Mainstreaming as rhetoric or reality? Gender and global health at the World Bank [version 1; referees: 1 approved with reservations]

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Abstract

Background: Over the past decade gender mainstreaming has gained visibility at global health organisations. The World Bank, one of the largest funders of global health activities, released two World Development Reports showcasing its gender policies, and recently announced a $1 billion initiative for women's entrepreneurship. However, the development of the Bank's gender policies and its financing for gender programmes have never been systematically analysed by external researchers in the context of global health. We use the Bank as a case study of how global health organisations frame their gender policies and measure their success.

Methods: We constructed a timeline of the Bank's governance of gender, through a review of published articles, grey literature, and Bank documents and reports. Additionally, we performed the first health-focused analysis of two publicly available Bank gender project databases, and tracked the Bank's financing of gender projects in the health sector from 1985-2017.

Results: The Bank's gender policy developed through four major phases from 1972-2017: 'women in development' (WID), institutionalisation of WID, gender mainstreaming, and gender equality through 'smart economics'. In the more inclusive of the two Bank project databases, gender projects comprised between 1.3% (1985-1989) and 6.2% (2010-2016) of all Bank commitments, which is significantly less than the Bank's claim that 98% of its lending is gender informed. Most funding targeted middle-income countries and particular themes, including communicable diseases and health systems. Major gender-related trust funds were absent from both databases.

Conclusion: The Bank focused most of its health sector gender projects on women's and girls' issues. It is increasingly embracing private sector financing of its gender activities, which may impact its poverty alleviation agenda. Measuring the success of gender mainstreaming in global health will require the Bank and global health organisations to reconsider their use of gender indicators.

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Introduction

Over the last decade, particularly since the launch of the sustainable development goals (SDGs) in 2015, gender has become increasingly visible within the global health community. The Bill and Melinda Gates Foundation selected gender as a ‘grand challenge’ for the first time in 2014 and pledged $80 million to close gender data gaps in 2016. This announcement was followed by a call to action from the ‘Women in Global Health’ initiative, which in turn was instrumental in lobbying World Health Organization (WHO) Director General Tedros Adhanom Ghebreyesus to appoint 60% women to the WHO’s leadership team for the first time in its – and in fact in any UN institution’s – history (reports here and here).

Yet, such widespread attention has not come without controversy. The Ebola and Zika epidemics, in particular, brought issues of ‘gender blindness’ to the forefront, as women’s voices were often underrepresented in planning and response activities, in spite of the fact that they were disproportionately affected by the outbreaks. Researchers and policymakers have questioned how major international development organisations define and frame gender. A dominant critique is that gender is often seen through the lens of women’s and girls’ empowerment, particularly through education (i.e. Millennium Development Goal 3). This may exclude men and members of the LGBTI community who have the highest burden of disease in some health contexts. Others have argued that the gender equality rhetoric does not match reality, as evidenced by few women in leadership and decision-making positions at global health organisations.

Finally, scholars worry that the rising involvement of the private sector in health (e.g. through global public-private partnerships) could link corporate profit with gender equality.

Such private investments in gender programming have come into vogue since the late 2000s, the newest of which is the World Bank’s Women in Entrepreneurs Finance Initiative (We-Fi). In 2017, G20 leaders pledged approximately $1 billion into this trust fund (a financing vehicle for voluntary contributions, of which the Bank serves as trustee), which will be implemented jointly by the traditional World Bank (the International Bank for Reconstruction and Development and International Development Association) and its private financing arm, the International Finance Corporation (IFC). The World Bank is arguably the most influential institution in global health, both ideologically and financially. Although its historical links to neoliberalism and women’s empowerment, the Bank publicly advocated for gender equity and mainstreaming through ‘smart economics’ (2005–2017). In the health sector, we then perform the first ever health sector analysis of two publicly available Bank gender databases.

However, does the rhetoric of the Bank’s work in gender match the reality of its operations and lending portfolio? The World Bank’s gender policies and corresponding financing flows in the health sector have never been systematically examined by external researchers. The Bank’s widespread influence in health makes it an ideal case study of how the gender policies of global health organisations match the reality of their programming and operations. Using Bank reports and secondary literature, we first explore the Bank’s conceptualisation of and policies for gender over time. In doing so, we identify four phases of the Bank’s gender approach (Figure 1): the launch of ‘women in development’ (WID) (1972–1984), the institutionalisation of WID at the Bank (1985–1994), gender mainstreaming (1995–2004), and gender equality through ‘smart economics’ (2005–2017). In order to compare this policy with Bank financing for gender in the health sector, we then perform the first ever health sector analysis of two publicly available Bank gender databases.

Methods

This paper relies on two major data sources. First, we used published articles and grey literature reports to construct a timeline of the governance of gender at the World Bank. Second, we extracted financial data from publicly available gender project databases, and analysed this data for the health sector.

PubMed and Scopus online databases were systematically searched for relevant published articles using the key words ‘World Bank’ and ‘gender’. We selected articles that presented information on the Bank’s gender policy and were published in English in a peer-reviewed journal. A total of 307 search results were reviewed for relevance, and 20 were included in this analysis. Additional peer-reviewed publications were identified through the reference lists of these 20 articles. Finally, we identified and analysed key publications on gender by the World Bank, its Operations Evaluation Department, and its Independent Evaluation Group.

