WORKSHOP REPORT

Lenses, Metaphors and Research Priorities on Community Health Systems

Chaminuka Lodge, Lusaka, Zambia

10-14 June 2019

PREFACE

This report has been compiled by a group of public health and health system players, engaged in thinking, researching, policy-making and advocacy on community health systems (CHS). With an explicit interdisciplinary focus, this group met for a week (10-14 June 2019) at the Chaminuka Lodge in Lusaka, Zambia to collate our collective understandings of the CHS and generate a set of research priorities that can form the basis of future collaboration. Our common starting point was our positioning as embedded researchers and practitioners in our respective country settings, namely, Zambia, Sweden, South Africa, Guatemala, Tanzania and Uganda.

We thought it important to capture the rich and diverse thinking that emerged during the course of the week, not only for ourselves but also for others involved in the global conversations on the CHS. We are embarking on a series of dissemination activities and products based on the workshop, and are planning further gatherings that will bring together researchers, practitioners and decision-makers across diverse settings.

This report is the first step in this process and is intended as an overview of our deliberations at the workshop, which culminated in the drafting of a collective statement, the Chaminuka Manifesto on the CHS.

The workshop was organised by our three institutions and hosted by the University of Zambia. It forms part of an ongoing collaboration between us, jointly funded by the Swedish Foundation for International Cooperation in Research and Higher Education (STINT), the South African National Research Foundation (NRF), and a network grant (ResearchLink) from the Swedish Research Council (Vetenskapsrådet, VR).

We trust you will find the contents of this report interesting, and look forward to further debate on the meanings and practices of community health systems.

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November 2019.

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WHY THE WORKSHOP?

The idea of a community health system (CHS), while by no means recent, is gaining traction as part of new global agendas on primary health care (PHC) and universal health coverage (UHC). The current concept of the CHS brings together various strands of thinking and programming that have evolved over the past two decades. These strands include renewed support for community health worker (CHW) programmes as part of the Millennium (and now Sustainable) Development Goals, community system strengthening linked to the Global Fund for HIV/AIDS, Malaria and TB, and a growing interest in social accountability as an engine of health system change.

In 2017, a coalition of bilateral, multi-lateral and international non-governmental organisations held a conference entitled 'Institutionalising Community Health' in Johannesburg, South Africa. A 'Community Health Roadmap', led by USAID, UNICEF and the Bill and Melinda Gates Foundation (https://www.communityhealthroadmap.org/) was subsequently launched in September 2019 as a follow-up to the conference. The Roadmap seeks to consolidate the activities and direct the investments of international agencies in an initial group of 15 low and middle-income 'RoadMap' countries. These global processes are associated with an array of consensus statements, guidelines, web portals, e-health technologies, toolkits and research prioritisation exercises on the CHS, which collectively, constitute a veritable 'epistemic' project to shape global thinking and policy direction on the CHS at country level.

While less fragmentation in international initiative on the CHS is to be welcomed, a historian of global health recently remarked of the convergence of UHC and the Health Security Agendas: Is this being done 'so that a handful of people can presume to civilise the whole world? Reaching effective UHC is based on creating variable, context specific healthcare at different levels of national and sub-national governance. Not to be confused with the top-down imposition of [the] idea of a few.' (Sanjoy Bhattacharya @JoyAgnost 22 Sep 2019). This report represents the perspectives of a network of players, informed by their experiences of the CHS in a range of country settings (low, middle and high income), and keen to centre a diversity of perspectives in emerging global developments.

Since 2017, the Universities of Zambia, Umeå and UWC have met on a regular basis, finding synergies between two initiatives to build our research capacity and collaborations on the theme of the CHS. This has been funded by South African NRF - Swedish STINT and a network grant (Zambia-Sweden) from the Swedish Research Council VR. This collaboration (referred to as "U2U") has drawn in a wider network of researchers and activists linked to the three partner Universities – from the Universities of Cape Town, Makerere, Muhimbili and the Center for the Study of Equity and Governance in Health Systems, Guatemala. Over the three years, U2U has hosted the following activities: a workshop for doctoral candidates from our various institutions, in Cape Town in November 2017; joint sessions at the 5th Global Symposium of Health Systems Research in Liverpool in October 2018; comparative case studies of collaborative governance in local health systems; and exchange visits between institutions.

We report here on the last and summative workshop held under the NRF-STINT agreement in June this year. The workshop brought together 33 participants (listed in an appendix to this report) from the seven institutions in our wider the network, as well as frontline workers, managers and senior policy makers from the Zambian Ministry of Health. Over one week, this collective leveraged their diversity (discipline, position and geography) to undertake a multi-disciplinary exploration and mapping of research priorities for the CHS.

WHY THE REPORT?

Our varied positionalities encouraged us to consider more carefully our starting points and assumptions on the CHS. For example, some of us have focused on the role of community health workers in health systems, others on citizen mobilisation and advocacy; some of us on health systems, others on multi-sectoral development; some on macro-level policy and design, others on frontline action; some of us are researchers, others practitioners and policy-makers.

By explicitly surfacing and harnessing different perspectives, we were able to stimulate rich thinking and a variety of representations of the CHS (textual, visual and metaphorical) at the workshop. In the process, we challenged the idea of a single narrative on the CHS, and emphasized the development of a multi-faceted research agenda that could accommodate multiple perspectives and starting points. We have compiled this report in part to inform our own future work and collaboration, and in part to share insights developed during the course of the week with others working in or researching the CHS.

WHAT DID WE DO?

The workshop programme is provided in the appendix to this report. In sum, it involved activities and processes focused on:

- Lenses and definitions of the CHS: the workshop began with an exploration of different starting points or 'lenses' on the CHS, and the different definitions of a CHS arising from these.
- Research priorities for the CHS: in the build-up to the workshop, participants were asked to contribute a list of research themes they considered to be priorities. These were further elaborated and grouped over the week using a modified concept mapping methodology. The outcome of this was a series of concept domains, metaphors and collective statements (declarations) for research on the CHS.
- Engaging the practice of the CHS: thinking on priorities was informed by a day of inputs from policy-makers, practitioners, and trainers on the experiences of the Zambian Community Health System.
- Research methodologies for the CHS: while the concept mapping process was unfolding we shared experiences with novel research methodologies for the CHS.
- Chaminuka Manifesto: the statements and deliberations of the week were compiled into a joint manifesto for research and practice on community health systems.

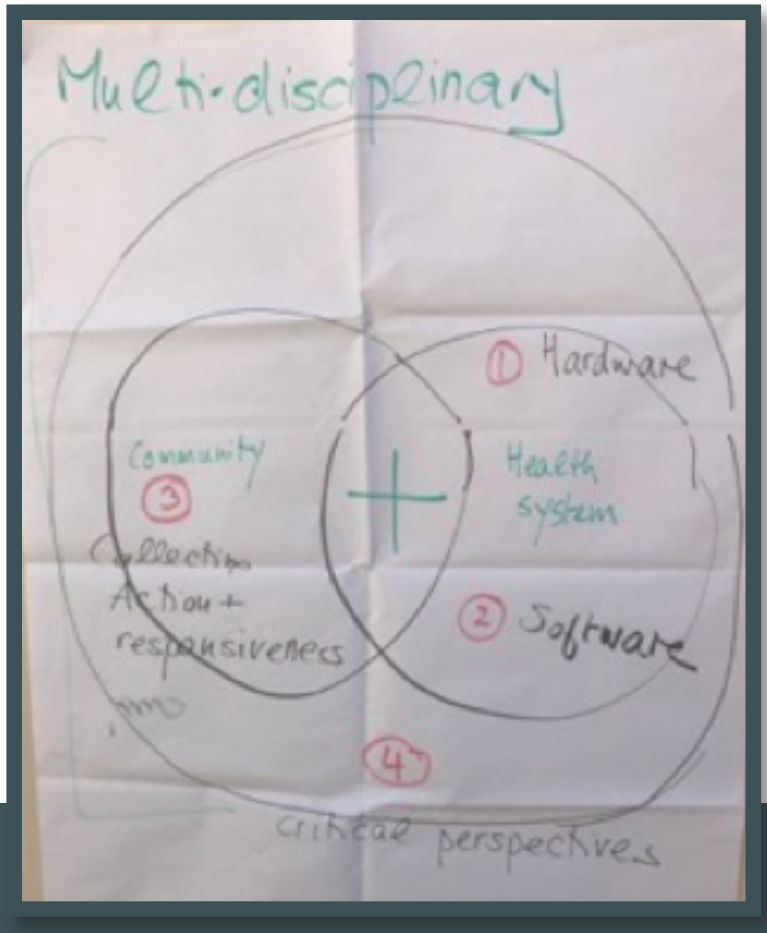
In the pages which follow report in more detail on these various elements.

