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Unpacking women's health in public-private partnerships

A return to instrumentalism in development policy and practice?

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Abstract: There has been a significant increase in funding for health programmes in development over the last two decades, partly due to the formation of public-private partnerships. This paper examines the impact of public-private partnerships from the perspective of women's health, and asks whether the current culture of funding has led to an increased instrumentalism in women's health programming, and what effects this has on how women's health is addressed at the level of practice. The paper is based on research carried out with UK-based non-governmental organizations, and its conclusions raise further challenges for improving women's health policies and programmes in development.

Keywords: gender, health, development, private sector, NGOs
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1 Introduction

The past two decades has seen a significant transformation within the global aid architecture with the emergence of new donors and the growing role of the private sector within development assistance. In the health sector there has been a proliferation of global public private partnerships (GPPPs)[1] that bring together actors from the public and private sector and are frequently oriented toward a specific disease or group of diseases. Among the most prominent GPPPs are the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI).

The interaction between the public and private sector is not new in itself, but changing ideology in the international development landscape (or among development actors) has facilitated the growth of public-private partnerships (PPPs), embedding a new type of relationship. PPPs bring together players from both the public and private sectors, including state and global-level organizations, private foundations, and trans-national corporations. There has been extensive study of these partnerships at the global and national levels (Buse et al. 2009), particularly on the governance-related challenges and their unintended health system effects. However, as Kapilashrami and McPake (2013) argue, much less attention has been given to the ideas that underpin these types of partnerships and the practices they generate. At the same time, the majority of the literature has focused on global level PPPs with very little attention given to smaller scale PPPs operating at a national level. Taking this as a point of departure and drawing on research conducted with UK-based NGOs, this paper will argue that insufficient attention has been given to how these partnerships impact on development policy and practice. Specifically, the paper will argue that the majority of the discussion of PPPs in health has been gender blind and fails to consider that not only are PPPs gendered institutions but they also have gendered impacts on development practice in health. Focusing on women's health programming within UK-based NGOs, the paper argues that PPPs have institutionalized and legitimized an instrumental discourse of women's health in development practice. The paper will argue that this is problematic because it serves to curtail the potential overall gains and fails to uphold wider government- and international-level commitments to human rights.

The US-based Inter-agency Gender Working Group (IGWG) 'So What? Report' (Boender et al. 2004) concluded that 'the evidence reviewed suggests that integrating gender into reproductive health programmes appears to have a positive impact on achieving reproductive health outcomes' (Boender et al. 2004: 2). More broadly than reproductive health interventions, the importance of gender equality as a key social determinant of health has been acknowledged (c.f. CSDH 2008; Sen and Östlin 2009) and a number of authors have pointed to the importance of uncovering gender bias within health sector institutions. This means understanding the ways in which health systems themselves are gendered and contain deeply embedded assumptions about women's and men's roles, responsibilities and behaviour (Elson and Evers 1998; Mackintosh and Tibandebage 2006; Gideon, forthcoming 2014). In particular it is essential that women's voices are incorporated into governance and regulation mechanisms to ensure their needs are recognized (Tibandebage and Mackintosh 2010; Prost et al. 2013). This body of work supports the need for a broader understanding of women's health that goes beyond a focus on their reproductive health needs. Women's health can thus be understood as involving their emotional, social, cultural, spiritual and physical wellbeing, and is determined by the social, political, cultural

[1] Global Public-Private Partnerships (GPPPs) in Health are also described as Global Health Initiatives (GHIs), Global Health Partnerships (GHPs) or Public-Private Interactions (PPIs). This paper will refer to them as PPPs, unless quoting a specific study which refers to them by one of the other acronyms.

and economic context of women's lives, as well as by biology. This definition recognizes the validity of women's life experiences, and women's own beliefs about, and experiences of, health (Phillips 1995; Inhorn 2006).

The paper begins with a summary of the funding and policy environment in which an understanding of women's health is reduced to an instrumentalized set of goals and targets. This is then followed by a review of the literature on GPPPs/PPPs and their gendered critiques. The second section of the paper focuses on a study conducted by the authors of the impact of PPPs within UK-based NGOs and considers the implications of this for questions around women's health issues. In particular the analysis highlights how competition for funding and the increased emphasis placed on NGOs as agents of service delivery within PPPs has meant that the framing of women's health issues within NGO policy and programmes has tended to draw on and reflect instrumentalist discourse commonly found at the global level. While PPPs do offer important benefits to NGOs, not least access to greater resources, fundamental constraints remain as to how these programmes are able to support women to claim their rights to health, beyond sexual and reproductive health (SRH). It concludes that the idea of women's health supported by PPPs must embody a far broader understanding of health that is based on rights, linking to notions of citizenship and empowerment, rather than instrumental benefits to the wider economy, if it is to lead to the more transformational gains imagined by the initiatives themselves.

In order to help make the distinction between a purely instrumental approach to women's health, and a broader approach based on transformative gains, the paper draws on the distinction between a gender equity and gender equality approach. Gender equity applies the general concept of equity in provision of health services to men and women, asking for example whether health systems respond equally to men and women in equal need (Standing 1997). Such approaches attempt to address gender inequalities in health status by strengthening services to women and by drawing attention to the need for greater participation of women at all stages of health planning. However, one significant shortfall is that these methods fail to also consider the socially constructed relations between men and women, instead focusing solely on the gaps in women's health (Elson and Evers 1998: 11). Women are seen as a special case of beneficiaries—attention is generally given to the special needs of women as mothers—but the ways in which gender inequalities affect morbidity throughout a woman's life are ignored. Men's needs are not adequately addressed, for example by ignoring their role in reproductive health.

Tibandebage and Mackintosh (2010) highlight the importance of a broader approach when they argue that high maternal death rates provide a gender lens that illuminates the discriminatory gendered structure of health systems and health policy. Drawing on a range of evidence from Tanzania they argue that a number of inter-linking factors contribute to the exclusion of women from health care service which in turn fails to bring about a significant reduction in the MMR. One critical factor is women's lack of income and lack of economic decision-making powers within the household, including around health care issues (Tolhurst et al. 2008). Tibandebage and Mackintosh (2010) caution that despite the widespread use of charging for maternity services in Tanzania there is a lack of understanding of their gendered impacts. Nevertheless, the available evidence clearly shows that many women in rural areas are not able to command high wages yet the total cost of antenatal hospitalization—including informal costs—may be the equivalent of around one-third of their monthly income. The pressure on women to find money to pay these charges can be great and can contribute to intra-household conflict, therefore many women do not to seek formal care and place themselves'—and their babies—at greater risk (Spangler 2012).

A more useful means of understanding women's health is thus offered by a gender equality approach which is centrally concerned with power relations and considers that health may also

be a site of gender conflict. It is primarily focused on the role of gender relations in the production of vulnerability to ill health or disadvantage within health care systems and the conditions which promote inequality between the sexes in relation to access and utilization of services. This allows a far broader analysis that associates women's vulnerability to ill health with their lack of power and control in all areas of their life (WHO)[2].

2 Understanding gender in the context of global health policy and funding

2.1 The challenges of policy framing and instrumentalism in women's health

Priority setting in global health policy is a highly politicized process and is not simply established through evaluations of burden or distribution of disease (Parkhurst and Vulimiri 2013: 1094). This is particularly evident around women's health issues and advocates have reflected on the challenges of placing certain health issues on the global policy agenda. Issues such as maternal health and cervical cancer fail to generate widespread political support as they are 'women's issues' (Starrs 2006; Shiffman and Smith 2007; Parkhurst and Vulimiri 2013). Moreover, as Shiffman and Smith (2007) contend that one of the most significant challenges is when the primary victims of health issues—such as maternal mortality—are poor women in the global South who lack voice or power and are not in a position to mobilize civil society and ensure their health needs become a global priority. Starrs also considers the difficulties of presenting complex issues, such as maternal mortality, to policy makers. In her analysis of the Safe Motherhood Initiative (SMI) she contends that one of the reasons for the lack of earlier progress on the SMI was that the maternal death was conceptualized as a multi-sectoral problem 'with equal emphasis on the range of direct and indirect problems that contribute to poor maternal health' (2006: 1131). In practice this meant that

> Attempting to address all these complex and deeply rooted factors frequently resulted in large national action plans for safe motherhood that were complicated and expensive. Donors were unwilling to support these massive undertakings, and there was often no clear leadership within countries. Ministries of health, education, and women's affairs were all expected to play a role, as were a range of civil society groups, but the reality was that rivalries over funding, visibility, and control mitigated against the development and implementation of clear, focused, realistic strategies for reducing maternal mortality (Starrs 2006: 1131).

The subsequent integration of maternal mortality into the MDG agenda and the lack of attention elsewhere to women's health issues has led to widespread criticism of the translation of women's health issues into easy-to-understand targets that fit within a wider instrumentalist agenda. One of the main concerns with this approach to women's health, is the failure to take into account the wider health systems. Freedman et al. (2005) contend that a major element of health system strengthening is ensuring accountability to all citizens. They argue that an accountability-oriented health system functions in a way that promotes the ability of all people, including poor and marginalized populations, to assert and satisfy their health care rights and entitlements and actively seeks to ensure their access to services (2005: 998). Evidence has shown how the separation of activities around treatment and prevention of infectious diseases such as HIV AIDS, undermine overall health systems approaches to tackling their spread (Hanefeld 2010; Kapilashrami and McPake 2013).

[2] http://www.who.int/gender/mainstreaming/strategy/en/index.html, accessed 30/10/13.