Data on World Bank financing of projects with a gender component are available publicly through the Bank’s ‘Projects & Operations’ (PO) and ‘Development Topics’ (DT) databases. Both databases include projects with gender focuses from 1985–2017 and allow projects to be searched by sector and theme, but they do not include identical projects. In order to understand the Bank’s reported funding for gender projects in the health sector, we therefore exported project data from both databases (as of July 1, 2017). Figure 2 provides a summary of the inclusion/exclusion criteria and analysis framework.

For each database, projects with a health sector classification were selected for further analysis, and the absolute Bank commitments to gender projects in the health sector were calculated. Although some projects took place over multiple years, the Bank releases funding data by the project’s approval date (PO database) or starting year (DT database), and all commitments were assigned to this year. We then disaggregated all health
Figure 1. Timeline of gender policy development at the World Bank. The World Bank introduced gender policy for development in the 1970s through a ‘women in development’ approach, increasingly institutionalized and mainstreamed its policy in the 1980s–1990s, and began a ‘smart economics’ to gender equality approach in the mid-1990s.

### Results

**Timeline: The governance of gender at the World Bank, 1972–2017**

- **Women in development (WID): 1972 to 1984.** The first phase of gender at the World Bank (1972–1984) was characterised by growing theoretical arguments for women’s importance to development, but little institutional impetus for their implementation. Initially, the Bank’s involvement was limited to an informal working group of Bank staff, formed in 1972, which discussed the concerns of women in the institution. The United Nations (UN) declaration of the International Women’s Year in 1975 prompted the Bank to publish a booklet, *Integrating Women in Development*, which described measures to reach women through Bank projects. Around the same time, it coined the term ‘Women in Development’ (WID), to promote development activities that benefited women.

### Sector project commitments by theme, to determine the relative World Bank funding for health themes each year. To facilitate comparison of health themes, some Bank themes were combined (see Table 1). Finally, we determined the total commitments for gender projects in the health sector for each recipient country and geographical region from 1990–2017.

The Institute for Health Metrics and Evaluation (IHME)’s development assistance for health data does not include a gender marker, so comparative data on OECD donors’ development assistance in the health sector was obtained from the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee’s Creditor Reporting System (DAC-CRS) database. First, gender projects funded by all OECD donors were targeted using the ‘gender equality and women’s empowerment’ policy marker, which tracks projects with gender objectives from 2002–2015. Second, these gender projects were sorted by target geographical region, health sector category, and year. We report all OECD CRS funding in constant 2015 USD commitments, and include projects with gender as a ‘principal’ or ‘significant’ objective (see OECD gender equality policy marker handbook). For comparative analyses, OECD health sector themes were combined: ‘communicable diseases’ includes infectious disease control, malaria control, and tuberculosis control themes, while ‘health systems’ includes basic health care, basic health infrastructure, and health personnel themes.
Figure 2: Analysis framework and inclusion criteria for World Bank gender financial databases. All active and completed World Bank gender projects from 1985–2017 were analysed using two World Bank databases, and Bank commitments were tracked for health sector projects.
<table>
<thead>
<tr>
<th>Compiled theme used for analysis</th>
<th>Corresponding World Bank theme(s) given to projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable diseases</td>
<td>HIV/AIDS, Communicable diseases, Malaria, Tuberculosis</td>
</tr>
<tr>
<td>Child health</td>
<td>Child health</td>
</tr>
<tr>
<td>Nutrition &amp; food security</td>
<td>Nutrition &amp; food security</td>
</tr>
<tr>
<td>Gender</td>
<td>Gender</td>
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<tr>
<td>Health system performance</td>
<td>Health system performance</td>
</tr>
<tr>
<td>Population &amp; reproductive health</td>
<td>Population &amp; reproductive health</td>
</tr>
<tr>
<td>Injuries &amp; non-communicable diseases</td>
<td>Injuries &amp; non-communicable diseases</td>
</tr>
<tr>
<td>Environment</td>
<td>Pollution management &amp; environmental health, Environmental policies &amp; institutions, Water resource management, National disaster management</td>
</tr>
<tr>
<td>Education</td>
<td>Education for all</td>
</tr>
<tr>
<td>Social development</td>
<td>Other social protection &amp; risk management, Social analysis &amp; monitoring, Social risk mitigation, Social protection, Other social development, Social safety nets, Social inclusion</td>
</tr>
<tr>
<td>Rural services</td>
<td>Rural services &amp; infrastructure, Rural markets, Other rural development, Rural policies &amp; institutions</td>
</tr>
<tr>
<td>Participation &amp; civic engagement</td>
<td>Participation &amp; civic engagement</td>
</tr>
<tr>
<td>Conflict preparation &amp; reconstruction</td>
<td>Conflict prevention &amp; post-conflict reconstruction</td>
</tr>
<tr>
<td>Private sector development</td>
<td>Micro, small &amp; medium enterprise support, Infrastructure services for private sector development, Other private sector development</td>
</tr>
<tr>
<td>Public sector development</td>
<td>Municipal governance &amp; institution building, Other economic management, Improving labour markets, State-owned enterprise restructuring &amp; privatization, Macroeconomic management, Law reform, Tax policy &amp; administration, Decentralization, Administrative &amp; civil service reform, Regional integration, Other public service governance, Public expenditure, financial management &amp; procurement</td>
</tr>
<tr>
<td>Poverty &amp; urban development</td>
<td>Other human development, Vulnerability &amp; assessment monitoring, Urban services &amp; housing for the poor, Poverty strategy, analysis &amp; monitoring, Other urban development</td>
</tr>
<tr>
<td>Indigenous peoples</td>
<td>Indigenous peoples</td>
</tr>
</tbody>
</table>
As a result of this appointment, from 1979–1985, the Bank published its first major gender publication\textsuperscript{35,36} completed thirty-five case studies of gender issues in Bank projects, and held five gender-related workshops for staff\textsuperscript{37}. While these activities provided legitimacy for gender issues at the Bank, they were of limited scope and met with scepticism by many Bank staff. For instance, Bank Presidents Robert McNamara and Alden Clausen focused primarily on reproduction and population control in their speeches\textsuperscript{36,37}, and the Bank’s first gender-related directive (1984) – which called on staff to consider women in the project cycle – only applied to projects in which women were considered important beneficiaries or recipients\textsuperscript{38}. In this phase, women’s issues received sporadic attention in the Bank’s lending decisions\textsuperscript{39}, and the WID advisor’s budget never exceeded $90,000\textsuperscript{31,30}.

