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**Unpacking ‘women’s health’ in the context of PPPs:**

**A return to instrumentalism in development policy and practice?**

**Jasmine Gideon and Fenella Porter**

**Introduction**

The global aid architecture has undergone a significant transformation 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<sup>1</sup>) 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 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

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<sup>1</sup> 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.

foundations, and trans-national corporations. A useful definition is offered by Buse and Harmer (2007) who describe GPPPs as:

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 ... (2007: 259-60).

In practice these 'partnerships' can take a number of different forms, with 'partners' providing a whole range of activities from funding, to education, to joint research activities. Hawkes and Buse (2011: 400) suggest that an important distinction is between partnerships where decision-making powers are shared among partners and those PPPs which are merely characterised by 'participation' from both the public and private sector.

A growing body of research has explored the history and diverse composition of PPPs (Buse and Walt, 2000; Buse and Tanaka, 2011; Hanefeld et al, 2007) with particular attention given to the governance-related challenges of PPPs and their unintended health system effects (Buse et al. 2009; Ruckert and Labonté, 2014). However, as Kapilashrami and McPake (2013) argue less attention has been given to the ideas underpinning these partnerships and the practices they generate. At the same time, discussion has focused on global level PPPs with very little attention given to smaller scale, national level PPPs. 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 women's rights.

### **Defining Women's Health**

Women's health can be understood as involving their emotional, social, cultural, and physical well being, and is determined by the social, political, cultural 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 (Inhorn 2006). However, 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 promoting 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.

In contrast, a gender equality approach is centrally concerned with power relations and considers that health may also be a site of gender conflict. It considers 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 (Sen and Östlin, 2009). 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<sup>2</sup>).

## **Understanding gender in the context of global health policy and funding**

### ***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 'women's issues' such as cervical cancer or maternal health on the global policy agenda (Starrs 2006; Shiffman and Smith 2007; Storeng and Béhague, 2014; Parkhurst and Vulimiri 2013).

Consequently women's health issues are frequently translated into easy-to-understand targets that fit within a wider instrumentalist agenda - as is evident in the integration of maternal mortality into the MDG agenda. However, this fails to take into account the wider health systems, yet a major element of health system strengthening is ensuring accountability to all citizens (Freedman et al., 2005). Moreover, 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).

Critical analyses of the shortcomings of the MDG framework also provide valuable lessons for work on PPPs. The narrow focus within the MDGs has diverted attention away from the wider

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<sup>2</sup> <http://www.who.int/gender/mainstreaming/strategy/en/index.html>, accessed 30/10/13.

goals of social justice; this is particularly evident in efforts to meet the MDG target 5, especially the reduction of maternal mortality rates (Freedman 2005; Fukuda-Parr 2012; Storeng and Béhague, 2014; Yamin and Boulanger 2013). Similar concerns have been raised in relation to PPPs, as Birn (2014: 26) warns ‘there is no PPP for social justice in health’. 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). Moreover, evidence has shown that interventions that promote women’s participation in meaningful ways and recognise women’s knowledge are more likely to bring about effective reductions of maternal mortality rates (Lo, 2008; Prost et al. 2013). Indeed, health systems themselves are gendered institutions and frequently constrain women’s access to services (Mackintosh and Tibandebage 2006; Gideon, 2014).

### ***Negotiating ideas of gender in the context of global health PPPs***

Considerable discussion has been generated by the growing role of PPPs in global health. Here particular focus will be given to the implications of PPPs for gender and health, and within that how ‘women’s health’ reflects 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 – including the GFATM and the UK Department for International Development [DFID] - still advocated an ‘add women and stir’ i.e. a gender equity approach to health policy. Similarly an analysis of PPPs in SRH 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 (Ravindran and Weller, 2005).

The MDG agenda clearly placed women's reproductive health on the global development agenda and it is therefore not surprising that the Gates Foundation 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 (<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). Gates has 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 voluntary family planning has transformational benefits for women and girls and is one of the most cost-effective investments a country can make in its future. It is estimated that every US\$1 spent on family planning can save up to \$6 on health, housing, water, and other public services.

Access to contraceptives also leads to:

- Fewer deaths among women and newborn babies and wider health benefits;
- More girls completing their education and greater opportunities for girls;
- Healthier and more prosperous families and communities;
- Reduced demands on social sector budgets (Family Planning 2020)<sup>3</sup>.

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. 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.

