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Partnerships for Women's Health - Striving for Best Practice within the UN Global Compact / United Nations University Research Brief 1/2009 (www.unu.edu)

Timmermann, Martina and Kruesmann, Monika

United Nations University

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Overview

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 policy declarations, this tragic situation remains particularly severe in developing countries, violating a fundamental human right. Is a new approach possible, one that looks beyond common project paradigms and standards? What could such an approach look like, how might it operate, and what might be its effect? The *Women's Health Initiative*, an innovative public private partnership that drew reference from the UN Global Compact, provides a possible model.

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

Written by Monika Kruesmann and Martina Timmermann

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Women represent the great majority of the world's poor. With this poverty comes a range of well-documented problems: low educational attainment; low income and earning potential; inferior social power, status and influence compared with men; and importantly, poor health outcomes for both women and their children. High rates of maternal mortality and morbidity remain apparently intractable problems in many countries, particularly developing countries. The World Health Organization (WHO) reports that every minute, at least one woman dies from complications related to pregnancy and childbirth; and 20 more suffer injury, infection or disease.

These statistics are shocking for two key reasons.

First, the vast majority of deaths and injuries are preventable; women need not die in childbirth. Second, the large scale of the maternal mortality problem is not a new discovery. Rather, it was acknowledged internationally as early as 1994 at the UN International Conference on Population and Development in Cairo, and again in 1995 in Beijing at the Fourth World Conference on Women; and further at the Millennium Summit in 2000. That the problem persists has been emphasized in several recent reports by the *UN Special Rapporteur on the Right to the Best Attainable Physical and Mental Health*, Paul Hunt.[1]

On 16 June 2009 the Human Rights Council in Geneva drafted a resolution on *Preventable maternal mortality and morbidity and human rights.* [A/HRC/11/L.16, 16 June 2009], requesting renewed and vigorous efforts to improve women's health and human rights.

Clearly, more work, and more *innovative* work, is needed. Here, we summarize the development, implementation and outcomes of a trilateral partnership project, the *Women's Health Initiative* (WHI), that sought to improve reproductive and maternal health for women and girls in India. The project's principal objective was

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UN Human Rights Council (16 June 2009)
***Preventable maternal mortality and morbidity and human rights* [A/HRC/11/L.16]**

[Paragraph 3] *Requests* all States to renew their political commitment to eliminating preventable maternal mortality and morbidity at the local, national, regional and international levels, and to redouble their efforts to ensure the full and effective implementation of their human rights obligations, the Beijing Declaration and Platform for Action, the International Conference for Population Development Programme of Action and their review conferences, and the Millennium Declaration and the Millennium Development Goals, in particular the Goals on improving maternal health and promoting gender equality and empowering women including through the allocation of necessary domestic resources to health systems;

[Paragraph 4] *Requests* States to give renewed emphasis to maternal mortality and morbidity initiatives in their development partnerships and cooperation arrangements, including through honouring existing commitments and considering new commitments, and the exchange of effective practices and technical assistance to strengthen national capacities, as well as to integrate a human rights perspective into such initiatives, addressing the impact that discrimination against women has on maternal mortality and morbidity[.]

to train selected doctors in endoscopic methods of diagnosis and therapy at six Endoscopy Training Centres (ETCs) established for the project at existing Indian hospitals (four public and two private). This straightforward objective was augmented to a new standard of innovation through a focus on 'self-learning', guided by transparent and independent assessment, and coupled with explicit consideration of the United Nations Global Compact (UNGC) initiative. Commencing in 2005 and concluding in 2007, the WHI provides beneficial lessons informing the ongoing search for solutions to the tragedy of women's poor health. This research brief discusses key ideas, actions and outcomes; and serves as an accompaniment to our book publication, *Partnerships for Women's Health: Striving for Best Practice within the UN Global Compact* (Tokyo: United Nations University, forthcoming), which provides further details and analysis.

The Situation of Maternal and Child Mortality in India

The WHI was based in India, taking note of research showing that the countries most severely affected by maternal mortality are in South Asia and Africa.[2] In India, one woman dies from pregnancy or child-birth related causes every five to seven minutes. This situation continues despite recent advances in technology and the availability of equipment. Further, unsafe abortion practices contribute to high maternal mortality; although legal, many abortions are not recorded, or practiced safely, and there are concerns about the abuse of technology for sex-selective abortions.[3]

Identifying and implementing measures appropriate to improve this situation is complex. Many commentators, including Lynn Freedman of Columbia University, point out that the problem lies not in a lack of doctors,

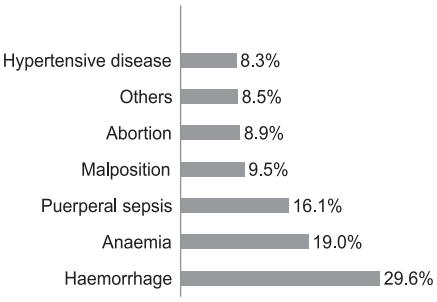

Figure 1: Causes of maternal mortality in India.
Source: Office of the Registrar General, India, *Sample Registration Bulletin*, 33(1), 1999.

midwives or nurses, but in poor nutrition, anaemia, severe bleeding, infections, eclampsia, obstructed labour and the consequences of unsafe abortions. Additional factors are poor infrastructure, inadequate emergency transport systems, inadequate access to blood bank services, poor referral services, and a lack of health care providers in rural areas. Social and cultural norms and practices may also hinder women's access to health services in some circumstances (see Figure 2).

