Partnerships for Health

A Way of Working with Women's Groups to Improve Community Health in Rural Nepal

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1 Background

The people of the hills of Eastern Nepal face many hardships; not least among them is the lack of quality primary health care services. The health statistics of the country reflect the poor services offered. The maternal mortality rate is 515 deaths per 100,000 live births and the infant mortality rate is 165 deaths per 1,000 live births (UNICEF 1996). Most of the deaths are preventable; diarrhoeal disease is the biggest killer.

Several studies depict a scenario of underutilisation of the existing health care services (Sigdel 1998,;Justice 1996). Among the reasons suggested are lack of medicines, the health posts not being situated conveniently and the rudeness of the medical personnel (Sigdel 1998). Others comment on the lack of awareness surrounding health issues and health being a low priority for village people. It was with this in mind that a different approach was devised that used an alternative model: a health action approach with women's groups, which was called the Health Analysis and Action Cycle (Gibbon and Cazottes 1999).

A local non-governmental organisation called the Women's Empowerment Strengthening Team (WEST) used the approach to work with a community in Dhankuta district. The community comprised Chettri-caste Hindu families and Rai families. The Rai are an indigenous ethnic group that lives in Eastern Nepal. WEST worked in partnership with two women's groups.

2 What is Meant by Partnership?

I have chosen a definition of partnership that also seems pertinent to the development discourse. Cadbury (1993:11) defines partnership as:

> *Consultation* implies seeking views which will be taken into account when making a decision; *participation* implies that local people are really able to influence decisions and occasionally take part in the decision-making process;

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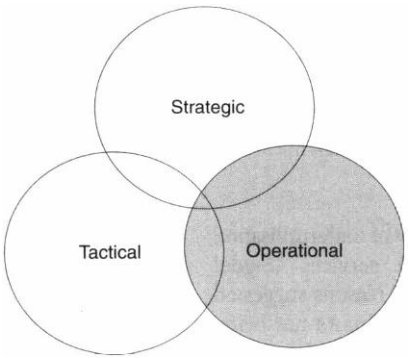
Figure 1: Different components of partnership



partnership is a more involved form of participation, with a wide variety of meanings, but implies power being shared equally with all partners.

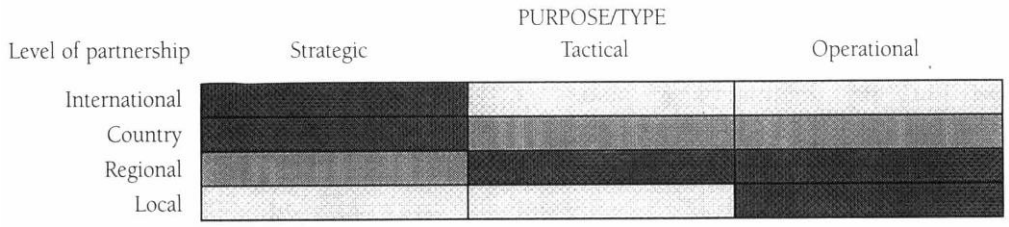
Fowler (1997:117) uses the following definition of an 'authentic partnership' as one where, 'understood and mutually enabling, interdependent interaction with shared intentions' occurs. He considers such partnerships as invaluable as they enhance social capital and bring about a more civil society better able to deal with states and markets at all levels of operation.

Partnerships take place at a number of different levels: international, national, regional and local. They also fulfil a number of different purposes. Taket (1998) suggests there are three different types of partnership, or, more usefully, they should perhaps be viewed as ***components*** of partnership, as there can be an overlapping of the different types in any one instance (see Figure 1).

The ***strategic component*** consists of developing preventative and curative health policy, improving the perceptions of health problems and issues and their corresponding understanding, and the development of political will.

The ***tactical component*** consists of establishing bodies or committees to carry out defined tasks, developing of instruments such as budgets, expertise, legislation, etc. The setting of operational targets and the allocation of resources are also objectives of this component.

Figure 2: Partnership – different levels and different purposes/types



Darker shading indicates increased frequency/importance of partnerships at level shown for purpose shown.

Table 1: Important relationships in power distribution and participation

Shared identity	Leadership	Trust	Authority	Controls	Flexibility	Effect on participation
Strong Weak	Consultative Autocratic	High Low	Decentralised Centralised	Relaxed Firm	High Low	Positive Negative

Source: Fowler, 1997: 57.

The *operational component* consists of the use of instruments, delivery of services, implementation and monitoring and evaluation. It is the action-orientated aspect of a partnership. Taket (1998) also suggests that the different levels of partnership can have differing purposes (Figure 2).

The relationship I have been concerned with focuses most on the operational component. It does, however, have facets of both the tactical and strategic components.

