GLOBAL 50/50

SUMMARY REPORT

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

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

A two-day convening of the Lancet Commission on gender and global health and the Lancet Commission on Investing in Health.

Background

This two-day workshop convened twenty-one researchers, funders, communications experts, journal editors, and practitioners. The convening was hosted by the Brocher Foundation with joint funding from Global 50/50. The meeting brought together members of two Lancet Commissions: *Achieving gender justice for global health equity: the Lancet Commission on gender and global health* (the Gender and Health Commission) and the *Lancet Commission on Investing in Health*.

The workshop operated under the Chatham House Rule.

Context: why the two Commissions came together

The two Commissions have approached questions around improving health equity from distinct analytical traditions. The Gender and Health Commission examines the structural, historical and political drivers of gender-based health injustices and identifies the conditions necessary for gender justice and health equity. The Investing in Health Commission asks which health investments produce the greatest reductions in premature mortality and at what cost. The Commission on Investing in Health identified three striking empirical patterns at the outset of the workshop: i) females live longer than males across nearly all ages and countries, with the gap reaching nine to ten years in some settings; ii) mortality rates declined more rapidly for females than males between 2010 and 2019; and iii) female deaths are less dispersed than male deaths, meaning female age-at-death is more predictable. These findings sit alongside well-documented female disadvantages in morbidity, quality of life, and caretaking burden.

These findings reflect a deeper conceptual problem: the field lacks agreed frameworks for analysing sex and gender differences in health in ways that are analytically rigorous, politically coherent, and useful for policy. Meanwhile, opposition movements have weaponised gender discussions, and the commercial sector continues to manipulate gender norms to promote health-harming products. Countering these forces requires clarity of analysis, shared language, and coordinated action. The Brocher workshop was convened to begin that work across the two Commissions.

Workshop objectives

Five objectives framed the two days:

1. To foster informed dialogue across diverse and contested perspectives on sex and gender differences in health, surfacing points of convergence and clarifying key tensions across funding, research, policy, and practice communities.

2. To critically examine the narratives and power dynamics shaping the field, analysing how political, institutional, and commercial forms of power shape what evidence is produced, interpreted, and acted upon.

3. To identify key conceptual, empirical, and analytical gaps, and to generate priority questions that can strengthen understanding of sex and gender differences in health.

4. To crystallise current evidence and experience into actionable guidance for policymakers, analysts, and funders, identifying feasible strategies for strengthening evidence-informed action in complex and contested environments.

5. To develop a shared set of priorities, identify opportunities for collaboration, and lay the foundation for joint outputs and coordinated follow-up activities.

Key insights and agreed actions

1 The measurement gap: incomplete data, invisible populations, and missing costs

A consistent thread was the extent to which existing measurement frameworks systematically obscure the relationship between gender (as a structural and social construct) and health. Sex-disaggregated data, where collected, is frequently not used to identify where or how to intervene using gender-responsive approaches. There is a meaningful distinction between reporting outcomes by sex and interrogating gender as a structural driver of differential health: the former has grown; the latter remains inconspicuous and underfunded.

The data landscape is further distorted by five persistent challenges. **First, cherry-picking:** the same datasets can be selectively deployed to tell contradictory stories about which sex faces greater health disadvantage, depending on which indicators are chosen and which populations are included. This is not only an academic problem. Advocacy groups may exploit this malleability. A more objective approach, drawing on frontier comparison methods that compare populations to the best-performing group of the same sex rather than to each other, helps reframe the problem without dismissing sex as a relevant variable, and resists the political trap of zero-sum arguments, i.e. pitting male and female health interests against each other.

> *"Disaggregating by sex doesn't give you a gender analysis. Gender is not a polite word for sex."*

Second, some standard global health surveys define populations of interest as women of reproductive age, often operationalised as married women and girls aged 15 to 49. This is an administrative convention, not a biological standard. It renders women and girls outside those age ranges, men across all ages, adolescents below twelve, and people outside heterosexual marriage largely invisible to data systems and can distort survey findings across populations. For example, when Norwegian researchers oversampled older men in a large population study, they found depression was more common in older men than older women, directly contradicting the established literature.

