SOCIALLY CONSTRUCTED DETERMINANTS OF HEALTH: THE CASE FOR SYNERGIES TO ARRIVE AT GENDERED GLOBAL HEALTH LAW

Abstract:

Both gender and the law are significant determinants of health and wellbeing. Here we put forward evidence to unpack the relationship between gender and outcomes in health and wellbeing, and explore how legal determinants interact and intersect with gender norms to amplify or reduce health inequities across populations. The paper explores the similarities between legal and health systems in their response to gender - both systems portray gender neutrality but would be better described as gender-blind. We conclude with a set of recommendations to address both law and gender in implementing the work of the Lancet Commission on the legal determinants of health to improve health outcomes for all, irrespective of gender.

Introduction

In a world that is rapidly globalizing, urbanizing and industrializing, where politics is highly polarized, the speed of social and cultural change is amplified by ever more pervasive technologies and surveillance mechanisms, and the accumulation of global capital is concentrated in the hands of an ever-diminishing proportion of the global population, the need for understanding and addressing the social and structural determinants of health has never been greater.

The seminal 2008 report of the WHO Commission on the Social Determinants of Health proposed a framework and set of interventions for improving health equity (and reducing health inequity) that operated on both the "circumstances of daily life" and the structural drivers of those circumstance – which included the nature of social stratification, biases, norms and values in any society, and processes of governance (WHO, 2008). While the WHO Commission's report recognized the importance of both law and gender as determinants of

health and wellbeing over the life course, the intersection between these two sets of determinants was only briefly outlined and focused predominantly on promoting legislation to increase girls' access to education, protect girls and women from discrimination and exploitation in labour markets, and reduce all types of violence against women (see Chapter 13 of the report). The 2019 Lancet Commission on the legal determinants of health (Gostin et al, 2019) argues that the law is ubiquitous and thus a critical influence over health—for better or worse in terms of individual outcomes and population level health equity. The Lancet Commission addresses gender both as it relates to Sustainable Development Goal 5 ("achieve gender equality and empower all women and girls" (UN, 2015)) and also highlights the importance of addressing vulnerability and exclusion on the basis of gender identity.

While the both the WHO Commission and the Lancet Commission make clear cases for the relevance of addressing gender inequalities and inequities in order to promote health equity, and propose law as one mechanism through which this can be achieved, neither Commission looks in detail at the complex relationship between these two determinants, nor addresses what gender-responsive legal and health systems might look like. Of concern, in both Commissions the relationship between gender and health is predominantly focused on the inequities suffered by women and girls – a necessary component of gender-responsiveness in health, but an insufficient vision to address gender as a determinant of health inequity among everyone.

In this paper we put forward evidence to unpack the relationship between gender and outcomes in health and wellbeing, and explore how legal determinants interact and intersect with gender to amplify or reduce health inequities across populations. The paper goes on to explore the similarities between legal and health systems in their response to gender. The paper then concludes with a set of recommendations to address both law and gender in implementing the work of the Lancet Commission to improve health outcomes for all, irrespective of gender.

We start by exploring the nature and meaning of gender, investigate its relationship to the health and wellbeing of everyone, and review how gender interacts with legal determinants across a conceptual framework of gender and health.

Gender and sex – definitions

Gender is defined within global health as referring to "the roles, behaviours, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men. Gender interacts with, but is different from, the binary categories of biological sex" (WHO, Gender Health Topic). Gender is relational, referring not only to relationships between people (Connell, 1987), but also to other types of relation – power, property, economic, symbolic, and operating at multiple levels from the intrapersonal to the organizational, political and institutional (Lorber, 1994; Connell 2012). As a social construction, gender is mutable, malleable, and non-binary. The expression of gender can change over time and place, and the performance of gender can change over the life-course (Butler, 1999). Gender is frequently described as being on a spectrum (Nagoshi et al, 2014) where gender identity is non-binary and fluid (Connell, 2012) – thus providing challenges in capturing the category of gender in quantitative health research (Weber, 2019). As a political construction, gender is frequently a contested terminology, particularly in socially and politically conservative settings – as we currently see in countries such as Brazil, Hungary and the United States of America (Beinart, 2019; Durso, 2018; Sovik 2019).

