Exploring system drivers of gender inequity in development assistance for health and opportunities for action [version 1; peer review: awaiting peer review]

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Abstract

Background: Deep-rooted and widespread gender-based bias and discrimination threaten achievement of the Sustainable Development Goals. Despite evidence that addressing gender inequities contributes to better health and development outcomes, the resources for, and effectiveness of, such efforts in development assistance for health (DAH) have been insufficient. This paper explores systemic challenges in DAH that perpetuate or contribute to gender inequities, with a particular focus on the role of external donors and funders.

Methods: We applied a co-creation system design process to map and analyze interactions between donors and recipient countries, and articulate drivers of gender inequities within the landscape of DAH. We conducted qualitative primary data collection and analysis in 2021 via virtual facilitated discussions and visual mapping exercises among a diverse set of 41 stakeholders, including representatives from donor institutions, country governments, academia, and civil society.

Results: Six systemic challenges emerged as perpetuating or contributing to gender inequities in DAH: 1) insufficient input and leadership from groups affected by gender bias and discrimination; 2)
decision-maker blind spots inhibit capacity to address gender inequities; 3) imbalanced power dynamics contribute to insufficient resources and attention to gender priorities; 4) donor funding structures limit efforts to effectively address gender inequities; 5) fragmented programming impedes coordinated attention to the root causes of gender inequities; and 6) data bias contributes to insufficient understanding of and attention to gender inequities.

Conclusions: Many of the drivers impeding progress on gender equity in DAH are embedded in power dynamics that distance and disempower people affected by gender inequities. Overcoming these dynamics will require more than technical solutions. Groups affected by gender inequities must be centered in leadership and decision-making at micro and macro levels, with practices and structures that enable co-creation and mutual accountability in the design, implementation, and evaluation of health programs.

Keywords
gender, gender inequity, development assistance for health, system analysis, co-creation, power, gender transformative, health system
Introduction
Deep-rooted and widespread gender-based bias and discrimination threaten the achievement of the Sustainable Development Goals (SDGs) ([https://sdgs.un.org/goals](https://sdgs.un.org/goals)), including ensuring healthy lives and wellbeing of people at all ages and gender equality as a fundamental human right. Here, gender refers to the culturally defined roles, responsibilities, attributes, and entitlements associated with being, or being perceived as, female or male in a given setting, commonly learned through socialization, along with related social and structural power dynamics.

Gender is one of many social determinants that contribute to health and development outcomes. Gender norms can shape institutional systems and practices, including whether and how the health needs of certain groups of people are acknowledged, whether they can access resources such as health care, and whether they can realize their choices and rights. Gender bias and discrimination in institutions and national health systems enables practices and policies that produce inequitable health and gender outcomes. These inequities are socially produced, systematic in their distribution, avoidable, unfair, and unjust.

A growing body of evidence suggests that eliminating or mitigating gender and health inequities contributes to better health and development outcomes. However, despite decades of global commitments and advocacy by women’s groups and scholars, resources and effectiveness of efforts to reduce gender inequities in development assistance for health (DAH) investments have been limited or insufficient.

Scholars and feminist activist groups are asking why actions are weak, resources small or ineffective, and progress is slow. A complex and multifaceted set of contributing factors is possible. For example, recent studies show that global health institution accountability for and implementation of gender policies and practices are inadequate. Gender bias and inequities pervade the leadership, organizational structures, and culture of global health institutions such as donors, international nongovernmental organizations (INGOs), and multilateral agencies. Furthermore, some studies suggest that broader system dynamics and power asymmetries between actors in DAH play a role in shaping the way that health systems are conceptualized, funded, governed, and implemented, and can inadvertently reinforce gender and health inequities.

There is growing recognition within the global health community that complex and protracted challenges such as gender and health inequities require a deeper understanding of the linkages, relationships, interactions, and behaviors of such actors. While there has been significant research in how system dynamics and power asymmetries between actors in global health aid play a role in shaping health systems, no studies, to our knowledge, have examined the drivers of gender inequity across the broader landscape of DAH.

A systems approach to gender and health inequities
Systems theory, an interdisciplinary field of science that analyzes the dynamic interactions of interrelated, interdependent parts that make up a complex whole, has gained attention as relevant for health systems analysis and interventions. Application of systems theory can benefit the exploration of macro-level dynamics affecting complex and protracted issues, making it a useful basis for exploring the drivers of gender and health inequities in DAH. Systems approaches have been used in social intervention research, such as studies examining interventions that tackle intimate partner violence. However, there are relatively few studies that use a systems approach to analyze progress in minimizing gender and health inequities. Moreover, the operant dynamics and drivers in the landscape of DAH that reinforce gender bias are poorly documented.

