The *Lancet* Commission on peaceful societies through health equity and gender equality

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Executive summary

The multiple and overlapping crises faced by countries, regions, and the world appear unprecedented in their magnitude and complexity. Protracted conflicts continue and new ones emerge, fuelled by geopolitics and social, political, and economic pressures. The legacy of the COVID-19 pandemic, economic uncertainty, climatic events ranging from droughts to fires to cyclones, and rising food insecurity add to these pressures. These crises have exposed the inadequacy of national and global leadership and governance structures. The world is experiencing a polycrisis—ie, an interaction of multiple crises that dramatically intensifies suffering, harm, and turmoil, and overwhelms societies' ability to develop effective policy responses.

Bold approaches are needed to enable communities and countries to transition out of harmful cycles of inequity and violence into beneficial cycles of equity and peace. The *Lancet* Commission on peaceful societies through health equity and gender equality provides such an approach. The Commission, which had its inaugural meeting in May, 2019, examines the interlinkages between Sustainable Development Goal 3 (SDG3) on health; SDG5 on gender equality; and SDG16 on peace, justice, and strong institutions. Our research suggests that improvements to health equity and gender equality are transformative, placing societies on pathways towards peace and wellbeing.

Four key messages emerge from our research. First, health equity and gender equality have a unique and powerful ability to contribute to more peaceful societies. This Commission recognises the complex web of factors that contribute to conflict. Moreover, health equity and gender equality are themselves shaped by social and economic processes that are complex, contextually specific, and unfold over long timescales. Even accounting for this complexity, our Commission provides evidence that improvements in health equity and gender equality can place societies on pathways to peace.

Health equity and gender equality are powerful agents of transformation because they require definitive actions, namely tangible and sustained policies that improve health and gender equality outcomes. We refer to these definitive actions as the mechanisms of health equity and gender equality. Health equity requires countries to embrace the right to health, acknowledge disparities, and recognise that universal access to health-care services is crucial for human potential and dignity. Gender equality requires laws to protect the rights of women and sexual and gender minorities. All individuals need equal access to education, resources, technology, infrastructure, and safety and security to enable participation in the economy, civil society, and politics. Processes to advance health equity and gender equality are more powerful when they operate together, through access to comprehensive sexual and reproductive health services. Advocacy is also an essential component as it builds a social consensus that the principles of health equity and gender equality apply to all individuals, regardless of their gender or other forms of identity.

These tangible actions or mechanisms transform capabilities, a term that we define here as what people are able to do and to be. With improved health equity and gender equality, individuals can access economic resources and assets, live in safety and security, and exercise greater agency. Through these changes, human capital improves and economic growth becomes more inclusive. Social capital is strengthened and social norms are altered to inhibit violence and aggression. Although political processes are characterised by short-term dynamics, the

institutionalisation of gender equality and health equity improves the quality of governance and can strengthen the social contract between the government and the citizenry.

These processes interact with each other in self-reinforcing feedback loops creating beneficial cycles that influence the dynamics of economic, social, and political systems. For countries locked in harmful cycles of inequity, conflict, and instability, our research suggests that improvements in gender equality and health equity help nudge them onto pathways towards peace.

Second, to deliver the promise of the Commission's research, health equity and gender equality principles and processes must be led by communities and tailored to their context. Local and national actors must drive improvements in health equity and gender equality, a process we refer to as change from the inside out. Although communities benefit from evidence from other contexts, we highlight the danger of importing policy models from other contexts. Health and gender systems are social systems, deeply intertwined in culture, contexts, and politics. Tangible and sustained improvements require gender equality and health equity mechanisms to be led by national actors, rooted in the local context, shaped by data, sustained through national systems, and accountable to communities. Efforts to improve gender equality are always contentious, but are transformative, enabling the recognition of the equal rights of women, girls, and sexual and gender minorities within the private and public spheres. Our Commission supports the call from decolonisation advocates for structural reform of global development processes to enable locally driven, context-specific change. However, we also stress that these local and national efforts should leverage and build upon the global scaffolding or architecture of norms, initiatives, funding, and institutions designed to advance health equity and gender equality.

Third, within the health sector and beyond, the Commission calls on policy makers to embrace, advocate for, and advance health equity and gender equality. In the health sector, services and systems must adopt, implement, and be accountable to benchmarks for gender equal health responses. The health sector is a key social, economic, and political institution. Individuals engage with health services throughout their lifespan. Health professionals are respected leaders within their communities. Given their reproductive and caregiving roles, women are a majority of users as well as providers of health care. Yet health services and systems can reflect and reinforce implicit biases that undermine access to and delivery of services and the effectiveness of health policy decisions. The gender-blind response to the COVID-19 pandemic and the tolerance of sexual exploitation within humanitarian contexts are examples of the failure to integrate gender equality principles within health sector strategies and responses. Our Commission provides definitive benchmarks for gender equal health services and humanitarian action. If policy makers advance these benchmarks, health outcomes as well as the level of gender equality would improve.

Finally, given the evidence we present in this Commission, health equity and gender equality must form an integral part of national and global processes to promote peace and wellbeing. The beneficial cycles of health equity and gender equality unfold over long time scales. Conflict management and humanitarian efforts understandably prioritise short-term interventions to reduce human suffering and stop violence. However, given the path dependencies established by such engagement, gender equality and health equity must be built into these short-term interventions. When integrating health equity and gender equality into humanitarian and conflict management interventions, we need to better analyse conflict dynamics and understand what conditions foster backlash, including when and how best to

confront, counter, navigate, and minimise backlash. Gender equality and health equity processes must also recognise how gender norms impact men and boys, and not assume women and girls have the power to single-handedly transform their environments. Policy processes from the UN Sustainable Development Goals to the Group of Seven and Group of 20 Agendas present an important opportunity to advance this agenda. Although global initiatives can provide financial and technical support, gender or health outcomes cannot be instrumentalised or pursued for the interests of external actors rather than for the benefit of communities.
The *Lancet* Commission provides an agenda for a path forward, rooted in a vision of our shared human dignity and collective responsibility to build a more equitable world. This agenda takes communities, governments, and international agencies on a challenging and sometimes contentious journey forward. We can accept the challenge and leverage this moment of opportunity to advance this agenda, or our politics and policies can entrench inequities and create the conditions for a more conflictual world. The choice is ours.

Introduction

Yeats wrote the poem *The Second Coming* in the wake of World War 1 and the 1918 influenza pandemic. He despaired that "Things fall apart; the centre cannot hold; Mere anarchy is loosed upon the world... The best lack all conviction, while the worst are full of passionate intensity."[1] The same words are eerily applicable today. Many regions of the world continue to be affected by organised violence as protracted conflicts continue and new ones emerge (panel 1). Communities are facing momentous challenges—eg, recovery from the effects of the COVID-19 pandemic, the risk of new outbreaks, food insecurity, natural disasters, and rising violence and insecurity. Researchers of complex systems have a term for such overlapping challenges: a polycrisis occurs when multiple crises influence and interact with each other in feedback loops to intensify the harm they produce. Our interconnected world facilitates "these interacting crises [to] produce harms greater than the sum of those the crises would produce in isolation, were their host systems not so deeply interconnected".[9] The entanglement of these crises complicates policy responses, and these policy failures then expand and intensify the social and economic impacts of these interacting crises.

The current polycrisis, which appears to have occurred rapidly, has been decades in the making. Leaders have missed opportunities to build more equitable and resilient economic, social, and political systems. The degradation of our environment tests the resilience of natural systems. Disputes among powerful states and leaders turning away from the global community towards nationalism weakens multilateralism and undermines the ability of international institutions to facilitate cooperation. Global networks can facilitate collaboration, yet some transnational actors use this interconnectivity to sow division and disinformation. The backlash against gender equality erodes human rights around the world. Many political leaders and their governments have failed to meet the challenges of our time, with devastating human consequences. By the cruelty of fate—being born in the wrong place and time—millions of people continue to be robbed of their childhoods, potential, livelihoods, and dignities.

Panel 1. Global fragility and conflict

Contemporary conflicts are intense, protracted, and geographically clustered. The Uppsala Conflict Data Program (UCDP) uses the concept of organised violence to encompass three forms of conflict with at least 25 deaths per year—ie, state-based, non-state, and one-sided violence. In 2022, UCDP reported that fatalities from organised violence were higher than in 2021, an increase driven by state-based conflicts in Ethiopia and Ukraine.[2] The world map in figure 1 shows the geographical distribution of these fatalities from all forms of organised violence from 2000 to 2022.[3]

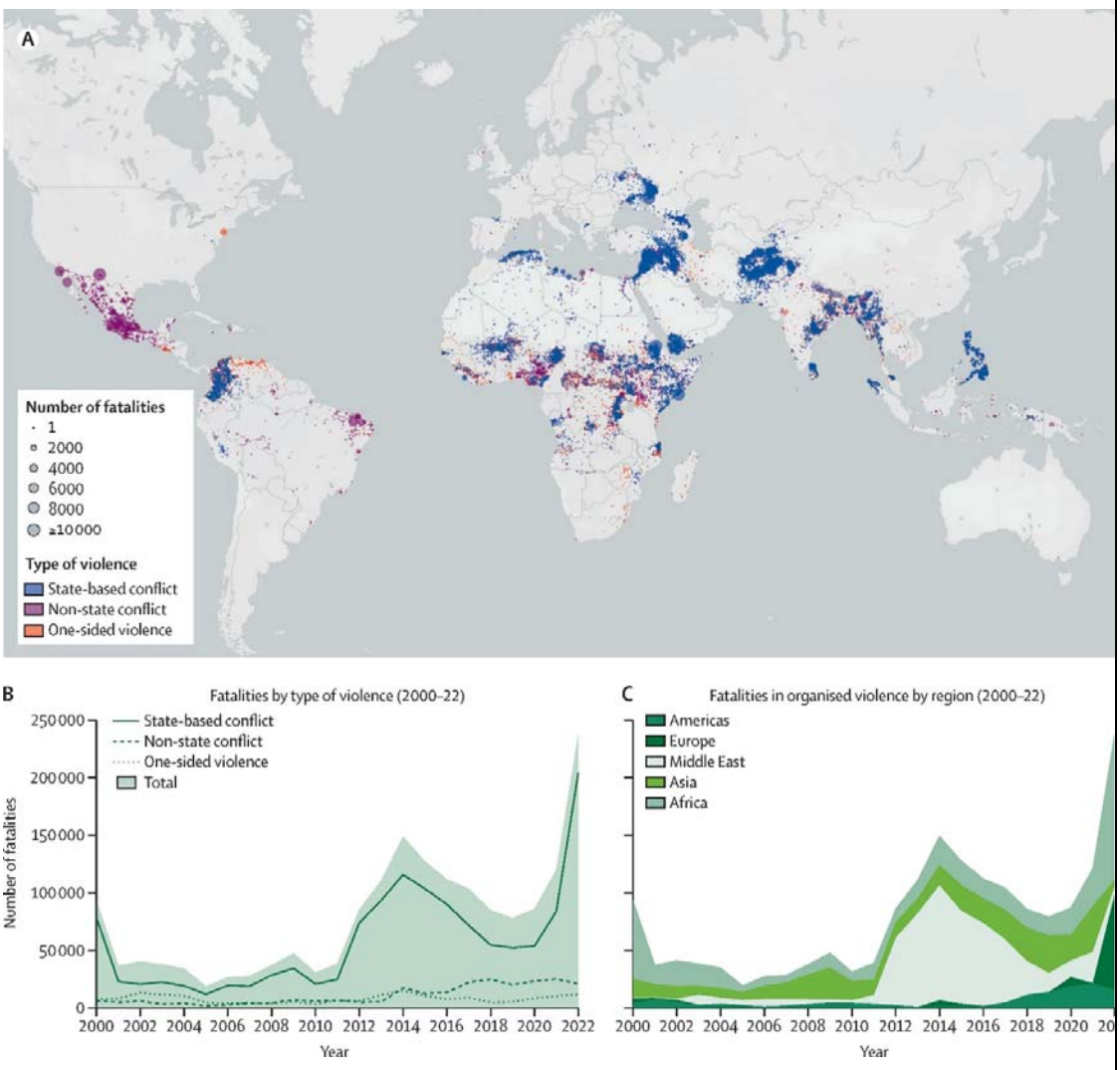

Figure 1. Fatalities in organised violence from 2000 to 2022

Map displaying fatalities in organised violence from 2000 to 2022. (B) Graph illustrating fatalities by type of violence from 2000 to 2022. (C) Graph illustrating fatalities in organised violence by region from 2000 to 2022. The graphs illustrate the trends in organised violence, including the increase in fatalities and the geographical concentration of the fatalities. Protracted and new conflicts continue to drive fatalities, displacement, and social and economic devastation in many regions throughout the world. In 2022, the Uppsala Conflict Data Program reported that fatalities from organised violence increased by 97% over 2021, driven by state-based conflicts in Ethiopia and Ukraine. Such violence has driven historically high levels of forced displacement.

The causes of these conflicts are complex and difficult to disentangle. Multiple individual, community, state, and system level factors interact to increase the risk of violence. The willingness of individual leaders to fuel group grievances and stoke anger through populist strategies can mobilise social and political movements. Structural or contextual conditions—ie, the type of regime (particularly the existence of partial democracies); the nature of state institutions; strong in-group biases and the scarcity of cross-cutting connections across identity groups; as well as economic, demographic, and environmental factors—raise the risk of violence. Global factors, including geopolitical configurations and patterns of competition, international flows of financial and military aid, and transnational cultural or religious networks are powerful forces that can drive violence.

Although these factors heighten the risk of conflict, two pre-conditions are necessary for state-based organised violence to erupt. First, a segment of the population must be mobilised to fight. Leaders often use grievance narratives as a mobilisation tool, focusing on fears related to security, loss of political power, economic circumstance, and control over territory and resources; aspects of social identity, including ethnic, religious, or cultural identity; or horizontal inequities among identity groups. Second, an opportunity structure for violence must exist, namely the factors that enable armed groups to form, recruit fighters, finance their activities, and operate. Crucial factors that shape the opportunity for violence include sufficient financial and human resources, favourable geography (eg, rough or inaccessible terrain offering rebel groups safe space to operate), the availability of weapons, a government without a full monopoly on the use of force within its territory, low government competence and capacity, and societal distrust. External actors can shape this opportunity structure through the provision of resources, weapons, fighters, technical support or training, advocacy, and propaganda. None of these factors are necessary conditions for conflict to occur, but individually and collectively, they influence the likelihood of organised violence. Interstate conflict also has a myriad of causes, including disputes over borders, security dilemmas in which efforts to increase state security are perceived as threatening to other states, cross-border attacks from non-state actors, the misperception and miscalculation of state leadership, an effort to secure resources, and attempts to divert attention from domestic policies.[4, 5, 6]

Many conflict zones overlap with densely populated and economically important urban areas, complicating efforts to protect and provide services to civilians. Multiple warring parties often coexist in conflict zones, and allegiances and battlelines constantly shift. Many conflicts are internationalised, which can heighten the use of one-sided violence—ie, the deliberate targeting of civilians. Evidence also suggests the increased presence of non-state armed groups with religious goals or claims has reduced the amenability of some conflicts to mediation and resolution.[7] The high frequency of attacks against health-care services and health-care personnel by both governments and non-state armed groups, despite their protection under international humanitarian law, is another disturbing feature of organised violence.[8] In addition, digital operations by conflict actors to gain strategic advantage are new weapons of war; examples include cyber-attacks on essential services and the weaponisation of information to sow distrust and spread hatred (appendix pp 165–66).

What has gone wrong? Some commentators point to the legacy of colonial exploitation, division, and distrust perpetuated through neo-colonial structures. Others refer to the us-versus-them nature of the post-9/11 security discourse that undermined the successes of international cooperation and diplomacy achieved after the end of the Cold War. Whatever the cause, current global responses to crises reveal the ineffectiveness of global governance and diplomacy, the consequences of gender, racial, and socioeconomic inequities, and the failure of leaders to navigate the challenging waters of national self-interest. Societies are increasingly polarised, a process facilitated by political leaders, whose demonisation of their opponents tears apart the social fabric needed to confront these unprecedented challenges.

Policy makers often see health equity and gender equality as outcomes of these broader social, political, and economic processes. However, this Commission finds evidence that improvements to health equity and gender equality can catalyse transformation in economic, social, and political systems. As we argue in this Commission, tangible progress in health and

gender outcomes requires societies to accept core principles that promote the intrinsic dignity and shared humanity of individuals and groups. Locally driven mechanisms to achieve health equity and gender equality alter capabilities, namely what people are able to do and to be, by transforming agency, structures (including formal and informal institutions), and ultimately altering power structures.[10, 11] These efforts have beneficial effects across social, economic, and political systems that lead to more peaceful societies.

Panel 2. Report roadmap

Section 1: the Commission's approach

- Summarises the objectives and the research approach
- Reviews key terms, research methods, and parameters
- Introduces the concept of self-reinforcing cycles

Section 2: the beneficial and harmful cycles of health equity and gender equality

- Summarises the drivers of levels of health equity, gender equality, and peace and violence
- Examines if statistical associations exist between indicators of health equity and gender equality and conflict and peace

Section 3: processes and pathways to peace

- Examines the Commission's theory of change, namely that health equity and gender equality can enable societies to transition from harmful to beneficial cycles
- Illustrates how the principles and mechanisms of gender equality and health equity transform human capabilities
- Shows the effect of enhanced capabilities, including economic (eg, human capital and inclusive economic growth); social (eg, social capital and changed social norms); and political (eg, improved quality of governance and strengthened social contract)
- Provides a conceptual framework to illustrate how these economic, social, and political effects place societies on pathways to peace

Section 4: the responsibility of the health sector to advance gender equality

- Examines the implications of our theory of change and conceptual framework for the health sector
- Illustrates the gendered nature of health responses with the example of the COVID-19 pandemic
- Outlines how the health sector can integrate gender equality as an objective of health-care services and systems

Section 5: the promise of health and gender equality

- Examines the promise of the Commission's research and illustrates the conditions that must be met to fulfil this promise
- Discusses harmful mistakes made when efforts to build health equity and gender equality do not focus on the principles, processes, and pathways outlined in our conceptual framework

Conclusion and recommendations

- Situates the Commission's research within the current international context
- Articulates policy recommendations and a learning agenda to fulfil the promise of the Commission's research on health equity and gender equality

The world is at an inflection point, a crucial juncture. Inflection points can lead to beneficial or harmful outcomes. It is not too late to reverse course. We have a window of opportunity to develop bold approaches that are long term, have broad appeal, and bring together a diverse set of forces needed to confront the unprecedented challenges we face. In these uncertain times, this Commission provides one such approach, a hopeful path forward towards more peaceful societies (panel 2).

Section 1: the Commission's approach

In this section we present the objectives and research approach for the Commission; review key terms, research methods, and parameters; and introduce the concept of self-reinforcing cycles.

In 2019, *The Lancet* and the Swedish Institute for Global Health Transformation (SIGHT) launched the Commission on peaceful societies through health equity and gender equality to further the 2030 Agenda for Sustainable Development and help realise its vision for a more equitable, inclusive, and peaceful world (appendix pp 6–7). SIGHT was dissolved in December, 2022. Specifically, the Commission looked at the interlinkages among three Sustainable Development Goals (SDGs), namely SDG3 on health and wellbeing, SDG5 on gender equality, and SDG16 on peace, justice, and strong institutions. We aimed to build a future-oriented research and policy agenda to provide practical and actionable guidance to communities, civil society groups, states, and international institutions. Guided by our commitment to social justice and our belief that health equity and gender equality are indispensable components of just societies, the Commission recognises that systemic forces such as geopolitics, patriarchy, and global economic structures have driven economic, social, and political inequities as well as violence. We understand the frustration and anger among people experiencing those inequities, and their desire to confront and dismantle these unjust structures. While we are keenly aware of the path dependencies established by historical injustices, our research was forward looking, focused on the implications of improved gender equality and health equity for the peace and wellbeing of societies.

Through our research, we sought to empirically identify the associations among health equity, gender equality, and levels of violence, specifically the independent contribution of health equity and gender equality to more peaceful societies (panel 3, appendix pp 8–11). The Commission encountered substantial knowledge gaps (appendix pp 13–17). Health equity and gender equality are seen as outcomes of economic and political systems, shaped by history, culture, geography, and geopolitics (appendix pp 18–30). Scholarship has not examined if and how gender equality and health equity can independently influence levels of peace and violence. In our effort to fill these knowledge gaps and build evidence, our approach and findings needed to resonate with the diversity of researchers and policy makers engaged in health equity, gender equality, and peace and conflict scholarship and practice.

Panel 3. Defining key terms

- Health equity asserts that all individuals and groups should have an equal opportunity, without bias, to be healthy. The Commission uses the Braveman and Gruskin definition of health equity: "the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige".[12]
- Gender equality means that all human beings, irrespective of their sex or gender identity, must be free to develop their personal abilities and make choices without the limitations set by gender stereotypes, rigid gender roles, or discrimination. The different behaviours, aspirations, and needs of males, females, and other sexual and gender identities must be considered, valued, and favoured equally.[13]
- Sexual and reproductive health and rights are defined by the Guttmacher–Lancet Commission as the "state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity".[14] Sexual and reproductive health requires the protection and promotion of rights as well as the provision of services in ways that meet the standards of availability, accessibility, acceptability, and quality.
- Definitions of conflict, fragility, and peace are contested. The Commission uses definitions of conflict from the Uppsala Conflict Data Program (UCDP).
- Organised violence is an umbrella term that refers to three mutually exclusive categories of conflict in which the use of armed force results in at least 25 deaths per year, which are: (1) state-based armed conflict, (2) non-state conflict, and (3) one-sided violence.
- There are two forms of state-based armed conflict. Interstate conflict refers to the use of armed force between two or more warring parties that represent states or governments, which results in at least 25 battle-related deaths in one calendar year. Intrastate conflict refers to armed force between two or more warring parties when one party is a government, which results in at least 25 battle-related deaths in one calendar year.
- Internationalised intrastate conflict is a conflict with at least 25 battle-related deaths per year between a government and a non-government party in which the government side, the opposing side, or both sides receive active support from other governments in the form of troops. The UCDP definition does not include support in the form of weapons or financing as qualifying as an internationalised intrastate conflict. Financial support and the provision of weapons would qualify as a proxy war, which Mumford defines as "indirect engagement in a conflict by third parties wishing to influence its outcome".[15]
- Non-state conflict occurs when at least 25 battle-related deaths per year result from fighting between two or more organised groups, none of which are the government. These organised groups can include criminal organisations, such as drug trafficking cartels, but the violence inflicted by informal gangs is not included.
- One-sided violence is the deliberate and targeted use of violence against civilians by the state or an organised group, which results in at least 25 deaths in a year.[16]
- The World Bank defines fragility as countries or settings with high levels of institutional and social instability—assessed through indicators that measure the quality of policy and institutions; and countries or settings affected by violent conflict based on a threshold number of conflict-related deaths per year relative to the population.[17] Critics argue that the use of the term fragility to describe states is based on problematic western assumptions that justify economic, political, and security intervention by western powers.[18]
- The academic discipline of international relations has traditionally defined peace as the absence of war. Peace research scholars refer to the absence of war or violence as negative peace. Although the concept of organised violence is easier to identify and measure than peace, peace scholars argued that it does not sufficiently capture the lived experiences of individuals and groups, including the effects of oppression, domination, and symbolic violence.[19] Galtung coined the phrase structural violence to describe the inequitable distribution of power and resources that is built into the structure of formal institutions and undermines the freedom, opportunities, and wellbeing of individuals and groups.[20]
- Quality peace, as defined by Wallensteen, incorporates goals of social justice and requires "conditions that make the inhabitants of a society (be it an area, a country, a region, a continent, or the planet) secure in life and dignity now and for the foreseeable future".[21] We build on Melander's expansion of quality peace[22] to incorporate the importance of gender equality and health equity within its conceptualisation.

The Commission's framework

To disentangle the role of health equity and gender equality in processes leading to conflict and peace, the Commission needed a conceptual tool that captured the complex interactions among these variables and how changes in the value of one or more of these variables impact on their interactions and the broader system. Inspired by the 2011 research of Suri and colleagues on human development and economic growth,[23] the Commission adopted the concept of self-reinforcing cycles. These cycles occur when a change in one variable leads to changes in other variables, which in turn prompts a cycle of further interactions within the system.

How we describe these cycles and their outcomes depends on our normative interpretation: when the interactions lead to a desired outcome, it is a beneficial cycle; when interactions lead to an undesirable outcome, they produce a harmful cycle. Path dependency, when "the probability of taking further steps along a path increases with each move down that path", is a characteristic of self-reinforcing cycles. [24] Any initial change in one of the variables is amplified and then further amplified. In unstable systems, this amplification cycle continues unabated. In stable systems, these interactions diminish over time, and the system reaches an equilibrium where communities and countries either become trapped within harmful cycles or sustained within beneficial ones. A change in the value of one or more of the variables can prompt changes in other variables in the system and enable communities and countries to escape the trap of a harmful cycle.

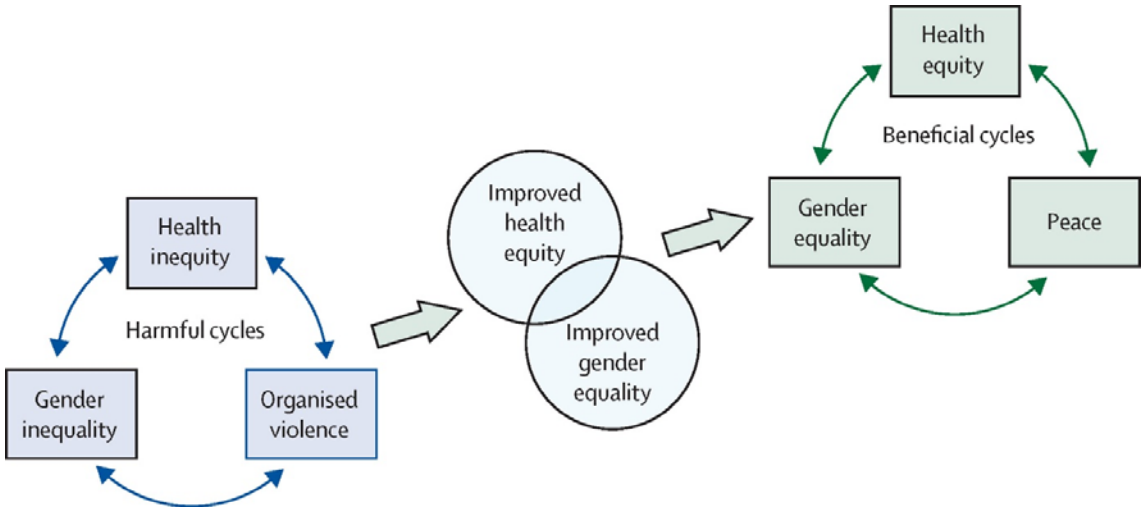

Figure 2. Theory of change

The Commission examined if and how improvements in health equity and gender equality impact levels of violence and peace. These relationships are complex. Health equity and gender equality are endogenous; embedded within and influenced by the surrounding social, economic, and political context; and characterised by self-reinforcing cycles or feedback loops where these cycles of interaction lead to changes in the values of health equity, gender equality, and violence. In fragile and conflict-affected contexts, feedback loops among health inequities, gender inequalities, and violence interact in harmful cycles. In more peaceful societies, health equity, gender equality, and peace reinforce each other in beneficial cycles. The Commission's theory of change suggests that improvements in health equity and gender can exercise an independent influence on the dynamics of violence and peace, transforming economic and political systems to enable communities to transition from harmful to beneficial cycles.

Panel 4. Research methods

First, the Commission established its research questions: (1) how does variation in health equity and gender equality influence the dynamics of conflict and peace? (2) How are health inequities and gender inequalities associated with violence and conflict? (3) How are health equity and gender equality associated with more peaceful societies? And are improvements in health equity and gender equality associated with the transition to more peaceful societies? If so, through what pathways?

