

Philanthropic foundations and the governance of global  
health: The Rockefeller Foundation and Product  
Development Partnerships

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# Philanthropic foundations and the governance of global health: The Rockefeller Foundation and Product Development Partnerships

## Abstract

This paper explores the influence of private philanthropic foundations in the governance of global health. Such foundations, including Rockefeller and Ford, have historically played an important role in infectious disease control, providing seed finance to develop vaccines (e.g. yellow fever) and subsidies for the eradication of certain parasites (e.g. hookworm). More recently these actors have utilised their material resources to facilitate and broker strategic coalitions between civil society groups, transnational corporations, international organisations (IOs) and states in innovative policy arrangements variously known in the literature as public-private, multi-sectoral and multi-stakeholder partnerships. Partnerships, such as the GAVI Alliance, the Institute for OneWorld Health and the Global Fund to Fight AIDS, Malaria and Tuberculosis, to name but a few high-profile cases, have been identified as appropriate policy responses to complex, and seemingly intractable, global health threats. However while theorists and practitioners have devoted considerable attention to the implications of these instruments for health governance, focussing their attention on the quality of health outcomes as well as the normative desirability of multi-actor collaboration, there remains a relative paucity of empirical research on the role played by private philanthropic foundations in both financing partnerships and influencing global health policy. While some researchers recognise the central importance of these actors to the development of the partnership model there is a continued perception that they remain benign agents, rather than actors with considerable leverage to achieve both desirable and undesirable outcomes. This paper attempts to address this vacuum by undertaking a case study analysis of the Rockefeller Foundation's support for Product Development Partnerships (PDPs) throughout the 1990s and early 2000s. Particular attention is paid to the International AIDS Vaccine Initiative (IAVI), a PDP initiated by the Foundation which played an important role in the emergence of the model as a norm in global health governance. It is suggested that the Rockefeller Foundation's instrumental role in establishing a blueprint for PDPs, as well as convening meetings that led to the development of financing partnerships like the GAVI Alliance, enabled the Foundation to retain influence in the health sphere, despite its relative decline in assets and diminished importance in the philanthropic sector more generally.<sup>1</sup>

## Introduction

Large-scale philanthropic foundations based in the United States (US) and elsewhere in the developed world have long had an interest in the area of health. This interest has extended to the institutional arrangements set-up to deliver essential medicines, but also to promote sexual and reproductive health as a means to curb population growth and reduce infant mortality rates (Scott et al 2003). However in recent years we have seen a significant (re) up-scaling in foundation funding for seemingly intractable transnational health problems, notably in the area of infectious diseases such as HIV/AIDS, malaria and tuberculosis which disproportionately effect communities in low and lower-middle income countries (LMICs). While this up-scaling can largely be attributed to the emergence of the Bill and Melinda Gates Foundation (Renz and Atienza

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<sup>1</sup> A second paper on the Gates Foundation and the GAVI Alliance will follow shortly. Primary data has been gathered and literary research completed. This paper will examine the up-scaling in health funding by the Gates Foundation and will test the assumption that this will not only alter the political economy of global health, but rather will significantly alter the policy-making environment as non-state actors, from foundations through the pharmaceutical industry, gain deeper authority via these arrangements.

2006) it is broadly indicative of trends which can be observed in the field of global health and development where we have begun to see greater private sector intervention in health policy making, and by implication, governance of global health problems (Bull and McNeill 2007). This can be seen as a continuation of earlier programmatic work of private philanthropic foundations, notably the Rockefeller and Ford Foundations, who pioneered research and development and established policy networks in health, paving the way for the present wave of philanthropists from Gates through to Soros. Nonetheless while we have seen much media commentary on this phenomenon – particularly surrounding investor Warren Buffett's extraordinary announcement that he would be handing over the bulk of his assets to the world's largest foundation, the Gates Foundation – there has been limited scholarly analysis of the implications of this up-scaling on health policy making and financing. Scholars and practitioners have (appropriately) focussed their energy on examining the implications of public-private partnerships (PPPs) on health outcomes in LMICs and the normative desirability of multi-actor collaboration, but have (largely) seen foundations as benign agents rather than actors with considerable ability to leverage both desirable and undesirable outcomes. This paper seeks to address this by undertaking a discursive mapping of the programmes of the Rockefeller in the area of health in an attempt to offer some conclusions as to its influence in global health governance. In doing so it argues that *private* foundations have not only played a central role in the emergence of partnerships – arguably the dominant policy paradigm in global health governance – they have also further normalised private sector involvement, sometimes, but not always at the expense of proactive state and IO interventions, while acting as interlocutors between the public, private and third sectors.

It begins by examining the reasons why partnerships have emerged as a common policy response to development problems, particularly in health. It then goes on to define and critique the partnership model in an effort to remove some of the ambiguities associated with the term, before situating philanthropic foundations in the formation of these arrangements. Finally a case analysis of the Rockefeller Foundation's health programmes is undertaken to demonstrate how foundations influence global health policy making through partnerships.<sup>2</sup> It is suggested that they do this in four ways. First, they utilise their financial assets to garner *material support* from other actors by providing seed funding for health PPPs, which acts to reassure other contributors that projects are both financially viable and likely to achieve measurable outcomes, a core of objective of private sector entities. Second, their position at the intersection of the public and private, the domestic and the international, enables them to capitalise on their *multi-level and inter-sectoral relationships* to nurture dialogue between (antagonistic) actors (e.g. pharmaceutical companies, non-governmental organisations). This serves to promote what Bull and McNeill (2007, 87) have termed "*new norms of collaboration*". Finally, private foundations, such as the Rockefeller Foundation, have been able to attract talented and well-connected employees and management who have acted as *policy entrepreneurs*<sup>3</sup>, alerting decision-makers and other influential agents to policy problems and offering solutions that enables these to be quickly absorbed and acted on. This places them in a central position, in PPPs at least, within health policy networks as evidenced by the presence of foundations on the governing boards of key partnerships and their privileged access to decision-makers in governmental and inter-governmental bodies, ultimately enabling them to advance their interests, preferences, and importantly, their ideas within the international system.