Gender interacts with biological sex – the genetic, physiological and morphological characteristics that define male, female or intersex (Jazin and Cahill, 2010). Biological sex contributes strongly (wholly in some cases) to many diseases; for example, cervical cancer and prostate cancer are sex-dependent (female and male, respectively). However, even in those cases where a condition is sex-associated (e.g. prostate cancer or cervical cancer), gender will still impact on disease outcome, for example influencing pathways of care within gendered health systems – a subject to which we return in the latter half of this paper.

Understanding the contribution of either sex or gender (or both) to outcomes of health and wellbeing is complicated by the frequent misuse and under-use of these terms and analytical categories in medical and health research and publications (Clayton and Tannenbaum, 2016; Sugimoto et al, 2019). Additionally, data which are collected and presented as sex-disaggregated alone can overlook the health experiences of people with non-binary identities

– and there is an emerging body of work to show that transgender populations, or those with other non-binary gender identities, experience a range of adverse health outcomes that are frequently under-recognised or under-recorded within health data (Wylie et al, 2016).

Nonetheless, when health data are differentiated by sex they can usefully describe the distribution of disease, risk factors, outcomes and impact of illnesses in both people and populations. What sex-disaggregated data cannot do, however, is interpret and provide an explanation for difference – for that we need to employ the analytical lens of gender. In the following section we present a selection of health data disaggregated by sex to highlight where, and to what extent, we see global differences in morbidity and mortality. We then use our conceptual framework of gender and health to explain the sex-disaggregated differences in the data. The intersection of each of the three domains of the conceptual framework with the legal determinants of health and wellbeing is then explored.

Sex-disaggregated differences: a (brief) selection of global health data

In 2019, WHO for the first time presented its *World Health Statistics* disaggregated by sex across all health-related sustainable development goal targets (WHO, 2019). The extensive global database provided a detailed picture of sex-differences in rates of morbidity and life expectancy between women and men in all regions of the world. In terms of mortality, the data showed that women have a longer life expectancy than men at all ages – at birth the global difference is currently 4.4 years (69.8 years for men, 74.2 years for women). In terms of morbidity, women live longer in worse health – although they can still expect to experience a longer healthy life expectancy than men (HALE; currently 64.8 years at birth for women compared to 60 years for men). Where sex-disaggregated data are available for the targets of Sustainable Development Goal 3 (SDG3, 'the health Goal'), WHO *World Health Statistics* reports that male disadvantage is more common in 11 of 12 targets – the exception being female disadvantage in the case of illness related to water and sanitation.

These data reflect trends that have been observed within the UK for centuries (Graunt, 1665), and systematically quantified at a global level over the past 30 years. The World Bank's

ground-breaking development report of 1993 presenting a rationale for investing in the health sector, noted, for example, that "females have about a 10 percent lower diseases burden per 1000 population than males for the world as a whole" (World Bank, 1993).

Gender explains (some) sex-disaggregated differences

While the 2019 *World Health Statistics* confirm a persistent pattern in the categorical and dichotomous (i.e. differentiated into male and female) distribution of ill-health and lower life expectancies that has been well-reported in the literature for many years, the dataset cannot explain *why* we see such differences. Applying a gender lens to the many examples of global, national and subnational survey, cross-sectional, programmatic or study datasets that record observable differences in sex-disaggregated health statistics between males and females (and, less commonly, among people with non-binary identities), can help to explain the origins of difference and suggest strategies for intervention.

We propose to use an existing conceptual framework (Hawkes and Buse, 2020) outlining the interactions between gender and health outcomes to better understand why we see such sex-disaggregated differences, and to then explore how legal determinants interact across the framework – see Figure 1.

