THE STORY

# Sailing below the waves

*A 20-year journey of Strengthening Local Health Systems in India*

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Abhijit Das
Aloysius James
Biswanath Basu

Meena Putturaj
Bart Criel
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Sandip Bagchi
Felipe Sere
Madhumita Dobe

STUDIES IN HEALTH SERVICES ORGANISATION & POLICY, 35, 2022

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Belgium
partner in development

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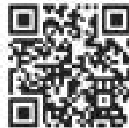

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# Table of contents


| | | |
|---|---|---|
| | Acknowledgements | 11 |
| | Preface | 15 |
| 1 | People, journeys and destinations<br>*Stories of change* | 31 |
| 2 | People and places<br>*Living in the Himalayas and the Ganges delta: challenging contexts* | 53 |
| 3 | Sailing towards the open sea<br>*Milestones along a journey of 20 years* | 73 |
| 4 | A compass to sail below the waves<br>*The guiding principles of the Basic Health Care and Support programme* | 87 |
| 5 | Searching a way out of the cave, a journey of penciling and gumming<br>*Emerging Representations, Theories and Practices of Change using Action-research* | 109 |

6 Strong headwinds and currents 151
*Exploring the boundaries of power along the road to equity and people's autonomy*

7 Building boats and fleets 195
*Designing Health Forums for stronger Local Health Systems*

8 Building strong fishing crews 223
*Contributing to a renewed public health governance framework*

9 Catching some fish 253
*Local solutions to local problems*

10 How did we sail below the waves? 287
*Methods and tools to manage complex social development programmes*

11 Bits and bobs for beachcombers 323
*Zooming in on additional tools*

12 Sailing on big ocean waves 345
*Connecting local work with public health trends in India and the global level*

13 Are we ready to face future cyclones and tsunamis? 369
*Musings on BHCSP's capacity to cope with current and future systemic challenges*

Statements of BHCSP actors 393

Milestones and partners 403

Bibliography 419

Reflections and notes from the reader 431

# List of abbreviations

| | |
|---|---|
| AAAQ | Availability, Accessibility, Acceptability and Quality |
| AGP | Ashurali Gramonnayan Parishad (NGO Partner) |
| AIIH&PH | All India Institute of Hygiene & Public Health |
| ANC | Ante Natal Care |
| ANM | Auxiliary Nurse Midwife |
| AR | Action Research |
| ASHA | Accredited Social Health Activist |
| ASPBAE | Asia Pacific Bureau of Adult Education |
| AWC | Angan Wadi Centre (ICDS Centre) |
| AWW | Angan Wadi Worker (ICDS Worker) |
| AYUSH | Ayurveda, Yoga, Unani, Siddha and Homoeopathy |
| BDO | Block (Sub-district) Development Officer |
| BFCWS | Bhetkipur Family & Child Welfare Society (NGO Partner) |
| BHCSP | Basic Health Care Support Programme |
| BMOH | Block (Sub-district) Medical Officer of Health |
| BPHC | Block (Sub-district) Primary Health Centre |
| BPHN | Block (Sub-district) Public Health Nurse |
| BSF | Border Security Force |
| CATCH | Comprehensive Annual Total Check-up of Health |
| CBO | Community Based Organisation |

| | |
|---|---|
| CHC | Central Health Committee |
| CHCMI | Community Health Care Management Initiative |
| CHF | Community Health Fund |
| CMOH | Chief Medical Officer of Health |
| COVID-19 | Corona Virus Disease of 2019 |
| CPPE | Comprehensive Participatory Planning & Evaluation |
| CSC | COMMUNITY SCORE CARD |
| DCPO | District Child Protection Officer |
| DDD | Doing Development Differently |
| DGD | The Directorate-General for Development Cooperation and Humanitarian Aid |
| DHAC | District Health Action Committee |
| DHAF | District Health Action Fora |
| DHF | District Health Forum |
| DPIP | District Project Implementation Plan |
| ESCR | Economic Social and Cultural Right |
| FAO | Food and Agriculture Organisation |
| FFH | Freedom From Hunger |
| FGD | Focus Group Discussion |
| GDH | Gross Domestic Happiness |
| GDP | Gross Domestic Product |
| GP | Gram Panchayat |
| HIV | Human Immunodeficiency Virus |
| HSS | Health Systems Strengthening |
| IAD | Itarai Asha Deep (NGO Partner) |
| IAG | Inter Agency Group |

| | |
|---|---|
| ICDS | Integrated Child Development Service |
| ICESCR | International Convenant of Economic Social and Cultural Rights |
| ICPD | International Conference on Population & Development |
| ICPD POA | International Conference on Population & Development Programme of Action |
| IDS | Institute of Development Studies |
| IFA | Iron Folic Acid |
| IITD | Indian Institute of Training & Development (NGO Partner) |
| IMA | Indian Medical Association |
| INR | Indian Rupee |
| IPH | Institute of Public Health |
| ITM | Institute of Tropical Medicine |
| JSY | Janani Suraksha Yojana |
| KFSC | Kautala Friends' Sporting Club (NGO Partner) |
| KGUK | Khanpur Gana Unnayan Kendra (NGO Partner) |
| KII | Key Informant Interview |
| LGB | Local Governing Body |
| LHS | Local Health System |
| LMIC | Low and Low Middle Income Countries |
| M&E | Monitoring & Evaluation |
| MCH | Mother & Child Health |
| MDG | Millennium Development Goal |
| MSC | Most Significant Changes |
| NCD | Non Communicable Disease |
| NGO | Non Government Organisation |
| NHG | Neighbourhood Group |

| | |
|---|---|
| NHM | National Health Mission |
| NRHM | National Rural Health Mission |
| NRLM | National Rural Livelihood Mission |
| N24P | North 24 Parganas |
| ODF | Open Defecation Free |
| OH | Outcome Harvesting |
| OM | Outcome Mapping |
| OOP | Out-of-Pocket |
| OPD | Out Patient Department |
| PHC | Primary Health Centre |
| PHM | People's Health Movement |
| PPUS | Panitar Palli Unnayan Samiti (NGO Partner) |
| PRI | Panchayati Raj Institute (Local Government) |
| RE | Realist Evaluation |
| R&D | Research & Development |
| RKS | Rogi Kalyan Samiti (Patient Welfare Committee) |
| RLSK | Ramakrisha Loka Seva Kendra (NGO Partner) |
| RMP | Rural Medical Practitioner |
| RSBY | Rastriya Swasthya Bima Yojana (National Health Insurance Scheme) |
| S&L | Support & Learning |
| SDG | Sustainable Development Goal |
| SHG | Self Help Group |
| SMART | Specific, Measurable, Achievable, Relevant, Time-bound |
| SSDC | Sundarban Social Development Centre (NGO Partner) |
| SWOT | Strength Weakness Opportunity Threat |
| S24P | South 24 Parganas |

| | |
|---|---|
| TB | Tuberculosis |
| TBA | Traditional Birth Attendant |
| TOC | Theory of Change |
| UCL | Universite Catholique de Louvain |
| UHC | Universal Health Coverage |
| UN | United Nations |
| UNICEF | United Nations Children's Fund |
| USD | United States Dollar |
| USSR | United States of Soviet Russia |
| VDC | Village Development Committee |
| VHAS | Voluntary Health Association of Sikkim (NGO Partner) |
| VHC | Village Health Committee |
| VHSC | Village Health & Sanitation Committee |
| VHSNC | Village Health, Sanitation & Nutrition Committee |
| WASH | Water and Sanitation Health |
| WBVHA | West Bengal Voluntary Health Association |
| WHO | World Health Organisation |
| WSF | Worlds Social Forum |

I DON'T LIKE BOOKS
IT'S ABOUT ME!
AND THAT...
HMM...
WHAT'S THAT BOOK ABOUT?
IT'S ABOUT ME...
AND ME
AND ME!
IT'S ABOUT ME
AND THE BOAT
AND THE WAVES
IT'S ABOUT US!
IT' ABOUT US!
WE ARE IN THE WRONG BOOK!

# Acknowledgements

*"I think that so many of our abilities to do things depend on interaction with each other." (Amartya Sen)*

West Bengal Voluntary Health Association (WBVHA) and Memisa Belgium initiated the Basic Health Care Support Programme (BHCSP) in 2002. They would not have known at the time, but together they planted the seeds of a movement that would influence many. Karel Gyselinck, Medical Advisor of Memisa at the time, who had started working with WBVHA years before, played a significant role in the evolution of the programme. As did Aloysius James, who provided regular coaching to the whole process since 2002. Even though he is a very busy man, he always finds time for the BHCSP!

One must meet the WBVHA team and go to the villages to meet the different partner organisations, to get to know and understand the programme. Unlike most of the healthcare projects that are set up to organise and manage healthcare facilities, one wonders at first what exactly it is that the BHCSP aims to do. The women in the villages organising small funds for emergency transport; the adolescent girls and boys speaking out against child marriage; women reflecting together on the dangers of alcoholism; the PRI institutions trying to be relevant to the larger health needs of the community. All these people have little means but a lot of spirit. That's how you discover another dimension of healthcare: through the people, their reality, worries and passions.

Today we are delighted to bring you these twin books, an Image Book and a Story Book, documenting in an original, collective and thorough way the amazing voyage of a large number of people.

All of this would not have been possible without the dedication and continuous enthusiasm of the WBVHA coordination team: Biswanath Basu, Ketaki Das and Sandip Bagchi. They not only wrote several chapters of the book, but were the first source of information for every detail, every anecdote, every forgotten memory, having been there all along the way and guiding the programme from the beginning. Thank you!

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Elies Van Belle
General Director, Memisa

D. P. Poddar
Executive Director, WBVHA

# Preface
# Invitation to a Journey of Hope

*"If you think you are too small to make a difference, try sleeping with a mosquito."*
*(Dalai Lama)*

## About caves and sailing in the deep dark troubled waters far below the surface

"*The reality we perceive is fake. It's only the shadow of the real one.*" Plato (3), the ancient Greek philosopher, said this nearly 2500 years ago. In his allegory of the cave, he draws from the experiences of people who live inside a cave and facing the wall opposite an open fire only see dancing shadows that represent the world outside. All of us live in caves of our own, and we create images of 'reality' from the shadows that we see on the walls of our own limited lives. Nations, institutions, organisations, companies, all live in their own world of shadows. And sometimes, well-intentioned, visionary plans expressing their ambitions end up in failure. The shadows may have clouded their vision and affected the means (strategies, plans and activities) for achieving these lofty objectives. In practice, therefore, these means are rarely adapted to the complexity of the real world. The pathways to get out of the cave and into the light are seldom obvious.

We create images of 'reality' from the shadows that we see on the walls of our own limited lives

Like many other countries the Indian health system has its own shadows: the National Health Mission (NHM), health schemes, state policies, vision and mission statements of NGOs, project-related theories of change and log-frames, just to name a few. All claim that they know the reality. Especially the realities of people living in remote, rural areas. These plans assume to know their (health) needs and the way forward, guided by the 'leave no one behind' premise. However, to what extent do these projections really reflect people's realities? Dysfunctionalities within the Indian health system indicate that we're still in the cave. The hidden power dynamics within the system prevent finding a consensus on the pathways towards the light.

This book tells the remarkable story of the Basic Health Care Support Programme (BHCSP), a programme intended to improve the health and well-being of people living in the villages of West Bengal and Sikkim, two states (provinces) in eastern India.

This story is remarkable on many counts! It is the story of a journey out of the cave where the pathways were not obvious. Those of us familiar with international development, have seen how the development process is punctuated time and time again by changes in the global development agenda. This agenda is continuously translated into new themes, projects, and funding priorities. And yet another cohort of development experts inspired by their visions of shadows and images, draw up new guidelines reflecting their vision and considerations. In practice, these rapid changes in the development agenda result in short time horizons, time bound projects, and unachieved goals and targets and repeated planning cycles. The shadows trap us all in the cave again and again.

Our story is different. Though the BHCSP had many cycles of planning and execution over 20 years, continuity was there and many of the actors have stayed the same. This time frame allowed the programme to take root in the community. The communities have been both the drivers and the beneficiaries of change. They

have been supported throughout this process by non-government actors, government functionaries, and international aid organisations. The planning has been bottom-up, the process has been dynamic, and iterative, and the change has been emergent and transformative. How have the lives of people been affected through this programme? How were the minds of the stakeholders changed along the way? How did partners of different districts and continents mutually enrich each other, leading to growing trust, respect and even friendship? What will the future bring?

The journey starts in the year 2002 in the mangrove forests of Sundarbans, where the mighty rivers Ganga and Brahmaputra empty into the Bay of Bengal, creating the largest delta in the world which is spread over the two countries of Bangladesh and India. The people here live literally on the edge between land and sea. When the programme started, the area was relatively inaccessible and mobile phone connectivity was a distant future. Public services were poor and the relations between different actors were unequal. And people's lives were framed by myths and traditions. Today, road infrastructure and mobile phone information technology has brought the world much closer, people have gained confidence and are increasingly directing their own lives with the support of accountable public systems. This is the story of a public health programme which has benefitted children, adolescents, women, families and older people and has been able to increase maternal health and immunisation coverage. But it is also the story of increasing self-reliance of women's groups, and of lower caste communities participating in governance platforms with their heads held high. It's also the story of how community aspirations were able to grow and materialise through indigenous means, and were scaled up as the programme spread to over a hundred Panchayats in 28 blocks in 5 districts over two states, from the delta of the Sundarbans to the high Himalayas in Sikkim and Darjeeling. It's the story of respectful facilitation, of mindful support, of processes which provide

communities the confidence to assume leadership and take charge of the changes they want in their own lives.

Why should you read this story? Because finally it's about you too. It's about the deeper quest of every human being and every community on this planet to find the essence of things, to see reality as it is and not only its shadows. This book tells the story of this journey of emancipation. About how we muddled through, how we at least tried to sail from small, safe bays towards the wild open sea upon waves we did not always master. Or should we say 'sail below the waves' since most of the time we sailed in the deep dark troubled waters far below the surface? We didn't sail following a straight pre-planned route but meandered, guided by our compass, by wind and stars, and by opportunities and obstacles. We are still underway towards our final destination. The journey so far has been fascinating. This book invites you – practitioners in the field of public health and social sciences, as well as teachers and researchers interested in qualitative methods and action-oriented research – to jump on board and sail with us. Your boarding pass won't show the destination but we're happy to share our compass with you.

We didn't sail following a straight pre-planned route but meandered, guided by our compass

## About complexity-fit compasses

The BHCSP aims at enhancing people's capabilities to guide their development. It aims at enabling people to claim their right to health, to take decisions to live a healthy life, and to have equitable access to quality, people-centred health services focused on their needs. Sustainable change implies a change of behaviour of people, as individuals, or as part of a community, an organisation, an institution or a system. Mind-shifts resulting in change of behaviour and practices are complex processes as

will be illustrated in this book. Moreover, they take place in a complex context. This complexity is not a choice but a reality. And most of this reality is below the surface. This book is a lot about learning how to deal with complexity in practice and moving towards sustainable results. To sail in the deep, dark, troubled waters far below a surface we need an extraordinary compass because the rules are different down there. Magnetism is replaced by a force with four key variables that are absolutely critical to move beyond our shadows. They are, in the order of importance: 'people, people, people, people.' (2)

Four key variables absolutely critical to move beyond our shadows are, in the order of importance: 'people, people, people, people.'

This force, if taken seriously, cannot but lead to a different view on the Indian health system to reduce dysfunctionalities. Gradually, the BHCSP actors have become aware of four crucial principles when people's reality is put at the centre: being comprehensive (holistic), strengthening decision making by people and local stakeholders, linking up actors and adopting a learning mode. They have become part of the programme compass explicitly, not at the start of the journey but in the course of sailing.

Looking together at people's health with a comprehensive lens – a first principle of our compass – we realised that supporting the government in implementing health schemes was good but not good enough. People wanted to see their health concerns and claims properly addressed, and contextual factors impacting their health considered. Bit by bit, and with many obstacles on the way, it led to a mindshift in the way local services (health or other) should be provided. This book tells stories of small changes, particularly of first line health services starting to adapt to people's needs instead of the other way around. The needs of the health professionals themselves, especially those working in remote rural areas, got attention as well, as happy health providers are a precondition for quality services.

Health services adapting to users, people expressing concerns, communities taking initiatives to influence their social environment, do not happen automatically. Such things happen as a consequence of much effort and time. This programme provided space to reinforce local decision making by people and grassroot workers – a second principle of our compass. Even before the National Health Mission was implemented, people started to organise themselves and influence the health agenda, as members of self-help groups (SHGs) or Village Health Committees or in their Panchayats. For a long time, the initiatives were at the local level close to people's own comfort zones ('the safety of the bay'). But gradually their confidence grew. Many people started to share their experiences, inspiring SHGs in Panchayats and blocks beyond the programme area. And people and grassroot NGOs dared to move further away ('sailing out of the bay') and reach out to block and district authorities to share learnings, raise issues and influence decisions, with varying success.

Linking up actors – a third principle of our compass – has been an important driver throughout the programme. The assumption was that a strong local health system creates a better environment responding to people's needs. This programme explored new forms of multi-stakeholder governance. The metaphor of seven blind men touching an elephant (explained in Chapter 5) tells us that only collaboration can lead to a shared comprehensive understanding of reality and avoid reductionist thinking. It sounds so evident, but in practice the initial mindset of many grassroot NGOs involved in the programme was focused on service delivery at micro-level within their sphere of control, and fearful to go beyond their comfort zone engaging in dialogue and advocacy with decision makers at various levels. We had to build trust: between the NGOs and the public and private health providers, as well as the local decision makers at Panchayat, block, and district level. Instead of sterile criticism we started a hands-on collaboration with local public authorities in the

implementation of the NHM schemes, and that created the space and trust to later discuss the gaps in the system and talk of health rights. But trust needed to be built between the NGOs as well. At the core of the programme was the creation of NGO Health Forums in 5 districts and 28 blocks (subdistricts). The aim was that these Forums would evolve into a movement of people. We're not there yet but at least the NGOs in the programme learnt to work more effectively as a network.

This shift in thinking facilitated a different way of working. Horizontally, self-help groups engaged in peer-to-peer education to form new groups; multiple grassroot actors built a Panchayat health development plan together. And vertically, the health system worked on removing geographical, financial, and institutional barriers for people to access healthcare from primary up to tertiary level. A major challenge for the grassroot actors lay in implementing health schemes and providing constructive feedback to decision makers closer to the policy level, thus, linking realities of local people with state, national and international processes such as Universal Health Coverage. This 'double anchorage' is essential and was explicitly encouraged by the BHCSP: sustainable change cannot emerge from working only at the grassroots, or only at policy level. It is achieved by connecting both levels and engaging in a continuous learning cycle. Development is learning in progress (1).

This brings us to the fourth principle of the compass: learning by doing. Reality is complex which entails a lot of uncertainty. This may sound frightening or even paralysing. But we're in that reality every day. It's like parents building their family: regularly taking decisions with uncertain outcomes but drawing lessons from them for future decision making. This programme evolved in the same organic way through systematic learning with local actors jointly, regularly, and explicitly reflecting on experiences, successes and failures and context. It made us more conscious about our own shadows. All this led to becoming more confident to share documented

experiences and findings with other people through peer-to-peer learning and with decision makers. This process didn't require too many theories or prescriptive log-frames in advance, but involved taking time to make sense of reality, with Theories and Pathways of Change emerging along the journey. There was also a process of adjusting continuously, not with the certainty that we'll reach our destination, but with the humility and wisdom that was the only way forward.

An organic approach, involving heart and brain, guided by evidence and experience, inevitably demonstrates the limits of a classical project cycle management and its standard toolbox, which may lead to a certain degree of 'schizophrenic' behaviour turning people into project managers rather than human beings searching their way out of the cave. The programme adapted itself continuously: stories, pictures, Mind-shifts, Action-research, evolving Theories of Change and many other approaches and tools were introduced at the appropriate time according to evolving needs, insights, and dynamics. But there was always a focus on learning. It inspired the design of other WBVHA programmes. As the next paragraphs will show, writing and designing this book followed the same spirit: interweaving heart and brain and stimulating continuous, joint learning, because many questions remain unanswered. These unanswered questions too are a result of our work and stimulate further action and reflection.

This book is like an ancient Flemish wall-tapestry, composed of many threads woven by many people over a long time. 'Text' and 'textile' are both derived from the Latin verb 'texere' to 'weave'

## About woven texts and textiles

Writing this book has been an exciting as well as a challenging and complex task. It has been driven by the desire of many of us involved in this process to write down our experiences, thoughts and feelings; and to share our excitement and learning

for you to get inspired, learn and possibly apply the lessons in your work. To present the excitement, the processes, and the lessons in the form of a book has been an intense mental process. This book has been written by several people, each of them giving a specific, yet comprehensive representation of what is the essence of the Basic Health Care Support Programme. For some of us, who are Belgian, and represent the international development support aspect of this collaboration the entire programme as well as this book is like an ancient Flemish wall-tapestry, composed of many threads woven by many people over a long time. Etymologically, the words 'text' and 'textile' are related as both are derived from the Latin verb 'texere' which means 'to weave '. For each writer, the picture represented in their mental tapestry is a bit different although all are telling the same story. The book needs to be explicit about these mental processes so that the reader not only gets the overall picture but also the overall story and craftsmanship behind it. So, each writer has unravelled the cluster of threads of the tapestry in his or her mind. But by deconstructing our representations, emerging from mind and heart, and then recomposing it, each one got a new picture which is a bit different from the one they had, hopefully sharper but certainly altered. By engaging in a co-writing process and interweaving the threads of all the minds and hearts, a new product, a new picture, and a much richer wall-tapestry appears. The creative process allows us to view the picture from a fresh perspective, seeing things one never saw before.

By interweaving the threads of all the minds and hearts, a much richer wall-tapestry appears

This book wants to tell the – yet unfinished – story of the BHCSP. This long journey engages and transforms both mind and heart. Challenges and behavioural changes emerge at different levels and evolve over time. A richer story emerges and enables us to better understand its underlying dynamics and mechanisms. Inevitably, several narratives need to be interwoven. "*The heart has its reasons which reason knows not,*" said the philosopher Blaise Pascal. The book will therefore present evidence using

Written language is an imperfect translation of one's representations

both stories and measurable data of the last 20 years. Both are complementary to share the lessons learnt and inspire other experiences.

Written language has its limits. It is an imperfect translation of one's representations. We acknowledge this limitation. At the same time, however, we reach out to you, the reader, to complement the contents of the book with your own feelings and reflections emerging from the reading. The 'unfinished content' is also a metaphor for the design and spirit of the programme. There was no fixed design at the start. Through an iterative process of learning, the design, and the decisions to be made emerged, guiding a process of incremental change. This process is still ongoing and will hopefully continue in the future, and you may become part of its story. Our dream is that this book acts as a vehicle to plant seeds elsewhere in India, or other parts of the world. We hope the story of BHCSP may inspire people far beyond the shores of the river Ganges or the slopes of the Himalayas.

The format of the book provides an opportunity to become part of the story and help to co-design the BHCSP.

There is a constant need for pencilling and gumming

Firstly, the wide, generous margins allow you, the reader, to make notes and write down your thoughts and feelings. The BHCSP story is unfinished, it continuously needs to be nourished and refined, both by people involved directly and by external people. There is a constant need for pencilling and gumming in the margins.

Secondly, there are the blank pages at the end of the book. A space to lay down the book, listen to your mind and soul and write down what this book did to you and what messages you eventually would like to convey (wbvha1974@gmail.com). Please take time for this and engage in shaping the future BHCSP (ad)venture.

Finally, the book contains pictures, both photos and drawings. Even more, distinct from this book, a separate Image Book has been developed. Two books, like twins. The reader also becomes a spectator. Pictures and words together tell the

same story in a different way, like yin and yang each with its own appeal. This visual dimension played a very important role in the programme. A picture or drawing may say more than a thousand words. That's why you will find in each chapter of the Story Book cross-references to the numbered Rich pictures in the Image Book. They are marked as '[IB #]'. The Rich pictures, a visual, participatory tool used in complex systems research seeking a deeper understanding of the situation by sharing multiple perspectives was introduced in 2013 during a participative external evaluation. For people and grassroot actors it became a powerful tool to express themselves in an organic, empowering way about the valuable 'doings and beings' – as Amartya Sen would say – they developed during this journey. Since then, drawings have been used throughout the programme by all stakeholders to share their thoughts. The programme's lead metaphor, the sailing boat, also emerged from this work. You too, can add your own picture(s) to the blank pages at the end of the book.

A picture or drawing may say more than a thousand words

Like a fine wine, this book would benefit from maturing in the barrel for some more time before bottling it. But we decided to bottle it now for good reasons. We are however mindful of the words of the ancient Japanese artist Hokusai: "*I have drawn things since I was six. All that I made before the age of 65 is not worth counting. At 73 I began to understand the true construction of animals, plants, trees, birds, fishes, and insects. At 90 I will enter into the secret of things. At 110, everything – every dot, every dash – will live*." Despite our personal limitations as a group of writers and the limitations of the printed word, we hope that you enjoy this Story Book and its twin sister, the Image Book, and can use them in your work.

## About the book's structure

Before you dive into the BHCSP story, let us give you a brief overview of the structure and content of the book, illustrated by the image at the end of the preface.

Chapter 1 tells stories about what this programme did to people. Chapter 2 provides the reader some valuable information regarding the local context situated within the dramatic geography of eastern India, composed of the Himalayas, mighty rivers, and deltas and finally the Bay of Bengal. Chapter 3 briefly describes the overall evolution of the programme using the metaphor of the boat. Chapter 4 highlights the five guiding principles of the programme which serve as a compass to sail below the waves. Chapter 5 reflects the way the actors have been managing complexity, searching a way out of the cave using an 'action-reflection' approach, and the gradual emergence of principles, models, programme theories and practices of change. Chapter 6 talks about the change in power-relations between the local communities and the actors of the local health system in the BHCSP.

The next three chapters focus on some achievements of the programme – the fish we caught – along with a critical reflection on them. Chapter 7 goes deeper into the diversity in structure and functioning of the Health Forums. Chapter 8 talks about the contribution of Health Forums to local health governance functions based on a stronger partnership with local authorities and other actors within the local health system. Chapter 9 describes achievements ranging from increasing community confidence and autonomy to reducing the gaps in services.

Chapter 10 displays the methods, processes and tools which were used to manage consecutive complex programme cycles in an adaptive way. Chapter 11 is for those who like to stroll around on beaches, searching for some interesting stuff lying around. It's like an overflow system, sharing some more methods and tools

used in the programme. Chapter 12 puts the BHCSP in the larger Indian and global health context. Finally, Chapter 13 reflects on the BHCSP legacy and its capacity to cope with current and future systemic challenges. And on how to sustain the assets and learnings of the BHCSP by formulating questions to all stakeholders. The Story Book ends with some individual statements as well as an overview of the factual milestones of the programme and the list of NGO partners and supporting actors as well as some individual statements.

The narrative in this book is iterative. We often come back to the same things using a different lens, each time pulling a different string in the mind and heart of the reader. We believe this approach helps to widen and deepen the understanding of readers. It is based on twenty years of our experience in the BHCSP where the cyclic, iterative nature of our reflections and actions have proved adaptable in the complex context in which the programme is embedded.

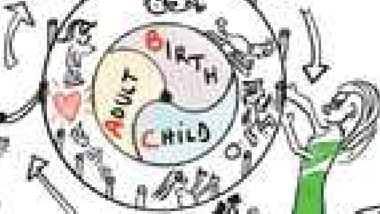
This book doesn't aspire to be a strict scientific publication. It aims at sharing stories about the what and the how of this programme, looking from different perspectives and unravelling the BHCSP tapestry in separate chapters. There is no concluding chapter at the end of the book. Instead, 'messages in a bottle' at the end of each chapter summarise important points. They try to answer – not one on one though – the questions listed at the beginning of each chapter, questions that you might have asked yourself when reading this book. Definitely a trick to hook you on.

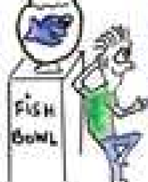
Welcome aboard and enjoy the voyage! And remember the words of Marcel Proust: "*The real voyage of discovery consists not in seeking new landscapes, but in having new eyes*." We hope your comments and reflections will give us new eyes too.