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<sup>2</sup> This paper is also part of wider PhD research that examines the role of philanthropic foundations in facilitating international development partnerships using cases selected from health, agriculture and the environment. The programmes and partnerships of five US-based philanthropic foundations including the Ford Foundation, the Rockefeller Foundation, the Gates Foundation, the Clinton Foundation and the United Nations Foundation (UNF) comprise the empirical aspects of this project. For further information, or correspondence with the author, contact [moranm@unimelb.edu.au](mailto:moranm@unimelb.edu.au).

<sup>3</sup> This term is borrowed from Kingdon's (1995) seminal work on agenda-setting in the public policy making process and in its simplest refers to an agent(s) ability initiate policy change by identifying a problem and offering a palatable solution at the opportune time.

### **'Partnerships' and the emerging global health landscape**

The rise of partnerships as an instrument in international development is often attributed to a number of changes which have occurred in the global political economy since the 1970s. Firstly, the ascendance of neo-liberalism as a policy philosophy in the 1980s – particularly within multilateral development banks (MDBs) – not only led to structural adjustment but also to greater use of not-for-profit and for-profit actors in service provision due to the (perceived) inefficiencies associated with official aid programmes and monopolistic bureaucracies (Scholte 2000). Secondly, as states restructured and adopted the tools of 'new public management' they not only began to rely on non-state actors but also became more open, integrated, and thus constrained in their ability to address development problems unilaterally leading to the search for partners who could help combat intractable health problems. Thirdly, while the decline of statism and Keynesianism in states and MDBs created a space for greater involvement of non-state agents in governance, this also coincided with a belief, particularly toward the end of the 1990s, that crude market-led development strategies, as espoused by key agencies in the form of 'Washington consensus' policies (cf. Clift 2003; Scholte 2000; Stiglitz 2002), not only failed to act as an engine of sustainable growth in LMICs, but had a detrimental impact on health outcomes.

Underpinning these shifts is the process of globalisation which has had a significant impact not just on the way governance is conducted and the actors involved, but also on the way health problems are perceived, which are now often viewed through a "global" lens and framed in terms of "transborder risks" (Dodgson et al 2002, 7; Lee et al 2002). From this perspective, health issues, particularly, but far from exclusively those associated with communicable diseases, can no longer be viewed as state-centric (Buse and Lee 2005). Accelerated globalisation, while on occasion disputed, has led to a growing spatial and temporal interconnectedness through travel, migration, trade, finance and communications technologies that has had a particularly significant impact on the way human societies interact (Held et al 1999; Scholte 2000), while further illustrating the importance of collective responses to global problems (Reinicke 1999).

The consequences of this for health have been twofold. First, traditional barriers between North and South have been partially eroded as increased migration, travel and growth in the seasonal and temporary migrant labour market has increased the likelihood of the spread of existing diseases within and between states, while potentially facilitating the proliferation of emerging threats such as SARS and the H5N1 virus. Second, the gradual erosion of the state as the sole arbiter of protection has rendered it unable to act "alone or in cooperation with other states, to deal with global health challenges" (Dogson et al 2002, 8). Instead states must navigate an increasingly complex array of issues in concert with other important players including private sector entities, NGOs, philanthropic foundations, affected communities and IOs. This has led to a rise in the literature (cf. Lee et al 2002) of the use of the phrase *global health governance* to describe the myriad of ways in which state and non-state actors now interact in the health sphere to set rules, define agendas and deliver product and services, which contrasts with the *international* character of health for much of the twentieth century.

The partnership, in its various forms, has emerged as the *de rigueur* (Martens 2007), and some argue natural (World Economic Forum Financing for Development Initiative 2005), policy response to health challenges. Health problems, which are comparatively fluid and have to a certain degree always been a concern of non-state actors necessitates cooperation that is not only multi-sectoral, but innovative, transnational and open to flexibility – traits oft cited as characteristic of these arrangements (cf. World Economic Forum Corporate Citizenship Initiative 2005) – due to the intractable nature of the threats posed to human security (Johnson 2001). This is compounded by the stymieing effect that disease, particularly communicable diseases, has on development as evidenced by the burden malaria and HIV/AIDS have in certain regions, which have not been adequately addressed by conventional government-to-government or IO-to-government aid programmes. Linked to this is the complex issue of financing of these neglected diseases which have not received adequate research and development (R&D) funding by

pharmaceutical companies (or developed states) due to the low prospect of return on products destined for LMIC markets (Grace 2006), a point which warrants further discussion below. As a consequence we have seen actors from across the political spectrum support partnerships that harness the expertise and capabilities of various agents and break down the historical sectoral divides and “division of labour” which has traditionally characterised multilateral responses to health problems (Buse and Walt 2000a).

### **Partnership typologies**

So where do philanthropic foundations fit into this equation and what role have they played in fostering partnerships? To answer this question it must be asked, first, what exactly are (health) partnerships, and second, where have philanthropic foundations been historically placed in the formation of these institutional arrangements.