Figure 1 here

Source: Hawkes and Buse, 2020

This framework draws upon the work of Doyal and Payne (2011) and our own work in gender and global health (Hawkes and Buse, 2013). Within this framework, gender and health interact across three interlinked domains – i.e. these domains do not exist in exclusion to each other, but are frequently mutually reinforcing. In the first domain, gender is embodied through its intersection with other structural determinants of health to produce and reproduce vulnerability, inequality or privilege with respect to health outcomes. While the classical notion of intersectionality refers predominantly to the intersection of gender and race (Crenshaw, 1989), a wealth of epidemiological and demographic literature presents

evidence of the compounding role that gender norms can play through their interaction with many other structural factors. A recent review of global survey data (Weber et al. 2019) using global, national and subnational datasets looked for associations between gender norms and health and noted that gender intersected *inter alia* with age, wealth, geographical location and labour-force participation rates, to provide explanatory pathways for a range of conditions including mental health, intimate partner violence and care-seeking for childhood illness. A gendered explanation of these types of intersection has been previously proposed by Connell (2012) who cautions against simply combining categorical approaches to understanding gender or race or class, and instead to focus on understanding the complex inter-relationships both between and within identities and categories. Such an approach, she argues, allows for a more in-depth and nuanced analysis of diversity within and across identities – and thereby across and within families, communities and societies.

The second domain refers to the enactment of gender through health behaviours – which can in general be protective or harmful. Some of the starkest examples of gendered norms of behaviour are seen in relation to patterns of consumption of health-harming products. In many societies tobacco smoking and alcohol consumption are closely associated with masculine gender norms, and frequently portrayed as positive features of masculinity (Courtenay, 2000; Wilsnack et al 2005). As early as the 1970s scholars raised concerns that men's lower life expectancy in the United States of America was due to "lethal aspects of the male role" which included recognition that older boys "often begin smoking and drinking as a symbol of adult male status" (Harrison, 1978). At a global level, alcohol and tobacco drive a significant proportion of the excess mortality suffered by men in all regions of the world. For example, using data from birth cohorts in 13 countries 1800-1935, it has been estimated that tobacco smoking alone contributed to approximately 30% of the excess mortality observed in men over the course of the 20th century (Beltrán-Sánchez et al. 2015).

Gender norms can also be protective of health. For example, some studies have shown that boys are more likely than girls to participate in organized sports activities – and hence have higher rates of physical exercise. Gendered analysis to examine these differences finds that gender roles (Chalabaev et al, 2013) and concerns of body image (Slater and Tiggeman, 2011) play a part in reducing girls' participation – but may be enabling boys to exercise more.

The evidence for health-care seeking patterns influencing differentials between the sexes in health outcomes is more mixed, partly because at a population level the overall level of impact of the health system on many health outcomes is unclear in many parts of the world and for many conditions. In the 1970s, Thomas Mckeown (1979) famously opined that "the contribution of clinical medicine to the prevention of death and increase in expectation of life….was smaller than that of other influences" – setting in motion a continuing line of questioning as to the exact role that health systems and health services play in keeping populations healthy as compared to their function of treating people when they become sick - see, for example Ostry (2010) and Gostin (2016). Irrespective of precise attribution to health outcomes, comprehensive data on patterns of health-seeking behaviours disaggregated by sex are woefully inadequate at a global level. For example, the most recent WHO monitoring report on Universal Health Coverage (UHC) does not provide comprehensive data on health service use that is sex-disaggregated (WHO, 2019b).

Select national datasets tend to show that at an aggregate level women and girls are more likely to use health services over the course of a lifetime compared to men and boys. In the United Kingdom (UK), for example, Wang and colleagues (2013) report that "women aged 16-44 years are twice as likely as men of the same age to have visited their general practitioner in the previous 12 months". However, in-depth analysis of this data point examining medical records for almost 4 million registered patients across the UK in 2010, notes two important caveats: firstly, some of this difference can be explained by consultations for reproductive health care needs among women (approximately 240,000 consultations for women compared to 830 for men); and secondly that men and women with "similar underlying morbidities differ much less in their use of primary healthcare services than men and women in the population as a whole". Despite these caveats, other scholars have highlighted the contribution of masculine gender norms towards men's relative under-use of health services – including for health screening checks (Dryden et al, 2012). Courtenay (2010) ascribes the behaviours associated with hegemonic [idealized] masculinity as driving health risks. The rigidity and power of these gender norms contributes, for example, towards men's lower rates of help-seeking for mental health services (Pattyn et al, 2015) and may be influencing

the high rates of men's poor mental health outcomes (including suicide) seen in many settings and regions of the world (Adinkrah, 2012; Braswell and Kushner, 2012; Bantjes et al, 2017).