My experience suggests that partnerships need to be:

- Flexible
- Systematic
- Able to negotiate on equal terms
- Able to work with difference
- Realistic
- Locally designed
- Creative
- Pluralistic (in terms of mechanisms and process).

The organisational structure of a partnership needs to be flexible. Hierarchical relationships are built on inequalities and tend to be centralised. This type of relationship is not conducive to flexibility, a more helpful mode of operation is where there is openness, flexibility and collaboration of all the different stakeholders on equal terms. Rigid frameworks and timetables set by the implementing or donor agency is not the basis for a successful partnership. Table 1 summarises this relationship.

Partnerships do need to have a systematic approach to be successful. There has to be a concept of capacity growth for the local organisation and mechanisms for collaboration built into this. Systems need to be set in place that are responsive to change and that can adapt quickly to changes in circumstances.

There has to be a willingness to negotiate with potential partners on equal terms. Often organisations wield considerable amounts of power and can manipulate local groups to follow their agenda rather than the agenda of local communities.

Communities are often considered as homogeneous entities. In reality there are usually different cultural groups and widely differing interests. The cultural organisation of development agencies may also be at variance with local groups. There may also be differences in terms of the language spoken. Certain groups have distinct dialects or a different mother tongue to the dominant societal group. In Nepal there are over 30 different local languages although the national language is Nepali. In the course of this research there were difficulties in communication at times due to language. For successful partnerships there needs to be clear communication. Pictures and metaphors can be beneficially used.

The goal of partnership can force partners into setting unrealistic timeframes, and the expectations of different stakeholders may be conflicting. Thus, it is important to recognise the need for setting realistic schedules and ensuring negotiation of goals, roles and responsibilities that are clearly understood by all the stakeholders. Partnerships need to be locally designed. Differences in organisational culture and environment mean that what works well in one context will not necessarily work well in another. It is not possible to design a partnership without involving the local beneficiary groups from the inception.

Creativity is a feature of a successful partnership. Creative thinking allows communication barriers to

Table 2: Modes of participation

Mode of participation	Involvement of local people	Relationship of research and action by local people
Collective action	Local people set their own agenda and mobilise to carry it out, in absence of outside initiation and facilitators	By
Delegated power	Local people hold a clear majority of seats on committees with delegated power to make decisions	By
Partnership	Sharing of knowledge, planning and decision-making responsibilities to create new understanding	By/with
Cooperation	Local people work together with outsiders to determine priorities, responsibility remains with outsiders for directing process	With
Consultation	Soliciting of views, those with power analyse, decide on course of action and control inputs	For/with
Informing	Tasks are assigned, those in power decide agenda, direct process, no channel for feedback guaranteed	For
Co-option	Token representatives are chosen, but no real input or power	On
Manipulation	Distortion of participation into Public Relations vehicle	On

Note: In the case of the research process on which this article is based there was no one mode of participation observed. It took different forms over the course of the relationship. The first phase took the form of a collaborative or cooperative process in which local people worked together with outsiders to determine priorities. At this stage the outside agency directed the process. This took the form of a need assessment (See Figure 3).

be crossed. It helps in the identification of common goals. Flexibility and creativity go hand in hand, as it is through these two features that rapid response to changing situations is possible. In this way strategies for action can be built that adapt to successful tactics and build on successes.

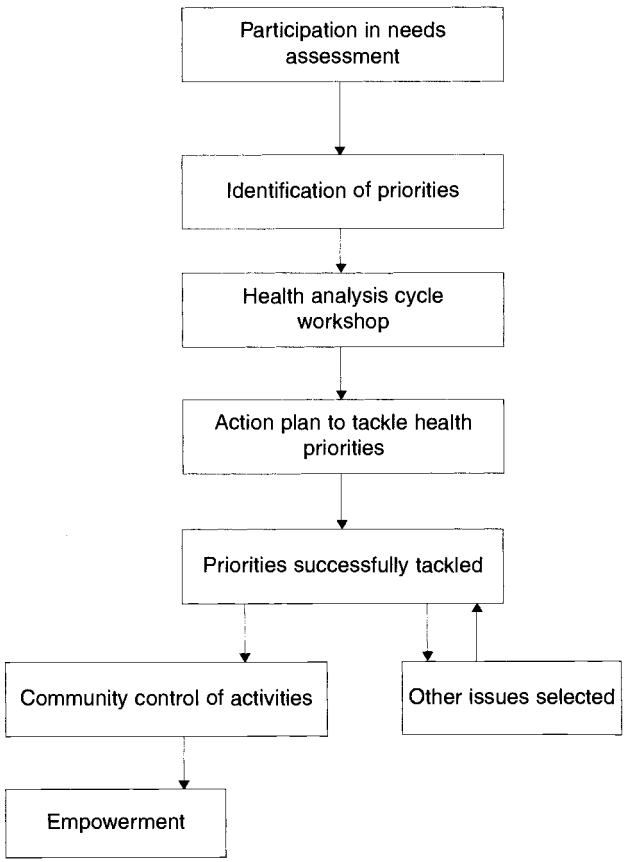
Pluralism allows for the ideal of intersectoral action, where the health sector enters into equal partnerships with other sectors, organisations and community groups at all levels. The understanding of appropriate strategy, mechanisms and tactics does not guarantee success. Each intersectoral partnership created requires specific designing to fit the demands of the particular issue concerned and the contours of the socio-political-economic-context.