Despite widespread usage of the term confusion still remains on what actually constitutes a ‘development’ partnership. Numerous authors (cf. Bull and McNeill 2007; Lewis 2005; Richter 2004a, 2004b; Utting and Zammit 2006) argue that the term is often ill-defined, employed loosely and, according to Utting and Zammit (2006, iv), is thus rendered an “infinitely elastic concept”.<sup>4</sup> Critics note that what is often labelled a PPP is actually more of a loose alliance that lacks effective coordinating structures and mechanisms. While such arrangements, for example multi-stakeholder initiatives to promote corporate social responsibility (CSR), may be considered ‘partnerships’ they often lack the level of institutionalisation to fit within the PPP paradigm and may be purely business-to-business arrangements that lack the crucially important governmental or inter-governmental player.<sup>5</sup> In addition that may be merely “ad hoc coalitions” which raises issues of sustainability (Forman and Segaar 2006, 213).

However, the comparatively large volume of literature on *global* health PPPs that has arisen in the past few years makes such definitional ambiguity less of an issue, mainly because the PPP model is more advanced in this sector (Richter 2004a). Scholars such as Buse and Walt (2000a, 2000b, 2002), and more recently Caines et al (2004), have devised models and types that provide a framework through which partnerships can be categorised. Caines et al (2004, 9), working in a capacity as consultant evaluators for the United Kingdom’s (UK) Department for International Development (DFID), identify four broad categories as the dominant models in the global health arena (see also Carlson 2004). These include:

- *research and development (R&D) partnerships* – sometimes referred to as product development partnerships (PDPs), are directed at “product discovery and development of new diagnostics, drugs and vaccines”, particularly for neglected diseases. Examples include the Global Alliance for TB Drug Development or the International AIDS Vaccine Initiative (IAVI)
- *technical assistance/service support partnerships* – “support improved service access, may provide discounted or donated drugs, and give technical assistance” such as in-kind

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<sup>4</sup> Buse and Walt’s (2000a, 550) definition is often utilised to distinguish health PPPs from other forms of multi-stakeholder and multi-sectoral collaboration – which are arguably less institutionalised – and is worth repeating here: “[A] collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour.”

<sup>5</sup> Insights from domestic health policy scholars prove useful here. Lewis (2005), examining typologies devised by Mandell (2004) and Kooiman (2003), notes for example that collaboration offers a deeper form of integration which leads to “systems change”, like for example the GAVI Alliance; networks “involve limited joint problem solving”, while partnerships are merely “intermittent coordination and temporary taskforces” which perhaps accords to health advocacy partnerships or voluntary standards in the international sphere. While this conceptual distinction may not be entirely applicable to discussions of global health partnerships, notably as there is less likely to be a steering state actor, a factor which Lewis (2006, 131) argues a crucial distinction from partnerships that have “arisen spontaneously from the community”, it does highlight the importance of establishing parameters for core terms that are often used interchangeably both in the literature and by practitioners. So the point that needs to be emphasised here is that while we see the term regularly utilised in the discourse, it in some respects remains contested, and certainly warrants clarification.

- donations by pharmaceutical companies to developing countries, for example, Merck & Co's pioneering donation of Mectizan to treat onchocerciasis (commonly known as 'river blindness') or the Accelerating Access Initiative to HIV Care (AAI) which provides in-kind ARVs and ancillary support for affected communities
- *advocacy partnerships* – “which raise the profile of the disease and advocate for increased international and/or national response, and resource mobilization” such as the Roll Back Malaria (RBM) project (and),
  - *financing partnerships* “which provides funds for specific disease programs” such as the Global Fund to Fight AIDS, Tuberculosis and Malaria

This descriptive, policy-oriented typology attempts to locate existing partnerships in four outcome-focussed areas, many of which have been supported by significant foundation funds and cover the broad spectrum of global health PPPs, which, it is generally asserted, number approximately 80-100 (although scholars such as Buse and Harmer (2007, 260) argue that this figure should in fact be lower (23) when one factors in a criteria such as board composition and presence of actors from *all* sectors in board-level decision-making processes).

However, perhaps the most comprehensive typology of global<sup>6</sup> PPPs is forwarded by Kaul (2006), and proves particularly useful when discussing philanthropic foundations. After surveying a sample of 100 global PPPs Kaul (2006, 223) has constructed a typology based on “three venture classes and seven functional types”. These classes – *business ventures*, *double-bottom line ventures* and *social ventures* – are designed to provide a working analytical model through which partnerships can be examined and compartmentalised. Within the social venture class – broadly defined as those “oriented toward public service” (Kaul 2006, 235) – two functional types are applicable to partnerships financed (and often initiated) by philanthropic foundations. Among these is ‘Type 5’ – *brokering affordable price deals*, which can be seen as analogous with technical assistance/service support partnerships. In these partnerships a key mediator “with political clout and persuasiveness” brokers a “market transaction” between a purchaser (e.g. a developing country state) and supplier (e.g. a pharmaceutical company) to facilitate pro-poor access to essential medicines (Kaul 2006, 235). Kaul (2006) uses the example of the Clinton Foundation's negotiation of a favourable contract with pharmaceutical companies, in tandem with the Global Fund, the World Bank and UNICEF, under which developing countries commit to “longer term purchase” agreements in exchange for lower cost access to HIV drugs.

