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## **Forthcoming in Development & Change**

### **Challenging gendered inequalities in global health: dilemmas for NGOs**

**Jasmine Gideon & Fenella Porter**

#### **The landscape of development funding for health**

In her introductory paper O’Laughlin (this volume) draws attention to the shifting landscape of international cooperation in health. As the role of the public sector and the WHO has declined over the past few decades, the World Bank, the private-for-profit sector, philanthropic foundations and NGOs have taken on an increasingly significant position within the health sector (Walt and Buse, 2000; Gore, 2013). In particular there has been a growth in new partnerships and alliances between many of these diverse actors, often coming together in what are called public- private partnerships (PPPs) (Buse and Walt, 2000; Buse and Tanaka, 2011; Hanefeld et al, 2007). PPPs in the health sector tend to be 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 (Buse and Harmer, 2007: 259). However, as critics have cautioned, it is necessary to distinguish 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 (Hawkes and Buse, 2011: 400). As O’Laughlin (this volume) notes, NGOs are frequently engaged within PPPs either as a direct partner or in a service delivery role – something which is discussed in more depth later in the paper. Yet the wider implications of NGOs involvement within PPPs have been relatively under-researched and are beset with a number of deeply-embedded assumptions. Susan Murray (2016, forthcoming) asserts, the ‘pairing up’ of NGOs, and particularly those working at the international level, with corporates, is frequently presented as unproblematic, yet NGOs are now directly involved in helping corporate organisations develop new markets in exchange for basic

health care services for ‘the poor’. The long term impacts on these communities remain open to debate, particularly when out-of-pocket payments for medicines represents one of the highest causes of health inequalities (Mackintosh, 2006). Moreover, critics have also argued that when NGOs become embroiled in relationships with within PPPs their ability to address other forms of inequality – particularly gender and race – also comes into question (Gideon and Porter, 2015; Murray, forthcoming, 2016). In many cases PPPs have institutionalized and legitimized an instrumental discourse of women’s health in development practice which fails to engage with the broader gendered and racialized social determinants of health which are critical in understanding the causes of poor health.

The paper starts with an overview of the changing funding landscape in global health before considering what this means for NGOs working within the health sector, particularly where organisations have aspired to promote gender equality and justice through their health work. The paper reflects on the tensions that are caused as a result of the growing influence of business norms within health funding alongside what critics have termed the ‘scientization’ of global health and how this is played out in work around gender and health. As the paper argues, community-based work that provides spaces for women’s voice in the design and delivery of health interventions is often marginalised as these inputs are not ‘valued’ and instead large scale, ‘technical’ interventions are prioritised. The paper reflects on what this means in terms of NGOs ability to work towards producing transformative change around gender – and indeed racial - equality.

### **NGOs and the changing funding environment in health**

Several factors account for the rise in PPPs – most notably the declining power of the WHO and at the same time the wider shift to neoliberalism in which a greater role for the private sector was seen as a solution to the perceived failure of states to deliver on the health front (Cueto, 2013; Walt and Buse, 2000). Moreover, concern over the withdrawal of industry from the manufacture

and development of vaccines, diagnostics and medicines for tropical diseases, initiated a discourse focusing on new modes of collaboration between the public and private sectors (Walt and Buse, 2000: 467).

The rapid expansion of NGOs working in the health sector within this changing context has been well documented (Bebbington et al. 2008; Gideon, 1998; Hulme and Edwards 1997). The negative impact of these NGOs on health sectors has also been widely discussed, with critics particularly pointing to the lack of aid coordination and the subsequent fragmentation of health activities. As Banks et al. (2015: 707) note, over the past two decades NGOs have significantly grown in size, number and levels of sophistication and now receive a larger slice of foreign aid and other forms of development finance than ever before. Yet, the plethora of funding mechanisms currently operating within the development arena point to differing implications for the role of NGOs and their ability to promote 'sustainable' models of development (Copestake, 2013). As a consequence, most NGO efforts remain 'palliative rather than transformative' (Banks et al., 2015: 708).

For many NGOs the impact of the funding imperative has created a situation in which the search for funding frequently over-rides the stated commitment of NGOs to principles of equality, justice and inclusion. When responding to funding agendas, NGOs will often seek to 'fit' complex and difficult issues into programmes that are designed far from the communities involved, but can demonstrate 'quick wins' that are easily documented and measured (Walker 2013: 63). This experience is echoed by respondents in Gideon and Porter's (2015) analysis of NGOs working in the health sector, who felt that their ability to accurately reflect the complex levels and layers of inequalities within the lives of the women they worked with was compromised as a result of current funding processes.