While many datasets show that women have a generally higher use of health services, at national and subnational levels studies report on the continued impact of entrenched gender inequalities limiting women's use of health services. For example, when health care relies upon out-of-pocket payments, women may lack the financial autonomy to access services (Saikia et al. 2016).

This brings us to the third domain in the framework – the extent to which gender is embedded in organizations and institutions, affecting not only those who seek to use services or access interventions to protect and promote their health, but also determining the career pathways of those who work within these systems. The embedded gender of institutions and organisations has been referred to as the 'gender regime' – reflecting the "entire set of social structures that influence sexual division of sexual roles" (Lett, 2012).

The impact of the unequal gender regime of organisations and institutions within global health and medicine can be seen from 'bench to bedside'. Consider, for example, the case of cardiovascular diseases (CVD) – a leading cause of both morbidity and mortality in women and men across the world. Women have been under-represented in clinical trials of drugs to treat CVD: a review of 36 trials for approval by the US Food and Drug Administration and involving a quarter of a million participants, found that only 34% were women (Scott et al, 2018). In addition to failing to take sex- and gender-differences sufficiently into account when assessing drug efficacy and safety, gender influences the pathways of care for people with symptoms. For example, compared to men, women with symptoms and signs of CVD are less likely to be investigated using common diagnostic techniques (Sekhri et al, 2008), are less likely to receive evidence-based therapies, receive cardiac rehabilitation or behavioural recommendations (Shaw et al, 2017). These inequalities contribute to women's higher rates of both morbidity and mortality at similar levels of clinical CVD (Radovanovic et al, 2007; Hayes et al. 2015).

Embedded gender norms, entrenched gender regimes and working environments that fail to foster and support respectful and inclusive working environments also impact the career pathways of people within systems – including but not limited to global health and medical systems. While less than 30% of the world's science researchers are women (UNESCO, 2018), women make up an estimated 70% of the global health and social care workforce (ILO, 2017) – with substantial regional variation. Despite the large proportion of women in the health and care workforce, patterns of occupational segregation, an absence of clear targets and strategies for gender equality in leadership, and unprotected working conditions, mean that at the top-most levels of global health, around 70% of the leadership is male (Global Health 50/50, 2019).

The interaction of gender and legal determinants of health

In the preceding section we described a conceptual framework that provides a basis for analyzing how gender impacts on health equity. Where does the law fit into this framework? We believe that legal determinants of health, as described by Gostin et al. (2019), play an important role in all three domains of the framework - perpetuating the intersecting structural drivers of health inequalities, underpinning health behaviours, and exacerbating unequal gender regimes within systems of health and medicine. In the following section we provide select examples of how the legal determinants of health interact with the three domains of our framework, and explore the impact that this is likely to have on inequities in health and wellbeing.

Gender, intersectionality and legal determinants

'Intersectionality' as a means for understanding the multiple systems of oppression and inequality experienced by individuals and communities was first proposed by legal scholar Crenshaw (1989). Applying an intersectional lens to the experiences of subordination, marginalization and exclusion experienced by black women in the USA, Crenshaw highlighted that "the intersectional experience is greater than the sum of racism and sexism" (Crenshaw, 1989). According to Crenshaw, failure to take intersecting inequalities into account risks perpetuating systems of privilege – whereby the most marginalized in society benefit least from policies and systems to redress inequality.

