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Pathways to gender-transformative women's health aid: Comparative evidence from five donors

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Abstract

Motivation: Gender equality and women's health remain priorities, yet recent fiscal retrenchment and shifting geopolitical agendas have narrowed the space for gender-transformative programming. Despite growing donor endorsement of gender-transformative approaches, substantial gaps persist between rhetorical commitment and operational practice, particularly in women's health ODA. This raises a critical policy question: under constrained resources, which forms of gender-focused health aid are most likely to generate meaningful and durable outcomes?

Purpose: This study examines how gender-transformative approaches are operationalized within women's health ODA and asks two questions: how do women's health ODA projects integrate gender-transformative principles in practice, and what combinations of institutional, programmatic and participatory features are associated with improved women's health outcomes?

Approach and Methods: The study analyses 100 completed women's health ODA projects funded by five bilateral donors (Australia, Germany, Sweden, the United Kingdom, and the United States). Projects were coded across five dimensions of gender-transformative practice: gender analysis, donor support, alignment with health needs, comprehensive health orientation, and community participation. A crisp-set qualitative comparative analysis was applied to identify recurring pathways through which different combinations of these elements are associated with positive outcomes.

Findings: Successful projects combine three core elements: gender analysis, donor institutional support, and alignment with health needs, while comprehensive health approaches and community participation function as critical enhancers. Distinct pathways emerge across donors, reflecting different institutional logics; some emphasize system-level health integration, while others rely on intensive community engagement.

Policy Implications: For donors, the challenge is not whether gender-transformative principles matter but how they are combined in practice. Embedding gender analysis into institutional incentives, aligning projects with national health priorities, and strategically investing in systemic reform or participatory mechanisms can improve impact

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under fiscal and political constraints. Gender-transformative health ODA is most effective when treated as a structural design choice rather than an add-on.

KEYWORDS
community participation, gender-transformative approach, global health aid, official development assistance, qualitative comparative analysis, women's health

1 | INTRODUCTION

Global commitments to gender equality and sustainable development have encountered significant setbacks in recent years. Across major donor countries, official development assistance (ODA) budgets have contracted, gender-focused policy frameworks have been scaled back or dismantled, and aid priorities have increasingly shifted toward geopolitical competition, security concerns, and humanitarian crises (OECD, 2024). These changes have significantly narrowed the fiscal and political space for gender-equality programming. In several donor systems, including the United Kingdom and Sweden, the United States gender units have been restructured or deprioritized, and explicit commitments to gender equality within foreign policy agendas have weakened. As a result, development actors face mounting pressure to demonstrate which forms of gender-focused aid deliver meaningful and durable outcomes under increasingly constrained conditions.

These shifts coincide with a broader reversal in women's health outcomes globally. Restrictions on reproductive autonomy, unequal access to essential health services, and the gendered socioeconomic consequences of recent crises, including the COVID-19 pandemic, have deepened pre-existing structural inequalities (Dempere & Grassa, 2023; Starrs et al., 2018). Although gender equality remains a formal pillar of the Sustainable Development Goals (SDGs), progress has stalled or reversed in many contexts. In this environment, the central policy question is no longer whether gender should be prioritized in development cooperation, but how limited resources can be allocated in ways that genuinely address the structural determinants of women's well-being.

In this article, structural determinants refer to institutional, economic, and social arrangements that systematically shape women's exposure to health risks and their ability to obtain timely and dignified care, such as financing and coverage, gendered divisions of labour and mobility, and informal norms that govern decision-making. In women's health, these determinants matter because they condition whether gains in service availability translate into equitable utilization and sustained health outcomes. While the present analysis centres on structural and institutional determinants of gender inequality, sex-related biological factors also shape patterns of health, illness and treatment outcomes. Framed this way, gender-transformative programming is not primarily an "add-on" to service delivery, but rather a design approach that targets these underlying structures and power relations.

Because women's health inequalities are produced through structural determinants and power relations, gender-transformative approaches have emerged as a response to long-standing critiques of gender mainstreaming. Although gender-responsive programming has contributed to improvements in access and service coverage, it has often failed to confront the underlying power relations, institutional arrangements, and social norms that reproduce gender inequality (Kabeer, 2016; Klasen, 2019; Unterhalter, 2019). Gender-transformative approaches seek to address these deeper constraints by reshaping norms, redistributing power, and embedding gender equality within institutional and governance structures (Dworkin et al., 2015; Pederson et al., 2014). However, despite widespread rhetorical endorsement, donors vary considerably in how such principles are translated into concrete programme design, implementation, and accountability mechanisms. This persistent gap between policy commitment and operational practice raises critical questions about the conditions under which gender-transformative ambitions are realized in practice.

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Women's health ODA provides a particularly revealing lens through which to examine these dynamics. Gendered health inequalities are shaped not only by biological factors, but by social norms, household decision-making, labour roles, access to financial resources, and institutional practices that influence exposure to risk and access to care (Kwon et al., 2005; Legato, 2004). Although these determinants are well recognized in global health scholarship, empirical evidence remains limited on how women's health aid projects operationalize gender-transformative principles and the identification of combinations of design features that enable sustained improvements. Existing studies tend to focus on individual components such as gender analysis, community participation, or service delivery without examining how institutional, structural, and participatory elements interact to shape outcomes across different donor systems and contexts (Doyal, 2002; Im & Meleis, 2001; Taukobong et al., 2016).