LENSES AND DEFINITIONS

In the first activity of the workshop, different perspectives and assumptions on the CHS were explored. Based on contributions prior to the workshop, we proposed four general starting points or 'lenses' on the CHS.

- The first lens, 'health systems hardware', involves looking 'into the CHS' as the site of programmes, most commonly CHW programmes, but also other outreach activities of the formal health system, such as adherence clubs, women's groups and clinic committees. This lens foregrounds the design, alignment, financing, training, supervision, supply chain processes, M&E systems and health outcomes of such programmes. Such a lens would typically be associated with national ministries of health.
- The second lens, 'health systems software', also involves looking into the CHS from the health system, but from a relational and social point of view. This lens also shifts from an emphasis on the what (design) to the how (implementation) and typically speaks to realities at lower levels of the health system. At this level, the 'people' and 'every day governance' challenges of rigid mindsets, fragmented relationships, power dynamics and mistrust amongst an array CHS actors are felt most strongly.

- The third lens, ‘responsiveness and collective action’, is the view from ‘within the CHS’ taking the perspectives of community actors as the starting point. Needs and priorities are as defined by community actors themselves, who seek – either as individuals or collectives - to establish their own health agendas and achieve greater responsiveness from formal sector players for these agendas. This perspective is underpinned by values of rights and justice.
- The fourth and final lens, ‘critical perspectives’, looking ‘above the CHS’, examines the CHS from political-economy perspective, interrogating and seeking to critically examine normative and dominant discourses and practices on the CHS. It asks: what interests lie behind current global developments? How should we view the CHS from a decolonial perspective? How do we ensure that contextually relevant programmes emerge at national and sub-national levels?



Each of the lenses was presented as equally valid, whilst acknowledging that in research and practice, certain lenses are more dominant than others. Participants selected a group, based on their own positionality, and were given an hour to collectively draw a ‘rich picture’, write a definition and identify key frameworks or methodologies associated with this lens. Instructions (Box 1) and examples of the rich picture were given to participants.

Box 1: Rich picture instructions:

A rich picture is used to identify the main connections, influences, interactions and relationships in a situation

It is called a rich picture because it illustrates the richness and complexity of a situation.
Use pictures, text, symbols (arrows, money) and icons to graphically illustrate the situation
Some starting questions:

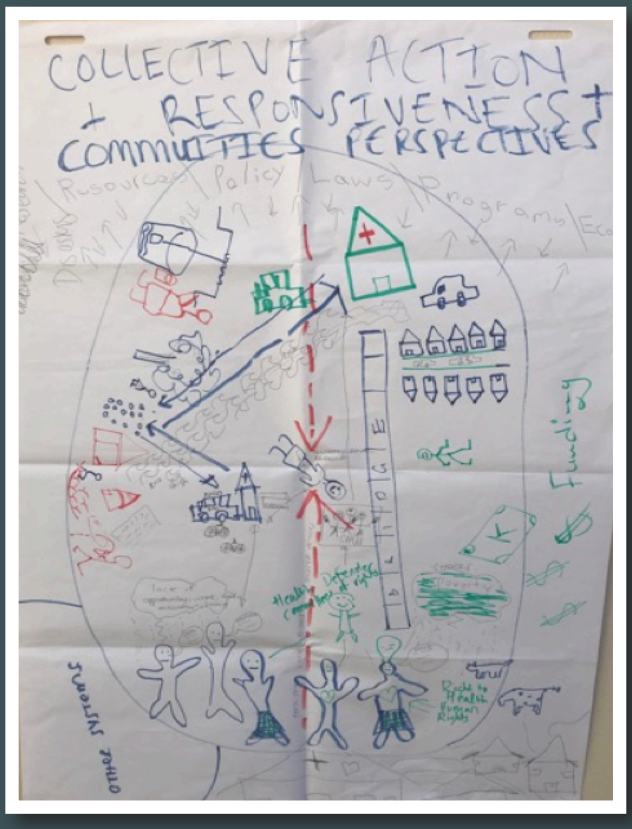
- Who are the stakeholders and how do they relate to the CHS?
- Are there important relationships between stakeholders in the CHS?
- Are there any key physical structures?
- Are there intangibles you need to mention?

COLLECTIVE ACTION AND RESPONSIVENESS (community) lens

This group represented a community health system as a geographically bounded (although porous) and complex set of inter-related systems within other systems. The group recognised that the CHS is influenced by top down (macro level) influences, for example, law, policy, donors/ funding structures, global and national politics, economics etc. and bottom-up factors and processes (housing, water, sanitation, environment, livelihoods and shocks). Both perspectives are relevant to understanding the CHS and the need and possibilities for collective action.

The picture also represents the nature of action in the CHS, specifically the need for building 'bridges' to enable community voice, empowerment and collective action, underpinned by values of the right to health and human rights. Key actors include health advocates/champions, community health workers and other 'boundary spanners'; and community leaders. Intermediary spaces include health facility committees/clinic committees; ward based committees/local government and the ombudsman.

They defined the CHS as follows:
Community health systems are complex, overlapping systems that are generating of health, well-being and development; that foreground and are responsive to community voice, empowerment, rights and accountability; and which recognise the importance of intermediaries (individuals, organisations, networks) that align communities within systems.

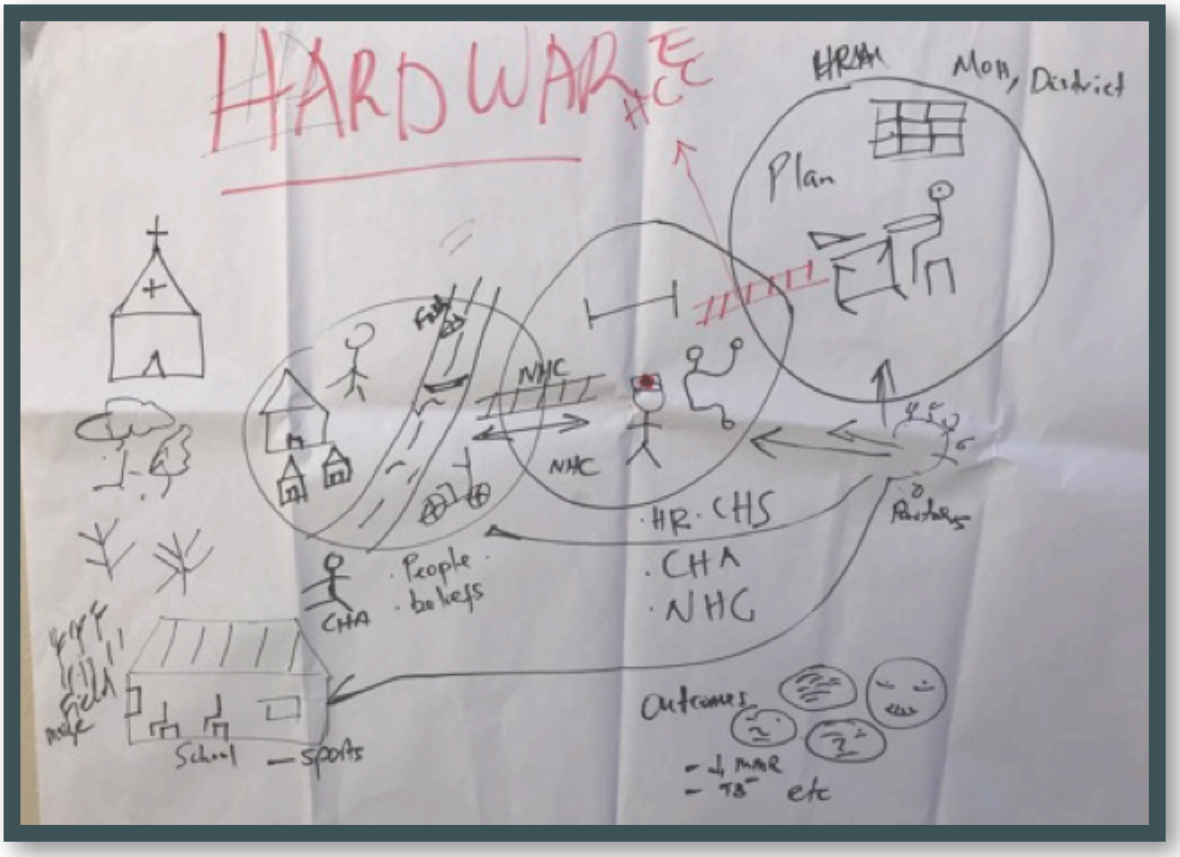


Research would typically examine:
Feedback mechanisms into the formal health system, such as health centre committees, hospital boards, ombuds, and local political structures;
Community monitoring (such as citizen score cards);
Asset based community development;
Multisectoral engagement;
Intermediary or boundary spanners;
Social networks.