An intersectional and evidence-informed approach to gender and other social determinants of health inequity (race, age, geography, dis/ability, caste, migration status, class, etc) provides an opportunity to strengthen legal interventions to promote and protect health so that benefit is accrued even by the most excluded, vulnerable members of society. In the framework of the *Lancet Commission on legal determinants*, legal determinant three (implementation of fair, evidence-based health interventions) argues for just and effective public health laws that are, inter alia, "evidence based (and) equity promoting" (Gostin et al, 2019). The Commission argues that disadvantaged communities include "racial, ethnic or sexual minorities; and women and children". In this paper we have highlighted that, on the basis of sex-disaggregated evidence collected through global monitoring systems supplemented by in-depth gender analysis, disproportionate burdens of morbidity and premature mortality are, in fact, distributed across the gender spectrum – with trans and non-binary communities, and men and boys suffering the highest rates of many common global health conditions.

Using health laws to promote equity will, therefore, require taking into account the depth and breadth evidence of gender as a determinant of health inequities for everyone. The next conceptual step is to recognize that gender does not act alone. Moving from a binary gender lens in global health (with its traditional focus on the health of women and girls – see, for example, Hawkes and Buse, 2013 and Gupta 2019), to an evidence-informed approach of gender as one of a range of intersecting inequalities that embody and embed health inequities will, we propose, strengthen the impact of laws to protect and promote health.

As a starting point, the Commission's call for health laws to be evidence-based and for national law makers to pay attention to the "most vulnerable" when striving for health with justice, would be well placed to apply an intersectional gender lens that helps identify and understand the existing evidence within each country as to who is actually disadvantaged in terms of health outcomes. An intersectional gender lens applied to identify the particular health risks and rights of pregnant black women in the US would show that their maternal mortality rate is 3 times higher than white women in the country (Metcalfe et al, 2018). An intersectional analysis of gender, geography and occupation would highlight that men

working in the gold mines in South Africa have tuberculosis incidence rates that are among the highest in the world (Rees et al, 2010). Thus, using gender-responsive legal strategies to realise the rights of all pregnant American women to health care, or uphold the rights of all South African men, and the smaller number of women, who work in the mining industry to safe occupational working conditions, would act to reduce health disparities in each country.

Gender, law and health behaviours

The Lancet Commission highlights the role that law can play in promoting health-enabling environments. In the example of tobacco control, many domestic laws and regulations (rightly) draw heavily on the international Framework Convention on Tobacco Control (FCTC) to protect the health of the population by reducing exposure to and consumption of tobacco and tobacco products. WHO annual surveys find that globally 86% of adult smokers (25-69 years) and 83% of young smokers (15-24 years) are male (Hawkes et al, 2018a). Yet, even in the face of such stark sex-disaggregated evidence, and gender analysis that clearly links tobacco consumption to masculine gender norms (Courtenay, 2000; Kohrman 2007), public policy responses, including the FCTC documents, are gender-blind (Hawkes et al, 2018b) – i.e. they ignore gender norms, roles and relations and are constructed on the basis of "fairness", i.e. treating everyone the same (WHO, 2011).

A gender-responsive approach to tobacco control would see the FCTC guidance integrate a gender lens into policy, implementation and evaluation. Gender-responsive policies could include, for example, restrictions on the use of harmful gender stereotypes in advertisements for tobacco and tobacco-related products (where still in operation). Tobacco companies have exploited and manipulated the flexibility of gender norms for decades, from the 'iconic' imagery of the Marlboro adverts using images of cowboys as they were "an almost universal symbol of admired masculinity" (Burnett 1955) to the idea that women smoking is associated with independence (and weight control) (Brandt, 1996).

In contrast to the gender-awareness and savvy of industry, public health responses in the legal and policy domains have virtually ignored gender. Integrating a gender-responsive set of legal responses to tobacco control could, for example, include legislating to ensure that gender is taken into account in programmatic design and service delivery, and including

gender-responsive and equitable systems of inclusive participation in the governance of tobacco harm. A limited evidence base in this area reflects the lack of gender-responsive policy and programme design till now, but there is some evidence to suggest that gender-responsive tobacco control is likely to be more effective than gender-blind tobacco control. Research with new fathers in Canada, for example, highlighted that gender-responsive health promotion (to encourage them to quit smoking) was likely to be more effective than focusing on strategies to blame and shame them into quitting smoking since it would focus on positive aspects of masculinity and fatherhood (Oliffe et al, 2012). Additionally, evaluation of laws, regulations and policies that takes gender into account can help identify where an intervention is, or is not, having impact. For example, a systematic review of the effects of price on smoking behaviours in young people (Rice et al, 2010) found (limited) evidence that price may have a greater impact on the smoking rates of young men compared to young women – which carries implications for additional strategies to be implemented to reduce smoking rates equitably.