> *"The size and direction of gender inequality in health really depends on the indicator we choose. If you want to highlight male disadvantage, you highlight smoking, you highlight mortality. If you want to show female disadvantage, you show sexual reproductive health. Advocates can sort of pick and choose what they want to highlight."*

Third, standard cost-effectiveness analyses do not include social costs, which are associated with gendered labour divisions in most societies. The care burden associated with long-term conditions, borne predominantly by women, including foregone earnings, time costs, and physical and psychological burden, does not appear in health economic calculations. Incorporating these costs may change the economic case for many interventions, producing a more accurate and more honest picture of who subsidises health systems and at what personal cost. This is not merely a technical refinement: it is a structural correction to an analytical framework that systematically undervalues women's unpaid contribution to health and wellbeing. The concrete illustration offered was smoking: the full cost of a man dying of lung cancer includes the foregone earnings, time, and career opportunities of the woman who cares for him. That cost is invisible in standard health economic analysis. Including it could materially change the investment case.

Fourth, the broad question as to who should make the value judgments embedded in health economic frameworks? The group reached broad agreement that decisions about how to weigh the interests of different groups, including across sexes, are ethical and political rather than technical, and that participatory approaches to eliciting those weights will increase legitimacy over purely expert-determined ones. The evolution of disability weights in the GBD, which moved from expert panels to population participation precisely because of this concern, was cited as a precedent. However, translating this principle into a workable analytical framework for gender-responsive health investment remains an open methodological question.

The **fifth** challenge area is the power asymmetry between commercial and public health actors which distorts the evidence available for decision-making. For example, the alcohol industry, the ultra-processed food industry, and pharmaceutical companies all conduct sex-disaggregated and gender-sensitive analysis when it serves commercial purposes. The same industries have actively resisted the production of research that would expose their role in generating gendered health

harms. The data landscape is therefore not neutral: it reflects deliberate decisions about what gets measured, by whom, and for whose benefit.

> *"When I started, not only did you have to be aged 15 to 49 to be included in data — you had to be married. A lot of the data we take for granted as the cornerstone for decisions are completely unrepresentative of the human population."*

ACTIONS

- Undertake social cost analysis of a small number of exemplar conditions to demonstrate what a more comprehensive (time-use, social plus financial) cost analysis reveals. **Global 50/50 to lead** as a convergence point between the two Commissions.
- The Commission on Investing in Health to lead analysis of sex-disaggregation of DCP essential packages to surface where existing prioritisation logic embeds gender-blind assumptions.
- Explore integrating social-state pairwise comparison questions into the planned four-country trade-off survey, to generate population-based weights for different dimensions of gender inequality.

2 The intervention gap: from description to design

Challenges for interventions were identified as follows. **First, the endpoint.** Is the goal equality of health outcomes across sexes, or equality within sex groups taking into account other structural vulnerabilities such as class, race, and disability? These two framings imply different intervention designs, different metrics of success, and different political arguments. Agreeing on the endpoint is necessary before designing the means.

Second, the gap between the field's capacity to measure gender-related health inequalities and its capacity to design responses that address them. Sex-disaggregated data on exposure and outcomes is available (within the caveats identified above). Gender-responsive intervention design and evaluation is lacking.