Research methodologies would typically involve:
Critical lenses/theories;
Participatory action research;
Photovoice and other visual methods;
Embedded research;
Power analysis;
Stakeholder engagement;
Asset mapping.

HEALTH SYSTEM HARDWARE LENS

The hardware group focused primarily on the CHS as a sphere/space of service delivery. Initiatives in the CHS would include CHW programmes and accountability and coordinating structures such as neighbourhood health committees (NHC) in Zambia. The CHS sphere is connected in a hierarchical manner with the local and higher levels of the health system (districts and ministries of health) by a series of bridges between spaces. This lens is concerned with how to reduce barriers to access, for example, 'a crocodile might stand in the way of crossing the river' or there may be long distances to the health service. It is also concerned with improving health outcomes, such as reducing maternal mortality and HIV/TB. This lens may recognise that outcomes are influenced by community level factors outside of health (e.g. schools, sports fields, community beliefs, faith-based organisations and activities of NHCs). Ideally outcome indicators would be discussed with the NHCs and CHWs at the centre of the CHS, and joint solutions developed, although the group noted that most of the time this happened in a top down manner. This group also reflected on the many different partners engaging actors at all three levels of the health system, all trying to meet health targets. This results in fragmentation, even if the partners do enable communities to access needed services. This group acknowledged that the hardware (designs, structures, outcomes), ultimately cannot be seen as separate from the 'software' (relationships, cultures etc.) of the CHS.



The group defined the CHS as follows:
The CHS is a focus of service delivery designed to provide accessible and acceptable health services at community level, by the community and for the community. It is the interplay between the formal health system and what goes on in the communities, informed by what we want to achieve, both in the communities and formal health services. It involves leveraging community resources, with the allocation of resources, implementation and coordination from the formal health system. It also involves mechanisms to enable communities to take part in decision making on resource mobilization, and promote community ownership and hold the health system accountable. The CHS is the place where we can gauge whether service delivery/activities have been successful through indicators measuring outcomes and general health systems performance.

Research would typically examine:
Affordability, acceptability, availability, appropriateness and quality of services in the CHS;
Health system building blocks: service delivery, financing, HRH, information systems etc.;
Priority setting frameworks, such as effectiveness and cost-effectiveness;
Integration frameworks; Quality improvement frameworks.

HEALTH SYSTEM SOFTWARE LENS

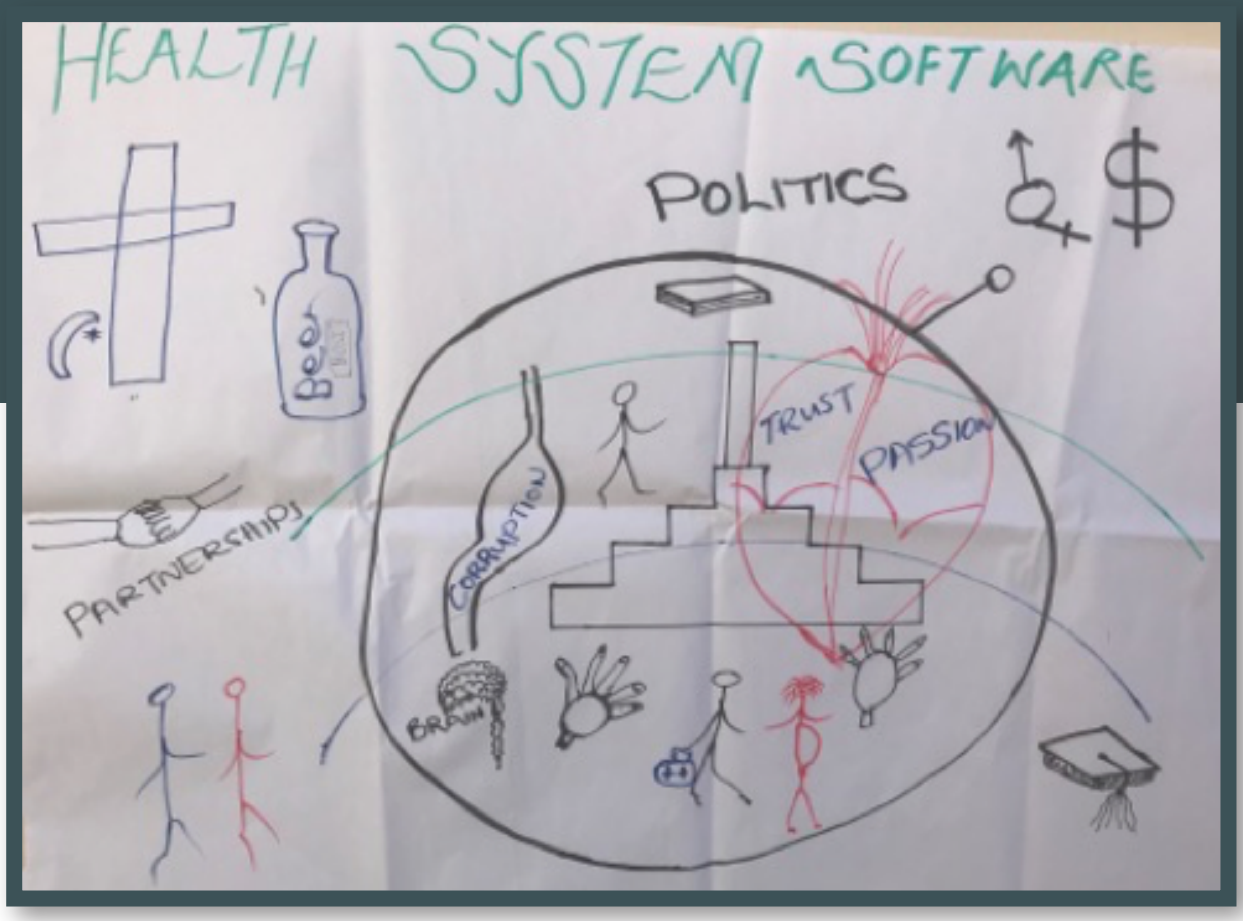
A health system software lens places actors, their relationships and power at the heart of the CHS. These actors are part of larger, layered hierarchies (from micro to macro), existing in political, economic and gendered contexts. Relationships are both within and across elements of the wider system. Relationships are influenced by contextual factors as well as our differences as human beings (individual personalities, religious beliefs, agency and capacity), and entail issues of trust, motivation and power. The multiple 'hands' in the CHS are an indication of the capacity for collective action ('power with'), the brain represents knowledge and mindsets ('power to'), while the heart represents intrinsic motivation (passion), trust and agency ('power within').

Initiatives in the CHS need to engage questions of power. For example, do these initiatives reinforce or actively challenge gender norms.

The group defined the CHS as follows:
Community health systems are complex, dynamic and adaptive systems built by diverse people with different levels of power in relation to each other. Relationships can be formal or informal; cut across different levels (micro, meso, macro); involve a variety of actors - private and public, individual and institutional; and have both tangible (seen) or intangible (unseen) components.

Research would typically examine:
Power and power relations, using a variety of frameworks (Gaventa's cube, street level bureaucracy, Foucault etc.);
Relationships of trust;
Intersectionality;
Adaptive implementation;
Legal, moral, ethical frameworks for decision-making, governance and leadership
Values of solidarity, equity and participation.

Research would typically involve:
Use of critical and feminist theories;
Co-production, embedded, participatory action research;
Social network and stakeholder analysis;
Discourse analysis;
Power mapping;
Ethnography.