In order to assess how and why NGOs have got to the position where they are so closely related to corporate and other large institutional funding partners that they are risking

undermining the knowledge and expertise about gender and racial inequalities in health, it is important to understand how much the funding environment has changed in the last 15 years.

### **The impact of the private sector on the funding environment for NGOs**

The past two decades has seen a growing influence of the corporate sector in development (Copestake 2013; Richey and Ponte 2014; Nagaraj 2015), and in particular there has been significant global growth in business management consultancy firms managing health provisioning, such as KPMG and McKinsey & Company (Erikson, 2012: 268). This shift to health business has impacted on NGO relations with both government and private sector actors as well as establishing the need to meet and fit in with corporate norms of working, such as ‘value for money’ (Porter and Wallace 2013; Nagaraj 2015). Many of these norms are enforced through funding mechanisms such as contracting and payment-by-results (PBR). At the same time the global health arena has also undergone a process of ‘scientization’ with a growing reliance on the use of evidence based medicine (EBM) to determine which interventions *really* works (Adams, 2013). Current mainstream thinking in global health has established that randomised control trials (RCTs) are the ‘gold standard’ for determining what is or is not effective and producing appropriate evidence. As a consequence funding decisions for health interventions, even within a development context, have tended to favour projects employing RCTs in the belief that results from these projects will be more reliable because they can be more easily evaluated (Adams, 2013: 58). The emphasis that is now placed on measurement creates a system of knowledge or ‘technology of truth’ (Merry 2011, Merry and Coutin 2013) that is reproduced by both funding structures and the organisations that work within it. Yet the knowledge underpinning these ‘technologies of truth’ within science and medicine are frequently gender biased (Goldenberg, 2006).

As critics have observed, this confluence of EBM and the advent of private funding and neoliberal measures of accountability and efficiency have established a set of demands that

traditional players in global health are ill equipped to handle (Biehl and Petryna, 2013: 25). An internal review at the WHO that recommended 3500 health indicators—numerical characterizations of health conditions—as necessary to lever financial and political support of its initiatives (Murray 2007:862, cited in Erikson, 2012: 268).

This new global health landscape is replicated across the development field, producing a series of challenges for NGOs – yet while some NGOs consider this kind of cooperation as the new face of development Aid, others are struggling to survive in this world. Nevertheless, Banks and colleagues (2015) have warned that many NGOs are struggling to maintain their identity in the current climate as a result of the tensions created by contemporary funding relationships. This forms another combination of private sector discourse in development funding, and gender and development discourse, in which a set of exclusions are produced that serve to ‘hide’ gendered and racialized inequalities.

Reflecting on the rise of private sector ‘International Development Contractors’ (IDCs), Nagaraj (2015) identifies how in NGO-corporate ‘partnerships’, the differences between for-profit organisations (or vendors) and non-profits, are often blurred. The category of ‘non-profits’ is also broader than development NGOs – it can also include organisations such as universities and social enterprises (2015: 588). Partnerships in these funding mechanisms have become ways to implement private sector solutions for public sector problems (Nagaraj 2015:591). Thus whilst non-profit organisations may publically espouse principles of equal partnerships created to serve a social good, they are far from insulated from the demands and constraints of the market.

Organisations such as Bond (a membership body for development NGOs in Britain<sup>1</sup>) have cautioned against the potential impact of these shifts, particularly in the context of funding relationships such as ‘payment by results’ (PBR):

Wider risks of PBR [include] ... its effect on the diversity of the market of NGOs who may be able to bid for PBR contracts, the risk of skewing aid priorities,

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<sup>1</sup> <https://www.bond.org.uk/>

inhibiting open relationships and learning among aid partners, and undermining organisations intrinsic motivations to achieve results. (BOND <https://www.bond.org.uk/payment-by-results>)

PBR particularly, is based on the idea that it will encourage development organisations (or ‘suppliers’ in the new language) not to undertake projects for their own sake, but to concentrate more on the impact that the work is having. However, impact is not a neutral concept – it is imbued with the ‘power of numbers’ (Fukuda Parr et al. 2014). ‘Successful’ development work is therefore biased towards projects which can be ‘scaled up’ and reach more people. This means that much work by NGOs is now based on measuring rather than understanding local context and their complexities. As Berry (2014) contends

‘As cultures of accountability and audit increasingly pervade the domain of global health, the sheer act of counting in particular ways can legitimize activities’ (2014: 345).