To explore these questions, we did comprehensive literature reviews to identify knowledge gaps (appendix pp 13–14) and the conceptual tool of beneficial and harmful self-reinforcing cycles (appendix pp 46–49).

Second, we did an analysis of gender, health, and violence indicators against a common template. Through this process, we selected gender, health, and violence indicators that were reasonable representations of health equity, gender equality, and peace and violence concepts. Equity and equality are challenging concepts to measure with cross-national indicators, as inequities across distinct social and economic groups can only be discerned with data at the subnational level. We selected indicators of health equity (eg, life expectancy and infant mortality rate) and gender equality (eg, adolescent fertility rate and ratio of female-to-male mean years of education received) with this limitation in mind.

Third, to explore beneficial and harmful cycles we did statistical analyses to determine whether statistically significant associations existed across time and in multiple contexts. We systematically analysed and categorised these associations to identify findings that were supportive, non-supportive, and contradictory. These statistical analyses operationalise negative peace, or the level of organised violence within society, as one of the variables. In contrast to positive peace, violence can be readily quantified and measured, facilitating comparisons across time and space. This narrow focus was necessary to establish a baseline empirical foundation for our research, as it helps isolate the role of health equity and gender equality processes and reduce—to the extent possible—confounding factors. Section 2 summarises the results of this analysis, while the appendix (pp 54–121) details our methods and results.

Fourth, once we established that gender equality and health equity were broadly associated with more peaceful societies, the Commission drew on pre-existing theories and bodies of research to create a conceptual framework to explain how and why these associations exist. This conceptual framework outlined the principles and processes through which health equity and gender equality improve and suggested how these improvements precipitate social, economic, and political changes that lead to more peaceful societies.

Fifth, to operationalise our theory of change, the Commission did qualitative case studies based on desk reviews to trace the plausibility of the causal mechanisms and pathways. The selection of these case studies was based on convenience rather than a purposive strategy, as we selected cases familiar to Commission members. Although no country has fully reached the gender equality and health equity targets established within the Sustainable Development Goals (SDGs), we focused our case studies on fragile and conflict-affected settings. At this early stage of our research agenda, this focus enabled us to better identify and trace how gender equality and health equity processes can facilitate self-reinforcing feedback loops with beneficial effects.

We balanced our recognition of the universal applicability of the SDGs with the reality that fragile and conflict-affected settings are most affected by the lack of progress towards SDG targets. Much of the research in conflict contexts focuses on short-term engagement—humanitarian action, peacekeeping, and mediation. By contrast, our report fills an important gap with its focus on the long-term impact of efforts to improve health equity and gender equality within fragile and conflict-affected settings. As outlined in our learning agenda, the empirical findings can be applied and tested across multiple contexts.

Future investigations of these relationships could be based on a deliberate mixed methods design, with cross-national statistical analysis identifying cases meriting in-depth research, or through the identification of cases that warrant further investigation (namely most-likely and least-likely cases, and deviant cases [ie, cases with results not predicted by theory). Future case studies could also apply our theory of change to vulnerable and marginalised populations at the subnational level.

Panel 5. Research approach and parameters

Positivist approach

To establish an empirical evidence base that resonates across research and policy communities and builds a research and policy agenda, we adopted a positivist approach, where researchers accept the existence of an objective reality and use empirical scientific approaches to analyse that reality. We recognise and appreciate the criticisms and limitations of positivism. Through our effort to engage in interdisciplinary co-production, we were influenced by interpretivist approaches to research, which emphasise the importance of subjective interpretations of reality and integrated these insights into our analysis. Moreover, we acknowledge our positionality: this report was written by a team (appendix pp 6–7) and it reflects our interpretation of the research findings based on our training and epistemological perspectives. Yet we also believe in the value of researchers striving for objective and generalisable research findings. The positivist empirical approach summarised in this report provides a strong foundation upon which other research approaches can build. At this early stage of the research agenda, we suggest that our approach will translate across the relevant disciplines and policy communities.

Equality and equity

The Commission embraces and advocates for the principle of equality, namely that all human beings possess and should be able to exercise the same rights. Yet we also recognise that individual attributes and structural factors influence the ability of individuals to realise rights, access opportunities, and be considered equal. When referring to health, we use the concept of health equity, which requires research and policy to recognise, analyse, and address the factors that generate unequal outcomes between individuals and groups. These factors include socioeconomic status; discrimination; racism; misogyny; cognitive, sensory, and physical abilities; and mental health.[25]

However, we are aware that the concept of equity has a problematic historical legacy in efforts to advance women's rights. In international negotiations, including the Fourth World Conference on Women in Beijing in 1995, some governments, influenced by religious institutions, co-opted the term gender equity to argue against equal rights for women and girls.[26] As noted by Braveman and Gruskin, the term equity can be used against the cause of equality, "where women are particularly disenfranchised, those in power have argued that conditions for women in their countries are not unfair but rather are appropriate given the different capacities and roles of women".[12] Given the accepted and widespread use of the term gender equality in the Sustainable Development Goals and in other political documents, we use the term gender equality.

Sex and gender

We recognise the differences between sex and gender (appendix p 8). Feminist scholars critique quantitative research that conflates sex and gender when such statistical analysis uses sex-disaggregated indicators. Given the lack of cross-national time-series data that rigorously conceptualise and measure gender, when trying to establish the generalisability of their findings across time and context, researchers have little option but to use sex-disaggregated indicators as a proxy for gender. Equity and equality are similarly challenging concepts to measure with cross-national indicators, as inequities across distinct social and economic groups can only be discerned with data at the subnational level. As outlined in our learning agenda, we encourage researchers to apply decolonial, feminist, and intersectional lenses to engage with and critique the Commission's research and further our understanding of these relationships.

Intersectionality

Explicitly adopting intersectional approaches forces researchers to analyse the simultaneous and overlapping identities that shape the social, economic, and political experiences of individuals and groups. We recognise the importance of this approach and integrated the logic of intersectionality into our framework by recognising that social norms, including gender norms, interact with other forms of identity, such as race, ethnicity, class, disability, and geography, to shape individual and group experiences and opportunities.[27] Full intersectional analysis requires high resolution data, disaggregated to reflect social stratifications including gender, class, other forms of identity, and geographical region. As outlined in our indicator analysis in panel 6, this level of disaggregation of data is often unavailable without field research to gather that information. We draw attention

to the importance of intersectional approaches when we discuss the principles and mechanisms for gender equality and health equity. Our analyses of various indicators as well as our conceptual framework could guide future research that explores how levels of health equity and gender equality influence the dynamics of conflict and peace.

Contextual determinants

The Commission acknowledges the importance of the social, economic, political, and broader contextual factors that shape health equity. We did not interrogate the social determinants of health in our analysis of the mechanisms of health equity (section 3) and our analysis of health equity mechanisms limits its focus to health services and health systems. Examining the wide array of social determinants of health would require substantial new theory development and statistical analysis. The Commission's objectives include the establishment of the theoretical and empirical foundations for a future research agenda. We anticipate that future researchers will refine our work by operationalising the broader social determinants of health.

Displacement

The UN announced in June, 2023 that an estimated 108 million individuals were forcibly displaced around the world. Behind these alarming numbers are stories of lives lost, families disrupted, and human potential undermined. These problems are urgent, but the Commission did not fully examine the relevance of our framework of self-reinforcing harmful cycles of gender inequality, health inequity, and violence to forcibly displaced populations, nor did we examine the potential for beneficial cycles to generate meaningful change for the displaced and their communities. We did examine how humanitarian organisations integrate principles of gender equality into their approach to health service delivery. A full interrogation of the experience of displacement, and the community, national, and international institutions implicated in the response to displacement, was beyond the scope of this report. We highlight the importance of such research in our recommendations and learning agenda.

The concept of self-reinforcing cycles applies to the interactions among levels of health equity, gender equality, and peace and violence. Harmful cycles exist when health inequity, gender inequality, and violence interact, further reducing levels of health equity and gender equality and increasing levels of violence (figure 2). Beneficial cycles occur when improvements in health equity interact with gender equality and low levels of violence to produce greater levels of health equity, which in turn contributes to greater levels of gender equality and more peaceful societies. We provide further detail on self-reinforcing cycles in the appendix (pp 46–50), and information on the research methods to explore these cycles (panel 4) and our research parameters (panel 5).

The concept of self-reinforcing cycles provides insight into the causes—and solutions—to the polycrisis. Many communities are characterised by harmful cycles within multiple systems—eg, economic, governance, social, and natural systems. The COVID-19 pandemic, the cost-of-living crisis, and climatic events like droughts or floods have exacerbated inequities and further entrenched some communities within these cycles. Due to the interconnectedness of these systems, outcomes in one system interact and influence other systems. [9] For example, a low quality of governance often means public services such as education are not provided in sufficient quality or quantity, which in turn reduces economic potential and contributes to low levels of trust in formal institutions.

Our Commission's theory of change (figure 2) is that substantial improvements in both health equity and gender equality can disrupt and potentially transform harmful cycles into beneficial ones. Given the interconnection among global social, economic, and political systems, such a

transformation can set in motion beneficial cycles across multiple systems. The Commission's research underscores the importance of focusing on long-term processes that enable sustained improvements in health equity and gender equality; enhance capabilities; and catalyse change in economic, social, and political systems.

Reflections and considerations

Disciplinary divides

Our Commission navigated multiple disciplines: health policy, gender studies, peace and conflict studies, political science, sociology, and economics. While the intellectual advantages of interdisciplinary research are widely acknowledged, barriers to collaboration across disciplines are less discussed, understood, or addressed. These barriers include differing epistemologies, the privileging of some research methods and tools over others, and the institutional reinforcement of disciplinary divisions. Each discipline promotes certain approaches and methods of inquiry, which shape how research problems are defined and explained. These methods form the discipline's intellectual framework: its assumptions about the social world, approach to knowledge, and how to disentangle cause and effect.

Some of these disciplines, such as medicine, political science, and economics, privilege positivist, empirical approaches to knowledge generation. Positivist approaches value objectivity, logic, and neutrality and work to identify, observe, and objectively measure social phenomena across time and space to discern generalisable patterns of cause and effect. Other researchers—such as gender scholars—favour interpretivist approaches that believe social phenomena, such as gender norms, are not directly or neutrally observable as they are socially constructed. Researchers must, therefore, be aware that their own positions within society influence their ability to observe and understand political, economic, and social processes.[28, 29, 30]

These seemingly neutral intellectual frameworks are intertwined with broader social dynamics of power and privilege. As critical scholars have pointed out, positivist approaches dominate research and policy because of predominant assumptions about what counts as knowledge, and what can be reliably measured or observed.[29] The prevalence of positivist approaches has direct implications on whose voices and experiences are heard, seen, and valued. Disciplinary divides are further reinforced by institutional silos, funding structures, and the activities of knowledge networks or epistemic communities—all of which do not favour interdisciplinary research and impede meaningful connections among researchers. Adding to these divisions, researchers from countries with political and economic power fill all levels of these knowledge networks and are disproportionately funded and published. To facilitate collaboration and knowledge transfer across these disciplinary divides, the Commission engaged in a process of research co-production that acknowledged and respected the value of different research approaches.[31]

Decolonisation discourses

The Commission reflected on what the decolonisation movement means for our research approach, findings, and policy recommendations, namely whether our Commission reinforced what Kwete and colleagues refer to as the "colonial remnant" or whether we challenged it.[32]

As a Commission, we support the importance of challenging power structures in global health, humanitarian, development, and peace research and practice. The decolonisation movement

draws attention to the legacies of colonialism that led to the domination by many western countries within global systems, including in systems of knowledge production and dissemination. The colonial conquests of territories and peoples were enabled and accompanied by oppression, racism, exploitation, and other forms of violence. Although formal colonial systems were dismantled, decolonisation scholars argue that these systems evolved into neo-colonial structures with similar dynamics of power and oppression. The denial of the humanity of people from conquered nations and territories, which enabled slavery and colonial exploitation, evolved into the othering of post-colonial states and their people. The decolonisation movement argues that dominant research and policy approaches implicitly lack respect for non-western cultures, value-systems, and epistemologies, and further this othering mentality.

Decolonisation scholars have criticised global governance frameworks and the norms and international institutions that underpin them. For these scholars, such frameworks represent a process of neo-colonialism. They suggest that a modernisation imperative underpins the norms and policies advocated by global institutions. In other words, to progress towards a western-defined universal ideal, countries need to adopt specific policies, and individuals and groups must adhere to particular value systems and patterns of behaviour.[33, 34, 35, 36] Through these global norms, policies, and institutions, neo-colonial policies have constructed "a racialized, hierarchical, hegemonic, patriarchal, and capitalist global social system".[37] In the field of global health, Kwete and colleagues suggest a decolonising approach would recognise and enable low-income and middle-income countries to define and solve their own problems, establish multipolar global health governance structures, and remove neo-colonial power structures in global health.[32, 38]

Some decolonisation scholars caution that an implicit ethnocentric modernisation mission lies within global gender equality and health equity policy initiatives. These scholars suggest appeals to universal ideas and beliefs, including those related to gender equality, reflect an effort to impose western values. This suspicion of universalism lies in tension with the Commission's belief in the universality of the principles of gender equality and health equity—outlined in section 3.[39, 40] Advocates, intellectuals, and government representatives from countries subjected to the violence and exploitation of colonialism played a formative role in global debates on gender equality and health equity. Such advocacy continues to be crucial to the articulation and refinement of the principles of gender equality and health equity reflected in the Commission's approach. While communities should determine the precise mechanisms to achieve gender equality and health equity, we argue the principles themselves are universal, rooted in a recognition of our shared humanity and intrinsic dignity and the global recognition and endorsement of human rights.

The Commission's findings echo the call from the decolonisation movement for a paradigm shift in global health and governance and our recommendations propose a feasible implementation pathway to support structural change. Our analysis of principles and processes in section 3 argues that gender equality and health equity must be led from the inside out, to build agency and capabilities, transform structures, and alter power dynamics within societies. Such inside-out change creates social capital, trust, stronger governance, and a greater social contract between communities and governing authorities. In section 5, we illustrate the dangers of imitation projects and their efforts to impose externally designed and oriented institutional structures. However, our report also challenges decolonisation scholars to accept the importance of universal principles and the potential for such principles to guide community and nationally driven change.

Section 2: the beneficial and harmful cycles of health equity and gender equality

This section summarises the drivers of levels of health equity, gender equality, and peace and violence; and examines whether statistical associations exist among indicators of health equity and gender equality and conflict and peace, and whether these associations reflect harmful and beneficial cycles.

Levels of health equity and gender equality in communities and countries are shaped by historical events, geopolitics, and the international political economy, as well as domestic politics, culture, and leadership. Armed conflict devastates health equity and gender equality, and these harmful effects linger for decades. The Commission analysed the factors that shaped health equity, gender equality, and peace and conflict. We adopted the conceptual tool of harmful and beneficial cycles and tested its applicability for the interactions among health equity, gender equality, and levels of peace and violence through cross-national statistical analysis.

Drivers of health equity and gender equality

The Commission adopts a future oriented research and policy agenda. However, we recognise that these cycles did not begin in a vacuum, and were influenced by historical, geopolitical, social, and economic factors. The Commission analysed the factors that shape health equity and gender equality (appendix pp 18–30) and categorised them as contextual, distal, and proximate factors. Contextual factors include historical events, such as the legacies of slavery and colonialism (table 1). Such historical legacies set in motion path dependencies that shape the future trajectories of states and regions. Contextual conditions at the global level also include geopolitics, the international political economy, the international exchange of ideas, and efforts by multilateral organisations to evolve global norms and frameworks. At the state and community levels, the nature of formal institutions, such as political regimes and economic systems, as well as the structure of informal institutions and social relations influence health equity, gender equality, as well as the level of peace and conflict. The social construction of identity, and the material consequences of that construction, is a key driver of both health inequities and gender inequalities. [41]

Contextual conditions combine with more remote (ie, distal) and immediate (ie, proximate) processes to determine gender inequality, health inequity, and violence and peace (table 1). Within our self-reinforcing cycles, the three variables of health equity, gender equality, and peace and violence are further affected by their interactions. We overview the dynamics of self-reinforcing cycles in the appendix (pp 46–50).

Table 1. Drivers of health equity, gender equality, and violence

	Contextual	Distal	Proximate
Drivers of health equity and inequity			
Global	Geopolitics; international political economy; multilateral organisations (eg, global norms and global frameworks); and the international exchange of ideas (eg, epistemic communities and advocacy coalitions)	International engagement (eg, international economic activity, state participation in multilateral organisations and initiatives, and state engagement in developing and accepting global norms on health equity)	Exogenous shocks (eg, pandemics, natural disasters, violence, and organised violence)
State and national	Formal institutions of the state (eg, regime type, economic system, and state capacity)	Political and economic determinants (eg, governance and leadership including responsiveness, strength and inclusivity of domestic economy, laws and regulations, and financing and public revenues)	Accessible and responsive health systems (eg, delivery of high-quality health-care services, including comprehensive sexual and reproductive health; human resources for health; financing; infrastructure; health information systems; and medicines and technologies)
Social, community, and individual	Informal institutions and systems of social relations (eg, gender systems and other identity systems such as race, class, and religion)	Social determinants (eg, food security, water and sanitation, housing, social infrastructure, and safe and secure environment)	Individual and group circumstance (eg, economic circumstances; racial, sexual, and gender identity; access to high-quality health services; and access to housing, water, sanitation, social infrastructure, and fair employment)
Drivers of gender equality and inequality			
Global	Geopolitics; international political economy; multilateral organisations (eg, global norms and global frameworks); and the international exchange of ideas (eg, epistemic communities and advocacy coalitions)	International engagement (eg, state engagement in developing and accepting global norms on gender equality)	Exogenous shocks (eg, pandemics, natural disasters, violence, organised violence, and economic shocks)
State and national	Formal institutions of the state (eg regime type, economic system, and state capacity)	Political and economic determinants (eg, governance and leadership, strength and inclusivity of domestic economy, laws and regulations, and budget and financing for gender equality)	Accessible health care, including comprehensive sexual and reproductive health services; accessible education; accessible political systems (eg, participation in politics and responsiveness of politics to gender equality); accessible economic systems (eg, economic opportunities and participation; access to assets, infrastructure, and technologies; and access to social infrastructure)

Social, community, and individual	Informal institutions and systems of social relations (eg, gender systems and other identity systems such as race, class, and religion)	Social determinants (eg, active civil society and safe and secure environment)	Access to social systems (eg, participation in civil society); individual and group circumstance (eg, economic circumstances and access to education)
Drivers of organised violence and peace			
Global	Geopolitics; international political economy; environmental and demographic factors; multilateral organisations (eg, global norms and global treaties or frameworks to support cooperation); and the international exchange of ideas (eg, epistemic communities and advocacy coalitions)	Geopolitical contestation and institutional involvement (eg, engagement of state in international or regional cooperative structures)	Exogenous shocks (eg, neighbourhood conflict, proxy wars, economic shocks, natural disasters, and pandemics) and international mediation and negotiation (eg, credible commitments to facilitate peace agreements)
State and structural	Formal institutions of the state (eg, regime type, economic system, and state capacity) and identity cleavages (eg, ethnicity, race, religion, and class)	Political and economic determinants (eg, quality of governance and leadership including responsiveness, social contract, and strength and inclusivity of domestic economy); civil society and social capital (eg, bridging social capital and linking social capital); and identity grievances (eg, if and how identity shapes economic, political, and other forms of opportunity)	Populist and grievance narratives; availability of weapons and resources; mobilisation for organised violence; mobilisation for peace; and economic opportunities and participation
Social, community, and individual	Informal institutions and systems of social relations (eg, social norms surrounding use of violence and aggression)	Social contract and trust in formal institutions	Nature of leadership (eg, psychological risk factors and risk perception) and individual beliefs and norms

Building an evidentiary foundation: cross-national statistical analyses

To test the existence of harmful and beneficial cycles, as well as our theory of change, we used cross-national statistical analyses. The Commission's full statistical methods and findings are presented in the appendix (pp 54–121). As outlined in the following subsections, we found statistical patterns largely supportive of the association between stronger performance on health and gender measures and more peaceful societies. We interpreted our results as establishing an empirical foundation for the Commission's conceptual framework—outlined in section 3.

Our statistical analyses examined whether clear patterns exist among health, gender, and violence indicators, specifically whether we can discern patterns of beneficial or harmful self-reinforcing cycles. Before undertaking the analyses, the Commission critically examined a range of health, gender, and violence indicators, assessing these indicators against a common template (panel 6). Our statistical analyses also paid particular attention to problems of multicollinearity, as many of these variables are closely associated theoretically and empirically. We controlled for broader political and economic conditions and found that these conditions had minimal influence on the strength or robustness of our findings. For example, in our cross-sectional analyses, the coefficient estimates for the health and gender variables did not significantly change with the addition of political and economic indicators—ie, per-capita income and measures of democracy.

Panel 6. Indicator analysis [42]

Researchers and policy makers often use data to identify and track policy problems without sufficiently reflecting on the sources of data or how they are derived, verifying their quality, or understanding the various biases of different data sources, particularly estimates generated by complex statistical models. To better understand the quality of the data available to measure gender equality, health equity, and violence and provide guidance on the interpretation of that data, the Commission did an in-depth investigation of 38 gender, health, and violence indicators. We focused our analysis on indicators selected to measure the progress of targets for Sustainable Development Goal (SDG) 3, SDG5, and SDG16.

As part of this process, the Commission assessed each indicator against a common template to analyse the following:

- How the indicator is calculated
- Sources for the indicator
- Indicator utility (ie, what the indicator does and does not measure)
- Indicator availability across time and geographical areas
- The granularity of the indicator (ie, if and how it is disaggregated by sex, age, identity group, citizenship, etc)
- Sources of bias, including whether clear standards exist for the estimation of the indicator and whether its reliability is widely accepted
- The degree to which the indicator is an actual—empirically measured—value or an imputed or modelled value

Through this process, the Commission documented key data shortfalls, including the lack of disaggregation at the subnational level, by sex and gender, by income, and other forms of social identity. The templates also document potential sources of bias. The Commission also showed that many data sources lack transparency on the methods for estimating data, including the failure to include uncertainty bounds. Each indicator template is available on the Commission website. To the best of our knowledge, this explicit and structured approach to assessing a wide range of health and gender data is rarely conducted.

The Commission found that many datasets lacked clear, transparent documentation to allow technical experts as well as non-technical consumers of statistical information to understand how indicators are constructed, what assumptions are made, and what questions can—and cannot—be answered, given the quality and robustness of the underlying data. This type of documentation is particularly important, as researchers, policy makers, journalists, and advocacy organisations often draw on estimates to highlight policy issues. These consumers of data need transparent documentation of statistical methods and quality to enable them to put those numbers in context and draw sound inferences from the data. The 2021 World Development Report calls for the development of a data governance strategy to fill these gaps through heightened sharing of existing data, financing data systems, and developing technical capacity, including human resources as well as information technology.[43] However, when the 2021 World Development Report discusses transparency, it primarily emphasises the potential for accurate, reliable official statistics to increase trust and accountability. It does not sufficiently engage with the need for greater—and more interpretable—transparency into how data are collected and estimates generated, which is particularly important for complex, granular, and intersectional data.

As the indicator analysis illustrates, large proportions of gender equality and health equity datasets were constructed using statistical models or imputation techniques. Yet these datasets often provide little documentation and metadata to support analysts in making informed judgements about potential sources, directions, and magnitudes of bias, the degree of uncertainty around estimates, or the potential pitfalls in using modelled or imputed data in other analyses. For example, the World Population Prospects' fertility and child mortality datasets that cover 1950–2020 for most countries are based on a combination of empirical data and data generated from statistical models (eg, imputation techniques), which are based on a number of assumptions. Values are provided without confidence intervals and must be interpreted using information on country-specific sources and methods from the associated metadata documentation. [44] Although this documentation is provided, it is in the form of a list of sources and estimation methods without further explanation. Interpretation of the accuracy and possible biases in the data is further complicated in countries with low data availability, where different sources and estimation methods are used for different sections of the time series.

To assess whether policy makers were aware of these data limitations, the Commission analysed key policy documents, namely 25 UN Security Council Resolutions, as these documents use data to reference international peace and security. Although all the documents referred to data, none interpreted those data, used qualitative checks to verify data values, or referenced the limitations of the data.

To identify the presence of cycles and feedback loops, we used models to examine statistical associations between gender and health outcomes, from gender and health outcomes to violence and peace, and from violence and peace to gender and health outcomes (figure 3).

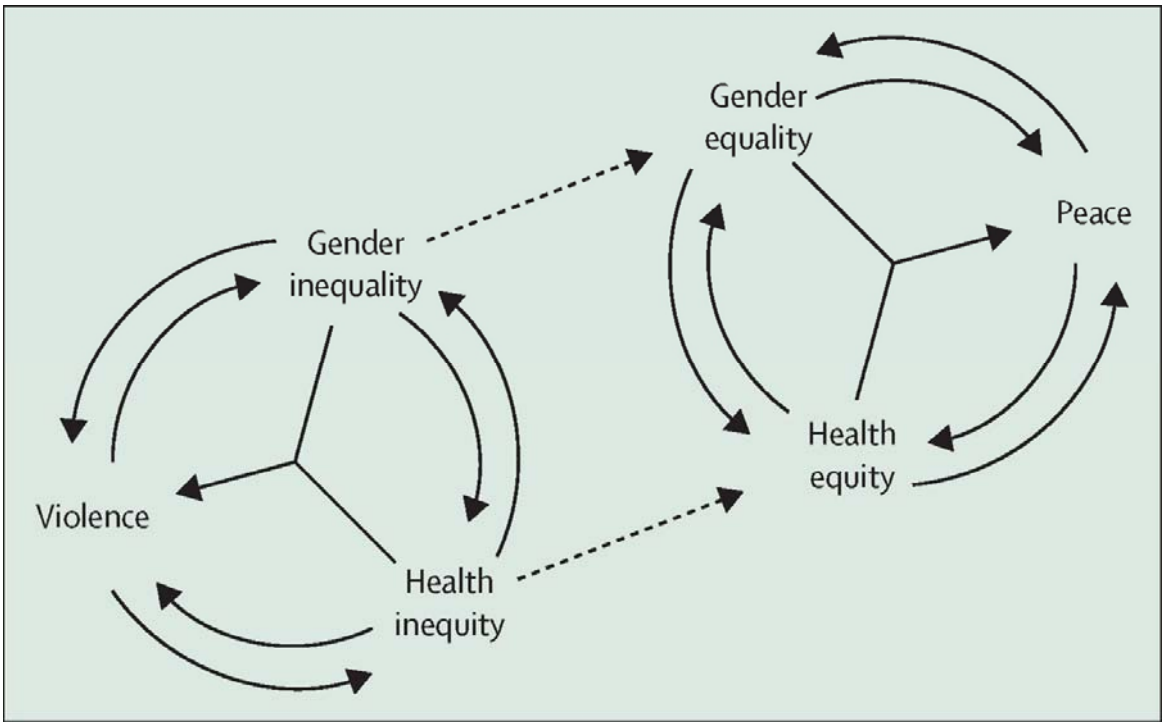

Figure 3. Relationships examined in the Commission's large-N analyses
To identify the presence of feedback loops and self-reinforcing cycles among health equity, gender equality, and violence, the Commission used multiple statistical models that alternated the dependent variable among indicators of gender equality, health equity, and levels of violence. To identify the existence of harmful cycles, these statistical models explored the relationship between health inequity and violence (ie, associations between indicators of health inequity with various indicators of violence and vice versa); relationship between gender inequality and violence (ie, associations between indicators of gender equality with various indicators of violence and vice versa); and interactions among indicators of health inequity and gender equality with violence. To identify the existence of beneficial cycles, models explored the relationship between indicators of health equity with peace (and vice versa); relationship between indicators of gender equality and peace (and vice versa); and interactions among health equity and gender equality with peace. Additional models examine the Commission's theory of change, which proposes that improvements in indicators of health equity and gender equality enable countries to transition from harmful to beneficial cycles.

