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The Disconnect Between Gender-Transformative Language and Action in Global Health

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INTRODUCTION

THE DISCONNECT BETWEEN GENDER TRANSFORMATIVE LANGUAGE AND ACTION IN GLOBAL HEALTH

In this essay, I reflect on the misappropriation of the "gender transformative" language from its original intended purpose to becoming an important contributor in the continued marginalisation of gender equality concerns in global health programmes. As we consider the underwhelming achievements with respect to the many aspirations outlined in the Beijing Declaration at the Fourth World Conference on Women 25 years ago, and the recurrent examples of backsliding in the wake of the COVID-19 crisis [1, 2], it is important to candidly assess why fundamental shifts towards gender equality have been much slower than desired or anticipated. In particular, it can be helpful to reflect on strategies that have taken a very different turn from our optimistic expectations so that we do not repeat mistakes of the past. I hope that my reflections on how a lofty term such as gender transformative may be holding back the feminist agenda in health rather than moving it forward will assist in spurring further discussion and help crowdsource creative ideas for faster, deeper change than we have been able to achieve thus far.

Over the last two decades, the language of gender transformation has become ubiquitous in the gender policies, frameworks, tools, guidance, programmes, and evidence produced and utilised by global health organisations and experts. The terminology has not only permeated most institutional strategies for gender mainstreaming, but has also become the standard for gender programming and evidence in health. Institutions as wide-ranging as the Global Finance Facility (GFF), Gavi, WHO, USAID, and Global Affairs Canada all frame their institutional and programmatic health goals in the language of gender transformation to showcase their progressive intent and commitment [3–8]. Similarly, gender and health programmes and evaluations are increasingly using a gender-transformative framing to demonstrate the extent to which their efforts are adequately "gendered" [9–11].

Unfortunately, while the concept of transformation is big and bold – signifying fundamental, thorough and dramatic change – most of the changes resulting from commitments and programmes in health with a gender-transformative label have been small, modest, quotidian, and ambiguous at best [12, 13]. While advocates for gender equality called for transformation in its truest sense, the misappropriation of the term has made its use a symbolic and diluted gesture, without the commensurate depth and breadth of investments in structural and systemic shifts towards gender equality in global health. Thus, the growing appropriation and codification of such terminology in health policy, programmes, and research spaces signals concern rather than celebration because the political and substantive significance of what gender transformation means is diminished.

Here, I outline three reasons for articulating concern, focusing primarily on programmes and evaluations and less so on organisational strategies, although a similar case could be made there as well. First, the classification of gender-transformative programmes has been defined by what a programme *intends* rather than what it achieves– a practice that defies the basic rules of good programming and evidence. This point relates to the second concern that such framing typically promises much more than what corresponding programmes can deliver, since they are often based on overly optimistic theories of change, frequently ignoring the likelihood of ineffectiveness or negative consequences and the lack of institutional pathways to broader impact. Third, specific interventions associated with gender-transformative approaches place the burden of change mostly on women, men, and communities rather than on health systems, which hold the more substantial power, infrastructure and resources for making the kinds of fundamental changes necessary for transforming the health space. Despite these basic distortions, gender-transformative framing continues to influence – and limit – the type of gender-relevant health interventions that are funded and implemented on the ground. It also continues to influence – and limit – the generation of evidence on successful programming models that have the scope and scale for shifting power dynamics and resources toward a more gender equitable health sector.

PROBLEM 1

ASSESSING TRANSFORMATION BY INTENTION RATHER THAN OUTCOME

The need for a framing around gender transformative programs originated with the best of intentions. Following the International Conference on Population and Development (ICPD) in Cairo, 1994, and the Fourth World Conference on Women in Beijing, 1995, many gender and health advocates were frustrated by check-box exercises and sought deeper, more thoughtful gender analyses in defining major health concerns and their incorporation into programmes. The superficial treatment of gender inequality was evident in early efforts to address the raging HIV/AIDS pandemic, in the execution of the Cairo and Beijing recommendations on sexual and reproductive health, and in the emergence of non-communicable diseases as part of the health agenda for the Global South [14–16]. Thus, the idea of a gender continuum to classify the extent to which programmes and strategies address gender equality was originally motivated by a need to simplify and make practical what can and should be done by health services and systems to advance gender equality. The aim was to de-mystify gender equality so that instead of considering it an alien, "cultural" concept, health experts would connect it to their core work and foster it proactively [17].

