

Partnerships for Women's Health: Striving for Best Practice within the UN Global Compact

Edited by

Martina Timmermann and **Monika Kruesmann**

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within the UN Global Compact*

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AND MONIKA KRUESMANN



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Introduction

Women's health through PPP within the UN Global Compact – At the nexus of business, ethics and human rights

MARTINA TIMMERMANN

Improving the health of people in low- and middle-income countries will be a major international concern for the next few decades. The necessity of improving individual health as well as health care systems has found its most fundamental reflection in several of the UN Millennium Development Goals (MDGs),¹ which were articulated in the *Millennium Declaration* as a common vision for the new century by the UN member states at the historic summit in New York in 2000.² In the economic and social sphere, especially, this vision is linked to specific, measurable targets for the first 15 years of the century. Collectively, the MDGs constitute the single most important normative mandate for the United Nations in its development operations.³

By the end of 2008, however, it seemed that this vision would not match reality. The World Bank's *Global Monitoring Report 2008* warns that most countries will fall short of the Millennium Development Goals.⁴ Among the eight MDGs, the prospects are worst for

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the health-related targets, especially MDG5, with its ambitious goal of achieving a reduction of 75 per cent in the maternal mortality rate between 1990 and 2015. In an even more recent report by UNICEF, such warnings are further underlined.⁵ Ann Venneman, Director of UNICEF, in her announcement of the UNICEF report commented: “As the 2015 deadline for the Millennium Development Goals draws closer, the challenge for improving maternal and newborn health goes beyond meeting the goals . . . Success will be measured in terms of lives saved and lives improved.”⁶

About 90 per cent of maternal deaths occur in sub-Saharan Africa and Asia (see Chapter 1 in this volume). The rate of maternal mortality in developing countries is more than 100 times higher than in industrialised countries, making it the health statistic that shows the greatest disparity between developing and industrialised countries. In October 2007, the United Nations Population Fund (UNFPA), the World Health Organization (WHO), the United Nations Children’s Fund (UNICEF) and the World Bank released the first new international (estimated) data in five years, which revealed that women continue to die of pregnancy-related causes at a rate of about one a minute.⁷

The total number of women dying in pregnancy or childbirth has . . . shown a modest decrease between 1990 and 2005. In 2005, 536,000 women died of maternal causes, compared to 576,000 in 1990. . . . Although maternal mortality ratios (the number of maternal deaths per 100,000 live births) are declining globally, and in all regions, the decline is too slow to meet the target of Millennium Development Goal 5. . . . Meeting that goal would have required an annual drop of 5.5 per cent, whereas the recorded declines have been less than 1 per cent.⁸

With regard to the Asia-Pacific region, most countries are not on track to achieve MDG5, which makes any contribution to the improvement of women’s health in those countries a highly important endeavour. Among them, India – with a current population of more than 1 billion people, an impressive 24 per cent ratio of young adolescents, a very low contraceptive prevalence rate, an increasing rate of sex-selective abortions, and an estimated 136,000 maternal deaths

per annum – is a focus of grave international concern (see Chapter 7 in this volume).

In India, roughly 30 million women experience pregnancy each year, and 27 million give live birth.⁹ The maternal mortality rate is estimated to be 407 deaths per 100,000 live births, which makes India one of the countries with the worst maternal death records. Such numbers indicate a pressing priority for the Indian government, as well as the international community, which is equally obliged by international human rights treaties and the Millennium Declaration, to tackle maternal and child mortality and to develop policies for the improvement of maternal health.

India itself, a signatory to the Millennium Declaration, has made those eight goals the guidelines in setting its political priorities. This is reflected in its several national health and population policy plans, such as the National Health Policy 2002 (NHP-2002), the Tenth Five Year Plan (2002–2007) and the current Eleventh Five Year Plan (2007–2012) as well as Vision 2020 India (see Chapters 8 and 9 in this volume). These plans contain, as major government goals, the achievement of population stabilisation, the promotion of reproductive health and the reduction of infant and maternal mortality. Because of the strong urban–rural and inter-state disparity in terms of access to public health services, it is “a principal objective of NHP-2002 to evolve a policy structure which reduces these inequities and allows the disadvantaged sections of society a fairer access to public health services”.¹⁰ Paying tribute to the strong role of the private sector, the government, the corporate sector and the voluntary and non-voluntary sectors are expected to work towards this goal in partnership.