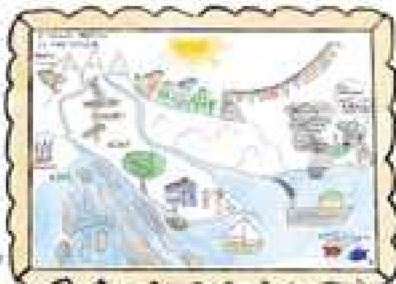
We hope your comments and reflections will give us new eyes too

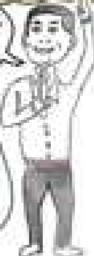
Karel Gyselinck

EXHIBITION : THE JOURNEY OF BHCSP
AUDIO GUIDE
STAY HERE!
IT ALL STARTS WITH THE LIFE CYCLE



CHAPT 1
THE LIFE CYCLE
BIRTH
CHILD
ADULT
YOU ARE HERE
I'M TIRED
CAN I TRY?
ME TOO!


CHAPT 2
IT'S MY COUSIN!
FISH BOWL

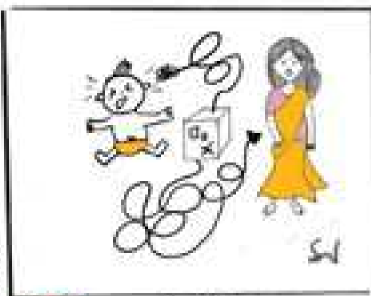




THIS PAINTING IS ABOUT PEOPLE & PLACES
WHAT IS THIS MEXICAN DOING THERE ??

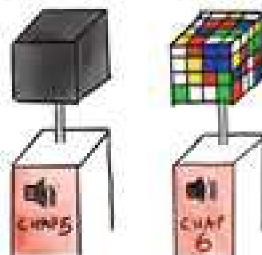
GUIDING PRINCIPLES

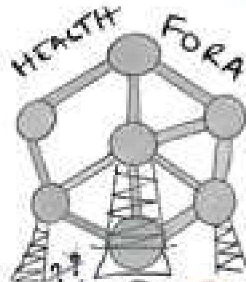
THIS COMPASS SHOWS MORE THAN N, S W & E!
CHAP 4
DOES IT SHOW THE TOILET?

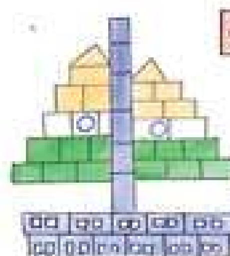
DURING THESE 20 YEARS, CHANGE WAS NOT A STRAIGHT LINE FOR BHCSP

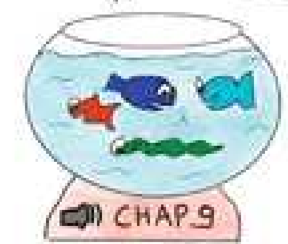


THE BHCSP MOVIE

I CAN DO THAT TOO!
SSSHHHTT!
ZZZ
CHAPT 3
SV.


BLACK BOX
POWERCUBE
CHAP 5
CHAP 6
THESE CUBES ARE RADICALLY DIFFERENT!
LIKE THE BLACK BOX!
THE COLOURED ONE HAS MORE POWER!


HEALTH FORA
IT REMINDS ME SOMETHING
DON'T DEPEND OFF MAMMA, YOU NEVER LEFT THE VILLAGE!
CHAP 7
THIS PIECE OF ART REPRESENTS THE HEALTH FORA


CHAP 8
THIS LOOKS FAMILIAR
I DOUBT IT IS FLOATING


THIS IS NOT MY COMFORT ZONE!
CHAP 9

TUUUUT!
CHAP 12
DOES THE AUDIOGUIDE EXPLAIN THE ABBREVIATIONS?
(INTER)NATIONAL PUBLIC HEALTH POLICIES
LOCAL BOAT
LOCAL ACTION

CHAP 13
THE 4 WAVES - FUTURE
MATRI MUSEUM SHOP
DON'T LEAVE WITHOUT A VISIT! LOTS OF RICH PICTURES!!

ACTION-RESEARCH
CHAP 11

CONFERENCE ON COMPLEXITY
EVERY 30 MIN
IF YOU THINK YOU'RE TOO SMALL TO MAKE A DIFFERENCE, LOOK AT THAT MOSQUITO!!
• METHODS TO MANAGE COMPLEXITY
• SYSTEM THINKING
• DOING DEVELOPMENT DIFFERENTLY
COMPLEXITY IS COMPLEX...
LET'S GO TO CHAP 11!
CHAP 10
WHERE IS MY CHAP(TER)?
SV.

# Chapter 1

«You can't really change the heart without telling a story.»

MARTHA C. NUSSBAUM

# People, journeys and destinations

Stories of change

Biswanath Basu
Ketaki Das
Sandip Bagchi
Abhijit Das

## ¿uestions

- ¿ What has been the path of the development of the Basic Health Care Support Programme (BHCSP)?
- ¿ How can the development community make the global development goals relevant for local communities, and vice-versa?
- ¿ Who owns the development process as it usually unfolds from the international arena through countries and governments, and eventually into local (marginalised) communities?
- ¿ And what about your questions?

Most journeys begin with a purpose and the idea of a destination. The world today is connected with information superhighways, and the best planning exercises are meant to reduce margins of error and we abhor uncertainties. But it was not always so. Earlier, journeys began with a mental picture of the destination, an imagination [IB5] built in part through snatches of information gleaned from books, pictures, conversations, and another part that represented the traveller's own aspirations and needs.

The journey of the BHCSP began in a similar fashion twenty years ago in 2002.

## Way back in 2002

The seeds for the BHCSP were sowed in the city of Kolkata in West Bengal, India in 2002, when a group of Community Based Organisations (CBOs) working in the district of South 24 Parganas met with the team at West Bengal Voluntary Health Association. It was a time of some churning in the global development scenario. The 1990s had been setting a new agenda for development through a series of international conferences notable among which were the Rio Conference (1992), Vienna Conference (1993), Cairo Conference (1994) and Beijing Conference (1995). Non-Government Organisations had started playing an important role in setting this agenda and highlighting the role of the 'state' in serving the needs of 'citizens' within the newly emerging rights-based approach. The 'Health for All by 2000' call for health which had been issued by the WHO in 1978, had not been met. However, General Comment 14 on the Right to the Highest Attainable Standard of Health, Article 12 of the International Convention of Economic Social and Cultural Rights (ICESCR) was adopted by the United Nations in 2000, giving directions as to how health as a human right could be achieved in practical terms. The People's Health

Assembly in 2001 in Dhaka had reinvigorated civil society to continue their quest for health rights for all.

Tremors of these global shifts had reached the small remote villages set among the silt and mangrove forests of Sundarbans in India. This region is not physically far from the erstwhile colonial capital city of Kolkata, but it is inaccessible. With its dense network of silt laden distributaries and shifting mudbanks it is part of the largest delta in the world with dense forests famous as the abode of the Royal Bengal Tiger. The region comprises many small islands with hardly any modern facilities like electricity and roads and access is often only by boats. The area is close to the Bay of Bengal and agriculture is difficult because of the high salinity of the rivers and the underground water. Access to potable water is also a huge challenge owing to the high salinity of the underground water.

In 2002 the region was struggling with dire poverty. A third of all households were living below the poverty line or on less than one Euro per head per day. Nearly two third of the population of the Sundarbans are Dalits and Muslims. It is not surprising that availability to and access to public services like health care were poor. Therefore, when compared to the other districts of West Bengal health indicators were also the worst in the Sundarbans region, which is in the district of South 24 Parganas. For instance, the infant mortality rate in the South 24 Parganas district was 51/1000 population which was the highest when compared to the other districts of West Bengal (Development and Planning Department, Government of West Bengal, 2004). The local self-government institutions were also not well developed in the Sundarbans region compared to other parts of West Bengal and this affected the effective implementation of programmes in this region.

With the limited infrastructure and resources provided by the state, many CBOs provided essential services including health care services to the people living in this

remote region. International development organisations provided grants enabling these organisations to run clinics and provide essential care like safe motherhood and child services. Other city based non-profit organisations provided training and other techno-managerial support to these organisations enabling them to provide these services with competence.

This world of small clinics and decentralised services through CBOs in the remote villages of the Sundarbans came to a sudden halt because of the global shifts described earlier. International development as well as bi-lateral and multi-lateral organisations reorganised their expectations and the conditions through which they would continue providing grants in the future. In the health care sector 'service delivery' through non-profit clinics was now seen as running a parallel mechanism and was letting the state 'off the hook' from its roles and responsibilities. CBOs in Sundarbans suddenly found that their funding had dried up, the work that they had been doing for years, providing useful and essential services to the poor was no longer relevant in the new development paradigm.

CBOs working in different villages of South 24 Parganas had a tradition of meeting from time to share their experiences. All of them were faced with the same problem. At one of their meetings, Amritalal Parui, the Secretary of Ashurali Gramonnayan Parishad, suggested that they should go together as a group and discuss this problem with colleagues at the West Bengal Voluntary Health Association (WBVHA) in Kolkata. Maybe they could suggest a way forward. WBVHA was then involved in providing training and other kinds of support to such CBOs and assisted international donor organisations to identify and screen CBOs for potential funding support. The team at WBVHA, including Dipti Prakash Poddar and Biswanath Basu, who were familiar with the changes taking place in the development world realised that to secure funds these organisations would need to reorganise the way they worked.

WBVHA was already working with Memisa of Belgium. Poddar and Basu felt that Memisa would recognise the difficulty that was being faced by these CBOs. During the next annual visit by the Memisa team to Kolkata they arranged for a meeting between the Memisa team and these CBOs. In the winter of 2003, the providential meeting between the CBOs of Sundarbans, Memisa and WBVHA took place. The seeds of the BHCSP were sown. Many, like Gyselinck, James, Poddar and Basu, who were present that day continue to be associated with the process and are part of the team that has brought this book together. It is unfortunate that Amritalal Parui, one of the main inspirers of this process, died in 2020, but the journey continues.

## Imagining the change

Memisa Belgium was already involved in supporting small community-based efforts in the state of West Bengal in India and was familiar with the new funding predicaments faced by international donors and the downstream impact on the work that was being done by CBOs. There was a growing consensus that 'professional' skills were needed to supplement the good intentions of the community-based organisations. The role of intermediary organisations like WBVHA who could provide the necessary capacity building inputs was very important. Hence, Memisa, along with WBVHA, decided to provisionally support a programme development process which integrated the elements of the new approach that was being discussed globally.

The change imagined by the programme was to enable local communities claim their right to health, have equitable access to quality health services and take the responsibility to have healthy lives. Quality meant person-centred and comprehensive

services. This implied changes in the behaviours of individual persons as well as organisations and institutions and of the health system.

The initial hypothesis at the heart of the programme was to create a platform, called 'Health Forum'

To achieve this objective, the initial hypothesis at the heart of the programme was to create a platform, called 'Health Forum' [IB9,10,13]. This platform would be composed of CBOs linking with each other and then linking with other actors, for example, citizens, community groups, local authorities, private and public health providers and managers, non-health actors, researchers, and decision-makers. Together, these actors would make a joint contribution to changes in the health system.

This forum would allow all actors to have a common understanding of the real needs and service gaps at the grassroots, to learn from each other, to share responsibilities within the local health system, to effectively tap potential resources in the system, to engage in advocacy with decision-makers and policy-makers and to improve upward and downward accountability mechanisms.

But this was still some time in the future. The first iteration of the programme developed by the eight CBOs, who had come together, was a set of fragmented proposals on themes like health, education, and livelihood. The CBOs were still not able to identify the elements of integration, their approach was still fragmented and still very much in thematic 'silos', the bane of most development projects. Over a two year process the groups sat together to develop a more collective programme, building upon that same joint energy that had brought them together. Collaboration and joint endeavours with the community at the centre marked the central spirit of the new programme outlines [IB21].

It was serendipitous that while the BHCSP was being put together

It was serendipitous that while the outlines of BHCSP were being put together in Kolkata and several places in the Sundarbans, a similar health sector reform process was being envisioned in the National Capital, Delhi. The National Rural

Health Mission (NRHM) subsequently the National Health Mission, a quality focused 'architectural' overhaul of the public health system of the country was being designed through a partnership of policy makers, researchers, and civil society public health experts. Community engagement was one of the central pillars of this approach and subsequently this allowed the BHCSP to integrate with NRHM seamlessly.

The National Rural Health Mission (NRHM) was being designed

## Experiencing the change

Goragachha is a small village in South 24 Parganas in the state of West Bengal. As the crow flies, it is only about 50 kilometres from the bustling metropolis of Kolkata but this small village of about 250 families is in a totally different world. The people living in the village are mostly Muslim and in addition to agriculture, many people also work as tailors to earn money. While girls are married off early, young boys are apprenticed at an early age, and most don't attend school. It was only in 2017 that someone from the village completed high school. In terms of health indicators, it is one of the 85 most backward villages in the state. As a socially backward community, the people of Goragachha had many local beliefs and practices and did not feel any need for health services like immunisation, pregnancy related check-up and care that were promoted by the government.

As a part of the Global Polio Eradication Programme, an intensified Pulse Polio programme was being implemented in the state. There was a misconception among some communities that the polio drops would later render children infertile and there was a strong community resistance to this campaign. The Auxiliary Nurse Midwife (ANM), a frontline health worker of the government, was beaten up while immunising the children. Antenatal care was unknown and home birth with the

support of Traditional Birth Attendants (TBAS) was common. If necessary, women would call on the local untrained medical practitioners, commonly called RMPS or quacks.

Ashurali Gramonnayan Parishad (AGP) worked in the area where Goragaccha is located and partnered with the government to promote immunisation in this village. It was clear for the AGP team that the first task would be to build trust with the community. They started working on building a community collective and Self-Help Groups (SHG) were organised. Regular training programmes were held with this group. The community had many issues they wanted to share and resolve. Women faced domestic violence and abuse, men were often intoxicated, adolescent girls were harassed, and early marriage was also seen as a problem by many. As community members talked among themselves, shared their problems and sought collective solutions, trust increased. At first there was one SHG. The numbers swelled and soon there were eighteen SHGS in Ashurali.

Once some trust was established, senior health authorities came to talk to the SHGS and explained their purpose. Community members also shared their concern with them. The SHG members realised that the health care activities proposed by the government would benefit them. They started reaching out to the more reluctant community members. Immunisation and antenatal services started picking up in due course and families started opting for institutional delivery. Women who earlier would rarely visit any RMP even when they were ill became the engines of change. Today over 175 women through these 18 SHGS are the key players in preparing health plans for the entire village. This process of transformation has taken a decade.

175 women through these 18 SHGS are the key players in preparing health plans for the entire village of Goragachha

The story of Goragachcha is important on many counts. It is not just the story of change of health parameters like immunisation rates and institutional delivery but the change in many layers of social relationships. The global health goals like the

MDGs and SDGs talk about change in indicators but rarely acknowledge that the state of health systems and the way people perceive, and experience health services is embedded in various local realities. The idea of understanding 'context' is becoming important in present times. However, understanding context is not merely the adding of new variables and creating more disaggregated data tables or developing alternate statistical models. It requires understanding the socio-economic as well as cultural and political realities of peoples' lives. It requires understanding their belief systems, their immediate concerns, their current predicaments, as well as the bases of the relationships that people have among each other, with local leadership as well as with public functionaries. In India, this also includes caste, religion, and gender concerns, and in this part of West Bengal it included local hierarchies and affiliations with local political parties. These contextual factors determine how people respond to a particular situation and how different people respond differently in what may appear to be similar conditions.

The women of Goragachcha who appear to be the 'drivers' in many ways today, did not earlier have access to the male village doctor. These doctors have little in the way of formal training and have simply served as an apprentice with another such 'doctor', locally called quack or RMP. A male relative of the woman patient would give a description of the woman's symptoms to the RMP, and he would prescribe a treatment. The relationship between the men in the community and the health system functionaries was adversarial. There was a lack of trust between the Muslim community of the village and the health authorities. The health system was notionally interested in adolescent health, but early marriage was a matter for the police and law. There was no alignment of interest and relationships were fraught. To expect change in this situation without understanding this tangle of human actions, emotions, and relationships was futile. In such situations, it is imperative

to create bottom-up solutions. BHCSP in many ways provides some insight into how such a process can be inspired, initiated, and implemented.

The village of Uttar Chandannagar of Kakdwip Block is in the south and deep into the delta. Fishing is the main livelihood here along with some agriculture. The men go fishing in the deep sea while the women throw small nets along the banks of the river to catch small fish. Most adult men are out of the village much of the time. Some go fishing while others migrate to other places for work. Families are worried about their daughters. The 'safety' of unmarried daughters is a matter of great concern for families across India. If girls have a 'love affair' it becomes exceedingly difficult to arrange their marriage. And arranged marriages are still the norm in most places in India. Once a girl has married her 'safety'/ 'honour' becomes a matter of concern for her husband and his family. After marriage, girls or women also become extremely busy in the never-ending chores, in child rearing and in helping to make two ends meet. In Uttar Chandannagar there was great anxiety about unmarried daughters, and they would be married off at an early age. Since families were aware that marrying girls off below, they were eighteen and boys before they were twenty-one was illegal, these marriages took place in secret but in collusion with the authorities. Early marriage is a criminal offence in India, but society sympathises with the plight of the family with young unmarried daughters and so the local police, and administration, the Panchayat (local government authorities) looked the other way when such marriages were solemnised.

The story of 16-year-old son Shibu Gharami and 14-year-old Puja Mandal needs to be understood in the light of the social reality described above. Shibu and Puja were neighbours and had fallen in love. Love among teenagers is usually frowned upon and Shibu felt that the only way he could stay with his beloved would be through marriage. Marriage among teenagers is socially acceptable because marriage is seen as

'respectable'. Puja was still in school while Shibu had dropped out, and she wanted to continue her studies. Puja had lost her father and lived with her uncle. Puja's uncle came to know of Shibu's interest in marrying Puja and felt that this was an excellent opportunity to marry off his niece, and to rid himself and the family of a liability.

Indian Institute for Training and Development (IITD), a partner NGO in BHCSP was already working with the community in Uttar Chandannagar and had been organising community level groups, Puja was already a member of such a group for adolescent girls. Puja was uncomfortable with the pressure being brought upon her by Shibu and her uncle and shared her predicament with members of her group. Her peers in the group decided to act. They started discussing the matter with their families and with others including some Panchayat members, health workers, the adolescent counsellors and even the police. No one appeared to be too concerned and instead, told the girls not to interfere in these matters. At the same time, both Shibu and Puja's families started preparations for the marriage.

Seeing their efforts being wasted, the girls went to the IITD facilitators who worked with them. Together with the IITD facilitators they met with the police once again, but the police advised them to settle the matter in the village by discussions between the families of Shibu and Puja. It was then decided that the issue would be taken up at the Kakdwip Block Health Forum. The Forum decided to contact the District Child Protection Officer (DCPO) of South 24 Parganas. The DCPO directed the police to take urgent action and they dared not disobey this order. In a dramatic turn of events, the police went to the scene of the wedding and ordered that the marriage be stopped immediately, or the bride and groom's parents would be arrested.

The story of Puja provides an interesting story of local empowerment where adolescent girls, who are often considered the weakest in a community, showed remarkable courage and persistence after being ignored and fobbed off by adults

Adolescent girls showed remarkable courage

in the family and community, and the local authorities. The Block Health Forum facilitated by the BHCSP processes took up an issue which health workers otherwise ignore. It has been repeatedly emphasised that early marriage is not just a law-and-order issue but is intimately associated with the health and well-being of women. It is an important social determinant of health for the future generation as well. This story provides an interesting case study of the linkages which most health projects would ignore.

Changes in health indicators require more changes than simply better and more proactive health services. In places like rural West Bengal health care is affected by a multitude of factors and the Social Determinants of Health framework can provide a better insight into these. The two stories above illustrate how the BHCSP provided opportunities to explore the complex realities and social relationships within which health belief systems, healthcare, rule of law and administrative responses are embedded.

The BHCSP provided opportunities to explore the complex realities and social relationships

## Understanding the change

Another aspect of change that the BHCSP has been able to show over time relates to the dynamic nature of the change processes. Development practitioners all over the world are increasingly enamoured of the twin concepts of sustainability and scaling-up. They also want to ensure that lessons learnt from innovations and experiences should not be lost. Proven successful interventions can become templates for implementation elsewhere with minor adaptations. This has resulted in social scientists applying methodology developed for a specific context to far more complex social realities. Randomised control trials, p-values and modelling have become the

standard tools for the study of social interventions, and community-based insight drawn from years of keeping one's ears close to the ground and empathetic listening have been replaced by probability statistics.

Complex social processes are rarely 'predictable' in the strictly scientific manner. Michael Quinn Patton, one of the gurus of evaluation, compares these complex change processes to that of raising a child. Having raised one child successfully is no guarantee that the same child rearing processes repeated with the second child will give the same results. Variability is in-built into human relationships, actions and responses. One feature of such complex social processes includes emergence or evolution. Starting a facilitated change process within any social reality does not imply that the community within which the change was started was static or an empty slate to begin with. Similarly, while projects and interventions end, social processes continue. Sustainability does not imply that a steady 'desirable' state has been achieved forever. Even after the end-line evaluation is over and all the project inputs cease, the processes facilitated through the development intervention continue. They could decline, change direction, or even accelerate further in the desired direction, but rarely would they stay 'constant'.

While projects end, social processes continue

Another long-term feature of such social processes is diffusion or circulation of ideas, actions and processes. Society is rarely an airtight box: even in the most controlled experiment, the changes can be seen and felt and shared with those outside the intervention space. The reaction of the external world may be appreciative, indifferent or inimical. Empowering the poor to become more aware of their rights, making public services accountable, helping adolescent girls decide whether they want to get married, all imply changing existing social relationships. Not only do people who wield authority within the space of intervention resist such change, but neighbours can become worried too. So, the result of diffusion is not necessarily

The news of this collaborative project spread to other organisations in the adjoining districts

salutary. Projects with short time cycles, even those with the most promising statistical outcomes, can rarely predict the future of their life story.

The BHCSP has had a relatively long twenty-year journey and diffusion and scaling up have provided lessons and mixed results. Soon after the BHCSP had started working in South 24 Parganas, the news of this collaborative project spread to other organisations in the adjoining districts of North 24 Parganas and Howrah. Ashok Ghosh was a friend of many of these organisations and he, along with Dilip Pal of Bithari Disha, a CBO working in North 24 Parganas reached out to WBVHA to explore the possibility of joining this partnership. They were already working on health issues like TB care and were invited to the BHSCP Annual Meeting to present their case on behalf of the informal network of CBOs. In 2010, a network of NGOs from North 24 Parganas joined the BHCSP and were soon followed by those in Howrah. This group learned from the experiences of their neighbours in South 24 Parganas and many of the successes were replicated. It is important however to note that the community realities in these two districts were vastly different.

Even though the districts of South 24 Parganas, North 24 Parganas and Howrah border Kolkata on different sides, their characteristics are different. The district of South 24 Parganas extends from the southern edges of the metropolis into the delta region of the Sundarbans. Even though large tracts of the district are close to Kolkata, much of the land area is remote and far away from the city. The land is cut up into islands and strips by the numerous distributaries and channels of the river Hooghly as it empties itself into the Bay of Bengal creating the world's largest delta and the famous forests of the Sundarbans. The people living there are mostly farmers or fisherfolk. Nearly forty percent of the population lives below the poverty line and a similar proportion are either Dalit (legally called Scheduled Castes) or Muslim.

The district of Howrah lies to the west of Kolkata across the river Hooghly. When

Calcutta was the jewel in the crown of the British Empire, Howrah was its industrial twin city. Ranged on the River Hooghly were numerous mills and factories. It was once called the Sheffield of the East, but it has been in decline for many years now. It is a small densely populated district as it is predominantly urban and industrialised. Roads and railway tracks criss-cross the district and it connects Kolkata to the rest of the country on the west.

The district of North 24 Parganas also lies to the north and east of Kolkata sandwiched in the east between the River Hoogly and Bangladesh. Being close to Kolkata, it is dotted with many small municipal towns. It is one of the most populous districts of the country with a population of over 10 million. Close to sixty percent of the people live in designated urban areas. Though it has some industries, farming and fishing are the main occupation for many the people of the district.

Panitar is a small village of 40 families in the North 24 Parganas, outside the Sundarban delta but bordering Bangladesh and close to the Ghojadanga check-post. The village has both Hindu and Muslim families and most adults are farmers and fisherpersons with little or no literacy or formal education. As a border village it serves as a transit point for illegal movement of goods and people and is under strict surveillance of the Border Security Force (BSF). There were no schools, pre-school centres or health services when the BHCSP was initiated in this village. Providing any health care services including arranging of health camps was difficult and required the permission of the BSF. As a result, all children remained unimmunised and without supplementary nutritional support and women received no antenatal care services. Unlike the situation in Goragachcha, narrated earlier in this chapter, the villagers in Panitar were keen to receive health care services but were disappointed by the reluctance of the BSF to enable them. Together with BHCSP partner Panitar Palli Unnayan Samiti (PPUS), a local organisation, they raised this issue at

the meeting of the Health Forum and then petitioned the local government (Gram Panchayat). Thereafter, the community members, along with members of the Health Forum, went to the Block Development Officer (BDO) at the block office (Sub District unit of government) at Basirhat. The Health Forum already had some credibility with the authorities as they had collaborated with them during a recent dengue outbreak. The funds were sanctioned and with this government endorsement the community went back to the BSF for permission. Today the villagers of Panitar are immensely proud to have their own ICDS centre and healthcare outreach services are also provided there.

The BHCSP interventions were also started in the northern part of the state of West Bengal in Darjeeling District and in the neighbouring Himalayan state of Sikkim in 2008. The contexts here was very different. The people were different, community relationships were different, the state-citizen relationships and the political realities were different. It is not surprising that the results obtained too were different.

Darjeeling is a district in the state of West Bengal, but the majority ethnic group people living in Darjeeling district are not Bengalis. They identify themselves as Gorkha and speak Nepali. This ethnic division has been a source of political unrest over the last fifty years or more and led a violent movement for Gorkhaland in formation of an autonomous Darjeeling Gorkha Hill Council in 1988 which was subsequently converted to the Gorkhaland Territorial Administration and included within its ambit the administrative affairs of the hill districts of Darjeeling and Kalimpong.

Strikes have been part of the ethnic tensions and a strike which began on June 15 in 2017 lasted for 104 days. The hills of North Bengal were crippled under the strike. Everything in the hills from markets to schools, hospitals to communication services, business establishments to entertainment zones remained closed causing untold misery to the people. At this time the doctors working in the primary health centres

(most of whom came from other districts of West Bengal), felt unsafe and insecure as they were threatened by the other staff of the health centres. As a result of that, three doctors from Takdah Block Primary Health Centre crossed the mountains on foot in the dark of night and fled to the plains.

In such a situation, the health service of the hospital was completely disrupted. As such, healthcare in many places in Darjeeling was not up to the mark. There were problems like irregular supply of medicines, lack of adequate personnel and poor road communication. And now that the doctors had left, the hospital's service system had completely collapsed.

Through BHCSP, People's Forum in the district, both at GP and block level was always very strong and active. In normal times, its members always tried to establish good relations between the service providers and the recipients. For this, very often they had visited, discussed and exchanged views with the district level officials. The officers also respected them and hoped to get their cooperation in all their activities.

During the strike, the members of this forum worked hard to ensure proper access to public health services. It wasn't as if all members were against the strike, but they had a commitment to stand by people in need. They had repeated discussions with the rest of the hospital staff about the importance keeping the hospital running and they had also asked the Chief Medical Officer of Health in the district to send doctors to the hospital with an assurance that the forum would take care of their safety and security. The district health officer arranged for a doctor to visit Takdah daily till the situation normalised [IB18].

Sikkim shares a common border with Darjeeling but though they are similar in terms of geography, the society as well as the political traditions are different. Sikkim was an independent country till 1973 when it became a protectorate of India. In 1975 Sikkim became a separate state of Indian. The state – citizen relationships

in Sikkim and in Darjeeling have their own unique character deriving from the specific histories. In Sikkim, civil society action is of recent origin and there are far fewer CBOs. Most of the NGOs in Sikkim are headquartered close to the state capital and their role has been primarily to provide outreach support to state services [IB2]. It is not surprising that the aspirations of the BHCSP to provide a fuller articulation of rights awareness and citizen engagement through the facilitation of civil society organisations was not fully realised in Sikkim.

The BHCSP started implementation in 2008 in Sombari Block of West Sikkim District and continued till 2016. The forum concept was shared with the local partners of Sikkim. Here, the District Health Forum was initiated and led by Government functionaries like the Block Medical Officer of Health (BMOH), the Block Public Health Nurse (BPHN) and the Voluntary Health Association of Sikkim (VHAS). The local civil society partners were not registered under the Foreign Contribution (Regulation) Act of 2010 and so were not eligible to receive foreign funds. With no direct relationships with the communities in the district, having little financial autonomy and with few leadership roles within the District Health Forum, these organisations soon lost their interest in this process. The Sikkim programme had to be closed in 2016. This was an important lesson in rootedness and the organic nature of community driven processes. Good intentions and well-designed programmes, which are successful in one context, may not be appropriate for a different place.