Third, the case studies on alcohol use, ultra-processed foods, and the medicalisation of the menopause illustrated the same structural pattern across three different domains. Commercial actors deploy sophisticated, gender-targeted strategies: the alcohol industry constructs and exploits masculine norms and social isolation; the ultra-processed food industry exploits the gendered burden of care and time poverty; pharmaceutical companies and femtech funders medicalise female life-course transitions while male equivalents, including low-testosterone influencers, emerge from a parallel commercial logic. In each case, the commercial sector operates with detailed understanding of how gender norms shape behaviour and health risk. Public health

responses, by contrast, are largely gender-blind: they tend to target individual behaviour rather than structural drivers, and apply population-level tools without engaging with why particular groups are differentially exposed. This reflects Lukes' third face of power, the preference-shaping capacity that makes it seem natural for researchers to stop at description and leave design to another sector.

> *"The public health community's response to alcohol is essentially to keep telling women of the 15–49 year age group that they're going to end up with babies with fetal alcohol syndrome. Whereas we all know from the data that it's a male problem in most places. But we just totally overlook it."*

In summary, participants were explicit that there is an intervention gap and it is not an oversight. It is a structural product of the same power dynamics that determine which research questions are considered legitimate and which are funded. The field has accumulated substantial descriptive capacity because description can be framed as neutral and technical. Intervention design is harder to separate from politics: it requires explicit choices about which populations to prioritise, which structural drivers to address, and whose interests an intervention is designed to serve. Those choices are contested, and the institutional systems that fund and evaluate research are not well configured to make them.

> *"Despite everything we could all write a new PhD on in terms of how commercial companies manipulate gender to sell their products — whether it's meat or yogurt or alcohol — as a public health response, we totally overlook it. We focus on description of the problem and what the outcome is. And for something like alcohol or the food system, we say: oh, that's too difficult, that's another sector. It feels almost like a third face of power — that designing solutions isn't part of what we do as researchers."*

The practical proposal that generated most traction was to work directly with the Best Buys framework — the WHO-endorsed set of cost-effective interventions that has become the dominant reference point for NCD policy prioritisation globally — and make it gender-responsive. The argument was not to displace Best Buys but to interrogate and strengthen it: to show, systematically and in terms policymakers already use, where existing Best Buy recommendations rest on gender-blind assumptions, where gender-targeted adaptation would improve effectiveness within the existing intervention logic, and where the evidence base requires structurally different approaches altogether. This reframing matters because Best Buys carries institutional authority. Producing a gender-responsive Best Buys analysis — or a parallel gender lens applied to equivalent priority packages — would reach audiences that a stand-alone gender justice argument does not, and would do so in the language of cost-effectiveness that finance ministries and health planners already accept.

> *"In general quality work, we focus a lot on patriarchy, and that's not a bad thing. But I would argue there is something deeper underneath it. What would it look like to create gender equality interventions that actually embody the relationality of the process? Not so that you achieve an outcome, not so that you go to the clinic — but so that we learn to be together in a way that solves the most fundamental problems for which we only see the consequences."*

ACTIONS

- Develop illustrative scenarios showing what a gender-responsive investing-in-health analysis reveals across exemplar disease areas, linking sex-disaggregated exposure data to gendered analysis and intervention design.
- Produce a joint advocacy two-pager from both Commissions on sex-disaggregated data and gender-responsive investment.
- Apply a gender lens to the WHO Best Buys framework to identify where current recommendations embed gender-neutral assumptions and where gender-responsive adaptation would improve effectiveness. **Global 50/50 to lead**, with both Commissions.

3 Gender is about everyone, across the whole life course

One of the most substantive convergences across the two days was a collective move away from the dominant framing of gender in global health as a question primarily about women and girls and primarily about reproductive health. This is not a new argument in the literature, but the depth of agreement across participants from very different disciplines, including health economics, demography, social science, and feminist scholarship, gave it renewed analytical weight.

