



How Social Capital in Community Systems Strengthens Health Systems: People, Structures, Processes

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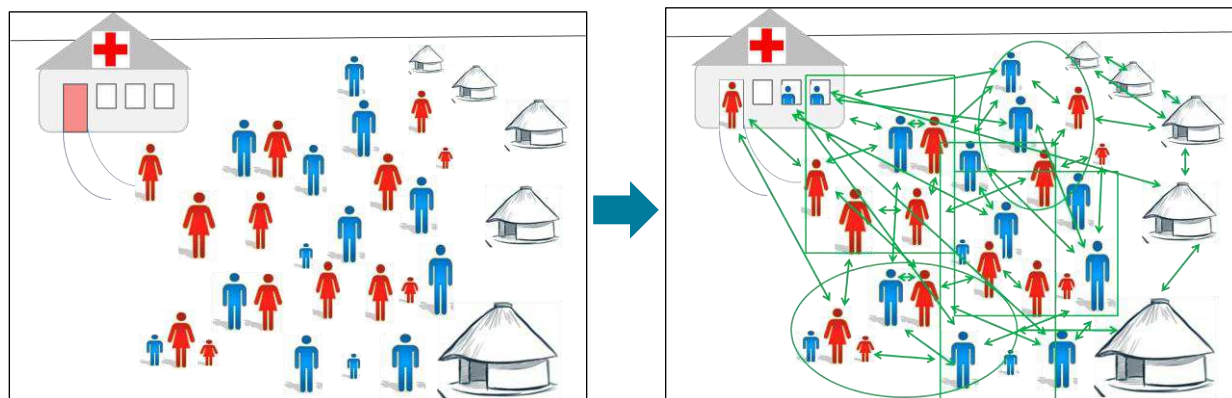
I. INTRODUCTION

Communities play instrumental roles in improving health outcomes within the scope of national health systems. However, the role of the community in health system strengthening, as well as specific components of the community health sub-system itself have not been systematically documented. In this paper, we explore the relationship among the community, the community health sub-system and the national health system, and propose a set of actors, structures and processes critical for promoting positive health outcomes, especially in underserved areas.

This paper is based on an analysis of the Child Survival and Health Grants Program (CSHGP), under the United States Agency for International Development (USAID), discussions with CORE Group members and partner organizations, and a literature review of community health maternal and child survival projects. Since its inception in 1985, CSHGP has funded 420 maternal, newborn and child health (MNCH) projects, implemented by 55 U.S. nongovernmental organizations (NGOs) and their local partners in 62 countries. NGO grantees do not deliver services directly, but work in conjunction with local implementers (i.e., ministries of health [MOHs], local civil society organizations and communities). Their interventions focus on activities at the household and community levels, as well as strengthening linkages with and quality of local MOH health service facilities, and have a long history of increasing the use of key family practices and health services that improve coverage beyond the Demographic and Health Survey (DHS) secular trend. ¹

The purpose of this document is to draw attention to the undervalued resources of a community in programming to improve health status for maternal and child health (MCH), infectious diseases, nutrition, family planning (FP) and chronic diseases. We apply a systems thinking lens to review the actors, structure and processes of community contexts where national health service systems interact with individual beneficiaries. In taking this approach, we identify links between the communities and national health systems and propose a set of key components comprising a community health sub-system that serves as the interface between community realities and health system elements, where health services, health workers, community dynamics and actors, and cultural norms and practices interact and promote improved health outcomes. In conclusion, we propose that the social capital within a community and between the community and the national health system actors is a critical element, perhaps a seventh building block of a highly functioning health system, which needs strengthening and further research.

II. BACKGROUND: COMMUNITY SYSTEMS



¹ www.mchipngo.net and Edward A., Ernst, P., Taylor, CE et al. 2007. Examining the evidence of under-five mortality reduction in a community-based program in Gaza, Mozambique. Transactions of the Royal Society of Tropical Medicine and Hygiene. Doii:10.1016/j.trstmj.2007.02.025

“There is a saying that a stranger has eyes but cannot see. That is why it is good to see the chief to introduce you to the community.”

~ Focus group with chiefs and elders

Communities are organized and influenced by larger units, such as municipalities, districts, counties and local administrative units, but a health system ultimately intersects in people’s lives in their local community spaces. Social support, social capital, empowerment to make decisions and trust between individuals within a community are important determinants of health service usage and outcome, even within the larger categories. These dynamics and relationships within communities and between communities and their environment influence health status most directly. Powerful external forces, including globalization, the economy and politics, are the context within which the community functions.

Community contexts are mini universes of complex social, political, associational, economic, power and cultural dynamics, providing a different theater for providing health services and facilitating behavior change than in a health facility. Some communities may consist of relatively homogenous populations (whether it be the same tribe, cultural group or religious affiliation), while other communities may be quite heterogeneous. Some communities may be stable, while others have high levels of migration in certain seasons. Communities also differ a great deal in the degree of social cohesion; often they are made up of various ethnic or caste groups or clans, whose identity is not at the level of a geographically or spatially defined community. Communities will mirror the value systems specific to the region, nation-state, religion or other cultural attribute. While western values focus on individual behavior change and individual actualization, many African and Asian systems focus on group procedures and relationship programs to enhance one-on-one relationships of trust.²

Communities present different challenges than standardized health service delivery systems and large-scale public health approaches, as dynamic, evolving entities. Demographics and epidemiology will inevitably change over time. High-impact health prevention and promotion activities—such as promotion of exclusive breastfeeding, infant and young child feeding, birth delivery planning, use of an insecticide-treated nets (ITNs) for malaria prevention and essential newborn care—are of particularly high importance in community settings. In such situations, effective behavior change approaches are essential when compared to facility settings where more complex medical procedures are promoted for maximum impact.

The community, as a local system, shares underlying characteristics common to all systems. Their architecture is dynamic and builds on opportunities and interactions both within the community and between the community and outside forces, such as the health system. Every intervention, from the simplest to the most complex, will have an effect on the overall community system.³ What seems like an obvious solution to a problem may sometimes worsen the problem or have unanticipated effects because the problem is part of a wider, dynamic system.

Communities are self-organizing, constantly changing, tightly linked, governed by feedback, non-linear, history dependent, counter-intuitive and often resistant to change.

² Patient, David R. Western vs African Value Systems. Accessed at www.midego.com/docs/David_Patient_Value_Systems.pdf on 9-6-2011

³ World Health Organization (WHO). 2009. Systems Thinking for Health Systems Strengthening. de Savigny D and Adam T. Geneva.

III. THE COMMUNITY HEALTH SUB-SYSTEM

Within a community, we can consider there to be a micro-level community health sub-system that functions within the broader national system. There is no universal agreement on a definition of a community health system, yet the literature is rich in examples of the positive effects of community participation, community empowerment and community mobilization.^{4, 5} In addition, there is extensive evidence from the CSHGP's NGO project evaluations suggesting that programs using a community-oriented participatory approach achieve above-average health outcomes, especially for interventions requiring behavioral change.⁶

Existing Frameworks for Community Systems

Limited work has been done to define key terms and elements related to community systems and community health sub-systems. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), the United Nations Children's Relief Fund (UNICEF) and the CORE Group have developed frameworks applicable to different facets of the community health sub-system.

The Global Fund has developed a framework on Community Systems Strengthening to define the roles of various actors that work with civil society in the design, delivery, monitoring and evaluation of services, which aim to improve health outcomes. They define community systems as "community-led structures and mechanisms used by communities through which community members and community-based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities."⁷

The Community Systems Strengthening framework proposes several core areas that must be fully functioning for community systems to contribute to sustainable health outcomes. One such area is the development of community networks, linkages, partnerships and coordination.