Well-designed programmes, which are successful in one context, may not be appropriate for a different place

As development practitioners, we start with an aspiration to support and facilitate change processes in the lives of the less privileged. We have an imagination of this changed state through the experiences and realities of our own lives. At the international level we advocate for such changes to be incorporated into the everyday business of global development discourse and at the national level into public policy and budgets. We create maps and chart pathways to launch projects which are

the vehicles of our aspirations. But the realities tha t these projects must negotiate are very different from our own realities, even from the ones we can imagine. It is important to understand the complexity of social realities and the many challenges to achieving equity as we embark on these difficult but challenging and often exhilarating journeys through thoughtfully articulated 'theories of change'.

IN CHAPTER 1, PEOPLE COME TOGETHER & CHANGE
TV
VOTE FOR ME
OUR VILLAGE
OUR HEALTH
OUR SERVICE
OUR SOLUTIONS
WHERE IS MY BAND?
THIS IS NOT GOOD FOR US...

## Messages in a bottle

- Development programmes in every single context should remain attentive and responsive to the realities of people's lives.
- The 'development' process must be co-owned by all parties involved, and most importantly by the communities whose life it aims to improve.
- Civil society organisations act as a link and play a facilitative role for the communites to find their space to raise their voices and act.

# Chapter 2

> «As the water shapes itself to the vessel that contains it, so a wise man adapts himself to circumstances.»
>
> CONFUCIUS

# People and Places

Biswanath Basu
Ketaki Das
Sandip Bagchi
Abhijit Das

## Living in the Himalayas and the Ganges delta: challenging contexts

### ¿uestions

- How was the BHCSP implemented in a great variety of sometimes very distinct contexts?
- How and why did the BHCSP become relevant to the lives and complex realities of marginalised communities in different places? What did these communities gain?
- And what about your questions?

## Different worlds in the same state

The region historically known as Bengal is situated towards the eastern end of South Asia. It extends from the seas of Bay of Bengal in the south to the high Himalayas in the north. It has a rich and varied history. It is also remarkably diverse culturally and ethnically. To understand the Basic Health Care Support Programme, it is necessary to engage with this rich diversity.

Historians (1,4) have written that Bengal was the richest province of Mughal India. It was famous for its silk and muslin which were coveted all over the world. Murshidabad, the capital of the province, was famous for its textiles. It was only after the British defeated the Nawab of Bengal in 1757 that Calcutta, located further to the south on the river Hooghly and bordering the Sundarban forests emerged as the colonial capital. Calcutta became the second seat of the Empire under patronage of the British. In 1911 the capital was shifted to Delhi. The province was divided during the Partition of India which accompanied independence from the British in 1947. Calcutta became part of West Bengal in India, while the eastern part of Bengal became East Pakistan. Partition was accompanied by a large migration of Muslims from the western part of the province to East Pakistan and Hindus from the eastern part moved to West Bengal. In 1971, Bengali speaking people of Pakistan won their Liberation War and established Bangladesh. The international border is often a river or distributary of the river Hooghly separating the people on the two sides. This is particularly true in the delta of Sundarbans which was the place where the Basic Health Care Support Programme started in 2003.

As the colonial capital Kolkata (then called Calcutta by the British) assimilated British culture, received traders from across the world and became a cultural melting pot, it evolved not only as a city of commerce and industry but also became the

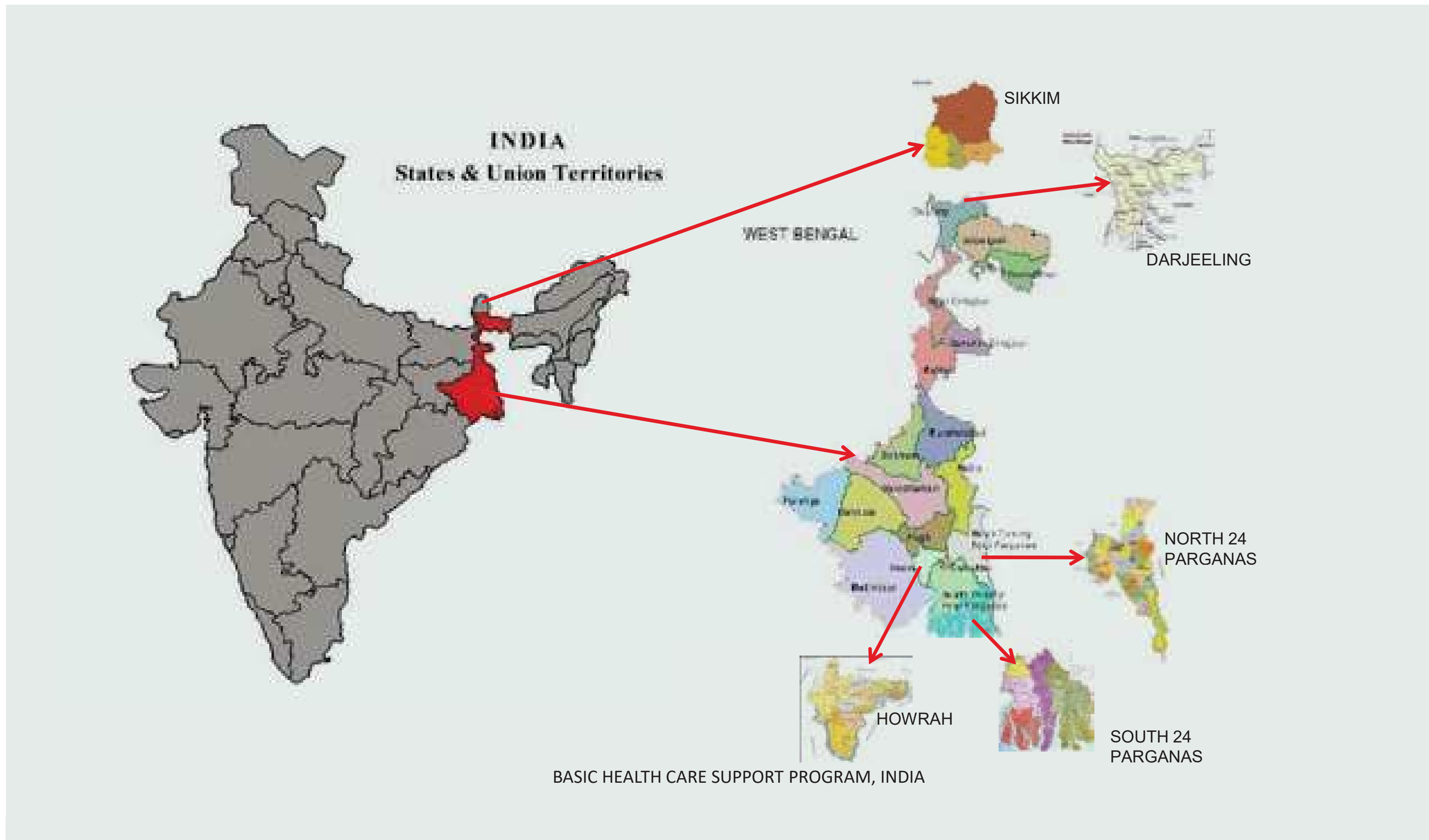



Figure 1. BHCSP implementation districts in West Bengal and Sikkim

epicentre of the Indian renaissance. Economic activity and high culture went hand in hand for many years. However, over the past few decades Kolkata has been in economic decline. There has been a rapid growth of urban slums. Overcrowding is common and civic amenities are poor. There were signs of extreme poverty with people living on pavements, or near the railway bridges and tracks, when the programme started.

As Kolkata grew as a major industrial and trading city during colonial times, many factories and mills were established on both sides of the river Hooghly a little upriver. These industries drew migrants from the nearby districts and other states of eastern India. The city spilled into the countryside and many small towns sprung up around Kolkata. Today, these areas are part of the districts of Howrah and North 24 Parganas, which are also part of the Basic Health Care Support Programme.

In 2008, five years after it has been started in South 24 Parganas, the Basic Health Care Support Programme extended to the hill regions of Darjeeling and Sikkim, both of which are nearly 500 kilometres from Kolkata. The history of Darjeeling, even though it is part of West Bengal, is vastly different from that of the other districts in which the programme had been implemented till then. In the early 19th century, the Darjeeling region was part of the kingdom of Sikkim. There were conflicts over the territory between the Gorkhas of Nepal and the Chogyal of Sikkim with the British acting as intermediaries. In 1866 the British annexed the region and included it within India. They found the climate very pleasant, and the town of Darjeeling was established as a major hill station and summer capital of the Bengal Presidency. The region was also important to the British for cultivating tea and tea estates were started all over the hills and the foothills. The tea estates required labourers who were brought in from Nepal and Sikkim. The ethnic identity of the people living in this region are asserted through the movement for Gorkhaland or an autonomous

hill state. The implementation of the BHCSP in this region has included negotiating better health care services within this ongoing political struggle.

These four different locations provide some idea of the diversity of the state of West Bengal. But there are other districts in the state that the BHCSP did not engage with.

When Sikkim became part of the BHCSP, the programme moved beyond the state of West Bengal. Sikkim and Darjeeling share many common characteristics but there are many differences as well. Sikkim was an independent Himalayan country till 1973 and became the 22nd state of the Indian Union in 1975. The original inhabitants of Sikkim were the Lepchas and other indigenous people, but over time, many Nepali speaking people and others from mainland India migrated to Sikkim. Bordering Tibet to the north, Sikkim has many Buddhist monasteries and a large Buddhist population. However, Hindus constitute the majority population and there is a small proportion of Christians as well.

## First interactions with the people and health systems

The Sundarbans region in West Bengal is one of the most challenging areas for human survival. There are many islands which are vulnerable to natural disasters and experience flooding every year. The region is mired in extreme poverty and has poor communication facilities with the mainland. The main occupations are agriculture and fishing. Cultivation depends on rain as the water available in these regions has high salinity. In order to prevent salt water entering the farmlands, high embankments have been raised around cultivable plots and people use these mud embankments as a means for local transportation and use the waterways to connect with the mainland.

The Sundarbans region in West Bengal is one of the most challenging areas for human survival

Distance and access take on a different meaning in the villages of South 24 Parganas

In the winter of 2003, WBVHA arranged for a meeting between the CBOs of Sundarbans and the Memisa team from Belgium, who were on their annual field visit to West Bengal. The Memisa team then visited South 24 Parganas, to get a firsthand understanding of the health situation of the people. The following is a recollection of that experience from a member of that team.

The district also includes the Sundarbans, the largest mangrove delta in the world. Access to most of those villages was limited. You needed to travel in a cycle van or walk kilometres by foot or use boats. Most of the children and women were malnourished and anaemic, due to limited livelihood options and limited access to food. The lives of pregnant mothers and newborn children could have been saved by simple preventable measures and providing basic health care services. Availability of piped or safe water and having pit toilets were a distant dream for most people. There was a high incidence of diseases among more impoverished and economically vulnerable populations. The socially marginalised groups like Dalits and Muslims were at higher risk. At the same time, many of these villages were always exposed to frequent cyclones and floods. But the resilience, hope and the strength of the people helps them move forward against all these adverse conditions.

The villages lacked necessary health facilities though many were said to be available on paper. A parallel system comprising traditional healers, indigenous practitioners, Dais (traditional midwives) and quacks (untrained and unlicensed practitioners) managed most of the health needs of the communities. People were forced to seek health care facilities from the distant district hospital or Kolkata during emergencies. During our initial visits to the communities and health institution, we recognised that the local community only had limited space and opportunities to interact with the health personnel. The official health system was mostly managed

by the experts, whereas the local people as well as community representatives remained as mere spectators.

The people living in the most remote villages and islands were also often those from lowest socio-economic strata. These communities, as well as women, children and those from socially marginalised communities, lacked appropriate information and services and did not have any say in how services could be provided to them.

Through our interactions with various health actors in the private and government realm, we realized that the health seekers were seen not only as patients but as 'problem' patients. They were provided with prescriptions and advice in a hurried and uncaring manner. No care was taken to understand their needs, preferences or even their reality. Besides, there was no recognition of the inherent wisdom and traditional knowledge available within the community which had helped these communities survive adversity for centuries. They were shown no respect and whatever self-esteem the people may have possessed was destroyed. At best, the focus was on treatment, ignoring health promotion or prevention of disease through a contextually relevant approach.

Health seekers were seen as 'problem' patients. No care was taken to understand their needs, preferences, their reality or even their reality and traditional knowledge

Swamps, open sewage disposal, lack of clean water contributed to unsanitary living conditions in rural areas and islands. The necessary facilities were missing in most of those villages. The absence of roads was a clear barrier to accessing services. Elderly people, along with women and children, as well as the socially and economically marginalised communities, did not receive health services when they needed them. The existing health services were inadequate and had bare minimum facilities for the motivated and committed middle-level workers working in isolation in far-flung villages. The health system was unable to address the health needs of the local community as it failed to recognise the interplay of the socio-economic

and political forces that determined the health of the people. The existing health system was both inappropriate and inequitable.

This region required a wiser and pragmatic approach rooted in the overall health of the public. In this approach, the people had to be participants and an equal decision-maker on matters related to their health and the health system [IB21]. The Basic Health Care Support Programme has envisioned filling this gap, to advance the health of the people and their wellbeing and to support the communities' journeys with enhanced health conditions.

Putting this resolve into practice required a different approach. In the past, when civil society organisations tried to integrate social change processes within health programming, these interventions often ended up challenging the government healthcare systems or providing alternative service delivery mechanisms. Many of these initiatives remained as piecemeal efforts. They were either isolated from the broader social issues affecting the wellbeing of the people, or isolated from the range of public services. Rarely was dialogue promoted between the community and the institutions which wielded power and had the resources. To do this, BHCSP needed to get a more nuanced understanding of the local context as well as facilitate leadership among community members and local institutions.

## Confronting complex realities

Public health or community health is often seen as being synonymous with the health of the poor

Public health or community health is often seen as being synonymous with the health of the poor. The poor cannot 'afford' health services which those with more resources can otherwise buy. The poor also live in less sanitary conditions and do not have access to safe drinking water and lack 'health education'. These are some of

the common assumptions in the field of public health, and some of the field realities would suggest that these could be true! A Social Determinants of Health approach would however suggest that the relationship between poverty and health is probably a little more complex.

The BHCSP was implemented in rural areas. Even though the locations were rural the first three areas in which it was implemented were all quite close to the city of Kolkata. But the similarity ended there. Distance and access take on a different meaning in the villages of South 24 Parganas , with most villages being situated between the embankments of the rivulets and distributaries that separate the region into countless islands. Communication is poor, transport facilities often mean irregular boat services which navigate these channels depending upon the tides. As mentioned earlier a large proportion of the population, nearly 40% are poor, and are Muslim or Dalit.

In a segregated society like India, it is important to understand the implications of such social differences. India is a secular and multi-religious society, but the socially dominant religion is Hinduism. During British colonial rule the province of Bengal, had roughly equal proportion of Hindus and Muslims. While poor Hindu and Muslim farmers have been living side by side in the villages of South 24 Parganas for generations, religion has become an organising identity in India over the years.

The Dalits, earlier considered the 'untouchable' castes, comprise nearly a fifth of the Indian population. Though equality is a constitutional value in India, the Hindu caste hierarchy continues to create many barriers for Dalit communities. In West Bengal, caste hierarchies are supposed to be more flexible but they exist. West Bengal is also considered a more egalitarian state with a left-wing political coalition, Left Front, having been in power for seven terms between 1977 and 2011, before being

voted out. Political rivalries intensified in the later years of the Left Front government and these were reflected at the community level.

The physical character of each district in which BHCSP was implemented is different. Both North 24 Parganas and Howrah are urbanised and industrialised districts. Howrah is a smaller district than North 24 Parganas, which also has an extremely high density of population. Out of the 22 administrative blocks in North 24 Parganas, 16 blocks have drinking water sources contaminated with hazardous arsenic levels. Further, the ponds in front of almost every house are fertile breeding spots for vectors that spread diseases. Howrah district is bounded by the Hooghly River and hence many villages in this district are more prone to flooding every year. Darjeeling is far away from these districts and in the extreme north of the state. It is nestled in the Himalayan foothills with steep slopes and loose topsoil, leading to frequent landslides during the monsoons and access to even basic healthcare services is quite challenging. West Sikkim is a district in the neighbouring state of Sikkim. It also has a hilly terrain which makes it difficult for people to access healthcare.

The unique geography and history of each area created different social dynamics in each place

The unique geography and history of each area created different social dynamics in each place and some of this has already been described. The relationship between people and public authorities and even between women and men in the community are mediated by these dynamics. In a programme which considered changes in these relationships to be at the heart of improving health outcomes of the most marginalised in society, understanding and navigating these relationships was of immense importance.

## Reconciling with local health system realities

Remote rural areas often lack health services and are referred to as under-served and unserved areas in public health parlance. However, in these areas too, people develop their own systems of healthcare. This healthcare system is based on a health belief system which emerges from their own experiences and interpretations of illness, survival, and death. Locally embedded providers support such systems with their traditional knowledge imbued over decades and even centuries. Some of these health traditions are based on herbal medicine; or even exorcism while others draw upon principles derived from Ayurveda, Siddha or Unani or Tibbi depending upon the region. In some cases, they also draw upon Homeopathy creating a pluralistic and complex health system at the local community level.

In the absence of formally trained healthcare providers, unqualified practitioners serve the health needs of the poor. In India such providers have many names like Informal Health Care Providers, Local Medical Practitioners, quacks, Alternative Medical Practitioners, Herbalists, Hakeem, Traditional Healer and Rural Medical Practitioners. They practice a wide range of systems of medicine including combinations of allopathy and indigenous systems of medicine. In West Bengal, these unqualified medical practitioners are often referred to as Rural Medical Practitioners (RMPs). These RMPs deliver a substantial proportion of healthcare to communities living in rural areas, as well as in urban slums. Despite their lack of formal training or qualifications they are very popular with people and do 'good business' in the absence of trained public and private sector health workers (2). In many places, people have no other choice but in other places these practitioners are popular because they are able to tap into people's preferences and local beliefs and practices, and

In the absence of formally trained healthcare providers, unqualified practitioners serve the health needs of the poor

people are able to relate to them and also get some measure of relief which is often considered treatment.

Studies have shown that around 8% of the Primary Health Centres (PHC) in India operate without doctors. Even where health professionals are appointed, high rates of absenteeism are evident. Several strategies such as additional financial incentives, task shifting to mid-level healthcare workers, introduction of community healthcare workers' programme have been attempted, yet the problem remains unresolved. There is a recognition that this has led to a proliferation of informal healthcare providers in the rural areas (3,5). However, little has been done to integrate them within the formal system.

RMPs are popular because they are both easily accessible and affordable, and able to tap into people's preferences and local beliefs and practices

When BHCSP was launched in Gosaba block of South 24 Parganas district, it was observed that the communities preferred the services of the RMPs. RMPs were both easily accessible and affordable. Considering this reality, Ramakrishna Loka Seva Kendra (RLSK), the NGO partner, decided to involve these RMPs within BHCSP.

They discussed the idea with the Block Medical Officer of Health (BMOH) of Gosaba block, who was concerned about the high proportion of home deliveries in this region. Together, they explored the idea of engaging with the RMPs to improve the MCH status of the population. The engagement started with training organised by the grassroot NGOs in partnership with the BMOH. There was an overwhelming response from the RMPs to such trainings. RMPs felt that such trainings would help them gain recognition from the government. The grassroot NGO partners made alliances with the block authorities for RMP sensitisation programmes. They also involved the RMP associations at the subdistrict level so that they could reach out to as many RMPs as possible.

This experience of training the RMPs by RLSK was shared with the other BHCSP NGO partners during the coaching workshops held as part of the programme.

Learning from the experience of RLSK, other NGO partners like AGP in Diamond Harbour II block and IITD in the Kakdwip block also started engaging with RMPs. Later, partners in North 24 Parganas and Howrah also involved the RMPs in their initiatives. More than 750 RMPs from the remote villages were trained by the BHCSP with active collaboration and involvement of local health officials. By recognising local health systems and practitioners who are part of the community the BHCSP was able to transform health relationships in favour of the poor and marginalised in profound ways.

As a result of this initiative the Block Medical Officer started meeting regularly with the RMPs and getting updates of the local health problems that the RMPs were coming across in their practice. The RMPs became involved in government health initiatives and in promoting government schemes. In one particular case the RMPs were involved in a dengue mitigation programme of the government. RMPs also started making referrals to public hospitals strengthening curative care.

More than 750 RMPs from the remote villages were trained by the BHCSP

## Negotiating local relationships with the community at the centre

It was possible for the health system to acknowledge RMPs because of a range of changes that were being ushered in through the National Rural Health Mission (NRHM) – later National Health Mission (NHM). NHM was integrating community engagement and involvement of local governance mechanisms through platforms like the Village Health and Sanitation Committees and the Rogi Kalyan Samitis (Patient Welfare Committees). These common platforms envisaged within the NHM framework allowed for the formation of the District Health Forums which emerged

as the fulcrum of BHCSP. The flexibility of the BHCSP to adapt to the context allowed a different pattern of coordination to emerge in the different districts and this is described later.

Located outside the formal political and governance structures, the District Health Forum allowed for the integration of key actors within the BHCSP. This required understanding the key players, building trust and then moving towards collaboration. The Panchayat or local self-governance system in West Bengal is intensely political and competitive. Local leaders are suspicious and yet, looking for possible allies at the same time. They wield or aim to wield a strong influence on public systems. The same is not true for Sikkim. In Darjeeling, the relationship between the community, the local self-government system and the public functionaries was further mediated through the demand for political autonomy or the Gorkhaland movement. The District Health Forum also allowed community members like women's groups, adolescent groups and others to directly access the public systems and functionaries. In order to facilitate these processes the BHCSP partners needed to be attuned to the local political realities.

The initial conversations that led to the formulation of BHCSP started with 16 Community Based Organisations (CBO) in 8 subdistrict (blocks) areas of South 24 Parganas. For various reasons not all could join the formal process and BHCSP started with 9 CBO partners in 8 places. Over time the partnership extended to 40 CBOs in 5 districts. A list of these organisations is provided at the end of the book. Later, academic partnerships developed with All India Institute of Hygiene and Public Health (AIIH&PH, Kolkata), Institute of Public Health (IPH, Bangalore) and the Institute of Tropical Medicine (ITM, Antwerp). The overall coordination of BHCSP remained under the stewardship of WBVHA and Memisa.

Collaborations, developed through strong local ownership, increased the effectiveness of National and State schemes because of flexibility and adaptation to the local context

Partnerships and collaborations were at the heart of the BHCSP. Collaborative relations were developed with various actors at multiple levels [IB4, 10, 12, 13]. Joint actions were undertaken at the village, subdistrict and district level with local government authorities or PRI bodies. These collaborations, developed through strong local ownership, made the implementation more flexible and adapted to the local context. In the final analysis, these actions increased the effectiveness of National and State level schemes and programmes and the influence they had on the lives of the most poor and marginalised.

This decentralised implementation of more national and state level programmes led to the development of a distinct Local Health System (LHS). This required the acknowledgement and distribution of roles and responsibilities between different local actors including community, public sector, as well as private health service providers at various levels. While many of these responsibilities are formally defined, they are not formally acknowledged or even operational. Local ownership by communities and by community-based organisations and relationships of trust developed through the BHCSP processes led towards distributed stewardship where all *health system* actors were held accountable for their actions.

Health system actors were held accountable for their actions

Basic health care services are meant for the people. BHCSP found that several gaps in reaching or accessing basic health care services occur mainly because of inadequate information about the availability of services and service providers, and ignorance about right to health. Here is a story about the people's initiative to ensure healthcare at the Gram Panchayat of Bhadura Haridaspur in subdistrict Sarisha, district South 24 Parganas, West Bengal, India. This initiative was facilitated by Ashurali Gramonnayan Parishad (AGP), a partner of BHCSP.

AGP organised awareness programmes at community level on various healthcare services and schemes. The ANM, BMOH and other health service providers were

People started writing all the problems on a chart paper and displayed it on walls at public places

invited to the awareness programmes with an idea to build understanding and relationships with service recipients. This helped the people to identify existing health services.

AGP also mobilised the community to form Neighbourhood Groups (NHG) for demand generation of health services. The NHGs met several times with the service providers but there was very low or no response. The NHGs wanted to bring a visibility of their demand and dialogue, and they started writing all the problems on a chart paper and displayed it on walls at public places like markets, schools, clubs or temples. Initially the displays were mostly about the non-availability of services and obviously this was not taken well by the service providers.

AGP then facilitated a mutual discussion between service providers and NHGs. The information board was mainly maintained by community members and it was mutually agreed that the service providers also used this as a tool for communication and information dissemination [IB3]. For example, if NHGs wrote about non-availability of immunisation, the ANM would write when it would be available. Later, other social service providers also saw this as an opportunity and began to use the board.

The information was no more limited to only health services but also included other issues like human trafficking, early marriage, alcoholism and domestic violence.

As a result, vaccination coverage increased, quality food supply from the ICDS centre was ensured, services were extended to remote areas (outreach camps) and the quality of information improved because community ownership had been established in dissemination of information.

Service providers also used the information boards as a tool for communication

The mechanisms and dynamics promoted by the BHCSP allowed local government officials and service providers to engage with people to jointly assess, prioritise and prepare action plans. This can be considered a successful model of governance

for health, developed through the involvement and cooperation of the community, working directly with the public systems and strengthening effectiveness as well as transparency and accountability. Community Forums [IB10] become the engines for innovation in the complex relations between government and society and a key player in the global goal of sustainable development.

Keeping the communities at the centre of these development interventions is a lesson that has been emphasised time and again. But how do communities understand such change processes? Do they relate to numbers, percentages, charts and graphs the way we do? New methodologies like 'Realist Evaluation', 'development evaluation', 'most significant change' are being honed for understanding the changes in ways that enable development practitioners and community members to learn together. Stories, metaphors and pictures are extremely important in developing this common and shared understanding. Along the course of our journey in the BHCSP, we discovered that the people of Sundarbans, living in a world surrounded by water, could easily identify with the metaphor of a voyage and a boat and the programme team found it helpful to use this metaphor to understand the evolution of this programme. We will share this metaphor with you in the following chapter.

The BHCSP allowed local government officials and service providers to engage with people to jointly assess, prioritise and prepare action plans

I THINK MEXICO
IS THE OTHER
WAY...
MEXICO
DARJEELING
SIKKIM
KOLKATA
N24P.
HOWRAH
S24P.
THIS
TYPHOON
LOOKS LIKE
A MEXICAN
HURRICANE!
HOW IS
LIFE?
SO SO...

## Messages in a bottle

- People's health related practices are influenced by factors such as local history, culture, geography, and availability and performance of health services.

- Change requires deep understanding of local context and relationships between the various actors at different levels.

- The purpose of change is to strengthen people's agency so that they gain greater control of their lives and solve their problems. Identifying local agents of change and building local leadership is key to community engagement.

# Chapter 3

«In development work, plan for sailboats, not trains.»

RACHEL KLEINFELD

# Sailing towards the open sea

Karel Gyselinck

Milestones along a journey of 20 years

## ¿uestions

- ¿ How did the different actors relate to the programme?
- ¿ Which conditions are important to allow a development support programme to reach its objectives and outcomes and lead to sustainable change?
- ¿ How was change achieved in people's lives at local level although such change depended on dynamics, decisions and doings in the wider context?
- ¿ What were the overall changes and how did they emerge?
- ¿ Can small community-based programmes aspire to lead policy level changes?
- ¿ And what about your questions?

## Looking at this journey using the boat metaphor

"A picture says more than a thousand words"

'A picture says more than a thousand words' is a common saying in English. The truth of this saying became apparent when the tool of 'Rich pictures' [see accompanying Image Book] was introduced to discuss the BHCSP with communities and other grassroot actors during the external evaluation in 2013. It was like discovering a new language. It allowed people to express themselves in a comfortable way and strengthened their voice. It allowed all the actors concerned to be explicit about their thoughts and ideas without immediately falling back on abstract theoretical frameworks.

The power of the picture was picked up immediately at all levels of the programme. It became part of our language. The boat metaphor was born in that momentum during the annual review workshop in 2013. Since the programme started in the remote island area south of Kolkata, in the Bay of Bengal, the boat was the obvious metaphor. Why? Well, it connected with the daily context of many of the actors involved. It also reflected the underlying dynamics of this programme: sailing is full of uncertainty, never following a straight pre-set route because you take into account the wind and so many other variables in the context. In a complex world, our voyage is mostly determined by what is below the surface, in the deep dark waters [IB28]. We embarked on a dramatic and hazardous journey, full of opportunities and obstacles, with plenty of choices to be made, with only a compass (with four key principles replacing the forces of magnetism) as a guide to constantly adapt our sailing route. We were on a craft, where jointly learning from experience was more helpful than knowledge from books. It was an adventure, where we were never sure of reaching the final destination, but where in the meantime, new landscapes and

In a complex world, our voyage is mostly determined by what is below the surface

horizons emerged. At the BHCSP conference in Kolkata in 2019 [IB22], additional pictures related to the boat metaphor were developed and most of them are displayed below to tell the story of the 20-year journey of the BHCSP.