CRITICAL PERSPECTIVES LENS

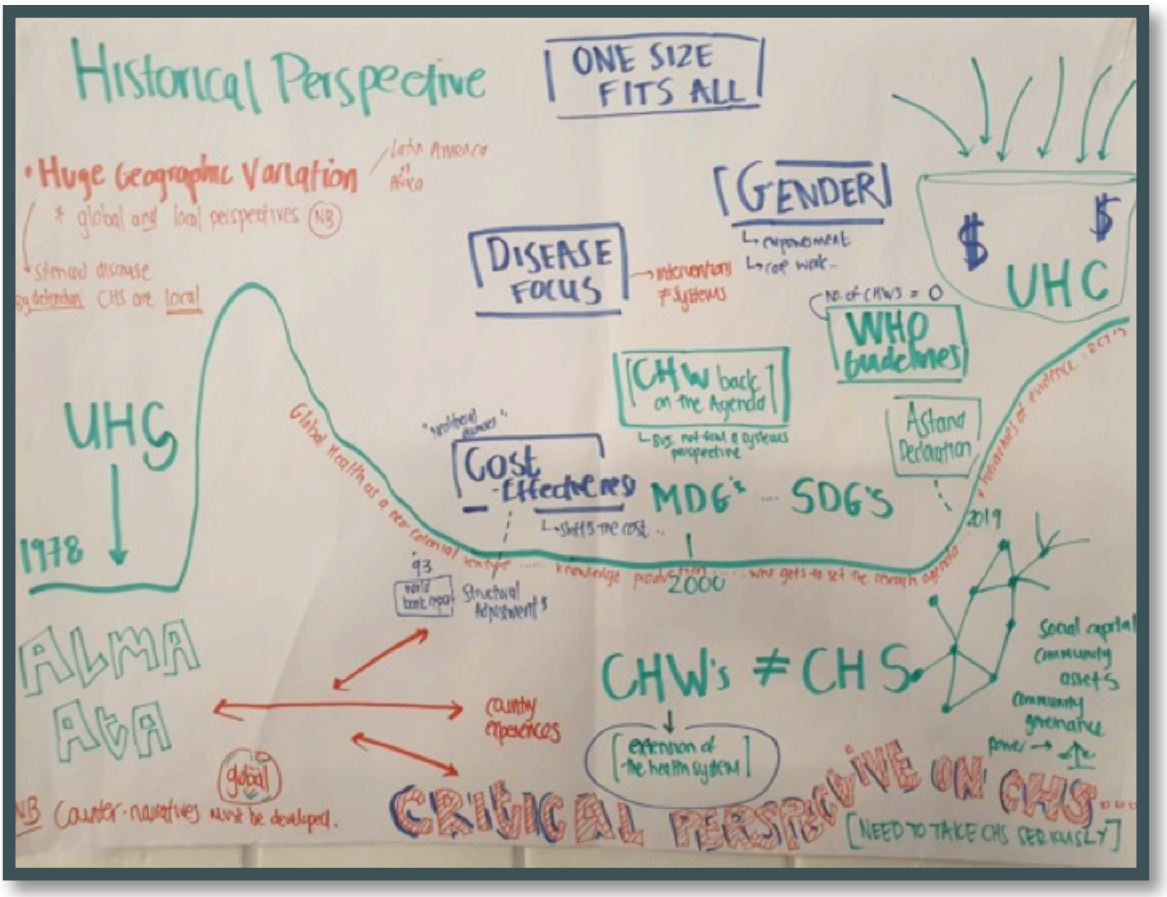
A critical perspective lens on the CHS is not generally regarded as important or relevant, with research often focused on the immediate preoccupations of service delivery or collective action in the CHS. However, such a lens is key to understanding the evolution, forms and dominant discourses on the CHS globally and in country health systems.

This lens locates the CHS historically, showing its origins in the post Alma Ata period, its ebbs and flows globally, up to the recent re-emergence as part of Universal Health Coverage (UHC). These ebbs and flows have to be seen in relation to major forces impacting on countries, such as the structural adjustment programmes and neo-liberal economic orders from the 1980's onwards, the health crises which have followed and the re-emergence of disease-specific community programmes as part of 'task-shifting' ideas in the Millennium Development Goals era.

This lens also recognizes the huge geographic variation in manifestations of the CHS, the need for approaches to the CHS to be locally defined within specific contexts, rather than a one-size-fits-all approach and to not essentialise the CHS as a (often disease-specific) CHW programme, as is often the case in global guidance. It asks: where are agendas being set and who is sitting at the table and where? who is involved in the development of the guidelines, who gets to generate (and consume) knowledge, with what underlying assumptions about the CHS? Is the current enthusiasm for the CHS a genuine effort to widen access and empower communities, or a symptom of the failure to resolve health system challenges at other levels?

This group defined the CHS in a normative sense as follows:
A CHS is an intersectoral, participatory, equity focused, locally embedded, context appropriate, empowering set of complex relationships, actors and processes for health, well-being and social justice that forms the foundation for the formal health system and is a key element of health system strengthening.

With respect to research, this lens would typically:
Be pre-occupied with the biography (who) and geography (where) of knowledge production on the CHS;
Undertake historical analyses, including of shifting global discourses;
Draw on contemporary thinking on de-coloniality;
Adopt political economy, feminist, intersectional approaches;
Seek to disrupt dominant discourses and put forward counter narratives;
Make visible the way in which power operates.



DEFINING RESEARCH PRIORITIES FOR THE CHS

Building on the different lenses, concept mapping was used to facilitate a structured, participatory approach for integrating our collective ideas about what is important for strengthening and researching community health systems. The concept mapping process was guided by the steps outlined by Trochim & Kane (2005). Some adjustments to the steps were made in an effort to ensure that the process was inclusive and participatory.

The steps followed were as follows:

- An invitation to participate in a brainstorm, the first step of the concept mapping process, was sent by email to workshop attendees two weeks prior to the meeting. The email asked participants to respond to the focus prompt statement - "In order to strengthen Community Health Systems, the research priorities I would like to see are…." Responses were compiled and consolidated, reaching a total 75 statements after removing or combining statements with similar focus.

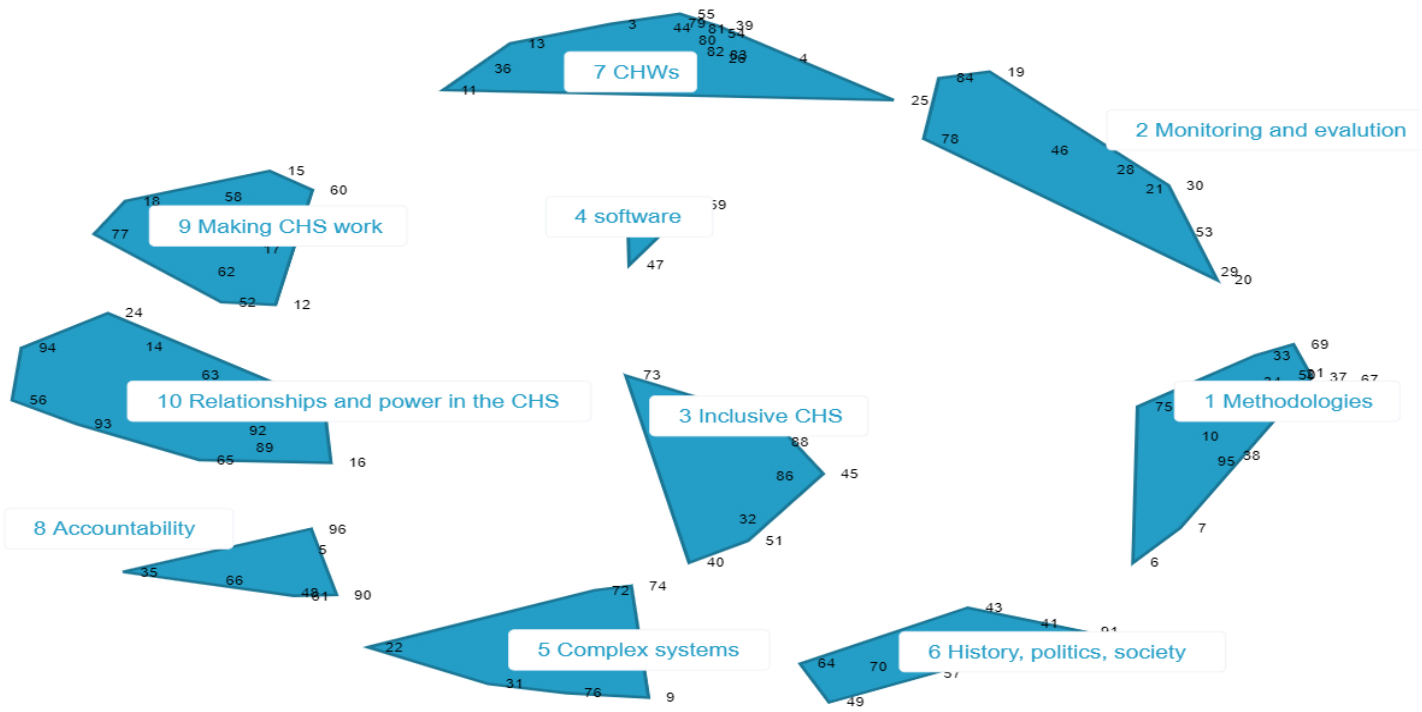
- When the workshop commenced, there were new participants who had not had the opportunity to participate in the brainstorming by email. To ensure that everyone's voice was included in the workshop's collective efforts to conceptualize what is important to strengthen community health systems, and drawing on the discussion of lenses, all workshop participants took time to review the list of 75 statements, assess if their own ideas were reflected and add statements if their ideas were missing. This assessment took place in small groups, from which an expanded list of 98 statements was drawn up.