The role of literacy in improving women's health is also, unfortunately, often underestimated despite a multi-directional relationship between poverty, ill health and illiteracy (see Figure 3).[4]

Partnerships for Health

How can these pressing and complex problems be addressed? Public private partnerships (PPPs) suggest one possibility for effective action. In recent years, these partnerships have come to be seen as viable options for improving health care.[5] In India, the government acknowledges that partnerships with the private sector – both the for-profit and non-profit – are important to attain public health goals and to improve the health delivery system. Collaboration to this end has been formally anchored in the government's *Five Year Plans*, the current one of which covers the period 2007–2012.[6]

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But do such partnerships actually contribute to improving women's health? Rama Baru and Madhurima Nundy's analysis in our forthcoming volume shows that forming and sustaining partnerships requires various social, institutional, administrative and technical elements. They therefore conclude that "PPPs can, at best, play only a supplementary role to government in women's reproductive health services".

Baru and Nundy's conclusion points to one major criticism of health PPPs by human rights defenders: it is the state that has responsibility for protecting its citizens, and which should therefore also be responsible for providing the best attainable health care to them. Where responsibility for health care is abnegated to the private sector, critics suggest the poor and economically disadvantaged will not be able to afford fundamental health services.

How can such conflicting views be mediated?[7] How far should business be involved in this sensitive area of health care provision? How much can business do and what are its limits?[8]

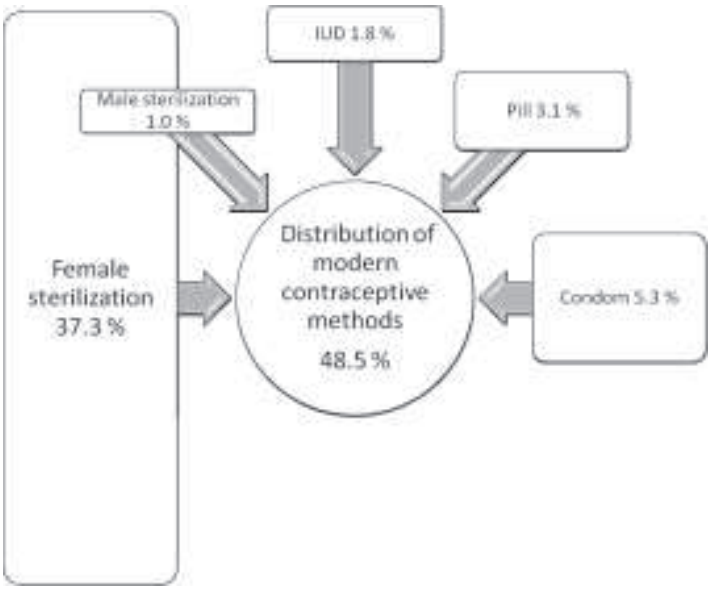

Figure 2: Distribution of modern contraceptive methods, 2005–2006 (per cent). *Source*: Government of India, National Family Health Survey 3, <http://www.nfhsindia.org/nfhs3.html> (accessed 16 June 2009).

The UN Global Compact

In examining these questions, ideas of corporate social responsibility (CSR) and the role of the UN Global Compact become relevant.

The UNGC, launched in 2000 by then-UN Secretary-General Kofi Annan, aims to help business comply, on a voluntary basis, with international ethics as they are expressed in several UN conventions on human rights, labour standards, the environment and anti-corruption.[9]

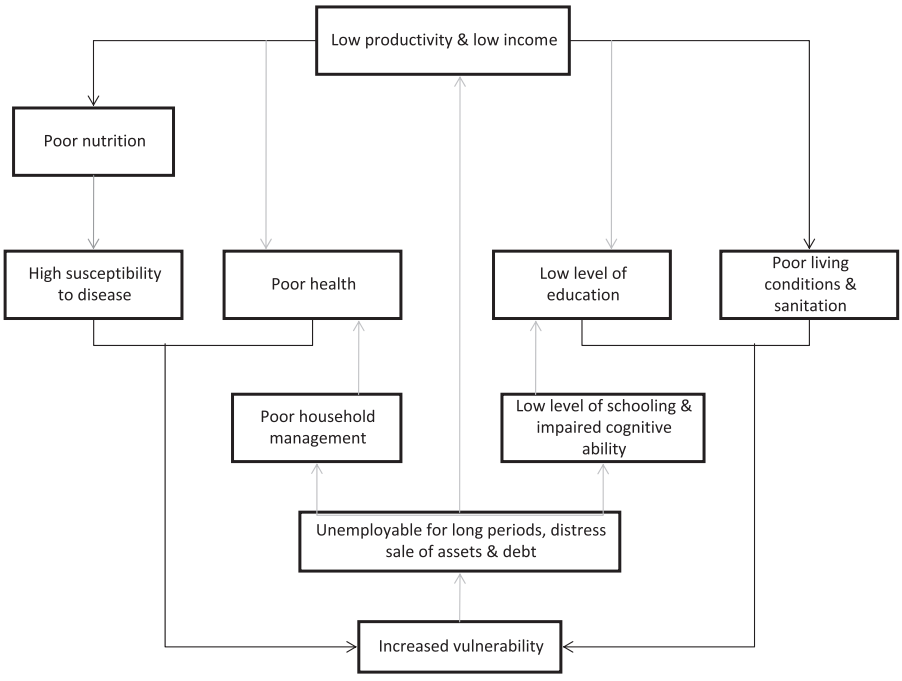

Figure 3: Multidirectional relationships between poverty, ill health and illiteracy. *Source*: Ghosh (see note 4).