Given the variable nature of PPPs it is hard to generalise about their operation on the ground but a number of studies do offer some insights. Within the field of maternal health PPPs have focused on a number of different initiatives but the majority are primarily oriented towards improving access to affordable services, particularly for poor women (Ravindran, 2011). One strategy that has proved popular is the implementation of performance-based financing schemes such as that funded by GAVI in Cambodia. Here health centres are reimbursed for antenatal care visits and immunisation doses (Matsuka et al., 2014). Another widespread initiative funded through PPPs is the use of voucher-like schemes such as that found in Gujarat state in India. Here the Scheme for Long Life provides free institutional delivery care to poor women by contracting out delivery services to private obstetricians (Jehan et al., 2012: 146). While the long term impact of many of these types of schemes is not yet clear due to a lack of evidence, several critics have argued that questions of equity are still not being sufficiently addressed through such

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<sup>3</sup>Family Planning 2020, p.4  
[http://www.familyplanning2020.org/images/content/documents/About\\_the\\_London\\_Summit\\_on\\_FP\\_-\\_Summary\\_Document.pdf](http://www.familyplanning2020.org/images/content/documents/About_the_London_Summit_on_FP_-_Summary_Document.pdf)

projects and the issue of accessibility and quality of care remains an on-going challenge (Matksuoka et al., 2014;; Jehan et al., 2012; Kanya et al., 2014; Ravindran, 2011).

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

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).

Several 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 (Storeng, 2014). Nevertheless, 'vertical-horizontal tensions persist, even in these more carefully designed efforts' (Shiffman 2006: 418). Furthermore, empirical studies show that there is little evidence of donor priorities reflecting country level need or priorities (Esser and Bench 2011; Greco et al. 2008 Paul et al. 2013). 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. Moreover, several studies point to the way in which funding for HIV work has come to dominate reproductive health work across a variety of country settings (Hsu et al., 2013; Shiffman et al., 2009).

Indeed, the preference for technical interventions that results in improvements in measurable indicators (such as birth-rates), but also creates new markets for health products, can mean that PPP interventions shift the balance between available contraceptive methods. In effect this can 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 which are rarely available through PPPs, suggesting that ‘commercial interests and profit motives may in fact lead the agent to underplay the risks of the method’ (Ravindran and Weller, 2005: 122). Moreover, results-based health care is often the guiding principles of PPPs – an approach which privileges quantitative methods but 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).

### **Power relations between PPP ‘partners’**

Another concern around PPPs is the quality of the partnerships themselves, particularly where global donor partners frequently 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 (Spicer et al., 2011; Zaidi et al., 2012). This raises important questions and challenges for the ability of women’s rights advocates to challenge the dominant model of women’s health and have any meaningful voice in policy processes.

### ***Philanthropic organisations***

At the global level, private philanthropic foundations have played a large role in the emergence and acceptance of PPPs, with the 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. While this high level of resources sets philanthropic organisations apart from other actors and provides them with the ‘risk tolerance’ to undergo projects that require many years of interventions, concerns have been raised around their legitimacy (Birn, 2014; Moran and Stevenson, 2013).

In contrast to organisations such as NGOs that are able to claim a bounded form of legitimacy derived from direct association with their members and supporters, or loose links with social movements or grassroots organisations, philanthropic foundations lack this ‘democratic’ dimension (Moran and Stevenson, 2013). At the same time, while they operate in an atypical space, distinct from but closely associated with market actors such as firms, they also retain unusually strong links with the private sector for example familial connections through trustees who remain active in the corporate world (2013: 136). 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 and Bench 2011).

### ***NGO partnerships***

Questions around the balance of power between partners within PPPs have been raised within the broader literature (Farah and Rizvi, 2007; Hawkes and Buse, 2011). When NGOs engage with private sector partners, the partnership can involve many different roles. These partnerships can include working with donor funds to implement activities, working with accountancy and/or consultancy firms who manage consortia projects since they are often seen as having a comparative advantage over NGOs because of their ability to present a ‘business case’ for

development work and consortia partners. Partners in NGO work can therefore include large accountancy and consultancy firms, international commercial banks, global insurance companies and other global corporate enterprises. Some NGO workers argue that these developments have led to a shift from private sector partners ‘raising profile’ through involvement in development work, to a more accepted notion that development work should harmonise with business objectives to generate markets and profit (DSA Study Group report, 2015). Some NGO workers identify positive elements to the relationship with corporate partners, such as spreading the risk of new, innovative, projects, and increased expertise in areas such as monitoring and evaluation, as well as the opportunity to influence corporate partners positively on gender issues. However, there are also more negative consequences, including an often-felt preference for quantitative rather than qualitative data, a reluctance to invest in more intractable problems with harder-to-reach communities, and a lack of (downwards) accountability to NGO partners and communities.