- In the next step of the process, participants were invited to sort and rate the 98 ideas that were generated. Participants had the option to complete the sorting and rating individually or in groups. This step was conducted using the 'GroupWisdom' software platform, which enables participants to group statements into themes and to label the themes electronically. A total of 17 returns (whether completed as individuals or in groups) for this activity was received. A hierarchical cluster analysis of the data enabled visualization of the ideas that were more frequently grouped together on a point map (see below), where proximity of the points corresponding to each statement (as numbers) reflects the frequency with which they were sorted together. A core team reviewed the outcome of this analysis, from which coherent 10 clusters (or domains) were identified (Figure).

- The 10 'cluster solution' (or domains) was then presented to the workshop participants, who then reviewed the coherence of the domains and the idea statements clustered within them in small groups. Based on these discussions, the concept mapping team found general consensus about the domains that were judged to be coherent and adequately capturing an important theme. An overview of the integrated list of domains with examples of what they represented was presented back to the workshop participants.

- In a final, qualitative and interpretive step, participants (in four groups) developed CHS research 'landscapes' in the form of hand drawn concept maps capturing the CHS research domains identified. These maps drew on, but differed from the computer-generated cluster map in two key ways: they depicted the meaningful relationships between domains (visually and in the declaration) and presented an overarching conceptualisation, analogous to a metaphor, for research on the CHS. The process thus enabled a new level of synthesis, collective sense-making and consensus on research priorities (reflected in the Table below). Groups then wrote a consensus "declaration" for strengthening community health systems, which fed into an overall Chaminuka Manifesto on research and practice for strengthening the CHS.

The sections which follows report on the final research domains identified through this process, and on the maps produced.



[1] William Trochim, Mary Kane, Concept mapping: an introduction to structured conceptualization in health care, International Journal for Quality in Health Care, Volume 17, Issue 3, June 2005, Pages 187–191, https://doi.org/10.1093/intqhc/mzi038

RESEARCH PRIORITIES FOR THE CHS

The table below is a synthesis of priority research domains, with their definitions and examples arrived at through the group process.

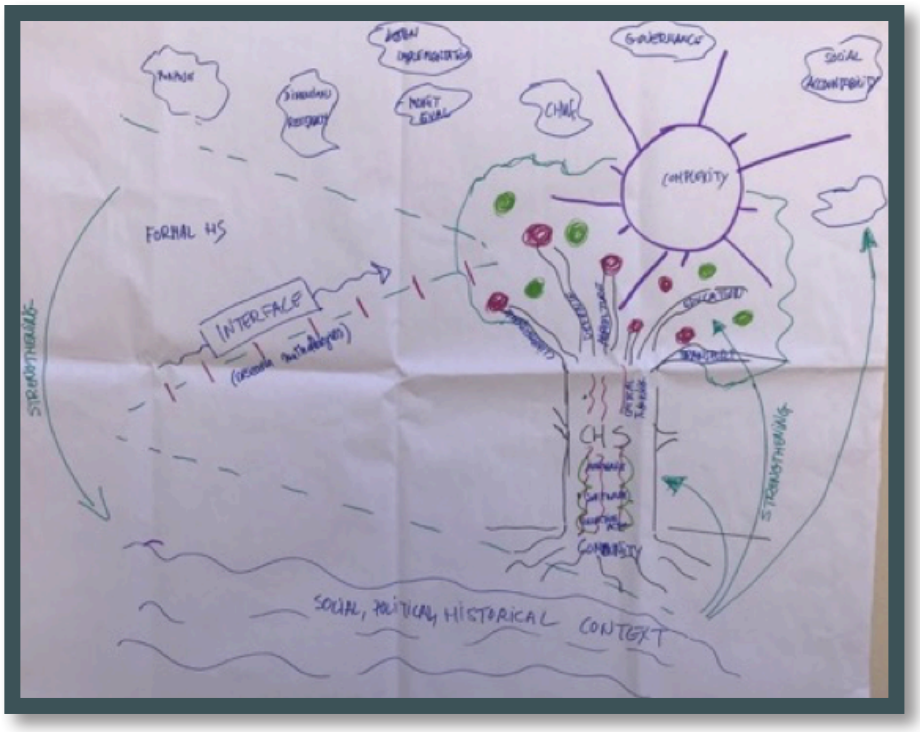
Cluster domain	Definition	Examples of statements
Clarifying purpose and values, ensuring inclusive CHS	The core values, assumptions and principles that characterise our framing of the CHS and therefore of research on the CHS, such as equity, inclusiveness, whole of society approach, social determinants and locally driven.	• Geared towards reducing inequalities • Focused on intersectional needs • Concern with the health of people (vs disease) • Focused on the social determinants of health • Takes into account perspectives of vulnerable groups
Design, implementation, M&E of strategies to strengthen the CHS	Decision-making and programmes to strengthen the CHS through all phases, from context-sensitive designs and models, the implementation and scale-up of programmes, and monitoring and evaluation strategies.	• Different models of the CHS • Examples of strong community health systems • Strategies to guide programme implementation • Scaling up locally driven innovations • Monitoring at community level • Performance indicators for the CHS • Context sensitive evaluation strategies
Social, political and historical contexts	The history, political-economy, social and gendered contexts of the CHS at all levels, from global to local knowledge, beliefs and practices.	• Historical development of CHS • Politics and policy on the CHS • Discourses on CHS • Influence of local knowledge, beliefs and cultural practices • Gender relations • CHS and the PHC approach • The CHS as nested in larger systems and society
Community health workers	Focus on the life-cycle of the CHWs, including effective strategies for identifying, selecting and recruiting, training and developing, supporting and retaining CHWs.	• Retention • Motivation • Training • Roles on paper vs practice • Embeddedness in communities • Empowerment and agency • Impact
Social accountability	Community accountability and responsiveness and participation mechanisms; strategies for collective action and effective citizen participation.	• Participation mechanisms • Responsiveness • Collective action • Power relations
Interface between CHS and the broader health system	The interface/interplay between community health systems and the broader health system; between the community and health service, and between the CHS and other CHS.	• Resource allocation • Overcoming fragmentation • Partner coordination • Balance between formal sector and volunteers • Roles of boundary spanners • Building trust between formal health care system and CHS
Governance and stewardship	The oversight, direction and stewardship required to strengthen the CHS, ensure accountability, promote inter-sectoral collaboration, overcome fragmentation, ensure allocation of resources and build trust.	• Power dynamics within CHS • Involving private for profit actors • Intersectoral collaboration in CHS • Overcoming fragmentation • Partner coordination • Community resource mobilization • Sustainability
Ethical methodologies for researching the CHS	Methodologies and processes that align with the values of the CHS and contribute to social change.	• Embeddedness • Catching complexity • Participatory action research • Engaging with communities • Contributing to change • Co-producing knowledge • Context sensitive

DOMAIN MAPS AND METAPHORS FOR RESEARCH ON THE CHS

As individual groups developed concept maps showing the relationships between cluster domains, they spontaneously produced four distinct metaphors or representations of the CHS: 1) the CHS as a living, ecological system; 2) the CHS as a building; 3) the CHS as systems nested within other systems; and 4) the CHS as level of action (micro, meso, macro). These are described further below.

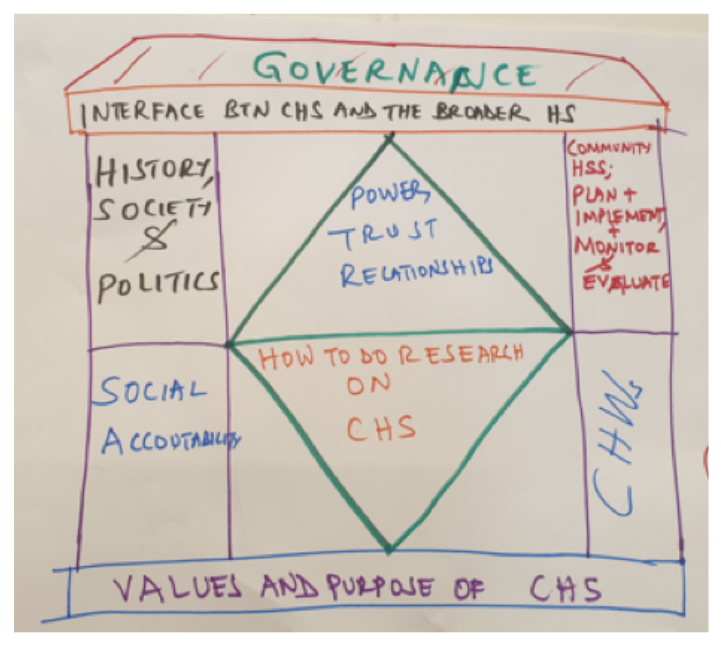
CHS as a complex, living system

The relationships between research priorities for the CHS can be illustrated with the metaphor of a holistic, connected ecosystem life cycle. The CHS is the trunk of the tree, with the size of the trunk representing the stages of development of the CHS and different trees, the different CHS contexts, as in the figure below. The size of the trunk represents the significance of the CHS in overall health system contexts. Inside the trunk, the different lenses of software-hardware-social accountability constitute the core of the trunk, being all three permeated by the tree sap (critical thinking). The roots of the tree are the community which influences and decides the organization of the CHS. To survive, the trees need water from the river. The river represents the historical, political and social context that shapes the CHS and the in water-flow, is the time dimension. The branches of the tree represent the different sectors of the society (transport, agriculture, services, trade, ….) that should be influenced by the trunk (CHS in all sectors) and the fruits mirror the health and well-being of the communities. These various ideas form the basis for a contextualised approach to research on the CHS, but can also be the focus of research themselves. The clouds depict specific research priorities for the CHS (including governance, the role of CHWs, mechanisms of social accountability etc.) and the rain falling into the trees and river, the strengthening of the CHS, as a product of research. The CHS ideally grow slowly, engaging the formal health system in a process of continuous collaboration represented by the interface of the two systems.