Critical analyses of the shortcomings of the MDG framework can also provide valuable lessons for work on PPPs, particularly discussions around how the MDGs conceptualize complex issues within a simplified structure of goals and targets. Commentators have argued that the narrow focus within the MDGs has diverted attention away from the wider goals of social justice; this is particularly evident in efforts to meet the MDG target 5, notably the reduction of maternal mortality rates (Freedman 2005; Yamin and Boulanger 2013; Fukuda-Parr 2012). One concern raised in the literature is that the introduction of specific targets and measurable outcomes can often lead to unintended consequences for individual's health and wellbeing. The choice of the proportion of births attended by skilled birth attendants (SBA) in the MDG 5 targets was in part selected because it was easy to measure. However, this had significant limitations

> SBA focused specifically on a subset of delivery care without improving or assessing the quality of the health system or taking into consideration additional reproductive health needs (Yamin and Boulanger 2013: 19).

Unsafe abortions are estimated to cause 13-18 per cent of maternal deaths each year but are not being addressed. As other commentators[3] have noted

> The practice of international health is political rather than technical, political rather than bureaucratic, political rather than academic. [...] The choice between interventions is presented as a question of efficacy that can be measured and scientifically evaluated. But the world is not that simple. Choices are often based on ideology, values, and national and organizational interests (Perlman and Roy 2009: xiv, cited in Esser and Bench 2011: 1272).

Whilst measurable outcomes such as reducing maternal mortality are clearly important in order to guide policy and programming, they can also often obscure significant inequalities within the data. Spangler (2012) argues that categorizing health sector staff as skilled or unskilled can be potentially problematic in low income settings where there is a lack of uniformity in training, resources and regulation. Drawing on research in rural Tanzania he argues that

> Determining which birth attendants were skilled was highly problematic. Assessment by title alone would have resulted in gross mischaracterization. Due to inconsistencies in pre-service training and regulation, a good many doctors, nurses, midwives, and clinical officers did not uniformly possess or perform many of the competencies that would qualify them as skilled. At the same time, some birth attendants who were not considered accredited professionals (i.e. aides and rural officers) practised some degree of skilled care every day. Besides formal training, health workers influenced each other's practice—skilled aides learned from skilled midwives, and less competent midwives picked up bad habits from other less competent practitioners (Spangler 2012: 138).

As Spangler concludes, one of the biggest challenges facing policy makers remains the balance between reconciling the need for global standards with the need to take account of local realities (Spangler 2012: 140).

The instrumentalization of women's health, that frequently reduces it to sexual and reproductive health (SRH), fails to take into account the range of gendered vulnerabilities that jeopardize women's health and wellbeing, particularly in low income settings (Sen and Östlin 2009). Indeed gender roles and responsibilities and the subsequent burden of care work have been recognized by the WHO as an important aspect of the social determinants of health (WHO 2008). More

[3] See also Berer (2011); Crane and Dusenberry (2004); Shiffman and Smith (2007).

recently this has also been identified by the UN Special Rapporteur on extreme poverty and human rights as a major gendered constraint to securing women's human rights and condemning women to poverty (UN 2013). At the level of policy and practice, instrumental understandings of women's health can reinforce the narrowing of interventions to those that fit within the goal-based model of development (Esser and Bench 2011; Porter and Wallace 2013). At the same time evidence has shown that interventions that promote women's participation in meaningful ways are more likely to bring about effective reductions of maternal mortality rates. Research conducted in Bangladesh, India, Malawi, and Nepal found that women's groups that employed participatory strategies which acknowledged how many health problems are rooted in powerlessness and then worked towards social and political empowerment achieved positive results in terms of reducing maternal mortality results (Prost et al. 2013). The authors conclude that health education involving dialogue and problem solving is potentially more empowering for people than mere 'message giving' (Prost et al. 2013).

Moreover, health systems themselves are gendered institutions and frequently constrain women's access to services (Mackintosh and Tibandebage 2006; Gideon, forthcoming 2014). Health systems are also significant social determinants of health (Mackintosh 2001; Gilson et al. 2007) and are thus integral to individual's experience of poverty. As Freedman contends, health systems are:

> Core social institutions that help define the experience of poverty, must now be given equal weight in health policy. Poverty is not just a state of being. Poverty is also fundamentally relational. It concerns the interaction between individuals/communities and structures of power
>
> … Health systems are part of the very fabric of social and civic life. A new respect for the role of health systems in creating or reinforcing poverty and, conversely, in building a democratic society should be the foundation for policies to achieve the health MDGs (2005: 4).

Studies from Latin America echo research from around the globe that points to the diverse ways that systematic and deeply embedded inequalities within societies limit women's access to adequate health care services and this is directly related to the slow progress in reducing women's maternal mortality (Brentlinger et al. 2005; Physicians for Human Rights 2007). Drawing on evidence from a 51-country programme aimed at reducing maternal mortality, Freedman (2005), stresses the importance of emergency obstetric care but argues there is a need for interventions that simultaneously address the technical, management and human rights issues within health facilities. Whilst this principle is now reflected in global health discourse which advocates the need for universal health care coverage (WHO 2013), the impacts of out-of-pocket payments still pose a considerable barrier to accessing health care services for many lower income households (c.f. Orem et al. 2011) and the effects are likely to be gendered (Ewig and Bello 2009; Tibandebage and Mackintosh 2010).

These arguments show that while there is a need to focus on outcomes, and that there has been some progress on the part of many donors and national governments to integrate broader, socially determined, factors in women's health, there are limits to this approach. These limits are imposed by underlying motives that can reduce ideas of women's health, to a goal-based set of initiatives which can only be measured by simplified outcome measurements, rather than the more complex measurement systems which attempt to capture process-oriented indicators and far broader aspects of women's health.

2.2 Global Public Private Partnerships in health and the changing landscape of development funding

Over the past decades the number of public private partnerships at the global level has proliferated enormously. These are extremely diverse in nature, scope and size but in the main they can be characterized by a partnership between a more traditional development actor, such as a multilateral agency and a new actor, either a corporate partner or philanthropic organization such as Rockefeller or the Clinton Foundations or the Gates Foundation (Hanefeld et al. 2007). Moreover, as Buse and Tanaka (2011) note, global health partnerships are now critical health actors in themselves. This paper focuses on the impact that these partnerships have had on how 'women's health' is understood by UK-based NGOs working on health issues in development. These organizations may or may not be a part of GPPPs, but they are nevertheless influenced by the dominance of these partnerships in the funding landscape for health interventions in development. The study found that this influence predominantly reflects the narrow goal-based ideas of women's health, rather than the broader socially determined understandings.

Defining PPPs

The term 'public-private partnership' and has been subject to considerable discussion within the health sector. Reich (2000: 618) suggests that three characteristics are necessary for a relationship to be classified as a public-private partnership. First, these partnerships involve at least one private for-profit organization with at least one not-for-profit organization. Second, the core partners provide a joint sharing of efforts and of benefits. Finally, partnerships in public health are committed to the creation of social value (improved health), especially for disadvantaged populations. Many of these partnerships also transcend national boundaries and should be oriented toward a shared health-creating goal on the basis of a mutually agreed division of labour (Buse and Walt 2000: 550).

There has been a proliferation of terms in order to capture the complexity of the current partnerships in the health sector, including global health programmes, global health initiatives or global public policy networks (Hanefeld et al. 2007). A useful definition is offered by Buse and Harmer (2007) who use the term 'Global Health Partnerships' to describe GPPPs:

> Relatively institutionalised initiatives, established to address global health problems, in which public and for-profit private sector organizations have a voice in collective decision-making. Such partnerships vary across a range of variables including their functional aims, the size of their secretariats and budgets, their governing arrangements, and their performance. Yet it is their innovative approach to joint decision-making among multiple partners from the public and private sectors which make them a unique unit of analysis which we call global health partnerships (Buse and Harmer 2007: 259-60).

GPPPs in health can be broadly characterized as falling into two main groups. First product development partnerships which first emerged in the mid 1990s as a means of developing new products to combat the diseases of the developing world (Widdus 2005: S5). One of the first of this type of was the International AIDS Vaccine Initiative (AVI) set up in 1996, similar models were then used in other areas including malaria and contraception. This model of GPPPs is clearly focused on a single, often disease-focused goal, and therefore do not address the embedded complexities of marginalized peoples' experiences of ill-health. The second most widespread type of PPP in the area of global health is product access partnerships. These are partnerships based on addressing access to drugs in low- and middle-income countries and are based on pharmaceutical industry donations or discount pricing (Widdus 2005: S7). Yet while

these have clearly led to significant gains, for example in terms of reducing the cost of essential drugs for low income countries (Molyneux et al. 2005), they predominantly reflect medicalized ideas of health that are not able to address the more complex experiences of ill-health. Many of these access partnerships pre-date those focusing on product development, and in many ways they also provide the original model of PPPs. PPPs have, however, evolved considerably in the last decade, and now even relationships based on access to markets are far more complex negotiations of interests. In addition, a small number of health partnerships fall into two additional groups: global co-ordination and financing mechanisms (Buse and Tanaka 2011).

Partnerships between actors drawn from different sectors (often characterised as public, private and third sectors) for development co-operation are not new and indeed can be dated back to the late 1960s, but there has been a proliferation of PPPs over the past few decades, particularly within the health sector (Buse and Walt 2000). Several factors account for this expansion. Firstly the ideological shift of the 1990s, associated with the Post Washington Consensus where emphasis was given to 'modifying' rather than 'freeing' the market. Second, there was widespread disillusionment with the UN and its agencies. Partnerships with the corporate sector were seen as a more efficient way of 'getting things done' (Hanefeld et al. 2007).