The field of systems approaches is evolving. Diverse approaches are emerging from different fields of study, epistemologies, and contextual boundaries. Many such approaches focus on describing the system, without emphasis on opportunities for change. In contrast, System Acupuncture® is a theory and method that enables the design of innovative, actionable, and synergistic interventions that drive deep and sustained transformation of system behaviors and outcomes. The System Acupuncture® approach adds value by enabling engagement of diverse actors in understanding the complexity of system drivers in gender inequity in DAH and identifying opportunities for system-level transformation.

Framing and purpose of this paper
This paper builds on prior work examining the shifts needed in DAH to facilitate a redistribution of power, and coordination and accountability between countries and donors in designing health technical assistance (TA) interventions. Such shifts are needed to foster more resilient health systems and sustained

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1. We use the term DAH landscape to refer to the actors, norms, and structures that interact in the context of external financial contributions for activities aimed at improving health in low- and middle-income countries.

2. This approach combines multiple theories and concepts ranging from systems theory, innovation and diffusion theory, design thinking, and resilience theory.

3. Throughout this paper, we use the term donor to denote institutions that provide external funding for health. We recognize the varying terminology and labels—including development partners, funding partners, external funding, lending institutions, and investors—and approaches across those providing funding for health, and acknowledge the nuances and connotations of these terminologies. For our purposes, we continue to use the term donor for clarity and consistency, as this is how we framed the conversation with co-creation participants throughout the process.
health outcomes. We anticipate that efforts to redistribute power in ways that center local stakeholders in decision-making and build mutual accountability cannot be fully realized without addressing gender inequities.

The objective of this paper is to identify systemic challenges in DAH that are perpetuating or contributing to gender inequities, with a particular focus on the role of external donors and funders. In this paper, we map and analyze interactions between donors and recipient countries and articulate drivers of gender inequities within the landscape of DAH. As a basis for exploring and identifying actionable steps to improve gender and health equity outcomes, we aim to highlight systemic issues that impede or slow progress in addressing gender and health inequities in DAH.

Methods

Study design

The work presented in this paper was conducted as part of a broader initiative led by the Inter-agency Working Group (IAWG) for Capacity Strengthening to co-create a systems’ understanding of capacity strengthening in the context of global DAH.

Using the methods and tools from System Acupuncture®, we took a structured process consistent with social constructivist approaches to enable system actors to collectively understand and improve a complex adaptive system. For the IAWG initiative and this paper, the scope of the system is defined by the complex relationships of actors and institutions interacting within the landscape of DAH, and the norms that inform their behaviors and decisions.

The IAWG aligned around a set of critical shifts for capacity strengthening (Figure 1), which outlines a vision for more country-driven, coordinated, and equitable health investments. These critical shifts served as a framework to co-create a systems understanding of capacity strengthening and collectively investigate ways to improve programming in DAH. The initiative’s hypothesis was that application and realization of the critical shifts by actors in the system would enhance the capacity of global health institutions to deliver sustained health outcomes. A gender lens was prioritized as part of the process in recognition that gender bias and inequities are manifest throughout the global health landscape, and the critical shifts and desired impact from health investments cannot be fully realized without addressing these factors.

Primary data were collected and analyzed via facilitated discussions and visual mapping exercises to develop and iterate emerging themes, explore insights from stakeholders, and refine the maps to reach a shared understanding of system dynamics across the DAH landscape. The discussions helped articulate and clarify the perspectives and experiences of a diverse set of stakeholders, which included donors, national government ministry representatives, academia, and civil society. This iterative virtual engagement was facilitated by the secretariat over nine months in 2021.

Guided by the System Acupuncture® approach, we undertook the following steps:

Desk Review: We conducted discussions with the IAWG and completed an iterative and non-systematic literature review to inform the system mapping process. The literature review was based on Google Scholar and PubMed searches using multiple permutations of search terms: gender, power, social determinants, social accountability, development assistance for health, donor, and health system. An iterative approach was applied, refining terms and adding articles from sources cited as the review proceeded. Sources were selected on the basis of relevance to the topic of gender, power, and development assistance for health. The literature review was limited to English language sources from the years 2000 to 2022. In total, 52 peer-reviewed journal articles and nine relevant reports and commentaries were reviewed. Systematic analysis of the sources included thematic coding for themes based on questions driving the review, including:

1. How do gender bias, discrimination and power dynamics manifest in national health systems, and how do gender inequities contribute to poor health?
2. How do gender bias, discrimination and power dynamics manifest in the landscape of donor assistance for health?
3. How does donor assistance for health programming succeed or fail to support attention to gender bias and discrimination?