**Institutionalising WID in the Bank: 1985 to 1994.** During the second phase (1985–1994), theories of human capital were integrated into the Bank’s gender framework and gender was broadly institutionalised. A series of changes to gender policies occurred in fast succession; a senior Bank economist was appointed the new WID advisor in 1985\textsuperscript{29}, a WID unit was established in 1987\textsuperscript{20}, and Bank President Barber Conable designated gender as one of four formal areas of special interest the same year. This top-down support of the WID framework gave earlier gender directives ‘teeth’, as managers were required to show that they addressed women’s issues in their portfolios. The WID budget grew to $2.5 million in 1992, and with it the WID team expanded both at Bank headquarters and through regional coordinators\textsuperscript{31}.

The Bank’s interest in the economic gains of investing in women led to a series of gender studies in the late 1980s and early 1990s\textsuperscript{40}, culminating in its first official policy paper on gender\textsuperscript{32} and new ‘Gender and Development’ approach\textsuperscript{4}. This approach argued that women should be analysed in relation to men, rather than independently. It underscored the human capital argument for investing in women: financing empowerment activities could increase productivity, promote efficient use of resources, lead to social returns (like family planning and child survival), and reduce poverty\textsuperscript{12,33}. A new policy (OP 4.20) reinforced the Bank’s commitment to consider gender during the project cycle, through its Country Assessment Strategies. In line with its evolving conceptualisation of gender, the Bank renamed the WID division the ‘Gender Analysis and Policy Team’ in 1994\textsuperscript{43}.

**Gender mainstreaming: 1995 to 2004.** In the third phase (1995–2004), the Bank focused on mainstreaming gender in its lending operations and increasingly embraced the concept of gender equality. Gender mainstreaming became visible at the Bank in 1995 when Bank President James Wolfensohn gave a speech at the Fourth World Conference on Women in Beijing\textsuperscript{38}. Subsequently, a campaign called ‘Women’s Eyes on the World Bank’ called for increased participation of women in the Bank’s policies and programmes\textsuperscript{44}. In response to this push for more inclusive gender policies, the Bank created an External Gender Consultative Group, which included representatives of civil society, non-governmental, academic, and political organisations\textsuperscript{35}. It also established a Gender and Development Board within the Bank’s Poverty Reduction and Economic Management Network in 1997, to monitor and report on the status of policy implementation\textsuperscript{39}. Finally, the Bank developed tools to measure gender’s role in development, including sex-disaggregated statistics, gender impact assessments, and gender monitoring procedures\textsuperscript{36–38}.

Gender mainstreaming was justified by its role in economic growth, poverty reduction, development effectiveness, and promoting gender equality\textsuperscript{49}. As part of its mainstreaming efforts, the Bank expanded its existing operational policy on gender consideration, which covered social sector programmes, to include all foreign direct investment programmes\textsuperscript{40}. Ultimately, between 1995 and 2001, the proportion of projects that included some consideration of gender issues in their design almost doubled, to nearly 40%\textsuperscript{41}.

**Gender equality as smart economics: 2005 to 2017.** In the most recent phase, the Bank promoted ‘smart economics’ and showcased its approach to gender within the international community. A dominant theme in this phase is the tension between framing gender equality as a human right and an agent for economic growth. The Bank’s 2006 *World Development Report* argued that gender equality is important both in its own right and as an instrument for faster economic growth, particularly in the Global South\textsuperscript{42}. Its subsequent *Gender Equality as Smart Economics* report (2007) dubbed such investment in women and girls for development goals ‘smart economics’, and largely omitted the concept of gender equality as a human right\textsuperscript{43,44}. Finally, in its seminal 2012 *World Development Report*, the Bank reasserted the importance of gender equality as an objective in its own right, while also promoting smart economics\textsuperscript{45}.