The demographic evidence on male health is more striking than the field has acknowledged. Male mortality varies considerably across countries, which reflects social rather than biological determinism. In Norway, the income gradient in life expectancy is fourteen years for men: income matters for men's survival and marriage is protective for men. In Norwegian municipalities with the most favourable social conditions, the sex gap in life expectancy approaches zero. These findings are not obscure. They suggest that the sex gap in mortality is substantially malleable through social intervention, and not an immutable biological certainty. The reproductive health trap, the reduction of gender in health to fertility and contraception, has historical roots that run deep. Global health and its precursor, international public health, emerged during a period dominated by Malthusian population anxieties. Women's health was institutionally framed around reproduction not because these were the only relevant dimensions of women's lives, but because these were the dimensions that mattered to the demographic and development agendas of major funders and colonial powers. The 15-to-49 age band for women is the most visible residue of this legacy. It forecloses

attention to women's health outside childbearing years and has no equivalent standard for men. Only one of eleven ASEAN countries in a recent Global 50/50 analysis addressed women's health as a life-course concern; the rest remained in an MDG-era framing.

> *"In Norwegian municipalities with the most favourable social conditions, the sex gap in life expectancy approaches zero. That's hard to explain biologically. It might be possible to achieve equity in life expectancy between men and women. It would be a bit cowardly to say this is biological and we shouldn't focus on it."*

The parallel question, what a male life course in health would look like, was asked seriously for what appeared to be the first time in the room. Puberty, occupational hazard exposure, social isolation, mental health in older age, and the prostate health transition are all under-researched relative to their health burden. The emergence of commercial low-testosterone influencers targeting men was noted as an exact commercial parallel to the medicalisation of menopause, operating through identical mechanisms.

> *"Getting the health community to think about gender beyond anything in what's classically called the bikini area is very, very challenging."*

The convergence the group reached was not that reproductive health and bodily autonomy are unimportant. They remain central and non-negotiable. It was that leading with them as the primary frame for gender and health has historically narrowed what the field sees, measures, funds, and acts upon. A gender approach to health that takes seriously the whole life course, for all people, is both analytically stronger and more politically tractable in the current moment.

> *"I really dislike the language of backlash, because I think it gives the sense that the permanent state of being was gender equity. It was not. The continuity is patriarchy."*

The empirical case for this argument was highlighted within the Investing in Health Commission's analysis of the DCP health benefits package. The finding that the package appears to skew toward conditions primarily affecting women's reproductive health while likely generating proportionally larger reductions in male premature mortality was raised. It illustrates the argument directly: a framework that treats gender as a women's health question can simultaneously over-include women as a target population and under-serve them in terms of mortality impact, while also failing to interrogate the conditions driving male premature death. Gender-blind investment decisions, in other words, do not produce gender-neutral outcomes — they produce a different and largely unexamined set of gendered outcomes.

> *"Take trachoma — an infection of the eye. There's nothing in the biology of the female eye that makes it different. But women are 158 times more likely to experience greater disease burden than men, because of entirely non-biological reasons: children are vectors, and women are caretakers of children."*

However, concerns were raised that by expanding the frame to the whole life course for all people there is a risk that the specific, structural, and ongoing disadvantages faced by women — in access, in treatment, in research representation, in care burden, in bodily autonomy — become submerged. "Gender is about everyone" has been used in some contexts as a rhetorical move to dilute women-specific advocacy rather than to strengthen the analytical framework. The group's response to this risk was not to retreat from the broader framing, but to insist on precision about what it means. A whole life-course framework is not a claim that men and women face equivalent disadvantages, or that structural gender inequality has been resolved. It is a claim that the analytical tools the field uses should be capable of seeing all the ways gender operates as a structural and social system — including the ways it harms men and the ways it intersects with class, race, disability, and geography — while remaining clear about where the structural weight of the system falls.

ACTION

- Commission a conceptual paper setting out a life-course framework for gender and health applicable to all populations.

4 The language and framing challenge

Gender has become a wedge issue, intentionally leveraged as a culture-war destabiliser, to actively obstruct the agenda it is meant to advance. This operates through distinct but related mechanisms.

