GLOBAL HEALTH, GLOBAL PROBLEMS: A CASE STUDY OF THE BENEFITS AND DRAWBACKS OF SOUTH-SOUTH COLLABORATION IN THE GLOBAL HEALTH FIELD

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On my honor

I have neither given nor received

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Abstract

Global health organizations attempt to eradicate health issues in different ways. While some organizations focus on specific diseases, others work to strengthen healthcare structures and improve primary healthcare. This paper looks specifically at the Women and Health Taskforce (WHTF), a group of women and men working in women's and reproductive health around the world. The purpose of this thesis is twofold: to establish the ways in which the taskforce fits into the global health field and to provide concrete feedback for the WHTF in order to improve its functioning. Data was collected through an online survey and Skype interviews providing quantitative, qualitative and network data. The research shows that the WHTF can benefit from strengthening youth engagement to increase innovation and ensure long-term sustainability, as well as expanding their network to increase their impact. This paper also looks at the ways in which the taskforce relies on funding from the global North, and the implications of this reliance for South-South collaboration.

"For tireless acts of courage and mercy, for buying the world time to boost its defenses, for risking, for persisting, for sacrificing and saving, the Ebola fighters are *TIME's* 2014 Person of the Year" (Gibbs 2014:67). Last year the award went to Pope Francis, the year before it went to President Obama. But this year, *TIME* Magazine's person of the year award went to all of the nurses, doctors, ambulance drivers, burial parties and local and international volunteers who took part in fighting a deadly virus described as a "mythic monster" and a "Hollywood horror" (Gibbs 2014:67). The same day *TIME* announced the person of the year award winner, the *Economist* published an article titled "The Toll of a Tragedy" in which they outlined the effect of Ebola by the numbers (Data Team 2014). By the end of June 2014, 759 people had been infected, and of those, 467 had died. By December 7, 20,206 cases had been reported, and of those, 7,905 had died (Data Team 2014). The 2014 Ebola outbreak represents and brings to light global health inequalities that people often forget plague the world. Spain spends over $3,000 per person on healthcare, while Sierra Leone, a country with high concentrations of Ebola, spends slightly under $300 per person (Data Team 2014). The United States has 245 doctors per 100,000 people, while Guinea, another country with high concentrations of Ebola, has 10 (Data Team 2014). Many international aid organizations are working to fight these inequalities in various ways. Some fight specific diseases like HIV/AIDS and malaria that have caused even more deaths than Ebola, others bring in well-trained foreign doctors and nurses to treat patients and train local healthcare workers, while others address the root causes that often lead to tragic diseases such as Ebola.

In November 2014, I had the privilege of attending the Network: Towards Unity for Health conference in Fortaleza, Brazil. The Network conference brings together health professionals, educators and organizations working to improve healthcare around the world. It

was at this conference that I became interested in the potential of expanding resources dedicated to increasing collaboration between healthcare professionals in the global South as an alternative to the typical North-South model in global health. In Fortaleza, I met a passionate, engaged and driven group of women and men who are part of the Women and Health Taskforce (WHTF). It was through conversations with various members of the taskforce that I decided to explore the benefits and drawbacks of their model of South-South collaboration. Through collecting survey results, analyzing the network of respondents and conducting interviews, I found that the model of the taskforce faces many issues similar to other community-based global health projects and programs regarding funding, resources and collaboration. The purpose of this thesis is twofold: to establish the ways in which the taskforce fits into the global health field and to provide concrete feedback for the WHTF in order to improve its functioning.

LITERATURE REVIEW

The Strengths and Limitations of Vertical Approaches

In the growing field of global health, a field driven by the idea that health is a human right, many organizations are trying to find ways to make this far fetched dream a reality in the developing world, or global South. Most of the well-known global health non-profits use vertical approaches, which often focus on one disease, typically HIV/AIDS, malaria or tuberculosis (Duber et al. 2010; El-Sadr & Hoos 2008; Walensky & Juritzkes 2010). While vertical approaches target their efforts at one specific disease, horizontal approaches focus on improving healthcare systems and basic primary healthcare. Typically therefore, vertical approaches are predominantly focused on treatment while horizontal approaches are focused on prevention. Some of these vertical organizations, such as Doctors without Borders, the President's Emergency Plan for AIDS Relief and the Global Fund will be discussed in this paper.

Organizations using vertical approaches are often criticized for not addressing the root causes of the problems they attempt to fix (El Sadr and Hoos 2008; Egilman et al. 2011). Vertical approaches often look at global health through a narrow lens that disregards the other public health concerns related and unrelated to HIV/AIDS, malaria and/or tuberculosis. Organizations that utilize vertical approaches also receive criticism for contributing towards the brain drain, or the removal of local talent from the areas and organizations that need it the most. The three vertical organizations discussed in this paper have all been criticized for drawing healthcare workers from their government positions to work for higher salaries in disease-specific intervention programs (El Sadr and Hoos 2008; Egilman et al. 2011). Despite these concerns, the practice of hiring local people is in many ways more beneficial than strictly sending in foreign aid workers, and these organizations should also be commended for attempting to work within the pre-existing healthcare systems.

Vertical approaches have proven to be very successful in some ways and even necessary in the current global health movement. It is important to acknowledge that vertical programs have helped millions of people receive life-saving treatment that they may otherwise not be able to access, as will be discussed later in the paper. Many of these organizations use a donor driven model in which programs receive substantial funding because the care they provide is seen as direct and largely impactful by donors. Although most of these vertical organizations are sustainable in the sense that they will continue to receive funding from donors who admire their work, they do very little to improve the sustainability of long-term healthcare in the communities in which they work. Several organizations, such as Partners in Health and GlobeMed, have created a different model to focus on long-term healthcare, which relies largely on community-based solutions. The benefits of community-based solutions are explained by a dean at a school

of medicine in Kenya who stated that funding "should be decided bilaterally... not unilaterally from the funder, because if you come, for example, directly to where I work, I should be able to say what are priority health areas and funding and resources can be directed accordingly" (Egilman et al. 2011:369). This literature review will explore the ways in which some vertical and community-based organizations function to better understand the potential and existing role of South-South collaboration in the global health movement.

Doctors Without Borders: Effective Yet Limited

Doctors without Borders, or MSF (Médecins Sans Frontieres), was founded in 1968 by several French doctors who were working with the Red Cross in Nigeria. The doctors were frustrated with the Red Cross's practice of remaining silent despite the atrocities its volunteers saw in their relief work. In 1971, MSF was formally created and since then it has become the most respected humanitarian aid organization in the world (Bortolotti 2004). Its leaders have found ways to stay relevant in and adapt to the constantly changing fields of global health and humanitarian assistance (Bortolotti 2004). MSF's model is also one of controversy in the current global health movement as organizations begin to shift to more long-term prevention based solutions. MSF has attempted to adapt to this change by expanding from the strictly emergency relief care approach on which it was first founded, to more long-term medical care and other non-emergency based situations as well (Fox 1995).