At the same time that these reports placed the Bank’s framework for gender on the international stage, President Jim Yong Kim and Bank leaders reinforced the importance of gender within the institution. For instance, gender was declared a ‘cross-cutting solution’ and was used as a ‘special theme’ in the successful 2014–2017 replenishment of the Bank’s concessional lending arm, the International Development Association (IDA)\textsuperscript{45,46}. Over the past decade, the Bank’s mechanisms for achieving these gender equality and development goals have increasingly involved the private sector. For instance, the Bank began to form transnational partnerships for gender equality with private sector organisations in the late 2000s\textsuperscript{47}, and Bank President Robert Zoellick emphasized the importance of ‘investing in women’ at the 2009 Global Private Sector Leaders Forum, which included corporate giants like Nike, ExxonMobil, and Goldman Sachs\textsuperscript{48}. The Bank’s latest gender strategy (2016–2023) includes human rights and aspects of smart economics, but expands conceptions of gender equality to include enhancing women’s voice and agency\textsuperscript{49}.
The World Bank’s lending portfolio

The Projects & Operations (PO) database provided more comprehensive coverage of Bank commitments to gender projects than the Development Topics (DT) database. According to the PO database, the Bank committed $39.3 billion to gender-related projects from 1985–2017, which ranged from 1.25% to 6.16% of total IBRD and IDA commitments. The DT database recorded $3.3 billion in gender-related projects during the same years, or between 0.02% and 0.4% of the Bank’s commitments from 1985–2017 (Table 2).

In both databases, the health sector represented a high percentage of the Bank’s total commitments to gender projects (Figure 3). The percentage of the health sector within all gender projects peaked at 56.8% in 2005–2009 for the PO dataset, and at 96.0% in 1995–1999 for the DT dataset. However, while many gender projects were in the health sector, they consistently formed only a small part of the Bank’s total funding for Health, Nutrition, and Population (HNP) projects (Figure 4). The PO database’s commitments to gender projects in the health sector formed a maximum of 23.0% of the Bank’s commitments to HNP projects (in 1995–2009), and only approximately 11% of HNP commitments since 2005 (Table 2).

For gender projects in the health sector, particular health themes were emphasized over others (Figure 5 and Figure 6). Definitions of the major health themes are given in Table 3. In the PO database, communicable disease and health system performance themes received the highest commitments. Funding for gender projects with communicable disease themes peaked in 2000–2004 and have since declined, while funding for health system performance remained relatively steady from 1990–2015 and peaked in 2010–2014. Population and reproductive health and child health projects with gender components received relatively less funding from 1990–2015, and only one project targeted injuries and non-communicable diseases during this period. The DT database similarly included only one project for injuries and non-communicable diseases from 1985–2017. However, the relative importance of population and reproductive health, child health, communicable diseases, and health system performance was different in the DT than the PO database (Figure 6). The DT database lacked many health projects included in the PO database, and particularly omitted communicable disease projects.

Bank commitments to gender projects were given inconsistently to countries and geographic regions over time (Figure 7). For instance, in the PO dataset, low-income countries in Sub-Saharan Africa received funding for gender projects in the health sector most years from 1990–2017. However, this funding was typically in small commitments to many different countries. In contrast, the large commitments for health sector projects were given to five countries: Brazil, India, Argentina, Pakistan, and India. These five lower and upper-middle income countries collectively received nearly half of all Bank commitments to gender projects in the health sector from 1990–2017 (Figure 8). The

<table>
<thead>
<tr>
<th>Theme</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Child health</strong></td>
<td>Activities aimed to improve the health status of children and to reduce child morbidity and mortality.</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>For the purposes of coding, the theme encompasses World Bank Group activities that – irrespective of sector – address and/or close gaps between males and females and other gaps that may be identified at the Country Partnership Framework at the country level.</td>
</tr>
<tr>
<td><strong>Communicable diseases</strong></td>
<td>HIV/AIDS – Programmes that increase access to HIV/AIDS prevention, treatment, care and support services.</td>
</tr>
<tr>
<td></td>
<td>Tuberculosis – Activities aimed at the prevention, diagnosis and/or treatment of tuberculosis.</td>
</tr>
<tr>
<td></td>
<td>Malaria – Activities aimed at the prevention, diagnosis, control and/or treatment of malaria.</td>
</tr>
<tr>
<td><strong>Health system performance</strong></td>
<td>Programmes and policies which aim to bring about improvements in the management, financing and overall functioning of health systems.</td>
</tr>
<tr>
<td><strong>Injuries &amp; non-communicable diseases</strong></td>
<td>Activities aimed to reduce morbidity and premature mortality from cardiovascular disease, hypertension, cerebrovascular disease, peripheral vascular disease, cancer, chronic obstructive pulmonary disease, asthma, diabetes, mental illness (including depression, post-traumatic stress disorder, suicide, psychosis, alcohol and drug abuse), and other non-infectious, chronic conditions such as arthritis and osteoporosis. This theme also includes preventable injuries (excluding road/traffic accidents).</td>
</tr>
<tr>
<td><strong>Nutrition &amp; food safety</strong></td>
<td>Programmes that include objectives and specific activities related to improving nutritional status or food security at the household level.</td>
</tr>
<tr>
<td><strong>Population &amp; reproductive health</strong></td>
<td>Activities to improve reproductive health and reduce maternal morbidity and mortality.</td>
</tr>
</tbody>
</table>
Figure 3. World Bank funding for gender projects in all sectors and in the health sectors, by database, from 1985–2017. Both databases show an increase in the World Bank’s commitments to gender projects since 1985, but this increase is volatile and peak gender financing for the health sector is inconsistent. PO = Projects & Operations; DT = Development Topics.

