# Motivational Conditions of Successful Corporate Social Responsibility (CSR) Actions in Form of Cross Sector Collaborations in International Health

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# List of Figures and Tables

# Table of Abbreviations

| | |
|---|---|
| CC | Corporate Citizenship |
| CEO | Chief Executive Officer |
| CHF | Swiss Francs |
| CSR | Corporate Social Responsibility |
| Cat. SR | Cataract Surgical Rate |
| DALY | Disability-Adjusted Life Years |
| GDP | Gross Domestic Product |
| GPPP | Global Public Private Partnerships |
| GAVI | Global Alliance for Vaccines and Immunisation |
| MDGs | Millennium Development Goals |
| MoU | Memorandum of Understanding |
| NGO(s) | Nongovernmental Organization(s) |
| PBL | Prevention Blindness Programme |
| PPP | Public Private Partnerships |
| UN | United Nations |
| USD | US-Dollar |
| WHO | World Health Organization |

# Summary

It is clearly of paramount importance to secure both short-term and long-term provision and access to drugs and healthcare services in order to accomplish a substantial impact on public health in any country. Nevertheless, there are millions of people, especially in the developing world, that have no or limited access to such pharmaceutics and services. Faced with the situation, some important cross-sector efforts that make drugs and services available through the engagement of private for profit firms in corporate social responsibility (CSR) have been launched in the international health scene.

Yet CSR and civil involvement in cross-sector collaborations also open the door to exploitation and opportunistic behavior. Hence, it is essential to learn more about what makes cross-sector partnerships succeed, while developing a framework that supports sustainable partnerships in a morally and ethically sound context. Furthermore, as cross-collaborations do not simply "happen", but are rather built, and since little information is available on the necessary conditions leading to their successful formation, governance and management - despite the number of collaborations that have been established in the past decades - further research is urgently called for.

The aim of this work is to investigate how cross-sector collaborations attempting to improve access to healthcare in the developing world could be strengthened and improved through the involvement of firms in CSR. By assessing motivational factors and skills that allow a favorable collaborative culture and value creation to the company through such collaborations, partnerships could be strengthened and their outcomes maximized. The ultimate aim of this thesis is to identify prerequisites and favorable, motivational frameworks for collaborative success, and to develop a first, preliminary tool that can assess intangible and tangible value created though cross-sector collaborations.

Through a longitudinal case study[1], involving for profit businesses in Germany and Switzerland, an established NGO in Ethiopia, as well as the Tigray Regional Health Bureau of the Ethiopian Ministry of Health, we were able to identify initial motivational factors that lead to the engagement of firms in CSR in the form of cross-sector collaborations, as well as motivational factors and conditions which promote value creation and long-term commitment of organizations to CSR. Using multiple qualitative methods, including in-depth interviews of key informants, participating focus group observations, questionnaires and document analysis, we found that by allowing a win-win situation of cross-sector collaborations, where all parties could profit from the partnership, sustainable and long-term collaborations are more likely to ensue.

Furthermore, we identified three motivational cornerstones that allow a positive output in form of a motivating collaborative culture and intangible asset creation, namely 1) the need of help and the already mentioned mutual value exchange approach, with value creation as a primary motivation for embarking in the project 2) alignment between collaboration-/project-mission and core activity/mission of the participating businesses, and strategic congruency between participating parties, as incentives, and 3) the implementation of sound motivational competencies such as catalyzing-, leadership- and management- skills.

When these cornerstones are in place, an environment that favors intangible asset creation and positive outcome, as well as sustainability, can evolve. This favorable environment, or TIES-culture, is characterized by **T**rusting relationships between the various parties involved, **I**dentification and emotional connection with the cause, **E**mpowering environment that stimulates learning, as well as a **S**uccessful organizational culture that feeds gratification and satisfaction. The TIES-culture is an important intangible asset per se, yet the defined collaborative culture also supports further intangible value creation in form of human capital, information capital and organizational capital, and the consequent ability of an organization to mobilize and sustain processes of change that are required to execute its strategy.

[1] See www.MyProjectVision.com

As the global economy is changing and shifting from manufacturing to a service oriented economy, intangible assets and intellectual capital have become increasingly important resources for a company's, organization's or partnership's success and value creation, especially in the healthcare industry. Intangible assets can support the improving of business and collaborative processes and performance, and finally be converted into tangible outcomes in form of improved health and other social outcomes, revenue growth and in form of cost reduction.

Based on data obtained through this case study, we were able to develop a tool (**The Collaboration Scorecard**) that allows a systematic analysis of input, output and outcome, and the correlation between these components and the tangible and intangible value created to organizations through cross-sector collaborations. Just like the traditional **Balanced Scorecard**, our developed tool articulates *"the links between leading inputs (human and physical), processes, and lagging outcomes, and focuses on the importance of managing these components to achieve the organization's strategic priorities."* [2]

Our scorecard is therefore a prototype strategic performance management tool for businesses involved in CSR in form of cross-sector collaborations. It is a semi-structured tool that builds on the Balanced Score Card by Kaplan and Norton,[3] and adapts to the specific settings of CSR and cross-sector collaborations. It takes into account the importance of the here identified motivational prerequisites or conditions of collaborative success, while assessing the potential value of a cross-sector collaboration. It allows an analysis of the formed organizational culture and the created intangible assets through such partnerships, as well as the monitoring of organizational performance against strategic goals. The tool can hence also serve as a preliminary evaluation tool and guide for businesses, immersed in cross-sector collaborations, in how to create future value through investment in customers, suppliers, employees, processes, technology, and innovation.

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[2] See K Kaplan RS, Norton DP. *Strategy Maps – converting intangible assets into tangible outcomes.* Cambridge: Harvard Business School Press, 2004.

[3] See Kaplan RS, Norton DP. The balanced scorecard: measures that drive performance, *Harvard Business Review, 1992,* Jan – Feb: 71–80. or http://www.balancedscorecard.org/

In sum, in order to accomplish a long-term impact on global public health, it is of great importance to encourage the commitment of private firms to CSR and to a stronger collaboration between businesses, NGOs and governments involved in the international health sector. Based on the knowledge gained through this explorative study, motivational frameworks and strategies that maximize both tangible and intangible asset creation through cross-sector collaborations may be developed. The preliminary tool, which analyzes the value creation within organizations through cross-sector collaborations, may be very useful in the further investigation of similar themes, albeit its pilot nature requiring more research and validation, as no such tools exist today. Businesses may capitalized on the intangible assets created through cross-sector collaborations, and the ensuing value creation, for all participants involved, may encourage stronger civil involvement in public health. The ultimate goal of this thesis is therefore to allow the development of morally and ethically sound strategies that encourage private actors to embrace CSR, and that allow sustainable as well as outcome-oriented public private partnerships, especially when governments fail to provide public goods and services in the international health sector.

# Part I: Introduction

## 1.1. Foundation

Despite a strong range of health interventions that could prevent much of the burden of disease in the poorest countries in the world, effective coverage of these interventions is expanding too slowly and health inequities are widening [228]. Even though health is increasingly seen as a key aspect of human security, and occupies a prominent place in debates on the priorities for development, we have been witnessing widening gaps in health over the last 20 years. International health interventions are inadequately provided and the challenges of meeting Millennium Development Goals (MDGs) for health remain formidable [228].

As access to healthcare and to medications vary across countries, groups and individuals, and as it is heavily influenced by socio-economic conditions as well as pre-existing health policies [216], it is increasingly recognized that stronger health systems are needed to deliver health care interventions at the scale necessary to achieve and sustain health- related Millennium Development Goals [195]. Furthermore, building and managing partnerships is essential to the systems perspective [228]. In other words, apart from good governance and political leadership, a stronger collaboration with civil society and with the private sector is urgently called for [106)]. In order to be an effective partner amongst the numerous other agencies working with governments, UN and WHO have therefore embraced the concept of partnerships [5].

Simultaneously, the societal shift towards more civic autonomy and self determination has led to an altered dynamic between state, economy and civil society, as well as to new perceptions, and importance, of corporate social responsibility (CSR) [263] [179]. *"It would be a challenge to find a recent annual report of any big international company that justifies the firm's existence merely in terms of profit, rather than "service to community"... Big firms nowadays are called upon to be good corporate citizens, and they all want to show that they are"* [40]. Faced with this situation, together with the scarce resources and challenges in healthcare delivery,

especially in international health, some important CSR-actions in form of cross-sector collaborations making drugs and services available, have been launched. The Mectizan Donation Program by Merck & Co, for instance, is one of the best-known examples of the commitment of private firms to good corporate citizenship and societal needs.

On one hand CSR initiatives provide a base for opportunistic behavior and the participation in such initiatives does not guarantee any real implementation of ideas and actual execution of programs. On the other hand, the movements truly open doors for novel participation of companies in public processes of deliberation and justification as well as a great potential for civil society to actively engage and improve the state of international health, as demonstrated by Merck & Co through its River Blindness initiative or by Pfizer through the International Trachoma Initiative.

According to Kaufmann multi-sectoriality and inclusiveness are critical especially from bottom up in order to reach the MDGs [106]. Also the World Health Organization has stated that one of its major aims, as part of the Millennium Development Goals, is to work with ministries of health to strengthen health systems and to build their understanding of what can realistically be done by working with other sectors. It aims to engage more systematically with civil society and industry, including international health care and pharmaceutical industries.

In order to accomplish a long-term impact on public health, it would be of great importance to encourage a closer and more lasting collaboration of private firms with NGOs involved in public health. However, although a number of PPP have been established in the past decades, little information is available on the necessary conditions leading to their formation, governance and management [199]. Simultaneously, observers of the public management landscape have in recent years been witnessing an increase in the number, variety and complexity of collaborations between the public and private sectors according to OECD.

The aim of this work is therefore to investigate how cross-sector collaborations attempting to improve access to healthcare in the developing world could be

strengthened and improved. Through a case study using multiple qualitative methods, including in-depth interviews with key informants and focus groups, participant observation, and document analysis, motivational factors that encourage a stronger collaboration and commitments of firms to CSR will be identified. The ultimate aim is to develop strategies to encourage private actors to successfully embrace CSR especially when governments fail to provide public goods and services in health care.

In the first part of this script the reader is briefly introduced to international health and healthcare -policy, -organization and -management, as well as healthcare financing in general. Furthermore, the reader will get an overview of current global strategies in international health. Finally he will be introduced to the research gaps and the purpose of this study more in detail, as well as to the potential significance of this study. Some limitations of this work will also briefly be briefly mentioned. The second part lays the theoretical foundation of this thesis, while the third part describes the methodology and design of the research project. Parts four, five and six, describe the initial study, the forming of a hypothesis, and the results respectively. In the last part the findings of this study will be summarized and a conclusion will be drawn.

## 1.2 Overview

### 1.2.1 Healthcare Delivery and Health Systems

Access to healthcare and to medications vary across countries, groups and individuals, and is heavily influenced by socio-economic conditions as well as pre-existing health policies. Furthermore, depending on the healthcare goals, both on individual and public health levels, countries and jurisdictions have different policies and plans in place. In order to meet the established health needs and goals of the target population, each country or region has developed and applied its own organizations or health systems. Yet their exact configuration varies from country to country. In some countries, regions or jurisdictions, healthcare planning is the responsibility of government bodies, whereas in other regions the planning is distributed among market participants. In all cases, however, a well-functioning health care system requires a robust financing mechanism. Furthermore, it requires a well trained and adequately paid workforce, reliable information on which to base decisions and policies, and well functioning facilities and logistics to deliver medicines and technologies effectively and efficiently [217].

A healthcare system is the organization of people, institutions and resources, with the aim to deliver healthcare services and products and to meet health needs of a target population *"The system includes all actors, institutions and resources that undertake health actions – where a health action is one where the primary intent is to improve health. Although the defining goal of a health system is to improve population health, other intrinsic goals are to be responsive to the population they serve, determined by the way and the environment in which people are treated, and to ensure that the financial burden of paying for health is fairly distributed across households. Four key functions determine the way inputs are transformed into outcomes that people value – resource generation, financing, service provision and stewardship"* [218].

According to WHO, a well functioning health system responds in an equilibrated fashion to a population's needs and expectations by: 1) improving the health status of individuals, families and communities, 2) defending the population against what

threatens its health, 3) protecting people against the financial consequences of ill-health, 4) providing equitable access to people-centered care, 5) making it possible for people to participate in decisions affecting their health and health system [230].

The aims and goals for health systems, according to the WHO, are good health, responsiveness to the expectations of the population, and fair financial contribution [216]. Progress towards the goals depends on how systems carry out four vital functions: 1) delivery of healthcare services, 2) resource generation and value creation, 3) financing, and 4) stewardship [216]. The evaluation of healthcare systems is based on dimensions such as quality, efficiency, acceptability, and equity as well as continuity of healthcare [37].

Health financing can be a key policy instrument to improve health and reduce health inequalities, if its primary objective is to facilitate universal coverage by removing financial barriers to access and preventing financial hardship and catastrophic expenditure [229]. Healthcare can form an enormous part of a country's economy. According to OECD, the various national healthcare industries in industrialized countries accounted for an average of 9.5 percent of the gross domestic product (GDP) in 2009 [153], where the United States (17.4 %), the Netherlands (12.0 %) and France (11.8%) were the top three spenders in regards to GDP, equaling a total amount per capita of more than $8000, of $4914, and of $3978 respectively (see figures 1 and 2).

The costs covering healthcare practitioners, account for the majority of the spending, equaling an estimated 65% to 80% of renewable health system expenditures [4] [115]. There are three ways to pay medical practitioners in a health system, namely through fee for service, capitation and through salaries [51].

> 1) In a “fee-for-service” arrangement, GPs or specialist working in ambulatory care are paid based on their service provided. Fee levels, on the other hand, are set either by the individual practitioners or through central negotiations (as in Japan, Germany, Canada and in France). Naturally also a hybrid model of the two methods exists (such as in Australia, France's sector 2, and New Zealand), where GPs can charge extra fees on top of standardized patient

reimbursement rates.

2) In “capitation payment systems”, GPs are paid for each patient, rather than for the services they provide, usually with adjustments for factors such as age and gender. According to OECD, this type of payments are dominant in for instance Italy, in the United Kingdom. Capitation payments have also become more frequent in “managed care” environments in the United States.

3) In a “salary system,” which is typical in several OECD countries, general practitioners (GPs) are employed by the government. According to Doteur and Oxley, salary arrangements allow funders to control primary care costs directly, yet they may lead to under-provision of services (to ease workloads), excessive referrals to secondary providers and lack of attention to the preferences of patients" [51].

In regards to the entire healthcare system, there are generally five primary methods of funding it [225]:

1) General taxation to the state, country of municipality
2) Social health insurance
3) Voluntary or private health insurance
4) Out-of-pocket payments
5) Donations

There are many topics in the politics and evidence that can influence how a specific country or region designs its finance structure of their health systems, and most countries apply a mix of all five models mentioned above. The exact distribution, however, varies across countries and over time within countries. Nevertheless, a parallel private, and usually for-profit, system, or a two-tire healthcare, is allowed to operate in almost every jurisdiction with a government-funded health care system.

Based on an estimate of the overall cost of health care expenses, a general finance structure in form of premiums of tax can be developed. The structure is designed in such a fashion that the availability of money for the healthcare benefits specified in

the insurance agreement is guaranteed, and the benefits are typically administered by a government agency, a non-profit health fund or a for profit [35].

Social health insurance is where a nation's entire population is eligible for healthcare coverage, and is generally used to describe a form of insurance that pays for medical expenses. Sometimes it even encompasses insurances that cover disability, long-term nursing or custodial care needs. It may be provided through a social insurance program, or from private insurance companies. It may be obtained on a group basis by a company for its employees or purchased by individual consumers. In each case premiums or taxes protect the insured from high or unexpected healthcare expenses.

Many forms of commercial health insurance, on the other hand, control their costs by restricting the benefits that are paid through co-payments, deductibles, coinsurance, policy exclusions, and total coverage limits and may also severely restrict or refuse coverage of pre-existing conditions and illnesses. Many governments also apply co-payment schemes, yet here exclusions are rare in contrary to the commercial health insurance.

Each health system funds healthcare differently, and may use one or more forms of the above-mentioned funding forms to finance the sector. Despite the local variations and forms of funding, health care systems tend to follow general patterns and can be divided into four basic systems [267]:

1. The ***Beveridge Model*** is named after William Beveridge and is financed by the government through tax payments. Many hospitals and clinics are owned by the government, and many doctors are government employees, yet also private doctors practice in this system. Examples of countries that implement the Beveridge plan include Great Britain, Spain, most of Scandinavia and New Zealand.

2. The ***Bismarck Model*** is a multi-payer model named after the Prussian Chancellor Otto von Bismarck and employs an insurance system that is typically financed jointly by employers and employees through payroll deduction. Much of the sector is privatized but, due to tight regulations,

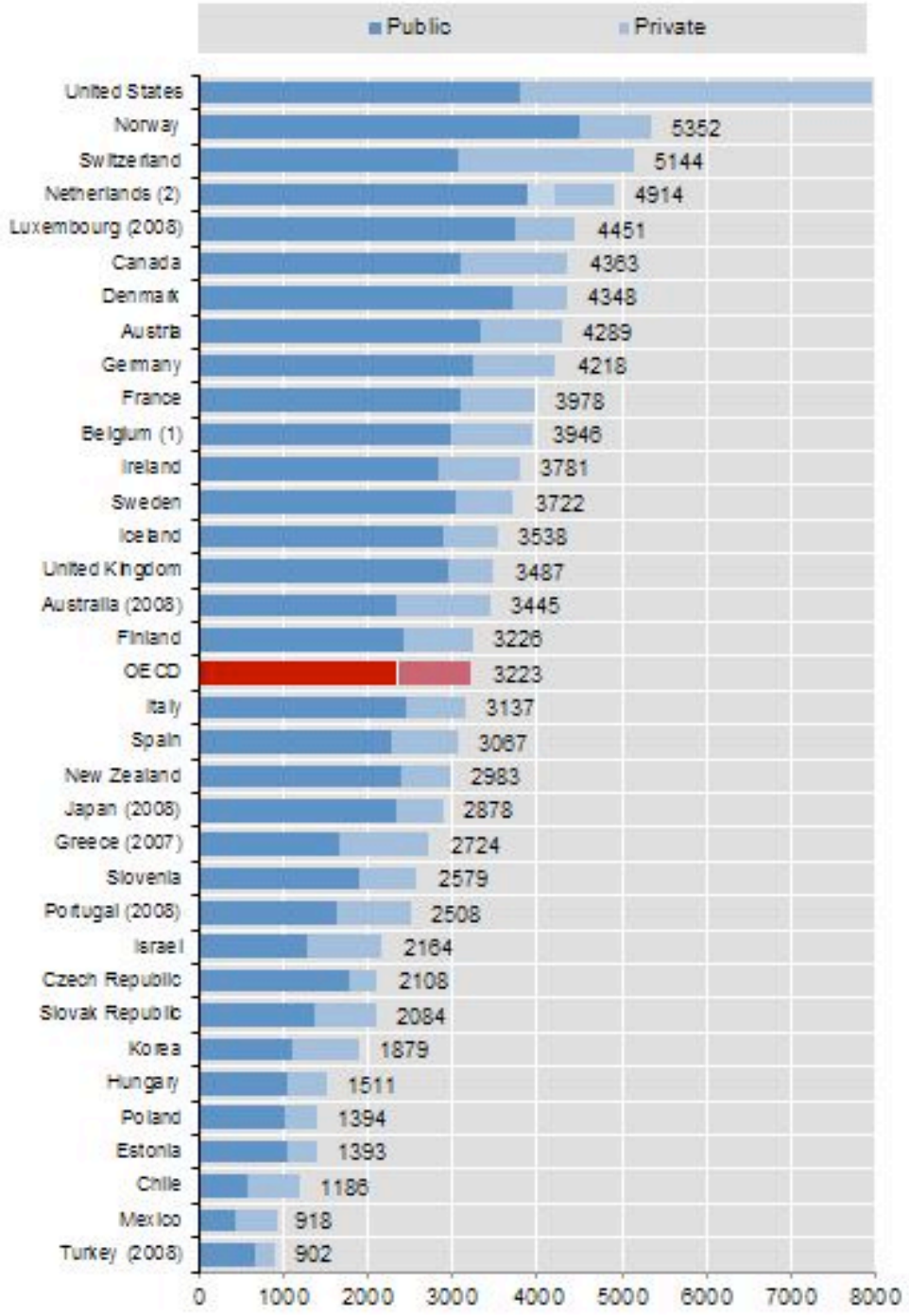
the government is given much of the cost-control clout that the single-payer Beveridge Model provides. Examples of countries in which the model can be found include Germany, France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America as well as USA albeit its fragmented national health care apparatus, where all four health system models play a role.

3. The ***National Health Insurance Model*** is a universal insurance program that uses private-sector providers while being financed by a government-run insurance program that every citizen pays into. This model includes elements of both the Beveridge and the Bismarck Model, but tends to be less expensive than for instance for profit systems in USA, as the single payer tends to have considerable market power to negotiate for lower prices, and since it can control costs by limiting the medical services it will pay for. The classic NHI system can be found in countries such as Canada, Taiwan and South Korea.

4. The ***Out-of-Pocket Model***, on the other hand, is self-explanatory and is typically found in developing countries or countries that are not capable of providing public goods and services such as healthcare. As most countries in the world fall into this last category, the out of pocket model is the most spread of all models.

In addition to these traditional healthcare financing models and systems designs in the industrialized world, some lower income countries and development partners are also implementing non-traditional finance and organizational modes. Due to, for instance scarce governmental and fiscal resources, innovative mechanisms that allow healthcare delivery such as micro-contributions, public-private partnerships, and market-based financial transaction taxes, may be applied. Furthermore, as many health problems cannot be successfully dealt with in national isolation, systems and structures that allow international governance, financing and cooperation are necessary. The following chapter will therefore address the issue of international health. Subsequently the reader will be introduced to healthcare governance and public private partnerships in international health.

**Figure 1. Total health expenditure in OECD countries 2009. (Source OECD)**



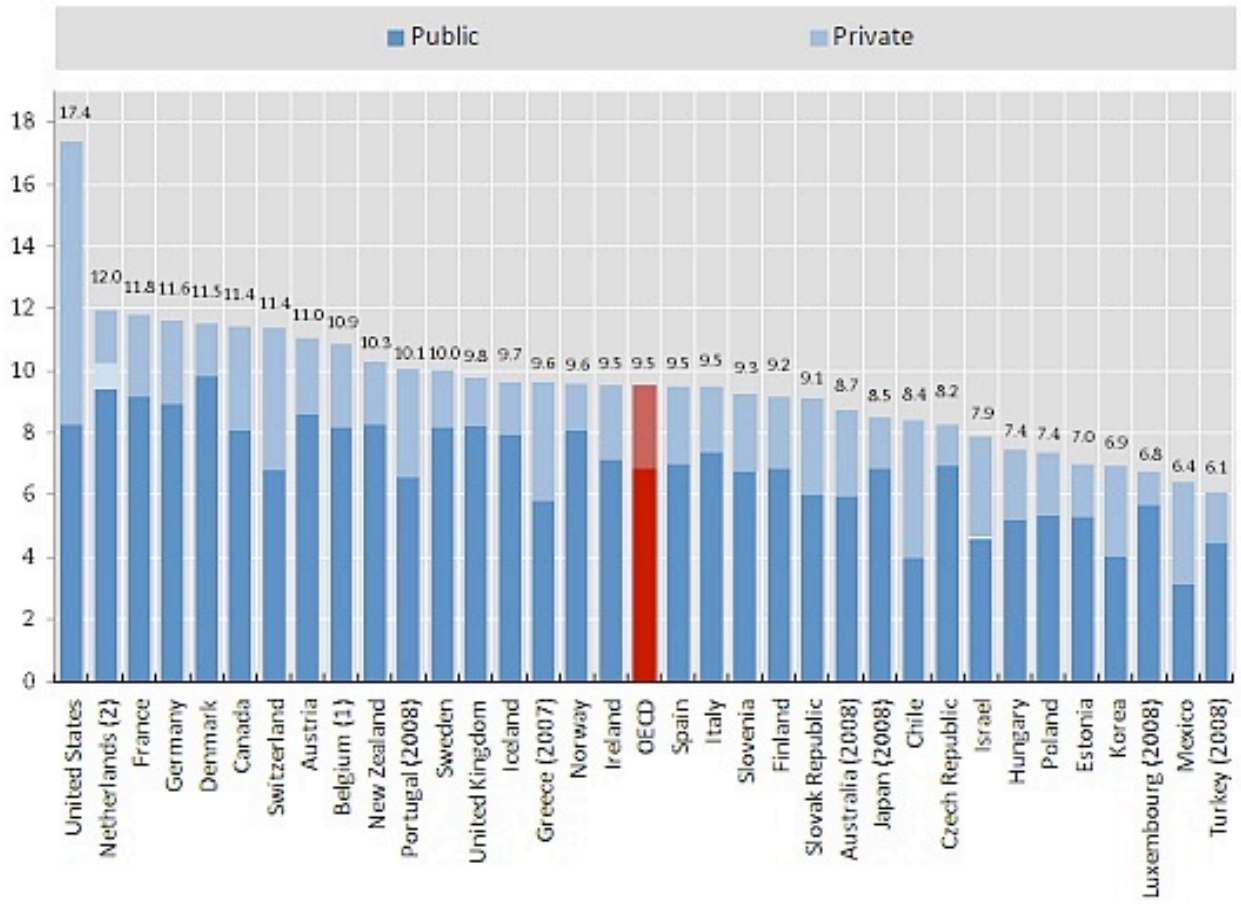



**Figure 2. Health expenditure as a share in GDP among OECD countries 2009. (Source: OECD)**

### 1.2.2 International Health

#### 1.2.2.1 Introduction

Health and disease do clearly not respect national borders. Furthermore, physicians are today confronted with new situations and modes of disease-transmission, regardless of their geographical location, due to globalization in all its direct and indirect forms. The spread of HIV or SARS (Severe Acute Respiratory Syndrome) as well as problems related to the massive population growth and the medical care of refugees, are examples of these phenomena, just to mention a few. International health deals with health across regional or national boundaries and is sometimes called geographic medicine [236].

In addition to travel medicine, which is a subset of international medicine and prepares travelers with immunizations, prophylactic medications, preventive in-transit care, and post-travel care for exotic illnesses, international health also refers to health personnel or organizations from one area or nation providing direct healthcare, or health sector development, in another area or nation. It is a field of healthcare, usually with a public health emphasis, that deals with global processes that have an impact on human health.

The comparison of the state of health between various groups as well as the wellbeing in different socio-cultural and economic contexts, constitute the base and essence of international health [123]. Through comparative analysis of various health determinants, the study of international health strives to promote positive change within health systems and hence to collaboratively allow improvement in health nationally and internationally, as there are paramount differences in the state of health between different populations on a national and especially on an international level.

For comparative purposes, nations and countries can be categorized either according to development and mortality (WHO) or GDP (World Bank). Burundi, Honduras and Switzerland, for instance, are very similar in landmass and size, yet they are characterized by very different levels of development and mortality. When comparing these three countries, it becomes evident that they are characterized by different development and mortality levels, and that they face very different public health challenges as a result of geographical, economical and variations, among others (table 1). Despite these differences, however, certain policies and strategies to combat disease and to promote health may be very similar in such a diverse group of countries, as we shall see later in this work.

In addition to evident geographical, economical and biological variations - that all contribute to differences in development and mortality of these countries - also social variations may contribute to these differences significantly. Sexual discrimination for instance, such as unequal access to elementary education, may play a significant role in the experienced difference in health status between the countries and regions; globally, 2/3 of all children that do not have any access to elementary education are girls. Uneducated girls then pass on unhealthy habits and faulty information to their

offspring, which can partially explain the observed difference in the health of children to mothers with poor education as compared to well-educated mothers.

| Indicators | Burundi | Honduras | Switzerland |
|---|---|---|---|
| **Inhabitants** | 8.5 Mio | 7.1 Mio | 7.5 Mio |
| **Population growth** | 4 % | 2% | 0.4% |
| **Life expectancy (at birth)** | 49 years | 71 years | 82 years |
| **Infant mortality rates, 2008 (m/f)** | 179/155 | 32/29 | 5/4 |
| **Maternal death per 100000 births, 2005** | 620 | 110 | 5 |

**Table 1. Population indicators and mortality rates in Burundi, Honduras and Switzerland. (Source: Global Health Observatory: http://apps.who.int/ghodata, 2011).**

Furthermore, as girls are less appreciated than boys in some Asian regions, selective abortions and infanticide are practiced in many countries across the region. On one hand, the resulting increase in abortions has lead to a global situation where approximately 20 million abortions are yearly conducted in precarious, health-hazardous conditions [123]. Consequently, maternal mortality is much higher in discriminative countries and regions where such practices and conditions are common. On the other hand, sexual discrimination has led to a skewed ratio between men and women, and hence to a sexually disadvantageous situation with conflict potential as well as to widely spread prostitution. Hence, sexually transmitted diseases typically flourish in these regions.

In sum, geographical, economical, biological, and social variations all contribute to differences in development and mortality of given countries or regions. Hence it is important to understand why and how these factors impact health when planning public health policies and interventions both on national and international levels. In the following passages, the reader will first be introduced to elementary measures of health and disease - to morbidity and mortality - followed by an introduction to demography and its impact on morbidity and death. This is particularly important as changes in death rate and birth rate lead to radical transformation in demography and

age structure, and consequently in morbidity, mortality and public health priorities. Finally the reader will be briefly introduced to elementary factors that impact morbidity and mortality, i.e. geographical, economical, biological, and social variations, more in detail.

***Morbidity and Mortality***

Approximately 80% of the global population lives in developing countries, yet this fraction contributes up to 98 % of the yearly cases of death. Of all deaths (57 million yearly), 1.5 Million affect children that are less than 5-years of age. The distribution of these deaths is highly uneven as 99 % occur in developing countries, and a child in Burundi, for instance, is 30 times as likely to die before the age of 5 than a child in Switzerland. Since 1970, the world has experienced a 60% decrease in "under the age of 5-years" mortality mainly in the industrialized countries and in regions of stark economic growth and development. Nevertheless, in countries such as Gabun, Ghana and Gambia, where the HIV/AIDS epidemic has been strong, the child mortality is partially increasing [123].

Infant death or death in children that are less than one year of age, is often a variable used to compare the state of health of different countries and regions. The variable is strongly correlated to general state of development and mortality of a country, although some exceptions do exist. The infant death in Cuba for instance, equals 6 deaths per 1000 new born, or that of USA. Large variations can however be seen even within a country such as USA. These variations are due to socioeconomic and ethnic factors, which in turn impact the access to medical care and reflect inequity in healthcare.

As opposed to infant death, which is largely influenced by avoidable infectious diseases, adult mortality is often due to non-communal diseases such as cardiovascular disease, cancer and diabetes. In populations where the birthrate is decreasing and where the average life expectancy rises, the burden of chronic diseases largely overweighs that of infectious diseases. Such countries have undergone epidemiological transition, which is exemplified by Switzerland where chronic diseases contribute to 90% of all deaths.

The health state cannot however solely be judged by mortality, but rather also by impairment due to morbidity. Psychological disorders, for instance, are rarely lethal, yet they significantly contribute to morbidity. In order to incorporate morbidity into the equation, and to extend the concept of "potential years of life lost due to premature death," by including equivalent years of "healthy life lost by virtue of being in states of poor health or disability," the disability-adjusted life year (DALY) measure was developed [221]. In so doing, mortality and morbidity were combined into a single, common metric. DALY was originally developed by Harvard University for the World Bank in 1990, and the WHO subsequently adopted the method ten years later. The DALY uses Japanese life expectancy statistics as the standard for measuring premature death, as the Japanese have the longest life expectancies [140].

***Population and Demography***

Demography is concerned with the analysis of population size and structure, especially in relation to its determinants, fertility, mortality and migration. Demography underpins many major social and policy issues, including global population growth, the challenges of population ageing and the implications of migration. These areas are closely inter-connected: fewer children will put pressure on informal care and pension costs for older populations, but possible responses such as increasing fertility and/or mass migration raise thorny policy issues [122].

The demographic transition (DT) is the transition from high death rates to low birth and death rates, as a country develops from a pre-industrial to an industrialized economic system, and was first described by the American demographer Warren Thompson in 1929 [59]. The traditional demographic transition model consist of four stages, where stage one took place during pre-industrialization, and where stage two exists in very poor countries today, mainly in Sub-Saharan Africa, and some Middle Eastern countries, or in countries affected by government policy or civil strife, notably Pakistan, Palestinian Territories and Afghanistan. Today, the majority of developing countries have reached stage 2 or stage 3, and most developed countries are in stage 3 or 4 of the model [30].

The decline in death rate and birth rate that occurs during the demographic transition

leads to a radical transformation of the age structure and in morbidity and mortality. During pre-industrialized times, the death rate was very high, particularly the infant mortality rate, which was often above 200 deaths per 1000 children born. When the death rate subsequently declines during the second stage of the transition, the result is primarily a significant decrease in infant mortality and an increase in the child population. Over time, as cohorts that increased in size - due to higher survival rates - get older, the fertile population grows. Granted that the fertility rates remain constant, this will lead to yet an increase in the number of children born; the second stage of the demographic transition, therefore, implies a rise in child dependency.

In stage three, birth rates fall due to access to contraception, urbanization, a reduction in subsistence agriculture, an increase in the status and education of women, as well as an increase in parental investment in the education of children and an increase in parental salary. Stage four, on the other hand, is characterized by both low birth rates and low death rates. Here, the population remains constant. In some countries like Germany and Italy, the population is even shrinking, which may be a threat to many industries that rely on population growth, as a drop in birth rates below replacement level has been taking place. Hence, some theorists consider that a fifth stage is needed to represent countries that have sub-replacement fertility (that is, below 2.1 children per woman). As development promotes fertility decline at low and medium human development index (HDI) levels, but advanced HDI may promote a rebound in fertility, even a possible sixth stage has been suggested [148].

In demography and medical geography, epidemiological transition is a phase of development witnessed by a sudden and strong increase in population growth rates due to medical innovations followed by a re-leveling of population growth from subsequent declines in fertility rates. The theory was originally proposed by Abdel R Omran in 1971, and explains why the epidemiological pattern changes as a country undergoes demographic transition and the process of modernization from third to first world status [155]. The developments of modern healthcare and medicine like antibiotics, for instance, drastically reduce infant mortality rates. Furthermore, they increase average life expectancy, which, coupled with subsequent declines in fertility rates, reflects a transition to chronic and degenerative diseases as more common causes of death.

According to the WHO, there will be dramatic changes and transitions in the world's health needs in the next two decades as a result of epidemiological transition. On a global level, lifestyle and behavior are currently linked to 20-25% of the burden of disease, but this proportion is rapidly increasing in poorer countries, and non-communicable diseases are expected to account for seven out of every ten deaths in the developing regions by 2020. Already today, non-communicable diseases such as depression and heart disease, as well as road traffic deaths, are quickly replacing the traditional enemies like infectious diseases and malnutrition as leading causes of disability and premature death in the developing regions. Injuries, both unintentional and intentional, are also increasing rapidly in importance, and by 2020 could rival infectious diseases as a source of ill-health [231]. In the following passages, some major causes of ill health and mortality, or elementary factors that are contributing and changing the landscape of epidemiology and international health, will be highlighted more in depth.

#### 1.2.2.2. Elementary factors impacting international health

***Poverty***

Poverty and poor health are strongly correlated (see figure 3). Many people have little or no access to healthcare, as about half of the world population lives with less than two dollars daily, and since poverty often limits people's access to medical facilities and treatment. On the other hand, poor health of a population and a workforce also leads to poor economics, which in turn leads to worse healthcare provision. It is therefore hardly surprising that an increase in GDP often inversely correlates with child-mortality. Nevertheless, in countries like South Africa where income is unevenly dispersed among the population, a high GDP has not led to a low child-mortality. Furthermore, there are also countries with a relatively low GDP that experience child mortalities par with countries with a much higher GDP. These exceptions to the rule have been thoroughly and systematically studied after the declaration of Alma Ata in 1978, and 5 key factors have been identified that allow a relatively good state of health despite a low GDP, namely 1) incorporation of tradition and traditional health systems, 2) the involvement of the state in social security, 3)

community involvement and participation, 4) equity through taking minorities and disadvantageous groups into consideration, 5) inter- and cross-sector collaboration [123].

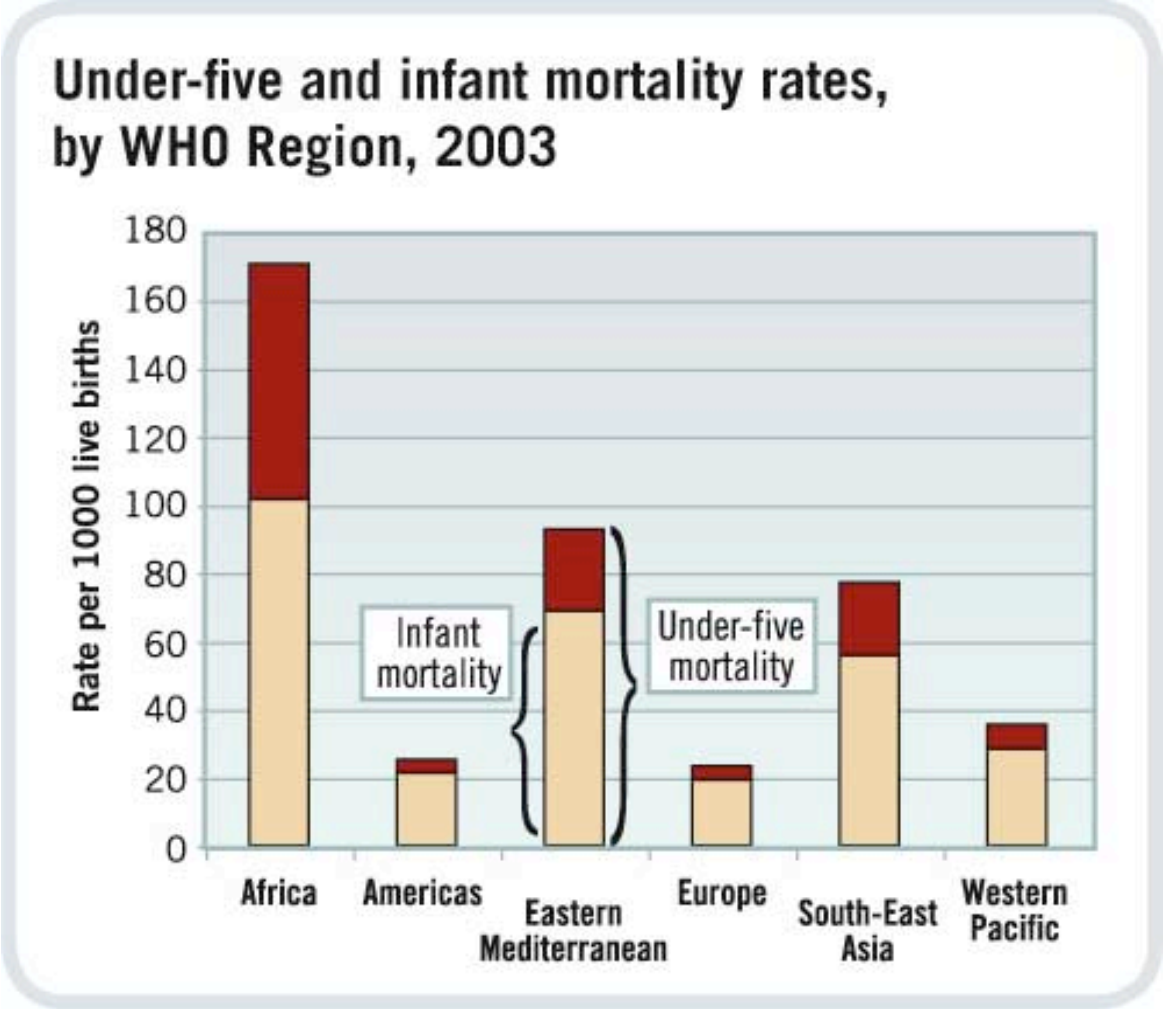



**Figure 3. Under-five and infant mortality rates by WHO Region 2003. (Source: WHO, 2003).**

***Hunger and malnutrition***

Poverty and hunger are very closely related, and the relationship between hunger and population growth is obvious. Today more than 800 Million people suffer from hunger or starvation and malnutrition is one of the leading causes of death in children. Malnutrition includes iron-, iodide- and vitamin A deficiency, which may directly lead to i.e. blindness or mental disabilities as well as to significant increase in disease

susceptibility and impaired immune systems. In industrialized countries or nations that have undergone demographic transition, on the other hand, malnutrition may be manifested by adiposity or diabetes due to excessive intake of fats and sugars [123].

***Education***

Health is strongly correlated with the educational level of the population in all countries globally. Even in industrialized countries, the impact is apparent. In Switzerland for instance, the life expectancy between persons with a university degree and persons without a diploma differs by 10 years [123]. It is important to note, however, that the increase in educational levels of girls has a stronger impact on health and the economy of a country, than that of boys, since well-educated women marry later, use contraceptives, have fewer children and more strongly convey healthy habits to their offspring.

***Environmental Changes***

The environment is a major determinant of health. An estimated 20 % of all deaths in the WHO European region are due to environmental determinants. In order to prevent disease and injury in this context, the collaboration between different sectors in the pursuit of protecting human health from risks from a hazardous or contaminated environment is essential [232].

Climate change is a significant and emerging threat to public health, and it must determine the way we approach vulnerable populations and protect them. Today, climate change already has a great an impact on human health, and is affecting the wellbeing of a large amount of people by causing new risks and pressures such as food shortages and hunger, alteration of water resources and damage to physical infrastructure. The rise in sea-level and extreme weather events are particularly evident changes that we are facing today, and they are effecting health not only directly, but also indirectly, through their impact on economic activities and human settlements [233].

***Political and Armed Conflicts***

Political and armed conflicts between states and groups have been major causes of morbidity and mortality for most of human history. The impact of war on populations arises partially from the direct effects of combat through deaths and injuries on the battlefield. Yet indirect consequences of war – namely the displacement of populations, the breakdown of health and social services, and the heightened risk of disease transmission – play an important role in the increased morbidity and mortality during conflicts and may occur for several years after a conflict ends. Despite the magnitude of the health consequences, military conflict has not received the same attention from public health research and policy as many other causes of illness and death [147].

#### 1.2.2.3. Summary

As we have seen in the previous text, health and disease cannot be purely dealt with in national or regional isolation, since epidemiology and diseases do not respect man-drawn boarders. To address these issues, the discipline of international health deals with global processes that impact human health. International health is therefore embedded in a network of various health systems and actors, and deals with complex issues characterized by geographical, economical, biological, and social variations that all contribute to human well being, morbidity and mortality. However, as we shall see in the next chapter, the trans- or supranational context - with its diverse health- and legal- systems - naturally also poses challenges to health governance and accountability; who is ultimately responsible for international health?

### 1.2.3. Healthcare - The Responsibility of Whom?

The right to access medical care is enshrined in Article 25 of the Universal Declaration of Human Rights (UN 1948). Article 25 has also been interpreted as the *"right to the highest attainable standard of physical and mental health."* Nevertheless, there are billions of people suffering from treatable diseases as they are deprived of access to even the cheapest generic drugs or the most basic medical treatment.

### 1.2.3.1. Traditional Roles of Various Players in the Protection of Health

***a) On a National Level***

A good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well maintained facilities and logistics to deliver quality medicines and technologies [229].

*The Role of the State*

Health is a global public good. The state is responsible and accountable for setting up certain minimal frameworks to insure, for example, that infectious diseases are not so easily spread [75]. The state is also responsible and accountable or formulating a sound health policy that strengthens public health.

According to the World Health Report 2008, Primary Health Care, Now More than Ever [227], people in resource-constrained settings should not have to settle for less than "*the full provision of universal coverage to improve health equity, people-centered service delivery, public policy reforms to promote and protect community health, and leadership reforms to make health authorities more reliable."* According to the report, an array of public policies should be put in place by governments in order to deal with health challenges such as those posed by urbanization, climate change, gender discrimination or social stratification, in addition to protecting people's health and enabling and health equity [227].

*The Role of the Private Player*

Classification of public good is not an absolute; it depends on market conditions and the state of technology [172]. The right to health is codified in many legally binding international and regional human right treaties, and the failure of government to provide public goods and services involved in health care, automatically puts some of

the responsibility on private actors (if not legally then morally).

***b) On an International Level***

Health, however, does not respect national borders. In today's world of changing health risks and opportunities, the capacity to influence health determinants, status and outcomes cannot be assured through national actions alone because of the intensification of cross-border and trans-border flows of people, goods and services, and ideas. As health is a global challenge in industrialized and developing countries alike, there is a need for effective collective action by governments, business and civil society to better manage these risks and opportunities. The need for strong international health governance is more acute than ever before since a range of health determinants are increasingly affected by factors outside of the health sector – trade and investment flows, collective violence and conflict, illicit and criminal activity, environmental change and communication technologies.

*World Health Organization (WHO):*

WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. In the 21st century, health is a shared responsibility, involving equitable access to essential care and collective defense against transnational threats. Building on WHO's mandate and its comparative advantage, six core functions have been defined for the organization: 1) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed; 2) Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; 3) Setting norms and standards, and promoting and monitoring their implementation; 4) Articulating ethical and evidence-based policy options; 5) Providing technical support, catalyzing change, and building sustainable institutional capacity; 6) Monitoring the health situation and assessing health trends [224].

The General Programme of Work is a requirement specified in Article 28 of the WHO

Constitution. This document, covering the period of 2006-2015, is more far-reaching than the previous General Programme of Work, and is linked to the Millennium Development Goals.[4] It examines current global health problems, the challenges they imply, and the ways in which the international community, not just WHO, must respond to them over the next decade. The missing elements can be summarized as [224]:

- gaps in social justice;
- gaps in responsibility;
- gaps in implementation; and
- gaps in knowledge.

In order to be an effective partner amongst the numerous other agencies working with governments, UN and WHO have embraced the concept of partnerships. Former UN Secretary- General Kofi Annan, for instance, stated that *"the United Nations once dealt only with governments. By now we know that peace and prosperity cannot be achieved without partnerships involving governments, international organizations, the business community, and civil society"* in his address to the annual meeting of the World Economic Forum [5]. One year before leaving office as Director-General of WHO in 2002, Gro Harlem Brundtland categorically stated that *"In a world filled with complex health problems, WHO cannot solve them alone. Governments cannot solve them alone. Nongovernmental organizations, private sector and Foundations cannot solve them alone. Only trough new and innovative partnerships can we make a difference…Whether we like it or not, we are dependent on the partners…to bridge*

[4] Adopted by world leaders in the year 2000, the Millennium Development Goals (MDGs) provide concrete, numerical benchmarks for tackling extreme poverty in its many dimensions. As part of the United Nations Development Programme, the MDGs also provide a framework for the global community to work together towards a common goal: assuring that human development reaches everyone, regardless of location, by 2015. More in detail, the set goals include: 1) Eliminate extreme poverty and hunger; 2) Allow universal primary education; 3) Support gender equality and empowering of women; 4) cut down child mortality; 5) ameliorate maternal health; 6) Figt HIV/AIDS, malaria, and other diseases; 7) Ensure environmental sustainability; 8) Develop a global partnership for development. All together, if these goals are me, world poverty will be cut by half, tens of millions of lives will be saved, and billions more people will be able to benefit from the global economy. See http://www.undp.org/mdg/basics.shtml (Accessed 02 December 2010).

*the gap and achieve health for all"* [24].