The Women's Health Initiative – Striving for Best Practice within the UN Global Compact

In its design and implementation, the *Women's Health Initiative* (WHI,

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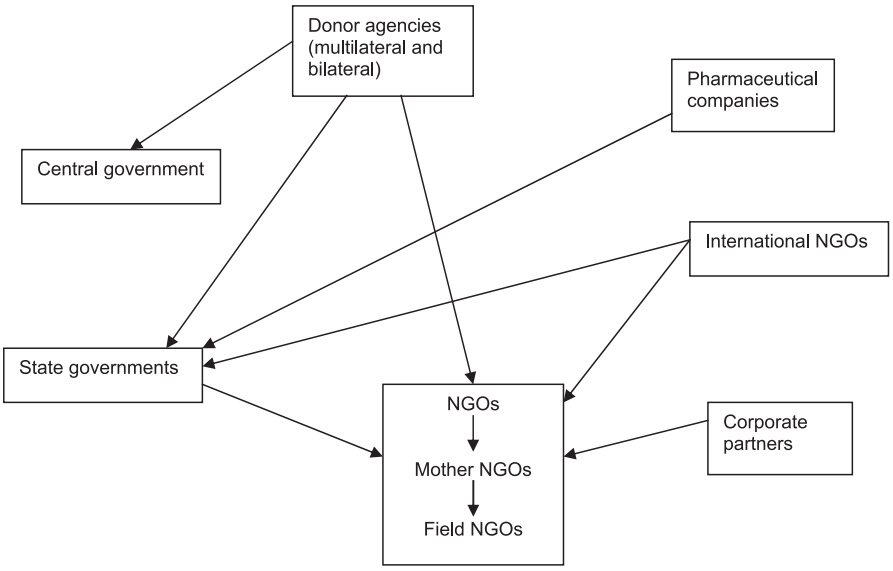

Figure 4: Pathways of partnerships.
Source: Baru and Nundy (see note 6).

Figure 5: Mapping corporate social responsibility: Issues and stakeholders.
Source: P. Raynard, M. Forstater et al., *Corporate Social Responsibility – Implications for Small and Medium Enterprises in Developing Countries*, Vienna: UNIDO, 2002, Figure 2, p. 6.

2005–2007) was cognizant of these institutional, conceptual and practical circumstances, and sought to build on the strengths of the partnership and UNGC concepts to develop and articulate an improved project model.

Two key actions were especially important in pursuing this objective. First, as a pilot project, the WHI was developed and implemented *explicitly* within the framework of the UNGC, with all partners demonstrating their willingness to embrace the principles contained therein. Second, the WHI partners allowed the pilot to be externally assessed, thereby aiming not only to understand the project's outcomes in relation to women's health, but also to highlight the importance of transparency and accountability in contributing to genuine progress towards improving the human rights of women and girls.

The Structure of the WHI

The WHI involved a trilateral partnership, with each partner having different roles and responsibilities, and bringing their own areas of expertise to the project. Those partners were:

KARL STORZ GmbH & Co. KG, under the direction of Dr. Sybill Storz, a leading producer of endoscopic instruments and equipment, provided the technical equipment and training resources necessary for the project.

The *Deutsche Gesellschaft für Technische Zusammenarbeit GmbH* (GTZ) is an enterprise for international cooperation working to promote sustainable development and improved living conditions in a globalized world. Under the umbrella of the Federal German Ministry for Economic Cooperation and Development (BMZ), GTZ and the KARL STORZ group co-financed the project and, in addition, held responsibility for the practical

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Figure 6: The WHI at the interface of challenges of global concern.
Source: Timmermann, *Partnerships for Women's Health*, Introduction.

implementation and on-the-ground monitoring of the project.

The third partner was the *United Nations University* (UNU), a unique network of research institutions and researchers from across the world.[10] UNU provided conceptual support and guidance for the project, and developed an academic assessment approach which goes beyond simple quantitative measures.

The activities of the three partners were supervised by a steering committee comprising representatives of KARL STORZ, GTZ and UNU, with overall project coordination by *TIMA GmbH* (TIMA) on behalf of KARL STORZ GmbH & Co. KG. TIMA's key roles were to keep the partners integrated, to provide technical assistance and to ensure that an awareness of the business/ethics interface was prioritized.

Striving For Best Practice

Given the WHI's defining emphasis on transparency and accountability, the project's implementation was shaped to accommodate independent, staged assessment activities examining its operation and efficacy. It was through these activities that the major research findings (below) were identified. These findings may also answer other major questions: Can this project serve as a role model for best practice? What would be needed for transferral to other countries in Asia or Africa?

As a partnership, all actors made important contributions to both implementation and assessment, with UNU playing a central role in the latter. The rationale for UNU's involvement in the WHI was to ensure independence with UNU acting as an independent international assessment agency. To realize this function, UNU led a series of assessment activities across the life of the project, allowing an element of self-learning, or action research, to be included. Two project workshops were important among these activities; one held in Chennai, India, at the start of the project in October 2005, and one held in Bonn, Germany, closer to the conclusion of the project in December 2006. The list of workshop participants for both workshops shows the breadth of expertise and interest in the project, which was also reflected in the range of contributors to the WHI publication

Definitions of Best Practice, Good Practice and Failure of a PPP

Here, we will proclaim **best practice** if the goals of the project are achieved and continuous self-learning is demonstrated: from design to implementation to results, the project avoids the typical weaknesses and challenges found in other global health PPPs and therefore demonstrates that it is effective, transparent (ensured through continuous independent monitoring), sustainable and up-scalable/transferable.