Despite the addition of more long-term medical care, MSF retains its focus on the fundamental principles on which it was founded. Bortolotti (2004) says, "Delivering life-saving aid in war zones is at the root of the organization's ethos" (p. 91). MSF was and is popular to the public because it provides what at least appears to be heroic and rule bending opportunities to volunteer, and is seen in a dramatic light in which people leave their comfortable lives to

perform life saving surgeries in war zones. In its early days, MSF also provided a unique avenue for people who were tired of the less controversial approaches of the United Nations and the Red Cross (Bortolotti 2004). "The kind of action espoused by Doctors Without Borders... is passionately committed, heroically aggressive, 'warrior-like,' medical action, that is also 'masculine' and doctor-centered in its ethos and self-presentation" (Fox 1995:1609). Fox also talks about the "mediatization" of MSF's projects as an indispensible aspect of its system. That is, MSF uses media to create worldwide attention, and also as a way to gain support and funding. The public prefers donating to causes with tangible and visible outcomes, which provides an explanation for why MSF is most commonly known for its emergency relief services, and less for long-term programs. In reality, only 40 percent of MSF volunteers are doctors; the rest are project and financial coordinators, logisticians and administrators, and most of the medical staff is comprised of locals (Bortolotti 2004). The fact is, MSF is a primarily reactive organization, entering into conflicts and epidemics after they begin. While it is important to work on preventing such epidemics from occurring in the first place, MSF often plays a crucial role when local healthcare systems are not prepared to deal with the atrocities. MSF represents a category of humanitarian assistance that has been massively successful in saving individual lives by providing medical services that may otherwise not exist.

MSF focuses on training local medical professionals, which is seen as a more sustainable method, but the international aid organization still faces many contradictions in its practices. MSF "almost invariably works closely with health ministries and trains local staff, and may work in an area for several years, though it does not attempt to address the underlying causes of the emergencies. MSF operates feeding centers, but does not supply shovels and seeds to grow crops; it brings healthcare to poor areas, but does not try to eradicate poverty" (Bortolotti

2004:13). Fox (1995) provides a similar opinion, "No matter how exalted their mission, how strong their commitment, or how impressive the human and material resources they are able to mobilize, it is not within the purview of organizations like Doctors Without Borders to create and implement a model of multicultural and global coexistence and action that can remedy the maladies of our times" (p. 1616).

MSF taps into the potential of local doctors, nurses and other healthcare workers, but struggles to find a way to work with these healthcare workers in collaboration with the local healthcare structures. MSF provides excellent wages for local healthcare workers and administrative assistants, but by doing so they pull some of the best workers out of the local government and economy. Despite its drawbacks, until the entire healthcare systems of the countries in which MSF works are restructured, MSF's work remains necessary and beneficial.

PEPFAR: Changing Individual Lives Rather Than Systems

While MSF focuses on using manpower and expertise to make a difference through cooperative healthcare, other organizations, such as the President's Emergency Plan for AIDS Relief (PEPFAR), use a different model. In his State of the Union address in 2003, President George W. Bush announced a program he called the President's Emergency Plan for AIDS Relief which asked Congress to commit $15 billion over 5 years to help fight the HIV/AIDS battle (El-Sadr and Hoos 2008:553). Since then, this program has received a significant amount of praise and criticism alike. PEPFAR represents a donor and resource driven model that has created a massive impact by the numbers. As of 2010, PEPFAR treatment reduced AIDS related deaths by approximately 10 percent compared to countries with no PEPFAR funding, translating to around one million lives saved (Walensky and Juritzkes 2010:273). PEPFAR is the largest effort by a single government to fight HIV/AIDS, and there is a wide body of literature that

supports the progress PEPFAR has made (Duber et al. 2010; El-Sadr & Hoos 2008; Walensky & Juritzkes 2010). Similar to MSF, PEPFAR attracts donors through advertising its life saving, tangible treatments. In a critique of vertical approaches, David Egilman et al. (2011) state, "It's much easier to get people to donate to an identifiable victim with a specific disease or deformity than it is to get people to donate to mass causes such as sanitation issues" (p. 268). Walensky and Juritzkes (2010) note that PEPFAR's work in other areas of global health, like prevention and medical professional trainings, often goes unacknowledged.

El-Sadr and Hoos (2008) acknowledge that PEPFAR has been "both condemned as unilateral, paternalistic, narrowly focused, and distorted by a political agenda and lauded as groundbreaking, visionary, effective, and responsible for saving hundreds of thousands of lives" (p. 553). Walensky and Juritzkes (2010) discuss the positives of PEPFAR, and try to address many misconceptions people have regarding PEPFAR's work by arguing that HIV/AIDS treatment is central to all other healthcare issues. Walensky and Juritzkes (2010) see HIV/AIDS focused treatment as a necessary first step in improving healthcare systems. "Bringing the HIV epidemic under control through treatment and prevention is fundamental to the success of all other health measures" (Walensky & Juritzkes 2010:273). HIV/AIDS is often economically debilitating to individuals and countries widely affected by HIV. Walensky and Juritzkes (2010) also believe improving the lives of people living with HIV through treatment and prevention can lead to increased countrywide economic stability.

PEPFAR has received a wide array of criticism on various aspects of its approach. El-Sadr and Hoos (2008) believe that PEPFAR "has not substantially altered the landscape in terms of stigma against people with HIV/inequity between the sexes, environmental threats to health, lack of educational opportunities for young people, and policies that restrict the expansion of the

healthcare work force" (p. 555). El-Sadr and Hoos suggest PEPFAR transition from an organization focused solely on HIV/AIDS prevention and treatment towards an organization focused on addressing the root causes of HIV and strengthening the pre-existing healthcare systems. While this is a worthwhile suggestion, PEPFAR will ultimately be more successful continuing to work in its existing framework. PEPFAR should continue utilizing the resources and funding it has as an international aid organization to help people living with HIV/AIDS, while other, ideally local organizations, should focus on strengthening the pre-existing healthcare structures.

It cannot be denied that PEPFAR has had an immense impact on the fight against HIV/AIDS in the global South. PEPFAR has brought anti-retroviral drugs to places where people have no access to this medicine that costs patients in the US thousands of dollars a year, which has created hope for millions of people and erased the death sentence typically associated with an HIV positive diagnosis. Whether PEPFAR has had a lasting impact on the healthcare systems in the 14 countries it serves remains unclear, as different authors have reached contradictory and conflicting conclusions. Its massive budget is one of PEPFAR's greatest assets, and it is not surprising that with billions of dollars they have been able to create a large impact.

The Global Fund: Good Intentions

The Global Fund to Fight AIDS, Tuberculosis and Malaria, more commonly known as the Global Fund, is an example of another government-funded organization that uses yet a different model. The Global Fund is a public-private partnership designed to provide funding to treat AIDS, tuberculosis and malaria (Hanefeld 2014). The Global Fund was seen as part of a new breed of players in the global health field (Hanefeld 2014; Kapilashrami and Hanefeld 2014). Unlike organizations like MSF and PEPFAR, the Global Fund is not an implementing

agency and has no offices in recipient countries (Hanefeld 2014). It works under a model of providing funding based on proposals from recipient countries. An expert panel reviews proposals, and then makes recommendations to the Board. Similar to PEPFAR, the Global Fund has had massive success by the numbers (Kapilashrami and Hanefeld 2014). By 2013, the organization had treated 2.4 million people with AIDS and 9.7 million people with tuberculosis, and had handed out 310 million mosquito nets to prevent malaria (Hanefeld 2014:55).

Despite its success, the Global Fund has received criticism for various aspects of their system. The implementers of the Global Fund recognized that the weak local healthcare systems and poorly trained medical professionals in the recipient countries were limiting the effects of its programs, but attempted to strengthen the healthcare systems only within its vertical, disease-focused approach and therefore did not have a far-reaching impact (Hanefeld 2014; Kapilashrami and Hanefeld 2014). Another point of criticism is the Global Fund's focus on short-term health goals instead of long-term.