*The World Bank:*

The World Bank was founded in 1944 to provide financial and technical assistance to developing countries around the world and to fight poverty by providing resources, sharing knowledge, building capacity and forging partnerships in the public and private sectors. In his address to the UN plenary session, the Director-General Zoellicks stated that *"The Millennium Development Goals are central to the World Bank Group's mission and everyday work."* In regards to the health related MDGs specifically, the World Bank aims to help developing low-and middle-income countries to improve people's health and guard against the poverty that can result from sudden illness. Poor families often tap into savings or sell their belongings to cover the costs of healthcare and drugs. As a result, all too often people end up falling below the poverty line and get trapped in a vicious circle.

According to the World Bank, it is therefore an essential priority to improve the perilous health of millions of the world's poorest people for the global development community. Under its new health nutrition and population (HNP) strategy, the bank will specifically help countries to control priority diseases where they constitute a large part of the burden of disease. Furthermore, the bank will increasingly endeavor to ensure that banks operational and policy advice support for priority diseases will strengthen the ability of health systems to solve systemic constraints that impair the effectiveness of countries, the bank, and the international financing community in achieving HNP results [243].

*The Health 8:*

Health 8 is an informal group that was created in mid-2007 to stimulate a global sense of urgency for reaching the health related MDGs. The health 8 group is composed of eight major international health-related agencies (i.e. WHO, World Bank, GAVI, UNICEF, UNFPA, UNAIDS, the Global Fund to fight AIDS, Tuberculosis and Malaria and the Bill and Melinda Gates Foundation, which meet informally to discuss and reflect on ways to scale up services and improve health related MDG outcomes

[150]. It aims to ensure systematic and robust knowledge management and learning around the MDGs, and to seize opportunities presented by renewed interest in health systems and the horizontal cross-sector approach.

### 1.2.3.2 Paradigmatic Shifts in Approach to Health and Healthcare

Health is increasingly seen as a key aspect of human security, and occupies a prominent place in debates on the priorities for development. Over the last 20 years, there have been major gains in life expectancy, but there are widening gaps in health. There have been sharp contrasts in health trends across the world, with reversals in some areas due to factors such as infectious diseases, in particular HIV/AIDS, collapsing health services and deteriorating social and economic conditions. The target year for achieving the improvements set out in the Millennium Development Goals is 2015, but the trends for goals relating to health are not encouraging. According to WHO Eleventh General Programme of Work, any significant progress towards the health-related Millennium Development Goals will require action in many sectors and at all levels – individual, community, national, regional and global – and requires investing in seven priority areas [224]:

1. Investing in health to reduce poverty;
2. Building individual and global health security;
3. Promoting universal coverage, gender equality, and health- related human rights;
4. Tackling the determinants of health;
5. Strengthening health systems and equitable access;
6. Harnessing knowledge, science and technology;
7. Strengthening governance, leadership and accountability [224].

The success of these processes depends mainly on the people involved and their experience, expertise and sensitivity to developing partnerships. In the case of AIDS, Joan Kaufmann asserts that it is essential to look at the issue as more than a mare health issue and to see it as a serious developmental and public policy challenge requiring governance response. This means multi-sectoral programmes and sectoral

collaborations for prevention, treatment and social and economic impact mitigation. It also requires good governance and political leadership, as well as collaboration with civil society, the private sector and people living with AIDS and their families [106].

### *The Involvement of the Industry in the Provision of Public Goods in Form of Public Private Partnerships (PPP) / Cross-Sector Collaborations*

Until the late 1970s, government and development agencies contracted the private sector to execute large infrastructure projects, such as railroads, sewers, and road networks. A clear agreement was draw up which defined the roles of the contractor and provider and the incentives and benefits that would accrue to each party. There was limited collaboration outside the contractual agreement. Where non-contractual collaborations existed, such as those between pharmaceutical manufacturers and public health agencies for the donation of vaccines or treatments, they were informal and descendant on the mandate and motivation of individual private and public sector entities [234]. The rise of neo-liberal ideologies, such as globalization, free markets, privatization, and competition, in the late 1970s and early 1980s coincided with the international debt crisis of 1982. The poor performance of state-owned enterprises and government's unsuccessful involvement in market processes in many countries became apparent. This was followed ideological shifts and by a wave of deregulation, liberalization and privatization all around the world in the 1980s. Subsequently, the market in the 1990s was characterized by an ideological shift from 'freeing' to 'modifying' it [199].

Despite that this ideological change shifted the performance risk for projects from domestic tax payers to private investors, the shift was not solely driven by economic philosophy but also due to changes in the prevailing sociopolitical orthodoxy, as an increasing number and variety of stakeholders were believed to have a legitimate say in public policy-making [79]. More importantly, these stakeholders also included private sector representatives. Subsequently, influential international organizations began to champion a greater role and more responsibility for the private sector in providing efficient and cost-effective public services [27].

The emergence of partnerships, not only on a regional level, but even on a global

scale in form of global Private Public Partnerships (GPPPs), was additionally fuelled by the growing disillusion with the UN and its organizations. Increasing evidence of overlapping mandates and interagency competition, in other words ineffectiveness, led to the establishing and development of cross-collaborations to deal with specific and limited issues such as drug and vaccine development and delivery. This trend of involving the industry in partnerships, as the UN bureaucracy was viewed as ineffective, was reflected for instance in the Medicines for Malaria Venture (a drug research PPP), for example, where it was agreed that *"the organization should run as a not-for-profit-business and be based on operational paradigms of industry, not the public sector"* [168].

Due to the already mentioned increasingly negative perceptions of the UN, including the UN ineffectiveness, donors began imposing a policy of zero real growth in UN budgets and shifted toward supplementary-, such as voluntary- and ear-marked-, funding. These funding trends therefore turned the UN's attention towards global PPPs (GPPPs), as the partnerships became more attractive and perhaps unavoidable to the organization [29], and since resources provided by the private sector became necessary [13]. In addition, other important new sources of funding for UN partnerships included those from the "new philanthropists" (i.e. Bill Gates, George Soros and Ted Turner). Furthermore, the re-emergence of a broader approach to public health, partially moving away from a vertical disease approach and more towards a system wide approach, may have also provided more fertile ground for global PPPs [136].

Market failures, changing markets and technology have heightened this appreciation of interdependence and have contributed to the push towards PPPs in international health. New developments in medical- and biotechnology, for instance, are making drug and vaccine discovery and development increasingly expensive. Similarly, changes in the sphere of intellectual property rights are also hiking up the costs. Simultaneously, extensive consolidation of the pharmaceutical industry has led to greater competition within companies, and therefore to an elevation in the opportunity costs associated with investment in tropical diseases. These trends have led some health policy makers to advocate PPPs and to explore ways in which public and private decision makers could work together to overcome market failures through

cross-sector collaborations. The aim of such partnerships is for example to develop and make available health promoting goods and services at a low cost compatible with the buying power of developing countries, while minimizing the risk and guaranteeing a return to the private sector. *"Economic tools that reduce the costs of R&D, called 'push' factors, and those that address the lack of effective markets, termed 'pull' factors, are at the center of many health GPPPs (e.g., the International AIDS Vaccine Initiative, the Global Alliance for TB Drug Development, the Malaria Vaccine Initiative, etc.)"* [29].

In summary, whether international or national scope, PPPs challenge the traditional distinction between the public and private sector, and their perceived aims and responsibilities. Together with a societal shift towards more civic autonomy and self-determination, PPPs have clearly altered the dynamic between state, economy and civil society, as well as to a new perceptions, and importance, of CSR. Today, PPPs pool public and private resources, and capitalize on the skills of the respective sectors to improve the delivery of services. In the health sector they focus on preventing disease such as sexually transmitted infections and malaria, developing and facilitating access to vaccines and drugs, and improving health service delivery. Simultaneously, the private industry is experiencing fundamental market changes and is progressively accepting more social responsibility as well as participation in public processes.

### *The Private Industry is Experiencing Fundamental Market Changes – Corporate Social Responsibility (CSR)*

Today the relevant customer environment of pharmaceutical, healthcare and other companies is becoming more complex as a result of a shift in decision making power due to external factors such as: (1) cost pressures, (2) new legal and managed care plans regulations, (3) changes in political influence and societal expectations, and due to (4) increased medical education and proliferation of medical and general knowledge [163]. Fundamental market developments, combined with the rapidly increasing need to improve corporate sales success, has called for an in-depth reflection about what could be done to improve the image and viability of commercial operations. There has been pressure on private firms to develop relationships with

new influencing stakeholders, positively influence image, and to become engaged in good and productive corporate responsibility (CSR). In order to deal with changing societal demands in a reasonable way, the implicit compliance with consensual societal norms and expectations has to be replaced by the explicit participation of the company in public processes of deliberation and justification [179].

Today top managers almost universally embrace CSR as an integral component of their executive roles, whether motivated by self-interest, altruism, strategic advantage or political gain [31]. Their approach is apparent and plain to see on the companies' corporate web sites. "*It would be a challenge to find a recent annual report of any big international company that justifies the firm's existence merely in terms of profit, rather than "service to community"* [40]. Furthermore, some evidence for moral sensitivity of multinational companies is seen in the formation of the CAUX Principles, a set of moral ideals not too unlike the UN global compact subscribed to by a number of prominent global companies [237].

In addition to moral reasons, several companies engage themselves in ethical sensitivity and non-profit activities also in order to promote a positive image and to increase stakeholder value [187]. Further, many leading CEOs argue that CSR creates positive internal corporate culture, and that giving their staff time to volunteer in humanitarian causes improves the companies ability to recruit top talent. Nevertheless, the negative publicity of businesses is more apparent than ever before. It seems as if negative consequences of businesses have intensified [146] [117], as has the public call for corporate responsibility [161]. Today's business firms, however, are not just considered the culprits of environmental disasters, financial scandals, and social ills, but are simultaneously considered to have the potential to provide solutions for global regulation and public goods problems [127][132], as state agencies are at times completely overtaxed or unwilling to administer citizenship rights or contribute to the public good.

According to Scherer and Palazzo, the solution of globalization problems is not just a matter of degree of engagement in CSR i.e. of more or less investments of business firms in CSR projects. Rather they suggest that, with globalization, a paradigm shift is necessary in the debate on CSR. Current discussions in CSR are based on the

assumption that responsible firms operate within a more or less properly working political framework of rules and regulations that are defined by governmental authorities. With globalization, they suggest that this assumption does not hold any more. The global framework of rules is fragile and incomplete. Therefore, business firms have an additional political responsibility to contribute to the development and proper working of global governance [159].

In summary, the reasons for the industry to get involved in CSR, especially to commit long-term to CSR, are many. However, whatever the reasons may be, the CSR movements truly opens the door for novel participation in the provision of public goods and support of societal needs including public health, as well as the participation as political actors in health governance.

***Partnerships and Global Health Governance***

Global political challenges like poverty, climate change and spread of infectious diseases cannot be mastered effectively by national political systems whose regulatory power is limited to their national jurisdiction. Therefore, a new mode of government is required to define and implement standards on behavior with global reach [74] [87]. Global governance as an emerging form of transnational regulation, combines the effort of public actors such as national governments and international governmental institutions and private actors such as NGOs and corporations [143] [169][170].[5]

The past decade has in fact been characterized by significant changes in international cooperation and cross-sector collaboration through the United Nations and its affiliated organizations and partners. Within this context two interrelated trends stand out in particular: 1) " *It is progressively more evident that a variety of challenges cannot be met efficiently at the national level, but require additional collective international, if not global, approaches in the era of globalization defined by the accelerated diffusion of capital, traded goods, people, ideas, etc. across increasingly*

[5] In this study, the term "public actors" is synonymous with state actors, while the term "private actors" refers to all non-state actors. This use is common in research on global governance (see e.g. Boerzel & Risse 2005).

*porous national boundaries*" [107]; 2) *"A second significant trend in international cooperation within the United Nations involves a shift from vertical representation to horizontal participation"* [27].

Vertical representation is a less typical form of representation, and entails a hierarchical and bureaucratic relationship between the state and its representation at the UN, allowing a form of democracy and accountability where citizens are represented through member states, where the member states are represented in decision-making bodies, and where the decision-making bodies are finally responsible to member states. Horizontal participation, or inter-organizational networking on the other hand, is more typical of the network society and is exemplified by global public-private partnerships (GPPPs). In this form of participation, states and non-state actors such as the UN and private for-profit businesses form less hierarchical and less bureaucratic inter-organizational relationships [29].

The intractability of progress in global health governance can be attributed to a number of "grand challenges" according to Gostin [84]. These grand challenges are the enduring, hard-to-solve obstacles that persist in the political, legal, economic and social contours of the current international landscape and prevent the achievement of global health with justice. According to Gostin there are six grand challenges in relation to global health governance, which are vital to the improvement of world health and the reduction in glaring health disparities. These challenges include 1) the lack of global health leadership; 2) the need to harness creativity, energy and resources for global health; 3) the need for collaboration and coordination of multiple players; 4) the neglect of basic survival needs and health systems strengthening; 5) the lack of funding and priority setting and 6) the need for accountability, transparency, monitoring and enforcement. He further elaborates the concept of collaboration and coordination by multiple players by stating that it is a critical problem in global heath efforts. He adds that a number of actors beyond the traditional state-centric governance system now occupy the field of global health, and that this has resulted in rampant problems of fragmentation and duplication in the sea of funding programmes and activities that span the global health domain.

Related to fragmentation among current proliferation of actors, is the growing

competition between international NGOs and local services providers (e.g. governments, business and community-based organizations) for funding and human resources [77]. It is feared that this encroachment of international actors upon capable actors at local level will hinder efforts of greater country ownership and control.
When well-funded NGOs create AIDS clinics or other services on the ground, they are often able to offer more lucrative salaries and far better working conditions than local providers. This can drain public or private initiatives in the host country, making it even more difficult to provide sustainable services. Rather what is needed is a system of governance that fosters effective partnerships and coordinates initiatives to creates synergies and avoid destructive competition at all levels – international, national and local [173].

Several recent efforts at coordination and harmonization among actors have been launched. The international Health Partnership (IHP+), for instance, is an effort launched in 2007 by seven donor countries to improve the coverage and use of health services – whether through public or private channels or through non governmental organizations – in order to deliver improved outcomes related to the Millennium Development Goals (MDGs).

Another effort of coordination and collaboration between health actors is illustrated by the formation of the "Health 8" and related PPPs as already mentioned earlier in this work. These efforts are not only striving for harmonization among the parties involved, but are also increasingly supporting a system wide approach where diseases are not combated in isolation, but rather in a sector wide or systemic approach, where various actors of society are brought together to address issues of health and disease in a more holistic fashion, taking into consideration the complex interactions between various diseases, sanitation, agriculture, infrastructure, education and economy, among others.

### 1.2.4. Systems Thinking as Global Strategy in International Health

#### 1.2.4.1. Introduction

Already in the declaration of the UN Alma ata in 1978, a horizontal, widely encompassing approach and global strategy to international health was apparent. The emphasis lay on combating burden of disease through the strengthening of primary health care. Subsequently the global strategies became dominated by more vertical approaches to tackle problems such as Tuberculosis and Malaria in a more isolated fashion. The approaches became fairly linear where singular diseases where combated often in isolation. Despite a strong range of implemented health interventions throughout the 1980s and 1990s, these interventions were often shown to be ineffective and inefficient. The desired outcomes where often not obtained since the funded interventions lacked powerful health-systems to deliver them.

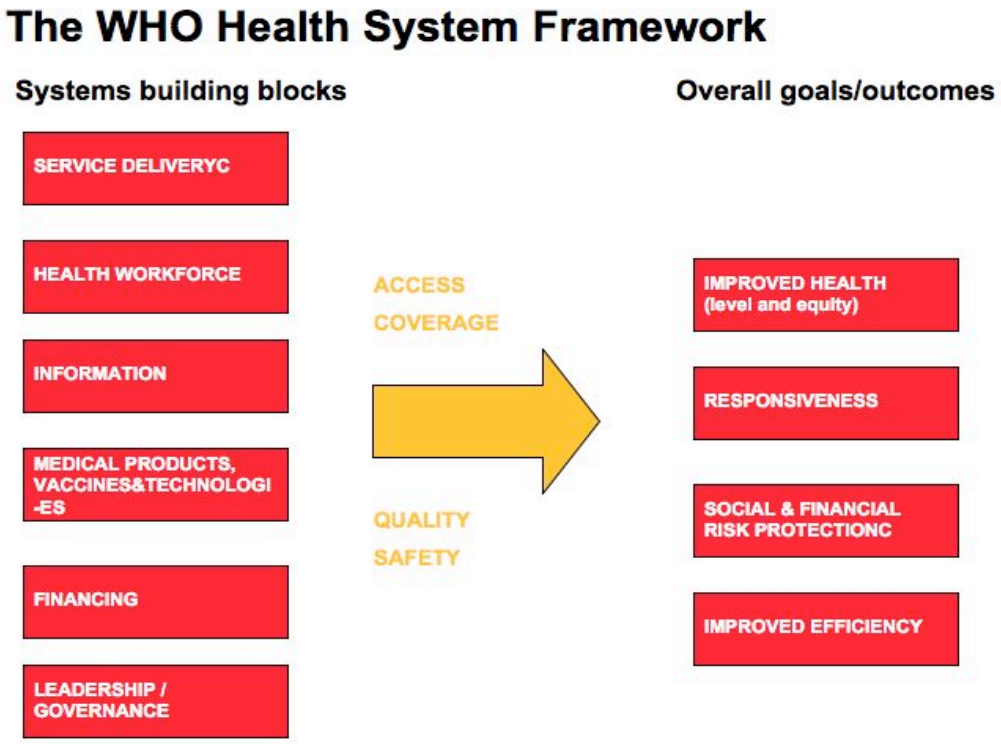
Today, the global strategy for better health is becoming more horizontal again with increased health systems thinking and a focus on health systems worldwide. This is evident in the growing willingness of the two of the largest global health initiatives, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Alliance for Vaccines and Immunization, to allow increasing shares of their contributions to be used for investments in health systems strengthening.

According to the WHO, a health system "*consists of all organizations, people, and actions whose primary intent is to promote, restore and maintain health*" [226]. The aim or goal or health systems is to *" improving health and health equity in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources"* (WHO 2007). The systems are composed of health systems building blocks as described in the 2007 report (see figure 4). According to the WHO Report "*Systems Thinking for Health Systems Strengthening,"* the building blocks alone do not constitute a system "*any more than a pile of bricks constitutes a functioning building*. *It is the multiple relationships and interactions among the blocks – how one affects and influences the others, and is in turn affected by them – that convert these blocks into a system*" [228].

"Systems thinking" is an approach to problem solving that views "problems" as part of a wider, dynamic system. Systems thinking involves much more than a reaction to present outcomes or events. It demands a deeper understanding of the linkages, relationships, interactions and behaviors among the elements that characterize the

entire system. Commonly used in other sectors where interventions and systems are complex, systems thinking in the health sector shifts focus to: 1) the nature of relationships aiming the building blocks, 2) the spaces between the blocks (and understanding what happens there), and 3) the synergies emerging from the interactions among the blocks [228].

**Figure 4. The building blocks of the health system: aims and attributes [228:31]. (Source: Derived from the original model by WHO, 2009).**




### 1.2.4.2. Shift in the Global Agenda and Systems Thinking

Despite a strong range of health interventions that can prevent much of the burden of disease in the poorest countries – with ever improving interventions in the pipeline – effective coverage of these interventions is expanding too slowly and health inequities are widening [228]. Cost effective interventions, when available, are both inadequately provided and underused, and the challenges of meeting Millennium Development Goals (MDGs) for health remain formidable. In many cases, the fundamental problem lies with the broader health system and its ability to deliver

interventions to those who need them. It is therefore increasingly recognized that stronger health systems are needed to deliver health care interventions at the scale necessary to achieve and sustain health- related Millennium Development Goals [220] [195].

According to the World Health Report 2008 *"Primary Health Care, Now More than Ever,"* health systems in developing countries have not responded adequately to people's needs. The report argues that health systems are failing because they have not kept abreast of the challenges of a changing world. "Strengthening health systems" may sound abstract and less important than specific-disease control technology or increased international financing to many people concerned about achieving public health results. But, well-organized and sustainable health systems are necessary to achieve results and health related Millennium Development Goals. On the ground, in practical terms, it means putting together the right chain of events (financing, regulatory framework for private-public collaboration, governance, insurance, logistics, provider payment and incentive mechanisms, information, well-trained personnel, basic infrastructure, and supplies) to ensure equitable access to effective health interventions and a continuum of care to save and improve people's lives [228].

The global health agenda is indeed shifting from an emphasis on disease specific approaches to focus on strengthening of health systems [193]. Yet, strengthening health systems is not a result in itself and the systems are only successful once the right chain of events on the ground prevents avoidable deaths and extreme financial hardship due to illness. However, without health system strengthening, there will be no results [244]. Health systems are fundamental if we are to improve health outcomes and accelerate towards the Millennium Development Goals of reducing maternal and child mortality, and combating HIV, malaria and other diseases. At time when economic downturn, a new influenza pandemic, and climate change add to the challenges of meeting those goals, the need for robust health systems is more acute than ever [34].

According to Marcel Tanner, the Director of the Swiss Tropical and Public Health Institute, poor health systems are the most urgent problem in global health and health

development: *"Health systems are not very well developed and/or poorly supported, particularly on the periphery. Or there is no good collaboration between the different service providers such as private and public. It is certainly not just a question of money."* Tanner uses a case study that his institute has been working on in Tanzania to examplify the importance of strengthening health systems. The mentioned project studies the issue of under-5 mortality, as part the MDGs call for a 4% reduction in child mortality per year. Despite that sub-Saharan Africa lags well behind the MDG target, the study found that two neighboring districts in Tanzania had experienced a dramatic 14% decline in under-5 mortality per year, even while two other adjacent districts – with almost identical socioeconomic profiles to the first pair – had enjoyed only a 5% decline per year. According to the study, the explanation rests with the fact that in the first two districts all the development actors had been brought together – i.e. the public, private and traditional sector – within the district health management team to develop new regular district health plans [194].

There is compelling evidence that improved health system performance is key to improved health, and hence to meeting health-related international development targets such as the Millennium Development Goals. In contrast, the strategies on how this is achieved are still open to debate. Since the mid-1990s, a new approach to health sector development has taken hold in a number of developing countries: the sector-wide approach. There are persuasive arguments for supporting a sector-wide approach (SWAp) as opposed to the traditional project approach: increased health sector coordination, stronger national leadership and ownership, and strengthened countrywide management and delivery systems. These are variously claimed to reduce duplication, lower transaction costs, increase equity and sustainability, and improve aid effectiveness and health sector efficiency. Furthermore, the SWAp has become an integral part of poverty reduction strategies, and its ideology has enjoyed a growing acceptance from donor agencies as well as aid recipients [195].

An example of the health systems approach within the context of vision impairment is the approach of the global Vision 2020 initiative to combat preventable blindness. The prevention of corneal blindness in the community, for instance, involves action by the community itself, as well as actions by non-governmental organizations in the form of health and development services, as many social factors such as poverty,

inadequate water supply and sanitation, poor nutrition, and dangerous agricultural practice are all associated with corneal disease. Since infections, in the absence of antibiotic creams or pills, are major causes of corneal blindness due to unclean water and poor hygiene, due to foreign particles in the cornea derived from dirt in farming or of vegetables in agriculture, or due to an underlying infection such as childhood measles, it is crucial to understand both medical causes of corneal scarring and the non-medical and social factors that may lead to corneal blindness when designing and implementing blindness prevention programs. It is important to understand the health systems that already serve the community to ensure that the new programme makes the best use of available resources and that the programme addresses other diseases and disorders that may impact its outcome. Furthermore, it is vital to understand the impact of development programmes led by other government departments (education, agriculture, water resources, community development, and justice) on the prevention of corneal blindness [36].

#### 1.2.4.3. Lessons Learned and the Way Forward

In order to introduce systems thinking in a context that is often dominated by a single disease and fragmented programme thinking, a 10-sequential-step model was described in the Systems Thinking for Health Systems Strengthening by the WHO in 2009 [228]. According to the report, none of the 10 steps should be alien to any practitioner in health systems research or development. But greater benefits emerge from the synergies generated when all ten steps are conducted in sequence. The proposed steps include **A) intervention design:** 1) convening stakeholders, 2) collective brainstorming, 3) conceptualizing effects, and 4) adapting and redesigning), and **B) evaluation design:** 1) determining indicators, 2) choosing methods, 3) selecting design, 4) developing plan, 5) setting budget, 6) sourcing funding.

According to Tanner, health systems are not very well developed and/or poorly supported, particularly on the periphery. *"Or there is no good collaboration between the different service providers such as private and public. It is certainly not just a question of money. We therefore have to introduce a more systematic approach. We need a "magic gun", effective health systems, instead of only "magic bullets", such*

*as new drugs or vaccines for malaria, HIV, tuberculosis etcetera. An important problem of weak health systems is the lack of human resources. If you really look at for instance the Millennium Development Goals; if you calculate what you need in terms of people working in the health sector to reach these goals, you will find that most countries have substantial deficiencies in human resources to be able to reach these noble goals"* [196].

Investing in health systems works: The investment needs to be on multiple, system-wide fronts as determined by needs felt at the decentralized level, and there is no single system intervention to which health gains can be attributed. Furthermore, local ownership of the process and control of resources, with annual plans and priorities decided by the districts themselves, gave greater incentives for the districts to make their own plans work. Systems are no quick fixes [195]. Furthermore, building and managing partnerships such as PPPs and cross-sector collaborations is essential to the systems perspective. Comprehensive and accessible information on available resources to acquire these skills, and whether there is a need for additional resources to meet the partnership-building needs of systems stewards, is a top priority [228].

## 1.3. Research Gaps and Purpose of Study

### 1.3.1. Research Gaps

According to Kaufmann, multi-sectoriality and inclusiveness are critical especially from bottom up in order to reach the MDGs. She continues that harmonization and joint accountability among donors, governments, and the private sector are essential for success [106]. The World Health Organization has also stated that one of its major aims, as part of the Millennium Development Goals, is to work with ministries of health to strengthen health systems and to build their understanding of what can realistically be done by working with other sectors. It aims to engage more systematically with civil society and industry, including international health care and pharmaceutical industries.

Simultaneously, observers of the public management landscape have in recent years been witnessing an increase in the number, variety and complexity of collaborations between the public and private sectors [254]. Although a number of PPP have been established in the past decades, little information is available on the necessary conditions leading to their formation, governance and management [199]. Clearly businesses' involvement in social initiatives can potentially create value to the company and is not necessarily of pure philanthropic nature. In some cases, however, it has been shown that the decision of corporations to engage in CSR were not the result of thorough review of potential benefits but merely an ad hoc reaction to the pressure of critical NGOs [251].

According to the theses of neoinstitutionalism, corporations may simply imitate the strategy of competitors by engaging in CSR [50] [144]. Alternatively, businesses may regain legitimacy through their involvement in CSR [158]. However, since empirical evidence for the profit-orientation as motivation for engaging in CSR is lacking [187] and there are a number of indications that profit orientation, including gain of intangible assets, might only be one part of many reasons for engaging in CSR, further research is necessary.

Despite the apparent, potential value creation through partnerships in terms of effectiveness (increased relevance or quality), scale (increase in reach), efficiency (reduction in time and/or cost), sustainability (increase in longevity of impact), and systemic change (increase in coordination across multi-faceted issue), little data about the value of alliances beyond anecdotes and qualitative success stories have been captured [207]. Having transcended the traditional PPP model, and with cross-sector alliances established as an acceptable approach to development, potential partners and alliance proponents increasingly seek proof of the incremental value achieved through partnership. Parallel to the rise in demand for alliances, there is an increasing need to measure their value and outcome. Previously, partnerships were founded and managed in good faith, believing that an increase in impact would naturally occur. Indeed it often did, however, this value has not been the centerpiece of evaluation and is not currently well measured or documented [207].

One reason for the lack of data on such partnerships is the complex nature and historical context of alliances. Hence, it remains unclear what needs to measure in order to demonstrate value [95]. Questions such as whether we are attributing to long-term change of an alliance or near-term contribution to smaller outcomes, or whether we should measure development results or business value, remain. As a result, evaluations are typically more descriptive than analytic, and they rather report the extent to which intended activities were carried out than describing whether desired outcomes are being achieved, and how these outcomes and impact can be correlated back to the partnership [48]. Furthermore, alliances have in the past typically been driven to accountability, but not to learning [207].

The measurement problem has been compounded by the fact that compliance reporting systems take significant time and effort and do not result in data that can be used to demonstrate value or improve strategy. It is therefore hardly surprising that so little data, even regarding the conditions when partnerships succeed, is available today, despite the vast number of cross-sector collaborations that exist [167]. Building upon the Global Health Initiative event in 2006 [240], participants gathered again in 2007 to seek a better understanding of how PPPs can be made successful and be used most effectively to improve the quality and quantity of healthcare in Sub-Saran Africa, and concluded that better data and evaluation are required to monitor the

effectiveness of PPPs and what makes them succeed [81]. In order to gain understanding in the impact and success of partnerships, it is crucial to collect data also long-term, and donors and funding agencies should invest in longitudinal studies over years in order to understand why and whether the partnerships are working or not. In other words, little longitudinal research and data on value creation through such partnerships exists today, hence more related research is urgently called for.

### 1.3.2. Purpose

The thesis is based on the premise that successful, long-term collaborations can be promoted by identifying and implementing factors which allow value-creation within the partnership for all parties involved. The suggested aims of this thesis-work is therefore to create direct value to patients and other stakeholders through the health care aid project *"My Project Vision – For people with Insight"* and to fill some of the research gaps, mentioned above, including a) the provision of empirical data on motivational aspects of businesses' engagement in CSR in form of PPPs and to b) analyze motivational factors, incentives and skills that enable a favorable collaborative culture and sustainable value creation of such partnerships. In other words, it aims to determine factors that promote closer, more efficient long-term collaboration between different parties through identifying incentives and needs of firms to form cross-sector collaborations in order to reach certain goals. It strives to understand how strategic congruency could be achieved, and how the commitments of private firms to social responsibility and public health initiatives (such as *"My Project Vision – for People with Insight"*) could be strengthened through defining factors that stimulate and allow value creation and profit through businesses engagement in such initiatives.

***The More Detailed Aims Are as Follows:***

The first aim of the thesis work is to create direct, tangible value by setting up a cross-sector collaboration *"My Project Vision – For People with Insight"* between private actors such as for profit firms (SBB, HRIAG, Gepard Media, Executive Insight, MKorb) and an NGO (Christoffel Blinden Mission, CBM) within a framework

supported by the Ethiopian Government and the Ministry of Health. The goal is to treat and restore vision of 2000 people affected by cataract in rural areas of Ethiopia. The collaboration will also serve as a case study to test the stipulated hypothesis or theory developed during the initial project phase through the use of a systematic, rigorous, triangulated, methodological approach also based on action research methodology.

The second aim of the thesis work is to identify motivational factors and conditions that allow value creation and sustainable commitment to cross-sector collaborations of businesses engaged in CSR, based on the *"My Project Vision – For People with insight"* case study, through a combined methodological approach based on grounded theory, applying methods that complement each other including document- and observational studies, in-depth interviews, and questionnaires. It strives to understand how the commitments of private firms to social responsibility and public health initiatives could be strengthened through defining motivational factors and conditions that support potential value creation and profit of such initiatives to the parties involved. It will do so by analyzing the following:

1) By analyzing the initial motivation and incentives of businesses for engaging in CSR through the collaboration project. By identifying potential incentives, motivational skills and other potential motivational factors, which could allow value creation to the company as well as strategic congruency.

2) By a mid-term and 5-year follow up analysis of the businesses, their commitment, and their perceived benefits through the project. By analyzing whether the initially stated incentives and strategies actually did create favorable conditions and value to the parties involved. By identifying unmet expectations and discrepancies between starting-point- and endpoint-motivation, -strategy and -goals of the parties involved. By finally assessing the impact of these changes on the commitment of the various parties to the project.

The final aim of this work is to summarize the findings for an inductive development of transferable strategies on how to improve cross-sector partnerships, through

motivational factors, and to develop a first, preliminary tool that can assess the value of a cross-sector collaboration through the analyzing of the formed organizational culture and created intangible assets through such partnerships. The tool aims to monitor organizational performance against strategic goals and to serve as a preliminary evaluation tool and guide for organizations, immersed in cross-sector collaborations, in how to create future value through investment in i.e. customers, suppliers, employees, processes, technology, and innovation through the alliance. The ultimate goal is therefore to allow the development of morally and ethically sound strategies that encourage private actors to embrace CSR, and that allow sustainable as well as outcome-oriented cross-sector collaborations in international health.

## 1.4. Potential Significance - Rational of Study

The societal shift towards more civic autonomy and self determination clearly has led to an altered dynamic between state, economy and civil society, as well as to a new perceptions, and importance, of CSR. "*It would be a challenge to find a recent annual report of any big international company that justifies the firm´s existence merely in terms of profit, rather than "service to community". Such reports often talk proudly of efforts to improve society and safeguard the environment-by restricting emission of greenhouse gases from the staff kitchen, say, or recycling office stationery-before turning hesitantly to less important matters, such as profits. Big firms nowadays are called upon to be good corporate citizens, and they all want to show that they are*" [40].

On one hand corporate social responsibility (CSR) initiatives provide a base for opportunistic behavior and the participation in CSR initiatives does not guarantee any real implementation of ideas and actual execution of programs. On the other hand, the movements truly open doors for novel participation of companies in public processes of deliberation and justification. The commitment of private firms to good corporate citizenship and societal needs, such as Merck through its Mectizan Donation PPP Program [142] or Pfizer through its River Blindness PPP [164], do have a great impact on public health. Furthermore, there is much evidence that PPPs are crucial for good state of public health particularly in countries with a low GDP and weak public finance of the health sector [123].

In order to accomplish a long-term impact on public health, it is important to encourage the commitment of private firms to CSR and to a closer collaboration between private firms and NGOs involved in public health and the health sector. Yet all parities should benefit from such partnerships. As preliminary studies of PPP or cross-sector partnerships have shown that, in order for them to be successful, they must be based on win-win partnerships, where both partners have an interest in carrying out mutually agreed-upon activities [199], the premise of this study is as follows: Successful, long-term collaborations can be promoted by identifying motivational factors that support favorable conditions and value-creation in

partnerships not only to the patients, governments, NGOs and other non-profit stakeholder involved, but also to the businesses involved. Industry incentives and motivational factors need to be in place for the successful initial partnership involvement and for continued commitment alike.

## 1.5. Framework and General Research Question

This is an explorative, longitudinal case study over 5 years, testing a hypothesis formulated after the first phase of the project, when a field research in Ethiopia was conducted and when recruitment of participants and sampling took place in Switzerland and Germany. The tested hypothesis, developed in the second phase of this project, is to an extent based on previous pilot studies in other regions, on case reports as well as other literature on the subject, and on interviews and observations. In the third phase, spanning over 5 years, the theory or hypothesis was confirmed mainly through a qualitative approach. Nevertheless, a small quantitative component was also incorporated into the research during the third phase within a mixed methods framework. All together the framework is similar to that of a sequential explorative study where an initial qualitative approach is followed by a quantitative phase, yet the subsequent phase is here characterized by mixed methodology and triangulation with a qualitative emphasis. However, the quantitative data will not be presented in this written thesis.

Even though the general purpose of study was clear from the very beginning of the project, the specific research questions changed during the research process - a typical characteristic of qualitative research. Due to the lack of research in the field, the initial intention to answer research questions through cross-sectional research quickly evolved into an explorative attempt to answer crucial questions through a longitudinal study. The final research questions are as follows:

a) How do motivational factors contribute the forming of a positive output - a favorable collaborative culture and intangible value creation - that allow a successful outcome in form of tangible value creation and sustainability of PPPs?

- Is the need of help as initial motivator to embark in the project important in impacting output/outcome?
- Is there a relationship between the notion of potential value creation (as an initial motivation) and output/outcome, or is a philanthropic approach (as an initial motivation) equally valid in favoring a positive output/outcome?

- Is there a relationship between mission alignment/strategic congruency and output/outcome?
- How do motivational skills impact output/outcome and what are they?

b) What is a motivational culture of cross-sector collaboration, which supports further intangible asset creation and a favorable outcome in form of tangible value creation and collaborative success? How is this motivational culture defined and what does it entail?

c) What is the impact of positive output and outcome on sustainability and commitment of the various parties to the cross-sector collaboration/PPP?

## 1.6. Limitations

The sample size in this work is too small for a statistically valid quantitative conclusion, as the sampling followed common rules of qualitative research, were the samples are selected based on their potential informative value and on the maximizing of their contribution to data extraction. Due to the highly unexplored nature of the topic, an explorative approach through qualitative methods was unavoidable. Hence the study investigates relationships but does not necessarily adequately address the issue of causality. Nevertheless, some quantitative data was gathered in this explorative, pilot study in order to extract as much information as possible and to form an informative base for future research questions and study designs. This study should therefore point the direction for future research projects; the theory generated through this study cannot be used for un-scrutinized generalizations but should rather be tested in a larger quantitative study.

The tool developed for assessing the output and outcome of a cross-sector collaboration is based on the studying of firms involved in this particular PPP. However, it is likely that the same factors, variables or markers that reflect collaborative culture and favorable conditions in the firm also reflect that of other parties in involved in the PPP, as all parties are immersed in the same collaboration. Nevertheless, more research is needed to confirm this assumption. Furthermore, the tool was developed based on this explorative pilot-study based on a very small sample (but information rich). Hence more research entailing a larger and different sample is needed to confirm the results and the validity of the tool. Yet, as no such tools exist today, the developed tool can be very useful in the further investigation of similar themes in the meanwhile.

# Part II: Theoretical Foundation

As the research questions of this work all deal with motivational prerequisites, conditions and skills of successful collaborative cultures and sustainable value creation through PPPs, the reader will be introduced to elementary literature on motivation, leadership and management, to organizational culture and asset creation, as well as to PPPs and cross-sector collaborations.

Part II first provides a brief introduction to motivational theory in leadership and management as well as an introduction to organizational culture and how it can motivate, encourage and support resource generation. It then provides a brief overview of current research in business administration and political science on the role of private actors in emerging global governance structures, as well as challenges that arise under the condition of globalization to the classic economic theory.

In addition, the reader is introduced to literature on PPPs and cross-sector collaborations, the possible benefits of such partnerships, and on latest criticism of such partnerships. Finally, basic information on healthcare in Ethiopia and on the project *"My Project Vision – For People with Insight"* (mPV) as well as *"Vision 2020"* is provided, as the research of this dissertation is based on the mPV-PPP case study within the context of "*Vision 2020"* in this sub-saharan country.

## 2.1. Motivational and Organizational Theory

Motivation is the driving force by which humans achieve their goals or factors that energize behavior and give it direction [93] [76]. Intrinsic motivation refers to motivation that is driven by an interest or enjoyment in the task itself, rather than relying on any external pressure whereas extrinsic motivation relies on external factors including money, grades or the threat of punishment [260] [181].

Conceptually, motivation should not be confused with either volition or optimism [181] [76]. Although motivation is closely related to emotion, these to terms and concepts are not interchangeable. According to some theories, motivation may be based on a basic need to minimize physical pain and maximize pleasure. Motivation may also include specific needs such as eating and resting, or receiving a desired object, or achieving state of being. Furthermore, form a philosophical point of view, it may be linked to reasons such as altruism, selfishness, morality, or avoiding mortality.

The fundaments of motivational theory lay in natural sciences and psychology and especially the behaviorist school of thought. Its main influences were Ivan Pavlov, who investigated classical conditioning, and Skinner who conducted research on operant conditioning [68]. Motivational theory is composed of several "sub-theories" including Incentive Theory, Drive Theory, Need Theory, Self-Efficacy and Goal Setting. Whereas Incentive Theory, for instance, focuses on positive reinforcement - or a stimulus which makes a person happier - Drive Theory regards negative reinforcement, or removal of the punishment and strive to achieve homeostasis in the body, to be the motivator and main stimulus.

The Drive Theory is based on the diverse ideas given by Sigmund Freud and proposes that human beings have certain biological drives, like hunger, that gain strength in the passing of time if they are not satisfied. When the drive has been satisfied, however, it will lose its strength. Incentive Theory, on the other hand, is promoted by behavioral psychologists such as Skinner, and claims that individuals are motivated to engage in activities that are expected to be profitable. The theory distinguishes between wanting

and liking, where liking is a passive function evaluating a stimulus, but wanting adds an active process "attracting" the person towards the stimulus [109].

According to Piers Steel and Cornelius Konig, motivation can be summarized in an integrative, broad theory called Temporal Motivational Theory [188]. Introduced in their 2007 Academy of Management Review article, it allows the primary aspects of all other major motivational theories, including Incentive Theory, Drive Theory, Need Theory, Self-Efficacy and Goal Setting to be synthesizes into a single formulation. In other words, it simplifies the field of motivation substantially and allows findings from one theory to be translated into terms of another. Similarly, the American motivation psychologist Abraham H. Maslow developed the Hierarchy of Needs, consistent of five hierarchic classes. According to his theory, the motivation is initially determined by future need for security. After that the individual has achieved security, however, the motives shift to the social sphere, and subsequently to satisfying the psychological requirements and finally to self- realization [129].

### 2.1.1. Motivational Theory in Business

Workers in any organization need something to keep them working, and the employee must be motivated to work for a company or the group. Furthermore, the worker should not only be encouraged to stay in the organization, but should also be motivated to work in an effective and efficient way. Motivation is a powerful tool and motivated workers are more productive. If no motivation is present in an employee, then that employee's quality of work will deteriorate. Motivated employees always look for better ways to do a job and they are more quality oriented according to [130]. Sometimes the salary of the employee is enough to keep an employee working for an organization. Often, however, just working for salary is not enough for employees to stay in an organization and to work productively.

According to Maslow's hierarchy of needs, money is a motivator, however, it tends to have a motivating effect on staff that lasts only for a short period of time [129]. He regards money at the lowest level of the hierarchy, and factors such as praise, respect, recognition, empowerment and a sense of belonging as far more powerful motivators

than money [130]. Satisfaction lay in aligning a person's life with their fundamental motivations. Apart from Taylor's belief that managers do not need to consider psychological or social aspects of work, as the essence of human motivation is wholly based on extrinsic rewards, (money) rather than intrinsic factors, most researchers agree that workers cannot be motivated by the mere need money [198].

Similar to Maslow, Elton Mayo found that social contacts at the workplace are very important for the worker, and that boredom and repetitiveness of tasks lead to reduced motivation. As a psychologist, sociologist and organization theorist, he conducted research showing the importance of groups in affecting the behavior of individuals at work. Mayo believed that workers could be motivated by acknowledging their social needs and by making them feel valued and of importance. Hence, by giving employees the freedom to make decisions on the job, and by allowing and supporting informal group formation, a motivating work situation may be created [133].

Furthermore, Frederick Herzberg's Two Factor Theory, also known as Herzberg's Motivation-Hygiene Theory, concludes that certain factors in the workplace result in job satisfaction. He distinguished between 1) motivators which give positive satisfaction and (e.g. challenging work, recognition, and responsibility) and 2) hygiene factors that do not motivate if present, but, if absent, result in de-motivation (e.g. status, job security, salary and fringe benefits). In other words, hygiene factors are needed to ensure that an employee is not dissatisfied, whereas motivation factors are needed to motivate an employee to higher performance [92].

In Essentials of Organizational Behavior, Robbins and Judge investigate recognition programs as motivators, and describe five principles that contribute to the success of an employee incentive program [171]:

1) Recognition of employees' individual differences, and clear identification of behavior deemed worthy of recognition
2) Allowing employees to participate
3) Linking rewards to performance
4) Rewarding of nominators
5) Visibility of the recognition process

When motivating an audience, group or organization, general motivational strategies or specific motivational appeals can be used. General motivational strategies include soft sell versus hard sell and personality type [200]. Soft sell strategies generally have logical appeals, emotional appeals, advice as well as praise. Hard sell strategies instrumentalize outnumbering, pressure and rank. In terms of specific targeted appeals, specific strategies designed according to audience personality may also be implemented, as asserted by Steinmetz. He discusses three common character types of subordinates: ascendant, indifferent, and ambivalent, and believes that these different personalities and groups must be motivated differently, as they all react and behave uniquely [189].

### 2.1.2 Leadership and Motivation

An effective leader must understand how to manage all characters, and more importantly, the manager must utilize avenues that motivate and allow room for employees to work, grow, and find answers independently. It is largely recognized and accepted by practitioners around the world that leadership is important. Current research supports the notion that leaders do contribute to key organizational outcomes [43] [104].

The “Functional Leadership Theory” is a highly useful theory when addressing organizational effectiveness though specific leader behavior [88] [135]. According to the theory, the leader's main task is to fulfill whatever requirements that are needed for a group to be effective and cohesive [88]. Although the Functional Leadership Theory has mainly been applied to team leadership [250], it has also been proven effective in broader organizational leadership [249].

According to main literature on functional leadership, five broad functions a leader must perform when promoting organization's effectiveness may be summed up as: (1) environmental monitoring, (2) organizing subordinate activities, (3) teaching and coaching subordinates, (4) motivating others, and (5) intervening actively in the group's work [250] [113] [88].

In sum, one of the most important roles of a leader is to motivate employers and to create as well as manage a positive and productive organizational culture. It can even be argued that the only thing of real importance that leaders do is to create and manage culture; that the unique talent of leaders is their ability to understand and work with culture [176], as many researchers report findings that cultural "strength" or certain kind of business cultures correlate with economic performance [44] [118] [186].

### 2.1.3 Management and Motivation

Philosophical term and terminology of "management" and "leadership" have, in the organizational context, often been used both as synonyms and with clearly differentiated meanings. Much debate about whether the use of these terms should be restricted has taken place, and the debate generally reflects an awareness of the distinction made by Burns between "transactional" leadership (characterized by e.g. emphasis on procedures, contingent reward, management by exception) and "transformational" leadership (characterized by e.g. charisma, personal relationships, creativity) [26].

According to Wikipedia management is the act of getting people together to accomplish desired goals and objectives using available resources efficiently and effectively in business and organizational activities.[6] A classical definition of management by Koontz and Kahn states that management is planning, organizing, staffing, leading and controlling an organization for the purpose of accomplishing a goal [116]. Ulrich states that management is designing, controlling and developing a purpose-oriented social system [255]. According to some sources, management has as its primary function the satisfaction of a range of stakeholders. Management can also be defined as human action, including design, to facilitate the production of useful outcomes from a system, since organizations can be viewed as systems. Follet defined management as *"the art of getting things done through people"*. According to Prof. Bernhard Guentert of University of Health Science in Hall, Austria, management is

[6] Retrieved 17 July 2011

the integration of a value chain based on the division of labor. [7] The objective can be divided into internal and external objective (table 2).

**Table 2: Objectives of management according to Bernhard Guentert (Source: Bernhard Guentert, 2011).**

| Internal objectives | External objectives |
|---|---|
| Design of processes and structures | Finding a strong and sustainable position on the market |
| Creating efficiency, corporate culture, working climate and security | Creating good relations with stakeholders |

One subfield of management that reflects the application of psychological principles of Applied Behavior Analysis and the Experimental Analysis of Behavior to organizations is Organizational Behavior Management (OBM). Among others, it aims to promote worker safety and allow other benefits through improving organizational behavior and culture through for instance systems analysis, management, training, and performance improvement. The ultimate goal of the field of OBM is to establish a technology of broad-scale performance improvement and organizational change so that employees will be more productive and happy, and so that organizations and institutions will be more effective and efficient in achieving their goals [154].

According to Mintzberg, the basic management roles are 1) interpersonal (figurehead, leader, liaison officer), 2) informational (monitor, dissemination, spokesman), and 3) decisional (entrepreneur, disturbance handler, resource allocator, negotiator) [141]. Motivation is a basic function of management, because without motivation, employees cannot work effectively. If motivation doesn't take place in an organization, then employees may not contribute to the other functions. Management operates through various functions including planning, organizing, staffing, leading/directing, controlling/monitoring and motivation. These functions are supported by management skills such as [112]:

[7] Lecture slide during the course in Strategic Management and strategic Change in

- Technical: used for specialized knowledge required for work.
- Political: used to build a power base and establish connections.
- Conceptual: used to analyze complex situations.
- Interpersonal: used to communicate, motivate, mentor and delegate.
- Diagnostic: ability to visualize most appropriate response to a situation.