Perhaps because of its original simplicity, ranking the degree of gender integration in health programs became an appealing approach. Over the last 10-15 years, this idea has been codified in the gender continuum, a version of which is represented in Figure 1. A growing number of agencies and initiatives have adopted similar versions as a core framework as well as a practical tool for guiding programming on gender and health [7, 8]. The continuum instructs that programmes should not be undertaken without gender *intentionality*, as that could maintain ("gender blind") or worsen ("gender exploitative") the status quo. Instead, programmes should at least try to address existing gender challenges ("gender accommodating") or, even better, try to change them ("gender transformative"). Although reasonable in concept, the formalisation of the gender continuum as a tool by standard-setting agencies such as WHO and USAID has led to the very same check-box exercises it was intended to prevent, pigeonholing gender-focused interventions further into the cultural sphere.

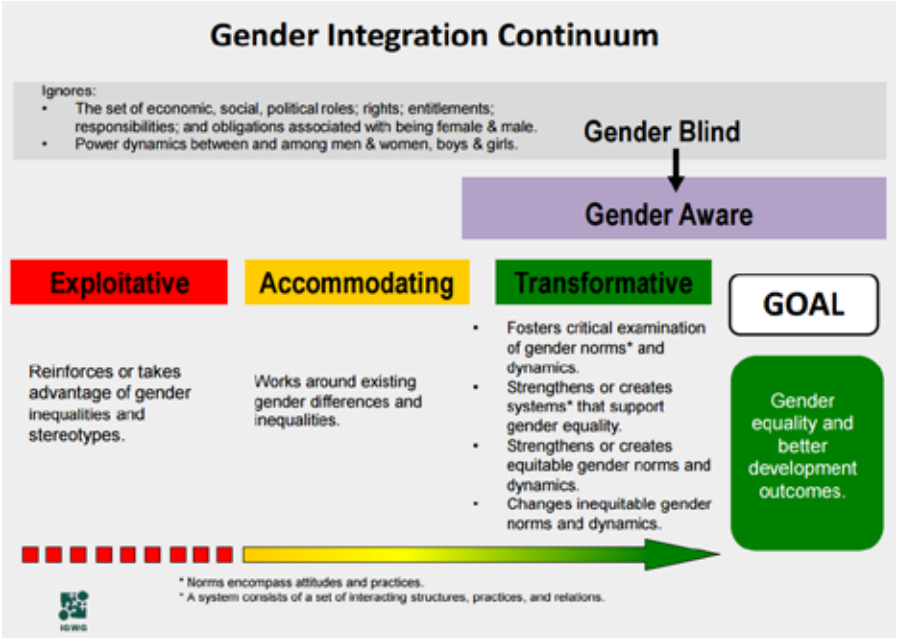

Figure 1. The gender integration continuum
Source: USAID Interagency Gender Working Group

The fundamental problem is that such a codification sets up a definition of gender accommodative or transformative around the degree and nature of gender intentionality in designing an intervention approach, while the pathway to actual outcomes is assumed rather than proven. There is no guarantee that an intervention hypothesised to be transformative will actually be so, and vice versa. For example, the birth control pill and medical abortion were innovative interventions intended to be gender-transformative by giving women more control over their childbearing, and they have demonstrated over decades that in many contexts they have indeed fundamentally transformed the life options for millions of women [18–20]. In contrast, the desired gender transformation from media or social messaging and laws against child sex selection in South Asia has not materialised, despite highly publicised intentionality [21]. On the other hand, piping water directly to the home was an intervention designed without any particular gender intentionality behind it. Nevertheless, it has significantly transformed women's lives through reducing women's time poverty, exposure to harassment and violence, and physical exertion from fetching water from distant sources, as well as providing the obvious health benefits of clean water [22].

