvantages for people of different ethnicities, and for groups that vary on the basis of abilities, sexuality, class, and geography, among other social stratifiers, in addition to gender.⁵

Despite this body of knowledge, however, consideration of gender in global health is neglected. Gender is everywhere in global health discourse and promises, but nowhere in action or accountability plans. As Clark and Horton wrote: “Gender now runs the risk of being treated like motherhood and apple pie—a common good no one would disparage, but neutered of its radical political nature.”¹² Or, as Geeta Rao Gupta and colleagues have argued, gender is “everyone’s problem but no one’s responsibility”.¹³ This represents a massive missed opportunity. The world’s community is not on track to meet the Sustainable Development Goals (SDGs) for health or for gender equality.¹⁴ COVID-19 could widen the gaps. Now is the



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time to leverage the benefit of addressing gender and global health targets simultaneously.

The underlying cultural, social, political, legal, and economic drivers that create disadvantage are not immutable. With this in mind and building on the journal's past commitments to gender equity, *The Lancet* announces a new Commission on Gender and Global Health. This Commission has been set up with the explicit and uncompromising aim to move beyond the evidence to catalyse action. For change to happen, academic evidence is necessary but insufficient: the world does not need another report on the evidence and extent of a so-called gender problem in health. The Commission was borne of a collective and strategic understanding of the need to mobilise individuals and institutions to redress imbalances in the gender–health relationship, producing a politically informed, globally relevant, and intersectional feminist strategy for structural change in global health.

The Commission is co-chaired by three of us (SH, PA, ASE) along with 25 other independent Commissioners (appendix) who bring a wide range of expertise and experience—from people working with community health groups to those working on the global governance of the corporate determinants of health, through to human rights scholars and practitioners—and representing a range of global health topics and disciplines, geographies, and genders. The Commission will privilege a diversity of voices and scholarship. We plan to establish a programme of public engagement, seeking dialogue across a range of views and voices to understand the complexity of defining and addressing gender, intersectionality, and health. We are grateful for seed funding from the Wellcome Trust, The Ford Foundation, the United Nations University–International Institute for Global Health, and University College London. We plan to have our first Commissioners' meeting in late 2020, and a 2-year timeframe for the Commission's work.

The gender–health relationship is complicated and multidimensional, but with 10 years left in the SDG

agenda and as the world begins to exit from the profound disruption of COVID-19, now is the right time to unpick the complexity and identify solutions for gender-responsive change within systems and sectors. The change needed to reach a goal of gender equality and health equity is substantial, structural, and system-wide, and the voices demanding this change have never been louder. The *Lancet* Commission on Gender and Global Health aims to contribute to that change and deliver on the action agenda on gender and health.

ASE is Chair of the Kofi Annan Foundation and Co-Chair of the Global Preparedness Monitoring Board. We declare no other competing interests.

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See Online for appendix