Still, to reach this complex array of goals there are several hurdles to overcome, especially with regard to India's health care system and politics (see Chapters 7, 8 and 9 in this volume). Until 2002, health care was not a priority for the political agenda.¹¹ This was reflected by the very low level of national expenditure on health care as a share of gross national product (GNP). There was also an obvious neglect of rural areas in terms of providing health services. And, finally, there

was a lack of effective measures to tackle the persistent problems of poor people's difficulties in getting access to health facilities and of low investment in human resources and organisation capabilities for the public health sector. In 2005, K. Srinath Reddy, the convenor of the core Advisory Group on Public Health and Human Rights of the National Human Rights Commission of India, brought the Indian government's inadequate response to the growing health challenge to public attention in his stock-taking of India's health policies. In detail, he criticised the government's poor allocation of money spent on health and the inefficient utilisation of allocated resources.¹²

Within this context, public private partnerships (PPPs) have become key instruments of governmental health care policies (on PPPs in general see Chapter 4 in this volume; on PPPs in India, see Chapter 9 in this volume). However, the issues of whether such PPPs can help the government to fulfil its obligations, reach its political goals and contribute to good governance while solving the issue of accountability are central in the ongoing debate between the government, health care and development specialists, human rights activists and non-governmental organisations.

The case of India thus vividly illustrates the urgent need and paramount relevance of finding convincing answers to the question of how to achieve the health-related MDGs, and especially MDG5, by the target date of 2015.

Heading towards MDG5 with a comprehensive approach of integration

Any measures for reducing maternal mortality and for strengthening women's human rights to the best attainable physical and mental health need a comprehensive approach, starting with political determination and considering the particular social and cultural environment. It is crucial to keep in mind that reproductive health status depends heavily on income and gender, so gender-sensitive health policies are vitally necessary. Further, policies must recognise that achieving women's health goals under MDG5 involves issues of so-

cial justice, ethics and equity; diverse and comprehensive approaches must therefore be integrated within a broader framework. These are central understandings of the Women's Health Initiative, our case study, which recognises that integration is necessary at all levels, beginning with the international conceptions of human rights, through the specific health care needs of women and girls, to the public and private institutions and governance structures under which policies and programmes are implemented.

Integrating a human rights approach

The United Nations High Commissioner for Human Rights stressed in 2007 that the human rights approach is absolutely crucial to prevention, and emphasised the need for "addressing the political, social and economic inequalities behind mortality and the disease burden".¹³

The human rights approach to development is encapsulated in international human rights law. It is fundamentally based on the understanding that human rights are *not* about charity or the *goodness* on governments' or anyone else's part in providing some favour to the poor; rather, human rights contain certain obligations and entitlements. Human rights are underpinned by universally recognised moral values, which in the form of international human rights law create three major obligations for states:

1. the obligation to respect people's rights;
2. the obligation to protect those rights (that is, to prevent others from violating such rights); and
3. the obligation to create conditions that make human rights possible.

Within this rights-based approach, individuals are considered to be "rights holders", whereas (mainly) governments are recognised as "duty bearers". Among their duties is the establishment of equitable laws and systems that enable individuals to exercise and enjoy

their rights and to seek judicial recourse for violations under the rule of law. As rights holders, people can claim their legitimate entitlements. This approach is genuinely democratic because it specifically emphasises the participation of individuals and communities in political decision-making processes that directly affect them. States accept those obligations through ratifying international human rights treaties, which are binding under international law. If states fail to give effect to such rights, there are a number of different accountability mechanisms,¹⁴ including tribunals, parliamentary processes, a health ombudsperson, international human rights treaty monitoring bodies, and so on, which can take action. With regard to the perceived notion of the “punishment” in those mechanisms, however, and because of the complexity of the challenge of providing adequate health care, it seems more promising to use non-judicial procedures and strengthen self-commitment.

Integrating women’s health rights and needs

The judicial implications derived from the rights-based approach as well as the right to health have not been central to the debates on women’s reproductive and maternal health. One reason for this lack of interest may be that, in contrast to other rights, “the right to health has not yet gained the same human rights currency as more established rights”.¹⁵ (See also Chapter 2 in this volume.)

The right to health, enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), stipulates that everyone has the right to the highest attainable standard of physical and mental health. This does not mean that a person has a “right to be healthy”, but refers to freedoms and entitlements. In terms of freedoms, it includes the right to control one’s health and body, as well as the right to be free from interference (such as torture). In terms of entitlements, the right to health refers to the possibility of having access to the best attainable health care, as well as to the enjoyment of the broad range of conditions that make good health possible. The right to health and the approach to health based on

human rights are fundamentally built on this dynamic of freedoms and entitlements.

Integrating women's and girls' specific health (care) needs

The right to health creates an obligation for governments to provide the best attainable health care for both women and men. Nevertheless, there are gender-related differences in terms of their health care needs, which are noted in various documents.

With specific regard to women's health, the ICESCR and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) are of particular relevance. State signatories have to take steps to improve women's reproductive and maternal health, and thereby live up to the values and obligations manifested in several human rights provisions, such as the right to the best attainable health care (the Convention on the Rights of the Child (CRC), Article 24; CEDAW, Article 12); the right to life, survival and development (CRC, Article 6); the right to an adequate standard of living (CRC, Article 27); the right to be free from harmful traditional practices (CRC, Article 24.3); the right to non-discrimination (CRC, Article 2; CEDAW, Articles 1, 2); the duty of the state to undertake legislative, administrative and other measures for the implementation of rights (CRC, Article 4; CEDAW, Articles 3, 4); and the right to international cooperation (CRC, Article 24.4).