Moreover, few interventions have exclusively positive or negative gender outcomes, and most positive shifts in women's lives – especially regarding gender relations – generate resistance. Thus, interventions can present considerable ambiguity in their classification along the gender continuum because of mixed outcomes. For example, male engagement in sexual and reproductive health interventions could be accommodative or transformative, depending on the level of sustained support that male partners exhibit, and the initiative they take on behalf of their female partners' and their own health. The line is not always clear between a husband accompanying his pregnant wife to a clinic because he wants to support her health and has a shared interest in parenthood, versus his felt need to do so because he thinks a woman should not travel alone or would not be able to make important health decisions on her own. In many contexts, both motivations could be co-mingled. In fact, male engagement would be both gender-blind and exploitative in cases where women in problematic relationships face increased scrutiny, suspicion, physical violence or other reprisals from male partners who are encouraged to be privy to matters that were previously the well-guarded private concerns of these women. Another unintended, exploitative outcome resulting from greater male engagement would be new provider requirements for spousal approval or presence on matters that had previously been solely within women's purview [23, 24].

Similarly, the engagement and use of female community health workers has generally been seen as a gender-accommodative—even transformative--intervention because of the direct connection they make with women's health needs. However, there is more recent and evolving recognition that the expanded but poorly or unpaid, female community health workforce is reflective of systemic gender biases with regard to job status, responsibilities, respect, compensation, and professionalisation [25]. It is likely, therefore, that, in many settings, the expansion of female community health workers is simultaneously gender-accommodative and exploitative. Moreover, efforts to increase female health workers' remuneration or status has been met with significant resistance in many countries. Where these efforts have been partially successful, higher compensation and status for female health workers has frequently been followed by growing male interest in undertaking work previously performed by women (e.g. the growing share of male nurses in the US) [26,27]. Thus, the transformative potential of such efforts lies in a longer-term process, and one that is neither linear nor without contestation [28, 29].

PROBLEM 2

OVERLY OPTIMISTIC EXPECTATIONS FROM INTERVENTIONS WITH LIMITED SCOPE AND SCALE

Another problem with relying primarily on intentionality is that not only is the transformative nature of the intended outcome poorly specified, but so are the pathways to get there. Many "gender transformative" programs are overly optimistic and disregard the potential alternative—and especially ineffective or negative—paths and outcomes that could follow from the interventions they implement. Such programmes also underplay the scope, depth, scale, and sustainability required for interventions and outcomes to be truly classified as transformative. Most evidence reviews of gender-intentional health programmes indicate that the vast majority are small-scale, community-based efforts focused on changing health-related knowledge, attitudes, perceptions, and behaviours among women, men, and communities. These programmes are generally classified as gender-transformative when they primarily aim at relational shifts among women, men and women, family and community members, or at creating better dialogue, understanding and support – especially for women, but at times also for men – so as to overcome cultural barriers that restrict healthcare options and their access [9, 10, 12, 30].

Relational and cultural shifts – captured under the term "gender norms change" by the gender continuum – could be transformative in the true sense of being dramatic or metamorphic if they were sustained and occurred within a sufficiently significant size of population or number of communities. However, the reach of most norm change programmes is not large enough, duration long enough, and possible positive results sustainable enough to generate the substantial shifts necessary for such transformation. These programmes generally target a limited number of individuals and communities, typically for a 1–2 year period, providing information, education, and consultation from professionals, peers, media, or social media, in varying "dosages" of messaging or level of interaction. Services such as antenatal check-ups or family planning provisions may or may not accompany such efforts [28, 30]. Some interventions claim to consider structural components by incorporating economic or educational

empowerment interventions such as micro-credit provision or self-help groups. Such components, however, are often too small and not well-connected with the larger trends and initiatives on women's livelihoods and financial independence operating within the employment or financial sectors [31, 32] and are, therefore, not in a position to shift the structural aspects of gendered economic systems.