The Global Fund has created large-scale change in the communities and countries in which they are present. For those living with HIV/AIDS, tuberculosis or malaria, the Global Fund provides lifesaving treatment and prevention methods that most of the recipients would not have access to otherwise. The Global Fund fills a unique niche within the group of large-budget international aid organizations due to the fact that it does not have local offices in recipient countries. Instead, the organization provides care and resources through a need driven model that utilizes health experts in the recipient countries. This model attempts to eradicate the power dynamics often present in North-South partnerships, and does so successfully on many fronts by relying on local people for project creation and implementation.

Partners In Health: A Fight Against Issues of Power Dynamics

Organizations such as Partners in Health have created a new model involving North-South collaboration. The title cut of a hit record album in Haiti called *International Organizations* included the following lines: "International organizations are not on our side. They're there to help the thieves rob and devour... International health stays on the sidelines of our struggle" (Farmer 1999:1489). Paul Farmer, co-founder of Partners in Health, believed that this album represented a larger problem facing countries receiving aid, and set out to create an organization that uses a different model. Partners in Health works with community-based organizations in the global South to help provide better healthcare to underserved populations (Farmer 1999). Farmer created the term *pragmatic solidarity,* which he defined as the utilization of resources in the global North to improve the health of victimized people in the global South. Within the model of pragmatic solidarity, Farmer (1999) says it is important to "listen to the sick and abused and to those most likely to have their rights violated" (p. 1492). Partners in Health works with underfunded and understaffed health clinics through public-private partnerships, believing that the only way to slow down the pandemic and increase quality of life and life expectancy is through making resources available to communities in need (Walton et al. 2004). The Partners in Health model represents a larger goal in the global health movement: to eradicate social and economic inequalities and disparities regarding access that lead to the abuse of human and civil rights (Farmer 1999).

Walton et al. (2004) argue that instead of taking away from primary healthcare, HIV/AIDS treatment and prevention can actually improve primary healthcare. This idea mirrors the philosophy of PEPFAR as argued by Walensky and Juritzkes (2010). While several authors criticize all vertical approaches focused on HIV/AIDS, Farmer (2007) believes that "the influx of

AIDS funding can indeed strangle primary care, distort public health budgets, and contribute to brain drain, but... [this] occur[s] only when programs are poorly designed" (p. 159). He also reiterates the problems with donor driven funding, a huge criticism of vertical programs. In its work, Partners in Health has found it impossible to use a vertical approach, as most of their patients present with a multitude of diseases and illnesses, often at the same time.

Through the lens of viewing health as a human right, Farmer (1999) believes that "what has been lacking, with some notable exceptions has been concerted efforts to engage health professionals in human rights work" (p. 1492). In order to change the healthcare systems in the global South, health professionals have been, and must continue to play a large role in the global health movement. Partners in Health offers a different model to utilize local professionals that does not contribute to the brain drain as much as vertical programs in a twofold manner: using community health workers and working in the public sector. Partners in Health creates new job opportunities as *accompagnateurs*, or community health workers. *Accompagnateurs* are not medically trained, and instead focus on health promotion and patient supervision. Farmer and Garret (2007) believe that in the global South, and also the global North, it is necessary to rely on less-trained professionals to implement some of the tasks typically performed by doctors and nurses. Partners in Health works through the public sector "so that the doctors, nurses, and paraprofessionals who work with us are not part of the brain drain at all" (Farmer and Garrett 2007:157). The use of community health workers is an example of ways that organizations can work in a more horizontal manner to provide preventative care in impoverished communities.

Partners in Health has created a model that offers solutions to many of the problems faced and created by large international aid organizations. Partners in Health creates partnerships intentionally and thoughtfully with local people, and instead of presenting them with an agenda

as do many other international aid organizations, the organization asks the local people how they can help. By doing so, Partners in Health shifts some of the power and agency to the local people. Partners in Health has a large enough budget to create large-scale change in communities, but it is small and focused enough that it can be managed and tracked more successfully than organizations like PEPFAR and the Global Fund.

Community Based Solutions: For the People by the People

Physicians and healthcare workers at the community level must be empowered to look at ways to reduce suffering within their own communities. Not only do local healthcare professionals need to be utilized, they also need to be trained how to look at root causes and prevention options instead of just treatment. By focusing on root cause and prevention training, more successful healthcare systems focused on long-term healthcare sustainability can be created. Egilman et al. (2011) believe that it is important to “recognize that aid interventions are not sustainable unless people at the community level are empowered and physicians are encouraged - and expected - to find the most efficient ways to reduce suffering and prolong meaningful life” (p. 373). Egilman et al. (2011) also note the importance of healthcare professionals working directly with community leaders to identify issues in the community collaboratively. “If programs are implemented at the community level with local leaders, they become a sustainable and efficient foundation for national health systems” (Egilman et al. 2011:376). Developing this type of system returns agency to the people in the global South who have been stripped of many basic rights to healthcare. Through this type of grassroots approach, the issues of power and control so often enveloped in relationships between communities and international aid organizations can be eradicated. Even if people are empowered and trained to be health advocates and change makers in their communities, funding remains an issue. The idea

of pragmatic solidarity used by Paul Farmer can be adapted into a model in which the global North acts primarily as a funder, and secondarily as an intellectual resource (Keusch 2004).

GlobeMed: Reciprocal Learning and Low-Cost Interventions

GlobeMed, an organization that connects over 2,000 undergraduate students from 56 different colleges and universities in the United States with 56 global health grassroots organizations in 17 countries, was founded under the same premise as many other international aid organizations: to respond to and alleviate human suffering and global inequity (Cohen 2014). Maya Cohen (2014), executive director of GlobeMed from 2011-2014 believes, “As we must raise our voices against harmful approaches, it is our equal responsibility to develop and champion solutions” (p. 37). GlobeMed was founded after a group of Northwestern University students raised $20,000 to build a health clinic in Ghana, and several years later realized the clinic was not being used. When a Northwestern student asked a community leader why they let them build the health clinic if it was not what the community wanted, the community leader replied, “We are African. We listen to our donors” (Cohen 2014:38). The GlobeMed model utilizes the passion of undergraduate students to provide support for leaders of grassroots organizations to initiate change in their own communities. GlobeMed chapters raise money to fund projects created and implemented by their partner organizations. GlobeMed partner organizations implement projects in maternal health, sanitation and hygiene, income generation, nutrition, communicable disease prevention and capacity building (GlobeMed 2014). These projects reflect GlobeMed’s approach of addressing the root causes and social determinants of health that lead to illnesses that larger international aid organizations often end up treating instead of preventing. GlobeMed also values North-South collaboration, but they do so in a different way than MSF, PEPFAR and Partners in Health. Every summer students intern with

their partner organizations to learn about their projects and evaluate impact. Instead of bringing in experts from the global North to help fix the problems in the global South, GlobeMed sends students to learn from their partner organizations in the global South, inverting the power dynamics often present in North-South collaboration.