In particular, CEDAW (Article 12) notes:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting

free services where necessary, as well as adequate nutrition during pregnancy and lactation.¹⁶

Another important document pointing out the gender differences in access to health care is the Beijing Platform for Action (1995), which states that:

Women have different and unequal access to and use of basic health resources, including primary health services for the prevention and treatment of childhood diseases, malnutrition, anaemia, diarrhoeal diseases, communicable diseases, malaria and other tropical diseases and tuberculosis, among others . . . Women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate health services to women.¹⁷

Women's health needs differ from those of men not only as a result of biological distinctions but also because of gender differentials. Women face higher exposure to some risk factors. They are biologically more vulnerable than men to a number of reproductive health problems, including reproductive tract infections and sexually transmitted diseases. And, unlike men, women need health services when they are not ill, for example to carry pregnancies to term, to deliver safely or to avoid unwanted pregnancies.

Women's complex reproductive and maternal health care needs cut across all sectors of society, and require that any measure for the improvement of women's maternal and reproductive health and health care has to be addressed at multiple levels and in multiple sectors of society. Thus, it is essential to provide and improve access to reproductive health programmes that respond effectively to social, cultural, economic and gender factors.¹⁸

As a first step in improving the gravely unsatisfactory provision of women's reproductive and maternal health care, suggestions have been made to routinely address women's reproductive health issues within the context of primary health care provision. This, however, requires a strong public health system.

In addition, it has been noted that the indicators for achieving the ambitious goal of reducing maternal mortality by 75 per cent by 2015 are outdated. Consequently, there has been a growing demand for the use of supplementary information sources, such as UNICEF's 1997 *Guidelines for Monitoring the Availability and Use of Obstetric Services*.¹⁹

In acknowledgment of such differences, governments need to develop gender-specific responses in their health care services and politics. To develop adequate services, it is obviously also necessary to take a closer look at women's specific health and health care needs.

Yet the development and maintenance of viable public health and monitoring systems go beyond the issue of women's reproductive health and reach to the core of ongoing worldwide debates on how best to set up and maintain quality health care provisions.²⁰

Integrating health care politics

In Kofi Annan's MDG roadmap (2001), as in most of the following discussions on measures against maternal mortality, strong emphasis has been put on strengthening the health care sector.

The ["Making Pregnancy Safer"] initiative is based on the premise that achieving substantial and sustained reductions in maternal and neonatal mortality is critically dependent on the availability, accessibility and quality of maternal health care services, and therefore efforts must necessarily be focused on strengthening health-care systems.²¹

For several reasons, this demand poses serious challenges not only to national and local governments in South Asia and sub-Saharan Africa but also to the international community (see Chapter 1 in this volume). All of them are struggling with two very pertinent questions: How can we finance viable health care systems? How can we implement human rights and women's rights and pay adequate tribute to women's health needs?

Integrating the private sector

In addition to the obligation of the state to provide the best attainable health care – as rightfully demanded by human rights protagonists – such questions put enormous pressure on governments in developed countries, and even more so in developing countries. Designing, building and maintaining viable health care systems has thus become one of the most central issues for governments worldwide. Within this process, awareness has been rising that new models need to be developed – models that combine governmental obligations with complementary support activities by the private sector. As another consequence, there is also increasing recognition of the crucial role and the responsibilities of the private sector in the promotion and protection of human rights (see Chapters 2 and 3 in this volume).

This has even been reflected in international human rights law. Originally, international human rights law imposed obligations on states but not on non-state actors. In more recent times, however, the increasing role played by non-state actors in the economic and social spheres has been taken more into consideration. This was highlighted in a resolution adopted by the UN Sub-Commission on the Promotion and Protection of Human Rights, which states that, even though states have the primary responsibility towards human rights, “transnational corporations and other business enterprises, as organs of society, are also responsible for promoting and securing the human rights set forth in the Universal Declaration of Human Rights”.²²

In response to this general development, the question has been raised of how international human rights law can be applied to non-state actors. One suggested way is to apply it *indirectly*, by the duty of the state to protect. The alternative would be the *direct* application of human rights norms to business (see Chapter 2 in this volume).