This gap is particularly consequential in the current aid environment. Fiscal retrenchment and political pressures risk reinforcing project designs that prioritize short-term and measurable outcomes over structural transformation, thereby limiting the potential of health ODA to contribute to durable improvements in women's health and agency. Under such conditions, rather than identifying a single "best practice," the marking out of multiple effective pathways to gender-transformative outcomes becomes a central concern for donors and policy-makers.

This study addresses this challenge by examining how gender-transformative approaches are operationalized within women's health ODA and which combinations of enabling elements are associated with positive outcomes. Drawing on a crisp-set qualitative comparative analysis (QCA) of 100 women's health projects implemented by five major bilateral donors (Australia, Germany, Sweden, the United Kingdom and the United States), the analysis focuses on how institutional, programmatic, and participatory features interact in practice. The study goes beyond binary assessments of whether projects are gender transformative to identify distinct pathways through which transformative outcomes are achieved under different donor logics and contextual conditions.

Specifically, the study asks two questions: (i) how do women's health ODA projects integrate gender-transformative principles in their design and implementation?; and (ii) which combinations of institutional, structural, and participatory features are associated with improved women's health outcomes? By identifying recurring pathways across donor systems, the analysis enables comparison not only of whether projects adopt gender-transformative language but of how different donor strategies translate into distinct forms of impact. Importantly, these comparisons speak directly to policy-relevant trade-offs facing donors under conditions of fiscal constraints and increased accountability. The study provides an evidence-informed basis for donor agencies to make more strategic design choices, shifting attention from generic commitments to gender equality towards the institutional and programmatic features that consistently underpin gender-transformative outcomes in women's health aid.

The remainder of the article is organized as follows. Section 2 situates the study within the literature on gender-transformative approaches and women's health ODA, with particular attention to how donor institutions have operationalized gender commitments in practice. Section 3 outlines the data, case selection, and comparative methodology used in the analysis. Section 4 presents the empirical findings, highlighting recurrent pathways across donor systems. Finally, Section 5 discusses the implications of these findings for development cooperation policy and practice and reflects on their relevance for future research on gender-transformative aid.

2 | LITERATURE REVIEW

2.1 | Gender equality in development cooperation: From commitments to operational pathways

Gender equality has long been embedded in the normative architecture of development cooperation, reflected in global frameworks such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Beijing Platform for Action, and the SDGs. Over time, these frameworks have shaped donor

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policies, strategies, and funding commitments. However, a substantial body of research demonstrates that the translation of these commitments into operational practice remains uneven between donor agencies and project cycles (Cornwall & Rivas, 2015; Eyben, 2013). Gender mainstreaming has often improved visibility and procedural compliance, but has struggled to alter the institutional incentives, accountability structures, and power relations through which development priorities are implemented in practice (Cornwall & Rivas, 2015; Eyben, 2013).

In response to these limitations, gender-transformative approaches have emerged as a framework explicitly oriented toward structural and relational change. Rather than focusing solely on women's access to services or resources, gender-transformative approaches seek to reshape unequal power relations, challenge harmful gender norms, and embed gender equality within institutional and social systems (Dworkin et al., 2015; Pederson et al., 2014). For development cooperation, this shift implies a move away from treating gender as an ancillary project component toward addressing how aid is designed, governed and implemented across institutional levels, requiring donors to move beyond project-level interventions toward strategies that address institutional design, governance arrangements, and community-level dynamics simultaneously (Östlin et al., 2006; Ruane-McAteer et al., 2020).

Despite growing rhetorical endorsement, the operationalization of gender-transformative principles remains uneven and often partial. Donor agencies continue to face structural constraints, including short funding cycles, siloed sectoral planning, limited staff capacity, and performance frameworks that prioritize measurable outputs over long-term norm change (Cornwall & Rivas, 2015; March et al., 1999). As a result, gender-transformative language is frequently incorporated into policy documents and project proposals without corresponding shifts in budget allocations, implementation mechanisms, or monitoring systems. This persistent gap between normative commitment and operational practice raises critical policy-relevant questions about which institutional and programmatic features enable gender-transformative ambitions to be translated into tangible outcomes under real-world constraints.

2.2 | Women's health ODA and structural determinants of inequality

Women's health provides a particularly salient domain for examining these challenges. Health outcomes are shaped not only by biological factors, but by gendered norms, household decision-making, economic dependence, exposure to violence, and institutional biases within health systems (Doyal, 2002; Kwon et al., 2005; Legato, 2004). These factors interact with broader structural determinants such as poverty, health system capacity, financing arrangements, and national policy frameworks, thereby producing persistent and intersecting inequalities in access, quality of care, and health outcomes (Langer et al., 2015).

Although donor-funded women's health programmes increasingly acknowledge gender as a determinant of health, empirical evidence suggests that gender considerations are often treated in instrumental and fragmented ways (Im & Meleis, 2001; Moser & Moser, 2005; Taukobong et al., 2016). Many projects incorporate gender through sex-disaggregated indicators, targeted service delivery or short-term training activities, without embedding gender analysis into core decisions about programme design or addressing the social norms, power relations, or institutional constraints that shape women's ability to benefit from care (Cornwall & Rivas, 2015; Seims, 2011; Taukobong et al., 2016). As a result, improvements in service coverage do not consistently translate into durable or equitable health gains.