### ***Changing narratives of gender and health in UK-based NGOs***

The growth and acceptance of particular market-oriented norms and principles within the health sector has been documented in a number of studies (Birn, 2014; Storeng, 2014; Storeng and Béhaugé, 2014; Ravindran and Weller, 2005). The role of the private sector in the health sector has brought about shifts in how healthcare, and within that women’s health, can be understood and addressed. Nevertheless, there is a gap in understanding how NGOs have responded to this shift at the level of practice. Focusing on the local level impact of the Global Fund in India Kapilashrami and McPake (2013) emphasise the ‘hidden transcripts’ of power and the creation of a competitive environment in which projects struggle for funding. Although their study did not specifically focus on the gendered implications, the effects are such that the voices and work of local organizations are excluded.

NGOs are dependent on external funding, and echoing the ‘hidden transcripts of power’, 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). The research conducted for this paper has indicated that UK-based NGOs are increasingly reliant on institutional funding from bi- and multi-laterals, and also from PPPs or direct corporate partnerships.

Overall, amongst the NGOs participating in this research, the proportion of funding from the private sector is not more than a small percentage of the total funds. The vast majority of NGO funds still come from institutional funders such as DFID and the EU. Sometimes institutional funding is through programme partnership agreements (PPAs), which is highly valuable because it is unrestricted funding, but more often these funds are restricted and have high cost implications because of the level of monitoring and evaluation that is required to ‘service’ them (BOND, 2015).

However, the potential offered to NGOs via PPP funding is significant. This is evident in a recent DFID health investment programme - ‘Harnessing Non-State Actors for Better Health for the Poor’ (HANSHEP), which has a budget of just under £35 million over eight years (2010-2018). The HANSHEP website states its mission as ‘improving ‘the performance of the non-state sector in delivering better healthcare to the poor by working together, learning from each other, and sharing this learning with others’ (<http://www.hanshep.org/about-us/our-mission><sup>4</sup>). Moreover, its objectives include ensuring that ‘an increased number of poor people, in particular women and children will receive better quality and more affordable, or free, health services...’ (<http://devtracker.dfid.gov.uk/projects/GB-1-201101/><sup>5</sup>). Thus whilst direct funding from individual private sector partners is still a relatively small proportion of NGO funds, the *potential* to grow this funding was seen to be significant by most of the organisations participating in this research.

The ongoing shift in funding regimes for health programmes has profoundly affected NGO narratives around their work in this area. Organizations need to prove their ability to address the priority areas of the donors, and produce work that can be measured to show successful implementation (DSA Workshop report, 2005; Esser and Bench 2011; UKNGO1). NGOs are thus becoming active proponents of PPPs, and find that their work is now being shaped in specific ways to ‘fit’ the current development discourse (UKNGO 1, 8, 10). Similar findings have been reported elsewhere (Birn, 2014; Storeng, 2014).

This shift in the focus of the funding regimes has brought about many positive changes in the operational work of NGOs, not least by increasing the amount of funding available. However, this shift also has the potential to undermine the effectiveness of interventions in bringing about

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<sup>4</sup> Accessed 5/6/15

<sup>5</sup> Accessed 5/6/15

greater gender equality. This paper has shown how the differences between gender equality and gender equity approaches can have differential 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 there is a need for more detailed empirical studies which reveal the local level impact of the global health agenda and give particular attention to gendered power relations. As a step towards filling this knowledge gap the following section of the paper draws on an analysis of UK-based NGOs to examine how health policy and programming reflects the changing landscape of funding patterns. Specific attention is given to ability of NGOs to understand and incorporate an analysis of gender equality in their current work on women's health issues.

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

The research questions governing this study were: how and to what extent these underlying ideas around women's health had reached UK-based NGOs, and were affecting their understanding of, and ability to address, women's health needs. As the study investigated the construction of knowledge and understanding, it was important to draw on qualitative research methodologies, and be able to respond to the data as it emerged. 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. The sample can be understood as a broad case study approach, rather than a specific in-depth case study of a particular organisation (Yin, 1994).

Interviews were conducted over a 15 month period with 20 respondents - 13 from 7 different UK-based NGOs, 5 respondents from transnational women's health networks, and 2 global health governance experts. All respondents worked on health issues with 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 organisations. In the context of the UK, NGOs range from small local service-delivery organisations through to large primarily advocacy-based NGOs and funding organisations working internationally. This analysis is not concerned to pinpoint the individual differences between these organisations; rather it seeks to formulate an understanding of their changing relationship with the dominant underlying ideologies of the global health 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. For the respondents, funding was often from DFID, but many organisations also sought funding from private foundations or directly from corporate organisations.