The shifting health and development landscape

The huge cost of expanding access to drugs and vaccines across the Global South has also been a significant factor in seeking new ways of funding these global challenges (Reich 2002). Indeed, fiscal constraints faced by Governments have been a major factor in the push towards finding new funding sources for public services (Bovaird 2004). As a consequence since the late 1990s development assistance for health has significantly increased—between 1997 and 2002 it was estimated to have risen by 26 per cent (Hanefeld et al. 2007: 10). New funders have also entered the field, notably private philanthropic foundations. One of the most significant new actors is the Bill and Melinda Gates Foundation, a private philanthropic foundation, which contributed around US$6 billion for health alone between 1999 and 2006 (Hanefeld et al. 2007: 10).

Moreover, the entry of the World Bank into health in 1984 signalled a new opening of the health policy environment and a shift away from the dominance of the WHO and other UN agencies. As Hanefeld et al. (2007: 10) and colleagues argue, some of the new entrants, such as the Bill and Melinda Gates Foundation have had significant influence in global health policy, both as a Foundation in its own right, but more as a partner with others. Finally, there was also recognition that the challenges within the health sector were so broad that one sole organization could not tackle the work alone. Scholars have argued that many of the challenges associated with globalization have been one of the key drivers towards the introduction of PPPs in global health. As Widdus notes,

> It seems to be recognized that intractable problems require not just better coordination of traditional roles but also new ways of working together in order to achieve a synergistic combination of the strengths, resources, and expertise of the different sectors (Widdus 2001: 714).

The impact of PPPs in health and development has not only been in how these initiatives are financed, but also in terms of how they are designed and implemented. There have been multiple examples of successful partnerships, but more recently analysts have started to look more critically at PPPs and the types of ideas that underpin them. As Kapilashrami and McPake contend in relation to the wider debates around PPPs

> No systematic evaluation is carried out to examine the implicit assumptions in the 'intended' and how it departs from the 'unintended'. In other words, an uncritical view of GHIs themselves is put forward and studies fail to critically appraise practice in the light of the ideas and discourse that underpin creation and operations of GHIs and continue to grant them legitimacy (Kapilashrami and McPake 2013: 627).

They also argue that despite the establishment of mechanisms such as the country co-ordinating mechanism within many GPPPs that is intended as a means of ensuring community wide participation, inclusion within this was often seen as insufficient to guarantee equal treatment with other members. Reflecting on the case of the Global Fund to fight AIDS, TB and Malaria (GFATM) in India and the procedure around the development and shaping of the country proposal, the authors describe their findings

> Principle Recipients (PRs) [of GFATM funding] recalled certain individuals, with the ability to work effectively in the context of extensive and complex application procedures, as key to successful bids and applications. These local, paid consultants were sought out by large organizations and much of the grant preparation process was transferred to them. The resulting proposal passed through several rounds of closed door negotiations that bypassed formal structures like the CCM (Country Coordinating Mechanism) (Kapilashrami and McPake 2013: 630).

All partners within the Fund were clearly not given equal status and in many instances those from international NGOs and more powerful organizations had greater voice than representatives from national and local level NGOs who were potentially closer to those the Fund claimed to support. This raises important questions as to how the needs of health care users, and the constraints they face in meeting those needs, are integrated into the workings of PPPs. Although this is one example of Global Fund practice, it highlights potential limitations in the way that the mechanisms distribute the funding work, which might include or exclude actors, based on their closeness (or not) to the distribution mechanisms of the GFATM.

A growing body of research has also shown how norms and practises are important to question and examine more broadly, if women's experience of health and healthcare is to be understood adequately. Embedded norms and practices within health systems are gendered and result in discrimination against women, thus excluding them from access to vital health services (Doyal 2002; Ewig 2010; Gideon 2012, 2014; Mackintosh and Tibandebage 2006; Murray and Elston 2005; Pollack 2002; Tegtmeier et al. 2009). In their analysis of the Tanzanian case, Tibandebage and Mackintosh (2010) show how lack of transport facilities limits the transfer of pregnant women from primary level services to hospitals where they can receive life-saving emergency care. This reflects the lack of priority given to women's health needs and the failure to take a system wide approach that considers more inter-sectoral approaches to reducing maternal mortality rates.

2.3 Negotiating ideas of gender in the context of global health PPPs

Considerable debate and discussion has been generated by the growing role of PPPs in global health. While it is clearly not possible to cover all the dimensions of this debate, this section will consider some of the critiques that have been levelled at the approach. Particular focus will be given to the implications of PPPs for gender and health, and within that how 'women's health' is emphasized, reflecting the narrow and goal-based understandings that could be defined as a 'gender equity' approach, rather than the more broad-based, socially determined understandings of women's health represented by a 'gender equality' approach.

While very little work has focused on the gendered implications of PPPs, critics have noted the absence or limited engagement with gender issues within central policy documents pertaining to a number of PPPs. Hawkes and Buse (2013) found that a number of organizations still advocated an 'add women and stir' approach to health policy. They found that a range of organizations including the GFATM, the United States Agency for International Development [USAID], the Global Health Initiative, UNDP, UK Department for International Development [DFID] while emphasizing the need to address gender inequalities, see a focus on women and girls as the solution i.e. a gender equity approach.

An analysis of PPPs in SRH carried out by Ravindran and Weller (2005) found that despite aspirations to ensure more efficiency and more equity via PPPs, in many contexts these were based on assumptions that were not justified by the empirical evidence.

> One, that the private sector is inherently more efficient than the public sector in the provision of health services. Two, that the introduction of competition between public and private providers in the health sector will improve efficiency' (Ravindran and Weller 2005: 117).

In fact their review found that efficiency only works in very specific settings, where there is adequate managerial capacity in the public sector, and sufficient capacity within a large enough private sector to be able to fulfil the contractual obligations at reasonable rates (Ravindran and Weller 2005: 118). These conditions are clearly important in promoting successful PPPs, and yet they are rarely the case in situations where the public sector has been severely depleted, and where the private sector has not yet developed sufficiently.

At the global level, private foundations have played a large role in the emergence and acceptance of PPPs, with the Bill and Melinda Gates Foundation 'instrumental in the formation of public-private partnerships involving the WHO' (Ravindran and Weller 2005: 97). The important role played by the Gates Foundation is reinforced by the very large amounts of contributions, which dwarfed any other single contribution. For many foundations, measurability is also a key factor in determining where the money goes because it facilitates resource mobilization as well as the production of easily attributable success stories (Esser 2009, cited in Esser and Bench 2011). To quote Eichler and Levine 2009: 4, cited in Esser and Bench 2011: 1272) '[y]ou get what you pay for. And it is easier to pay for what you can easily measure'.

Moreover, in some cases the incentive to fund specific health initiatives is driven by more extreme factors. One foundation has been singled out as pursuing a specific accomplishment in the health field to celebrate an important anniversary: 'Rotary International had been looking for a global target to be achieved by the centennial of its foundation in 2005' (De Quadros 2009: 62, cited in Esser and Bench 2011: 1272).

The MDG agenda clearly placed women's reproductive health on the global development agenda and it is therefore not surprising that the Gates Foundation recently committed to funding work around reproductive health, notably family planning. Indeed as the Foundation announces on its website:

> Family planning is a key part of the foundation's broader commitment to empowering women and improving family health.[4]

[4] http://www.gatesfoundation.org/What-We-Do/Global-Development/Family-Planning

The Gates Foundation is currently a central player in the global health field, with a budget equal to that of the WHO in 2007 (McCoy et al. 2009). The Gates Foundation been active in a number of PPPs—notably in the Global Alliance for Vaccines and Immunisation (GAVI) the GFATM, and specifically in funding innovative research work to develop an HIV vaccine. In 2012 the Gates Foundation Family Planning initiative was set up which is a collaborative undertaking between the Gates Foundation, other private foundations, governments and bi- and multi-lateral funding bodies, NGOs and the private sector. The need that has been identified is for women to have access to safe, affordable and effective contraception. The justification for the initiative is, however, primarily economic:

> Access to safe, effective methods of contraception is considered one of the most cost-effective investments a country can make in its future. Studies show that every US$1 invested in family planning services yields up to US$6 in savings on health, housing, water, and other public services.
>
> Contraceptive use also leads to more education and greater opportunities for girls, helping to end the cycle of poverty for them and their families. Up to a quarter of girls in Sub-Saharan Africa drop out of school due to unintended pregnancies, stifling their potential to improve their lives and their children's lives (DFID and the Gates Foundation 2012).[5]

In line with earlier approaches to women's reproductive health advocated in the 1970s and 1980s, the approach of the Gates Foundation clearly draws on the more limited understanding of gender equity rather than gender equality approach and also perpetuates the instrumentalist analysis in its underlying justification for the focus on women's health. Whilst the Gates Foundation and individual staff may maintain a high level commitment to gender issues it is nevertheless important to acknowledge the potential limits of gender equity approaches. As critics have argued, the underlying principles of such initiatives betray a primary adherence to the agenda of economic development, and this clearly separates it from the promotion of women's equality and empowerment, yet these are essential elements in addressing the broader social determinants of health (Hartman 1987; Hartman and Standing 1989; Petchesky 2003). It is, then, important to understand how these new partnerships in global health formulate a very specific and limited understanding of women's health needs, and also then governs how the initiatives to respond to them are conceptualized.

One of the central justifications for PPPs is that there has been a significant increase in the amount of money that is available for health interventions. Yet since the late 2000s, the World Health Organization (2008) has once again reinforced the importance of the broader social determinants of health which must sit alongside the need for money. There is clearly a tension within the health governance architecture between the need for increased funding in order to respond to the huge and diverse health needs of the global population, and the need to maintain a more complex understanding of health, which large well-funded programmes can often disguise.