These limitations are particularly evident in disease-focused or narrowly biomedical interventions, which can achieve short-term outcomes aligned with donor reporting requirements, but fail to address the structural and relational drivers of inequality. Scholars argue that women's health outcomes are more likely to improve when interventions combine service delivery with efforts to strengthen health systems, address social determinants, and engage communities in norm change and accountability processes (Dworkin et al., 2015; Hafner & Shiffman, 2013; Östlin et al., 2006). However, there remains limited comparative and project-level evidence on

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how such multidimensional approaches are operationalized across donor portfolios or which combinations of design features are most conducive to sustained gender-transformative impact.

2.3 | Enabling pathways for women's health ODA

Existing research identifies three broad categories of factors that shape the effectiveness of women's health ODA: donor institutional commitment, comprehensive or integrated programme design, and community participation. Donor commitment influences how gender priorities are embedded across the project cycle, including resource allocation, partnership arrangements, and monitoring frameworks (Birdsall et al., 2010; White, 2011). Integrated approaches linking gender analysis with health system strengthening and cross-sectoral collaboration are associated with more durable outcomes, while participatory strategies are widely understood to enhance local ownership, accountability, and opportunities for norm change (Buffardi, 2018; Langer et al., 2015; Mansuri & Rao, 2004; Östlin et al., 2006; Rifkin, 1987).

However, development policy debates rarely address how these elements interact in practice. Most studies examine institutional commitment, programme integration, or participation as discrete factors, offering limited insight into why projects with similar objectives and resources often generate divergent outcomes across donor systems and contexts (Gill et al., 2007; Reynolds et al., 2006). This limitation is increasingly consequential in a policy environment characterized by fiscal entrenchment, heightened demands for measurable results, and growing scrutiny over aid effectiveness.

From a donor policy perspective, the central challenge is therefore not whether these enabling factors matter, but how they combine, and identifying the elements that render particular pathways feasible or politically sustainable. Understanding these pathways is critical for informing strategic decisions about where to allocate limited resources, what design features to prioritize, and how to navigate trade-offs between short-term deliverables and longer-term gender-transformative objectives in women's health ODA.

3 | METHODS

3.1 | Data and case selection

This study examines how gender-transformative principles are operationalized in women's health ODA projects and which combinations of enabling conditions are associated with improved outcomes. The analysis draws on a purposive sample of 100 complete women's health projects implemented by five major bilateral donors: Australia, Germany, Sweden, the United Kingdom, and the United States. Projects were identified using the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD DAC) Creditor Reporting System (CRS) and the Gender Equality Policy Marker (GEPM), which classifies aid activities according to the extent to which they target gender equality (OECD, 2025).

Donors were selected based on two criteria: consistently high aggregate GEPM scores in the health sector and the availability of complete project documentation throughout the project cycle. Although other donors such as Canada, France and the Netherlands also performed strongly on the GEPM, they were excluded due to limited public access to full project documentation, which would have constrained systematic comparison. Projects were included if they (i) were completed before 2020; (ii) identified women's health as a primary or substantial objective; and (iii) provided sufficient documentation throughout the project cycle to assess gender considerations in design, implementation, and outcomes. Documentation was assessed following the European Commission's Project Cycle Management (PCM) framework, ensuring that gender considerations could be traced from planning to evaluation. Projects lacking documentation were excluded.

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The final sample comprised 10 Australian, 20 German, 10 Swedish, 30 UK and 30 US projects. All documents were accessed through official donor portals, including Australian Aid, the German Agency for International Cooperation (also known as Deutsche Gesellschaft für Internationale Zusammenarbeit, GIZ), the Swedish International Development Cooperation Agency (Sida), the Department for International Development (now the UK Foreign, Commonwealth & Development Office), and the United States Agency for International Development (USAID). At the time of data collection, full project cycle documentation for USAID-funded projects was publicly accessible. The analysis of US projects is therefore based on official documentation available during the data collection period. Each project constituted a unit of analysis, enabling cross-case comparison across donor systems. Given the increasing fiscal and political constraints facing donors, the study is designed not to examine isolated project components but rather how combinations of institutional, programmatic and participatory features shape gender-transformative outcomes across donor systems.

3.2 | Coding and measurement of gender-transformative elements

The project documents were coded using a qualitative coding framework designed to capture how gender-transformative principles were operationalized in women's health ODA. The coding process was informed by grounded theory principles, allowing analytic categories to be refined inductively through iterative engagement with project documentation (Charmaz, 2006; Glaser & Strauss, 1967). Through this inductive review, five prominent domains were identified as recurrent features shaping gender-transformative practice in women's health programming: gender analysis, donor institutional support, alignment with contextualized health needs, comprehensive health orientation, and community participation. These domains are consistent with established frameworks in gender and global health, including the WHO Gender Assessment Tool and the Gender Roles Framework (March et al., 1999), but were adapted to capture gender considerations across all stages of the project cycle, from design and budgeting to implementation, monitoring, and evaluation.

