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**Public-private partnerships in sexual and reproductive healthcare provision:
establishing a gender analysis**

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Public-private partnerships (PPPs) is a term that is now used across the health sector to encompass diverse activities involving both public and private sector entities in areas of global and domestic health. At the global level these have included initiatives focused on encouraging the private sector pharmaceutical industry to pursue the discovery and development of new drugs, vaccines, or other health products addressing neglected diseases and conditions in low- and middle-income countries (LMICs), and the involvement of transnational corporations and private foundations with UN organisations in coordinated global governance projects around specified global health goals¹. At the domestic level examples include subsidies and contracting of for-profit companies by governmental organisations to build and administer hospitals, and programmes designed to ‘leverage’ private sector service providers in the implementation of public health programmes.

¹These types of PPPs are also commonly referred to as Global Public-Private Partnerships (GPPPs), Global Health Initiatives (GHIs), and Global Health Partnerships (GHPs) in the wider literature.

The rationale for PPPs stems from claimed inefficiencies of public bureaucracies and purported superior efficiency of private sector actors operating in healthcare markets (World Bank, 1993), and a wider penetration of neoliberalism's market fundamentalism into public policy since the 1980s (Harvey, 2005). Market-based conceptualisations of healthcare provision remain influential in health policy (Bloom et al., 2013), although the stated rationale for private sector involvement in public healthcare provision has shifted to one of 'pragmatism'; that the private sector is extensive and under-utilised and can be 'leveraged' for public gain (Mills et al., 2002; Mills, 2014). This process has gained additional impetus following recent international campaigns to promote universal health care coverage (Mills, 2014),

PPPs ascribe roles for private actors that come with possible benefits and potential costs to the public sector and public health. A major concern has to be the extent to which profit-seeking is a key driver of commercial private entities and what this implies for motivation, emphasis, and commitment to public health. Additionally there are issues of accountability, regulatory capacity of state organisations, additional costs incurred by the state, and sustainability of private sector interventions.

Sexual and reproductive health (SRH) services have been one area in which PPPs have been promoted on the local scale. Borrowing from the language of business entrepreneurship, much of this PPP activity is described in its supporting literature as "innovative" and by implication a positive progression. In the case of those PPPs aiming to promote aspects of SRH, there are also often claims to be 'empowering' to women (Grainger et al., 2014).

Claims of this nature require some detailed unpacking, and this article aims to contribute to this task, first by offering a set of questions for the interrogation of the use of PPPs in SRH service implementation using a critical gender lens, and then by illustrating this with a case study of a maternal health voucher programme in India.

Analysing PPPs through a gender lens

Despite growing use of PPPs as service provision models, evaluations and ensuing debates have focused largely on their effects on uptake of healthcare services. But can such interventions be expected to address wider questions of the causes of women's health inequality? (Ahmed and Khan, 2011; Jehan et al., 2012). To date very little attention has been given to analysing the gendered dimensions of PPPs or their gender impacts despite the frequent claims to innovation and empowerment (Ravindran and Weller, 2005; Gideon and Porter, 2016) and it is to this issue that we now turn.

This paper understands the term 'gender' in its broadest sense and recognises that a gendered analysis is not just about focusing on health outcomes but also examines the social relations between women and men, which are themselves bearers of gender (Gideon, 2016), and that gender inequalities are cross cut by other axes of inequalities². It also argues for a more transformative approach to gender justice and a move away from limited understandings of 'gender' as encompassed within more neoliberal interpretations of

²While the emphasis within this paper is predominantly on women's SRH in relation to PPPs, we acknowledge the importance of not using the term 'gender' as a shorthand for women and the need for more complex and nuanced gendered analyses that take into account the health needs of men and trans-gender groups.

gender (Prugl, 2017). In the following sections these dimensions are elaborated to develop a set of three questions that can be applied to interrogate PPPs in SRH using a gender lens.

The paper is written with an awareness that women's health research and services are marked by a research agenda that over-focuses on women's reproductive related issues (fertility, menstruation, menopause, and breast and gynaecological cancers) while failing to properly investigate gender dimensions of other health problems such as HIV AIDS, coronary heart disease and tuberculosis that appear to have gender-differentiated causes, incidences, responses to treatment, and prognoses due to a combination of biological factors, social conditions, and social processes (Rogers, 2004, cited in Goldenberg, 2006: 2627). In writing this article we do not wish to reinforce this emphasis, but rather to help to develop an analytical gender lens to employ in the light of the existing prioritisation of certain types of SRH intervention that have become popular with policy makers within the global health arena.