Most programmes labelled as gender-transformative are undertaken by NGOs and encompass multiple components that are often difficult to finance and implement. Few NGOs have the required expertise, capacity or experience to adequately implement all elements, and not all targeted beneficiaries have the time or interest to participate in every component. Moreover, in many cases, women and poor community members are actually looking for tangible assistance in the form of money, food, treatment, materials, or facilities and may consider dialogue and consultations as an imposition, or they may agree to participate simply to placate the implementers. Several programme evaluations have noted that work demands and gender structures lead to men having less time for, or interest in, health and social awareness-raising activities or interactive sessions. Inherent gender biases among trainers and facilitators – whether from the community or the NGO – can also subvert or dilute the intended messages. Thus, these programmes often face a range of execution challenges, and fidelity to the original intervention design is difficult to preserve. Further, the cost and complexity of such interventions make them hard to replicate, and they are rarely incorporated into larger government or private-sector programmes, taken to scale, or sustainably financed [12, 28].

Given these challenges, theories of change for such programs should at least specify the risk of not reaching the intended transformation. For example, it is not clear how well or for how long gender-equitable attitudes and beliefs imparted by programmes are sustained against the ongoing onslaught of gender-inequitable attitudes and beliefs experienced by the targeted populations in their daily lives and interactions with one another, their work environments, places of worship, radio, television, and social media sources, and so on. It is not surprising that evaluations are typically mixed, with knowledge and attitude outcomes generally outperforming behavioural outcomes [12, 28, 30, 33]. Moreover, success measures vary considerably across programmes, and the criteria to be met for improvement in outcomes to be considered gender-transformative are rarely specified.

Even when achieved, it is unclear how long the more equitable ideas and interpersonal relations are retained as few programmes have follow-up evaluations. Can change really be considered transformative if it does not survive beyond the intervention period? Women, men, and adolescents often find it difficult to enact newly adopted gender-equitable ideas when the majority of institutional structures in their lives are set up to the contrary, with social sanctions for deviation being far from trivial. Can change be transformative if equitable attitudes cannot be enacted in practice? And even then, can positive change, which is typically limited to a minuscule percentage of the population, be truly classified as transformative?

PROBLEM 3

FOCUS ON CHANGING INDIVIDUALS AND COMMUNITIES, NOT HEALTH SYSTEMS

This last point is especially important as current gender-transformative interventions in health place a disproportionate burden for change at the individual and community level, for the most part staying away from pathways towards gender transformation in health systems and infrastructure. The imbalance is so severe that it is difficult to find examples of interventions that explicitly address and evaluate gender transformation in the core building blocks of health systems. For example, in their 2020 comprehensive review of the effectiveness of 59 gender-integrated interventions in sexual and reproductive health (SRHR), Sikder, Challa and Kraft could not identify a single evaluated programme that aimed at gender-related shifts in financing or budget allocations, data and information systems, product, supply chain and technology innovations, or leadership and governance – areas that cover four of the six health system building blocks [10].

Remarkably, evaluated interventions on services and the workforce – the other two health system building blocks – were also limited, despite extensive documentation and advocacy around the poor availability and quality of health services for women, as well as a growing literature on gender biases in the health workforce. Only 8 out of 59 studies evaluated a component of service improvement, and these were limited mostly to providing short-term referrals and free HIV testing or contraceptives. Only

one programme focused on improving facility infrastructure, increasing supplies, checking the quality of care protocols, etc. The two studies that focused on workforce issues limited interventions to sensitisation training for providers [10], which is merely a short-term, temporary approach that is inadequate for shifting the longer term imbalance of power between health care providers and women seeking quality, respectful care.

In many ways, this lacuna illustrates the limitation of the space that gender issues have been able to forge within the broader health sector – even in an area as fundamentally gendered as SRHR – where they continue to be addressed at the periphery rather than at the core by making structural changes to health systems [5, 34]. Certainly, this is in part due to the persistent inattention within the health ecosystem to systemic issues in general and to gender inequalities in particular. It is quite common for implementers and evaluators not to apply a gender lens even when they do address endemic systemic problems such as supply chain bottlenecks or the quality of facilities. For example, a recent systematic review of the impact of clean water provision at health facilities assessed outcomes such as infections prevented, care-seeking behaviour and patient satisfaction, but without attention to sex differentials. Nor did it acknowledge the well-documented challenges faced by women when facilities lack clean water. It was a missed opportunity to ascertain the disproportionate impact on personal hygiene, convenience, and quality of care for women not only as the predominant care seekers for services such as maternal and child health, but also as family companions providing supportive care and as a significant share of workers at health facilities [35].