For the first seven years, the only collaboration in the GlobeMed network was between chapters and partner organizations. GlobeMed recently recognized the potential in creating connections between partner organizations in similar regions of the world, and in 2013 it hosted the first East Africa Forum. In July 2013, students on their internships and partner organization leaders met in Kampala, Uganda for a forum on global health and community based solutions. The following summer, GlobeMed hosted another forum, but only for partner organizations, called the Africa Partner Forum. By doing so, GlobeMed gave the employees of these grassroots organizations, many of whom work in similar areas and have similar interests, the chance to meet each other and discuss ways to further collaborate in the future. Through this method of South-South collaboration, GlobeMed created a unique system for grassroots organizations coming from countries of similar socioeconomic status to work together in a manner of equal partnership that is not possible through North-South partnerships. GlobeMed also created a space for leaders of grassroots organizations to talk about issues they may have with international partners, a topic which is often neglected.

GlobeMed creates partnerships that are often devoid of the power dynamics inherent in many North-South partnerships by partnering undergraduate students, not medical or development experts, with grassroots organizations who simply need a small amount of funding and support to create large change within their communities. For example, the establishment of small gardens in Western Kenya provides people living with HIV/AIDS income to help with

household costs, nutritious food and a decreased dependence on others for financial support. Most GlobeMed supported projects ideally become self-sustaining, as is the case with the gardens. Through the summer internships, GlobeMed creates an opportunity for its partnerships to be reciprocal. While partner organizations often do not need help implementing their projects, students who visit these grassroots organizations gain an immense amount of knowledge and experience by learning how global health grassroots organizations operate on a day-to-day basis. Despite its successes, GlobeMed does not have the budget to create systemic changes. Each chapter fundraises between $4,000 and $30,000 a year for their partner organizations, which can only go so far. Unless GlobeMed can find a way to expand its model exponentially, its impact will remain unnoticed by many.

The Women and Health Taskforce: Untapped Potential

The Women and Health Taskforce is a model of South-South collaboration designed to improve women's health and health professionals' education across the world (Gonzalez de Leon and Lewis 2009). The taskforce is comprised of healthcare professionals and community members focused on women's health. The main objectives of the taskforce are to teach healthcare providers how to address the determinants of women's health, encourage universities to partner with local women's groups and grassroots organizations, increase awareness of the importance of women's and gender rights at health professional schools, and cultivate leadership skills among female students (Gonzalez de Leon and Lewis 2009). The WHTF is also used as an "active and growing forum for the exchange of ideas and development of strategies and resources for women's health" (Gonzalez de Leon and Lewis 2009:2). The taskforce focuses on social and economic inequalities as well as prevention and treatment. The main issues its members deal with are violence against women, contraception, preventable obstetric conditions,

unsafe abortions, adolescent pregnancy, HIV infections, cervical cancer, female circumcision, malnutrition and obesity.

The WHTF is sponsored by Global Health Through Education, Training and Service (GHETS), a non-profit organization focused on improving health in underserved communities. They do so by providing grants and project support for healthcare professionals and advocates working in underserved communities. Members of the WHTF have access to mini grants, which are small amounts of money available for community-based health projects. Although the taskforce receives funding and support from GHETS, a Northern non-profit, it is a model of South-South collaboration that is unique in the fields of global and public health. The taskforce represents a model that does what many organizations struggle to do in global health: put the agency in the hands of the people in local communities. Not only does the taskforce work with people in local communities, they connect people throughout the global South who face similar health challenges to share best and worst practices.

The literature thus far has shown the benefits and drawbacks of various government and non-government funded organizations in addressing health disparities across the world. While some literature on South-South collaboration, specifically on the Women and Health Taskforce, exists, more research needs to be done on the benefits and drawbacks of such models. How effective is the taskforce in utilizing its members for collaboration? How can the taskforce improve on its existing structure to increase its impact?

METHODS

This research examines the question: what are the benefits of South-South collaboration in the global health field through an in depth look at the Women and Health Taskforce. The WHTF is a group of men and women working in women's and reproductive health around the

world, connected together by an email listserv. Some members of the WHTF meet annually at the Network Towards Unity for Health conference, while others simply communicate via email and Skype. Quantitative data was collected through a survey (see Appendix A) created in collaboration with Judy Lewis, a member of the management committee of the WHTF from the United States. After we finalized the survey, Judy sent it to the management committee, a group of eight health professionals from eight different countries for review. The survey was then sent out to the listserv for the WHTF, which has a total of 197 members. A total of 35 people responded to the survey from 18 different countries. The data was then entered into SPSS. Text responses to the question "on which women's health issues are you currently working" were coded into seven different categories. Text responses to the question "what are the three most important priorities for the WHTF" were coded into nine different categories. All 35 responses to both questions were placed into categories created to reflect common themes amongst responses.

The qualitative data used in this study was collected from five interviews. Interview subjects were from five different countries (Mexico, the United States, India, Uganda and Nigeria) and all interviews were done via Skype. One interview subject was male and four were female, and three are on the management committee and two are not. Interviews were audio-recorded, transcribed and coded to establish themes. The interview schedule (See Appendix B) was designed to clarify themes that emerged from the quantitative analysis, as well as provide an opportunity for members of the taskforce to discuss issues that were not part of the survey.

The network analysis component was completed using UCINET. The sociogram of the entire network was created in Mathematica, while the sociogram of the structurally equivalent blocks was created in Microsoft Word based on data analyzed in UCINET. Structural equivalence is "concerned with an actor's position within the network - that is, with the actor's

pattern of relations with others in the populations. Nodes (actors) are structurally equivalent if they have the same types of ties to the same others" (Giuffre 2013:162). Structurally equivalent blocks are utilized to simplify large networks into blocks that can be analyzed more effectively. Given the size of this network (N=35), structurally equivalent blocks are useful, but also combine several people who are not exactly structurally equivalent. The network analysis was used to enhance the research on the social interactions within the taskforce.