Statistical challenges associated with modelling cycles and feedback loops heightened the complexity of the Commission's analyses. To establish the existence of cycles, we used multiple statistical research designs that alternated indicators of gender equality, health equity, and violence as the outcome or dependent variable (table 2). Our methods are summarised in panel 7 and elaborated in the appendix (pp 54–121).

To analyse patterns among these selected health, gender, and violence indicators, the Commission used two primary, complementary statistical methods. First, we examined cross-sectional data to assess changes over a 25-year period (1991–2015). Second, we analysed panel data (ie, longitudinal data) over a 45-year period (1971–2015). In both the cross-sectional and panel data, we examined whether patterns of statistically significant associations are consistent or not with the presence of beneficial or harmful self-reinforcing cycles.

Table 2. Research designs used in the cross-national statistical analyses

	Cross-sectional analyses	**Panel analyses**	**Sequencing analysis**
Purpose	Examines how initial conditions influence long-term patterns of change in health, gender, and violence variables; enables us to detect statistical associations that might be small over the short term, but compound over the long term	Examines short-term dynamics in beneficial and harmful cycles; enables us to analyse how conditions in one 5-year period influence the next, and to account for the statistical effect of covariates over time.	Examines sequences or pathways of long-term gender and health change; enables us to explore whether specific sequences of improvements in gender and health outcomes are associated with better long-term health, gender, and violence outcomes, which could indicate that health and gender facilitate transitions from harmful to beneficial cycles
Type of Analysis	Multivariable	Multivariable	Bivariate
Health and gender variables	Life expectancy; infant mortality rate; adolescent fertility rate; ratio of female to male mean years of schooling; classifications	Combined health and gender indices or classifications	Combined health and gender indices
Covariates	GDP per capita; polyarchy (electoral democracy); previous value of dependent variable; previous and concurrent levels of select violence variables	Lagged dependent variable; GDP per capita; population density; electoral, participatory, and liberal democracy components	None
Years	1991–2015	1971–2015	1971–2015
Timeframe of analysis	Long term (25 years)	From one 5-year period to the next 5-year period	Long term (25–45 years, depending on violence variable examined)
Unit of analysis	Country	Country-period	Country
Countries	161–180	160	180
Data aggregation	Growth in average health or gender variables from initial (1991–95) to last period (2011–15); other variables are initial or concurrent averages, or incidence for conflict	5-year averages (eg, 1971–75 and 1976–80) or incidence for conflict	Sequencing typology coded on the basis of 5-year averages (eg, 1971–75 and 1976–80); mean outcome variables calculated over entire timeframe

GDP=gross domestic product.

Panel 7. Cross-national statistical analyses (variables, classifications, and sequence types)

Equity and equality are challenging concepts to measure with cross-national indicators, as inequities across distinct social and economic groups can only be discerned with data at the subnational level. We are aware of the criticisms of these indicators and did extensive analyses of them—summarised in panel 6. The large-N research designs are summarised in table 2 and in the appendix (pp 54–64). With these limitations in mind, the Commission selected the following national-level indicators that measured health and gender performance.

Variables and indicators

- Health performance: life expectancy and infant mortality rate
- Gender equality performance: adolescent fertility rate and ratio of female-to-male mean years of education received
- Violence and peace: state-based internal armed conflict, total and civilian battle-related deaths per population resulting from varying types of conflict, and state repression
- Following the Uppsala Conflict Data Programme's definitions of organised violence (appendix pp 10–11), we further distinguish between conflict (ie, at least 25 battle-related deaths per calendar year) and war (ie, at least 1000 battle related deaths per calendar year), and define long term as 5 years or more
- All measures are aggregated to 5-year periods

Combined health and gender indices

To decrease the combinations of variables in examining patterns of harmful and beneficial self-reinforcing cycles, and thereby simplify the analyses, the Commission also standardised and combined the two health indicators (ie, life expectancy and infant mortality rate) into one index of health performance, and the two gender equality indicators (ie, adolescent fertility rate and ratio of female-to-male mean years of education received) into one index of gender equality performance

Classifications

To facilitate comparison among diverse countries, discern how the gender and health indicators interact, and identify if and how these interactions are associated with and potentially influence beneficial and harmful cycles, the Commission developed a country classification system on the basis of the combined measures of health and gender performance. Both the cross-sectional and panel analyses use these classifications. We divided countries into five mutually exclusive categories (appendix pp 57–59):

- LOW: this classification includes countries in which health and gender performance are in the bottom two quintiles on both indices (56 countries in the period 1991–95)
- MID: this classification includes countries in which health and gender performance fall into the middle quintile on both indices (21 countries in the period 1991–95)
- HIGH: this classification includes countries in which health and gender performance are in the top two quintiles on both indices (58 countries in the period 1991–95)
- G>H: this classification includes the remaining countries in which the country ranks in a higher quintile on gender performance than it does on health performance (18 countries in the period 1991–95)
- H>G: this classification includes the remaining countries in which the country ranks in a higher quintile on health performance than it does on gender performance (27 countries in the period 1991–95)

Sequence types

To identify patterns or discernible pathways of change in health and gender performance over time, the Commission developed a simple sequencing typology. This typology coded each country in the dataset on the basis of the relative trajectories in the combined and standardised health and gender indices during the period 1971–2015. We divided countries into five mutually exclusive categories distinguishing whether change was primarily health led (64 countries) or gender led (34 countries)—ie, whether health equity or gender equality improved more on the standardised indices or whether countries had setbacks or declines in health equity (27 countries) or gender equality (44 countries) or both (11 countries).

Our analyses also examined the Commission's theory of change, namely that improvements in gender and health performance can nudge countries out of harmful cycles and into beneficial cycles. We analysed the differential effects of changes in health and gender performance by mapping sequences or pathways based on changes in these variables over several decades (1971–2015) and examining their bivariate associations with long-term violence and peace outcomes (appendix pp 109–21). This analysis helps identify which pathways are more likely to lead to long-term outcomes of heightened violence or sustained peace, laying important groundwork for future research.

Statistical analysis to identify the existence of harmful cycles

To support the existence of harmful cycles, statistical models would show associations between low gender and health indicators and high violence indicators. Specifically, countries that initially scored lower on gender and health performance would subsequently improve less than the global average and would be more prone to organised violence. Countries with higher initial levels of violence would be associated with lower subsequent improvements in gender and health performance, or their gender and health performance might deteriorate.

In general, the Commission's multivariable analyses provided strong supportive evidence for such associations. The cross-sectional analyses examined changes between the periods of 1991–95 and 2011–15, whereas the panel analyses examined changes from one 5-year period to the next during 1971–2015. These latter panel analyses illustrated a clear association between low levels of country performance on gender and health indicators and organised violence. Specifically, poor country performance on gender and health measures was associated with increased future incidence of internal conflict and worse latent physical integrity scores, which measure extrajudicial killings, torture, disappearances, and political imprisonment. Moreover, the LOW country classification (ie, countries in which health and gender performance are in the bottom two quintiles on both indices) was associated with a higher incidence of future internal conflict than all other classifications.

Bivariate analyses of sequences of change over four decades also supported the association between poor country performance on health and gender indicators and increased levels of violence. Sequences involving health equity setbacks or both health equity and gender equality setbacks had the highest proportion of countries in conflict or war, including long-term conflict. Together with the multivariable analyses, this association between health setbacks and violence suggests that poor health performance was particularly problematic for countries attempting to exit harmful cycles. Countries experiencing health equity setbacks were associated with more violence, as well as longer periods of violence, compared with other sequences. These countries had the most non-state conflict, one-sided violence (ie, the deliberate and targeted use of violence against civilians, which results in at least 25 deaths), and the worst average scores of latent physical integrity violations.

The statistical associations uncovered by our models illustrated the clear effect of violence on health and gender outcomes. Our cross-sectional analyses showed that the internal conflict death rate in 1995 was significantly associated with reduced rates of improvement in infant mortality and education equality over the subsequent 20 years. Unsurprisingly, ongoing large-scale civil violence reduced long-term health performance; these statistical effects were particularly severe within countries with initially poor health performance. Panel models illustrated an association between previous internal conflict and decreased future health performance, especially within the LOW classification group of countries based on health and

gender performance. Violence also had clear and problematic outcomes on gender equality. Conflict was associated with worse gender outcomes in all but the MID classification (ie, countries in which health and gender performance fall into the middle quintile on both indices), with the largest negative effect in the G>H classification (ie, countries that do not fit into other classifications, in which the country ranks in a higher quintile on gender performance than it does on health performance). These results illustrate how conflict can reverse decades of progress in health and gender outcomes.

Countries could become entrenched within harmful cycles, as evidenced by our statistical models. The LOW country classification was associated with worse future health outcomes than all other classifications. In the panel models, the LOW classification was associated with worse gender outcomes than some of the other classifications. Moreover, within the LOW, G>H, H>G (ie, countries that do not fit into other classifications, in which the country ranks in a higher quintile on health performance than it does on gender performance), and MID classifications, past war incidence was associated with increased future war incidence. When using the combined health measure in interaction, countries with low performance on health in the past show a clear association between internal war incidence with decreased future health performance. These associations suggest that the interaction of poor gender and health performance could further embed countries within cycles of violence and instability.

Statistical analysis to identify the existence of beneficial cycles

To support the existence of beneficial cycles, statistical patterns would show associations among gender equality, health equity, and peace (ie, low violence indicators). Countries with high initial gender and health performance would maintain stable and high levels of subsequent gender and health performance. Countries that initially scored higher on health and gender outcomes would be associated with less subsequent violence than those with poorer performance on health and gender indicators.

The Commission's statistical analyses provide broad support for these associations. However, the presence of ceiling effects (ie, operating when countries perform close to the maximum value of an indicator) makes it challenging to detect evidence of beneficial cycles for some of our indicators. Gains in life expectancy are constrained by the biological limits of the human lifespan. Further declines in the infant mortality rate and adolescent fertility rate (ie, the annual number of births to women aged 15–19 years per 1000 women averaged over 5-year periods) face similar limits. Countries that started with higher outcomes for the indicators of adolescent fertility, mean years of education received, life expectancy, and infant mortality could thus have reduced rates of improvement in these indicators.

Our cross-sectional and panel analyses both found evidence of important ceiling effects. The cross-sectional analyses found that countries with an adolescent fertility rate 10% higher than the 1995 sample average had a 9% decline in the average future improvement in adolescent fertility rate by 2015 relative to other countries. Similarly, an improvement of 10% of the average ratio of mean years of education received in 1995 was associated with a 6% decline in average future improvement in this indicator by 2015. When a country's life expectancy was 10% higher than the 1995 average for all countries, future life expectancy gains fell by 50% of the average improvement. Finally, an improvement of 10% of the 1995 infant mortality rate was associated with a decline in future infant mortality improvements by 12·5% of the average by 2015. Some of our panel analyses specifically explore this issue by examining conditional effects of health and gender on each other and find strong support for ceiling effects.

Despite the presence of ceiling effects, the Commission's multivariable statistical models showed evidence consistent with a beneficial cycle operating among indicators of gender, health, and peace. Cross-sectional analyses find support for the importance of gender equality in beneficial cycles. For example, gender equality as measured by a 10% increase in the average ratio of mean years of education received was weakly associated with a 28% subsequent decline in the average death rate from internal conflicts.

In addition, the cross-sectional analyses found strong evidence that improvements in health were associated with long-run reductions in the incidence and intensity of armed conflict. It showed that improved levels of infant mortality were associated with reduced future internal conflict incidence, as well as substantial decreases in the rate of civilian deaths from one-sided violence. Improving a country's 1995 infant mortality rate by 10% of the global average was associated with a 7·7% reduction in the incidence of internal armed conflicts; this finding is notable, as internal armed conflicts were by far the most prevalent form of conflict globally over this time period. Similarly, this 10% improvement in infant mortality was also associated with a 25% reduction in the mean civilian death rate from one-sided violence.

Analyses of panel data also illustrated that gender and health performance indicators were positively associated with peace. Higher levels of gender and health performance were positively associated with each other and associated with lower rates of internal conflict incidence and latent physical integrity repression (eg, extrajudicial killings, torture, disappearances, and political imprisonment), suggesting the operation of a beneficial cycle. Moreover, the MID, HIGH (ie, countries in which health and gender performance are in the top two quintiles on both indices), and H>G classifications are associated with better health performance than the LOW and G>H classifications. Crucially, the HIGH classification is the only group of countries in which past internal war does not have an association with increased future internal war.

Gender and health performance appeared to reinforce each other, and this interaction might help sustain beneficial cycles. Within our cross-sectional analyses, we found that a 10% decrease in the adolescent fertility rate in 1995 was associated with a 2·7% increase in average future (ie, by 2015) infant mortality improvements as well as a 1·8% improvement in the ratio of female-to-male mean years of education received by 2015. An annual decline of 7·6 adolescent live births from 1991–95 (10% of the mean) was associated with a 5·8% improvement over the average increase in future life expectancy by 2015, whereas a 10% improvement in the initial infant mortality rate was also associated with decreases of 3·7% in the future adolescent fertility rate.

Our statistical analyses also identified beneficial effects of peace—or low levels of violence—on gender equality and health equity. Cross-sectional analysis showed that a 10% decline in ongoing conflict incidence was associated with a 0·4% improvement in future education equality. However, the analysis also indicated, for instance, that a 10% decline in the previous 5-year period's internal conflict death rate was associated with a small increase of 0·25% improvement in future infant mortality. These associations are complex and small in magnitude, and likely reflect the recovery from conflict, namely that violence substantially reduced health outcomes allowing for rapid subsequent improvements. For example, higher rates of conflict in the pre-1996 period are often associated with better future improvements in life expectancy, infant mortality, and education equality, which could indicate more rapid recovery from conflict. By contrast, higher levels of contemporaneous conflict are more often associated with lower rates of improvement in health and gender measures.

We outline the highly destructive short-term and long-term effects of conflict on health equity and gender equality in the appendix (pp 18–45). Therefore, reductions in the frequency and severity of conflict may be an important contributor to beneficial cycles. Within our cross-sectional analysis, and aside from the previously noted ceiling effects, previous indicators of gender, health, income, political institutions, and conflict and violence are all generally associated with future improvements in health and gender performance. In terms of the cross-country variation explained by the models, the model performance was reasonably strong with goodness-of-fit measures (adjusted R^2) of 83% for the infant mortality rate, 49% for life expectancy, 38% for education equality, and 36% for adolescent fertility rate improvements.

Statistical analysis to examine our theory of change

To support the Commission's theory of change, namely that improvements in gender and health performance are associated with a transition from harmful to beneficial cycles, statistical evidence would show one of three possibilities. First, countries that initially score higher on health indicators would on average have greater subsequent improvements in gender and health outcomes and avoid future violence. Second, countries that initially score higher on gender indicators would have greater subsequent improvements in both gender and health outcomes and avoid future violence. Third, health and gender would have interaction effects. Countries scoring higher in both health and gender indicators would, therefore, show greater improvements in gender and health outcomes and avoid violence in later periods. Due to the complexity of these processes, these statistical associations do not prove that gender and health improvements nudge societies into beneficial cycles. Instead, they provide an evidentiary foundation to build our conceptual framework that traces the processes from improvements in health and gender performance to peace—outlined in section 3. In the following subsections, we outline the evidence for these three assertions.

Health equity and the transition to beneficial cycles

The Commission's statistical analyses support the assertion that health equity is associated with future health and gender improvements and reduced violence. Countries with higher health than gender achievements (ie, countries within the H>G classification) had greater gains in subsequent health improvements than other countries, especially those in the G>H classification. In cross-sectional analyses, the H>G classification was also weakly associated with a 31% improvement in life expectancy gains relative to the MID classification. Further, bivariate analyses suggest that health-led sequences were associated with more health improvements than gender-led sequences and sequences with health setbacks. Our panel analyses also suggest that past health performance is positively associated with improved future gender performance, except for countries at the highest levels of past gender performance, which is again suggestive of a ceiling effect.

As outlined previously, the association between higher health performance and lower levels of violence is clear in our cross-sectional analyses. Improvements in health variables were associated with reductions in future conflict incidence and death rates from one-sided violence. In addition, panel analyses show that health performance conditions the association between past internal conflict or war incidence and subsequent incidence of these measures of violence. As health performance increases, countries that previously had conflict or war are less likely to have future conflict or war (recidivism). At a very high level of past health performance, the association between past and future war loses statistical significance, and even becomes

negative and statistically significant. These findings provide strong support for health performance potentially facilitating the transition out of harmful cycles.

Gender equality and the transition to beneficial cycles

The Commission found mixed evidence to support the assertion that gender equality is associated with future gender and health improvements and less violence. Our panel analyses show evidence for an association between previous gender performance and future health performance except in countries at the highest levels of past health performance (again, suggestive of a ceiling effect).

The statistical associations between gender outcomes and health outcomes also present some complex results that warrant further investigation. Within our bivariate sequencing analyses, gender-led sequences do not result in great improvements in gender outcomes. Gender-led sequences also do not appear to facilitate great improvement in health indicators. Surprisingly, sequences involving setbacks in health equity or gender equality are associated with greater long-term improvement in health performance than gender-led sequences. These bivariate associations call for further empirical investigation.

Despite the mixed evidence for the association between gender performance and improvements in health performance, we found strong evidence in the bivariate sequencing analysis for the relationship between gender-led sequences and more peaceful societies across several measures of violence. For instance, gender-led sequences are associated with the least incidence of conflict and war, including the least non-state conflict as well as one-sided violence. These associations reflect the findings of previous research.[45]

Combined health equity and gender equality and the transition to beneficial cycles

The Commission's analyses support the assertion that elevated levels of health and gender performance are associated with reduced violence. Results from the panel analysis suggest that high health and gender performance may be linked to decreased future organised violence. Only in the HIGH country classification is past incidence of war not associated with increased future incidence of war. These data suggest that recidivism is not likely to occur among the countries with the highest health and gender outcomes.

Data also suggest an association between high health and gender performance and low levels of repression. Except in those countries with very low levels of gender performance in the past, improvements in health performance are associated with decreased future repression; this statistical effect increases in magnitude with high levels of gender outcomes. Conversely, countries with high health performance in the past exhibit associations between improvements in gender performance and decreased future physical integrity rights repression. Such statistical associations suggest that combined gender and health performance could dampen future repression.

Section 3: processes and pathways to peace

In this section we present the conceptual framework outlining how improvements to gender equality and health equity place societies on pathways to peace—health equity and gender equality are not simply products of, but contributors to peaceful societies. Our theory of change suggests that the process of improving gender equality and health equity can facilitate the

transition from harmful to beneficial cycles. To understand this transition, we examine how levels of gender equality and health equity improve, and the effect of these improvements. As outlined in the following subsections, we suggest that this process occurs in three interactive stages: (1) the development and implementation of the principles and mechanisms of gender equality and health equity; (2) the transformation of human capabilities; and (3) the catalysation of economic, social, and political effects (figure 4).

Advancing health equity and gender equality

To understand the transition from harmful to beneficial cycles, we need to examine how levels of gender equality and health equity improve. The Commission's approach was influenced by the human rights scholarship of Risse and colleagues who show how human rights are furthered through argumentation and persuasion, the institutionalisation of these rights through law and practice, and through their habitualisation—the creation of a "taken for granted status" or a social consensus that leads to the implementation of human rights norms "regardless of individual beliefs". [46] As outlined in the following subsections, we have adapted this approach to argue that gender equality and health equity improve through an interactive process that establishes the principles of health equity and gender equality and advances these principles through mechanisms, namely mobilisation and institutionalisation.

Gender equality and health equity principles: intrinsic dignity, shared humanity

A common, unifying principle underpins, facilitates, and is fostered by gender equality and health equity. This principle is the recognition that individuals, regardless of their gender, socioeconomic position, or other forms of identity, possess an intrinsic dignity and a shared humanity. [47] To advance health equity and gender equality, society needs to build a consensus on this common principle. It also needs to accept its responsibility to create and foster the social conditions that recognise this shared humanity and enable dignity. Societies must promote this unifying narrative while avoiding token universalism. For marginalised groups, "amorphous, universalist descriptors" of human rights, equality, and equity can obscure systemic inequities and ignore social injustices that shape their circumstances, experiences, and opportunities.[48]

Gender norms establish and reinforce the meaning of gender identities. These norms dictate behaviours and justify the allocation of tasks, roles, responsibilities, social positions, and power based on gender identity. Social systems support gender norms through formal and informal structures and processes; norms are learned and reinforced within the family, community, and broader society through observation, instruction, behavioural incentives, and social sanctions.[13] Stratifiers that reflect the social distribution of power, including gender, class, race, religion, and other identifiers, also influence health equity.[49]

As such, health inequities and gender inequalities are not experienced equally.[41, 49] The individual, group, and community experience of gender inequality and health inequity varies according to structural forms of discrimination. To avoid token universalism, efforts to advance health equity and gender equality principles must recognise the socially constructed nature of gender, as well as other forms of identity. Efforts to improve health equity and gender equality will not fully succeed without efforts to address these structures of discrimination and injustice. However, without the universal principles of health equity and gender equality, there is no benchmark against which to measure these experiences as inequitable or unjust.

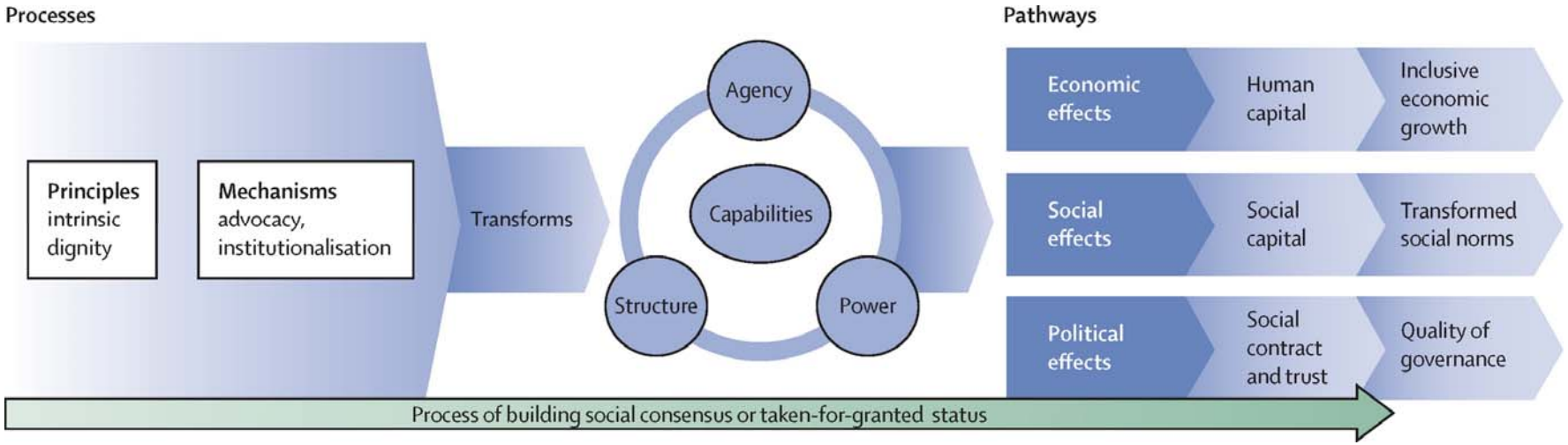

Figure 4. The processes and pathways of health equity and gender equality

Health equity and gender equality lead to more peaceful societies through three interactive stages. First, societies must advance the fundamental principles of health equity and gender equality, which requires a recognition of the intrinsic dignity and shared humanity of all individuals regardless of identity or social and economic advantage. Principles of health equity and gender equality are realised through deliberative mechanisms, namely advocacy and institutionalisation through laws, and the provision of health systems, education, and economic participation. Second, these processes of health equity and gender equality transform capabilities through their impact on individual agency and formal and informal institutional structures, shifting power within society. Third, the economic, social, and political effects of health equity and gender equality place societies on pathways to peace. Human capital and more inclusive economies change economic systems, higher social capital and evolving social norms transform social systems, whereas political systems have improved quality of governance, greater trust, and a stronger social contract. These three stages of health equity and gender equality build a social consensus for the importance of health equity and gender equality.

Mechanisms for health equity and gender equality

Health equity and gender equality principles are realised through two key mechanisms. First, civil society groups mobilise and advocate for these principles, building a social consensus and support for health equity and gender equality. Second, these principles must be institutionalised—reflected in and enabled by institutional processes. Although we describe the main parameters of these mechanisms in panel 8, a more complete description is found in the appendix (pp 122–27). These mechanisms closely align with the proximate drivers of health equity and gender equality.

Panel 8. Principles and mechanisms to improve gender equality and health equity

Common principles
Recognition of shared humanity and intrinsic dignity, reflecting an awareness and respect for individual differences and structural conditions which shape individual and group inequities

Health equity principles
Ability of everyone, regardless of identity or social and economic advantage, to enjoy good health and wellbeing in a manner that:

- Ensures universal access to health-care services and essential medicines and technologies
- Provides those health-care services in a safe environment, respectful of individual autonomy, bodily integrity, dignity, and the importance of informed consent
- Protects against catastrophic health expenses
- Ensures that health-care services and systems recognise and address social inequities
- Recognises society's responsibility to address the broader social determinants of health

Health equity mechanisms
Advocacy and mobilisation

- Creation of norms articulating the right to the highest attainable standard of health and wellbeing
- Transnational networks share evidence on how to advance health equity, advocate for global norms on the right to health, advance the social determinants of health, push for a recognition of how social inequities shape health equity, and press donors and governments for additional funds
- Civil society groups work with national and community stakeholders to promote health equity

Institutionalisation

- Laws and regulatory frameworks
- Equitable health systems reflected in: governance and leadership, health services and organisation, human resources, and health information, with disaggregated data to enable intersectional analysis, medicines and technology, and health financing and payments
- Direct provision of health services: when the health system is not able to fully provide services (eg, during conflict and natural disasters), when the health system is not able or willing to provide adequate or respectful services (eg, for marginalised individuals and groups), and for specific and highly effective vertical interventions (eg, immunisation)
- Efforts to work across sectors to advance the social determinants of health

Gender equality principles
Everyone, regardless of gender and other forms of identity, should benefit from the ability to: develop human capabilities, access economic and broader public sector resources and assets, live in safety and security, and exercise individual agency

Gender equality mechanisms
Advocacy and mobilisation

- Evolve and advance society's understanding of gender equality
- Build consensus on the mechanisms necessary for gender equality; document gender-based discrimination, exploitation, and violence
- Provide oversight and monitoring of domestic and international gender equality efforts

Institutionalisation
Equal access, regardless of sexual or gender identity, to:

- Laws and regulatory frameworks, including those that address sexual and gender-based violence
- Education
- Economic participation
- Access to economic assets, infrastructure, childcare, and technology
- Comprehensive sexuality education to ensure health and wellbeing, develop respectful relationships, and enable agency and autonomy
- Participation and leadership roles in civil society, formal institutions, and politics

Health equity advocacy and mobilisation

Health equity principles are rooted in the right of individuals and groups to dignity through the highest attainable standard of health and wellbeing. This right obliges states to provide universal access to quality health services, essential medicines, and commodities. Individuals, regardless of gender and other forms of identity, must be free from dehumanising treatment and able to exercise their rights of informed consent when accessing and receiving these services. To fully realise health equity, states must also address broader determinants of health that undermine the ability to be healthy, such as access to clean water, sanitation, and adequate and affordable housing.[50]

The right to health provides an important mechanism for advocacy. With reference to this right, advocates can mobilise researchers and civil society groups from local communities, national organisations, and global networks. These advocacy networks document inequitable health outcomes, share evidence to advance health equity, and advocate for policies to rectify these inequities and advance the right to health.[51, 52] This advocacy has fostered and furthered a global consensus for a wide range of norms including, but not limited to, universal health coverage; newborn and child health; sexual, reproductive, and maternal health; and HIV/AIDS treatment. Advocacy groups press donors to provide development assistance and encourage innovation and collaboration across public and private institutions. Organisations monitor progress and hold governments and multilateral institutions accountable to these standards. This mobilisation of funding for services and research, coupled with improving accountability, increases health and wellbeing, and profoundly influences the realisation of health equity within both global governance and domestic health policy.