But an equally important reason for this lacuna is the very explicit bias in many gender programming guidance documents and tools that defines gender-transformative approaches almost exclusively in terms of changing gender norms and relations, which are then addressed at the individual and community levels. For example, in the gender continuum tool shown in Figure 1, three of the four bullet points defining gender-transformative approaches refer to gender norms and dynamics. As noted earlier, norms are generally addressed through a narrow range of intervention options, limited mostly to information, education, counselling, or awareness-raising among women, men and communities so that they are better informed and empowered to seek improved health care.

What about also changing health systems so they are in a position to deliver better health care? The figure depicting the gender continuum does devote one bullet point to strengthening or creating gender equitable systems, but the evidence base indicates that, rather than being translated

into interventions targeting the health system, this injunction has resulted in programmes on educational or economic empowerment, still largely targeting women as individual or groups. Thus, it is ironic that those with experience and expertise in the health field have undertaken ostensibly systems-oriented programmatic efforts at gender transformation through interventions such as microfinance, savings clubs, skill building, or business training – areas in which they have little or limited knowledge, expertise, resources, institutional links, or influence – while paying scarce attention to addressing the weaknesses and biases in health systems where they could deploy their expertise and influence to a home-turf advantage.

The preoccupation with community-level norms in gender-related programming not only misses the opportunity for a more fundamental transformation in how health systems address women as both consumers and producers of health care; it also confirms existing gender biases in the health field by classifying small, boutique, poorly resourced programmes, which are at the margins of the health sector as gender-transformative while dismissing matters at the heart of health systems as being outside of the gender domain. This overwhelming reliance on community-based and non-health interventions in programming and evidence-building has been a missed opportunity to build on the strong body of work by feminist health researchers who have highlighted not only how health systems exhibit, but also reproduce, gender inequalities (as most recently and starkly illustrated throughout the progression of the COVID-19 pandemic) [36,37].

As a case in point, even though feminist research has repeatedly highlighted the gender biases and poor availability, low quality, and high cost of health services for disadvantaged women, the implementation and evaluation of tangible supply-side, service, or financial interventions – such as more clinics, better stocked supplies, subsidies or insurance options, telemedicine, or women-friendly medical innovations – have not been picked up in frameworks and guidance on gender-transformative programmes and policies [30, 38]. In practice, a disproportionate focus on changing hearts and minds, but not services and quality, can leave women in poor health without the very agency that interventions aimed at empowerment and changing norms hope to foster.

Consider, for example, a woman who wants to delay her next birth but who must access family planning in a public health system that is poorly run, with inadequate and distant facilities, chronic supply shortages, and a paternalistic policy that serves administrative needs but distrusts women's ability to select and use the right method. Thus, public health services offer women only two contraceptive choices: either a tubal

ligation or a single brand of oral contraceptive pill with side effects and frequent stockouts. Such a scenario is common in the Global South and not unknown in the Global North. Even if a gender norm change programme is successful in improving this woman's knowledge and negotiating ability, or securing her partner's support on the use of family planning, it is hard to argue that she is empowered to exercise her reproductive rights if her only contraceptive options are either unreliable access to an oral pill with side effects, or a trip to the clinic to be sterilised.

While there is no question that community-level resources, agency, and insights, as well as the engagement of women, men and grassroots groups, are essential for addressing gender inequalities in health, a disproportionate focus on community-level programmatic solutions can perpetuate and further distort existing power dynamics and imbalances in the locus of responsibility for change [27, 38]. Communities are very important actors for change, but they are neither benign nor homogenous, and the powerbrokers in communities who benefit from current hierarchies can, and frequently do, undermine programmatic efforts that might result in shifting their power base. Moreover, making communities the sole showpiece for change can have the perverse effect of making rights holders suffering deprivations and disenfranchisement responsible for their own plight while power holders managing health systems and wielding substantially more clout and resources get a free pass.