Coding was guided by a gender-transformative assessment checklist developed by the authors (see Supplementary Table S1). Instead of coding the presence of gender language alone, the projects were assessed based on whether the documentation demonstrated concrete mechanisms to address structural gender barriers, such as explicit identification of gendered constraints, integration of gender objectives into institutional arrangements, or participatory mechanisms that enabled women's agency and accountability. Gender was coded as present only where such mechanisms were embedded in project design and operational practice, rather than referenced solely in narrative or aspirational terms. Although the primary focus of the coding framework is on structural and institutional gender-transformative mechanisms, projects that explicitly addressed sex-disaggregated data, biological risk differentials, or reproductive health vulnerabilities were captured insofar as they were integrated into system alignment, outcome reporting, or programme-design features.

To ensure comparability across heterogeneous interventions, including health system strengthening, maternal and child health programmes, community mobilization initiatives, and infrastructure-oriented projects, the study applied functional equivalence criteria, focusing on the role each project component played in addressing gendered determinants of health rather than sector-specific activities. Coding drew on observable practices documented in project documents, monitoring reports, mid-term reviews and completion evaluations, with analytic memos used to document coding decisions and emerging patterns (Amsteus, 2014).

The authors conducted an initial pilot coding of 15 projects to refine coding categories and decision rules. Following this calibration phase, the remaining 85 projects were coded independently, with periodic cross-checks and consensus-based resolution of discrepancies for better consistency and reliability. Triangulation was used across multiple project cycle documents wherever possible to assess whether gender-transformative intentions articulated during planning were reflected in implementation and outcomes.

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3.3 | Qualitative comparative analysis

To examine how combinations of project design features are associated with improved women's health outcomes, this study uses crisp-set QCA. It is a case-oriented comparative method designed to capture complexity, with outcomes shaped by multiple interacting conditions (George & Bennett, 2005; Ragin, 2013). This approach is particularly well suited to the analysis of development interventions, where institutional arrangements, programmatic choices, and participatory strategies often operate jointly.

Each project was treated as a case and key conditions were calibrated dichotomously to indicate the 1 (presence) or 0 (absence) of specific gender-transformative features. Calibrated cases were compiled into a truth table representing all empirically observed configurations of conditions. Boolean minimization techniques were then applied to identify combinations of conditions associated with positive outcomes, allowing for the identification of multiple pathways rather than a single optimal model.

The decision to employ crisp-set rather than fuzzy-set QCA reflects the nature of the available data. Donor project documentation typically reports gender integration in categorical terms such as the inclusion or absence of gender analysis, participatory mechanisms, or institutional commitments rather than along continuous scales. Binary calibration was therefore analytically appropriate and consistent with the level of precision in the source materials. For instance, gender analysis was coded as present only when project documents explicitly identified gendered barriers, articulated mechanisms to address them, and integrated gender considerations across multiple stages of the project cycle. Where gender was referenced only descriptively or without operational mechanisms, the condition was coded as absent.

Cases displaying identical configurations of conditions but divergent outcomes were examined by means of within-case comparison to assess whether inconsistencies reflected contextual constraints, implementation gaps, or limitations in documentation. Where ambiguity remained, conservative coding rules were applied to avoid overstating claims of necessity or sufficiency. This strategy prioritizes analytical robustness and aligns with QCA best practice in policy-oriented comparative research.

4 | KEY FINDINGS

4.1 | Classification of gender-transformative integration in women's health ODA

The first research question examines the extent to which women's health ODA projects integrate gender-transformative principles in practice. Figure 1 summarizes the three-stage coding process applied to the 100 projects: (i) application of the gender transformation assessment checklist; (ii) classification into project types (gender-transformative, gender-neutral, and gender-blind); and (iii) cross-coder validation to ensure consistency across heterogeneous cases. Across the full sample, 30 projects were classified as gender-transformative, 26 as gender-neutral, and 44 as gender-blind. Projects classified as gender-transformative consistently displayed three observable features. First, they incorporated explicit gender analysis at the design stage, identifying gendered barriers to health and articulating mechanisms through which project activities would address these constraints. Second, they were supported by identifiable donor-level institutional arrangements, such as dedicated gender focal points, gender budgeting practices, or the integration of gender objectives into performance and monitoring frameworks. Third, they included structured forms of community engagement that addressed gendered power relations—for example through partnerships with women's organizations, leadership development among women and girls, or facilitated dialogue on gender norms.

By contrast, gender-neutral or gender-blind projects were predominantly service delivery oriented. These projects focused on clinical services, infrastructure development, training, or disease-specific interventions. Although women were identified as a target population, gender was typically treated as a beneficiary category

