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BUILDING BRIDGES BETWEEN COMMUNITY SYSTEMS AND HEALTH SYSTEMS FOR SUSTAINABLE HEALTH

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ABSTRACT

Recognizing and meaningfully engaging with the strengths of various frontline community, health and other sectoral systems has been recognised as a way to building effective, efficient, accessible, acceptable and sustainable health programmes. However, the translation of this rhetoric into implementation often falls short. This gap is spotlighted with the present changing global health architecture and financing landscape. This paper will highlight some lessons learnt on how to successfully bridge between community, health and other sectoral systems. The paper synthesizes findings from multiple literature reviews on community engagement in vector-borne and neglected tropical diseases and one health. This complements the data from evaluations undertaken through the Civil Society Platform for Health Equity and Inclusiveness on community engagement strategies to support government systems. Common themes of meaningful engagement of community from conception, through design, implementation, monitoring and evaluation; sharing vision and outcome ambitions; empowering communities; respectful bidirectional communication; contextualised approaches to cultures, settings and partners; and having strong governance foundations and principles for true partnership will be discussed. These will be illustrated with actual Asia Pacific examples. There is strong evidence on how to effectively, efficiently and sustainably build, maintain and strengthen these bridges between community, health and other sectoral systems. The present geopolitical and global heath architecture ecosystems provide, and indeed necessitate, moving from business-as-usual to these models, which will help achieve universal health coverage.

Keywords: community systems, health systems, One Health, vector-borne and neglected tropical diseases.

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INTRODUCTION

Recognising and meaningfully engaging with the strengths of the various frontline health and other sectoral systems and community systems has been recognised as a way to building effective, efficient, accessible, acceptable and sustainable health programmes – to reach the universal right to health. However, the translation of this rhetoric into implementation often falls short. This gap is spotlighted with the present changing health architecture and financing landscape at a global level.

This paper synthesises findings from multiple literature reviews on community engagement in vector borne and neglected tropical diseases and in one health, and from field work and evaluations undertaken through the regional Civil Society Platform for Health Equity and Inclusiveness (https://www.cso-platform.org).

OBJECTIVES

The objectives of this paper are to a) define meaningful community engagement (CE) and some of the common themes of meaningful CE; b) explore the concepts of Community systems (CS) and CS strengthening and Community assets; and c) provide examples of bridges between community and health systems in the Asia Pacific Region.

SETTING THE SCENE

What is meaningful community engagement? The Cambridge Dictionary defines community as "the people in living in one particular area or people who are considered as a unit because of their common interests, social group, or nationality". Community engagement can be described as the collaborative undertaking of working with groups of individuals who share proximity in terms of geography, common special interests, or comparable situations pertaining to their health or well-being (CDC, 1997; O'Mara-Eves et al 2013; WHO, 2020). WHO (2023) has defined meaningful engagement as "respectful, dignified, and equitable inclusion of individuals with lived experience in a range of processes and activities within an enabling environment where power is transferred to people, valuing lived experience as a form of expertise and applying it to improve health outcomes".

In our work we use the concept of meaningful community engagement as a composite of these, namely as the collaborative undertaking of working with groups of individuals who share proximity in terms of geography, common special interests, or comparable situations pertaining to their health or well-being in a respectful, dignified and equitably inclusive way, within an enabling environment, where power is transferred to people, valuing their lived experiences as a form of expertise that is valued and applied to in the process of achieving desired outcomes.

Based on the literature of work done by the author/s for Tropical Disease Research (Naing, et. al, 2023a; Naing, et. al, 2023b; Naing, et. al, 2023c), with a Wellcome Trust Community Engagement in Health Research Community of Practice and recently for the One Health High Level Panel (under review) there emerges five common themes on what makes community engagement meaningful. These are:

1. Meaningful engagement of the community from conception of the idea or project, through design, implementation, monitoring and evaluation, with shared learning.
2. Sharing vision and outcome ambitions
    a. Empowering communities. Empowerment means people's

ability to better understand and exercise their power and agency, which can enable women and men to have increased control over their lives.
3. Respectful bidirectional communication
4. Contextualised approaches to cultures, settings and partners
5. Strong participatory governance foundations and principles for true partnership. Participatory governance describes a governance model where all the stakeholders have both the opportunity and capacity to participate in processes of decision-making processes and of influencing the outcomes and has provided for the fair consideration of their interests, views and experiences (Osmani, S., 2008).

Communities have systems. Community systems are "structures and mechanisms through which community members, community-based organizations and other actors respond to the challenges and needs they face" (ICASO 2013). These systems can be strengthened through processes that:

- Promote the development of informed, capable and coordinated communities and community-based organisations, groups and structures.
- Enable them to contribute to long-term sustainability of health and other interventions at community level.
- Create an enabling and responsive environment in which these contributions can be effective.

In considering the role of community systems in the health sector, community systems can be working within the health system partially with the health system or may work completely outside the health system. (Figure 1). But in all these models the shared vision is universal access to health care and the right to health.