We will affirm **good practice** if the project meets its major goals but some weaknesses in design, implementation and results in terms of effectiveness, transparency, sustainability and up-scalability/transferability are apparent; however, progress will be evident and there will be encouraging potential for learning and positive development in the future.

We will certainly need to speak of **failure** if the project goals are not achieved, the typical weaknesses and challenges of previous health PPPs are repeated and no positive learning outcomes, potential for future improvements, up-scaling or transfer can be detected.

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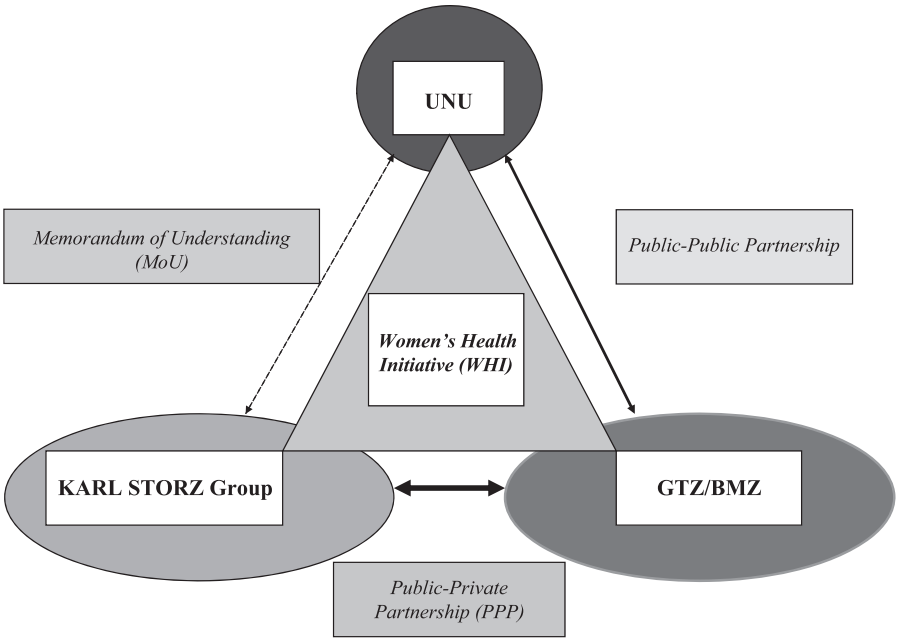

Figure 7: WHI partnership structure.
Source: Timmermann (see note 13).

(see the end of this brief for a list of workshop participants).

In India, GTZ undertook the input/output monitoring. India-based staff from GTZ collected data from medical practitioners and patients involved in the WHI. This monitoring was supported by a computer-based evaluation programme (*E-val*) which had been designed for GTZ (prior to this project). The findings of the monitoring report were made available to UNU staff for the final outcome report in June 2008.

Most important to the overall assessment process, however, were comments of the expert participants at the workshops. Those who could not physically participate (such as Paul Hunt and Nirmal Ganguly) were invited to provide individual reference chapters to the final book, where their analytical contributions also supported the WHI's overall focus on transparency.

Also invited to present their particular perspectives were the partners: Sybill Storz for KARL STORZ, Diana Kraft and Jörg Hartmann for the GTZ, Nicolaus von der Goltz for the BMZ, as well as medical doctors and GTZ and KARL STORZ field staff.

And finally, an independent workshop rapporteur (Monika Kruesmann) was invited to collect the views of the workshop participants and provide an impartial analysis in an independent workshop report (some of the findings of the report are outlined in this brief).

Taken together, these assessment activities provide a rich source of data not only on the WHI itself, but also more generally, on the efficacy of public private partnerships with a strong component on women's health and human rights in developing countries.

Major Findings 1: The Roles of Partners

One of the major findings of the WHI, in relation to public private partnerships in developing countries, emphasizes the need to clearly understand the roles of different partners and to accommodate these within projects. In particular, it is important to have clear expectations of the respective roles, interests and expectations of both the private sector and the government.

The Private Sector

While the private sector is often seen primarily as a source of financial support in partnerships, it has more to offer. To disregard this would be to miss important opportunities for development. In reality, businesses approach corporate social responsibility from a hierarchical perspective, defining that which is essential (such as adhering to relevant regulations, upholding occupational health and safety standards and minimum emission standards, being profitable and being successful in research and development); that which is expected (corporate citizenship beyond bare legal duties); and that which is desired (such as broad corporate philanthropy). While CSR at the 'desired' level is very positive, it is not the core business of the private sector; the core business is profit generation. Consequently, public private partnerships which aim to succeed within the ethical framework of the Global Compact must assume there will be a central role for enlightened self-interest.[11]

The WHI experience emphasized the role of enlightened self-interest, showing that if one partner can involve others in becoming more profitable that is not a negative outcome, and that this should be recognized more explicitly as a basic philosophy of public private partnerships. This does not exclude the understanding, of course, that public private partnerships must be about more than simple profit generation; they must also be about sustainability by other, mutually agreed, measures.