Mapping the system: System maps were used to co-create, describe, and visualize the multi-dimensional view of causal connections between individual drivers in the system. Drivers refer to social constructivist approaches are grounded in the idea that learning is a collaborative process. Research processes using social constructivist approaches are based on the idea that understanding something better comes from interaction between people, and the historical, cultural, and social context within a specific period of time. This is in contrast to positivist approaches, which assume there is only one valid reality that can be “discovered” and “made known” through objective research.

The IAWG was formed in 2020 by representatives from the United States Agency for International Development, The World Bank, and the Bill & Melinda Gates Foundation to examine and advance the critical shifts to redistribute power and achieve more effective health outcomes. ChangeLabs, served as the IAWG secretariat.

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To support co-creation and allow simpler annotation of the system maps to facilitate legibility, the System Acupuncture® process intentionally frames the drivers to be valence-aligned to reflect barriers to or inhibitors of achieving desired outcomes. This reduces the need to annotate reinforcing or counteracting relationships between drivers, as most causal relationships will be correlated positively.
Figure 1. Critical shifts for capacity Strengthening.
to identifiable forces (i.e., structural, policy, and funding decisions or behaviors) that can influence different elements of the system to act in specific ways (in this case, perpetuating gender inequities in the DAH landscape). The maps were then reviewed, discussed, and honed through a virtual co-creation workshop as part of the broader system mapping exercise. The workshop was held over two days in April 2021 and convened 41 people from 13 countries. Participants included representatives of government, civil society, funding institutions, academia, and implementing agencies. The IAWG members and the Secretariat identified participants within their networks who could bring diverse perspectives on how health funding and TA is structured at various levels and how donor processes, models, and norms constrain or amplify health system capacity strengthening and sustainable health outcomes. Participants were selected to ensure diversity in background, institutional affiliation, geography and perspectives in order to co-create a systems view.

A subset of six participants, facilitated by a gender expert, explored dynamics and drivers related to gender and health inequities that are slowing or impeding progress in DAH. During the workshop, participants used a collaborative virtual whiteboard tool to capture and depict specific behaviors, dynamics, and characteristics of donor and country stakeholder group interactions that hinder progress to reduce gender and health inequities, as they experienced them in their context.

**Synthesizing key challenge areas in the system:** We then synthesized the content developed by the workshop participants by spatially arranging the drivers into three broad contexts based on where the policy or funding decisions, behaviors, or actions occur: the donor space, the country space, and the space where they intersect. The synthesis resulted in the identification and mapping of six systemic challenges (referred to hereafter as ‘syndromes’) that highlight a collection of system drivers that pose barriers to the critical shifts and ultimately to gender and health equity.

**Iteration and expansion of six system syndromes:** The same subset of six participants from the original workshop and several IAWG and secretariat members participated in two follow-on virtual co-creation sessions to iterate and expand on these six syndromes. In addition, three semi-structured key informant interviews were held with gender experts with expertise in DAH, gender institutional capacity-strengthening or health system capacity strengthening, to validate the findings.

**Ethical statement**

All data collection was carried out through a facilitated co-creation process, including one virtual workshop and a series of discussions. The process elicited impersonal and anonymous feedback from selected participants. To ensure privacy and confidentiality, participant insights were gathered anonymously via a virtual whiteboard tool.

In the first phase, co-creation workshops, oral consent to collect inputs and record sessions was obtained from all participants at the start of the workshop sessions, per standard practice for minimal risk interactions. Participants were assured of confidentiality and that all findings would be anonymized and provisions made for the protection of privacy and confidentiality of the participants and the information they provided. No individual interviews were conducted. All inputs were collected and analyzed with complete anonymity and are therefore unable to be linked to a single individual. The project team did not seek ethical approval for the first phase because we determined the activities were exempt, given that they did not constitute human subjects research as described under US HHS regulation 45 CFR 46(e)(1). In the case of the workshops, the information obtained was not about the participants, but rather their expert opinions and feedback.

In the second phase, small group discussions, the JSI institutional review board deemed the process and tools exempt from full review under CFR 46.101(b)(2), which covers survey activities without identifiers or sensitive questions that could result in harm; no participants in the study were minors (less than 18 years of age). Written informed consent was obtained from participants during this phase of the initiative, since it involved meetings with a smaller group of participants and thus inputs could not be fully anonymized.