Figure 4. Funding for gender projects in the health sector compared to all health sector (Health, Nutrition, and Population) projects at the World Bank, from 1990–2017. The World Bank’s Health, Nutrition and Population (HNP) portfolio has grown faster than financing for gender projects in the health sector. According to both analysed databases, health sector projects with gender components made-up less than 12% of total HNP commitments from 2010–2016. PO = Projects & Operations; DT = Development Topics.
The World Bank's commitments to gender projects in the health sector included many themes, and the relative financing for communicable diseases, health system performance, population and reproductive health, and child health varied over time. This data was obtained from the more comprehensive Projects & Operations (PO) database.

**Figure 5. Total World Bank funding for gender projects in the health sector for the PO database, by theme.** The World Bank's commitments to gender projects in the health sector included many themes, and the relative financing for communicable diseases, health system performance, population and reproductive health, and child health varied over time. This data was obtained from the more comprehensive Projects & Operations (PO) database. NCD = non-communicable disease.
Figure 6. Total World Bank funding for gender projects in the health sector for the DT database, by theme. The Development Topics (DT) database included similar health sector themes to the more inclusive Projects & Operations (PO) database, and included less projects with a communicable disease theme. NCD = non-communicable disease.
### Table 3. Gender funding at the World Bank relative to total funding for IBRD/IDA projects and Health, Nutrition and Population (HNP) sector projects.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>World Bank (IBRD/IDA) total</td>
<td>92,770</td>
<td>111,979</td>
<td>120,418</td>
<td>100,285</td>
<td>162,580</td>
<td>261,326</td>
</tr>
<tr>
<td>World Bank HNP sector total</td>
<td>1,386</td>
<td>7,142</td>
<td>10,925</td>
<td>15,544</td>
<td>20,074</td>
<td>35,050</td>
</tr>
<tr>
<td>Gender PO database – all projects</td>
<td>1,163</td>
<td>5,710</td>
<td>6,450</td>
<td>6,016</td>
<td>3,891</td>
<td>16,101</td>
</tr>
<tr>
<td>% of IBRD/IDA total</td>
<td>1.3%</td>
<td>5.1%</td>
<td>5.4%</td>
<td>6.0%</td>
<td>2.4%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Gender DT database – all projects</td>
<td>20</td>
<td>500</td>
<td>305</td>
<td>1,015</td>
<td>407</td>
<td>1,037</td>
</tr>
<tr>
<td>% of IBRD/IDA total</td>
<td>0.02%</td>
<td>0.5%</td>
<td>0.3%</td>
<td>1.0%</td>
<td>0.2%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Gender PO database – health sector</td>
<td>0</td>
<td>1,105</td>
<td>2,510</td>
<td>1,849</td>
<td>2,208</td>
<td>3,908</td>
</tr>
<tr>
<td>% of HNP total</td>
<td>0.0%</td>
<td>15.5%</td>
<td>23.0%</td>
<td>11.9%</td>
<td>11.0%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Gender DT database – health sector</td>
<td>0</td>
<td>423</td>
<td>292.7</td>
<td>886</td>
<td>389</td>
<td>579</td>
</tr>
<tr>
<td>% of HNP total</td>
<td>0.0%</td>
<td>5.9%</td>
<td>2.7%</td>
<td>5.7%</td>
<td>1.9%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Health % of all gender projects - PO database</td>
<td>0.0%</td>
<td>19.4%</td>
<td>38.9%</td>
<td>30.7%</td>
<td>56.8%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Health % of all gender projects - DT database</td>
<td>0.0%</td>
<td>84.6%</td>
<td>96.0%</td>
<td>87.3%</td>
<td>95.6%</td>
<td>55.8%</td>
</tr>
</tbody>
</table>

Table legend: IBRD = International Bank for Reconstruction and Development; IDA = International Development Association; HNP = Health Nutrition and Population; PO = Projects & Operations; DT = Development Topics.

**Figure 7.** World Bank commitments to the health sector, by recipient country region, 1990–2017 (PO database). The recipient regions for World Bank-funded gender projects in the health sector showed significant volatility from 1990–2017, with Latin America & the Caribbean and South Asia receiving the highest commitments. This data was obtained from the more comprehensive Projects & Operations (PO) database.
Figure 8. Proportional funding by country for World Bank commitments to gender projects in the health sector, 1990–2017 (PO database). Five countries received over half of all Bank commitments for gender projects in the health sector from 1990–2017. This data was obtained from the more comprehensive Projects & Operations (PO) database.