Given the WHI's structure, specific findings about the role of small and medium-sized enterprises (SMEs)

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in partnerships also arose. SMEs can play a central role in achieving the Millennium Development Goals (MDGs), especially in the field of technology-driven medical applications, by linking with larger enterprises to spread the benefits of growth to more isolated regions. Being an SME does not of itself exclude a company from being a global player. Financial efficiencies can often mean it is easier for an SME with a particular goal to join a partnership with others, giving them an advantage in terms of economy of scale. Further, because SMEs often operate in niche markets (such as specialized technology development), partnerships can help ameliorate risks such as intellectual property right protection. As long as partners are flexible and focus on each other's complementary strengths, and provided partners hold common views and a common set of standards, this can be a highly successful arrangement. This is a particularly pertinent consideration given that SMEs make up about 90 per cent of businesses globally, and account for approximately 60 per cent of employment.

However, there are also complexities in a partnership approach based only on SMEs. The definition of an SME can vary and is often country-specific; there are many programmes doing similar work and SME partnerships may run the risk of duplication or overlap. Furthermore, while the relatively small size of SMEs does mean they may be more flexible than larger enterprises, it can also mean they have limited outreach. Some argue that SMEs may not be best suited to Global Compact projects with a focus on corporate social responsibility, as it is the bigger enterprises which have the most scope to embrace practices driven by considerations other than the profit imperative. Further, larger enterprises have more extensive outreach mechanisms; a more effective approach may be to engage a number of these larger enterprises as sectoral leaders. However, counterarguments point out that real corporate social responsibility is not an 'add on', but rather must be part of a core business approach and consequently should not be out of reach for enterprises of any size.[12]

The Public Sector

The role of the public sector is equally critical in a successful partnership. As noted above, the WHI is informed by its wish to contribute to achieving the health-related MDGs, particularly MDG 5, within the framework of the Global Compact. As such, the WHI seeks to follow a human rights-based approach to development, implying an important role for the government as the key actor with responsibility for ensuring citizens' right to the best attainable physical and mental health. There was very little direct Indian Government involvement in the WHI, however. This was problematic not only because the Indian Government has responsibility for administering public hospitals and ensuring adequate and appropriate infrastructure to support healthcare services, but also because it has legal jurisdiction over the arrangements for training medical staff in India. Consequently, striving for governmental involvement is of central importance to the effectiveness of partnerships like the WHI.
Drawing these ideas together, it is clear that in a globalized system of economy and governance, the concept of collaboration between public and private actors is inadequate and that, in fact, more attention could be given to the potential for private/private partnerships, or public/public partnerships.

Major Findings 2: The Operation of a Partnership

Once the roles of partners are clearly understood, in order to ensure success

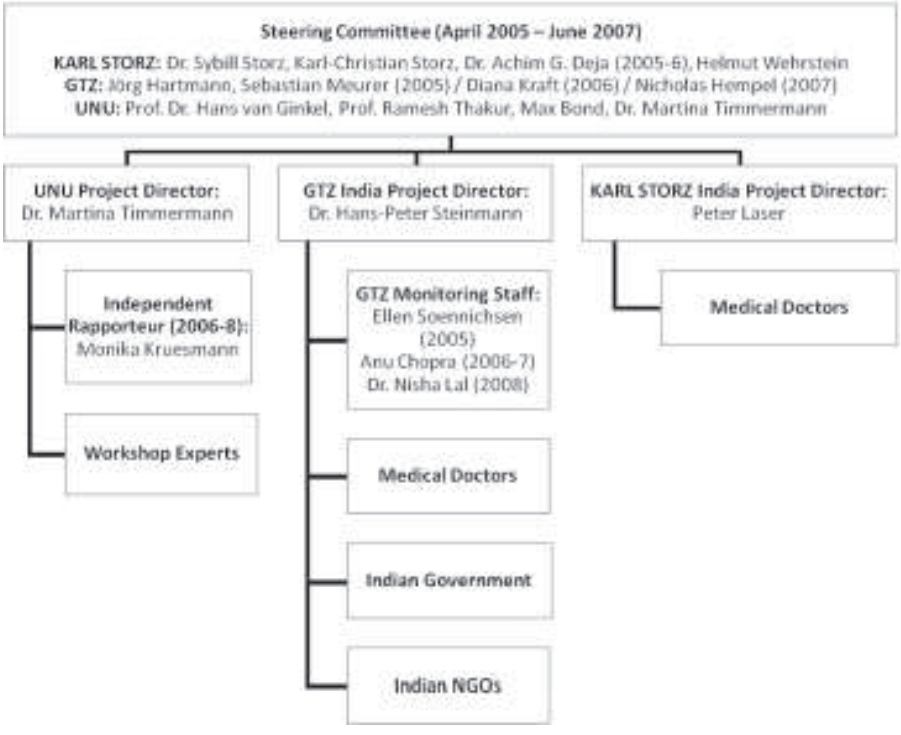

Figure 8: WHI internal structure.
Source: Timmermann, *Partnerships for Women's Health* (see note 1), Chapter 11.

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it is important that there be common understandings and expectations about the operation of the partnership and processes in place to allow partners to interact and collaborate. Here too, the WHI experience provided valuable lessons.