‘Type 6’ partnerships – *leveraging research and development* – seek to mobilise the resources, expertise and knowledge of the private sector by setting the appropriate incentives to stimulate investments in “products for which there is no readily available market” (Kaul 2006, 237). This is achieved by establishing “‘push’ policies” (Grace 2006, 1) – direct research funding, tax incentives, R&D expenditure etc – that reduce industry costs and offsets risks, while incentivising R&D inputs in diseases which commonly affect, although far from exclusively, those in the developing world. Ultimately these financing instruments aim to bring these products to market “acting as a sort of virtual non-profit pharmaceutical company” that promotes drug R&D activity in neglected diseases, while ensuring that there are sufficient incentives to invest in poor country diseases such as HIV/AIDS, malaria, dengue and tuberculosis (Grace 2006, 1).<sup>7</sup>

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<sup>6</sup> Importantly Kaul (2006, 219) recognises the terms *domestic* origins and has noted some of the features, which distinguish *global* PPPs from the models that have become commonplace, particularly in Anglo-American economies for leveraging resources for infrastructure developments such as “construction and operation of airports, hospitals, roads” etc that represent a break with the largely state-financed (and owned) models of the post-war era.

<sup>7</sup> While the partnership arrangements under investigation here generally fall into these two categories pure advocacy partnerships have also been popular with philanthropic foundations as they form a high-impact and cost effective means of achieving missions and objectives. Naturally all PDPs and affordable price partnerships require some form of advocacy, and the Rockefeller Foundation for example has seen this as a central component and benefit of its work in this area (Rockefeller Foundation 2007).

As a consequence these instruments mirror those in operation in the private sector and function as quasi-markets, but with outwardly public goals and objectives (Carlson 2004). Consequently they are often portrayed in the literature (cf. Benner et al 2004; Witte 2005; World Economic Forum Financing for Development Initiative 2005, 2006) as 'win-win' situations in which all actors accrue a mutually beneficial gain. This claim is not without merit. First, as Caines et al (2004) note PPPs raise the profile of neglected diseases adding intangible benefits such as an enhanced profile for health issues outside IOs and the traditional health community, while garnering significant tangible resources. Second, as Buse and Harmer (2007, 261) have argued, such resource mobilisation has produced concrete results, generating "efforts to combat communicable diseases and to stimulate the development of new products". Third, they have "improved access to cost-effective healthcare interventions", and in some cases, an improved policy making environment, facilitated by country-level coordinating mechanisms (Buse and Harmer 2007, 261).

However before moving on to discuss the role of philanthropic foundations in fostering these arrangements it must be noted that partnerships are not without their critics. Some commentators, such as Richter (2004a, 2004b), suggest that this model has been somewhat uncritically adopted by the UN and its agencies including the World Health Organisation (WHO), which has played a central role in promoting take-up, particularly under the stewardship of former Director-General Gro Harlem Brundtland. These commentators (cf. Buse and Harmer 2004; Martens 2007; Richter 2004a; Utting 2005; Utting and Zammit 2006) have argued that contrary to the conventional wisdom these arrangements pose a number of dangers not just during implementation – where issues have arisen (cf. Buse and Harmer 2007) and will be discussed below – but also to the wider multilateral system. From this perspective partnerships represent a kind of 'privatisation' of governance by stealth (Bull et al 2004), which enhances the power of business at the expense of critical voices (Martens 2007). This can be evidenced by the lack of representation of NGOs and affected communities on partnership governing boards (Buse and Harmer 2007) and what some see as a privileged position of multilateral agencies, the private sector (and foundation) representatives in decision-making. However, it is the contention of this researcher that such changes, that is the shift toward greater private sector involvement in governance, has always, to a certain degree at least, been a feature of international development and also has historical parallels to programmatic work of foundations. It is to this that I shall now turn.

### **Philanthropic foundations and health partnership formation**

The emergence of philanthropic foundations as actors in health is by no means a new phenomenon. Some commentators (cf. Levy and Chernyak 2006) cite the Rockefeller and Ford Foundations as pioneers in multi-sectoral collaboration in international development. Indeed as early as the 1970s observers (cf. Thompson 1972) looking at the role of foundations in facilitating the green revolution in agriculture in Mexico and India noted that these agents played a central role in uniting actors from across sectors in novel institutional arrangements which in hindsight closely resemble contemporary partnerships. This approach, however, was not confined to agriculture but was also famously employed in the health arena, which had been a core concern of the 'big' foundations from their emergence in the late nineteenth and early twentieth centuries (Kiger 2000). Widely known programmes such the Rockefeller Foundation's search for a vaccine for yellow fever and its efforts to eradicate hookworm in the southern US states – as well as the formation of modern schools of public health – to some degree acted as antecedent to the modern global health partnership (Rodin 2007). These contributions, while sometimes seen as controversial (cf. Brown 1979 on hookworm), are widely recognised as successful foundation-led programmes that demonstrated that private funds could be put to use in tackling health and development challenges (Scott et al 2003). However, while these projects successfully forged strategic alliances between research scientists, establishing transnational epistemic communities and engaging directly with state and non-state actors, it was not until the early 1990s that foundations began to revisit the partnership approach, particularly with the private sector (Community Wealth Ventures 2004).

It is hardly surprising that philanthropic foundations have found the partnership approach attractive. These organisations have always had a strong interest in promoting inter-sectoral cooperation, as noted above, while their relationship with both the private sector, as a source of seed funds, and civil society, as financiers of non-governmental activity, has meant that the partnership model would seem a natural fit. The early foundations, such as Carnegie and Rockefeller, also emerged at a time when state intervention in society (not to mention multilateral cooperation) was comparatively limited.<sup>8</sup> This meant that these foundations assumed a role of almost governmental importance in American public life (Bulmer 1999) – and aspired to do so (Karl and Katz 1981) – while their post-war activity in the development field was pioneering in both scale and impact. Parallels can therefore be seen with the contemporary era in which developed states, largely lagging in their commitment to allocate 0.7% of GDP to official development assistance (ODA) not to mention the flailing Millennium Development Goals (MDGs) (Sachs 2005), has meant that private philanthropy (and of course development NGOs) retain significance as funders, partners, implementers, and by default, policy-makers, as states appear unwilling or unable to make the fiscal commitments required to improve development outcomes.