FINDINGS

Network Analysis

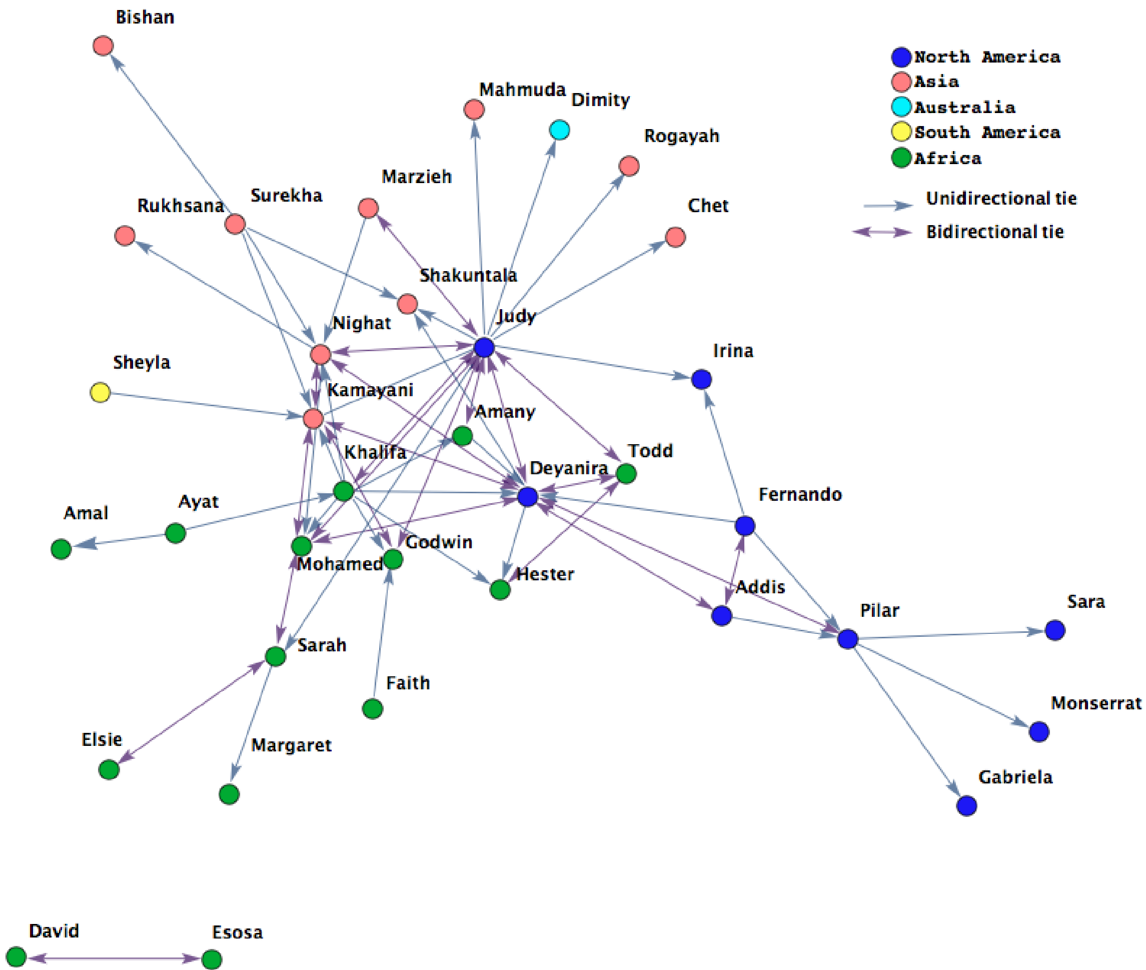

Figure 1. Sociogram of the WHTF

Figure 1 represents the connections between members of the WHTF. The color of the dot signifies the continent of citizenship for each person, and the color of the arrow signifies if the relationship is bidirectional or unidirectional. Some unidirectional ties may actually be bidirectional, as the sociogram includes eight people who did not take the survey. Five survey respondents did not choose anyone, for unknown reasons. The sociogram suggests that regional affiliation is a strong indicator of interaction in the WHTF. It is also important to note that most of the people in the middle of the network are on the management committee of the WHTF.

Figure 2. Structurally Equivalent Block Sociogram of the Unsymmetrized Matrix with Tie Strength
(Italicized names are on the management committee, bolded names are from Mexico and underlined names are from Nigeria. Colors correspond to the continent labels in Figure 1.)

While Figure 1 provides a visual of the entire network, it is difficult to analyze network ties without creating structurally equivalent blocks. Figure 2 represents the same matrix as Figure 1 with the addition of tie strength. Respondents got a 1 for each method of collaboration selected, creating scores between 0 and 6. The arrow between blocks 1 and 2 represents the connection between the two structurally equivalent groups, and the self-tie arrows represent the connection between members that are in the same structurally equivalent group. Ties were created if the density between groups was higher than the overall density for the matrix. Measures of degree of centrality, closeness centrality and betweenness centrality were also examined. People with the

top three highest scores for each measure of centrality were noted and are represented by the thickness of the circle.

Figure 2 presents two themes that appeared to increase interaction between taskforce members. The first major determinant was being on the management committee. In block 1, 6 of the 13 people are on the management committee, and the other two management committee members are two of the five people in block 2. The other determinant of block grouping is country of citizenship. Four of the five people in block 2 are from Mexico and both people in block 3 are from Nigeria. Regional and country affiliation can also be seen in Figure 1, as the sociogram is primarily divided by continent. The idea of establishing regional groups to improve the effectiveness of the taskforce is looked at in more depth later. The density scores show that while the management committee members and those who are from the same country work together, others are marginalized, such as the people in block 4 who have few ties with people in other blocks and even with each other. The overall density of the matrix is 0.295. The density of the connections within block 1 is 0.577, more than double the density of the whole matrix. The density of block 2 is 1.900, more than six times the density of the whole matrix. The density of block 3 is 2.000, which is also more than six times the density of the whole matrix. The density of the connection between blocks 1 and 2 is 0.292, while the density of the connection between blocks 2 and 1 is 0.323, meaning slightly more people in block 2 indicated higher tie strengths with members in block 1 than did members in block 1 with members in block 2. In contrast, the density of block 4 is .048, which is more than six times smaller than the overall density of the matrix.

Descriptive Statistics

Given the small sample size (N=35), very few tests produced statistical significance. Several independent-sample t tests were run that produced statistically significant results and are shown in the tables below. The independent-sample t tests also produced interesting and notable results that were not statistically significant, but still merit examination. In several cases, variables were collapsed to facilitate analysis. Given the nature of the survey, most of the variables are descriptive.

Table 1 shows the descriptive statistics for the survey population (N=35). The percentages of all participants in each category are shown, as well as the percentages of the management committee (N=8) in each category. As shown in the network analysis, the management committee is central to the taskforce, therefore it was decided that they should be examined separately. There are survey respondents from every continent except Antarctica, although the majority of respondents are from Africa (31.4 percent) or Asia (37.1 percent). For profession, respondents could choose more than one option, therefore the percentages do not add up to 100. Medical professional and public health professional are the two most popular responses both among all respondents and amongst the management committee. A large number (82.9 percent) of survey respondents have been in the health field for 10 or more years. Only 2 survey respondents (5.7 percent) have been a part of the WHTF since it was founded 24 years ago. Around half (57.1 percent) of the respondents have been in the taskforce for 10-19 years, while 75 percent of the management committee is in this category. The other 25 percent (n=2) of management committee respondents represent the 5.7 percent of respondents who have been in the taskforce since its founding.

Table 1. Descriptive Statistics in Percentages (n)s for the Participants

Variable	All	Management Committee
Gender		
Female	74.3 (26)	75.0 (6)
Male	25.7 (9)	25.0 (2)
Continent		
Asia	37.1 (13)	25.0 (2)
Africa	31.4 (11)	50.0 (4)
North America	20.0 (7)	0.0 (0)
Europe	5.7 (2)	0.0 (0)
Australia	2.9 (1)	25.0 (2)
South America	2.9 (1)	0.0 (0)
World Bank Income Brackets		
Low-Middle Income	37.1 (13)	25.0 (2)
Upper-Middle Income	25.7 (9)	25.0 (2)
High Income	22.9 (8)	37.5 (3)
Low Income	14.3 (5)	12.5 (1)
Profession		
Medical Professional	60.0 (21)	50.0 (4)
Public Health Professional	31.4 (11)	50.0 (4)
Education	14.3 (5)	25.0 (2)
Social Scientist	11.4 (4)	12.5 (1)
Lawyer	2.9 (1)	12.5 (1)
Scientist	2.9 (1)	0.0 (0)
Social Worker	2.9 (1)	0.0 (0)
Areas of Interest		
Women's and Reproductive Health	48.6 (17)	50.0 (4)
Diseases	28.6 (10)	12.5 (1)
Violence Prevention	17.1 (6)	25.0 (2)
Gender Equity and Empowerment	17.1 (6)	37.5 (3)
Sexual and Reproductive Rights	11.4 (4)	25.0 (2)
Mental Health	11.4 (4)	12.5 (1)
Nutrition	8.6 (3)	12.5 (1)
Years in the Health Field		
1-9 Years	17.1 (6)	0.0 (0)
10-25 Years	40.0 (14)	25.0 (2)
26-52 Years	42.9 (15)	75.0 (2)
Years in the Network: TUFH		
1-9 Years	45.7 (16)	12.5 (1)
10-24 Years	40.0 (14)	62.5 (5)
25-35 Years	14.3 (5)	25.0 (2)
Years in the WHTF		
0-9 Years	37.1 (13)	0.0 (0)
10-19 Years	57.1 (20)	75.0 (6)
20-24 Years	5.7 (2)	25.0 (2)

Figure 3 represents the ways in which members of the WHTF collaborate with one another. There were 81 total ties between survey respondents. Respondents were told to check all that apply, 206 options were chosen total. Percentages represent the percent of ties between members that include each method of collaboration. The most common response was individual discussions, which could range in topic, duration and frequency.