The second option seems to be flourishing more strongly, as reflected, for instance, in documents such as the International Labour Organization (ILO) *Tripartite Declaration of Principles Concerning Multinational Enterprises and Social Policy* (2000), the Organisation for Economic Co-operation and Development (OECD) *OECD Guide-*

lines for Multinational Enterprises (2008), and the UN “Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights” (2003).²³ An example has been *A Guide for Integrating Human Rights into Business Management*, which was developed by the Business Leaders Initiative on Human Rights, the UN Global Compact and the Office of the High Commissioner on Human Rights in 2006.²⁴

Still, even if business and human rights norms are brought together from a legal point of view, another major (and more political) question is how best to *involve* corporate business in public policies? What are, or should be, the common binding ethics? And, most importantly, who will finally be held accountable to whom?²⁵

Integrating the concept of public private partnership

The state is increasingly losing ground as a provider of the public good “health” but is still obliged to fulfil its responsibility towards its citizens by providing equal access to the best attainable health services. In order to meet the increasing financial and organisational challenges associated with this obligation, one solution has been sought in the development of public private partnerships (PPPs). PPPs are understood as a “cooperative venture between the public and private sectors, built on the expertise of each partner, that best meets clearly defined public needs through the appropriate allocation of resources, risks and rewards”²⁶ (for details see Chapter 4 in this volume).

There are a great number of different PPPs that, on varying levels, engage the expertise or capital of the private sector. There are examples not only of straight contracting-out but also of traditionally delivered public services. Other forms may include simpler partnerships that are publicly administered but within a framework that still allows for private finance, design, operation and (possibly) temporary ownership of an asset.

On a positive note, PPPs in general – but especially in the health sector – are contributing to fund-raising and tackling the financial challenges facing governments.²⁷ They help in developing stronger

planning strategies and setting standards for future practice, and they contribute to improving access to products and the delivery of services. On a more critical note, there have been complaints about the exclusion of important stakeholders in the planning and implementation process, the lack of a clear definition of the roles and responsibilities of partners, the lack of information on national policies (or the disregard of such information) and, as a consequence, the wasting of resources.

A major issue in the debate on PPPs in the health care sector is the question of who is accountable to whom. Since traditionally the state is responsible for providing the public good “health”, the question that arises is: Who actually sits in the driver’s seat and controls or manages the provision of health care when the private sector is involved via PPPs? The generally accepted answer is that PPPs may contribute to improving the delivery of health care services but should be excluded from the political process of defining public priorities.

Concerns regarding business interference in government affairs are being countered by PPP defenders with the argument that, in the case of a successful PPP, not only does the private sector benefit from the partnership, but so too do the other partners and the target public as well. The important issue of binding ethics, norms and procedures is to be solved by recognising that, in successful public private partnerships, the public and private competitors automatically serve as each other’s watchdogs. An ideal PPP, therefore, should represent a win–win situation for all partners and the target public. But what will happen in international PPPs that operate in foreign settings? What happens when there are different legal and ethical settings? What will happen to the request for transparency? In short, how do partners make sure that their partners comply with what they have promised to deliver and that they are accountable?

Integrating the UN Global Compact

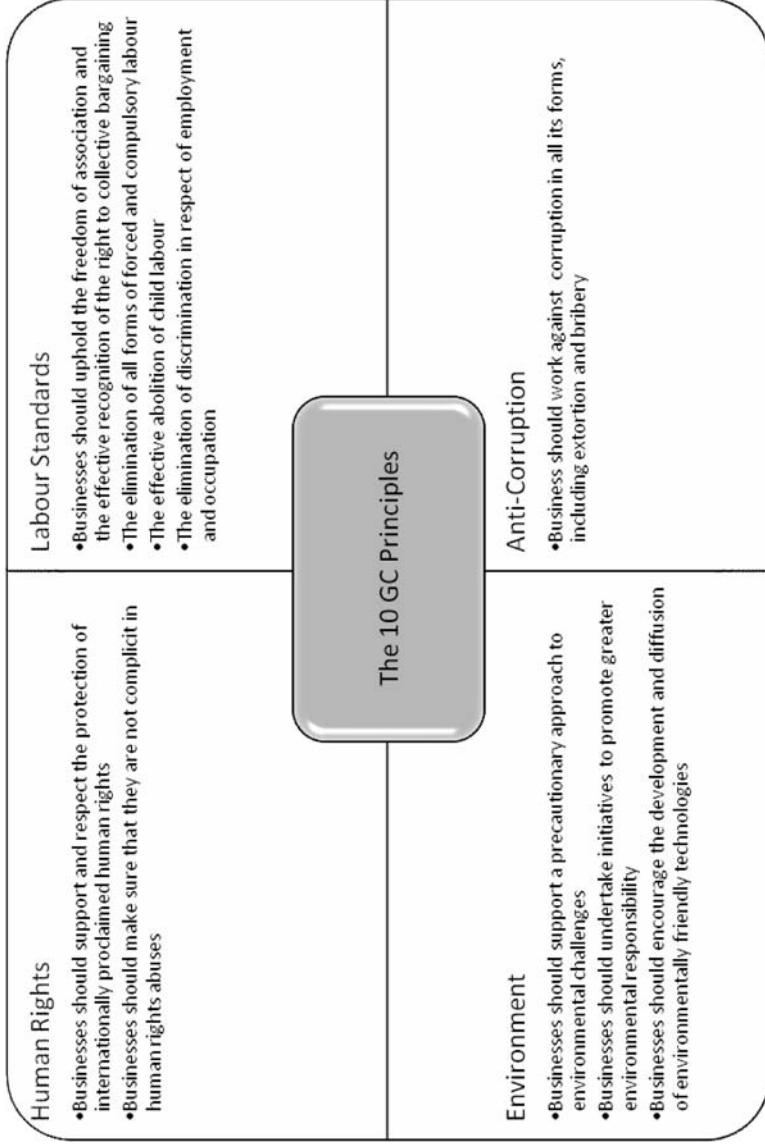
Perhaps the most prominent international forum for this debate has been the UN Global Compact (GC) Initiative, which was started by UN Secretary-General Kofi Annan at the World Economic Forum in Davos