There are various levels of management covered typically by the most junior managers at operative levels up to the most senior managers at strategic and normative levels. According to Bernhard Guentert [8] there are three main levels of management, namely:

1. Normative
2. Strategic
3. Operative.

Here it becomes particularly evident that the terms "management" and "leadership" can to some extent be used as synonyms, yet at times have distinctive meanings. Whatever the use of these terms, however, both management- and leadership- skills have a direct or indirect impact on organizational culture and employee motivation. In the following chapter the relationship between these skills and organizational culture will be investigated more in detail. Furthermore, the relationship between a motivating business culture and value creation is illuminated, which is of particular interest in this work, as one of the objectives of the thesis is to understand how cross-sector collaborations can be strengthened through the cultivation of a motivational collaborative culture and intangible value creation.

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Healthcare Organizations, 2011 Summer School Swiss School of Public Health

[8] Derived from a lecture slide in the course in Strategic Management and Change in Healthcare Organizations, 2011-Summer School Swiss School of Public Health

## 2.2. Organizational Culture and Resource Generation

### 2.2.1. Organizational Culture

*"When we examine culture and leadership closely, we see that they are two sides of the same coin"* [176]. While leadership arguably creates and changes culture, management and administration act within a culture. *"Culture is an abstraction, yet the forces that are created in social and organizational situations that derive from culture are powerful. If we don't understand the operations of these forces, we become victim to them"* [176:3]. Whether a culture is favorable or not - or functionally effective- however, depends not solely on the culture, but also on the relationship of the culture to the environment in which it exist [176].

There are many definitions of culture, and to make matters worse, the concept of culture has been the subject of vigorous academic debate in recent years. Some define culture as being the "rule of the game" entailing implicit, unwritten rules for getting along in the organization; "The ropes" that a newcomer must learn in order to become an accepted member [175] [208], while other encompass embedded skills such as special competencies displayed by group members in accomplishing certain tasks, the ability to make things that get passed from generation to generation without necessarily being articulated in writing within the concept of culture [36]. According to Schein, culture is pervasive, it influences all aspects of how an organization deals with its primary task, its various environments and its internal operations, and implies rituals, climate, values, and behaviors that tie together into a coherent whole [176:14-15]. He formally defines culture as *" a pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems"* [176:17].

Joint ventures and strategic alliances require cultural analysis to an even larger extent than for instance mergers and acquisitions, not to mention a well-defined and

established organizational entity [176:413]. Deciphering differences between two companies in the same national culture is not as difficult as deciphering both national and company differences when a partnership or cross-sector collaboration is immersed in a transnational setting [174]. In this context, a group would not be able to adapt to the changing environmental conditions without proper leadership. Here, leadership requires not only insight into the dynamics of the culture but also the motivation and skill to intervene in one's own cultural process. Furthermore, the unfreezing of an organization requires the creation of psychological safety, the ability to change cultural assumptions, and to create involvement and participation of others in the venture [176:415].

Furthermore, apart from the essentiality of understanding organizational culture, since only by understanding the dynamic of organizational culture, and the crucial role of leaders in the successful applying of the principles of culture to achieve organizational goals, can organizational effectiveness be practiced [176:417], organizational culture can also be an asset per se. Especially in a service driven and knowledge intense industry, intangible assets such as positive, stimulating and empowering organizational cultures, can be absolutely crucial for a company's success, as we shall see in the following chapter.

### 2.2.2. Value Creation Through Resource Generation and Intangible Assets

More than 75 percent of the average firm's market value is derived from intangible assets or assets that traditional financial metrics cannot measure [105]. Intangible assets can be highly valuable for a firm and can be critical to its long-term success or failure even, even though they lack obvious physical value of a factory or equipment. A company such as Coca-Cola, for instance, wouldn't be nearly as successful were it not for the high value obtained through its brand-name recognition, as the brand strength drives global sales year after year [102].

As the global economy is changing, a shift from manufacturing to a service oriented economy has been witnessed in many regions around the world [18]. Tangible assets have therefore diminished in importance [85] and intellectual capital has become an

important resource for a company's success and value creation [253]. The rise of a new knowledge economy driven by information and knowledge, and characterized by intellectual capital, which is a form of knowledge-based intangible asset, has been particularly obvious in the healthcare sector – as it is a knowledge intensive industry.

Intangible assets can be divided into three categories according to Kaplan and Norton: a) Human capital (employee's skills, talent, and knowledge), b) Information capital (databases, information systems, networks and technology infrastructure) and c) Organizational capital (improved corporate culture, employee alignment, teamwork). None of these intangible assets have value that can be measured separately or independently. The value of these intangible assets derives from their ability to allow and help the organization to implement its strategy [105]. Strategic alignment determines the value of intangible assets and their role in allowing and motivating learning and growth within the organization. When all three components, or human, information, and organization capital, are aligned with the strategy, the entity has a high degree of organization readiness: It has the ability to mobilize and sustain the processes of change required to execute its strategy [105]. According to other sources, the value or importance of these assets, including books, software products, equipment, patents, and inventions, lay in the potential conversion of the intangible assets into tangible ones, are ultimately generating revenue [211].

Processes in the internal as well as learning and growth perspectives drive the strategy. They describe how the organization will implement its strategy. Internal processes can be divided into four clusters according to Kaplan and Norton [105]:

1. Operations management: Producing and delivering products and service to customers
2. Customer management: Establishing and leveraging relationships with customers
3. Innovation: Developing new products, services, processes, and relationships
4. Regulatory and social: Conforming to regulations and societal expectations and building stronger communities.

Effective and aligned internal processes determine how value can be created and

sustained. Companies must therefore focus on the critical few internal processes that deliver the differentiating value position and that are most critical for improving productivity and maintaining the organization's franchise to operate.

### 2.2.3. Motivational Frameworks, Collaborative Culture and Resource Generation

In order to accelerate progress towards the health MDGs, keeping focus on health results and outcomes are on top of are IHP+'s list [100]. Outcome or value creation can be measure either directly though financial profit or through resource generation in from of tangible and intangible assets. Similar to IHP+, the emphasis of this thesis also lies in value creation and outcome. Here it is asserted that successful, long-term collaborations can be promoted by identifying factors that allow value-creation and improve outcome in form of curing blindness, which is the common and ultimate goal of all stakeholders, in an effective and efficient fashion. Cross-sector collaborations or PPPS can however also create other kinds of value for the partners involved in form of tangible and intangible assets. By developing motivational strategies for the maximizing of tangible as well as intangible asset creation, value is created, and the outcome and impact of the collaboration is improved.

In management science, resource generation can be defined as gain in: 1) physical capital, 2) human capital, 3) intellectual capital or 4) social capital,[9] which includes tangible and intangible assets. Management and leadership are crucial components in not only the creation of a strategy, but also in the creation of a favorable, motivating organizational culture and resource generation to implement the strategy. The generation of a favorable, motivating organizational culture is an integral part of value creation, as business culture is the deepest, often unconscious part of a group, and it influences all aspects of how an organization deals with its primary task, its various environments, and its internal operations [176:14].

Furthermore, leadership and culture are sometimes viewed as interchangeable, and

[9] According to lecture on health systems, during Planning for Vision 2020 course at London School of Hygiene and Tropical Medicine in July 2011.

culture is considered as the primary act of leadership. Hence, the resource generation and creation of tangible and especially intangible assets are highly dependent on the capability of managers and persons in formal and informal leadership positions to motivated and to create a favorable environment for these assets to evolve. This work therefore focuses on understanding favorable motivational factors and conditions that allow sustainable value creation for all parties involved in of cross-sector collaborations, including various forms of intangible and tangible assets. It aims to identify initial motivational factors that lead to the engagement of firms in CSR in form of cross-sector collaborations, as well as motivational factors and conditions that promote value creation, and long-term commitment of firms to CSR.

## 2.3. Corporate Social Responsibility (CSR) and Partnerships

### 2.3.1. CSR/Businesses for Social Responsibility

***Definition of CSR***

In response to societal and political developments, academia has increasingly begun to consider the meaning of the role of business in society and CSR. In practice, the rapid growth of CSR reports in recent years indicates that most major multinational companies today publicly commit to CSR; that it is no longer a question for corporations of whether engaging in CSR is the right thing to do, but rather how to implement it [185]. Nevertheless, there is no clear consensus on how the term "CSR" should be used and what it means in theory and practice. Interpretations stretch from philanthropy to the so-called "business case."[10]

The World Business Council for Sustainable Development, used the following definition of CSR in its publication "Making Good Business Sense" by Lord Holme and Richard Watts: *"Corporate Social Responsibility is the continuing commitment by business to behave ethically and contribute to economic development while improving the quality of life of the workforce and their families as well as of the local community and society at large."* The European Commission's definition of CSR, on the other hand, is the following: *"A concept whereby companies integrate social and environmental concerns in their business operations and in their interaction with their stakeholders on a voluntary basis."* Further, the CSR definition used by Business for Social Responsibility is: "*Operating a business in a manner that meets or exceeds the ethical, legal, commercial and public expectations that society has of business."* [11]

[10] For example "the business case" of CSR is highlighted on the website of Nestle "Creating shared value"; see http://www.Nestle.com/ShardValueCSR/Overview.htm

[11] For an overview of definitions and different schools of thought in CSR literature, please refer to Scherer & Palazzo, 2007: 1113

CSR as a term and as a definable business concept has been created mainly by and for larger companies. According to the European commission, small and medium-sized enterprises (SMEs) are, however, the predominant form of enterprise in the European Union. If Europe and its enterprises are to reap the full benefits of CSR, it is vital to make sure that SMEs are fully engaged and that what they do is fully recognized. The support and encouragement of CSR amongst small businesses is therefore one of the priority areas of the European Commission's policy on CSR.[12] In this work, CSR is viewed as a concept where businesses of all sizes are viewed as economic and political actors and operate in a manner that contribute to economic development while improving the quality of life of the workforce and their families as well as of the local community and society at large.

***Traditional Paradigm of CSR and Enlarged CSR Concept***

Whatever the scope of CSR in management theory and practice, it has implicitly been built upon the neoclassic concept of strict division of labor between political and economic actors and domains. The neoclassic thinking is deeply embedded in managerial perceptions of societal responsibilities. The corporation as a private actor should focus on profit seeking, and public problems should be dealt with by the state and its institutions [72]. While corporations act on markets the state provides the stable contexts for these markets by making the required infrastructural investments.

Paradoxically, even in scholarly debate on CSR, this neoclassic focus is salient. Large part of the literature operates with an instrumentalist understanding of corporate responsibility, thereby reducing it to another success factor in the corporate pursuit of profits [103]. Furthermore, corporations are considered private and thus non-political actors in the liberal model of democracy [58]. As private actors on the market, corporations are according to this view freed from any immediate legitimacy demands and thus are not required to expose themselves to public scrutiny and justify their behavior as long as they comply with the law [72]. In other words, only the state as a

[12] According to European Commission available at:
ttp://ec.europa.eu/enterprise/policies/sustainable-business/files/csr/documents/stakeholder_forum/compendium_commission_en.pdf

public and political actor is held accountable by the polity.

In the age of globalization, however, the emerging "post-national constellation" is a key challenge to democracy [87]. Globalization is weakening the power of (national) political authorities to regulate the activities of corporations that globally expand their operations [179]. The capacity of the state to regulate economic behavior and to set the conditions for market exchange is in decline as seen in short supply of public good such as drugs and vaccines. Therefore new forms of political regulation have to be considered beyond the nation-state, with not only public actors such as international governmental institutions (UN, ILO, OECD, WHO) contributing to the order, but also with private actors such as NGOs, civil groups and business firms [178]. According to Palazzo and Scherer, businesses have to be understood as economic and political actors in the changing global playing field.

Several empirical examples demonstrate that corporations have indeed begun to participate actively in some matters of the public good and to assume responsibilities that are traditionally regarded as solely government responsibilities [212] [215]. Corporations are promoting public health, education, social security, and human rights while operating in countries with repressive regimes [110] [132]. They engage in self-regulation to fill global gaps in legal regulations and moral orientation [119] [177]. Furthermore, they promote societal peace and stability [73]. As already mentioned earlier, these self-initiated, voluntary CSR activities have led governments and international organizations to explicitly invite corporations to support their agendas. Through their participation in the UN Global Compact (UNGC), for instance, corporations commit to ten principles in the areas of human rights, labor rights, the environment and anticorruption; since the launch of the initiative in 2000, almost 5000 companies have joined [203].

### 2.3.2. Public Private Partnerships (PPP) and Cross-Sector Collaborations

#### 2.3.2.1. Definition of Partnerships

Most of the recent literature in economics [191], organization theory [83][62] and sociology [79] points out a blurring of the boundary between public and private organizations rather than a bifurcation and clear division of tasks and responsibilities and therefore a public-private dichotomy. For purposes of this thesis, although the boundaries are blurry, it is here assumed that the main role of government agencies is to define and promote achievement of public purposes in a manner that retains the confidence of the public (based on research by Zarco-Jasso). It is the basic role of for profit firms, on the other hand, to produce good and services demanded by customers in a competitive market in a manner that generated favorable return on investment and creates the capital required for future investment innovation, and risk-taking. Finally, it is assumed that the core role of non-profit organizations is to meet worthy social needs and allocate voluntary resources in a manner compatible with broader public purposes and their own financial constraints [252].

As the boundary between public and private organizations is blurry, it is not surprising that the terms "cross-sector collaborations" and "Public-Private Partnerships" (PPPs) have taken on a very broad meaning and several definitions of PPPs have been provided by scholars, local and state governments, and international institutions. The term "partnership" includes contractual arrangements, alliances, cooperative agreements, and collaborative activities used for policy development, program support and delivery of government programs and services [157]. Combinations of cross-sector collaborations can include pairings of government agencies and for-profit firms, for profit firms and non-profit organizations, and government agencies and non-profit organizations [252].

Collaboration can also be defined as the linking or sharing of information, resources, activities, and capabilities by organizations to achieve jointly an outcome that could not be achieved by the organization separately. By this definition, power sharing in a collaboration does not imply equal power nor does it necessarily imply much in the way of share interests and goals [25]. Cross-sector collaborations occur for many reasons. The first is simply that we live in a shared-power world in which many groups and organizations are involved in, affected by, or have some partial responsibility to act on public health challenges [41].

According to Reich, "*a good working definition of PPP would include three points. First, these partnerships involve at least one private for-profit organization and at least one not-for-profit or public organization. Second, the partners have some shared objectives for the creation of social value, often for disadvantaged populations. Finally, the core partners agree to share both efforts and benefits"* [167]. According to the United Nations Development Program (UNDP), the broadest definition of PPPs includes agreement frameworks, traditional contracting, and joint ventures with shared ownership. A PPP is a voluntary durable collaboration between public and private organizations to ensure the development of infrastructures and services, sharing risks, costs and benefits [114] [248].

As we have seen, the topic of PPPs is complex. There are many amalgamations of partners, sectors, development issues and business imperatives that can be considered a public private partnership or development alliance [124]. According to Zarco-Jasso, some eight combinations are possible for alliances when considering simply the dimensions of control, funding and ownership [252]. In addition, due to the versatility of the PPP term several dissimilar projects have adopted it, leading some authors to describe PPP as an "illusive label" [49:278] or as a "language game" [197;197]. Aware of the breadth of the PPP term the Commission of the European Communities distinguishes between [33]:

> 1. Contractual PPPs, in which the relation between the public and the private sector is based solely on contractual links. The public sector assigns one or more tasks to private organizations; these tasks can include the design, funding, execution, renovation or exploitation of a work or service. The main example is the concession model, in which the public sector signs a contract with one or more private organizations to develop and manage a project. Contractual PPPs are extensively used in infrastructure development in order to share out the economic costs that they entail.
>
> 2. Institutional PPPs, in which public and private organizations cooperate by creating a new organization to be governed by all parties in the alliance. The main example is the joint venture1, in which one or more public and private organizations, respecting the premises of a PPP, engage in a project by

creating a new organization where all the parties will share the authority to decide.

In this paper, we will use public private partnerships (PPPs), public-private alliances (PPAs), and cross-sector collaborations interchangeably. These partnerships or alliances are defined as the co-investment of the public sector and the private sector into development-type programs of mutual benefit.

#### 2.3.2.2. Examples of Cross-Sector Collaborations

In recent years, various public health organizations have approached the private sector and established PPPs or cross-sector collaborations. Academic institutions, for instance, have engaged in collaborations with private organizations for specific research activities [16]. Furthermore, the World Bank has increasingly encouraged partnerships as part of its comprehensive development framework with MDG as an integral part of its agenda, and the former director-general of the World Health Organization (Dr. Gro Harlem Brundtland) explicitly called for *"open and constructive relations with the private sector and industry"* in her inaugural speech in 1998 [23]. Furthermore, NGOs have established new relationships with private for-profit firms and with international agencies in particular in efforts to expand access to drugs and vaccines in poor countries [90] [166] [184].

One of the reasons why PPPs have become so prominent is that NGOs, that have increasingly gained much influence in their advocacy in the past two decades as globalization processes have promoted the growth and influence of NGOs in international health, are increasingly pushing public health problems into the international policy agenda. [21]. Simultaneously, American private foundations have opted for an increasingly active role in creating and supporting PPPs. This trend is exemplified by the growing role of the Bill and Melinda Gates Foundation in PPPs, the formation of "Health 8," and in the increasing grants by the Rockefeller Foundation, the Edna McConell Clark Foundation towards such collaborations. The aims and objectives of these partnerships often involve the topic of health equity between the rich and the poor of the world, as new technologies and products are

quickly spread and accessed across rich countries due to globalization, while the access to these drugs, products and treatments is greatly reduced or hindered in poor countries. The contrast is stark and the gap in access can be devastating - creating dramatic differences in morbidity and mortality. This inequality in access to drugs was clearly exemplified by the unequal access to anti-AIDS drugs in the 1990s.

Also due to the dramatic impact of AIDS on the population in many regions around the world, private for-profit companies have come to recognize the importance of public health goals in order to assure a certain pool of healthy, capable employees for instance in HIV-endemic regions. Furthermore, private organizations are increasingly accepting a broader view of social responsibility also due to consumer pressure as a part of the corporate mandate. However, since neither public nor private organizations can solve all health problems in isolation, and as traditional public health groups are faced with limited financial resources, rapid spread of disease across national boundaries, complex social and behavioral issues, and reduced state resources, public and private actors are being driven towards each other in order to collaboratively work towards common or overlapping goals.

From a macroeconomic point of view, PPPs can improve public health by accelerating the timeline of drug discovery, development and distribution to the public. In addition, private players can make a significant contribution by improving access to existing products and services for neglected diseases. Merck Mectizan Donation Program, the partnership of Pfizer with Edna McConell Clark foundation, Sight for life vitamin A initiative launched by Roche, and Novartis discounted price Coartem malaria drug public private partnership (PPP), serve as outstanding examples of such initiatives. Other similar examples of PPPs are shown in the table in end of this chapter (table 4).

#### 2.3.2.3. The Formation and Evolving of Cross-Sector Collaborations

Although a number of PPP have been established in the past decades, little information is available on the necessary conditions leading to their formation, governance and management [199]. Arguably, there have to be enough incentives and

motivational factors, which encourage an initial formation as well as a closer, long-lasting collaboration between the various partners, embedded in a sector-wide approach. Through collaborations, private firms could potentially improve their image and their corporate culture, regain consumer confidence, expand information networks, and create stake-holder-value, while NGOs, not for profit institutions, and other participants could clearly benefit from additional donations, information and know-how. Trevor Neilson of the Global Business Coalition on HIV/AIDS argues that an important starting point for a strong collaboration is not necessarily only an emotional and ethical connection, but also strategic congruency and the need to collaborate [149].

In regards to the evolving of partnerships, Austin found that most of the partnerships he studied went through three stages of development that he terms *"the collaborative continuum."* According to Austin, there is a distinctive pattern in the types and evolution of relationships. As an analytical framework, he conceptualizes these as the cross-sector collaboration continuum along which there are three types and stages of relationships. *"Recognizing that relationships can evolve along this continuum, forward or backward,"* he says, *"is a useful strategic tool for managers who are assessing what type of relationship they're in and considering if and how they should progress to the next stage."* It is important to note that progression along the continuum is not automatic; it is the result of explicit decisions and actions by the partners. According to Austin, the evolving of partnerships can roughly be divided into three stages, namely [7]:

> *1) Philanthropic Stage:* According to Austin, this is the most common type of relationship between businesses and nonprofit organizations. This stage is mainly characterized by annual corporate donations of money or goods made in response to requests and fundraising by nonprofit organizations. The level of engagement and commitment is fairly low, simple, non-strategic and infrequent. The commitment of for profits is more of charity character, and a part of an effort to market the company as a caring, responsible institution. The recipients have a grateful attitude may be marketed as credible organizations meriting support.

*2) Transactional Stage:* A significant number of firms and nonprofits have transcended into this second stage characterized by a two-way value exchange. Hence, a simple transfer of funds is not sufficient in this stage; the organizations' core capabilities begin to be deployed and the partnership is more important to each other's missions and strategies. This stage entails for instance such activities as cause-related marketing programs, special projects and events including event sponsorships, and employee volunteer services.

3) Integrative Stage: The third stage encompasses strategic alliances that involve deep mission mesh, strategy congruency, and values compatibility. A smaller yet growing number of collaborations are evolving into this type of partnerships, where people begin to interact with greater frequency and many more kinds of joint activities are undertaken. Here, the core competencies are not simply deployed but combined to create unique and high value combinations and outcomes. The alliances begin to take appearance of a joint venture as the degree of organizational integration increases, and in some cases the parties have founded new, jointly governed entities to carry out their collaboration. Finally, at this stage the collaboration may at times involve market developments and internal organizational marketing.

#### 2.3.2.4. Possible Benefits of Cross-Sector Collaborations for Private Actors

All collaborations are clearly not of philanthropic nature. According to Austin, the need to partner (in order to enable both economic- as well as social goals), is shifting many cross-sector alliances from pure philanthropic to more integrative collaborations [7]. Not for profit organizations and governments are able to provide the alliance and the company with credibility, local connections, field experience and access to health structures as well as infrastructure, whereas private companies possess financial means and managerial skills etc.. Furthermore, according to Doz and Hamel, cross-sector collaborations could create internal value and direct benefits through co-optation, co-specialization and through expanding information networks and exchange of expertise and knowledge [55].

According to some research, one of the main benefits from partnerships is the gain in intangible assets. One normally may think of a successful company as one that effectively protects, stewards and expands capital, whether it is financial, human or natural. But one may also look at capital through the lens of intangibles and ask: How do intangibles relate to different forms of capital, where capital is an asset capable of yielding a future stream of benefits. For this purpose, intangible assets have been divided into 4 groups [261] [262]:

1. Human capital - knowledge assets, leadership
2. Organizational capital - communications, strategy
3. Market capital - reputation, brand development, alliances and networks, adaptability
4. Innovation capital - R&D capability, technology

Furthermore, some preliminary data, on experienced benefits through specific cross-sector partnerships, was published in the Review of the best Practices in the Health Sector by the Water and Sanitation Program of the World Bank [199]. Some of the benefits experienced by the industry were enhanced image as a global corporate citizen, market development with shared risk, staff motivation and retention, access to public infrastructures to stimulate markets, access to national and international research and knowledge, just to mention a few.

#### 2.3.2.5. Factors Contributing to Success of Cross-Sector Collaborations

According to Reich little is known about conditions when partnerships succeed, despite the vast number of cross-sector collaborations that exist [167]. It is generally recognized, however, that such collaborations may allow innovative strategies for well-defined public health goals, and powerful mechanisms for tackling difficult problems by leveraging ideas, expertise of different partners and naturally through an expanded and diverse pool of resources. The dominant trend in CSR and partnerships is to provide finances or services that reinforces a firm's core strategy. Diana Barret claims that the greater the value and the more balanced the mutual benefit, the stronger the alliance [10]. Similarly, preliminary studies of PPP and cross-sector

partnerships have shown that, in order for them to be successful, they must be based on win-win partnerships, where both partners have an interest in carrying out mutually agreed-upon activities [199].

According to Pearce and Doh in the MITSloan Management Review, there are five principles of successful collaborative social initiatives: (1) Long term commitment, (2) Contributing with products and services that are based on the firms core operation, (3) Cooperation, (4) Weighing Governments influence and (5) Putting a price on the total benefit package [160]. Furthermore, partnerships confront seven organizational challenges, "the seven Cs" [7] (table 3).

**Table 3. The seven C's of strategic collaboration according to Austin [7]. (Source: Austin, 2000).**

| **The seven C's of strategic collaborations** |
|---|
| Clarity of purpose |
| Congruency of mission |
| Creation of value |
| Connection with purpose and people |
| Communication between partners |
| Continual learning |
| Commitment to the partnership |

*"Of particular importance is the challenge of creating value. To assure a sustainable collaboration, the value created must be useful to society, and value must flow to all core partners. In addition, creating a partnership is a continual learning process, with the potential of unexpected lessons. For example, participating in the ITI partnership on Trachoma led the Clark Foundation to rethink its core work in philanthropy – to view its activities more in the form of long-term investments than short-term grants "*according to Michael Reich [268].

According to Marcel Tanner, whatever the various strategies in strengthening health systems, including partnerships, what is essential, in his view, is that the levels of need and the interventions required are identified [194]. This is not always trivial. Indeed, in her preliminary findings, Gehler asserts that the existing collaborations are often not need/demand driven. According to her studies, the following factors could potentially contribute to a better cross-sector collaboration involved in Drug donations in Tanzania: improvement of (1) quality of drugs, (2) communication between donor and recipient, (3) identification of needs and (4) the active participation of recipients [78].

While Austin's research underscores the importance of ensuring a good fit and alignment between partners' missions, strategies, and values, for a partnership to succeed, he also found that leadership is frequently of high importance in the development of cross-sector alliances. Strategic unions "need champions, or internal entrepreneurs at high levels on both sides who largely determine the acceptance and vigor of the collaboration," he writes. Finally, Austin emphasizes that the amount of value that's being created through the collaborative process is an underlying factor determining the sustainability and power of a partnership [7].

#### 2.3.2.6. How to Assess the Effectiveness and the Value of Cross-Sector Collaborations

“ The value of an alliance - or any initiative, program or any relationship for that matter - cannot be measured without defining success. And while measurement is often met with scorn and is underutilized in strategic decisions, an outcomes-based approach transforms the traditional relationship between measurement and strategy. This approach puts aside the task of measurement and focuses on the action of measuring value. Actively measuring value as opposed to engaging in the measurement of activities is very different – it requires a focus on outcomes, the use of indicators that are both practical and meaningful, and a tightly closed loop between performance data and strategic management decisions” [207].

Given this complexity, measuring the value of collaboration or its effectiveness

becomes challenging. While the demand to measure the value of alliances is great, the obstacles to doing so are perceived as equally daunting. The solution lies in adopting a new approach to measurement that not only enables partners to measure alliance value but also reveals critical insights as to alliance strategy and the next generation of strategic alliances. This approach relies on three critical tenets: a focus on outcomes, metrics that matter, and a strategic shift toward alliances built on shared interest [207].

Drawing on David Easton's famous definition [56], effectiveness is defined along four distinct dimensions: output, outcome, impact and goal attainment [205] [246] [247]. Derived from mentioned definition of effectiveness, together with Diana Barret's claim that "*the greater the value and more balanced the mutual benefit, the stronger the alliance*," or the win-win paradigm by Thomas and Curtis [199], success is here defined by outcome, rather than by activities, similar to that of USAID. In other words, success is defined by value creation to all parties and by sustainability (the achievement of long-term commitment).

As no tool that measures the value of cross sector collaborations exists to date, one of the major objectives of this work is to develop a preliminary tool that assesses the value of a cross-sector collaboration through the analyzing of the formed organizational culture and created intangible assets through such partnerships. It will be designed to monitor organizational performance against strategic goals and to serve as a preliminary evaluation tool and guide for organizations immersed in cross-sector collaborations.

#### 2.3.2.7. Organizational and Ethical Challenges of For Profit Firms' Involvement in PPP/Cross-Sector Collaborations and CSR, and Their Impact on the UN System

PPPs are at the top of many agendas in the field of international public health these days. When the market fails to distribute public good and services such as products and services that maintain or restore health to those that need them the most, especially to the poor in developing countries, PPPs are often regarded as innovative alternatives and approaches that allow desired outcomes to be achieved. These

partnerships or collaborations, however, also bring their own problems and may at times be fairly controversial. Health activists and researchers, for instance, have at times *"criticized partnerships for diverting resources from public actions and distorting public agendas in ways that favor private companies"* [167]. At the same time, the rules of the game of PPPs may be malleable, fluid or even ambiguous. *"Since no single formula exists, constructing an affective partnership requires substantial effort and risk. How then do organizations with different values, interests, and worldviews come together to address and resolve essential public health issues? Who sets criteria for evaluating success of PPP and with what kind of accountability and transparency?"* [167]

Through its Guidelines on Interaction with Commercial Enterprises, WHO is tackling the ethical issues of PPPs and addressing its own role in such collaborations [257]. The Guidelines, however, have been criticized by some activist groups like the Health Action International, for paying scarce attention to the reduction of conflicts of interest. Furthermore, Kent Buse and Gill Walt, have expressed serious concern about PPPs and their potential impact of partnerships on the UN [29]. The authors argue that partnerships *"often circumvent the organizations of the UN" and "may even threaten ... unique characteristics of the UN."* In particular, they are worried about the accountability of partnerships, their effect on global standards and norms decided by UN agencies, and the potential negative effect on global inequities (by focusing on easily achievable goals rather than on high hanging fruit and more complicated issues). According to Buse and Walt, one solution could be a regulatory framework established to *"differentiate between acceptable and unacceptable"* partnerships [29].

Furthermore, Buse and Walt call for efforts to strengthen the coordination and protection of the UN system's function as a global governor in health, including all partnerships within the UN system. They propose mechanisms of regulation to assure UN control of the agenda in international health. A contrasting viewpoint views the UN system as highly fragmented and competitive among its different agencies, and therefore proposes for PPPs to fill in gaps that are not covered by the UN system. This viewpoint considers the UN system to be too centralized, controlling and ineffective to cover all roles. This debate reflects *"fundamental questions about the kind of global health governance that is most desirable for international health:*

*centralized versus decentralized control, international regulation versus other forms of intervention, mechanisms to assure the accountability of corporations and international agencies, and the compatibility of the core values of public and private sectors"* [29].

Private actors have gained authority in global politics because corporate contributions to global public goods have become a significant feature of global regulation [42]. As such, corporations are no longer merely economic but also political actors because they engage in the design, implementation, and enforcement of rules [178] [143]. In this "political" role, however, the question raises regarding the legitimacy of private actors to fulfill such public functions [159] [187], as corporations, in contrast to public actors, aren't directly legitimized through democratic elections. As opposed to democratically legitimized public actors, corporations need to acquire legitimacy through alternative mechanisms [14]. Corporations are, however, struggling to build corporate legitimacy through current CSR practices and even corporations that engage in a large number of CSR activities often face tremendous public criticism; this situation gives rise to the question, how corporations implement CSR in a way that allows democratic oversight and also fosters their organizational legitimacy? The "legitimacy" of corporations is regarded as a critical resource for its "license to operate". Corporations are source-dependent, so in an increasingly heterogeneous environment to operate in a manner that is perceived as legitimate is vital for their survival [12] [158]. The legitimacy question does therefore represent a serious challenge for management and CSR practice also within the context of PPPs.

Rising criticism of CSR initiatives may on one hand result from issues regarding the potential diversion of resources, conflicts of interest, the mentioned ambiguous interpretation of the CSR-concept, accountability and legitimacy. On the other hand, the lack of data about the impact and actual value of CSR in form of PPPs [207] and the lack of empirical assessment methods and tools of CSR implementation, have also been subject to criticism. To date the only existing preliminary impact analysis of the UN Global Compact (UNGC) initiative, for instance, does not systematically develop criteria to assess the organizational implementation of CSR, relying instead on survey-based data that provide a broad overview of the significance of the UNGC to the participating companies [137] [138] [204].

Existing assessments are only weakly linked to theoretical concepts. Popular sustainability indexes (e.g. Dow Jones Sustainability Index, FTSE4Good, Good Company Ranking) passively analyze company data according to a set of indictors that are intuitively valid for measuring the state and the progress of implementing CSR, but which are not systematically derived from a theoretical framework and a clearly defined CSR concept such as e.g. Scherer's and Palazzos "political conception of CSR" [179]. Other sustainability rankings, such as SAS for Sustainability Management or the research by rating agencies, like Innovest or Oekom Reseach, also fall victim to methodological shortcomings. In conclusion, existing tools fail to effectively assess CSR implementation. Consequently, there is a need for tool and data on which the analysis or current CSR implementation can be based [12], just like there is a need for data and appropriate metrics for measuring the value of PPPs [207].

PPPs do indeed raise important questions regarding national and international social policy as well regarding the appropriate role and involvement of the private sector in public health. As global challenges such as poverty, climate change, and lack of access to drugs cannot always be mastered effectively by national political systems whose regulatory power is limited to their national jurisdiction, a new mode of government is required to define and implement standards of behavior with global reach [74] [87]. "Global Governance," as an emerging form of transnational regulation, combines the efforts of public actors such as national governments and international governmental institutions and private actors such as Non-Governmental Organizations (NGOs) and corporations [143] [169] [170]. This is of particular importance in developing countries such as Ethiopia, where the government largely fails to provide its population with sound healthcare services, but where existing CSR efforts in form of PPPs struggle to implement complementary strategies that are equitable as well as sustainable, and that avoid duplications and diversion of resources.

| Name | Interventions | Partners | Impact |
|---|---|---|---|
| Global Alliance for Vaccines and Immunization (GAVI) | Improve donor collaboration, strengthen national immunization services, provide low-cost vaccines, and support research for developing new vaccines primarily in the developing world (i.e., for Malaria, HIV). | Bill and Melinda Gates Children's Vaccine Program, International Federation of Pharmaceutical Manufacturers Association, public health and research Institutions, national governments, the Rockefeller Foundation, UNICEF, the World Bank and the WHO. | Outcome-based grants introduced, US$ 300 million committed to government health programs in 21 developing countries, the partnership extended a new vaccine procurement system developed that has reduced vaccine prices, created a viable marker in poor countries for sophisticated vaccines (GAVI). |
| Roll Back Malaria (RBM) | Subsidized drug development, production and distribution as well as the promotion of insecticide- treated nets. | UNDP, the World Bank, London School of Hygiene and Tropical Medicine (LSHTM), Academy for Educational Development (AED), USAUD, Schools, lending agencies, development agencies, initiatives such as NetMark and Medicines for Malaria Venture (MMV). | Greater awareness and availability of insecticide-treated nets and antimalaria drugs, research on resistant treatments (ITNs in the 21st Century 1999). |
| Salt iodization Pakistan | Increase iodized salt consumption to combat iodine deficiency. Generate a demand for and increase the production of iodized salt though social marketing. | UNICEF, CIDA, Population Services International (PSII), Social Marketing Pakistan (SMP), Government of Pakistan. | Over 30% of all edible salt is now iodized. Approximately 35 million people are new users of iodized salt (www.psi.org). |
| PHASE | Include hygiene/sanitation education in community activities, school, and local organizations to reduce worm-related diseases/infections. | GlaxoSmithKline, Ministries of Health and/or Education, local NGOs. | Greater awareness of worm infestations, prevention and treatment (GSK 1998) |
| NetMark | Prevent malaria in Africa by promoting insecticide-treatment materials. | AED, Malaria Consortium, John Hopkins University, Department of International Health, Group Africa | Increased understanding of market segmentation, consumer behaviors and private sector concerns (NetMark). |

**Table 4:Examples of PPPs in the health sector: their aims, partners, and impact according to Thomas & Curtis (Source: Thomas and Curtis, 2003) [199]**

## 2.4. Healthcare and Blindness in Ethiopia

As our case-study *"My Project Vision – For people with Insight"* is set in Ethiopia, with the aim to restore the vision of more than 2000 people affected by cataract, and therefore to ameliorate the burden of blindness on the individual as well as on society as a whole, the reader will briefly be introduced to some basic information on Ethiopia, and to healthcare and blindness in particular.

### 2.4.1 General Information About Ethiopia

#### 2.4.1.1. Introduction

Ethiopia, located in the North Eastern part of Africa, also known as the Horn of Africa, lies between 3 and 15 degrees North latitude and 33 and 48 degrees East longitude. With a total area of around 1.1 million square kilometers, it borders with five countries - Eritrea in the north, Djibouti in the east, Sudan in the west, Kenya in the south and Somalia in the southwest. The size of the country and its location has accorded it with diverse topography, geographic and climatic zones, and resources.

Demographic momentum, influenced by a slowly declining fertility rate, suggests Africa's population as a whole could swell to about 1.45 billion by 2030. Although fertility has declined, from 6.8 in 1970 to 5.4 in 2004, Africa still faces significant challenges in terms of population growth, including natural resource availability, access to education, urban migration, and employment opportunities. Ethiopia's population has been growing at a rate of 2.7% p.a. or by an increment of 2 million persons annually (Federal Republic of Ethiopia Ministry of Health 2010). With a total population of 77 million (table 5) in 2006 [223], it has become the second most populous country in Africa, following Nigeria. Half of the population (50.1%) is female. The average household size is 4.8. Out of the total population, 85% lives in rural areas, making Ethiopia one of the least urbanized countries in the world. As in many other developing countries, the rate of growth of the urban population (4.1%) is higher than that of the total population growth rate of 2.7%. Rapid population growth

exacerbates critical gaps in basic health services [64].

The literacy status of the Ethiopian population is low and this has marked influence on the spread of diseases, the acceptability of health practices and utilization of modern health services. The total adult literacy rate is 36% (46% for males and 25% for females). The gross enrollment ratio in primary schools at national level is 68.4% (59.1% for girls). Although more than triple from the 20% enrollment level of 1994, it is still much lower than the Sub Saharan Africa average of 86%. This makes the population more at risk of preventable diseases including HIV/AIDS [64].

| | |
|---|---|
| Total population: | 77,431,000 |
| Gross national income per capita (PPP international $): | 810 |
| Life expectancy at birth m/f (years): | 49/51 |
| Healthy life expectancy at birth m/f: | 41/42 |
| Probability of dying under five (per 1 000 live births): | 166 |
| Neonatal mortality m and f (per 1 000 population): | 55 |
| Infant mortality m and f (per 1 000 population): | 110 |
| Maternal mortality (per 100 000): | 850 |

T**able 5: General country information. (Source: WHO, 2006).**

### 2.4.1.2. Socioeconomic Aspects

Ethiopia is one of the least developed countries in the world with an estimated per capita income of US$100. Poverty is pervasive with 47% of the population estimated to live below the poverty line. The UNDP's Human Development Index (HDI) for 2004 ranks Ethiopia 170 out of 177 poorest countries and its HDI is estimated at 0.309. When adjusted for gender differences, the HDI in Ethiopia drops slightly to 0.297 reflecting some gender inequality. The Government has been implementing a comprehensive economic reform program over the past decade. This has had an important bearing on development in the health sector. Prior to 1991, economic policy was characterized by extensive government controls, macro-economic imbalances and restriction on private sector initiative all of which resulted in low economic

activity and persistent declines in economic growth. With a change of government in May 1991, new economic measures were put in for infrastructure development. In particular, health and education service delivery and investment in roads and water resources development were given prominence.

The policy environment created by the economic reform and macro-economic stability and growth helped to address poverty in a comprehensive way through the adoption of the Sustainable Development and Poverty Reduction Program (SDPRP), which is now instrumental in prioritizing poverty related health program targets. The Government is also committed to meeting targets set by global initiatives notably, the Millennium Development Goals (MDG) and the recommendations of the WHO Commission on Macroeconomics and Health (CMH) aimed at strengthening the link between improved health and economic development.

#### 2.4.1.3. Administrative Structure

The new Ethiopian constitution, introduced in 1994 created a federal government structure. The federal structure is composed of nine Regional States: Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Southern Nations Nationalities and Peoples Region (SNNPR), Gambella and Harrari and two city Administrations (Addis Ababa and Dire Dawa). The National Regional States and City Administrations are further divided into 611 woredas. Woreda is the basic decentralized administrative unit and has an administrative council composed of elected members. The 611 woredas are further divided into roughly 15,000 Kebeles organized under peasant associations in rural areas (10,000 Kebeles) and urban dwellers associations (5,000 Kebeles) in towns. With the devolution of power to regional governments, public service delivery, including health care, has to a large extent fallen under the jurisdiction of the regions. The approach has been to promote decentralization and meaningful participation of the population in local development activities. For administration of public health care, there is a Regional Health Bureau (RHB) at the regional level [64].

### 2.4.2. Health and Disease in Ethiopia

#### 2.4.2.1 The Burden of Disease

Ethiopia has a poor health status relative to other low-income countries, even in comparison to other Sub-Saharan countries. This dire health status is largely attributed to preventable infectious ailments and to nutritional deficiencies. Infectious and communicable diseases do indeed account for about 60-80% of the health problems in the country. The high burden of ill-health is further exacerbated by the shortage of trained manpower and health facilities or access to these facilities, as well as widespread poverty along with low income levels of the population, low education levels (especially among women), and inadequate access to clean water and sanitation facilities. Ethiopia has one of the highest infant and under-five child mortality rates in the world [223] (table 5). In addition, only 20 percent of children nationwide have been immunized against all six vaccine-preventable diseases: 1) tuberculosis, 2) diphtheria, 3) whooping cough, 4) tetanus, 5) polio, and 6) measles; and the percentage in rural areas is considerably lower. Since 47 percent of the population lives below the poverty line and income per capita is only around USD 100, most people cannot afford health care, and consequently the average life expectancy at birth remains only between 41 (see table 5) and 46 years [111].

***Malnutrition***

Average life expectancy at birth is also relatively low and poor nutritional status, infections and a high fertility rate, together with low levels of access to reproductive health and emergency obstetric services, contribute to one of the highest maternal mortality ratio in the world, which equals 850/100,000 live births (table 5). Malnutrition is widespread, especially among children, as is food insecurity. Because of growing population pressure on agricultural and pastoral land, soil degradation, and severe droughts that have occurred each decade since the 1970s, per capita food production is declining. According to the UN and the World Bank, Ethiopia at present suffers from a structural food deficit such that even in the most productive years, at least 5 million Ethiopians require food relief [121].

***Reproductive Health***

The poor health status in Ethiopia is further aggravated by the high population growth. Young people constitute one third of the total population in Ethiopia. This implies a profound reproductive health needs. The major reproductive health problems faced by the young population in the country are gender inequality, early marriage, female genital mutilation, unwanted pregnancy, closely spaced pregnancy, unsafe abortion, and Sexually Transmitted Diseases (STDs) including HIV/AIDS.

As of the end of 2003, the United Nations (UN) reported that 4.4 percent of adults were infected with human immunodeficiency virus acquired immune deficiency syndrome (HIV/AIDS); other estimates of the rate of infection ranged from a low of 7 percent to a high of 18 percent. Whatever the actual rate, the prevalence of HIV/AIDS has contributed to falling life expectancy since the early 1990s. According to the Ministry of Health, one-third of current young adult deaths are AIDS-related. The rural epidemic appears to be relatively widespread but heterogeneous. Recent studies suggest that the prevalence of HIV/AIDS is stabilizing in urban areas and increasing gradually in rural areas. In general, HIV incidence is leveling off after declining over the last few years.

***Tuberculosis (TB)***

Africa has the highest estimated incidence of tuberculosis (TB) worldwide. TB kills 500,000 Africans each year, or nearly 1,500 people per day. Ethiopia ranks seventh among the world's 22 high-burden tuberculosis (TB) countries. According to the World Health Organization's (WHO's) Global TB Report 2009, the country had an estimated 314,267 TB cases in 2007, with an estimated incidence rate of 378 cases per 100,000 population. The number of TB cases is likely to increase as Ethiopia's HIV/AIDS epidemic expands, as Co-infection with HIV exacerbates TB infection and transmission.; while 16 percent of notified TB patients tested for HIV, 40 percent are HIV positive [206].

***Malaria***

Malaria remains as the major causes of morbidity as well as mortality in the country. A study conducted in year 2001 indicated that only 31% of cases of fever seen in health facilities were properly managed; only 7% of children with malaria received early diagnosis and treatment and the case fatality rate was 5.2%. Although there is an encouraging result in the rate of progression of the epidemic in the last few years, the rate is not slow enough to be complacent. Given the size of the population and the magnitude of damage already inflicted, it will take a number of years to see a noticeable decline in the socio-economic impact of the disease. Likewise, despite the advances in management of the epidemic and the increasing resource availability, the condition faced is still far from the ideal, one which is unlikely to give respite in the near future [64].

#### 2.4.2.2. Health Care Systems and Delivery

One of sub-Saharan Africa's major challenges is to provide universal coverage of quality health services to its approximately 750 million people, especially to the poorest and most vulnerable. Metrics of health in the Sub-Saharan country of Ethiopia are among the world's worst. According to the U.S. government, Ethiopia's health care system is wholly inadequate, even after recent improvements [121], with the government being the main modern health care provider. According to the head of the World Bank's Global HIV/AIDS Program, Ethiopia has only 1 medical doctor per 100,000 people. However, the World Health Organization in its 2006 World Health Report gives a figure of 1936 physicians (for 2003), which comes to about 2.6 per 100,000. Furthermore, there are only 119 hospitals (12 in Addis Ababa) and 412 health centers in Ethiopia [271].

Throughout the 1990s, the government, as part of its reconstruction program, devoted ever-increasing amounts of funding to the social and health sectors, which brought corresponding improvements in school enrollments, adult literacy, and infant mortality rates. These expenditures stagnated or declined during the 1998–2000 war with Eritrea, but in the years since, outlays for health have grown steadily. In 2000–2001, the budget allocation for the health sector was approximately US$144 million; health expenditures per capita were estimated at US$4.50, compared with US$10 on

average in sub-Saharan Africa. In 2000 the country counted one hospital bed per 4,900 population and more than 27,000 people per primary health care facility [121].

There have been encouraging improvements in the coverage and utilization of the health service over the periods of implementation of Health Sector Development Plan (HSDP). HSDP constitutes the health chapter of the national poverty reduction strategy and aims to increase immunization coverage and decrease under-five mortality at large. The health service currently reaches about 72% of the population and The Ministry of Health aims to reach 85% of the population by 2009 through the Health Extension Program (HEP). The HEP is an innovative health service delivery program that was introduced by the government in 2003, as part of the primary health care service, designed to deliver health promotion, immunization and other disease prevention measures along with a limited number of high-impact curative interventions [60].

Nevertheless, health care is disproportionately available in urban centers; in rural areas where the vast majority of the population resides, access to health care varies from limited to nonexistent. The coverage distribution highly favors urban areas and there is a very high unmet healthcare need in rural Ethiopia that needs to be addressed through rapid expansion of Primary Health Care services. Expansion in terms of improving physical availability of essential health services will reduce distance between facilities and users. Cognizant of these facts, the accelerated expansion of Primary Health Care Coverage Strategy has already been developed and endorsed by the government with a view of achieving universal coverage of primary health care to the rural population.