Nonetheless there are a number of important distinctions between early US philanthropy which was often domestically or nationally concentrated, and contemporary philanthropy, which is often more diffuse, issue-specific and delivered horizontally in collaboration with diverse agents from the public, private and non-government sectors. This is compounded by the increasingly outward orientation of some large-scale philanthropic foundations, which now allocate an increasing proportion of funds to projects and programmes outside the US. Indeed, according to the Renz and Atienza (2006, 3) of the Council on Foundations – the peak body for philanthropy in the US – we have seen “international grants as a share of overall grant giving” increase from four percent in 1982 to over eighteen percent in 2004, health programmes experiencing the largest rise. While the most recent data indicates that this can be attributed to the Gates Foundation’s shift from a domestic to an international orientation – in particular its ten year grant of US\$750m to the GAVI Alliance skewing sample results – health, “far surpassed all fields by share of international giving in 2004” (Renz and Atienza 2006, 5).

This trend is set to continue for a number of reasons. Firstly, the tech boom of the 1990s led to the creation of a number of new foundations – for example the Hewlett Foundation, the Packard Foundation and more recently the Google Foundation – which have adopted an internationalist outlook in the tradition of Carnegie, Ford and Rockefeller, while bringing a ‘business-like’ approach to giving. Importantly these “philanthrocapitalists” as *The Economist* (2006a, 9) has labelled them, are generally less risk averse, more “entrepreneurial” and therefore more likely to favour interventions which mirror “for-profit capital markets”, while possessing a natural affinity with the private sector which places them at ease with cooperative arrangements with these actors. Secondly, the growth of CSR as a mainstream function of many multinational corporations in the developing world, in rhetoric if not entirely in practice (cf. Blowfield 2005), including pharmaceutical companies keen to counter negative sentiment and capitalise on the reputational benefits associated with development-oriented collaboration, has deepened engagement between philanthropic foundations, the private sector and multilateral institutions in the health sphere (Heimans 2003), culminating in an increasing propensity for strategically-gearred partnerships (Zadek and Radovich 2006).

Indeed key scholars of global health partnerships (cf. Buse and Lee 2005; Kaul 2006) have recognised that philanthropic foundations remain important drivers of collaboration. Foundations, notably the Gates Foundation, remain the key source of funds for many of the major health PPPs (Buse and Harmer 2007), while others such as Rockefeller have been instrumental in their adoption by the international community by acting as key advocates for multi-sectoral

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<sup>8</sup> It is worth noting that until the post-war growth of ODA, the Rockefeller Foundation was the largest development institution in the world and its overseas transfers surpassed official US health international programmes. Its successes in health – driven largely by technical interventions which targeted specific tropical and communicable diseases – was widely recognised and later applied to its work in promoting the green revolution.

approaches. Some such as Bull and McNeill (2007) go further, arguing that increasing foundation funding for partnerships, coupled with an emphasis on the application of private sector tools to public problems, sometimes referred to as 'venture philanthropy', is a key factor in the ascendance of this model in international public policy making, a sentiment at least partially recognised by others in the field. This raises a number of important issues regarding the legitimacy, accountability and sustainability of these organs – and indeed networked governance arrangements (Andonova 2005) – which warrants further examination below.

However importantly for this study this illustrates that these actors may retain (significant) influence in the multilateral system. Such influence has been identified as part of a growing trend toward private sector intervention in global governance (cf. Bull et al 2004; Hall and Biersteker 2002; Haufler 2001; Pattberg 2005) and represents a further shift away from the state-centric multilateralism characteristic of the post-war era (O'Brien et al 2000). It is the contention of this researcher that philanthropic foundations position at the intersection of the public and private, their long nurtured relationships with civil society, and obvious material wealth, that these agents should be seen as important players, particularly in health. To illustrate this I will now examine the health programmes of the Rockefeller Foundation, and in particular its support for health PPPs, to assess the implications of this influence and offer some conclusions as to how foundations play a role in global health governance.

### ***The Rockefeller Foundation and Product Development Partnerships***

In the early 1990s the Rockefeller Foundation began to review its approach to health programmes, particularly in LMICs (Evans 2002). Partially inspired by internal organisational changes and by external shifts in the strategic direction of pharmaceutical product development – which experienced a move away from investment in communicable diseases associated with LMICs – the Rockefeller Foundation instituted a shift from scientific research based advocacy, mainly through research papers, toward PDPs (Evans 2002). This shift has been seen as instrumental in the ascendance of this model and as Evans (2002, 2), a former researcher with the Rockefeller health programme has argued elsewhere, the Foundation's "niche has been a catalyst or incubator of public-private partnerships for specific global product development priorities". It is the contention of this researcher that such statements are not unwarranted – although other actors obviously played an integral role – as evidenced by the Foundation's position at the initiation of many successful and prominent PDPs. This has enabled the Rockefeller Foundation to punch above its weight, the former behemoth's endowment is now ranked 13<sup>th</sup> in the US (Foundation Center 2007), through effective networking strategies that have built on the organisation's historical position as a partnership broker in international development.