The first is deliberate weaponisation by organised opposition movements. Well-funded anti-gender campaigns have spent decades inserting restrictive definitions into multilateral processes, blocking consensus language in UN governing bodies, and framing gender as ideology to delegitimise evidence-based policy. The consequence is that in some negotiating rooms, the appearance of the word gender triggers immediate defensive closure from member states that might be persuadable on the substantive issues.

> *"There is a danger of lacking a clear definition: the risk is that the other side will define gender as merely the differential between the two biological sexes. I have seen this coming very strongly in places you wouldn't expect."*

The second mechanism is subtler and operates within the health sector itself. For much of the global health community, gender is understood primarily as women's health and specifically as reproductive health. This reflects the history described above, now institutionalised in training, data systems, programme design, and budget lines. The DCP packages treat gender as questions of maternal and reproductive health. The Gender and Health Commission spent years defining gender as a structural social system, but that definition is not widely shared even among health professionals who would consider themselves sympathetic to the agenda.

> *"There is no such thing as a global health system. That history — rising predominantly from colonial medical systems — had a focus on reproductive bodies for women and productive bodies for men. That thread has continued up till today. Gender and the female body has been collapsed into understanding gender as meaning women's reproductive capacity and the ability of the state to control it — rather than for what women themselves might want."*

A third mechanism operates differently from the first two and is in some respects harder to counter. Where external weaponisation attacks from outside and internal misunderstanding reflects genuine unfamiliarity, discourse capture works from within institutional success. Progressive language and concepts, once embedded in mandates and funding requirements, are routinely professionalised, institutionalised, and stripped of political content — often within a short period of their introduction. The mandate survives; the politics do not. The implication for the language challenge is uncomfortable: adopting new framings, however carefully designed, carries the risk that they too will be captured — acknowledged in institutional language while the structural conditions they were intended to contest remain untouched. This does not argue against strategic language adaptation, but argues for keeping the political content explicit and for building in accountability mechanisms that are harder to hollow out than a terminology requirement alone.

> *"I watched as something I thought was a crack in the system got institutionalised and professionalised very quickly. An ideas colleague of mine calls it discourse capture. People were now adopting my own words quite apolitically — as technically neutral acts — whereas I thought the crack was to keep it political, centred on unequal dynamics of power."*

Experience from HIV and comprehensive sexuality education suggested that programmatically oriented language, framed around specific health outcomes rather than contested identity terms, has sometimes enabled progress where explicitly rights-based or gender-framed language could not. A potential framing that emerged was to lead with a positive health argument for all, embedding gender analysis as the structural mechanism rather than as the entry point. This was understood explicitly not as retreat from the substance of gender justice, but as a strategic recognition that the door matters as well as what is behind it.

> *"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, can we get the analysis right. It's: can we get our values across."*

ACTIONS

- Produce guidance on strategic language use for negotiating environments where gender terminology triggers closure.
- Support development of locally resonant alternative framings through the proposed regional co-creation labs, treating language co-design as a core deliverable rather than a communications add-on.

5 The current political moment: window of opportunity, not crisis

The WHO Director-General election, UHC High-Level Meeting, forthcoming post-SDG negotiations, and US withdrawal from multilateral health processes represent a convergence of political moments that can be used strategically. The group was equally consistent in identifying a tendency, well-documented in prior experience, to respond to political windows with aspirational framing rather than specific, achievable proposals tied to named processes.

The tobacco convention offered a concrete counter-model. A coalition of women's groups inserted gender as a core component into the WHO Framework Convention on Tobacco Control (FCTC) negotiations through targeted advocacy piggybacking on an existing process. The Dirty Ashtray Award, given each morning to the most obstructive member state, made accountability visible and created reputational pressure. The lesson was not to issue a broad call to action that DG candidates can acknowledge and set aside, but to proactively request written public statements on specific commitments that create accountability records. When Global 50/50 published an interrogation of DG candidates' visions against the SDGs framework in the previous election, three campaigns sought advice in response, creating entry points that a general advocacy position would not have generated.