Health equity institutionalisation

The principles of health equity are institutionalised at the state and community levels through legal frameworks, the building of health systems, and the direct delivery of health services when health systems are not able or willing to provide those services. When health equity is

institutionalised, societies improve population health outcomes, reduce the financial consequences of ill health, and address the needs of vulnerable and marginalised groups.

As we note in the appendix (pp 18–45), the social determinants of health are important drivers of health equity, and broadly include economic factors, education, health and health care, neighbourhood and built environment or infrastructure, and the social and community context. Sectoral silos and a lack of consensus on how to measure and prioritise these factors have undermined efforts to institutionalise the social determinants of health.[53]

Laws and regulatory frameworks are a key foundation of health equity, as they recognise the right to health and the collective actions necessary to uphold this right across diverse social and economic groups. These laws provide the state with the powers and duties to assure the conditions for people to be healthy—to identify, prevent, and ameliorate risks to health in the population. Laws also establish the "limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the common good".[54]

In our examination of the institutionalisation of health equity, we largely focus on health systems. Strong and resilient health systems that provide universal access to high-quality, efficient, effective, and equitable health services are an important foundation for health equity. As part of that service delivery, research has highlighted the importance of close-to-community providers given their ability to negotiate between communities and health systems and act as a bridge between them in various contexts.[55] Health information systems are also essential to provide health data disaggregated by sex, race, and other relevant forms of identity, economic class, and geographical region. Infectious disease outbreaks like the COVID-19 pandemic underscore the crucial importance of such data for disease surveillance, policy development, and shaping risk communication.[56] Other key elements of health systems are outlined in panel 8 and the appendix (pp 122–23).

Health services should be delivered within national health systems. In some circumstances vertical health programmes that target specific diseases or health challenges can make important short-term contributions to health equity. In contexts affected by violent conflict or natural disasters, health care is often provided by dedicated programmes with centralised or coordinated staff, budgets, and operations. Such direct delivery of services can bridge the gap until health facilities are rebuilt and health systems are strengthened. Vertical interventions can also address specific diseases (eg, HIV/AIDS) or outbreaks (eg, Ebola virus), implement time-limited interventions such as immunisation programmes, or provide services to marginalised and vulnerable groups, such as sex workers or minority ethnic populations, that might otherwise be neglected by existing health infrastructure. Although most vertical services link with national health systems in some manner, the extent of that integration varies substantially across contexts.[57] Although such targeted health services often produce more rapid, measurable results,[58] the continuation of vertical services can lead to fragmentation of health service delivery, weakening the overall governance and administration of the system.

Gender equality advocacy and mobilisation

Gender equality requires society to embrace and commit to a vision of intrinsic dignity and shared humanity, which includes a recognition that all individuals, regardless of sexual or gender identity, have the same rights and entitlements as other members of society. Yet social consensus on this vision is undermined by deeply held beliefs that objectify and sexualise

women and gender minorities and devalue and denigrate their contributions to the family, community, and society. The realisation of gender equality also varies according to other forms of identity, including race, religion, class, and other social stratifiers. Efforts to build gender equality are heavily contested. Concerted efforts to realise gender equality are resisted by social norms surrounding gender, which are amorphous and persistent.[59]

Advocacy and mobilisation are essential to overcome these persistent gender norms. Through decades of mobilisation around gender equality principles, movements for women's rights and the rights of sexual and gender minorities have become transnational in scope. Advocates use this global reach to evolve the public understanding of gender equality through an intersectional lens, build consensus on its necessary elements and components, advance global norms through international agreements, document gender-based discrimination, provide oversight and monitoring of domestic and international gender equality efforts, and share experiences, evidence on what works, and lessons learned through the implementation process.[60]

Gender equality institutionalisation

Rights-based legal frameworks that ensure non-discrimination based on sex or gender identity are essential to institutionalise all elements of gender equality, from education to economic participation to the elimination of gender-based violence and other harmful and discriminatory practices. Laws must guarantee equality in both personal status (eg, citizenship) and economic status (eg, property rights and other assets).[61] Particularly crucial are family laws that govern equality in the private domain of the household, including marriage, divorce, guardianship, inheritance, and property.[61] As noted in detail in the following subsections, the law must also protect the reproductive rights of women, adolescent girls, and gender minorities to ensure individual control over their sexual and reproductive health.[62]

The benefits of gender equality in education cascade across society and are multigenerational in their effect.[63] Enshrining gender equality within educational institutions helps to ensure the participation of women and gender minorities in the economy, political life, and social movements. Girls and gender minorities must be able to safely access quality educational opportunities, stay in school throughout their adolescence, and enjoy equal and respectful treatment while in school.[64] Education curriculums cannot perpetuate misogynistic social norms surrounding sexual and gender identity. Ensuring young people have access to comprehensive sexuality education enables agency and autonomy, health and wellbeing, and development of respectful relationships.

A safe and secure environment supports women's participation in economic, social, and political life. The participation and leadership of women and gender minorities in the formal economy, with labour regulations that ensure workplace conditions of dignity, safety, and fairness, further institutionalises gender equality. Ownership of assets, such as land, property, and access to credit and access to childcare facilitates women's economic participation. Women's paid labour improves livelihoods and heightens bargaining power within families and communities. Men and women typically use household assets differently; evidence suggests that asset ownership by women is associated with substantial improvements in food security, reproductive and child health, and education, while also correlating with reductions in domestic violence.[65, 66, 67, 68]

Efforts to institutionalise gender equality also require the equal and full participation and leadership of women and gender minorities in civic life, politics, and institutions of

governance. Our Kosovo case review (appendix pp 155–58) illustrates how women's advocacy groups worked with female political leaders to challenge and transform deeply held beliefs about sexual violence experienced by women during the war. Societies with balanced political representation and leadership function differently. Evidence shows that female politicians typically prioritise social policies, increase the effectiveness of governance institutions, and modify the behaviour of men within those institutions.[69] Mechanisms to incentivise this political participation include gender quotas, mentorships and the creation of networks, and advocacy to encourage candidates and support them once elected.[70]

Processes that combine gender equality and health equity

Our statistical analyses—outlined in section 2—illustrate the important inter-relationship between health and gender performance. As outlined in the following subsections, the principles of both health equity and gender equality are advanced through the realisation of sexual and reproductive health and rights (SRHR). Although the principles and mechanisms for SRHR have strong foundations in evidence, their institutionalisation varies across contexts due to the difficulty in building a social consensus for these goals. Advocacy and practice must acknowledge the differential experiences of individuals and groups, including differences that result from sexual and gender identity, class, religion, ethnicity, or geographical region.

Sexual and reproductive health and rights

The protection of sexual and reproductive rights, as well as the provision of comprehensive sexual and reproductive health services to fulfil those rights (panel 9), is an essential prerequisite for health equity and gender equality.[71] Advocacy and mobilisation for SRHR is a complex and challenging process, one that confronts cultural and religious beliefs surrounding sexuality, gender roles, bodily integrity, as well as conception, human consciousness, and personhood. Although advocates in every context struggle to build a consensus on SRHR norms, their work is informed and influenced by the clear global evidence base on what constitutes effective SRHR practice. Individuals have the right to seek information and make decisions concerning sexual and reproductive health free of discrimination, coercion, and violence and have the right to privacy, confidentiality, respect, and informed consent. Women and sexual and gender minorities must have full control over their sexuality, including respect for their bodily integrity, which includes the right to access safe abortions, and the ability to make free and informed decisions on their sexuality, sexual orientation, and gender identity. Additionally, people should be able to choose their partners; when to engage in consensual sexual relations; whether, when, and with whom to marry or form a partnership; and when to exit a marriage, with the ability to safely exit that marriage or other forms of partnership.[14]

Advocacy is necessary but not sufficient; SRHR principles need to be institutionalised in services to ensure dignity is respected while providing care. Although we know that SRHR requires a rights-based approach, a systematic review by Hartmann and colleagues in 2016 suggested further research to understand the range of factors that facilitate sustained change in social norms and acceptance of the principles of SRHR.[72] The mechanisms for the institutionalisation of these SRHR principles are outlined in panel 9, and include laws and regulatory frameworks, as well as the provision of comprehensive health care and counselling services to promote the realisation of these rights.[14] The Guttmacher Institute estimates that US$10 per person per year can cover the cost of sexual and reproductive health services. Such an investment would also reduce the personal hardship and economic and social costs of maternal deaths, unsafe abortions, and unintended pregnancies.[73]

Panel 9. **Principles and mechanisms of sexual and reproductive health and rights (SRHR)**

SRHR principles
Ability of everyone, regardless of gender identity or social and economic advantage to: exercise bodily autonomy free of discrimination, fear, coercion, and violence; make their own decisions concerning their sexual and reproductive health; and have their right to privacy, confidentiality, and informed consent respected

SRHR mechanisms
Advocacy and mobilisation for SRHR
Led by national actors; navigates social and cultural context and evolves understanding on the principles of SRHR; and advocates for institutionalisation of SRHR

SRHR institutionalisation
Laws and Regulatory Frameworks that uphold individual rights to:

- Have their bodily integrity respected, including a recognition of the right to safe and legal abortions
- Seek and receive information related to sexuality
- Choose their sexual partner and engage in consensual sexual relations
- Choose whether, when, and who to marry
- Enter and exit from marriage with consent and equality between partners
- Make free and informed decisions on sexuality, sexual orientation, and gender identity
- Pursue a safe and satisfying sexual life free from stigma and discrimination
- Education, counselling, and care related to sexuality, which includes information on the prevention and management of sexually transmitted infections
- Comprehensive reproductive health services, including contraceptives of their choice, safe abortions, appropriate and acceptable health care for pregnancy and childbirth, as well as integrated services to prevent and respond to intimate partner violence and other forms of gender-based violence

Building capabilities: what people are able to do and to be

The Commission's theory of change is that improvements in health equity and gender equality can exercise independent influence on the dynamics of peace and conflict. We apply the capabilities approach developed by Amartya Sen and furthered by Martha Nussbaum.[11, 74] This approach asks a simple question that shapes efforts to improve equity and wellbeing: what are people able to do and to be?[11]

The interaction between principles and mechanisms of health equity and gender equality affect human capabilities because they transform agency—the ability of an individual to make independent choices—and structures, including formal and informal institutions, as well as the amorphous element of power (figure 4). This transformation occurs with tangible changes, namely new laws and regulations, access to health services (eg, comprehensive sexual and reproductive health services), improved education, increased asset ownership by women, availability and access to physical and social infrastructure, and increased participation in political and civic life. These mechanisms facilitate agency. If such mechanisms are attuned to and address the differential individual and group experiences of gender inequalities and health inequities, they challenge informal and formal institutions, which are the structures within society that perpetuate discrimination. Through this effect on agency and structure, health equity and gender equality can dramatically shift power within a society.

Pathways to peace

The principles and processes to further health equity and gender equality have important social, economic, and political consequences. The institutionalisation of health equity and gender equality transforms societies, disrupts harmful cycles, and enables societies to move towards what Wallensteen refers to as quality peace (panel 3). [21] We review the evidence for these pathways in the following subsections.

Economic effects of health equity and gender equality

Improvements in health equity and gender equality contribute to more inclusive and resilient economies.[75] Although these relationships are conditioned by contextual factors,[76] health equity and gender equality have two key economic effects. First, they contribute to enhanced human capital—"the knowledge, information, ideas, skills, and health of individuals", economic participation, and labour force productivity.[77] Second, they shape household incomes and facilitate patterns of inclusive economic growth.[78]

Universal access to health-care services improves child health and learning outcomes through increased school attendance, and enhanced cognitive ability to learn.[79, 80, 81] Better childhood educational performance contributes to broader human capital accumulation and socioeconomic development, with life-long benefits as research shows that it is challenging for adults to catch-up from cognitive delays caused by learning loss.[81] Health equity also reduces out-of-pocket expenditures on health-care services and limits catastrophic health expenditures.[82] Additionally, health equity enhances labour force productivity—workers have a reduced number of lost workdays because of illness or the need to care for family members.[83] Greater worker productivity also facilitates the accumulation of household assets through increased income, greater savings, and investment.[14, 79, 80, 83]

Sexual and reproductive rights and access to comprehensive reproductive health services are key for human capital accumulation and inclusive economic growth.[14] Access to contraception and safe abortions limit unwanted pregnancies, including adolescent pregnancies, which have elevated health risks for both the mother and their infant.[84] When adolescent girls have control over their sexual and reproductive health, they are more likely to stay in school, provided such educational opportunities exist. Increased educational attainment and skill development boost overall human capital.[79, 84] Similarly, when adult women control the timing of their pregnancies, their participation in paid labour—particularly the formal economy—increases and productivity rises.[14, 79, 84] Birth spacing increases infant survival, while high household income and savings enhance the health, wellbeing, and educational outcomes of children.[75, 79]

The provision of comprehensive sexual and reproductive services has broader economic benefits. Counselling and preventive care save health-care resources through reduced sexually transmitted infections, unsafe abortions, and high-risk pregnancies.[14] Access to these services is also associated with better health outcomes, which in turn increases labour force productivity,[75] reduces the demand on health systems, and saves health-care resources.[14] Safeguarding reproductive health rights also improves childhood development, which in turn furthers human capital.

Low fertility rates reduce the overall dependency ratio—ie, the number of dependents not in the labour force (normally children and older adults [aged >65 years]) supported by those earning an income.[79] Parents can invest more resources in fewer children, leading to increased

levels of human capital investment in each child.[85] Women's participation in the formal labour force increases the opportunity costs of having children, contributing to reductions in overall fertility.[86] When families become aware of the link between female education and improved household wellbeing, they are more likely to educate girls.[86] As more girls go to school, the overall educational attainment in society increases, which further enhances human capital and economic productivity.

Low fertility results in a demographic dividend when a decline in the birth and death rates and a reduced dependency ratio leads to economic growth. The benefits of a demographic transition are fully realised with improvements to gender equality, producing a gender dividend.[87] When gender equality mechanisms (outlined in above subsections) are implemented, the pool of talent that can participate in the economy grows, and the benefits of the demographic dividend can be realised.[86, 88]

Feminist economists rightly point out that gender equality has intrinsic value; it should not be pursued simply because it contributes to economic growth. Moreover, these economists argue that gross domestic product formulation ignores the informal workforce as well as the economic and social benefits of unpaid caregiving. Because of gender norms surrounding social reproduction, women perform the bulk of these caregiving roles, even when they participate in the labour force.[89] The *Lancet* Commission on Women and Health outlined how the burden of unpaid and underpaid caregiving activities falls predominantly on women.[90]

As reflected in section 5, we are sensitive to the instrumentalisation of gender equality. Government strategies often focus only on economic growth, emphasising to external actors the benefits of low paid labour, including female labour. Such strategies devalue traditionally female occupations and reinforce gendered wage discrimination rather than promoting decent, fairly compensated work.[91] Like feminist economists, our framework emphasises the transformative potential of gender equality through its contribution to economic and social wellbeing.[86] We also recognise that the relationship between gender, health, and economic growth is complex, shaped by both formal and informal institutions,[91] including the devaluing of caregiving roles.[90]

Countries with high levels of human capital and inclusive levels of economic growth are more peaceful. Higher per-capita income is associated with lower levels of violence, while stagnant economic conditions and rapid negative economic shocks are associated with organised violence.[92, 93, 94] However, when economic growth and increases in wealth are unequal and concentrated among economically and politically influential groups, such growth increases horizontal inequalities. Horizontal inequalities can contribute to social tension and unrest and ultimately fuel conflict.[93] The risk of such social unrest rises when marginalised groups face limited economic opportunities, such as in contexts of resource constraints, low levels of employment, restricted asset ownership, or limited ability to engage in politics.[95, 96] The inclusive growth generated by improvements in health equity and gender equality could reduce such horizontal inequalities.

Social effects of health equity and gender equality

Gender equality and health equity set in motion two important social processes. First, they strengthen social capital, defined as the norms, trust, and networks necessary for cooperative

action.[97] Second, they prompt a change in social norms, particularly norms surrounding the permissibility and acceptability of aggression and violence.

Social capital refers to the creation and strengthening of social connections.[98] Trust is a belief in the honesty, integrity, and reliability of others[99] and is essential for people to cooperate with each other and with formal institutions. Social capital builds trust within and between social groups; heightens the ability of communities to respond to social, political, and economic challenges; and helps prevent conflict.[100, 101] Three forms of social capital exist. Bonding social capital refers to strong connections within social groups, bridging social capital refers to connections between social groups, and linking social capital is connections between formal governing institutions and social groups.[97] Through their efforts to advance gender equality and health equity, civil society groups generate and reinforce all three forms of social capital.

When advocacy organisations mobilise, they build bridging social capital. Social networks are a natural byproduct of efforts to improve gender equality and health equity. Although networks vary in size, membership, and structure, they connect individuals and groups to potential allies, domestically and globally. Connections across civil society, research organisations, and the private sector expose individuals and groups to new approaches, prompt innovation, and build trust. Intergroup trust creates incentive structures for cooperation through the establishment of reputational effects that encourage individuals and groups to behave in trustworthy ways.[102] These connections expand the capacity, resources, and power of the network, which generates and strengthens bridging social capital. Clear feedback loops exist. Through connections and heightened levels of trust, gender and health issues can be reframed, particularly those issues that affect marginalised and vulnerable populations, to emphasise the shared humanity and intrinsic dignity of affected populations.[60, 103]

Linking social capital refers to connections between civil society organisations and power structures that enable them to influence policy. The effectiveness of networks to contribute to policy change is facilitated by what we refer to as receptors within formal institutions—formal and informal linkages that connect advocacy groups to governing institutions and build linking social capital. The creation of these receptors is enabled by international norms and savvy civil society leadership.[104] Such receptors include policy processes established to monitor the implementation of gender or health norms or principles, the establishment of formal consultative processes, the integration of civil society members into government delegations, and the placement of civil society members on governing boards of international organisations (such as the Global Fund and UNAIDS).

Another receptor that creates linking social capital is networks of epistemic communities. These networks span and link research institutions, civil society groups, government institutions, and multilateral organisations. Although these individuals might work for different organisations in different countries, they share expertise on a specific topic and accept the importance of a scientific approach to policy making. Epistemic communities agree upon the nature of a problem, the range of possible policy solutions, and enable the sharing of information and coordination of policies across government organisations and multilateral institutions.[105] Members of epistemic communities interact regularly through collaboration in research as well as discussions at scientific meetings and conferences.[106, 107]
Gender equality and health equity processes exemplify both bridging and linking social capital. Women's movements have been instrumental in many peace processes, as they broaden the definition of security, facilitate connections across social groups, and advocate for social issues to be addressed within negotiated settlements (panel 10). The UN Security Council Resolution

1325 on Women, Peace, and Security, adopted on Oct 31, 2000, advocated for women's participation in peace negotiations.[118] In 2011, the Nobel Peace Prize recognized women's contribution to peace processes by awarding the prize to Ellen Johnson Sirleaf, Leymah Gbowee, and Tawakkul Karman.[119] The extraordinary success of efforts to secure access to affordable antiretroviral therapy for those living with HIV/AIDS is another example of how health networks can overcome seemingly insurmountable policy problems.[120, 121] Networks have developed a global consensus on targets for the expansion of HIV/AIDS treatment, secured the availability of financing, found solutions to overcome intellectual property rights and patent laws, facilitated the production of these treatments, and undertaken their distribution.

Panel 10. Women in peace processes[108]

A study by Chopra and colleagues, conducted for this Commission, examined how women's organisations influenced peace processes through research on seven case studies of organised violence, namely Guatemala, Liberia, the Philippines, Kenya, Northern Ireland, India–Pakistan, and Israel–Palestine.[108]

Women's groups use several strategies to influence peace processes. First, they establish a persistent presence at peace talks to hold leaders accountable and advocate for peace. Second, women's groups participate in the negotiations to shape the content of peace agreements and advocate for the inclusion of issues related to gender equality. Third, to support the peace processes, these groups work across civil society organisations to build diverse coalitions. These strategies help break through political impasses, humanise the enemy, broaden the definition of security, facilitate the alignment of agreements with international norms, and push for constitutional amendments to secure women's rights within the law.

Examples of these efforts include the Guatemalan peace process in the 1990s. Building upon decades of women's activism, a coalition of 32 women's organisations formed the Women's Sector in the Civil Society Assembly, a group that helped negotiate the terms of peace for civil society stakeholders.[109] This Women's Sector network built cross-sectoral support for the inclusion of a broad spectrum of issues into the peace accords, including land reform, economic opportunities, refugee return, and gender equality. Through these efforts, 11 of the eventual peace agreement's 13 thematic accords integrated women's rights.[110]

In another example, the Women's Initiative for Peace in South Asia (WIPSA) facilitated collaborative dialogues between women from India and Pakistan to develop a shared vision for peace. In May, 2000, when hostilities between India and Pakistan escalated, WIPSA organised a peace bus, a journey of 40 Indian women from New Delhi to Lahore.[111] This journey facilitated the discussion of shared concerns and relationships across leadership from civil society and business.

Women's advocacy groups participated in the Israel–Palestinian cross-border mass action campaigns. The umbrella Israeli Women and Peace Coalition was established with Palestinian representation, while Palestinian advocates created a technical team on women's issues that advised the Palestinian negotiating team.[112]

In Liberia, women's grass-roots peace organisations launched a Mass Action for Peace campaign in 2003 and monitored the comprehensive peace agreement by establishing benchmarks and implementation timelines.[113] These organisations recruited and unified women across religious divides by focusing on their collective experience of war. The Women in Peacebuilding Network printed flyers that read “We are tired. We are tired of our children being killed! We are tired of being raped! Women—wake up—you have a voice in the peace process!” To break a political stalemate in the negotiations, women barricaded the negotiating hall and subverted traditional gender roles by stripping off their clothes to prevent men from leaving until productive talks recommenced.[114] Negotiators committed to producing an agreement in two weeks.

In the Philippines, women's presence at the negotiation table and their concerted efforts in civil society influenced the language and process of negotiation. Through this advocacy, security-related outcomes in the 2012 Framework Agreement and the 2014 Comprehensive Agreement on the Bangsamoro included gender provisions.[109] For example, provisions mandated that donors and the government allocate at least 5% of development funds to women's programmes and establish a consultation mechanism to nominate women to positions of authority.

In Kenya, Graça Machel co-chaired peace talks and mandated that each delegation include at least one female representative.[115] The Women's Consultation Group on the Current Crisis in Kenya was formed to use the negotiation talks as a platform to address long-standing issues for women. Women's rights organisations published evidence to raise support for survivors of sexual violence and used the media to bring public attention to women's experiences of Kenya's political violence.

Finally, in Northern Ireland, women formed a political party to gain access to the peace talks. The Northern Ireland Women's Coalition (NIWC) represented catholic and protestant communities, took no stance on Northern Ireland's independence, and included nationalist and unionist women.[116] The NIWC fielded 70 candidates by using their ties to networks of women's groups and won two seats in the 1997 election. The NIWC participated in the peace negotiations alongside representatives of Ireland, political parties of Northern Ireland, and the British government, and mounted a yes campaign for the Good Friday Agreement.[117] Marjorie Mowlam, the UK's Secretary of State for Northern Ireland, directly attributed the success of the yes campaign to the efforts of the NIWC.[117]

These examples show the unique and valuable role that women and women's groups play in advancing peace processes around the world.

To facilitate linking social capital, processes and governing structures must integrate receptors for civil society organisations and broader networks, such as through the formal participation of experts and groups in consultative and decision-making processes. For example, international norms on access to antiretroviral therapy for those living with HIV/AIDS are negotiated into political statements at the Group of Seven and the UN General Assembly. These norms recognise the importance of consultations with civil society; as such, the implementation process for these norms connects civil society groups, the private sector, and governments. Likewise, the UN Security Council Resolution 1325 pushes for the inclusion of gender advocates in peace processes.[122] The presence of female representatives in peace processes affects the quality and durability of peace as female signatories have stronger relationships with women's civil society groups. Their engagement can shape the content of peace agreements, incorporating mechanisms to improve health equity and gender equality and facilitating their implementation.[123]

Despite these benefits, social capital also has potential risks. Social cohesion among some identity groups can enable permissive attitudes towards violence and facilitate mobilisation and engagement in violent action.[124, 125] Moreover, the willingness and ability of social groups to connect to others depends in part on their openness to those connections. Economically or politically powerful groups typically have high levels of bonding social capital that can generate in-group biases and perpetuate discrimination, exclusion, and resistance to change. Discriminatory attitudes and social inequalities, including those related to gender, also undermine the openness and connectivity of networks.[126, 127] Social networks can become exclusive and closed, with high formal and informal barriers to entry. These barriers can include language, class, education levels, and access to resources.[128] These factors shape whose voices are included and which problems are prioritised.[129] People from marginalised groups who lack the ability to connect with individuals or institutions in power can, therefore, be excluded from decision-making processes and political, economic, and social resources. Evidence from humanitarian crises illustrates how groups displaced from their normal community networks, and who lack connections to decision makers, can be marginalised and receive less community support.[97]

Could improvements in gender equality and health equity dampen these potential negative dimensions of social capital? Increased investment in women and girls, combined with the

ability of women to access information and engage in the public space, enables their increased participation in civil society.[63] Women's social and economic roles often provide them with greater connectivity across social groups, connections that span ethnic, religious, or other social divides, and build and support social capital, all of which reduce the risk of recidivism of conflict in communities.[130] Strengthening women's social networks can build bridging social capital and enable society to handle conflicts more peacefully.[63] More research is needed to explore this possibility, as well as possible linkages between health and social capital—for example, what role do health providers play in fostering bridging and linking social capital? Although research highlights the critically important role of close-to-community providers in health service provision and health system resilience,[55, 131] how these providers affect social capital remains a knowledge gap.

Another key social effect of improved gender equality involves the transformation of social norms, which facilitates more peaceful social interactions.[132, 133] Gender norms can form an honour ideology, in which male honour is intertwined with ideals of toughness and aggression as well as the ability to protect and provide for the family and community. As we see from our case studies of Kosovo and Afghanistan, these norms arise from and are exacerbated by the context of fragility and shape individual and group behaviour, with particularly severe consequences for women and girls.

Masculine gender norms often condone, and sometimes promote, male engagement in a wide spectrum of violence, from intimate partner to interpersonal violence, and encourage participation in violent groups. Such norms also affect behaviour and aggression within militaries.[134] A study in Thailand found that honour ideology is conducive to male participation in political violence; male activists who espouse this ideology are more likely to engage in violence than activists who do not.[135, 136] Similarly, the study found a relationship between masculine gender norms that value domination and aggression and volunteering for military service in active armed conflict.[137] In Bangladesh, Indonesia, Libya, and the Philippines, survey respondents who agreed with statements concurring with the need for men to control women and the acceptability of the use of violence to defend male honour, were 2·5 times more likely to support violent extremism.[135] Our Afghanistan case review (appendix pp 129–38) illustrates how honour culture can collide with security operations and externally politicised efforts to promote gender equality. Evidence also suggests that countries that discourage female participation in public life are less likely to engage in negotiations to resolve armed conflict.[138]

As gender equality improves, norms surrounding the permissibility of violence transform.[134, 139] Some research suggests that gender equality within society generates greater "norms of inviolability and respect",[133] which reduces polarisation within society.[132] Societies with more gender equal norms exhibit a greater degree of mutual respect and tolerance.[140] Empirical evidence from India suggests that there is a relationship between social and political acceptance for women's rights and the capacity to manage disputes and conflicts non-violently.[63]

Political effects of health equity and gender equality

Our conceptual framework suggests that gender equality and health equity generate two political effects that are linked to a reduced risk of organised violence. First, the institutionalisation of health equity and gender equality improves the quality of governance. The concept of governance goes beyond a focus on formal state institutions to recognise that

broader state–society interactions influence the effectiveness and capacity of governments.[141, 142] Second, through the delivery of services that are gender equal and promote health equity, public services help build trust in formal institutions and strengthen the social contract between citizens and the state. The social contract refers to an implied agreement in which the governed accept the authority of the government in return for its protection of basic rights and provision of public goods. Research shows an association between improved governance, a stronger social contract and greater trust in the state, and more peaceful societies.[143, 144, 145]

These political processes are distinguished by important feedback loops. If gender equality and health equity improve governance, services are then delivered more effectively. Governments work to enhance the welfare of their societies through the generation and redistribution of resources and investments in public goods. Domestic health expenditure and official development assistance are more likely to be allocated appropriately, increasing the trust of citizens in their formal institutions. With better governance and levels of trust, citizens are more likely to pay taxes or otherwise invest in public goods.[146] Through higher investment in public goods, states are better able to invest in health services to promote health equity and the institutionalisation of gender equality.