Multiple Stakeholders

Accommodating the real scope of a partnership is vital, and includes understanding that there may be important stakeholders in addition to formal partners. The WHI had three formal partners; but in practice there were numerous other interested parties, some of whom were drawn progressively into the project over time. Because not all of these were represented in the partnership arrangement, valuable perspectives and expertise may have been lost, affecting the overall outcomes of the project. In the WHI, this was particularly the case for trainers in hospitals where ETCs had been established. As those 'delivering' the project in the most concrete and immediate way, trainers were well placed to advise on what was working well, and what was not. However, there had been little scope for their views to be taken into account in the planning and implementation stages of the project. For example, when given the opportunity, trainers explained that while the project parameters intended trainers and trainees to mutually agree on clear, relevant, well-formulated learning objectives, in practice this was rarely the case as learning objectives were generally developed before trainees were selected. Further, there was a lack of consistency in the type and level of training delivered at the different ETCs and how this training was assessed at the end of the course. These were issues which trainers felt were valuable for improving the effectiveness of the WHI, and as such it is important that their voices be heard in project management and planning discussions.

Understanding the Environment: Policy

As well as understanding the real scope of partnerships, it is vital to acknowledge and respond to the environment in which action takes place – both in terms of policy and physical circumstances (see Figure 5). Although the Indian Government had little direct involvement in the WHI project, there is a broad government policy framework setting parameters for health in general, providing indications of useful synergies. Key policy documents include the *National Health Policy (2002)* and *Vision 2020 India*, which describe major government goals of achieving population stabilization, promotion of reproductive health, and reduction of infant and maternal mortality.[13] Also relevant are the *National Population Policy*, which provides the overall framework for maternal health; and the *National Rural Health Mission (2005 to 2012)*,[14] which is based on a set of approaches including community involvement, flexible financing, monitoring and innovation in human rights.

These policies provide a broad framework for addressing health issues in practice. A challenge for partnerships is therefore to consider how reinforcing synergies between projects and policy may be drawn, to increase the overall efficacy of any intervention. In the WHI case, while the overall project aim of improving maternal and reproductive health was quite broad, in practice the project tended to focus on promoting the use of endoscopy and laparoscopy to reduce hospitalization and post-operative recovery time. This did not take into account the potential for these methods to be directed towards other issues highlighted in health policy. For example, the *Population and Family Planning Policy*[15] includes sterilization as a method of curbing rapid population growth; using laparoscopic methods of sterilization can be a successful way to do this in a safe and less invasive way.

Understanding the Environment: Infrastructure

Shaping a partnership to reflect physical realities, including the availability of necessary infrastructure, is also important. One of the other key issues facing the WHI was inequity and its associated poverty. A total of 32.8 per cent of the world's poor live in India, and although the country has been experiencing overall economic growth, distribution of the benefits of that growth is uneven.[16] Further, poverty, ill health and illiteracy are all linked and are multi-directional.[17] This had implications for the WHI. For example, it was found that many poor women, who were a target group in the project, were also illiterate and therefore education about endoscopic and laparoscopic treatment options could not be done through printed materials.[18] This experience prompted partners to discuss the possibility of education and awareness-raising through video as an alternative method for future work.[19]

It was also noted that in regions of India where economic development is occurring, disparities between men and women in social outcomes including health and education often increase. To address this, some project participants suggested the current Human Development Index be reconstructed to show these disparities more clearly and thereby provide more rigorous evidence for policy makers concerned with pro-poor capacity building.[20]

Difficulties are also posed by inadequate physical infrastructure; India is a large country and managing large distances with an effective transport system was cited as a key concern in implementing the WHI. Similarly, the

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hospitals where ETCs were located sometimes struggle with unreliable energy and access to clean water supplies.

Conclusions

The WHI project falls within the parameters of a number of contemporary global debates: debates about the MDGs, about human rights, about business and ethics and the UN Global Compact, about accountability and transparency, about health financing, about public private partnerships and about the role of SMEs. As such, it was a complex project and there were challenges assessing its overall effect and sustainability. However, based on our definitions of good and best practices, and guided by the input of the project stakeholders and invited project experts, we conclude that the WHI constituted an example of 'best practice', within the purposes and parameters that shaped its establishment.

In particular, the WHI demonstrated considerable success as a public private partnership within the ethical framework of the UN Global Compact. The UNGC exists with the objective of getting business involved in good corporate citizenship activities, suggesting that new business models which incorporate the strengths of both the business community and the public sector must be developed. In this sense, the WHI made very positive progress: partners were engaged and remained connected and committed, ETCs were established, equipment was supplied, training was undertaken, and procedures were carried out while striving for transparent, open and accountable processes.

Notably during the course of the WHI's implementation, a number of new principles for successful partnerships came to light. These may provide guidance towards development of a new standard of 'best practice' in the future. In particular, it became clear that PPPs must not be a substitute to the fundamental responsibility of governments to provide services and infrastructure, and develop and implement standards and operating regulations. Rather, public private partnership organizations must work *together* with governments to ensure activities are mutually beneficial, rather than obstructive or duplicative. Further, business must be allowed and supported to pursue its core objectives, including when engaged in corporate social responsibility activities. This means, for example, recognizing that companies have their own valid schedules and profit imperatives to consider, and that while public sector projects may prefer to operate with time-frames extending across multiple financial years, companies cannot always be expected to make the same kind of long term commitments, and flexibility in this regard must be possible.