Within this context “meaningful long-term involvement” of NGO or community workers is no longer valid and such actors no longer have a voice in the development process (Adams, 2013; Berry, 2014; Erikson, 2012). This has specifically gendered consequences, where NGOs no longer understand or can respond to the realities of women’s lives (Wallace and Porter 2013), and, more fundamentally, by complying with the neoliberal development frameworks, gender inequalities are in fact extended and deepened (Wilson 2015). As Adams contends, ‘relationships that play important roles in people’s health, including such contexts as families and communities, are not easily standardized, and therefore they are often ignored or made irrelevant to study designs’ (2013: 85). Yet it is precisely these relationships that are critical to understanding the gendered and racialised vulnerabilities to poor health and to wider health inequalities (Gideon, 2016; Sen and Östlin, 2009).

### **The limits of indicators for understanding gendered inequalities in health**

The shift in the funding environment has had a fundamental impact on how NGOs consider and work on health programmes. Research conducted with UK-based NGOs working on women's health programmes has highlighted how dominant discourse emerging from corporate sector actors are reducing the understanding of women's health to more instrumentalized notions of maternal and reproductive health. This in turn impacts on the types of projects that NGOs are able to promote and engage with which often serve to reinforce more limited understandings of women's health and fail to give voice to the women they claim to be supporting (Gideon and Porter, 2015). As outlined above, a number of historic developments within the health field have shaped the ways in which certain health conditions are given precedence over others and have led to the prioritisation of particular sets of indicators to determine the success of health care interventions. This can be seen more clearly against the wider backdrop of the reshaping of the politics of global health as outlined by O'Laughlin (this volume). During the 1990s the World Bank advocated the importance of 'burden of disease' priority-setting tools - thus cementing the idea that diseases and conditions accounting for a high burden of mortality and morbidity should be given priority (Storeng and Béhague, 2014). This demand for quantitative indicators was further reinforced in 2000 with the establishment of the UN Millennium Development Goals (MDGs). In their analysis of the impact of these trends on maternal health work, Storeng and Béhague (2014) cite an informant who explained that in the past 'donors never wanted indicators and then they wanted results and everybody started asking 'what are you using your money for?'' (2014: 265). From a health perspective this shift towards more narrowly defined quantitative indicators and a growing emphasis on 'cost effectiveness' has been seen as highly problematic (Esser and Bench, 2011; Freedman, 2005; Yamin and Boulanger, 2013; Fukuda-Parr, 2012; Spangler, 2012). As Erikson wryly observes

Whether statistics are accurate or enough to improve health is less important than whether statistics are performed and work to enable economic systems (2012: 373).

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 well-being. One example that has generated discussion is the choice of the proportion of births attended by skilled birth attendants (SBA) in the MDG 5. While this target was in part selected because it was easy to measure, it also has 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).

One of the biggest tests remains the balance between reconciling the need for global standards with the need to take account of local realities (Spangler, 2012). This clearly raises a number of challenges for NGOs working in the health field. In order to win funding, organisations 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 find that their work is now being underpinned by limited assumptions of efficiency and effectiveness, many of which are also gender-blind (Gideon and Porter, 2015). Moreover it has led to new conflicts in the work that NGOs carry out on the ground.

In their study conducted among UK based NGOs working with women's health projects Gideon and Porter (2015) found considerable evidence of these tensions. This is clearly illustrated in the comments of one respondent who spoke of the desperate search for an indicator for women's empowerment, as this would enable them to respond more easily to the reporting requirements for DFID funding. Such preoccupations are rife within NGOs, and the 'servicing' of large contracts and partnership agreements that demand that NGOs demonstrate 'value for money' can often cost the organisation dearly in terms of staff time and ultimately in terms of their relationships with partners.

This was clearly apparent in the work of a small feminist NGO working in Ghana with a programme designed to reduce violence against women. It was held up as an exceptional ‘beacon of good development practice’, employing a ‘bottom-up’ approach to bringing about meaningful change in women’s lives. The women targeted by the programme were also actively involved in shaping and altering it so that it responded more specifically to their own priorities. However, despite the success of the programme, it became increasingly at odds with the UK-based donors, who were under pressure ‘to demonstrate success through quick results for large numbers of women’ (Ahluwalia, 2013: 165). Gideon and Porter (2015) report similar findings where respondents suggested that the quality of their relationships with partners was increasingly focused on building the capacity of Southern partners (or picking Southern partners with the capacity already) to respond to technical reporting demands of funders, rather than the needs of ‘local’ women.