UNICEF developed a framework⁸ for engaging the community with the health system, a task that requires some facilitation and knowledge on the part of both the community and community health agents working locally. For community members to actively participate in the health system as a whole, the ideal community would need to have:

- Health knowledge—basic technical information on causes, prevention and treatment of health problems.
- Planning and management skills—analysis of assets and problems, understanding views of different groups in the community, gender analysis, problem solving and action planning, coordination, evaluation, information access and resource mobilization.
- Mobilizing and communication skills—democratic leadership, representation of diverse interests, promotion of equity in participation by including disenfranchised groups, group facilitation, conflict resolution and participatory learning methods.
- Commitment to collaboration with health services and policy makers—advocacy, negotiation, partnership development, and working with journalists and the media.

⁴ Perry H, and Freeman P. 2009. Review of the Evidence: How effective is primary health care in improving the health of children? International Section of the American Public Health Association.

⁵ Bhutta ZA, Ali S, Cousens S et al. 2008. Interventions to address maternal, newborn, and child survival: what difference can integrated primary health care strategies make? *Lancet* 372: 972-89.

⁶ http://mchipngo.net/controllers/link.cfc?method=project_doc_search.

⁷ Community Systems Strengthening Framework. 2010. Accessed at http://www.theglobalfund.org/documents/civilsociety/CSS_Framework.pdf.

⁸ Aube J. 1999. Communication for Empowerment: Strengthening Partnerships for Community Health and Development. UNICEF. New York.

To be most effective at facilitating this relationship, community health agents, a key connection between the greater health system and the local community, must be well trained and also have:

- Knowledge of the community—understanding community perspectives on health and well-being, identification of community resources and strengths such as supportive social practices and systems that benefit health.
- Planning, communication and collaboration skills—dialogue facilitation with the community, participatory analysis and planning techniques, mutual respect and learning, cultural competence, consensus-building, problem solving, advocacy and cross-sector collaboration.

The CORE Group developed a community health framework to guide the implementation of a comprehensive child health and nutrition program at the community level, based on extensive fieldwork across multiple international health and development NGOs. The framework continues to be used as a guide to develop community health strategies.^{9, 10} Three linked elements are considered essential for a functioning community health system:

1. Partnerships between health facilities and the communities they serve;
2. Appropriate and accessible health care and information from community-based providers (including community health workers [CHWs]); and
3. Home use of a set of integrated key family practices critical for child health and nutrition delivered through various communication and behavior change strategies and inter-personal counseling.

The elements of the community health framework, along with effective relationships and partnerships between the various elements, provide one way to situate health interventions within the community context. Health is inextricably linked with other sectors; as such, a multisectoral platform, involving local government, savings and loans programs, agriculture, water and sanitation, and education, among others, is key to supporting sustained improvement in health by engaging sectors that address key determinants of health. In every community, multiple sectors are involved in efforts that are effectively integrated and mutually supportive in contributing to population health and well-being across a continuum from “hardly at all” to “quite a bit.”

Additional research has suggested several conditions essential for establishing effective community-based approaches to improving health outcomes.¹¹ These include trust and respect between the community and the health system; a strong outreach system that brings technical expertise, medicines, vaccines and products to the community; training and deployment of community-based workers who can implement evidence-based interventions and reach patients who need them; a system for maintaining contact with all households and providing systematic visitation; a focus on interventions, which require behavior change for ingrained cultural beliefs and practices; and a referral system to compassionate and quality care.

Community-based approaches will have the greatest impact on health outcomes in areas where health systems are weak and mortality and morbidity is high.

⁹ CORE Group. The Household and Community Integrated Management of Childhood Illness Framework. 2003. Accessed at http://www.coregroup.org/storage/documents/Facilitators_Guide.pdf on April 13, 2011.

¹⁰ Winch P, LeBan K, Casazza L et al. 2002. An implementation framework for household and community integrated management of childhood illness. *Health Policy and Planning* 17 (4): 345–353.

¹¹ Perry H and Freeman P. 2009. Review of the Evidence: How effective is primary health care in improving the health of children? International Section of the American Public Health Association.

IV. COMMUNITY PARTICIPATION AND SOCIAL CAPITAL

At an organizational level, a high-functioning community underpins and supports an effective health system. This foundation includes networks of supportive relationships, community associations to support the impoverished, health service choices that are effective and equitable, and community institutions that monitor health outcomes and quality of services. A strong community also enables the government health system to best invest its limited health resources by tapping into local human resources and assets. After all, caregivers, families and communities are ultimately the key producers of good health outcomes.

Communities are composed of different people at different times, and depending on the needs and capacities of community members, participation runs a continuum from response to empowerment. Although community participation is situational, it is critical to health improvement for the following reasons:

- People are more likely to use and respond positively to health services if they have been involved in decisions about how these services are delivered.
- People have individual and collective resources (time, money, materials and energy) to contribute toward their individual and collective health goals.
- People are more likely to change risky behaviors when they are involved in deciding how that change might take place.
- People gain information, skills and experience in community involvement that help them take control of their own lives and challenge social systems.¹²

Although community participation must be viewed within a political, historical, social and cultural context, the bonds and connectedness of people within a community make it easier to set community health goals and engage positively with the health system.

Social capital, defined by Robert Putnam as the “connections among individuals in social networks and norms of reciprocity and trustworthiness that arise from them,” has shown a positive association with health and other community outcomes.^{13, 14} Social capital is the degree and quality of social networks, norms of reciprocity, mutual assistance and trustworthiness that bonds similar individuals within a community together or bridges diverse people together. Putnam demonstrated that the level of social capital distinguished more successful from less successful towns as measured by widespread relatedness that existed among citizens. Support from individuals and cognitive social capital (i.e., trust, social harmony) has been found to be associated with child nutritional status across four countries.¹⁵

Community social capital has been linked to a variety of community health status variables through different mechanisms such as reducing or buffering stress, coaching and urging of healthful practices, providing information to expand one’s knowledge base about health and increasing responsibility for the well-being of others.¹⁶ Community organization and social capital have also produced positive effects in helping families escape poverty by supporting households to cope better with illnesses and negative events, and enabling investments in land-

¹² Rifkin SB. 2009. Lessons from community participation in health programmes: a review of the post Alma-Ata experience. *Journal of International Health* 1, 31–36.

¹³ Putnam, R. 1993. *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton University Press, Princeton, NJ

¹⁴ Putnam, RD. 2001. Social Capital: Measurement and Consequences. *Isuma: Canadian Journal of Policy Research*. 2 (Spring 2001):41–51 accessed at www.oecd.org/dataoecd/25/6/1825848.pdf.

¹⁵ DeSilva MJ and Harpham T. 2007. Maternal social capital and child nutritional status in four developing countries. *Health and Place* 13 (2007) 341-355.