Question 1. What are the 'common sense' assumptions underpinning agendas in SRH interventions using PPPs?

A reading of the existing literature on gender analysis of healthcare services suggests that we need to pay attention to several dimensions of programme and service design: the first of these is to asking what is the 'common sense' that propels their agenda and direction. Sylvia Chant, for example, has highlighted the 'feminisation of obligation and responsibility' within the context of neoliberal economic restructuring (Chant, 2008).

In recent years the agenda and direction of programme design for SRH interventions has been driven forward in part by a 'common sense' which expresses a widespread concern, particularly on the part of global institutions and international donors, around the high levels of maternal mortality and fertility and a desire to promote gender equality and women's 'empowerment' (Filippi et al., 2006). Yet, the allocation and design of aid within the health sector is a highly political process and is frequently shaped by the ideological stance of the global institutions and the aid donors rather than the health priorities of a particular country or population group (Esser and Bench, 2011; Storeng and Béhague, 2014). Critical research has shown how particular health issues, such as maternal mortality, come to dominate the global health agenda at the expense of others, such as cervical cancer (Parkhurst and Vulimiri, 2013).

The incorporation of concerns around maternal mortality into the MDGs served to raise the profile of that neglected issue and generated considerable donor funding into seeking rapidly attainable 'solutions' to address the high rates that continue to occur across the world (Storeng and Béhague, 2014). But in an environment in which economic development is prioritised over other social gains, advocates for maternal health have tried to develop an argument that associates it with wider development objectives, and in the process maternal health has come to be portrayed as a means to development rather than an end in itself (Gideon, 2014; Mohindra and Nikiéma, 2010). This offers a clear example of the ways in which the neoliberalization of feminism has played out in the health sector. The push to extend women's access to health care services is primarily driven by a rationale of 'smart economics'. Although women may gain better access to services, at the same time

this trend potentially reinforces women's responsibilities and obligations, rather than their empowerment as independent social citizens with rights, and therefore diverts attention away from the wider goals of social justice (Storeng and Béhague, 2014; Yamin and Boulanger 2013; Gideon and Porter, 2016). As Prugl argues,

'not only the insertion of women into neoliberal economic projects, but also the translation of feminist ideas into a common sense that favours the commodification of nonmarket values and processes, the privatization of public goods, the casting of human endeavour in entrepreneurial terms, and the construction of subjectivities that lend themselves to being governed through markets and incentives' (Prugl, 2017: 33)

In the case of SRH services, global and national pressure to meet the 5th Millennium Development Goal (MDG 5) targets of reducing maternal mortality and ensuring universal access to reproductive health, and concurrent increases in funding from donors such as the UK Department for International Development (DFID), the World Bank and the Gates Foundation, provided opportunities for the expansion of PPP models in that sector that seemed to offer rapid and measurable results (Gideon and Porter, 2016). In the post-MDG context PPPs have gone on to be promoted as an important development financing mechanism in support of the Sustainable Development Goals (see SDG 17.3 and the Addis Ababa Declaration of the Third United Nations Financing for Development Summit, July 2015).

Question 2: On what criteria do the SRH-PPP programmes come to be framed and judged?

The emphasis on achieving maximum gains in SRH in a short period to accelerate processes towards global development goals also created a narrowing of intervention policies to focus on 'what works' (Campbell and Graham, 2006). This can be seen as part of a wider process of 'scientization' in global health (Drori et al., 2003) in which the techniques of evidence based medicine (EBM) were used to determine what is or is not effective using randomised control trials as the gold standard (Adams, 2013). In the field of SRH PPP, this emphasis on the easily quantifiable and comparable coupled with the rising influence of health economics also led to a focus on specific packages of care that were deemed cost effective such as use of modern contraception or birth-care in a healthcare facility (Loevinsohn and Harding, 2005; Murray et al., 2014). Such defined packages in turn facilitated the emergence of a series of PPP arrangements in which private sector provision of these packages was purchased by the public sector with donor assistance. Maternal healthcare services, for example, were considered well suited for such partnerships because they operated in a well-defined time period and there was a systematic review-supported evidence-base for the package elements with predictable typical costs that could be reimbursed to private providers once a woman has given birth.