The core strategy for bringing the primary health care services closer to the villages is the construction and rehabilitation of health facilities. Through the Health Extension Program (HEP), new health posts are continuously being constructed, rehabilitated and equipped as well as staffed. In order to assure sufficient educated staff, training programs for heath professionals in 11 Technical and Vocational Education Institutes/Centers have been created under HEP. In addition, a new task-shift paradigm is called for in order to prevent “brain drain potentials,” not only out of the entire country, but also brain drain from rural areas into the Addis Ababa. As of

December 2008 a total of 11,446 health posts had been constructed and 3,576 were planned to be constructed by the end of 2009, against the overall target of 15,000 health posts. Similarly, from the total required health posts, 5,106 of them have been fully equipped with a plan to equip 9,916 by the end of 2009. To achieve the planned universal primary health care coverage, Federal Ministry of Health aims to have 3,200 health centers in place by 2010. As of July 2010, a total of 2,104 health centers were available nation-wide. The Government has committed to fully finance the construction of 2,951 additional health centers, over 695 of which are currently under construction [64].

***PPPs***

In addition to disease, floods, droughts, and conflict have interrupted development, compromised political stability, and plagued African states, including Ethiopia, for decades. Inadequate management and fragile health systems limit services to millions of poor families. Complementary services provided by faith-based (FBO) and other nongovernmental organizations fill only part of the service delivery gap. Although clear opportunities exist for sound and strengthened PPPs, policy-makers and the private sector struggle to identify and implement complementary strategies that are equitable and sustainable. Most African policymakers agree that fully engaging the private sector is a strategic priority because both the rich and poor routinely access and pay for health services in the formal and informal sectors. Thus, PPPs are being increasingly encouraged as part of a comprehensive development framework.

On December 6, 2007, the Global Health Initiative and the Africa Program at the Woodrow Wilson International Center for Scholars hosted a forum with the support of Pfizer, Inc. on the health imperatives for Africa and Sub-Sahara in particular, and the need for the public and private sectors to cooperate in the provision of healthcare. The discussion included representatives from the public and private sectors, as well as non-governmental organizations (NGOs), foundations, multilateral organizations, and universities. It was concluded that African health care systems face daunting challenges, and most Africans depend on public health services that are hobbled by inadequate budgets, under- investment in physical infrastructure, and insufficient numbers of trained health care providers.

Most African countries also lack complementary PPPs and well-functioning private markets for health care delivery. These institutional weaknesses make it difficult for countries to respond effectively to communicable and non-communicable diseases that affect tens of millions of citizens. *"Health in Africa is not going to be solely a public sector responsibility,"* said Victor K. Barbiero, professor at the George Washington University School of Public Health and Health Services and Global Health Initiative senior advisor [11].

*"A combination of a global call to action against the diseases ravaging Africa, and ineffectiveness and inefficiency on the part of the public sector in providing public goods in particular in Africa, led to the birth of PPPs,"* explained Dr. Akudo Ikemba, Director of Friends of the Global Fund Africa.. "Public-private partnerships are really supposed to leverage a tremendous amount of money and skill from the various partners to combat these diseases," she said. However, major funding gaps – of $20 billion per year – still exist for AIDS, TB, and malaria. In addition to inadequate funding, Ikemba highlighted other challenges faced by PPPs, including governance, harmonization, conflict of interest, and effectiveness and efficiency. System efficiencies—including management, organization, resources, and staff—need to be improved. Moreover, PPPs must evolve to include the private-for-profit, NGO, FBO, civil society, and government sectors. The PPPs require rigorous evaluation and a broad dissemination of scaled success to define best practices and provide actionable models that can be widely implemented including the expansion of out-reach programs to underserved populations in rural regions [98].

### 2.4.3. Blindness in Ethiopia

#### 2.4.3.1. Introduction

The burden of blindness[13] in the Sub-Saharan Africa (SSA) is the worst of all the regions of the world. The prevalence of blindness is here 10-20 times greater than in the developed ones. The current (2006) National Survey Results [63] have shown that the prevalence of blindness and low vision in Ethiopia is among the highest in the

Sub-Saharan Africa. The survey which was carried out by the Ministry of Health together with various NGOs such as Orbis International, CBM, ITI and the Carter Center, showed that the national prevalence of blindness was 1.6% in 2006 (table 4), as compared to approximately 0,5% on a global scale (London School of Hygiene and Tropical Medicine Planning for Vision 2020 course, unpublished data). The national prevalence of low vision was 3.7% with considerable regional variations. The low prevalence in the B-Gumuz was attributed by the survey team to the presence of large number of healthy immigrants from the neighboring areas in the Sudan into the survey villages.

**Table 6. Prevalence of blindness according to region in Ethiopia. (Source: National and Regional Prevalence of Blindness and Low Vision based on presenting visual acuity. National Blindness and Low Vision Survey, 2005-6).**

| Region | Prevalence of Blindness (%) | Low Vision (%) |
|---|---|---|
| Tigray | 1.5 | 2.9 |
| Afar | 1.2 | 2.7 |
| Amhara | 1.4 | 4.9 |
| Oromiya | 1.6 | 3.1 |
| Somali | 5.4 | 9.7 |
| B-Gumz | 0.8 | 0.7 |
| SNNPR | 0.7 | 2.0 |
| Gambella | 1.7 | 3.4 |
| Harrari | 2.2 | 2.2 |
| Addia Ababa | 1.4 | 2.7 |
| Dire Dawa | 1.7 | 3.1 |
| **National (Weighted)** | **1.6** | **3.7** |

As expected, people above the age of sixty year had the highest prevalence of both blindness and low vision, yet it is important to note that the prevalence of childhood blindness was 0.1%, (accounting for over 6% of the total blindness burden nationwide). It is also note-worthy that in addition to rural residents, females in

[13] Blindness is defined as vision acuity of less than 3/60 in the better eye (WHO).

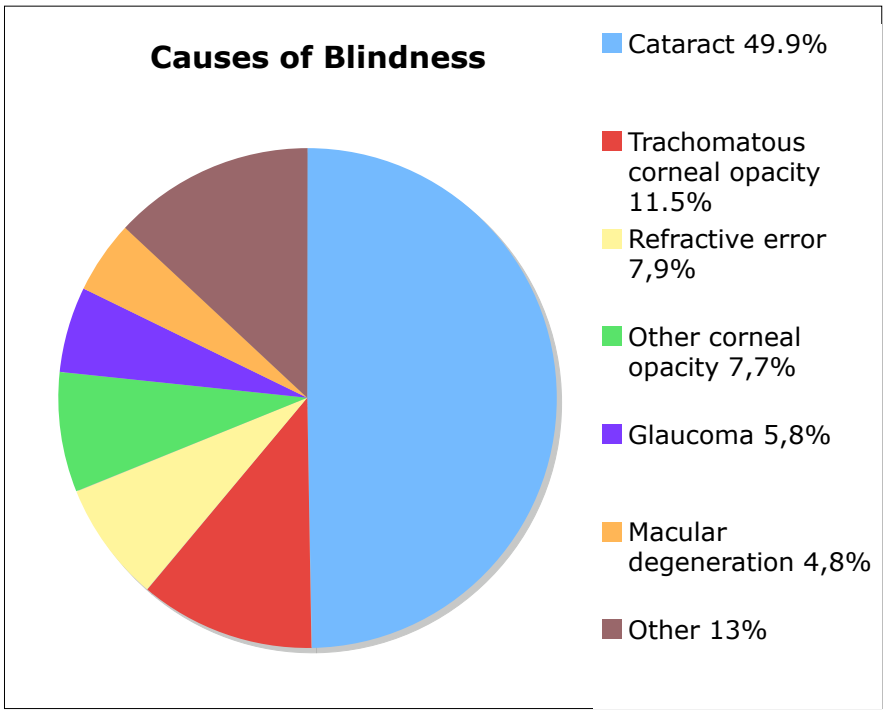
general carry greater risk for eye problems. Although age is a biological risk factor gender and residency reflect on the social inequalities in promoting health and accessing health services. Emphasis needs to be given to minimize the gender differences.

#### 2.4.3.2. Causes of Blindness in Ethiopia

Cataract is the leading cause of blindness in the world with approximately 600,000 new cases of blinding cataracts in Sub-Sahara occurring each year (see figure 5). Cataract is easily diagnosed and some 80 % of the cases leading to blindness are treatable. The therapy, which is of surgical nature, is inexpensive and technically simple. It is the most frequently performed operation in the world with one of the highest success-rates. One surgery can be financed with as little as $ 5, and if the lens is replace with an artificial one, the cost will amount to be ca. $35-$50 according to the World Bank [242]. Several NGOs have been involved in directly financing cataract surgeries in Ethiopia. Other NGOs such as Orbis international, CBM and Carter Center have put an emphasis of sponsoring equipment, personnel and medications needed for the treatment of cataract.

Other major causes of blindness in Ethiopia are Trachoma and River Blindness (see figure 5). Although Trachoma is preventable, the resources to fight the disease have not always been available. Pfizer has taken important action to fight the infectious disease through their partnership with Edna McConell Clark foundation [164]. Pfizer has committed to donate more than 35 million doses of Zithromax (Azithromycin), which is a single-does oral treatment of Trachoma [241]. River Blindness, on the other hand, can be treated with on annual dose of Ivermectin. Merck has launched a public/private partnership program: Merck Mectizan Donation Program, which is the single largest, longest standing partnership of its kind. Merck has provided more than one billion tablets of Mectizan (Invermectin) free of charge to people affected by river blindness. Merk´s commitment is of long term, and it aims to donate as much Mectizan as necessary to treat river blindness in affected geographic areas [142].

**Figure 5. Causes of Blindness in Ethiopia [63]. (Source: National Blindness and Low Vision Survey of Ethiopia, 2005-6).**




### 2.4.3.3. Eye Care and Treatment of Blindness

The National Programme for the Prevention of Blindness started in 1976 as Ethio-Italian Trachoma Control Project. In 1986, the project was up-graded to a comprehensive National Programme for the Prevention of Blindness (NPPB). The National Committee for the Prevention of Blindness (NCPB) was also established in the same year (1986). However, the NCPB was interrupted for 10 years and re-established in 1996. The committee was strengthened in February 2001 by electing a new Executive Committee and Sub-Committees. The programme is coordinated by 2 experts/ health professionals in the Diseases Prevention and Control Team of the Diseases Prevention and Control Department of FMOH and by one WHO National Professional Officer (NPO). The FMOH also serves as Chairman and Secretariat for the NCPB. Finally, Ethiopia embarked in the Vision 2020 initiative in September 2020 as described in the following chapter.

Currently there are two training programmes for ophthalmologists at Addis Ababa and Jimma Universities under the umbrella of Vision 2020. There are also three

cataract surgeons training programmes at Gonder, Jimma and Hawassa Universities. In addition, there is also one ophthalmic nursing course (BSc) at Gonder University and 2 ophthalmic nursing programmes/schools, in Addis Ababa (ALERT) and Tigray (Quiha).

All government eye care services in the country are an integral part of the overall health care system. Currently there are 46 primary and 25 secondary eye care units (non-private) and one tertiary center in the country. The available eye care personnel in Ethiopia are: 80 ophthalmologists, 4 cataract surgeons, 121 ophthalmic nurses and Ophthalmic Medical Assistants (OMAs ). The distribution of eye care workers in the country is uneven. Currently around 70% of all ophthalmologists work in the capital city (Addis Ababa). Hence, eye care services are extremely limited throughout the country, particularly in rural areas.

In conclusion, blindness and low vision are major public health problems in Ethiopia. According to the National Blindness and Low Vision Survey 2006, a large proportion of low vision (91.2%) and blindness (87.4%) are due to avoidable (either preventable or treatable) causes. Females and rural residents carry greater risk for eye problems. Active Trachoma and Trachomatous trichiasis (TT) are concentrated in the regions of the country with high population density; namely the Amhara, Oromia, and SNNP regional states. The burden of eye disease estimated from the survey is believed to pose huge economic and social impacts on individuals, society and the nation at large. The demand on health services/resources (cataract surgery, TT surgery, and trachoma mass treatment with Azithromycin) is also tremendous. Therefore, it is critical to recognize the severity of the problem of blindness and low vision and enhance the government commitment to improve the situation according to the National Blindness and Low Vision Survey 2006 [63].

#### 2.4.3.4. Vision 2020 – Right to Sight

The World Health Organization (WHO), the International Agency for the Prevention of Blindness (IAPB), a coalition of NGOs and private firms have launched a global initiative, Vision 2020: the right to sight, which aims to eliminate preventable

blindness and increase the rate of cataract surgeries by 2020. The overall aim is to eliminate the main causes of avoidable blindness and to prevent the projected doubling of avoidable vision impairment between 1990 and 2020. From the outset, it has been clear that the goal of eliminating avoidable blindness would best be achieved by integrating an equitable, sustainable, comprehensive eye-care system into every national health system.

The Vision 2020 initiative is intended to strengthen national health-care systems and facilitate national capacity-building. Vision 2020 is built on a foundation of community participation. Overarching issues, such as equity, quality of services and visual outcomes, are addressed as part of national programs. Although the supranational taskforce for Vision 2020 is responsible of advocacy together with WHO ad IAPB, the actual planning is done on a national level by national programmes together with respective ministries of health and NGOs. Furthermore, the execution takes place n district levels allowing decentralization of power and community participation.

Vision 2020 has been remarkably successful on a global scale. At the starting point of the project, the goal was to reduce the prevalence of blindness to less than 25 Mio as opposed to the projected estimate of 75+ Mio by the year 2020. All together, this would save an estimated 100 Mio people from going blind and 400 Mio person years of blindness resulting in an expected economic saving of over $150 billion between 2000 and 2020 [71]. Today, the blindness prevalence target of 40 Mio set for 2010 has actually been met, as the global blindness prevalence is approximately 39 Mio (unpublished data). Cataract, the leading cause of blindness is still a dominant issue, but Oncoceriasis and corneal opacity due to vitamin A deficiency, for instance, are becoming marginal as the prevalence of these diseases have diminished radically following the global initiatives and PPP such as the Mecitzan Donation Programme combating these diseases.

According to Hansjörg Baltensberger, one of the catalysts of *"My Project Vision – For people with Insight"* and the chairman of the Vision 2020 committee in Switzerland, the initiative has played a significant role in combating blindness also in Ethiopia. Ethiopia, as member state of the United Nations, supports the resolutions of

the World Health Assembly on the elimination of avoidable blindness globally, and has signed the Declaration of Support for VISION 2020. The first National Five- Year Vision 2020 Strategic Plan for Eye Care was implemented as of 2002, according to the WHO Guidelines, and in line with the Health Sector Development Programme (HSDP). Cognizant of the burden of the problem, the Federal Ministry of Health has assigned experts under the Diseases Prevention and Control Department to specifically coordinate all eye care activities in the country. In addition, the Ministry of Health also encourages the Regional Health Bureaus to assign appropriate experts to coordinate the implementation of eye care activities in their respective regional states.

#### 2.4.3.5. My Project Vision – For People With Insight

*"Project Vision-For People with Insight"* (mPV) is an aid initiative within the context of Vision 2020, and aims to serve as a nexus, or catalyst, between financial sponsors and for profit participants in Europe (Switzerland and Germany) and local healthcare staff, patients and facilities, associated with a well-established NGO in Ethiopia (namely Christoffel Blinden Missions - CBM). The entire venture is active under the umbrella of the Tigray Regional Health Bureau within the framework the Tigray Prevention of Blindness (PBL) program. Together with the for-profit firms (including SBB, Executive Insight, HRIAG, Gepard GmbH, MKorb, Erat Design Group edg) and the NGO, the local staff is actively involved in the planning and elaboration of the project plans and executions. The main role of mPV is to serve as an inter-mediatory platform that promotes contact between the NGO and the for-profit firms and sponsors of cataract surgeries, as well as the health-care staff and the regional health bureau in Ethiopia. The money provided by the sponsors is directly used to finance cataract surgeries in Ethiopia.

In brief, the sub-Saharan region was chosen due to its extremely high rate of treatable blindness, where the burden of blindness is the worst of all the regions of the world, combined with the region's inequity and incapacity to deliver the required treatment. Cataract was targeted in this project, as it is the leading cause of blindness in the world, and since it is easily treatable and one of the most successful and cost-effective

health interventions of all. In addition, cataract is highly debilitating and indirectly often leads to death, but once cured, the affected individuals are enabled to "help themselves," and continue securing their livelihood or practice their professions.

Although the principal and most important aim of mPV is to achieve a tangible outcome in form of healthcare delivery through a cross-sector collaboration, another aim of the project is to serve as a case study to test the stipulated hypothesis, by assessing motivational factors that strengthen cross-sector collaborations and maximize their outcomes. In the next section, the reader will be introduced to the research design and methodology of the entire research project more in detail, and part IV will provide further information on mPV, its pre-conception, initiation and development, as well as its aimed role as a case study and in curing blindness in Ethiopia.

# Part III: Research Design and Methodology

## 3.1. Research Approach

### 3.1.1. Qualitative Research and Mixed Methods Approach

The gathering of data in this study is principally based on qualitative, inductive approach using triangulated methods compromising observations, unstructured as well as semi-structured interviews with key informants, document research, questionnaires and meetings with experts. As the aim of this thesis is to create direct value to patients and other stakeholders through the health care aid project *"My Project Vision – For people with Insight"* (mPV), in addition to answering some explicit research questions, action research was chosen as an approach for generating knowledge, since the method was designed to study social systems with an aim of changing them [89]. Furthermore, a qualitative inquiry was chosen over a survey-based research design due to highly unexplored nature of the field and the research question, as a qualitative approach is usually chosen when a problem or issue needs to be explored [39]. A qualitative method helps to better describe the characteristics of successful cross-sector collaborations in practice. There is also some precedence for this kind of conceptual approach in the literature. For example, the study of "ethical leadership" first chose an interview-based approach over quantitative methods in order to further sharpen the concept and to develop a theory [22].

Qualitative research begins with the assumption, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning of individuals or groups ascribe to a social problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is inductive and establishes patterns or themes. Furthermore, the backbone of qualitative research is extensive collection of data, typically from multiple sources of information [39].

As the topic in this study is fairly unknown and possibly dependent on its political, social and cultural context, an "insider perspective" is highly valuable. Since qualitative research allows the researcher to collect the data, and as action research allows the scientist to gain an insider view while studying and shaping the environment, a qualitative inquiry based on grounded theory principles makes sense.

Even though this study is mainly based on a qualitative approach, it also includes a positivist approach using the hypothetico-deductive method through the application of semi-structured and standardized interviews and questionnaire in the 3rd phase of the research. All together the framework is similar to that of a sequential explorative study where an initial qualitative approach is followed by a quantitative phase, yet the second methodological step is here characterized by mixed methodology and triangulation with a qualitative emphasis rather than by a pure quantitative approach. Hence, the research approach is arguably best described as a convergent mixed study. It is however important to note that the quantitative component is not shown in this thesis, and does not have any statistical validity due to the nature of sampling and sample size, and can hence only serve as an indicator for future research direction.

### 3.1.2. Grounded Theory and Action Research

The term "action research" was coined by Lewin in 1946 to describe a method of generating knowledge about a social system while simultaneously trying to change it [120]. The emphasis of action research today has shifted from its early emphasis on rational social engineering to a method of community or organizational development by awareness raising, empowerment (an ability to influence decision-making) and collaborative investigation between trained researchers, professionals (e.g. nurses and doctors) and lay people, with the help of designated mediators (facilitators). The revival of interest in action research stems from some disillusionments with the use of positivist methods of evaluation according to Bowling in her book "Research Methods in Health" [19].

By "participatory action research," Reason refers to a set of approaches to research on social systems in which the researcher actively engage in the process under

investigation (the actors of the social system being studied can be considered as co-researchers) [165]. Through the phrase " look, think, act" Stringer coined to description of action research [190]. By "look" Stringer means that participants should defined and describe the problem to be investigated and its context; by "think" he means they should interpret and analyze the situation in order to develop their understanding of the problem; by "act" he means they should formulate solutions to the problem.

Hart and Bond selected seven criteria which distinguishes different types of action research, and which together distinguish action research from other methods. Action research according to Hart and Bond [89]:

- is educative; deals with individuals as members of social groups;
- is problem-focused, context specific and future-oriented;
- involves a change intervention;
- aims at improvement and involvement
- involves a cyclic process in which research, action and evaluation are interlinked;
- is founded on a research relationship in which those involved are participants in the change process.

Action research, which is based on grounded theory, entails inductive data coding and constant comparison. It is a formal procedure that is commonly used in health sciences and is characterized by the following components according to Strauss & Corbin in their "Basics of Qualitative Research" [192]:

- Concepts
- Building concepts: questioning & comparing
- Identifying relationships between concepts: axial coding
- Writing the storyline
- Integrating time-related changes.

***Motivation for Choosing This Method: Bridging Theory and Practice***

The method “action research” was chosen since the main goal of the project was to create tangible value in form of restored vision due to surgeries while simultaneously serving as a case study, and as the research approach allows just that: It allows the taking action and the actual creating of value, while also giving the opportunity for generating a theory and testing the validity of it. Furthermore, the methodology allows the solving of practical problems that members of organizations or partnerships face, and the observations and findings reflect on real world issues, which are clearly of importance in tackling complex issues such as curing blindness in Sub-Sahara. Furthermore, action research is a generally acknowledged scientific method used increasingly in public health and other related fields and it is shown to be able to base its scientific legitimacy in philosophical traditions.

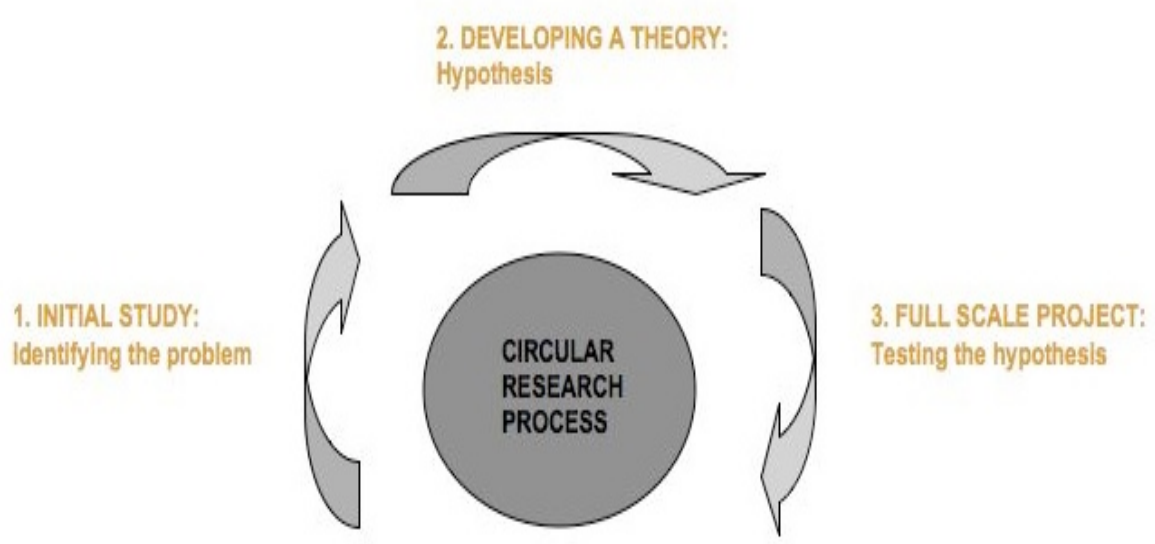
In the following chapters the reader will be introduced to the to the design of the project (mPV), to the collection of data, the type of sampling applied as well as the rationale behind it, and the design of the final written product. The design is typical for that of action research, and ideally maximizes the tangible impact of the project while allowing a scientifically sound research process in the study of CSR and PPP in international health. Hence, the design supports the aim of mPV as well as that of action research in general: The design allows the taking action and value creation, while simultaneously allowing the generation of a theory or hypothesis and testing the validity of it.

## 3.2. Research Design and Methods

### 3.2.1. Research Design

The design of the project is typical for that of action research based on grounded theory in that the researcher is actively involved the project during all phases and that the approach is of primarily inductive nature as described by Glaser [80]. Due to the complex nature and historical context of cross-sector alliances [95], and due to the highly unexplored nature of the topic, an approach with qualitative emphasis was chosen. Furthermore, this pilot study was divided into three phases in order to 1) first allow an explorative phase where the researcher first consults existing literature, then 2) to form a theory based on the knowledge gained in during the first phase, and 3) to test the theory through a mixed methods approach during the third phase of the project (see figure 6).

**Figure 6. The circular process of research design. (Source: author's own).**



### *Phase 1: Initial Study - Identifying the Problem Through a Qualitative Approach*

The first phase of this project (initial phase - identifying the problem), took place in Ethiopia as well as in Switzerland using document research and rapid appraisal techniques, as part of action research, through the use of triangulated research methods. According to Ong et al., rapid appraisal is a qualitative technique for community assessment, often used by action researchers for the swift assessment of local views and perceptions of problems and needs and is based on a combination of interviews with key people and group meetings [156]. The method involved working in the field with a qualitative approach, in order to learn from local people, and included open interviews with selected respondents and multidisciplinary meetings as well as a workshop to summarize findings and agree on priority areas of action, as we shall see in the following section.

### *Phase 2: Forming a Theory and Building a Collaboration That Will Serve as a Case Study*

In the second phase a theory concerning motivational factors that may allow a productive and sustainable commitment to cross-sector collaborations of businesses engaged in CSR was developed. Even though the general purpose of study was clear from the very beginning of the project, the specific research questions changed during the research process – a typical characteristic of qualitative research. Due to the lack of research in the field, the initial intention to answer research questions through cross-sectional research quickly evolved into an explorative attempt to answer crucial questions through a longitudinal study. During the second phase of the project the final research questions were stated as follows:

a) How do motivational factors contribute the forming of a positive output - a favorable collaborative culture - that allows a successful outcome in form of value creation and sustainability of PPPs?

- Is the need of help as initial motivator to embark in the project important in impacting output/outcome?
- Is there a relationship between mission alignment/strategic congruency -

as an incentive - and the output/outcome?

- Is support in form of services superior to pure financial support?
- Is there a relationship between the notion of potential value creation - as an incentive - and output/outcome, or is a philanthropic approach equally valid in favoring a positive output/outcome?
- How do motivational skills impact output/outcome and what are they?

b) What are motivational conditions or cultures of cross-sector collaborations that support intangible value creation and a favorable outcome in form of value creation and collaborative success?

c) What is the impact of positive outcome in form of value creation on sustainability and commitment of the various parties to the cross-sector collaboration/PPP?

Furthermore, "*My Project Vision – For People with Insight"* was created in this phase to allow direct value creation in form of a minimum of 2000 cataract operations and to allow the project to serve as a case study where the research questions could be addressed. The cross-sector collaboration created for this purpose was composed of private actors (such as the Swiss Railways Systems –SBB (Infrastructure division), Gepard Media/Cross motion, Executive Insight, Korb Media Solutions) and an NGO (Christoffel Blinden Mission, CBM) within a framework supported by the Ethiopian Government and the Ministry of Health. The actual actions taken in during the second phase are as follows:

- Setting up a collaboration and drafting of Memorandum of Understanding (MoU) and other contracts between NGO and firms (see Appendix iv).
- Organizing and allowing the execution of cataract surgeries.
- Development of DVD and flyers as well as the making of a website for interactive and motivational purposes (see Appendix ix).
- Personally meeting with the entire teams of the different companies to report on mPV developments, and to make observational studies on dynamics of firm culture.

***Phase 3: Testing the Theory Following a Qualitative Approach***

In the third phase the theory was tested and the research questions of this thesis work were directly addressed through a combined methodological approach, applying methods that complement each other, including observational studies, in-depth interviews, and questionnaires (see Appendices ii, v-viii).

### 3.2.2. Data Collection

**a) Initial Qualitative Approach:**

The Initial data was collected through observations and through unstructured and interviews with key stakeholders such as officers of NGOs in key executive positions as well as ophthalmologists and hospital staff during the field research in Ethiopia in December 2004. In order to ensure scientific rigor and comprehensiveness, all interview were recorded both by the researcher and by another observer in form of notes and subsequently cross-checked. In addition the interviews were filmed (see appendix ix).

At this stage the interviews were open and did not follow a strongly predefined structure in order to allow people to respond in a way that represents accurately and thoroughly their view points about the world (Patton 2002: 21) while allowing the researcher to enter the field without preconceptions that would prevent them from allowing those studied to tell it as they see it [45]. The purpose of gathering responses to open-ended questions is to enable the researcher to understand and capture points of view of other people without predetermining those points of views through prior selection of questionnaire categories [162:21].

Before building of the cross-sector collaboration that was studied in this project and before addressing the actual research question of the project, the author turned to literature to formulate questions that acted as a stepping off point during subsequent observations and interviews [192:51]. Together with the data collected during the field research in Ethiopia, the information gained through literature review served as a

foundation for the building of the initial cross sector collaboration and for the subsequent study of factors that may strengthen cross-sector collaborations. Hence, in a second step, the data collected in Ethiopia was compared with the literature, and ultimately allowed conceptualizing and the formation of a hypothesis which would subsequently be tested, as well as the suggestion of sampling.

**b) Subsequent Mixed Methods Approach:**

During this phase of the project, interviews were documented in form of notes in detail, yet not word-for-word (the interview questions are available in the appendices vii-viii). They did not contain judgments about the significance of the information, and they include numerous direct quotations. The interview not only served fact-finding purposes but also captured opinions of corporate representatives regarding the actual functioning and challenges of current organizational structures and procedures in the context of CSR and cross-sector collaborations. The study therefore aimed at providing a framework within which people can respond in a way that represents accurately and thoroughly their points of view about the world [162:21].

***Chronology***

In terms of timing and chronology, data was collected in from of three rounds of interviews, observations and a questionnaire addressed to contact persons for the project in each company at the kick-off of My Project Vision (mPV) and at the 5-year follow-up point (see appendix i and v-viii). In addition, data was also collected during meetings with other stakeholders in from of open discussions and observations as well as through the analysis of the each company's websites and other documents stating the core value, strategy and purpose of each company. This kind of data-triangulation allows potential biases of only one method of data collection to be minimized [46:300]. In addition, consolidated data from different sources may also increase the validity or at least paint a more accurate picture of the studied cases [256:55]. In sum, the data was collected as follows:

1. During the kick-off phase of the mPV: At this stage open interviews with an executive and contact person of each company took place. Only afterwards a

questionnaires with multiple choice questions as well as open questions were sent to the executive contact person and manager of "My Project Vision" of each company in order to cross validate the data (see appendix v). All data in this phase was collected between 2005 and 2006.

2. During execution of the project: Observational studies through the explicit researcher participation in company meetings were employees as well as key informants were present. Dynamics and characteristics of company culture as well as interactions with other parties involved in the project were observed. In addition, semi-structured interviews were conducted with the key informants in leadership positions (see appendix vii).

3. 5-year follow-up: Data was collected in form of semi-structured phone-interviews with the contact person responsible for the project in each company in December 2010 (see appendix viii). Subsequently the contact persons received a questionnaire with multiple choice questions as well as open questions (see appendix vi). The information was then compared to data collected at the initiation and during the execution phase of project.

### 3.2.3. Sampling – Information Oriented Selection

In order to address the problem of "representativeness" of case-study research, the sampling rational is essential and purposive sampling represents one solution, as it allows generalizations form cases to populations without following a purely statistical logic [182] [258]. "*Many qualitative researchers employ ... purposive, and not random, sampling methods. They seek out groups, settings, and individuals where…the processes being studied are most likely to occur"* [47:370]. To maximize the utility of information from small samples and single cases, the sampling in this study was conducted based on expectations about their information content, since purposive sampling allows the choice of strategic, information-rich cases in order to address research questions within a relatively unexplored field.

According to Mason, deviant cases should be sough out, rather than cases that are

likely to support the argument, in order to offer a crucial test of theory [131]. Yet, due to the unexplored nature of this study, with lack of empirical data regarding the research question, it was rather difficult to choose cases on such theoretical grounds. Doing so requires substantial knowledge in factors promoting successful cross-sector partnerships, yet such a systematic analysis of the impact of various factors on these collaborations is currently lacking. Accordingly, sampling of cases that would support the argument was not possible. Consequently, the research setting was chosen to *"provide a close-up, detailed view of particular units which may constitute…cases which are relevant to appear within the wider universe"* [131:92].

Thus, in order to maximize data-rich cases and to allow an adequate analysis of the impact of different forms of engagement in cross-sector collaborations on the quality and outcome of partnerships, two firms where therefore chosen to support the project in form of financial means only, and the other two where chosen based on their support in form of services, know-how and expertise, as we shall see in part VI of this thesis. It should be noted, however, that the selection was not unconditional, as the firms engaged in the partnership had to be willing to participate in the project in the first place and that they had to be directly or indirectly connected with the catalysts of this project. This potential bias will be taken into account in the interpretation of the empirical data, however.

Finally, the companies participating in this study were chosen based on their location in the Germanic region of central Europe. As the companies were embedded in a "common" or similar legislative, political and cultural context, such confounding factors and influences on the outcome could be excluded to a great extent. Furthermore, the research setting of the Germanic region was chosen due to its likelihood of yielding data rich cases and direct results in form of cataract surgeries not only because of the fact that he catalysts of the project were active mainly in Switzerland and Germany, but also because of the prevailing corporate and business culture in the region. The Swiss government, for instance, actively encourages firms to embrace social responsibility. A symposium organized in 2002 by the Swiss State Secretariat for Economic Affairs (SECO) together with the UNGC office and UNCTAD, to introduce Swiss executives to the UNGC, constitutes one such example. Furthermore, the government provides funding for events such as the UN Global

Compact Leaders Summit and the UNGC in general. In total, over 40 Swiss companies are currently participating in the initiative; considering the size of Switzerland, this is a large number [258].

### 3.2.4. Data Coding and Analysis

The analysis of collected data recorded in form of film and notes is based on Inductive Approach or Grounded Theory as described by Glaser and Strauss in 1967 (80). During the initial phase of the study in Ethiopia and in Switzerland, the purpose of the coding procedure was to build rather than to test theory. As in all qualitative inquiry based in open–ended questions, findings are detailed and variable in content, and responses are neither systematic nor standardized, making analysis difficult [162:432].

To ensure methodological rigor and comprehensiveness, the process of analyzing the data was guided by the assessment tool and reported with as much detail as possible in agreement with qualitative research and evaluation methodology described by Patton [162:434]. Notes were compared immediately afterwards and the initial data was discussed and analyzed in the interdisciplinary group every evening in order to confirm impressions. The resulting conclusion were summarized by the researcher and documented in form of film and memos on a daily basis. The analysis of the documents followed the process of content analysis, which enables the researcher to include large amounts of textual information and systematically identify its properties.

The content analysis was conducted manually by the author. The notes were analyzed at various stages of the project. Raw data was reduced and organized in relevant chunks initially through open coding followed by axial and selective coding. Data was cross-validated through the application of different methods such as questionnaires and observational studies during meetings. An organized assembly of information through graphs, matrices and charts, allowed a final conclusion drawing. The use of software program (e.g. ATLAS.ti) for the analysis of data was not possible because the transcripts were summaries and not literal records of interviews. The

method of inter-rater reliability, a method of giving the same set of data to an independent researcher to analyze the information independently, could not be used either because a lack of funding (182:286). Nevertheless, a second observer was present during the team meetings during the initiation and execution phase of the projects, and perceptions and captured data were systematically compared and consolidated after each meeting.

### 3.2.5. General Structure of the Final Written Product

No set format exists for how a written plan or proposal for a qualitative study should be structured, but several sources suggest general topics to be included in such a work. The format used here is based on a format typical for qualitative research described by Creswell [39] and advances the use of a "theoretical lens" described by Marshall & Rossmann [128]. The first part or the introduction includes:

- Overview
- Type and purpose
- Potential significance
- Framework and general research questions
- Limitations

The second part entails review of related literature and the third part describes the design and methodology:

- Overall approach and rational
- Site or population selection
- Data gathering methods
- Data analysis procedure

As seen in the table of contents, the fourth, and fifth part deal with the initial study as well as build-up of project, and forming of hypothesis respectively. The sixth part provides the reader with the results of the study whereas chapter seven sums up the

research project and allows a conclusion.

# Part IV: Initial Study and Build-Up of Project

*"When resources are scarce it is critical that we develop better ways to map and find those most in need, so that the limited money available is invested where it can make the greatest positive impact"* - Director of Swiss Tropical Institute Prof. Dr. Marcel Tanner, 2004 [194].

One aim of this thesis work is to enable the forming of a cross-sector collaboration that would serve as a case study for assessing motivational factors that strengthen cross-sector collaborations through value creation and mutual value exchange. Simultaneously, and more importantly, the project should lead to tangible outcome in form of the restoration of vision in persons affected by cataract in a region of highest need of help in Ethiopia. The project should promote local healthcare personnel and expertise through a strong collaboration between local organizations, the regional government and European for-profit businesses. Our support should increase the amount of cataract surgeries conducted in Ethiopia, without disturbing the long-term function and survival of the pre-existing structures.

In order to achieve our goals, however, we first had to identify problems of healthcare provision and blindness and in Ethiopia. We did so through a field research in the country in December 2004 as well as through key informant interviews and literature research. We then switched our focus to cross-sector collaborations and aid projects in general, and consulted literature on other similar case studies as well as reports on problems and challenges of such partnerships. Finally, based on our own data gathered in Ethiopia as well as on the reviewed literature, we were able to allocate the population most in need, and to identify bottleneck in healthcare provision. We then attempted to develop a strategy how to maximize the outcome and impact of our project on blindness in Ethiopia, as described in the following chapters.

## 4.1. Identifying the Problem

### 4.1.1. Problems With Eye Care in Ethiopia

In 2006, there were only 80 practicing ophthalmologists and 4 cataract surgeons in all of Ethiopia, yet approximately 1,2 million people suffer from blindness and 2.8 million people are affected by low vision (National Survey of Blindness, low Vision and Trachoma in Ethiopia 2005-06). During our field trip in 2004, the situation was even more severe, as only 72 ophthalmologists were practicing in the entire country. Despite that the share of blind and visually impaired is much higher in rural areas, and even though 85 % of the population lives outside cities [64], only two out of the 72 ophthalmologists were permanently active outside the capital Addis Ababa in 2004 [241]. Hence, eye care services are extremely limited throughout the country, but in particular in rural areas. Simultaneously, the highest percentage and number of people affected by blindness live on the countryside. Furthermore, due to the scarce educational resources, with only two medical schools training ophthalmologists, there are not a sufficient amount of students being trained for future purposes, particularly in rural areas.

Another clearly identifiable problem during our field trip was the accessibility to the few, unevenly distributed health care structures and eye care. The roads, if present, were usually in precarious conditions and the lack of cars and other means of transportation to the closest care and treatment point were apparent. In other words, even if there would have been enough health care personnel, equipment and patients, these crucial components could not be brought together in a cohesive manner due to weak infrastructure.

Thirdly, the awareness of blindness, prevention, and eye care was low among the population in general. Hence, even if treatment options were available, persons affected by blindness or their families were not aware of the treatment options and cure. In other words, even though people suffered from cataract, and treatment would have been available for free around the corner (sponsored by an NGO), the potential

was neither acknowledged by the people affected nor by their families. The mentioned unawareness could be divided into four major components: 1) diagnosis had not been done, hence the cause of blindness had not been established, 2) the possibility and method (surgery) to quickly and easily threat the cause of blindness was not recognized, 3) the potential patients were unaware of the subsidized treatment option through NGOs and hence the low cost of care or free care was not acknowledged, 4) the locations were the diagnosis and possible treatment took place (care posts or outreach programs) as well as transport to these facilities had not been effectively communicated to the blind population.

Finally, due to the low national as well as regional budget for sanitation and healthcare, as well as the poverty of the population in general, particularly in rural areas, the expenses for cataract surgeries could not be covered by local means. Furthermore, from a health systems point of view, the inadequate primary care and sanitation due to budget restraints and arguably poor planning, was far from adequate, which is highly limiting as many blinding causes, especially treatable childhood blindness, are due to simple infections are poor hygiene. Even cataract screening, could easily be done at least partially in a primary care setting i.e. in association with immunization schemes or in schools. The allocated budget and precarious development of primary care were therefore highly limiting as well.

According to the national survey the major constraint for eye care during the research period of 2005-2006 were 1) Few, unevenly distributed and de-motivated human resources (both technical and managerial), 2) Inadequate budget for eye care 3) Shortage of facilities/ infrastructure for eye care in the country, 4) Lack of basic equipment/ instruments for eye care 5) Lack of consumable supplies such as suture materials, 6) Absence of a prevention of blindness coordinator (focal person) at least at the level of regional health bureaus, 7) Inadequate ophthalmic research, training and services, 8) Lack of focused policy and strategy on prevention of blindness, and 9) Weak inter and intra-sector collaboration and coordination. The centers that we visited, however, were relatively well equipped with sufficient equipment, instruments and consumable supplies such as sutures, lenses, antibiotics and anesthetics provided or financed by NGOs such as CBM, Orbis or the Carter Center.

The situation did clearly not reflect the situation of the country as a whole, yet it again confirmed the existing problem regarding uneven distribution. It is important to note that the personnel of our visited centers were seemingly competent and motivated, yet they were not working to their full capacity. According to our observations, they had ample, apt equipment and supplies, and enough personnel to conduct more surgeries in average (except ophthalmologists and cataract surgeons). The limiting factor seemed to be the number of patients that arrived in the centers to be treated due to unawareness of treatment options and low accessibility to the few, unevenly distributed health care structures as well as the absence of an ophthalmologist or cataract surgeons at times. Indeed, the district model for Vision 2020 also identifies patients to be one of the three crucial components, along with eye care personnel and equipment, that need to be brought to in a cohesive manner though health systems management and community programmes, on order for any blindness prevention initiatives to be successful.[14]

In summary, we established that if we could attract more ophthalmologists and eye care personnel from Addis Ababa, where almost all of the countries' ophthalmologists were practicing, to preexisting, well-functioning and equipped structures on the country-side (for instance on a project base, during opportune times when less personnel was needed in the city), and if we could increase the pool of blind patients being brought to these facilities, the total amount of patients that could be treated would potentially increase significantly. The concrete strategy and solutions for increasing the amount of surgeries and successful interventions to treat the blind will be introduced in chapter 4.2. Long-term, however, it was clear to all parties that more money and efforts had be allocate into the development of primary care in a system-wide approach, and the training of more healthcare professionals, including cataract surgeons, was absolutely crucial.

### 4.1.2. Problems with Cross-Sector Collaborations within Aid Projects

[14] According to Prof. Foster during a short course "Planning for Vision 2020" at London School of Hygiene and Tropical Medicine, July 2011.

Aid within the health sector has increased substantially over the past decade both in absolute terms and as a share of total aid. According to the Institute for Health Metrics and Evaluation (IHME), development assistance to health (in real 2007 USD) quadrupled between 1990 and 2007, from USD 5.6 billion in 1990 to USD 21.8 billion [99]. The dramatic increase is partially due the emerging involvement of private players and Organizations such as the Bill and Melinda Gates Foundation or the Global Fund and the GAVI Alliance. A large share of this increase has been for specific diseases such as HIV/AIDS. Between 2002 and 2006, 32% of official development assistance (ODA) for health was allocated to HIV/AIDS according to the World Bank [244]. Yet, aid within the health sector is still well below the levels needed to reach the health Millennium Development Goals by 2015. Indeed an additional USD 36-45 billion is needed annually according to the high-level Taskforce on Innovative International Financing for Health Systems [100].

Furthermore, countries continue to experience varying degrees of aid fragmentation, especially with new financing innovations and global financing initiatives. According to OECD, one of the biggest challenges for strengthening domestic accountability in health is the prevalence of off-budget aid, including aid from some vertical funds. At best, working outside domestic systems does not support the systems, at worst it further undermines them [152]. While alignment with country priorities has seen progress, more efforts are required from development partners to fully embrace this principle. Some countries have developed robust, results oriented national strategies for better health outcomes. Mali, for instance recently signed a compact with the International Health Partnership (IHP+), an initiative which was launched in 2007 to achieve better health results through more harmonized donor support to a single country-led national health strategy.

Similarly, development partners should actively encourage country ownership, fully supporting partner countries to take complete charge of their own development programmes. It is also important that development partners support the strengthening and use of country systems, particularly as many partner countries have made tremendous efforts to ensure credibility in their systems. This will facilitate work processes and reduce transactions costs on both sides. Global programmes like the Global Fund and the GAVI Alliance, which have been criticized for setting up

parallel health delivery systems, now take aid effectiveness very seriously. They contribute to more predictable funding through innovative financing (such as UNITAID, the International Finance Facility for Immunization and Advanced Market Commitments), and they regularly monitor their own progress for implementing the 2005 Paris Declaration on Aid Effectiveness, including alignment within country priorities and systems.

To be more effective in managing aid, partner countries expect development partners to increase the predictability and transparency of aid, since this will help maintain the integrity and avoid distortion of country plans and programs. Guided by the Working Party on Aid Effectiveness, the OECD Task Team is focusing on key areas of the Accra Agenda for Action. The task teams work is organized in five clusters, each led by volunteer organizations. Three of the five clusters highlighted the importance of transparency, accountability and monitoring as follows 1) strengthening ownership and promoting accountability, 2) Promoting transparent and responsible aid and 3) Monitoring, assessing and evaluating progress [152].

Recently, the ability of foreign aid to achieve its goals is called into question and some conceptual and empirical literature suggests that foreign aid is ineffective. According to Williamson, the reason why so many aid projects are ineffective is largely due to failure to clearly define and align incentives and motivations, as well as the lack of information flow. The success of aid depends on incentives faced by all parties in donor and recipient countries. In addition, Williamson states that both donors and recipients must obtain the necessary information to actually target and achieve desired goals. She suggests that we could turn to private, decentralized actors operating in the market to achieve marginal successes. These private actors spontaneously emerge, can adapt to local conditions by tapping into the decentralized knowledge, and rely on feedback mechanisms for success [215].

Furthermore, long-term financing of and commitment to programmes is often regarded as a key element for successful aid projects. According to International Health Partnership and related initiatives (IHP+), longer term, more predictable financing is called for within the context of valuable aid programmes. During the field research in Ethiopia as well as during interviews in Switzerland, all project managers

agreed that lack of long term financing and commitment to programmes was a major limiting factor to successful aid projects and during interviews with the manager of CBM International, Hansjoerg Baltensperger, the failure of long-term commitment to projects was an essential reoccurring theme.

Finally, much literature highlights the significance of outcome-focused programs and a tightly closed loop between performance data and strategic management [207]. Many aid programmes do indeed fail to actually define and measure outcome such as changes in behavior or conditions that reflect a positive shift towards social impact, and are rather focused on activities and processes. The challenges faced by aid projects and the next steps that should be taken in order to accelerate progress towards the health MDGs are summerized by IHP+ as follows [100]:

- Keep a focus on health results;
- Build on what already exists, in national health policies, systems and coordination mechanisms;
- Enhance country-led health development, by getting more stakeholders to unite around one strategy;
- Reduce transaction costs from multiple initiatives, by changing ways of working of different partners;
- Longer term, more predictable financing;
- Promote mutual accountability.

## 4.2. Strategy to Increase the Total Amount of Vision Restorations

As the leading cause of blindness in Ethiopia is cataract, affecting all age groups of society, and since cataract is easily treatable through a highly effective, quick, inexpensive and simply surgery, we focused our efforts on increasing the total amount of high quality cataract surgeries (including lens replacement) in the country following our first SWOT-like analysis in December 2004. Another important factor affecting our choice of treating cataract, rather than other ophthalmologic ailments, was the high success-rate and low complication rate of cataract surgeries. However, instead of channeling out capital into surgical equipment and supplies, which had been supplied to the clinics in sufficient or even excessive amounts by various aid organizations, our solution lay in financing actual labor and support infrastructure. In other words, in response to the identified limiting factors or the bottle-necks mentioned in the previous chapter such as:

- uneven distribution of eye-care in an already extremely limited health care environment, with all but two ophthalmologists being active in the capital rather than in rural areas were most patients live,
- poor accessibility to the few, unevenly distributed health care structures and eye care,
- low awareness of blindness and treatment as well as prevention options,

we financed personnel including ophthalmologists and surgeons to be active in rural areas rather than in the capital at least on a project base, and most importantly, we supported infrastructure for outreach programs from rural clinics to small rural communities that lacked access to treatment or adequate knowledge of disease and therapy. The outreach programs were composed of competent personnel (yet not overqualified personnel such as cataract surgeons) that first identified which patients suffered from cataract rather than other illnesses that cause blindness, and then transported these patients to the rural clinics where surgeries were performed. Food and other necessities were also provided if necessary in order to allow even the poorest to travel to the clinics and back to their communities following the surgeries.