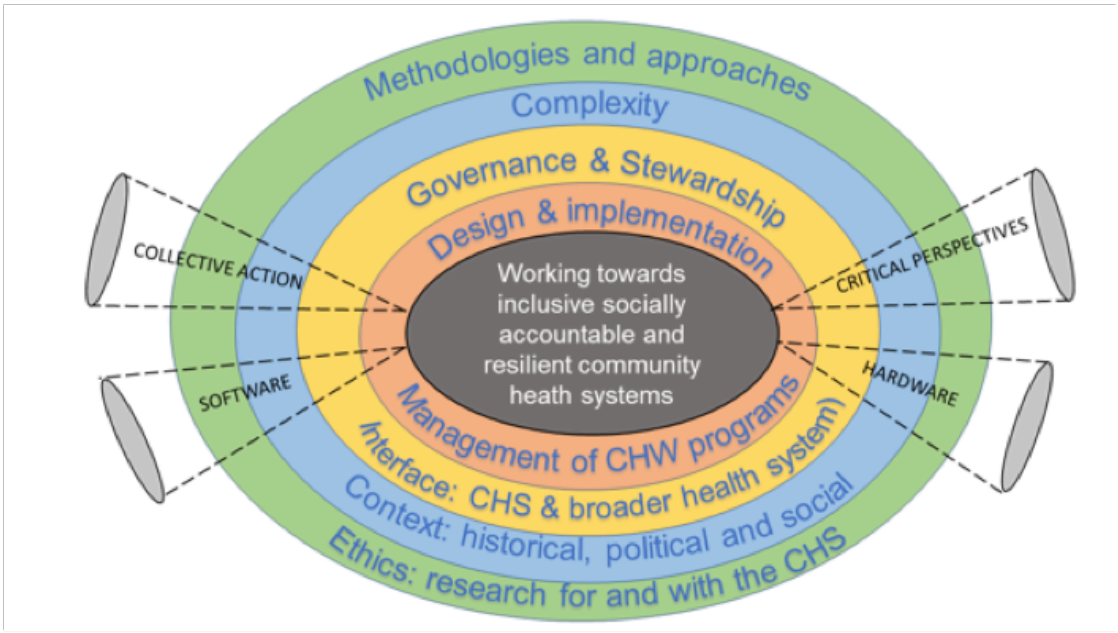
The CHS as bricks and mortar

In this representation, CHS research domains are presented as a connected whole, this time as a house. Values and purpose of the CHS form the foundation for research on CHS. Governance provides the roof and the interface between the CHS and the broader health system are the rafter beams supporting the roof. The pillars or walls represent specific thematic areas: CHWs; social accountability; CHS strengthening cycles (planning, implementing, monitoring and evaluating); and the historical, political and social contexts. Power, trust and relationships form the framework holding together the different elements. Our research methodologies should also reflect an understanding of the connectedness of the various domains.



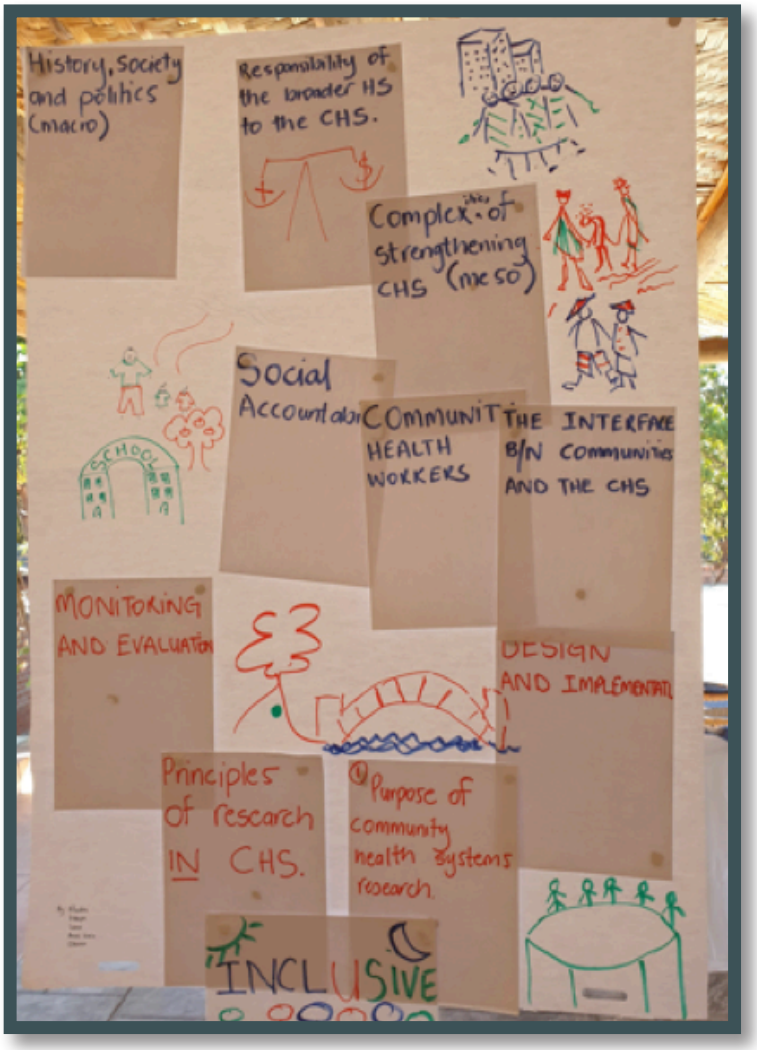
The CHS as systems within systems

In this representation of the key research domains and priorities, the community health system is embedded in communities and in the broader health systems with porous boundaries between them. As such, the CHS represents a significant health system asset comprising both hardware elements such as human resources, drugs and technologies, as well as software elements such as values, relationships and trust. Communities exist within and are part of health systems, and communities and health systems are comprised of systems within systems. Values and purpose are placed at the heart of research, and research priorities are framed by notions of complexity. Ideas of collective action and the need for critical perspectives cut across all the various domains.



The CHS as levels (micro, meso, macro)

Here the research domains for the CHS are represented at micro, meso and macro levels, underpinned by values of inclusivity that inform principles and practice of the CHS. Research on the design, implementation, monitoring and evaluation of programmes is conducted at the micro-level. This includes a focus on both social accountability and CHW programmes. The meso-level concerns research into the interfaces with the formal health system, and the governance responsibilities towards the CHS. These are embedded in macro-level considerations of history, society and politics.



METHODOLOGIES

The lenses and research priorities that surfaced during the course of the workshop were naturally tied to considerations of ethical methodologies for research and practice that align with the purposes and values espoused by the group. While addressing the range of CHS research priorities requires different methodologies, there was overall consensus that approaches needed to firstly, foreground social justice and social change, and secondly, recognise the CHS as a complex adaptive system. Key principles included participation, social action, embeddedness, co-production, ongoing reflective learning, context specificity and sensitivity to language ('on' vs 'in' vs 'for' vs 'with' the CHS). In addition to these key principles, the group recognised the critical importance of doing away conventional hierarchies of research evidence governing the field. So, for example, participatory research on the lived experiences of the community health system or political-economy analyses are as valid as a randomised controlled trial of a complex intervention, or a cost-effectiveness analysis of a CHW programme to reduce neonatal mortality. Research should be problem rather than method driven and the overarching methodology should draw on a range of data collection activities that best respond to the complex question at hand.

Participants shared their emerging experiences with various forms of participatory research in the CHS, including photovoice, 'DrawingOut', community dialogues, stakeholder reflective meetings, community asset mapping, and film. Co-production of knowledge and close attention to the 'biography' and 'geography' of knowledge production were at the core of these approaches.