in 2000. The Global Compact, first consisting of nine and then of ten ethical principles,²⁸ provides a framework for engaging the private sector on voluntary terms. By joining the GC, companies commit themselves to comply with the Ten Principles and to provide an annual report, the so-called Communication on Progress (CoP). Such a voluntary, self-commitment approach seems to be attractive: 5,209 business participants and 1,598 non-business participants were registered by the end of 2008.²⁹

Why do companies join the GC and commit themselves to such principles? Just for branding or marketing purposes? This was probably a major incentive at the beginning. Meanwhile, however, studies by Goldman Sachs in 2006 and on a smaller scale by TIMA (Transition Integration Management Agency) in 2004, have indicated that adhering to such principles pays off for the following reasons:³⁰

1. When joining the GC, companies decide to invest in their personnel by adhering to the ILO labour standards and human rights standards. This approach strengthens positive dispositions and leads to stronger commitment and loyalty from the employees. A positive effect of this increased loyalty is greater sustainability of business activities.
2. The GC is a crucial tool for strengthening good corporate governance, which, again, leads to a reduction in financial, economic and social risks; this is rewarded by the financial investment world.
3. The GC provides important foundations for process responsibility and leadership, which leads to higher value creation and an increase in corporate business value. Companies that decide to take over process responsibility also choose more competitive and cost-effective structures, which help them survive in this new global era of a genuinely changing international socio-economic environment.
4. Taking over process responsibility in a credible way necessarily contributes to gaining and keeping the trust of clients and customers in this new global market structure.

Figure 0.1 The Ten UN GC principles



Source: the author based on information retrieved from <<http://www.unglobalcompact.org/AboutTheGC/TheTenPrinciples/index.html>>

5. And, finally, through its universal principles the GC provides an overarching ethical framework, or ethical bridge, to all members of the world market(s), irrespective of their faith, race or sex. It is therefore a UN platform in the finest sense, where the world can meet and work while building mutual trust, reliability and stability in all sectors through business activities framed and accepted by the Global Compact.

Human rights implementation in business practice poses one of the strongest challenges. To human rights defenders, such a voluntary approach seems clearly insufficient. They insist on stronger forms of review and auditing. The search for compliance mechanisms and approaches for identifying good or best practices that live up to the promises and declarations of the GC has thus become a major focus of interest.

Paul Hunt, in his 2006 report to the Human Rights Council, noted that with particular regard to the human right to the best attainable health care and the role of business:

there is a new maturity about the health and human rights movement. "Naming and shaming", test cases and slogans all have a vital role to play in the promotion and protection of the right to health, but so do indicators, benchmarks, impact assessments, budgetary analysis, and the ability to take tough policy choices in a manner that is respectful of international human rights law and practice.³¹

In spite of this development, the alarming results of the 2009 UNICEF report, the Millennium Development Report 2008, and the 2007 study by UNFPA, UNDP and the World Bank emphasise only too vividly that there is an urgent need to go beyond declarations, debates and reporting issues if we want to keep some chance at least of meeting MDG5 by 2015.³²

This raises another important question. How can international public private partnerships that are embedded in the UN Global Compact be designed in order to be successful? What can be learned from other experiences?

Integrating lessons learnt from former health PPPs

Kent Buse from the Overseas Development Institute, London, found in his analysis of 22 global health PPPs largely focused on products and communicable diseases that such PPPs could demonstrate not only seven achievements but also seven challenges, which he provocatively called the “seven deadly sins”.³³ As positive achievements of global health partnerships (GHPs), Buse considered the opportunities of PPPs (1) to be rapidly established with many partners (3–300+), (2) to raise profiles and funds for certain issues, (3) to stimulate research and development, (4) to improve access to products, (5) to enhance service delivery capacity, (6) to strengthen policy and planning processes, and (7) to establish norms and standards.

In contrast, however, Buse also found seven particular challenges, the “seven deadly sins”, which, if unmet, will hamper effectiveness, efficiency and overall success for a PPP.