Concern has been expressed over the implications of PPPs for health inequalities given that the majority of PPPs do shift the focus away from broader approaches to health, focusing instead on disease-specific problems (Pitt et al. 2010). Indeed, Koivusalo and Mackintosh (2011) argue that

5 http://www.londonfamilyplanningsummit.co.uk/1530%20FINAL%20press%20release.pdf.

> The intervention of non-state (private sector) actors in health sector has also influenced global/national agenda setting in health sector and emphasized a shift away from a broader approach that encompasses the social determinants of health and towards more disease-specific and disease-based which can lead to *inequalities on the basis of diagnosis* ... it can also draw resources away from, rather than contribute to, the overall health system, and can fragment health system institutions and health policy action (2011: 249).

A number of mechanisms have been put in place to try to avoid these tensions and to ensure that disease-specific initiatives are consistent with health sector strengthening efforts. These include the Joint Funding Platform, consisting of GAVI, the GFATM, and the World Bank (England 2009). Another case is the Global Fund to Fight AIDS, Tuberculosis and Malaria which has created country co-ordinating mechanisms composed of local stakeholders to ensure projects initiated are consistent with national priorities. Nevertheless, 'vertical-horizontal tensions persist, even in these more carefully designed efforts' (Brugha et al. 2004, cited in Shiffman 2006: 418). Several empirical studies show that there is little evidence of donor priorities reflecting country level need or priorities (Esser and Bench 2011; Paul et al. 2013; Stierman et al. 2013). Indeed an analysis of aid disbursements in 68 countries found that while countries with higher under-5 mortality received more official development assistance per child, official development assistance to maternal and newborn health did not seem to be well targeted towards countries with the greatest maternal health needs (Greco et al. 2008).

This tension is evident in recent findings over the distribution of funding for reproductive health, where the focus has been shifted to work on HIV rather than other dimensions of reproductive health (Ravindran and Weller 2005). Indeed, some evidence suggests that donor spending on HIV/AIDS appears to be in excess of need (Esser 2009). Research on official development assistance (ODA) in the area of reproductive health found that global health initiatives and disease-specific funding channels play an important role in the financing of reproductive health (Hsu et al. 2013: 1779). The study found that while overall levels of funding slightly increased between 2009 and 2010, more than half was directed towards prevention, treatment, and care of HIV infection for women of reproductive age (15–49 years of age) (Hsu et al. 2013). On average, ODA to general reproductive health activities amounted to just under 16 per cent while ODA to family planning was around seven per cent of the total.

Similarly, Shiffman et al. (2009: 1) have shown that between 1998 and 2007, funding for HIV/AIDS control rose from just 5.5 per cent to nearly half of all aid for health. Over the same period, funding for health systems strengthening declined from 62.3 per cent to 23.9 per cent of total health aid and that for population and reproductive health declined from 26.4 per cent to 12.3 per cent. Also, even as total aid for health tripled during this decade, aid for health systems strengthening largely stagnated. The high levels of funding available for HIV/AIDS within World Bank interventions have also absorbed much of the funding available for sexual and reproductive health, leading to the marginalization of broader women's health concerns. This tendency has had the effect of undermining the effectiveness of World Bank interventions by limiting the way in which they are able to include gender equality (Lauterbach and Zuckerman 2013).

Furthermore, because of the preference of many PPPs for technical interventions that bring about not only significant improvements in measurable indicators (such as birth-rates), but also the creation of new markets for health products, many PPP interventions in the area of family planning will shift the balance between contraceptive methods advocated for women. Ravindran and Weller (2005) point out that the dangers of advocating a technical approach seems to create

a larger proportion of prescription of methods such as oral and injectable methods, that require screening and follow up care for possible side effects (see also Richter 1995)—neither of which were available through the PPPs they studied, which led them to suggest that 'commercial interests and profit motives may in fact lead the agent to underplay the risks of the method' (Ravindran and Weller 2005: 122; Esser and Bench 2011).

Moreover, results (or performance)—based health care is often the guiding principles of PPPs. Because of the focus on measurable results this approach privileges quantitative methods, which fail to take into account the broader dimensions of health, and particularly how gender inequality and women's subjugation affect their health needs, and their access to health services (Hanefield et al. 2007).

Critics have also argued that these shifts towards PPPs at the level of global health governance have implications for the quality of the partnerships they undertake with other actors. For example, global donor partners can often impose their agendas on recipient countries (Koivusalo and Mackintosh 2011). This can result in local level organizations having to amend their practice in order to secure funding even where this may go against the fundamental principles of the organization (Ghanotakis et al. 2009).

Commentators have also expressed concern about the impact of contracting on national-level NGOs and civil society organizations (CSOs) to carry out advocacy work in the context of Global Funds. Spicer et al. (2011) found that competition for funding from Global Funds among CSOs in the former Soviet Union was divisive, with the effect that the advocacy role of CSOs was significantly curtailed. Similarly Zaidi et al. (2012) found that where NGOs were contracted to carry out service delivery in the context of new types of partnerships this often resulted in NGOs becoming more distanced from their grounded attributes. This raises important questions and challenges for the ability of women's organizations and other advocates of women's rights to challenge the dominant model of women's health and have any meaningful voice in policy processes.

2.4 Changing narratives of gender and health in UK-based NGOs

The growth and acceptance of particular norms and principles which are associated with the greater efficiency and effectiveness of the private sector is illustrated by Ravindran and Weller (2005), in their careful analysis of public-private interactions in health. The financial as well as ideological imperatives of the 1990s and early 2000s meant that 'private foundations played a major catalysing role in the emergence of PPPs at a global level' (Ravindran and Weller 2005: 97). This also coincided with the establishment of the WTO, and the rise in importance of health services as markets for foreign direct investment. The growth in PPPs has led to several fundamental shifts that affect how work in this context is shaped. The first is:

> That donor funds are being utilised more for market creation … catering for those who can afford to pay. This is a move away from the earlier practice of donor funding and support for meeting the needs of low income groups (Ravindran and Weller 2005: 125).

The second is:

> A shift in the perceived role of the public as consumers and customers in a market place, and not so much as citizens of a nation state (Ravindran and Weller 2005: 125).

Clearly the interaction of the private sector in the realm of healthcare has brought about shifts in how healthcare, and within that women's health particularly, can be understood and addressed. There is, however, a gap in understanding how NGOs respond to this shift at the level of practice.

The study by Kapilashrami and McPake (2013) provides some insight into how the distinctive funding patterns of PPPs shape how interventions are organized at the country level. They clearly attribute these affects to the way that the funding mechanism is organized, particularly the 'hidden transcripts' of power involved in the distribution of funding by the country co-ordination mechanism (CCM).

> Multiple and discrete projects emerge, each leveraging control and resources and acting as conduits of power … management of HIV is punctuated with conflicts of power and interests in a competitive environment set off by the Fund protocol (Kapilashrami and McPake 2013: 626).

Although this study did not specifically focus on the implications for gender equality, the effects are such that the voices and work of local organizations, with a more rooted understanding of local power relations, are excluded. This clearly excludes an understanding of how gendered power relations at the local level constrain women's access to HIV/AIDS counselling, testing, and treatment facilities.

NGOs are dependent on external funding, and this dependence shapes how they frame the work that they undertake, and how they are able to report on this work. Authors such as Mosse (2005) have documented how development NGOs will create a 'narrative' of their work, reflecting the changing context in which they are being evaluated, and seeking funding.

> Projects do not 'work' because they turn policy into reality, but because they sustain policy models offering a significant interpretation of events (which is not the same as operational control over events or practices) (Mosse 2005: 17).

This has created huge tensions in development NGOs, where the pressure is felt to create a 'narrative' of development work that corresponds with donor requirements. These donor requirements are increasingly based on tightly controlled, efficient processes that can demonstrate 'value for money' (Porter and Wallace 2013). In the context of UK-based NGOs, the research conducted for this paper has indicated that NGOs are significantly affected by declines in individual funding levels, and are therefore increasingly tied to institutional funding from bi- and multi-laterals, and also from PPPs or direct corporate partnerships. This means that the shift in funding regimes for health programmes in development has a profound effect on the narrative that NGOs construct of their work in this area. In order to win funding, organizations need to prove that they are undertaking work that both addresses the priority areas of the donors, and that can be monitored and evaluated in a way that demonstrates successful implementation. In this way, NGOs are now becoming active proponents of PPPs, and find that their work is now being shaped in specific ways in the current context of global health PPPs, based on the assumption of increased efficiency and effectiveness.

This reflects the analysis of bureaucracies and institutional funding organizations within the UN, which are now finding that some agencies (or departments, or even particular people within them) are more clearly aligned with PPPs than with, for example, social movements. For example:

> Over time, WHO has moved from a human and social rights case (World Health Organization 1998) to promoting a business case for gender mainstreaming as integral to good governance and an efficient and equitable use of resources (World Health Organization 2008) (Payne 2011: 521).

The shift from the language of human and social rights to the language of making a 'business case' for gender equality echoes the ideas of Ravindran and Weller (2005), who identify the shift from people seeking healthcare being understood as citizens to being understood as consumers. The fear is that

> it would appear that for many donors and governments, increasing private sector participation has become a goal in itself, rather than a means to improving health status or even health care … 'in search of the means, the true end has been lost' (Bennett 1991: 31, cited in Ravindran and Weller 2005: 131).