A key concept of mPV was to take advantage of existing, well-functioning structures that were not utilized to their full capacity. Equally important were the support of local (Ethiopian) labor and expertise and the avoiding of pure foreign implementation. Through the outreach programs and the surgical procedures, we wanted to allow local professionals to maintain and to improve their skills, as well as train more professionals for the purpose of diagnosing cataract and informing the population of the disease.

We chose to work with the NGO Christoffel Blinden Mission (CBM), as the organization has ample experience in the country over nearly a century, and since their structures were well managed, staffed and supplied. We aimed to take advantage of CBMs structures and acquired knowledge and expertise throughout the years, and therefore not only learn from their past mistakes but to also avoid any overhead costs of our own, as well as to strengthen the coordination of interventions throughout the country and to avoid any waste or diversion of resources due to duplication. Hence, we aimed to strengthen the domestic systems and alignment as well as harmonization.

The choice of region where the surgeries were conducted, for instance, was chosen based on CBM's and the governments knowledge and statistics on were most underserved individuals were living, so that the limited money available would be invested where it can make the greatest positive impact. As a result, the Tigray region was chosen as a target for our out-reach ventures under the leadership of Edmund Gabriel, of CBM, and Dr. Fitsum Bekele, of the Tigray Regional Health Bureau and the Tigray prevention of blindness (PBL) programme. The region was based on its the relative peace and stability, as well as on well-functioning, central health care structures, allowing effective interventions and outreach activity to underserved rural populations.[15]

The basis of collaboration was built on trust and possibly also on emotional connection. It is therefore likely that the choice of NGO was also based on an emotional connection, since the NGO's roots are Germanic, just like the private

[15] The Quiha and Auxum hospitals were chosen to serve as bases for outreach activity through 2 fully equipped secondary eye-care units and some 15 primary ones (PEC Units).

actors' roots were Swiss or German. Nevertheless, the transparent modus operandi of CBM, as well as the auditing through Price Waterhouse Coppers, certainly supported the trust and the collaboration as a whole. In order to maximize decision power and flexibility of the local actors involved, the mode of financing as well as the pricing of surgeries were to a large extent planned and decided during discussions between CBM and the regional health care services and professionals. Furthermore, working closely with local expertise was critical in order not to set up a payment scheme that wouldn't undermine the local economy and incentives already in place.

Furthermore, we allowed the local collaborators of CBM to decide what fee the patient would be charged with (if any fee at all). Based on previous calculations, it was decided that 50 CHF was the apt cost per surgery (financed or subsidized by mPV) in average, covering the cost of out-reach diagnosing in villages through auxiliary health care workers, the transportation of patients from villages to the health care structures and back home post surgery, the costs of labor of ophthalmologists from Addis Ababa that worked on a project base, and finally of surgical assistants crucial for a successful execution of surgeries. In addition, digital cameras and necessary equipment was provided to all out-reach units, in order for them to document each patient diagnosed and treated for cataract for documentation and monitoring purposes. These pictures were handed over to CBM, although it was agreed among all partners that these pictures were only used for internal monitoring purposes.

## 4.3. Creation of a Cross-Sector Collaboration Serving as a Case Study

The burden of blindness in the Sub-Saharan Africa (SSA) is the worst of all the regions of the world and the prevalence of blindness is here 10-20 times greater than in industrialized countries [63]. One of the aims of this thesis work is therefore to cure people affected by cataract from blindness, as it is a highly debilitating and indirectly often leads to death. In other words, in a concerted effort together with an established, local NGO (CBM-Ethiopia) and the regional health bureau (Ethiopian Ministry of Health), as well as for-profit firms in Europe, the project objective is to achieve a tangible outcome in form of healthcare delivery through a cross-sector collaboration. As already mentioned several times before, another important aim of the collaboration, however, was to serve as a case study for the assessing motivational factors that strengthen cross-sector collaborations and maximize their outcomes. In the following chapters the reader will be introduced to the mission and vision of mPV as well as the build-up and structure of the case study more in detail.

### 4.3.1. Mission of My Project Vision – For People with Insight

***In Ethiopia:***

The mission of mPV in Ethiopia was to ameliorate or restore the eyesight of individuals in Ethiopia affected by cataract through the financing of cataract surgeries at a price of 50 CHF (around $35 USD).[16] The cataract surgery is a one-time measure, which shows an extremely high success-rate (over 90%), it restores vision within a day, and it does not have to be repeated later in life. Through the surgeries, affected individuals would be able to read again, to continue with the profession that they had to abandon when their vision was lost, and they would be able continue being productive and supportive constituents of society. In other words, through the financing of the surgeries and infrastructure that enables healthcare delivery, the

[16] According to approximate, average exchange rate in December 2004.

project aimed to allow people to help themselves.

The project promoted local health-care structures and personal that already existed and were functioning well. The project enjoyed the support of an organization (CBM) and native experts, with years of experience in the unique local environment and in the field of ophthalmology. The financial support would hence significantly increase the amount of cataract surgeries conducted, without disturbing but will not be essential for the long-term function and survival of the structures.

***In Europe:***

The aim of mPV in Europe was to sensitize and inform people in the industrialized world about the problems and consequences of blindness and cataract, and to empower people to become involved and to help individuals of Ethiopia affected by poor vision and cataract. Furthermore, mPV attempted to change the conception of aid work and volunteers allowing care and proactive behavior to become an attractive life style associated with, dynamic and innovative people. Most importantly, however, mPV aimed to serve as a nexus between for profit firms, the NGO and the Ethiopian Government and its people, and to increase the Cataract surgical rate (CSR) through the enabling and financing cataract surgeries in Ethiopia.

### 4.3.2. Motivation of Founders "Catalysts" to set up My Project Vision – For People with Insight

***Responsibility and Ethical Reasons:***

*"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care…"*
- Universal Declaration of Human Rights, article 25
(UN 1948)

***Social and Economic Reasons:***

According to Clare Gilbert of London School of Hygiene and Tropical Medicine, the implications of poor vision are 1) lower productivity, 2) interdependence, 3) lost earning potential. It is therefore not surprising that blindness is also an economical burden to the individual and society as a hole, apart from the obvious personal implication. It has in fact been estimated that if the Vision 2020 goals will be reached, the estimated 100 Mio people that will be saved from going blind will result in an economic saving of over $150 billion between 2000 and 2020 [71]. Furthermore, in the case of Ethiopia, cataract, which is the leading cause of blindness, was responsible for 2,6 % of all hospital admissions in 2001 according to WHO [222]. Hence, it is clear that blindness also puts a direct strain on healthcare spending and budget of a public health level. One motivation for embarking in this joint venture called mPV was therefore the socioeconomic, if not directly then indirectly.

*"Blindness of a great part of the working force inevitably leads to poor economics. Poor economics risk social and political turmoil. Riots do not restore business confidence. They drive capital out of the country; they do not attract capital into the country ... and riots are predictable-like any social phenomenon, not with certainty, but with a high probability… the consequence of bad economics…"* - Joseph Stiglitz, Nobel-prize winner in economics.

*"... development assistance is not charity, but a vital investment in global peace and security."* - Horst Köhler, former president of the Federal Republic of Germany.

### 4.3.3. Principal Parties Involved

***Mediators or "Catalysts":***

The facilitating or catalyzing team was composed of three persons each representing different interests and parties. The first catalyst had no interests to declare neither within the NGO/non-profit context nor the private firms/for profit context. The main reason for participation was to investigate the research topic and address the aim of this study, as well as to allow an actual intervention in form of cataract surgeries. The second catalyst represents the for profit business community with a clear interest in

promoting value creation in form of mainly intangible assets for the firms involved in the project. The third catalyst was representing the non-profit sector and the non-governmental sector with a significant interest within this domain. The participants are described more in detail below:

1) Anna Erat is the founder of the project. She studied and conducted research in medicine at and University of Zurich in Switzerland and BIDMC-Harvard Medical School in USA. She is currently preparing her inter-disciplinary doctoral thesis at the University of Zurich (Institute of Organization and Business Theories) and the University of Basel (Swiss Tropical and Public Health Institute) in Switzerland.

2) Jan Edlund is the co-founder of the project. He studied business at the University of St. Gallen and Harvard University. He is a business consultant and conducts trainings for up to 3000 managers, yearly.

3) Hansjörg Baltensberger is the chairman of the Vision 2020 committee in Switzerland. Vision 2020 is a global initiative of the International Agency for the Prevention of Blindness (IAPB) and the World Health Organization (WHO), with a coalition of international Non-Governmental Organizations.

***Non-Governmental Organization (CBM) and Governmental Agencies (Tigray Reginal Health Bureau and the Tigray Prevention of Blindness-PBL program):***

Christoffel Blinden Mission (CBM) is a highly regarded, well-established NGO targeting the people affected by disability through supporting programs - including health care, rehabilitation, education and livelihood opportunities. Together with a global network of partners, CBM aims to promote inclusion and make comprehensive healthcare, education and rehabilitation services available and accessible to an estimated 500 million persons with disabilities in low and middle-income countries (CBM Website, 2010). It was founded more than 100-years ago and it has all together supported more than10 Mio cataract operations worldwide. CBM is a partner of the global project Vision 2020-Right to Sight initiated by the UN-WHO, among others.
The project has mainly been active in the Tigray region under the leadership of

Edmund Gabriel, of CBM – Ethiopia, and Dr. Fitsum Bekele, of the Tigray Regional Health Bureau and the Tigray prevention of blindness (PBL) program.

***For Profit Firms (Table 7):***

- SBB (Swiss Railway Systems Infrastructure Division): It supports the project through pure financing of cataract surgeries.
- Executive Insight (Healthcare Consulting Firm): It supports the project through pure financing of surgeries.
- Gepard GmbH/Cross Motion (Documentary and Media Production Company): It supports the project through services related to core activity of firm – It filmed of the project and produced a documentary.
- Mkorb (Web-Application developer). It supports the project through services related to core activity of firm – It developed and designed our Website.
- Erat Design Group edg. (Graphic Design Company): It supports the project through services related to core activity of firm – It supported the project in form of graphic design such as development of a logo. [17]

**Table 7: Firms involved in mPV and their form of support. (Source: author's own).**

| Firm | Form of support |
|---|---|
| Swiss Railway Systems (SBB) | Financing of cataract surgeries |
| Executive Insight Healthcare Consulting | Financing of cataract surgeries |
| Gepard GmbH | Documentation of mPV in form of film |
| Mkorb | Web-Application developer |
| Erat Design Group edg | Graphic design and logo |

### 4.3.4. For Profit Firm Participation Modes

[17] HRIAG and Erat Design Group edg. was excluded from the study due to familial ties and non-objectivity.

One of the aims of this research project was to investigate whether the participation mode could have an impact on the intangible value creation and outcome. Hence the project involved companies that either supported mPV through financial means or through services. More in detail, the two types of participation modes (see table 7) included:

1. A company sponsoring cataract surgeries by donating money. For each 50 CHF deposited to a specific CBM bank account, one cataract surgery would be performed.

2. A company supporting the project by providing services and expertise free of charge. Companies and individuals were supporting the project for instance through web and logo design, web-hosting, banking, infrastructure and media production.

### 4.3.5. Legal Binding and Monitoring

According to written, legally binding (in Switzerland) Memorandums of Understanding (MoU), the project channeled money directly and free of charge into specific bank accounts of the mentioned NGO (CBM Switzerland). CBM has a local office in Ethiopia, and was therefore able to supervise and monitor the project from the actual site of activity. The expenditure was well documented and the cataract specialists, conducting the sponsored surgeries, reported directly to the NGO. The book keeping and auditing of CBM international, on the other hand, was under the responsibility of Price Waterhouse Coopers, which is one of the world's largest providers of assurance, tax, and business consulting services.

## 4.4. Summary

Through a strong collaborative effort with for profit businesses in Europe and with a local NGO in Ethiopia, as well as the Ethiopian government, mPV therefore aimed to make cataract surgeries more available, equitable and affordable in Ethiopia. Through out-reach programs, mPV aimed to restore vision in persons affected by cataract surgeries at a price of 50 CHF per patient, by taking advantage of the surplus pre-existing consumables, without upsetting the economy and the systems and award schemes already in place. Furthermore, the participants of mPV and their interactions during the initiation and implementation phases of the project, were also qualitatively analyzed, using multiple methods including interviews with key informants, observations and questionnaires as described in Part III. The ultimate aim in this context was to test the stipulated hypothesis as described in the following chapter.


**Figure 7: mPV official logo. (Source: author's own).**

# Part V: Forming of a Hypothesis

In order to identify motivational factors contributing to strong cross-sector collaborations, it is essential to first define a successful partnership. According to Pearce and Doh in the MITSloan Management Review, there are five principles of successful collaborative social initiatives: (1) Long term commitment, (2) Contributing with products and services that are based on the firms core operation, (3) Cooperation, (4) Weighing Governments influence and (5) Putting a price on the total benefit package [160].

According to Austin partnerships confront seven organizational challenges, "the seven Cs," which have to be tackled successfully to allow strong partnerships: 1) Clarity of purpose, 2) Congruency of mission, 3) Creation of value, 4) Connection with purpose and people, 5) Communication between partners, 6) Continual learning, and 7) Commitment to the partnership [7].

According to USAID's research on how to measure and improve the impact of alliances, the demand to measure the value of alliances is great as little data is available on their success. The publication states that the solution lies in adopting a new approach to measurement, including three critical tenets: a focus on outcome, metrics that matter, and strategic shift towards alliances built on shared interests. The value of an alliance - or any initiative, program or relationship for that matter – cannot be measured without defining success [207].

In short, based on literature studies and observations, on Undertal's and Young's definition on effectiveness [205] [246] [247], and on the Austin's assumption that the amount of value that's being created through the collaborative process is an underlying factor determining the sustainability and power of a partnership, success is here defined by value creation and by sustainability, in other words, by sustainable value creation. In agreement with the research by USAID, success is therefore not defined by activities, but rather by outcome (i.e. sustainable value creation).

Based on Barrett's claim that the greater the value and the more balanced the mutual

benefit, the stronger the alliance [10] and on Thomas and Curtis “win-win paradigm” [199], it is assumed that a collaboration will be stronger when all parties experience value creation. In other words, it is here asserted that the two major factors defining a successful collaboration are the value-creation through the partnership to all parties involved and the commitment of the various parties to the collaboration over time. Naturally, a prerequisite for value creation is the actual need to collaborate and an existing room for improvement. Furthermore, a pre-requisite for all collaborations is the adherence to high ethical and moral standards. As a crucial aspect of this work is to understand how the commitments of private firms to social responsibility and health care initiatives could be strengthened, following hypotheses on value creation long-term commitment are in regards to for profit firms, although the very same factors could potentially be valid for the other parties involved.

## 5.1. Initial Motivation for Joining a Partnership and its Impact on the Collaboration

### 5.1.1. Philanthropic Factors

It is hypothesized that most collaborations are based on philanthropic motives where the relationship is to a high extent of financial nature. It could for instance take place in response to requests from NGOs or a catalyst in form of annual corporate donations. In this work it is hypothesized that when the nature of engagement is purely financial, the level of engagement and the value creation in form of intangible assets are low. Yet, the relationship is valuable as part of an effort to market the company as a socially responsible business.

### 5.1.2. Value Exchange

In these cases the drive exceeds charitable motivations. In cases of alliances where the motivation is not purely philanthropic, interaction tends to focus on more specific activities in which there is a significant two-way value exchange. When the motivation for engaging in a collaborations is value creation, it is likely that these alliances encompasses more than transfer of funds including services such as fund-racing events, marketing, employee volunteer services. Furthermore, the partnership could potentially be more important to the various parties' missions and strategies and a significant increase in intangible assets could potentially follow.

## 5.2. Initial Starting Point of Partnerships: the Importance of Catalysts

Through PPPs, for-profit firms should be able to profit from market co-ordination mechanisms and potentially improve their image and their corporate culture, regain consumer confidence and create stake-holder-value, through their engagement in CSR, while NGOs could clearly benefit from additional financial means and managerial skills. Cross-sector partnerships, however, must deliberately be built and developed, as they do not "simply happen" and evolve on their own. To trigger the relationship there generally needs to be an emotional connection with the social objective or purpose. Furthermore, collaborative actions and measures are also built on understanding and trust. According to Austin, trust and emotional connection are therefore important building blocks for strategic alliances [8]. In other words, beyond traditional measures of effective leadership such as consensus building and strategic implementation, cross-sector collaborations are fueled by emotional connection that key participants make with the social mission as well as with their counterparts in the partnering organization. Perhaps this personal connection cultivates confidence, thus allows these collaborations to develop.

One hypothesis of this work is that trusting personal connections become invaluable, especially during the starting point, but also throughout the project while developing the necessary levels of trust necessary for the partnership to alliance unfold. This is particularly important when operating in an uncertain environment such as foreign, third world countries, geographically and culturally far away from the profit firms. Hence, a "catalyst" allowing an initial connection and trust between the various parties is essential for successful bonding and commitment to a collaboration.

## 5.3. The Evolving of and Commitment to Partnerships: Stronger Collaborations Through Increase of Assets and Value Creation in a Win-Win Constellation

According to Thomas and Curtis, among others, cross-sector collaborations need to be based on win-win partnerships in order to be successful [199]. Similarly Diana Barret claims that the greater the value and the more balanced the mutual benefit, the stronger the alliance [10]. As mentioned earlier, the premise of this study is therefore as follows: Successful, long-term collaborations can be promoted by identifying factors that allow value-creation within the partnership. Fighting blindness is the common and ultimate goal of all stakeholders. By defining strategies for fighting blindness and by successfully implementing them, value will be created for all parties involved, and a stronger collaboration will follow.

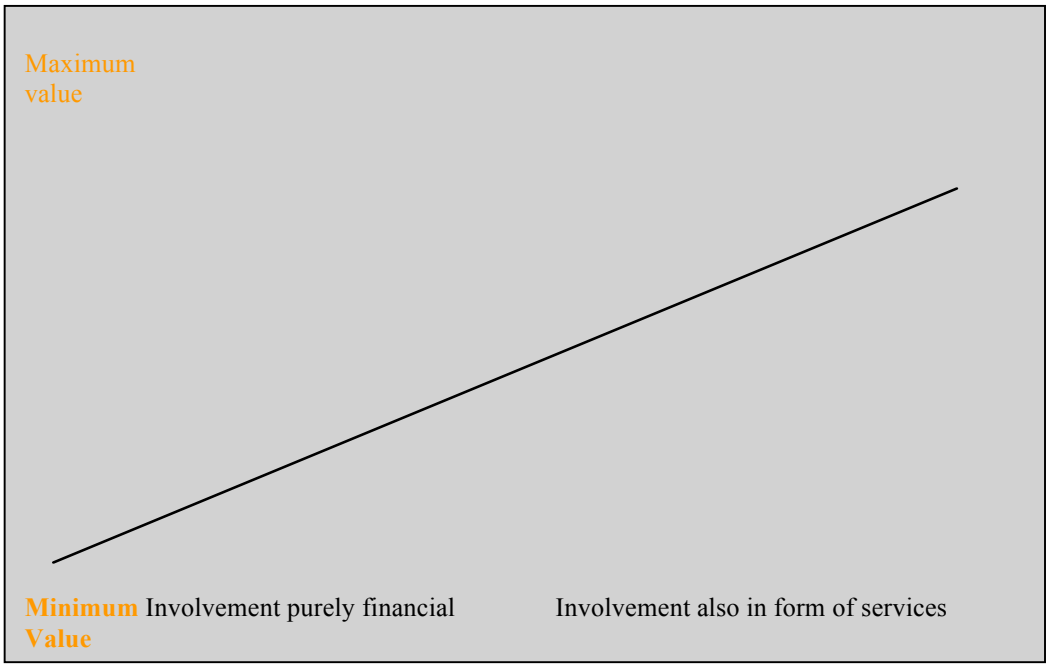
Yet cross-sector collaborations can also create other kind of value for the partners involved including 1) improved employee motivation and satisfaction 2) innovation 3) learning 4) improved corporate culture 5) improved business image 6) better prospects for new skilled employee recruitment and keeping current employees on board, 7) better customer & stakeholder contact and network interaction, 8) access to new markets, data, people and infra-structure. It is here hypothesized that collaborations may allow an increase in not only tangible assets but also intangible assets. Intangible assets can be divided into three categories a) Human capital (employee's skills, talent, and knowledge), b) Information capital (data bases, information systems, networks and technology infrastructure) and c) Organizational capital (Improved corporate culture, employee alignment, teamwork) [105].

However, none of these intangible assets has value that can be measured separately or independently and the final value of these assets derives from their ability to help the organization or a business to implement its strategy [105]. By developing strategies for the maximizing both tangible and intangible assets, much value can potentially be created for the various participants, including the firm, and a closer and more long lasting collaboration is enabled.

### 5.3.1. The Importance of Business Core Activity and Mode of Participation

In brief, it is hypothesized that when the areas of core-activity/mission of the firm are similar to that of the project, more value can be created through the collaboration, especially in terms of relevant customer & stakeholder contact and network interaction as well as access to new markets, data, people and infrastructure and increased innovation. Improved employee's skills, talent, and knowledge through the collaboration may clearly be of value to the company when these acquired assets are relevant to core activity, operation and mission of the company. This tends to be the case when the mission of core activity of the company is in alignment with the mission of the project. Furthermore, when the mode of participation is at least partially in form of services, rather than purely financial, employers are given the opportunity to develop certain skills, talent and knowledge. Hence it is here hypothesized that the more support is given in form of services, rather than in financial form, the more value will be created to the business involved (figure 8). In other words, it is beneficial for an organization to contribute to a cross-sector collaboration with products and services that are based on the firms core operation.

**Figure 8: The relationship between amount of value created to the company through the partnership and the type of support provided by the business. (Source: Author's own).**



### 5.3.2. The Importance of Leadership

Many researchers report findings that cultural "strength" or certain kind of business cultures correlate with economic performance [44] [118] [186]. When culture and leadership are studied closely, it can be seen that they are two sides of the same coin. On one hand cultural norms define how a given nation or organization will define leadership – who will get promoted, who will get the attention of followers. On the other hand it can be argued that the only thing of real importance that leaders do is to create and manage culture; that the unique talent of leaders is their ability to understand and work with culture [176]. It is here therefore hypothesized that strong senior leadership within the for-profit company is vital for the initial building of trust and emotional connection with the project and subsequently paramount in the evolvement of business culture in a desired direction as a result of or facilitated by the cross-sector collaboration.

### 5.3.3. The Impact of Emotional Connection, Trust and Empowerment

Business culture is the deepest, often unconscious part of a group, and it influences all aspects of how an organization deals with its primary task, its various environments, and its internal operations according to Schein. As already mentioned before, leadership and culture are sometimes viewed as interchangeable, and culture is considered as the primary act of leadership. Yet, culture is also the result of a complex group learning process that is only partially influenced by leader behavior [176].

Building on the theory of Schein, it is here hypothesized that the stronger the emotional connection to the project, the better the actors can relate to the project and the greater the potential impact of the project on business culture. Furthermore, if actors feel as if they are empowered and have an influence in the process, they tend to be more optimistic and committed to the project, as it has been shown by some driving force behind the study of Positive Organizational Behavior (POB) a clear relationship between the positive feelings of employees and their performance exists [125]. In addition, if actors are allowed to use their acquired skills and expertise for

the project, they tend to feel more empowered and influential in the shaping of the collaboration, which again will improve the business culture and ultimately strengthen the partnership. The building of a trusting relationship through value-creation that allows a productive and sustainable commitment of businesses to a collaboration, with the ultimate goal to improve patient access to cataract treatment in Ethiopia, are postulated more in detail as follows:

- ***Emotional Connection:*** The stronger the emotional connection, the better actors can relate to the problem. Subsequently, the potential impact of the project on business culture increases. Strong emotional connection and identification with the cause may subsequently lead to an improved corporate culture and ultimately, for instance, to better prospects for new skilled employee recruitment and keeping current employees on board. As a consequence, more value can potentially be created to the company and an improved the collaboration may ensue.

- ***Empowerment:*** Intangible assets and especially business culture are more likely to improve when the participants have influencing-power in the process and when the actors involved feel as if they have an impact on the decision-making and the implementation of the project.

- ***Trust:*** Credible and tangible/illustrative progress reports and direct human interaction between parties supports trustful relationships and lay the base for positive business culture and fruitful collaborations alike. Trust is a cornerstone in successful cross-sector collaborations.

### 5.3.4. Summary

In agreement with Thomas' and Curtis' "Win-Win Paradigm", it is here asserted that by defining strategies for fighting blindness and by successfully implementing them, value will be created for all parties involved, and a stronger collaboration will follow. Furthermore, it is hypothesized that strong senior leadership within the for-profit company is vital for the initial building of trust and emotional connection with the

project and subsequently paramount in the evolvement of business culture in a desired direction as a result of or facilitated by the cross-sector collaboration.

Furthermore, it is believed to be beneficial for an organization to contribute to a cross-sector collaboration with products and services that are based on the firms core operation. In addition, it is hypothesized that when the areas of core-operation or mission of the firm is similar to that of the project, more value can be created and exchanged through the collaboration. The reason being is that when an alignment exists, employers are given the opportunity to develop skills and acquire knowledge that is relevant to the implementation of the firm's strategy and to core activity and mission of the company.

It is also hypothesized that the stronger trust, the emotional connection, and the more empowered the actors are, the stronger their committed to the project. If actors are allowed to use their acquired skills and expertise for the project, it is here hypothesized that they tend to feel more empowered and influential in the shaping of the collaboration, which again will improve the business culture and ultimately strengthen the partnership. In the following chapter the various tested theories will be described and potentially validated. Hence, in part VI of this work the reader will finally gain insight in the research results of mPV and in the tangible outcomes of the project.

# Part VI: Results

Motivation is the driving force by which people achieve their set aims or factors that energize behavior and give it direction [93] [76]. This thesis therefore strives to understand how the commitments of private firms to social responsibility and public health initiatives could be strengthened through defining motivational factors and conditions that support potential value creation and profit of such initiatives to the parties involved by:

- Analyzing the initial motivation and incentives of businesses for engaging in CSR.
- A mid-term and a 5-year follow up analysis of the businesses, their commitment, and their perceived benefits through the project.
- Ultimately developing a first, preliminary tool that can assess the value of a cross-sector collaboration through the analyzing of the formed organizational culture and potential intangible assets through such partnerships.

According to some research, one of the most important benefit from partnerships is the gain in intangible assets, as more than 75 percent of the average firm's market value is derived from intangibles such as a) human capital (employee's skills, talent, and knowledge), b) information capital (databases, information systems, networks and technology infrastructure), and c) organizational capital (improved corporate culture, employee alignment and teamwork) [105].

Based on the assumption that a successful collaboration is defined by 1) the outcome through value creation in form of tangible as well as intangible assets, and 2) by the commitment of the various parties to the collaboration over time, this case study showed that the most successful collaborations comprised SBB and Executive Insight (table 8). Both firms experienced value creation through the collaboration, and both were eager to commit to mPV even at the 5-year follow-up point and actively elaborated ideas how to improve the collaboration and to shape it for future purposes. Gepard/Cross Motion and MKorb, on the other hand, experienced little value creation and were unsure whether they would be willing to commit to the project in the future,

despite that both had a positive attitude towards the collaboration during the end-point interviews (table 8). Nevertheless, during the time-period following the end-point interviews and questionnaires, these firms took initiative to further support the project in form of services. MKorb, was in fact the only firm that actually delivered services after the end-point of the study, and Gepard/Cross Motion inquired about the possibility to initiative anther out-reach programme and a follow up documentary regarding the outcome of the initial out-reach effort. These findings will be described and explained more in detail below.

In regards to Executive Insight, one of the two companies that experienced most value creation, the firm even wanted to send some junior consultants to the Ethiopia for a few weeks to help with the field work in addition to further financial support, according to the company representative. In return the consultants would gain insight in how small interventions, when conducted in an efficient manner through teamwork, can make a substantial impact. Furthermore, the representative believed that the firm could it-self do more to allow the project to further influence business culture, image and marketing.

In summary, the project had a clear positive impact on both SBB and Executive Insight in terms of assets and value creation. According to the representative of the SBB Infrastructure division, the project clearly created value to the company:

*„The project certainly created potential value to the company. It enabled us to eliminate some technical problems, The availability of our structures clearly improved. Our employees were significantly more prone to take initiative at work „* [18]

According to the representative of Executive Insight, the value creation experienced within the company was mainly in form of innovative thinking, learning and in form

[18] Translated from German. The original expression was as follows:
*"Das [wert-]Potenzial ist gut vorhanden. Wir konnten dadurch technische Störungen zT eliminieren. Die Verfügbarkeit unserer Anlagen wurde merkbar besser. Das Initiativepotenzial bei den Mitarbeitenden wurde merklich verbessert."*
During the endpoint-interview, Engler even stated that approximately 75% of the technical targets that had been set at the beginning of the project had actually been reached.

of a positive impact on business culture:

*"The consulting team could witness how small interventions can have a large real impact when planned and executed properly. The project served as an eye-opening experience."*

Gepard/Cross Motion and MKorb, on the other hand, did not experience any value creation for the businesses through the project. Yet, both the representative of MKorb and of Gepard/Cross Motion asserted that the project brought them personal gratification, especially as it had enabled such a high number of surgeries and consequently the restoration of vision of thousands of people. Both business representatives thought that the project was a *"good thing."*

**Table 8. Different dimensions of cross-sector collaborations. (Source: author's own).**

| **Firm** | Value Creation through the collaboration | Readiness for continued commitment to collaboration | Initial motivation purely philanthropic | Financial participatory mode only | Project mission related to core activity of firm or department |
|---|---|---|---|---|---|
| **SBB** | + | + | **-** | + | + |
| **Executive Insight** | + | + | **-** | + | + |
| **Gepard/Cross Motion** | **-** | **Maybe** | + | **-** | **-** |
| **MKorb** | **-** | **Maybe** | + | **-** | **-** |

## 6.1. Starting Point Motivation: The Importance Actual Need of Help, Potential of Improvement, and Potential Value Creation

Although many cross-sector collaborations have been created in the in the past decades, there is little information available on the necessary conditions leading to their formation, governance and management [199]. It has also been stated that companies have not engaged in CSR due to the potential benefits through such projects but merely an ad hoc reaction to the pressure of critical NGOs [251]. One of the aims of this thesis was therefore to learn more about why companies engage in CSR and whether different motivations for engagement would impact the outcome.

We found that the motivational factor for both SBB and Executive Insight was not purely philanthropic unlike that of Gepard/Cross Motion and MKorb (see tables 8 and 9). According to the representative of Gepard/Cross Motion, the initial motivation was rather philanthropic. He justified the participation by:

*"The theme combined with the interesting region [Ethiopia] and the possibility to make a small humanitarian contribution*." [19]

The initial motivation of Executive Insight was to support a sustainable, humanitarian cause based on moral and ethical alignment of the founding partners (table 9). The reason for specifically engaging in *"My Project Vision – For People with Insight"* was the perceived efficiency in which the donation was spent due to low overhead costs and high success rate of surgery among others, and due to the sustainable nature of the interventions where the vision was restored in order to enable the affected individuals to again live a prosperous life and earn their livelihood.

Furthermore, as a medical consulting company, the partners were interested in engaging in an aid project related to health. They hoped that the experience would

[19] Translated from German: "*Die Thematik – verbunden mit einer interessanten Region und der Möglichkeit, einen kleinen humanitären Beitrag zu leisten."*

serve as an eye-opening learning experience where the patients are in the center of all activities - just like they should be - also in the for profit sector such as pharmaceutical industry. Furthermore, they wished for junior consultants to learn how small innovative interventions can have a large impact in a real life setting. In other words, they were interested in engaging in the project due to need of help and room for improvement also in their own firm in form of gain in knowledge and skills among others.

The initial motivation of SBB was to use a humanitarian project as an incentive for mid-level managers of the infrastructure division to develop solutions how to improve infrastructure and how to reduce 10 000 accumulated late train-arrival minutes in the previous year (Table 9). According to the representative of SBB the goal was to:

*" Generate ideas and take measures in order to reduce technical problems related to infra-structure ".*[20]

The concept was subsequently further developed by Jan-Roy Edlund, who worked as a consultant for the division: For each late-train-arrival minute that a manager could eliminate through his/her developed strategies and methods, 5 CHF would be invested in an aid project. The goal was for the managers to eliminate late-arrivals by 10 000 minutes, and hence to raise a total of 50 000 CHF. The author of this thesis was subsequently contacted and asked to build up an aid project in which the money could be channeled efficiently. As a consequence, mPV was born. This was the first project of its kind that SBB had participated in. As the representative of SBB put it:

*"Within my branch [SBB infrastructure division], it was novel to combine a humanitarian cause with the pursuit of solving internal technical problems."* [21]

[20] Translated from German: "*Verbesserungsmassnahmen generieren zur Reduktion von technischen Betriebsstörungen."* Representative of SBB, 2006

[21] Translated from German: *"Für die Projektbeteiligten, innerhalb meiner Niederlassung, war es neu,einen humanitären Gedanken mit eigenen internen technischen Problemen lösungsorientiert zu verbinden."*

As the aim of SBB and of Executive Insight was to allow mPV to have a direct improving impact on the businesses and the employees, unlike that of Gepard/Cross Motion and MKorb, the executives of each company seemed to show a stronger interest in the evolvement of the project. The respective leaders where more keen to see the project succeed, whereas the executives of the firms with purely philanthropic motivations adapted a rather observational role after the initiation mPV. The leaders were more "passionate" about the success and the information flow regarding the status of the project within the companies, driven by value exchange, was higher than in that of the two companies with a purely philanthropic motive.

*„ It is a brilliant idea to combine a humanitarian and multi-social cause with a business goal. Our managers and workers at site were motivated and fascinated by the idea".*[22] The representative of SBB (2006).

**Table 9. Motivational factors for embarking in mPV. (Source: author's own).**

| Firm | Initial motivation |
|---|---|
| SBB | Value creation: A solution focused use of philanthropy as a motivational tool to encourage managers within the infrastructure division to solve internal technical problems |
| Executive Insight | Value creation: The experience would serve as an eye-opening experience for junior consultants to realize how small interventions can potentially have a very large impact when planned and implemented properly |
| Gepard/Cross Motion | Philanthropic |
| MKorb | Philanthropic |

[22] Translated German: *"Ein humanitärer und multisozialer Gedanken mit einem internen Geschäftsziel zu verbinden war und ist eine geniale Idee. Unsere MA und die Kader vor Ort wurden motiviert und von diesem Gedanken und der Aufgabe begeistert."*

## 6.2. Incentives: The Influence of Mission-/Core-Activity-Alignment and Strategic Congruency on the Quality of a Cross-Sector Collaboration as well as Value Exchange.

One hypothesis of this thesis work was that when the areas of core-activity/mission of the firm are similar to that of the project, more value could be created through the collaboration. The creation of potential intangible assets such as 1) innovation 2) relevant learning 3) better customer & stakeholder contact and network interaction, 4) access to relevant new markets, data, people and infra-structure was believed to be more likely in companies with similar core businesses aims and that were involved in related markets. According to observations and to the outcome of mPV, this is indeed the case - The most successful collaboration in this case study entailed the two firms (SBB and Executive Insight) whose primary function or core activity/aim was related to that of the project.

The core activity of the SBB infrastructure division is to ensure that all 9000 daily trains traveling the 3000km-SBB- network stay on the tracks and arrive safely and on time at their destinations.[23] Hence, their mission is to allow a smoothly running, reliable infrastructure and provide the entailing services, similar to that of mPV where the mission is to provide timely and smooth access to healthcare facilities and services. Similarly, the core mission of Executive Insight is to provide deep expertise in the area of commercial strategy, operations and organizational effectiveness for the healthcare industry.[24] MKorb and Gepard Media/Cross Motion, on the other hand, are specialized in multimedia solutions and documentary or audiovisual programs respectively.[25] Their core activities or missions are therefore not related to that of mPV.

According to the representative of SBB the identification with the mission of the

[23] http://mct.sbb.ch/mct/en/infrastruktur.htm , retrieved 10 January 2011.

[24] http://www.executiveinsight.ch/, retrieved on 10 January 2011.

[25] http://mkorb.org/, http://www.editorialoffice.ch/gepard/corporate/?id=11
http://www.crossmotion.ch/de/team/, retrieved on 10 Jan 2011.

project was *"highly important"*, and this was possible because of the similar nature of the company mission and the aim of mPV. The identification and the emotional connection was, according to the representative of SBB, further enhanced by visual material such as the documentary film and the pictures of cataract patients during one of the presentations for SBB by the author. The contact person of Executive Insight stated that an alignment of the core mission of the business with the aim of the collaboration, was of paramount importance at the initiation as well as during the course of the project.

***The Influence of Participatory Form and Mode; Services Versus Financial Support on Value Creation***

It was hypothesized that when the motivation for forming a collaboration is purely philanthropic and the type of involvement is of financial nature, the least value will be created to the company. Surprisingly, a participatory mode in form of services did not prove to be superior in comparison to a pure financial participation. Unexpectedly, the businesses that participated in mPV in form of financial support, ie. SBB and Executive Insight, experienced most value creation through the collaboration and showed the highest readiness for further commitment to the collaboration. The two businesses that provided support in form of services, experienced little or no benefits from the project and were more reluctant to further commit to the project at 5-year end-point evaluation (table 8). Nevertheless, it is interesting to note that the representative of Executive Insight, for instance, wished more direct involvement also in the field:

*" We would like to be more closely involved in the project in the future, yet the geographical distance to Ethiopia is hindering".*[26]

[26] Translated from German: "*Wir würden gerne in Zukunft noch mehr direktes Involvement suchen, aber da steht die Entfernung nach Äthiopien im Weg."*

## 6.3. Motivational Skills Influencing the Evolving and Long-term Success of a Cross-Sector Collaboration

Motivation is a powerful tool and motivated employees are more productive and efficient. The quality of an employee's work will deteriorate if he lacks motivation. Motivated workers always look for better ways to do a job and they are more quality oriented according to Maslow and McGregor [129] [130]. As there is hardly any data on skills that are necessary to motivate participants of cross-sector collaborations to engage and commit to PPPs, we investigated what motivational skills and competencies are favorable and essential for collaborative success.

Whereas hygiene factors are needed to ensure that an employee is not dissatisfied, motivation factors are needed to motivate an employee to higher performance [92]. Here we analyzed both competencies that avoid participants from becoming dissatisfied with the collaboration, as well as skills which are needed motivate an actor or party to commit to the project, and skills which are likely to stimulate positive outcome.

We were able to identify 3 main categories that allow the achieving of basic criteria necessary for the creation of a successful, motivational collaborative culture and outcome, namely 1) catalyzing or facilitating skills, 2) leadership skills, and 3) management skills (or operational management skills) (table 13). Catalyzing skills were particularly important on policy level, when setting aims and goals, whereas leadership skills were emphasized at strategy levels when planning on how reach certain set goals. The importance of management skills, on the other hand, became highly evident at the level of execution and operations.

Naturally the division into three categories may seem arbitrary, and the mentioned categories blend and overlap at times, also since the philosophical terms and terminology of "management" and "leadership" have, in the organizational context, often been used as synonyms. Drawing from Bernhard Guentert's three levels of management, catalyzing-skills and leadership-skills are of particular importance at normative- and strategic-management levels, whereas management skills are essential

at operative-management levels. In other words, in this work leadership skills and properties closely reflect that of transformational leadership described by Burns (characterized by e.g. charisma, personal relationships, creativity). Management skills, on the other hand, refer to the execution or operational level of management, and are characterized by e.g. emphasis on procedures, contingent reward, management by exception, or on transactional leadership, as described by Burns [26].

### 6.3.1. The Influence of Catalysts and Catalyzing Skills

According to researched firms, the catalysts were of paramount importance not only at the initiation of the collaboration through advocacy, but also throughout the project. According to the representative of SBB, the importance of the catalyst was *"great",* whereas Hans-Joachim Diedenhofen of Executive Insight described it as "*the single most important factor*." He further elaborated that a continued personal contact to the catalysts, following the initiation of the project, was highly relevant for the success of the collaboration. It allowed a trusting relationship to evolve and enhanced the capacity of participants to relate to the project. As pointed out by Rolf Roth of Gepard/Cross Motion and by Mario Korb, managing director of MKorb, the firms would not have engaged in the project in the first place, had it not been for the trust in the catalysts and the way the catalysts approached them.

The style of communication and people skills of the catalysts are clearly of paramount importance in communicating with the parties involved according to Mario Korb. In his view, the transparent, *"sympathetic"* and encouraging communication style was an important factor for his company to stick to mPV. The notion of people skills was also highlighted by Hans-Joachim Diedenhofen of Executive Insight who fully agreed on the importance of people skills in building trusting and sustainable relationships (Table 10).

Although all companies were up-dated and received the feedback from the catalysts to the same or similar extent, the firms that experienced least value creation through mPV were also the ones that perceived the feedback to be less satisfactory. Both MKorb and Gepard would have wished for more frequent and regular communication

and more interaction between the parties involved. However, both Daniel Engler of SBB and Hans-Jochim Diedenhofen of Executive Insight stressed the importance of regular, transparent and apt "*reminders"* or "*communications"* between the parties.

Due to the different social and business cultures of the various participants, we also found it important to not only exercise "people skills" but also "transcultural skills," despite the dominating Germanic context (Table 10). According to eT-SHaRE project sponsored by the European Union, transcultural skills and expertise allow "*cultural mediation in the health care sector in order to remove forms of exclusion, rejection or misunderstanding that often occur in health services, when the users have a hard time orienting themselves in a system of signs, interpretations and interventions that are too distant or disrespectful of their condition and culture"* [61]. Transcultural skills are the ability to realize, to comprehend individual circumstances according to the specific situation in various contexts and to develop appropriate treatments from this understanding [53]. The professionals skills entailed in this concept include self-awareness, background knowledge, experience, and empathy [54].

Due to the choice of method, namely action research, the researchers or catalysts involved in the project could also voice their own opinion on skills that they regarded as essential for successful outcomes. It became increasingly evident to the catalysts during the course of the project that a skillful catalyst not only had to allow value creation and value exchange, but to also "balance value exchange." In other words, it was important for all parties to experience value creation. Furthermore, it was important to avoid "unfair" or "unbalanced value creation, where one party experienced much more added value through the collaboration than the other parties (Table 10).

Finally, the importance of patience and resilience cannot be stressed enough. In any joint venture, but especially in a complex cross-sector collaboration that involves various different business and social cultures, languages, ethnic origins, financial and legal structures, as well as governance and law enforcements, the progress is neither linear nor fully predictable, and may entail many surprises and unforeseen obstacles. In order to achieve goals and allow value-creation, flexibility and adaptability are clearly of importance. Nevertheless, without catalyzing characteristics such as

patience, resilience and conviction, long-term goals will never be reached (table 10).

**Table 10. Catalyzing skills and properties that allow favorable motivational conditions of collaborative success. (Source: author's own).**

| Catalyzing skills and properties |
|---|
| Advocating |
| Facilitating interactions between parties and joint understanding |
| Allowing transparency, visualizing and reminding |
| Creating trust by: a) monitoring and reporting b) adapting language and sympathetic "people and transcultural skills c) balancing value exchange |
| Properties: Patience and resilience |

### 6.3.2. The Influence of Leadership and Leadership Skills

It is largely recognized that leaders do contribute to key organizational outcomes [43] [104]. However, leadership is not an inherited trait, but rather a set of characteristics and skills that can be learned [126]. Hence, it is important to analyze leadership skills and to identify relationships between certain skills and outcome, especially within cross-sector collaborations, where very little related data is available.

Within the field of functional leadership in general, five broad functions that are crucial for a leader when promoting organization's effectiveness can be identified: (1) environmental monitoring, (2) organizing subordinate activities, (3) teaching and coaching subordinates, (4) motivating others, and (5) intervening actively in the group's work [250] [88] [113].

In cross-sector collaborations, we found that strong leadership was crucial for collaborative success and value creation, especially on strategy-, but also policy- and even operational management- levels. Leaders, formal and informal, must lay the base

for change management and show the way. In any group or population, however, change can be regarded as a threat, and people tend to opt for the comfort of the established and known territories rather than venture into novel and unknown fields. Leaders must therefore first convince their team that change is desirable. Subsequently, they must also show that a desired change or a set aim can be achieved through a given collaboration. Finally, they must set a strategy and organize their teams in order to achieve their goals.

According to the representative of SBB *"The leaders of such projects have a very important role."*[27] The representative of Executive Insight believes that the company could have profited more from the cross-sector collaboration in form of image and marketing potential, if clear organizing and implementation of strategy through internal leaders would have been strengthened. Furthermore, he stated that a stronger learning curve could have been reached if junior managers would have been empowered to "get their hands dirty" and work on grass root level in the field. In addition, more value could have been created to the company in form of teamwork and business culture through motivating, coaching and empowering various players on all levels (Table 11).

All participants agreed that the personal connections between the persons in leadership positions and the catalysts were of paramount importance. Clearly personal connections were beneficial during the initiation of the negotiations regarding potential partnering, as it is easier for a catalyst to approach a potential partner if a connection already exists. Also during the subsequent phases, the information flow, the overcoming of obstacles, and the mutual searching for solutions, were heavily influenced by interpersonal connections and dynamics between persons in leadership positions (table 11).

A final observation of great impact was the personality or properties of the leaders. According to Coleman, a leader's mood is most transferable and has its greatest impact on employees' performance when it is upbeat [82]. The observations during

[27] Translated from German: "*Die Leadpersonen für ein solches Projekt sind sehr wichtig.*

the course of this study are fully in agreement with that of McClelland and Burnham, in that leaders with a positive charisma and mood create high morale, because they are able to inspire the greatest sense of organizational clarity and team spirit [134]. Strong leadership within the firm is a key to successful collaborations. The internal communication is of great importance in preparing the firm and its employees for the collaboration and their attitude towards the venture. The formal or informal leaders must create a positive and optimistic, yet realistic culture, and inspire the actors (table 11).

**Table 11: Leadership skills and properties that allow favorable motivational conditions of collaborative success. (Source: author's own).**

| Leadership skills and properties |
|---|
| Convincing, organizing and leading |
| Building good relationships with stakeholders and finding sustainable position on the market |
| Coaching and empowering actors |
| Create motivating business culture and climate and security |
| Properties: Creativity and charisma |

### 6.3.3. The Influence of Management and Management Skills

Skills that are necessary for successful management can be divided into 5 categories, namely [112]:

1. Technical: used for specialized knowledge required for work.
2. Political: used to build a power base and establish connections.
3. Conceptual: used to analyze complex situations.
4. Interpersonal: used to communicate, motivate, mentor and delegate.
5. Diagnostic: ability to visualize most appropriate response to a situation.

If motivation doesn't take place in an organization, however, then employees may not contribute to the other functions. Here we analyzed motivational prerequisites or hygiene factors [92] that avoid employee dissatisfaction, as well as factors that are needed to motivate an employee to higher performance. Based on Kleinman's classification [112], we organized our observations into similar large skill-classes, namely a) technical, b) political, c) interpersonal, and d) diagnostic. Although conceptual skills, as defined by Kleinman, are highly important for a manager in everyday life, they have a lesser direct value when it comes to motivating workers and allowing an inspiring framework. We therefore omitted the fifth category in this context, and divided the observed crucial motivational skills and prerequisites into the above-mentioned four large main categories.