> *"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."*

The WHO DG election and SDG negotiations are processes the gender justice community can engage, influence, and hold to account. The US withdrawal is of a different character: it is a structural shock that removes the world's largest single health funder from the normative architecture it helped construct, creates an immediate resource gap across multiple disease areas, and generates significant uncertainty about which institutions and alliances will fill the space it leaves. The group was clear that this should not be read only as a crisis. The withdrawal of a dominant actor that has historically combined financial power with normative conservatism on gender and sexuality — including through the Mexico City Policy and its various extensions — also removes a constraint. Processes that were blocked or diluted by US opposition become more

moveable. Normative positions that could not previously achieve consensus may now be achievable.

> *"Processes that were blocked or diluted by US opposition become more moveable. Normative positions that could not previously achieve consensus may now be achievable. The analytical task is to identify specifically which of those processes are now within reach, and to act before the political landscape shifts again."*

A related and underused opportunity is the growing influence of regional bodies. The Africa CDC, ASEAN health processes, and G20 health workstreams were each named as potentially more effective routes to driving country-level uptake of gender-responsive health policy than global UN structures — precisely because they operate closer to the implementation level, carry different political dynamics, and are less susceptible to the consensus-blocking that characterises some multilateral forums. The gender justice community has historically concentrated its advocacy at the global level, in part because that is where normative language is set. The current moment, in which global processes are under stress and regional actors are actively seeking to demonstrate leadership, may be the point at which rebalancing that allocation of effort becomes strategically rational rather than merely aspirational.

Acting on political windows requires resources that are available when the window opens, not six months later when a funding application has been processed. Participants noted that communications and dissemination capacity is routinely treated as an add-on in research funding bids — something trimmed when budgets are tight — rather than as a core component of translating evidence into policy influence. The group committed to requesting communications budget as a standard element of all research applications and to advocating within their own institutions for this to become routine practice. The argument is not only about dissemination efficiency. In a political environment where the opposition moves quickly and with significant resources, the inability to respond at speed is itself a strategic vulnerability.

> *"The other side has been so spectacularly successful at communications and we've been so spectacularly successful at just arguing amongst ourselves about what the communications issues are."*

ACTIONS

- Request written public commitments on gender and health from WHO DG candidates. Publish an evidence-informed assessment of candidates' stated positions.
- Develop a targeted engagement strategy for the highest-priority windows of opportunity (e.g. within multilateral processes).
- Prioritise engagement with regional health bodies including Africa CDC, ASEAN, and G20 health workstreams, as complementary routes to country-level uptake.

A MODEL FOR ACTION

Supporting allyship across the two Commissions

The proposal to explore a joint Lancet paper on gender and investing in health is the most structurally ambitious output from the convergence, and warrants a brief explanation of what it would add that the two existing Commissions cannot. Each Commission operates within its own analytical frame and institutional home. The Gender Justice Commission produces work on structural drivers of gender inequality in health; the Investing in Health Commission produces work on cost-effective intervention prioritisation. The convergence at Brocher demonstrated that these frames are complementary and mutually generative, but that complementarity currently depends on informal collaboration between Commission leads rather than on any institutional architecture designed to sustain it. A joint output would create a mandate to develop the methodology that neither Commission is currently resourced or positioned to develop alone: how to incorporate equity, justice, and gendered social costs into cost-effectiveness frameworks in ways that are analytically rigorous, policy-legible, and not easily dismissed as advocacy. That methodological gap was identified at Brocher as the hardest long-term problem in the field. A joint output would be the mechanism for working on it seriously.

On the strategic side, one group proposed a staged programme of regional co-creation labs to map what is working and what is resisting the integration of gender evidence into health policy and investment decisions in different regional contexts. A small activation group writes a background paper and designs the process. Regional labs convene in person in partnership with regional networks. Outputs are context-dependent in form but flow back for distillation and comparison, feeding into a larger convening and then into targeted policy engagement at different levels: country, regional, and global.