Vouchers and franchising approaches thus gained popularity in health and development policy circles in the early 2000s (Koehlmoos et al., 2009, Murray et al., 2014; Ravindran, 2011). Social franchising schemes in the health sector are networks of private-for-profit

health practitioners linked through contracts to provide a socially beneficial service under a common brand, while health voucher schemes, copied from the education sector, are designed to stimulate demand for a specific health service through the distribution of pre-paid vouchers for services. Voucher schemes, which we return to in the case study, are seen as a means of encouraging use of services like family planning, treatment of infectious diseases, immunizations, and maternal and child health services through subsidizing costs that may otherwise deter the user (Gupta et al., 2010: 4).

Advocates tend to frame success in terms of increased effectiveness. But despite widespread donor support for these PPPs in SRH there appears to be little evidence to support this. For example, despite claims that social franchising can improve access to and the quality of family planning services (Montagu, 2002), reviewers find it difficult to draw firm conclusions about their effect (Agha et al., 2007; Koehlmoos et al., 2009). Advocates suggest that social franchises could extend coverage to areas which are under-served, but in practice the franchises tend to operate in areas that are already covered by services and where private providers wish to live and work. Private clinics are typically recruited into a franchise when already in business, and private concerns are known to often congregate in areas with sufficient population and transport routes to provide an assured market for their services (Ravindran and Fonn, 2011: 93). The Merrygold franchise in Uttar Pradesh, for example, is in direct competition with public providers offering free contraceptive services, suggesting that they are operating in areas which are relatively well served (Ravindran and Fonn, 2011) and low-income groups are less likely to use the services compared to better-off women. In the words of a WHO report, there is 'a trade-off between

...serving the poor, providing a full range of reproductive health services and financial sustainability of the franchise' (2007: 8).

Critical attention needs to be paid to the choice of measurements selected to assess progress towards meeting goals around reducing maternal mortality and how the choice of targets can lead to unintended consequences for individual's health and well-being (Yamin and Boulanger, 2013), and the balance between reconciling the need for global standards with the need to take account of local realities (Spangler, 2012). It is important to determine how far prevailing norms acknowledge the importance of women's health knowledge or create spaces for women to define their own health needs and to challenge programmes where there is a deficit (Gideon, 2014). Relevant local sources of information around women's health may not be taken into consideration in decision making because of the attractiveness and 'scientific' nature of the Disability Adjusted Life Years (DALY) calculations or EBM), both of which have been critiqued because of their inherent male bias (Goldenberg, 2006, 2010; Sundby, 1999). A number of empirical studies have shown that 'local level' knowledge is often sidelined within dominant technical approaches to health care (Berry, 2014; Erikson, 2012). Community level health workers are those most likely to understand the challenges that women face in accessing maternity care and how this relates to broader societal and infrastructural challenges including gender norms, access to cash and transport (Theobald et al., 2015: 5). Yet the higher respect accorded to statistical evidence has meant that long-term involvement of community workers and their field-based knowledge is no longer considered valid and such actors often no longer have a voice in the development process (Adams, 2013; Erikson, 2012; Mishra, 2014).

Question 3: To what extent do the SRH-PPP interventions take into account, reinforce or confront the existing realities of gendered social and economic life?

The narrowly focused approach of many initiatives has meant that structural influences on well-being are frequently overlooked (Ravindran, 2011; Gideon and Porter, 2016). Within PPPs women tend to be constructed as 'deficient subjects who deserve investment' (Prugl, 2017: 44) and as 'responsible mothers, consumers and citizens who help others' (Sato, 2016: 163). There is a failure to acknowledge that pathways into poverty and poor health are frequently gendered and a tendency to marginalise unpaid care work and non-quantifiable, non-marketable values (Razavi, 2012; Prugl, 2016). While many interventions have focused on improving the MMR through increasing women's access to formal birth facilities these types of interventions fail to address the underlying inequalities that contribute to the exclusion of particular groups of women from services in the first place. This is evident in the Brazilian case where maternal deaths occur most frequently among poor black women and some of the most significant factors contributing to this maternal mortality are the high frequency of caesarean sections, illegal abortions, and regional and socio-economic inequalities in health (Gideon et al., 2015: 259). In Nicaragua the criminalisation of abortion in all circumstances, even if a woman's life is at risk, has undoubtedly contributed to the high levels of maternal mortality among the more marginalised sectors of society (Kvernflaten, 2013). These critical factors underpin high rates of MMR in certain parts of the world but are often not factored into the framing of interventions which seek to promote better access to packages of biomedical services.