To contextualize the Bank’s gender commitments within the larger aid landscape, we tracked OECD donor development assistance commitments to the health sector, using the ‘gender equality policy marker’, from 2002–2015. OECD donor contributions to all gender projects increased from $6.5 billion in 2002 to $39.3 billion in 2015. Health sector projects averaged about 10% of all OECD commitments to gender projects from 2002–2015 (Figure 9). Based on our PO database commitments, the World Bank therefore contributed approximately 10% of the total development assistance for gender projects from 2002–2013 (see Figure 3), but the Bank’s relative commitments dropped after 2013. The Bank emphasized gender projects in the health sector more than OECD donors; Bank health sector commitments averaged 37.3% of all gender commitments from 2000–2017 (PO database, Table 2), while those of OECD donors were 11.0% from 2002–2015. Within these health sector commitments, OECD donors prioritized reproductive policies and health projects more than the Bank (Figure 10), while the Bank prioritized health systems and communicable disease gender projects more than OECD donors (Figure 5 and Figure 10). Finally, unlike the Bank, a high proportion (58%) of OECD donor commitments to gender projects in the health sector from 2002–2015 targeted low-income countries in Sub-Saharan Africa (Figure 11).
OECD donor commitments to development assistance projects with 'gender equality policy marker' target, 2002-2015

Figure 9. OECD donor development assistance for gender projects across all sectors and in the health sector, from 2002–2015 (DAC-CRS). Organisation for Economic Co-operation and Development (OECD) donor commitments to development assistance projects with a 'principal' or 'significant' gender equality policy marker have increased relatively less for health sector projects than all projects since 2002. This data was obtained from the Development Assistance Committee Creditor Reporting System (DAC-CRS) database.

OECD donor commitments with a 'gender equality policy marker' target, by health category (2002-2015)

Figure 10. Total OECD donor commitments to gender projects in the health sector from 2002–2015, by health category. *Health systems includes basic health care, basic health infrastructure, and health personnel. Communicable diseases includes infectious disease control, malaria control, and tuberculosis control. Organisation for Economic Co-operation and Development (OECD) donor commitments to development assistance for health projects with a principal or significant gender target emphasized population and reproductive health from 2002–2015.
Figure 11. Development assistance for health from all OECD donors for health sector projects with a ‘gender equality policy marker’ target (2002–2015), by recipient region. Organisation for Economic Co-operation and Development (OECD) donor commitments to development assistance for health projects with a principal or significant gender target predominately financed projects in Sub-Saharan Africa from 2002–2015.

Discussion

Our analysis of World Bank gender datasets reveals a significant divide between its mainstreaming rhetoric and released data on gender projects. The more inclusive PO database’s projects comprise between 1.3% (1985–1989) and 6.2% (2010–2016) of all Bank commitments. This stands at contrast to the Bank’s recent claim that 98% of its total lending is gender informed and to the WID ratings for gender inclusion from 1988–1999, which indicate that 38% of all Bank (and 89% of HNP) projects addressed gender.

The PO database demonstrates that the Bank struggles to apply its framework for gender at the projects level in two major ways. First, although the 2012 World Development Report emphasized including men in gender projects, the Bank and other multilateral health organisations have faced challenges in doing so, as they risk losing their focus on women’s subordination. Only one project in the PO database financed the non-communicable diseases and injuries health theme, and none specifically targeted transgender populations. Yet, the global burden of disease for non-communicable diseases and road injuries is higher for men than women, the top ten contributors to DALYs (including alcohol and tobacco use) have a greater burden on men than women, and transgender populations may experience health inequities. This mirrors a wider problem in global health priority-setting; extremely little emphasis is given to non-communicable diseases, road accidents, and the needs of non-female populations in global public-private partnerships for health (like the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance). Second, our finding that, compared to OECD donors, the Bank invested more in health systems and communicable disease control than reproductive health themes from 1985–2017, reflects a shift in its gender policies. The Bank appears to have moved beyond McNamara and Clausen’s focuses on women’s reproductive roles for development goals. This shift falls in line with its HNP focuses on universal health coverage and disease control.

The Bank’s framing of gender as a women’s issue may be related to women’s prominent role in gender staff structure and trainings. According to the most recent evaluation of the Bank’s gender and development policies, 72% of the staff who attended training programmes from 2003–2009 were female and only 13% were from managerial staff levels. The Bank’s Independent Evaluation Group was unsure of the actual number of full and part time gender-related staff during this period, they estimated that about 0.8% of staff had a formal gender role. These figures indicate that, similar to the environment
in the 1980s, gender trainings are typically optional and there remains minimal top level staff buy-in for gender projects. The Gender and Development Board still sits within the Bank’s Poverty Reduction Economic Management (PREM) network69, which should indicate that the majority of its projects target low income populations. It is therefore interesting that the majority of the projects in the PO database targeted middle income countries, like India, Brazil, and Argentina. This stands in contrast to our findings of general OECD donor commitments to the gender marker in the health sector, which primarily targeted Sub-Saharan Africa.