As we shall see later in this chapter, technical skills such as negotiation, drafting MoUs, and allowing "meeting hygiene," were of great importance in motivating parties to collaborate and work close together (table 12). The drafting of a professional and fair mutual commitment expressed in form of a MoU, for instance, was highly valued by all parties. Furthermore, "meeting hygiene", including transparent, clear and sympathetic meetings, with the circulation of relevant preparative documents before meetings, and the capturing and distributing of written summaries after the meetings, was relevant.

In terms of political skills, the evolving and strengthening of networks and personal connections were of great importance (table 12). The representatives of Executive Insight, MKorb and Gepard/Crossmotion all thought that the evolving of personal connections was very important for the project. Trust - for instance - was cultivated through *"knowing the people one was dealing with."* Furthermore, communication and information flow also the clearly benefited from the personal connections.

Similar to Robbins et al. [171], we found that recognition of employees' individual differences was an important management skill. We also found that a manager could maximize learning through constructive feedback and visible rewards (table 12). This was particularly evident in the case of SBB where each manager was rewarded 50 SFr, or one cataract surgery, for each 10 minutes of late train arrival that he could eliminate through optimizing his infrastructure team and procedures. According to the

SBB representative.

*"The idea was a challenge yet brilliant. The mutual aim of the organization for blind and the specific SBB-Branch working together on the project, lead to a "motivational spark" [experienced by employees of SBB], and enabled a successful collaboration.."*[28]

**Table 12. Management skills and properties that allow favorable motivational conditions of collaborative success. (Source: author's own).**

| Management skills and properties |
|---|
| Technical skills: negotiation, drafting MoUs, "meeting hygiene," etc. |
| Political skills: strengthening of connections and a power base |
| Interpersonal skills: a) mentoring and team building b) recognition of employees' individual differences, and clear identification of behavior deemed worthy of recognition |
| Diagnostic skills: a) Maximizing learning through constructive feedback and visible rewards b) maximizing information flow through meetings and communication channels |
| Properties: Flexibility and adaptability |

As already briefly mentioned in the leadership section, diagnostic skills such as maximizing information flow through meetings and communication channels, was of great importance (table 12). Gepard/Cross Motion also encouraged more frequent use of multimedia channels whereas Executive Insight particularly valued personal face-to-face meetings.

[28] Translated from German: "*Die Idee, war herausfordernd und genial. Der "Motivatonsfunke", die Sehnsucht für beiden Seiten (Sehbehinderten-Organisation und SBB-Niederlassung, für Erfolg zu arbeiten, funktionierte"..*

Finally, flexibility as part of skillful management was also identified as an important factor of success (table 12). Executive Insight, for instance, experienced much value exchange arguably also because of their flexibility and adaptability. In the beginning of the project, the Executive Insight representative stated that„ *Image transfer between My Project Vision and the company"*[29] was a principal motivation, while at endpoint the main motivation had moved more in direction of learning as the educational aspect had become more evident.

[29] Translated from German: „*Imagetransfer zwischen PV und unserer Firma,"* Hans-Joachim Diedenhofen of Executive Insight (2006).

## 6.4. The Evolving of a Motivational Culture: the Importance of Trust, Identification and Emotional Connection, Empowerment and Learning and Success and Gratification

Business cultures correlate with economic performance [44] [118] [186]. Whether a culture is favorable or not - or functionally effective-, however, depends not solely on the culture, but also on the relationship of the culture to the environment in which it exist. Only by understanding the dynamic of organizational culture, can organizational effectiveness be practiced. If we don't understand the operations of these forces, on the other hand, we become victim to them" [176].

In the previous section we identified preconditions and skills that allow for a favorable collaborative culture to evolve. Once a favorable culture is in place, actual mutual value creation is enabled and the various parties are motivated to commit to the cross-sector collaboration also long-term. There is however, very little data available on the conditions in which partnerships succeed, despite the vast number of cross-sector collaborations that exist [167].

We found that when the initial motivational cornerstones and incentives as well as motivational capabilities, in form of catalyzing-, leadership- and management-skills, were in place, a favorable collaborative condition or culture for value creation and collaborative success could evolve. We called the identified culture a TIES-culture. The TIES-culture - characterized by **t**rust, **i**dentification with the cause/emotional connection, **e**mpowerment and learning, as well as **s**uccess and gratification - proved to be pivotal in laying the ground for mutual value exchange and sustainable value creation. In the following sections we will describe more in detail which basic elements we have found to be crucial in the forming of a favorable collaborative culture or conditions for sustainable value creation.

### 6.4.1. Trust

Trust was according to all firm representatives a key to a successful collaboration.

According to the representative of Executive Insight, the issue of trust was of *"extreme"* importance, a notion that all participants agreed with. He further stated that, in order to cultivate even more trust, his team would have wished for "*more direct feedback between patients and sponsors."*[30] In summary, factors encouraging trust were:

- **MoU:** Mutual commitment expressed in form of a MoU.
- **Frequent and transparent monitoring and reporting:** including visual imaging, as active monitoring was believed to be key to mutual accountability. Everyone also agreed that visual images significantly supported the creation of trust, especially during the execution phase of surgeries, when the patients where photographed before and after the intervention (the MOU that was prepared between the companies and the NGO included visual imaging for tracking progress).
- **Meeting hygiene:** Transparent, clear and sympathetic meetings or teleconferences and emails on a regular basis coordinated by a catalyst or manager. The circulation of relevant documents before meetings for preparations. Capturing and distributing of a written summary of issues discussed during the meeting.

### 6.4.2. Identification with the Cause and Emotional Connection

While trust and empowerment were considered important success factors, the emotional connection was regarded as less important, or unimportant, by all except Dthe representative of SBB. Observations by catalysts, however, indicate that the participant's capacity to related to the project mission in important for the success of the collaboration. As "relating or identifying with the mission" does at least partially entail an emotional connection, it is here asserted that the emotional connection is of importance in shaping fruitful collaborations. The emotional connection, which was to some extent present at Gepard/Cross Motion, could at least partially explain why

[30] Translated from German: Eine direktere Feedbackgestaltung von Patienten zum Sponsor.

the company did not explicitly exclude future participation despite the lack of value creation to the company through the project.

### 6.4.3. Empowerment and Learning

According to Frederick Herzberg's two factor theory, there are 1) motivators which give positive satisfaction and (e.g. challenging work, recognition, and responsibility) and 2) hygiene factors that do not motivate if present, but, if absent, result in de-motivation (e.g. status, job security, salary and fringe benefits). Similarly, Mayo believed that workers could be motivated by acknowledging their social needs and by making them feel valued and of importance [133]. Accordingly, we hypothesized that an empowering environment would be one of the cornerstones of successful collaborative culture and the base for value creation.

Indeed we found that actors that regarded themselves as actively involved and as empowered participants, also experienced most value creation. Although the form of support by the firms was either financial or in form or services, all of them participated equally in the initial planning of the project and the designing of the MoU. The catalysts encouraged active involvement of all parties in the designing of the project and feedback as well as expression of opinions throughout the project. Interestingly enough, both SBB and Executive Insight, the two firms that supported the project in form of financial means and that experienced most value creation through the collaboration, believed that they had had an influence on the project and it's outcome, whereas Gepard/Cross Motion and MKorb perceived their role as less empowered with little influence on the outcome.

### 6.4.4. Success and Gratification

Success feed success; the reaching of initial milestones of a given project feeds future success and commitment. The feeling of success is very important for motivating participants to continue their efforts and to aim for successfully achieving higher goals. According to the representative of Executive Insight it was *"very motivating to*

*see that such a simple effort could have such an effective and efficient outcome"*. His impression was that the promised outcome was achieved and this would indeed lay base for a potential future commitment to the project.

Nevertheless, according to the chief executive of MKorb the "*fun*" and factor was essential. Even though a feeling of empowerment as well as an emotional connection to the mission were lacking, he stated that the involvement had been enjoyable and fun. Hence, he did not exclude a future commitment to the project. Similarly, despite that Gepard/Cross Motion had not experienced any direct value creation through the project, the company representative did show some interest in a potential future involvement in the project, because of the "*interesting theme and people*,"[31] and as the initial participation had brought personal satisfaction and gratification. Also the representative of SBB appreciated this aspect of the project:

*"Allegria* (*Freude, Freundlichkeit, Fröhlichkeit)...I am left with a great satisfaction and memories. Thank you for this opportunity and collaboration."* [32]

[31] Translated from German: *"Interessantes Thema, interessante Personen."*

## 6.5. In sum: Motivational Prerequisites of Intangible Asset Creation

In summary, the essential skills and motivational cornerstones of successful collaborations – or value creation and commitment - are characterized by 1) the need of help and the mutual value exchange approach, with value creation as a primary motivation for embarking in the project 2) alignment between collaboration-/project-mission and core activity/mission of the participating businesses, and strategic congruency between participating parties, as incentives, and 3) the implementation of sound motivational competencies such as catalyzing-, leadership- and management-skills (table 13).

When these above-mentioned prerequisites have been enabled and supported by skillful catalyzing, leadership and management (table 13), a favorable collaborative culture that favors intangible asset creation and positive outcome, as well as sustainability, can evolve. In other words, these above mentioned motivational cornerstones lay the base for a motivational cross-sector collaborative culture, or TIES-culture, characterized by **t**rust, **i**dentification or emotional connection with the cause, **e**mpowerment as well as learning, and **s**uccess and gratification (figure 9).
The TIES-culture is an important intangible asset per se, yet the defined collaborative culture also supports further intangible value creation in form of human capital, information capital and organizational capital, and the consequent ability of an organization to mobilize and sustain processes of change that are required to execute its strategy.

Since intangible assets are becoming increasingly important in service oriented companies, as these assets support the improving of business and collaborative processes and performance, and finally the conversion of these assets into tangible outcomes in form of improved health and other social outcomes, revenue growth, and finally in form of cost reduction, it can be if great benefit to an organization to

[32]Translated from German: "*Allegria (Freude, Freundlichkeit, Fröhlichkeit)...Ein gutes Gefühl und Erinnerung bleibt in mir. Danke für diese Möglichkeit und Zusammenarbeit."*

systematically analyze how to maximize its intangible value creation through its ventures and collaborations. Furthermore, a tool to help organizations analyze their cultures can be essential to their success, as only by understanding the dynamic of organizational culture, and the crucial role of leaders in the successful applying of the principles of culture to achieve organizational goals, can organizational effectiveness be practiced [176:417].

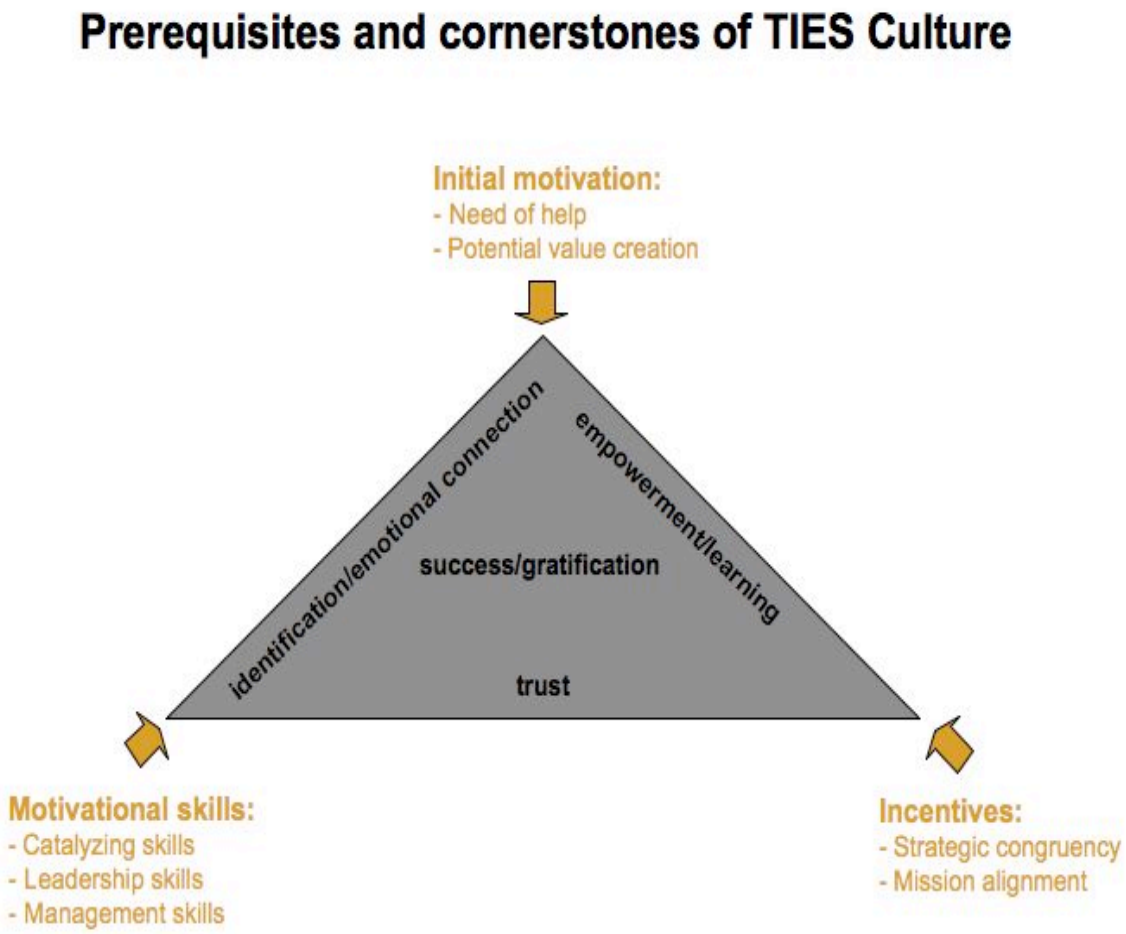
**Table 13. Essential prerequisites of collaborative success achieved through motivational-, catalyzing-, leadership- and management- skills and properties. (Source: Author's own).**

| Catalyzing skills and properties | Leadership skills and properties | Management skills and properties |
|---|---|---|
| Advocating | Convincing, organizing and leading | Technical skills: negotiation, drafting MoUs, "meeting hygiene," etc. |
| Facilitating interactions between parties and joint understanding | Building good relationships with stakeholders and finding sustainable position on the market | Political skills: strengthening of connections and a power base |
| Allowing transparency, visualizing and reminding | Coaching and empowering actors | Interpersonal skills: a) mentoring and team building, b) recognition of employees' individual differences, and clear identification of behavior deemed worthy of recognition |
| Creating trust by: a) monitoring and reporting b) adapting language and sympathetic people- and transcultural- skills c) Balancing value exchange | Create motivating business culture and climate and security | Diagnostic skills: Maximizing a) learning through constructive feedback and rewards b) information flow through meetings and communication channels |
| Properties: Patience and resilience | Properties: Creativity and charisma | Properties: Flexibility and adaptability |

Based on the here identified motivational prerequisites and cornerstones, we were able to develop a tool (**The Collaboration Scorecard**) that allows a systematic

analysis of input, output and outcome, and the correlation between these components and the tangible and intangible value created to organizations through cross-sector collaborations. The tool takes into account the importance of the here identified motivational prerequisites or conditions of collaborative success, while assessing the potential value of a cross-sector collaborations as we shall see in the following chapter (6.6).

**Figure 9: The cornerstones of collaborative success defined by value creation and commitment. (Source: author's own).**



## 6.6. Assessment Tool of Value of Cross-Sector Collaborations

### 6.6.1. Introduction

As the global economy is changing and shifting from manufacturing to a service oriented economy, intangible assets and intellectual capital have become increasingly important resources for a company's, organization' or partnership's success and value creation, especially in the healthcare industry. On one hand, intangible assets can support the improving of business and collaborative processes and performance, and on the other hand they can be converted into tangible outcomes in form of improved health and other social outcomes, revenue growth, and finally in form of cost reduction.

Indeed, more than 75 percent of the average firm's market value is derived from intangible assets or assets that traditional financial metrics cannot measure according to Kaplan and Norton [105]. In order to address this issue, among others, Porter and Kramer of Harvard Business School have proposed a new way of improving the relationship between business and society; In order to gain intangible assets in form of human capital (knowledge assets, leadership), organizational capital (communications, strategy), market capital (reputation, brand development, alliances and networks, adaptability) and innovation capital (R&D capability, technology) [261] [262], many organizations opt for collaborations or joint ventures.

Cross-sector collaborations can allow intangible asset creation to a given company involved in such an alliance. Intangible assets can then support the improving of business processes and performance, and finally be converted into tangible outcomes in form of revenue growth and cost reduction. The value of the intangible assets, however, derives from their ability to allow the organization to implement its strategy, and must therefore be aligned with an organizations objectives and strategies to reach these goals. In other words, the intangible assets should increase the ability of a business to mobilize and sustain processes of change that are required to execute its strategy.

According to some research, one of the main benefits from partnerships is indeed the increase in intangible assets. "*One normally may think of a successful company as one that effectively protects, stewards and expands capital, whether it is financial, human or natural. But one may also look at capital through the lens of intangibles and ask: How do intangibles relate to different forms of capital, where capital is an asset capable of yielding a future stream of benefits"* [105].

According to Austin, the need to partner (in order to enable both economic- as well as social goals), is shifting many cross-sector alliances from pure philanthropic to more integrative collaborations [7]. Not-for-profit organizations and governments are able to provide the alliance and the company with credibility, local connections, field experience and access to health structures as well as infrastructure, whereas private companies possess financial means and managerial skills etc.. Further, according to Doz and Hamel, cross-sector collaborations could create internal value and direct benefits through co-optation, co-specialization and through expanding information networks and exchange of expertise and knowledge [55].

Even though an increasing number of cross-sector collaborations or alliances have been established in recent years, and although it is believed that such partnerships can lead to much value creation, little data about the value of alliances beyond anecdotes and qualitative success stories have been captured according to USAID [207]. One reason for the lack of data is the complex nature and historical context of alliances, which leaves us unsure of what we need to measure in order to demonstrate value [95].

Based on data obtained through this case study, we were able to develop a first tool (**The Collaboration Scorecard**) that allows a systematic analysis of input, output and outcome, and the correlation between these components and the tangible and intangible value created to organizations through cross-sector collaborations (See Figure 12 and Appendix iii). Our scorecard is therefore a prototype or pilot strategic performance management tool for businesses involved in CSR in form of cross-sector collaborations. It is a semi-structured tool that builds on the Balanced Score Card by Kaplan and Norton and adapts to the specific settings of CSR and cross-sector

collaborations.[33] It takes into account the importance of the here identified motivational prerequisites or conditions of collaborative success, while assessing the potential value of a cross-sector collaboration. It allows an analysis of the formed organizational culture and the created intangible assets through such partnerships, as well as the monitoring of organizational performance against strategic goals.
The tool can hence also serve as a preliminary evaluation tool and guide for businesses, immersed in cross-sector collaborations, in how to create future value through investment in customers, suppliers, employees, processes, technology, and innovation.

### 6.6.2. The Original Balanced Scorecard Model

In agreement with Kaplan and Norton, the intangible assets potentially created through cross-sector collaborations can be divided into [75]:

a. Human capital (strategic competencies including skills and talents)
b. Information capital (strategic information including knowledge -systems, -applications and infrastructure).
c. Organizational capital (including culture, leadership, alignment of goals with the strategy, and teamwork).

Business processes, on the other hand, include learning-, customer-, financial- and internal-processes (see figure 10). According to Kaplan and Norton, the internal business processes can further be divided into four clusters:

1. Operations management (producing and delivering products and services to customers)
2. Customer management (establishing and leveraging relationships with customers)

[33] See Kaplan RS, Norton DP. The balanced scorecard: measures that drive performance, *Harvard Business Review,*
*1992,* Jan – Feb: 71–80. or http://www.balancedscorecard.org/

3. Innovation (developing new products, services, processes and relationships)
4. Regulatory and social (conforming to regulations and societal expectations and building stronger communities

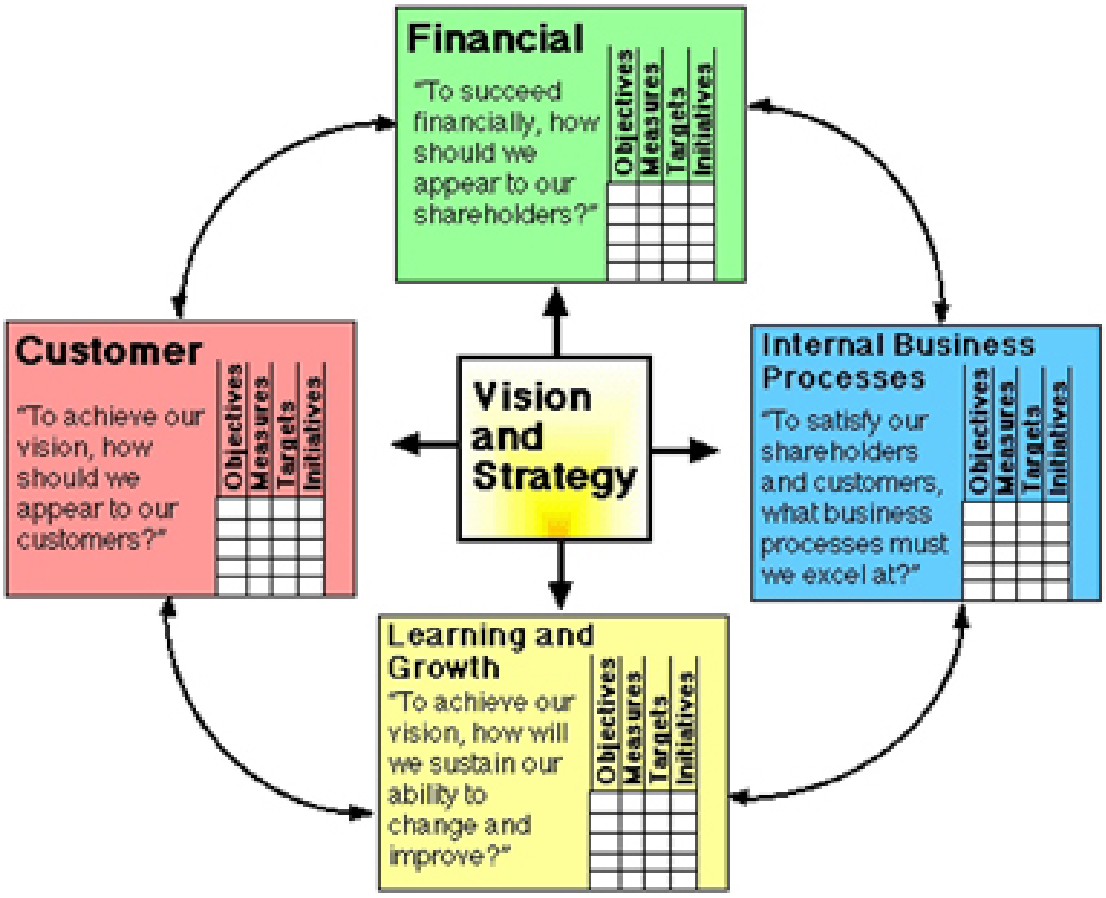
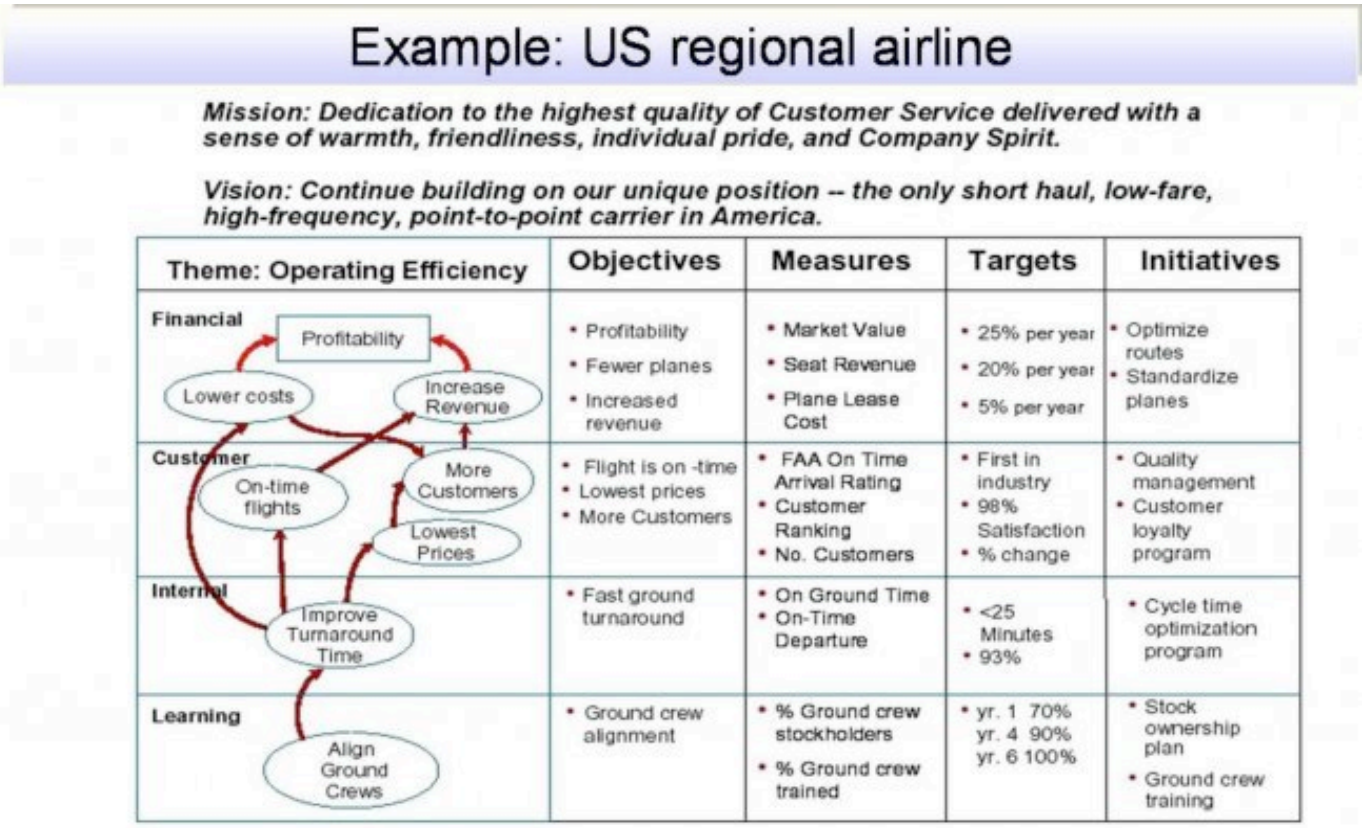



**Figure 10. The four major categories of business processes according to Kaplan and Norton. (Source: Adapted from Robert S. Kaplan and David P. Norton, "Using the Balanced Scorecard as a Strategic Management System," Harvard Business Review, 1996 (January-February): 76).**

The balanced scorecard by Kaplan and Norton is a strategic planning and management system that is designed to align these above mentioned business processes of a given organization with its vision and strategy. Furthermore, the aim of the tool is to improve internal and external communications, and monitor organization performance against strategic goals, and to add strategic non-financial performance measures to traditional financial metrics to give managers and executives a more 'balanced' view of organizational performance [272].

**Figure 11. Example of an implementation of the Balanced Scorecard. (Source: Balanced Scorecard Institute, 2009).**




### 6.6.3. The Adapted Collaboration Scorecard Model

As oppose to traditional business models where a company's purpose is primarily to maximize shareholder value, the involvement of businesses in corporate social responsibility (CSR) actions may involve a strong philanthropic component and social objective. In other words, apart from financial performance, a further desired outcome is per definition a social result, such as cataract operations and the restoration of vision in people affected by blindness (see www.MyProjectVision.com). Hence, we have here adapted the Balanced Scorecard Model to the CSR and cross-sector collaboration setting. The resulting **Collaboration Scorecard** evaluates the potential value of a cross-sector collaboration through the analysis of formed organizational culture and intangible asset creation through such partnerships.

The Collaboration Scorecard is a prototype strategic performance management tool for businesses involved in CSR in form of cross-sector collaborations. It is a semi-structured report built on the balanced score card by Kaplan and Norton and integrates intangible asset creation with financial outcome. It is flexible in structure and allows the each individual organization to capture the information most relevant for their business and information that relates to the implementation of a strategy and value creation. Just like the Balance Scorecard, it articulates *"the links between leading inputs (human and physical), processes, and lagging outcomes and focuses on the importance of managing these components to achieve the organization's strategic priorities."* Furthermore, it takes into account the importance of identified prerequisites or conditions of collaborative success, such as the necessary initial motivations for embarking in a cross-sector collaboration, mission alignment and strategic congruency, and required skills by evaluating:

a) Prerequisite motivational cornerstones of collaborative success as defined in chapter 6.1-6.6.
b) Value creation through the evaluation of ***1) the meeting stakeholder expectations***, ***2) customers/stakeholder networks and image*** (improved customer and stakeholder networks/ market access and/or image/marketing potential (see table 13)), ***3) internal business processes and*** **activities** (improved innovation and the gaining of relevant skills and now-how for operational processes and business activities (see table 13), and ***4) organization and culture*** (the evolving of a TIES-culture (see figure 9), including empowerment, learning, growth, change managmenet, employee satisfaction and retention, as well as teamwork).
**c)** Ojective and subjective outcome in form of financial results and social outcome.

***Procedure and Interpretation of Results***

The evaluator or user should answer the questions 1-18 with "yes," "no," or "not known/ not applicable (yet)." Each "yes" is assigned +1, each "no" is assigned -1 and each "not known/ not applicable (yet)" is assigned the number 0 (see figure 12). The questions are divided into eight categories (A-H):

- **Prerequisite conditions and inputs:** The first three categories (A-C) compromise questions regarding prerequisites or important initial motivational cornerstones, conditions or preferable frameworks that should be in place for a successful collaboration to evolve. These cornerstones include A) a strong starting point motivation to venture into a cross-sector collaboration (including the actual need of help and potential value creation for the firm), B) Incentives (such as mission alignment between company/division-core-mission and mission of the cross-sector-collaboration, or a strong congruency/alignment between the strategy set by the organization to reach its goal and the set strategy by the collaborative project task force to reach actual social goals), and C) motivational skills or inputs required for collaborative success (namely catalyzing-, leadership- and operational project- management-skills (see table 13).

- **Output:** The following four categories (D-G) encompass output and include D) the meeting of stakeholder expectations, E) improving customers/stakeholder networks, market access and business image F) the improving of internal business processes and activities through the gain of relevant skills or knowhow and information, and G) the improving of organizational business culture that is caracterized by trusting relationships, identification with the project cause and willigness to achieve the set goals, and finally an empowering climate where learning is stimulated and where workers are satisfied and experience the feeling of success. The categories are similar to that of the Balanced Scorecard, developed by Kaplan and Norton, and reflect business processes and intangible asset creation that may be gained and improved through the involvement of organizations in cross-sector collaborations.

- **(Preliminary) outcome:** The last category (H) is based on an overall outcome of the project in regard to preliminary social project results and financial gains for the business.

Once all questions are answered for each category, the sum of the numbers is calculated, with a maximum potential score equaling 18 and minimum score of minus 18. Based on the resulting score, conclusions regarding potential value creation through the cross-sector collaboration to the organization can be drawn (see figure 3). If a given business organization scores seven or more, the potential long-term value creation is great. A score between one and six also indicates potential value creation, albeit to a lesser extent. A score of 0 indicates possibly no value creation to the organization through the collaborative alliance and a score smaller than 0 reflects potential negative value and loss to the involved business.

The model also visualizes weaknesses and improvement potentials as well as possible future directions of the specific partnerships. Hence it can be used at various time-points of a cross-sector collaboration to 1) determine value created to a specific organization through a partnership in form of intangible assets, b) to predict future, potential long-term value creation and outcome, and c) finally to alert managers to areas where performance deviates from expectations and allow strategic planning to improve outcome.

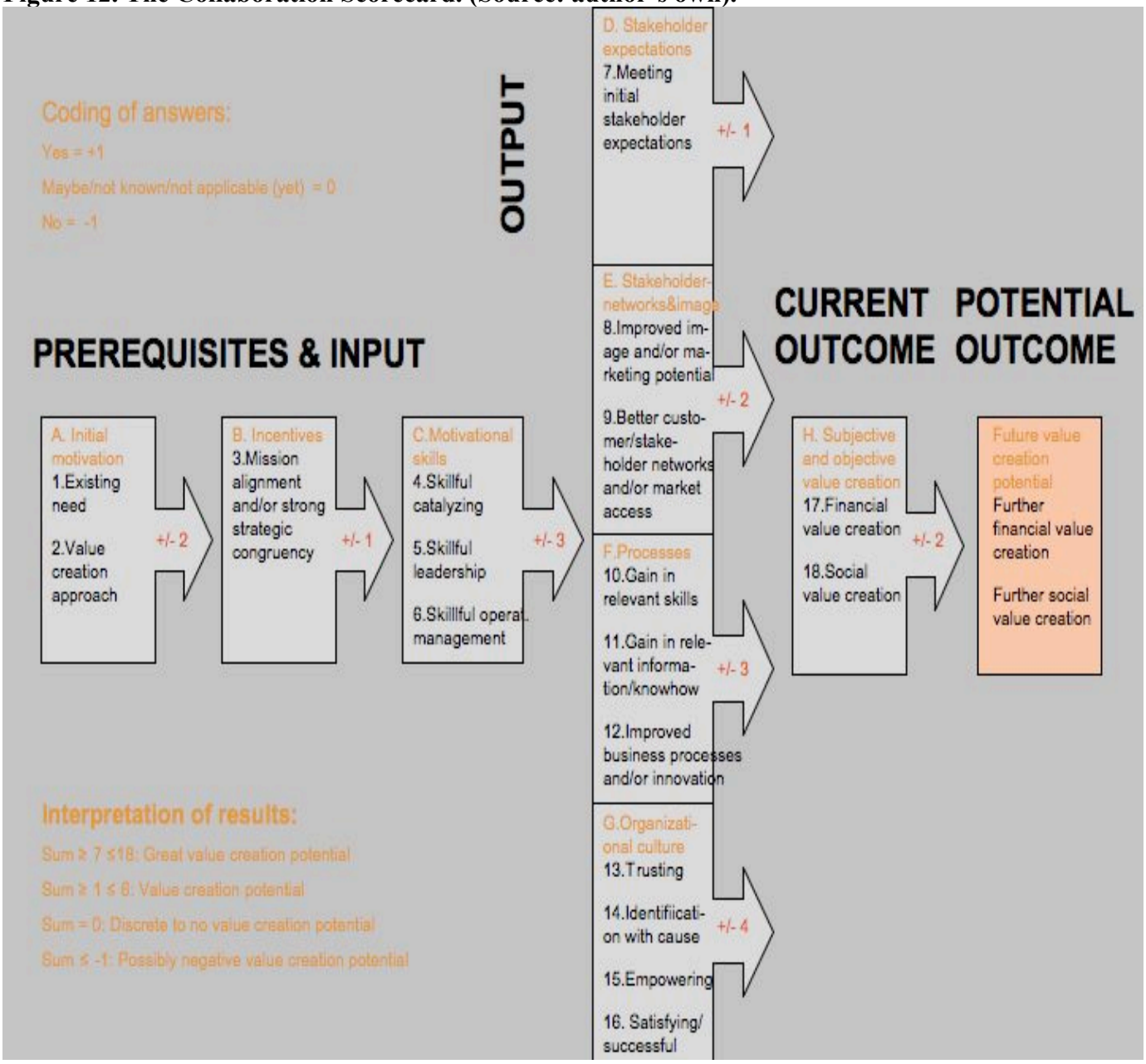
### 6.6.4. Summary

Just like the traditional **Balanced Scorecard**, our developed tool articulates *"the links between leading inputs (human and physical), processes, and lagging outcomes, and focuses on the importance of managing these components to achieve the organization's strategic priorities"* [266]. The tool can hence also serve as a preliminary evaluation tool and guide for businesses, immersed in cross-sector collaborations, in how to create future value through investment in customers, suppliers, employees, processes, technology, and innovation.

The tool is developed for assessing the input, output and outcome of a cross-sector collaboration and is based on the studying of firms involved in this particular PPP. However, as mentioned before, it is likely that the same factors and variables that reflect collaborative culture and favorable conditions in the firm also reflect that of other parties in involved in the PPP, as all parties are immersed in the same

collaboration. Yet, further research is necessary to confirm this assumption. Furthermore, the tool was developed based on this explorative pilot-study based on a limited but information rich sample. Consequently, more research entailing a larger and different sample is needed to confirm the results and the validity of the tool. Yet, as no such tools exist today, the developed tool can be very useful in the further investigation of similar themes in the meanwhile.

**Figure 12. The Collaboration Scorecard. (Source: author's own).**



## 6.7. Tangible Outcomes in Form of Surgeries

One of the main aims of this project was undoubtedly to lay the base for an intervention and allow value creation in form of curing people from blindness or poor visual acuity. In order to reduce the prevalence of blindness due to cataract on a global scale, with a visual acuity target of approximately 6/24 or better, a cataract surgical rate (CSR)[34] of 4000/Mio cases of cataract per year is necessary, although this rate depends on the demography and varies between regions. In Ethiopia for instance, the crucial CSR equals approximately 2000/Mio whereas in India it is higher than 4000/Mio due to the differences in incidence, demography and mortality rates. Yet the rate in Ethiopia today equals approximately 500/Mio per year, which equals approximately 40 000 cataract operations per year.

| |
|---|
| 500 cataract operations/Mio people per year x 80 Mio people = 40 000 operations per year |

During a time-period of two years, mPV enabled approximately 3000 operations according to CBM, which is also confirmed by pictures taken before and after each surgery. In other words, if the average number of operations in Ethiopia over two years equals:

| |
|---|
| 2 years x 40 000 operations per year = 80 000 operations |

mPV increased the number of operations in Ethiopia by approx. 3.5% - the most efficient cataract project in Africa according to Hansjoerg Baltensperger of CBM - without decreasing the number of surgeries conducted in the place of origin of the cataract surgeon or ophthalmologist, - as mPV was project-based and did not decrease the number of days that the surgeon spent operating in his home clinic or hospital. Hence we simply made cataract surgeries more available and affordable through 1) increase in productivity of personnel, 2) avoiding overhead costs, 3) avoiding nonessential materials and taking advantage of the surplus pre-existing

[34] CSR = Number of cataract operations per million population per year.

consumables.[35]

Furthermore, our absence in the following year did not affect the sustainability of the infrastructure, provision of medical equipment and supplies, or the basic salaries of the medical personnel, as these were already in place before we arrived. We simply provided the running costs (mainly an addition to the baseline salaries of the personnel, since the salaries constitute the major part of the expenditure, or 40-70% depending on the circumstances)[36] of the additional out-reach projects to remote areas, whereas the baseline training and development costs were/have long been provided by the Ethiopian government and CBM among others. Through the concerted effort with CBM and the regional health bureau, allowing these parties to decide the magnitude of salary increase as a reward to the additional work due to out-reach programmes, we aimed to avoid any duplications or draining of resources, and to invest in regions were the need of help was the highest. Furthermore, we attempted to avoid upsetting the economy and the systems and award schemes already in place.

Also in terms of setting a price for each cataract surgery, we allowed CBM to set an all- encompassing target cost of $35 (equaling approx. 50 CHF at the prevailing exchange rate in 2005) for each surgery including services, consumables, accommodation and food. In order to allow all patients to receive a surgery, regardless of their financial power, we proposed a scheme were everyone had to pay a smallest nominal sum for a surgery, but where every other form or service (such as transportation to the facilities, accommodation, food etc.), was either fully subsidized or partially subsidized depending on the patient's buying power and background. A proper all-covering cross-subsidy was clearly not possible as the outreach programs targeted the most rural areas inhabited by the poorest population. The magnitude of the smallest nominal sum, and the charging in general, was managed and decided by CBM together with the government. Through our proposed scheme, we aimed to avoid upsetting the pre-existing systems and economy, as well as creating tiers on

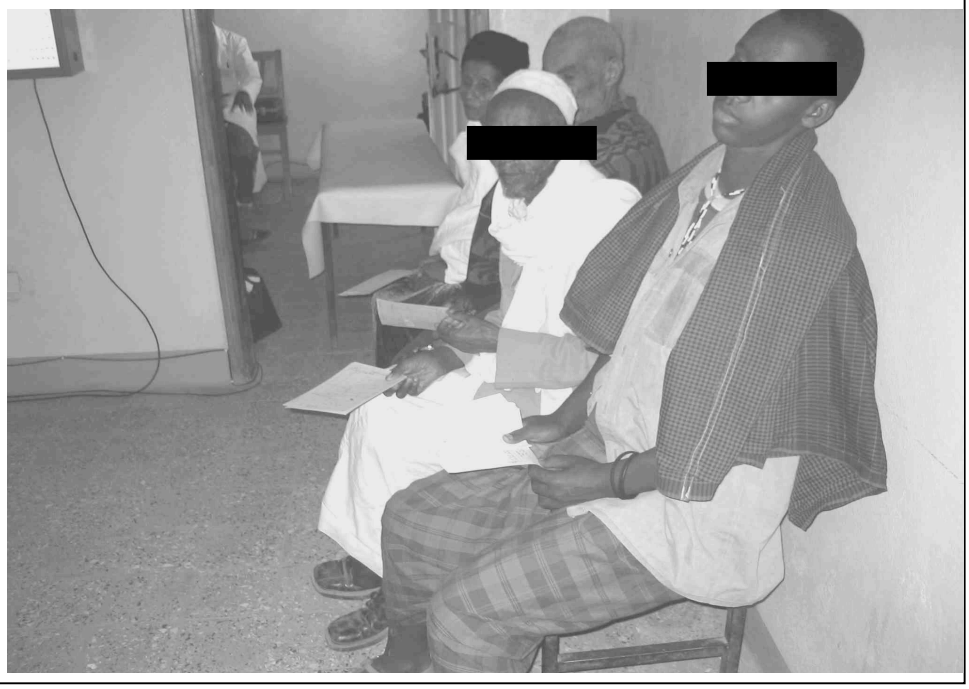
[35] Although consumables such as lenses, sutures and anesthetics are often limiting factors, as stated in the National Blindness and Low Vision Survey 2005-6, this was not true in our specific case as previously mentioned.

[36] According to Prof. Foster of London School of Hygiene and Tropical Medicine, 05 July 2011.

clinical care.

**Figure 13. Healthcare professionals in Ethiopia. (Source: author's own).**

**Figure 14. Ethiopian patients waiting to be treated for cataract. (Source: author's own).**



## 6.8. Discussion

Action research is an interactive inquiry process that balances problem solving action implemented in a collaborative context with data-driven collaborative analysis or research to understand underlying causes enabling future predictions about personal and organizational change [165]. Action research challenges traditional social science, by moving beyond reflective knowledge created by outside experts sampling variables to an active moment-to-moment theorizing, data collecting, and inquiring occurring in the midst of emergent structure. "Knowledge is always gained through action and for action. From this starting point, to question the validity of social knowledge is to question, not how to develop a reflective science about action, but how to develop genuinely well-informed action - how to conduct an action science" [201]. When tested against the criteria of positivist science, action research is found not to meet its critical tests and is therefore somewhat questioned by more traditional scientists [213:77]. The fact that the researcher is being perceived to have a personal stake in the researched project, and reporting on one's own role within the project, is considered to constitute a particularly challenging problem of participatory action research. To address these issues, multiple combined methods have been applied in this study to allow scientific rigor and validity, as described in part III.

Another arguable weakness of this work is the definition of successful collaborations. Success is here rather arbitrarily defined as value creation to all parties and commitment of the various parties to the project also over a longer period of time. In other words, successful collaborations are characterized by mutual value exchange and sustainability. Yet, rather than focusing on outcome, many authors include activities or processes and missions of alliances in the definition of success. According to Pearce J.P. and Doh J.P. in the MITSloan Management Review, for instance, there are five principles of successful collaborative social initiatives: (1) Long term commitment, (2) Contributing with products and services that are based on the firms core operation, (3) Cooperation, (4) Weighing Governments influence and (5) Putting a price on the total benefit package [160]. Although all principles seem reasonable, all but the long-term commitment principle define processes and activities rather than outcomes.

Similarly, the "seven Cs" or the seven organizational challenges that partnerships confront, and which have to be tackled successfully to allow strong partnerships to evolve "*1) Clarity of purpose, 2) Congruency of mission, 3) Creation of value, 4) Connection with purpose and people, 5) Communication between partners, 6) Continual learning, 7) Commitment to the partnership"* [7], do not actually define success. Although Austin does no imply that the seven Cs define success (he asserts that they constitute the challenges of successful relationships), but rather states that the amount of value that's being created through the collaborative process is an underlying factor determining the sustainability and power of a partnership, he is often misquoted in this context.

There is an extremely limited amount of research that actually defines collaborative success and outcome in general terms. Some case studies point out which factors or prerequisites that lead to success (critical success factors) in the particular case, yet these factors are often not generalizable, and what is meant by success is not clearly defined. This is very surprising, since the value of an alliance – or any initiative, program or relationship for that matter – cannot be measure without defining success [207]. In a publication in 2010, USAID attempted to tackle this problem and stated the following: Successful outcomes reflect desired change as a result of a particular set of programs or activities. Although some processes may be critical for success, these processes do not define success. Drawing on Undertal's and Young's definition that effectiveness is defined along four distinct dimensions: output, outcome, impact and goal attainment [205] [246] [247], and based on the Austin's assumption that the amount of value that's being created through the collaborative process is an underlying factor determining the sustainability and power of a partnership, success is here defined by value creation and by sustainability, in other words, by sustainable value creation. Based on research by USAID, success is therefore not defined by activities, but rather by outcome (i.e. sustainable value creation).

Hence, this thesis work defines motivational factors that have to be in place for a successful output, in form of a positive and motivating collaborative culture as well as intangible value creation, and outcome in form of sustainable and tangible value creation (i.e. restoration of vision in form of cataract surgeries and revenue) to ensue. Yet there are many parallels between Austin's identified "seven Cs" and our

identified motivational cornerstones that allow a consequent outcome in form of positive collaborative culture. In this work we identified 1) the need of aid as a clear purpose - similar to Austin's "clarity of purpose" 2) mission alignment or strategic congruency and value exchange as incentives - similar to "congruency of mission" and "creation of value", and 3) motivational catalyzing-, leadership- and management-skills - similar to Austin's "Communication between partners", as essential components that allow a positive outcome in form of motivating collaborative TIES-culture and sustainable value creation.

As already mentioned before, the TIES culture is characterized by trust, identification and emotional connection with the cause/purpose (similar to Austin's "connection with purpose and people) as well as empowerment and learning (similar to Austin's "continual learning"), and finally success and gratification. The sustainable value creation or value exchange and commitment to the project that is supported by the favorable collaborative culture, on the other hand, reflects Austin's 7th "C" or "commitment to the partnership."

Another potential weakness of this work lies in potential bias due to the personal relationship between some catalysts and firm employees. It is possible that the catalysts were supporting some firms more than others, however, this potential bias has been taken into account in the interpretation of the empirical data. In addition, in order to minimize or abolish the impact of the sort, the meetings were attended by two catalyst, and the data collected was immediately compared and consolidated afterwards, as consolidated data from different sources may increase the validity or at least paint a more accurate picture of the studied cases [256:55]. In addition, the cross validation and data triangulation, through the analysis of the each company's websites and other documents, as well as through questionnaires, allowed potential biases and errors if only one method of data collection to be minimized [46:300]. Furthermore, it is possible that the catalysts favored the for-profit field rather than the non-for profit sector. The composition of the group of catalyst, however, compromising one representative of the non-governmental/NGO field, one "impartial" representative and one representative of the firms/for profit sector, was designed and selected in such a manner that possible favoritism of the for profit sector would be minimized.