The Lancet Commission on legal determinants emphasizes the universality of the right to health care - and promotes the SDGs as a mechanism for achieving universal health coverage (UHC). The WHO 2019 Global Monitoring Report on UHC (WHO, 2019c) does not provide comprehensive UHC data that are sex-disaggregated, but does undertake a gender analysis of some of its health outcome data to highlight disparities in service access. As noted previously in this paper, men tend to seek health care at a lower rate than women for many conditions - although these generalisations may hold less strongly in countries with existing UHC systems (such as the United Kingdom). Where service-use disparities exist and gender analysis identifies potential interventions, many of these are rooted in the legal determinants of health, but a gender-aware monitoring their implementation is crucial. For example, a gender analysis found that legislative reforms intended to decrease health disparities in Chile had the opposite effect and served to widen gender inequalities in health care access to the disadvantage of women (Ewig and Palmucci, 2012).

Law and global health as gendered institutions

Law and medicine (and global health) are frequently seen as 'gender neutral' institutions that exist to promote notions of universality, equity and benefit for all, irrespective of gender and

other social stratifiers. As we have seen throughout this paper, however, health organisations and health care systems may frequently be described as gender-blind, but are rarely gender-neutral. The experiences (and expectations) of people accessing services within the health system, and the careers of people working or governing the global health system, are underpinned by gender. While decisions on resource allocation are, in theory, based on empirical evidence, in practice global health decision-making is rooted in the historical construction of gender that sees women as "reproducers" (Inhorn and Whittle, 2001) with an attendant public policy focus seeing resources directed to reproductive health care, pregnancy care, childbirth and child survival (Gupta, 2019). Data from the Institute for Health Metrics and Evaluation (IHME, 2019) shows, for example, that 12% (US$4.7 billion) of all development assistance for health (DAH) flows to programmes concerned with maternal health – an area that accounts for under 0.5% of disability adjusted life years (DALYs) and deaths in the world. In contrast, non-communicable diseases are responsible for approximately 60% of DALYs and 70% of deaths, but receive just 2% (US$778 million) of DAH.

In contrast to the gendered construction of global health with its focus on women of reproductive age, gender inequalities in the global health workforce drive stark disparities in: 1) pay (gender pay measured at over 13% in 2019; bonus pay gap of 23% - Global Health 5050, 2019); 2) career progression (see data above on lack of parity in global health leadership); and 3) in security and safety in the workplace. Illustrative of the latter, Jagshi et al (2016) found that among junior medical research faculty in the USA 30% of women and 4% of men reported sexual harassment in their professional careers, and this was associated with perceptions of negative impact on career advancement. While legal responses to these inequalities and injustices may not provide the full solution, they underpin strategies to ensure that gender pay gaps are made transparent so that corrective action can be taken, that women are not segregated to lower paid occupations or penalized by not being able to work at night (thus restricting their chances of career progression), that workplace discrimination is illegal, that there are laws covering sexual harassment in the workplace and that these laws provide for either criminal penalties or civil remedies in case of violation - World Bank surveys of gender equality find that in five countries where workplace sexual harassment policies have been newly introduced, no remedial actions are mentioned (World Bank, 2019).