The ‘power of numbers’ project (Fukuda-Parr et al. 2014) shows the influence of the MDGs and the accompanying normative effects on development discourses, which have chimed with the norms and practices of the corporate actors now so prevalent within the development sector. Two health-related issues specifically targeted within the MDGs and also the subjects of large scale private sector investment will allow us to explore these issues in more depth: these are HIV AIDS and maternal health. Both areas have been subject to discussion in the wider literature and provide clear examples of the possible tensions experienced by NGOs working within the current funding landscape.

### **‘Perverse outcomes’ on the ground: NGOs, HIV AIDS and maternal health**

The ascendancy of philanthropic organisations<sup>2</sup>, such as the Bill and Melinda Gates Foundation as well as global partnerships such as the Global Fund have led to growing concerns around the governance-related challenges of these mechanisms within the health sector as well as their unintended health system effects (Buse et al. 2009; Ruckert and Labonté, 2014; Birn, 2014; Sridhar and Batniji, 2009; McCoy et al., 2008). Within this debate attention has also been given to the role of NGOs with commentators observing that when NGOs become engaged in partnerships and become compliant with the norms of these funding systems, they are rarely seen as ‘agents of change’. Indeed critics have argued that NGO staff are pressured into spending large amounts of time to produce funding bids thus diverting their attention away from other tasks and even once funds are received the pressure to meet targets and produce measurable outcomes for funders has caused them to lose their advocacy role and their relationship with partners on the ground (Amaya et al., 2014; Gideon and Porter, 2015; Spicer et al. 2011; Harmer et al. 2012; Porter and Wallace, 2013). As the discussion in this section demonstrates, this can lead to ‘perverse outcomes’ on the ground, particularly in work around HIV AIDS and maternal health given the emphasis that has been placed on these two areas of health care, particularly for women’s health.

In some cases donor and corporate agendas can become prioritised over the voices of those that NGOs habitually claim to represent. This was particularly apparent in South Africa where the HIV AIDS funds are primarily channelled through the United States President’s Emergency Plan for AIDS Relief (PEPFAR). PEPFAR is South Africa’s largest HIV/AIDS donor but, with a mandate driven from Washington, a number of PEPFAR South Africa’s positions (notably on condoms and abortion) are in contradiction to South Africa’s own laws. Nevertheless, many organisations continued to apply for PEPFAR funding, finding various means of subverting the US moral agenda despite the constraints it placed on work on the

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<sup>2</sup> While philanthropic organizations such as the Gates Foundations are distinct from corporate players, they are often strongly associated with the values of efficiency and value for money, drawn from the success of the corporate organizations from which they and thus reflect similar underlying principles to the corporate sector.

ground, particularly in relation to addressing women's empowerment (Ghanotakis et al, 2009). Nevertheless, other concerns can also arise. For example 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.

In other instances, given their high levels of funding, NGOs and private foundations are able to supplant the role of national governments in decision-making processes around national health policy and national health priorities. On occasion this can have a positive impact on women's rights as NGOs are able to undermine oppressive government positions. Atukunda and colleagues documented the introduction of the drug misoprostol in Uganda, where it was proposed as a solution to the lack of access to oxytocin, the first line treatment for the prevention of postpartum haemorrhage (PPH) (2015: 243). Their analysis focused on the role of local level NGOs in the process of approval, procurement, distribution and the promotion of misoprostol in Uganda. The misoprostol programme in Uganda was driven by the need to reduce maternal mortality and look for a viable 'solution' to the problem. The study found that in practice the use of misoprostol had been significantly expanded and in some cases the NGOs were actively encouraging misoprostol use for unapproved indications including induction of labour and abortion, which can put women's health at risk. Issues of accountability, particularly downwards accountability to the communities in which these programmes are implemented, remain a significant challenge within these partnerships and require further consideration. Moreover, while the weaknesses of institutions for medicine approval in low-income countries are well documented, the use of NGOs to promote new drugs fails to tackle this problem within many southern health systems, and as the Ugandan case demonstrated, NGOs are able to bypass National level institutions (Atukunda et al., 2015).

There are many different ways in which the private sector can play a role in the health sector (Ravindran and Weller, 2005) and for some NGO workers, partnerships with corporate

organisations can offer new learning opportunities and a chance to share ideas and expertise. However, critics have argued that the increased role of corporate players can compromise the idea of development interventions being free of market-oriented involvement (Murray, forthcoming 2016). A study of UK-based NGOs working in the health sector found that these 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 working with those at ‘the grassroots’. This can be seen as an illustration of the knowledge technologies that are reinforced by the dominance of the market-led system of funding and partnership at the ‘top’ of the Aid Chain (Wallace et al. 2006).