**Results**

**Six syndromes that slow or impede progress in gender equity in DAH**

The mapping and co-creation processes resulted in: 1) a series of conceptual maps of the drivers of gender inequities within the landscape of DAH, 2) diagrams describing potential change points, and 3) a graphic representing the participants’ views on priority action steps by donors. The six syndromes that emerged from the co-creation process reveal distinct yet interconnected system dynamics driving barriers to achieving gender equity and health outcomes. The term syndrome represents a set of concurrent events that form an identifiable pattern or a group

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1Participants included a government representative from Ghana, two government representatives from Nigeria, an implementer from Malawi, an implementer from Mexico, and a U.S.-based donor representative.
of signs and symptoms that characterize a particular abnormality. By naming the thematic areas syndromes, we ask the reader to consider a metaphor for the system as a body in need of healing. The six syndromes highlight patterns of dysfunction in the system that are badly in need of repair.

Each syndrome is depicted visually (via a system map) and through a narrative summary. The narrative and maps should be read side-by-side to enhance understanding of the system dynamics. In the graphics, each circle represents a driver in the system. The circles are arranged spatially to show where the drivers are in one of three spaces: 1) donor (left); 2) country (right); and 3) interaction (middle) (i.e., between donors and funding recipients). The spatial arrangement of these drivers and their connections is designed to help the reader understand and explore where the drivers originate, and how they interact, for the ultimate purpose of identifying solutions. The lines between circles suggest a causal relationship in the direction of the arrow. The thicker arrows highlight important connections in the system, including feedback loops (i.e., cyclical clusters of drivers that reinforce each other, amplifying their effect and perpetuating a set of system behaviors).

While the six syndromes are depicted separately below, they are interconnected. Thus, while many syndromes touch on overlapping themes, they are explored from different angles. Overall, the syndromes should not be interpreted to reflect the behaviors of particular donors or countries, nor as manifesting in all contexts or donor initiatives. Rather, they represent the synthesis of experiences and perceptions that surfaced through the methods described above.

**Syndrome one: Insufficient input, feedback, and leadership from groups most affected by gender bias and discrimination render programs less effective (see Figure 2)**

There are limited opportunities for community-level groups or civil society organizations with gender expertise to co-create, lead, or give feedback about DAH programming. Health programs and decisions tend to be made by national-level policy makers and technocrats, or international implementers, who often lack sufficient information about gender and health inequities. Short timeframes and insufficient resources limit opportunities for co-creation or consultation with civil society or health system stakeholders with gender expertise. Furthermore, donor funding processes and national health programs lack robust citizen engagement and mechanisms to incorporate the perspectives and leadership of local groups. In particular, women and other socially marginalized groups lack awareness of and access to platforms to voice their concerns, share pertinent information, and assume leadership roles for health system decision-making. Local civil society groups that have compiled research findings, developed local solutions, or even demonstrated achievements in reducing gender inequities in their communities may be partially or fully excluded from health program planning. Without their input and participation, health programs are designed and implemented without a full understanding of local gender and health inequities and their drivers.

**Figure 2. Syndrome 1: Insufficient input, feedback, and leadership from groups most affected by gender bias and discrimination render programs less effective.**
Syndrome two: Decision-maker privilege creates blind spots and inhibits capacity to address gender and health inequities (see Figure 3)

Decision-makers at high levels (whether donors, national policymakers, or technocrats) may not sufficiently prioritize actions to remedy gender disparities. One contributing factor is the influence of biases. DAH decision-makers who plan, fund, implement, and evaluate health programs often come from economic or social privilege, and their unearned privilege and power can contribute to inherent bias and blinders about gender and health inequities. For instance, decision-makers may assume that they have the expertise needed to address gender. Furthermore, a biomedical worldview, which tends to under-emphasize sociological sciences, permeates DAH. Such preconceptions can lead to overly mechanistic or simplistic ways of understanding and addressing gender in programs that fail to dismantle the root causes of inequities. The assumption that high-level health experts can remedy local gender inequities also contributes to the underuse of community gender experts, whose input is needed.

Syndrome three: An imbalance in power dynamics contributes to insufficient allocation of resources for and attention to gender priorities in health programming (see Figure 4)

The imbalance of power in the funder-recipient relationship contributes to the de-emphasis of gender priorities in allocation of resources. Health institutions across the DAH landscape tend to use top-down leadership and operational models. Funding

Figure 3. Syndrome 2: Decision-maker privilege creates blind spots and inhibits capacity to address gender and health inequities.