Health policies also often contain implicit assumptions about the unitary nature of households which are highly problematic given the complexities of intra-household relations and family structures (Gideon, 2014). Complex decision-making processes which may be highly gendered can play a significant role in shaping where women (and of course other family members) seek health care and what happens to them afterwards. A detailed longitudinal follow up of women in Burkina Faso whose lives were saved by biomedical intervention during a pregnancy complication – an apparent success story – has demonstrated the subsequent loss of status and personal impact of having become a ‘costly’ wife and a drain on a household’s meagre resources (Storeng et al 2010; Murray et al, 2012). In the context of the growing marketization of health care and increasing out-of-pocket payments, it is essential that policy makers consider the gendered allocation of resources within households. While there is not extensive empirical research in this area, research in Latin America has shown that women tend to be more negatively impacted by the marketization of health care services compared to men (Ewig and Hernández Bello, 2009).

We now employ our three questions to consider a voucher and contracting approach in more detail, drawing on empirical data from a case study on experiences with implementation of the Sambhav scheme in Uttar Pradesh, India³.

³The data are drawn from doctoral research by one of the authors (BMH) on the aims, design and enactment of the Sambhav scheme. Qualitative data were collected during repeated visits to the city of Lucknow in 2013 and 2014, and include programme documents, notes generated following observations in programme offices, private hospitals and slum areas, and semi-structured interviews with programme designers and managers, obstetricians and managers at private hospitals, community workers and women voucher users. Ethical approval for the research was provided by King’s College London and Jawaharlal Nehru University. Data were coded and analysed thematically in the doctoral research project, and findings that are relevant to the above gender framework are presented below.

Examining a PPP healthcare voucher scheme through a gender lens: a case study of Sambhav in Uttar Pradesh, India

The marketization discourse that promoted voucher schemes from the early 2000s emphasised that they were to be a means of improving the desirable use of services among poor communities 'by placing purchasing power', and 'choice of provider' in the hands of the recipients (Gupta et al., 2010). This offers a clear example of the way in which poor women are disciplined to become 'rational economic women' (Rankin, 2001), thus reinforcing the 'smart economics' approach to gender equality.

The Sambhav- meaning 'possible' - scheme was one of six PPPs developed through USAID's Innovations in Family Planning Services Project. An early version of the voucher scheme was launched in 2007 in pilot sites in Agra district and subsequently in Kanpur district, then was re-launched in five cities in Uttar Pradesh in 2011 - Agra, Kanpur, Lucknow, Allahabad and Varanasi - and ended in 2013.

This second Sambhav scheme recruited lay community workers to distribute vouchers to qualifying families in urban slums. The six types of voucher (antenatal care, intrapartum care, postnatal care, SRH, family planning, and general health check-up) could be exchanged for specific services free-of-charge provided by between 10 and 20 accredited private hospitals in each city. Private hospitals accredited by the scheme received

reimbursements from the programme for each voucher submitted according to a tariff of pre-determined rates, and community workers received a smaller payment from the programme based on the number and type of vouchers submitted with their name.

What ‘common sense’ assumptions underpinned the voucher scheme?

Like with other types of PPP intervention in the health field, policy support for healthcare vouchers has been driven by an assumption that high maternal mortality and fertility rates can be reduced through increased targeted healthcare utilisation by the poor – including childbirth in medical facilities. The second underlying assumption is that low usage is primarily attributable to poor quality and inefficiency of public sector healthcare and the costs to the users of access, and that private providers will be more effective. In this scenario voucher and contracting programmes are purported to increase poor women’s demand for services, ‘empower’ them as service users by giving them means to exercise choice, and create incentives for providers to be ‘innovative, cost effective, and responsive to their clients’ (World Bank 2005: p. x).