Some (large, international) NGOs do have significant power, based on the value of their ‘brand’, and for respondents in these NGOs this power makes the relationship with some private sector partners more equal, or at least more nuanced in the way power is balanced. However, they did not want to use this power to fundamentally challenge their new funding partners to address more deeply embedded inequalities in health (Gideon and Porter, 2015). An example of the discussions around power and knowledge in this context is the increased reliance of RCTs to measure the impact of health programmes, particularly around maternal health. Although some respondents in NGOs felt these gave more credibility to women’s health programmes, others feared that an over-reliance on such methods reinforced the shift towards more technical understanding of women’s reproductive health rather than addressing questions of power and inequality which reinforce gendered vulnerabilities to poor health (Gideon and Porter, 2015). Several commentators have reflected on the ways in which the ongoing shift in funding regimes for health programmes has profoundly affected NGO ‘narratives’ around their work as they adapt to ‘fit’ the current development discourse (Birn, 2014; Gideon and Porter, 2015; Morfit, 2011; Storeng, 2014). Organizations need to prove their ability to address the priority areas of the donors – or private partners - and produce work that can be measured to show successful implementation (Esser and Bench 2011).

While this shift in the focus of the funding regimes has brought about some positive changes in the operational work of NGOs, not least by increasing the amount of funding available, it also has the potential to undermine the effectiveness of interventions in bringing about greater gender equality (Gideon and Porter, 2015). Where NGOs are being pushed to demonstrate ‘value for money’ they are often pressured to deliver services within projects which have narrowly defined parameters that reflect current global health discourse. As one UK-based NGO worker commented ‘the women and girls agenda in global health does ‘not necessarily reflect all we know about gender inequality’ (cited in Gideon and Porter, 2015: 10). Moreover in their study examining the implications of public-private partnerships for NGOs work on gender and health, Gideon and Porter found that while respondents acknowledged the current changes in the funding landscape were in part driven by the need to make up a shortfall in individual donations, they felt that there were also new opportunities to address the healthcare needs of women and girls, however narrowly these are conceptualized. They acknowledged the role of donors in shaping the wider agenda and were clear that 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. Empirical studies have also reported how a narrow focus on maternal health has taken attention away from broader understandings of women’s health and that as a consequence other aspects of women’s sexual and reproductive health are neglected (Kvernflaten, 2013; Mishra, 2015).

Other authors have noted similar trends in work around HIV AIDS which raises concerns not only for how issues around sexuality are addressed within a development context but also how deeply embedded gendered and racialised assumptions and norms can become further reinforced. As Bell (2015) suggests, donors’ prioritisation of male circumcision as a means of addressing the HIV AIDS epidemic, despite inconclusive medical evidence, is underpinned by problematic and racialised assumptions around African men’s sexuality and their lack of ‘restraint’. She argues that ‘male circumcision becomes a partial ‘technical’ solution that

helps to counterbalance entrenched ‘cultural’ patterns of sexual behaviour’ (2015: 564) yet no acknowledgement is given to the problematic way in which the assumed behaviour of African men is embedded within such programmes. It is worth noting here that in interviews conducted for the aforementioned study on the role of NGOs in the context of PPPs (see Gideon and Porter, 2015) one informant reported that in certain parts of Africa reproductive health clinics were now solely offering male circumcision since one of the targets for the service provider was number of circumcisions completed and funding was dependent on this. This clearly raises concerns for the ways in which reproductive health needs are now being considered and addressed.

Furthermore, in a study of work around HIV AIDS in Ghana, Benjamin Eveslage (forthcoming, 2016) found that international donors were keen to work with local Ghanaian NGOs with access to sexual minority groups. This provided donors not only with an entry point for work on HIV AIDS but enabled them to evidence their support for LGBT rights – something that since 2011 has been advocated by the UN and promoted by some Western governments as a foreign policy objective. Yet this led to tensions on the ground as donor funding prioritised work around HIV/AIDS awareness and prevention and the NGOs were then limited in the work they could do to promote human rights. Thus, as a consequence of their engagement with donors funding HIV interventions, the mandates of these NGOs shifted from one promoting sexual rights to an emphasis on sexual health that better fit donor priorities. As Eveslage has argued, as a consequence efforts to advance sexual rights in Ghana have been considerably constrained.