As the first challenge, Buse found that in many of his analysed PPPs there was a lack of respect for the primacy of national planning. This meant the failure of the ideas of the Paris Agenda of 2006, which aims at aid alignment, the use of government channels and national governmental budget support.³⁴ Even in the conceptual phase, PPPs may avoid adequate consideration of the national health sector, including evidence-based processes for national priority-setting and planning. The resources provided for national health policy already reflect shifting agendas linked to Medium-Term Expenditure Framework³⁵ and Poverty Reduction Strategy Papers.³⁶ It may therefore happen that existing parallel, pooled and sector budget support is not made use of to limit transaction costs. Issue-specific GHPs in particular find it difficult to accept the Paris Agenda, which may lead to an (unwanted) shift of resources from high-priority activities to this issue-specific area, including a lack of synchronicity with planning/budget cycles and high transaction costs as well as non-consideration of recurrent costs in light of budget constraints. Still, Buse also found some positive developments when looking at global health PPPs, most notably increased policy dialogue at the national level and respect for national priorities.

As a second major challenge, Buse found in his sample of 22 GHPs that not all stakeholders had an equal voice in decision-making. He particularly noted an imbalance between civil society, the private sector and the public. For effectiveness, buy-in and commitment, however, stakeholder involvement is necessary. Any PPP should therefore aim at ensuring seats for all stakeholders and improving its constituency management.

Buse's third finding was that there was a particular feeling of denial of, or even contempt for, the public sector in the 1990s. According to his analysis, there was a dominant perception that the market is good and the public sector is bad. Scandals at the WHO as well as controversial debates on the efficiency and effectiveness of PPPs and research and development versus service delivery added to this negative image. Consequently, programmes shifted from the WHO to GHPs and caused fragmentation.

The fourth challenge according to Buse is a mix of idleness, complacency and irresponsibility. Buse is referring not to the core group of partners that actually make cooperation possible, but to his analysis of evaluations of GHPs that comment on a lack of specificity of objectives, roles and responsibilities, which may then lead to inadequate work performance, misunderstandings, mistrust, a lack of commitment, a lack of mutual accountability and problematic performance monitoring. Buse criticises the fact that, despite developing norms and standards, few partnerships screen for corporate social responsibility. As a solution he recommends more business-like approaches to consolidated partnership-wide planning. He also notices insufficient oversight in global health PPPs, including a lack of screening criteria when looking for corporate partners. Buse suggests designing individual policies and guidelines in order to manage conflicts of interest, and stresses the need to communicate transparently by developing and sharing strategic and operational plans; by organising board meeting agendas, backgrounders and decisions; by making governance arrangements; by developing arrangements for managing constituencies and by writing performance reports against objectives.

As a fifth challenge, Buse states that miserliness in giving or meeting funding needs prevents "permanent reward". As a consequence,

he concludes that there are serious GHP financing challenges. He found a particular gap (an average of 60 per cent) between plans and commitments, with wary partners and a lack of mutual accountability mechanisms. Whereas the designers of a project usually favour lean, virtual and business-like secretariats, convening and coordination – necessary for success – are resource intensive. Alliance studies support Buse's point that saving on coordination is a false economy. Buse therefore concludes that there is a need for more realistic goals and improved business planning.

The sixth challenge is a wasting of scarce resources through failure to use existing country systems. This results in the duplication both of planning, monitoring and financial management and of service delivery. Buse recommends evaluating GHPs on their use of common systems and linking bilateral financing of GHPs to performance on the use of new aid modalities.

As a seventh and final challenge, Buse points to the sensitive issue of fidelity, loyalty and commitment to one's employer or primary organisation, which can conflict with outside loyalties. It therefore seems advisable to develop rules and incentives to facilitate external relationships by defining tasks and roles (expectations) explicitly, thereby consolidating planning, and by acknowledging and addressing dual accountability.

Buse's findings are further supported by a study by Rama Baru and Madhurima Nundy in 2006 (see Chapter 9 in this volume). For a PPP to be successful, they emphasise the importance of monitoring, accountability and transparency. They also put their finger on another crucial aspect of a partnership when pointing to the need for shared values. A partnership is built on the assumption of equality. If, however, values turn out to be different between partnering agencies, ethical dilemmas may evolve that negatively affect the results of the PPP.

In addition, partners are often not held accountable for the quality of services delivered. One reason could be that the Memorandum of Understanding (MOU) does not detail the required parameters; another might be that monitoring is inadequate. Baru and Nundy

criticise the fact that, “even when services are not up to the mark, there is a lack of clarity as to how they can be rectified and made accountable”. They go along with Nishtar, who notes that “[t]o hold partners accountable for their actions, it is imperative to have clear governance mechanisms and clarify partner’s rights and obligations. Clarity in such relationships is needed in order to avoid ambiguities that lead to break up of partnerships.”³⁷

The Women’s Health Initiative (WHI) against the background of such challenges

The debates alluded to above clearly illustrate the interlinkage of issues that need to be systematically integrated in designing a PPP project that aims to contribute to reaching (especially) MDG5 by the target date of 2015.