Rationales given for development of the Sambhav scheme in Uttar Pradesh typified such arguments in favour of health vouchers. In the lead-up, a USAID-commissioned report declared that ‘the government of India have recognized that unmet reproductive and child health needs outstrip their capacity and financial resources’ and there was ‘great potential to tap the private sector to expand the provision of quality RCH [reproductive and child health] services’ (Population Technical Assistance Project, 2004: Appendix A). Later programme documents made similar claims (IFPS Technical Assistance Project, 2012a).

It could be argued that the specific SRH aims of the scheme were really secondary to its fundamental ideological purpose, that of encouraging and extending commercialisation processes in public sector healthcare in India. Two rhetorical tropes were used throughout the Sambhav scheme's design and implementation to support a framing of this process: *partnership* and *innovation*. Partnership as Standing has observed, 'has a nice cuddly sound to it' (2007: 519), but in reality the Sambhav scheme's 'partnership' was a contracted service delivery model that had little precedent in Uttar Pradesh's healthcare systems and which minimised the direct involvement of the state in provision while creating a range of opportunities for private sector actors. Funding was channelled through a non-governmental organisation established by USAID. Government healthcare service providers were not involved in the programme but the state government was nonetheless required to monitor and regulate services and to provide free tetanus vaccines and contraceptives to participating private providers for their use with voucher users. Programme designers hoped that ultimately the government would take on the role of subsidising the private providers after the withdrawal of USAID funding.

'Innovation' was also euphemism for commercialisation. A USAID-commissioned background document for the Sambhav scheme made clear the link between innovation and commercialisation in provision of healthcare:

'government should become an active partner with the private sector to ensure the accessibility and safety of commercial sector FP/RH [family planning and reproductive health] services through appropriate licensing and regulation,

provision of population-based information, dissemination of information to consumers, and strategic planning. Innovative methods to link public and private providers for more effective private sector service delivery and to enhance the credibility of private sector providers should be developed and tested' (Population Technical Assistance Project 2003: p. 32)

Programme documents described an experimental framework for development of the voucher and contracting scheme (IFPS Technical Assistance Project, 2012b). This consisted of five stages – develop, design, demonstrate, document and disseminate. Aside of a fondness for alliteration, this framework reveals that the emphasis was not on *testing* this 'innovation' as might be anticipated, but rather on *demonstrating* it as a service delivery model. That ideological mission was reflected in the focus of the programme evaluations.

On what criteria was the voucher scheme framed and judged?

This driving concern to demonstrate that the Sambhav scheme was an appropriate service delivery model for SRH in Uttar Pradesh was reflected in the very limited focus of the three programme evaluations, which were designed to show voucher uptake and to glean 'lessons' for refining future implementation. The first two evaluations, by Futures Group in 2012, and Ipsos Research in 2013, described how many vouchers had been used, while making claims about increased uptake of maternity care that did not account for the concurrent effects of other programmes (IFPS Technical Assistance Project, 2012a; Ipsos Research, 2013). In a revealing foreword to the Futures Group evaluation report, Director of USAID India's Health Office Kerry Pelzman explained the tactical nature of the Sambhav scheme as a 'prototype' model for future service delivery:

'USAID hopes that models such as the Sambhav voucher schemes will serve as prototypes in the future to engage the private sector, ensure equity and accountability to those accessing services, and build on the existing systems for cost-effective and optimum service delivery and utilization.' (IFPS Technical Assistance Project, 2012a: p. v).

A third evaluation, also published by USAID in 2013, again highlighted how many vouchers had been used, but this time did not make any claims to success in terms of effect on uptake of services. The report provided a more critical analysis of the Sambhav scheme's service delivery model, on the grounds that it had little prospect of financial sustainability once aid was withdrawn. Despite these reservations the report's conclusions, which also drew on experiences with three other PPPs in northern India (all of which had poor prospects for sustainability), still stated that the Uttar Pradesh state government *should* 'focus on health systems strengthening by exploring options for PPP for health in order to expand quality care and services' (Andina et al. 2013: p. 78). Thus concerns with the PPP models were secondary to the need to expand private sector involvement in public healthcare provision, and the gendered dimensions of the programme and implications for women's health were incidental.