¹⁶ Folland S. 2007. Does “community social capital” contribute to population health? *Soc Sci Med* 64 (2007) 2342–2354.

based activities (such as livestock production or natural resource management) that provide a source of rural income.¹⁷

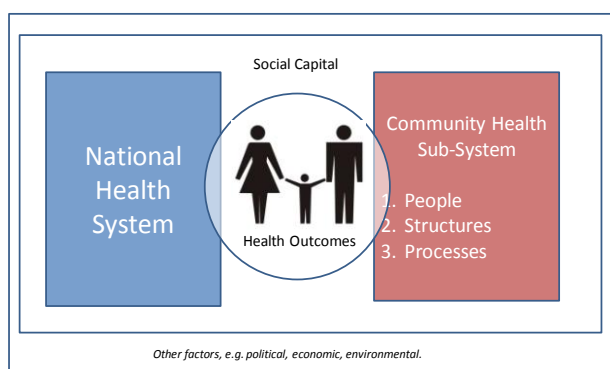
Social capital facilitates cooperation and lowers the cost of working together, primarily through four mechanisms: 1) Trust between people reduces their transaction costs since they have social obligations and act as expected. Trust and cooperation take time to build, especially when a community is permeated by distrust, and it's easily fractured; 2) Reciprocity and a continuing relationship of exchange that eventually is repaid contribute to the development of long-term obligations between people; 3) Common rules, norms and sanctions that are mutually agreed upon help place group interests above individual interests, and enable individuals to take actions to ensure their rights are met; and 4) Vertical and horizontal connectedness between and among networks and groups help bridge different points of view, and increase the community's ability to engage with external agencies or influence policies. The more linkages there are the better.¹⁸

Increased social capital within a community and between a community and the national health system is a key component of better health outcomes. We need a method to better understand its dynamics as well as to measure it.

V. KEY COMPONENTS OF THE COMMUNITY HEALTH SUB-SYSTEM

A health system and a community system are composed of multiple sub-systems, each reflecting the complex and multi-layered nature of players that must carry-out activities—from governance to logistical supplies and from the national level to the local level. Each community system has a community health sub-system that is unique to the local context, but has certain common components key to its success in supporting positive health outcomes. When developing a community approach to maximize health impact, identifying key community actors, strategizing on how to engage them collectively in the interventions and leveraging the power of their relationships are major challenges. The community system is not static, but emerges over time, so that what appears complex and what appears simple is relative. By rising to these challenges and working with local, high-impact groups, change can ripple through the community health system as a whole.

Figure 1. Social Capital Linking Households, National Health System and Community Health Sub-System



¹⁷ Krishna A. 2010. One illness away. Why people become poor and how they escape poverty. New York: Oxford University Press.

¹⁸ Pretty J. 2003. Social capital and connectedness: Issues and implications for agriculture, rural development and natural resource management in ACP countries. CTA (Technical Centre for Agricultural and Rural Cooperation), working document number 8032.

In order to conceptualize the components within a community health sub-system, we propose the following essential community assets that influence health outcomes: community members; community structures, such as groups, organizations and associations; and community processes and relationships that can provide equitable access to people-centered prevention and care. Each component plays an important role in improving household and community health by complementing the work of the national health system, increasing local access to people-centered care, and empowering individuals and communities to take action to address their health needs. Health outcome is seen as the interplay between the health system and the community, as influenced by macro-level political, economic and environmental factors, but bonded through the network of relationships and trust expressed as **social capital**.

People: Community Health Sub-System Actors

Home health practices by caregivers to prevent illness and promote health are key to achieving improvements in health and nutrition status. The challenge is to engage effectively with the caregivers to support or change these practices either directly or through other influential community resource persons. The challenge is more pronounced in communities with low literacy, limited health information, distrust of the health system, strong traditional beliefs and poor access to national health services. Key actors in the community health sub-system are people affected by disease or vulnerabilities, caregivers, household members such as husbands and grandmothers, community leaders and champions, and community health agents or frontline health workers based in the community. There has been renewed government interest, especially in the deployment of formalized community health agents.

People Affected By Diseases or Vulnerabilities

People affected by diseases or affected by disabilities or other vulnerabilities (such as orphans and traumatized persons) are often stigmatized by other community members or the national health system. They need to engage in political and social community life to advocate for the resources they need, reach their full health potential and ensure they have sustained access to critical medications so they don't create drug resistance for others.

Household Members

Households are the key influencers of health for their families by making daily decisions regarding foods to eat, healthy practices in the home, and use of scarce resources for health care and better nutrition. The household is a complex, dynamic system moderated by cultural, traditional and community factors. Key decision-makers for different health interventions vary: they may be the mother, caregiver of the child, husband or partner, or the grandmother or mother-in-law. Outside influencers may be a village chief or religious leader or a neighbor. Behavioral change strategies for different health needs must be analyzed and systems oriented.

Of particular importance are female-headed households, which require additional support. Krishna, in an analysis of poverty across several countries, found that gender was the only household characteristic that was consistently and negatively associated with one's ability to escape poverty. Female-headed households have fared much worse than other households due to additional stresses and were more likely to become poor or remain poor. Household size, age and education level of the head of household and other adult members had mixed effects, and were not consistently associated with "escapes from poverty." Community characteristics, relative remoteness and population size, also did not associate clearly.¹⁹

¹⁹ Krishna A. 2010. One illness away. Why people become poor and how they escape poverty. New York: Oxford University Press.

Community Leaders and Champions

Communities may have self-appointed champions, whether from a faith community, an influential or wealthy elite or someone personally affected by a health tragedy, who publicly highlights a critical community health issue and influences social and behavior change. These resource persons can be supported to ensure their message is heard and is not divisive to marginalized groups in the community.

Community Health Agents

Community health agents can take many forms and are increasingly used by MOHs to extend the presence of the health system to local settings to reach all households. These agents generally include CHWs, known by many different names, traditional birth attendants (TBAs), and other health resource persons who live in the community.

CHWs or community health volunteers (CHVs) are community members selected to conduct health promotion, provide basic health and medical care to their communities, and mobilize communities for health. These workers may be government-funded employees or volunteers assisting with and extending health services at the most peripheral governmental health facility within neglected communities. They may also serve as “extender” CHVs working on a limited basis out of their home and making home visits to their neighbors to support health education or provide basic treatment for life-threatening illnesses.

CHWs/CHVs are considered an essential part of a community health system, particularly in underserved and geographically peripheral areas, where their primary care services are supported by the national health system and may be the only services available. Community health agents can play a critical role in linking communities with health facilities for referral of emergency and complicated medical conditions, including pregnancy. Within a community, there may be a single agent, a pair of agents (typically one male and one female), or a cluster of several agents, each with specific but complementary functions.

Community Health Workers

Known by various terms, these workers have been defined as “health workers who perform a set of essential health services, receive standardized training outside the formal nursing or medical curricula, and have defined roles with the community and the larger health system.”²⁰ These workers are generally selected by the community; receive training, support, supplies and supervision from the national health system; may work full, nearly full-time or part-time; increasingly receive a salary or stipend from the MOH; and have an established referral protocol with the national health sector.

Though the term, CHW, is increasingly used to delineate a type of cadre of health worker that is being integrated into national human resources for health plans and national health systems, it is still an ambiguous term with varying functions and allegiances. Due to the intersection of a shortage of health workers, the quest to achieve the Millennium Development Goals (MDGs) and evidence that demonstrates CHWs can improve equitable access to care and improve health outcomes,²¹ this lower-level cadre of the national health system has gained momentum as a solution for extending access and care. Many, but not all, MOHs have asserted policies that these workers should be paid workers of the MOH, whether paid by the MOH itself or by NGOs.

²⁰ Crigler L and Hill K. 2010. Assessment and improvement of programs providing health services to communities. CHW AIM published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC.

²¹ Bhutta ZA, Zohra S, Lassi S, Pariyo G and Huicho L. 2010. Global experience of CHWs for delivery of health related Millennium Development Goals: a systematic review, country case studies, and recommendations for integration into national health systems. WHO.