This shift in the focus of the funding regimes has brought about many positive changes in the way that NGOs can operate to address the health needs of women in different contexts, not least by significantly increasing the amount of funding available for these activities. However, this shift also has the potential to undermine the effectiveness of interventions in bringing about greater gender equality. The analysis set out in earlier sections of this paper shows how the differences between gender equality and gender equity approaches can have important impacts on the outcomes of women's health interventions. Whilst instrumental gains in gender equity will often result in undeniably positive gains for women's health, they will not necessarily lead to desired outcomes in women's empowerment and the broader social determinants that govern how women experience health and health care. In order to investigate how to close the gap between these two approaches, it is important to understand their differential impact on development practice: specifically, how women's health programmes are funded, designed, and evaluated. There is clearly a need for more detailed empirical studies of how the global health agenda impacts on the local level in particular what the implications of the changing role of PPPs has on local level power relations, and gendered power relations in particular, in the context of health policy and programmes in development.

In the following section, the paper draws on a study of UK-based NGOs to examine how health policy and programming reflects the changing landscape of funding patterns, and how this has impacted on the ability of NGOs to understand and incorporate an analysis of gender equality in their work on women's health issues.

3 The case study: women's health within UK-based NGOs

3.1 The study

The research questions governing this study were: how and to what extent the impact of PPPs and the new funding regimes they bring had reached UK-based NGOs, and were affecting their understanding of, and ability to address, issues of gender equality in their health programming. As the study investigated the construction of knowledge and understanding in development practice, it used qualitative research methodologies, and put an emphasis on being able to respond to the data as it emerged. Therefore semi-structured interviewing techniques were used, identifying a range of respondents from UK-based NGOs and women's health networks, sampling both independently and progressively as the process continued (Bryman 2008). By identifying as wide a range of respondents as possible within UK-based NGOs, the study has

avoided narrow definitions of NGOs and their work, and concentrated rather on how each one (located differently, and with different styles/methods of working on health) was affected by the influence of PPPs in their work on women's health.

Interviews were carried out over a period of 15 months, with 20 respondents. Thirteen respondents were from seven different UK-based NGOs (two based overseas, 11 in the UK), five respondents from transnational networks on women's health (based in Scandinavia, Canada, and UK), and two global health governance experts (both based in the UK). All the respondents were involved with working on issues of health, some particularly concerned with women's health or gender equality in health, and others more generally with the governance and funding of health in development. NGOs are far from a homogeneous group of organizations. In the context of the UK, the term NGO can represent many different types of organizations, from small local service-delivery organizations through to large primarily advocacy-based NGOs and funding organizations working internationally. This analysis is not concerned to pin-point the individual differences between these organizations; rather it seeks to formulate an understanding of their changing relationship with the dominant underlying ideologies of the global health funding system, and particularly the role of PPPs within that, and how this has affected their fundraising, programming, and monitoring and evaluation. What all the NGOs studied have in common is that they are dependent on funding from external sources. This research concentrated on the relationship between funding patterns and the consequences of shifting patterns for the understanding of women's health. Funding was often from the UK Government Department for International Development (DFID), but many organizations also sought funding from private foundations or directly from corporate organizations. The growth of funding opportunities from private foundations or corporate partnerships plays a significant role in how NGOs shape their development agendas, and how their work on women's health is framed within this agenda.

3.2 Policy framing: women's health in NGO programmes and the need for resources

Respondents working in NGOs recognized that women's health is primarily seen in terms of technical interventions to address reproductive and maternal/child health and that this is a deliberate strategy to secure funding. Whilst some respondents individually had broader understandings of women's health, the organizations themselves have historically been associated with these narrower conceptualizations of women's health, which are often used to frame and plan interventions targeted at service-delivery. This has meant that many NGOs have found it relatively uncomplicated to negotiate funding relationships based on this approach. Respondents from an international NGO with a particular focus on women and girls, recognized how the women and girls agenda in global health does 'not necessarily reflect all we know about gender inequality' (UKNGO5), but clearly accepted the need to respond to the agenda as it is currently constructed, which concentrates on single-issue, technical interventions targeted at reproductive health needs, such as family planning, and maternal and child health.

All the NGO respondents predominantly saw the shifting funding patterns from a very pragmatic point of view, and acknowledged the change in the funding landscape that has been brought about by the increased participation of global PPPs. Many attributed the increase in reliance on PPPs to the current climate of austerity, in which individual donations are falling [UKNGO10]. Most respondents understood the opportunities to gain increased funding via PPP-led funding, and saw these as directly increasing their ability to address the healthcare needs of women and girls, however narrowly these are conceptualized [FONGO1, UKNGO10, UKNGO7, UKNGO8, FONGO2, UKNGO5]. They saw their work to ensure a focus on women and girls in global health as on-going, and negotiated within a broader set of priorities

that are often shaped by donors. However, it was also clear that the opportunity to pursue funding through further corporate partnerships, whether directly or via a PPP, often undermined how far they were able to integrate a more complex gender analysis of women's health.

For example, one large international NGO included in the study focuses much of its international advocacy work at the level of the WHO, lobbying for universal coverage for healthcare. But this was not associated with 'women's health'. 'Women's health' is defined differently because it is funded from different sources, and is limited to reproductive and maternal/child health (MCH). There was no clear gender analysis of health systems or broader understandings of women's health within their advocacy work to support universal coverage for healthcare systems. This reflects the difficulties that NGOs have in incorporating a broader understanding of gender equality in health, which requires an attention to gender inequalities not just in reproductive and MCH programmes, but also in work to address how health systems themselves reflect and perpetuate gender inequality. As Freedman (2005) points out, health systems are social institutions, and there are clearly gendered aspects to this, with gender inequality acting as a further barrier to women accessing health services, even if the health system is nominally 'free access'. Furthermore, Tibandebage and Mackintosh (2010) and Ewig and Bello (2009) have documented the differential effect of (often informal) out of pocket payments (OPPs) on women. But these analytical approaches are not clearly reflected, even in the work of an NGO working to advocate for universal coverage for healthcare. Women's health remains defined within the narrow confines of reproductive health and MCH programmes.

Clearly funding is a crucial determinant in how work on women's health is conceptualized and implemented through programming, and funding patterns have changed significantly since PPPs have become such an accepted part of the development funding landscape. NGO respondents and transnational network respondents recognized that the requirement for results-based management and 'value for money' is currently a high priority for funders, including both PPP-led funders and bi-lateral funders such as DFID, and that this impacts on how far they are able to integrate understandings of women's health based on broader dimensions of health and on ideas of women's empowerment and citizenship. When asked about how these funding frameworks affect their work on health, respondents within NGOs, and in transnational networks, confirmed that when health work is managed within these frameworks, there is far more emphasis put on developing robust indicators (which are often quantitative) and ensuring that these are met in order to win continued funding [UKNGO1, TNN1, FONGO1, FONGO2]. For example, there has been an increase in interest in the use of Randomized Controlled Trials to measure the impact of health programmes in development (Welbourn 2013). Some respondents saw these as an opportunity to give credibility to women's health programmes, and were keen to find ways to use these methods more in the evaluation of women's health programmes. Others feared that an over-reliance on methods such as these would continue to shape the understanding of women's reproductive health around quantitative indicators, rather than more complex analyses of power and inequality [TNN2]. Another example involves the international partnerships on health that are being co-ordinated by one of the NGOs, which are awarded to organizations who are able to respond to the demands for interventions that can be robustly monitored and evaluated within the framework of the DFID funding regime. Whilst this clearly has positive effects for some organizations, and ensures that the partnerships continue to receive funding, it also excludes others whose work does not fit as easily into the frameworks for monitoring and evaluating their work. [So it might be easier to get an orthopaedic partnership in a capital city accepted, than a mental health partnership in a more remote, conflict-hit part of central Africa]. Another clear shift in funding patterns was the increased interest from private foundations and corporates in forming direct partnerships with NGOs. Whilst all funding opportunities are welcomed by NGOs, the consequence for many

staff is that they spend much more time on preparing proposals, and pursuing fund-raising opportunities [FONGO1]. This has a negative effect on the quality of programmes as they are designed to respond to donor agendas, rather than needs articulated by partners (see also Walker 2013).

3.3 The impact of PPPs on the negotiation of gender issues in NGO health programming

The impact of PPPs in shaping NGO programmes can be seen more broadly, showing that the influence of donor priorities goes beyond the immediate need for resources to fund specific programmes. This influence was identified by respondents in our research interviews and points to both the opportunities and constraints for NGOs that are offered by PPPs. A number of the NGO respondents (UKNGO2, UKNGO3, UKNGO10, TNN5, TNN3, UKNGO7) commented on the influence of private foundations, the Gates Foundation in particular, at least one major NGO made clear that the stated agenda of the Gates Foundation influenced how their own programmes would be shaped (for example, in order to respond to the Gates interest in vaccinations their work would shift to an emphasis on vaccinations, in order to target the Foundation with relevant fundraising proposals UKNGO10). The role of the Gates Foundation was welcomed by most NGO respondents, as it has significantly increased the funding available for work on women's health, and also the profile of women's health within the development contexts. However, as seen in the previous section, this profile is generally limited to technical interventions targeting immediate reproductive health and MCH needs.