In this chapter we do the process in reverse. Instead of replacing thousand words by a picture we use the pictures to tell the evolution of 20 years of BHCSP. After all, the purpose of writing a book is to share and boost our learning, and for that, we need to be explicit.

## Sailing within the comfort of the bay

The initial ambition back in 2004 had been high. Under the impulse of WBVHA, supported by Memisa, a programme was launched to go beyond a fragmented approach, which up to then was funding health-related micro-projects of separate NGO partners. The dream was to build one big, strong boat named the 'Health Forum', with one team, ready to sail out to the open sea to catch big fish to cover the basic health needs of the population.

Each NGO 'partner' was sailing in its own small boat

An attempt was made to work out an initial Theory of Change together. Common principles and entry points for action for the first group of 8 NGO partners in 5 blocks (subdistricts) were identified using a system analysis and mapping available public and private health services as well as service gaps related to reproductive health care in Gosaba Block in South 24 Parganas, as an example. But it proved to be too vast, too complex, too theoretical and far too public health focused. There was not yet a common vision nor a strategy nor the confidence to claim rights. Each NGO 'partner' was sailing in its own small boat, being opportunistic and interested in securing funds to cover certain health-related needs in their villages.

So, in a first phase, we moved from a ‘Theory of Change’ to ‘Practise a Change’, starting to build the pathways of change from the grassroots. The focus was on selected villages, close to the reality of the community groups and the grassroot NGOs. The main objective was to get the government health schemes, framed in 2005 within the National Rural Health Mission, to the people. This was a good starting point because people living in remote rural areas could not access the schemes easily. At that stage people mostly remained in their own boat, in their comfort zone, yet, in the safety of the bay [IB23], a modest mind-shift took place. The fourth Saturday meeting, at the Gram Panchayat (GP) was an opportunity to connect, discuss health needs within a wider context and to facilitate joint action. This meeting brought together various community groups like adolescent groups, self-help groups of women and later on of elderly people, grassroot NGOs, first line health providers, both government providers like the ASHAS, ANMS, and ICDS workers, as well as indigenous, traditional and private health care providers and GP representatives.

Locating health issues within a wider social context allowed integration of a social determinants approach and provided health issues a prominent place within the development agenda and planning by the Panchayat. The Village Health Committees became more dynamic through this collaboration, and it led to better coordination between local actors concerned with health. Sailing out together in the Panchayati Raj Institution (PRI) boat from time to time allowed them to ‘catch some fish’, that is, achieve some results that they could not reach alone previously. It was possible to build the capacities of the ‘sailors’ and lay a strong foundation for the programme by taking time to build relationships and going into a learning mode to jointly reflect regularly on valuable actions at the village and Panchayat level.

## Exploring the neighbouring islands

As the programme evolved, NGO partners of the District Health Forum in South 24 Parganas also caught some fish, meaning results were emerging. That did not pass unnoticed. Other boats that were passing by got inspired. Neighbouring community grou ps, village councils, NGOs, partners in blocks and districts got interested, docked close by and knocked at the door. One can remember the story of the NGOs from North 24 Parganas coming to a programme workshop in 2007, not asking for resources but eager to know how the partners in South 24 Parganas were organised and managed to catch more and bigger fish.

There was an increasing demand from outside

This increasing demand from 'outside' was a great test for the actors already involved for five years in the programme. In general, they had an open attitude. More than that, their confidence grew and so they started to move out of their comfort zone, going out of the bay to explore the islands nearby [IB25]. Community groups and NGOs connected with other community groups, other Panchayats, and later on other blocks of the other islands and proudly shared their experiences.

From this phase onwards, 'horizontal' joint learning, meaning peer-to-peer, increased exponentially. This rippling effect [IB8] was, to a large extent, an organic process. The neighbouring boats saw opportunities to sail better and catch more and bigger fish, that is, address bigger issues of their own. In a later phase, block and district officials, based on a relation of trust, grown from a hands-on support of the NGOs to bridge the implementation gap concerning government schemes reinforced this process by asking the partners of the Health Forums to conduct training in villages, Panchayats and blocks not covered by the programme, on issues where the programme had gained experience or had been innovative. We learnt that monitoring this ripple effect beyond the formal horizon of the programme is a

programme indicator. It illustrates the gradual Mind-shifts which were taking place in a variable degree amongst the Forum NGOs: they started to work in a more flexible, facilitating, person-centred and systemic way, linking up with other actors beyond their traditional, territorial, micro project mode. These Mind-shifts are nevertheless continuous working points and not final achievements. Behavioural change is, just like sailing, a non-linear process, with the cursor along the mind-shift line shifting back and forth.

By the end of 2008 the BHCSP supported Health Forums in 5 districts with more than 40 NGO partners who reached out to 28 blocks (subdistricts) and 111 Panchayats in West-Bengal and Sikkim. Even if the geography and context of the hill districts in Darjeeling and Sikkim are quite different from the Sundarbans area, the boat metaphor is useful here as well because it refers to a generic way of doing things in a complex and remote environment, rather than to specific activities, which are more context dependent.

## Building a bigger, seaworthy boat and fleet

Meanwhile, a balance had to be found between widening and deepening the perspective. A balance had to be found between sharing experiences with peer-actors beyond the programme and reinforcing the collaboration between the actors of the existing Health Forums at Panchayat, block and district level to ensure the quality of their work and build evidence for advocacy. These Forums needed to be reinforced continuously.

People gradually realised they could not stay in the bay or the islands forever. Cyclones and tsunamis are made far off-shore. In order to sustain the changes, they

needed to focus on the wider context and influence decisions at levels far beyond their comfort zone, beyond the safety of the bay and the BHCSP. They needed an anchorage at both operational and strategic level. However, horizontal scaling-up between peers is one thing, vertical scaling-up by engaging with policymakers and high-level decision-makers is quite another thing [IB8]. For that a big, strong boat [IB8] was needed to go to the open sea and to catch bigger fish, that is, tackling bigger issues and get more passengers on board. The District Health Forum was that big boat.

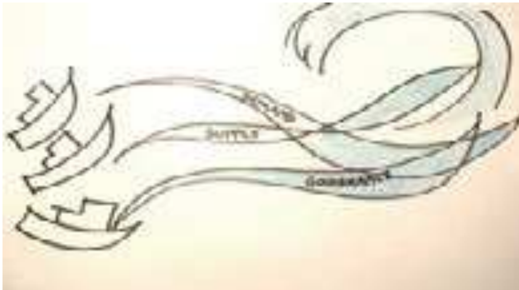
Each district developed its own design of a Health Forum according to its specific needs and dynamic. This diversity was not a weakness. On the contrary, it allowed people to learn from each other. Whatever the design, the crew was key. Over the years the Forum partners had acquired some skills to undertake that adventurous journey: they had gained experience in a wide range of health issues, for example, building Community Health Funds, and developing a Panchayat health plan. They had learned to work as a team and were confident about making decisions in uncertainty because the exact route to change is not known. They also had some tools to go to the ocean, like strong nets (strong evidence for advocacy) for big fish, a strong motor and sails (Action-research as a motor for learning), a radio to connect with other boats (other Health Forums), and a compass (explicit values, Mind-shifts and models for change reinforced during quarterly coaching workshops reflecting on the actions undertaken) [IB26].

But would that be enough? The only way to find out was to test it. Even the boldest ones, lifted the anchor timidly. Of course, they suffered damage and had to return regularly to the bay to learn from the experience, make necessary repairs and introduce complementary tools. But each time they lifted the anchor they grew in autonomy. And they were not alone. They were guided by the stars: the Friends

To sustain the changes, they needed to focus on the wider context and influence decisions at levels far beyond their comfort zone

of the Forum. Who were those friends? Apart from WBVHA and Memisa, academic actors such as the AIIH&PH (Kolkata), IPH (Bangalore), ITM (Antwerp), selected public health professionals, managers and public-private practitioners came in support. They came together once a year and acted as a sounding board and shared knowledge of other horizons.

## Confronting the strong currents and big waves in the open sea



If you want to survive a tsunami, you cannot stay close to the shore. You must go to the open, deep sea or you might lose everything. The ocean is also the place where you can catch really big fish in terms of influencing state or national policies and strategies, beyond merely changing the lives of people in a few villages temporarily. But it requires a lot of sailing skills and knowledge of the sea currents [IB27].

These currents can take you far… in the 'right' direction, but in the opposite direction as well. The undercurrents in the open sea are strong, with divergent forces: the rights-based approach, neo-liberal paradigm and bureaucratic attitude are just a few. There are fierce forces pulling and pushing and trying to influence the content and funding of national policies like the National Health Mission. Which model of health governance would they promote? Which health service model? What were the roles for the people? All of these had an impact on the health of people in the villages and their ways of coping.

So after about 8-10 years of sailing, the time was ripe to go back to the drawing table and, with the help of the Friends of the Forum , start to draw 'sailing maps' based on the collective learnings of the journey. Sea currents (underlying mechanisms),

possible pathways (Theories of Change), new lands and sailing techniques (innovations) were documented in a systematic and understandable way. Vision, values and strategies, actions and experiences supported by evidence were brought together in new navigation models (Action-research models). These emerged, continuously polished by practice, with the potential to enrich existing, robust navigation theories such as the National Health Mission or Universal Health Coverage.

For that endeavour, contributing to making a big wave, it was imperative to be with many boats together and constitute a fleet, a network of Health Forums, and ultimately... a people's health movement.

It was imperative to be with many boats together

## Sailing below the waves

This part of the metaphor was added when reflecting on the title of the book. Writing this book is in itself a learning process as it requires making things explicit, making sense of them, reframing them and discovering new insights.

From the very beginning the BHCSP paid a lot of attention to 'HOW to do things', not only to 'WHY and WHAT to do'. First implicitly, and later explicitly, the programme followed a Realist Inquiry approach. Instead of just asking 'what are the results (outcomes)?' the Realist Inquiry tries to answer questions like 'What works, for whom, in what circumstances, in which way, over which period and why?' It is interested in the context and the underlying mechanisms of change with a view to catching the big fish, that is, making sustainable change. It is important to spot what lies below the surface.

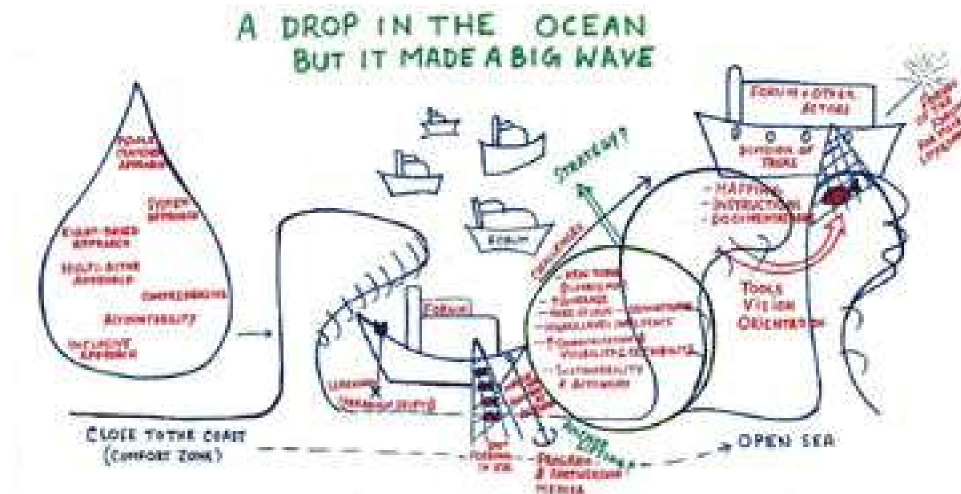
One of the major achievements of the programme is that grassroot actors learnt to sail below the waves [IB28], dealing with uncertainty in the deep, dark, troubled

From the very beginning the BHCSP paid a lot of attention to 'HOW to do things'

waters far below the surface. Such change of mind-set and behaviour of individuals, organisations and institutions requires a comprehensive approach. Change is a matter of both the heart and the brain. It also needs time to gradually and jointly make sense of diverse, complex local realities and their underlying mechanisms, and co-construct models and theories. This seems more natural and pertinent than developing a comprehensive, 'final' Theory of Change and comprehensive conceptual model(s) at the start of the programme.

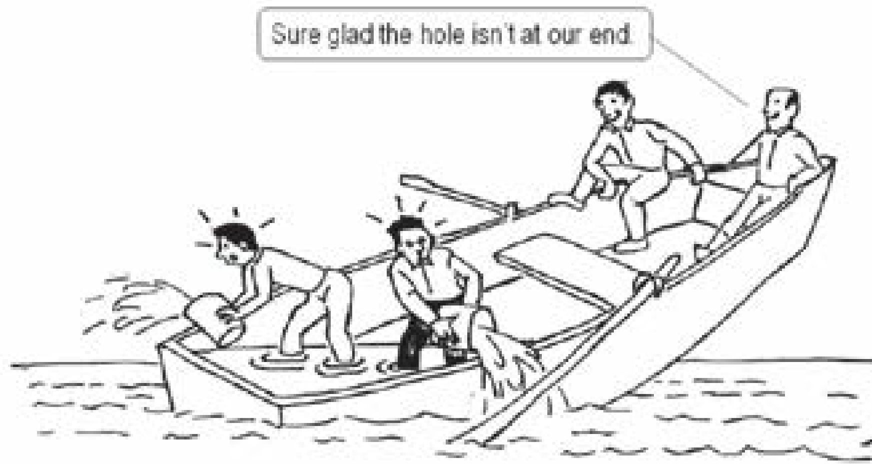
## A drop in the ocean but it can make a big wave

The attention to the underlying mechanisms and the context and how to do things, allowed BHCSP to go beyond short-term changes in the lives of people in a few villages and aim to contribute to more structural changes in the Indian health system. This RICH picture [IB5], developed during the annual workshop in 2013, attempted to illustrate this.



## We’re all in the same boat

Please jump on board if you haven’t already done so because we need more crew. We can’t work in isolation if we want to change things. After all, we’re in the same boat. .



CHANGE NEEDS TIME &
COLLABORATION
GIVE ME MY H!
THAT IS FOR THE NEXT CHAPTER!
SN BRU CCU
ALOYSIUS, CAN I TRY THESE GLASSES?
YES! THEY ARE LIKE NEW EYES
CHANGE
SV

## Messages in a bottle

- Sustainable change implies behavioural change of individuals, organisations and institutions, which is complex. The design and implementation of a social development support programme should, therefore, be flexible and adaptive taking into account the complex reality.

- Social change requires time. It's an emergent and evolutionary process. All actors involved need time to jointly reflect and achieve small, tangible gains at local level. It helps to build confidence and capacities for achieving the larger objectives and outcomes at macrolevel. Therefore, donors need to be open to long term commitment to their partners, ensuring continuity between programme cycles.

- A development support programme should go beyond local service delivery and capacity building and work on both the operational level of the local stakeholders and the strategic level of programme managers and decisionmakers. This strategy, called a 'strategy of double anchorage', is necessary to obtain sustainable results and system-wide changes. Local results need to inform the policy-level so that strategies and policies can be adapted, and in return, contribute to sustainable local results adapted to people's needs.

- A social development process should aim at not only vertically scaling-up the lessons learnt, to influence state or national policies but also horizontally to share experiences with other contexts through peer-to-peer learning. This scaling-up is empowering in itself as it increases the confidence, capacities and ownership of the local stakeholders.

- To achieve sustainable change in a sustainable development programme, development actors need to pay attention not only to What and For Whom, but also to why, how to do and in which conditions.

# Chapter 4

«Everyone thinks of changing the world, but no one thinks of changing himself.»

LEO TOLSTOY

# A compass to sail below the waves

Aloysius James
Karel Gyselinck

## The guiding principles of the Basic Health Care and Support programme

## ¿uestions

- ¿ On what principles was the BHCSP based and why?
- ¿ How can a programme be developed using a compass or principles as guidance?
- ¿ How was the focus on healthcare and health rights balanced in the BHCSP?
- ¿ What does community 'participation' really mean? How could local communities be given a voice? How was it strengthened in the BHCSP?
- ¿ How were different stakeholders involved in the programme? How did the BHCSP engage with diverse actors in a complex environment?
- ¿ And what about your questions?

People often feel helpless when it comes to matters relating to healthcare. They feel entirely dependent on experts and healthcare institutions to address their health problems. There is an imbalance of power, between people or patients and providers or health system functionaries, because of the overwhelming disparity in knowledge and competencies related to medical treatment. This imbalance is further increased due to social inequalities. People seldom consider health a 'right' and are, therefore, reluctant to claim their basic right to access healthcare and demand protection and restoration of their health. The unequal distribution of health resources and differing social conditions, especially of disadvantaged communities living in the rural and excluded geographical areas, make health services inaccessible for them.
Many civil society organisations and individuals recognise this power imbalance (1) and implement health programmes as part of broader social change processes and request the government and other available systems for providing healthcare services. However, most of these initiatives remain piecemeal and isolated and do not touch the broader structural issues that prevent the wellbeing of people. Often, these attempts at questioning are rather aggressive and fail to facilitate a dialogue between people and the institutions wielding power and resources.

BHCSP was an attempt by some courageous and determined community members and local institutions working in different geographical areas in West Bengal to bring social change through health interventions. But BHCSP was also a partnership between NGOs, government health leaders, academics and practitioners. They are now trying to co-create a functional health system at multiple levels, bringing together different actors and operationalising health programmes envisioned under the National Health Mission. They are also conducting joint reviews and reflections and suggesting policy changes and new ways of working.

[IB13]

BHCSP aims to enhance the capacity of the health system so it can support the public health needs of people and deliver universal health coverage. It also seeks to support the government to realise the Sustainable Development Goals (6) while creating mutually beneficial synergies between health and local governance.

BHCSP created opportunities for people to claim their rights through social mobilisation and dialogue, creating a favourable environment to participate in the decision-making processes on matters affecting their health. By developing and strengthening existing and new social structures and platforms, BHCSP created meaningful interfaces between people and their representatives and with those in power at different levels. Besides, in a non-confrontational manner, it created opportunities to access a better quality of health services.

BHCSP created meaningful interfaces between people and their representatives and with those in power at different levels

## We had a dream

The programme stakeholders imagined that the people would claim their right to health and take up responsibilities to live their lives in a healthy way and have equitable access to good quality health services. Quality meant person-centred, need-based services which were in tune with the realities of their lives. It implied a change in behaviour of individuals, and changes in the organisations and institutions involved in the process. Individuals within the health system, along with its structures, systems and ways of working would have to change in different ways.

The initial hypothesis was to create a platform called 'Health Forum' to achieve this objective. The Health Forum would be at the heart of the programme. It would be initiated by grassroot NGOs, linking them to each other and linking them with other actors like citizens, community groups, local authorities, private

Quality meant person-centred, need-based services which were in tune with the realities of their lives

and public health providers and managers, non-health actors, researchers, and decision-makers [IB9].

This Forum would enable all actors to have a common understanding of the real needs and service gaps at the grassroots, to learn from each other, to take up responsibility for some tasks within the local health system, tap available resources in the system, engage in advocacy towards decision-makers and policymakers and improve upward and downward accountability mechanisms. The Forum was a pathway, using civil society as an entry point, to support all actors to strengthen the local health system. This was a fundamental condition for people to live healthy lives.

Since there was no preconceived or fixed design, the Forum could be organised in different ways in different settings with different stakeholders. But all had the same basic purpose: all actors together would create a people-centred health system. And of course, ultimately, the Forum would inspire a people's movement for health.

## We developed a compass

Since there was no 'fixed design' it was important to set up some guidelines or principles. Five principles guided the BHCSP. The umbrella in the figure below represents this set of principles. It was revisited and refined for the BHCSP conference in Kolkata, in February 2019, where the programme shared its experiences with a local, national and international audience. The central principle of the BHCSP was People Centredness, represented as the central axis or shaft which holds the umbrella together.

The central principle of the BHCSP was People Centredness

A boat needs a compass. The five principles constitute the programme's compass allowing the actors to navigate below the surface in a complex environment and be

Figure 1. The guiding principles of the Basic Health Care and Support Programme

sensitive to what may be invisible in daily reality. They were the guiding principles from the start, even though all the principles were not so explicit at the beginning. The WBVHA logo (figure 2), led us to the compass we were looking for: people at the centre, arms in the air expressing happiness and reflecting the comprehensive approach with a focus on well-being, inward looking arrows referring to empowerment and subsidiarity (decentralisation), bidirectional arrows linking up actors with the idea of dialogue and mutual learning, and finally the suggestion of a turning wheel representing continuous learning cycles.

Figure 2. The WBVHA logo as the compass to sail below the waves

We will now look at the how the BHCSP programme followed these guiding principles [IB24] during its implementation.

## People-centredness

The Alma Ata declaration of 1978 with its call for 'Health for All by 2000', was a guiding document for global public health practice for over two decades. The role of global consensus is discussed later in Chapter 12, and the statement that " *people*

*have the right and duty to participate individually and collectively in the planning and implementation of their health care*" has been an inspiration for people working in public health the world over. However, over the years, the global socio-political scenario, heavily influenced by neoliberal policies, considers health a commodity. The poor and the marginalised do not have access to healthcare. Poverty, which is an outcome of exploitative practices in society, determines the health status of people. A large section of people is denied adequate nutrition, a clean environment, potable water and fair housing, which are all prerequisites for good health. Often, the poor and vulnerable victims of an unjust society and its practices, have barely any opportunity to bring changes in their lives or influence the decision-makers and the powerful groups in the community. The Commission on Social Determinants of Health explicitly spelled out these interconnections in its report entitled "*Closing the Gap in a Generation*" (WHO 2008).

A people-centred health programme [IB12] implies that every citizen has access to primary health care, irrespective of paying capacity. These services should respond to the specific needs of the local community. But beyond that, people, especially the poor and marginalised communities, including women and other vulnerable groups, also get involved and committed to demanding and managing their health (5). The BHCSP facilitated a social change process where people created opportunities to participate, dialogue with local authorities and health providers, and influence health plans, systems, and policies based on social equity and people's needs. It was very different from merely participating in activities to achieve the targets set by government schemes. In that perspective, a Health Forum composed of NGO partners was only an in-between step towards an inclusive 'movement' of local communities (7) taking charge of their health at the grassroots. Community-based groups like Village Health Committees, Community Health Committees, Village

*"No matter how ignorant a person is, there is one thing he knows better than anybody else, and that is where the shoes pinch his feet."*
(John Dewey)

Health Sanitation and Nutrition Committees, Adolescent groups, Women's Self-help groups, and Elderly Persons' groups developed their health plan according to their needs and local context. For example, some Elderly Persons' Groups in the BHCSP focused more on mental health and social activities, while others concentrated more on the prevention and care of chronic health conditions. Some adolescent groups primarily worked on awareness and prevention of early marriages, while others worked on hygiene and menstrual care. The expressed community needs and concerns were integrated while developing the GP level health plan.

*In Gosaba Block, till 2011, most of the villages received only erratic electric supply. The Primary Health Care Centre in Gosaba island received electricity only for a couple of hours a day. Snakebite was widespread, and the patients were taken to Canning, 15 kilometres away from Gosaba villages, for treatment. Due to the erratic power supply, the Gosaba PHC did not have a cold chain facility to maintain antivenom. The community brought up this issue with the local health and development authorities. The problem was further discussed with the Block Medical officer for Health (BMOH), Block Development Officer (BDO) and Sabhapati, the head of Block Samiti. The BDO approved a generator for the PHC to keep the antivenom. The availability of antivenom saved many lives, reduced the burden of people travelling kilometres for treatments. The expressed community needs and concerns were integrated while developing the GP level health plan.*

Healthcare providers deserve a people-centred approach too

People-centredness in the BHCSP also focused on the healthcare providers, who deserve a people-centred approach too. Local communities took responsibility for improving the conditions and facilities of the healthcare providers, especially in the remote rural areas. This created an enabling environment for them and that improved the quality of care. For example, in collaboration with the Panchayats and the block and district health authorities, the BHCSP actors secured better infrastructure of

subcentres and primary health centres. They also improved the working conditions for the first-line health workers in remote areas by facilitating their communication with people and mobilising communities for their primary healthcare activities or even assisting with some materials.

## Subsidiarity and Empowerment

*"There is nothing as important as informed public discussion and the participation of the people in pressing for changes that can protect our lives and liberties. The public has to see itself not merely as a patient, but also as an agent of change. The penalty of inaction and apathy can be illness and death." (Amartya Sen)*

Subsidiarity and empowerment (4) are integral to people-centredness. This idea is in line with Amartya Sen's concept of 'strengthening people's capabilities'.

The principle of subsidiarity, grounded in human dignity and respect for each person, talks about empowering communities. Its first premise is that decision-making happens at the appropriate level. The 'higher level' authorities should allow local health teams to make decisions to solve local problems at the operational level and facilitate this process and build capacities. One step further is to encourage local people and communities to make decisions on their health and quality of life. After all, they know best the context in which they live their daily lives.

Though people have the right to be part of the decision-making processes on matters related to health and development, they have rarely had the opportunity or the permission to participate in those processes. The existing bureaucratic model is built around centralisation, ignoring the local people's inherent rich knowledge and competencies. Even in grassroot NGOs, the prevailing culture was to do things

*"The public has to see itself not merely as a patient, but also as an agent of change."*
(Amartya Sen)

Community members made choices according to their needs

'for the people' rather than doing it 'with the people' by involving them in making decisions.

The BHCSP worked on changing this culture. The NGO partners worked in a mode to facilitate rather than to implement. So, community members made choices according to their needs, as in the use of untied funds, and took responsibility for their health and rights. At the same time, the NGOs also facilitated the interface between existing health institutions and local institutions and communities. And the higher authorities at the block and district supported community health providers to respond to needs expressed locally. All this gradually made the Panchayat and local health authorities understand their roles better and made them integrate relationship-building, trust and dialogue into their way of working. Thus, downward accountability became regular practice.

Here are some examples of how subsidiarity and empowerment have evolved in the BHCSP. At the start of the programme in 2002, the partners of the BHCSP were mainly providers of services to their communities in the villages. The modus operandi largely was implementing activities financed by foreign NGO donors or funded through government schemes based on fixed action plans.

Regular coaching was organised in the BHCSP. It consisted of ongoing intervention through a peer coaching process, visits by WBVHA and quarterly workshops with an external facilitator. It enabled the NGOs to step out of their daily routine, get into a reflection mode, and gradually change mindset or experience a mind-shift. The NGO partners became facilitators rather than implementers. They were no longer seeing people in the community simply as receivers but as stakeholders and partners.

Though this process took a lot of time, it also brought changes within the health authorities and Panchayats. The existing tensions and distrust between civil society and government actors faded away over time, leading to more cooperative and

collaborative actions, along with recognising each other's complementary roles and capacities. The government took the responsibility of regulating and organising health services and ensuring transparent information, thus being more accountable to the local governance systems. On the other hand, civil society assisted the government in improving access to services for everyone and providing feedback on gaps. Exciting experiences at the grassroots were brought to the government through various existing Forums providing evidence and ideas to strengthen policies or enhance operational qualities. These interactive meetings and exchanges of data enabled the local units to track the decision-making process and act immediately on issues or quickly plan interventions.

The fourth Saturday meetings [IB6] enhanced the quality of interactions among the members of Gram Panchayats, who are the elected representatives of the people, and the local health actors such as ANMs (Auxiliary Nurse Midwives) the ICDS (Integrated Child Development Services) team, ASHAs (Accredited Social Health Activists), local Dai (traditional birth attendants), Community Based Organisations and others. The values of empowerment, trust and transparency that were promoted enhanced the relationships among the actors at the grassroots and also enabled a partnership with government institutions at various levels.

## A comprehensive approach

*"The enhancement of health is a constitutive part of development. Those who ask the question whether better health is a good "instrument" for development may be overlooking the most basic diagnostic point that good health is an integral part of good development." (Amartya Sen on health and development)*

*"Good health is an integral part of good development."*
(Amartya Sen)

When embracing people-centredness, you cannot but take a comprehensive, holistic approach to health [IB1]. This leads to a different view on health. It's about enjoying health as "a state of physical, mental and social wellbeing", about the right to health, about taking into account both the 'perceived' needs including psychosocial needs of people, as well as their 'objective' needs, and consequently, about taking into account all determinants of health.