The ideological project – to promote a model for commercialisation of public healthcare services via a SRH scheme - has been very apparent. Despite the clear weaknesses and very limited scope of research and evaluations, 'lessons' promoting the Sambhav scheme model have been widely circulated and have been influential in India and in the global health arena. The scheme recently featured as a positive example of 'innovation' in two

publications by the Public Health Foundation of India (itself a public-private partnership): a 'white paper' entitled *Innovative Ways to Meet Health Challenges of Urban India* (Arora et al. 2011) and a book *Innovations in Maternal Health: Case Studies from India* (Satia et al. 2014). At an international level, 'success' experiences with the Sambhav scheme were presented at the 2009 and 2011 International Conference on Family Planning. The former, in Uganda, was followed by the launch of a voucher and contracting programme in Uganda that was funded and managed by the conference's leading organisations: Bill and Melinda Gates Foundation, Johns Hopkins Bloomberg School of Public Health and Makerere University School of Public Health. Documentation on the Sambhav scheme is typical of a wider policy landscape that prioritises narrow interpretations of EBM at the expense of critical discussion on how policies are formulated, framed and implemented (Adams, 2013; Ghaffar et al., 2016; Murray et al., 2014). Given the inherent problems in contracting private providers to deliver public SRH services and likely implications for women's health and position in society, it is important that evaluations of PPPs go beyond short-term assessments of service use and predictable analyses of programme 'challenges' if policy-makers and practitioners are to learn any meaningful lessons where interventions are replicated on a large scale.

What gendered aspects of social and economic lives are reinforced or challenged by the voucher scheme?

So what part do such voucher and contracting schemes play in empowering women? Most importantly from a gender perspective, the programme evaluations and the subsequent promotional literature on the Sambhav scheme (and on voucher and contracting

approaches more widely) failed to examine the programme's interplay with gender norms. Analysis of our empirical data reveals that the Sambhav scheme reinforced gendered household and community roles during voucher distribution. Easy notions of 'empowering' individual women failed to take into account that other more powerful family members – specifically a woman's husband and/or mother-in-law – played key roles in decision-making on where she would seek care. Community workers did little or nothing to challenge this, as one explained during an interview:

“We always tell the woman to seek the opinion of elders in the family such as the mother-in-law, father-in-law and also husband. Then I provide them with my phone numbers. I tell them that after having a discussion with your family members and seeking suggestions from your family members, then you can call me.” Community worker.

Moreover, any potential for 'empowerment' and 'choice' for women was moderated by (typically) male managers and the female community workers who worked under them, who had vested interests in promoting a narrow interpretation of the Sambhav scheme, publicising and validating their own activity while (in the case of the community workers) minimising their own personal travel costs. Those community workers were women who lived in or near slum areas and who met minimum criteria for literacy and marital status. They were typically better educated than other women in the slum areas and had prior experience with community programmes, and their monopoly of access to information on the programme's details further distorted their local relationships.

Community workers withheld vouchers from women service users in order to prevent vouchers being damaged or lost, and instead preferred to be personally visible accompanying women to nearby participating hospitals. In some cases therefore women were never themselves aware that the vouchers had a physical form nor that they had a choice of which hospital to go to in the scheme, they simply knew that their local community worker could help them to obtain cheap care at a specific hospital – typically a nearby hospital as community workers did not feel they were adequately reimbursed for transport costs. This can be seen as an instance of women taking power away from other less knowledgeable women, and signifies that while community health workers play an important role in building relationships between communities and healthcare systems (Gilson, 2005; Mishra, 2014), they can also subvert those relationships. It is therefore important not to over-romanticise the role played by community workers, and to understand the context in which their activities take place.

The fetishization of the paper voucher reflected its function within the project as a tool for monitoring and accounting; programme managers would only process payments to community workers and hospitals if a voucher had been physically submitted. The programme also created other pressures on the community workers by setting targets that they must meet and by competing with the government maternity services. The government's Janani Suraksha Yojana [Safe Motherhood Scheme] paid a woman 1,000 rupees (£10) if she gave birth in an urban government facility. To meet their targets the community workers therefore tried to convince families to use their voucher scheme and not government services by presenting this good quality of care versus cash. The pragmatic

response of the community workers was encouraged by the precarious nature of their employment at the front line of service delivery and reveals ways in which the gendered nature of health systems reflects and reinforces power relations in communities.