Figure 4. Syndrome 3: An imbalance in power dynamics contributes to insufficient allocation of resources for and attention to gender priorities in health programming.
Figure 5. Syndrome four: Donor health funding approaches, conditions, and requirements pose limitations to addressing gender inequities effectively (see Figure 5)

Funding structures for DAH can limit the efficacy of approaches to overcoming gender inequities in a number of ways. First, donor funding is structured to advantage large grants or contracts to reduce administrative costs and time and is tied to accountability measures for specific health outcomes. Local groups with gender expertise typically do not have access to information about availability of the funds or are unable to compete for this funding because of stringent accountability requirements. This contributes to a lack of genuine engagement and co-creation with local civil society organizations and stakeholders who have the requisite expertise. Stringent donor monitoring and evaluation mandates that focus on attribution of the funding to specific health outcomes leaves insufficient time and resources to track gender factors that contribute to social determinants of health. Health program reporting is typically structured for and provided directly to the donor. Critical gender inequity program information is seldom reported to decision-makers or used to share learning about gender issues with program participants and affected populations. This along with funding firewalls also limit the ability to adapt to emerging contextual changes. Beyond these factors, there is general insufficient allocation of time and resources to focus on gender outcomes in health programming and enable holistic, integrated approaches to gender in health system strengthening.
Syndrome five: Fragmented programming contributes to a lack of coordinated and systematic attention to the root causes of gender inequities (see Figure 6)

Despite significant efforts to achieve better coordination, fragmentation is an enduring feature of health financing and programming. In general, coordinated frameworks or goals related to gender inequities among and across donor organizations are lacking, which contributes to a deprioritization of gender as a crosscutting issue. Donor-funded health programs tend to have limited resources for coordination across sector stakeholders for crosscutting issues like gender inequity, perhaps because they are more difficult for donors to administer. Large funding tranches available to a few competitors can incentivize organizations or consortium groups to work against each other or withhold information, further impeding collaboration and coordination. Government agencies and teams leading gender integration efforts across health or other sectors seldom have adequate staff or financial resources for such coordination efforts, leading to unsystematic attention to gender inequities. Despite this, DAH programs rarely focus on fixing these crosscutting and coordination challenges.

Syndrome six: Vicious cycles in data bias contribute to insufficient understanding of and attention to gender inequities (see Figure 7)

Donors, national policy makers, and health technocrats may rely on incomplete or overly generalizable data to make decisions, which ultimately perpetuates gender and health inequities.

Figure 6. Syndrome 5: Fragmented programming contributes to a lack of coordinated and systematic attention to the root causes of gender inequities.

Figure 7. Syndrome 6: Vicious cycles in data bias contribute to insufficient understanding of and attention to gender inequities.
inequities. DAH programs and national health systems have common gender data weaknesses. Emphasis on siloed programs in global health that focus on singular health or disease areas hinder capacity and resources to understand and overcome system-wide challenges like gender inequity. In national health information systems, data are rarely collected and disaggregated in ways that provide nuance to reveal gender inequities (and other social inequities) and their contribution to poor health outcomes. Data relevant to explaining gender and health inequities (e.g., son preference, women’s mobility and ability to make decisions about their own bodies) may be overlooked by donors or country technocrats when making decisions about health investments. There is also a preference for and over-reliance on quantitative over qualitative data, which can limit understanding of gender dynamics. Furthermore, health programs lack input and feedback from populations affected by gender and health inequities, or other gender experts, about whom data are important for decision-making. These factors contribute to insufficient recognition of the role of gender inequities in poor health outcomes, and thus, to the perpetuation of gender and health inequities.

**Discussion**

Using a systems approach and co-creation with a diverse group of stakeholders, we explored and identified six syndromes impeding progress in addressing gender and health inequities within DAH, with a particular focus on the donor space.

While the drivers in the six syndrome maps do not reflect how challenges manifest in all cases, the findings are widely reflected in the global health literature. For instance, studies confirm that gender and power asymmetries affect the staffing, conceptual and operational models, decisions, and information flow in global health institutions, impeding progress in effectively addressing gender and health inequity. Evidence also indicates that many leaders of global health organizations represent groups with societal, historical, and educational privilege that typically lack insight into the realities of gender and other forms of discrimination in low- and middle-income countries. Another factor is the insufficient tracking of data about gender inequity, which contributes to gender being overlooked in health programs. Rigid funding requirements and structures, including short budget cycles and timeframes, funding thresholds that are too high or too low, and stringent audit or reporting requirements, also limit efforts to tackle gender and health inequities. These restrictions, coupled with a competitive funding environment, may also contribute to poor coordination, hinder gender mainstreaming efforts, and even contribute to harmful fractures in networks and social movements working to collectively overcome gender and health inequities.

