

Sex and Gender Differences in Health: Evidence, Power, and Pathways to Action

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Twenty-one experts from a range of disciplines and areas — health research, communications, journal editors, practitioners, funders, civil society — convened at the Brocher Foundation, brought together by Global 50/50 with members of two Lancet Commissions: the Commission on Gender and Global Health and the Commission on Investing in Health — bodies that had not previously been in substantive dialogue. Key insights and actions are listed below.

Key insights and agreed actions

1 The measurement gap

Existing frameworks systematically obscure the relationship between gender and health. Despite widespread recommendations in health data reporting, disaggregating outcomes by sex remains under-implemented while interrogating gender as a structural driver of differential health is usually absent. Five persistent evidence and data challenges were identified: selective use of data to tell contradictory stories about health disadvantage; survey designs that can render women outside reproductive age, men, and adolescents largely invisible; the exclusion of carer burden from cost-effectiveness analyses — foregone earnings, time costs, and psychological burden borne predominantly by women; the unresolved question of who should make value judgements embedded in health economic frameworks; and commercial distortion of the evidence base by industries that conduct gender-sensitive marketing to sell products while resisting research that exposes their role in gendered harms.

“Disaggregating by sex doesn’t give you a gender analysis. Gender is not a polite word for sex.”

ACTIONS

- Social cost analysis of exemplar conditions to demonstrate what comprehensive cost accounting reveals. **Investing in Health Commission, supported by Global 50/50.**
- Sex-disaggregate the DCP2017 package; submit to The Lancet; build gender analysis into DCP4. **Investing in Health Commission.**
- Integrate pairwise comparison questions on gender inequality states into existing survey work. **Investing in Health Commission with Gender and Health Commission.**

2 The intervention gap

Sex-disaggregated differences have been described, but there has been comparatively little investment in gender-responsive intervention design. This is not an oversight but a structural product of how research funding and legitimacy work: description can be framed as neutral, intervention design cannot. The case studies on alcohol, ultra-processed foods, and the medicalisation of menopause each illustrated the same pattern — commercial actors deploy sophisticated gender-targeted strategies while public health responses remain gender-blind.

The proposal generating most traction was to work with the WHO NCDs Best Buys framework directly and make it gender-responsive — not to displace it but to interrogate it, showing where recommendations rest on gender-blind assumptions and where targeted adaptation would improve effectiveness. Best Buys carries institutional authority and reaches finance ministries in language they already accept. A gender-responsive Best Buys analysis would reach audiences where a stand-alone gender justice argument does not.

ACTIONS

- Apply a gender lens to WHO NCDs Best Buys, identifying where recommendations embed gender-blind assumptions. **Global 50/50 with both Commissions.**
- Develop illustrative scenarios showing what gender-responsive investing-in-health analysis reveals across disease areas. **Gender and Health Commission with Investing in Health Commission.**
- Produce a joint advocacy two-pager on sex-disaggregated data and gender-responsive investment. **Global 50/50 with both Commissions.**

3 Gender is about everyone, across the whole life course

A substantive convergence was a collective move away from framing gender in global health primarily as a question about women and girls and reproductive health. The demographic evidence supports this: in Norway, the income gradient in life expectancy is fourteen years for men; in municipalities with the most favourable social conditions, the sex gap approaches zero — suggesting the mortality gap is substantially malleable through social intervention, not an immutable biological given. The reproductive health trap has deep historical roots in Malthusian population anxieties, leaving the 15–49 age band as its most visible residue.

“In Norwegian municipalities with the most favourable social conditions, the sex gap in life expectancy approaches zero. That’s hard to explain biologically. It would be a bit cowardly to say this is biological and we shouldn’t focus on it.”

The group was alert to the risk that a whole-life-course framing could submerge the specific structural disadvantages faced by women. Its response was precise: a life-course framework is not a symmetry claim. It is a claim that analytical tools should be capable of seeing all the ways gender operates as a social system, while remaining clear about where the structural weight falls. An initial read of the DCP2017 package appears to suggest skewing toward conditions affecting women while generating proportionally larger reductions in male premature mortality — this illustrates why this matters for investment decisions.

ACTION

- Commission a conceptual paper on a life-course framework for gender and health applicable to all populations. **Gender and Health Commission.**

4 The language and framing challenge

Gender has become a deliberate wedge issue. Three distinct mechanisms operate: external weaponisation by organised opposition movements inserting restrictive definitions into multilateral processes; internal sector misunderstanding, where gender remains synonymous with women’s reproductive health, now institutionalised in training, data systems, and budget lines; and discourse capture, the most insidious — progressive language embedded in mandates is routinely stripped of political content, leaving the terminology while removing the politics.

“The anti-gender side understands, absolutely and completely, that what we’re talking about is values and history and politics. It’s not just about: can we get the definitions right, can we get the data right. It’s: can we get our values across.”

Experience from HIV and comprehensive sexuality education suggests programmatically framed language has sometimes enabled progress where explicitly rights-based language could not. The proposed response: lead with a positive health argument for all, embedding gender analysis as the structural mechanism rather than the entry point. This is a strategic adaptation, not a retreat.

ACTIONS

- Produce guidance on strategic language for negotiating environments where gender terminology triggers closure.
- Develop locally resonant framings through regional co-creation labs, treating language co-design as a core deliverable.

5 Windows of opportunity to advance the gendered health equity agenda

The WHO DG election, UHC High Level Meeting, post-SDG negotiations, and US withdrawal from multilateral health processes represent a convergence of political conditions that can be used. The group identified the persistent tendency to respond with aspirational framing rather than specific proposals tied to named processes — and named the tobacco convention as the counter-model: targeted advocacy piggybacking on an existing process, with visible accountability mechanisms. US withdrawal is a structural shock but also a release of constraint. A dominant actor combining financial power with normative conservatism on gender and sexuality — including through the Mexico City Policy — has removed itself. Processes previously blocked are now more moveable. The analytical task is to identify which, specifically, and to act before the landscape shifts again. Regional bodies — African CDC, ASEAN, G20 health workstreams — were identified as underused routes to country-level uptake, less susceptible to the consensus-blocking that characterises multilateral forums.

“Don’t issue a broad call to action that DG candidates can acknowledge and set aside. Request written public statements on specific commitments that create accountability records.”

ACTIONS

- Request written public commitments from WHO DG candidates; publish an evidence-informed assessment of stated positions. **Global 50/50.**
- Identify which multilateral processes are now within reach following US withdrawal; develop a targeted engagement strategy. **Global 50/50.**
- Prioritise engagement with African CDC, ASEAN, and G20 health workstreams as complementary routes to country-level uptake. **Global 50/50.**
- Include communications budgets in all research funding applications as standard. **All participants.**

6 A model for action: Commission convergence

The most concrete structural output was the commitment by both Commissions to work together — creating a mandate to develop methodology that neither is currently resourced to develop alone: how to incorporate equity, justice, and gendered social costs into cost-effectiveness frameworks in ways that are analytically rigorous and policy-legible. The DCP2017 package has never been sex-disaggregated; an initial read suggests it skews toward conditions affecting women while generating proportionally larger reductions in male premature mortality — a finding that, if confirmed, significantly complicates assumptions about whose interests gender-blind investment serves. The regional co-creation labs proposal offers the strategic complement: generating locally resonant framing rather than translating northern academic terminology.

ACTIONS

- Explore a joint Lancet paper on gender and investing in health as the mechanism for developing shared methodology. **Both Commission leads.**
- Write background paper for regional co-creation labs; approach identified funders for seed funding.