ACTIONS

- Explore establishing a joint Lancet paper on gender and investing in health, as the mechanism for developing methodology to incorporate equity, justice, and gendered social costs into cost-effectiveness frameworks.
- Commission sex-disaggregation of the DCP2017 benefits package and submit findings to The Lancet as a joint output of both Commissions.
- Write a background paper for the regional co-creation labs and approach identified funders for seed funding.

SUMMARY

Recommended actions and next steps

The following actions were agreed or committed to during the convening. Attribution reflects collective commitment at Commission or group level, consistent with the Chatham House Rule. A separate follow-up communication will confirm individual responsibilities.

ACTION	LED BY
Undertake social cost analysis of exemplar conditions, linking carer burden to gender-responsive health economics	**Investing in Health Commission, convened by Global 50/50**
Sex-disaggregate the DCP2017 health benefits package and submit findings to The Lancet; insert sex perspective into current child health Commission work; build gender analysis into DCP4 from the start	**Investing in Health Commission**
Develop a taxonomy of gender-neutral versus gender-specific approaches to reducing health inequalities as a first methodological paper	**Both Commissions jointly, with Global 50/50**
Produce a joint advocacy two-pager on sex-disaggregated data and gender-responsive health investment	**Global 50/50, with both Commissions**
Commission a conceptual paper on a life-course framework for gender and health	**Gender and Health Commission**
Request written vision statements from WHO DG candidates on gender and health; publish evidence-based assessment of positions	**Global 50/50**

ACTION	LED BY
Write a background paper for the regional co-creation labs; approach French Development Corporation, Ford Foundation, and Hewlett Foundation for seed funding	**Global 50/50 and activation group drawn from workshop participants**
Integrate pairwise comparison questions on gender inequality states into existing survey work to generate population-derived weights for structural disadvantage	**Investing in Health Commission, with Gender and Health Commission**
Identify which multilateral processes and normative positions on gender and health are now within reach following US withdrawal; develop targeted engagement strategy	**Global 50/50**
Include communications and dissemination budgets in all research funding proposals; advocate within home institutions for this to become standard practice	**All participants**
Explore establishing a joint Lancet paper on gender and investing in health, as the mechanism for developing methodology to incorporate equity, justice, and gendered social costs into cost-effectiveness frameworks	**Both Commission leads**

What the convening did not resolve

The workshop was explicit about the questions that remain open. How to incorporate justice and equity considerations into cost-effectiveness frameworks without losing analytical rigour or political substance was identified as a methodological problem requiring sustained work. The group concluded that a short-term political track and a longer-term evidentiary track need to be kept deliberately separate because they operate on different timelines, require different kinds of evidence, and address different audiences.

A related and unresolved question is what, precisely, the field is asking for. The discussions on coalition-building surfaced this honestly: unlike tobacco control, where the goal is unambiguous and progress measurable, gender-responsive health investment does not yet have a settled, shared endpoint. Is the goal equality of outcomes across sexes, reduction of health disparities within disadvantaged groups, or universal improvement in health through gender-responsive design? The answer shapes everything that follows, and Brocher did not produce one.

> *"If you ask any Russian woman how much of their life expectancy advantage they're willing to give up to live like a man — to not fear rape, not fear limits on political representation, abortion rights, all those things — a substantial portion would give it up. When I explain the question that way to policymakers, they get it. It's not just mortality or survival. It's everything else in life."*

How to build counter-narratives that match the emotional force and cultural reach of anti-gender storytelling without sacrificing evidential credibility was raised repeatedly and left unresolved. The group acknowledged that the opposition understands, as one participant observed, that this is fundamentally about values, history, and politics, not just about getting the definitions and data right. The field has not yet found a consistently effective response to adversaries who operate on that terrain.