A recent review of CHWs suggested that when managed effectively, a CHW program that is integrated with a well-functioning primary health care system can promote care at the household level and function as a crucial link between community members and the primary health care system; thereby, providing a means for continuum of care across multiple points of care.²²

An earlier review by the World Health Organization (WHO) though warned that CHWs were not achieving their potential at scale due to social, cultural and management factors, which are inextricably linked with the CHW's position between the health sector and the community.²³ This same review pointed out that CHWs are members of highly stratified communities, within which they may face a great deal of conflict. Class, caste and other divisions affect their own positions and loyalties. The political climate in which they work, in society at large and in the communities may affect their work.

CHWs are by definition part of the social setting of both the health and community systems, which brings with it strengths and weaknesses. On the one hand, they are empowered by belonging to both systems, while on the other, they may be torn by where their loyalties and interests lie. CHWs serve not a solitary social group of unified purpose, but a population whose commitment to an activity varies according to members' expectations of its benefits and the social and political context of the activity.

CHW programs need not be confined to a single type of CHW. Different kinds, with different levels of training and tasks, and different motivational and retention systems may be more flexible and responsive to local needs. CHWs can serve many different functions at various levels of effort, depending on the type of services they provide. Four basic typologies have been suggested to describe different CHW functions:²⁴

1. **Generic CHW:** important in contexts with shortages of qualified local staff and a need to fill basic gaps in health prevention and provide limited curative care.
2. **Specialized CHW:** focuses on conditions that are of high prevalence or great public health need such as acute respiratory infection or tuberculosis. They can be linked to government and/or an NGO, and often provide **simple treatments** such as antibiotics, anti-malarial drugs, oral rehydration salt (ORS) and FP products.
3. **Expert patient advocate:** patient peer educators empower those affected by the same illness to take responsibility for their own health. These are popular with non-communicable disease programs such as diabetes or as an alternative for managing the treatment of AIDS.
4. **Community mediator:** serves as a local facilitator, enabling people to develop solutions to problems, access resources, negotiate market alternatives and increase awareness of their rights.

Other types of CHWs may include social workers and counselors. Each community may have one or several types of CHWs who are engaged along a continuum of services from health promotion and preventive practices to the provision of curative services and care, to community mobilization. CHW activities may cover multiple diseases or be disease specific. CHWs may be health para-professionals or volunteer with limited training. These options are often dictated by different funding streams rather than community need, and must be coordinated at the community level to be most effective. WHO has recommended that different kinds of CHWs, with different levels of training and tasks, may be more flexible and responsive to local needs. Intersectoral cooperation is also necessary. To be successful, a CHW program must have a support group, a development council or a health committee. Program effectiveness depends on

²²Liu A, Sullivan S, Khan M, Sachs Sa and Singh P. 2011. Community Health Workers in Global Health: Scale and Scalability. Mt Sinai J Med 78: 419–435.

²³ WHO. 1989. Strengthening the Performance of Community Health Workers in Primary Health Care. Report of a WHO Study Group. Technical Report Series 780. Geneva.

²⁴ Standing H and Chowdhury M. 2008. Producing effective knowledge agents in a pluralistic environment: What future for community health workers? Soc Sci Med 66: 2096–2107.

the strength of these support groups. In a recent review,²⁵ a CHW sub-system was recommended, which is made up of the CHWs themselves, as well as their multi-tiered support structure of supervisors and community members. The core of the CHW sub-system is the interaction between the CHW and families in the community. The report recommended that the relationship between CHW cadres and other frontline health workers should be clearly defined. Team-based approaches were recommended, in which CHWs are paired with skilled birth attendants under the same supervisory structure and collaboration with other frontline health workers, such as volunteers to support household coverage requirements and mitigate problems of high-task loads. It was recommended that CHWs receive both peer- and community-based support.

CHWs often have large coverage areas with a high number of households to serve across multiple communities. In many cases, CHWs spend time supporting health facility services due to the shortage of other qualified personnel and have minimal time to administer services within their community. CHWs also require substantial investments from political leaders in financial, technical and material support, especially when tied to government health services. When employed by the government, CHWs may feel more responsible to their employer than to the community, limiting success in motivating behavior change and making one-on-one visits.

Extender Community Health Workers or Community Health Volunteers

Known by various terms, these community health agents are volunteers who may receive a small stipend or incentive. They are not generally civil servants or para-professional employees of the MOH, nor do they work full time. Communities select CHV trainees, and they often work in their neighborhoods to provide health education, counseling and/or or basic health services. These workers may serve as trained traditional birth attendants to support pregnancy, childbirth and early newborn care for a small stipend or incentive. Extender CHVs are increasingly being linked to the formal CHWs, expanding the reach of the formal CHW cadre and health workforce to the household level. Extender CHVs often have small coverage areas, enabling them to make home visits for health education. Home visits and one-on-one contacts are especially powerful in communities with limited health information or social cohesion.

Various models of “extender” CHVs exist. One increasingly successful model is the “Care Group,”²⁶ where a group of 10 to 15 volunteer community-based health educators meet regularly with project or MOH staff for training, supervision and support. They are different from typical mothers’ groups in that each volunteer is responsible for regularly visiting 10 to 15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level.

CHVs serving as members of care groups provide greater peer support, develop stronger commitment to health activities and find more creative solutions to challenges by working as a group rather than as individual volunteers expected to work independently.

Structures Important to the Community Health Sub-System

There are several commonly used structures to enable community engagement in health activities. Some of these structures are critical to support a CHW’s effectiveness, while other group structures, such as women’s groups, have resulted in improved health for neonates, children and women. There are groups indigenous to a community and others that have a regional or national scale; groups formed by outside agencies that have a legacy and can be

²⁵ Earth Institute. 2011. One Million Community Health Workers Technical Task Force Report. Columbia University. New York City, USA.

²⁶ <http://www.caregroupinfo.org/blog> accessed on April 22, 2011 provides definitions, criteria and “The Care Group Difference: A guide to mobilizing community-based volunteer health educators.” 2010 (2nd edition) World Relief and CORE Group.

tapped into; and groups that can be formed in response to community interest or government legislation.

Community Governance Groups

Governance groups provide local oversight of government policies, institutions and actions; build community coalitions for aggregate action; and offer creative solutions to equity issues and community needs. They have the ability to provide for local financing or to reallocate budgets of health facilities or services to more directly meet local health needs. These groups may evolve into or include advocacy groups, and link with other community-based groups.

Governance groups are organized by the local community, by self-volition, by governmental mandate or by an NGO to provide accountability for health and development activities. Generally, a governance group represents various constituencies within the community and does the following:

- Provides strategic guidance for overall management and development of health services
Creates community awareness about health services, disease outbreaks, and consumer and provider rights
- Maintains a health information board and calendar
- Obtains and acts upon information about key health problems and complaints from community members
- Coordinates health activities of health volunteers
- Provides feedback to relevant functionaries and officials

These groups may also review user fee levels, set policies to exempt the poor from payment and help define community health agent incentives. Examples of governance groups include the following committees, which are each explained in more detail below: village development, village health, dispensary health, neighborhood health, health facility management and district management.

Village Health Committees (VHCs), also known by different names, have been used and recommended by WHO as one type of governance group important to the support and management of a CHW. CHWs need the support of a group composed of community members with active links to the national health sector. These committees define specific CHW functions, coordinate various services and programs in each CHW area, make CHWs more accountable to the people they serve, and keep the center better informed about what happens in the periphery.²⁷

While important, the position of VHCs within village hierarchies is often contested, leading to political tensions between VHC members and other community leaders. Evidence suggests that CHW programs thrive in mobilized communities, but struggle when they are given the responsibility of galvanizing and mobilizing communities themselves. Examples of successful CHW programs supported by communities can be found either as part of large-scale political transformation (e.g., Brazil and China), or through local mobilization often facilitated by NGOs, community-based organizations (CBOs) or faith-based organizations (FBOs). However, many such programs wither as mobilization momentum decreases.²⁸

²⁷ WHO, 1989

²⁸ Lehman U. and Sanders D. 2007. WHO. Community Health Workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. WHO Geneva.