It also leads to a different way of organising health services. Emphasis on vertical health programmes, like the health schemes in India, addressing specific priority health problems leads to fragmentation and parallel mechanisms. Moreover, such programmes tend to focus on specific needs and gaps in service delivery only. Despite the intentions of the National Health Mission, they do not situate health in a broader context or integrate other sectors to promote health. However, it is known that a reduction in the effects of diseases and incidences of diseases is dependent on increased social wellbeing. Again, the Alma Ata Declaration shows the way. It emphasises that primary health care can only be achieved by providing curative, preventive, promotive and rehabilitative services.

Health services should adapt to the people and not vice versa

BHCSP therefore deliberately took a comprehensive approach [IB14]. Two important Mind-shifts occurred amongst the actors in the programme. First, health services should adapt to the people and not vice versa, and second, health services should work more closely together with other social services. This approach offered opportunities to a) bring various stakeholders together b) support the collective involvement of local decision-makers and communities and other actors in understanding, analysing, and prioritising health needs and challenges and c) create synergies and mobilise resources for joint actions in an effective way. BHCSP believes that strengthening the local health system requires a multi-sectoral collaboration at the local, state and national level. This holistic approach is a reaffirmation of the Alma

Ata Declaration 1978, the WHO Commission on the Social Determinants of Health in 2008 and SDG agenda 2030.

The actors within the BHCSP worked with a logic different from the vertical logic of the government health schemes. Some examples of the BHCSP actors concentrating on alternative, more comprehensive strategies at the grassroots, are the following: i) the Community Health Fund managed by the Self-Help Groups ii) the Community Dialogue at the Village Health and Sanitation & Nutrition Committees iii) the family-centred care approach adopted at the Lamahatta village subcentre in Darjeeling district and in the Asha Kiran Hospital (secondary care centre) in the Mathurapur II subdistrict in South Parganas district.

## Linking up actors

This fourth principle was a mean to achieve the three previous ones. The assumption was that a better local health system would create a better environment to respond to people's needs than just implementing vertical national health schemes. This would also lead to a better match between the needs of the people and the response of the health system.

But first we needed to agree on the answer to the question: what is a system? In its essence, a system may be defined as 'actors and their inter-relations'. To strengthen a system, one needs to understand which actors are part of the system and the quality of the relationship between these actors. Subsequently, changing the behaviour of these actors and improving relations between them may lead to strengthening the system.

*"Dialogue is on,*
*The cause of Health is at stake,*
*Spirits are moving."* x2
(Haiku – Karel Gyselinck)

The actors in some systems, including health systems, can be grouped into

This journey was not about implementing as many schemes in as many places as possible but creating a collaborative mind-set among actors

demand-side actors, supply-side actors, and governance-actors. The BHCSP, being an NGO-initiated programme, naturally took the demand-side actors, eight grassroot NGOs of South 24 Parganas, as the initial entry point to strengthen the local health system. Reinforcing the local health system is a different ambition than merely bridging the service gap between the national health schemes and their implementation in the remote villages supported by these NGOs. The BHCSP aimed at improving the health system's response to the objective and perceived needs of the population instead of focusing on priority health problems identified by the authorities. So, this journey was not about implementing as many schemes in as many places as possible but creating a collaborative mind-set among actors with Health Forums as the catalyser to contribute to more robust local health systems. Everyone wanted health systems with more collaboration and trust between stakeholders and facilitated by leaders valorising and encouraging contributions of all the people.

The programme plunged into the black box of improving collaboration between a diverse range of stakeholders at different levels. The BHCSP concentrated on 'how to do things' rather than on 'what to do'. It focused on changing the mind-set of the actors (the 'Mind-shifts' as will be explained in chapter 5) and their relationships by getting to know each other, building trust and confidence, developing a shared understanding of the local reality, and working together more effectively and in a coordinated way. The programme funding reinforced that strategy. A conscious decision was taken not to fund individual NGO activities in the villages, but to set up health platforms ('Health Forums'), build capacity of its members (NGO partners), pool resources more effectively and implement joint activities at village, Panchayat, subdistrict (block) and district level resulting from this collaborative approach. In other words, instead of funding the bricks for the house, the programme primarily funded the cement.

The black box of health system strengthening was even more complex. There are many interlinkages and people's health in villages is conditioned by national and even international policy decisions. So, to keep things manageable, we had to start small. System-thinking offers a solution for that: it allows you to define a sub-system tailored to your capacities and ambitions, and manageable by the programme partners involved. Actors outside this sub-system are considered to be part of the context. They, however, influence what happens within the subsystem, so you have to keep the context constantly on your radar – monitor and anticipate attitudes, decisions, opportunities and constraints.

Within the BHCSP, the partners first started mapping the actors and their relations, including the gaps in those relations, in the local health system up to district level using system analysis of maternal care in the remote islands of the Sundarbans area as the lead story. Afterwards, the villages and the first line government health workers supported by grassroot NGOs were defined as the subsystem, while the 'higher' levels (Panchayats, block/subdistrict, district, state, nation) were part of the context. In 20 years, the boundaries of what would be considered sub-system and context shifted, with subdistricts and later on districts becoming the subsystem. This shift took place as the confidence of the grassroot NGOs grew and the need to engage with stakeholders at a higher level increased.

The links between actors [IB10] gradually expanded in two ways. Firstly, in a horizontal way, as small but tangible results of the collaborative approach became visible, neighbours – neighbouring families, villages, Panchayats, blocks and districts – became interested. But also in a vertical way where the grassroot-level and the decision-making level got linked. NGOs gained the confidence of the decision-makers and were called more often to participate in joint planning, implement schemes or provide capacity building, and from their side, the NGOs started, timidly, to share

grassroot experiences, raise issues such as the fight against alcohol in Howrah with the higher levels of administration and engaged in advocacy [IB4]. Since the social determinants of health and well-being were also considered, the engagement of multiple actors outside the health sector was required. From 2014, advocacy also meant collecting evidence and working with academics to establish and explain different inter-relations. The expectation was that this kind of feedback and 'evidence for policy' would encourage decision-makers to deal with the problems more structurally and finally have a positive impact on the health of the people in the villages.

We, however, experienced the limitations of working at this micro-level only

*"Traditionally, our work is close to the people in the villages. We, however, experienced the limitations of working at this micro-level only. We have all the expertise to manage issues related to health in the villages. Still, we do not have control over the delivery of services such as the availability of vaccines. Therefore, we realised the need to also link with other actors at the decision-making and policy-making levels to express our needs and look for solutions to our problems. We made an effort through the fourth Saturday meetings at the level of the Gram Panchayats but later moved up to the block, district and sometimes even at the level of the state government,"* explained a veteran staff member of a partner NGO.

As the BHCSP imagines it, the local health system may still seem like an exotic island beyond the horizon, a promise of good things but still not fulfilled. As the journey has continued, more and more minds have matured, and many capacities have been built. The Health Forums at different levels proved to be excellent 'playgrounds' or 'learning labs' for people to move 'their cursor' as they thought appropriate. The 'cursor' moves according to the Mind-shifts. These Mind-shifts happen gradually. For each of the actors, the degree of mind-shift at one point may be different. Each one has their 'cursor' in a different place along the continuum between the old mind-set and the new mind-set, for example, from 'doing' to 'facilitating'. In this

process of experimentation, they learnt to think more in terms of systems. This included learning to move beyond their own personal and institutional prejudices, convictions, dogmas, vested interests and socio-cultural barriers; learning to accept diversity and to overcome apparent oppositions like public versus private, civil society versus government or policy-makers versus implementers; learning to work in a flexible way by adapting to a changing context; learning to develop functional networks and adapted leadership styles; learning to build arguments and evidence; learning to seize opportunities offered by evolving health policies and strategies; and so many more learnings.

By engaging in this process, unconsciously to a large extent, the BHCSP actors were putting in practice, with both successes and failures, dreams imagined elsewhere at the same time, be it the National Health Mission in India or the Declaration on the Local Health system in Dakar back in 2013.

## Learning by doing

The previous principles all imply a change in the way of working of the actors within the BHCSP. Changing behaviour is difficult and complex. This is on top of working within a health system, which is already a complex environment. For the actors to take valuable decisions in such a messy, unpredictable and uncontrollable setting, they needed to adopt a certain mode of functioning: a learning mode. This was the last, but not least, important guiding principle of the programme.

Learning is development [IB8]. Learning is about taking decisions, and many of them in a state of uncertainty. It means implementing these decisions, reflecting on them, learning from them and taking better informed decisions for future action.

*"Only a fool learns from his own mistakes. The wise man learns from the mistakes of others."*
(Otto von Bismarck)

In this way we can speak of a learning cycle, which continued to turn all through the 20 years of the journey in a continuous process of incremental change. These learning cycles were actively stimulated and organised at all levels and phases of the programme.

Plans, strategies and theories were not fixed but continuously developed and adapted according to the understanding of the underlying reality, the changing context and needs. As a consequence, planning, implementation, monitoring and evaluation, and documenting and sharing of knowledge, weren't separate processes, but were embedded in this dynamic of continuous cycles of joint learning. Approaches and methods like the Theory of Change, Action-research, Coaching and Learning and Intervision, the Realist Inquiry in planning, monitoring and evaluation, and the Adult and Non-Formal Education model of Paulo Freire supported this dynamic.

This joint learning process was encouraged at different levels, working on the dynamic of existing meeting spaces such as the VHSNC, the meeting of community self-help groups, the fourth Saturday meetings at the GP and second Saturday meetings at the subdistrict level. The programme complemented this by explicitly organising different learning events throughout the programme cycle. It invested in the quarterly coaching workshops for the Forum partners, namely, grassroot NGOs and WBVHA, facilitated by an external facilitator; the annual support and learning visit of Memisa; the peer-to-peer learning between community groups or between NGOs; the exchange visits; the cluster meetings at the subdistrict and district levels; the meetings between civil society, public and private health practitioners; the participative external evaluations; and later on, the 'out of the box' thinking during the meetings with the 'Friends of the Forum ' and academic partners. However, all this collaborative learning did not replace individual learning but complemented it.

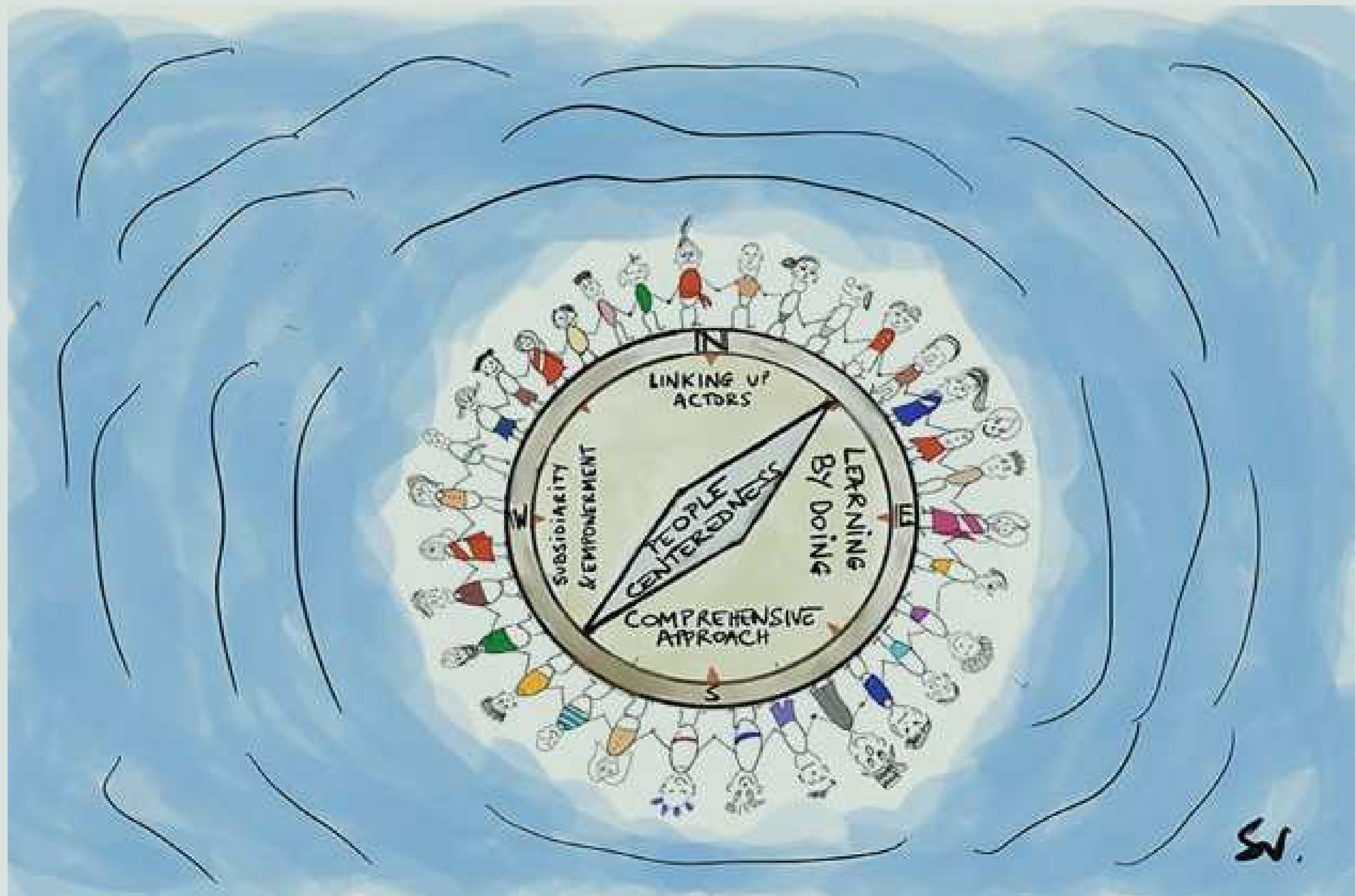
The choice to go for 'deepening and widening the perspective' by accompanying

change processes in a few selected villages, Panchayats and blocks/subdistricts rather than in maximising the coverage of services didn't prevent the programme from going beyond its geographical scope and ensuring that lessons were taken to other areas where there were demands. In this horizontal scaling-up, peer-to-peer learning played a prominent role. A vertical scaling-up complemented it by engaging with decision-makers at higher levels. This double anchorage of the programme, which meant it was working simultaneously at the operational and strategic level, with emerging feedback loops between them, gave way to a learning cycle of its own.

All these learning efforts also led to some tangible results. Apart from improved services, it yielded arguments for case-building to influence decisions. And it was possible to advocate for support or investments like the successful advocacy for constructing a health subcentre in Lamahatta [IB17] by decision-makers at the Gram Panchayat and block level and, to a certain extent, the district level. Learning also resulted in some innovative ideas, such as, the locally produced good quality sanitary napkins, which could be replicated by other actors. As time progressed, the need was felt to document and scale up the BHCSP experiences more scientifically using Action-research.

Initially, all the NGO partners, that is, the grassroot NGOs, WBVHA and Memisa thought BHCSP was one of their many projects. However, it started to influence their organisational culture and processes and how they set up and implemented other projects. Some even changed their organisational culture and anchored learning within the organisation, and so, moving to a higher level of organisational consciousness as Richard Barrett (2) put it. Also, in that organisational culture, failure is allowed, as long as you learn from it. Isn't it better to risk taking a bad decision and learn from it afterwards than taking no decision at all and be paralysed? In his book, 'How Change Happens', Duncan Green (2016) exhorts us 'to fail faster to learn and adapt'.

BHCSP started to influence the organisational culture and processes of the NGOs and how they set up and implemented other projects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LINKING UP ACTORS
LEARNING BY DOING
COMPREHENSIVE APPROACH
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## Messages in a bottle

- Community engagement is different from community participation for fulfilling targets of government schemes. Community engagement means that people get committed towards their own health and rights and have the space to take initiative themselves, beyond NGOs or other decision-makers. This contributes to a shift from a Health Forum to a People's Health Movement or people-centred health governance, whereby the Health Forum facilitates the empowerment of people, even those outside the programme area.

- Communities are empowered and grow in confidence and capacities when the programme mechanisms allow them to co-design their development support programme. And take decisions and actions during implementation, even those that may fail.

- A development support programme is more than a results framework. The guiding principles and values steering the programme theories and decisions need to be explicitly developed by all stakeholders at the design phase and must also be challenged during the programme through regular joint reflection. This process contributes to a more profound, shared understanding of the meaning and relevance of these guiding principles.

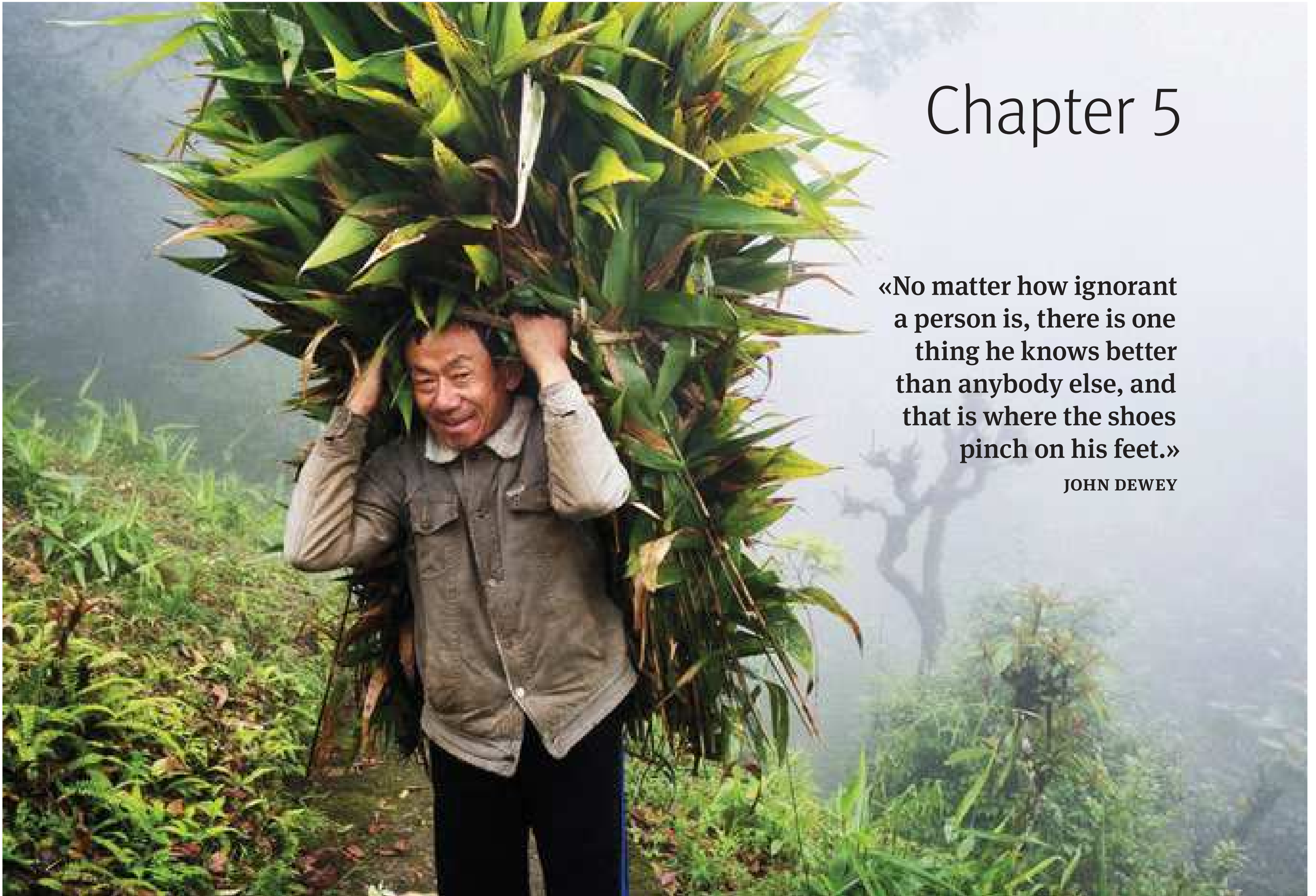
- The guiding principles were a tool to identify and monitor the Mind-shifts and related behavioural change of the programme actors, in an explicit way, during the coaching workshops.

- Regular reflection by the grassroot actors upon their actions is key in the change process and needs to be organised explicitly. In BHCSP it was done through quarterly coaching workshops with external facilitation. It helps to make sense of reality and build shared understanding, common purpose, capacity and solidarity.

- Change is complex and needs a comprehensive approach. Vertical and topic-specific health schemes or short-term development programmes controlled and managed in a linear way through pre-designed log-frames with SMART indicators do not lead to sustainable change.

- Solving problems to allow people to lead healthy lives can only occur if one reinforces the local health system. This means improving the capacities of the actors who are part of the system, and the quality of their relations with other actors within the system or in the wider context .

- A people-centred approach in health goes beyond assuring quality healthcare. It also focuses on health rights allowing people to make informed equitable choices regarding their health.



# Chapter 5

«No matter how ignorant a person is, there is one thing he knows better than anybody else, and that is where the shoes pinch on his feet.»

JOHN DEWEY

# Searching a way out of the cave, a journey of penciling and gumming

Karel Gyselinck
Aloysius James

Emerging Representations, Theories and Practices of Change using Action-research

## ¿uestions

- ¿ How to design a development support programme in a complex environment?
- ¿ Given the complexity of changing local realities, can we limit ourselves to just follow the operational instructions of the national health schemes?
- ¿ What is the role of theories and models in such programmes? How were they developed in the BHCSP?
- ¿ What were the important factors facilitating theory building in the BHCSP?
- ¿ What were the challenges faced by the key actors in changing their practices and aligning practice with theory?
- ¿ How were these challenges addressed?
- ¿ And what about your questions?

## The blind men and the elephant

*"Reality is one, though wise men speak of it variously."*
(From The Rigveda, composed between 1500 and 1200 BCE)

This chapter is about how minds and hearts, how theory and practice, how reflection and action related to each other evolved in the course of the BHCSP journey. Even for those who dare to undertake this endeavour, the search to discover reality ('truth') is not an easy one. Finding the pathways to get out of the cave is a messy process, one of muddling through all the time. Even with the five guiding principles as a compass, the emerging representations, theories, and change practices did not happen spontaneously. We had to reflect and make changes – what we call constant pencilling and gumming – to find the road to the final – or at least, to the intermediate – destination.

The parable of the Blind Men and the Elephant found in Buddhist, Hindu and Jain texts is illustrative of this perspective. It is an allegory on truth and interpretation. The parable has several Indian variations, but broadly goes as follows: a group of blind men heard that a strange animal, called an elephant, had been brought to the town, but none of them were aware of its shape and form. Out of curiosity, they said: "*We must inspect and know it by touch, of which we are capable*". So, they sought it out, and when they found it they groped about it. The first person, whose hand landed on the trunk, said, *"This being is like a thick snake"*. For another one whose hand reached its ear, it seemed like a kind of fan. As for another person, whose hand was upon its leg, said, the elephant is a pillar like a tree-trunk. The blind man who placed his hand upon its side said the elephant, "*is a wall*". Another who felt its tail, described it as a rope. The last felt its tusk, stating the elephant is hard, smooth and like a spear.

In some versions, the blind men discover their disagreements, suspect the others of not telling the truth and come to blows. In some versions, they stop talking, start listening and collaborate to "see" the whole elephant. The blind men then learn that

they were all partially correct and partially wrong. While one's subjective experience is authentic, it may not be the totality of truth. It reveals the limits of perception and the importance of full context. The parable provides insight into the relativism, opaqueness or inexpressible nature of truth, the behaviour of experts and their contradicting theories, the need for deeper understanding, and respect for different perspectives on the same object of observation.

The parable of the blind men and the elephant can be seen to symbolise the Forum dynamic within BHCSP. By collaborating and putting their ideas together, the actors could better understand the reality and see the whole elephant. The particularity of the wall relief version in Northeast Thailand (see Figure 1) is that it has a driver sitting on the elephant. This may represent the decision-makers in the system. They are the ones – at least in the system as it 'functions' now – in the driving seat. In order to get the elephant moving ('change'), it is necessary to interact with the higher levels as well. This 'double anchorage' of the BHCSP, working at both the grassroot level and strategic level, was an essential element in the programme's strategy. Change cannot occur if one doesn't understand the broader context and influence it.

Figure 1. The statue of the blind men and the elephant (wall relief in Northeast Thailand )

## The flow of two streams but one river

Two streams can be detected when discussing the representations, theories and practices within the BHCSP: the 'how' and the 'what' stream. This may be tricky as the how and the what were intrinsically interwoven. Both were part of the same river. But we have separated them artificially to share better how the lines of theorising the BHCSP have evolved.

It's another way of representing the programme's evolution, this time starting at the source of the river. (See Figure 2).

Both streams were nourished by the five guiding principles.

The 'how' stream was related to co-constructing a Theory of Change over time. This means an analysis of how change can be triggered in the context of the programme, how action is supposed to lead to the desired results, what conditions need to be fulfilled and how the actors can contribute to it. The BHCSP Theory of Change

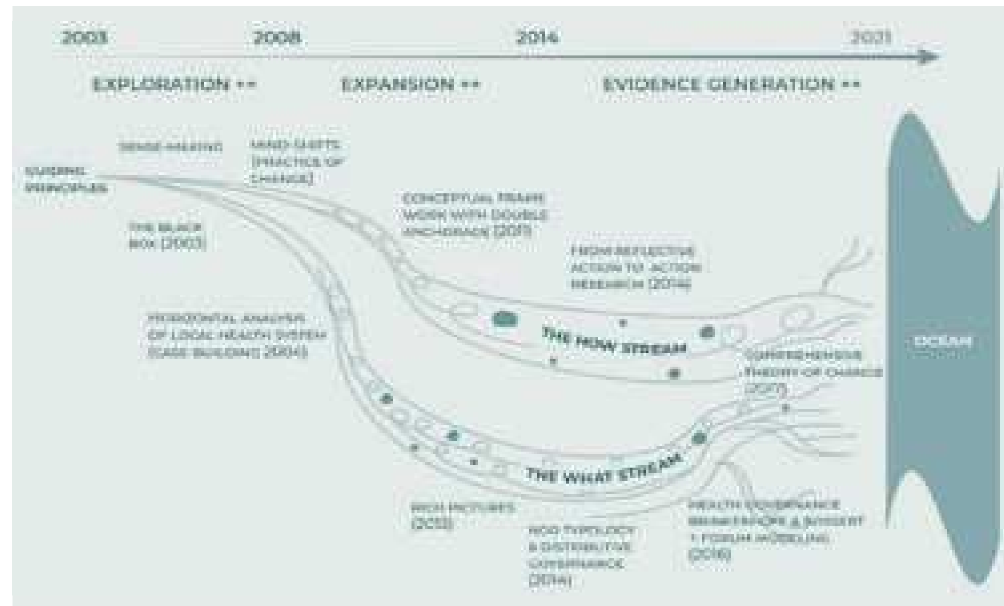



Figure 2. Emerging representations over 20 years in the BHCSP along two mind streams (the how and the what) within the same river

was not created out of the blue, designed by one person as a fixed blueprint for the whole lifecycle of a programme. It was co-constructed over time with the various stakeholders involved in the programme [IB1]. Later on, this reflection process became more sophisticated as 'reflective action' turned into 'Action-research'. A layer of systematic and scientific reflection was added, and models emerged. The stream of 'how to achieve that change' took a similar course.

The 'what' stream was about the gradual development of a series of models helpful in guiding decision-making and resulting actions. The models were explicit visual representations based on values and principles, also representing actors in the local health system and their actual and future relations. The visual aspect facilitated understanding and discussion by the actors. This visualisation took different shapes in the programme. Diagrams were used but also drawings called Rich pictures.

The primary drive of the grassroot actors was operational ('doing things') rather than conceptual ('developing theories and models'). However, the programme managed to balance action and explicit moments of reflection upon that action together with the actors involved. An organic, iterative process developed, allowing a gradual deeper understanding of the underlying mechanisms and the change pathways. As this understanding grew, also peoples' capacities to communicate their thoughts, feelings and perceptions increased. This 'making things explicit' took place along the two streams: it could either be about which change they wanted or how to arrive at that change.

Both streams were wild and tricky though and full of currents, counter-currents, whirlpools, rapids, and silent waters, transparent at one time, turbid at another time. It was a hazardous journey with many blocks (blockages) in the streams. These streams were heavily meandering, indicating that in the BHCSP the process of conceptualisation has not been a linear process. It was rather a spiral process

with continuous cycles of sense-making and theorising efforts, with emerging bits and pieces as part of a larger 'Middle Range' Theory which is still partially hidden up to now.