Also discussed was the increasing commercialisation of publishing and the need to develop and promote open access alternatives. Participants were challenged to play an active role in identifying ways and opportunities to engage debates and developments in this area.

ENGAGING DECISION-MAKERS AND PRACTITIONERS

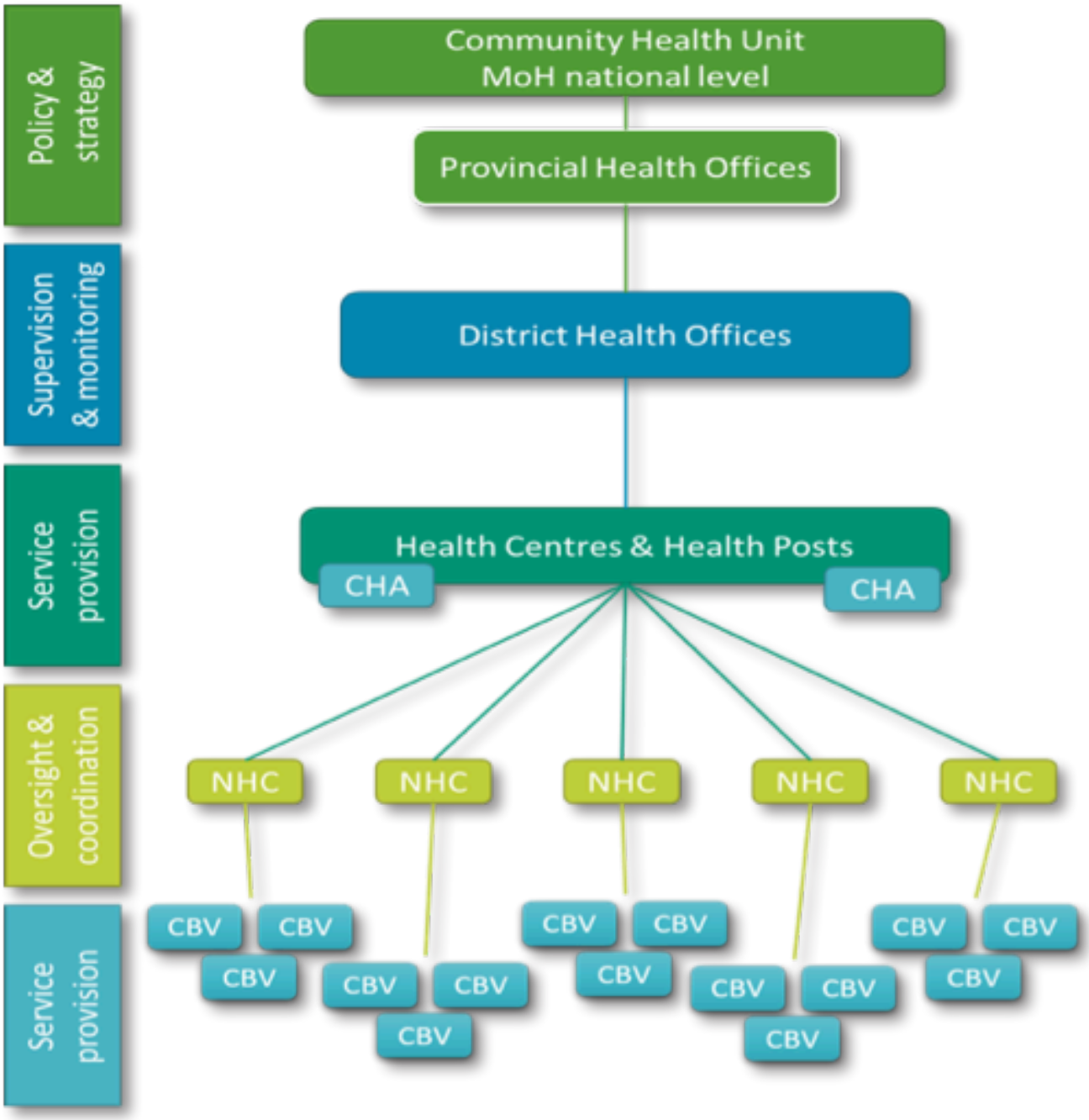
Decision makers and practitioners involved in the Zambian CHS, with whom UNZA's School of Public Health has long standing relationships, formed an integral part of the workshop. They included senior policy makers, trainers, frontline providers (Community Health Assistants - CHAs) and their supervisors in the Ministry of Health, and partner agencies (Clinton Health Access Initiative (CHAI) and Innovation Poverty Action (IPA)).

One day of the workshop was devoted to presentations and discussion of developments in the Zambian CHS, with additional reflections on the Tanzanian experience. These inputs were immensely valuable in the following ways:

- The long-term relationship between SPH, UNZA and Zambian MOH provided an example of embedded research that addresses context specific research, implementation and development needs;
- Examples of constructive partnerships between MoH and non-state (including external) actors demonstrated how these can complement government efforts in strengthening social accountability, availability and use of information by the community as well as capacity of community structures and actors in providing and monitoring service delivery;
- Knowledge of current developments, such as the recent establishment of the Community Health Unit in the Zambian Ministry of Health, provided insight into the visions, constraints and possibilities of implementation, ensuring that thinking on research priorities remained grounded in real-world concerns and contexts;
- Inputs from experienced CHAs provided insights on the challenges and strategies for engaging and promoting community participation in planning, coordination, implementation and monitoring in the CHS.
- Case studies on the training and supervision of CHAs illustrated how training in supportive supervision coupled with provision of supervisory tools can help address supervisory challenges, by building the capacity to provide mentorship and coaching to CHWs.
- The experiences of Tanzania highlighted the long histories and many waves of intervention in the CHS and the need for critical perspectives on developments in the CHS.

There was unanimity in the group on the need for more opportunities to promote dialogue between researchers, policy-makers and practitioners, within and across the countries represented at the workshop.

Structure of Zambian Community Health System (Source: Zambian Ministry of Health)



The Chaminuka manifesto on research and practice in the community health system

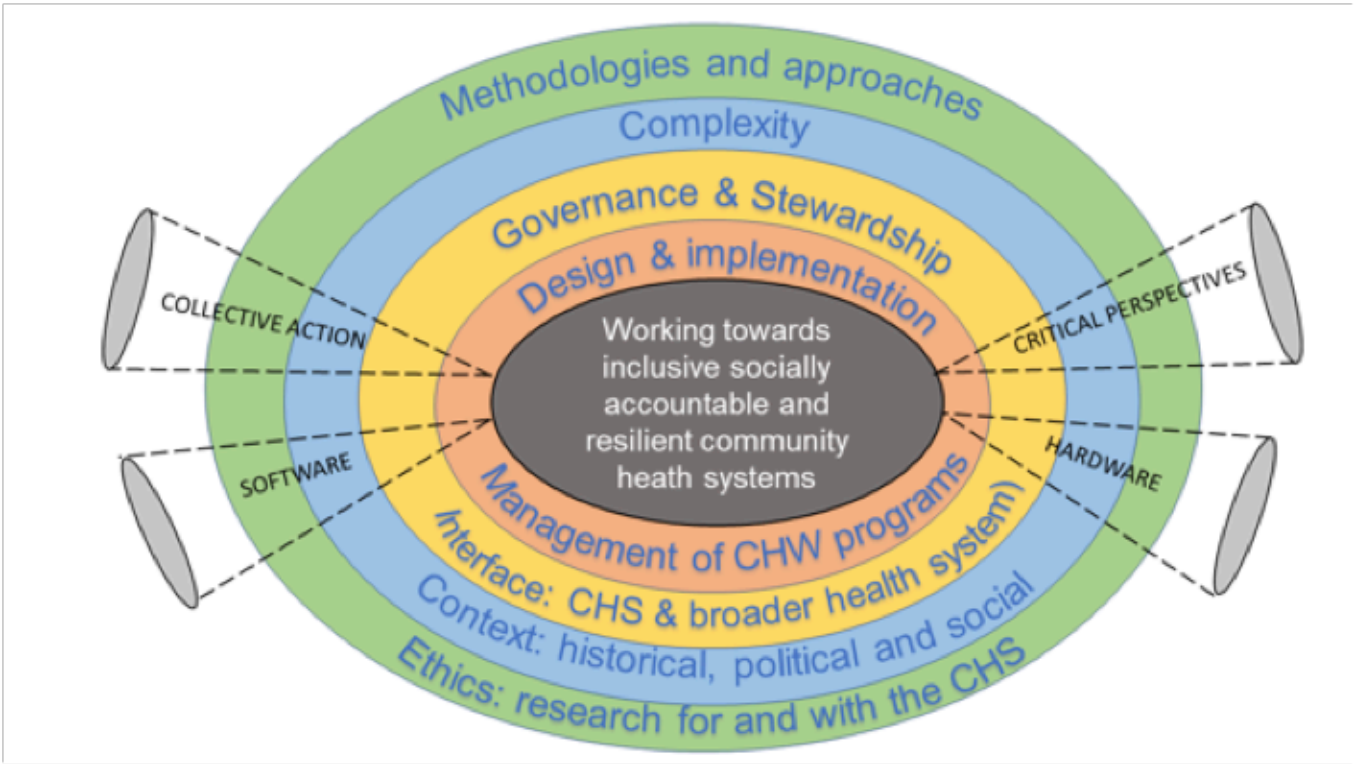
From 10-14 June 2019 a group of people came together at the Chaminuka Lodge, Zambia to develop an agenda for research and practice to strengthen community health systems (CHSs). The group included community health workers (CHWs), scholars, policy-makers and practitioners from six countries: Zam-bia, South Africa, Sweden, Tanzania, Uganda and Guatemala, encompassing a wide range of personal and professional experiences. We recognised that our different experiences shaped our views of the world and our approach to the CHS. Deliberately approaching the CHS through a variety of lenses and acknowledging that there is no single narrative of the CHS, we grappled collectively with the complexity of the CHS and the multiple perspectives on research and action in the CHS which need to co-exist with each other.