Health Center Management Committees are another community structure legislated in some countries to ensure local leadership, legitimacy, accountability and governance of public health facilities. These committees can play important roles in ensuring that the quality of health services meets community expectations and ability to pay.

Community-Based Groups, Associations, Organizations

There are many different types of community groups and organizations that provide social and behavior change support, individual counseling to improve health practices and advocacy activities. All are organized in different ways around local relationships and needs, and can be leveraged directly or indirectly to generate increased demand for health services and promote positive behavior change. These groups are generally developed where need for public health services is high and requires advocacy and social mobilization to involve communities in health program design, implementation and evaluation. Many of these groups develop into CBOs and further diversify their program functions to respond to beneficiary needs. NGOs that are legally registered with local or national authorities also provide community-level services, develop local capacity, and strengthen local institutions and systems. NGOs may operate solely at the local level or work in the community as part of a larger program. Examples of such groups include peer support groups, participatory women's groups, community associations and advocacy groups, which are all explored in more detail below.

Peer Support Groups are gatherings of neighbors, friends, colleagues or other peers who may or may not know each other. Participants meet regularly to support one another in taking desired actions, and come together as equals. Peer support groups are used when barriers to change are particularly high or the desired outcomes are numerous or complex. Peer support groups have also been called solidarity groups, circles, community groups and self-help groups.

Peer support groups have been effective at reducing stigma, supporting home care and overcoming obstacles to care-seeking and practice of key behaviors.

Evidence is increasing that peer support, when frequent and flexible, is a critical and effective strategy for ongoing health care and sustained behavior change for people with chronic disease/risks and other conditions. Studies have found that social support, a broader definition of peer support, decreases morbidity and mortality rates; reduces health care service use; increases life expectancy, self-efficacy, knowledge of a disease or conditions and self-reported health status and better self-care skills, including improved medication adherence. Additionally, providers of social support report less depression, heightened self-esteem and self-efficacy, and improved quality of life.²⁹

Participatory Women's Groups in particular have been cited for their effect on women's empowerment, leading to positive health outcomes, especially when using effective community mobilization techniques such as a community action cycle³⁰ or when linked to savings and loans programs.

Community Associations are nongovernmental associations of participating members of a community, neighborhood or village. Participation may be voluntary, require dues or mandate

MCH projects frequently use the following types of support groups:

- Mother-to-mother
- Women's
- Grandmothers'
- "Care group" leader
- Breastfeeding mothers
- Men's
- People living with HIV/AIDS
- Radio listening
- Village health

29 Peers for Progress: http://www.peersforprogress.org/learn_whatls.php. Accessed on September 2, 2011.

30 O'Rourke K, Howard-Grabman L and Seoane G. 1998. Impact of community organization of women on perinatal outcomes in rural Bolivia. *Pan Am J Pub Health* 3 (1): 9-14

regular participation. These associations may be local or tied to provincial or national structures, and may serve as social clubs (such as Rotary or Kiwanis), service organizations or youth groups. An example of a national community association is a traditional burial society to which members make monthly contributions and receive payment when needed to help cover funeral expenses, as in the Edir society in Ethiopia.

Advocacy Groups work toward social or policy change related to specific issues or sectors. Persons living with HIV/AIDS have most vividly demonstrated the power of advocacy groups for social action and change, though there are numerous types of such groups, related to key cross-cutting issues, human rights and other topics. Many of these groups and their leaders participate in various policy forums, multisectoral groups or inter-agency working groups, where they advocate for systematic change at a national level. Other local advocacy groups promote change related to local issues.

Political Groups, Local Government Institutions and Traditional Authorities

Local government institutions refer collectively to administrative authorities over areas that are smaller than national government. Local government acts within powers delegated to it by legislation or directives of the higher level of government and may be at the province, departmental, district or village level. In several countries, the tribal chief or village headman represents the lowest tier of government within the community or village. In other countries, the traditional leadership structure may be powerful but not tied to the governmental system. Local government institutions have the power to raise taxes to support local health services and volunteers, and to prioritize services for the poor. These institutions have the power to enable and support health activities or undermine them.

The permission of a traditional authority, such as a Paramount Chief, may be necessary to enter the community and implement activities and provide access to community members, especially women. Negotiation with all competing political structures, especially in fragile settings or conflict areas, may be necessary to reach health goals.

Private Health Sector

The private health sector consists of all health services outside of government-managed health services. This sector includes both regulated and non-regulated services, formal and informal services, not-for-profit and for-profit services, and traditional services. In many countries, the private sector is a larger than the public government services.

This sector is complicated and is not readily mapped. Modern medicine has an identifiable organizational structure, which is outside of most people's social network, while indigenous medicine may have no organizational scheme outside of the community context. This sector includes private clinics, often staffed by government workers after hours, pharmacies, drug sellers, traditional healers, traditional birth attendants or community midwives, and village doctors. These services often cater to poor people, providing easy community access and a culture of respect for indigenous groups who might otherwise feel mistreated or misunderstood in governmental health facilities. Informal health actors may also serve as a key source of medications and supplies. Many people may view traditional services as complementary to western health services and seek both. The private sector can also have a negative impact on health outcomes; for example, practitioners may provide alternative health care at a relatively high cost while delaying much-needed, lifesaving care or distribute counterfeit medications, which potentially increase mortality and cause large-scale drug resistance.

Faith-Based Organizations

FBOs and religious leaders play important roles in the provision of health information, education and communication to local congregations, and can be powerful influences in establishing behavioral and social norms in a culturally appropriate way. Their perspective on “well-being,” combined with their stature, enables them to contribute to both the supply and demand side of health services. Religious leaders often provide individual health counseling to members of their religious communities. Many FBOs have national influence and, in some countries, various faith-based groups may be networked together at the national or regional levels.

In some countries, FBOs may provide a significant portion of health care services, especially for the poor. For example, in sub-Saharan Africa, WHO estimates that FBOs provide roughly 40 percent of all health care services.³¹

Information Highways

Local Communication—Each community has a local communication system, in addition to national and global mass media. Local communications can have a strong impact on health knowledge, attitudes and practices. Local media approaches may include the use of signs, local radio, megaphones and local theatre. These are often combined with group discussions, such as the formation of radio listening groups, dialogue circles or reflection circles. Communities have their own alert systems for calling community members to a meeting to discuss an incident or an issue as needed.

Local Health Information Systems—Community-based health information systems, birth registries and community scoreboards enable local residents to understand the epidemiology of their community settings and prioritize solutions. Communication, data collection and data-sharing tools are rapidly changing due to advances in and increased coverage of technology. Increasingly, the Internet, mobile phones and social media are expanding traditional information highways, increasing the power of health communication among neighbors, peers and the formal health system.

Communities that are better served by physical and communication infrastructures have experienced a proportionately higher number of “escapes from poverty.”³²

Other Sectoral Institutions and Associations

Many other sectors, such as education, water/sanitation, livelihoods, agriculture, women, youth, sports, etc. play important roles in community health systems by providing education, aligning resources for health and reinforcing positive health policies. Many of these sectors also form community groups and associations that become partners, working to reinforce and incentivize good health practices. These sectors address the underlying determinants of health and offer sustainable solutions to good health. Many of them are also affiliated at the national level. Local, multi-agency, cross-sectoral coordination committees can address determinants of health, contributing to sustainable cause-specific reductions in mortality.