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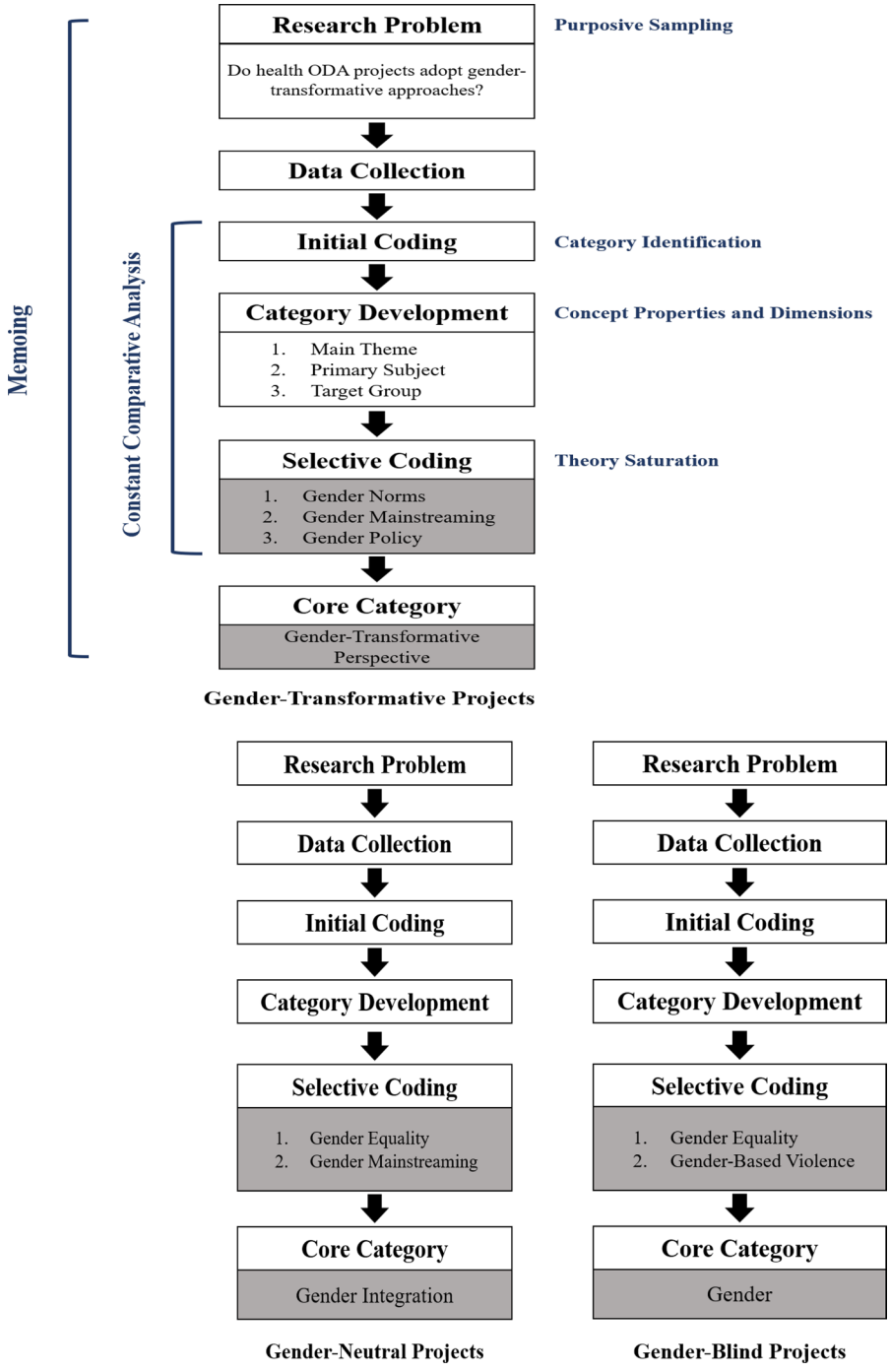


FIGURE 1 Data coding process by project type.

rather than as an analytical lens shaping project logic. Several projects classified as gender-neutral included sex-disaggregated indicators or narrative references to gender equality but lacked operational mechanisms such as gender-responsive budgeting, institutional accountability for gender objectives, or explicit strategies for

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addressing harmful gender norms. This pattern highlights a clear distinction between rhetorical recognition of gender and its operational integration within project design and implementation.

Patterns of gender-transformative integration also varied across implementation contexts. Projects implemented in settings with pre-existing gender-equality policies and active civil society engagement were more frequently able to translate gender-transformative design elements into practice. In more restrictive governance environments, including fragile or conflict-affected contexts, similar design features were associated with more limited forms of implementation. In such settings, gender analysis tended to be applied conservatively and community engagement mechanisms were narrower in scope, even where transformative language was present in project documentation. These patterns suggest that observed forms of gender-transformative integration are shaped not only by project design but also by broader institutional and sociopolitical elements.

4.2 | Pathways to improved women's health outcomes

The second research question examines how different pathways of programme design and institutional support are associated with improved women's health outcomes in gender-transformative ODA projects. To capture the interaction of multiple enabling factors, a crisp-set QCA was used to identify recurring patterns across projects. Five elements were examined: (i) comprehensive health orientation (C); (ii) gender analysis (G); (iii) donor institutional support (D); (iv) alignment with health needs (H); and (v) community participation (P). Table 1 summarizes the calibrated case patterns, and Table 2 presents the comparative results by donor.

Across donors and contexts, three recurrent pathways were observed (Figure 2). The first pathway, characterized by the combination of gender analysis, donor institutional support, and alignment with health priorities (G*D*H), appeared most frequently in Australian and Swedish projects. In these cases, gender-transformative efforts were grounded in explicit diagnostic analysis of gendered barriers and supported by donor-level commitments, such as gender-sensitive monitoring frameworks or alignment with national health strategies. This pathway provided a foundational basis for improving women's health outcomes, particularly in terms of service access and utilization. However, in the absence of broader system integration or sustained participatory mechanisms, these projects often struggled to address deeply embedded gender norms. As a result, observed improvements tended to be measurable but modest, with limited effects on intra-household decision-making or longer-term power relations.