Discussion

The interrogation of a case study of a PPP in SRH presented here suggests that despite the rhetoric around 'innovative approaches' that generally accompanies PPPs, it did little to confront gender norms and values that are often deeply embedded within health systems as well as the households that interact with them. The literature on SRH interventions in the MDG and post-MDG period suggests that questions around gender equality are often neglected, both in terms of the design and also the implementation of target-orientated programmes. As the paper has shown, this has a number of implications, particularly in terms of constraining responses to address the underlying structural factors that exacerbate gender-based vulnerabilities to poor health - this was clearly apparent in the Indian case study which shows how a narrowly defined package of services was promoted with the Sambhav voucher scheme.

Other studies of voucher schemes in other settings also indicate that these have failed to address the deeply embedded gendered norms and power relations within both households and health systems that can constrain women's access to health care services. Research from Kenya found negative responses from men towards the use of the vouchers and a lack of support for women during childbirth discouraged some eligible women from purchasing the voucher while others who had purchased the voucher were reluctant to use

it. Men often opposed use of the vouchers because of the associated stigma for them of being identified as head of a very poor household (Njuki et al., 2013:7). Evaluative studies in Bangladesh, Kenya and Cambodia reported claims by programme workers and women voucher users that the women were stigmatised and poorly treated by health providers (Murray et al., 2014). In the Kenyan case women also feared mandatory HIV testing and were not confident that test results would be kept confidential if they used the voucher scheme to deliver in a facility, and were also concerned that they would be at risk of Caesarean section. Irrespective of if these fears were founded or unfounded, they also highlight the need for thinking about intersectionality and recognising the ways in which other forms of difference, such as class/ race/ ethnicity can also interact with gender and result in feelings of powerlessness among individuals. In the context of medical encounters this illustrates the ways in which gendered and racialised power relations can potentially shape medical encounters and reinforce the exclusion of low income women and that this has not been sufficiently challenged by voucher programmes.

Although they claim to address gender-based inequalities such schemes do so within a limited framework whose simplistic focus on the gaps in women's health fails to consider the socially constructed relations between men and women. Such PPPs therefore become part of a wider trend of interventions that have contributed to the depoliticization of women's health and instead maintain a simplistic focus on maternal health that ignores the gendered power relations. This is clearly illustrated in the Sambhav case which has demonstrated the ways in which gender-based power relations are not addressed, and become reinforced in the day to day practice of the scheme, with effects on the women's

ability to make choices around childbirth and on the situation and behaviour of low-paid female workers precariously employed within the schemes.

At the same time, lack of resources within the public sector in countries such as India continues to impact hugely on the quality of care provided to users (Mishra, 2015). Given the gendered hierarchy within the majority of health systems, low paid women health workers are often bear the brunt of these tensions and this can play out in terms of antagonistic relationships with health care users. The push for commercialisation in many PPP voucher programmes simply reinforces those inadequacies in public sector provision.

Roalkvam and McNeill (2016) have reflected on the growing prominence of 'technologies of distance' within the global health arena. These occur through processes such as the emphasis given to quantifiable indicators that are justified through the employment of EBM and incorporate practices which minimize the need for intimate knowledge of specific context, and socio-political processes within that particular context (2016: 16). The extent to which PPP arrangements such as health voucher schemes represent yet another example of this trend is an important issue that requires further investigation. As we have argued in the paper the emphasis within many of the voucher schemes is on the number of women who deliver their babies within formal health care settings with very little attention given to the quality of service they receive or the broader structural constraints to achieving healthier outcomes for all. At the same time this emphasis on the medicalization of birth prioritises 'scientific' knowledge and negates the importance of other forms of

knowledge, leading in practice to a rejection of 'local level' understandings which are critical to ensuring the 'messiness' of everyday life is successfully integrated into health practices and policies as exemplified by reproductive health voucher schemes.

Despite their adoption of the buzzwords of the moment, do PPP arrangements move us further away from the ability of the health sector to address the wider social determinants of health that are critical to ensuring the longer term success of any pro-women healthcare intervention? Further research is required, for example, to determine how far the artificial emphasis on choice offered within health care delivery PPPs weakens the public sector further diverting public funds to subsidise private providers. At the same time further empirical data is required to fully understanding the gendered impacts of this trend - both in terms of health care users as well as for those working within the health sector. Certainly social franchising requires to be put in the same analytical spotlight as we have applied to voucher and contracting schemes here. This paper offers a preliminary set of questions which could be applied more widely to the interrogation of PPPs and which seem to bring to the fore the importance of critically evaluating PPP healthcare delivery programmes through a gender lens.

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