The influence of the Gates Foundation was, however, not limited to the possibility of financial support. It was clearly recognized by all respondents in large international NGOs that Bill Gates in particular has a high level of influence with both the WHO,[6] within large PPPs such as GAVI, and with individual ministers of health in different countries in the North and South [UKNGO2, UKNGO10]. Thus the increased role of PPPs has led to more than just an increase in the amount of money available for women's health initiatives; they can be seen to have embedded a discourse of women's health within the narrative of NGO programming. The influence of the Gates Foundation has particular implications for the discourse of women's health, because of the focus on women's reproductive health via family planning initiatives. Respondents were divided on the potential of the 'Golden Moment' initiative for improving women's health. Respondents from within NGOs saw the focus as an opportunity to raise the profile of women's reproductive health and rights, and to achieve 'real' gains in terms of the number of women who would have increased access to family planning [UKNGO10]. One of the major positive contributions that respondents pointed to was the change in the discourse brought about by the participation of Melinda Gates—after many years of the language around sexual and reproductive rights being constrained by the very ideologically and politically constrained position of the US government,[7] her participation is seen as an opportunity to expand the discourse and include the idea of rights alongside reproductive health [TNN3]. However, respondents (particularly from European transnational networks) who were involved in lobbying around the London Summit identified a risk that in concentrating resources and services on access to contraception (particularly on the more technical aspects of contraception), other aspects of women's reproductive health (such as women's ability to negotiate sexual relationships in a context in which violence against women is accepted and endemic) may become even further neglected (GADN 2012). Thus, whilst acknowledging some gains in terms of measures to meet the goals of the MDGs (for example, a

6 Gates gave a keynote speech to the World Health Assembly, 17 May 2011.

7 Mayhew (2002) documents the way that the US government's conservative position on sexuality negatively affected how organizations involved in HIV/AIDS in sub-Saharan Africa were able to respond to the needs of the community for sexual and reproductive health services and advocacy.

reduction in maternal mortality), this study also highlights concerns with the weaknesses of such an approach. These concerns are also evident in the literature. For example, Yamin and Boulanger (2013) and Yamin and Falb (2012) highlight concerns that even where health programmes can be shown to have contributed towards a reduction in maternal mortality, data targeted at this kind of simple goal does not capture the broader constraints faced by women in accessing healthcare, as well as concerns that the more complex areas of women's health are being neglected (see also Petchesky 2003). These broader understandings of women's health (for example, mortality as a result of unsafe abortion) can in fact undermine the apparent gains of the more instrumentalist ideas (Yamin and Boulanger 2013).

3.4 Negotiating NGO relationships with private sector partners at the local level

Critics have argued that in the context of global PPPs civil society organizations tend to be viewed as agents of service delivery rather than as agents of change (Spicer et al. 2011; Harmer et al. 2012). Indeed Spicer et al. (2011) found that in the former Soviet Union, where NGOs invited were to play a role in high level partnerships they ultimately lost their connection with the social movements from which they had initially evolved. Similarly, Harmer et al. (2012) found that the pressure for securing resources from the PPPs led to competition between civil society organizations and limited any real potential for advocacy work. This study of UK-based NGOs similarly found that many had only a limited space to engage in advocacy and push for a broader understanding of women's health in their work. Instead they were frequently limited to refining their role in health service delivery.

NGO respondents recognized that partnerships are often a way in which corporate organizations can improve their own credibility through their association with the NGO [UKNGO8]. This might give the NGO partner some power to assert their own knowledge and experience of local realities. However, most respondents in fact saw the partnerships with corporate organizations as an opportunity to learn about improving efficiencies and about designing effective implementation and distribution mechanisms [UKNGO10]. So although such NGO-corporate partnerships could enable a more fundamental sharing of ideas and expertise between NGOs and corporate organizations, the shared ideas appear to privilege the market-led needs of distributing products or services, rather than utilizing the knowledge and experience of NGOs derived from broad-based work around women's empowerment. As one respondent reflected, this type of knowledge can be much more complex and more difficult to encapsulate within simplistic goal-based models (FONGO2). It appeared from the study that although NGOs had significant power, based on the value of their 'brand', they did not want to use this power to fundamentally challenge their new partners on, for example, the need to address the broader social and political determinants of women's health.

Reflecting the work of Ravindran and Weller (2005) our analysis found that NGO respondents (FONGO2, UKNGO8) have, in many cases, accepted private sector involvement, and expertise—for example through designing and running service-delivery initiatives that can be easily measured and 'success' proved. Some (FONGO2, UKNGO7) expressed the tensions that this causes within the organization, as other people feel that their own expertise and their alignment perhaps with other categories of actors (such as transnational advocacy networks) are being undermined. Indeed, this reinforces the findings in other studies, for example in relation to work around HIV/AIDS in the context of the Global Fund. Cáceres et al. (2013) found that broader knowledge around HIV/AIDS prevention can become lost in practice where the medical components of models are prioritized over and above other more participative approaches involving a wider range of stakeholders.

However, other corporate-NGO partnerships are negotiated and take place at the local level, and are managed by the country offices of the different NGOs. This can provide the opportunity for the organization to respond differently. In the case of one such partnership, it was not so much the ideas of women's health that were compromised, but more the ideas of development interventions being free of market-oriented involvement. In this case, the corporate partner was not necessarily looking for improved health outcomes that can be measured and evaluated. This had the effect of freeing up the NGO from the need to design an initiative that could be easily measured and reported, and enabled resources to be focused on a more complex programme to address issues of gender inequality in health. But this had to be in conjunction with an acceptance of the corporate partner's priority as well: access to markets. There are many different ways in which private sector players have a role in the development of health systems and health care (Ravindran and Weller 2005), and this is another illustration of how partnership with the private sector shifts the way that gender equality in health and development is understood and addressed by NGOs.

In sum, our analysis of UK-based international development NGOs has found that there has been a widespread impact of PPPs, and their influence both on funding regimes and more broadly in constructing a narrative of women's health in development, whether or not the NGOs are directly in partnership with PPPs. Whilst the influence of PPPs has been to increase the funding available, the role of NGOs within these partnerships is frequently reduced to one of service delivery. In effect the role of NGOs in advocating for women's health is marginalized, thus reinforcing narrow understandings of women's health—as reproductive and maternal/child health in practice. Furthermore, although the influence of PPPs has led to an emphasis on efficiency and effectiveness, which has been welcomed by many in NGOs, it has also changed how interventions are designed and managed, focusing much more on showing value for money through quantifiable indicators of impact, than on showing more qualitative shifts in how women experience health and health care. While partnerships can clearly differ in quality, and when NGOs are in a relatively comfortable position they appear to be able to negotiate their own interests, but the way that the agenda has shifted away from an understanding of gender inequality in health remains of concern to many respondents (TNN1, TNN4, TNN5).

4 Conclusion

It is clear that in the context of global health, a significant shift has occurred in both funding patterns and the management of health care in development policy and practice. Power and influence has not only shifted away from the state and inter-governmental structures of governance towards the global structures of the UN, WB, and WHO, but it has also been changed by the increased participation of non-state actors, notably from large private sector organizations, operating within 'PPPs' at the level of global health governance.

The shift in the funding architecture of global health has had a profound impact on how the health of women is understood in development policy and practice. Despite a wealth of knowledge and analysis of gender equality in health, it is clear that the influences emerging from some of the private foundations and private sector actors are reducing the understanding of women's health to more instrumentalized notions of maternal and reproductive health. Whilst in some cases this may have led to a reduction in particular indicators such as maternal mortality, it does restrict how women's health is understood, separating it from broader and more complex ideas that govern how women (particularly poor and marginalized women) are able to access health care throughout their lives. Health systems must be understood as social institutions, and women's ability to access health systems will be based not only on the rather abstracted notions

of women's rights to health contained within UN documents, but also on how women's empowerment and citizenship can be negotiated in each context.

Furthermore, gender equality in health is significantly undermined by the models of healthcare that are promoted by PPPs, which promote goal-based and predictable models, with easily quantifiable outcomes and indicators with which to measure them. Although the effect of these influences has been relatively well documented at the global level there is still very little understanding of the impact that these influences have at other levels in development policy and practice. This research has begun to trace this influence from the increased participation of PPPs at the global level, to their impact in development policy and practice at the national and local level.

In order to better address the deeply embedded gender inequalities in health, it is important that partnerships between different actors draw on the knowledge and expertise from both the private sector, and those organizations and movements with a broader understanding of the constraints faced by women in accessing healthcare. It is essential therefore that PPPs:

- Develop closer links with women's organizations and movements in the countries where large-scale initiatives are focused on women's health needs. This will enable development organizations to understand what are the needs of women in terms of their healthcare in different contexts, and to design relevant initiatives to respond to these.
- Value the knowledge and experience of women themselves and provide policy spaces for women to express their knowledge freely and without constraint.
- Develop and make use of 'process indicators' that better reflect the broader social dimensions of women's health.
- Support engaged research to develop indicators to reflect a focus on women's rights—around, for example, women's choice.
- Learn historical lessons from this sector—in which coercion has been a significant feature at certain points. Instrumentalism carries with it the danger of policy makers forgetting that women's health is fundamentally linked to women's empowerment and rights.

Respondents:

NGO respondents based in the UK (UKNGO1 – UKNGO11)
NGO respondents based in field offices (FONGO1 – FONGO2)
Trans-national network respondents (TNN1 – TNN5)
Global Health Governance experts (GHG1 – GHG2)

References

Bennett, S. (1991). 'The Mystique of Markets: Public and Private Health Care in Developing Countries'. London School of Hygiene and Tropical Medicine, PHP Departmental publication no. 4, LSHTM.

Berer, M. (2011). 'Editorial: Privatisation in Health Systems in Developing Countries: What's in a Name?'. *Reproductive Health Matters*, 19(37): 4-9.

Boender, C., D. Santana, D. Santillán, K. Hardee, M. Greene, and S. Schuler (2004). 'The "So What?" Report: A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes'. Washington, DC: IGWG.

Bovaird, T. (2004). 'Public–private Partnerships: From Contested Concepts to Prevalent Practice'. *International Review of Administrative Sciences*, 70(2): 199-215.