National Health Sector

Actions of the national health sector play a critical role within the community. The manifestation of the national system at the local level—either through policies, facilities or outreach services—determines how the community views government services, and whether the community will trust the services, use them or follow their advice and guidance. Changing community perceptions on the use of immunization services provides a clear example of the need to manage the health sector through community relations.

³¹ Bandy G, Crouch C et al. 2008. Building from common foundations: the WHO and faith-based organizations in primary healthcare.(eds.) Ted Karpf and Alex Ross. ARHAP.

³² Krishna, 2011.

Solutions to national sector involvement differ by context. For example, while most governments choose to centralize the job description of a CHW and decentralize the hiring to the local level, Brazil successfully used a central process to hire and pay its municipal health agents. The government did so in a highly visible community forum, to mitigate local political leaders trying to usurp oversight of these workers. They developed a broad job description that allowed for “self enlarged” jobs, which responded to community needs. The workers reported that the respect and trust they received from the community were more important than the respect from their formal supervisor.³³

Processes and Relationships in the Community Health Sub-System

The relationship between the national government and other high-level organizations and the community and community organizations has a strong influence on local actions. Communities are structured within larger provincial and state bodies, and many communities have community groups or local associations that are linked to and governed at the larger provincial or national levels. Examples include FBOs, self-help or mutual groups, schools and agriculture cooperatives. Each community’s relationship with the formal government health system depends on its history and the national sector’s visibility in the community setting. The links between various associations of people and the formal health system affect and influence how people select and prioritize health services, make decisions about health service use and adopt behavior changes.

Within the community, the social environment has an indirect but powerful effect on the practice of personal behaviors that promote good health. Among marginalized populations, risk factors such as isolation, poverty, low self-esteem, discrimination, lack of social support, nomadic living, language barriers and dysfunctional power dynamics are common. These risk factors may limit knowledge, bias attitudes and prevent the practice of lifesaving, preventive, home and care-seeking practices.³⁴

To generate behavioral change, daily life must be connected to timely, state-of-the-art information and services within and outside of the community—information delivered through multiple communication vehicles and information highways (peer groups, religious sermons, local theatre and radio, government broadcasts, mobile health applications, etc.). This messaging needs to intersect at the family and community levels to spark action. Local connections and relationships enable programs to be contextually specific, while the regional or national connections and relationships can serve as critical platforms for supporting large-scale governmental health services.

As government and health systems become increasingly decentralized, local government units are provided with opportunities to provide additional leadership and have additional decision-making capacity related to health programs and priorities. Community leaders who emerge can follow models developed by these decentralized structures to have an impact on health outcomes in the community. A community empowerment continuum has been proposed that starts with personal action and participation; moves next to small mutual groups, community organizations and partnerships; and ultimately results in social and political action, which may also inform the process of community members emerging and establishing themselves as local leaders and change-makers with links to other people, resources and organizations.³⁵

³³ Tendler J. and Freedheim S. 1994. Trust in a rent-seeking world: health and government transformed in northeast Brazil. *World Development* v22: no12, 1771–1791.

³⁴ Rosato M, Laverack G, Howard Grabman L et al. 2008. Community participation: lessons for maternal, newborn and child health. *The Lancet* 372:962-71.

³⁵ Laverack G. Improving health outcomes through community empowerment: a review of the literature. 2006. *J Health Popul Nutr* 24:1, 113–120.

Evidence supports several successful strategies to improve health outcome.³⁶ These strategies seek to increase the skill and confidence of mothers to maintain their own well-being and that of their children, and of patients affected by disease. Community empowerment—the process and outcome of those without the power of gaining information, skills and confidence and thus control over decisions about their own lives—can take place on an individual, organizational and community level.³⁷ Relations of mutual trust between workers and their clients and between governments and social networks are key to successful public programs.

The following strategies can be carried out by governments, NGOs, FBOs or CBOS, but will only be effective if they are carried out in coordination with the community's support.

Periodic Facility Outreach Services

Depending on the circumstances, direct health services can be effectively offered at a community level, at least periodically. Local provision of quality health services allows the system to build its credibility, advertise its services, raise awareness about health issues, and provide services to those unable to access the nearest health facility or who may be distrustful of the services provided there. These outreach activities work best when the nearest health facility works in partnership with the community to plan and implement activities in a locally acceptable way, providing the opportunity for local individuals to maximize personal contact with the formal health system.

In some cases, the activity may be **facility-directed** in which the community plays a small but important role to arrange logistics, notify other community members and support health education activities. However, in such cases, the community does not manage the activities. Examples include well-child clinics within the community, immunization outreach camps, child health days, family planning clinics or other health campaigns.

In other cases, the activity may be **community-directed** in which the community is mobilized to play an extensive role in the design of the activity, its implementation and monitoring of the outcome.

The Community-Directed Intervention (CDI) approach used by the onchocerciasis program in Africa demonstrates an effective application of this participatory approach for integrated delivery of appropriate health interventions (including ivermectin, Vitamin A, malaria treatment and ITNs for malaria prevention).³⁸ CDI employs a community empowerment approach; open community meetings are used to engage community stakeholders including local leaders and local government officials in program decision-making, implementation and evaluation. The village may then designate a leader, committee or community-based group to ensure community participation in the activity.

The national health system often plays a supporting role in the CDI and other community mobilization approaches. Responsibilities may include a logistics system that provides critical medications and supplies to health huts, community depot holders, or community agents or institutions. In other cases, the private sector provides an alternative source for critical supplies (bed nets, medicines, ORS sachets); in some settings, these supplies are procured and managed through community revolving funds.

³⁶ Freeman P, Perry HB, Gupta SK and Rassekh B. 2009. Accelerating progress in achieving the millennium development goal for children through community-based approaches. *Glob Public Health* 3:1–20.

³⁷ Rosato et al. 2008.

³⁸ CDI Study Group. 2010. Community-directed interventions for priority health problems in Africa: results of a multi-country study. *Bull World Health Organ* 88: 509–518.

Household Visits

CHWs are often employed or linked with other community agents to map households; register vital events (births and deaths); document coverage of interventions; identify at-risk families or family members needing assistance; provide counseling and support to women, patients and caregivers of children; and help with referral for more urgent care. CHWs often help women with household tasks, and observe and demonstrate new practices in order to garner additional trust, critical for behavior change. Household visits are often the best strategy to discuss sensitive topics such as FP and HIV/AIDS; support drug adherence, such as for TB; and encourage the adoption of new household practices such as those related to nutrition.

Community Case Management

Community case management (CCM) is a strategy to deliver lifesaving, curative interventions for common childhood illnesses in the community, in particular where there is little access to facility-based services. Supervised and supported community members—who could be paraprofessional CHWs, private sector workers or MOH outreach workers—are trained to counsel on preventive measures, such as exclusive breastfeeding, and to provide treatment for pneumonia, neonatal sepsis, malaria, measles, diarrhea and malnutrition. These workers may perform their duties from their homes, a community-constructed building, or government or private health facility.