THE WAY FORWARD

I have argued that the overwhelming emphasis on changing relational and social dynamics with small-scale, poorly resourced, difficult-to-implement, and unsustainable interventions based on questionable theories of change has not only failed to deliver the desired gender transformation in health, but has also reinforced the health sector's abdication of responsibility in addressing gender inequalities and improving women's health through structural interventions within its own purview.

The misappropriation of gender language and the adoption of rhetoric without commensurate action are problems with a long history in the gender and development space. Thus the marginalisation of core gender issues in health that the misappropriation of "gender transformative" has contributed to and sustained cannot be fixed through a simple solution like finding a substitute term. Instead, a meaningful and honest dialogue among advocates, experts, and stakeholders is necessary to acknowledge that even the best intentions can miscarry and to prioritise new strategies that are more difficult to subvert. Such a discussion could begin by considering the following three potential action points:

1 **Define successful progress towards gender equality in health programming by the outcomes actually achieved rather than by the intentions of a programmatic approach.** This is not to say that intentionality is not important; it is highly desirable to strategise and undertake efforts that deliberately intend to address gender inequalities. However, ultimate success must be assessed not only by intentions, but by whether or not both women's health and gender equality are improved in meaningful ways. For this purpose, it is important to be ambitious, specific, and frugal in measuring outcomes on gender equality rather than continuing with the vast array of disparate indicators that make it impossible to compare and ascertain the depth and breadth of impact from different intervention strategies. Moreover, progress towards both women's health and gender equality outcomes needs to be the criteria for determining success, rather than one or the other alone. Finally, a bar should be considered for determining if the degree of change achieved, its robustness, duration and breadth are indicative of substantial progress. If we want transformative change, we need to define what it looks like so that it is recognisable in clear terms when achieved.

2 **Shift away from broad and hypothetical theories of change (TOC) to more specific mappings of the progression of interventions in specific contexts, with deliberate inclusion of both optimistic and pessimistic scenarios.** This type of thorough deliberation during intervention design may also assist programmes to more effectively transition from problem identification through gender analysis exercises towards practical, detailed and context-specific solutions. Intervention design tools need to be developed in closer coordination with programme personnel to support the development of realistic, locally relevant TOCs that openly acknowledge real implementation challenges and the risk of pushback and negative consequences. Theories of change also need to proactively consider pathways to scale and sustainability upfront rather than as afterthoughts, recalibrating resource needs and time horizons

in line with the real magnitude of desired change. These better planned, ambitious, and potentially fallible programme designs require more robust donor support. At the same time, addressing scale and sustainability as essential intervention components from the very beginning also requires a clear understanding by programme implementers that donor-funded programmes on their own will not deliver transformative change; for that, they must concurrently mobilise strategic channels of domestic financing.

3 **Rebalance gender and health interventions towards a much more substantial focus on changing health systems for gender equality.** Transformative change requires going beyond the scope of community-based interventions alone and focusing strategically on change in the six health system building blocks. As there are numerous sub-elements to health systems change, this effort will require honing in on those aspects that are not just essential, but also ripe for reducing gender inequalities within any given context. National and sub-national action on systems change needs to prioritise entry points opportunistically, targeting areas with the greatest promise of success in light of political momentum, civil society activism, socio-economic shifts, budgetary allocations, as well as global mandates and pressures. Moreover, gender experts and health experts committed to systems change will have to learn to communicate with one another and co-strategise more effectively if the strong inertia against gender equitable systems change is to be overcome. Collaborations where expertise on gender equality in health gets equal leadership, billing, respect, recognition, and resources as the expertise on health systems could be amazingly powerful in developing and executing an innovative shared agenda. While the role of other sectors, such as education and employment, is also critical for achieving strong and equitable health systems and outcomes, it is important that, rather than trying to do their job for them, gender and health experts reach out and build alliances, collaborations, and advocacy with counterparts in these other sectors, and let them take the leadership in advancing gender equality in those areas within their purview.

These actions could hopefully produce a body of evidence on well-designed strategies that demonstrate concrete ways in which improvements to specific dimensions of health systems can stop perpetuating gender inequality and proactively advance women's health and rights—bringing us much closer to the gender transformation we all desire.

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