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

NGO respondents 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 on an individual basis some respondents had broader understandings of women's health, the NGOs they represented had historically been associated with narrower conceptualizations of women's health, which were often used to frame and plan interventions targeted at service-delivery (UKNGO10, UKNGO11). This meant that many NGOs found it relatively uncomplicated to negotiate funding relationships based on this approach. While one respondent commented that the women and girls agenda in global health does 'not necessarily reflect all we know about gender inequality' (UKNGO5), she 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 respondents acknowledged the current changes in the funding landscape related to the increased participation of private sector and corporate partners, often in global PPPs, which many attributed to the current climate of austerity, in which individual donations are falling [UKNGO7, UKNGO10]. Most respondents understood the opportunities to gain increased funding via PPP-led funding, and saw these new opportunities to address the healthcare needs of women and girls, however narrowly these are conceptualized [FONGO1, UKNGO10, UKNGO7, UKNGO8, FONGO2, UKNGO5]. They saw their work focused 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, the opportunity to pursue funding through further corporate partnerships, whether directly or via a PPP, frequently undermined how far they were able to integrate a more complex gender analysis of women's health.

While one NGO focused much of its international advocacy work at the level of the WHO, lobbying for universal coverage for healthcare 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 (UKNGO10). 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. Despite widespread empirical evidence that has shown how gender inequalities can constrain women’s access to health services these analytical approaches rarely translate into the work of NGOs 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. Respondents recognized that the requirement for results-based management and ‘value for money’ is currently a high priority, including for both PPP-led funders and bi-lateral funders such as DFID, and that this impacts on how far they are able to integrate broader understandings of women’s health. When asked about how these funding frameworks affect their health work, respondents confirmed that when managed within these frameworks, there is far more emphasis put on developing and meeting robust indicators (which are often quantitative) to secure further 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 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.

### ***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. A number of the respondents (UKNGO2, UKNGO3, UKNGO10, TNN5, TNN3, UKNGO7) commented on the influence of private foundations, the Gates Foundation in particular, and 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 developing new project work to reflect the Gates interest in vaccinations - UKNGO10). The role of the Gates Foundation was welcomed by most NGO respondents given the increase in funding and greater profile of women's health within the development contexts. However, this profile is generally limited to technical interventions targeting immediate reproductive health and MCH needs.

The influence of the Gates Foundation was not limited to the possibility of financial support. The pervasive influence of Bill Gates in the health field was widely acknowledged by respondents [UKNGO2, 3, 4, 7, 8, 10, GHG2]. Storeng and Béhague (2014) argue that the ‘Gates approach’ has encouraged the international maternal health community to focus on ‘magic bullets’ such as antibiotics to prevent maternal deaths. Similarly this study points to an embedding of a limited discourse of women’s health within the narrative of NGO programming. The ‘Gates approach’ 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. Those within NGOs saw an opportunity to raise the profile of women’s reproductive health and rights and achieve ‘real’ gains in terms of numbers of women accessing family planning [UKNGO10]. Moreover, the participation of Melinda Gates was seen as having a positive impact in terms of expanding discourse and including the idea of rights alongside reproductive health [TNN3] after the restrictions placed on language around sexual and reproductive rights given the ideologically and politically constrained position of the US government<sup>6</sup>. However, respondents involved in lobbying around the 2012 London Summit identified a risk that in concentrating resources on access to 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 development goals such as reducing maternal mortality, there are limitations to such an approach. 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 (Petchesky 2003; Yamin and Boulanger, 2013; Yamin and Falb, 2012). These broader understandings of

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<sup>6</sup> 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.

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). The 'Gates approach' is increasingly seen in other PPPs, such as DFID's HANSHEP initiative.

### ***Negotiating NGO relationships with private sector partners at the local level***

Within the context of global PPPs civil society organizations have often been 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 were invited 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. Similarly this research found that many NGOs 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.

Research respondents recognized that partnerships are often a way in which corporate organizations can improve their own credibility through their association with the NGO [UKNGO7, 8]. This might give the NGO partner some power to assert their own knowledge and experience of local realities. However, most respondents saw the corporate partnerships as an opportunity to learn about improving efficiencies and 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 one case 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. The corporate partner was not necessarily looking for improved measurable health outcomes, thus providing more flexibility and enabling resources to be focused on a more complex programme addressing gender inequality in health. However, the

NGO had to accept the corporate partner's priority as well: access to markets. There are many different ways in which the private sector can play a role in the health sector (Ravindran and Weller 2005), and this is another illustration of how PPPs can shift the understandings and practice of work around gender equality.

In sum, our analysis 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, 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).

## **Conclusion**

It is clear that in the context of global health, a significant shift is occurring 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.

## **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)

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