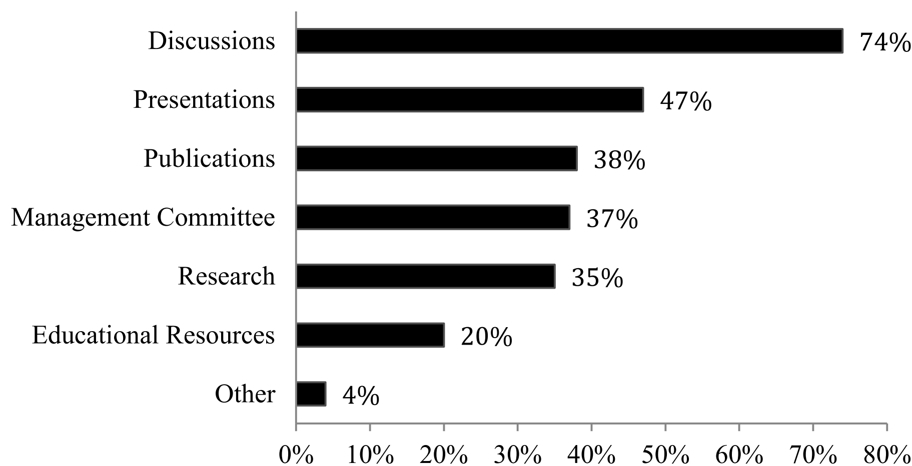

Figure 3. Ways in Which Members of the WHTF Collaborate (N=81 ties)

Figure 4 represents the ways in which members use the WHTF. Respondents were told to check all that apply, 166 options were chosen total. Most respondents (89 percent) said they attend WHTF sessions at the annual Network: Towards Unity for Health conference. The percentages represent the percent of respondents who chose each option. All but two options are utilized by more than half of the respondents.

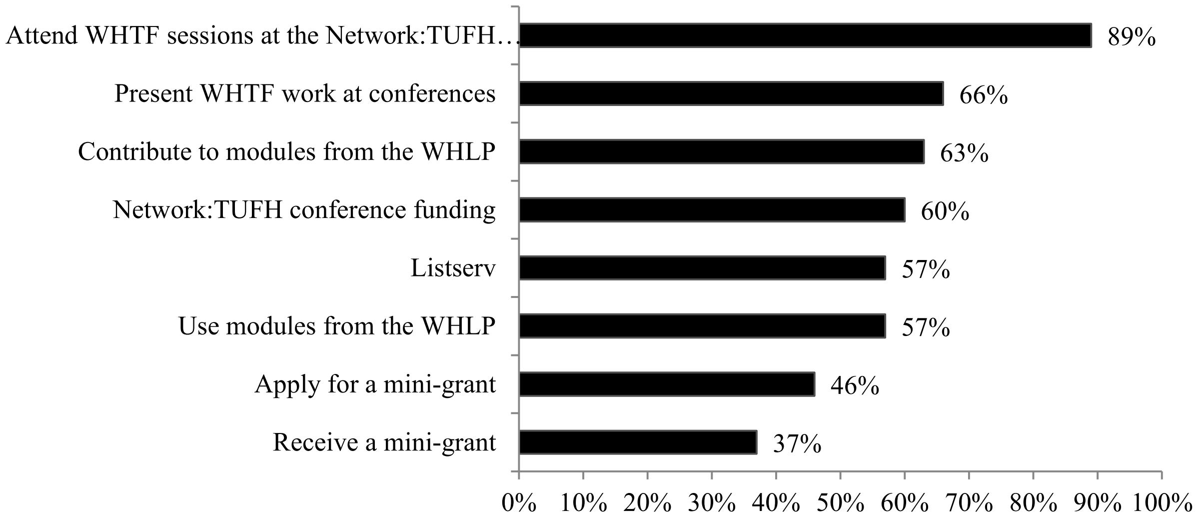

Figure 4. Ways in Which Members Use the Taskforce (N=35 participants)

Priorities of the Women and Health Taskforce

Table 2 demonstrates the priorities of members of the WHTF. The priorities were coded into nine categories, as shown in Table 2. Each priority was given a 3, 2, 1 or 0 to reflect the order in which it was listed in survey responses. Mean scores were then calculated to order the priorities from most important to least important. All mean scores are between 0 and 3, 3 as the most important.

Table 2. Priorities of the Women and Health Taskforce

Priority	Mean	Standard Deviation
Women's Health Learning Package Development	1.06	1.315
Women's Health Initiatives	1.03	1.378
Gender Equity and Women's Empowerment	0.68	1.166
Taskforce Expansion	0.65	1.050
Research and Collaboration	0.58	0.848
Community Based Women's Health Advocacy	0.42	0.923
Women's Health Training and Capacity Building	0.26	0.682
Violence Prevention	0.26	0.729
Mental Health Issues	0.10	0.539

Table 3 demonstrates the differences in mean scores between male (n=9) and female (n=26) respondents. Although only two of the differences were statistically significant, others were notable. Of the eight male respondents, none chose women's health initiatives as a priority.

In contrast, the mean score for females on that item is 1.39, which is the highest rated priority for women. The mean scores for men on research and collaboration, expanding the taskforce and increasing resources are more than twice as large as the respective mean scores of female respondents. Mental health issues ranked as a low priority for both males and females. No males chose this priority and the mean score for females is only 0.13.

Table 3. Comparison of priority mean scores between male and female respondents

Variable	Mean	Standard Deviation	*t*
Women's health initiatives			
Male	0.00	0.000	-4.641**
Female	1.39	1.438	
Expand the taskforce and increase resources			
Male	1.63	1.408	2.564**
Female	0.30	0.638	
Research and collaboration			
Male	1.00	0.926	1.673
Female	0.43	0.788	
Mental Health Issues			
Male	0.00	0.000	0.583
Female	0.13	0.626	

* p <.05

Table 4 demonstrates the difference in priority mean scores between respondents from low-income (n=18) and high-income (n=17) countries. Low and lower-middle income countries were combined into one category, and upper-middle and high-income countries were combined into another category for the purpose of analysis. Income bracket categories were based on the World Bank's classifications. The World Bank denotes low and middle-income groups as developing countries, also referred to as the global South (World Bank 2015). Women's health training and capacity building is the only priority with a statistically significant difference. The mean score for low-income country respondents is 0.47, while zero respondents from high-income countries chose this priority. The prioritizing of women's health initiatives is almost equally important to low-income country (m=1.06) and high-income country (m=1.00) respondents. Similarly,

expanding the taskforce and increasing resources was of relatively equal importance between low-income (m=0.65) and high-income (m=0.64) country respondents. Mental health remains a low priority, with mean scores of 0.00 for low-income country respondents and 0.21 for high-income country respondents. Low-income country respondents reported higher mean scores than high-income country respondents on both women's health advocacy through community-based approaches and on Women's Health Learning Package development.