Furthermore, it cannot be excluded that the different sizes of the companies may be confounding. Due to the unfamiliar and unexplored nature of the study, a qualitative methodology was chosen, as explained above. Furthermore, in order to maximize the amount and quality of information, the sampling was based on information oriented selection rather than random sampling. Hence, in order to cover a large spectrum of sizes, one company represented the size of less than 10 employees/direct collaborators (MKorb), two companies represented a business size of 10-30 employees/direct collaborators (Executive Insight and Gepard/Cross Motion), and the fourth company was composed of more than 30 employees/direct collaborators (SBB).

In addition, the tool developed for assessing the culture and output of a cross-sector collaboration is based on a very small sample (but information rich) by the studying of firms involved in this particular PPP. Hence more research entailing a larger and different sample is needed to confirm the results and the validity of the tool. Yet, as no such tools exist today, the developed tool can be very useful in the further investigation of similar themes in the meanwhile.

In regards to tangible outcomes and surgeries, although each patient was documented before and after surgery, to allow transparency and monitoring, and even tough the visual acuity was checked before and 1 day after each intervention, a proper monitoring of the surgical outcome did not take place. Since we used properly trained and skilled cataract surgeons and ophthalmologist, and implanted intraocular lenses into all operated eyes, we are assuming that surgical success target set by the WHO was reached. Nevertheless, as no monitoring or evaluation took place, and as no 6-week post-surgical check-up took place, we lack objective data on the surgical outcome and on any possible immediate or long-term complications.

Furthermore, the Tigray region chosen for the intervention with its 5 Mio inhabitants, and a 1.6% prevalence of blindness, is clearly too large for a simple regional blindness prevention programme, as the recommended size for such an intervention would be approximately 1 Mio people according to recommendations set by Vision 2020. Furthermore, with an incidence that is approximately ten times higher than that in the USA [264], the achieved CSR was not high enough to reverse the trend and to allow a decrease in the total pool of blind. Hence the increase in CSR due to mPV

was not sufficient to address the backlog[37] of approximately 40,000 cases, which is sobering given that Tigray has one of the highest surgical rates in the country.

In addition, we didn't address the issue of training more healthcare professionals, including cataract surgeons and ophthalmologic nurses. Nevertheless, it was absolutely clear to our team that these measures were essential for a successful elimination or even to simply stop the increase in prevalence of blindness in the region, in addition to the developing of primary care services within a system wide approach context. Hence, we were involved in discussions regarding the matter with NGOs and local health care staff, and inquired into the efforts that were made by CBM in building and developing training programmes and primary care infrastructure. The programmes were all coordinated and under the supervision of the national ministry of health, and although respectable efforts were undertaken, there was significant room for improvement. However, the covering of development and training costs was beyond the scope and capacity of mPV in its initial phase, as the project only covered running costs for additional outreach projects[38] - in agreement with CBM - but the issue could (and should) certainly be of interest in the future.

Nevertheless, ***as the productivity of an ophthalmologist was increased*** through a temporary shift of the surgical site form an urban area into rural areas through brief out-reach programmes (between every-day work in centralized locations such as Addis Ababa or Mekele), ***the critical patient waiting-list could each time (each outreach) be eliminated*** in these rural areas without creating an additional waiting list in the cities, whereas the ***limiting factor of patient diagnosis and mobilization in rural areas remained.*** So even if the out-reach programmes solved the problem of lack of ophthalmologists in a pragmatic way without addressing the training of more

[37] Ideally the CSR should equal the incidence rate in order to decrease the backlog, which is significantly affected also by mortality rates according to Prof. Foster of London School of Hygiene and Tropical Medicine during the "Planning for Vision 2020" course in July 2011.

[38] The sole covering of running costs of additional outreach programmes by mPV was deliberate, as we did not want the sustainability and survival of baseline activities as well as infrastructure and the provision of consumables, including training healthcare-personnel, treating patients and acquiring surgical equipment and materials, to be dependent at the initiation point of the project.

highly qualified professionals, it did actively addresses the problem of patient diagnosis and mobilization - the most critical limiting factor, as the waiting list could always be eliminated - by increasing the total number of out-reach efforts to go out to the population most in need. It did so by training primary personnel to diagnose cataract, by raising community awareness of blindness and cataract, and by bringing the diagnosed patients into the decentralized temporary surgical sites.

Finally, a weakness of mPV was reflected in the fact that it did not address children affected by cataract, as treatment of children is quite different from adults and entails different consumables and a much higher level of expertise of the surgical team. For once, the intraocular lenses (IOLs) are not PMMA-IOLs but rather soft lenses and ten times more expensive. Both eyes also have to be treated in children during the same admission due to “lazy eye phenomenon”, and the hospital stay encompasses a time-period of approximately 10 days. Refractory corrections and regular check ups are also essential in children. Hence, our resources, skills and expertise were insufficient for the pediatric patient pool. Nevertheless, CBM and especially Orbis international, are active in the field of pediatric cataracts, and the control of blindness due to cataract in children should be of primary concern in the regional, national and global agenda.

## 6.9. Lessons Learned and Future Research

Most of the findings in this study were in agreement with the hypothesized key factors of successful cross-sector collaborations. As expected, the initial motivational factors of "actual need of help" and of "mutual value exchange," as well as incentives characterized by mission alignment (the alignment between the project aim and the primary core mission of the company), or strategic congruency between participating parties, were pivotal in allowing of successful cross-sector collaborations to evolve.

According to our preliminary observations, the more actively the participants engage in the project, and the more influencing power they have in the process, the more committed they are to the project and the larger the potential impact of the project in learning processes and on corporate culture in general. This seems fairly plausible, since a participatory mode that also entails services gives employees the opportunity to develop certain skills, talent and knowledge. Hence, the lack of a relationship or positive correlation between the participatory form of support (services rather than pure financial support) and collaborative success came as a surprise. It is however important to note that the two firms that experienced most value creation whilst supporting the project purely through financial means, where also the ones that stated value exchange as initial motivation and incentive. Hence it is possible that the importance of these factors overshadow the impact of participatory mode on the collaboration success.

Furthermore, these two firms also possessed a better mission alignment and strategic congruency, which may be confounding and explain why, despite their pure financial support. Even though the two firms that were participating in form of services were more reluctant to commit to the project after the end-point interviews and questionnaire, both firms subsequently actually provided the project with either substantial support or proactively offered to participate in the future. Hence, this particular research question could not reliably be answered through this work, and this topic requires further research before clear conclusions can be drawn.

Another success-factor, that was initially underestimated, was the importance of a

catalyzing skills and management skills. According to all participants, the personal connection and transparent, honest and appealing communication style was of paramount importance for initial engagement as well as for future commitment. Furthermore, the frequency and fashion in which meetings were conducted and feedback was communicated, were considered equally important. The weakness of mPV was in fact the low frequency of communication and feedback at later stages and all participants agreed that some improvement- potential lay here. This observation is in agreement with the international health partnership and relative initiatives IHP+ core team report, which states that as greater 'meeting hygiene' has been introduced into Executive Team meetings, their quality has improved. When agendas are more focused and documents are shorter and circulated further in advance, more people engage, perspectives are broader, and meeting conclusions clearer. Furthermore, increased communication and efforts to get greater joint understanding by WHO and the World Bank, has led to positive results within their partnerships (2010).[39]

The third lesson learned was the importance of leadership within the company. Business leaders and managers can capitalize on the positive benefits of optimism, but as emotions and behaviors are contagious [91], leaders interested in fostering positive organizational behavior constructs within their organizations must first look inward and analyze their own beliefs and attitudes. Furthermore, these emotions and moods tend to travel fastest within an organization and leader's mood is most transferable and has its greatest impact on employees' performance when it is upbeat [82]. The observations during the course of this study are fully in agreement with that of McClelland and Burnham, that positive leaders create high morale because they are able to inspire the greatest sense of organizational clarity and team spirit according to McClelland & Burnham [134]. Furthermore, an organization, which contains a culture and leadership derived from complex optimism, is one in which motivation, achievement, resilience and success flourish. In this study it could be observed that a project such as mPV can foster positive organizational behavior, yet leadership characterized by realistic optimism is important in the maximizing of this effect.

[39] http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_core_team_report_april_2009m_EN.pdf Retrieved 10 Jan 2011.

Similarly, negative leadership can abolish the optimism and the "feel-good" effect of the collaboration. Nevertheless, leaders should remain realistic about the goals, since the closer and the more similar the initial outcome- expectations are with the actual final achievements, the better the perceived value creation and the subsequent adherence to the project.

In sum, by allowing a win-win situation of cross-sector collaborations, where a mutual value-exchange is enabled, all parties can profit from the partnership. Yet, there are some basic prerequisites and frameworks that have to be in place in order for mutual value to be created and for sustainable and long-term collaboration to evolve, namely: 1) Starting point motivation: actual need of help and improvement potential as well as a mutual value exchange approach, 2) Incentives: mission alignment and strategic congruency, and 3) Motivational skills: motivational catalyzing skills, leadership skills and operational management skills. When these prerequisites or cornerstones are in place, an environment that favors a prosperous environment, or a TIES-culture (comprised of trust, identification with the cause/emotional connection, empowerment and learning as well as success and gratification), is enabled. The results of this qualitative pilot study should point us in the direction in which future studies should evolve. The information could be transferred into another setting tested through a quantitative study.

# Part VII: Conclusion

"*...We believe we have an important role to play, in partnership with others in the public and private sectors and civil society, to help spread the benefits of development more widely by the manner in which we pursue our business activities. A commitment on our part to listen to and work with these other groups makes sound business sense and will enable us to better serve the interests of our shareholders and other key stakeholders, especially over the longer term."*

Joint statement, CEO Task Force on Global Corporate Citizenship (World Economic Forum 2005).

It is generally acknowledged by the World Health Organization, and arguably by the international health community, that cross-sector collaborations are essential in the provision of healthcare, especially in developing countries with weak government support [123]. Through a longitudinal case study over five years, this research project therefore strived to understand how the commitments of private firms to social responsibility and public health initiatives could be strengthened through defining motivational factors and conditions that support potential value creation and mutual value exchange. As very little is known about how these types of cross-sector alliances are formed, and what makes them succeed, this explorative study provides novel insight into motivational factors and prerequisites that lead to the engagement of firms in CSR in the form of cross-sector collaborations, as well as motivational conditions that promote value creation in the form of tangible and intangible assets. Finally, this doctoral thesis highlights motivational conditions and provides strategies that promote long-term commitment of firms to CSR in international health, particularly when governments fail to provide public good and healthcare services.

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## 7.1. Private Actors in Provision of Public Good

As health is a global challenge in industrialized and developing countries alike, there is a need for more effective collective action by governments, business and civil society to better manage these risks and opportunities, which has led to a reassessment of the rules and institutions that govern health policy and practice at subnational, national, transnational and global levels. The need for reevaluation and re-organization is more important than ever before, since a range of health determinants are increasingly affected by factors outside of the health sector; trade and investment flows, collective violence and conflict, illicit and criminal activity, environmental change and communication technologies all effect health directly or indirectly. There is a widespread belief that the current system of international health governance does not sufficiently meet these needs [52] and that there is an acute need to broaden the public health agenda to take account of these globalizing forces, and to ensure that the protection and promotion of human health is placed higher on other policy agendas [139].

Both U.S. President Barack Obama and Secretary of State Hillary Rodham Clinton have emphasized the importance of cross-sector collaboration in their central role in U.S. foreign policy and international development strategy. As President Obama stated at the 2009 annual meeting of the Clinton Global Initiative [151]:

*"Today's threats demand new partnerships across sectors and cross societies – creative collaborations to achieve what no one can accomplish alone."*

Secretary Clinton presented a similar vision at the Global Philanthropy Forum in 2009 [269]:

*"...I'm even more convinced now than I was when I became Secretary of State that the problems we face today will not be solved by governments alone. It will be in partnerships – partnerships with philanthropy, with global business, partnerships with civil society."*

Civil society engagement in national health planning processes is getting more attention outside the U.S. as well. Most countries do in fact have some civil society organization participation, but ways to make this more effective are urgently called for according to IHP+ [99]. In the voluntary sector, non-profit or non-governmental organizations are collaborating increasingly among themselves, as well as with the other sectors, to tackle broad and multi-faceted problems that require a range of skills sets and significant resources [5] [7] [57] [67]. In turn, they are themselves becoming more collaborative as they seek to address issues of greater magnitude that require more or different resources. Especially in the health sector, this trend has become increasingly apparent, as very significant resources are required to support major studies, which typically involve collaboration among a number of scientists, academic institutions or research centres.

Today, we have a better understanding of how both commercial and non-profit organizations can contribute to improving not only society but also the economy as a whole [1]. According to Austin at the Social Enterprise Initiative of Harvard Business School, the nonprofit sector comprises 7 percent of U.S. gross domestic product, employs more than a million people, and mobilizes 7 million volunteers. Worldwide, the sector makes up almost 5 percent of the GDP [9]. Yet, one of the key leadership challenges of our time is to find new ways to harness the innovation, technology, networks, and problem-solving skills of the private sector, in partnership with others, in order to support international development goals. Furthermore, it is a challenge to do so in a manner that makes sound business sense and does not replace, or undermine, the role of government. During a session at the World Economic Forum in 2005, it was concluded that business leaders have a growing interest, both in terms of risk management and harnessing new opportunities, to get engaged in CSR [245]. According to Kim B. Clark, Dean of Harvard Business School [270]:

*“We have come to understand and believe strongly that the leaders we prepare need to be associated with social enterprise. It is part of what it means to be a leader in our society."*

Current theorizing in CSR is dominated by an economic view of the firm and an instrumental view of CSR projects [103], and CSR is justified with an empirical

argument that social performance contributes to financial performance [15] [6] [210]. A "business case" for CSR is made, i.e. the management of business firms in social responsibility is considered similar to an investment in any other product attributes such as quality, service, or reputation that contribute to the profit-making of the firm [265]. The behavior of the business firm is directed towards profit making, and this is justified as long as the firm complies with the rules of the game set by the state and defined by morality of the circumscribing social community.

This new situation provides ground for opportunistic behavior, and may be contra-productive for public welfare, as it is assumed that it is finally the "invisible hand" of the well functioning and well defined market that directs economic behavior towards the common good, while the capacity of the state to regulate economic behavior and or set the conditions for market exchange is in decline in our globalized world. The state apparatus is not only limited, but even fails on many occasions (e.g. public goods in short supply, gaps in regulation, lack of enforcement, externalities of market exchange without provisions from the state etc.). Consequently, economic forces are set free without appropriate restrictions in legal or moral terms, as also the moral standards for business behavior get fuzzy and loose their restrictive power, due to the individualization and pluralization of values in social communities according to Scherer and Palazzo [179].

Nevertheless, it is here asserted that the "win-win" situation of partnerships [199], where for-profit firms, NGOs and governments all profit, is highly important in maximizing the success and impact of cross-sector partnerships. Yet, it is believed that this should and must be done in an ethically and morally sound context. According to CECP, based on research by McKinsey & Company, businesses should and are in fact able to do more because the model of sustainable value creation dissolves the longstanding zero-sum tension faced by corporate executives: to increase shareholder returns or do the right thing for society [32]. In doing so, it is essential to consider new forms of political regulation above and beyond the nation-state, in order to re-establish the political order and circumscribe economic reality by new means of democratic institutions and procedures [86], and to support a "politization of corporations" [179].

The current situation provides a unique and expansive opportunity for the private sector. However, balancing sound business models and broader development support remains challenging. There is a long history of the study of alliances in the management literature, yet the public sector literature has not been able to develop at the same rate according to Fischbacher and Beaumont [66]. Moreover, the difficulties presented by cooperation across public and private sectors [97] [114] may compound those that characteristically emerge in collaborative management [2]. Thus, the management complexities that alliances between public and private sectors entail need to be better understood. Furthermore, little is known about conditions when partnerships succeed according to Reich [167]. Similarly, in an article in Economic Affairs, Hodge and Greve argue that despite continuing political popularity, greater care is needed to strengthen future evaluations and conduct such assessments away from the policy cheerleaders [94].

The aim of this work was therefore to investigate how cross-sector collaborations attempting to improve access to healthcare in the developing world could be strengthened and improved through the involvement of firms in CSR, by assessing motivational factors and skills that allow a favorable collaborative culture and value creation in a ethically and morally solid framework. Through a longitudinal case study, using multiple qualitative methods, we were able to identify initial motivational factors that lead to the engagement of firms in CSR in the form of cross-sector collaborations, as well as motivational factors and conditions that promote value creation in the form of tangible and intangible assets, as well as long-term commitment of firms to CSR.

## 7.2. The Tangible Outcome of "My Project Vision – For People with Insight" Cross-Sector Collaboration

One of the aims of this thesis work was to achieve a tangible outcome in form of healthcare delivery through a cross-sector collaboration, while simultaneously assessing motivational factors that strengthen cross-sector collaborations and maximize their outcomes. The restoration of vision in persons affected by cataract in Ethiopia was chosen to be the aimed tangible outcome. The Sub-Saharan region was chosen due to its extremely high rate of treatable blindness combined with its incapacity to deliver the required healthcare and the low access to treatment. Blindness was targeted in this project, as it is a highly debilitating and indirectly often leads to death, and as the leading cause of blindness (cataract) is not only easily treatable, but one of the most successful and cost-effective of all health interventions. Furthermore, the affected individuals are enabled to "help themselves," as they can continue with securing their livelihood or professions once cured.

In a concerted effort together with a well established, local NGO (CBM-Ethiopia) and the regional health bureau (Ethiopian Ministry of Health), we were able to allocate and invest in a region where the need of help was the highest, and enable approximately 3000 cataract operations to take place, which exceeded our initial goal by approximately 1000 surgeries. Furthermore, through out-reach programs, the project increased the total number of operations in Ethiopia by approx. 3.5% - making this the most efficient cataract project in Africa according to Hansjoerg Baltensperger of CBM. Through a strong collaborative effort with for profit businesses in Europe and with the local NGO as well as the Ethiopian government, we therefore made cataract surgeries more available and affordable through 1) an increase in productivity of personnel, 2) avoiding overhead costs, 3) avoiding non-essential materials and taking advantage of the surplus pre-existing consumables, without upsetting the economy and the systems and award schemes already in place.

We did so by allowing the local experts and collaborators to allocated the target population and the personnel needed for outreach programs, to decide the magnitude of salary increase for involved personnel (as a reward for their additional work-load

due to out-reach programs), and by simply providing the running costs of the additional out-reach projects to remote areas. The baseline training and development costs, on the other hand, continued to be covered by the Ethiopian government and CBM, among others. Hence, our absence in the following year did not affect the sustainability of the infrastructure, provision of medical equipment and supplies, or the baseline salaries of the medical personnel, as these were already in place before we arrived.

In sum, we ameliorated or restored the eyesight of individuals in Ethiopia affected by cataract, through the financing of cataract surgeries at a price of 50 CHF per patient. The project promoted local healthcare personnel and structures that were already in place and were functioning fairly well, through a strong collaboration between local organizations and native experts with years of experience in the unique local environment and in the field of ophthalmology; The financial support increased the amount of cataract surgeries conducted in the region, without disturbing the long-term function and survival of the pre-existing structures. Through the surgeries, affected individuals were able to read again, to continue with the profession that they had to abandon when their vision was lost, and they were potentially able to continue being productive and supportive constituents of society. In other words, through the financing of the surgeries the project potentially allowed people to help themselves.

## 7.3. The Theoretical Contribution

The premise of this work is that successful cross-sector collaborations allow value creation to ***ALL*** parties involved, including for-profit firms in a "win-win" constellation, as this constellation has shown to be highly important for collaborative success [199] [10]. Naturally, a prerequisite for value creation is the actual need to collaborate and an existing room for improvement in any form.

By assessing motivational factors that improve the potential of partnerships to allow value-creation for the firm, within an ethically and morally valid context, a sustainable business case may be built and company participation and commitment to partnerships may be strengthened in the future. This is particularly important in the developing world, since sound cross-sector collaborations have been identified by the WHO as one of the five key factors that allow a relatively good state of public health, despite a low GDP and weak public finance of the health sector. Nevertheless, even though numerous cross-sector partnerships have been established in the past decades, little information is available on the necessary conditions leading to their formation, governance and management according to Thomas and Curtis [199]. Similarly, little data about the value of alliances beyond anecdotes and qualitative success stories have been captured. Furthermore, partnerships have in the past formed in good faith, believing that an increase in impact would naturally occur, and it often did. However, this value has not been the centerpiece of evaluation and is not currently well measured or documented [207].

This explorative, longitudinal study addressed these important research gaps and provides novel insight and information regarding motivational factors that strengthen the for-profit sectors commitment to such partnerships and that maximize the impact of such collaborations. The first research question addresses the motivation for businesses to embrace CSR and to get involved in cross-sector partnerships, since empirical evidence for the profit-orientation as motivation for engaging in CSR is lacking [187], and since there are a number of indications that profit orientation, including gain of intangible assets, might only be one part of many reasons for engaging in CSR. In addition, it is important to learn more about the motivating

forces behind the decisions of businesses and Civil Society Organizations to enter collaborations, because they form the cornerstone upon which alliances are built according to Austin [8]. What drives organizations to engage in cross-sector collaborations, and what do they expect to gain from them? Does the nature of initial motivation have an impact of the strength of the partnership?

We found that philanthropy or simply "doing the right thing" from an ethical standpoint is a strong driver when help is actually needed. Yet two out of the four businesses studied also embarked in the initiative, at least partially, due to the potential mutual value exchange through the collaboration. In agreement with previous studies, we found that partnerships profit from a 'win-win" approach. Yet, it is also essential that each partner has clarity regarding its own motivations, as well as the motivation of the other partners involved, so that it can shape the relationships to attain the desired outcome. Furthermore, the business leaders should remain realistic about the goals, since the closer and the more similar the initial expectations are with the actual final achievements, the better the perceived value creation and the subsequent adherence to the project.

Secondly, in agreement with our hypothesis, we found that when the areas of core-activity/mission of the firm are similar to that of the project, more value can be created through the collaboration. The creation of potential intangible assets such as 1) innovation 2) relevant learning 3) better customer & stakeholder contact and network interaction, 4) access to relevant new markets, data, people and infra-structure was believed to be more likely in companies with similar core businesses aims involved in related markets.

Thirdly, the role of catalyzing skills, leadership skills and management skills are vital not only during the initial phase, but also throughout the project. In terms of catalyzing skills the personal connection, reports and direct human interaction, and transparent, honest and appealing communication style are of paramount importance for initial engagement as well as for future commitment. The catalyst, but also other actors in similar roles, should possess "people skills" and "transcultural skills" that aren't taught in traditional business school programs, such as active listening, building trusting relationships, humility, sensibility, and transparency. The catalyst

should be patient and yet resilient, and allow the group to elaborate ideas rather than entering the relationship with predetermined solution.

Just like the support of senior leadership was clear and vital both the Clark Foundation and Pfizer for the trachoma program [8], strong leadership skills proved to be essential in creating a positive and favorable environment, as leadership and culture are two sides of the same coin [176]. It could be observed that a project such as mPV can foster positive organizational behavior, yet leadership characterized by realistic optimism is important in the maximizing of this effect and in the capitalizing on it. Similarly, negative leadership can abolish the optimism and the "feel-good" effect of the collaboration.

Technical management skills such as negotiation, drafting MoUs, and allowing "meeting hygiene," or drafting credible and tangible/illustrative progress reports, also proved to be of great importance in laying the base for positive business culture and fruitful collaborations alike. Furthermore, in terms of political skills, the evolving and strengthening of networks and personal connections were of great importance, and interpersonal skills were important for mentoring and teambuilding. Similarly, we found that that a manager could maximize learning through diagnostic skills such as constructive feedback and visible rewards.

***The TIES-Culture, or the TIES of Cross-Sector Collaborations***

Together with the initial motivational cornerstones and incentives, the motivational capabilities in form of catalyzing-, leadership- and management-skills were important in cultivating a favorable collaborative culture. The TIES-culture - or a culture characterized by trust, identification/emotional connection and empowerment, optimism, success and gratification - proved to be pivotal in laying the ground for mutual value exchange and sustainable value creation:

- *Trust:* The catalysts are important at all stages of the project in cultivating trust. People and communication skills as well as transcultural skills are considered highly important in the fostering of trusting relationships and

strong personal connections. Furthermore, as active monitoring of progress was regarded as a key to mutual accountability and for cultivating trustful relationships, the partnership highly benefited from transparent monitoring and reporting, and from frequent bilateral (multilateral) communications and feedback. In addition, the preparation of MoUs, containing means of tracking progress (such as photographs), also fostered trust. Finally, a situation where mutual value exchange could be observed, rather than unilateral value creation, also fostered trust and strengthened the interpersonal connections and stakeholder networks.

- *Identification/Emotional Connection:* Both strong leadership as well as the nature and skills of the catalysts play a role in allowing an emotional connection and identification. The catalysts and the leaders within the company, on the other hand, could through pictures and other tools foster emotional connection and identification. Strong emotional connection and identification with the cause may subsequently lead to an improved corporate culture and ultimately, for instance, to better prospects for new skilled employee recruitment and keeping current employees on board.

- *Empowerment and Learning:* Mutual value exchange and alignment between project aim and company mission has a clear impact on empowerment and optimism of participants. When there is an alignment between project mission and company mission, and when the core activities are similar, it is likely that preexisting skills and knowledge of an actor can directly be applied within the project. If actors are allowed to use their skills and expertise for the project, they tend to feel more empowered and influential in the shaping of the collaboration, which again will improve the business culture and ultimately strengthen the partnership. The potential skills, knowledge, networks, market shares, R&D capability, technology and reputation gained through the cross sector collaboration, on the other hand, tend to be more relevant and applicable in cases of mission alignment and strategic congruency. Yet, also positive leadership plays a paramount role here. If actors feel as if they were empowered and have an influence in the process, they tend to be more

optimistic and committed to the project. Intangible assets and especially business culture are therefore more likely to improve when the participants feel as if they have influencing-power in the process. This is hardly surprising, as a clear relationship between the positive feelings of employees and their performance exists [125:57].

- *Success and Gratification:* Positive realism, success and reaching set goals are of paramount importance for the collaborative culture. It is important to build a framework that allows the achieving of desired outcome and to communicate milestones to the stakeholders. Leaders should however also remain realistic about the goals, since the closer and the more similar the initial outcome- expectations are with the actual final achievements, the better the perceived value creation and the subsequent adherence to the project. Furthermore, positive leadership plays a paramount role here, as negative leadership can abolish the optimism and the "feel-good" effect of the collaboration.

Apart from the TIES culture being an important intangible asset in itself, it supports further intangible value creation in form of human capital, information capital and organizational capital, and the consequent ability of an organization to mobilize and sustain processes of change that are required to execute its strategy. In other words, in a knowledge and skill intense sector such as the healthcare industry, the intangible assets should increase the ability of a related organization to execute its strategy and attain positive outcome. Hence, as an intangible asset, the TIES culture can support the improving of business processes and performance, which can subsequently be converted into tangible outcomes in form of revenue growth and cost reduction.

Building on the traditional **Balanced Scorecard,** and on data obtained through this case study, we were able to develop a tool, the **Collaboration Scorecard**, that allows the assessment of the potential value of a cross-sector collaboration, while taking into account the importance of the here identified motivational prerequisites or conditions of collaborative success. As we have seen, the Collaboration Scorecard is a prototype strategic performance management tool for businesses involved in CSR in form of

cross-sector collaborations that adapts to the specific settings of CSR and cross-sector collaborations. It allows an analysis of the formed organizational culture and the created intangible assets through such partnerships, as well as the monitoring of organizational performance against strategic goals. As a tool for organizations immersed in cross-sector collaborations, it may be very useful in guiding businesses in how to create future value through investment in customers, suppliers, employees, processes, technology, as well as innovation, and finally capitalized on the intangible assets created through the given cross- sector collaborations. The ensuing value creation may encourage stronger civil involvement in public health and allow sustainable as well as outcome-oriented partnerships, especially when governments fail to provide public goods and services.

## 7.4. Summary

The participation of private actors in securing health delivery is pivotal not only on a national level in developing countries where governments often fail to provide basic healthcare, but also on a transnational level, as diseases neither respect man-drawn boarders nor national boundaries. Channeling and expanding business engagement in health systems is at least partially the key to success, particularly in the developing world, also since the WHO has identified sound cross-sector collaborations as a principal key factor that allows healthy population in countries characterized by low GDP and weak public finance [123]. Yet civil involvement also opens the door for exploitation and opportunistic behavior. Hence it is crucial to learn more about what makes cross-sector partnerships succeed, while developing a framework that supports sustainable partnerships in a morally and ethically sound context.

Hence, research on cross-sector collaborations or public private partnerships should not be approached in academic isolation, but public and the private sectors should rather be actively involved in the shaping of this new environment. Although clear and effective institutional policies and measures that put the public interest at centre stage in all public-private interactions should be established, the transnational environment of the globalized world requires companies to participate in setting global governance and embracing social corporate citizenship. The private sector, with its capacity of wealth and job creation, should not be automatically discredited and excluded, but rather closely tied into the process of optimizing the healthcare sector and other public sectors alike.

By allowing a win-win situation of cross-sector collaborations, where all parties can profit from the partnership, sustainable and long-term collaborations may ensue. By assessing motivational factors and skills that allow a favorable collaborative culture and value creation to organizations involved in such collaborations, partnerships could be strengthened and their outcomes maximized. In this longitudinal study, three motivational cornerstones that allow a positive motivating culture and collaborative success through sustainable value creation could be identified: 1) The need of help and a mutual value exchange approach, with value creation, as primary motivations

for embarking in the project 2) mission/core activity alignment and strategic congruency as incentives, and 3) the application of motivational competencies such as proper catalyzing-, leadership- and management- skills. When these cornerstones where in place, an environment that favors positive outcome and commitment, or a TIES-culture (comprised of trust, identification with the cause and emotional connection, empowerment and learning, as well as success and gratification), could evolve.

As we have seen, this work casts light on motivational conditions and cultures that are necessary for collaborative success. Understanding favorable frameworks and essential aspects of a motivating culture is crucial for the survival and success of PPPs, as business cultures correlate with economic and organizational performance [44] [118] [186]. Furthermore, organizational effectiveness can be practiced only by understanding the dynamic of organizational culture, and by understanding the crucial role of leaders in the successful applying of the principles of culture to achieve organizational goals. Whether a culture is favorable or not - or functionally effective - however, depends not solely on the culture, but also on the relationship of the culture to the environment in which it exist. *"Only by understanding the dynamic of organizational culture, can organizational effectiveness be practiced…If we don't understand the operations of these forces, on the other hand, we become victim to them"* [176].

In other words, apart from that the TIES-culture is an important intangible asset per se, it also provides a favorable "breeding ground" for intangible and ultimately tangible value creation. Since intangible assets in form of human capital, information capital and organizational capital, are becoming increasingly important in service oriented companies, a systematic analysis of how intangible value creation can be enabled and maximized is crucial for any given knowledge intense organization.

Based on the here identified motivational prerequisites and cornerstones, we have been able to develop a tool (**The Collaboration Scorecard**) that allows a systematic analysis of input, output and outcome, and the correlation between these components and the tangible and intangible value created to organizations through cross-sector collaborations. Our scorecard is a pilot strategic performance management tool for

businesses involved in CSR in form of cross-sector collaborations, and it allows an analysis of the formed organizational culture and the created intangible assets to businesses immersed in these forms of joint ventures. The tool takes into account the importance of the here identified motivational prerequisites or conditions of collaborative success, while assessing the potential value of cross-sector collaborations, highlighting weaknesses and strengths of collaborations, and while pointing out the direction in which the cross-sector collaboration should evolve in order to maximize outcome and allow sustainability.

In sum, in order to accomplish a long-term impact on global public health, it is of great importance to encourage the commitment of private firms to CSR and to a stronger collaboration between businesses, NGOs and governments involved in the international health sector. Based on the knowledge gained through this explorative study, motivational frameworks and strategies that maximize both tangible and intangible asset creation through cross-sector collaborations may be developed. The first preliminary tool, which analyzes the value creation to organizations through cross-sector collaborations, may be very useful in the further investigation of similar themes, albeit its pilot nature requiring more research and validation, as no such tools exist today. This tool may support the development of morally and ethically sound strategies that encourage private actors to embrace CSR. Businesses may then capitalize on the intangible assets created through cross sector collaborations, and the ensuing value creation, for all participants involved, may encourage stronger civil involvement in international health. All together, our findings through this case study may allow sustainable as well as outcome-oriented cross-sector alliances to be designed and developed in the future, especially when governments fail to provide public goods and services in the international health sector.

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# Appendices
## Appendix i: Timetable and Milestones of the Project

a. Initial literature research December 2004
b. Field Research including interviews in Ethiopia in December 2004
    - Dr. A Muhdi (Ophthalmologist of CBM-Ethiopia), 13/12/2004
    - E. Gabriel (Head of CBM-Ethiopia), 16/12/2004
    - Dr. R. Yossef (Ophtalmologist at Yergallem HCS) 16/12/2004
    - Dr. D. Meres (Ophthalmologist at St. Francis Health Care Center), 20/12/2004
    - A. Alemayehu (Nurse at St. Francis Health Care Center), 20/12/2004
    - Dr. A. Worku (president of Orbis-International-Ethiopia), 21/12/2004
c. My Project Vision kick-off celebration and starting-point open interviews with leaders of the various participating businesses on 6/4/2005
d. Interviews with the director of the participating NGO
    - H. Baltensperger (head of the UN-WHO initiative Vision 2020-Switzerland), 20/5/2005, 3/3/2006.
    - R. Studer (dir. of Provisus and board member of SwissAssociation for Blind), 3/3/2006
e. SBB management Work-Shops, Bern 14/2/2005 and 15/3/2006
f. Executive Insight Annual Business Strategy Meeting, Helsinki July 2005
g. UN Association seminar on Global Compact and Public-Private-Partnerships, Helsinki 29/9/2005.
h. First written progress report by E. Gabriel (Head of CBM-Ethiopia), Ethiopia March 2006.
i. Initial questionnaire to leaders of the various participating businesses as well as the NGO, June 2006.
j. Mid-term interviews with leaders of the various participating businesses on during the course of 2007.
k. Follow-up questionnaire to leaders of the various participating businesses, December 2010

# Appendix ii: Course- and Fieldwork Associated With the Thesis

1) 2-Week research field trip to Ethiopia December 2004
Topic: Preliminary field research for My Project Vision

2) Doctoral block-seminar in Walzenhausen, Switzerland
Date: 17 – 20 February 2005
Host: University of Zurich - Institute of Organization and Administrative Science
Topic: Multinational businesses in a globalized world

3) Internal doctoral research seminar in Zurich, Switzerland
Date: Summer semester 2005
Host: University of Zurich - Institute of Organization and Administrative Science
Topic: CSR

4) Doctoral block-seminar in Nuernberg, Germany
Date: 2 – 5 March 2006
Host: University of Zurich - Institute of Organization and Administrative Science
Topic: CSR, globalization, economy and law

5) One-month internship on international health in Basel, Switzerland
Date: 01 June – 30 June 2006
Host: University of Basel - Swiss Tropical and Public Health Institute
Topic: International health

6) Internal doctoral research seminar in Maennedorf, Switzerland
Date: 30 June – 1 July 2006
Host: University of Zurich - Institute of Organization and Administrative Science
Topic: CSR

7) Prevention summit in Zurich, Switzerland
Date: 02 September 2010
Host: University Hospital of Zurich

Topic: Medical prevention in the practice

8) Public health and sport-medicine course in Tenero, Switzerland
Date: 24 – 26 March 2011
Host: Swiss Association of Sportsmedicine (SGSM)
Topic: Sportsmedicine in the practice, pediatric sportsmedicine and preventive medicine

9) PhD epidemiology research seminar in Basel, Switzerland
Date: Summer semester 2011
Host: University of Basel - Swiss Tropical and Public Health Institute
Topic: Epidemiology and public health

10) Applied mixed methods & mixed studies reviews for health research course for health care professionals in Lausanne, Switzerland
Date: 27 – 28 June, 30 June, 01 July 2011
Host: University of Lausanne/EPFL
Topic: Applied mixed methods & mixed studies reviews

11) Planning for Vision 2020 course in London, UK
Date: 4 – 8 July 2011
Host: London School of Hygiene and Tropical Medicine
Topic: Health initiative district planning course within the context of Vision 2020

12) Swiss School of Public Health Summer School course in Lugano, Switzerland
Date: 15 – 20.08.2011
Host: Swiss School of Public Health/University of Lugano
Topic: Strategic management and strategic change in health care organizations

13) Master's and advanced degree course in health systems and services in Basel, Switzerland
Date: 30 August – 02 September 2011
Host: University of Basel - Swiss Tropical and Public Health Institute
Topic: Health systems and services in international comparison

# Appendix iii: The Collaboration Scorecard

This tool builds on the Balanced Score Card by Kaplan and Norton[*] and is adapted to CSR and cross-sector collaborations based on data obtain through the *"My Project Vision*" [**] case study. It is a preliminary tool that analyzes the input and value created to organizations involved in CSR through such cross-sector collaborations. It aims to assess the potential value of a cross-sector collaboration through the analyzing of the formed organizational culture and created intangible assets through such partnerships, as well as to monitor organizational performance against strategic goals. The tool can hence also serve as a preliminary evaluation tool and guide for businesses, immersed in cross-sector collaborations, in how to create future value through investment in customers, suppliers, employees, processes, technology, and innovation.

Cross-sector collaborations can allow intangible asset creation to a given company involved in such an alliance. Intangible assets can then support the improving of business processes and performance, and finally be converted into tangible outcomes in form of revenue growth and cost reduction. The value of the intangible assets, however, derives from their ability to allow the organization to implement its strategy, and must therefore be aligned with an organizations objectives and strategies to reach these goals. In other words, the intangible assets should increase the ability of a business to mobilize and sustain processes of change that are required to execute its strategy.

***The Balanced Scorecard model***

In agreement with Kaplan and Norton[***], the intangible assets potentially created through cross-sector collaborations can be divided into:

1. Human capital (strategic competencies including skills and talents)

[*] See Kaplan RS, Norton DP. The balanced scorecard: measures that drive performance, *Harvard Business Review, 1992,* Jan – Feb: 71–80. or http://www.balancedscorecard.org/

[**] See www.MyProjectVision.com

2. Information capital (strategic information including knowledge -systems, -applications and infrastructure).
3. Organizational capital (including culture, leadership, alignment of goals with the strategy, and teamwork).

Business processes, on the other hand, include learning-, customer-, financial- and internal-processes.

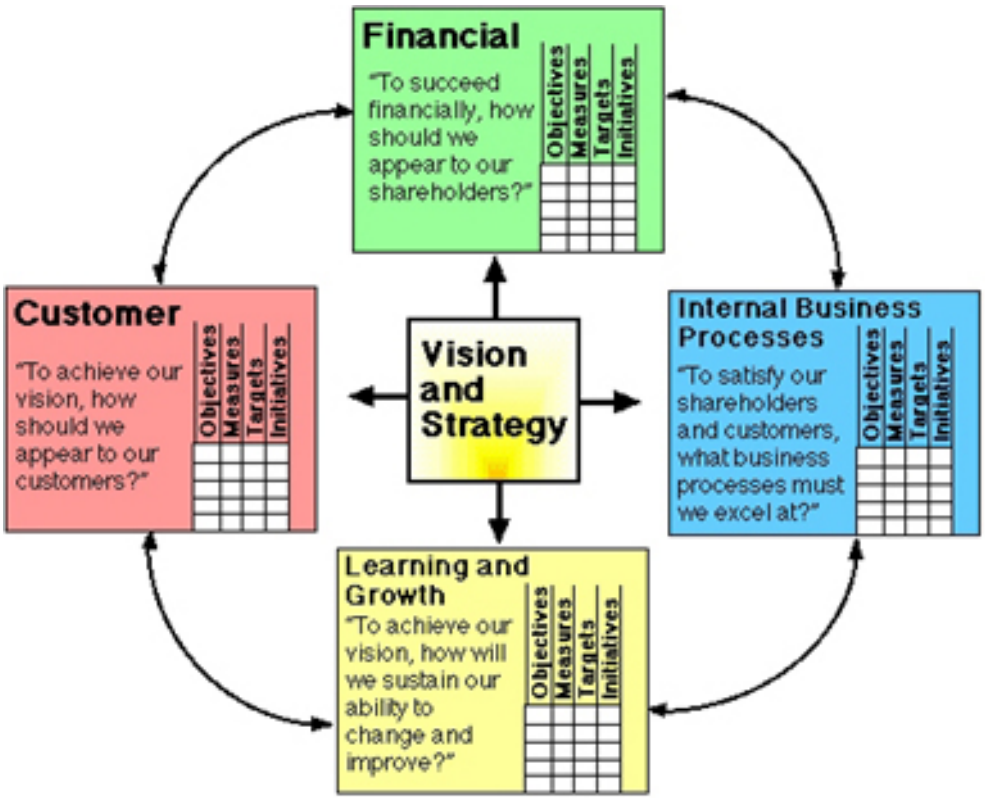


**Figure 1. Adapted from Robert S. Kaplan and David P. Norton, "Using the Balanced Scorecard as a Strategic Management System," Harvard Business Review (January-February 1996): 76.**

According to Kaplan and Norton, the internal business processes can further be divided into four clusters:

- Operations management (producing and delivering products and services to customers)
- Customer management (establishing and leveraging relationships with customers)

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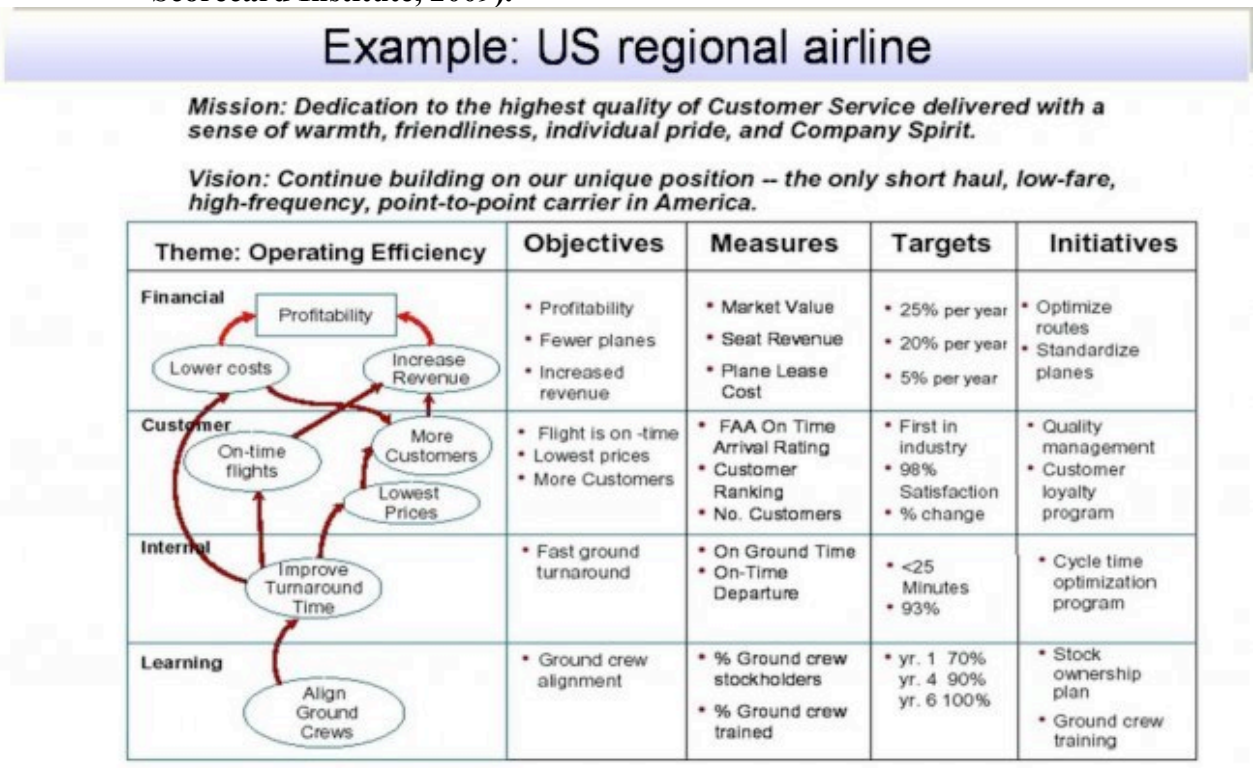
*** See Kaplan R, Norton, D. *Strategy Maps*. Boston: Harvard Business School Press, 2004 :199

- Innovation (developing new products, services, processes and relationships)
- Regulatory and social (conforming to regulations and societal expectations and building stronger communities

**Table 1. Example of Balance Scorecard implementation. (Source: Balanced Scorecard Institute, 2009).**




***The Adapted Collaboration Scorecard Model***

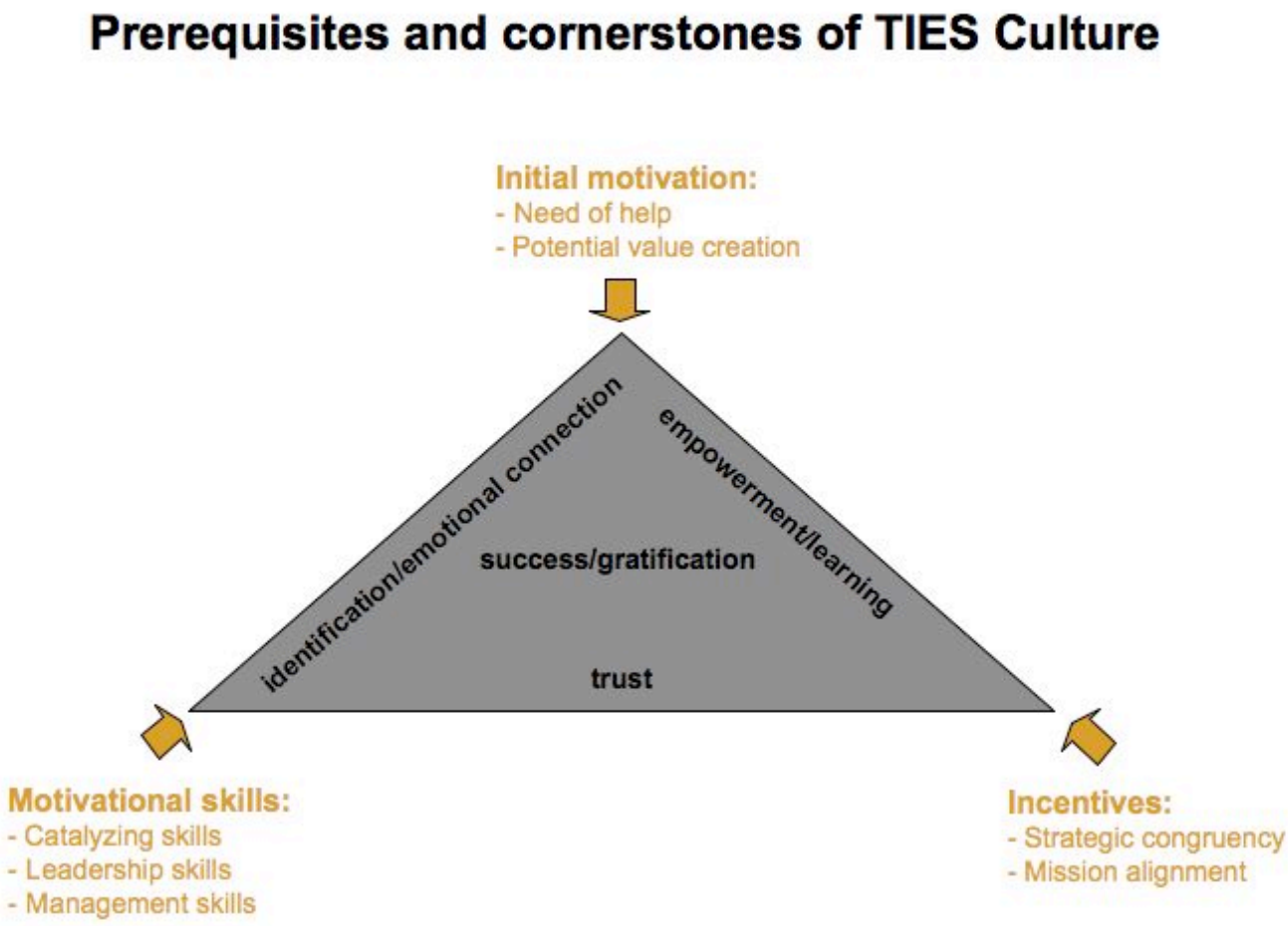
As oppose to traditional business models where a company's purpose is primarily to maximize shareholder value, the involvement of businesses in corporate social responsibility (CSR) actions may involve a strong philanthropic component and social objective. In other words, apart from financial performance, a further desired outcome is per definition a social result, such as cataract operations and the restoration of vision in people affected by blindness (see www.MyProjectVision.com). Hence, we have here adapted the Balanced Scorecard Model to the CSR and cross sector collaboration setting. The resulting Collaboration Scorecard evaluates the potential value of a cross-sector collaboration through the analysis of formed organizational culture and intangible asset creation through such partnerships.