The second pathway emerged when the core elements of G*D*H were combined with a comprehensive health orientation. This pathway was most evident in German projects and in a subset of Australian initiatives. Here, gender-transformative objectives were embedded within wider health system reforms, including primary healthcare strengthening, multisectoral coordination, and policy or planning processes. Integrating gender into systemic health structures improved the institutionalization and scalability of project impacts. In several German cases, embedding gender considerations within national health governance mechanisms generated spillover effects beyond the immediate project scope, suggesting that system-level integration can amplify and sustain gender-transformative gains over time.

The third pathway was defined by the addition of community participation to the other two pathways and was most strongly associated with projects funded by the United Kingdom and the United States. In these cases, participatory mechanisms played a critical role in translating gender-transformative principles into locally meaningful practices. Projects actively engaged women's groups, community health workers, and male advocates through dialogue forums, participatory planning, and community monitoring. These strategies strengthened accountability and facilitated shifts in social norms. In several UK-supported maternal health programmes, community-driven feedback mechanisms enabled the identification of gender-specific barriers that were subsequently addressed through adaptive programming. Projects that combined community participation with broader system reforms demonstrated the strongest improvements in maternal and reproductive health outcomes.

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TABLE 1 Truth table of gender-transformative health ODA projects.

Code	Comprehensive Health (C)	Gender Analysis (G)	Donor Support (D)	Health Needs (H)	Community Participation (P)	Women's Health Improvement	Gender-Transformative Factors Checklist
Australia 1	1	1	1	1	0	1	1
Australia 3	0	1	1	1	1	1	1
Australia 4	0	1	1	1	1	1	1
Australia 5	1	1	1	1	1	1	1
Australia 8	1	1	1	1	1	1	1
Germany 2	1	1	1	1	1	1	1
Germany 4	1	1	1	1	0	1	1
Germany 11	1	1	1	1	1	1	1
Germany 16	1	1	1	1	1	1	1
Sweden 1	1	1	1	1	1	1	1
Sweden 3	1	1	1	1	0	1	1
Sweden 4	1	1	1	1	0	1	1
Sweden 5	0	1	1	1	1	1	1
UK 2	1	1	1	1	1	1	1
UK 4	1	1	1	1	1	1	1
UK 5	1	1	1	1	1	1	1
UK 11	1	1	1	1	1	1	1
UK 20	1	1	1	1	1	1	1
UK 24	1	1	1	1	1	1	1
USA 3	0	1	1	1	1	1	1
USA 5	1	1	1	1	1	1	1
USA 8	1	1	1	1	1	1	1
USA 13	1	1	1	1	1	1	1
USA 18	1	1	1	1	1	1	1

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TABLE 1 (Continued)

Code	Comprehensive Health (C)	Gender Analysis (G)	Donor Support (D)	Health Needs (H)	Community Participation (P)	Women's Health Improvement	Gender-Transformative Factors Checklist
USA 19	1	1	1	1	1	1	1
USA 22	0	1	1	1	1	1	1
USA 23	0	1	1	1	1	1	1
USA 26	1	1	1	1	1	1	1
USA 28	1	1	1	1	1	1	1
USA 30	0	1	1	1	1	1	1

Note: 0 denotes that a specific component is absent, while 1 denotes that a specific component is present. Grey-shaded cells represent factors that commonly appeared across multiple projects conducted by each donor agency. These factors reflect consistent themes within agencies and are considered important for gender-transformative health ODA projects.

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TABLE 2 Crisp-set QCA operations results based on Boolean algebra.

Country	Results Based on Boolean Algebra[a]	Critical Components
Australia	C*G*D*H*p + c*G*D*H*P + C*G*D*H*P	Gender Analysis (G), Donor Support (D), Health Needs (H)
Germany	C*G*D*H*P + C*G*D*H*p	Comprehensive Health (C), Gender Analysis (G), Donor Support (D), Health Needs (H)
Sweden	C*G*D*H*P + C*G*D*H*p + c*G*D*H*P	Comprehensive Health (C), Gender Analysis (G), Donor Support (D), Health Needs (H)
UK	C*G*D*H*P	Comprehensive Health (C), Gender analysis (G), Donor Support (D), Health Needs (H), Community Participation (P)
US	c*G*D*H*P + C*G*D*H*P	Gender Analysis (G), Donor Support (D), Health Needs (H), Community Participation (P)

Note: Multiplication symbol (*) denotes a logical "AND" while addition symbol (+) denotes a logical "OR."

[a]C: Comprehensive Health; G: Gender Analysis; D: Donor Support; H: Health Needs; P: Community Participation. Uppercase letters indicate that a specific condition is large, present, or high, while lowercase letters indicate that a specific condition is small, absent, or low.

	Comprehensive Health (C)	Gender Analysis (G)	Donor Support (D)	Health Needs (H)	Community Participation (P)
AUSAID		O	O	O	
GIZ	O	O	O	O	
SIDA		O	O	O	
DFID	O	O	O	O	O
USAID		O	O	O	O

FIGURE 2 Gender-transformative health ODA projects matrix.