An aspiration for the WHI was that, following the original project's successful completion, the model might be further developed, extended and translated to different contexts. In this sense, consideration and adoption of the newly emerged principles may result in projects that not only make a contribution to improving women's health, but which also achieve new standards of 'best practice' for PPPs in general. Successfully extending conceptual and practical boundaries in this way would articulate most profoundly the important place that public private partnerships occupy within the turbulent crucible of policy and practice in a globalizing world.

About the Authors

Monika Kruesmann is a PhD student in the Department of International Relations, London School of Economics and Political Science, and was formerly Assistant Director in the Australian Government Department of Education. She holds a Master of Arts (International Relations) from the Australian National University, and has worked and studied in India, the Pacific region, London and Tokyo.

Martina Timmermann served as director of studies on Human Rights and Ethics in the Peace and Governance Programme at the United Nations University headquarters in Tokyo and Bonn (2004–2007). In 2008 she joined the TIMA GmbH (Transition and Integration Management Agency) as vice-president and managing director of international projects.

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Notes

1. Paul Hunt and Judith Bueno de Mesquita, "Poverty, health and the human right to the highest attainable standard of health," in *Partnerships for Women's Health: Striving for Best Practice within the UN Global Compact*, ed. Martina Timmermann and Monika Kruesmann (Tokyo: United Nations University, forthcoming), Chapter 2; "Paul Hunt's 2008 Preliminary Mission Report on India" in *Partnerships for Women's Health*, Appendix C.
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3. Suneeta Mittal and Arvind Mathur, "The health situation of women in India: Policies and programmes," in *Partnerships for Women's Health*, Chapter 7.
4. Arabinda Ghosh, "Pro-poor capacity-building in India's women's health sector," in *Partnerships for Women's Health*, Chapter 10.
5. Günter Neubauer and Iris Driessle, "The challenge of equal financial access to the best available health care: Bringing in the private sector," in *Partnerships for Women's Health*, Chapter 4.
6. Nirmal Kumar Ganguly and Malabika Roy, "India's medical system," in *Partnerships for Women's Health*, Chapter 8; Rama Baru and Madhurima Nundy, "Health PPPs in India: Stepping stones for improving women's reproductive health care?" in *Partnerships for Women's Health*, Chapter 9; Planning Commission, Government of India, *Eleventh Five Year Plan 2007-2012 Volume II: Social Sector Services* (New Delhi: OUP India, 2008).
7. Hunt and Bueno de Mesquita (see note 1)
8. Klaus M. Leisinger, "Partnering in support of the right to health: What role for business?" in *Partnerships for Women's Health*, Chapter 3.
9. Monika Kruesmann, "The United Nations Global Compact: Embracing diversity," in *Partnerships for Women's Health*, Chapter 5; Kai Bethke and Manuela Bösendorfer, "Small and medium-sized enterprises: Their role in achieving the Millenium Development Goals," in *Partnerships for Women's Health*, Chapter 6.
10. The United Nations University is a unique international community of scholars engaged in research and training in fields related to the purposes and principles of the Charter of the United Nations. For further information see <http://www.unu.edu> (accessed 14 August 2009).
11. There was some discussion during the second project workshop in Bonn about what actually constitutes enlightened self-interest, but a general consensus found it to include recognition that reputation is important to shareholders and company profits, that undesirable actions can lead to increased regulation, and that efficiencies can actually be increased through good corporate citizenship approaches.
12. Bethke and Bösendorfer (see note 9); Martina Timmermann and Monika Kruesmann, "PPPs for women's health and human rights beyond India: Probing new standards and methodologies," in *Partnerships for Women's Health*, Chapter 19.
13. Martina Timmermann, "Meeting the MDG challenges of women's health, human rights and health care politics: The Women's Health Initiative (WHI) for improving women's and girls' reproductive and maternal health in India," in *Human Rights and Development: Law, Policy and Governance*, ed. C. Raj Kumar. and D.K. Srivastava, D. K. (Hong Kong: LexisNexis, 2006), 475–493.
14. Government of India, *National Rural Health Mission (2005–2012) Mission Document*, available from <http://www.mohfw.nic.in/NRHM%20Mission%20Document.pdf > (accessed 14 August 2009).
15. Country Studies, *Population and Family Planning Policy*, available from <http://www.country-studies.com/india/population-and-family-planning-policy.html> (accessed 14 August 2009).
16. Noted in a presentation at the Bonn Workshop on *Pro-poor Capacity-Building in India's Women's Health Sector* by Dr. Arabinda Ghosh, State Government of West Bengal, 4 December 2006.
17. Ghosh (see note 4)
18. It was interesting to note during discussions of women's health situations in other countries at the Bonn workshop, that Sri Lanka has relatively positive maternal health indicators, which are largely attributed to a mass education campaign, made possible through the fact that the female literacy rate in Sri Lanka is recorded at more than 95 per cent.
19. Ganguly and Roy (see note 6); Mathur and Mittal (see note 3); Martina Timmermann and Monika Kruesmann, "A PPP for women's health and human rights in India: Striving for best practice within the framework of the UN Global Compact," in *Partnerships for Women's Health*, Chapter 18.
20. Noted in a presentation at the Bonn workshop on *Pro-poor Capacity-Building in India's Women's Health Sector* by Dr. Arabina Ghosh, State Government of West Bengal, 4 December 2006.