All this was probably at odds with a strict methodological approach, but at least this sense-making made things clear. It was adapted to the context and the state of mind of the actors at a given time. Different representations emerged – complementary yet divergent because of different contexts within the programme itself. They emerged at different places at different times, highlighting the underlying reality and the pathways of change from a certain angle. Indeed, these were imperfect representations, but they were food for debate and catalysed learning because they were explicit. An external observer could label this as a chaotic process. But isn't that how our minds work, where reason and heart are interwoven with complex realities? In that way, one could also see it as an organic process, with (the luxury of) time to let things mature. We may look at it as a painting: adding a layer on a painting may enrich it and deepen its perspective.

But isn't that how our minds work, where reason and heart are interwoven with complex realities?

Roughly, three parts were in the river, corresponding to the three phases in this journey over more than twenty years. The three E's: Exploration, Expansion and Evidence-generation.

The upper reach of the river corresponds to the Exploration phase. Here the river tried to find its way. It was not clear where exactly it would go, meandering, going back and forth, shaped by a mighty context, with high mountains and dense hill forests. Exploration refers to the mutual understanding of the changes the BHCSP partners in their raft wanted to pursue, the underlying mechanisms and the context. It also relates to the mind-set, models, methods, and tools necessary to allow those change to happen. Exploration also meant knowing the different types of rocks and trees on the way, the depth of the route and becoming familiar with different actors

and institutions and building a positive relationship with them. Some invited us to water their fields, and with some, we did joint cultivation. Though some showed initial resistance, many changed their hearts and minds constructively in associating with us. All this provided inputs about building the appropriate raft, team and technology.

The middle course of the river is called ‘Expansion’. Here the river dramatically increased its flow. This occurred in BHCSP because the approach in South 24 Parganas allowed to catch ‘small fish’ or mainly small results contributing to reducing the health service delivery gap. After some time, this caught the attention of neighbouring SHGs, NGOs, Panchayats, Blocks (subdistricts) and Districts. The two streams of the river took different routes, found their ways to replenish the low-lying areas with their rich sediments. They found it impossible to stay within their riverbeds. And that was good. We all know that such flooding processes yield fertile grounds. So, engaging with higher level decision-makers at Panchayat, sub-district and district level became inevitable if sustainable change was the objective. The wider context had to be taken into account as they were determining what happened at the grassroots.

The lower course of the river was called evidence–generation. A lot of material was carried away by the river over a long distance and a long time. Stones were turned over and gradually got polished. At one point many stones were deposited along the shores of the two streams and their many side streams. There were some beach-combers strolling around the shores, on the lookout for precious stones. Evidence generation became necessary to ‘build our case’ and build the arguments when discussing issues with decision-makers. This process of structuring our thoughts and experiences into explicit theories and models, using the large number of stories, pictures and data, was also needed to communicate and share the spirit and

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experiences of the programme with external stakeholders and interested actors. So, there was evidence for both practice and policy.

The two streams of the river came together again in a huge delta in a mighty bay and ultimately in an even more robust ocean where big winds and currents rule [IB27]. It had been a frightening journey for the actors, with some hitting the rocks, with others getting stranded somewhere or getting off-track in a side-river, but with many also reaching the ocean.

These three phases appear to be chronological, but they are overlapping as illustrated by Figure 3. When you look from above, the river might seem to flow in one direction but when you are on the river in your raft, you feel the currents and whirlpools going in all directions. Development support programmes are complex and therefore never linear. Exploration was quite intensive at the start, with a lot of Coaching and Learning to work on the understanding and mind-set of the different actors. But this remained a challenge throughout the programme. The expansion phase was exponential at one point and then remained stable. Evidence-generation was more intensive in the later phases of the programme with the need to conceptualise and build an argument. There was generation of evidence in the early stages too but in a simpler way: through the collection and subsequent sense-making of stories and Rich pictures and through specific studies using the existing qualitative and quantitative database built up in the course of the programme.

Different conceptual frameworks, focusing on either the what or the how in line with the guiding principles, were developed in the course of the BHCSP and gradually refined, ultimately contributing to a more encompassing programme theory.

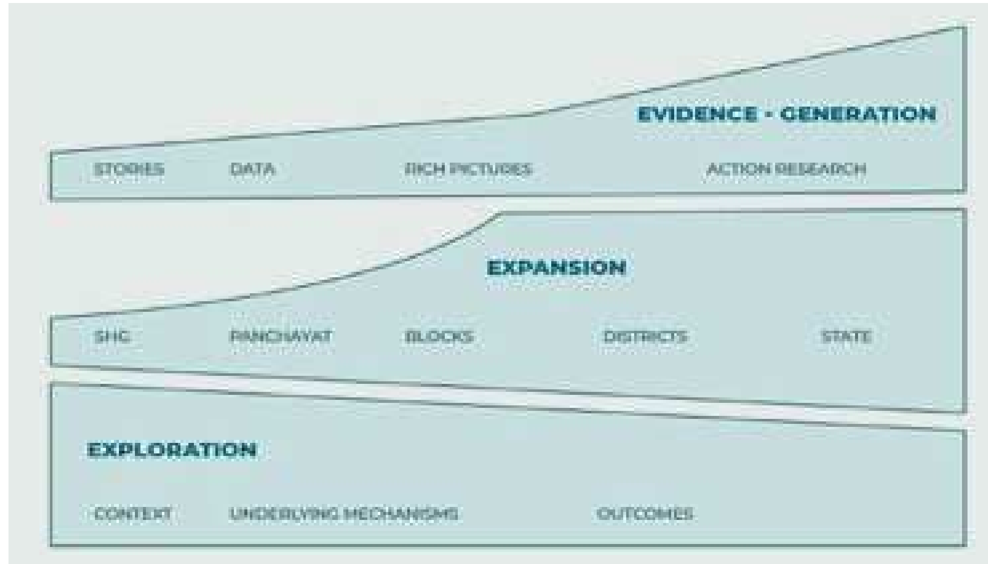



Figure 3. The three encompassing phases of the BHCSP over 20 years

## Making guiding principles explicit is a good start for theorising and modelling

At the start of the BHCSP, back in 2003, there was no explicit Theory of Change or conceptual models, apart from the five guiding principles. resulting from a participatory planning workshop together with eight partner NGOs of South 24 Parganas, along with WBVHA and Memisa, as has already been described earlier in the book.

Strengthening the local health system would create a better environment to respond to people's needs

The initial representation of the BHCSP based on those principles is shown in Figure 4. It was a rough representation, rather a sketch, far from an elaborate programme theory. But it showed the intention: this programme is not about implementing as many schemes as possible in as many places as possible. With the BHCSP as the interface – essentially a black box at that time – the overall assumption was that strengthening the local health system would create a better environment, not only to implement the national health schemes more effectively but principally to

Figure 4. Initial representation of the BHCSP theory, largely a black box

respond to people's needs in terms of health and access to quality health services, and to empower them to claim their rights.

This sketchy initial design may be surprising, knowing how most programmes are designed today, using a control mode. But it is not so incredible in a programme following a 'learning by doing' mode. Theories of Change and conceptual models need time to develop, simply because they are about change. And sustainable social change implies behavioural changes at the level of the population, civil society organisations, health providers and managers, local authorities, health institutions and other actors involved. These changes are the expected outcomes that may ultimately lead to impact.

Hence developing a Theory of Change and related models, requires a critical understanding of the existing reality, the interplay and interactions of various systems and sub-systems influencing health behaviours and the 'invisible' factors, and opportunities and structural constraints. And just as in an iceberg, most of the reality is hidden, below the surface. Moreover, we were dealing with complex processes here. This complexity was at different levels: at the level of the (sub) system the programme was focusing on, at the level of the individual institutions and organisations, and ultimately at each person's level. Just as in an atom which is also composed of sub-elements. So, if at all relevant, presenting a Theory of Change or conceptual models at the start of a new programme, can only provide a very incomplete image. Agreeing on a set of principles acting as a compass, guiding our decisions along the journey, is a good start. But even with a compass there are so many ways to reach the destination, influenced by a changing context and underlying mechanisms at play.

## Using system analysis to represent the local health system and its care pathways

We had only the five guiding principles [IB24], a rough sketch with a black box in the middle, and a programme results framework. So, there was no other choice but to go back to the drawing board, or 'into the black box'. At a workshop together with the initial NGO partners of South 24 Parganas in 2004, we used the flipside of the paper on which the log-frame was written. And then, we made the first attempt to articulate a Theory of Change and a conceptual model was made using a systemic approach.

To keep the work manageable, we started mapping the local health system in the selected blocks of South 24 Parganas: who was doing, what, where, why, how, with whom, for whom and so on. This put us face-to face with the complexity of our programme. We tried to make explicit all relevant stakeholders in the programme area concerned with health and their actual relationships and make it visual. Although we only focused on the local part of the health system it almost became chaos. This comprehensive exercise appeared too complex given the multitude of health actors and health streams.

We needed an entry point, a story telling us how the local health system worked or did not work. We found that story in the stories of pregnant women from the isolated island near Gosaba, which is 8 hours away from Kolkata by bus, boat and cycle rickshaw, and their efforts to deliver their children safely and plan their family in the way they wanted. So, using the method of system analysis, we mapped possible healthcare pathways for maternal and reproductive care for families from this island area These pathways revealed available services and the potential links between healthcare providers and the service gaps. These could be entry points for action and serve for advocacy purposes with the Gram Panchayats, the block and district authorities. We called it a 'case-building' exercise.

## Taking a step back: from Theory to Practice of Change

Though the map yielded exciting information and had potential, it was beyond the capacities of the NGO partners at that time. It wasn't an excellent practical tool for them to work with. It was still too complex and too medical for them and required some public health skills. Moreover, back in 2004 issues like health rights and health governance were less prominent on the agenda of most of the NGOs in West Bengal. Being community-based organisations, the NGO partners' focus was to ensure access to health and related services of the people in their villages. Each one focused on their own villages. There was no common vision or strategy as yet. At that time, they came together in the BHCSP with the primary purpose of having access to funds. At that time, the NGO 'partners' did not stick together as partners or as one Health Forum. Some of the partners working on a wide range of issues, beyond the scope of health, lacked an in-depth understanding of the health system and its challenges. Therefore, initially, they had a limited capacity to relate and negotiate with the other actors in the health system. So, the effort to make a theoretical model at this stage of the programme was postponed. We took a step back. A more pragmatic approach was needed to let the NGO partners engage in health initiatives, regularly reflect on their actions and experiences, and make useful decisions to progress. We could call it a 'Practice of Change'. This was closer to the partners' comfort zone [IB23].

Their focus and also that of the community groups was on connecting and facilitating the work of the first line health providers, both government providers like the ASHAs, ANMs, and ICDS workers, and indigenous, traditional and private healthcare providers at grassroots. The fourth Saturday meetings at the Panchayat office allowed for regular exchange between grassroot NGOs, service providers and Gram Panchayat members. The exchange of health information [IB3], supported

by advocacy actions, encouraged villages and Panchayat leaders to place health prominently on their plan and coordinate health related activities. This led to health getting specific attention within the Gram Panchayat Development Plan.

## Working on Mind-shifts through regular reflection on action

At the same time a learning mode was adopted. The NGO partners reflected regularly on their practice. This happened amongst themselves during Health Forum meetings or together with the community groups in meetings of the village development committee and with first line providers mainly during the fourth Saturday meetings at the panchayat. At the programme level, quarterly workshops were organised with the NGO partners. These workshops were facilitated by mentors of WBVHA and an external consultant, who accompanied the programme since its inception. Once a year the Memisa team also participated in the workshop. The purpose of these meetings was to share with each other stories of people, incidents, issues, initiatives, needs, challenges and opportunities. These field experiences provided the 'food' for the internal reflection and learning during this period. With the five guiding principles as a compass, the workshops focused on sense-making, understanding the context and mechanisms, widening and broadening the perspective, identifying levers of action, and recognising positive changes in the way of working of the partners. The changes were labelled as 'Mind-shifts'. These Mind-shifts were explicitly and visually displayed at every workshop using a wall flipchart and served as a reference. This tool helped the members to internalise the Mind-shifts further. Whenever the members jointly identified a new mind-shift, it got added to the list. After about eight years, fifteen Mind-shifts had emerged (see Figure 5). This process is still ongoing.

New Mind-shifts may be identified but also internalising the existing Mind-shifts by all actors involved in the programme remains a challenge as will be illustrated later on in this chapter.

Figure 5. Mind-shifts identified during the quarterly coaching workshops in the Basic Health Care and Support programme over eight years

This learning approach became the motor of the programme. Rather than following a fixed programme or action-plan, the 'action-reflection-action' mode guided the decisions on moving forward and accordingly adapted to the context and reality on the ground. This dynamic also made the NGO partners aware of the need to collaborate

and to have a common action and strategy. This whole learning process is another key learning from the BHCSP. It's has been one of the conditions of success.

To start at the grass-root level proved to be a good choice. If the process would have started at the 'top'-level we may never have reached the grass-root level. Usually, policies and strategies are nicely formulated and even visionary at times. The main challenges however are related to their implementation at operational level, embedding them in the practice of every day. For this you need change agents, catalysts such as the NGO partners and the Health Forums. The programme had gained goodwill from the government by extending this helping hand. The help consisted mainly of bringing preventive and promotive services to the village level and translating village people's need to higher levels. This practice resulted in a growing trust over time. Both government officials and NGO partners progressively realised they needed each other. Government staff discovered that the NGOs had developed their competencies in reaching and working with the communities. They started working flexibly beyond the project mode and were prepared to engage in the longer term.

## Expanding the pro gramme using peer-to-peer learning

All this was noticed by NGOs in other districts as well. They got interested. So, there was the unforgettable surprise visit of a group of NGOs of North 24 Parganas during a workshop in South 24 Parganas in 2008. Soon after the visit they started to organise themselves and work according to the spirit of the programme, without formally being part of the BHCSP. And soon others followed. Peer-to-peer learning at the Forums, among the NGOs and even the community groups resulted in a horizontal scaling-up of the programme [IB8]. The programme flowed into a demand-driven

expansion phase. It could not control this process, but generously supported it by sharing its rich experience. And this horizontal learning contributed to empowering both the community and NGO actors. They realised they had acquired some skills which could inspire others.

In the initial phase of the programme 8 NGO partners were active in 51 villages,12 Panchayats, 5 blocks and 1 district. By the second phase the programme (2008-2013) 44 NGOs were on board in 112 Panchayats, 24 blocks in five districts (South 24 Parganas, North 24 Parganas, Howrah, Darjeeling and Sikkim) as shown in Table 1.

This was however not a simple copy-paste exercise. Each of the NGO partners in the other districts organised their Health Forum and related activities differently at

| Variable | Where we started? | Where are we now? |
| --- | --- | --- |
| Districts covered in BHCSP | S24P | S24P, N24P, Howrah, Darjeeling, Sikkim |
| No of Panchayats covered in BHCSP | 12 | 112 |
| Population coverage (million) | 0.12 | 4.68 |
| Stakeholders engaged | Individual NGOs | Multiple stakeholders involving communities, health service providers, government authorities in other sectors apart from health |
| Focus areas of work | Health | Multiple sectors for inter-sectoral action for health |
| Level of engagement | Village | Sub-District (Block)/District |
| NGO partner in the district health forums | 8 | 44 |

Table 1. Showing progress of the programme over the years in terms of coverage

Allowing this diversity was important in order to achieve local solutions by local people for local problems

multiple levels, according to their context and their priorities. Some were primarily concentrating on facilitating service delivery, while others engaged more in advocacy. Some were focused on health, while others were on broader issues related to development and social change processes. This will be discussed more in detail later on in this book. The message here is that even if the common denominator for all partners in the other districts were the five guiding principles and their actions based on them, the translation of these in practice could be quite different from one district to another. Allowing this diversity was important in order to achieve local solutions by local people for local problems.

## Organising our thoughts to go the next level: a renewed conceptual framework

Until 2011, the entry point had been improving access to health services for the people in remote villages, whether in the Sundarban islands or the Himalaya mountains. With four other districts basing their action on the same principles, the horizontal scaling-up was in full swing. This demand-driven process was encouraging but remained within a local logic. As local problems could not be completely dealt with at local level, there was need to engage with health actors and decision-makers at block and district levels. A strong space for trust and dialogue had been created at the levels of the Gram Panchayat and health centre but was fairly nascent at the subdistrict and certainly the district level. We realised that the government accepted operational feedback from NGOs and assistance with getting services to the people fairly easily. But engaging in a dialogue with government to claim health rights of people or influencing state or national strategies and policies would be an arduous

task. Most partners, in 2011, were not ready for that kind of transformative agenda and advocacy. So, the vertical scaling-up needed a push. The actors would have to focus as a collective, going beyond their comfort zone and challenging some of the policy and operational issues in the health and development field. This required a renewed, more explicit framework.

The Practice of Change, through the action-reflection mode, the intervention by WBVHA and, in particular, the coaching during the quarterly workshops had helped minds ripen over the years. Being engaged in a change process influencing your daily practice doesn't m ean you can easily explain to others how to change their practice. At one point you have to make an effort to get things straight in your own mind before you can share it with others. So, in 2011, eight years after the start of the programme, we went back to the drawing table enriched by the experience of the Practice of Change and constructed a new Conceptual Framework. The programme mentors, namely, WBVHA, the external coach, and Memisa, played an important role in putting the pieces together and constructing the scheme below on how to move forward. This scheme would help all understand and represent the mechanisms and spirit of what had been done so far and why, and guide the future pathways of change within the programme. However, this framework wasn't over-prescriptive and left sufficient space for the actors to develop ways of doing according to their local context.

The Conceptual Framework shown above is a learning cycle. Development is learning and this principle also applies to social development. Just as a person has dreams, visions and strategies and then takes decisions in line with them, puts those decisions in practice, learns from them and then takes new decisions, this cycle can be applied when supporting social development processes. The health programme in West Bengal had the ambition to go beyond local service delivery and targeted

health schemes. It aimed at transforming the system into something better for the benefit of people including people outside the areas covered by the programme. So the programme used a strategy of 'double anchorage' [IB8]. 'Double' means operating at two fronts: at the operational level (field level) and the decision-making level (whether the GP, subdistrict, district or state). The initial entry points in the cycle were the existing or emerging government policies and strategies such as the health schemes, the West Bengal Community Health Care Management Initiative involving the Panchayats in local health governance (2005), the National Rural Health Mission (6) (NRHM, (2005) and later on the National Health Mission (7) (NHM, 2013). And the learning cycle turned as follows: facilitating the implementation of government schemes and the N(R)HM, adapting them to local circumstances, then sharing the learnings at the grassroots, and finally providing a feedback to the decision making level mainly at G P and subdistrict levels in 2012 in the hope that decisions would be taken and policies/schemes adapted according to field needs. This double anchorage strategy put the BHCSP into a perspective of health system strengthening, contributing to reinforcing the role of the different actors within that system and consolidating their relationships. It is a strategy in which civil society plays its role of a privileged witness of the reality at the grassroots, and critically, yet constructively, aligns with the policies and strategies, connecting the operational and the strategic level. This goes beyond the scope of a traditional project approach largely focusing at service delivery and capacity building at local level. Concretely, the NGO partners in the BHCSP aim to refine the NHM policies and adapt them to their local context. Their work helps in enabling government to implement their policies and schemes effectively. The advocacy work done by NGOs is based on their field experiences and contributes to refining the NHM policies. The experiences of working with elderly people and adolescents are good examples of this.

Figure 6. The Conceptual Framework of the Basic Health Care and Support Programme in 2011

The Conceptual Framework contains three components: action, reflection and change facilitation. Its design is inspired by the five guiding principles. The vision text quoted below is part of a strategic document written back in 2013 as a guidance for the programme stakeholders. It provides interesting insights into the logic of the BHCSP Conceptual Framework as it was conceived and implemented. It explains the reason for explicitly making the link with the most important Mind-shifts that emerged earlier on in the programme. The section in italics below shows how the Mind-shifts were linked with the three components of the broader framework.

*ACTION: SUPPORTING AND COMPLEMENTING THE ROLE OF GOVERNMENT*

*In the last 15 years, India has developed many government health schemes and overarching policies like the National Rural Health Mission (NRHM, 2005) and later on the National Health Mission (NHM,2013). The challenge is to inform the communities about these schemes and policies and connect them to the services they are entitled to for their right to health. The BHCSP contributes to the implementation of the N(R) HM policies and schemes by creating awareness about the right to health among the people; by assuring that there is proper operational planning, joint implementation and monitoring of the schemes; by identifying the health service gaps taking the basic principles of the programme as a reference; by addressing the gaps so that they are progressively covered by the system. So the objective is to have equitable access to quality services, meaning person-centred, holistic services well co-ordinated with each other.*

*The major Mind-shifts related to the action-component are:*

*1/ Shifting from doing – 'providing the services' – to facilitating – 'catalysing the provision of services by government services. The intention is not to create a parallel service delivery system but to help the government services fulfil their tasks.*

*2/ Shifting from 'customer or user adapting to service' to 'service adapting to customer' starting from their needs. In other words, assuring a people-centred approach.*

*3/ Shifting to a more comprehensive approach towards health and health care, offered by more polyvalent, client-centred services. This is in contrast with the existing government schemes tackling priority problems largely decided upon by policymakers and offering services in a fragmented, vertical way, not considering the other needs of people and not considering the person as a whole.*

*REFLECTION: SUPPORTING THE CIVIL SOCIETY ROLE*

*Systematic reflection on action does occur at multiple levels, at the level of the Self-help groups, the VHSNC, the Panchayats (fourth Saturday meetings), the block and the district level (Advisory Committees) besides the Health Forum. The intervision visits by WBVHA and the quarterly workshops with the five Health Forums support this process.*

*Regularly evaluating the decisions taken at different levels in the system may lead to better, informed decisions and allows continuous improvement in the quality of services. Both quantitative and qualitative information such as stories or other feedback are helpful to debate and make that evaluation. The basic principles and Mind-shifts serve as a guide.*

*Reflection also reinforces the capacities of the local actors. Moreover, it empowers them to formulate their needs and claim their right to health systematically and convincingly. It also helps them identify opportunities in their context.*

Reflection also reinforces the capacities of the local actors. Moreover, it empowers them

*Beyond the local level, the lessons and evidence inspire actors in other GP, subdistricts, or districts beyond the programme's scope (horizontal scaling-up). It may also serve for advocacy purposes to influence policy (vertical scaling-up). So, reflection supports the civil society role of giving a constructive but critical feedback from the field to the decision-making level (whether the local, state or national level). To that effect the programme, using Community Score Cards and other reporting mechanisms, monitors and using stories and 'case-building' as tools documents ) the access and quality of services in the areas covered by the programme; develops innovative, operational strategies to implement government schemes more effectively, or to fill up the gaps in service delivery e.g. the Nutrimix strategy, family-centred care by the ASHAs or also to better link the local actors; identifies priority issues together with the local communities and the first line health providers; attempts to communicate experiences, operational strategies, tools and concepts.*

*The major Mind-shifts related to the reflection-component are:*

*1/ Moving from concentrating exclusively on schemes decided by government to focus on issues of priority concern of the population.*

*2/ Moving also from NGO-based activities to community-led 'doings and beings' related to their health decided upon by the community themselves but with guidance from the NGO partners or other first line health actors.*

*CHANGE FACILITATION: ENGAGING IN STRATEGIC PARTNERSHIPS*

The learning cycle is not a spontaneous process

*The learning cycle in the Theory of Change is not a spontaneous process. Channels of communication between various stakeholders (horizontal links), and between the grass-root level and the strategic level(s) at multiple levels (vertical links) need to be ensured and maintained. An important principle of the programme is that it wanted to strengthen the (health) system. A system may be defined as 'actors and their inter-relations'. So the programme intensively invested in linking up actors and in the quality of their relations enabling them with 'how to do' skills, mind-sets and competence. The hypothesis is that a conducive environment, resulting from collaboration and trust between stakeholders, contributes in an effective way to assure access to quality services and to deal with the priorities of local communities. The (People's) Health Forums may contribute to this conducive environment. But ultimately, the aim is that the subdistrict and district managers develop an adapted working relation with multiple actors at multiple levels. This requires more than management capacities. It requires leadership, giving space to everyone who may help construct a long-term vision and put it into reality. The Dakar Declaration (3) (2013) recommendations have been a source of inspiration to encourage this new type of leadership, which is called 'distributive stewardship (5)'.*

A system may be defined as 'actors and their inter-relations'

*An entity player such as WBVHA is needed to manage this complexity and keep NGO partners and other stakeholders connected and in co-ordination. There aren't*

*that many NGOs at state level. WBVHA's position at state level functions as a hub. It facilitates contacts with strategic partners such as universities which is harder to do for organisations at the grassroots.*

*The major Mind-shifts related to this third component were:*

*1/ Moving from partnerships at micro-level only (comfort-zone) to partnerships at more strategic levels as well (principally the subdistrict, the district and to some extent the state level at this point).*

*2/ Moving from a closed NGO Forum to an open People's Health Forum. It included joining hands with the Health Forums in the other districts as well ('a Forum of Forums'). A Health Forum should be a movement rather than an institution. The forum is the cement between the individual bricks, that is, its members. Making the forum 'too formal' may lead the forum becoming a brick instead of cement. At that moment it may enter into competition with its member organisations. The focus should be on the common agenda. Structure should follow content. "Less formalised, self-organising structures will produce less predictable outcomes but might lead to more active participation, more initiatives and more creative outcomes" (8).*

A Health Forum should be a movement rather than an institution. The forum is the cement between the individual bricks

## Moving to Action-research to develop more robust models and documentation

The Conceptual Framework was challenging for most NGO partners, including WBVHA, as it pulled them out of their comfort zone. Especially things like moving towards an open Forum, functioning as a network of Forums, building strong evidence and engaging in policy advocacy dialogue at district, state or even national level were challenging.

Therefore, it was necessary to take another step forward in the conceptualisation of the programme. We needed to build a more robust boat a strong motor ready to go to the open sea [IB26]. In 2016, a new challenge was put forward. So far, the BHCSP principally engaged in reflective action which is nothing more than the classical management cycle (Deming cycle) (4) and on the principle of "muddling through", an eternal search for improvement linked to a specific trajectory of change. It's about making informed decisions, assuring the proper implementation of these decisions, and evaluating them taking into account data, context and all other useful information. Action-research does the same, but it adds a systematic scientific dimension to the process of reflective action. It generates its own model and evidence by explicitly making use of documented experiences and evidence from other contexts.

In order to convince policymakers, that some innovative operational strategies developed in the course of the programme were leading to results effectively and could also be helpful in other contexts in West-Bengal, India and even beyond, there was a need to go beyond local anecdotes, stories and locally applicable knowledge and contribute to general knowledge. Concepts like a local health system approach, shared governance, the structure and role of the Health Forum, the link between the Forum and communities, and also the approach and methods needed to be clarified and documented as local health authorities and NGOs from other GPs, subdistricts and districts became more interested. Moreover, the BHCSP had to link up with new national and state level policies like NRHM and CHCMI. The programme was already working in the spirit of these policies, so its integration in the policies was easy. For example, the village health committees and central health committees set up in phase I of BHCSP could easily be turned into the NRHM structures like VHSNC, District Health Committee and RKS since they had similar functions.

The choices and decisions made by the BHCSP so far needed to be based on evidence. First, there was a need to improve data-collection both quantitative and qualitative and analysis and systematic aggregation of the data. There was data on Sexual and Reproductive Health issues of adolescent girls and women or on financial autonomy of women, and prevention and management of Non-Communicable Diseases and Mental Health of the elderly population. Despite the rich and diverse information available in the programme, one of its weak points had been the absence of a systematic, prospective, and theory-driven data collection.

Data and explicit models and related working hypotheses underpinning the strategies were needed. Exchange visits and literature review of similar experiences could help in this endeavour. But this was far beyond the work and competencies of the NGOs partners, including WBVHA. So scientific support was mobilised to support this process.

However, we didn't want research disconnected from the operational work. So, the programme opted for Action-research. Local knowledge and experiences of all groups in a local health system needed to be valorised to develop context-specific solutions owned by them. As Cilliers (2) once said: "*One cannot change the system unless from within.*" Therefore, it was important that decision-making remained in the hands of the Forum partners while the academic institutions such as the All-India Institute of Hygiene and Public Health (AIIH&PH) in Kolkata, the Institute of Public Health (IPH) in Bengaluru, as well as the Institute of Tropical Medicine (ITM) in Antwerp became strategic partners. They helped improve the documentation of experiences and enabled evidence generation for knowledge building and policy advocacy. Other strategic partners such as practitioners, policy makers, people from the private sector, other NGOs, members of the art community called Friends of the Forum (s), provided additional guidance.