These pathways indicate that gender analysis, donor support, and alignment with health needs form a common foundation, while comprehensive health approaches and community participation operate as enhancing dimensions that shape the depth, sustainability, and distribution of outcomes. Rather than any single design feature driving success, improved outcomes arise through the interaction of these elements within specific institutional and country contexts.

4.3 | Comparative patterns across donors

Comparative analysis across the five donors highlights distinct institutional emphases in how these pathways are operationalized (Figure 2). All donors exhibited the foundational G*D*H elements, but they differed in the extent to which projects incorporated comprehensive health approaches or participatory strategies. Germany and the United Kingdom showed a strong tendency to embed gender-transformative objectives within broader health system reforms, linking project-level interventions to sector strategies and governance processes. By contrast, projects funded by the United States were particularly notable for their intensive use of community participation, working closely with civil society organizations and local actors to support norm change and accountability. Sweden maintained a consistent focus on gender analysis and alignment with health priorities, although participatory and system-level components were less systematically integrated. Australia displayed a mixed profile, with some projects reflecting only the foundational pathway and others incorporating additional enhancing elements.

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These donor-specific patterns suggest that the observed pathways are complementary rather than mutually exclusive. Approaches centred on system integration tend to enhance institutional continuity and policy coherence, while participation-oriented strategies strengthen local ownership and behavioural change. Importantly, documentation practices varied across donors. UK and US projects generally provided more detailed accounts of participatory processes, which may partially explain the greater visibility of participation-oriented pathways in these portfolios. Conversely, more concise reporting styles limited the empirical traceability of community-level dynamics in some donor systems.

Projects that combined both system-level integration and community participation, particularly within the UK portfolio, achieved the most sustained and wide-ranging improvements in women's health outcomes. At the same time, national context mediated these effects. Participatory strategies were most effective where civil society capacity and inclusive governance structures were present, while system-oriented approaches performed better in settings with stable institutions and functioning health systems.

5 | DISCUSSION

This study examined 100 women's health ODA projects to assess whether and with what elements gender-transformative approaches are associated with improved health outcomes. The findings point to a consistent and policy-relevant pattern: incorporating gender considerations alone is insufficient unless they are embedded within a broader constellation of institutional, structural, and participatory arrangements. This observation reinforces long-standing critiques in gender and development research that gender mainstreaming often remains symbolic, treated as an administrative requirement rather than as a guiding framework shaping programme logic, implementation strategies, and system-level reform (Cornwall & Rivas, 2015). Projects that referenced gender without operational mechanisms rarely demonstrated meaningful progress, even when they performed well in terms of service delivery, highlighting the persistent gap between rhetorical commitment and transformative practice.

Rather than identifying a single driver of success, the analysis shows that improved women's health outcomes tend to emerge through distinct but recurring pathways, built around a shared set of foundational elements. Across donors, projects that performed well consistently combined gender analysis, donor-level institutional support, and alignment with national or local health priorities. These elements form a core foundation for gender-transformative programming, indicating that transformative potential is rooted in institutional architecture, such as incentives, accountability structures, and policy alignment, rather than in stand-alone gender activities. This insight challenges prevailing development practices that treat gender as an add-on or secondary objective, and instead underscores the importance of embedding gender priorities within core systems of planning and governance.

At the same time, the findings show that these core elements are necessary but not sufficient. Projects that achieved deeper and more durable change typically incorporated additional dimensions, notably comprehensive health system engagement and meaningful community participation. Comprehensive approaches linked gender objectives to broader health system reforms, enabling interventions to move beyond isolated project activities and generate spillover effects at the policy or system level. Participatory approaches strengthened local ownership, accountability, and norm change by engaging women's groups, community actors and, in some cases men and boys. Together, these enhancing dimensions amplified the impact of the core foundation through complementary institutional and social mechanisms, illustrating that transformative change requires influence across multiple levels (Figure 3).

The study also reveals an important variation across donor systems. While all five donors supported projects reflecting the core foundation, the dominant pathways differed according to organizational cultures, strategic priorities, and operating modalities. Germany's portfolio emphasized system-level integration, reflecting a long-standing focus on health system strengthening and multisectoral coordination. UK and US projects, by contrast, were more strongly associated with participatory pathways, drawing on principles incorporated into locally meaningful practices.

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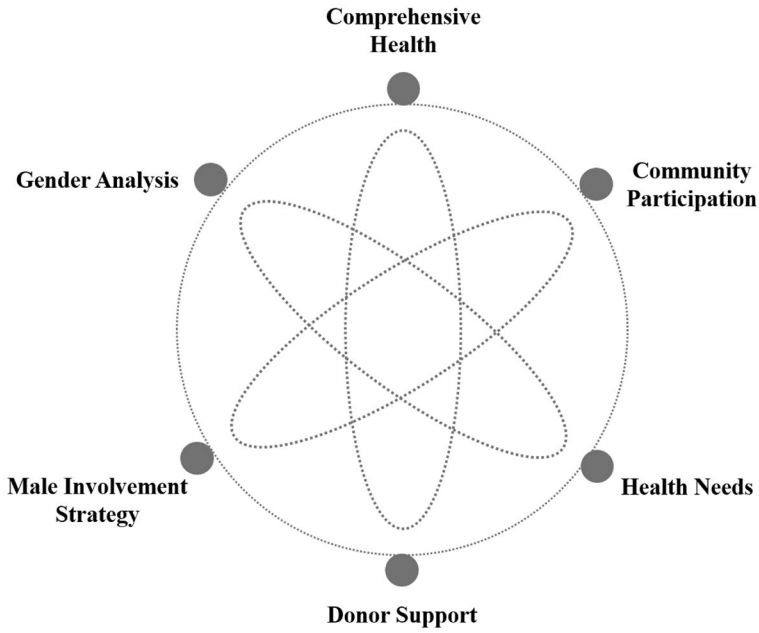


FIGURE 3 Index of gender-transformative health ODA.