The complex and unpredictable nature of political processes complicates our ability to discern or isolate the influence of gender equality and health equity on these processes. Variables with immediate or short-term effects, such as individual leadership attributes and regime type, as well as regional and international events, can dramatically shape the quality of governance, trust in formal institutions, and the strength of the social contract. These short-term effects can quickly undermine the long-term gains made by gender equality and health equity. In addition, the processes of institutionalising health equity and gender equality can be deeply political, contentious, and provoke backlash.

Most research examines government capacity as an input into health equity and gender equality. Few studies explore the effect of improved gender equality or health equity on government effectiveness. The concept of the quality of government is generally assessed through the indicators of bureaucratic competence, the rule of law, and levels of corruption. To be competent, bureaucratic institutions should have the information and expertise to identify policy gaps, and the capacity to design and implement policies to address those gaps. Governments must be able to draft legislation and enforce and adjudicate the rule of law. In addition, corruption should be minimal, to enable bureaucratic institutions to deploy evidence-based interventions for the broader public interest rather than policies that advance private gain.[147]

Research does illustrate the influence of gender equality on one measure of the quality of government, namely reduced levels of corruption. Particularly within mature democracies, societal corruption appears to decrease when more women hold elected office.[148, 149, 150, 151] In 2016, Brollo and Troiano estimated that the probability of observing a so-called corruption episode in Brazil is 28–33% lower in municipalities with female mayors than in those with male mayors.[152] In a similar study in India, Beaman and colleagues found that households pay fewer bribes in villages with female councillors than in those with male councillors.[153] Some explanations for these reduced levels of corruption suggest that women might be less tolerant of corruption.[154, 155, 156, 157, 158, 159] Gender equality could also increase broader adherence to the norms of impartiality and fairness, which reduces tolerance of corruption among citizens as well as those in positions of authority.[160, 161] This lack of tolerance for corrupt behaviour

could also be a result of women's marginalisation from political networks that normalise and incentivise corruption. In addition, women's greater dependence on state services could limit their willingness to accept the diversion of state resources away from service delivery.[162]

The relationship between gender equality and other dimensions of the quality of governance has received less attention. In a 2013 study, Garcia-Sanchez and colleagues found an association between gender diversity and government effectiveness in high-income countries, and suggested gender equality increases the diversity of decision-making processes, which leads to more responsive, innovative, and creative policies. The study also suggests that gender equality and health equity improve levels of human capital, which increases the technical competence of the civil service as well as the ability of citizens to hold governments accountable.[163] Gender equality results in lower levels of corruption, which is in turn linked to greater levels of trust in government.[164] Yet these explanations remain hypotheses to be explored in detail or tested in other studies.

Research suggests that when the participation of women in government is accompanied by broader gender equality, informal institutions and power structures are disrupted and the quality of governance improves.[63] Yet how women and sexual and gender minorities navigate and access both formal and informal political power structures is complex and poorly understood.[165] Some scholars point to Rwanda, praised for tangible improvements in gender equality, as an example of the limitations of the top-down implementation of gender equality. Although Rwanda's gender equality gains are impressive, the effect on the broader quality of governance is less clear. For example, to facilitate women's engagement in governance and politics, Rwanda established a network of women's councils. Some researchers caution that these councils enable the participation of a small subset of elite women in governance.[166]

Similar knowledge gaps limit our understanding of the relationship between health equity and political processes. An influential body of development theory and practice argues that improving the delivery of public services, such as health, can build trust between citizens and the state. The state shows its ability and willingness to fulfil its side of the social contract and provide for the needs of the population.[167, 168] Increased trust and cohesion can, in turn, reduce the risk of armed conflict. Health service delivery has, therefore, been used as an element of state building[168] and counterinsurgency projects,[169, 170] which attempt to improve perceptions of the legitimacy of state institutions. From Viet Nam[171] to Kosovo[172], to Afghanistan[173] and Iraq,[170] health-care services have been an important part of nation-building operations with the belief that beyond improving population health, the provision of health services could potentially contribute to state legitimacy and improve trust in formal institutions.[167, 174]

Despite periodic efforts to mobilise health service delivery to build institutional trust, there is scarce research and empirical data suggestive of a link between health service delivery and improvements to trust and the social contract.[168] To deepen this evidence base, the Commission analysed data on the relationship between health service delivery and perceptions of state legitimacy (panel 11). Existing evidence suggests that other factors influence whether, and to what extent, improvements in service delivery translate into increased levels of trust and perceptions of state legitimacy. These include the expectations of the public, perceptions of equity and fairness,[173] the management and delivery of services, and people's experiences with these services, in particular the quality of services provided. [168]
The increase in levels of institutional trust associated with health services appears strongest at the local level (panel 11).

Panel 11. Cross-national evidence on the effect of health service delivery on institutional trust[175]

The Commission collaborated with colleagues from the Secure Livelihoods Research Consortium (SLRC), a multi-country, longitudinal research project that explored household livelihoods, service delivery, and perceptions of state and local governance in conflict-affected areas.[175] We studied whether perceived changes in health equity, as measured by the quality and accessibility of health services, were associated with stronger trust in government institutions and the legitimacy of state institutions. Conflict research shows that institutional trust and legitimacy are associated with reduced risk of armed conflict.[176, 177]

The SLRC collected panel survey data in conflict-affected areas of the Democratic Republic of the Congo, Nepal, Pakistan, Sri Lanka, and Uganda, from the same respondents in multiple waves over a 7-year period. The surveys measured household access to health facilities and perceptions of the quality of health services, as well as other indicators measuring multiple dimensions of institutional trust and legitimacy at the local and national levels. Given that the surveys tracked the same households over a multi-year period in extremely challenging research environments, and used comparable indicators across countries, they provide us with a unique resource to examine how service delivery influences public perceptions in conflict-affected areas over time.

We used fixed and random effects regression models over multiple survey waves to analyse the association between health-care services and state legitimacy. The models controlled for household characteristics, including demographic and socioeconomic factors. We also analysed the effect of exposure to armed conflict.

Our results suggest that the relationship between service delivery and public perceptions of state legitimacy is complex and contextually specific. We found consistent associations across multiple countries between the perceived quality of health services and measures of institutional trust—ie, higher levels of satisfaction with the quality of health services were associated with higher levels of trust in local government and, to a lesser extent, national government. However, in most contexts and model specifications, the effect size was small. These data suggest that while improvements to health service delivery can potentially contribute to strengthening institutional legitimacy, they will do so incrementally, over long periods of time, and cannot be regarded as a quick fix for long-standing trust deficits.

We found no association between the accessibility of health facilities (measured by travel time to the nearest clinic) and institutional legitimacy (measured by perceptions that the government cares about the respondent's opinion, and that government decisions align with the respondent's priorities). We also did a preliminary analysis of service providers, to determine if people who used clinics that they perceived were run by the government had larger changes in trust levels than people who used clinics perceived to be non-governmental. We found no major differences.

Our findings suggest that the degree to which health service delivery affects state legitimacy depends on local context and politics. In our analysis of survey data drawn from the North Kivu and South Kivu provinces in the Democratic Republic of the Congo, we found no association between satisfaction with health service delivery and trust in the central government, but a beneficial, substantial effect on trust in the perceived legitimacy of local government. This finding is consistent with other studies, which found endemic distrust of the central government, suggesting that services cannot buy legitimacy if larger political cleavages are unresolved.

These findings are broadly consistent with other cross-national evidence generated by the SLRC. Qualitative data gathered across various contexts suggest that mediating factors influence public trust in the state, such as whether services—including health—are a politically salient issue and whether they are perceived to be delivered with dignity, and influence whether improvements in delivery yield improved relationships between citizens and the state.

The Commission also found evidence that distrust can undermine health service delivery. Our analysis of how COVID-19 affected attacks on health services by humanitarian actors (appendix p 165) showed that a combination of xenophobia, distrust, and stigmatisation of health workers created an environment in which recipient communities often perceived humanitarian workers as potential vectors of harm rather than vectors of assistance.

Within political science scholarship, evidence links improved governance, increased levels of trust, and a stronger social contract with more peaceful societies. Although we found evidence to support this pathway, more research is needed to explore how, why, and under what conditions gender equality and health equity strengthens the quality of governance, trust, and the social contract.

Our conceptual framework

The Commission argues that improvements in health equity and gender equality are not simply outputs of social, economic, and political processes. Our theory of change posits that these improvements can exercise an independent influence on society, facilitating peace. Through this review of the processes and pathways from gender equality and health equity to more peaceful societies, we developed a conceptual framework (figure 5). This conceptual framework suggests that the institutionalisation of health equity and gender equality occurs through the acceptance of principles and implementation of key mechanisms that produce meaningful improvements in gender equality and health equity. As a result of improved levels of health equity and gender equality, human capabilities are transformed, altering agency, structures—including formal and informal institutions—and power dynamics within society. These improved capabilities set in motion economic, social, and political processes that place societies on economic, social, and political pathways towards peace. Through these processes and pathways, self-reinforcing cycles transition from harmful to beneficial cycles. These beneficial cycles are in turn sustained through feedback loops with the economic, social, and political effects outlined previously. More research is needed to examine these processes within detailed case studies. We provide suggestions for further research within our proposed learning agenda.

Section 4: the responsibility of the health sector to advance gender equality

In this section we examine the implications of our theory of change for the health sector. Furthermore, we argue that the health sector needs to integrate gender equality as an objective of health-care services and systems.

The health sector has the ability—and the responsibility—to help create the conditions for more peaceful societies. Health professionals are respected leaders within their communities. Individuals engage with health services throughout their lifespans, and health systems contribute to the economy, governance, social capital, and trust. Yet health services and systems reflect both implicit and explicit biases, including biases related to gender. Such biases impact how roles within the health sector are valued and financially rewarded, as well as the career trajectory of health professionals. The willingness of individuals to access health services, the quality of care they receive, and ultimately their health outcomes are affected by these biases.[178, 179, 180] As outlined in the following subsections, the health sector has not adequately embraced its role in advancing gender equality. We now examine how the health sector can avoid reinforcing gender inequalities with the adoption and implementation of gender equality principles and mechanisms through its health responses, services, and systems.

COVID-19: a gender unequal response

Gender emerged as a crucial factor that shaped vulnerability to COVID-19. The Commission examined the health sector's response to the gender dimensions of the pandemic. Our findings

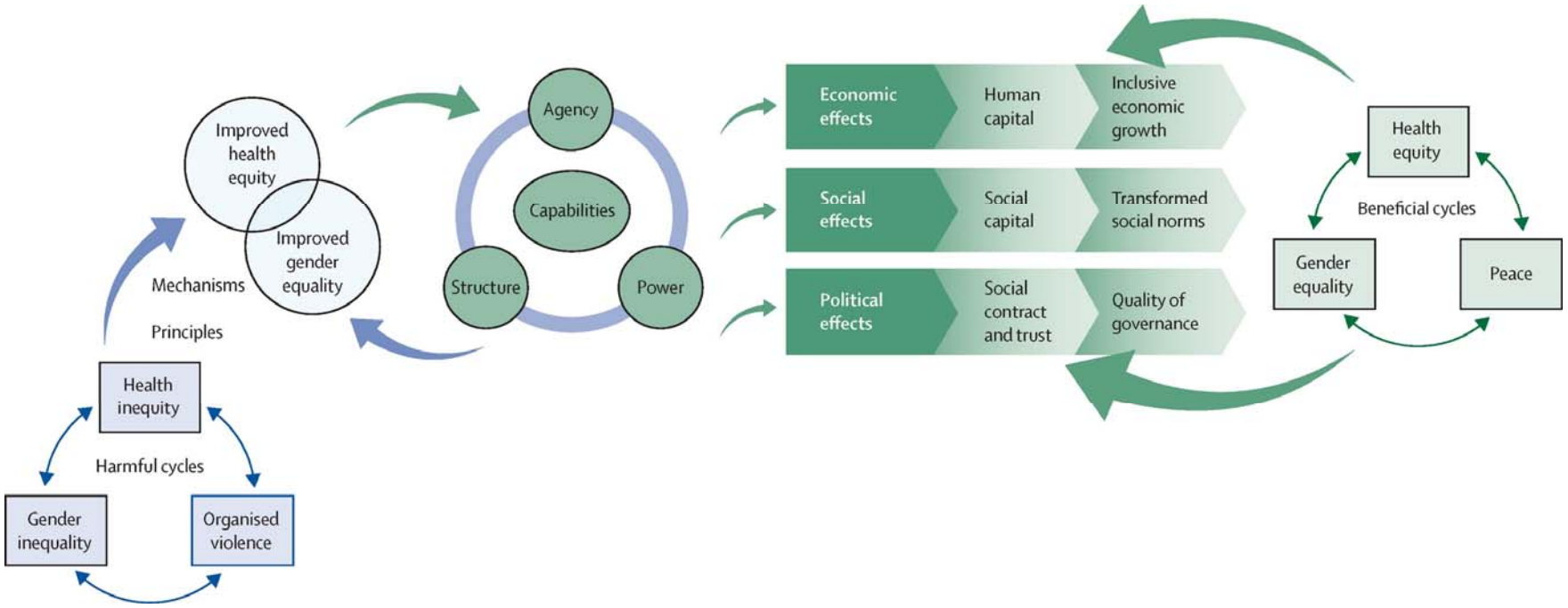

Figure 5. The Commission's conceptual framework

The Commission's conceptual framework outlines the relationships between improvements in health equity and gender equality with more peaceful societies. Health inequity, gender inequality, and violence interact in self-reinforcing harmful cycles. Improvements in health equity and gender equality disrupt these harmful cycles. The principles and mechanisms of health equity and gender equality improves capabilities, increasing agency, transforming formal and informal structures, and shifting power within society. Heightened capabilities in turn prompts further improvements in health equity and gender equality. The economic, social, and political effects of improved health equity and gender equality enable societies to transition into beneficial cycles. These beneficial cycles are sustained by interactions among health equity, gender equality, and peace as well as the economic, social, and political effects of health equity and gender equality.

showed that the health sector did not sufficiently acknowledge and address these gendered vulnerabilities. Instead, in many places around the world, COVID-19 revealed and weakened the precarious scaffolding upon which gender equality rests. This gender-blind nature of the response was not inevitable; the health sector needs to ensure that responses to future infectious disease outbreaks do not exacerbate gender inequality.

Gendered vulnerabilities to COVID-19

In many countries, men had higher mortality rates from COVID-19 than women. Men were more susceptible to infection than women due to differences in immune responses and a higher prevalence of comorbidities, among other biological factors.[181, 182] Masculinity norms, which encourage delays in seeking health care, also increased men's risk of acquiring COVID-19 and experiencing adverse health outcomes.[181, 182] Male-dominated occupations, such as construction, transportation, and the military, required in-person work and often involved temporary housing in crowded conditions. Employment loss associated with COVID-19's economic shock also created a substantial mental health burden on men.[183]

Women's reproductive, caregiving, and occupational roles within their families and communities combined to elevate their vulnerability to COVID-19 in unique and devastating ways. The pandemic affected women's maternal and reproductive health. The pandemic disrupted comprehensive sexual and reproductive care, including outreach services for contraception, menstrual hygiene supplies, and maternal health care. WHO's pulse survey of 135 countries and territories found that between May, 2020 and September, 2020, 66% of countries had some form of interruption to family planning and contraceptive services, with 44% reporting that disruptions continued from January to March, 2021.[184]

The ability and willingness for women to access reproductive health services was also affected by misinformation about COVID-19, transportation restrictions, the fear of becoming infected on public transit or in health facilities,[185] and the objections of male family members who were at home during lockdowns.[183] Moreover, some governments used the cover of the pandemic to limit abortion services.[186] Women and adolescent girls also faced a rising burden of gender-based violence (GBV), sexual exploitation, and adolescent pregnancy.[183] Although many governments implemented measures to address GBV, lockdowns undermined the ability of individuals to access safety and support, and community beliefs that women and girls should simply tolerate GBV to keep families together undermined the implementation of official policies.[183]

Governments generally failed to monitor and address the unique effect of the pandemic on women's economic security and wellbeing.[187] As countries went into lockdown and schools were closed, women assumed the unpaid burden of caregiving responsibility for children and other family members at a higher rate than men.[183] Women were often forced to withdraw from formal employment reversing previously hard-won gains in female labour force participation.[188] Women also faced higher job loss rates than men, due to disproportionate female employment levels in hard-hit sectors that require in-person work, such as hospitality and tourism.

Much of the attention paid to sex and gender has focused on cisgender, heterosexual men and women.[189] Although the effect of COVID-19 on gender and sexual minorities has not been sufficiently researched, available evidence suggests that these groups—particularly within

minority ethnic communities—could have faced elevated infection and mortality rates, and increased impediments to accessing health services.[189, 190]

COVID-19 forecasting models: gender blind

COVID-19's emergence, rapid spread, and evolution created large demands for real-time data and forecasting tools. Policy makers needed to understand the status and potential trajectory of morbidity and mortality, as well as estimate the effect of potential mitigation measures. Epidemiological models became an invaluable tool to support public health decision makers. Models are simplifications of the world, designed to study processes of disease transmission, constructed on the basis of data—and assumptions—about pathogen characteristics and population behaviour. Most models are designed with parsimony in mind and for a specific purpose: to answer a research question, understand a disease, or predict outcomes in a certain context.[191] Models can also estimate how public health interventions could affect transmission and control the spread of infectious disease. The performance, accuracy, and ultimate usefulness of a model depends on its design, the quality and rigour of any underlying data and assumptions, and its appropriateness for a given infectious disease and research question.[192, 193, 194]

Given the role that forecasting models played in policy responses to COVID-19, we did a review of models to assess if and how models differentiated between exposure, vulnerability, and adaptive capacity to COVID-19 for different vulnerabilities such as age, gender, race or ethnicity, occupation, and socioeconomic status. The Commission reviewed 181 models of the first wave of COVID-19 (appendix pp 163–64). Our review identified several challenges, notably a lack of data with the required degree of spatial and sociodemographic granularity to provide robust projections at the level of specific communities of interest. We found models included insufficient data on population characteristics, such as socioeconomic status, sex and gender, and occupation or living and working conditions. Without such information, public health policies could not incorporate how these factors would influence COVID-19 transmission and mortality, as well as the impact of public health measures on these communities.

We found that COVID-19 models were also not designed to integrate gendered vulnerabilities to COVID-19 risk or the impact of public health mitigation measures. This gap might reflect several factors—ie, modelling techniques, scarcity of data to inform models, as well as the lack of demand from policy makers. Although several models incorporated age and comorbidities into their exposure and vulnerability estimates, we found no examples of models that incorporated characteristics such as sex and gender, socioeconomic status, or occupational vulnerabilities. The gender-blind nature of COVID-19 models meant that policy makers had limited capacity to understand how patterns of COVID-19 morbidity and mortality followed and exacerbated existing inequalities. As such, policy makers largely failed to respond to these gendered and intersectional vulnerabilities.

Gender equal responses to infectious disease emergencies

Researchers and policy makers must acknowledge the devastating effects of the public health response to COVID-19 on gender equality and the inability of policy instruments to anticipate, respond to, and effectively mitigate this impact. During epidemics, public health decision makers are often forced to make difficult policy choices to balance the broader health of the

community against the rights of individuals. Across the world, the burden of these policy choices all too often disproportionately falls on women. Efforts to prepare for future infectious disease emergencies must integrate gender equality into assessments of vulnerability, analysis of the impacts of mitigation measures, and the design of response measures. Ongoing negotiations over the WHO-led Global Pandemic Accord represent an important opportunity. Through these negotiations, decision makers must address the gendered vulnerability to pandemics and establish gender equality as a clear objective of pandemic preparedness and response measures including forecasting, pharmaceutical interventions, and vaccination and treatment.

Health services that promote gender equality

The Commission examined if and how health services recognise gendered vulnerabilities and incorporate gender equality as an objective of health responses, services, and systems. In panel 12 we investigated this question within the humanitarian community and in panel 13 we focused on health services for sexual and gender minorities. Progress in integrating gender equality as an objective of health services and systems has been stymied by the failure to recognise it as a problem as well as the lack of political will. With clear guidance on how gender equality can be integrated into the principles of health engagement, namely how health services and systems can become more gender equal (panel 14), the health sector is uniquely well placed to be an important agent of change.

Panel 12. Transforming humanitarian action to address gender differences and inequalities[195]

Through a literature review, analysis of organisational programme and planning documents, and interviews with 44 key informants, a background study conducted for the Commission assessed the extent to which humanitarian responses in conflict settings have addressed gender equality. Gupta and colleagues' study has five key findings.[195]

First, a gap exists between the guidelines for humanitarian programmes and the actual practices that characterise their implementation. The study authors found inconsistent quality of sex and age disaggregated data and a lack of linkage across the analyses and actions at different stages of the humanitarian programme cycle.

Second, in their effort to integrate gender into their programming, the humanitarian sector focuses on process, not results. Annual reports emphasise the number of beneficiaries served and activities implemented rather than reporting on the closure of gaps between men and women compared with a baseline. Although the sector focuses on the processes of gender mainstreaming and gender-based analysis, increased evidence and better monitoring is needed.

Third, the operationalisation of gender is characterised by conceptual confusion, inadequate technical resources, and a lack of specificity. The study found that multiple terms exist, which include gender responsive, gender sensitive, gender balanced, gender intentional, and gender transformative. These terms are rarely clearly defined. Moreover, gender is code for women and girls rather than an understanding of the structural inequalities that disproportionately disadvantage women and girls in humanitarian settings.

Fourth, the humanitarian sector prioritises basic needs, protection, and participation over actions that would transform gender norms. Within that prioritisation, clear gender biases emerge. Livelihoods programmes tend to reinforce gender-stereotypical caregiving or domestic roles for women and girls, rather than provide women with employable skills. Protection programming focuses on lack of personal identification and broader community safety rather than on gender-based violence. Gender-based violence, including intimate partner violence, is mentioned but often insufficiently resourced.

Fifth, despite rhetoric from leaders of humanitarian agencies and governments on the importance of gender equality, technical and financial resources are inadequate and inconsistent. Overwhelmed field staff struggle to translate available guidance into practice. As one key informant stated, “Just tell us the 5–10 things that must

be done—there is no time to read all the guidance."[195] Further, humanitarian funding for gender equality and the empowerment of women and girls falls far short of funding requests.

Sixth, for too long, the humanitarian sector has tolerated sexual exploitation and abuse by individuals affiliated with the humanitarian response. Such actions violate the rights of communities, undermine trust, and erode the dignity and potential of those affected. These abuses of power reflect deeply problematic attitudes towards women and local communities. For years, many in the humanitarian sector witnessed such problematic, exploitative, and criminal behaviour from their colleagues and did little to stop it.

Finally, this study suggests that the humanitarian culture, often characterised by a saviour mentality, an overly masculine culture, and a tolerance for abuse of power and exploitation of the weak, combines with the lack of focus on clear results to stymie meaningful progress. In addition, despite the protracted nature of many humanitarian contexts and the renewed focus on the humanitarian–development nexus, humanitarian action continues to be dominated by short-term programming and policy time horizons. Until these cultural characteristics are confronted, the humanitarian system will continue to be blind to its responsibility to contribute to gender equality.

Panel 13. **Sexual and gender minorities: health care access in Ghana[196]**

Lebbos reviewed available literature on health services for sexual and gender minorities and conducted semi-structured interviews in Ghana.[196] This research suggests health-care access barriers for sexual and gender minorities fall under four broad categories.

Individual-level barriers
Gender minorities are particularly affected by poverty,[197] making access to health care and health insurance coverage unaffordable.[198, 199, 200, 201] Unemployment, largely fuelled by employment discrimination based on sexual orientation, gender identity or expression, and sex characteristics (SOGIESC), was reported as a main factor contributing to the high poverty rate among sexual and gender minorities in Ghana. Competing financial priorities for food, shelter, or education over health care also contributed to whether sexual and gender minorities in Ghana were able to access necessary care.

Structural and societal barriers
Homophobia and transphobia are documented to be some of the most common forms of discrimination faced by sexual and gender minorities in health-care systems.[197, 202, 203] Interviewees in Ghana indicated that experiences of discrimination when accessing health care were very common and often drove members of their community to avoid future attempts to access care. Specifically, fear of discriminatory attitudes from health-care workers causes avoidance of care or premature departure from health facilities without receiving adequate help. A general mistrust in the health system is a key barrier to health access for sexual and gender minorities, particularly for publicly funded health facilities. As a result, compared with heterosexual and cisgendered individuals, sexual and gender minorities are more likely to delay or avoid necessary medical care or to be reluctant to disclose their sexual orientation or gender identity when receiving medical care.[204]

Health system barriers
Health service availability remains sporadic to sexual and gender minorities across Ghana, with services often limited to HIV and the prevention and control of other sexually transmitted infections. Such services target mostly men who have sex with men and transgender women. Participants also raised concerns related to physical accessibility to those services, particularly in rural areas. Moreover, it was noted that health-care professionals generally lacked knowledge of sexual and gender minority specific health-care needs and held negative attitudes towards sexual and gender minorities. Participants also noted that the health system lacked accountability, namely through grievance or other reporting mechanisms. As a result, individuals rarely attempted to seek assistance for abuse or discrimination in health-care settings. These factors contributed to many sexual and gender minorities avoiding the health-care system altogether.

Policy making barriers
Lack of SOGIESC considerations in health policy is a barrier to accessing health care for sexual and gender minorities in Ghana. Participants emphasised that policy dialogues and health programmes are rarely designed and implemented to reflect SOGIESC concerns. A common example mentioned by participants was the lack of mandatory training on non-discrimination for health professionals. The lack of consultation with sexual and

gender minorities undermined the integration of SOGIESC considerations into health policy. Further, the lack of SOGIESC-specific evidence or data undermines responsive policies. Questions relating to SOGIESC are often absent from demographic surveys used by researchers and governments, which hinders efforts to better understand the health needs of sexual and gender minorities.[205]

Panel 14. Research on gender and health systems[206]

Research by Percival and colleagues examined how health system models address the relationship between gender and health systems.[206] The research mapped the evolution of health system thinking against historical developments on gender, specifically focusing on women's health and rights. Additionally, to inform its understanding of the interaction between social norms and health systems, the review examined research on health system complexity and resilience. Four key findings emerged from this analysis.

First, health systems frameworks do not incorporate the inter-relationship between gender and health-care services. Some models highlight the importance of understanding health system processes as well as social context—namely the role and importance of people; ideas; and interests, values, and norms. However, even these models do not fully interrogate the interface between the social context and the health system and analyse how that social context, including gender norms, influences the health system.

Conceptualisations of health as a complex system also largely ignore gender. Resilience is broadly interpreted as a positive characteristic, an attribute of health systems to be fostered. Yet could the self-organising characteristics of health systems mean that problematic social norms—including those related to gender—are some of the emergent and self-regulating properties of health systems? That problematic social norms are reinforced through daily interactions and institutions to resist change?

Second, the lack of interdisciplinary collaboration undermines the understanding of health systems as social systems. Health economists dominated the early development of health systems models. Driven by the impetus to identify the parameters of the health system to facilitate planning and estimate the cost of health services, health system frameworks identified the boundaries of the health-care system, its main actors, and the institutional components of the system.