In her seminal work on Law and Gender, Conaghan (2013) describes law as a similarly gendered institution: theoretically gender-neutral, but frequently gender-unequal in practice. While all people are, in theory, equal (and 'genderless') before the law, decades of feminist legal scholarship have served to highlight the "inherent masculinity" of the archetypal 'liberal legal person' (Hunter, 2013). Critiques of Western medical scholarship note that is has been similarly imbued with the notion of the masculine norm since at least the time of Aristotle, who observed that "the female is, as it were, a mutilated male" (Mayhew, 2004). Feminist legal scholars focusing on the engagement of law with the body, bodies and embodiment, have studied the ways in which the (predominantly female) body has been subjected to legislation (and also criminalization) (Fox and Murphy 2013). The absence of laws to protect gendered bodies is also important to understand and address. For example, in 49 countries there is an absence of laws to protect against women against domestic violence (World Bank, 2017), while a study of laws against child sexual abuse and exploitation in 40 countries found that around half (19) lack legal protection for boys (Economist Intelligence Unit, 2019). This rich stream of intellectual enquiry in legal scholarship continues to highlight that the institution of the law is inherently gendered, and we concur with Fox and Murphy when they point out, in public health law debate "feminist voices to date have been somewhat muted" but would extend that to say "gender-responsive voices have been somewhat muted" in public health law till now.

Discussion and recommendations

The Lancet Commission on the legal determinants of health clearly articulates that the right to health is a legal entitlement of all people—states have obligation to respect, protect and fulfil this right through variety of mechanisms, including the law. Additionally, as we have seen in the paper so far, the law can help clarify state obligations, including in relation to the promotion of gender equality in the health sector – both when upholding the rights of people to health-promoting environments and equitable health services, or the realisation of gender-equitable opportunities for career progression in those services. The global health community thus needs to take an active role in shaping those laws that affect health determinants, health outcomes and the health system (as a place of care and career), and provide the guidance

needed to enact and implement laws that are gender-responsive. Right now, such capacity is thin in general and, as we have highlighted, tends to be for the most part gender-blind.

In this paper we have emphasized the important role that gender plays in determining health inequities, but have also shown that for the most part the health community relies upon notions of gender neutrality (or assume such to be the case) and thereby risks gender-blindness. It appears that much of the health law system suffers under similar illusions – derived from similar long-standing notions that medical and legal systems are gender-neutral and promote universality. Even a brief review of the application of law within global health, however, reminds us that legal systems can both entrench or remedy gender discriminations, stigmas and inequalities.

We propose that the time has come for the systems of both global health and health law to become more gender-responsive. A gender-responsive approach to global health law would apply a gendered lens to the analysis of and action on the legal determinants that can transform unhealthy norms that affect the health of everyone, as part of a wider movement for health equity. In other words, there needs to be a more critical reflection of the gender dynamics at play in both the law and global health, to move beyond the assumptions of gender neutrality in both of these spheres (or to pigeonhole gender as meaning women and girls only). This will entail both recognizing and addressing the gendered nature of law itself, as well as evaluating how the legal determinants of health can be made more gender-responsive. Concurrently we strongly believe that there is a need for the gender community working in global health to become more legally literate and cognizant of the opportunities offered by addressing the legal determinants of global health.

The fields of sexual and reproductive health (SRH) and HIV provide evidence that gender-responsive approaches to addressing legal determinants can be effective. In many countries women's health advocates have used both national and international legal systems to uphold rights in relation to sexuality and SRH - including, inter alia, women's access to services free of third party authorization, promoting equitable access to safe and legal abortion, and recognition of rape within marriage (Kismödi et al. 2015). Such progress is underpinned by a clear recognition of the gender inequalities suffered by women as a result of structural,

including legal, drivers of inequality. Similarly, the HIV field has a long and rich history of the use of law to promote and protect the rights of people living with HIV and people affected by HIV who are subject to discrimination on their grounds of their gender identity (see, for example, Hunter, 1995 and Weait, 2013).

We propose that taking a gender-responsive approach to the legal determinants of health in other areas will reap synergistic benefits. As we have shown in this paper, nowhere is the need for the global health law to be more gender-responsive than in addressing the commercial determinants of health. A gender-blind global health law (and associated policies and programmes) in this area risks failing to appreciate and obviate the manner in which industry leverages the malleability of gender to promote the consumption of unhealthy products. While global health and legal systems may be relatively unaware of the power of gender as a determinant of health behaviours, it is clear that industry has long recognized and exploited gender norms – as noted above in the examples from the tobacco industry but similar cases can be made for alcohol and many parts of the food industry.

