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

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June 2021

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INTRODUCTION

THE DISCONNECT BETWEEN "GENDER TRANSFORMATIVE" LANGUAGE AND ACTION IN GLOBAL HEALTH

Over the last two decades, the language of "gender transformative" approaches has become ubiquitous in the gender policies, frameworks, tools, guidance, programs, and evidence produced and utilized by global health organizations and experts. This terminology has not only permeated most strategies for institutional gender mainstreaming, but it has also become the "gold standard" for gender programming and evidence in health. Institutions as wide-ranging as the Global Finance Facility, GAVI, UNICEF, USAID, and Global Affairs Canada frame their institutional and programmatic health goals in the language of gender transformation and are rewarded with approval and accolades by many in the gender and health field for being bold and progressive. Similarly, programming models and intervention evaluations are increasingly judged as adequately gendered only if they utilize a gender transformative framing.

Although well-intentioned, this widespread adoption of the gender transformative terminology has occurred without the commensurate depth and breadth of investments in structural and systemic shifts toward gender inequality in global health endeavors. As such, the use of gender transformation terminology as the standard to meet is a disturbing trend rather than a cause for celebration, signalling further marginalization rather than concerted integration of gender inequality concerns in global health. For feminists working in the global health space, the growing appropriation and codification of this terminology in the health policy, program, and research spaces should be a reason for concern because it diminishes the political and substantive significance of what gender transformation means.

In considering how the gender transformative framing is applied in health programs and evidence generation, there are four key reasons for articulating this concern. First, the classification of gender transformative programs has been defined by what a program intends rather than what it achieves, a practice that defies the basic rules of good programming and evidence. This point is related to the second concern that such framing typically promises much more than what the commensurate programs can deliver since they are often based on overly optimistic theories of change. Third, the specific interventions associated with gender transformative approaches place the burden of change mostly on women, men, and communities rather than on health systems which often leaves the crux

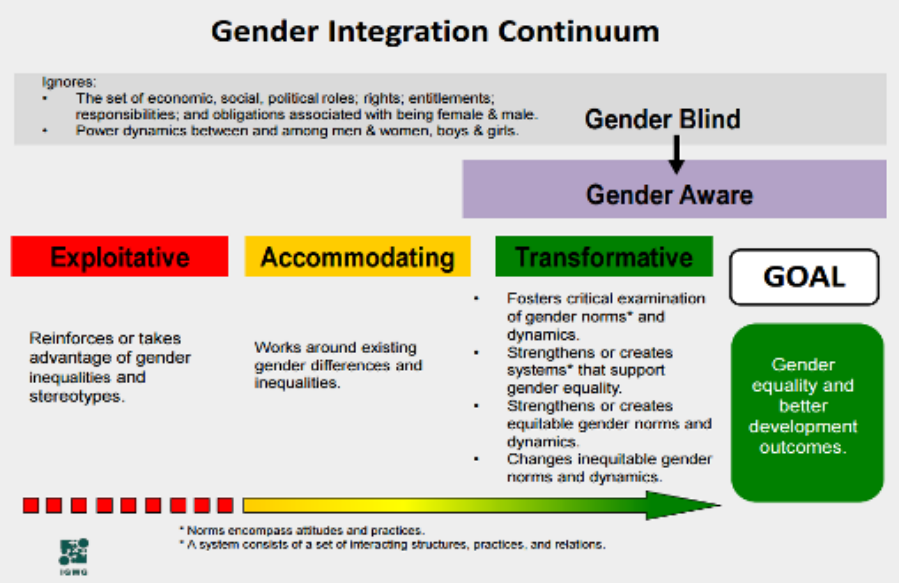
of the problem unaddressed. This, in part. leads to the fourth concern in that the disproportionate focus on communities and multi-sectoral programming by gender transformative approaches has exacerbated the health sector's reluctance to address gender inequalities through structural interventions within its purview: achieving gender equality continues to be seen primarily as someone else's responsibility.

PROBLEM 1

INTENTIONS RATHER THAN OUTCOMES

The need for a framing around gender transformative programs originated with the best of intentions. Post ICPD 1994 and Beijing 1995, many gender and health advocates were frustrated by check box exercises and lack of thoughtful gender analyses in defining major health concerns and programs. This superficial treatment of gender 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 areas, and in the emergence of non-communicable diseases as part of the health agenda for the Global South. Thus, gender analysis tools and frameworks such as the "gender continuum" (see below) were developed to more intentionally address gender issues in program design, attempting to avoid "gender blind" programs and cautioning against "gender exploitative" interventions. Further, the continuum aimed to provide a clear distinction between what was a "good enough" (accommodating) versus what was a "desirable" (transformative) intervention from a gender perspective. Over the last 10-15 years, some version of the gender continuum has become a standard intervention tool and core guidance framework on gender and health routinely deployed by most agencies.