Health economists developed early health system models at the same time as the ground-breaking International Conference on Population and Development in Cairo in 1994 and the Fourth International Women's Conference in Beijing in 1995. Policy makers launched and promoted the dominant Control Knobs framework in 2004 and Building Blocks framework in 2007 just after the Millennium Development Goals in 2000 and its goal to improve maternal health, and the UN Security Council Women Peace and Security Resolution (UNSCR 1325), which emphasised the importance of women's leadership in 2000.

Despite this research and advocacy on gender and health, health systems policies did not address this relationship. This exclusion mirrored the inability of gender scholars to have their research and gendered approaches to the health sector fully integrated and accepted into broader health policy. Decades of research by gender scholars on gender norms and their effect on health did not translate into health systems research or models.

Third, this failure of health systems policy guidance to address social inequities assumes the health system is transferable across social settings. With the right manipulation and inputs, these systems will provide effective health services to respond to the health needs of the population. Yet research shows how deeply intertwined health systems are with their local context.

Finally, our research suggests the need for a new conceptualisation of health systems that reflects their deep embeddedness within the social context, shows how social principles flow into the system, and identifies potential points of intervention to make these systems more equitable. Our suggested framework extends the work of other researchers to divide the health system into inputs, outputs, and outcomes; shows how the social context influences principles that flow into the system; and identifies points of leverage to harness the power of the health system to promote gender equality.

Gender-equal humanitarian action

Health services are a key component of humanitarian engagement. Research conducted for the Commission (panel 12) illustrates that while the humanitarian sector has highlighted the importance of gender-based analysis, the sector has not fully institutionalised the principles of gender equality within humanitarian practice. Mistreatment and sexual exploitation, abuse, and harassment committed by members of the humanitarian community further undermine trust. Given its pivotal role in engaging with the community in fragile and conflict-affected settings, the humanitarian community is well placed to promote gender equality through these responses. As outlined in the following subsections, to play that role, humanitarian principles need to articulate the role of humanitarian action in gender equality.

Adherence to humanitarian principles in dynamic and politicised conflict-affected contexts poses clear dilemmas and challenges. To navigate these challenges, humanitarian actors have institutionalised humanitarian principles through international humanitarian law and decades of humanitarian practice. Humanitarian commentators continue to debate the tension among humanitarian principles and the realities of the provision of assistance in complex contexts.[207, 208] Organisations such as Médecins Sans Frontières argue that neutrality does not prevent them from documenting the suffering of civilians and advocating for civilians in the face of violations of international humanitarian law and other abuses.[209] These debates have largely failed to interrogate and resolve the potential contradictions between humanitarian principles and the resistance of the humanitarian community to recognise and address harmful gender inequalities through their engagement.

This resistance manifests itself through the lack of leadership in crucial areas of action (eg, GBV),[210] including from members of the humanitarian community. The humanitarian community has not prioritised gender equality in staffing and leadership positions. [211] Humanitarian actors seem indifferent to the effect of gender inequalities on the participation of women-led organisations in the humanitarian response, [212] the essential role of women's caregiving activities and other unpaid contributions in emergency contexts,[213] and the need for approaches that advance gender equality through humanitarian action.[214] For example, the International Committee of the Red Cross (ICRC) opted not to focus on gender equality or women's empowerment because such programming is perceived to be in violation of neutrality and impartiality principles.[195] We have highlighted the importance of understanding how conflict dynamics condition health interventions. More research is, therefore, needed on if and how gender equality programming within humanitarian contexts affects humanitarian access or the safety of humanitarian workers.[214]

The Commission defines gender equal humanitarian action as engagement that ensures that everyone, regardless of gender identity, can live in safety and security, exercise individual agency, develop their capabilities, and access economic resources and assets and suggest benchmarks for humanitarian actors (panel 15).

Panel 15 .Gender equal humanitarian action

Principles
Humanitarian engagement that provides assistance in a manner that:

- Respects the humanitarian principles of neutrality, independence, impartiality, and humanity
- Extends the meaning of humanity to promote gender equality regardless of sex or gender identity
- Ensures that everyone, regardless of gender identity, benefits from the ability to: develop human capabilities, access economic resources and assets, live in safety and security, and exercise individual agency

Benchmarks
Governance and Leadership

- Integrates gender equality as a principle of humanitarian engagement and articulates support for that principle
- Institutionalises gender equality as an objective in humanitarian health engagement, including within the delivery of health services, human resource policies, and outreach to communities
- Develops accountability mechanisms to monitor the institutionalisation of gender equality within humanitarian engagement, with specific attention to mechanisms to prevent and investigate complaints of sexual abuse, harassment, and any other abuses of power by the humanitarian community, and hold perpetrators accountable
- Responds to the gendered health needs of communities
- Creates engagement forums with community leaders across gender and other forms of identity to understand and address gendered barriers to accessing services

Financing

- Mechanisms created for sustained financing that supports gender equality within humanitarian engagementHealth information
- Sex disaggregated data that is rapidly collected, collated, and analysed to assess gender dimensions of health and health-care access

Human resources

- Health workers across gender identities represented within the humanitarian workforce
- Gender disparities in the workforce, including among nationally engaged staff, monitored and addressed
- Gender focal points that are well resourced and integrated within decision-making forums

Health services

- Provision of gender equal health services that are accessible, integrated, and include comprehensive sexual and reproductive health services
- Provision of affordable medicines, vaccines, and technologies in a manner that is sensitive to gendered differences in efficacy, access, and use

To meet the goal of gender equal humanitarian action, the Commission suggests three crucial steps. First, key humanitarian actors such as the ICRC must clearly articulate how gender equality relates to the core principles of humanitarian action. These principles have often promoted a saviour mentality that undermines the agency of affected populations, including women and gender minorities. The principle of humanity states that humanitarian action must work to protect life and health, ensure respect, and recognise the inherent dignity of a person.[215]

The Commission encourages the humanitarian sector to extend the meaning of humanity to include the recognition and the promotion of gender equality (panel 15).

Second, the Commission challenges the humanitarian community to embrace its responsibility to advance gender equality outcomes. Humanitarian organisations must advance the principles of gender equality within their field operations, their treatment of locally engaged staff, and engagement with communities. Although gender analysis has influenced humanitarian policies (section 5 and panel 16), gender equality objectives were not sufficiently integrated in the implementation of programmes. Consistent with research on broader health settings,[217] we found that in many contexts gender mainstreaming, the effort to integrate an analysis of gender into the design and implementation of policies, has focused on promoting gender-based analyses (appendix pp 123–24) rather than identifying tangible actions that achieve gender equality. To fulfil the promise of gender equality while still respecting humanitarian principles, the humanitarian community must articulate clear and easily operationalisable benchmarks in each of its sectors. In panel 15, we suggest benchmarks for a gender equal humanitarian system, focusing on the areas of governance and leadership, financing, health information and data, human resources, and the delivery of health services.

Finally, the abuses of power in humanitarian settings must end. Gender equal humanitarian action includes a zero-tolerance policy for mistreatment, abuse, and sexual exploitation within humanitarian operations. The Inter-Agency Standing Committee (IASC), a forum of UN and non-governmental humanitarian organisations, has developed guidance on safeguarding measures, including six core principles to prevent and address sexual exploitation, abuse, and harassment.[218] This guidance also needs to be integrated into health research in humanitarian contexts.

Panel 16. The integration of gender norms in humanitarian health responses[216]

A study by Gloppen and colleagues, conducted for this Commission, examined how the International Rescue Committee (IRC) and the International Federation of the Red Cross and its constituent National Societies (IFRCNS) engage with global and local gender norms in their policies, programmes, and practices.[216] Through a review of 94 organisational documents and interviews with 30 key informants, the study examined the relationship between global gender frameworks and organisational gender policies. To establish a common frame of reference to compare how organisations address gender equality, global gender norms were operationalised using the WHO Gender Responsive Assessment Scale, which describes five criteria to assess gender responsiveness that range from gender unequal to gender transformative.

The comparative analysis of 94 documents from the IRC and IFRCNS included organisation-wide and gender-specific programming policies in addition to country-level documents. Findings indicated substantial coherence with global gender norms—including similar approaches for the adaptation of these norms into local contexts—despite the organisations' differences in structure and culture. Additionally, the interactions between global gender norms and organisational gender policies of both organisations were found to be multi-directional; both the IRC and IFRCNS seek to acknowledge and incorporate global gender norms into their work as well as advocating for alignment with these global commitments across the humanitarian sphere.

Findings from the key informant interviews supported some of the multi-directional relationships between global gender norms and organisational policies; respondents described how global gender norms have been integrated into overarching organisational objectives as well as into specific programmes. Respondents working at organisational headquarters more frequently referred to inter-organisational shared norms and documents like the Inter-Agency Standing Committee standards, while field-level staff suggested that organisational documents that incorporated global principles were more useful to their work. Both headquarters and field staff affirmed the need for feedback mechanisms and ways to integrate local input into organisational documents to maximise their perceived utility in diverse contexts.

The interview analysis also expanded on some pragmatic challenges that arose in the document analysis and that are associated with integrating gender equality goals in challenging humanitarian contexts. Specifically, the analysis highlighted the importance of developing a common understanding of gender issues for field-level humanitarian staff, the need to integrate gender equality goals explicitly into sector-specific strategies, and the importance of adequate resources for gender programming. Although dedicated allocation of resources is essential to ensure the prioritisation of gender, some respondents expressed concerns that integration of such concerns into humanitarian programming might be done to satisfy donors rather than to support the organisations' high-level commitments to gender equality. This finding underscores the need for the humanitarian sector to better articulate their responsibility to gender equality and to ensure that sufficient human and financial capital is dedicated to address gender equality meaningfully and sustainably. Additionally, respondents highlighted tools and strategies to increase acceptability of gender-related programming in diverse sociocultural contexts, including careful and long-term engagement with community members, reference to gender as important for broader health and safety, and operating within local gender-related and ethnocultural-related expectations where and when feasible.

Gender equal health services

As discussed by the *Lancet* Series on Gender Equality, Norms, and Health,[180] the potential contribution of health services and the broader health system to gender equality has not been fully embraced.[219, 220] Health services and systems are often characterised as neutral and technical institutions. To improve the efficiency and effectiveness of health-care services, policy makers focus on the hardware of these systems, working to ensure the appropriate mix of human and financial resources as well as infrastructure, medicines, and technologies. Advocates have pointed out their neglect of the software of these systems, including if and how these services reflect and reinforce structural discrimination. Research on the experience of sexual and gender minorities and health systems policy (panel 13) illustrates the opportunity for health services to explicitly integrate gender equality as an objective of health services.

The experience of sexual and gender minorities

The past three decades have seen an unprecedented expansion of social awareness and acceptance of people who identify as sexual and gender minorities.[221] Although this awareness has worked to reduce stigma and improve the health and wellbeing of sexual and gender minorities, structural discrimination remains widespread. Moreover, sexual and gender minorities continue to lack social acceptance and protection within many countries. Little research has examined the experiences of sexual and gender minorities with health services. In panel 13, we summarise research in Ghana that examines the experiences of sexual and gender minorities with health services.

Gender and health systems

As the research on sexual and gender minorities illustrates, health systems are never neutral. They are social systems, deeply embedded in the local context, influenced by history, culture, politics, and the economy. Health services and systems as well as the people who serve in them reinforce social norms in the choices of what to research, fund, and measure; leadership and employment patterns; how they value and respond to the experiences of health-care professionals, including close-to-community providers;[222] the provision of health-care services, tools, and information; and where and to whom these services are directed.[223] Research on gender and health systems (panel 12) underscores the need for health policy to embrace health systems as social systems and integrate gender equality as one of the objectives of those systems.

As we illustrated in our research on humanitarian action, the health sector lacks guidance on what gender equality means. Without gender awareness in health systems models, and in health policy and systems research more generally, there may be a risk that efforts to strengthen health systems and foster resilience inadvertently reinforce gender and social inequities. Health policy needs to embrace gender equality as an output of health systems, build consensus on the necessary principles to enable gender equal health systems, and institutionalise the objectives of gender equality within these systems. In panel 17, we outline our suggested principles and benchmarks to achieve the vision of gender equal health engagement.

Panel 17. Gender equal health engagement

Principles
Health services and responses reflect and reinforce a gender equal society through their ability to:

- Acknowledge the health effect of gender norms and the root causes of inequalities across the life course;
- Incorporate gender equality as an objective of health engagement
- Provide equal opportunity for health-care professionals of all sexual and gender identities to enter, thrive, and advance within the health sector
- Ensure equal access and usage of high-quality health services by people of all sexual and gender identities, unimpeded by financial, social, and geographical barriers
- Commit to being held accountable to address inequalities at all levels

Benchmarks
Governance

- Promote gender equality within the health sector
- Be responsive to the gendered health needs of clients and patients across sexual and gendered identities
- Engage with community leaders across gender and other forms of identity

Health service delivery

- Affordable, integrated, and equitable access to basic services including comprehensive sexual and reproductive health services;
- Provision of these comprehensive health services in a manner that respects the dignity of patients and informed consent

Human resources

- Equitable career opportunities for health workers across sexual and gender identities
- Minimise gender disparities in the workforce, including in compensation
- Ensure equitable compensation for health workers, including community health workers

Health information

- Sex disaggregated data, rapidly collected, collated, analysed, and used to assess and respond to gender dimensions of health and health-care access
- Ensure that health information addresses the particular health needs of sexual and gender minorities

Health system financing

- Equitable financing that recognises the different needs of women, men, and sexual and gender minorities and minimises risk of catastrophic health expenditures

Medical products and technology

- Equitable access to and utilisation of medical products and technologies;
- Ensure that research and development of new medicines and technologies, including clinical research, is representative of all population groups, incorporates sex and racial differences, and is conducted with informed consent

The health sector: agents of change

The contribution of the health sector to gender equality was clear through some of our case studies. In El Salvador, the health system embraced its unique role in the promotion of gender equality through the innovative Ciudad Mujer initiative (appendix pp 148–52). Vanda Pignato, a gender equality activist, Frente Farabundo Martí para la Liberación Nacional politician, and former First Lady of El Salvador spearheaded this initiative, which provided health and other public services for women in one location—the Ciudad Mujer. Six centres were established across the country. In these centres, women were provided with free childcare while they accessed health-care services and received skills training to participate in the formal labour market and strengthen their financial independence. At the Ciudad Mujer, survivors of sexual and gender-based violence (SGBV) could report this violence to police officers, receive legal advice, and access medical services and psychological counselling. Although the Ciudad Mujer initiative was criticised for not sufficiently integrating these health services into the broader system, more than half of El Salvador's female population have used these centres. Given its success and with support from the Inter-American Development Bank, the initiative was replicated in other Latin American countries, including Bolivia, Dominican Republic, Honduras, Mexico, and Paraguay. However, in 2019, the El Salvador government reallocated the budget away from Ciudad Mujer, and some centres closed in the time since as a result.[224]

The role of community health workers (panel 18) in improving health equity, trust, and promoting gender equality is another example of the role of health sector as agents of change. The health policy community should ensure community health workers are trained, fairly compensated, supported and supervised. Their role in addressing gender barriers to accessing health care should be further explored and better supported.

Panel 18. The power of community health workers

Throughout much of the world, community health workers (CHWs) deliver essential maternal, newborn, and child health services; provide HIV/AIDS, malaria, and tuberculosis prevention, testing, and treatment programmes; refer individuals and families to facility-based health services; and engage in broader health promotion activities.[225, 226]

In this panel, we summarise research that examines the crucial role of CHWs in advancing health equity, shows how gender norms shape the experiences of CHWs, and illustrates the ability of CHWs to transform gender norms and promote gender equality.[222, 227, 228, 229]

Who are they?
CHWs are individuals without a professional health certification who are trained to carry out health-care delivery at the community level.[230] In many settings, CHWs are mostly women; examples include lady health workers in Pakistan and community extension workers in Ethiopia. People are motivated to become a CHW for many reasons—eg, to serve their communities, for elevated status within these communities, and to gain experience that could provide an opportunity for further employment.[227] However, CHWs face constraints as their role in health systems is not formally recognised, and there is no clear path forward for advancement.

Where do they work?
CHWs are important in both urban and rural settings. Although health policy has largely focused on CHWs in rural settings,[226] some studies have suggested that CHWs might be equally effective in urban settings in part because of the limited geographical responsibility and the ease of communication with community members.[231]

Their crucial importance to the health system
When CHWs are trained, properly supported, and have adequate supplies, they are highly effective in advancing the health of their communities.[227] For those living in fragile and conflict-affected settings, CHWs can help ensure access to essential health-care services and maintain crucial public health interventions such as vaccination. Female CHWs ensure that women are able to comfortably access reproductive and maternal

health services, as male CHWs are often uncomfortable or not trusted to deliver home-based services in some settings.[222] CHWs also connect communities' realities, concerns, and priorities to the health system, increasing levels of community trust.[232] Given this important role, CHWs should be fairly compensated, well trained, recognised, and connected to higher levels of the health system.[225, 226, 227]

CHWs and gender equality

Emerging research suggests that CHW programmes can be a key channel for women's empowerment and gender equality. Although gender norms have a profound influence on CHW recruitment, retention, and their experience as providers,[222] research shows that CHWs can transform these gender norms over time.

In countries without free public education, where gender norms do not value girls' education, or where education has been disrupted by conflict, the recruitment and training of CHWs needs to compensate for this lack of basic literacy.[232] Gendered responsibilities within families can also affect women's recruitment and retention. Female CHWs also face constraints in their ability to travel to deliver services, particularly in situations of insecurity. Male partners in some settings oppose women working outside the home as CHWs.[222, 232] However, research shows that these gender norms can shift over time. Female CHWs reported feeling more empowered to improve the environment of their home and take charge of decision making from their husbands.[233]

CHWs can also promote gender equality through their delivery of services. Once in place, CHWs can serve as change agents.[232] Female CHWs can create a platform for women's voices to be heard, supporte vulnerable girls and women in the community, and encourage female community members to become more economically independent through income generating activities.[232] Male CHWs also played an important role in transforming gender norms, as they helped increase male receptivity to health messages in the community and facilitated the uptake of family planning and other important health services.[222]

Despite their importance, research shows how female CHWs might not be recognised as skilled workers, and have to constantly defend the value of their work to their family, the health system, and the broader community.[234] The lack of remuneration for CHWs illustrates gender biases that “idealize women's volunteer labour, and devalue their skilled professional needs”.[234] For example, female CHWs struggled to effectively convey COVID-19 messages because of these gender norms in some communities.[229] Health systems, and specifically human resource policies, need to recognise the valuable contribution of CHWs to gender equality, and develop stronger human resource policies to harness this potential.[222]

Section 5: the promise of health and gender equality

In this section, we examine the promise of the Commission's research and illustrate the conditions that must be met to fulfil this promise. Furthermore, we discuss harmful mistakes made when efforts to build health equity and gender equality do not focus on the principles, processes, and pathways outlined in our conceptual framework.

The Commission has explored if, how, and why improvements in health equity and gender equality influence more peaceful societies. The processes of gender equality and health equity challenge, confront, and necessarily adapt to their national context. Societies confront, debate, and negotiate fundamental norms, values, and questions, including what is society's responsibility towards individuals within their community and beyond? What is the nature of that community, its shared principles, and its sense of purpose? Who does society deem worthy of dignity, moral standing, and of inclusion as community members? What are both the entitlements and the duties that accompany inclusion? Who does society exclude and what is the impact of that exclusion? And how can societies recognise and respond to differences to build equity without sowing division?[235, 236, 237]

When societies engage in efforts to improve gender equality and health equity, the approach to these questions shifts. The process of answering these questions is unavoidably political and

non-linear. But to fully realise gender equality and health equity, society is forced to recognise the moral standing of all individuals, including women and sexual and gender minorities, and accept them as equal community members deserving of dignity.

The promise of our research lies in the ability of societies to confront these questions and make concerted efforts to improve gender equality and health equity. Within health systems and gender systems, such improvements enable a transition from harmful to beneficial cycles. Gender equality and health equity in turn build human capabilities and shift power structures to transform economic, social, and political processes, nudging communities and countries towards beneficial cycles. As outlined in the following subsections, these efforts will be successful if they can build upon existing initiatives and learn from the missteps of the past.

Global health equity and gender equality architecture

Although the Commission's framework presents a new perspective on the role of health equity and gender equality in society, societies have long worked to improve health and gender equality outcomes. Over time, these efforts have created a global scaffolding or architecture that is constantly evolving to uphold and enable further progress on gender equality and health equity. This structure consists of continuously evolving global norms, laws and regulations, national and multilateral institutions, and domestic and global funding mechanisms.

The UN Declaration of Human Rights in 1948; WHO's recognition of the Right to the Highest Attainable Standard of Health within its Constitution in 1948; and the International Covenant on Economic, Social, and Cultural Rights in 1966 recognise various dimensions of the right to health. The Alma-Ata Declaration of 1978 incorporates principles of social equity and community participation into its vision of primary health care. SDG3 and its target of universal health coverage furthers the global commitment to health equity. As noted previously, the negotiations for a global pandemic accord provide a new opportunity to reform global health architecture and ensure pandemic preparedness and response efforts advance health equity and gender equality.

Efforts to advance gender equality through the UN system began with the Commission of the Status of Women first held in 1946, followed by annual meetings on the margins of the UN General Assembly. World Conferences on Women from Mexico City in 1975 to Beijing in 1995 and international agreements such as the UN Convention on the Elimination of all Forms of Discrimination towards Women in 1979 have evolved our understanding of the dimensions of gender equality. Particularly noteworthy is the UN Security Council Resolution on Women, Peace, and Security, adopted in 2000 to address the effect of conflict on the lives of women and to advocate for a formal role for women in peacebuilding and security processes. UN Women was created in 2010 to consolidate global efforts to advance gender equality.[238]

The efforts of humanitarian organisations to integrate gender awareness into their programming provides one example of how global architecture evolves. The humanitarian sector has adopted comprehensive gender handbooks and guidelines; committed to collecting data disaggregated by sex, age, and vulnerability; and created a pool of gender advisors to strengthen field capacity (panel 16).

This global architecture supports and directs the flow of donor assistance towards health equity and gender equality. The Organisation for Economic Co-operation and Development reported that in 2020–21 donors directed US$57·4 billion of official development assistance towards

gender equality and women's empowerment, with $5·7 billion dedicated to gender equality as its principal objective.[239] The Institute for Health Metrics and Evaluation estimated that donors dispersed $67·4 billion in development assistance for health in 2021.[240] Donor assistance for gender equality and health equity are not distinct categories, so these estimates overlap. Although critics of development assistance argue that such assistance has deepened existing power imbalances, such funding remains essential. Moreover, our research also suggests that development assistance for health is associated with reduced rates of conflict recurrence (panel 19).

Panel 19. Development assistance for health and conflict recurrence[241]

Humanitarian and development aid to health services is a substantial component of international engagement in fragile and conflict-affected settings. While determining the impact of such aid on health status is challenging, case studies illustrate an association between development assistance for health and reduced levels of mortality.[242, 243] The impact of such assistance on the dynamics of violence and peace is less clear. Some research suggests humanitarian aid increases violent conflict,[244, 245, 246] while others caution that the results of these studies and the evidence that humanitarian aid causes such harm are not replicable.[247] Some scholars argue that much of the research that suggests foreign aid fuels violence has not sufficiently examined the different types of conflict context or identified the conflict conditions under which aid contributes to either violence or peace.[248]

The Commission analysed data on patterns of development assistance for health in armed conflict-affected areas to identify whether external assistance to improve health outcomes reduced the risk that conflict-affected countries relapse into war. There are good reasons to be sceptical of such a relationship: conflict relapse is a common occurrence, driven by a complex set of political, institutional, and economic factors, as well as conflict processes.[249, 250, 251]However, we found consistent evidence across multiple types of armed conflict that suggests external health assistance is associated with longer periods of peace before conflict recurrence, which may buy time for other interventions or endogenous processes to further mitigate conflict risk. Although this is promising, we acknowledge that further research is needed, specifically more granular research that can assess the effect of specific types of health assistance and modalities of aid delivery on patterns of armed conflict and the duration and resilience of peace. Levels of development assistance for health could indicate a greater degree of global attention to conflict-affected areas, which is accompanied by diplomatic resources that assist in conflict resolution efforts.

While imperfect, this global architecture provides an important foundation for gender equality and health equity. Norms are gradually improved over time and reflect the evolution of our understanding of gender equality and health equity. Institutional structures are also not static and evolve in both formal and informal ways. As we note in section 3 and the appendix (pp 18–45), civil society networks and the international exchange of ideas work within this structure to identify gaps in knowledge and policy, share best practices, and mobilise to promote change.

The promise of gender equality and health equity

An important opportunity exists to build on this architecture and leverage existing health and gender equality programmes to advance peace. Our conceptual framework, or theory of change, argues that the principles and processes of health equity and gender equality transform capabilities—what people are able to do and to be. Meaningful improvements in gender equality and health outcomes cannot be simply rhetorical; definitive change must occur through one or more of the mechanisms outlined in section 3. This transformation can be inspired and influenced by global networks and norms. However, to improve health equity and gender equality—tangibly and sustainably—we argue that this change must be led from the inside out. Such transformation places societies on economic, social, and political pathways to peace.

As outlined in the following subsections, the promise of these relationships can only be realised if certain conditions are met; if societies understand conflict dynamics, navigate informal institutions, address the needs of men and boys in addition to women and girls, and anticipate backlash. Failure to navigate these conditions leads to the instrumentalisation of health equity and gender equality programmes, the superheroine fallacy—the belief that women can single handedly change their social, political, and economic contexts, and imitation projects.

Understand conflict dynamics

Although incredibly important, the provision of health services in fragile and conflict-affected settings is not a neutral endeavour. The type of conflict and its continuously evolving dynamics influence if health services will be targeted or accepted, as well as the potential for the inadvertent fuelling of violence.

Despite being protected under international humanitarian law, attacks against health-care facilities, health-care transport, and health-care workers continue.[8] Certain types of conflict environments can increase the likelihood that health facilities and health workers will be deliberately targeted. In identity-based conflicts, where groups are dehumanised, warring parties can violently counter efforts to provide these groups with assistance. In conflicts over control of the state, health services are symbolic of the authority of the government and targeting them becomes a strategic tactic. Attacks against health services undermine public trust and confidence in the government, signalling to the population that governments cannot be relied upon for services or protection.

Civil wars in Afghanistan, Kosovo, Mozambique, Syria, and Yemen, among other places, witnessed constant attacks against their health facilities because of the association of health care facilities with warring parties.[252, 253] In Mozambique, health infrastructure is symbolic of the Frelimo government and was targeted by insurgents in the conflict in the northern province of Cabo Delgado, with approximately a third of the health units damaged or destroyed between 2017 and 2021.[254] Similarly, in internationalised conflicts, donor-funded efforts to improve health services through state institutions or through non-government organisations can be deeply political and highly contested, particularly if those donors support a party to the conflict. Health facilities or organisations supported by external donors may, therefore, be attacked.[252] In Afghanistan, violence against health-care workers often appeared deliberate, a planned effort to undermine trust in the government and drive out foreign influence.