In operationalizing gender-responsiveness within the legal determinants of health, we are aware that, above all else, the approach needs to be practical and usable. Legislators and policy makers would benefit from tools that provide a more informed understanding of gender and the benefits of gender-responsive laws and policies to reduce health inequities. Those working in the field of gender and health would similarly benefit from a range of tools that build their capacity to understand and apply legal instruments, including strategic litigation, to realise health goals. A proposed next step is to encourage the development of tools that can be used across both communities to implement and monitor gender-responsiveness within the legal determinants of health. Such tools could build upon and adapt existing reporting mechanisms such as the World Bank's annual survey of Women, Business and the Law (World Bank, 2019). Such tools should not, however, be limited to implementation and monitoring but should be components of an overall approach to accountability (Williams and Hunt, 2017) - holding countries, institutions and organisations to account for their commitments to narrow the health equity gap in a manner that is not only gender-responsive, but also takes into consideration a range of intersectional stratifiers of inequality.

The drive for changing institutional norms (from gender blind to gender responsive) will almost certainly be enabled and emboldened by demand from civil society. A challenge here is that community action in the fields of law, gender and health have tended to be siloed and not well networked (although, as noted, the communities of SRH and HIV advocates, activists and academics tend to be an exception to this). Community-led demand for gender-responsive health and legal systems is likely to provide the most fertile source of political willingness to take the agenda of gendered global health law forward.

The Lancet Commission on legal determinants provides a clear set of recommendations for action to ensure that the "rule of law [is] an effective tool to advance population health and equity". We commend and fully support this approach. In this paper we have provided some examples of the critical role that gender plays in determining health outcomes. We propose that by integrating a gender-responsive lens into the next phase of the Commission, including the implementation of its recommendations, the goals of reducing health inequity and improving health and wellbeing for all, are more likely to be achievable (see Panel 1). Incorporating a gender lens into the Commission's recommendations is not simply a case of "add gender and stir" but will require a deep understanding of the role that gender and other inequalities play in determining and perpetuating health inequities, and identifying opportunities to redress these injustices, including through the use of legal instruments.

To conclude, if it is clear that the potential of the law has not been fully realized to respect, protect and fulfil the right to health for all, it is equally the case that its potential will only be realized when the law is responsive to and reflects an intersectional feminist agenda.

Panel 1: Gender-responsive recommendations for the Commission on the legal determinants of health

Recommendation 1: **Using law to translate vision into action on sustainable development**

Gender responsive recommendation: Ensuring that laws, policies, plans and programmes for UHC take gender (and other social stratifiers) into account, e.g. through the use of sex-disaggregated data and gender resource flow analysis, and do not rest upon the assumption that UHC is likely to be gender-neutral and universal.

Recommendation 2: **Using law to strengthen the governance of national and global health institutions**

Gender-responsive recommendation: Promoting systems of inclusion/participation, transparency and accountability that are gender-aware and take social stratifiers into consideration. Existing systems that can be drawn on include methods developed by the World Economic Forum (2020) and Global Health 50/50 (2019). For the latter, signatory agencies for the Global Action Plan for Health and Wellbeing have committed to using this methodology to monitor their progress in this area (World Health Organization, 2019d).

Recommendation 3: **Using law to implement fair and evidence-based health interventions**

Gender-responsive recommendation: Allocate sufficient resources to strengthen the evidence base for the role that gender-responsive laws can play in addressing gender as both a health determinant and in the delivery of health interventions.

Recommendation 4: Building legal capacity for health

Gender-responsive recommendation: Incorporating gender-responsive capacity strengthening approaches at multiple levels to ensure that gender norms are understood and addressed (institutional level), systems are strengthened to tackle gender discrimination

(organizational level) and opportunities for capacity strengthening are gender equitable (individual level). A variety of tools exist to strengthen capacity to understand gender and assess and address gender inequality (see, for example, the comprehensive collection of capacity strengthening tools referenced by the UN, 2012, and capacity assessment tools published by UNWomen, 2014) and should be more widely adopted.

The views expressed in this paper do not necessarily reflect the view of UNAIDS.

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