This finding has implications for gender equality within the Bank’s poverty alleviation agenda, which is increasingly accepting financing from the private sector. The dip in the Bank’s commitments to all gender projects in 2014 may be due to its investment in trust funds (extra-budgetary or ‘multi-bi’ aid). For example, the multimillion dollar Umbrella Fund for Gender Equality (est. 2012) and the new We-Fi facility each have a private window, managed by the IFC80. Similarly, many new innovative financing mechanisms for health at the Bank, like the Global Financing Facility (GFF)89 and the Pandemic Emergency Financing Facility (PEF)90, may have gender components. The PO database does not include trust funds, and none of these large gender trust funds are included in the DT database. This difficulty in tracking gender trust funds is part of a larger issue; researchers have flagged the Bank’s lack of transparency in its use of health sector trust funds and recommended methods to improve data availability85. In all, the new gender trust funds since 2010 could demonstrate the Bank’s move towards financing gender mainstreaming through extra-budgetary and private sources. In a 2017 speech, for instance, President Kim used gender equality as an example of new pathways to bring the private sector into development finance. Associating gender with the private sector and market-based activities could adversely affect the Bank’s gender equality and poverty alleviation goals40,72,74,91.

Ultimately, the discrepancies identified through our financial analyses raise a key question: how much can we rely on the datasets that we have analysed? Are projects missing from these databases, and could the trends that we see in health sector financing simply be inaccurate? The answer is that external researchers have to rely on these databases, because they are the only data publicly released by the Bank on its financing of gender projects. The Bank does not describe its inclusion criteria for each database, and there is no comprehensive list of projects classified as gender informed over time. Even within the PO dataset, there is a ‘gender’ theme and percentage, which is only applied to certain projects, and no explanation is given for how this percentage is calculated.

Issues with Bank transparency and accountability for gender programmes have been raised in the past, although they have focused more on the absence of clear monitoring. For instance, the Bank’s Operations Evaluation Department pointed to a lack of framework for staff accountability and quantitative targets to assess gender projects’ implementation in 200583, while in 2010 the Independent Evaluation Group emphasized the absence of a results framework87. Our data emphasizes another aspect of accountability: a lack of clarity in how projects are classified as gender informed, and how classified projects are then reported in accessible datasets. The criteria for a ‘gender informed’ project is that it takes gender into account in either the analysis, actions, or monitoring and evaluation dimensions of a project and projects are scored on how many dimensions (1, 2, or 3) include a gender consideration. The Bank reports the percentage of gender informed projects using staff estimates and no data is available for 2001–200889. This means that, even for projects listed in the PO database, there is no clear way to determine at which project level gender was considered, and what the outcomes of the project were on women and men. The Bank’s new gender strategy (2016–2023) outlines goals for improved data, staff capacity, results frameworks, and monitoring, which may help to fill these gaps85.

**Conclusion**

Most global health organisations have a defined gender policy84. However, institutionalising this policy and developing clear metrics to measure its outcomes have often lacked priority, particularly in the form of financial resources85. The Bill and Melinda Gates Foundation does not currently have metrics in place to measure gender inequalities or women’s empowerment (although its pledge may fill this gap), the Global Fund has been criticized for poor monitoring indicators44, and the Institute for Health Metrics and Evaluation (IHME)’s development assistance for health database does not currently have a gender marker.

Ultimately, success in global health comes down to metrics. How we define and measure indicators – like gender inclusion at the Bank – determines whether programmes reach their objectives. Indicators for the impact of gender mainstreaming should therefore be revisited: why are they not universally present, what are they capturing when used, and is this what we need to be monitoring to reach gender equality goals? In the case of the World Bank, tackling these questions would require two initial steps. First, we recommend systematic reporting of all projects – including trust funds – with a gender component in the Projects & Operations database. Second, the Bank should revisit its gender informed indicator, so that it only includes projects with gender considerations in all three dimensions (design, implementation, and evaluation), and these ratings should be included in the database. This data will foster future examination of the impact of gender policies and private investments on poverty reduction and health goals. Until such metrics are reconsidered and strengthened at global health
organisations, the success of gender mainstreaming will remain rhetoric rather than reality.

Data availability

Data for this article are available on OSF: http://doi.org/10.17605/OSF.IO/FDHGM

Data are available under the terms of the Creative Commons Zero “No rights reserved” data waiver (CC0 1.0 Public domain dedication).

Competing interests

A senior member of the World Bank is on our project’s advisory board.

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References

Thank you for giving us the opportunity to peer review this interesting and potentially important study.

Janelle Winters and colleagues have conducted an analysis of the World Bank’s gender policies and the Bank’s financing of gender programs. As discussed further below, there have been several previous analyses of the World Bank’s gender projects, but Winters and colleagues’ study applies a specific global health lens, which appears to be novel.

There are two parts to the study, which are somewhat disconnected. The first part is a literature review, reviewing both the peer-reviewed and grey literature, to construct a “timeline” of the evolution of the Bank’s gender focus. The second part is a quantitative financial analysis of the Bank’s spending on gender projects. The timeline resulting from part 1 is shown as a figure (Figure 1) and also described through 4 key phases (women in development [WID]; institutionalization of WID; gender mainstreaming; gender equality through ‘smart economics’). This timeline is very valuable. We think it will provide a helpful “roadmap” for others who wish to conduct research related to the World Bank’s gender portfolio in the future. The results of Part 2 suggest that from 1985-2016, the Bank committed only between 1.2-6.2% of IBRD and IDA commitments to “gender projects.”