Other essential services that affect health, such as water and sanitation systems, are also deliberately targeted. In Yemen, the deliberate bombing of water infrastructure exacerbated the effect of the cholera epidemic in 2016–18.[255] These dynamics on the ground can influence the ability or willingness of the civilian population to access health-care services. An analysis conducted for the Commission illustrates that shifts in territorial control by non-state armed groups can reduce civilian use of health care services due to the interruption of supply chains of medicines and health-care commodities as well as governance and security challenges. Women's access to health care is more sensitive to changes in a security context.[256] In Afghanistan, the political transition to the Taliban in August, 2021, and the temporary pausing of funding from donors compromised the implementation of the Integrated Package of Essential Health Services and reversed gains made over the past two decades in the country's health-care system.[257]

Research also suggests that in some contexts, humanitarian aid can potentially heighten instability and violence. Refugee camps can inadvertently provide shelter for combatants and an opportunity for recruitment for insurgent organisations.[258, 259] The influx of financial resources for humanitarian aid provides opportunities for warring parties—either rebels or governing authorities—to loot resources to augment their capacities.[245, 260] Additionally, aid flows can entrench corruption and strengthen conflict protagonists. Donor resources flow into complex war economies, with a plethora of actors with private and organisational interests. The inflows of foreign currency, the sense of urgency to provide assistance, and the general lack of governance, oversight, and accountability provide major opportunities for corruption, which has implications for levels of corruption in post-war economic and political governance.[261]

Humanitarian actors can also fuel violence and conflict through their actions, as discussed by Phillips and Norris in their analysis of attacks on humanitarians during the early days of the COVID-19 pandemic: "Almost all the attention... is placed on explaining perpetrator behaviour, reinforcing an image of aid and healthcare providers as devoid of any potential responsibility for harm that may be directed against them. Violence is thus explained entirely as something that emanates from external causes, obscuring the potential role that internal actions may have placed in provoking or creating the conditions for its emergence. When one closely examines many specific instances of violence, such internal causes are not hard to find. An expatriate aid workers' disregard for local custom and culture in the way they dress, for example, the way the manager of a hospital speaks to her staff, or aid workers' sexual relationships have all engendered, in some place at some time, grievances that erupted into violence."
[262]

Navigate informal institutions

As outlined in section 2, informal institutions are the complex networks of social relationships that are shaped by the shared moral beliefs and frequent interactions of individuals within a community and society. These informal institutions regulate the behaviour of community members. As such, health inequities and gender inequalities cannot be exclusively addressed through formal institutional channels; they must also navigate complex social norms, networks, and systems. Efforts to improve health and gender outcomes interact with this social context. Ignoring that context can undermine efforts to improve health equity and gender equality.

For example, the Mulheres Primero—or Women First—programme was implemented in Zambezia Province in Mozambique from 2010 to 2015 to empower girls and women, reduce HIV/AIDS transmission, improve school attendance, and prevent SGBV. The programme did increase women's participation in the economy, girls' school attendance, and the likelihood of having only one sexual partner. Transactional and inter-generational sexual relationships also decreased.[263, 264] Yet an evaluation by Lenzi and colleagues in 2018 suggested that the programme may have inadvertently strengthened gender norms that emphasised the subordination of women and girls to men and boys, and valued and rewarded submissive female behaviour. These gender norms viewed so-called good girls as those who showed deference to boys, men, and older adults; were productive by providing services—unpaid reproductive labour—to their communities; and whose behaviour and appearance was chaste and modest. By not engaging with the informal institutions that uphold these gender norms, the programme might have inadvertently reinforced deference to men, to the detriment of women's autonomy and agency. If and how this reinforcement of deferential behaviour affected the

ability of women and girls to fully participate in household and community decision making, negotiate condom use, and refuse unwanted sex was not researched.[264]

In Afghanistan, efforts to promote gender equality navigated and interacted with social structures shaped by ideas surrounding *namus*—meaning honour or moral reputation in the community. Honour is almost inseparable from masculinity, as honour is connected to a man's ability to regulate the behaviour of the women in his household. This extends to the societal level, where a family's honour is measured by the perception of the purity and moral conduct of family members, both male and female. Religious and cultural duty obliges men to preserve their honour by enforcing patriarchal norms that regulate women's behaviour in the private and public sphere. Informal institutions—local customs, traditions, religious interpretations, and social norms such as *namus*—governed the day-to-day life of the vast majority of the mostly rural population. The Elimination of Violence Against Women law was endorsed in 2009 in Afghanistan. Most judges were men educated in *madrasas*, which resulted in a judiciary that was influenced by the informal networks and belief systems of these *madrasas*, and ill-equipped to objectively interpret the law. Many cases of GBV continued to be referred to exclusively informal male justice mechanisms, such as *jirgas, shuras*, or village mediators.[265]

Pay attention to men and boys

Descriptions of the gendered implications of conflict and war focus almost exclusively on women and girls, particularly in relation to SGBV. Although the detrimental effect of conflict on gender equality and the rights of women and girls requires substantial policy attention and resources, researchers and policy makers fail to sufficiently acknowledge a similar effect on men and boys, including adolescents. The neglect by international institutions and policies to address this impact could be the result of several factors. First, gender norms surrounding masculinity suggest that adolescent boys and men are strong and tough and do not need protection. Second, given that most armed combatants are men and adolescent boys, policy makers and advocates see them as perpetrators, not victims. And third, the strength of advocacy coalitions for women and girls is not replicated for men and boys. Our Afghanistan case review illustrates the vulnerability of boys to SGBV given their heightened freedom of movement, yet the SGBV experienced by adolescent boys received little policy attention or resources (appendix pp 129–38).

A comprehensive literature review conducted for the Commission illustrates that this sexual exploitation and abuse of men and boys is not isolated to a few cases but is widespread in conflict-affected areas.[266] Sexual violence against men and boys is a tactic of war, used for torture and interrogation, for initiation into military or paramilitary forces, to destabilise families and terrorise communities, and as a means of ethnic cleansing. It is also a consequence of conflict and displacement, with child soldiers and unaccompanied adolescent boys particularly vulnerable to sexual exploitation and abuse as well as trafficking. The impact of sexual violence, coupled with the stigma and lack of support for survivors, is substantial and includes both physical injuries and mental ill health. Some research suggests that such traumatic experiences could increase future participation in violence, as well as have intergenerational effects. This review also illustrated that policies frame SGBV as largely an issue for women and girls. Despite its widespread prevalence, male sexual assault has few policy or clinical guidelines, and lacks attention and resources.[237]
Moreover, gender norms that accept and promote the subordination of women as a component of masculinity cannot be transformed by women. Boys and men need to be engaged and motivated to change these norms. For example, in Mozambique, sexual relationships between

adolescent girls and older men are widely tolerated (appendix pp 139–47). Gender systems that normalise the subordination of women also contribute to sexual violence in schools, where girls have reported that teachers use sexual intercourse as a condition for promotion between grades, and state that both teachers and boys in their peer groups harass and abuse them, further undermining their potential.[267] In Afghanistan, the concept of *namus* or honour meant that abuse and violations of the rights of girls and women were not interpreted as such by most families; instead, they were considered a prerogative, necessary to uphold honour. Boys and men need to be engaged and motivated to change these norms.

Anticipate backlash against sexual and reproductive health and rights

For the Commission, SRHR represents one of the clearest intersections between health and gender, and as such, is important to advance both health equity and gender equality. However, we also are keenly aware of the global backlash against SRHR. In 2022, Kavakli and Rotondi estimated that the implementation of the Mexico City policy that restricted US funding to organisations that perform or promote abortion from 2017 to 2021 led to 108 000 maternal and child deaths and 360 000 new HIV infections.[268] Resistance and backlash to SRHR reduces the availability of accurate information—and also fosters misinformation about family planning, access to contraception, and safe abortions. The lack of access to accurate information results in elevated levels of unwanted pregnancies, unsafe abortions, and reduced quality of care for women.

Our case review of El Salvador shows how women's advocacy groups were unable to prevent the country from adopting restrictive policies on SRHR (appendix pp 148–52). Before 1998, national legislation allowed for abortions (1) when the pregnancy was a result of rape or incest; (2) when the pregnancy put the life of the woman in danger; and (3) when fetal abnormalities were detected. In 1998, El Salvador passed one of the strictest anti-abortion laws in the region, banning and criminalising all abortions under any circumstances. In 1999, the new constitution recognised the embryo as a human being at the moment of conception. Women and health professionals who undergo or conduct abortive procedures can, therefore, be charged with homicide. Women who are vulnerable and economically marginalised are disproportionately prosecuted for violating these very strict anti-abortion laws. These laws criminalise survivors of sexual violence with unwanted pregnancies who seek abortions.

Despite the history of resistance to gender equality and health equity efforts, policy initiatives are ill prepared to navigate backlash. Scholarship on backlash is characterised by conceptual confusion and many knowledge gaps. Although the term backlash is broadly used, it is rarely defined. Socio-psychological research argues that backlash is about system maintenance—by which changes to the system of social relations are resisted.[269] Political scientists focus on the importance of power, arguing that backlash results from those in power resisting efforts to diminish that power.[270] Much more research is needed in this area, including an analysis of the distal and proximate factors that fuel backlash, and best practices to prevent, mitigate, and respond to backlash.

The pitfalls of efforts to improve health equity and gender equality

Through our research, we observed that health equity and gender equality processes inadvertently create problematic processes—the pitfalls outlined in the following subsections. To fully realise the promise of health equity and gender equality, we must avoid these missteps.

The instrumentalisation of gender equality and health

Efforts to improve gender equality and health outcomes can quickly and easily become instrumentalised, tied to the political, security, and foreign policy objectives of various actors within a conflict context, namely governments, donors, and rebels and insurgents. When health and gender equality interventions and outcomes are connected to the policies or ideologies of one or more conflict actors, efforts to improve health equity and gender equality become deeply contested. Health and gender equality programmes and projects can also be instrumentalised when they are delivered by conflict protagonists themselves. In Afghanistan, North Atlantic Treaty Organization troops leveraged health care for their hearts and minds strategy. This led to the perception of health infrastructure and health workers as not neutral and could have contributed to attacks against health infrastructure.

In places where the state and legitimacy of the government is challenged by rival groups, close association of health services with the state can reduce trust in health care among some groups. In places with substantial development assistance for health, the requirement of donors for visibility mean that any health gains are attributed to international actors.[271, 272] Moreover, health programmes are generally not designed, implemented, or evaluated in terms of their effect on trust or the social contract. Waldman and Kruk note that "vaccination programs measure the coverage they have achieved in getting BCG, DPT [diphtheria, tetanus, and polio], and measles vaccines into the arms of children, not whether the services they are providing lowers the level of mistrust and suspicion of central authorities".[271]

Gender equality initiatives can be similarly instrumentalised. Women's rights are too often the battleground upon which political, ideological, and other fights play out—with the objective of women's rights being subsumed by these political or geo-strategic objectives. Our case study of Afghanistan illustrates this point (appendix pp 129–38). For Afghanistan's political and religious leaders as well as international actors working to influence Afghanistan politics, the behaviour and activities of women have become symbols of either Afghanistan's modernisation or its adherence to religious and cultural values. This instrumentalisation of women's equality undermined, rather than created, the necessary conditions for structural change.[273]

In some contexts, efforts to promote gender equality can appear hypocritical. In 2017, Maria Al Abdeh, the Director of Women Now for Development, reflected on the international community's selective engagement with Syrian women during the Syrian war. "I'm completely astonished at the expectations of the international community, which pushes women to the front line of countering terrorism, but then ignores them as they call to stop the bombing, stop arming, break the siege; when they cry that fighting extremism cannot be done by arms and airstrikes: an ideology of hate can only be defeated by one of solidarity and justice for all; when they demand justice and accountably; when they request support for the education of children and youth. The international community that disregards all these calls—and then expects women to have a solution to the mire created by militarisation, the lack of accountability, and the decline in education, which only put women in more danger."[274]
The instrumentalisation of women's rights for foreign policy agendas is particularly concerning in an environment where attacks against female political and civil society leadership is widespread. In 2022, the Armed Conflict, Location, and Events Data Project analysed attacks against women in politics and their data illustrated the widespread and targeted nature of violence against women political leaders and activists.[275]

Imitation projects that attempt change from the outside-in

Many gender equality and health equity processes are driven from the outside by external actors. International donors have long prioritised the creation of western-style institutions, such as liberal democratic structures, as a key objective of international engagement in low-income countries, fragile and conflict-affected settings, and countries going through periods of economic and political transition such as in eastern Europe after the fall of the Berlin Wall. This approach, underpinned by modernisation theory, is predicated on an essentially linear process of societal and economic transformation from traditional values and institutions towards the western model.[276] After the end of the Cold War, a derivative of this model of development was applied to conflict-affected states to build liberal democratic institutions.[277] Some scholars label this process the imitation project.[278] Projects to improve gender equality and health equity often form one component of these broader institution building efforts.

These imitation projects copy institutional structures from one setting and transplant them to another, a process described by public administration and development scholars as isomorphic mimicry.[278, 279] Pressured to conform with global development agendas, states accept international standards on gender and health, and adopt processes to support these standards, namely laws, policies, and systems. Such processes can conflate form with function, where states adopt programmes that appear to address gender equality and health equity, without the achievement of meaningful outcomes or results.

Important insights can be learned from the efforts to implement gender equality and health equity in other settings, and such learning—policy transference—is an important tool to help communities and countries implement evidence-based programmes. However, external actors are insufficiently reflective, believing in the benevolence and superiority of their technocratic approaches and institutional structures compared with local equivalents that are already in place. These external actors mistakenly assume that institutional configurations are transferable across different communities and countries, and simply require the right mix of financial and technical assistance to be properly established.

Using such a model, external donors have funded projects and programmes designed to advance health equity and gender equality. Externally driven efforts erase local institutions and replace them with what external actors believe to be more effective imported ones.[278] Such externally driven processes ignore “the chains of people, relationships, and understandings through which any policy is implemented”.[280] These processes neglect the historical roots of these institutions, shame the local social and political context, and fuel defiance and resistance. Efforts to implement family medicine into Kosovo's health reform process began in 2000 as part of the effort to strengthen the primary care system. As outlined in our Kosovo case study review, these efforts attempted to build a western-European style health system within a compressed period, rather than engage in incremental and ultimately more sustainable change (appendix pp 155–58). As a result, the family medicine programme faced many challenges: the Kosovo medical establishment and the public did not fully accept or respect family medicine, and a 2019 survey found parents often sought the care of paediatricians within the private system instead of taking their children to family health-care centres.[281]

The superheroine fallacy

Canada's Feminist International Assistance Policy states “Women and girls can change the world. As powerful agents of change, women and girls have the ability to transform their

households, their societies, and their economies."[282] Foreign and development policy platforms that recognise the role of women and girls in contributing to global peace, security, and prosperity, and that commit to protect and promote their rights are crucially important. Yet as noted by Laura Shepherd, too often this discourse frames women "as superheroines, agents of their own salvation, capable of representing the needs and priorities of others and with the capacity to effect positive transformation in their given environments".[283]

Global efforts to promote gender equality are often underpinned by this superheroine fallacy and neglect the structural conditions that enable female leadership to be transformative. As such, they place unrealistic expectations on women. This Commission shows how gender equality and health equity transform societies; however, this process is structural in nature and unfolds over long timeframes. Although research reviewed in section 3 suggests that female representation in politics can facilitate good governance, female representation by itself is not enough.[284, 285] Our case studies illustrate this point. The Government of Mozambique established a quota of 30% female candidates on the electoral list leading to more female parliamentarians.[286] Although Mozambique has adopted progressive gender policies, in practice, their implementation remains incomplete.[287, 288, 289, 290] Similarly in El Salvador, female parliamentarians led the development of legislation to improve women's rights and address SGBV, yet these efforts received insufficient financial, human, and technical resources.[291, 292, 293, 294, 295]

During the early days of the COVID-19 pandemic, commentators raised the possibility that countries led by women were more effective at managing the spread of COVID-19. The Commission reviewed research on the response of female leaders to COVID-19 (panel 20). Research suggests that gender equal societies appear to have facilitated better leadership, rather than the sex of the leaders generating a better pandemic response.

The superheroine fallacy might also inadvertently focus attention on the wrong superheroines—namely politicians—and take attention away from civil society leaders. Yet the focus on female leadership within formal political institutions might draw skilled and seasoned female leadership away from civil society organisations. The engagement of experienced female leaders in civil society and formal government institutions is both symbolically and substantively important. As one study noted "the loss of experienced leaders lessens the effectiveness of advocacy on hot button issues, like land use, as the new civil society leaders do not have the *savoir faire* to manoeuvre behind the scenes".[166] The loss of such experienced leadership could have important consequences. A 2002 study by Weldon compared the effect of various forms of women's representation on policies to address violence against women in 36 democratic countries in 1994. [307] The study found that female-led advocacy movements might be more effective than female politicians in challenging and transforming the structural conditions which shape policies.[307]

Panel 20. Female leaders and the management of COVID-19

Did female leaders respond more effectively than their male counterparts to the COVID-19 pandemic?[296] Research has shown that the association between the sex of political leaders and the management of COVID-19 is not as clear, simple, or direct as suggested. Isolating the effect of gender is challenging given the wide range of confounding variables shaping pandemic responses and their effectiveness.[297, 298] Female leaders might have been more likely to implement extensive lockdown measures[297, 299] and more likely to implement these measures quicker than male leaders.[300] However, there is scarce evidence that jurisdictions with female leaders have consistently had better health outcomes than those led by men, including lower deaths per person and lower fatality rates.[300, 301, 302, 303] Some researchers have suggested that cultural values and other social, political, and economic factors offer more substantive explanations for COVID-19 outcomes than the gender of leaders.[296, 297, 304]

Windsor and colleagues examined data for 175 countries, specifically the association between female leadership and COVID-19 fatality rates per person 30, 60, 90, and 120 days after the first case of COVID-19 in each country. This analysis accounted for COVID-19 infection levels, cultural traits, and gender parity in national elected assemblies. The study found no statistically significant differences between male and female leadership and COVID-19 fatality rates unless the country was characterised by cultural norms supportive of gender equality. Such cultural norms both support female leadership and appeared to facilitate more effective pandemic responses.[296]

Several important limitations should be noted. Research has focused on the response of leaders to the initial outbreak of the virus in early 2020, largely ignoring responses after this early period. There is also a strong focus on national heads of state and government rather than other political and bureaucratic figures and civil society leaders who have also played important roles in pandemic responses.[305] Existing research also strongly focuses on high-income settings and ignores the experiences of female leaders in low-income, middle-income, and conflict-affected settings despite the presence of active female leaders in these contexts.[306]

Reinforcing power structures

In section 1, we discuss the dynamics of power in research initiatives and partnerships. Moon outlines the various forms of power wielded by different actors in the global governance of health.[308] These actors include donor governments, multilateral agencies, and foundations, as well as non-governmental organisations, advocates, and researchers.[308] Forms of power include the use of institutions, financial resources, discourse, and expert knowledge. Those who exercise power influence how issues are framed, what solutions are offered, whose views are heard, and ultimately the outcomes of global health equity and gender equality efforts.

When efforts to improve health equity and gender equality do not focus on building capabilities, they can reinforce harmful power structures. Financial power provides the clearest example. Observers of development assistance have long questioned the effectiveness and documented the harmful externalities of development aid[309] and humanitarian aid.[310] Research has highlighted the risk of such assistance fuelling conflict,[244, 311] and documented the abuses of power in the aid industry,[312] including sexual abuse and exploitation (section 3).[313] Such aid also enabled donors and international financial institutions to wield extraordinary power in recipient countries with few mechanisms to check that power. As we outlined in section 2 and discuss further in the appendix (pp 20–21), development actors supported neoliberal reforms that undermined state capacity and exacerbated health and gender inequities. Since the 1990s, strict neoliberal approaches have given way to poverty reduction strategies and a focus on supporting government structures.[314] Yet despite these new strategies power imbalances remain, with donors deciding whether, where, and to whom they provide aid. Despite the proliferation of actors, governments and multilateral agencies retain substantial power in global health governance with little accountability to recipient populations.[315]

Promise or pitfall? Focus areas for the future

Two important areas emerged in our research, which were neither promises nor pitfalls—yet. The future will undoubtedly see further digital transformation and expanded availability and use of data. Further research and policy action is needed to ensure that the promise of digital technologies and data is fully harnessed to promote and improve health equity and gender equality and potential pitfalls avoided.

Digital transformation

The internet continues to transform the social, structural, political, and individual aspects of life [316] and with it, gender norms. In 2021, the International Telecommunications Union estimated that 63% of the world's population was connected to the internet.[317] This expansion provides people worldwide with the opportunity to access information and resources, create and maintain social networks, and seek and retain employment.

Just as the internet expands access to information and capabilities, it provides opportunities for connection and collaboration for advocates of gender equality, as well as for their antagonists. Although the digital transformation has great potential to advance gender equality, the effect of heightened access to the internet on gender norms is complex. We cannot ignore the risks that the internet poses for women and gender minorities, as harassment and misogyny are amplified online. How the internet affects gender norms and equality will depend on governance, both at the level of governing institutions, and within technology companies and platforms. The ability of governments to restrict access to online content, the lack of digital privacy, and the deliberate spread of misinformation are all troubling features of the online environment. Such misinformation contributes to social divisions and deepens political polarisation within society, particularly within fragile and conflict-affected settings.

The mobile internet has had huge and unexpected effects on gender equality. The mobile internet provides everyone with the opportunity to access, create, and share information. It limits the power of male household members over this information. The mobile internet also allows for the sharing of information about experiences, including experiences of harassment and violence, and to raise awareness about rights, laws, and services. It can provide adolescent girls, women, and sexual and gender minorities with information about reproductive health services, and how and where to access those services.[318, 319] The mobile internet increases online access for large numbers of people, it can, therefore, also increase exposure to different representations of gender norms in other societies and opportunities for the expansion of social contacts and networks in ways that are not possible or even dangerous offline.[316, 320, 321, 322, 323]

Research for the Commission suggests the digital internet can facilitate the transformation of gender norms to support gender equality (panel 21). However, the promise of the mobile internet to build capabilities and facilitate change, although substantial, is not yet fully realised equally for women and men. Globally women are 26% less likely to own a mobile phone than men. This divide is particularly stark in some regions of the world: in south Asia, women are 70% less likely to own a mobile phone than men; and in Africa, women are 34% less likely to own a mobile phone than men.[320]

Panel 21. The mobile internet and gender norm transformation in Afghanistan from 2014 to 2019[324]

The diffusion of internet access via mobile phones can facilitate societal transformation at a rapid pace. Perhaps the most compelling effect of the mobile internet as it relates to gender is that users can virtually leave their geographical location with implications for gender equality.

Research using the Asia Foundation's Survey of the Afghan People examined whether variation in mobile internet usage from 2014 to 2019 predicted variation in support for women to work outside the home in Afghanistan. The Asia Foundation's Survey was selected for several reasons. It is the longest running nationwide survey of attitudes and opinions of Afghan adults, featuring large random samples that were nationally and regionally representative of gender and urban and rural proportions as per estimates provided by Afghanistan's National Statistics and Information Authority. The survey contained information about a range of gender attitudes, demographics, and internet usage. The data were gathered and analysed before the Taliban assumed control of the government in August, 2021.

Afghanistan had gradual increases in internet usage after 2004, nearing 12% in 2018. The rapid growth in internet usage enabled access to new information that challenged gender attitudes and to social media networks that broadened communication networks. In 2021, Afghanistan had 4·1 million active Facebook users (10·8% of the population estimate in 2019), and 99·5% of these users accessed social media via mobile devices, and 83·3% were identified as men by Facebook. [325]

In 2014–19, internet usage increased at a high rate. On the basis of this information, the study explored two questions. First, did variation in mobile internet usage predict variation in support for women working outside the home in Afghanistan from 2014 to 2019? And second, how did variation in mobile internet usage interact with the structural, social, political, and individual drivers of gender attitudes? This study aggregated data from six cross-sections, one for every year between 2014 to 2019 inclusive, to form a pooled cross-sectional time series model. The independent variable is mobile internet usage and the dependent variable is attitudes towards women working outside the home. The statistical analysis controlled for age, gender, socioeconomic status, region, rural and urban status, and direct experience with violence.

This research found a statistically significant ($p<0·001$), average marginal effect of 0·0658, indicating the increase in mobile internet usage in Afghanistan from 2014 to 2019 was associated with an increase in support for women to work outside the home. If a respondent reported using the internet to obtain information, they were on average 6·58% more likely to indicate that they supported women working outside the home, when all other variables were held constant.

The direct violence coefficient in the logit model had an average marginal effect of –0·0615 ($p<0·001$), meaning that if a respondent reported that they or their family were victim to some form of violence in the home or community in the last year, they were on average 6·15% less likely to indicate that they support women working outside the home, when all other variables are held constant. Being female (18·7%) and living in an urban setting (11·1%) also indicated support for women working outside the home. Neither age nor income predicted support for women working outside the home. Although the positive direction and magnitude of this relationship was consistent across all cross-validation models, the cross-sectional nature of the study limits any claim to causation.

Some important insights can still be drawn from this analysis. Neither age nor income were associated with support for women working outside the home. The magnitude of the positive effect of internet usage was similar to the negative effect of having experienced direct violence on predicting support for women's work. In addition, context is very important. This study found large negative (in the south west region) or large positive (in the central and highlands region) effects, despite both regions having the second lowest and lowest levels of internet usage, respectively.

As noted by this analysis, the decentralised and gender-blind ethos of the internet and the connectivity afforded by mobiles might help individuals evade place-based and resource-based male control of women's agency. Women-led businesses, social movements promoting gender equality, and progressive Islamic leaders were all amplified by the internet. The Taliban, Afghan politicians, and regional actors did use social media to deliver narratives about masculinity, shame, and honour to win hearts and minds in their favour. However, in the online environment, Generation Z youth in Afghanistan and in the diaspora were able to challenge this discourse and engage in debates in a manner that was not possible before the mobile internet.

The mobile internet does present opportunities to extend patriarchal norms, misogyny, and violence to the online environment. Internet usage interacts with the structural, social, political, and individual drivers of gender equality in both harmful and beneficial directions, expanding the battlefield for gender. However, before the takeover by the Taliban, our research indicates that it offered Afghan women with opportunities to reduce place-based and resource-based male control of information and communications technology compared with fixed internet or no internet or voice connectivity at all. Furthermore, mobile internet did seem to influence gender norms in ways that favoured gender equality.

The power of data

The Commission's examination of data on gender, health, and peace found substantial shortcomings—eg, spatial and temporal gaps; insufficient data on collection and estimation techniques for widely used indicators; and insufficient investment in collecting and creating the kinds of disaggregated, intersectional statistical resources needed to track progress and implement responsive policies. Without efforts to address these shortcomings, we might lack the data needed to make the most effective choices to advance gender equality, health equity, and peace.

Yet the potential is clear: high-quality data allow researchers and policy makers to facilitate the identification and prioritisation of public policy challenges. Data also enable policy makers to determine the most efficient use of scarce resources and the efficacy of public policies and programmes. When data can be disaggregated by race, ethnicity, class, and sexual and gender identity, intersectional analyses can ensure that groups are not invisible and ignored or deprioritised. Data further enable civil society as well as donors to hold public officials and private actors to account for their actions—or inaction. [43] To truly advance health equity and gender equality, we need to ensure that these disaggregated data are available. We also need to ensure transparency in data gathering methods, and that such data are widely shared.

Rising demand for evidence-based policy has increased pressure for data production. Although demand has increased, the supply of funding to produce high-quality statistics remains insufficient. The World Bank has found substantial underinvestment in basic systems for data collection and the production of statistics—particularly in low-income countries, not one of which had a fully funded national statistical plan in 2019. Donor governments contribute only a tiny share of development assistance—estimated by the World Bank in 2019 to be less than 0·5%—to build statistical capacity, leaving a large funding gap.[43] Broad deficiencies in statistical capacity are also present in the health sector: governments and donors in low-income and lower-middle-income countries do not sufficiently invest in the civil registration and health surveillance systems needed to produce and enable timely, accurate, and high-resolution data.[326]

Although the SDGs establish clear targets and indicators for monitoring purposes, data for these indicators are often not available, particularly for women, girls, and sexual and gender minorities. Of 54 gender-specific indicators for the SDGs, the World Bank reports that only ten indicators are widely available,[43] with low temporal coverage. An analysis from September, 2022, by the Center for Global Development found that only 43% of countries had sufficient data to monitor targets for SDG5.[327] Furthermore, Data2X, an international partnership that works to improve the availability and use of gender data, has documented the scarcity of data disaggregated by sex and gender for SDGs, concerns about the timely availability of such data, the scarcity of information available specifically to monitor SDG5, and the low level of funding for gender data systems.[328, 329] Data coverage is particularly poor within low-income and

lower-middle-income countries and at the subnational level. Data, and the statistical capacity to collect information, are especially low in conflict-affected states.[43] Moreover, data gathered by non-governmental organisations and researchers are often not available on publicly accessible platforms.