Despite numerous calls for localization of aid and co-creation processes, local civil society groups and women’s organizations typically have limited leadership roles in health programs.

Overall, there is a fundamental ideological tension in DAH between its explicit and implicit objectives. Our findings depict how, despite an explicit goal to improve health and health equity in low- and middle-income countries, at a systems level, DAH appears to be implicitly structured to maintain power over and distance from people most affected by gender inequities—the very people it aims to serve. For instance, as reflected in syndromes one, three, four, and five, DAH funding limits engagement and leadership of those most affected by gender inequities and reinforces power imbalances that favor donors. The findings confirm that the drive toward progress on gender equity in DAH is a political project more than a technical one, requiring shifts in power and relationship dynamics at micro and macro levels.

The six syndromes presented in this paper offer insight into the key systemic barriers to an improved DAH model, as reflected by the critical shifts. The future model of DAH must be fundamentally reoriented to function with, for, and led by groups affected by gender inequities. Below are promising practices for disrupting the syndromes and advancing gender-transformative programs in DAH. These are presented as preliminary areas for consideration, rather than prescriptions.

Co-creation of solutions that transform the system will require further coordinated analysis, dialogue, and action.

Reflect on institutional biases and move toward approaches that shift or share decision-making power

There are growing calls for global health institutions to face their own biases, shift mindsets of privilege, and adopt practices that correct power imbalances. Such processes are not amenable to checklists or prescriptive approaches, but require both safe spaces to talk about personal biases, cultural beliefs, and practices, and endorsement of the work by leadership. An integrated approach to increasing participation and engagement of underrepresented groups is essential to achieving diversity and inclusion within an organization, though other efforts are needed to complement

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1”Gender transformative” refers to policies and programs that seek to transform gender relations to promote equality and achieve program objectives by: 1) fostering critical examination of inequalities and gender norms, roles, and dynamics; 2) recognizing and strengthening norms that support equality and an enabling environment; 3) promoting the relative position of women, girls, and marginalized groups; and 4) transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities.
mechanism or community advisory committees provided during implementation and evaluation, a country coordination. These dialogues emphasized involvement of most-at-risk populations, in the program design phase at country level. These dialogues established mechanisms to optimize input and transparency for confidential and anonymous feedback. Some donors have implemented community advisory committees in their grant-making processes, which offer a formal platform for transparency about a funder’s plans at the country level and for members of affected populations and civil society organizations that represent them to provide input about the proposed interventions.

There is also a need to restructure the donor-recipient relationship. Shifting power dynamics between donors and grantees requires recognizing their complementary skills, expertise, and interdependence in achieving common objectives. Mechanisms for candid reflection and shared learning, trust-building, and mutual accountability are important components of this. One such approach is a mechanism for confidential and anonymous feedback. Some donors have implemented community advisory committees in their grant-making processes, which offer a formal platform for transparency about a funder’s plans at the country level and for members of affected populations and civil society organizations that represent them to provide input about the proposed interventions.

Beyond engagement, some donors are embracing participatory grant-making models that aim to shift or share decision-making power about funding. These range from building in more representation of affected groups as advisors and funding decision-making bodies to ceding decision-making power about funding strategies and criteria to the communities and groups that funders aim to serve.

Create leadership and funding opportunities for groups most affected by gender and health inequities. The leadership of grassroots civil society groups focused on gender issues in program design phases can improve the contextualization of issues that may be missed in standard gender assessments, and ensure that projects are relevant, responsive to the needs of participants, and sustainable. Donors are called on to create opportunities for consultation and leadership of these groups, enabling them to exert influence on health programming.

Where they do not exist, donors can support civil society engagement mechanisms as a foundational step. Such mechanisms can reveal issues of unintended harm or opportunities for program modifications that improve effectiveness. For example, the Global Fund to Fight HIV, TB, and Malaria established dialogues to optimize input and transparency at country level. These dialogues emphasized involvement from a wide range of civil society stakeholders, including most-at-risk populations, in the program design phase. During implementation and evaluation, a country coordination mechanism or community advisory committees provided opportunities for dialogue and feedback from local stakeholders.

