Introduction

This policy brief addresses the role of partnerships between health workers and the community, for the purposes of improving maternal, newborn and child health (MNCH) in resource-constrained settings, with a particular focus on the Asia-Pacific region. It is based on a comprehensive synthesis of the literature prepared by Dawson & Gray (2010) and relevant supporting material identified through a search of the extant literature. This brief is intended as a reference document for policy and decision makers working in or with developing countries in the areas of human resources for health (HRH) and MNCH.

Key Messages

- Improving health outcomes in resource-constrained settings is dependent on community mobilisation. Such mobilisation is facilitated through effective partnerships between human resources for health (HRH) actors and communities themselves.
- Skills and competencies for successful community partnerships need to be cultivated. For example awareness of the political operating environment, and proactive engagement with community leaders.
- Building effective partnerships takes time.

Defining the problem

Poor newborn, maternal and child health outcomes, which represent persistent disparities in health and wellbeing, continue to be a major impediment to achieving the Millennium Development Goals (MDGs) in many low and middle-income countries (Dawson & Gray, 2010).

Addressing these disparities requires ongoing commitment by key stakeholders, including international and domestic agencies, health workers and other parties involved in human resources for health, in order to close the gap between policy and practice within the field of MNCH (Bennett & Ssengooba, 2010). Within this, investment in improving communication and collaboration between stakeholders, as well as fostering the requisite skills required to overcome the often poor and fragmented services that exist on the ground, is needed.

An enduring problem identified in the existing literature on partnerships within community health work programs, however, is the lack of any formal structures to give effect to community participation. This is essential to achieving optimal levels of service delivery and utilisation, and has been found to reduce maternal and child mortality rates (Manandhar et al., 2004). A review of 18 World Bank project information documents on health sector reform initiatives in Asia, for instance, revealed that one third of the projects had a weak emphasis on community participation (Murthy & Klugman, 2004).

This situation is often a by-product of narrow technocratic approaches to addressing health and wellbeing, including vertical programs. These vertical programs tend to be disease or condition specific, and fail to address the context(s) in which disease(s) or condition(s) arise (Bang & Bang, 1989). This context includes enduring human resource issues, such as chronic understaffing and skills shortages, ineffective communication procedures and vague contractual agreements for the delivery of MNCH services for individual health workers. As the evidence
Operational activities, including the establishment of village health committees and, perhaps most notably, led to a failure to secure funding for, and access to, a means of transport.

Crucially this case study points to the importance of developing on-the-ground competencies aimed at alleviating political tensions in everyday settings. This engagement should be prospective, rather than retrospective, occurring prior to resource allocation and other decisions that impact on the provision of services at a local level.

An alternative approach to addressing these on-the-ground challenges, through working in partnership with communities to achieve ‘buy-in’, is provided in the case study below. Through examining real life scenarios, policy makers, health professionals and community members are able to make informed decisions on what shape policies and interventions will take, irrespective of the sparse evidence base. Within this, assessment of the contribution these partnerships have on the delivery of MNCH programs and services must be identified, discussed and disseminated.

Case Study: Involving and empowering end users of MNCH in partnership with community health workers - Indian example

Adolescent girls in India were trained to encourage the community to use health services, particularly reproductive services. The program selected non-school attending adolescent girls from the villages who were trained by village health nurses on various aspects of sexual and reproductive health. The training included information on personal hygiene, menstrual hygiene and other problems for adolescents, as well as information about conception, antenatal care, danger signs during pregnancy and the importance of institutional deliveries and postnatal care. This aimed to empower them to take care of and support pregnant women in their community. Each participant was also allocated a contact person for use if complications arose.

Finally, each girl was expected to take care of 5 to 6 pregnant women and 5 postnatal women in their village. Their role included providing dietary advice, such as the need to consume iron and folic acid tablets, and information on the benefits of breastfeeding, as well as persuading women to use institutional services.

The program was rigorously monitored with a monthly review on various measures including the number of visits made by the adolescent girls to pregnant women; the number of women taking iron and folic acid supplements; the number of cases referred to village health nurses/other hospitals; the number of women having antenatal and postnatal care; the number of newborns referred and the number of infants fully immunised (Government of India 2004).
Policy options

In order to develop and maintain effective partnerships within the field of MNCH in resource-constrained settings, including within the ambit of vertical programs, there is a need to clarify what specific skills and attributes are required to ensure the timely delivery of ‘available, accessible, appropriate and good quality’ services (Hunt, 2005) for communities. There is an emerging view that this can be achieved through the alignment of work plans and individual contracts with broader policy statements and goals. These should focus on partnership as an imperative to health care planning, service development, delivery and evaluation, a perspective first articulated in the Alma Ata Declaration of 1979 (Dawson & Gray, 2010).

Intensified efforts to provide information and resources to build capacity and foster collaboration between health workers and the community are required within the field of MNCH. This may include the promotion and provision of specific tools, such as the Catchment Area Planning and Action (CAPA) handbook (Obi & Orisasona, 2004), or funding specific skills development programs adapted to the needs of specific resource-constrained settings.

In a randomised control trial conducted by Hien et al. (2008) it was found that such education programs resulted in significant capacity building for community leaders and improved the competencies required for the promotion of a healthy living environment. Communities and HRH actors therefore need to be in a meaningful partnership for any successful community level intervention. Figure 1 displays the crucial factors that affect the interaction between HRH and community (Dawson & Gray, 2010).

Figure 1. Factors affecting health worker partnership building with communities

Recommendations

- Ensure that community-based approaches to the delivery of maternal, newborn and child health services are entrenched in funding agreements and contracts entered into between funders and service providers and/or individuals.
- Provide clear guidance in health worker job descriptions regarding expectations for community engagement, in order to promote clarity and accountability in service delivery.
- Undertake rigorous impact studies to assess the contributions that community and health worker partnerships can make in the delivery of maternal, newborn and child health programs and services.
- Develop and disseminate current knowledge of what works in establishing and maintaining community partnerships in health through case studies of real-life scenarios.

Further Information

For further information please download the full document: Human Resources for Health in Maternal, Neonatal and Reproductive Health at the Community Level: A Synthesis of the Literature with a focus on the Asia Pacific Region

References


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