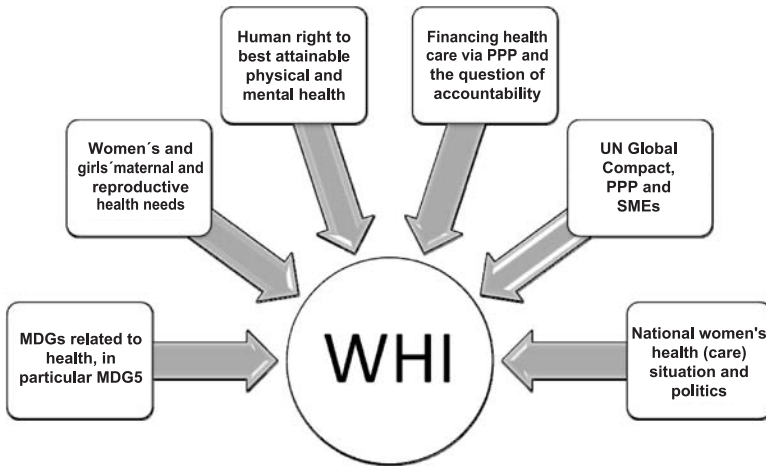
It is a major challenge to find convincing ways to respond to women’s maternal and reproductive health needs while also incorporating human rights demands into everyday business and ensuring compliance and accountability. Public private partnerships, especially those concerned with public goods, will need to be viewed in light of their effectiveness and potential to be up-scaled in order to contribute credibly to MDG efforts.

The UN Global Compact, with all its strengths and weaknesses, provides a reference framework for the corporate, as well as the governmental and non-governmental, actors who engage in such international efforts and cooperation. There is a need to involve small and medium-sized enterprises more strongly in such efforts in order to be successful in the long run (see Chapters 5 and 6).

A final but equally important question, however, is how UN GC PPP approaches can be assessed with due (but also fair) consideration of the increasingly complex requirements of our globalising world?

“The Women’s Health Initiative for Improving Women’s Maternal and Reproductive Health in India: A PPP within the Framework of the UN Global Compact” was designed against this background

Figure 0.2 The WHI at the interface of challenges of global concern



Source: the author.

of challenges and questions (see Figure 0.2). Within the project it was the task of the United Nations University (UNU) to undertake an impartial assessment of the public private partnership at the end of the project. For this reason, UNU developed an assessment model (see Chapter 11 in this volume) that included a self-learning process with two workshops – one learning workshop at the beginning of the project and one stocktaking workshop close to the end of the intervention. Most importantly, however, UNU drew from its very particular structure and mission to serve as a think tank for the exchange of ideas on issues of global concern in organising the final assessment.

Organising a platform for transparency and comprehensive documentation

A comprehensive outcome assessment needs to take into consideration the various national and global challenges outlined above. In addition, it needs to build on outside expert resources. But it is also vital to consult with shareholders in this process.

Inviting the partners to share their perceptions

In order to provide the partners as well as the experts with more scope for their arguments, UNU invited each partner to contribute a chapter in which they could present their particular positions and perceptions from both the management side in Germany and from the implementation side in India.

Inviting the experts to provide in-depth reference chapters

The experts were invited to the workshops and to contribute academic chapters for this book. They thereby had the opportunity to provide information that went beyond their workshop comments, which were additionally collected and summarised by the workshop rapporteur. In their chapters they were asked to tackle the topics of their expertise and thereby support their positions in greater academic depth. At the same time, their contributions were thought to form a useful framework of reference for the other participants and those interested parties who may think of setting up similar projects. Such contributions constitute Part A of this book and also offer the contextual framework for the following case study.

Since from the beginning the project was thought to have the potential for transfer to other countries where maternal mortality is a very serious issue, we invited Moazzam Ali to introduce the situation of maternal and reproductive health in South Asia and Africa (see Chapter 1). The UN Special Rapporteur on the right to the best attainable physical and mental health, Paul Hunt, together with Judith Bueno de Mesquito, was requested to put his finger on the interlinkage of "Poverty, Health and the Human Right to the Highest Attainable Standard of Health" (Chapter 2). A large part of their study concerns Peru, which contributes to widening the scope beyond Asia and Africa (Paul Hunt's 2008 mission report on India can be found in Appendix C). Their chapter is followed by the question of what business can do when partnering in support of the right to health. This topic is discussed by Klaus M. Leisinger, the former UN Secretary-General's Special Adviser on the UN Global Compact and President and CEO of Novartis Foundation (Chapter 3). Adding the perspective of an economist who used to advise the German

government on health care issues, Günter Neubauer along with Iris Driessle discuss the financial challenges that make equal access to the best available health care difficult (Chapter 4). They suggest bringing the private sector in via public private partnerships. However, with partnerships increasingly going beyond national borders, international ethical platforms are needed for communication and for creating trust, reliability and accountability (while also lowering risks). Because the UN Global Compact promises to function as such a platform, and because the UN GC shapes this particular partnership project with two partners being UN GC members, Monika Kruesmann discusses the United Nations Global Compact with particular regard to its potential for embracing diversity (Chapter 5). Kruesmann also provides the background for Chapter 6 by Kai Bethke and Manuela Bösendorfer from UNIDO (United Nations Industrial Development Organization) who write on the particular role of small and medium-sized enterprises within the UN GC and their roles in achieving the Millennium Development Goals.