To demonstrate this, I provide a brief overview of the Rockefeller Foundation's ground-breaking work in the financing of the IAVI. Under the stewardship of Seth Berkley, the IAVI advanced the partnership model internally within the organisation, with some resistance (Community Wealth Ventures 2004), and externally, by acting as a catalyst for the growth of PDPs in other areas, which the Foundation pursued after its favourable experience with IAVI. It is therefore an example of how a foundation (and savvy agents within a foundation) can have an impact on public policy models in health governance by providing a blueprint for multi-sectoral programmes, while normalising relationships with agents from the private sector. The section concludes with some discussion on the Rockefeller Foundation's direction noting that despite its relative decline in assets its reputational capital and preference for innovative ideas should ensure that it continues to play a role in global health, a role that has been taken-up with gusto by the Gates Foundation.

The 1990s marked a partial turning point for financing of neglected diseases. While tropical diseases research had been pursued with vigour in the post-war era, by the 1970s western scientists and the pharmaceutical industry began to reallocate resources to 'rich country' ailments such as heart disease and cancer, which had emerged as the most pressing problems due to a combination of dietary and lifestyle shifts and problems associated with aging (Evans 2002). While as Evans (2002) notes the Rockefeller Foundation, via its Great Neglected Diseases of

Mankind program, played a role in maintaining some semblance of a research agenda on diseases associated with the South, by the late 1980s R&D on communicable diseases such as malaria had slowed and funding had all but dried up. Pharmaceutical companies and state-funded research institutes, such as the US National Institutes for Health (NIH), had curbed funding ultimately leaving significant gaps in research spending, while at the same time, those vaccines that had become widely available in the developed North – such as Hib (*Haemophilus influenzae* type B) – were not reaching many infants in low-income countries (Barder et al 2005), further widening disparities between regions. Essentially as the twentieth century progressed R&D shifted from being a largely state-based function to one primarily conducted by the private sector – with research universities playing a supporting role – due to a number of factors ranging from compliance costs associated with regulatory regimes, the emergence of multi-national pharmaceutical companies and the rising cost of research inputs (Interviewee B). When these companies no longer saw a profitable market for certain diseases, research became marginal (although there were instances where a pathogen could be treated using an existing drug which could then be provided in-kind to communities as was the case with Merck & Co's donation of Mectizan to treat onchocerciasis referred to earlier. Mectizan being originally designed for veterinary use).

This prompted the Rockefeller Foundation and others within the global health community to search for alternative financing mechanisms to tackle diseases associated with poverty. One such project was the IAVI. In 1994 the Rockefeller Foundation convened a meeting “of 24 AIDS authorities from around the world” at its Bellagio Centre in Northern Italy (IAVI 2006, 2). The chief purpose of the meeting was to discuss possible measures to facilitate research into an HIV/AIDS vaccine for sub-types common to developing countries, not just to industrialised countries, where the bulk of the (albeit limited) research funding was presently allocated. The public-private health PDP, akin to Kaul's (2006) *leveraging research and development* functional type, emerged as the consensus response to under investment in strains common in regions where the majority of HIV cases were occurring, namely Asia and Africa. This “small group of committed individuals” – as the participants are described in IAVI's official history (IAVI 2006, 1) – laid the foundations for the emergence of one of the first PDPs and in 1996 the IAVI project was officially launched.

The IAVI, which was initially operated as an “in-house” programme within the Rockefeller Foundation, was “spun-off” in 1997 (Rockefeller Foundation 2007) and adopted its own institutional form, complete with secretariat and governing board, helping to establish a governance framework for future PPPs. From the outset agents close to the organisation, attempted to build a broad-based coalition of stakeholders to leverage support for vaccine development and provide other ancillary supports for HIV mitigation. The coalition of interested parties included “NGOs, governments, and industry, not only to promote global awareness but also to attract new partners” (IAVI 2006, 3). The IAVI's core objective was essentially to leverage resources to ignite interest in the formation of a network of research scientists to conduct clinical trials for a vaccine. In doing so, it had core advocacy role, which was enhanced by the manner in which the key individuals involved utilised their existing networks to access decision-makers and put potentially palatable policy options on the table. The IAVI, was subsequently able to garner significant material support for vaccine trials from a wide variety of sources including European donor agencies, NGOs, “public and private institutions” and has continued to work to establish a series of Vaccine Development Partnerships (VDPs). These VDPs draw together leading edge researchers from the North and South to formulate a global vaccine trial network, and while no entirely effective vaccine candidate has been identified, it has raised significant funds to support trials while at same time helping to place the search for a vaccine on the international agenda (IAVI 2006).

The modality unashamedly mirrored private sector operations, and at the time, was considered controversial both within the Rockefeller Foundation (Interviewee B) and in broader civil society (Interviewee A). Context is important here. While we now see widespread support for PDPs and other health PPPs, as noted earlier, such programmes were at the time a radical departure from traditional financing models and to a certain degree ran counter to the Foundation's conventional

approach. Certainly these arrangements, with their emphasis on funding disease-specific programmes resembled earlier Foundation work on hookworm and yellow fever, but the use of market mechanisms and incorporation of private sector entities into the policy network was controversial, not least because of the poor reputation of pharmaceutical industry in the international development community. In addition, there were also serious concerns about whether this move would constitute a shift from a *grant-making* foundation, the dominant model for large-scale US foundations (Anheier and Toepler 1999), toward an *operating* foundation, which had not been in the Rockefeller Foundation's remit since prior to the 1950s when the organisation actively conducted in-house research and programmatic work (for example the green revolution research) (Community Wealth Ventures 2004).