Increase and restructure funding to gender and health equity advocates and stakeholder groups, including local women's organizations. Donor funding that enables collective efforts by country-based or regional health and gender coalitions has been shown to facilitate successful efforts to address gender inequities and achievement of outcomes. Donors are called on to increase accessibility of funds to local groups working to achieve health and gender equality. Mechanisms for increasing accessibility include offering different funding tranche sizes to accommodate needs and capacities of local groups; structuring funding so that it can be accessed by gender advocacy networks, coalitions, and cross-sector working groups; structuring funds in a way that supports core funding; being responsive to the needs of grantees and adaptable to a changing political context; and building in adequate timelines and resources. When unable to provide grant funding directly, donors should consider re-granting and other flexible mechanisms that allow funds to be allocated from larger institutions to smaller groups.

Furthermore, donors can structure funding for planning and exit strategies in ways that build sustainability for gender-focused civil society groups to engage with government health counterparts through specific planning, catalytic, bridge, or exit grants. Beyond greater support for local civil society actors, donors should fund crosscutting governmental institutions tasked with integrating gender.

Implement coordinated approaches to reduce fragmentation of gender efforts. Some donors have begun restructuring funding to overcome the challenge of fragmentation in gender and health efforts. For example, the government of Ireland has established standard resources for ensuring cross-sectoral linkages across partners and government sectors on gender issues. The government of Switzerland’s approach includes basket funding for gender-related activities. Other donors have opted to create pooled funding mechanisms via multi-donor collaborations that incorporate incentives for harmonized efforts in addressing gender.

Donors are also being called on to finance and convene platforms for demand-driven multi-stakeholder co-learning including groups most affected by gender and health inequities. Some donors have added resources for groups typically excluded from DAH, such as grassroots civil society organizations and activists. Other donors are providing funding that enables multi-institution efforts to address gender and health inequities, such as supporting networking and coordination across diverse social movement actors.
Generate and improve access to complete, reliable, and useful information for addressing gender and health inequities

Donors can support improved gender and health equity outcomes by enabling equitable analysis of and access to gender-specific data and information. The World Health Organization has partnered with national governments to strengthen capacity to analyze which constituents are missing from health service data and why.\(^\text{46-49}\) Such tools can help donors and health policy makers set priorities by identifying the largest health inequities within a country. However, more in-depth measures and tools are required to explain why inequalities exist. Better measures are needed to examine who has what (access to resources); who does what (division of labor and everyday practices); how values are defined (social norms); who decides (rules and decision-making); and who benefits.\(^\text{40}\) Donors are called to support research to design gender-specific measures that can be used to assess structural elements of gender (such as gender norms, policies, and institutional practices), beyond individual aspects of gender discrimination.\(^\text{41}\) Stronger collection and analysis of data on structural and systemic gender factors will facilitate a deeper understanding of how interventions work and how to evaluate system-wide efficacy.\(^\text{42,43}\)

Beyond incorporating more explanatory gender measures, donors are called to improve their mechanisms for gathering and using data to make decisions. Donor funding that supports civil society advocacy groups to access and translate health information for policy makers has been shown to support improved health services.\(^\text{44}\) Models with more inclusive methods of data collection and open data sharing and sustained human capacity are showing promise in supporting a more equitable data landscape.\(^\text{46,44}\)

Limitations

The findings presented in this paper were informed by a co-creation process to develop a shared understanding of system drivers of gender inequity in DAH. The results are therefore shaped by the perspectives and insights drawn from the lived experiences of the initiative participants and are not exhaustive or representative of all contexts. For instance, we were not able to engage a wide cross-section of representatives across geographic areas or linguistic backgrounds, or representatives of community groups most affected by gender inequities in low-income countries. While we believe that the broad findings would not be significantly different, engaging more and varied representatives in similar co-creation exercises may yield more detailed and nuanced findings.

The scenarios depicted in the syndrome maps should not be interpreted as an absolute or holistic view of how gender inequity manifests, nor do they reflect the nuances of individual donor modalities or country or community contexts. Rather, the specific drivers and dynamics portrayed in the syndromes are examples of underlying factors of gender inequities in a highly dynamic and complex system.

Areas for additional exploration

This initiative explored systems dynamics affecting gender inequities in health, with a particular focus on the donor space. The six syndromes represent an overview of the drivers; each syndrome would benefit from further analysis. In the dynamic complexity of DAH and global health, a fuller conceptualization and analysis of gender and power, drawing on insights from community members, civil society organizations, implementing partners, and staff and custodians of national health systems is needed. More research on dynamics in the coordination and collaboration spaces between civil society and health system actors that drive gender inequality is needed. An analysis of institutional culture and leadership would be useful to find opportunities for more equitable and inclusive structures for grant-making and health service delivery. Modalities to understand and address gender inequities manifested in national health systems will be vital for improving gender and health equity. Further studies of efforts to improve accountability to achieve more equitable and inclusive DAH strategies are also needed.