Support Group Meetings

Group meetings of community residents for education and support have been demonstrated to be effective for certain health outcomes and to reduce stigma. Studies have validated the effectiveness of groups of pregnant women for improved perinatal, neonatal and maternal outcomes (Warmi); groups of mothers of malnourished children for nutrition (positive deviance/hearth); groups of neighbors for general maternal and child health (care groups); and peer group interactions to combat chronic disease. Meetings also provide opportunities for the development of local skills in health and management, including time management, strategy planning, team-building, networking, negotiation, fundraising and marketing. Individuals can achieve their health goals by working with other people affected by similar circumstances to build interpersonal trust and trust in public institutions. Social support provides a sense of connection to a community and is a determinant of health (overlapping with social capital, inclusiveness and cohesion).³⁹ Empowerment literature highlights intermediate outcomes of these groups.⁴⁰

Community Events

Effective community engagement strategies include the use of community events to increase community knowledge and demand. Social and behavior change activities for health employ multiple venues such as village theatre; film; marketing and distribution of free or subsidized commodities at markets or festivals; and use of participatory appraisal processes, such as community-led total sanitation. Advocacy at governmental forums and political events is key to changing power dynamics that influence health outcomes.

³⁹ Laverack G. 2006. Improving health outcomes through community empowerment: a review of the literature. *J Health Popul Nutr Mar*;24(1): 113-20.

⁴⁰ Wallerstein N. 2006. What is the Evidence on Effectiveness of Empowerment to Improve Health? Copenhagen, Denmark: WHO Regional Office for Europe. Health Evidence network Report. Available at http://www.euro.who.int/_data/assets/pdf_file/0010/74656/E88086.pdf.

Local Data Management and Use

Strategies to increase widespread information dissemination and use, and collection and analysis of local statistical information on births, deaths and disease are needed to understand problems, assess inequities, develop local solutions and hold local authorities accountable. The use of mobile technologies may be an innovation that can facilitate this process. Information needs to be collected in a way that is acceptable to the national health system, but also to the community so that they can assess the contextual causes of their poor health, and take necessary action to effect change. Motivation to improve must come from within the community.

VI. ROLE OF COMMUNITIES IN THE NATIONAL HEALTH SYSTEM

From the publication of the *World Health Report* 2000 forward, the WHO and other research bodies have proposed numerous conceptualizations of a health system. Most commonly referenced is the WHO Building Blocks model, in which a health system is defined as “all organizations, institutions, resources and people whose primary intent is to improve health”.⁴¹ The goal of health systems strengthening includes efforts to influence determinants of health as well as more direct provision of health services. The system is organized to improve health at all levels with processes that ensure equity, responsiveness, social and financial risk protection, and efficiency.

According to WHO, six basic building blocks compose a health system:⁴²

- Delivery of effective and safe **health services** to those who need them, when and where they need them;
- A **health workforce** responsive to the needs and expectations of individuals and families, which is fair and efficient at achieving the best health outcomes possible within the confines of available resources and circumstances;
- A well-functioning **health information system** that ensures reliable health data is collected, analyzed, disseminated and used;
- **Essential medical products, vaccines and technologies** are available to all, and are safe, efficacious and cost-effective;
- A **health financing** system that raises adequate funds for health and protects people from financial hardship due to poor health; and
- **Leadership and governance** processes resulting in strategic policy frameworks that provide effective oversight, regulation, coalition-building and accountability for health.

WHO states that a well-functioning health system improves health status of individuals, families and communities and makes it possible for people to participate in decisions affecting their health.

However, the WHO Building Blocks model and others proposed to date do not place sufficient emphasis on community actors, structure and processes that play a significant role in improving health outcomes. The importance of the role of the community has been established in past MNCH programs, but community involvement in the design and implementation of the program has been limited. “Communities have rarely been considered true partners in the implementation and evaluation of interventions to improve child health. Community-based programs have most commonly used the community as a passive recipient (i.e., a target) rather than as a valued resource and partner with joint ownership of the process of program

⁴¹ <http://www.who.int/healthsystems/about/en/> accessed on 3/14/2011.

⁴² WHO, 2007. Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes. <http://www.wpro.who.int/sites/hsd/documents/Everybodys+Business.htm> accessed on April 11, 2011.

implementation. Increasing evidence demonstrates that community and women’s empowerment can have a remarkable impact on the health of children.”⁴³

WHO acknowledges that weaknesses and obstacles exist across the greater health system, including demand-side issues such as people’s participation, knowledge and behavior. “It is the multiple relationships and interactions among the building blocks – how one affects and influences the others, and is in turn affect by them, that convert these blocks into a system. As such, a health system may be understood through the arrangement and interaction of its parts, and how they enable the system to achieve the purpose for which it was designed ... Anticipating relationships and reactions among the sub-systems and the various actors in the system is essential in predicting possible system-wide implications and effects.”⁴⁴

Despite this gap in the existing health system models, the relationship between the formal health sector and the communities they serve determines the pace and degree to which community members and families utilize and support health services. With the renewed interest in strengthening health systems and achieving the vision of the Alma-Ata declaration⁴⁵ (universal access for care, equity, community participation, intersectoral collaboration and appropriate use of resources), additional emphasis is needed on a more population-directed approach to health, including the community’s role in the formal health system, and the community health sub-system itself.

Table 1 describes select illustrative examples of the different roles the community can play within each of the health system building blocks.

Table 1. Illustrative Roles Communities Can Play in Health Systems, by WHO Building Block

HEALTH SYSTEM BUILDING BLOCKS	ILLUSTRATIVE COMMUNITY ROLES
Service Delivery	<p>Participate in multiple levels of health programming, including identification of objectives, formulation of sequential action steps, support of health outreach activities, selection of health agents (CHWs) or project participants, allocation of responsibility for follow-up, and evaluation of health performance.</p> <p>Increase demand and use of health services.</p> <p>Determine fair and just distribution of program benefits.</p> <p>Provide support and incentives for health agents to perform interpersonal counseling, especially for home care and key family practices and referral.</p> <p>Develop and support collective systems for emergency transport.</p> <p>Participate in micro-planning meetings and problem solve when the health situation changes.</p> <p>Utilize new information technologies to support health information sharing.</p> <p>Take collective action whether it’s advocacy, behavior change or participation in delivery.</p> <p>Utilize behavior change and communication strategies to accelerate the correct use and uptake of health products, vaccines and technologies.</p> <p>Advocate for quality of care.</p>
Health Workforce	<p>Utilize health innovations and share them with their peers.</p> <p>Take appropriate action for themselves and for disadvantaged groups in their community.</p> <p>Extend the reach of health services, for example, through the activities of CHVs.</p>

⁴³ Perry H, and Freeman P. 2009. Review of the Evidence: How effective is primary health care in improving the health of children? International Section of the American Public Health Association.

⁴⁴ WHO. 2009. Systems Thinking for Health Systems Strengthening. de Savigny D and Adam T. Geneva.

⁴⁵ Lawn JE, Rohde J, Rifkin S, Were M, Paul VK, Chopra, M. 2008. Alma-Ata 30 years on: revolutionary, relevant and time to revitalize. *Lancet* 372(9642): 917-27; original Declaration of Alma Ata, 1978, accessed at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

HEALTH SYSTEM BUILDING BLOCKS	ILLUSTRATIVE COMMUNITY ROLES
Health Information System	Collect vital event information, and identify and prioritize health problems based on accessible local data. Utilize local communication vehicles to diffuse the information and make it public.
Essential Medical Products, Vaccines and Technologies	Develop and support collective systems for emergency transport. Provide authorized health products, medications and technologies at accessible locations at reasonable cost through social marketing of products.
Health Financing	Contribute labor, land, produce, cash and other resources to support locally appropriate health services, health agents and disadvantaged populations. Access and leverage government and other resources to address local health priorities or through free distribution. Establish or contribute to community insurance schemes. Subsidize events and products.
Leadership and Governance	Organize representative local leadership and governance structures with viable support networks and inter-group collaboration to ensure health services and facilities meet and are accountable to community needs and provide quality care. Focus political attention on government resource allocation decisions, prioritization of basic health services and formal health system disruptions.