So why did the Rockefeller Foundation support such market-oriented approaches and what were the implications of this for the broader foundation and global health communities? As noted above the Foundation's shift can be attributed to broader structural changes in the global political economy which gave rise to multi-sectoral approaches as well as the broader external debates regarding the need to find alternative solutions to intractable health problems. From this perspective the Foundation and other supporters of PDPs were responding to external trends such as those mentioned earlier in this paper (e.g. globalisation) and in particular the new "geo-political climate", which facilitated cooperation, while diminishing "the polarisation between public and private that was characteristic of the Cold War era" (Interviewee B). In doing so, the Rockefeller Foundation was continuing its tradition of acting as a leader in health by adopting new strategies – in tandem with other actors – while at the same time advancing its internationalist mission. This also accords with its private sector roots and position as an incubator of ideas that seek to shape the way different actors within policy networks operate.

However the Foundation's shift, and in particular the decision to move forward with the IAVI, was also rooted in internal debates which occurred from Board-level down to practitioners in the health programme (Berkley 2004). For example, in an interview with Community Wealth Ventures (2004, 81), Seth Berkley and Kenneth Prewitt, a former Senior Vice President at the Rockefeller Foundation and an advocate of PDPs, indicated that that there "was the question of whether this was the moment when private philanthropy should form partnerships with the for-profit sector" stating that without Berkley's lobbying such programmes would not have moved forward. Similar sentiments were expressed in interviews with other key players (Interviewee B, Interviewee A) from the foundation community who stated that there were resistance from the public sector, elements within the WHO and NGOs who were concerned that what we were seeing was a challenge to the WHO's mandate, while bringing in partners that were the cause of, not the solution to, the complex problems regarding neglected diseases (although MSF had been an early advocate for PPPs).

However the concept of the *policy entrepreneur* – a term originally coined by Kingdon (1995) to explain agenda-setting processes in domestic public policy making – proves particularly useful here (at least when applied to IAVI, although further research will test its applicability to other health PPPs, notably the GAVI Alliance). It has already been suggested that Berkley and others such as Evans played a decisive role in convincing senior members of the Foundation Board to break with past practice and adopt these somewhat unconventional policy instruments (Berkley 2004; Community Wealth Ventures 2004). Their fervent belief that a lack of financial (and political) will was the main impediment to a substantive HIV vaccine programme was pivotal in the Board's ultimate decision to run with the IAVI partnership, and planted the seed for the Foundation's support for other similar modalities. Nonetheless, importantly the participants – in what was essentially an emerging transnational policy network – had a plan for action that could be readily adopted at the opportune time. Kingdon (1995) argues that in domestic public policy making certain actors operate across three process streams – *problems, solutions and politics*. When these streams converge, or are coupled, "the greatest policy changes occur" (Lewis 2005, 8). It can be argued that Seth Berkley and others identified the problem (a lack of investment in an AIDS vaccine), attached a solution (a multi-sectoral PPP) and brought this to the attention of decision-makers in IOs, governments and the private sector, partially relying on the Rockefeller

'brand' and *material resources* to leverage support. This occurred at time when there was a changing political climate that would make such programme(s) not only possible but politically feasible, enabling these actors to utilise a policy 'window' to forward a broad-based policy tool. In doing so, these actors, along with many other important agents within the global health community – referred to as the 'Jedi's' by one interviewee who has worked both within the Rockefeller Foundation and WHO – radically altered the global health landscape by helping to normalise private sector involvement, while setting the PPP project in motion.

After the experience with the IAVI, the Rockefeller Foundation decided to back the PDP model and subsequently "provided management advice and seed funding to establish five such organisations" to "foster an enabling environment for product development and access more broadly" (Rockefeller Foundation 2007, 1). These included PDPs such as the Global Alliance for TB Drug Development (TB Alliance), the International Partnership for Microbicides (IPM), the Paediatric Dengue Vaccine Initiative (PDVI), and the Centre for the Management of Intellectual Property in Health R&D (MIHR). More recently the Rockefeller Foundation has lent its support to the Global Call to Stop Cervical Cancer, which aims to promote access to the newly developed cervical cancer vaccine in Latin America, and eventually, to other Southern regions. As these entities have matured, and the Foundation entered a period of restructure, it has reduced or ceased funding for these partnerships (which has concerned some such as Berkley (2004) who feel foundations still have an important role beyond seed funding as Gates continues to do so). However importantly for this study, which has attempted to show how foundations can retain influence in global health, it demonstrates that, in this instance at least, the Rockefeller Foundation was able to utilise its brand "to open doors to other funders" (Community Wealth Ventures 2004) and foster resource mobilisation for neglected diseases.

#### ***What is the Rockefeller Foundation's future in global health?***

The Foundation's recent overtures to strategic partnerships in other areas through the new Innovation for Development Initiative, suggests that it will continue this approach. Indeed, a recent plenary address by the current President of the Rockefeller Foundation, Judith Rodin (2007), on the Foundation's efforts to combat hookworm in the American South, is replete with the discourse of participatory development and establishes this early intervention as a model for its foray into developing states in the post-war era and beyond. What is significant here is that the Foundation's programmes are framed, in a somewhat revisionist fashion but not without merit, as conforming to notions of community empowerment, local ownership, stakeholder engagement and collaboration (cf. Rodin 2007, 4). While one must be cautious with such accounts this speech plainly emphasised the importance of "seeking local alliances, building trust, and being mindful of local culture" (Rodin 2007, 4) that is present in the language of partnerships in contemporary approaches to global health. In doing so she emphasised the fact that the foundation currently operated as an interlocutor between agents from affected communities, the state, civil society and IOs, using the example of the Mekong Basin Disease Surveillance Network (MDSN) to illustrate how lessons learned in Southern interventions greatly influenced approaches to health threats stemming from migration, but also the requirement that systems work "within an integrated, multidisciplinary public-private partnership" (Rodin 2007, 8).