*"One cannot change the system unless from within."*
(Cilliers)

Models are always a simplification of reality, but it allows actors to communicate better

There was good reason to engage in this explicit, scientific Action-research starting with some innovative operational strategies. With the introduction of the National Health Mission a lot of the operational strategies which were already practiced within the context of the programme had become national policy. The inclusion of these strategies in NHM was not the credit of the programme. But since the programme had already tested these strategies in the field and adapted them to the local reality of the rural areas, it was in an excellent position to document the experiences, conceptualise them and give feedback to the policymakers. The implementation of a Community Health fund at the level of the women's Self-Help Groups described later in Chapter 9 was one of them. The use of the untied funds at the Village Health Sanitation and Nutrition Committee was another one. The establishment of the Health Forums launched in the frame of the BCHSP and their contribution to enhancing governance and accountability of the local health system was also one. The way Health Forums were developed in the programme was innovative. Quite some effort was put into modelling the strategy as is described in detail in the chapter on Health System Strengthening. A complementary model was the one on the governance of the local health system based on the modified Health Governance Framework (see Figure 8) inspired by the Brinkerhoff & Bossert model (1), 2014 (see Figure 7). This model was relevant to all subdistricts and districts within the programme but it didn't exclude diversity of the application of the model in practice, according to the local context. Such models are not designed to make things more complex. By identifying the actors in the (sub) system the programme is focusing on and describing the actual and/or the desired relations between these actors and things are made explicit and visual. Of course, these models are always a simplification of reality, but it allows actors to communicate better and identify entry points for action to improve the system. Such models can be based on existing

models but adapted to the local context as the figures illustrate. The content of these models will be further discussed in detail in Chapter 9.

All the experiences of innovation in the programme were not necessarily successful. For example, some NGO partners had initiated health centres and even hospital care. But structural constraints, as will be discussed later, hampered these initiatives. They prevented the NGOs from offering curative health services that were

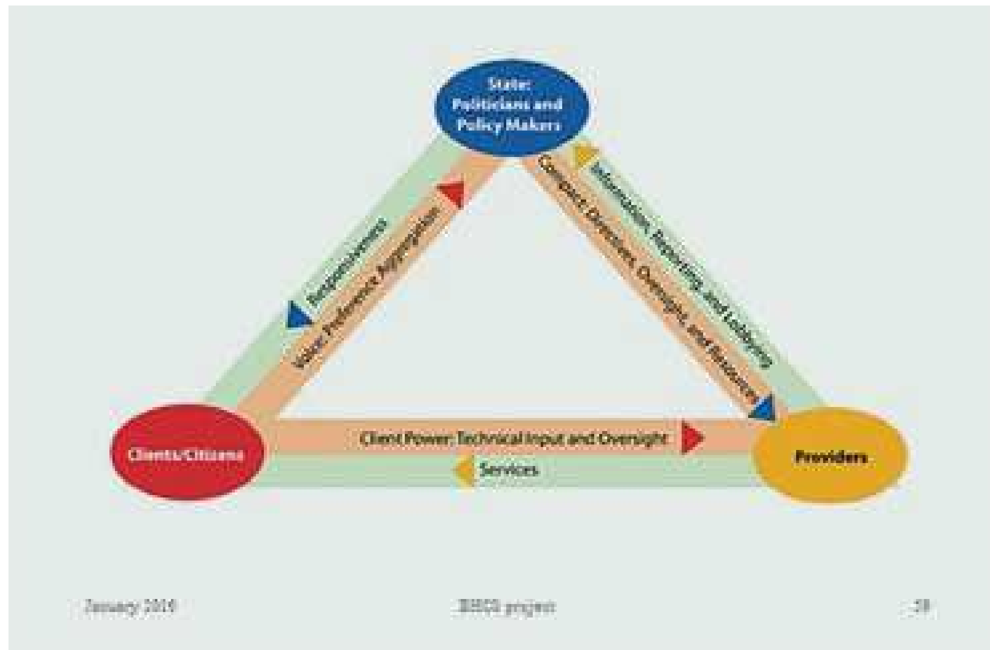



Figure 7. The Health Governance Framework of Brinkerhoff & Bossert (2014)

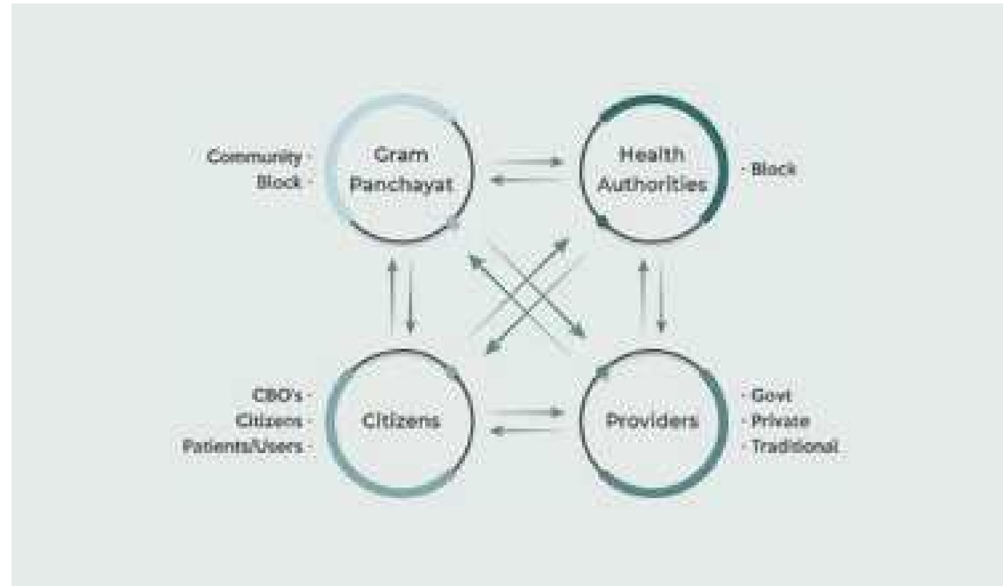



Figure 8. The modified Health Governance Framework in the context of the Basic Health Care and Support Programme based on Brinkerhoff & Bossert

person-centred, accessible, good quality and sustainable. The connection between these centres and the local communities on the one hand, and the referral and access to the higher-level hospital care on the other hand, remained important challenges. Critical incidents, documented by the stories related to those experiences, revealed the suboptimal functioning of the local health system. These challenging experiences, nevertheless, yielded interesting questions for Action-research. Documenting failures requires courage but is necessary so that lessons can be learnt from them.

## Attempting to make a synthesis: an encompassing Theory of Change

The latest layer on the painting in the conceptualisation and sense-making process of the BHCSP, was the development of an encompassing Theory of Change (see Figure 9) in the strategic planning for the programme cycle 2017-2021 which Memisa had to

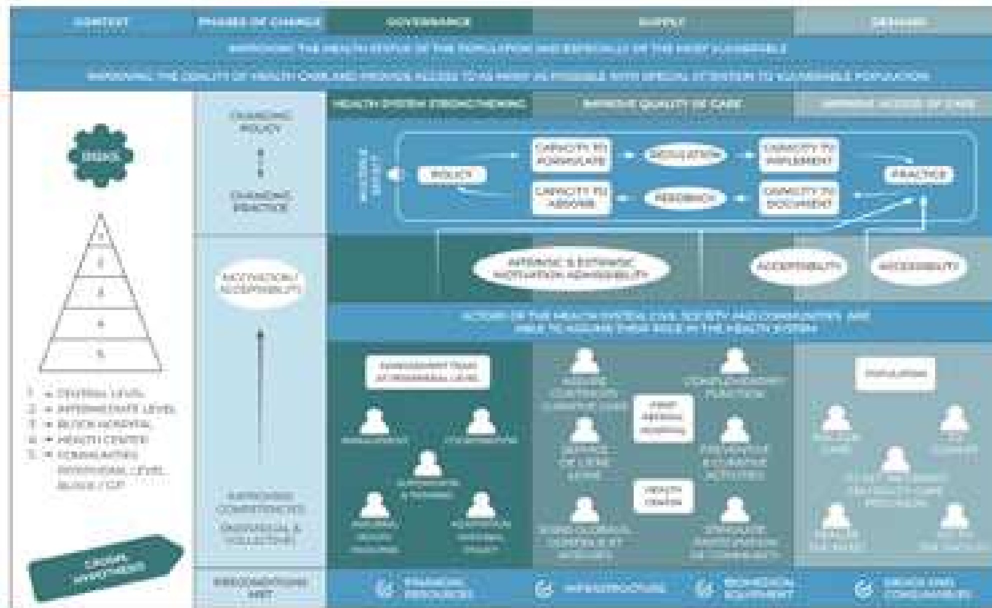


Figure 9. Theory of Change of the BHCSP in the Memisa programme 2017-2021 submitted to the donor agency for Belgian International Cooperation

submit to the donor agency DGD (the agency for Belgian International Cooperation). Though it attempted to be comprehensive, it inevitably remains a simplification of reality and thus imperfect. But it is enriching and complementary to the already existing representations. This exercise allowed actors to look back at almost 15 years of work and further understand the underlying mechanisms. This retrospective modelling was useful for the future as well. It allowed us to identify future challenges, future pathways of action and future ambitions.

Particularly interesting is that the narrative explanation of this framework is formulated as a series of hypotheses along three tracks of change. As quoted from the plan:

*The strategy is based on three tracks of change: the promotion of good governance, the improvement of the supply side and support to the demand side. Gender, environment and digitalisation are transversal themes that will receive particular attention within each track of change. Based on that seven change processes have been formulated as cause-effect hypotheses:*

*H1 (Hypothesis 1): The staff's individual skills in health care facilities will be improved if professional training and internships are organised (on-the-job training).*

*H2: Change of practice demands improved individual skills and improved collective skills.*

*H3: For an individual to change their behaviour and put the skills acquired into practice, other factors are essential: motivational aspects (intrinsic and extrinsic) and acceptability.*

*H4: If the analytical and documentation skills have improved, targeted actors could learn from experience and influence the decision-making level.*

*H5: If the health system actors assume their roles in the health system, the quality of care will be improved.*

*H6: If financial mechanisms exist and health facilities are seen as acceptable, people have better access to health services.*
*H7 If the leadership of management teams of health districts and hospitals, as well as Community Participation are strengthened, then the governance of local health systems will be improved.*

## Imagining a better reality: one single model cannot capture it all

A lesson taken from working with such an Action-research approach in the BHCSP is that you may need more than one model to describe the programme's vision, the desired reality and the pathways to get there. It's like an architect who needs different blueprints to construct the house he imagined: blueprints for the overall design of the house, the electricity and water circuits, the aeration, and so on. Different blueprints with a variable degree of detail are needed to guide the actual construction work. The same applies to a social development programme. Reality is complex with different streams, layers and perspectives challenging to grasp in one representation. The figure of the two streams (Figure 10) made it clear that we need multiple representations to express what we wanted to achieve and how to achieve it. Different actors preferred different representations because they felt more comfortable expressing themselves through a particular representation. For example, at community-level Rich pictures (see Image Book) were quite popular. For the first time during an external evaluation these Rich pictures proved to be a very powerful means for the community stakeholders to imagine the change they wanted and how to get there. On the other hand, diagrams representing actors and

their relations facilitated the discussions during the quarterly coaching workshops amongst the NGO Forum partners. Some models like the ones representing the Forums referred to 'the what' factors whereas others like the Conceptual Framework with the three components represented in a learning cycle referred to 'the how', that is, to the pathways of change.

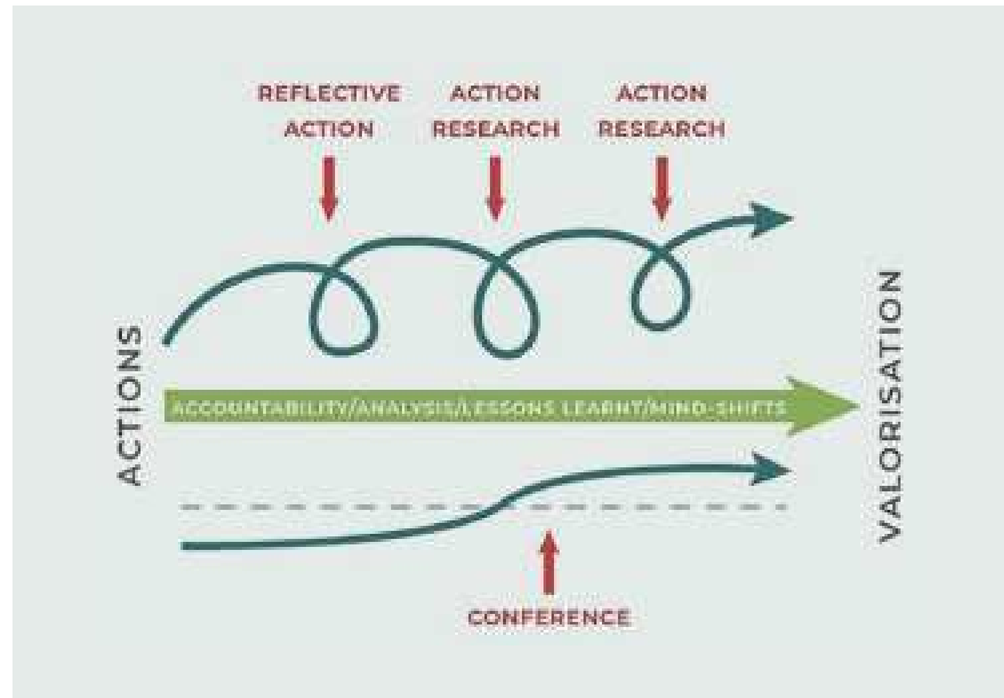



Figure 10. The continuous process of learning through Action-research

As insight grew or need arose, these repre sentations or programme theories were continuously refined and embedded in an Action-research dynamic. Action-research is an attitude, not a study. It's a mind-set more than a tool. Once this mind-shift is made and owned by the local actors, this process can even take processes beyond the scope of a programme. Further details on the Action-research process is provided later in Chapter 10.

## Headwind and windless moments on the way: 'no sweat, no glory'

There is a football club in Belgium, Club Brugge with the slogan 'No sweat, no glory'. The story of the BHCSP is not complete without talking about the obstacles, resistance, limitations, or unintended adverse effects encountered. Irreversible progress cannot be denied, but the process has been slowed down along the way by the context in which the NGO partners had to operate, their operational, cultural and competence gaps.

Change processes take time

The Mind-shifts at the NGO partners and WBVHA described earlier are not achievements but continuous working points. Changing your way of working radically is inevitably challenged by prevailing values, culture, and habits. Such change processes take time, a lot of time. The BHCSP had the luck to benefit from several consecutive and uninterrupted programme cycles. A rare luxury in present times.

For each mind-shift the cursor indicating to what extent the mind-shift has taken place, is at very different levels for each Health Forum, for each NGO, and for each NGO staff member, and could vary over time. This in itself can create tensions between more 'progressive' and more 'conservative' NGO partners and staff.

It was difficult for most NGOs to get out of the traditional, territorial '(micro)project-mind-set'. This mind-set was geared towards searching for funds to implement projects at the village-level. These funds could come from government schemes or external funding usually from international NGOs such as Memisa. And there was a competition between the NGOs to obtain funding. Even if collaboration between them was there through the Health Forums, it was inspired by opportunistic reasons to some extent. This was not abnormal, but it had to be managed continuously. Even where it concerned advocacy, silo-thinking prevailed. NGOs remained anecdotic for a long time, failing to aggregate stories and critical incidents to a coherent case building and then formulate improvement strategies.

Many NGOs were also reluctant to get out of their comfort zone [IB23]. They wanted to continue to do what they could do best: implementing government schemes based on fixed plans and guidelines, rendering services to 'their' populations to whom they were connected, and accounting for it to the hierarchical level. They preferred to stay on the right side of the BHCSP Conceptual Framework (see figure 6), so the top-down part. Making the U-turn and linking up with other actors was tough. But the most difficult part was challenging government schemes, engaging in advocacy regarding unmet community needs and influencing policies. It was about aligning to those policies but in a critical, yet constructive way. That this was not a straightforward challenge was not surprising in a context where initially trust between government actors and NGOs was low. Even when gradually trust had been built, it needed constant attention, especially in recent years where for political reasons the space of dialogue between government and NGOs is shrinking again. On top of that, there was also the lack of self-confidence at the level of NGO partners, because of the skills gap to conceptualise and build up their arguments in a scientific way based on pro-active and systematic data-collection. And last but not least, there was also the fear of losing funding.

A particularly difficult problem was to get into a systemic perspective and see the importance of linking with other levels and influencing the context. For example, grassroot NGOs were quite comfortable with health promotion, prevention and community health services. But these could be effective only if complemented by access to quality services at PHC or hospital level and an operational referral system between the various levels of care. Some NGOs tried to offer certain services themselves like maternity care and advanced OPD care but with mixed results. There were limitations in terms of clinical, public health and management skills along with a private-for-profit logic. There is surely a need to organise accessible person-centred health services closely linked to the local communities but it's hard to do in a highly competitive health market and in an overregulated bureaucratic context. So far, alternative win-win strategies resulting in public-private partnerships with local private actors have been insufficiently explored. There is lack of a global vision on how to organise the local health system and capacities to engage in this dialogue.

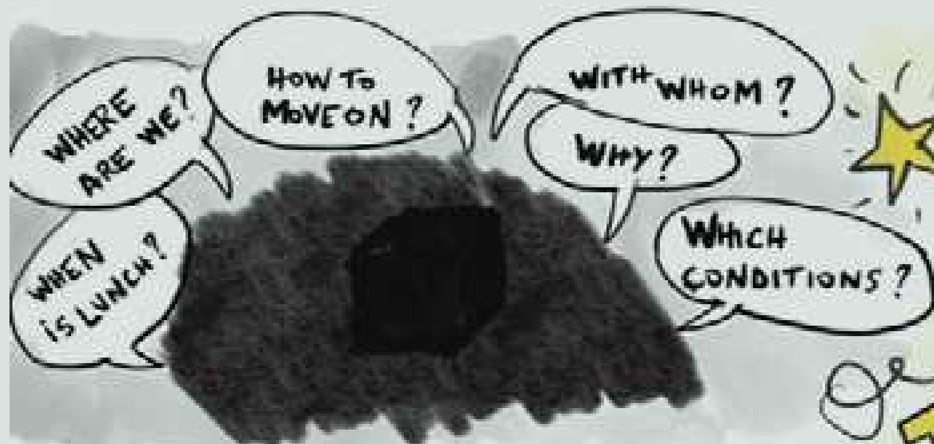
Deeply rooted, as well, was the control mode in which NGOs operate. This mode is not adapted to a complex environment. People don't like uncertainty. Going beyond the prescribed standard solutions or adapting plans and roles to a changing context has been challenging. When NHM became the national policy, the Health Forums had problems defining their role and space. Though, to some extent, they had been pioneers in implementing some of the strategies before they were integrated into NHM, they continued to function in an implementing mode. They were hesitant to claim a seat in Forums involved in advising policy and engage in a more equal partnership with the health authorities at higher levels. Even for WBVHA, this constitutes an institutional challenge despite the progress already made.

Another challenge was that the BHCSP was considered for a long time as a programme like other projects managed by NGOs. It was hard to transpose the alternative BHCSP approach with its principles, methods and tools and mainstream it in their other projects. The extent to which NGOs managed to adapt the design of their training programmes for their staff or external participants based on the lessons learnt in the BHCSP, was quite a revealing indicator. Though progress has been made, in many cases, there is still substantial room for improvement.

A sensitive issue has been the scope and internal organisation of the Health Forums. Questions like 'to what extent should it become an open People's Health Forum' or 'how to move from a Health Forum in one district to an inter-district and state-level Forum', 'should Health Forums become formal structures with hierarchical leadership instead of remaining an informal network' have been subject to debate and reflect the diversity in culture between the NGO partners. Time was needed to overcome resistance of individual NGOs to give up their dominant position and accept the Forum dynamic. All Health Forums have found their balance in this, each of them in a different way. Furthermore, the Health Forums were also confronted with external constraints such as the inherent bureaucracy in the system, or the turnover of decision-makers in local government after every election.

Finally, there were also the biases linked to the presence of a programme financed by an external donor. Despite the enriching partnership between WBVHA, Memisa and the NGO partners, and the programme's flexibility, space, and timeframe, this set-up has its limits and risks. The power balance in these conditions is mostly a thin line. Moreover, external funds may put partners into a too comfortable position and incite them to make opportunistic decisions. To some extent, differences in dynamics may be observed but yet to be proven between those Health Forums formed with financial support from the programme and those who

got inspired and formed a Forum on their own initiative, initially outside the programme's scope. In the longer term, once the programme funding ends, it remains to be seen how strong the Health Forums will be and the nature of the partnership between WBVHA and Memisa. Both financial and technical sustainability remain a point of attention even today.




EXISTENTIAL QUESTIONS ABOUT "THE BLACK BOX IN A DARK CAVE"

## Messages in a bottle

- Explicit values and guiding principles, theories and related models are necessary for stakeholders to make sense and have a common understanding of their local reality and the programme, and make the best possible decisions in a complex, and therefore, unpredictable environment.

- Theories and models for development support programmes should be conceived gradually in a participative way. It cannot be done on a drawing board, before starting of the programme, without being grounded in the reality and the change people desire.

- Moving from practice to theory building is pragmatic and leads to a more robust operational theory. Imposing a well-constructed yet relatively fixed model from the start of an intervention may turn out to be counter-productive due to rigid application and missed opportunities.

- Theories and models are not cut in stone. They are evolving sketches, emerging through joint reflection and action, and gradually fine-tuned, adapted, or profoundly modified. This iterative learning process requires time and space for people to understand their reality, imagine the change they want, and find actions and strategies which make sense to them.

- You may need various, evolving models to capture one reality, like you need several, evolving architectural plans (building, electricity, water, ventilation) to construct a house.

- The change process is not linear and is confronted with the hesitation of key actors as they move beyond their 'comfort zone' into an uncertain environment.

- Theory building requires adequate capacities of the programme managers/facilitators in terms of technical knowledge of concepts and theories in the domain of development, and methodological and coaching skills.

- Theories and related models should be as robust as possible. This means they are applicable, at least partially, in different contexts even if they are expressed under a different form in each of those contexts. External resource persons like researchers, system managers and policymakers can help to move the work beyond the local context, raise evidence for policy and align the programme theories and models to the regional and national priorities.

# Chapter 6

«The most common way people give up their power is by thinking they don't have any.»

ALICE WALKER

# Strong headwinds and currents

Aloysius James

Exploring the boundaries of power along the road to equity and people's autonomy

## ¿uestions

- ¿ How did the BHCSP work with power?
- ¿ How did power relations change among the different stakeholders? How fragile are these relationships?
- ¿ Did the community gain power through the Programme?
- ¿ Does support to the health system yield better results than simply implementing health schemes?
- ¿ And what about your questions?

## Looking at the programme through the 'POWER' lens

There are several intertwined storylines in the BHCSP depending on which lens is used and who is telling the story. It is like a refined wall-tapestry composed of several interwoven threads of different colours, thicknesses and materials. In this chapter, we will unravel these different threads into separate stories and find their different meanings. These threads will tell us how different people experienced the BHCSP in their way and their perception of their roles, and how it has affected their lives. All these stories or narratives are complementary, weaving a richer image of the journey, appealing to both heart and mind.

This is in line with the iterative dynamic which characterised our journey: continuously revisiting the same actions, results, approaches, strategies, models and theories, but each time with a slightly different perspective and mindset. It is moulded by ongoing action-reflection, where those actions, results, approaches, strategies, models and theories are continuously enriched.

Power, (12) or the way people experience and exercise influence on their own lives, is central to understanding how various stakeholders in any society interact with each other. It is a core component in influencing health policies or translating existing policies favouring the disadvantaged and marginalised people. Developing a people-centred health programme involving collective engagement of influential stakeholders with varied interests demands a deeper analysis of how power is manifested at the grassroots or subdistrict level.

Power (1) is often seen as a negative concept linking it with abuse of power, control or domination by few individuals or institutions. However, power can be used effectively to transform people's lives through collaborative efforts of communities and institutions. Alternatively, in other words, it is an opportunity for the powerless

and marginalised to work together for social change. Power is contextual, where apparently powerful communities or institutions can experience powerlessness in a different context. The community members who felt powerful while working with BHCSP partners or even with the elected representatives of the local GP felt powerless when they started interacting with government health care institutions and health authorities during the initial stages. However, the community empowerment process, which was central to the Programme, enabled a shift in power relations. In our context, community empowerment is understood as an enabling process where the powerless individuals and communities recognise their inherent worth and power, work together, and take charge of the situation affecting their lives and health. These community mobilisation and social action processes create opportunities for the empowered community to be part of the decision-making bodies and process.

This chapter will share stories of the people, the health providers, and the policymakers. It will also include the interplay of power between them and how the local health system and people-centred governance were influenced and affected. It helps explain how the BHCSP worked with relatively powerless people to increase their control over events, institutions, and resources that influence their health.

## BHCSP and changes in power relations

The development of progressive health policies and legal frameworks, the establishment of institutional support systems, and resource allocation in the health sector do not necessarily guarantee good quality health services and the well-being of the people, especially those of disadvantaged and marginalised communities. While implementing the BHCSP, the partners became more aware that social and political

power was unequally distributed. It also came to light how those underlying power relationships, interests and dynamics were reflected in the health system thus creating inequality. We recognised that power dynamics influenced the health system. It became visible when the actors started interacting with officials at the local, sub-regional and national level. Interests of the powerful popped up whenever health needs of the community were prioritised, whenever resources were allocated, or health activities were implemented or when political decisions were made on collaborative programmes and community engagement. Hence it was central to understand POWER while working on health policies or practices.

The initial activities around healthcare services did not challenge those power relationships in the system; instead, they were reinforced and legitimised. Our limited activities restricted us from challenging the exclusion, the inequalities and social injustices prevailing in the system. . So, we had to find new ways and strategies for creating democratic spaces for the citizens through a participatory discourse where multiple actors in the health system exercising different dimensions of power could join.

When we started the programme, we also had limitations in doing a detailed power analysis for understanding the different actors within the given context and how power interplays at different levels with different actors. For partners it was difficult to comprehend the interplay of power within the health system during that period. We did, however, attempt to address the issues of power dynamics among the health providers, between health providers and community members and civil society organisations, between health care providers and local governance mechanisms once the team members started to recognise the importance and relevance of power in our work.

*"Power can be defined as the degree of control over the material, human, intellectual and financial resources exercised by different sections of society. The control of these resources becomes a source of personal and social power. Power is dynamic and relational, rather than absolute — it is exercised in the social, economic and political relations between individuals and groups. It is also unequally distributed – some individuals and groups having greater control over the sources of power, and others having little or no control. The extent of the power of an individual or group is correlated to how many different kinds of resources they can access and control." (13)*

*"The Asia Pacific Bureau of Adult Education's (ASPBAE) 1993 study undertaken with FAO's Freedom from Hunger campaign as quoted in Women's Empowerment in South Asia" – Concepts and Practices, Srilatha Batliwala, ASPBAE/FAO (Draft), 1993.*

*Power holds and shapes the relationship between two parties. Hence, power is understood as a relational process: a relationship either over others or with others or with oneself.*

## How did BHCSP work with different dimensions and expressions of power?

Power can be understood in many ways. The two commonly used frameworks on the expression and manifestation of power were developed by John Gaventa (4) of the Institute of Development Studies (IDS) on the "Power cube and" Lisa Veneklasen and Valerie Miller (12) on "Expressions of Power." They are used here to explain how BHCSP played a role to challenge and change power relations in the health system.

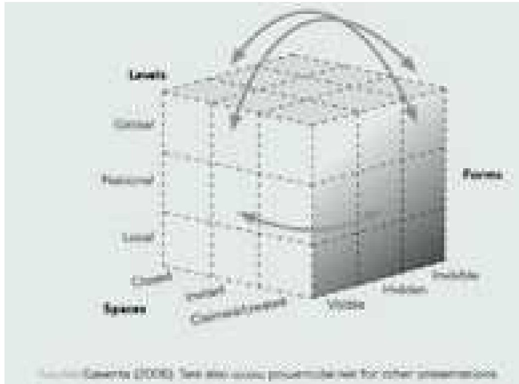



Figure 1. The power cube: the levels, spaces and forms of power

The Power cube (8) talks about three critical dimensions of power:

1. The forms of power refer to how power manifests itself, including its visible, hidden and invisible forms.
2. Spaces refer to the potential arenas for participation and action, including closed, invited and claimed spaces.
3. The levels dimension of the cube refers to the different layers of decision-making and authority.
4. The Expressions of Power describes the positive aspects of power, especially for the marginalised, as being either power over, power to, power with and power within.