The community components and roles within each health system building block need to be further articulated as critical elements of a functioning health system. One resource not well-defined under the six existing building blocks is **social capital**: the connections and rich interplay of relationships, partnerships and links across social networks that can enable a community to work together to assume a vital role in health care planning, implementation, and evaluation and generate demand for health services. Social capital, defined as bonds between similar people and bridging differences between diverse people, with norms of reciprocity,⁴⁶ can take several forms within a health systems context, including how the community interacts with the formal health system and with other sectoral institutions and sub-systems. A community with high social capital may have increased use of health services, reduced stigma associated with health issues and an increased understanding of how to utilize community relationships to respond to various problems in a comprehensive, integrated way.

Findings have shown that specific pre-existing features of the community have greatly facilitated community engagement and limited social disruption associated with research conducted by outsiders.⁴⁷

“If one hadn’t gone through the right procedure, that is, seeing the district authorities and the paramount chiefs and the sub-section chiefs and so forth, there might have been a lot more suspicion about what was going on, why we were doing this, who we were....”⁴⁷

Recommendations made for engaging the community are relevant for both research and service delivery and include: using social mapping related to the structure of local authorities and community decision-making processes; using traditional community engagement mechanisms; ensuring that tangible benefits flow from the research (or other health activity) back to the community; and understanding that some cultural issues, such as gender inequities, may exist that will not be addressed by traditional practices alone.

⁴⁶ Dekker P and Uslaner EM. 2001. Social Capital and Participation in Everyday Life. London: Routledge.

⁴⁷ Tindana PO, Rozmovits L, Boulanger R et al. 2011. Aligning Community Engagement with Traditional Authority Structures in Global Health Research: A Case Study from Northern Ghana. *Health Policy and Ethics* Vol 101, No 10, 1857–1867.

The relationships and links within the community and the ties and bridges between the community and the health system help accelerate and foster positive health outcomes. Illustrative examples using the frameworks related to people, structures and processes are shown in Table 2.

Table 2. Illustrative Social Capital Contribution by Community Component

COMMUNITY HEALTH SUB-SYSTEM COMPONENT	ILLUSTRATIVE SOCIAL CAPITAL CONTRIBUTION: BONDS AND BRIDGES
1. PEOPLE	
People Affected by Diseases	Advocate and work with national health system for political support and resources toward preventive and curative solutions to neglected or “stigmatic” diseases
Households	Make better informed, preventive and lifesaving decisions based on culturally acceptable knowledge and trust of the health system
Champions and Leaders	Influence individuals to make appropriate preventive health choices and utilize health services of the national health system
Community Health Agents	Build trust between the household and the health system by extending MOH preventive and curative services closer to the household and reinforce key practices
2. STRUCTURES	
Governance Groups	Strengthen links between a) community and facilities and b) local government, community and the health system to support and influence locally appropriate decisions and resources for health services, policies and systems
Community Support Groups	Increase social and peer support for practice of key health behaviors, culturally competent local care and reduction of stigma
Political Groups, Local Government and Traditional Authorities	Support rather than undermine national health systems and research activities
Private Health Sector	Increase community options for health services and products, reinforcing demand for health and extending supply
FBOs	Strengthen faith links to health system platforms to encourage demand for and utilization of key services; extend health care services and home care; support marginalized populations
Information Highways	Increase access to culturally tailored health information, including transparent information to increase health systems accountability and local action
Other Sectoral Institutions and Associations	Address social determinants of health and well-being and empowerment to take leadership roles
National Health System	Link with other people and organizations through partnerships, coalitions and alliances formed to address community health needs and take collective action
3. PROCESSES	
Outreach Services	Strengthen community health system alliances to deliver locally acceptable health services reaching underserved groups and communities
Household Visits	Build trust with the health system, self-efficacy to practice new behaviors and empower individuals to act
CCM	Build trust with health system by providing immediate, quality, lifesaving interventions and commodities
Support Group Meetings	Build peer support and leadership skills for community health actions
Community Events	Build knowledge base for health interventions and motivation for their use
Local Data Management and Use	Bring evidence into the open for local collective action

VII. CONCLUSION

As evident in existing literature and from individuals and organizations involved in health systems work, community-level determinants of health, community interventions and community resources play key roles in improving health outcomes. This paper emphasizes the critical role the community system plays in health outcomes; proposes select roles of the community in each of the six existing WHO health system building blocks; and lists key components of a community health sub-system. Health programs are more appropriate and effective when based on the cultural realities of the communities they support. These cultural realities encompass the social structures and organizations in which individuals and households are embedded, and are influenced by the normative system of beliefs and values that affect behaviors.

A challenge of the health system is to balance the prescriptive culture of medicine with the more dynamic and collaborative culture of local communities. Understanding and appreciating the differences in these two cultures has proven essential for successful partnerships.

This analysis makes the case that **social capital**, the bonds between similar people and the bridges between diverse people with norms of reciprocity, is a concept that could be used to build links between the two cultures. It is a concept that requires further analysis and measurement tools, but would help us understand how to better tap into the relationships that are critical to positive health outcome. Social capital may be a seventh building block for the WHO building blocks framework.

Given that all communities are unique, collaboration with the health system will also be so. The actors, existing structures and circumstances that mitigate the use of certain processes will be distinct in each setting. However, there are shared experiences across communities and partnerships that can form a base for learning at scale. Communities will have similar health challenges, they will celebrate successes in improving health outcome and they will do this with comparable resources. If we believe that citizens must come together within their communities to take collective action for health, scale may need to occur in a patchwork quilt, as was done in Brazil, through community pressure for leaders to “opt in.”

Understanding how to foster social capital to strengthen the community-national health system collaboration in different contexts will help us better understand options for programming at scale. Many of the community health sub-system actors, structures and processes can be supported at a national scale through appropriate policies and an enabling environment, but they must be complemented by systems that support local management. The challenge lies in understanding the choices that national-level programmers can make to set a national framework, and understanding what choices must be left to the local level. Systems thinking may provide a way to analyze the social capital that is needed to bond dynamic networks of diverse stakeholders together across various sub-systems of the health system.

How can we better support the participation of citizens in health care? We can engage communities by working within traditional structures and being appreciative of community systems; support consumer education and health promotion; include marginalized groups in decision-making forums; involve traditional and national media organizations in policy dialogue and reporting; and encourage donor support for community participation.

In analyzing existing literature and strategies, it is evident that we need to better understand how to effectively tap into the local knowledge of community-based actors in health, especially those community groups and associations that work at both the national and local levels. We should consider the following questions:

- How do we prioritize and build the social capital with different community institutions to maximize the effectiveness of community health agents?
- What are the effective indicators of social capital?
- How do we tap into the assets of multiple community components to enable a comprehensive community participation approach that equitably supports the health system to improve health outcomes?

In any one country, we will find multiple community components and modalities working in different states, regions or districts that respond to the specific local context. In each country, we may consider the following:

- How can we strengthen national community participation policies that enable local decentralized leadership to support appropriate community participation strategies?
- How do we extend the assets and power of community networks for health through cross-sectoral coordinating bodies that share a similar vision and can harmonize efforts?
- How do we design a community program at scale, knowing that community participation cannot be mandated and is locally contextual?

New knowledge about the community's role in health systems strengthening will enable programs to leverage these components and systems for impact at scale.

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