Whereas Section I discusses the overarching themes that frame this UN GC public private partnership, Section II of this volume focuses deliberately on India – the country where this PPP pilot was conducted. Very valuable insights are provided by Suneeta Mittal and Arvind Mathur, who outline “The Health Situation of Women in India: Policies and Programmes” (Chapter 7). Their chapter is followed by a sound overview of “India’s Medical System” by Nirmal K. Ganguly and Malabika Roy (Chapter 8). Rama Baru and Madhurima Nundy look at the situation of “Health PPPs in India: Stepping Stones for Improving Women’s Health Care?” in Chapter 9. And, finally, Arabinda Ghosh, from the capacity-building department of the government of West Bengal, outlines the features of “Pro-Poor Capacity-Building in India’s Women’s Health Sector” in Chapter 10.

In Part B we present the case study, and the project participants have the opportunity to put forward their individual perspectives and experiences (see Chapters 12–16: Sybill Storz for KARL STORZ GmbH & Co. KG (KS); Nicolaus von der Goltz for the Federal Ministry of Economic Cooperation and Development – BMZ; Diana Kraft and Jörg Hartmann for GTZ; Peter Laser and Anu Chopra for

KS/GTZ in the field; and Kurian Joseph and Alka Kriplani for private and public medical doctors). Christina Gradl, the first UN GC fellow (funded by KS), was invited to provide an academic discussion of the business model developed by Achim Deja as the “practitioner” for KARL STORZ, with particular regard to its impact on the poor (see Chapter 17). In Chapter 18, Timmermann and Kruesmann discuss the outcome of the PPP intervention from the perspective of 2008, based on data from the GTZ final report (2008), a UNU mission report (2007) and two UNU workshop reports (2005 and 2006).³⁸

In Part C, this complex input is tied together and discussed with regard to the impact of the project beyond India – in the spirit of UNU’s mission goals – and with policy recommendations for this PPP and others that might take this project as a blueprint for action.

By offering this publication platform to all the stakeholders in this project, UNU aims at creating an additional opportunity for transparency and information sharing as well as constructive further debate on those issues that formed the starting point for the project. And finally, through offering insight into the project results, impact and lessons learnt, this publication shall serve as a useful reference framework on the needs and measures of PPPs for improving women’s health and human rights within the framework of the UN Global Compact beyond India.

Notes

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- ing framework was revised to include four new targets agreed by member states at the 2005 World Summit and recommended, in 2006, by the UN Secretary-General in his report on the Work of the Organization. In 2007, the General Assembly took note of the Secretary-General's report in which he presented the new framework as recommended by the Inter-Agency and Expert Group on MDG Indicators (IAEG). See the Millennium Development Goals Reports, <<http://www.un.org/millenniumgoals/reports.shtml>>; and World Bank, "About the Goals", <<http://ddp-ext.worldbank.org/ext/GMIS/gdmis.do?siteId=2&menuId=LNAV01HOME1>> (accessed 24 June 2009).
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Partnerships for Women's Health: Striving for Best Practice within the UN Global Compact

Edited by **Martina Timmermann** and **Monika Kruesmann**

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Every minute, at least one woman dies from pregnancy and childbirth complications; a further 20 suffer injury, infection or disease. Despite medical advances, and years of national and international policy declarations, this tragic situation remains particularly severe in developing countries, violating a fundamental human right.

This book draws together insights and experiences of development practitioners, policy-makers, academic experts and private sector partners to describe the Women's Health Initiative (WHI). A public private partnership based in India, the WHI took a new approach to solving the apparently intractable problem of poor women's health.

Informed by the growing literature on public private partnerships, the observations and analyses in this volume describe how the WHI drew reference from both the Millennium Development Goals and the United Nations Global Compact to implement a project that would make a real difference in women's lives, simultaneous with meeting private sector commercial imperatives.

By opening the project to independent transnational assessment, as it is reported here, the WHI articulated new standards for best practice in public private partnerships, including with reference to such issues as communications, objective-setting, ongoing partnership management, and real health outcomes. In line with the WHI's ambition to grow and become transferable to other contexts, these standards can inform and shape more effective public private partnerships in the future.

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