The fundamental problem with such a framework is that the very essence of the gender continuum 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 that is hypothesized to be transformative will actually be so, and vice versa. For example, the birth control pill and medical abortion were



The Gender Integration Continuum used and recommended by the USAID Interagency Gender Working Group

innovative interventions intended to be gender transformative by giving women more control over their childbearing, and they have demonstrated over decades that they have indeed fundamentally transformed the life options for millions of women. On the other hand, piped water in the home as an intervention has rarely had gender intentionality. Regardless, it has been significantly transformative in 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 from clean water.

Moreover, few interventions have exclusively positive or negative gender outcomes, and most positive shifts in women's lives—and especially 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 and initiative male partners take on behalf of their female partner's and their own health. The line is not always clear between a husband accompanying his pregnant wife to a clinic because he wants to be there for her check-up and has a shared interest in parenthood, versus his felt need to do so because 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 when women in problematic relationships face increased scrutiny, suspicion and physical violence or other reprisals from male partners who are encouraged to be privy to matters that were previously

well-guarded private concerns for these women. Another unintended "exploitative" outcome resulting from male engagement would be new provider requirements for spousal approval or engagement on matters that had previously been solely within women's purview.

Similarly, the engagement and use of female community health workers has generally been seen at least as a gender accommodative intervention in health providers making a more direct connection 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 gaps in the health workforce with regard to job responsibilities, compensation, and professionalization. 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 met with significant resistance in many countries. Where these efforts have been partially successful, higher compensation and status for women health workers has frequently been followed by growing male interest in undertaking previously female held jobs (as for example, the growing share of male nurses in the U.S.). Thus, the transformative potential of such efforts is a longer term process, and one that is neither linear, nor without contestation.

PROBLEM 2

OVERLY OPTIMISTIC EXPECTATIONS FROM INTERVENTIONS WITH LIMITED SCOPE

Many "gender transformative" programs are overly optimistic and disregard the potential alternative—and especially negative--paths and outcomes that could follow from the interventions they implement. In addition, they underplay the scope, depth, scale, and sustainability of interventions and outcome required for them to be classified as transformative. A review of the health programmatic and evaluation literature indicates that the vast majority of gender responsive programs are small scale, community-based efforts that focus on women, men, families, and communities in changing health related knowledge, attitudes, perceptions, and behaviors. When they are "accommodative," they generally only aim to increase the demand and access to services and their utilization. When they purport to

be transformative, they aim for relational shifts—among women, men and women, family members, community members, and sometimes providers—that reflect a better understanding of and desire to change gender dynamics and constraints that restrict health care options and their use.

Relational shifts—captured under the term "gender norms change" by the gender continuum--could be considered transformative if they are sustained and occur among significant size populations or number of communities. However, the reach of most norm change programs is not large enough, duration long enough, and possible positive results sustainable enough to generate the substantial shifts necessary for such transformation. These programs generally target a limited number of individuals and communities, typically for a 1-2 year period. Individuals, couples, and/or groups receive information, education, and consultation from NGO professionals, community health workers, peers, media, or social media. The "dosage" of such messaging or interactions can be sporadic (once in a few months) or intense (several times a week). Services such as antenatal checks ups or family planning provision may or may not accompany such efforts. Some interventions claim to consider "structural" components by incorporating economic or educational empowerment through micro-credit provision or self-help group programs. Such components, however, are often small and not well-connected with the larger trends and initiatives on women's livelihoods and financial independence in the economic sector and are, therefore, not in a position to shift the structural aspects of gendered educational or economic systems.

Generally undertaken by NGOs, the multiple components of self-defined gender transformative programs are difficult to finance and implement, especially as few NGOs have the required expertise, capacity and experience to adequately implement all elements, and not all targeted beneficiary communities have time and interest in taking up every component. Thus, interventions often face a range of implementation challenges, and fidelity to the intervention design is frequently difficult to preserve. Their cost and complexity make such interventions hard to replicate. They have been rarely picked up by larger government or private sector programs and taken to scale or made sustainable through an assured source of financing.

Given these frequent challenges, the theory of change for such programs should at least be specifying the risk of not reaching the intended transformation. For example, it is not clear how well—and for how long- - gender equitable attitudes and beliefs imparted by periodic program sessions are sustained against the ongoing onslaught of gender inequitable attitudes and beliefs experienced by the targeted populations in their

daily lives and interactions with each other, their work environments, places of worship, radio, television, and social media sources, etc. Thus, it is not surprising that there are often mixed findings among the varied knowledge, attitudinal, and behavioral outcomes that evaluations of such programs measure, with knowledge and attitudinal outcomes generally outperforming behavioral outcomes. As the range and specification of these measures vary considerably across programs, it is difficult to determine what bar one or more outcomes have to meet in being considered "gender transformative."

It is also unclear how long the more equitable ideas and interpersonal relations are retained as few programs have follow-up interventions or evaluations. Can the change be transformative if it does not survive beyond the intervention period? Women, men, and adolescents often find it difficult to enact even internalized gender equitable ideas when the majority of institutional structures in their lives are set up to the contrary, with the punishments for deviation being far from trivial. Can the change be transformative if equitable attitudes cannot be enacted in practice? Even if positive, can change limited to typically a miniscule percentage of the population experiencing a given gender inequalitable norm be classified as transformative?