2.1 The community as partner

The nature of partnerships can be discerned through a framework such as that of Arnstein (1969) or Cornwall (1996) (summarised in Table 2). Clear definition of roles and responsibilities is important if a successful partnership is to be achieved. The values of all the partners have to be taken into account and made explicit. Partners have to work to shared agendas, display commitment and have the chance to voice any concerns at all stages of the process.

After the priorities had been identified, a health analysis cycle workshop was held. This step enabled a sharing of knowledge and a planning process to be initiated. The health analysis cycle workshop was the impetus in the formation of a partnership between the local non-governmental organisation and the community. Participatory health groups were formed during the workshop and they then formulated action plans to tackle health priorities at local level (See Figure 3). A participatory health group is a community-based

Figure 3: Flow of activities carried out by participatory health groups



organisation; each group elects a chair, secretary and treasurer.

The groups were able to tackle their priorities successfully and later select other issues. They then took control of the action planning process and went on to develop other activities. The groups have the power to make their own decisions and set their own agenda. They can act collectively and acquire a feeling of group empowerment (Table 3). The process has led to changes within the groups. Indicators were chosen to ascertain change and the discussion focussed on differences before the intervention and what they felt about their situation at the present time (See Table 3).

2.2 Conclusions

The way the research process was structured enabled the outsider to listen and learn from the community on an equal footing. The health analysis cycle gives a focus for discussion and inquiry. The community priorities are paramount and the groups decide on the health-related activities they want to pursue. The process enables a negotiation to take place that is egalitarian in nature. The approach is flexible, but does take a considerable amount of time and effort, and good facilitation skills are required for its operationalisation.

It is not possible to use a single definition of partnership. The relationship changes over time. Once a particular activity is completed, although a group

Table 3: Changes over the research process

Indicator	Before	Now
Decision-making	No group decisions were made as no group existed	Able to discuss issues, decide in a group and then act
Identifying problems	None identified	During the workshop they learned how to identify problems. They can now discuss issues and identify problems together
Planning	None carried out	After the workshop they started to plan activities. They are now able to make an action plan themselves to carry out an activity in the community.
Implementation of projects	None implemented	They have carried out the following projects • Latrine building • Health education • Supply of ORS
Completion of projects	None started	They feel project completion has occurred through involving the community and fuller participation of the community in their projects
Working together	Worked alone	We are now able to cooperate and have good working relationships and participation.
Conflict in the community	Before we were unaware of conflict	During the latrine building a conflict occurred where the ward chairman gave cement to one section of the community (Chettri). They held a community meeting and discussed the conflict and were able to resolve it.

may reach a high level of operation, it may then disintegrate if there is no new focus for action. Conversely, the next activity may no longer be directly health-related but serve a different prioritised need.

References

Arnstein, S. R., 1969, 'A ladder of participation', *Journal of the American Institute of Planners*, 35, 216–24.

Cadbury, R., 1993, 'The partnership challenge: the need for public partnership in urban regeneration, *Public Policy Review*, 1(3): 11–12.

Cornwall, A., 1996, 'Towards participatory practice: participatory rural appraisal and the participatory process', in de Koning and Martin (eds), *Participatory Research in Health*, London: Zed Books.

Fowler, A., 1997, *Striking a Balance: A Guide to Enhancing the Effectiveness of Non-Governmental Organisations in International Development*, London: Earthscan.

Gibbon, M. and I. Cazottes, 1999, 'Cycles within cycles: the effectiveness of the Health Analysis Cycle', Proceedings of the FICOSSER Health Systems Research Conference, 28–30 July, 1998, Cuevernaca, Mexico.

Justice, J., 1986, *Policies, Plans and People: Foreign Aid and Health Development*, Berkeley: University of California Press.

Sigdel, S., 1998, *Primary Health Care Provision in Nepal*, Kathmandu: Sangita Sigdel.

Taket, A., 1998, 'Health research for the 21st century', Proceedings of the FICOSSER Health Systems Research Conference, 28–30 July, 1998, Cuevernaca, Mexico.

UNICEF, 1996, 'Children and women of Nepal: a situational analysis', Kathmandu: UNICEF.