Figure 1 Relationships between community response and government health sector responses (Source: https://undp-capacitydevelopmentforhealth.org/wp-content/uploads/2021/09/UNDP-Info_Note_Key-concepts-community-systesm_2021.pdf)

As a system, communities have assets that are part of that system and, based on the topic of this conference – and assets available to collaborate and share with the health systems to help advance the vision of universal health care (UHC). These assets can be categorised into seven areas (University of Kansas, 2025).

a. People such as community leaders (women, men, youth), people with lived experience, community volunteers, teachers, community health workers, storytellers, traditional healers and faith leaders.
b. Places such as village squares and halls, schools, faith-based institutions, roads, village water pumps, or community gardens.
c. Partnership assets for example public health and housing and education partnerships, public-private partnerships, and referral networks both informal and formal between service providers,
d. Economic assets e.g. local small businesses, community banks, local funders/philanthropists or grant makers.
e. Institutional assets like local and state government agencies, hospitals and community health centres, Schools, non-profit/community-based organisations,
f. Cultural assets such as the festivals, Indigenous knowledge holders, or cultural centres for ethnic or immigrant groups.
g. Communication (including digital assets) may include community radio, community talk hubs, "coconut wireless" and internet cafes,

EXAMPLES FOR THE FIELD

Using the People assets within the health sector: Community health workers and volunteers

Throughout the Asia Pacific Community health workers and a range of community health volunteers are the frontline of health promotion, primary health care services, peer counselling, patient navigation and adherence support. When I asked one woman in Lao PDR last week why she become a volunteer she said: "My sister died of malaria many years ago – I don't want anyone else to die or grieve".

Community based workers often have cultural understanding, languages, community trust, are accessible and have, as this woman had, lived experience of the health issues and accessibility of services. Building on this people asset in the community system is one of the ways of spanning the gap between community and health systems. More could be done if engaging them beyond service provision, to helping plan and design the services to be responsive to the local needs.

The harnessing of People, Communication, Partnership and Institutional assets: Community based surveillance (CBS) and response

CBS is defined as system where community members systematically detect and report public health events, such as disease outbreaks in humans, animals or plants; or other events like environmental changes, e.g. loss of forests, changes in water ways, death of wildlife (animals and plants), to a government authority, directly or through a bridging organisation.

In many countries in the Asia Pacific Region it is being used for early detection of a cluster of syndromically defined health events that may have outbreak potential, developed by the health authorities. It often utilizes local language and culturally defined concepts of the community, as well as local communication modes e.g. coconut wireless or bush telegraph, and networks to identify someone who may have the symptoms. Through a partnership with the health system these events, which may not have presented to a health centre to be passively detected and reported, are identified and the health system with the

community system react to investigate, define, treat and respond with a public health approach.

A recent story heard from the Thai-Myanmar border, where the principles of mobilizing community systems for surveillance was demonstrated. (This was not formally developed as CBS but how the community system was operating). Communities at the border heard about rabies cases in the communities in Myanmar villages and were able to, through their community volunteers, inform the Thai health authorities who mounted a dog vaccination campaign In Thailand before it spread into Thai villages.

Capitalizing on all community assets - People, Communication, Cultural, Places, Partnership, Economic and Institutional assets: Community led monitoring (CLM)

CLM is a systematic process where communities, especially those affected by health inequities, collect, analyze, and use data to improve services and advocate for change (IAS n.d) in order improve the quality of those services and the community's access to the services which includes health promotion, diagnosis and treatment, follow-up and counselling. The community has a key role to play to ensure that the right services are available, accessible, and considered to be of good quality.

CLM needs to be led by the community, meaning:

1. The community decides what to monitor and how the information should be used.
2. The community leads data collection using people and communication assets.
3. The community leads data analysis.
4. The community shares the information and follows up to ensure that action is taken to respond to the data through partnership, institutional and communication assets.

An example from by CLM activities supported by the Raks Thai and the CSO Platform with funding from the Government of Thailand and The Global Fund, is a good illustration of this in operation. CLM activities in one village identified that people wanted Indoor residual spraying as one response to the increased malaria cases they were seeing. This request was communicated to the health authorities, but they were initially unable to respond due to lack of enough equipment and transport money. The community and the local health authorities acted together to request support from the Local Administrative Organization for funding – which helped purchase the tanks, health had the chemicals and some costs towards transportation, and then they went to a local business which topped up the travel costs. Select community members were trained on safe and effective Indoor Residual Spraying (IRS) application and implemented the response in partnership with the health system.

IN SUMMARY

Strong community systems have been shown to play an important role in facilitating community participation in: design, implementation and evaluation of programs and services; advocacy; creation of demand for good-quality health services and equitable access; addressing broader determinants of health including gender inequalities and human rights; and promoting meaningful community engagement in health-related governance, oversight and accountability.

In some contexts, community actors may have to operate outside of mainstream health systems to protect the health and human rights of people who are marginalized or criminalized – for example, undocumented migrants, sex workers,

sexual minorities or people who use drugs. But even in this case it is working for the shared vision of the health system of health for all.

Harnessing this capacity within community systems to work for the achievement of health for all, needs a strong bridge developed, supported and sustained between the community systems and the health system.

Often Civil Society Organisations help both sides build this bridge, and ensure it is operational before it becomes part of the everyday way of doing things, which is it is sustainable.

CONCLUSION

There is strong evidence on how to effectively efficiently and sustainably build, maintain and strengthen these bridges between community, health and other sectoral systems.

The present geopolitical and global health architecture ecosystems provide a reason to, and indeed necessitate, moving from business as usual to these models which will help achieve universal health coverage and sustain it.

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