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A glaring omission from the WHO's health system building blocks was the community. It was perceived as a passive recipient of the health system's services and not part of it

CO-CREATING HEALTH WITH COMMUNITIES

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In 2007, the WHO listed six building blocks of the health system: service delivery; health workforce; medical products, vaccines and technologies; information; financing; and leadership/governance. Though somewhat arbitrary in their definitions, these building blocks became very popular for analysing the capacity and performance of health systems across the world.

One glaring omission from this list was the community. It appeared that the community was being perceived as a passive recipient and beneficiary of services provided by the organised health system and was not part of it. The fact that members of the community, individually and collectively, contribute to the creation of health was lost in this mechanistic model. The functioning of the health system, even as described by the WHO, is greatly dependent on the role played by people's attitudes and actions that set the demand for and acceptance of services. More important, people too provide health services to themselves, families, friends and others. That dynamic construct was lost in the Lego model of the health system, which appeared to perceive the community as an outsider.

Who constitutes the community, in relation to the health system? Community-based organisations working in health and other developmental sectors are an obvious component. Other voluntary groups, whether women's self-help groups or youth associations, can also be effective contributors to health programmes. Other social, religious and political groups too can take up the health agenda for advocacy and action. Even the informal networks of people that operate at the neighbourhood or family level contribute to community dynamics for health.

Behaviour change for health is a critical component of many public health programmes. Whether it is uptake of polio immunisation in children, not smoking in public places or wearing of face masks in Covid-19 times, the community's willing acceptance of a health advisory is dependent on information flow and changing health beliefs within it. While celebrity role models have appeal on mass media, it is the local community network that breaks down pockets of resistance. Even for combating fear and stigma during pandemic time, the local influencers have a major role to play.

Members of the community also play a part in efficient and equitable delivery of health services. Women's self-help groups in Uttar Pradesh helped reduce neonatal and maternal mortality through health education, behaviour change and monitoring in the community, after training provided by public health experts. Throughout the AIDS pandemic, those living with the infection received care from families and community volunteers. Persons with diabetes practise and greatly benefit from self-monitoring and care, often with family support. Persons with disabilities or mental health challenges get maximum care and support from families and the local community. None of these fit into the enumeration of the formal health workforce. Yet, as technology-enabled primary care extends across many areas of health and institutional care yields space to home-based care, the distinction between the formal and informal health workforce will become increasingly blurred.

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Community-based monitoring of health programmes has been shown to greatly enhance performance and impact through real-world feedback, corrective advice and assertion of accountability. In Thailand, a National Health Assembly annually convenes with community representatives, government agencies and health experts to review performance of health programmes, identify unmet needs and chart the course for the year ahead. In Brazil, municipal councils conduct monthly monitoring. In some parts of India too, community-based NGOs and panchayats have enhanced the quality of health services through monitoring. Apart from appraising the level and quality of service provision, community monitoring also brings a rights perspective and vigilantly protects the interests of vulnerable and marginalised groups.

The community can also function as an alert health information system. In an infectious disease outbreak, early warnings can come from the community. Even reports of unusual deaths among animals may raise the red flag of a potential zoonotic spread to humans. The impact of chemical pollutants is first noticed by the community, as is the rise of substance abuse. More accurate information on availability of health personnel, drugs and emergency services is better obtained from the community than from health department records.

Multi-sectoral action, in domains that profoundly impact health but lie outside the conventional construct of the health system, can also be catalysed, supported and speeded up through community action. Convergence of many health and development programmes takes place at the community level. With increased awareness of the health impact of water, sanitation, nutrition and food systems, pollution and climate change, and by relating education of girls to family health, transport systems to road accidents and technology to local health priorities, the community can set the demand for coherent multi-sectoral policies and actions that enable and not erode health. As the WHO rightly calls for primary healthcare-led universal coverage, it is also time to unfurl the flag of people-partnered public health.

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