Brentlinger, P.E., H.J. Sánchez-Pérez, M.A. Cedeño, L.G. Morales, M.A. Hernán, M.A. Micek, and D. Ford (2005). 'Pregnancy Outcomes, Site of Delivery, and Community Schisms in Regions Affected by the Armed Conflict in Chiapas, Mexico'. *Social Science & Medicine*, 61 (5): 1001-14.

Brugha, R., M. Donoghue, M. Starling, P. Ndubani, F. Ssengooba, B. Fernandes, and G. Walt (2004). 'The Global Fund: Managing Great Expectation'. *The Lancet*, 364: 95-100.

Bryman, A. (2008). *Social Research Methods*. London and New York: Sage.

Buse, K. and A. Harmer (2007). 'Seven Habits of Highly Effective Global Public–Private Health Partnerships: Practice and Potential'. *Social Science & Medicine*, 64: 259-71.

Buse, K. and S. Tanaka (2011). 'Global Public-Private Health Partnerships: Lessons Learned from Ten Years of Experience and Evaluation'. *International Dental Journal*, 61 (Suppl. 2): 2-10, doi: 10.1111/j.1875-595X.2011.00034.x.

Buse, K. and G. Walt (2000). 'Global Public-Private Partnerships: Part II – What are the Health Issues for Global Governance?'. *Bulletin of World Health Organization*, 78(5): 699-709.

Buse, K., N. Drager, W. Hein, B. Dal, and K. Lee (2009). 'Global Health Governance: The Emerging Agenda'. In K. Buse, W. Hein, and N. Drager (eds), *Making Sense of Global Health Governance*. Palgrave Macmillan: Basingstoke and New York.

Cáceres, C., A. Amaya, C. Sandoval, and R. Valverde (2013). 'A Critical Analysis of Peru's HIV Grant Proposals to the Global Fund'. *Global Public Health: An International Journal for Research, Policy and Practice*, 8(10): 1123-37, doi: 10.1080/17441692.2013.861859.

Crane, B. and J. Dusenberry (2004). 'Power and Politics in International Funding for Reproductive Health: The US Global Gag Rule'. *Reproductive Health Matters*, 12(24): 128-37.

CSDH (2008). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Final Report of the Commission on Social Determinants of Health, Geneva, World Health Organization, http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf, last accessed 21-12-13.

De Quadros, C.A. (2009). 'The Whole is Greater: How Polio was Eradicated from the Western Hemisphere'. In D. Perlman and A. Roy (eds), *The Practice of International Health*, pp. 54-69. Oxford: Oxford University Press.

Doyal, L. (2002). 'Putting Gender into Health and Globalisation Debates: New Perspectives and Old Challenges. *Third World Quarterly*, 23(2): 233-50.

Eichler, R. and R. Levine (2009). 'The Performance-Based Incentives. Performances Incentives for Global Health: Potential and Pitfalls'. Washington: Brookings Institution Press.

Elson, D. and B. Evers (1998). 'Sector Programme Support: The Health Sector – A Gender Aware Analysis'. Mimeo, GENECON Unit, University of Manchester.

England, R. (2009). 'The GAVI, Global Fund, and World Bank Joint Funding Platform'. *The Lancet*, 374(9701): 1595-96.

Esser, D. and K. Bench (2011). 'Does Global Health Funding Respond to Recipients' Needs? Comparing Public and Private Donors' Allocations'. *World Development*, 39(8): 1271-80.

Esser, D.E. (2009). 'More Money, Less Cure: Why Global Health Assistance Needs Restructuring'. *Ethics and International Affairs*, 23(3): 225-34.

Ewig, C. (2010). *Second-Wave Neoliberalism: Gender, Race and Health Sector Reform in Peru*. Pennsylvania: Pennsylvania State University Press.

Ewig, C. and A.H. Bello (2009). 'Gender Equity and Health Sector Reform in Colombia: Mixed State-market Model Yields Mixed Results'. *Social Science & Medicine*, 68: 1145-52.

Freedman, L. (2005). 'Achieving the MDGs: Health Systems as Core Social Institutions'. *Development*, suppl. *The Millennium Development Goals*, 48(1): 19-24.

Freedman, L.P., R.J. Waldman, H. de Pinho, M.E. Wirth, A. Mushtaque, R. Chowdhury, and A. Rosenfield (2005). 'Transforming Health Systems to Improve the Lives of Women and Children'. *Lancet*, 365: 997-1000.

Fukuda-Parr, S. (2012). 'Should Global Goal Setting Continue, and How, in the Post-2015 Era?'. DESA Working Paper No. 117, ST/ESA/2012/DWP/117, http://www.un.org/esa/desa/papers/2012/wp117_2012.pdf, accessed 30/10/13.

Gender and Development Network (GADN) (2012). 'DFID's Golden Moment Initiative on Family Planning: A Gender and Development Network Response'. Briefing No. 1, http://www.gadnetwork.org.uk/storage/GADN%20Briefing%201%20-%20DFID's%20Family%20Planning%20Summit.pdf, accessed 26 March 2013.

Ghanotakis, E., S. Mayhew, and C. Watts (2009). 'Tackling HIV and Gender-based Violence in South Africa: How has PEPFAR Responded and What are the Implications for Implementing Organizations?'. *Health Policy and Planning*, 24: 357-66.

Gideon, J. (2012). 'Engendering the Health Agenda? Reflections from the Chilean Case, 2000-2010'. *Social Politics*, 19(3): 333-60.

Gideon, J. (forthcoming 2014). *Gender, Globalisation and Health in a Latin American Context*. Palgrave Macmillan: New York and Hampshire.

Gilson, L., J. Doherty, R. Loewenson, and V. Francis (2007). 'Challenging Inequity Through Health Systems'. Final Report Knowledge Network on Health Systems, WHO Commission on the Social Determinants of Health, accessed via http://www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf, 6/7/2012.

Greco, G., T. Powell-Jackson, J. Borghi, and A. Mills (2008). 'Countdown to 2015: Assessment of Donor Assistance to Maternal, Newborn, and Child Health between 2003 and 2006'. *Lancet*, 371: 1268-75.

Hanefeld, J. (2010). 'The Impact of Global Health Initiatives at National and Sub-national Level a Policy Analysis of their Role in Implementation Processes of Antiretroviral Treatment (ART) Roll-out in Zambia and South Africa'. *AIDSCare*, 22 supp 1, 93-102.

Hanefeld, J., N. Spicer, R. Brugha, and G. Walt (2007). 'How Have Global Health Initiatives Impacted on Health Equity?'. A Literature Review Commissioned by the Health Systems Knowledge Network, http://www.who.int/social_determinants/resources/csdh_media/global_health_initiatives_2007_en.pdf (last accessed 31/1/12).

Harmer, A., N. Spicer, J. Aleshkina, D. Bogdan, K. Chkhatarashvili, G. Murzalieva, N. Rukhadze, A. Samiev, and G. Walt (2012). 'Has Global Fund Support for Civil Society Advocacy in the Former Soviet Union Established Meaningful Engagement or 'A Lot of Jabber about Nothing'? *Health Policy and Planning*, 1-10, doi:10.1093/heapol/czs060.

Hartmann, B. (1987). *Reproductive Rights and Wrongs: The Global Politics of Population Control and Contraceptive Choice*. Harper and Row, New York.

Hartmann, B. and H. Standing (1989). *The Poverty of Population Control*. London: Bangladesh International Action Group.

Hawkes S. and K. Buse (2013). 'Gender and Global Health: Evidence, Policy and Inconvenient Truths'. *The Lancet*, 381: 1783-87.

Hsu, J., P. Berman, and A. Mills (2013). 'Reproductive Health Priorities: Evidence from a Resource Tracking Analysis of Official Development Assistance in 2009 and 2010'. *The Lancet*, 381: 1772-82.

Inhorn, M.C. (2006). 'Defining Women's Health: A Dozen Messages from more than 150 Ethnographies'. *Medical Anthropology Quarterly*, 20(3): 345-78.

Kapilashrami, A. and B. McPake (2013). 'Transforming Governance or Reinforcing Hierarchies and Competition: Examining the Public and Hidden Transcripts of the Global Fund and HIV in India'. *Health Policy and Planning*, 28: 626-35.

Koivusalo, M. and M. Mackintosh (2011). 'Commercial Influence and Global Nongovernmental Public Action in Health and Pharmaceutical Policies'. *International Journal of Health Services*, 41(3): 539-63.

Lauterbach, C. and E. Zuckerman (2013). 'Assessing the Effectiveness of World Bank Investments'. WIDER Working Paper No. 2013/017. Helsinki: UNU-WIDER.

Mackintosh, M. (2001). 'Do Health Care Systems Contribute to Inequalities?'. In D. Leon and G. Walt (eds), *Poverty, Inequality and Health*. Oxford: Oxford University Press.

Mackintosh, M. and P. Tibandebage (2006). 'Gender and Health Sector Reform: Analytical Perspectives on African Experience'. In S. Razavi and S. Hassim (eds), *Gender and Social Policy in a Global Context: Uncovering the Gendered Structure of 'The Social'*. Palgrave: Basingstoke.

Mayhew, S. (2002). 'Donor Dealings: The Impact of International Donor Aid on Sexual and Reproductive Health Services'. *International Family Planning Perspectives*, 28(4): 220-24.

McCoy, D., S. Chand, and D. Sridhar (2009). 'Global Health Funding: How Much, Where it Comes from and Where it Goes'. *Health Policy and Planning*, 24: 407-17.