Gaps in data systems are, in some cases, addressed by investments in time-delimited data collection programmes such as surveys. Ad-hoc surveys are invaluable to fill specific information needs, but not a substitute for basic statistical capacity and routine collection of administrative statistics. Moreover, population surveys can be subject to a wide range of biases, particularly in conflict-affected areas where the information needed to construct high-quality sampling designs and collect high-quality data are often missing. These challenges are often compounded by more generic data collection issues, including biases towards easier-to-access population centres, false responses, interviewer effects, inaccurate data entry, mistranslation, and lost data.[330] Moreover, survey data collected at the level of the household might not reveal important intra-household dynamics, including differences among men, women, people with disabilities, children, and older adults (aged >65 years) living in the same household.[43] The failure to establish individual rather than household-level estimates can introduce bias, such as incorrect estimates of gender differences in control of assets and income, labour force participation, and decision making.[43]

Conclusion: the path forward

When the Commission launched in 2019, we focused on the 2030 Agenda for Sustainable Development with the goal of understanding the interlinkages among SDG3 on health and wellbeing; SDG5 on gender equality; and SDG16 on peace, justice, and strong institutions. As our work progressed, we saw troubling declines in levels of health equity and gender equality, and increased levels of violence in many regions around the world. We also saw declining global cooperation to address these pressing global challenges.

Given the global interconnectedness of political, economic, and social systems, "it no longer seems plausible to point to a single cause and, by implication, a single fix" for these overlapping crises that have created the polycrisis.[331] Global cooperative governance systems operate in silos and struggle to prevent, mitigate, or effectively manage the interconnected nature of these contemporary challenges.[332] Multilateral agencies and mechanisms for collective action are undermined by powerful states and other powerful actors who protect their short-term self-interests at the expense of the world's long-term wellbeing.

The global effort to confront COVID-19 vividly illustrates this dynamic. As waves of the COVID-19 pandemic enveloped the world, billions of people shared the experience of illness, death of family and friends, lockdowns, school closures, and the loss of employment and livelihoods. Despite these shared experiences, the global community did not unite to effectively respond to the urgency of the moment. Vaccine inequity is a clear illustration. The global rollout of COVID-19 vaccines took place at a pace unmatched in history. But poor countries still lagged far behind wealthy states in securing access to vaccines to protect their populations.[333] Powerful countries that produced and could purchase vaccines prioritised national interest over the global good, undermining international cooperation.

Flaws in global governance also undermined efforts to seize the COVID-19 moment to mobilise for peace. The UN Secretary-General, António Guterres, called for a COVID-19 ceasefire in March, 2020, hopeful that the common threat posed by the virus would prompt

more cooperative behaviour between warring parties. Our analysis of the COVID-19 ceasefire call shows that these efforts lacked meaningful international support, namely diplomacy and third-party security guarantees (appendix pp 165–66). Our analysis of cybersecurity illustrates how state and non-state actors used disinformation and misinformation campaigns to erode trust in public health approaches and science (appendix pp 166–67). The effects of such distrust might linger, most visibly, in vaccine hesitancy for routine childhood and other vaccinations.

The Commission's findings emerge at a pivotal moment. Globalisation and interdependence are at historically high levels, but universalism seems in crisis. The structure that upholds international cooperation appears flimsy and close to collapse. The polycrisis—fuelled by the impact of COVID-19, the escalation of protracted conflicts, and the emergence of new conflicts, such as Russia's invasion of Ukraine—has distracted the international community from the Sustainable Development Agenda, rapidly rolled back progress on the SDGs, and eroded development gains.[334] With less than a decade left, the ability to fully deliver on the SDG agenda and its associated goals is doubtful, but its objectives are more urgent and relevant than ever. The failure of the international community to protect and sustain progress on the SDGs should prompt a reconsideration—not for new or more ambitious goals, but on the adequacy of the institutions, strategies, and resources that have been deployed to meet these goals.

The Commission's research has shown the power and promise of community-led approaches to health equity and gender equality—change from the inside out. In practice, this means unique, locally developed approaches that best enable the achievement of the universal principles of gender equality and health equity in a manner that is appropriate for each community. We recognise that efforts to improve gender equality and health equity can be contentious.

These processes of change do not unfold quickly—durable changes in social norms and institutions take decades to solidify. Yet our evidence suggests that such efforts are worth patient, long-term investment, because advancing health equity and gender equality can help place societies on a promising pathway to sustained peace.

Communities cannot do this alone. Civil society, multilateral organisations, and political leaders and change makers worldwide must share ideas, innovations, resources, and experiences to enable these transformations. Our research underscores the importance of the international exchange of ideas, the breaking down of disciplinary and sectoral boundaries, the altering of power structures in global governance, and the strengthening of linkages among local, national, regional, and global processes to support such change. To facilitate what Secretary-General Guterres calls networked multilateralism, we need a shift in global governance to a “horizontal and open system that harnesses the power and efficacy of both governments and global actors”.[335]

The Commission reaches four conclusions that serve as its main messages: (1) improvements in health equity and gender equality have a unique and powerful ability to contribute to more peaceful societies; (2) to deliver the promise of the Commission's research, health equity and gender equality principles and processes must be led by communities and tailored to their context; (3) within the health sector and beyond, the Commission calls on policy makers to embrace, advocate for, and advance gender equality—health services and systems must adopt, implement, and be accountable to benchmarks for gender equal health responses; (4) given the

evidence we present in this Commission, health equity and gender equality must form an integral part of national and global processes to promote peace and wellbeing.

To realise this promise of health equity and gender equality for peace, the Commission establishes a policy and learning agenda. We provide four overarching recommendations with priorities for all actors (panel 22). Our implementation pathway for these recommendations focuses on specific actions for civil society, national governments, donor governments and multilateral organisations, philanthropic organisations, and the private sector (Panel 27, Panel 28). We call for health equity and gender equality to be integrated in all efforts to address fragility and promote peace. Secretary-General Guterres, through the Our Common Agenda report, outlines a vision for global cooperation. He calls for a Summit of the Future to be held in 2024 to establish a new agenda for peace.[336] Health equity and gender equality must be prioritised in the policy discussions and outcomes initiatives of this Summit.

Panel 22. Recommendations

Recommendation 1

Communities and context should shape and drive gender equality and health equity initiatives; these community-driven approaches—ie, change from the inside out—will result in sustained and meaningful progress.

- Locally led initiatives
    - Support tangible, sustainable, and locally led initiatives to institutionalise the principles and mechanisms of health equity and gender equality.
- Evidence-based assessments
    - Develop data-driven, accessible evidence-based assessments to determine the state of gender equality and state of health equity. These assessments should be universal, measuring outcomes and progress in high-income countries and low-income and middle-income countries (LMICs) alike. As outlined in the rest of this panel, these assessments could be produced by an alliance of national governments, civil society actors, and multilateral agencies working to advance health equity and gender equality, including WHO, UNICEF, UN Women, and UN Population Fund. The assessments would identify priority areas for policy interventions through a clear, accessible examination of progress measured against the principles and mechanisms for gender equality and health equity outlined in this Commission. Such assessments must include an analysis of the differential experiences and vulnerabilities of individuals and groups based on their sexual and gender identity, class, religion, ethnicity, and geographical region. Data must be disaggregated by gender identity, other salient forms of identity (eg, ethnicity, race, and class), and geographical region.
- Focus on implementation of the mechanisms for gender equality and health equity, which include:
    - Laws and regulatory frameworks to protect gender equality and health equity
    - Universal access to gender equal health services, including comprehensive sexual and reproductive health services
    - Gender equal access to education, financial assets, infrastructure, technology, economic opportunities, and participation in civil society, politics, caregiving support, and security and safety.
- Coordination processes
    - Create or strengthen coordination processes and data sharing to facilitate the development of these assessments and the evaluation of the implementation of these mechanisms (panel 23).

Recommendation 2

Embrace, advance, and advocate for gender equality within health services, health systems, and broader health responses.

- Establish an expert group for gender equality
- Establish a high-level expert group for gender equality within health responses to create and implement guidelines, such as gender equality benchmarks for health sector responses, including humanitarian settings, as well as epidemics and health emergencies, and monitor progress on their implementation. This group should include experts from conflict-affected and fragile settings. To encourage independence, this group could be housed outside multilateral institutions like WHO and within a research or policy centre.
- Adopt and implement these guidelines
    - Adopt and implement these guidelines, including benchmarks for gender equal health engagement to ensure gender equality is a core objective of health sector responses, health systems, and health services, including in health emergencies, such as humanitarian contexts and pandemics.
- Safeguard financing
    - Safeguard financing for comprehensive sexual and reproductive health services by meeting the target set by the Guttmacher Institute of US$10 per person per year earmarked towards these services.
- Career advancement
    - Support, protect, and establish pathways for career advancement for female health workers representing the majority of the health-care workforce, and for sexual and gender minorities.
- Zero-tolerance policies
    - Implement zero-tolerance policies towards sexual exploitation and violence within the health sector and strengthen safeguarding measures to prevent and address sexual exploitation, abuse, and harassment for the health-care workforce and community members. Protect whistleblowers from retribution (panel 24).

Recommendation 3

Incorporate processes that support and foster openness, connectivity, and accountability in all initiatives to advance health equity and gender equality.

- Inclusive policy development
    - Ensure open and transparent and inclusive policy development, coordination, and monitoring inclusive of diverse community voices, structured to ensure connections between policy processes and communities and civil society groups.
- Cross-national networks
    - Build and support cross-national networks among health equity and gender equality advocates, policy makers, and researchers, inclusive of LMICs and the next generation, to enable the identification of knowledge gaps, implementation gaps, and shared learning (panel 25).

Recommendation 4

Ensure that health equity and gender equality are integrated within conflict prevention and development agendas, including climate efforts

- Health equity and gender equality as central components in local, regional, and international peace processes
    - Incorporate health equity and gender equality as central components within the 2024 Agenda for Peace, the Group of Seven and Group of 20, the African Union and the Association of Southeast Asian Nations, as well as in national agendas. Ensure that these processes focus on universal principles of health equity and gender equality, are informed

by data-driven, evidence-based assessments of progress on the mechanisms of gender equality and health equity

- Through these processes:
    - Recognise that health equity and gender equality are not experienced equally and vary according to structural forms of discrimination
    - Support women's groups and activists as part of the conflict and development agenda
    - Avoid the instrumentalisation of health equity and gender equality by promoting the universality of the principles of gender equality and health equity
    - Avoid the superheroine fallacy by engaging in data driven, evidence-based assessments that identify the mechanisms to build the structural conditions for gender equality
    - Promote the full engagement of men and boys within global efforts to promote health equity and gender equality (panel 26)

Panel 23. Implementation pathway for recommendation 1 (ie, communities and context should shape and drive gender equality and health equity initiatives)

For civil society actors

- Support assessments of progress towards the mechanisms for gender equality and health equity through collection and sharing of data and analyses while respecting the need for confidentiality
- Engage with transnational civil society to share information and strategies for progress towards these principles and mechanisms
- Lead or support coordination processes at the local and national levels to monitor progress, identify gaps, and hold accountable national governments, donor countries, and multilateral organisations

For health sector actors, including not-for-profit and private providers

- Strengthen community-based health-care services; collaborate with local health-care providers and community organisations to establish or enhance accessible and affordable health-care facilities in underserved areas
- Ensure health information gathered in the not-for-profit and for-profit sector is shared with the broader health system, while protecting confidentiality through data anonymisation, aggregation, or other means
- Participate in subnational and national coordination mechanisms
- Develop partnerships with local women's groups and organisations to promote health education, awareness, and preventive measures tailored to the specific needs of women and girls in the community

For national governments

- Lead the development of data driven, accessible, evidence-based assessments of progress towards the mechanisms for gender equality and health equity, building on the Sustainable Development Goal process
- Create platforms for organisations to share data on health equity and gender equality
- Identify gaps in national legislation and regulations that impede gender equality, the protection of sexual and gender identity, and the right to health
- In partnership with civil society, lead dedicated national coordination mechanisms to monitor progress towards gender equality and health equity, including progress towards benchmarks for gender equal health responses

For philanthropic organisations

- Provide sustained, flexible, core funding to civil society organisations focused on data-driven assessment and advocacy for health equity and gender equality, ensuring open access to this data

- Invest in training and capacity-building programmes for health-care professionals in LMICs, focusing on data analysis as well as gender-sensitive care, reproductive health, and disease prevention
- Support research and innovation in collaboration with local academic institutions to develop cost-effective and context-specific solutions to address the burden of health, including for women and sexual and gender minorities, in low-income and middle-income countries

For bilateral donor agencies

- Support or create mechanisms to gather and share data on health equity and gender equality, mandating recipients of bilateral funds to share their data while safeguarding privacy; ensure data are disaggregated by gender identity, other salient forms of identity (eg, ethnicity, race, and class), and geographical region
- Provide national governments, civil society, and national researchers with financial and technical support to lead data driven assessments and establish coordination processes
- In line with the target set within the humanitarian sector, provide a minimum of 25% of official development assistance to promote initiatives led by national governments and organisations; ensure this funding provides dedicated, long-term resources to civil society organisations and researchers
- Support national organisations to draft and promote legislation and regulations for gender equality, protection for sexual and gender identity, and the right to health including sexual and reproductive rights

For multilateral organisations

- Conduct or support data driven, accessible, evidence-based gender equality assessments
- Support or create mechanisms to share data on health equity and gender equality, mandating recipients of multilateral funds to share their data while safeguarding confidentiality and privacy
- Establish a separate and dedicated coordination process within UN-led development and humanitarian contexts to monitor progress towards gender equality
- Structure multilateral processes to ensure the participation of civil society, including researchers, in the assessment and coordination of gender equality and health equity

Panel 24. Implementation pathway for recommendation 2 (ie, embrace, advance, and advocate for gender equality within health services, health systems, and broader health responses)

For civil society actors

- Advocate for gender equal health responses; hold national governments, donor countries, and multilateral organisations to account against benchmarks for gender equality across the health sector, ensuring they recognise and monitor the diversity of individual and group experiences and identities; monitor the response from national and local governments and authorities to pandemics to ensure a gender equal pandemic response
- Monitor budget allocation to comprehensive sexual and reproductive health services and the delivery of these services at the national and local levels
- Raise awareness within communities of the rights of individuals to be protected from exploitation and abusive behaviour; share with community members the processes for individuals to report exploitation and abuse and provide support to those individuals who choose to come forward
- Monitor human resources policies and practice at the national and local levels to hold governments and the health sector accountable for the advancement of female health workers and sexual and gender minorities; advocate for community health workers, including for fair compensation and support
-

For health sector actors, including the private sector

- Implement mechanisms to facilitate career advancement for female health workers and sexual and gender minorities; in assessments of health equity (including the Sustainable Development Goal target for universal health care), analyse the pathways for training, mentorship, and career advancement for female health workers
- Establish mechanisms to ensure community health workers are professionalised, well trained, fairly compensated, and supported to advance their important role as agents of change that can transform gender norms within their communities and build trust
- Ensure the health sector can identify and provide clinical care for sexual and gender-based violence, including intimate partner violence

For national governments

- Establish and implement benchmarks for gender equal health services and systems within governance, service delivery, human resources, health information, and medical products and technology including in health emergencies like pandemics and humanitarian contexts
- Ensure that national health budgets provide sufficient support to comprehensive sexual and reproductive health services, estimated to cost US$10 per person per year
- Establish mechanisms to hold members of the health sector to account for exploitation and abuse; implement zero-tolerance policies towards exploitation and violence for all health sector operations and activities; put in place legislation to protect whistleblowers from retribution; strengthen collaboration and coordination between the health sector and the justice system, including the police, to provide remedies for survivors

For philanthropic organisations

- Support gender-focused entrepreneurship and innovation that support gender equal health systems, to support women's engagement in the economy, and provide funding and mentorship programmes for local women-led startups or enterprises that focus on health-care solutions targeting women's health needs
- To realise the promise of the digital transformation, leverage this technology and innovation for women's health; use digital health technologies to expand access to health-care services for women, particularly in remote or underserved areas

For bilateral donor agencies

- Support the development of benchmarks and incentivise progress towards benchmarks for gender equal health services and systems including in the humanitarian sector and pandemic response
- Through participation in the WHO-led Global Pandemic Accord, advocate for gender equality benchmarks to be integrated into the Accord
- Fund specific and dedicated coordination mechanisms within the development and humanitarian systems to monitor progress against these benchmarks
- Ensure health budgets include sufficient funding for comprehensive sexual and reproductive health services, estimated at US$10 per person per year
- Within development assistance programmes, promote community health workers, ensuring that they are provided compensation, training, supervision, and support
- Support national governments and civil society actors to establish reporting, monitoring, investigative, and accountability mechanisms to enable survivors of sexual and gender-based violence to report these crimes to authorities, including within the health sector

For multilateral organisations

- Integrate gender equality as an objective of global health responses; establish clear guidelines through the creation of gender equal benchmarks in all levels of the health sector response, including health emergencies

- Through the negotiation of the WHO-led Global Pandemic Accord, address the gendered vulnerability to pandemics and establish gender equality as a clear objective of pandemic response measures including forecasting and pharmaceutical interventions (eg, vaccination and treatment)
- The International Committee of the Red Cross, the Inter-Agency Standing Committee, UN Office for the Coordination of Humanitarian Affairs, the WHO Emergencies Programme, and other multilateral agencies engaged in humanitarian crises must clearly identify gender equality as an objective of humanitarian action, and explicitly integrate gender equality within humanitarian principles
- Multilateral agencies and programmes, including the WHO Emergencies Programme, must dedicate a worthwhile percentage of its budget towards comprehensive sexual and reproductive health services and programmes
- Support the implementation of the WHO guideline on health policy and system support to optimise community health worker programmes to guide national efforts and ensure community health workers are trained, compensated, supported, and supervised, including in how to address gender barriers to accessing health care
- Implement zero-tolerance policies towards exploitation and violence within all operations and activities, including those of implementing partners; establish clear policies that protect whistleblowers from retribution

Panel 25. Implementation pathway for recommendation 3 (ie, incorporate processes that support and foster openness, connectivity, and accountability in all initiatives to advance health equity and gender equality)

For civil society actors

- Advocate for coordination processes to be structured to ensure representation from and engagement with civil society, including researchers, through permanent positions and networks
- Within these coordination processes, ensure diversity, including representatives from groups that advocate for the rights of women, girls, and sexual and gender minorities, as well as individuals that advocate for men and boys
- Participate in cross-national networks to share experiences and lessons, engage in global advocacy, and learn from and support other organisations
- Advocate for and assist community members to navigate health services to ensure that all community members, including women, adolescent girls, adolescent boys, and sexual and gender minorities, are able to access and receive quality health care

For health sector actors, including the private sector

- Through the establishment of community engagement mechanisms, increase the accountability of health services to community members
- Participate in cross-national networks to share experiences and lessons learned to advance gender equality and health equity

For bilateral donor agencies

- Provide sustained support to a wide range of civil society organisations, including researchers, to build accountability for health systems and foster trust
- Require funded projects to share data, respecting confidentiality

For multilateral organisations

- Structure coordination mechanisms led by the UN Resident Coordinator and the WHO Emergencies Programme to ensure permanent representation from civil society, connections with health and gender advocacy and research networks, and open, transparent information sharing

- Ensure that any multilateral strategies to advance health equity and gender equality include permanent representation from civil society, connections with health and gender advocacy and research networks, and open, transparent information sharing

Panel 26. Implementation pathway for recommendation 4 (ie, ensure that health equity and gender equality are integrated within conflict prevention and development agendas, including climate efforts)

For civil society actors

- Document how structural forms of discrimination affect health equity and gender equality
- Advocate for the participation of women in peace processes, regional initiatives, and international peacebuilding efforts; within these processes, encourage inclusive participation and connection with transnational advocacy networks
- Counter the narrative of women and girls as victims by promoting the agency of women and girls, their roles as leaders within the community, and support tangible measures to build their capabilities and enable their agency

For health sector actors, including the private sector

- Within all health sector responses, including fragile and conflict-affected contexts, incorporate gender equality as an outcome of health sector responses

For national governments

- Incorporate health equity and gender equality into national conflict prevention, peace, and development processes
- Incorporate a data-driven assessment of relevant outcomes for men and boys, including sexual and gender-based violence, within gender equality assessments to identify potential areas of engagement
- Prioritise the collection and dissemination of data that are disaggregated by gender identity, other salient forms of identity (eg, race, ethnicity, and class), and geographical region

For philanthropic organisations

- Provide funding to support gender advocacy organisations in fragile and conflict-affected settings and encourage the creation of transnational advocacy networks
- Fund research to understand the experiences of men and boys in conflict-affected settings, including those who faced sexual and gender-based violence, who were or are adolescent unaccompanied minors, and were recruited into the military and armed groups

For bilateral donor agencies

- In funding and development cooperation, focus on the universality of health equity and gender equality principles to avoid the instrumentalisation of gender equality and health equity initiatives
- Encourage the inclusion of the situation of men and boys within any data-driven assessments of gender equality and health equity, including sexual and gender-based violence
- Provide support to national advocates for gender equality and health equity

For multilateral organisations

- Ensure that health equity and gender equality is integral to the 2024 UN Summit for the Future
- Prioritise health equity and gender equality initiatives through the Sustainable Development Goal process

- Advocate for the integration of health equity and gender equality into relevant global and regional initiatives, including the Group of Seven, the African Union, Association of Southeast Asian Nations, Asia-Pacific Economic Cooperation, the UN's Our Common Agenda, peace processes and post-conflict reconstruction
- Ensure that health equity and gender equality initiatives avoid instrumentalisation, the superheroine fallacy, and are inclusive of an analysis of the situation of men and boys

Panel 27. **Implementation of learning agenda (research themes)**

The Commission establishes an empirical foundation for the relationships among health equity, gender equality, and more peaceful societies; as outlined, key themes and approaches emerged from our research (appendix pp 168–69) that inform our recommendations for the research community; as the research community advances this learning agenda, it will be important for research partnerships between the high-income countries and low-income and middle-income countries to be mutually beneficial, and that advocates and scholars from low-income and middle-income countries have equitable access to research funding and leadership opportunities

Knowledge gaps
Health equity

- Examine the role of the social and political determinants of health in the self-reinforcing cycles of health equity, gender equality, and peaceful societies, with a focus on how structural forms of discrimination shape the social and political determinants of health
- Analyse how sexual and gender identity, class, race, religion, ethnicity, or other forms of identity influence health service access and delivery

Infectious disease models

- Examine how to integrate gendered vulnerabilities into infectious disease models; for example, develop model structures that can incorporate variables capturing the experiences of different groups (by gender, age, and sexual and gender minorities) to estimate the impact of structural discrimination on health responses to infectious diseases

Distinctiveness of health

- Examine the distinctiveness of health compared with other human development sectors such as education; determine whether health systems, particularly service delivery, have particular characteristics that facilitate trust, social capital, and other economic, social, and political effects in this Commission
- Examine if and how the efforts to implement health interventions for peace within fragile and conflict-affected settings promote gender equality or are hindered by gender inequalities

Social trust

- Examine the relationships among health services, social capital, and levels of trust through in-depth comparative case studies; support coordinated experimental research to examine if and how health services providers, particularly community health workers, facilitate trust in the health system and within the community
- Ensure that such research is carried out in various settings, including fragile and conflict-affected countries, to identify and characterise effects through multiple phases of conflict, transition to peace, and reconstruction

Forcibly displaced populations

- Examine the relevance for the Commission's theory of change for forcibly displaced populations, in particular the principles and mechanisms of health equity and gender equality

Integration of climate, gender, and health

- Examine how gender equality and health equity initiatives can be integrated into existing climate action initiatives

Digital technologies

- Examine if and how digital health technologies can expand gender equal access to health-care services, particularly in remote or underserved areas
- Examine if and how mobile health applications or telemedicine platforms that provide information, consultations, and remote monitoring capabilities can reduce gendered barriers to health care

Application of conflict analysis
Resistance and backlash

- Examine backlash against efforts to improve gender equality and health equity; define the concept and forms of backlash; understand what conditions foster backlash, and when and how best to confront, counter, navigate, and minimise backlash
- Examine how health service providers within the community, particularly community health workers, navigate and mitigate backlash while providing sexual and reproductive health services

Phases of conflict

- Analyse how efforts to promote health equity and gender equality are affected by the various phases of conflict, such as conflict prevention, management, peacebuilding, and post-conflict reconstruction
- Across multiple cases, examine the long-term consequences of health and gender equality engagement in humanitarian and conflict-affected settings

Panel 28. Implementation of learning agenda (research approaches)

Interpretivist, critical scholarship

- Apply a decolonising lens to health equity, gender equality, and the pathways towards more peaceful societies to identify and interrogate how the legacy of colonialism affects these processes
- Apply feminist and intersectional perspectives to the principles and mechanisms of gender equality to better interrogate the role of power and privilege within these processes

Inclusive and interdisciplinary scholarship

- Commit to interdisciplinary and inclusive research approaches
- Support funding structures that incentivise co-production of research, especially in neglected subject areas and geographies
- Funding structures should build bridges across gender equality, health equity, and peace and conflict studies research communities
- Incorporate transparent, participatory, community-based approaches to research, such as communities of practice
- Share research findings with communities through consultative mechanisms like communities of practice

Implementation research

- Funders and implementing organisations (including multilateral organisations and non-governmental organisations) should develop, support, and implement coordinated research designs to test common policy interventions across different contexts
- The UN Peacebuilding Fund should implement pilot projects to assess how to advance the mechanisms for gender equality and health equity outlined through our Commission in fragile and conflict-affected settings; when possible, fund coordinated pilots and experiments across multiple settings to improve external validity and understand the efficacy of interventions across varying social, political, and conflict contexts
- Examine the role of health-care providers and health-care services in the broader transformative processes described in this Commission; through implementation research across cases, examine how these health services could better facilitate economic, social, and political transformations
- Within this implementation research, gather and share data that is disaggregated by gender identity, class, geographical region, and other important factors that can drive inequities

Case study research

- Conduct in-depth quantitative and qualitative research of cases, including historical cases in high-income settings, of contexts that have moved from harmful into beneficial cycles; provide additional rigour through mixed methods research that formally links the selection of such cases for in-depth study to large-N analysis across cases
- Funding agencies should support longitudinal studies; our research has found that important processes and feedback cycles between health and gender equality unfold over long timescales, yet much of the empirical research on these topics is cross-sectional, which can limit opportunities to examine processes of social change and transformation in power, identities, and norms; a larger body of longitudinal research could better elucidate processes and mechanisms of change and strengthen the basis for policy interventions

The Commission presents a hopeful path forward through the multiple, overlapping crises facing the world. Our research suggests that improvements to health equity and gender equality can catalyse change in economic systems, social systems, and governance, prompting societies out of harmful cycles and into beneficial ones. Tangible and meaningful improvements in health equity and gender equality not only advance dignity and potential, but they also place societies on a pathway towards more enduring peace. In this interconnected world, the influences of these beneficial cycles can aggregate over time and become global in scope. It is our hope that civil society, academics, and political leaders from all levels—local, national, and global—will consider the Commission's findings in their efforts to build a more peaceful world.

For the **Commission website** see https://peacefulsocietiescommission.org/

Contributors

The Commission concept was first conceived of by PF (Co-Chair) with *The Lancet*, and it was further developed by TH (Chair), ZAB, and CK (Co-Chairs), and all members of the Commission. VP led the core research and framework development, as well as the writing of the first draft and all subsequent revisions of the report, working with a writing team that met regularly during the Commission's work. All members of the Commission contributed to the overall report structure and concepts, review and editing of drafts, and the conclusions. OTT and DR conducted the statistical analyses described in section 2 and the appendix (pp 54–121). Other authors made contributions to specific sections of the report. All authors approved the

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