These differences highlight that gender-transformative outcomes do not depend on a single best-practice model but rather emerge through multiple pathways shaped by donor institutional logics and country contexts.

A further observation emerging from the analysis concerns the uneven institutionalization of gender-transformative principles. While gender-transformative language and programme-design features are increasingly visible in international aid portfolios, comparable commitments appear less consistently incorporated within domestic health and social policy frameworks in several donor countries.

This asymmetry raises broader questions about the political economy of gender-transformative reform. Development cooperation operates within an international policy arena in which donors can articulate ambitious gender commitments as part of global leadership and agenda setting. Domestic policy reform, by contrast, is shaped by entrenched institutional arrangements, fiscal constraints, and politically contested debates over redistribution and social norms. As a result, the incorporation of gender-transformative principles in aid programmes does not necessarily translate into equivalent structural transformation within donor states themselves.

Although this study does not directly evaluate domestic policy alignment, the contrast suggests that gender-transformative aid may function as a distinct policy domain, where normative ambition can advance more rapidly than in domestic reform. This tension calls for further comparative research on the coherence between external commitments and internal policy trajectories.

Crucially, the effectiveness of any pathway was context dependent. Identical combinations of project features produced different outcomes depending on governance capacity, civic space, and prevailing gender norms. Participatory strategies were more effective where civil society was active and gender-inclusive institutions were present, while system-oriented approaches were more successful in relatively stable policy environments. This finding cautions against universal templates for gender-transformative programming and underscores the need for adaptive designs that respond to institutional and sociocultural contexts.

These insights carry particular significance in the current political economy of development cooperation. Reductions in gender-equality funding, the rollback of feminist policy commitments, and increasing pressure to demonstrate short-term results have narrowed the space for transformative approaches. In this context, the findings suggest that gender-transformative programming is not merely a normative aspiration, but a strategic

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investment in the effectiveness and resilience of health systems. Embedding gender within core institutional and participatory structures can help safeguard equity goals even under conditions of fiscal and political constraint.

The findings offer several implications for donor agencies and practitioners. First, gender analysis should function as an operational requirement integrated into project approval, budgeting, and evaluation processes rather than as a symbolic add-on. Second, linking gender objectives to health system governance, financing, and planning enhances durability and scalability of gender-transformative outcomes. Third, participatory mechanisms are critical for translating institutional commitments into locally grounded change. Finally, donors should adopt adaptive approaches that recognize variation in institutional capacity and social norms, designing interventions around feasible pathways rather than assuming uniform models of success.

This study focused on five bilateral donors and relied on publicly available documentation, which necessarily restricted the scope of analysis. Future research could extend this pathway-oriented approach to additional donors and multilateral actors, and explore how internal incentives, risk management practices, and political pressure shape the operationalization of gender-transformative principles. As more detailed data become available, further work could also examine degrees of condition presence and implementation depth.

In sum, the findings demonstrate that gender-transformative health ODA succeeds not through isolated gender components, but through the convergence of institutional commitment, system alignment, and participatory engagement, operating through multiple and context-sensitive pathways. Advancing women's health therefore requires moving beyond symbolic mainstreaming towards structurally embedded and locally grounded approaches that reshape both health systems and the power relations that sustain gender inequality.

6 | CONCLUSION

This study examined how gender-transformative principles are translated into practice within women's health ODA and which combinations of enabling elements are associated with improved outcomes. Drawing on a comparative analysis of 100 projects across five bilateral donors, the findings demonstrate that gender-transformative impact is not achieved through the presence of gender components alone. Instead, it emerges when gender priorities are embedded within institutional commitments, aligned with health system needs and supported by mechanisms that enable participation and accountability.

Across diverse donor systems and country contexts, projects that performed well shared a common foundation: gender analysis integrated into project logic, donor-level institutional support, and alignment with national or local health priorities. These elements provided the minimum conditions for moving beyond symbolic gender mainstreaming. At the same time, projects that combined this foundation with broader health system engagement or meaningful community participation were better positioned to address the social and structural determinants of women's health. The existence of multiple effective pathways highlights that gender-transformative programming is not a linear or one-size-fits-all process, but a context-sensitive endeavour shaped by institutional capacities and sociopolitical environments.

For development cooperation, these findings suggest a shift in emphasis from expanding gender-related activities to strengthening the institutional and participatory elements under which such activities operate. Embedding gender analysis within core planning, financing, and governance processes, and investing in locally grounded engagement mechanisms, can help safeguard equality objectives even under conditions of fiscal and political constraints. At a time when gender-equality agendas face growing pressure within international aid systems, pathway-based approaches offer a pragmatic framework for sustaining gender-transformative ambitions in women's health ODA.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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