Below we comment on the importance, originality, validity, presentation, and interpretation of the research.

Importance of research question

The role of gender in development has gained increasing momentum and has moved higher up the agenda with SDG 6, “achieve gender equality and empower all women and girls.”

Many development and health agencies, including the World Bank, make claims about how they are mainstreaming gender in their work. An external assessment such as this one is an important way to keep the World Bank accountable and provides a foundation to advocate for changes if results deem it necessary.

This study is also very timely indeed given that the Swedish Institute for Global Health Transformation has just launched a new Lancet Commission exploring the links between SDGs 3 (health), 5 (women and girls), and 16 (institutions) (one of us, GY, is a Commissioner). Understanding how a major development
institution approaches gender is helpful for that Commission’s work.

**Originality of the research**

We would like to make two points on originality. First, one of us (GY) used to be a journal editor, at the BMJ and PLOS, and at both publishers we would not let authors claim that there has “never” been a similar study. What we asked authors to say, out of caution, is something like “to the best of our knowledge, there have been no previous studies that examined X and we believe ours is the first.” This terminology allows for the possibility that you may have missed a study (e.g. in a non-English language, in the grey literature, in a consulting report, by the Bank itself, etc.).

Second, there have been several studies of the World Bank’s gender policies in recent years and we think it would be helpful for the authors to more explicitly review and summarize what these found. Perhaps the most high profile was Kenny and O’Donnell’s study “Do the Results Match the Rhetoric? An Examination of World Bank Gender Projects,” published by CGD. That study used a Bank dataset, “Monitoring Gender Mainstreaming in World Bank Lending Operations,” for its analysis (with 1666 projects that date from July 2009 to June 2014). We also note that the Bank itself conducted a study of its gender policy that included health sector projects (Evaluating a Decade of World Bank Gender Policy: 1990–99, World Bank Operations Evaluation Department, 2005).

**Validity of the research**

Overall, the methods seem appropriate and the mix of a more qualitative literature review with a quantitative financial analysis is a strength. However, as mentioned, it would be helpful to better connect these two distinct parts of the study (one easy way to do this, for example, would be to display key measurements/commitments in each phase of World Bank gender policies alongside financial data from the years during that phase). It was excellent, and highly valuable, to see a comparison of the World Bank’s financial data from the PO and DT databases with a broader analysis of development assistance for gender projects using the CRS database. The breakdown of gender funding in the health sector by theme and also by recipient country are also interesting and helpful.

Below, we make a few specific comments about the overall approach and we note some minor inconsistencies or possible errors.

First, it is heartening to see in the introduction a discussion of men and the LGBTI community. As the authors note, in many parts of the world, men’s health outcomes are much worse (e.g. the IHME’s GBD2010 study found that women in the Russian Federation were outliving men by an average of 11.6 years). In a paper that one of us co-authored (reference 9 in Winters et al’s paper), we note that, “In many societies, men generally enjoy more opportunities, privileges and power than women, yet these multiple advantages do not translate into better health outcomes.” This is likely to be due to a combination of factors, including risk-taking behavior, occupational exposure to risk factors, gendered norms of male behavior, etc. While the introduction makes this point, it is not clear whether the authors specifically examined whether the World Bank has any specific policies on or funding for men’s health or LGBTI health. EMRO (WHO Europe) is developing its first men’s health strategy (due to be published in September 2018) and PAHO is also working on this issue, so it would be good to know where the Bank is.

Second, while it is clearly highly appropriate to use the gender policy marker for analyzing projects in the CRS database, it would be helpful to know if there are any data on how well this marker captures gender-specific project financing. Might some projects be missed? Would there be value, for example, in
taking a sample of projects that were not captured by the marker to see if gender was included?

Third, in Figure 2, the numbers from the Development Topics Database don’t seem right—it starts with n = 90, then 8 were dropped, but then the figure still says 90 (after dropping 8, it should say 82). In addition, we think it would be good to mention the date restriction in figure 2 itself and not just in the methods section. Looking at figure 2 right now, readers may think the search was from January 1, 1985 through December 31, 2017 (the figure says 1985-2017, and this would give 92 projects); the methods section states a narrower date range, i.e. to July 1, 2017 (which yields 90 projects).


Presentation

The presentation is generally clear.

Interpretation

The conclusions focus primarily on the shortcomings of the reporting mechanisms and indicators for gender mainstreaming in general. Gender reporting shortcomings were also a key theme in the CGD study on World Bank gender rhetoric. It would be valuable, we think, to discuss the concrete concerns with the gender project evaluation criteria moving forward and the conclusions could align more with the specific research question on gender-focused health programs.

There is one comparison that the authors make that we think may not be a valid one. The authors note “the Bank’s recent claim that 98% of its total lending is gender informed” and then they compare this 98% figure with the proportion of IBRD/IDA financing that is specifically for gender projects. Is this really an apples to apples comparison? Being “gender informed” is not the same as financing a gender project.

Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Not applicable

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Partly

**Competing Interests:** One of us (GY) personally knows one of the authors (DS); he has been at meetings with DS, but they have not collaborated or co-authored work.
We have read this submission. We believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however we have significant reservations, as outlined above.