We were brought together:

- by a shared belief in the centrality of communities to health systems functioning, and the need to move towards recognising and (re)centering the people, families and communities that are at the core of any health system;
- with a common purpose to further understanding of the vital role played by communities and community health systems in building responsive health systems; and to strengthen community health systems within and across their settings;
- the need to shift the 'biographies' (who conducts) and 'geographies' (where conducted) of research and thinking on the CHS.

Over the course of a week-long workshop, the participants developed a set of core principles that should inform all work on CHS, and a research agenda to guide future collaborations.

This is the Chaminuka Manifesto:



We believe that communities are complex social systems with long histories, imbued with power relations that play out between people, families, neighbourhoods, committees, and health workers. We understand community health systems as embedded in these community social systems and in broader health systems, with porous boundaries between them. The CHS represent a significant health system asset or resource comprising both hardware elements, such as human resources, drugs and technologies, as well as software elements such as values, relationships and trust.

Health systems typically engage the CHS through community health worker (CHW) programmes. CHWs are mandated to provide primary and preventive health services, but both their mandate and their capacity to carry it out effectively are impacted by factors such as motivation, training, degree of embeddedness in communities they serve, and the disjuncture between their role as described on paper, and what is expected in practice. It is therefore vital that the research takes seriously the lived realities of CHWs, and seek to establish effective strategies for identification, selection and recruitment of CHWs and best practice for training and continuous development of CHWs, enhance their agency, motivation and job satisfaction, and remove barriers to effective retention of CHWs in and relationships with the health system.

We believe that the CHS is also a site for the empowerment and participation of communities within broader health systems, allowing communities to hold government to account. This is to be achieved by strengthening community participation mechanisms that shift power relations, ensuring responsiveness of health systems to community needs, and actively pursuing strategies for collective action. This entails:

- Building capacity for collaborative governance and accountability, understood to include oversight, direction and stewardship to enable and strengthen the CHS, promote intersectoral collaboration, overcome fragmentation, ensure allocation of resources and build trust;
- Strengthening the interface and relationships between CHSs and their broader health systems, as well as between the community and health services;
- Recognising the importance of addressing imbalances in power and building trust in relationships between stakeholders in strengthening the CHS.

We also believe that it is the responsibility of governments to support and strengthen the CHS, which includes:

- Working to overcome health system fragmentation
- Ensuring equitable resource allocation to CHSs
- Coordinating partnerships between actors within CHSs, and monitoring the impact of external partner actions on CHSs
- Ensuring balance of power between formal sector health workers and volunteer CHWs
- Recognising the importance of boundary spanners which mediate relations between CHSs and broader health systems
- Building trust between the formal health care system and the CHS
- Strengthening the capacity of communities to hold government to account for maintaining their responsibility to the CHS.

We are explicit in positioning the values and principles underpinning our understanding and conceptualisation of CHS, and therefore our research in, on and for the CHS. Core to our values is the need to foreground marginal and vulnerable populations, and to fight to make those who are invisible, visible.

The values and principles we believe should be taken into account when designing, implementing, monitoring and evaluating the CHS, are:

- A focus on reducing inequalities by acknowledging and striving to meet the intersectional needs of individuals as members of complex communities
- A concern with the health and wellbeing (including physical, mental and social wellbeing), rather than a disease-focused approach
- A commitment to locally-driven solutions
- A whole-of-society perspective that seeks to harness the social determinants of health to promote wellbeing.

As such, we believe that research on, in, for, and with CHS should:

- Be inclusive
- Be locally-driven and embedded in communities and societies
- Generate new knowledge through co-production
- Centre around community engagement through non-hierarchical participatory methodologies that foreground trust, balance of power, and strong and sustained interpersonal relationships
- Acknowledge the complexity and context sensitive nature of CHSs, through a whole-of-society perspective
- Always be conducted with the intention of contributing to real-world social change
- Shift the centre of knowledge generation on the CHS to countries themselves, and in ongoing dialogue with policy-makers and practitioners.

In conducting this research, it is crucial to take account of, and research, the history, political-economy, and social and gendered contexts of the CHS, from global to local, including local knowledge beliefs and cultural practices. We understand this complex context not only as the context in which CHS are embedded, but also as the context in which researchers conduct their work. In doing so, we recognise that global imbalances in knowledge generation may allow for certain ideas, interests and discourses on the CHS to dominate in ways that silence others.

The participants of the Chaminuka workshop resolve to continue building collaborations, research partnerships and community engagement platforms to strengthen community health systems. We further commit to conducting ethical, emancipatory research for and with all stakeholders towards inclusive empowered communities, while acknowledging the importance of histories, power and relationships, and using critical perspectives to understand the impact of these contextual factors on our daily work and relationships.

APPENDIXES

U2U Workshop on Community Health Systems
Lusaka, Zambia
10-14 June 2019

Monday: Setting the scene and getting going

09:00-10:00 Welcome and introductions (Zambia team)
10:00-10:30 Overview of workshop (Helen and Anna-Karin)
10.00-11.00 TEA
11:00-13:00 Multiple lenses on Community Health Systems (group work)
12:00-13:00 LUNCH
14:00-15:00 Report back of group work
15:00-15.30 TEA
15:30-16:30 Sorting and rating themes within the CHS (Concept mapping group)

Tuesday: Adopting different methods in CHS

8:30-10:30 Participatory and visual methods and in CHS (Chama, Meg, Leanne, Moses)
10:30-11:00 TEA
11:00-12:00 Concept mapping (Alison)
12:00-14:00 LUNCH
14:00-15:00 Asset mapping and other tools from the field of development (Jill)
15:00-15:30 TEA
15.30-1630 Open access for free? Some reflections (Miguel)

Wednesday: Towards resilient community health systems in Zambia

08:30-9:00 Role of the School of Public Health in promoting resilient CHS – an overview; Prof Michelo
09:00-10:30 Community health in Zambia

- Structures and policies that handle planning processes; Director, Department of Public Health, MoH
- Continuum of health systems:
  - Recruitment, training, placement and supervision of CHAs - Director for Training School for CHAs
  - Career ladder for CHAS recruitment and motivation of CHWs by IPA (Nampaka)
  - Plenary

10:30-11:00: TEA
11:00-13:00: Experiences of working in community health systems

- Health messaging, translating messages and referrals = in community health systems – case studies (Experiences of CHAs) By CHAs
- Training CHAs/CHWs to deliver CSE in schools in the Zambia; the case of the RISE study (by Chavula)
- Experiences of integrating CHWs in Tanzania – Sirili
- Plenary

13:00-14:00	**LUNCH**
14:00-15:00	Developing and communicating health programs/policies • The MMDP project in Luangwa – Patricia and Adam • Communication of policies from the national level to the community health systems- Kasapo
15:00-15:30	**TEA**
15.30-17:00	Concept mapping: best fit of maps (Concept mapping group)

Thursday: Discussion on priorities and way forward

8:30-10:30	Concept mapping including consolidation of research priorities (Concept mapping group)
10:30-11:00	**TEA**
11:00-13:00	Concept mapping including consolidation of research priorities (Concept mapping group)
13:00-14:00	**LUNCH**
14:00-15:00	Collaborations and writing teams
15:00-15:30	**TEA**
15:00-16:30	Collaborations and writing teams

Friday:	**Wrapping up**
8.30-10:30	Report back on discussions on Thursday afternoon and next steps
10:30-11:00	**TEA**
11:00-12:00	Next steps
12:00	**LUNCH**

Departure

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Who	Role/Institution	Country
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