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Two UNU-led project workshops (one held in Chennai, India, Oct 2005 and one held in Bonn, Germany, Dec 2006) supported the work of this project. Participants and their affiliations at the time of the workshops are listed below:

1. Mr. Baschar Al-Frangi, Centre for Cooperation with the Private Sector – GTZ, Berlin
2. Prof. Dr. Moazzam Ali, Institute of International Health, Tokyo University
3. Prof. Dr. Rama Baru, Associate Professor, Jawaharlal Nehru University
4. Dr. Pamela Bell, Research Fellow, Louvain University
5. Dr. Peter Berman, Harvard School of Public Health / Lead Economist, World Bank India
6. Prof. Dr. Janos Bogardi, Director, UNU-EHS, Bonn
7. Ms. Manuela Bösendorfer, UNIDO, Vienna
8. Dr. Kent Buse, Research Fellow, Overseas Development Institute (ODI), London
9. Dr. Meera Chatterjee, Senior Social Development Specialist, World Bank India
10. Mr. S. Chidambaranathan (Nathan), Special Advisor to the Rector of the United Nations University, New York
11. Ms. Anu Chopra, GTZ-India
12. Dr. Achim G. Deja, KARL STORZ WHI-Project Coordinator / CEO, TIMA GmbH
13. Prof. Dr. Lynn Freedman, Director of the Averting Maternal Death and Disability (AMDD) Program, Mailman School of Public Health, Columbia University
14. Prof. Dr. N. K. Ganguly, Director, Indian Council for Medical Research (ICMR)
15. Dr. Arabinda Ghosh, Joint Director, Administrative Training Institute, State Government, West Bengal
16. Dr. Minna Gillberg, Senior Advisor to EU Vice-President M. Wallström, Brussels
17. Ms. Christina Gradl, Doctoral Candidate, Martin-Luther University Halle-Wittenberg, Germany
18. Mr. Jörg Hartmann, Head of PPP, Head of Centre for Cooperation with the Private Sector – GTZ, Berlin
19. Ms. Ulrike Haupt, Head of Division, Federal Ministry of Economic Cooperation and Development (BMZ), Bonn
20. Prof. Dr. Kurian Joseph, Chairman, Endoscopy Committee, Asia Oceania Federation of Obstetrics & Gynaecology
21. Prof. Peter H. Katjavivi, Ambassador of the Republic of Namibia to Germany, Chair of the UNU Council (2006)
22. Prof. Dr. Gundapuneni Koteswara Prasad, Director of the Mahatma Gandhi Centre for Peace and Conflict Resolution, University of Madras, India
23. Ms. Antigoni Koumpounis, Technical Officer for Family Planning, WHO-India
24. Ms. Diana Kraft, PPP Manager, GTZ, Eschborn
25. Prof. Dr. Alka Kriplani, MD, WHI-Co-Chairperson, AIIMS, New Delhi
26. Ms. Monika Kruesmann, Assistant Director, Department of Education, Employment and Workplace Relations (DEEWR), Australian Government – UNU Workshop II Rapporteur
27. Dr. Preeti Kudesia, Senior Public Health Specialist, World Bank India
28. Dr. Vasant Kumar, M.D., Joseph's Nursing Home, Chennai
29. Mr. Peter Laser, WHI Project Director, KARL STORZ GmbH & Co. KG, New Delhi/Tuttlingen
30. Prof. Dr. Klaus Leisinger, Special Advisor to the UN SG on the UN Global Compact, President & CEO, Novartis Foundation
31. Dr. Arvind Mathur, Cluster Coordinator for 'Family and Community Health,' WHO-India
32. Prof. Dr. Suneeta Mittal, MD, Dean of Department of Gynaecology, AIIMS
33. Prof. Dr. V. R. Muraleedharan, Head of Department of Humanities & Social Sciences, IIT-Madras
34. Ms. Alka Narang, Head of HIV/AIDS Unit, UNDP India
35. Prof. Dr. Günter Neubauer, Director of the Institute of Health Economics, Munich
36. Ms. Ellen Soennichsen, GTZ India
37. Dr. Johann P. Steinmann, Director of Indo-German Health Programme, GTZ India
38. Dr. hc. mult. Sybill Storz, CEO, KARL STORZ GmbH & Co. KG, Tuttlingen
39. Mr. Karl-Christian Storz, Senior Management, KARL STORZ GmbH & Co. KG, Tuttlingen
40. Prof. Dr. Ramesh Thakur, Senior Vice-Rector, UNU, Tokyo, Assistant Secretary-General, UN
41. Dr. Martina Timmermann, Director of Studies on Human Rights and Ethics / UNU WHI Project Director, Tokyo/Bonn
42. Prof. Tehemton Udwadia, President of the International Federation of Societies of Endoscopic Surgeons (IFSES), Head, Department of M.A.S. Hinduja Hospital
43. Ms. Jasja van der Zijde, Director, Sama Advies, Amsterdam
44. Prof. Dr. Hans van Ginkel, Rector, UNU, Tokyo, Under-Secretary-General, UN
45. Mr. Nicolaus von der Goltz, Division for Cooperation with the Business Sector, German Federal Ministry for Economic Cooperation and Development (BMZ), Bonn/Berlin
46. Prof. Dr. Diethelm Wallwiener, Medical Director, University-Clinic for Women, Tübingen (via Video)
47. Mr. Helmut Wehrstein, Senior Management, KARL STORZ GmbH & Co. KG, Tuttlingen
48. Prof. Dr. Stefan F. Winter, State Secretary, Ministry of Labour, Health and Social Affairs, North Rhine-Westphalia

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