Molyneux, D.H., P.J. Hotez, and A. Fenwick (2005). '"Rapid-Impact Interventions": How a Policy of Integrated Control for Africa's Neglected Tropical Diseases Could Benefit the Poor'. *PLoS Med* 2(11): e336. doi:10.1371/journal.pmed.0020336.

Mosse, D. (2005). *Cultivating Development: An Ethnography of Aid Policy and Practice*. London and New York: Pluto Press.

Murray, S. and M.A. Elston (2005). 'The Promotion of Private Health Insurance and its Implications for the Social Organisation of Healthcare: A Case Study of Private Sector Obstetric Practice in Chile. *Sociology of Health & Illness*, 27(6): 701-21.

Orem, J.N., F. Mugisha, C. Kirunga, J. Macq, and B. Criel (2011). 'Abolition of User Fees: The Uganda Paradox'. *Health Policy and Planning*, 26: ii41-ii51.

Parkhurst, J.O. and M. Vulimiri (2013). 'Cervical Cancer and the Global Health Agenda: Insights from Multiple Policy-analysis Frameworks'. *Global Public Health: An International Journal for Research, Policy and Practice*, 8(10): 1093-1108, doi:10.1080/17441692.2013.850524.

Paul, E., M. Ireland, J. Martini, V. Zinnen, I. Ronse, S. Samaké, and B. Dujardin (2013). 'Results from the Implementation of Aid Effectiveness Principles in the Health Sector in Mali'.

Journal of Public Health Policy, 34: 140-52. doi:10.1057/jphp.2012.64; published online 29 November 2012.

Payne, S. (2011). 'Beijing Fifteen Years On: The Persistence of Barriers to Gender Mainstreaming in Health Policy'. *Social Politics*, 18(4): 515-42.

Perlman, D. and A. Roy (eds) (2009). *The Practice of International Health*. Oxford: Oxford University Press.

Petchesky, R. (2003). *Global Prescriptions: Gendering Health and Human Rights*. Zed Press: London.

Phillips, S. (1995). 'The Social Context of Women's Health: Goals and Objectives for Medical Education'. *Canadian Medical Association Journal*, 152(4): 507-11.

Physicians for Human Rights (2007). 'Deadly Delays. Maternal Mortality in Peru a Rights-Based Approach to Safe Motherhood'. https://s3.amazonaws.com/PHR_Reports/maternal-mortality-in-peru2007.pdf.

Pitt, C., G. Greco, T. Powell-Jackson, and A. Mills (2010). 'Countdown to 2015: Assessment of Official Development Assistance to Maternal, Newborn, and Child Health, 2003–08'. *The Lancet*, 376: 1485-96.

Pollack, M. (2002). 'Equidad de Género en el Sistema de Salud Chileno'. Serie Financiamiento del Desarollo, No. 123. Santiago: CEPAL.

Porter, F. and T. Wallace (2013). 'Aid, NGOs and the Shrinking Space for Women: A Perfect Storm'. In T. Wallace and F. Porter, with R. Bowman (eds), *Aid, NGOs and the Realities of Women's Lives: A Perfect Storm*. Practical Action, Rugby.

Prost, A., T. Colbourn, N. Seward, K. Azad, A. Coomarasamy, A. Copas, T. Houweling, E. Fottrell, E. Kuddus, S. Lewycka, C. MacArthur, D. Manandhar, J. Morrison, C. Mwansambo, N. Nair, B. Nambiar, D. Osrin, C. Pagel, T. Phiri, A-M. Pulkki-Brännström, M. Rosato, J. Skordis-Worrall, N. Saville, N. Shah More, B. Shrestha, P. Tripathy, A. Wilson, and A. Costello (2013). 'Women's Groups Practising Participatory Learning and Action to Improve Maternal and Newborn Health in Low-resource Settings: A Systematic Review and Meta-analysis'. *The Lancet*, 381: 1736-46.

Ravindran, T.K. and S. Weller (2005). 'Public-private Interactions in Health'. In T.K. Ravindran and H. de Pinho (eds), *The Right Reforms? Health Sector Reforms and Sexual and Reproductive Health,* http://www.wits.ac.za/academic/health/publichealth/genderhealth/rightsandreforms/10608/book:_the_right_reforms.html, accessed 30/10/13.

Reich, M. (2000). 'Public–private Partnerships for Public Health'. *Nature Medicine*, 6(6): 617-20.

Reich, M. (2002). 'Introduction: Public–private Partnerships for Health'. In M. Reich (ed.), *Public–Private Partnerships for Public Health*, Harvard Centre for Population and Development: Cambridge, MA.

Richter, J. (1995). *Vaccination Against Pregnancy: Miracle or Menace?* Zed Books, London and New York.

Sen, G. and P. Östlin (2009). *Gender Equity in Health: The Shifting Frontiers of Evidence and Action*. London and New York: Routledge.

Shiffman, J. (2006). 'Donor Funding Priorities for Communicable Disease Control in the Developing World'. *Health Policy and Planning*, 21(6): 411-20.

Shiffman, J. and S. Smith (2007). 'Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality'. *The Lancet*, 370: 1370-79.

Shiffman, J., D. Berlan, and T. Hafner (2009). 'Has Aid for AIDS Raised All Health Funding Boats?'. *Journal Acquired Immune Deficiency Syndrome*, 52: S45-S48.

Spangler, S.A. (2012). 'Assessing Skilled Birth Attendants and Emergency Obstetric Care in Rural Tanzania: The Inadequacy of Using Global Standards and Indicators to Measure Local Realities'. *Reproductive Health Matters*, 20(39): 133-41.

Spicer, N., A. Harmer, J. Aleshkina, D. Bogdan, K. Chkhatarashvili, G. Murzalieva, N. Rukhadze, A. Samiev, and G. Walt (2011). 'Circus Monkeys or Change Agents? Civil Society Advocacy for HIV/AIDS in Adverse Policy Environments'. *Social Science & Medicine*, 73: 1748-55.

Starrs, A.M. (2006). 'Safe Motherhood Initiative: 20 Years and Counting'. *The Lancet*, 368: 1130-32.

Standing, H. (1997). 'Gender and Equity in Health Sector Reform Programmes: A Review'. *Health Policy and Planning*, 12(1): 1-18.

Stiermann, E., F. Ssengooba, and S. Bennett (2013). 'Aid Alignment: A Longer Term Lens on Trends in Development Assistance for Health in Uganda'. *Globalization and Health*, 9: 7, http://www.globalizationandhealth.com/content/9/1/7

Tegtmeier, R., C. Cid, and M. Sánchez (2009). 'Discriminación y equidad de género pre y post reforma de salud año 2009', Santiago: Departamento de Estudios y Desarrollo, Superintendencia de Salud.

Tibandebage, P. and M. Mackintosh (2010). 'Maternal Mortality in Africa: A Gendered Lens on Health System Failure'. *Socialist Register*, 46.

Tolhurst, R., Y.P. Amekudzi, F.K. Nyonator, S. Bertel Squire, and S. Theobald (2008). '"He Will Ask Why the Child Gets Sick so Often": The Gendered Dynamics of Intra-household Bargaining over Healthcare for Children with Fever in the Volta Region of Ghana'. *Social Science & Medicine*, 66: 1106-17.

UN (2013). Extreme Poverty and Human Rights, Note by the General Secretary, Sixty-eight session, Promotion and protection of human rights: human rights situations and reports of special rapporteurs and representatives, 9 August.

Walker, S. (2013). 'Losing Sight of Our Purpose'. In T. Wallace and F. Porter, with R. Bowman (eds), *Aid, NGOs and the Realities of Women's Lives: A Perfect Storm*, Practical Action Publishing.

Welbourn, A. (2013). 'From Local to Global and Back Again – Learning from Stepping Stones'. In T. Wallace and F. Porter, with R. Bowman (eds), *Aid, NGOs and the Realities of Women's Lives: A Perfect Storm*, Practical Action Publishing.

World Health Organization (WHO) (1998). *Gender and Health: A Technical Paper*. Geneva: World Health Organization.

World Health Organization (WHO) (2008). *Closing the Gap in a Generation. Health Equity Through Action on the Social Determinants of Health*. Final Report, Commission on Social Determinants of Health, Geneva: WHO, accessible via (http://www.who.int/social_determinants/themes/en/), last accessed 6 July 2012.

World Health Organization (WHO) (2013). 'Research for Universal Health Coverage'. World Health Report 2013, WHO: Geneva.

Widdus, R. (2001). 'Public–private Partnerships for Health: Their Main Targets, Their Diversity, and Their Future Directions'. *Bulletin of the World Health Organization*, 79: 713-20.

Widdus, R. (2005). 'Public-private Partnerships: An Overview'. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 99: 1-8.

Yamin, A.E. and V.M. Boulanger (2013). 'From Transforming Power to Counting Numbers: The Evolution of Sexual and Reproductive Health and Rights in Development; and Where we Want to go from Here'. Working Paper Series, *The Power of Numbers, a Critical Review of MDG Targets for Human Development and Human Rights*, FXB Centre for Health and Human Rights, Harvard University, http://fxb.harvard.edu/working-paper-series, accessed 30/10/13.

Yamin, A.E. and K.L. Falb (2012). 'Counting What We Know: Knowing what to Count: Sexual and Reproductive Rights, Maternal Health, and the Millennium Development Goals'. *Nordic Journal on Human Rights*, 30(3): 350-71.

Zaidi, S., S. Mayhew, J. Cleland, and A. Green (2012). 'Context Matters in NGO–Government Contracting for Health Service Delivery: A Case Study from Pakistan'. *Health Policy and Planning*, 27: 570-81.