The Collaboration Scorecard is a prototype strategic performance management tool for businesses involved in CSR in form of cross-sector collaborations. It is a semi-structured report built on the balanced score card by Kaplan and Norton and integrates intangible asset creation with financial outcome. It is based on the findings of "*My Project Vision"* 5-year longitudinal case study and is adapted to the field of CSR and cross-sector collaborations.

It is flexible in structure and allows the each individual organization to capture the information most relevant for their business and information that relates to the implementation of a strategy and value creation. Just like the Balance Scorecard, it articulates *"the links between leading inputs (human and physical), processes, and lagging outcomes and focuses on the importance of managing these components to achieve the organization's strategic priorities."* Furthermore, it takes into account the importance of identified prerequisites or conditions of collaborative success, such as the necessary initial motivations for embarking in a cross-sector collaboration, mission alignment and strategic congruency, and required skills by evaluating:

a) Prerequisite motivational cornerstones of collaborative success as defined by Erat (See figure and table below).
b) Value creation through the evaluation of ***1) the meeting stakeholder expectations***, ***2) customers/stakeholder networks and image*** (improved customer and stakeholder networks/ market access and/or image/marketing potential), ***3) internal business processes and*** **activities** (improved innovation and the gaining of relevant skills and now-how for operational processes and business activities**)**, and ***4) organization and culture*** (the evolving of a TIES-culture - see figure below - including empowerment, learning, growth, change managmenet, employee satisfaction and retention, as well as teamwork).
c) Ojective and subjective outcome in form of financial results and social outcome.

**Figure 2. Motivational prerequisite cornerstones and TIES culture of collaborative success as defined by Erat A, 2011.**




The design of this prototype CSR Balanced Scorecard should allow organizations to determine whether current performance 'meets expectations' and whether the cross-sector collaboration will create value to the company long-term. Ultimately, the aims are to alert managers to areas where performance deviates from expectations and allow strategic planning to improve outcome. In addition, the model points out weaknesses and improvement potentials as well as and possible future directions of the specific cross-sector collaboration.

**Table 2. Motivational skills necessary for collaborative success as defined by Erat A, 2011.**

| Catalyzing skills and properties | Leadership skills and properties | Management skills and properties |
|---|---|---|
| Advocating | Convincing, organizing and leading | Technical skills: negotiation, drafting MoUs, "meeting hygiene," etc. |
| Facilitating interactions between parties and joint understanding | Building good relationships with stakeholders and finding sustainable position on the market | Political skills: strengthening of connections and a power base |
| Allowing transparency, visualizing and reminding | Coaching and empowering actors | Interpersonal skills: a) mentoring and team building, b) recognition of employees' individual differences, and clear identification of behavior deemed worthy of recognition |
| Creating trust by: a) monitoring and reporting b) adapting language and sympathetic "people and transcultural skills c) Balancing value exchange | Create motivating business culture and climate and security | Diagnostic skills: Maximizing a) learning through constructive feedback and rewards b) information flow through meetings and communication channels |
| Properties: Patience and resilience | Properties: Creativity and charisma | Properties: Flexibility and adaptability |

***Procedure and interpretation of results***

The evaluator or user should answer the questions 1-18 with "yes," "no," or "not known/ not applicable (yet)." Each "yes" is assigned +1, each "no" is assigned -1 and each "not known/ not applicable (yet)" is assigned the number 0 (See figure 3). The questions are divided into eight categories (A-H):

- **Prerequisite conditions and inputs:** The first three categories (A-C) compromise questions regarding prerequisites or important initial motivational cornerstones, conditions or preferable frameworks that should be in place for a successful collaboration to evolve. These cornerstones include A) a strong starting point motivation to venture into a cross-sector collaboration (including the actual need of help and potential value creation for the firm), B) Incentives (such as mission alignment

between company/division-core-mission and mission of the cross-sector-collaboration, or a strong congruency/alignment between the strategy set by the organization to reach its goal and the set strategy by the collaborative project task force to reach actual social goals), and C) motivational skills or inputs required for collaborative success (namely catalyzing-, leadership- and operational project- management-skills (see table 2)).

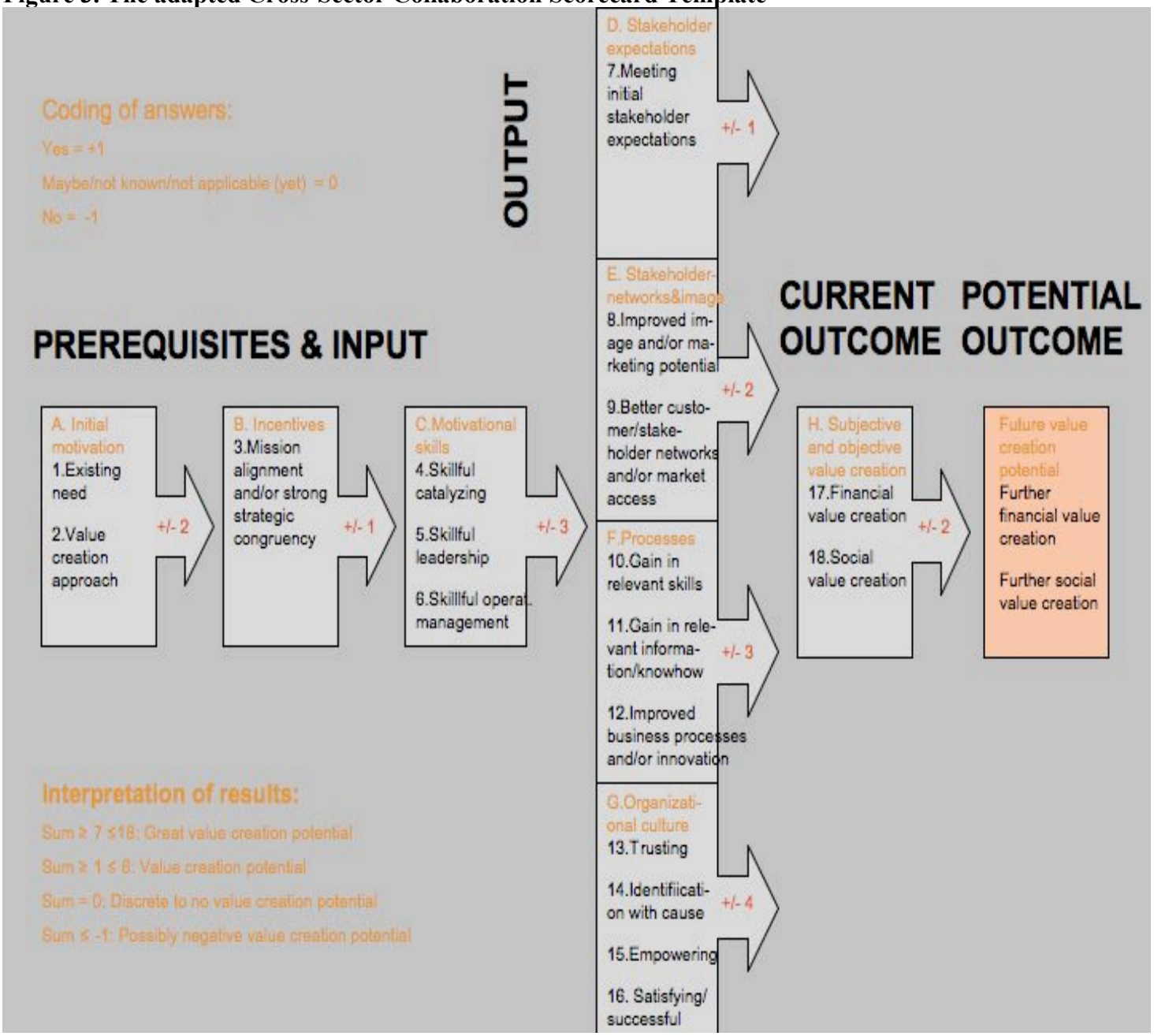
- **Output:** The following four categories (D-G) encompass output and include D) the meeting of stakeholder expectations, E) improving customers/stakeholder networks, market access and business image F) the improving of internal business processes and activities through the gain of relevant skills or knowhow and information, and G) the improving of organizational business culture that is caracterized by trusting relationships, identification with the project cause and willigness to achieve the set goals, and finally an empowering climate where learning is stimulated and where workers are satisfied and experience the feeling of success. The categories are similar to that of the Balanced Scorecard, developed by Kaplan and Norton, and reflect business processes and intangible asset creation that may be gained and improved through the involvement of organizations in cross-sector collaborations.

- **(Preliminary) outcome:** The last category (H) is based on an overall outcome of the project in regard to preliminary social project results and financial gains for the business.

Once all questions are answered for each category, the sum of the numbers is calculated, with a maximum potential score equaling 18 and minimum score of minus 18. Based on the resulting score, conclusions regarding potential value creation through the cross-sector collaboration to the organization can be drawn (see figure 3). If a given business organization scores seven or more, the potential long-term value creation is great. A score between one and six also indicates potential value creation, albeit to a lesser extent. A score of 0 indicates possibly no value creation to the

organization through the collaborative alliance and a score smaller than 0 reflects potential negative value and loss to the involved business.

**Figure 3. The adapted Cross-Sector Collaboration Scorecard Template**




The model also visualizes weaknesses and improvement potentials as well as possible future directions of the specific partnerships. Hence it can be used at various time-points of a cross-sector collaboration to 1) determine value created to a specific organization through a partnership in form of intangible assets, b) to predict future

long-term value creation and outcome, and c) finally to alert managers to areas where performance deviates from expectations and allow strategic planning to improve outcome.

***Summary***

In sum, as the global economy is changing and shifting from manufacturing to a service oriented economy, intangible assets and intellectual capital has become an increasingly important resource for a company's success and value creation[****]. The value of these intangible assets, however, derives from their ability to allow and help the organization to implement its strategy and to mobilize and sustain the processes of change required to execute its strategy[*****]. The premise of the cross-sector collaboration scorecard is therefore an alignment between mission and strategy to reach goals, or the alignment of goals with the strategy. The semi-flexible framework of the tool allows the user to evaluate factors that are important for his/her organization to execute its specific strategy. The cross-sector scorecard is the first of its kind and is intended to serve as a preliminary tool to assess the value of such alliances and to identify intangible assets created through cross-sector partnerships.

***Further readings***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3. Kaplan RS, Klein N. *Chemical Bank: Implementing the Balanced Scorecard.*


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4. Kaplan RS, Norton DP. Using the balanced scorecard as a strategic management system. *Harvard Business Review, 1996,* Jan – Feb: 75–85.

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6. Kaplan RS, Norton DP. Measuring the strategic readiness of intangible assets. Harvard Business Review, 2004, 82(2): 52-63.

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# Appendix iv: Example of a MoU

Between

**SBB AG, Bern**
**Infrastruktur – Assetmanagement (I-ASM)**
**Schanzenstrasse 5**
**3000 Bern 65**

and

**Christoffel Blindenmission Schweiz (CBM)**
**Postfach**
**Seestrasse 160**
**8027 Zürich**

***Purpose/ Intention***

The Infrastructure Division of Swiss Railways (SBB) is to donate a sum of CHF 75´000 for cataract eye-surgeries aid in Ethiopia. In the course of developing a concept for this endeavor, Dr. Jan Roy Edlund, a consultant and trust person of SBB I-ASM, put together a team to research how the money should be invested best (the **TEAM**). Anna Erat, a research fellow of BIDMC-Harvard Medical School, was then put in charge of the organizational activities.

CBM was chosen as a partner and specialist in allocating the raised money. The purpose of this agreement is to indicate to CBM which principles should be applied, and which methods should be used, in allocating the raised money and to commit to the project with all duties from both sides

***Principles***

1. The money must be spent on a 1:1 basis. This means, that all the money should be directly invested in cataract surgeries carried out in Ethiopia at an average price of CHF 50 per intervention per person. Any other costs e.g. office administration of CBM (Switzerland and Regional Office) should be covered by other means of CBM or other sources. It is also understood that Project Vision is

not using any donated money for advertising purposes. As a result, a total number of 1500 people is currently envisaged to be treated. If there are more funds available, the number of people with cataract blindness being operated will increase accordingly.

2. Based on local field research in Ethiopia (Dec 04) the team has found out that the major limiting factors for cataract treatment is insufficient outreach activity. Whereas in the long run, it makes sense to invest more money in increasing the pool of cataract specialists through training programs, in the short term there are two major effective approaches.
   (1) Campaigns, where existing surgeons conduct temporary, brief, intense outreach programs, where patients are treated in the field (villages).
   (2) Hiring existing cataract specialists, who are underemployed in the capital, with an incentive to go out and conduct surgeries in rural hospitals (Of a total of 72 ophthalmologists in Ethiopia around 50 work in the capital. Only 22 Ophthalmologists cover the remaining land (around 65 mio km2). The TEAM has concluded that the money preferably should be invested as a starting short-term project in option number (2) if not possible (1) will take priority.

3. To guarantee that the above mentioned number of claimed patients have actually been treated, a digital photo (preferably two with one before and one after the operation) with some additional personal information (including name and age) must be collected and turned in as proof to the TEAM. The photos will be used for internal and external promotional issues of SBB, the TEAM and possibly CBM.

4. For actual payment of the cataract surgeries the following payment conditions were agreed on. SBB transfer to the account of CBM/ my project vision
   1. CHF 37´500 per end of June 2005 and
   2. CHF 37´500 per end of June 2006
   3. a “Spendenbescheinigung” will be issued by CBM.

5. The Project will start at May/ June 2005 with its first phase according to the implementation plans provided already by CBM in supplementary papers

6. Team will make sure that implementation is followed on according to principles defined and will most probably travel down to Ethiopia to observe and monitor project progress of phase 1.

## For SBB

**Place and Date**

**Bern,**_____

Hansjörg Hess
President of
SBB Infra-
structure
Switzerland

Reto Burkhardt
Director of I-ASM
Switzerland

## For CBM

**Place and Date**

**Zürich,**_____

Hansjörg Baltensberger
President of CBM
Switzerland

# Appendix v: Initial Questionnaire For Business Leaders

**Aims of Questionnaire/ *Ziel des Fragebogens:***

- To receive feed-back on Project Vision – For People with Insight (PV) from all parties involved in the project / *Ein feed-back über das Projekt "Vision – For People with Insight (PV) von allen Teilnehmern im Projekt zu bekommen.*

- To allow the participants to voice their opinions and have an impact on the project /
  *Den Beteiligten eine Möglichkeit zu geben, ihre Meinung zu äussern und damit Einfluss auf das Projekt auszuüben.*

- To analyze the feed-back and to learn from it for future Public Private Partnership Health Projects with the aim of saving and improving human lives /
  *Das "feed-back zu analysieren und davon zu lernen, wie in Zukunft "Public Private Patnership Health Projects", mit dem Ziel Leben zu retten und zu verbessern, durchgeführt werden können.*

**Comments on Handling the Questionnaire / *Anleitung zum Ausfüllen des Fragebogens:***

**There are two types of questions to be answered: 1) multiple choice questions where one answer (yes=Y, no=N or I do not know=0) may be chosen by underlining it and 2) open questions where the respondent is allowed to express himself freely. Please note that all questions are written in English (in black) and German (in red). You should chose to respond in either English or German NOT IN BOTH LANGUAGES. Once the questionnaire is answered, it should kindly be saved with the changes, in Doc format, and be sent to the following email address: aerat@bidmc.harvard.edu. This document is 6 pages long and it takes approximately 8 to 10 minutes to fill out the form completely. The information gathered through the questionnaire will be complemented with phone interviews /**

***Zwei Fragentypen sollten beantwortet werden: 1) Fragen mit vorgegebenen Antworten, von welchen eine gewählt werden soll ( ja=J, nein=N oder ich weiss es nicht = 0). Dies geschieht durch unterstreichen der gewählten Antwort. 2) Offenen Fragen, die der Beantworter frei beantworten kann. Bitte beachten Sie, dass alle Fragen in English (schwarz) und deutsch (rot) geschrieben sind. Wir bitten Sie, entweder in englisch oder deutsch zu antworten. BITTE NICHT IN BEIDEN SPRACHEN ANTWORTEN. Wir bitten Sie freundlich, den ausgefüllten Fragebogen in Doc-Format an die e-mail-Adresse:aerat@bidmc.harvard.edu zu senden. Das Dokument ist 6 Seiten lang und es braucht ungefähr 8-10 Minuten, um die Fragen zu beantworten. Die erhaltene Information wird in der Folge ergänzt durch Telefoninterviews.***

**Your feedback is very important / *Ihr Feedback ist uns sehr wichtig:***
In order to learn from our mistakes and our success, we much depend on your honest reply. We therefore highly value your support and would like to thank you in advance for your collaboration /
*Um von unseren weniger gelungenen und von unseren erfolgreich durchgeführten Massnahmen lernen zu können, brauchen wir Ihre aufrichtigen Antworten. Wir legen deswegen grossen Wert auf Ihre Unterstützung und bedanken uns herzlich für Ihre Zusammenarbeit.*

## *a.* Questions regarding the starting point of PV: / *Fragen über die Ausgangslage des PV:*

**Answer in form of Yes=Y / No=N / I do not know=0 by underlining one of the options!**

1. Was curing the blind the principal motivation/incentive for joining PV? Y / N / 0
2. Was curing the blind the principal aim/goal of your involvement in PV? Y / N / 0
3. Was one goal of your involvement in PV to improve employee motivation or your business culture? Y / N / 0
4. Could you personally relate to the aim/goal of PV? Y / N / 0
5. Did you regard medicine or pharmacology, health care, public health or blindness to be related to your core activities in any form? Y / N / 0
6. Did you intend to participate in the project in the form of a service related to your field of work/activity of your business? Y / N / 0
7. Did you (your company) intend to participate in the project in form of providing financial means only? Y / N / 0
8. Did you (your company) intend to participate in the project in form of providing financial means at least partially? Y / N / 0

***Antworten in der Form von Ja=J / Nein=N / Ich weiss es nicht=0, durch unterstreichen von einer der Varianten!***

1. *War das Heilen von Blinden Motivation/Ansporn zur Beteiligung an PV?* *J / N / 0*
2. *War das Heilen von Blinden das Ziel für Ihre Beteiligung an PV?* *J / N / 0*
3. *War eine Zielsetzung Ihrer Beteiligung die Verbesserung der Motivation Ihrer Angestellten oder Ihrer Unternehmenskultur?* *J /N/ 0*
4. *Hatten Sie eine persönliche Beziehung zu den PV Zielen?* *J / N / 0*
5. *Haben Medizin oder Pharmakologie, Gesunheitsdienst, öffentliches Gesund-Heitswesen oder Blindheit eine Beziehung zu den Kernaktivitäten Ihres Unternehmens?* *J / N / 0*
6. *War es Ihre Absicht, in Form eines auf Ihr Arbeitsfeld bezogenen Services am Projekt mitzumachen?* *J / N / 0*
7. *War es Ihre Absicht (Absicht ihrer Unternehmung), ausschliesslich durch Finanzierungshilfe am Projekt teilzunehmen?* *J / N / 0*
8. *War es Ihre Absicht (Absicht ihrer Unternehmung) wenigstens teilweise durch Finanzierungshilfe am Projekt teilzunehmen?* *J / N / 0*

**Answers in free form: / *Antworten in freier Form:***

- What was the motivation for your involvement in PV ? /
  *Welches war Ihre Motivation zur Beteiligung in PV?*
- What did you wish to accomplish through the project ? /
  *Welches Ziel wollten Sie durch das Projekt erreichen?*
- How did you define the value/values potentially created through the project? /
  *Welches Wertpotential/ -potentiale hatte das Projekt für Sie?*

## *b.* Questions regarding the execution phase of PV: */ Fragen im Bezug auf die Durchführung von PV:*

**Answer in form of Yes=Y / No=N / I do not know=0 by underlining one of the options!**

1. Did you have any say or influence on the process? Y / N / 0

2. Did you generally agree on how the project was conducted? Y / N / 0
3. Did you (your company) actually participate in the project in form of a service related to your field of work or related to your business? Y / N / 0
4. Did you (your company) participate in the project in form of providing financial means only? Y / N / 0

***Antworten in der Form von Ja=J / Nein=N / Ich weiss es nicht=0, durch unterstreichen von einer der Varianten!***

1. *Konnten Sie auf den Prozess Einfluss nehmen? J / N / 0*
2. *Waren Sie grundsätzlich mit der Durchführung des Projektes einverstanden? J / N / 0*
3. *Haben Sie (Ihre Unternehmung) am Projekt in Form eines auf Ihr Arbeitsfeld bezogenen Services teilgenommen? J / N / 0*
4. *Haben Sie (Ihre Unternehmung) ausschliesslich durch Finanzierungshilfe am Projekt teilgenommen? J / N / 0*

## *c.* Questions regarding the outcome of PV: */ Fragen im Bezug auf das Resultat des PV:*

**Answer in form of Yes=Y / No=N / I do not know=0 by underlining one of the options!**

1. Have the initial expectations been met? Y / N / 0
2. Has employee motivation or performance been improved during your commitment to PV? Y / N / 0
3. Has corporate culture or the working environment improved during your commitment to PV? Y / N / 0
4. Did you feel moral ease or more pride working for your company during your commitment to PV? Y / N / 0
5. Did you feel better working for the company during your commitment to PV? Y / N / 0
6. Have you noticed more innovation in normal business activities during your commitment to PV? Y / N / 0
7. Do you believe that commitment to PV or other aid/social responsibility actions could attract and allow better recruitment of new employees? Y / N / 0
8. Did PV potentially allow your company a better reputation or image? Y / N / 0
9. Have you noticed unexpected benefits of the project? Y / N / 0
10. Have you noticed unexpected benefits of the project on your business? Y / N / 0
11. Have you noticed unexpected disadvantages of the project? Y / N / 0
12. Have you noticed unexpected disadvantages of the project on your business? Y / N / 0
13. Can you still relate to the cause? Y / N / 0
14. In your opinion, could the project have been done without a close collaboration between the Firms and CBM (Christoffel Blinden Mission)? Y / N / 0
15. Was the collaboration efficient? Y / N / 0

***Antworten in der Form von Ja=J / Nein=N / Ich weiss es nicht=0, durch unterstreichen von einer der Varianten!***

1. *Wurden Ihre ursprünglichen Erwartungen erüllt? J / N / 0*
2. *Hatte das Projekt einen positiven Einfluss auf die Motivation oder Produktivität Ihre Angestellten ? J / N / 0*
3. *Hatte das Projekt einen positiven Einfluss auf die Unternehmenskultur? J / N / 0*
4. *Hatten Sie während Ihrer Beteilung an PV ein Gefühl moralischer Erleichterung oder fuehlten Sie mehr Stoltz fuer ihre Unternehmung zu arbeiten? J / N / 0*
5. *War das Arbeiteten in der Unternehmung befriedigender während PV? J / N / 0*
6. *Waren Sie innovativer in Ihren normalen Arbeitsaktivitäten während Ihrer Beteiligung an PV? J / N / 0*
7. *Glauben Sie, dass die Betiligung an PV, oder die Zusammenarbei mit anderen Hilfe-/Sozialaktionen möglicherweise, die Rekrutierung von neuen Mitarbeitern Unterstützen und verbessern könnte? J / N / 0*

8. *Hatte PV die Möglichkeit, die Reputation oder das Imago Ihres Unternehmens zu verbessern?* *J / N / 0*
9. *Haben Sie durch das Projekt unerwartete positive Effekte registriert?* *J / N / 0*
10. *Haben Sie durch das Projekt unerwartete Vorteile für Ihr Unternehmen festgestellt?* *J / N / 0*
11. *Haben Sie durch das Projekt unerwartete negative Effekte registriert?* *J / N / 0*
12. *Haben Sie durch das Projekt unerwartete negative Effekte auf Ihr Unternehmen festgestellt?* *J / N / 0*
13. *Ist für Sie die ursprüngliche Zielsetzung immer noch relevant?* *J / N / 0*
14. *Hätte das Projekt nach Ihrer Meinung ohne nahe Zusammenarbeit zwischen den beteiligten Firmen und CBM (Christoffel Blinden Mission) durchgeführt werden können?* *J / N / 0*
15. *War die Zusammenarbeit effizient?* *J / N / 0*

**Answers in free form! / *Antworten in freier Form!***

- If you have noticed ANY unexpected benefit(s) of the project, please explain what it is/they are / *Falls Sie durch das Projekt IRGENDEINIGE unerwartete, positive Effekte registriert haben, bitte erklären Sie diesen/diese:*

- If you have noticed unexpected benefit(s) of the project on YOUR BUSINESS, please explain what it is/they are: */ Falls Sie durch das Projekt unerwartete Vorteile für IHR UNTERNEHMEN festgestellt haben, bitte erklären Sie diesen/diese:*

- If you have noticed ANY unexpected disadvantage(s) of the project, please explain what it is/they are: / *Falls Sie durch das Projekt IRGENDWELCHE unerwartete, negative Effekte festgestellt haben, bitte erklären Sie diesen/diese:*

- If you have noticed unexpected disadvantages of the project on YOUR BUSINESS, please explain what it is/they are: / *Falls Sie durch das Projekt unerwartete, negative Effekte AUF IHR UNTERNEHMEN festgestellt haben, bitte erklären Sie diesen/diese:*

## *d.* Questions regarding the future of PV: / *Fragen im Bezug auf die Zukuft von PV:*

**Answer in form of Yes=Y / No=N / I do not know=0 by underlining one of the options!**

1. Would you (your company) potentially like to continue supporting the project? Y / N / 0
2. Has the experience triggered you (your company) to potentially support other aid/social responsibility initiatives? Y / N / 0
3. Are you actually going to continue supporting PV? Y / N / 0
4. Are you going to support PV in the same form (by providing services/financial means)? Y / N / 0
5. Are you changing your form of support? Y / N / 0
6. Do you expect benefits of the project on your company in the future? Y / N / 0
7. Is the motivation behind being involved in PV the same as at the
8. starting point? Y / N / 0
9. Is the goal of being involved the same as at the starting point? Y / N / 0

***Antworten in der Form von Ja=J / Nein=N / Ich weiss es nicht=0, durch unterstreichen von einer der Varianten!***

1. *Können Sie (Ihr Unternehmen) sich vorstellen das Projekt weiter zu unterstützen?J / N / 0*
2. *Hatte die Erfahrung den Effekt, dass Sie (Ihr Unternehmen) sich denken können, auch andere Hilfe-/Sozialaktionen zu unterstützen?* *J / N / 0*

3. *Werden Sie das Projekt tatsätzlich auch weiter unterstützen?* *J / N / 0*
4. *Gedenken Sie PV in bisheriger Form ( Services/finanziell) zu unterstützen?* *J / N / 0*
5. *Gedenken Sie PV in einer anderen Form zu unterstützen?* *J / N / 0*
6. *Erwarten Sie, dass das Projekt in Zukunft Vorteile für Ihr Unternehmen bringen könnte?* *J / N / 0*
7. *Ist Ihre Motivation zur Unterstütung die gleiche wie in der Ausgangslage?* *J / N / 0*
8. *Ist Ihre Zielsetzung mit dem Projekt die gleiche wie in der Ausgangslage?* *J / N / 0*

**Answer in free form! / *Antworten in freier Form!***

- Reasons why will or why you will not continue supporting PV? / *Warum wollen Sie oder warum wollen Sie nicht PV weiter unterstützen?*

- In retrospect, what would you like to do differently? / *Was würden Sie im Rückblick anders machen wollen?*

- How do you expect for the others involved in PV to change? / *Wie wünschen Sie, dass die übrigen Partner im Projekt Dinge anders machen könnten?*

- Do you have any other comments or suggestions? / *Haben Sie andere Wünsche oder Vorschläge?*

# Appendix vi: Follow-Up Questionnaire For Business Leaders

**Aims of Questionnaire/** ***Ziel des Fragebogens:***

- 5 year follow-up: To receive feed-back on Project Vision – For People with Insight (PV) from all parties involved in the project / *5-J Follow-up: Feed-back über das Projekt "Vision – For People with Insight (PV) von allen Projekt Teilnehmern zu bekommen.*

- To allow the participants to voice their opinions and have an impact on the project / *Den Beteiligten eine Möglichkeit zu geben, ihre Meinung zu äussern und damit Einfluss auf das Projekt auszuüben*.

- To analyze the feed-back and to learn from it for future Public Private Partnership Health Projects / *Das "Feed-back zu analysieren und davon zu lernen, um "Public Private Partnerships im Bereich Gesundheitswesen zu verbessern.*

**Comments on Handling the Questionnaire** ***/ Anleitung zum Ausfüllen des Fragebogens:***

There are three types of questions to be answered: 1) rating on a scale from 1-5 the importance of a stated factor by underlining the number that corresponds to the chosen level of importance (5=crucial, 4=very important, 3=important, 2=unimportant, 1=irrelevant) 2) agreeing or disagreeing to a statement by underlying yes or no respectively or alternatively "I do not know" (yes=Y, no=N or I do not know=0), 3) open questions allowing free expressions. Please note that all questions are written in English (in black) and German (in red). You should chose to respond in either English or German NOT IN BOTH LANGUAGES. Once the questionnaire is answered, it should kindly be saved with the changes, in Doc format, and be sent to the following email address: erat_anna@hotmail.com. This document is 4 pages long and it takes approximately 8 to 10 minutes to fill out the form completely. The information gathered through the questionnaire will be complemented with phone interviews /
*Drei Fragentypen sollten beantwortet werden: 1) Fragen mit vorgegebenen Antworten, von welchen eine gewählt werden soll (5=essentiell, 4=sehr wichtig, 3=wichtig, 2=unwichtig, 1=komplett irrelevant), 2) Fragen mit vorgegebenen Antworten, von welchen eine gewählt werden soll ( ja=J, nein=N oder ich weiss es nicht = 0). Dies geschieht durch unterstreichen der gewählten Antwort. 2) Offenen Fragen, die der Beantworter frei beantworten kann. Bitte beachten Sie, dass alle Fragen in English (schwarz) und deutsch (rot) geschrieben sind. Wir bitten Sie, entweder in englisch oder deutsch zu antworten. BITTE NICHT IN BEIDEN SPRACHEN ANTWORTEN. Wir bitten Sie freundlich, den ausgefüllten Fragebogen in Doc-Format an die e-mail-Adresse:erat_anna@hotmail.com zu senden. Das Dokument ist 4 Seiten lang und es braucht ungefähr 8-10 Minuten, um die Fragen zu beantworten. Die erhaltene Information wird in der Folge ergänzt durch Telefoninterviews.*

**Your feedback is very important** ***/ Ihr Feedback ist uns sehr wichtig:***
In order to learn from our mistakes and our success, we much depend on your honest reply. We therefore highly value your support and would like to thank you in advance for your collaboration /
*Um von unseren weniger gelungenen und von unseren erfolgreich durchgeführten Massnahmen lernen zu können, brauchen wir Ihre aufrichtigen Antworten. Wir legen deswegen grossen Wert auf Ihre Unterstützung und bedanken uns herzlich für Ihre Zusammenarbeit.*

## a. Questions regarding the starting point of PV: / *Fragen über die Ausgangslage des PV:*

Answer on a scale from 1-5 (5=essential, 4=very important, 3=important, 2=unimportant, 1=completely irrelevant) by underlining the number that corresponds

to the chosen level of importance

- On a scale from 1-5, how important was trust in other collaborators as a catalyst for your firms initial commitment to the project? 5/4/3/2/1
- On a scale from 1-5, how great was the influence of your relationship with the PV-founder/founders on your firms initial commitment to the project? 5/4/3/2/1

- On a scale from 1-5, how great was the influence of emotional connection to the cause on your firms initial commitment to the project? 5/4/3/2/1

***Beurteilen Sie bitte die folgende Aussagen auf einem Skala von 1-5 (5=essentiell, 4=sehr wichtig, 3=wichtig, 2=unwichtig, 1=komplett irrelevant), durch unterstreichen von einer der Varianten!***

- *Auf einem Skala von 1-5, wie Wichtig war das Vertrauen in anderen mitbeteiligten als Katalysator für Ihre Beteiligung an PV? 5/4/3/2/1*

- *Auf einem Skala von 1-5, wie gross war der Einfluss der Gründer des Projektes (und Ihre Beziehung zu den Gründern) auf Ihre Beteiligung an PV? 5/4/3/2/1*

- *Auf einem Skala von 1-5, wie Wichtig waren emotionelle Faktoren für Ihre Beteiligung an PV? 5/4/3/2/1*

## b. Questions regarding the execution phase of PV: */ Fragen im Bezug auf die Durchführung von PV:*

**Answer in form of Yes=Y / No=N / I do not know=0 by underlining one of the options!**

- Did you have any say or influence on the process? Y / N / 0
- Did you generally agree on how the project was conducted? Y / N / 0
- Did you (your company) actually participate in the project in form of a service
- related to your field of work or related to your business? Y / N / 0
- Did you (your company) participate in the project in form of providing financial
- means only? Y / N / 0

***Antworten in der Form von Ja=J / Nein=N / Ich weiss es nicht=0, durch unterstreichen von einer der Varianten!***

- *Konnten Sie auf den Prozess Einfluss nehmen? J / N / 0*
- *Waren Sie grundsätzlich mit der Durchführung des Projektes einverstanden? J / N / 0*
- *Haben Sie (Ihre Unternehmung) am Projekt in Form eines auf Ihr Arbeitsfeld bezogenen Services teilgenommen? J / N / 0*
- *Haben Sie (Ihre Unternehmung) ausschliesslich durch Finanzierungshilfe am Projekt teilgenommen? J / N / 0*

## c. Questions regarding the outcome of PV: */ Fragen im Bezug auf das Resultat des PV:*

**Answer in form of Yes=Y / No=N / I do not know=0 by underlining one of the options!**

- Have the initial expectations been met? Y / N / 0
- Has employee motivation or performance been improved during your
- commitment to PV? Y / N / 0
- Has corporate culture or the working environment improved during

- your commitment to PV? Y / N / 0
- Did you feel moral ease or more pride working for your company during
- your commitment to PV? Y / N / 0
- Did you feel better working for the company during your commitment to PV? Y / N / 0
- Have you noticed more innovation in normal business activities during
- your commitment to PV? Y / N / 0
- Do you believe that commitment to PV or other aid/social responsibility
- actions could attract and allow better recruitment of new employees? Y / N / 0
- Did PV potentially allow your company a better reputation or image? Y / N / 0
- Have you noticed unexpected benefits of the project? Y / N / 0
- Have you noticed unexpected benefits of the project on your business? Y / N / 0
- Have you noticed unexpected disadvantages of the project? Y / N / 0
- Have you noticed unexpected disadvantages of the project on your business? Y / N / 0
- Can you still relate to the cause? Y / N / 0
- In your opinion, could the project have been done without a close collaboration
- between the Firms and CBM (Christoffel Blinden Mission)? Y / N / 0
- Was the collaboration efficient? Y / N / 0

***Antworten in der Form von Ja=J / Nein=N / Ich weiss es nicht=0, durch unterstreichen von einer der Varianten!***

- *Wurden Ihre ursprünglichen Erwartungen erfüllt? J / N / 0*
- *Hatte das Projekt einen positiven Einfluss auf die Motivation oder Produktivität Ihre Angestellten ? J / N / 0*
- *Hatte das Projekt einen positiven Einfluss auf die Unternehmenskultur? J / N / 0*
- *Hatten Sie während Ihrer Beteilung an PV ein Gefühl moralischer Erleichterung oder fühlten Sie mehr Stoltz für ihre Unternehmung zu arbeiten? J / N / 0*
- *War das Arbeiteten in der Unternehmung befriedigender während PV? J / N / 0*
- *Waren Sie innovativer in Ihren normalen Arbeitsaktivitäten während Ihrer Beteiligung an PV? J / N / 0*
- *Glauben Sie, dass die Beteiligung an PV, oder die Zusammenarbeit mit anderen Hilfe-/Sozialaktionen möglicherweise, die Rekrutierung von neuen Mitarbeitern Unterstützen und verbessern könnte? J / N / 0*
- *Hatte PV die Möglichkeit, die Reputation oder das Imago Ihres Unternehmens zu verbessern? J / N / 0*
- *Haben Sie durch das Projekt unerwartete positive Effekte registriert? J / N / 0*
- *Haben Sie durch das Projekt unerwartete Vorteile für Ihr Unternehmen festgestellt? J / N / 0*
- *Haben Sie durch das Projekt unerwartete negative Effekte registriert? J / N / 0*
- *Haben Sie durch das Projekt unerwartete negative Effekte auf Ihr Unternehmen festgestellt? J / N / 0*
- *Ist für Sie die ursprüngliche Zielsetzung immer noch relevant? J / N / 0*
- *Hätte das Projekt nach Ihrer Meinung ohne nahe Zusammenarbeit zwischen den beteiligten Firmen und CBM (Christoffel Blinden Mission) durchgeführt werden können? J / N / 0*
- *War die Zusammenarbeit effizient? J / N / 0*

**Answer on a scale from 1-5 (5=essential, 4=very important, 3=important, 2=unimportant, 1=completely irrelevant) by underlining the number that corresponds to the chosen level of importance**

- On a scale from 1-5, how important was transparency supported by reporting (for instance the presentation of results during SBBs workshop) for your continued support of PV?? 5/4/3/2/1

- On a scale from 1-5, how important was a continued interactions with the other actors (for instance the screening of the film by Gepard) for your continued support of the PV? 5/4/3/2/1

- On a scale from 1-5, how important was emotional connection for your continued

support of PV? 5/4/3/2/1

- On a scale from 1-5, how important was trust in collaborative actors for your continued support of PV? 5/4/3/2/1

***Beurteilen Sie bitte die folgende Aussagen auf einem Skala von 1-5 (5=essentiell, 4=sehr wichtig, 3=wichtig, 2=unwichtig, 1=komplett irrelevant), durch unterstreichen von einer der Varianten!***

- *Auf einem Skala von 1-5, wie wichtig war Transparenz und „Reporting" (wie z.B. die Präsentation and der SBB „Workshop) für Ihre weitere Beteiligung an PV? 5/4/3/2/1*

- *Auf einem Skala von 1-5, wie gross war der Einfluss von direkte Interaktionen mit anderen PV-Mitbeteiligten (wie z.B. die Film Aufführung durch Gepard) für Ihre weitere Beteiligung an PV 5/4/3/2/1*

- *Auf einem Skala von 1-5, wie wichtig waren die emotionelle Faktoren für Ihre Weitere Beteiligung an PV? 5/4/3/2/1*

*Auf einem Skala von 1-5, wie Wichtig war das Vertrauen in den verschiedenen Mitbeteiligten für Ihre weitere Beteiligung an PV? 5/4/3/2/1*

**Answers in free form: / *Antworten in freier Form:***

- Define the value/values created through the project? / *Welches Wertpotential/ -potentiale hatte das Projekt für Sie?*

- If you have noticed unexpected disadvantages of the project on YOUR BUSINESS, please explain what it is/they are: / *Falls Sie durch das Projekt unerwartete, negative Effekte AUF IHR UNTERNEHMEN festgestellt haben, bitte erklären Sie diesen/diese:*

- In free form and on a scale from 1-5, how would you describe the collaboration all together (5=very good, 4=good, 3=acceptable, 2=barely sufficient, 1=insufficient / *In freier Form und auf einem Skala von 1-5, beschreiben Sie bitte ihre Ingesamte Meinung zu der Zusammenarbeit (5=sehr gut, 4=gut, 3= akzeptabel, 2=gerade genügend, 1=ungenügnd*

## d. Questions regarding the future of PV: / *Fragen im Bezug auf die Zukuft von PV:*

**Answer in form of Yes=Y / No=N / I do not know=0 by underlining one of the options!**

- Would you (your company) potentially like to continue supporting the project? Y / N / 0
- Has the experience triggered you (your company) to potentially support other aid/social responsibility initiatives? Y / N / 0

- Do you expect benefits of the project on your company in the future? Y / N / 0

- Was the motivation behind being involved in PV the same at endpoint as at the starting point? Y / N / 0

***Antworten in der Form von Ja=J / Nein=N / Ich weiss es nicht=0, durch unterstreichen von einer der Varianten!***

- *Können Sie (Ihr Unternehmen) sich vorstellen das Projekt weiter zu unterstützen?J / N / 0*
- *Hatte die Erfahrung den Effekt, dass Sie (Ihr Unternehmen) sich denken können,*
- *auch andere Hilfe-/Sozialaktionen zu unterstützen? J / N / 0*
- *Erwarten Sie, dass das Projekt in Zukunft Vorteile für Ihr Unternehmen bringen könnte? J / N / 0*
- *War Ihre Motivation zur Unterstützung am ende die gleiche wie in der Ausgangslage*? J / N / 0

# Appendix vii: Guiding Questions for Mid-Term Interviews with Business Leaders

1. How do you value the cross-sector collaboration?

2. How important were progress reports and monitoring and what were their effects?

- Effect of pictures?
- Effect of film?
- Effect of catalyst?
- Impact of personal interaction with CBM representatives (how important was the launching event, building up team-spirit)?

3. What was the effect of following on quality of collaboration with CBM:

- Having been in direct contact with representatives of CBM?
- Having an emotional connection to the mission?
- Having a contact to catalysts?

4. What was the effect of following on future commitment to collaboration:

- Having been in direct contact with representatives of CBM?
- Trusting CBM (what increases the trust)?
- Quality of reporting?
- The fact that goals have been met?
- Having an emotional connection to the mission?
- Having a contact to inter-mediators/catalysts?
- Having fun doing it?

5. Do you think "My Project Vision" has improved:

- Employee skill and knowledge alignment with company strategy and mission?
- Collaboration between employees?
- Focus on strategy?

6. Do you think "My Project Vision" has altered:

- Company mission or vision?
- Value system or strategy?

7. Do you think your social contribution through PV is in conflict with eventual profit-making?

# Appendix viii: Guiding Questions for End-Term Interviews with Business Leaders

a. Initial motivational factors and incentives

- What were your reasons to participate in the project?
- What role did the catalysts play?
- What role did emotional connection and identification with the cause play?
- How important was trust

b. Execution of project

- How do you value the execution of the project, did you agree with how it was done?
- Have the set aims and goals been reached?
- Did the project have any kind of impact on your organiztion?

c. Future perspectives

- Would you like to continue supporting the project? If yes, in form of financial means only, or also in form of services, Why?
- Has this project spurred you to participate in other aid projects or changed your view of an participation in CSR?

# Appendix ix: mPV Project Documentation Material

***mPV DVD***

The catalysts of *"My Project Vision – For people with Insight*" (mPV) were accompanied by a film team, namely Gepard GmbH, already during the field trip in Ethiopia in December 2004 with the objective to document the research process as well as to produce photographic print an film material for project marketing and advocacy purposes. Please contact Gepard/Cross Motion directly for further information regarding film material or for purchasing a copy of the DVD.

***mPV Website***

In addition to photography and film, a website was developed by MKorb for informative purposes as well as to serve as a tool for cataract financing.
For more information, please visit the project website: www.MyProjectVision.com.

**My Project Vision – For People with Insight (mPV) documenting the research process in Ethiopia, December 2004. (Source: Author's own).**

# Curriculum Vitae

**Name:** Anna Margareta Erat
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## Education

**2011** Thesis defense - Interdisciplinary doctorate in public health (PhD): University of Zurich Institute of Organization and Administrative Science, and Swiss Tropical and Public Health Institute. Advisors: M. Tanner, AG Scherer

**2008 - 09** Post-doctoral fellowship - Medical/basic science research: Harvard University /Harvard Medical School

**2007** Medical school graduation and medical licensing examination (MD): University of Zurich Medical School/Swiss Ministry of Health

**2003 - 07** Visiting studentship and pre-doctoral research fellowship: Harvard Medical School and Beth Israel Deaconess Medical Center

**2003** Radiation protection for the use of radionuclides in research certification: Harvard University

## Professional Experience

**2013 -** Co-manager and leader of the joint Swiss government committee on the regulation and legislation of experimental therapies and investigational new drugs. Reporting to Brigitte Meier at the Swiss Ministry of Health, Switzerland.

**2011 -** Chief medical officer of the Swiss national female ice-hockey team (U18), responsible for the medical staff and for injury prevention, anti-doping and medical supervision of players. Reporting to Director of Medical Services Dr. Daniele Mona at the Swiss Icehockey Federation, Switzerland.

**2011 - 13** Visiting scientist and consultant involved in research, publishing and strategic operations. Reporting to director of basic science research Prof. Dr. A. Usheva at Harvard Medical School/BIDMC dept. of medicine, USA.

**2009 - 12** Medical officer responsible for patient- emergency-room- and clinic- management as well as medical staff training. Reporting to

Prof. E. Battegay, Drs. A. Knoflach and H. Perschak at University Hospital Zurich (2011-12), Dialysis Center Zurich (2011) and Hirslanden Clinic (2009-10), Switzerland.

**2011 (Apr)** Deputy chief medical officer of the event medical committee at the female ice-hockey world championships 2011 responsible of emergency procedures and ensuring player safety. Reporting to the Director of Medical Services Dr. Daniele Mona of the International Ice Hockey Federation (IIHF).

**2005 - 11** External consultant and advisor on healthcare management and research, including the leading of work-shops for medical doctors on treatment-flow optimization and cardiologic- and diabetic-patient management on national & European levels for Executive Insight AG Healthcare Consultants, Switzerland**.**

**2002 - 09** Researcher, authoring various articles, presenting data at conferences, and supervising students. Reporting to Prof. Dr. S.C. Robson and director of basic science research Prof. Dr. A. Usheva at Harvard Medical School/BIDMC, depts. of medicine and ob/gyn, division of endocrinology, diabetes and metabolism, USA.

**2004 - 07** Founder and manager of "My Project Vision" public-private partnership (between Christoffel Blinden Mission (CBM), the Ethiopian Ministry of Health (Tigray state regional office), and various European for profit firms), which enabled the restoration of vision in more than 3000 blind patients in Ethiopia.

## Recognitions and Scholarships

**2008** Research fellowship, Swiss National Fund

**2008** Research grant, Academy of Finland

**2007** Research award, Finnish Medical Association

**2005 - 07** Tuition scholarships, University of Zurich

**2006** Research scholarship, Svenska Litteratursällskapet

**2005 - 06** Research award, Perklens Stiftelse

**2005** Best presentation award, 16th ESC at Humboldt University/Charitè

**1996 - 05** Student grant, State of Finland

**2004** Student scholarship, Svenska Studiestödskommitten

**2004** Research scholarship, Svenska Litteratursällskapet

**1998** Student scholarship, Svenska Studiestödskommitten

## Publications

Alexandrov, BS., Phipps, LS., Alexandrov , L. B., Erat, A. et al. Specificity and Heterogeneity of Terahertz Radiation Effect on Gene Expression in Mouse Mesenchymal Stem Cells. *Scientific Reports* 2013 3:1184.

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