Late last year *The Lancet* (2006) editorialised concerns, reportedly shared by prominent US public health scholars who had directly approached the Board of Trustees, that the Rockefeller Foundation had planned to retreat from its interest in public health. However, in response, Rodin reassured the journal that no such withdrawal was imminent. Rather the Foundation was entering a period of organisational and programmatic restructure and would continue "to work in health robustly" (Rodin cited in *The Lancet* 2006, 523). Its recent initiatives in health – along with the announcement of an Alliance for a Green Revolution in Africa in partnership with the Gates Foundation and others which is designed along PPP lines – would suggest that it will continue its efforts in this area, and importantly, attempt to act as catalyst in the emergence of the partnership model as a norm in international public policy.

At the time of writing the Rockefeller Foundation was continuing this restructure and had replaced or made redundant a third of workforce in an effort to engender organisational culture change (*The Economist* 2006b). This involved a shift from a *programme* based structure toward an *initiative* based framework and the Foundation has begun to rely less on in-house specialists, for example in public health, and more on generalists with finance or management consulting experience (Interviewee C) to drive forward initiatives which are modelled on private sector approaches, namely venture philanthropy. In doing so it has opted to assume the social entrepreneurial style of the newer, second generation foundations, like Google or Gates, a move, at least in part inspired by its experience with PDPs and the private sector in the 1990s. Whether this shift is desirable or not, remains to be seen. Nonetheless, the Foundation has begun to focus on lessons learned during the PDP period and is now looking to formulate new approaches, which build on its experience in this area. This includes a new focus on 'e-health' and ways in which information technology can be applied to improve health systems, service delivery and ultimately health outcomes in LMICs (Interviewee B). However while this foundation was clearly integral to the formation of global health partnerships – at least in this researcher's opinion – and punches above its financial weight through an effective combination of networking, reputation and field-nurtured relationships it is the Gates Foundation that will undoubtedly play the greatest role in fostering partnerships in health, and by implication the most active role in influencing global health policy. It is to this foundation – “the 800-pound Gorilla” as it has been affectionately labelled (Moon and Szlezák 2006) – that the future research agenda on partnerships, foundations and health should undoubtedly be focussed.

## Conclusion

This paper has attempted to illustrate how one of the world's most prominent private philanthropic foundations, the Rockefeller Foundation, played an influential role in establishing the PPP model as a norm in international public policy, despite a declining asset base relative to other players in the foundation community. It began by first providing some context into the emergence of the partnership approach in international development, noting that a number of shifts in the global political economy, such as accelerated globalisation and the gradual blurring of public and private associated with this phenomenon, have converged to create conditions in which inter-sectoral collaboration would seem an appropriate policy response to intractable health problems. It then introduced some of the typologies that have been developed in an attempt to reduce some of the ambiguity associated with the term, 'partnership', arguing that, in the health field at least, some definitional certainty has been introduced by the scholarly community, although contention clearly still remains. Finally after examining some of the core reasons why we are seeing more strategically-gearred partnerships and greater use of private funds for public goals, a brief case analysis of the Rockefeller Foundation's support for PDPs was undertaken. It was suggested that the Rockefeller Foundation utilised its financial assets to garner *material resources* to leverage support from other actors by providing seed funding for the PDP model. It was also able to rely on its *multi-level and inter-sectoral* networks to foster collaboration, while particular agents within the Foundation were able to act as *policy entrepreneurs* by placing palatable policy options on the table at an opportune moment. Ultimately, it was asserted, that this contributed to the dissemination of this modality in global health and Rockefeller's efforts, while obviously not undertaken unilaterally, had a “catalytic” affect – to borrow one interviewee's term – on the manner in which the PDP model was absorbed into the suite of policies utilised to promote access to essential medicines.

However a number of questions certainly remain. While the emergence of health PDPs has undoubtedly had a positive impact on health outcomes in LMICs, leveraging funds while raising the profile of certain neglected illnesses, core implementation problems, mainly relating to health systems, service delivery and equity, still remain. In addition, questions remain regarding the extent to which (developed) states are living up to their responsibilities under UN norms such as the MDGs. This paper has only briefly touched on these concerns, although other scholars and practitioners have highlighted teething problems as well as the broader structural implications of increased private sector involvement. Nonetheless, there remains scope for further research on

the politics and pitfalls of inter-organisational collaboration and the impact this has on the effectiveness of these policy instruments. Furthermore, as has been emphasised in this paper the entry of the Gates Foundation onto the global health stage over the past six or seven years has reiterated both the critical importance of private philanthropy to global health, but also the need for greater scholarly analysis of these agents to better understand their influence in governance. Indeed as Jeffry Sachs has observed perhaps the Rockefeller Foundation “was the world’s most important development institution of the twentieth century” while the “the Gates Foundation can be that of the 21st century” (Boulton and Lamont 2007). While such statements overlook the important role that UN agencies such as the World Bank, UNICEF and UNDP have played in development, and not least the myriad of development NGOs operating on tighter budgets (or with Rockefeller funds), may still have some credence, and suggests that the Gates Foundation is worthy of further scholarly research.

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