The political nature of priority setting in global health policy has been widely acknowledged and concern has been expressed that donor prioritization of HIV/AIDS treatment and prevention in developing countries has displaced aid for other health issues (Parkhurst and Vulimiri 2013). Indeed, this is particularly apparent in sub-Saharan Africa where development has become nearly synonymous with the HIV AIDS and there has been a

profound reconfiguration in development efforts targeted to the region prioritizing AIDS over other concerns (Morfitt, 2011). Since 2004 the most important financial donor for HIV/AIDS at an international level has been the Global Fund to fight AIDS, Tuberculosis and Malaria – commonly known as the Global Fund (Cabrera, 2010). In turn the Global Fund itself is funded by a range of donors including the Bill and Melinda Gates Foundation although they also fund HIV AIDS work through other channels (McCoy et al., 2009). Country recipients of Global Fund assistance are expected to create national structures called Country Coordination Mechanisms (CCMs) to identify priorities, develop and submit proposals according to the specific priorities and harmonise disease-specific programmes with national policies and programmes (Amaya et al., 2014: 177). NGOs are frequently then subcontracted to deliver services funded via the Global Fund or in some cases, such as India, NGOs have formed direct alliances with the corporate sector and the national AIDS control organization (NACO), a project management organization under the Ministry of Health and become co-recipients of the Fund grant (Kapilashrami and McPake, 2013). In effect, these trends have brought about a significant expansion in the number of NGOs working on HIV AIDS, particularly because of their presumed comparative advantage and ability to ‘scale up’ projects. In the words of a former director of a Global Health PPP,

‘They [NGOs] are more nimble, there may be less corruption, they’re quicker off their feet, individuals [in NGOs] are more motivated’ (cited in Yamey, 2011: 2).

However, these trends to increase the scale of NGO work, have tended also to undermine the understanding of the political, gendered and racialized inequalities that exist in healthcare, and the longer-term, more complex and community based work that is needed to address these.

Similar trends have occurred around development assistance targeted towards improving maternal health in the global South. The establishment of MDG5 to reduce maternal mortality and increase access to contraception for women has also led to an increase of development initiatives intended to help countries reach this goal. While MDG 5 is one of the goals where

least progress has been made (Horton, 2010) global level programme such as the Safe Motherhood Initiative as well as the 2012 Gates Foundation Family Planning initiative, a collaborative undertaking between Gates and other state and non-governmental, as well as corporate, partners, have also led to a reframing of the work of NGOs on the ground and a shift towards more 'technical fixes' to women's health problems (Gideon and Porter, 2015; Storeng and Béhague, 2014; Kumar et al., forthcoming 2016).

## **Conclusion**

This paper has highlighted some important questions around the dilemmas and challenges faced by NGOs in the context of PPPs as they seek to address the deeply embedded inequalities that constrain access to health care of many marginalised individuals and communities, particularly women. Peoples' experience of health seeking is shaped by gendered and racialised norms and assumptions, yet a growing body of evidence suggests that in the context of PPPs – and the concurrent 'scientization' of public health and the embedding of 'business norms' within health funding, NGOs are failing to challenge these inequalities. Global policy-makers are therefore not simply responding to health problems, they are actively framing them and thereby shaping what can be thought about and acted upon (Roalkvam and McNeill, 2016). Yet as argued in this paper, feminist critics have shown how the values, interests and power relations underpinning the dominant global health discourse are highly problematic from a gender perspective. As a consequence NGOs are inadvertently working to fortify and re-embed a limited understanding of gender inequalities in health that fail to address the wider gendered and racialised social determinants of health.

A recent Lancet Commission on health inequality pointed to the 'democratic deficit' in global health, highlighting the lack of representation of civil society actors, marginalised groups and even health experts in current decision-making processes. At the same time weak accountability mechanisms make it difficult to constrain the power of other actors or hold them

to account (Ottersen et al., 2014). Given the central role of the corporate sector and private foundations within the global health field this is clearly a significant challenge. Yet as the paper has argued local level knowledge is critical to addressing the ways in which people are marginalised from health and health care services. Moreover, research has also shown that community mobilisation can potentially bring about cost-effective and substantial improvements in health outcomes (Rosato et al., 2008: 970). NGOs have a clear role to play in this type of work but there is an urgent need for further research into the impacts of NGOs working within PPPs. Any such analysis must capture the ‘messiness of everyday life’ that can subvert any well intentioned project and help shed more light on the gendered impacts of PPPs.

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