Table 4. Comparison of priority mean scores between respondents from low-income and high-income countries

Variable	Mean	Standard Deviation	*t*
Women's health training and capacity building			
Low-income	0.47	0.874	2.219**
High-income	0.00	0.000	
Women's Health Learning Package development			
Low-income	1.24	1.348	0.792
High-income	0.86	1.292	
Women's health initiatives			
Low-income	1.06	1.391	0.116
High-income	1.00	1.414	
Expand the taskforce and increase resources			
Low-income	0.65	1.115	0.011
High-income	0.64	1.008	
Women's health advocacy through community based approaches			
Low-income	0.65	1.115	1.649
High-income	0.14	0.535	
Mental Health Issues			
Low-income	0.00	0.000	-1.000
High-income	0.21	0.802	

* $p < .05$

Table 5 represents the mean scores of the two broader categories, "Women's health issues, empowerment and training", and "Expand of the taskforce and increase resources, research and collaboration" to highlight the differences between males and females on these priorities. Female respondents had a mean score of 1.96 for "Women's health issues,

empowerment and training," while male respondents had a mean score of 0.63. In contrast, males had a mean score of 2.00 for "Expand the taskforce and increase resources, research and collaboration" and females had a mean score of 0.65.

Table 5. Mean scores of collapsed priorities by gender

Variable	Mean	Standard Deviation	*t*
Women's health issues, empowerment and training			
Male	0.63	1.061	-2.829**
Female	1.96	1.364	
Expand the taskforce and increase resources, research and collaboration			
Male	2.00	1.061	3.205**
Female	0.65	0.885	

* $p < .05$

DISCUSSION

In order to gain a richer perspective on the WHTF and to explore themes from survey responses, five interviews were conducted. In these interviews several themes arose regarding various facets of the WHTF including the benefits of the taskforce as well as ways in which it can improve. Other themes that will be explored include the Network: Towards Unity for Health and the role of international aid organizations in the global South. While the quantitative analysis provides interesting insights into the demographics of the WHTF, as well as striking differences between priorities for the WHTF based on gender, a qualitative analysis provides a platform to analyze broader concepts and to establish the ways in which the model of the WHTF represents the pros and cons of South-South collaboration in the field of global health.

The Network: Towards Unity for Health

The Network: Towards Unity for Health is "a global network of individuals, institutions and organizations committed to improving the health of the people and their communities" (Network Towards Unity for Health 2014). The Network, as it is commonly called amongst

members, is a non-governmental organization with an official relationship with the World Health Organization. Members of the Network come together annually for the Network: TUFH conference, which is held in a different World Health Organization region of the world every year. The Network plays an important role in the operation of the WHTF, and is itself an important platform for collaboration. One respondent said, “At network conferences primary healthcare providers and teachers have real opportunities to share their work, to receive feedback and to improve the ways they do their work.” Another respondent noted that the network is different from other organizations because “it is a very progressive organization. People can present their work in many different and flexible formats.”

The Role of the WHTF

The WHTF is one of six taskforces created through the Network, and according to one respondent, it is the most active taskforce in the network. When asked about the purpose of the WHTF, interview participants had several different responses. One respondent who is on the management committee believes that one of the main priorities of the taskforce should be to support South-South collaboration as a way to improve healthcare education and services. She also noted that the work the taskforce has done in this realm has increased its prestige within the Network. Another respondent, who is not well connected in the WHTF network, looked at the role of the taskforce as addressing the root causes that often lead to other, more complex problems. He believes the root cause issue regarding the work of the taskforce is education. The role of the taskforce is to increase awareness on fundamental issues concerning women and women’s health. According to a new member of the taskforce, the objective of the WHTF is to enhance training for healthcare professionals by reaching out to communities that face global health challenges.

The WHTF also has a social aspect for some of the members of the management committee. One of the founders of the WHTF said “I get to see my friends because they have become my friends over the years.” Another long-term member echoed these sentiments; “Now some of my colleagues of the taskforce are among some of my best friends.” The taskforce creates friendships between people around the world. The international aspect of the taskforce was talked about as both an asset and a weakness. The taskforce provides an opportunity for people from different countries and cultures to meet one another and collaborate on pertinent women’s health issues. A younger member talked about the idea of expanding the taskforce to increase awareness. He believes that if you have a group with a small number of members, the message will not spread. “Each one of us is from a different part of the world, but we should have at least two members from each country. Then, rest assured you are spreading whatever information has been shared within the group to the entire world.” According to another young member of the taskforce, it is difficult to coordinate such a big taskforce with members scattered around the world. It is a challenge to bring members together and agree on decisions. She believes that organizing regional groups would increase the impact of the taskforce, a concept that was listed as a priority by five of the 35 survey respondents.

The annual Network conference is the only opportunity for members of the WHTF to come together. One respondent believes the taskforce needs to find another platform for collaboration because traveling is a huge expense for an international network. Another concern that is often overlooked is the issue of visas. One respondent noted that when the Network conference is held in the global North, oftentimes people coming from the global South have difficulty getting visas, which often discourages people from attending. In order for the Network

and the WHTF to truly be an effective platform for global collaboration, issues such as travel costs and visas must be addressed.

Youth Engagement

When asked about the limitations of the taskforce, the most common answer was lack of student and youth engagement. While this concept was brought up in almost every interview, it was not mentioned once as a priority of the taskforce amongst survey respondents. Among survey respondents, only 18 percent said they have been in the health field for fewer than 10 years, validating the concern regarding the lack of youth engagement. In response to the question about limitations of the taskforce, a member of the management committee said she believes the taskforce needs to attract more medical students. “We need to have more of the younger generation to carry this forward.” Another member of the management committee felt similarly. She believes that the taskforce needs to be refreshed with new members, ideally young people. She acknowledged that most of the younger members they want to recruit are still in school, so it is difficult to increase their involvement until they graduate and have established themselves in the healthcare field. When prompted about the lack of youth engagement as a limitation of the taskforce, the two younger interview subjects offered their perspective on the importance of investing in medical students and young medical professionals. One respondent said young people have new ideas that must be brought up. She believes that “young people will bring a new energy, a newer side of innovation.” The other younger taskforce member acknowledged that for the long-term sustainability of the taskforce it is important for younger members to be mentored by the older members. He also discussed the idea of youth innovation. “It is very interesting when you have young minds creating ideas.”

Although it did not emerge as a priority among survey respondents, increasing youth engagement and participation in WHTF activities appears to be a crucial point of improvement for the success of the taskforce. The lack of youth participation is again limited by the expense of attending the Network conferences. A respondent from the global North noted, “my students can’t even afford it and they’re American.” If students from high-income countries cannot afford to attend these conferences, it is difficult to expect students from low-income to be in attendance. The effectiveness of a taskforce focused on South-South collaboration will be hindered if youth from the global South cannot fully participate.