Based on these findings, teams responsible for DAH strategies and funding can begin to overcome the barriers to gender equity by asking how their individual and institutional ideologies, practices, and structures can be shifted to advance fairer, more inclusive, and gender-transformative programs and systems (see Figure 8). The answers to these questions can inform more effective health investments.

Conclusions

Our findings present a novel perspective on systemic challenges in DAH that perpetuate or contribute to gender inequities, with a particular focus on the role of donors. The findings emphasize that many of the barriers to gender equity in DAH are embedded in unequal power dynamics that distance and disempower those most affected by gender inequity in the very programs intended to help them. Overcoming these dynamics will require more than technical solutions. To advance progress in gender equity in global health, and specifically DAH, leaders (including donors, ministry representatives, health technocrats, and those implementing health programs) must apply tools and processes that center groups affected by gender inequity in leadership and decision-making at micro and macro levels. This should include building practices and structures that enable co-creation and mutual accountability in the design, implementation, and evaluation of health programs.

An important feature of this effort was convening a diverse set of stakeholders to examine a common problem. The shared dialogue provided nuanced insights on why progress addressing gender inequity has been slower than hoped, despite attempts to do so in health programs. Such platforms for cross-stakeholder dialogue are, in themselves, promising for future gender equity endeavors.
1. How can we shift toward more equitable development partnerships, and apply the principle of *nothing about us without us*[^1] to decision-making in health programming?
   - How can we center the people most affected by gender inequities in our health program strategies and investments, honoring and building from their wisdom, expertise, and leadership? (syndromes 1, 2, and 3)
   - How can we improve our programming processes in ways that provide enough time and funds for relationships and trust to flourish? (syndromes 3, 4, 5)
   - How can we explore ceding or sharing power about funding and funding priorities (e.g., initiating participatory grant-making practices), with groups affected by gender inequity? (syndromes 3 and 4)
   - How can we build accountability for gender commitments in our practices, including greater transparency about where funding comes from, where it goes, and how decisions are made? How can we create safe spaces for candid feedback and input on health program plans from people most affected by gender inequity? (syndromes 2 and 3)
   - How can we restructure our funding mechanisms to enable flexible and long-term funding for a wider variety of local gender equity advocates and stakeholder groups? How can we restructure support for coordination and collective action among local coalitions and networks? (syndromes 4 and 5)

2. How can we authentically engage groups affected by gender equity as co-learners, and co-generate and co-analyze data for making decisions in the local context?
   - How can we support platforms to facilitate a shared understanding of the problems and solutions among funders, recipients, and the communities most affected by gender inequity? (syndromes 1 and 3)
   - How can we expand our analytical methods, frameworks, and tools to understand the diverse experiences of people affected by gender inequity; how power and privilege play out in those experiences; and how health and wellness can be advanced? (syndrome 6)
   - How can we build stronger listening and learning skills, embrace diverse perspectives, and actively reflect on our individual power and privilege and how that affects decisions? (syndrome 2)

3. As leaders and influencers, how can we advance systemic change in how DAH is conceptualized and operationalized to be more fair and inclusive?
   - How can we influence the values, ideology, and discourse in DAH in ways that advance fairer, more inclusive, and gender-transformative health programs and systems? (syndromes 2 and 5)
   - How can we welcome alternative views, voices, and identities in the global discourse? How can we include community leaders with an array of lived experience in gender inequity in spaces for reflection and reframing? (syndromes 1, 2, 3, and 5)
   - How can we use our convening power and platforms to create accountability frameworks for achieving the critical shifts to achieve better health and equity outcomes? (all syndromes)


**Figure 8.** Questions to prompt donor reflection on development assistance for health strategies.
Data availability

Underlying data


This project contains the following underlying data:

• Draft Syndrome maps_compiled.pdf. (System maps of original syndromes using Miro virtual whiteboard tool to synthesize findings from first phase of data collection, i.e., co-creation workshops. Combined into one PDF page.).

• Draft Syndrome Maps_individual.pdf. (System maps of original syndromes using Miro virtual whiteboard tool to synthesize findings from first phase of data collection. Each syndrome listed in a separate map.).

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