The quantitative analysis found that Women’s Health Learning Package (WHLP) module development was the most important priority of the WHTF. One respondent believes that the modules are a major output of the taskforce. She noted that they have been spread in communities around the world and adapted to different countries and cultures. The modules are an example of an output of the WHTF that is not hindered by distance, as they are strictly online resources. Modules are a tangible way for members of the WHTF to collaborate. “We have modules where we have come together from various countries to see what are the most prevalent, most common things that need to be addressed, and also the uncommon things that people are unaware of that also need to be addressed.” While WHLP development was the most important priority from survey responses, it was not a common topic in the interviews.

Funding and GHETS Dependency

Initially, this paper was going to look at the ways in which the model of South-South collaboration can be used as an alternative to the utilization of international aid organizations to address global health issues. But, a key theme in the interviews was the taskforce’s dependency on GHETS, a non-profit in the global North. GHETS, Global Health through Education Training

and Service, is a US based organization that provides funding and support for healthcare professionals and advocates around the world. In 2002, GHETS gave the financial and logistical support to allow the WHTF to expand and work together in a more formal way. GHETS currently provides funds for mini-grants and for Network conference attendance, and also helps coordinate the taskforce. When asked if the WHTF could continue to function without the support of GHETS a member of the management committee responded,

> I don't think so. We are trying to look for other sources of money and support but we are in that process and now GHETS is crucial for our work... which now is a limitation that every time you want to do something you have to ask GHETS, and GHETS is giving us whatever, but they also have many other projects to fund.

Another member of the management committee agreed that the taskforce needs to look for alternative funding options. She said she looks for funding opportunities for women's health projects, but wants to start looking for more innovative funding options such as crowd sourcing or having a film festival. The one respondent from the global North added "there's nothing about the taskforce that can make it sustainable unless we get a huge donation from somebody." Instead of acting as an alternative to international aid organizations in addressing global health issues, the WHTF represents a model in which organizations in the global North can simply act as funders for projects created and implemented by people in the global South, a concept that was discussed in the literature review.

Relationships with Global International Aid Organizations

When prompted on relationships with and opinions regarding global North international aid organizations, interview participants had varying opinions, many of which reflected ideas in the existing literature. In describing her interactions with the Peace Corps, one respondent said "we got more skills, we were trained how to equip people with skills to train others on health challenges and how to implement projects. I think it was good." She looks at the role of

international aid organizations as fulfilling their duties as international actors. “Since it’s global health it’s global problems, solving problems for all.” She believes that it is important for organizations to have clear objectives as well as ways to measure their impact. Others had a more critical view of international aid organizations. One respondent talked about organizations like the Bill and Melinda Gates Foundation as coming to the global South thinking they know how to solve the problems, but in reality they are coming from an entirely different perspective and often make uninformed assumptions. She believes it is important to work with the local people to create and implement programs instead of coming in with foreign agendas. Another respondent provided the following example of international aid organizations not being cognizant of the actual needs of community: “If for instance you think of building a school, what if the need of the community is not building a school? What if their need is maybe just a borehole that can give them water? You diverge the needs and they don’t appreciate it because that is not what they need. They may want a school but they don’t need it, they have enough.”

The views of people in the global South who receive assistance from international aid organizations are often overlooked, but are an important part of the picture. Although some relationships between international aid workers and people from the local community are good, many are not and concerns regarding mutual respect and decision making arise. Funding and dependency on an international aid organization are a concern for the WHTF, but the relationship between the taskforce and GHETS is one of respect and trust.

CONCLUSION

This research looks at the ways in which global health organizations, both international and local, work to address health issues around the world, as well as the benefits and drawbacks of the model of the WHTF. The Women and Health Taskforce is one of many organizations

trying to address health inequities that plague the world. Organizations like MSF, PEPFAR and the Global Fund are doing incredible work to help millions of people, but the critiques of these organizations cannot be ignored. One of the most common critiques in the literature is the disregard for improving existing health infrastructures, and instead creating separate privatized models that rely on donor funding. In contrast, the WHTF works to connect healthcare professionals and educators around the world to share and collaborate. By doing so, the WHTF is helping bridge the gap in the field of global health that large international aid organizations cannot successfully address using their current models. The work of the WHTF can help ensure that the efforts of international aid organizations are implemented into established healthcare systems that can benefit from international funding, supplies and support to create long-term benefits for communities in need.

This research produced several key findings. First, within the taskforce there is a significant difference between the priorities of men and women. Men value expanding the taskforce and increasing resources and collaboration more, while women value focusing on women's health initiatives. According to interview respondents, the taskforce has several limitations. First, they must increase youth engagement to ensure its long-term sustainability, learn about modern techniques in the health field, and benefit from the energy and innovation that youth can bring. Second, while a benefit of the taskforce is its globally diverse network, in order to increase tangible actions, the taskforce should create regional groups in which members from similar regions can meet to collaborate on projects. The taskforce must capitalize on the potential benefits of its globally diverse network in order to increase its impact. Additionally, the taskforce is heavily reliant on GHETS, a non-profit from the global North. This reliance indicates that organizations that focus on South-South collaboration still require support from the

global North. Lastly, given the size of the taskforce, it cannot create large-scale systemic change. Despite this concern, the model in which it operates should be utilized more widely in the global health field. People from the communities in which health issues exist should be working in collaboration with one another to address these concerns together.

Further research is needed to look at new models that potentially focus on combining aspects of existing North-South and South-South models. The global health field could benefit from the establishment of new, creative solutions that combine the effectiveness of working with people from the global South with the benefits of utilizing the massive amount of international aid funding available in the global North. It is clear that the global North is needed, but the implications of this dependence in creating a new model are complicated, and will require more nuanced research.

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Appendix A:
Survey Questions

- Name
- Gender
- In which country do you currently live?
- What is your country of citizenship?
- How many years have you been involved with the Network TUFH? (Network Towards Unity for Health)
- How many years have you been involved with the WHTF?
- How do you use the WHTF? (Check all that apply)
    - Listserv
    - Attending WHTF sessions at the Network Towards Unity for Health conferences
    - Contribute cases/overviews to WHLP modules
    - Use WHLP modules
    - Funding/ Fellowships for Network Towards Unity for Health conference participation
    - Present work of WHTF at professional meetings/ conferences
    - Apply for Mini-grant
    - Received Mini-grant
- What is your profession? (Check all that apply)
    - Anthropologist
    - Community organizer
    - Lawyer
    - Nurse/midwife
    - Nutritionist
    - Public health professional
    - Physician
    - Psychologist
    - Social worker
    - Sociologist
    - Other
- In which setting do you work?
    - Academic
    - Hospital/clinic
    - Community-based organization
    - Primary health care
    - National health committee
    - Other
- How many years have you been with your current organization?
- How many years have you been in the health field?
- On which women’s health issues are you currently working?
- What are the most important priorities for the WHTF? Please write up to three.
- Please list other members of the taskforce with whom you communicate outside the listserv

Appendix B:
Interview Schedule

- How did you hear about the Network: TUFH?
- How did you first hear about the WHTF?
- What role do you think the taskforce plays in the larger fields of global health and women's health?
- How do you personally benefit from being on the taskforce?
- Do you see any limitations of the taskforce? If so, what are they?
- Have you attended a Network: TUFH conference?
    - If Yes:
        - Why do you attend these conferences?
        - What do you see as the benefits of primary health care providers and educators meeting for such conferences?
- Have you worked with any aid organizations from the global North?
    - If yes:
        - Tell me about your experiences
        - What are your thoughts on international aid organizations in general?

For management committee members:

- How long have you been on the management committee?
- Why are you on the management committee?