**Power Over** refers to a relatively powerful actor's action to affect the actions and thoughts of the relatively powerless. In other words, they were using or exercising one's influence over something or someone.

**Power To** refers to the capacity to act, exercise agency, and realise the potential of rights, citizenship, or voice.

**Power Within** refers to the inner empowerment of individuals, gaining the sense of self-identity, confidence and awareness that is a precondition for action.

**Power With** describes the process of collective power, of people working or struggling together. It refers to the synergy between partnerships and collaboration with others or collective action and alliance building processes.

The frameworks mentioned above enabled us to understand and conceptualise the multidimensional power relations, strategise our actions, and prepare our partners and grassroots level facilitators during our internal reflections and planning process.

## Dealing with the forms of power

The BHCSP worked with people with power from an advocacy perspective and people without power through an empowering process. It played a facilitative role with the various Forums at different levels, wherein people, groups and institutions working in health were brought together for collaborative action to transform power relations. The Programme considered the Health Forum a space where power could be negotiated to raise the voices of the voiceless, challenge prevailing inequalities and assert rights. Hence it tried to bring similar interest groups and individuals with knowledge, experiences, resources and capacities together to influence the powerful for social transformation.

While initiating the Programme, we tried to understand the health vulnerabilities in South 24 Parganas by mapping and identifying the vulnerable areas and vulnerable groups. Many villages and communities were barely linked with the health institutions or health authorities.

The ANMs and other public health personnel at the subcentre, PHC and the ICDS centres functioned as **visible power** centres. They made decisions at the local level on health services, based on institutional rules and procedures. The immunisation, ante natal care (ANC) services and nutrition programmes in these remote areas were irregular. In many instances, the health personnel demanded that the local community should visit their centres if they wanted their services. The BHCSP team engaged with the health personnel, identified their limitations and challenges and extended support in delivering services to marginalised communities. The dialogue and engagement process helped identify and work with institutions and decision-makers at multiple levels, even up to the district level. BHCSP engaged with the health and development institutions, local governance structures and the

The Health Forum is a space where power could be negotiated to raise the voices of the voiceless, challenge prevailing inequalities and assert rights

leaders to ensure proper implementation of health schemes. Together with them, BHCSP worked towards operational policy changes and advocated for developing people-centred schemes.

People resisted some of the BHCSP initiatives with women and adolescent girls because of existing social values and belief systems. The fight against early marriages, the women-led anti-alcohol movement in Howrah, the promotion of institutional and safe deliveries took a lot of energy, time and resources to yield positive changes. The team used popular education and alternative media to change the deep-rooted traditional beliefs and mindset on the role of women in society. We had to evolve different strategies to influence the visible power centres who were strongly influenced by the **invisible power** of existing social norms, mainstream ideology and religious belief systems. In Howrah, the local goons could not come to terms with the participation of women in the anti-alcohol campaign and used their invisible power to thwart the initiatives of the women's group.

Khanpur Gana Unnayan Kendra (KGUK) in Howrah district organised the local women to form a Self Help Group (SHG) to stand up against the widespread alcoholism in the village of Tulsiberia. The men drank alcohol and were violent and abusive towards women in their families. Initially the SHG organised a few awareness camps but that did not work. Then they created a village protection group with the help of the Additional Police Superintendent and started breaking all the liquor dens. Following the SHG in Tulsiberia, women from other villages also organised themselves and engaged in action against alcoholism.

*But such actions of the SHG created resentment in the minds of some men. They didn't say anything in public but they harassed the girls when they went to school, to the shops or were out for anything else. The community leaders were afraid of these men and pretended not to see what was going on. The SHG decided that this had to be stopped.*

*Raksha Bandhan or Rakhi is a festival in India celebrated in the month of August. This festival is observed as a symbol of attachment between brothers and sisters. On this day, a sister ties a rakhi (a decorative band) around the wrist of her brother in order to pray for his prosperity, health and well-being and the brothers take an oath to protect the sisters from all dangers.*

*Kguk shg members taught teenage girls how to make rakhi. The girls also got excited and started learning. On the day of the festival, groups of girls reached out to all the men and tied the rakhi on their wrists with a smile on their faces. A very pleasant atmosphere was created. Through this festival, the bitterness between men and women began diminishing. It's not that drinking has totally stopped, some people still drink during festivals but not in public.*

In another context, we had to organise separate meetings and awareness programmes for adolescents to address cultural and religious issues based on gender. We formed separate girls' groups and boys' groups. During the initial stages, the partners had to invest a lot of energy and resources in forming the adolescent groups and influence them to challenge the cultural constraints related to marriage, socialisation, available medical facilities and other services from the government or others. Some of the partners interacted with cultural, political and religious leaders separately for support, organised specific meetings and awareness programmes to change their mindsets. On a positive note, we received support from a religious leader in a polio vaccination campaign that had met community resistance.

We faced resistance, even within the team, in identifying or working with the **hidden power** centres operating within the health system. We were successful in some subdistricts where the partners had a long-standing association with the elected political leaders. In general, differences of opinion between different political parties in the state are very natural. Even in this situation, the partners or forum members

did not have any difficulty in getting the cooperation of the political leaders. One of the possible reasons was that, many BHCSP workers later became candidates in elections and represented different political parties, and got Panchayat membership [IB5], and they still give the same importance to BHCSP and always cooperate [IB5]. However, In some places, it takes time for partners or forum members to gain the trust of newly elected members, but this has never seemed completely impossible. Reluctance of some higher-level bureaucrats to co-operate in certain districts and subdistricts contributed to slowing down the Programme's pace. The Health Forum in different districts and subdistricts strategically invited the political leaders and bureaucrats whenever they initiated direct actions like the dengue prevention and response programme in North 24 Parganas or the disaster response programmes during floods and cyclones in South 24 Parganas. Other occasions included major campaigns on Community Health Care Management Initiative (CHCMI) and nutrition promotion in collaboration with ICDS authorities, conventions and conferences for health workers and Village Health, Sanitation and Nutrition Committees (VHSNC) at the subdistrict or district level. Health Mela at the district level also received their attention and support. Some of these constituency building actions demonstrated the Forum's relationship with the people and local leadership, ensuring greater acceptance and political support of the district and state-level political leaders and bureaucrats.

## Working with the 'Spaces'

The BHCSP during the last 20 years, came across different people and institutions in the health system offering different types of spaces for health actors to interact. The

Programme team explored those opportunities both formally and informally and used those spaces to bring social and political changes in the health governance and service delivery dimensions. These spaces were also utilised to participate in the decision-making processes and influence them.

### *Closed spaces*

In 2002, BHSCP developed its initial strategy and interventions within the existing policy environment at the state and national levels. In those days, the health policies were developed and operationalised by a closed group without much consultation with the communities. However, the global and national level developments created a conducive environment to challenge these closed-door policy development processes. The World Health Organisation (WHO) and global financial institutions batted for public-private partnerships in the health sector. The People's Health Movement (PHM) and World Social Forum (WSF), promoted and supported by civil society and other people's movements across the globe, demanded people-centred health policies and programmes. At the national level, in line with PHM, the success of various health initiatives in different parts of the country through the new health policy offered an impetus for piloting innovative ideas and models of health.

The current National (Rural) Health Mission (2005, 2013) and the new health policy (2017), were outcomes of various consultations and deliberations based on some health promotion experiments and models in the country. However, the health policy does not adequately consider the local health needs of the community, especially those of the vulnerable, and does not have the flexibility to adapt to specific needs. The decisions are still managed by the national leaders and a group of bureaucrats, without understanding the people's diversity and needs. BHCSP engaged [IB17] with

policymakers and opened up these closed spaces by creating **claimed spaces** and pushed the boundaries to the **invited spaces.**

The Programme worked to support current policy at the grassroots through an inclusive process demanding better governance, accountability, and transparency in health matters. It created a network of grassroots level organisations linked with multiple actors who negotiate and dialogue with those who make decisions for them. At the same time, the Programme also contacted concerned authorities with suggestions about corrective measures to overcome the operational limitations and constraints of the existing health policies. However, there were significant gaps in the Programme in relating and linking with the state and national health leaders due to internal capacity limitations and the fear of confronting the policy issues openly.

### *Claimed / Created spaces*

*"When spider webs unite, they can tie up a lion."*
(Ethiopian proverb)

It was very challenging to build a constructive relationship with the powerful and converting that social capital to access services and resources and becoming a part of those decision-making bodies . The team was very creative in analysing the available spaces or creating spaces for engagement. Inspired by their country's people's health movement, the Programme viewed empowerment of marginalised communities and people's participation as a primary strategy to bring transformative changes in health. Alongside, efforts were made to build constructive relations with people and institutions in power. The formation of health committees at the village level and linking them at the Gram Panchayat (GP) level was seen as a constructive mechanism to ensure people's participation in health. These social spaces, representing all sections , especially women and marginalised communities, facilitated an understanding of the ground level health reality and could also identify gaps in services. The partners

converted these spaces to grassroot platforms creating an interface with the health authorities at the village, GP and subdistrict level. The resource support given [IB4] to the health centres, complementing the government health services, helped gain the ' trust and confidence of the authorities. The participation in the Samsad and first Saturday meeting at the subdistrict level provided opportunities for partners and representatives of the health committee to raise matters related to health. They brought up matters like access to good quality health services, prevailing diseases, community concerns on water, sanitation, and nutrition, the poor functioning of the public health institutions and suggested measures to improve them. These spaces supported people in identifying and addressing possible solutions through collective action or in activating the concerned institutions.

The team mobilised and organised vulnerable communities such as elderly people, women, youth and adolescents and created spaces for them to interact locally and at the subdistrict level to exchange their ideas and specific concerns. They also initiated collective action with the support of the authorities and leaders. The success of these local actions enhanced their confidence and self-image and motivated them to display leadership in addressing social issues such as early marriage, trafficking, malnutrition and mental health problems at the health centres.

The Forum extended critical collaboration and support to ICDS centres and sub-centres and strengthened peoples' participation in these centres. The existing village health committees, which later transformed into Village Health Sanitation and Nutrition Committees (VHSNC) in accordance with National Health Mission (NHM), received a formal mandate from the government to monitor health services in a village. They could oversee the health actions at the village level, plan health programmes, and conduct community monitoring . The process helped in improving the transparency and accountability practices of health services and health programmes.

## *Invited spaces*

Over the years, the national and state government policies on health governance and its delivery have acknowledged that they cannot solve the health problems in the country / state by themselves. Hence, they invited public and private actors to participate in healthcare service delivery with their resources and skills. The government set up the rules of participation, a top-down approach with little space for negotiation. However, BHCSP wanted to explore these opportunities and push the boundaries because it allowed us space to work in a collaborative model and influence the existing policies or define the operational agendas of the existing policies. Our experiences have been mixed, depending on the context and the type of leadership. On many occasions, especially during the initial stages, the health authorities wanted our support only to implement their schemes. They wanted BHCSP to reach out to the remote areas to deliver the services or ensure the community's participation in the schemes. They recognised an increase in immunisation coverage, improvement in the nutrition status of women and an increase in institutional deliveries in the BHCSP target villages and GPs.

With increased trust and acceptance, the relationship moved to collaborative actions. Invitations from the people and institutions in power were the starting points. In North 24 Parganas, there was a joint initiative and drive to prevent dengue at the district level. The Forum received similar requests for joint actions to control swine flu and bird flu. In 2005, the Chief Medical Officer of Health (CMOH) of South 24 Parganas sent an official letter to all the Block (subdistrict) Medical Officers of Health (BMOH) and Block(subdistrict) Public Health Nurses (BPHN) to invite health forum members every month to the subdistrict level and extend support to the ongoing BHCSP programmes in their areas. The social mobilisers and team members of BHCSP

received invitations to join the third Saturday meetings to review and plan along with the ANMs and ICDS team at the sub-centre . Over time, all Forum members received a formal invitation to join the fourth Saturday meeting at the GP level and the first Saturday meeting at the subdistrict level on health. This was a recognition of the value that the Forum added to the health programmes. The health authorities nominated some of the Forum members Human Development Centre (HDC), Sunderban Social Development Centre (SSDC), Ashurali Gramonnoyan Parishad (AGP), Kautala Friends' Sporting Club (KFSC) to the Rogi Kalyan Samitis (RKS) of the subdistrict hospitals in their respective areas. Recognising the resources and skills available, the government requested the health forum partners to animate and support VHSNC at the district level (South 24 Parganas and Howrah).

The Government of West Bengal then invited WBVHA to be part of the ASHA Mentoring group at the state level. The Forum's role changed over some time while working with the government using those invited spaces. In 2015, WBVHA played a facilitating role in responding to the draft national health policy by bringing together various actors, advocating for changes. The team played a facilitator role in 5 GPs and 1 subdistrict in developing health plans as required by the health authorities. From BHCSP, the ICDS team learned a new method of growth monitoring – weight for height to monitor the nutritional status of children below six years. They adopted the methodology for the whole district of South 24 Parganas. The interface meetings jointly done with the GP and subdistrict authorities facilitated getting new land and permanent structures for ICDS centres and also repairing a sub-centre in South 24 Parganas.

Thus, the Forum enhanced its status, playing different roles in the continuum of partnership with government, i.e. from a service delivery support agency to undertaking joint actions, then becoming a resource support and knowledge development

agency and also supporting policy development and planning. The relationship and power equation with the health leadership changed over some time. We learned that time is an essential factor in building relationships and getting acceptance within the government system. Please refer to Figure 2 relating time against power and relationships. The time needed to reach the highest level of partnership varied from place to place according to the context, depending on the government's leadership, the Forum, and the political environment we operated in. The level of partnership was not uniform across the districts, subdistricts and GPs.

Similarly, the Forums are at different places in the continuum in relating with government institutions and other partners. Building trust was not easy and the graph was not linear in many places. In some places, the progress was linear, whereas it moved in a spiral in some contexts. It moved fast in some centres where the leadership recognised the value of the Forum. Hence, they were receptive to new ideas and suggestions. The change of PRI leadership, transfer of bureaucrats, the social capital of Forum members gained over the years, and the relevance and acceptance of the interventions contributed to quickening or slowing down the changing power equations.

In some places, relationship building was a back-and-forth exercise. In Patharpratima subdistrict, the relationship was smooth and steady right from the beginning as the partners developed a mature relationship with the subdistrict and PRI leadership at an early stage. In North 24 Parganas and West Sikkim, the partners had strong linkages with the subdistrict leadership even before starting the BHCSP, which facilitated smooth sailing right from the beginning. The strong presence and rapport with the government leaders of the Voluntary Health Association of Sikkim worked in favour of West Sikkim. In Darjeeling, the community leaders had excellent rapport and relationships with bureaucrats and political leaders, favouring the

Forum. As a result, the Forum received more invitations for collaborative work. In Howrah, the general political climate was tense due to factors beyond civil society organisations and partners. In some subdistricts and GPs, both the bureaucrats and PRI members did not like the interventions of some Forum members. They did not acknowledge specific interventions for women's empowerment, violence against women or the anti-alcohol movement by Khanpur Gana Unnayan Kendra (KGUK) in Haturia I and II GP of Bagnan subdistrict in Howrah district. So, some GPs and Block (subdistrict) Forums had some constraints.

Figure 2 shows a diagrammatic representation of two types of experiences while working with the institutions of local governance and the subdistrict leaders. Graph A shows the progressive development without many constraints, whereas Graph B

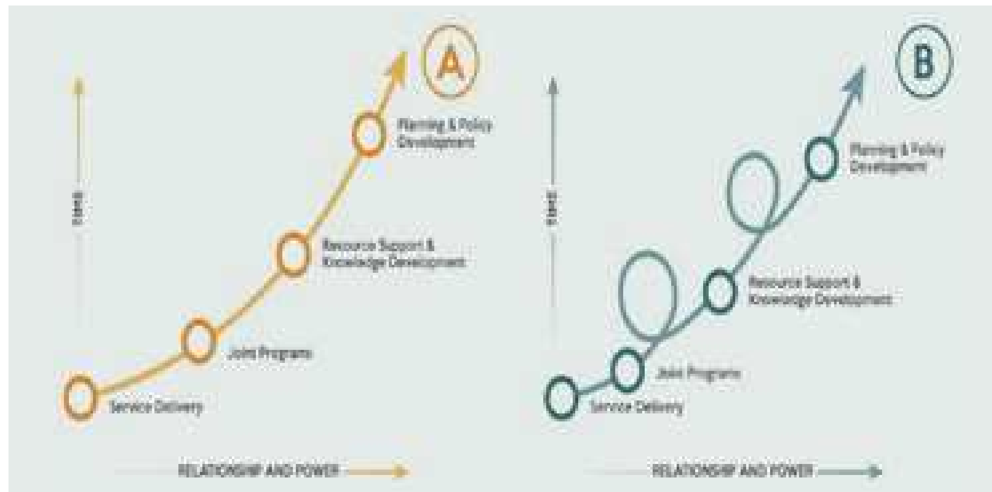


Figure 2. The change of relationship and power among the actors change with time

shows the challenging and time-consuming process of relationship development. There was no uniform progress. The contexts and experiences varied across the programme area for the reasons stated earlier. At the same time, the degree of partnership with all GPs and subdistricts also varied. In some subdistricts, we still collaborate with the PHCs and PRIs for service delivery and joint programmes. With some GPs and subdistricts, we organise capacity building activities and facilitate reflection meetings and reviews of the ongoing programmes. With a few partners, we assist and support in developing health plans and operational policies.

These invited spaces helped us negotiate the boundaries and thus positively impact the power relations of the Forum with the government. However, it was a time consuming and complex experience. We anticipate a challenging time ahead to sustain those relationships due to the changing socio-political scenario and change of guard at multiple levels at different times.

*Durbachati GP under the Pathar Pratima subdistrict of South 24 Parganas district had a high prevalence of malnutrition among women and girls. The ASHA and AWW and other frontline workers identified many pregnant women who were not accessing the sub-centre and IC services for various reasons. They brought the issue to the notice of SSDC, one of the Forum members working in those villages. SSDC and the ANM raised the issue during the fourth Saturday meeting at the subdistrict level with the Panchayat, subdistrict health authorities and ICDS.*

*The BMOH observed the high prevalence of malnutrition among women, low birth weight of babies and increased child death in Durbachati. Most of the women were anaemic and lacked a proper diet, especially iron-rich food. They were reluctant to use the services available in the ICDS and subcentres. They requested SSDC to guide and support them to reduce child deaths and malnutrition. SSDC conducted a study on 15 pregnant and 37 post-natal (till 48 days after delivery) mothers. The study revealed*

*that, 70% of women had babies with low birth weight, 29% of mothers were anaemic and one low birth weight baby died in the past year. Fifteen pregnant women had an Hb less than 8.*

*Based on the findings, the team developed a joint action plan. The GP provided three days of food in a week, that is, 1 egg and dates 50 gm per mother per day, ICDS supported with supplementary food regularly, which was monitored by AWW and ASHA. (4) The PHC provided immunisation, ANC & PNC check-up & IFA supplementation. ASHA monitored the mother's health and reported to ANM about changes. SSDC provided three days of food support in a week consisting of 50 gm each of fruit and mixed pulses per person per day along with regular health education. They extended service to all 15 anaemic women during their pregnancy . Thirteen out of 15 mothers gave birth to healthy babies with average birth weight. The success of this joint initiative became an agenda of the GP health plan. The health plan contained additional food support and medicines for all malnourished women.*

*SSDC took the learning to the other members of the Forum and they suggested similar actions in other GPs and subdistricts.*

## Levels of power

Friel S (3) emph asises and reinforce the arguments of Farmer (2), Navarro (7) and various other political scientists argue that health inequities flow from the systematically unequal distribution of power and prestige among different social groups. Global, national and local politics and modes of governance, economic, physical and social policies, infrastructure, and cultural norms generate and distribute power, income, goods, and services. These are distributed unequally across the social hierarchy (7).

A decentralised approach and principle of subsidiarity defined our level of engagement and decisions about mediating power

The future of local healthcare systems increasingly depends on changes at a global level. The BHCSP programme worked at different levels optimising the available resources within the network. A decentralised approach and principle of subsidiarity defined our level of engagement and decisions about mediating power. The local community mobilisation and transformation actions influenced the national, sub-national and global forces and vice versa. The local partners and CBOs acted mainly at the village GP level. However, these experiences were taken forward to the next level, i.e. with subdistrict and district level, to influence the policies and programmes. The District Forum, together with WBVHA, worked with the state authorities, building on the knowledge and learnings generated from the field. The academic and research institutions linked to BHCSP and Memisa worked at the national and global levels. Similarly, the global developments in health and

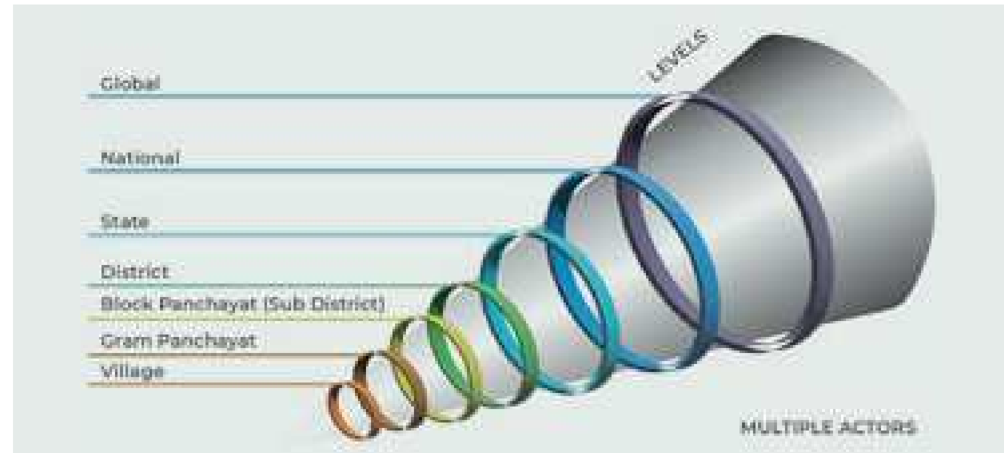



Figure 3. Working at multiple levels with multiple actors

shifts in policies were brought to the national and local level to revisit decisions or make adaptations. We see these different levels as interrelated spheres.

Please refer to figure 1,2 and 3 in Chapter 7, explaining the multiple actors and levels in detail. The power dynamics at these levels vary according to the type of actors at each level. As we climbed up the ladder, the changing power relations faced much resistance, especially from the bureaucracy, whereas the government officials working closely with the community were more flexible and ready to accept and adapt.

## Working with expressions of power

Various health and development institutions such as PHC, sub-centres, and health actors exerted power directly and indirectly over the community and other actors through their rules, procedures, and regulations while discharging their responsibilities and roles. They use visible, hidden and invisible power to influence people's minds to support rules, ideology, social and cultural norms, beliefs and value systems. In the process, vulnerable and marginalised groups get excluded from mainstream services. These excluded communities felt powerless and could not take advantage of the opportunities to participate, even when available, nor could they challenge the discrimination they faced due to the low self-image they acquired historically over the years. Factors like financial capacity, geographical isolation, class, caste and gender hierarchy in society, religious and ethnic background worked against them. They did not have the opportunity to exercise their collective energy against decisions that oppressed them.

The BHCSP, rooted in empowerment principles, attempted to identify other

forms of power to counter these negative and constraining factors to achieve positive changes in the field of health, primarily for the disadvantaged communities. It worked with multiple individuals and communities to improve accountability and transparency, strengthen governance, and change power relationships. The diagrammatic representation given below offers insights into how BHCSP worked

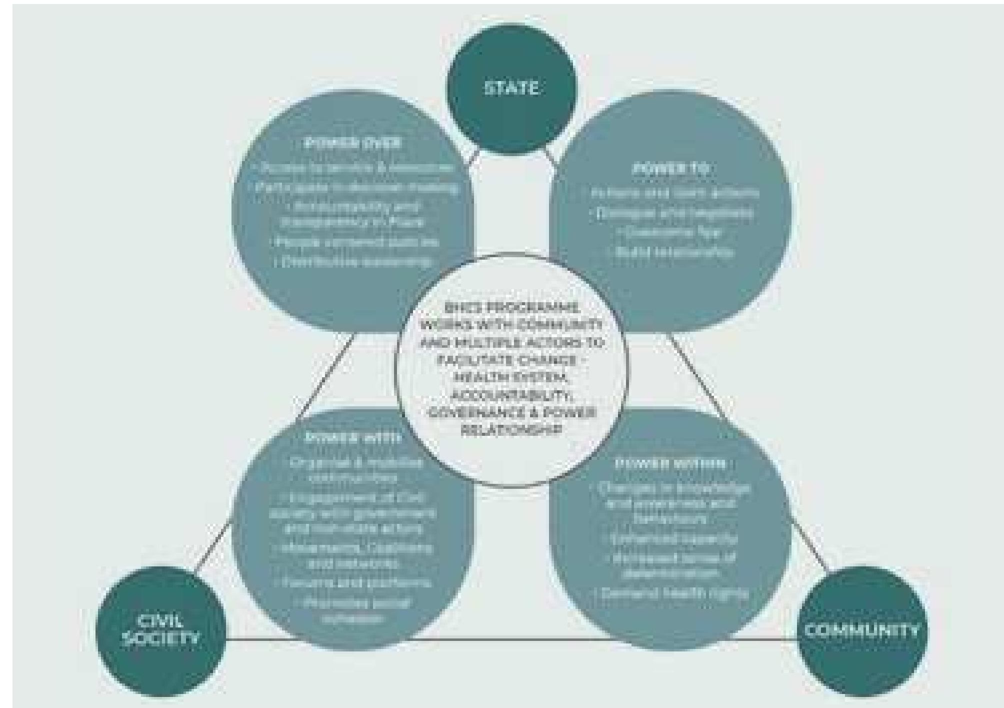



Figure 4. BHCSP and expressions of power and the intended changes

with different expressions of power. The Programme engaged with civil society organisations and government health authorities and institutions to ensure positive transformation in the health sector. It used multiple strategies at different levels, using a multi-pronged approach through the key actors to balance unequal power equations. BHCSP facilitated interactions between the state and community and that helped the state understand community needs and gaps in the state health services. The state health actors developed or amended policies favouring the community by working closely with civil society organisations. Alongside, these processes ensured that marginalised and unorganised communities, recognised their inherent power, collaborated with others and reclaimed and asserted their power through a democratic process.

Bringing all the healthcare actors to the same platform was a challenge. The BHCSP could not include the private healthcare institutions, which play a crucial role in addressing the healthcare needs of communities. The forum did not have sufficient resources and capacities to broaden the network to include them. Strategic partnership with the private actors is a priority agenda for the next cycle of BHCSP.

### *Constructing the future (Power over)*

Power over, a commonly recognised form of power, often has a negative connotation and is linked to domination and superiority in relationships. We consider that people with authority have "power over" to dominate others. In the health sector, we often found that power is concentrated among a few, who draw their power due to their role, skills, knowledge or access to resources and exercise their power over a group of communities or institutions. The professionals, local political leaders, invisible and hidden power sources try to retain control over decision-making and

resource allocation, excluding others without maintaining transparency. Creating a countervailing source of power had led to conflict in the past, where the powerful had to lose power that got transferred to the powerless.

However, if one sees power as a positive force that can be used for good, one is more concerned about democratising power relations. According to Gohler (5), power is not always a zero-sum game, but instead, competing powers can be mutually supportive. Accordingly, it allows the powerless to enhance power without diminishing others, thus creating a win-win situation for all. The recipients of health services, the vulnerable and disadvantaged members, could use other expressions and forms of power, i.e. power within to challenge dominant forces.

The BHCSP is more inclined to see power over as a positive force for good. The focus is to create an enabling environment for good health governance, accountable and responsive to people's health concerns, especially those of the most vulnerable and marginalised communities. BHCSP introduced its partners and Health Forums to various options and models of changing power relations and creating alternate power structures and decision-making Forums without causing hostility. The process enhanced accountability and transparency at different levels for accessing health services and facilities and exerting pressure to develop people-centred health policies and frameworks.

### *Finding common ground (Power with)*

"Power with" (11) is a form of collective power created by coming together around a common agenda while respecting differences. It is a shared power that grows out of collaboration and relationships. It is built on trust, respect, mutual support, shared

power, solidarity, influence, empowerment and collaborative decision-making leading to collective action and creating an environment to act together.

In principle, the current health system has provisions for people to participate in the health planning process. However, in practice, they could not participate. The disadvantaged and vulnerable people living in remote villages and islands are considered illiterate and incapable of participating in the decision-making process. Often the women, youth, elderly people and communities belonging to marginalised sections were excluded in the decision-making process on matters affecting their health. However, the current Panchayati Raj level governance model has a provision for them to voice their concerns. The Health Forum [IB1] at the village level allowed the community members to come together and build a shared understanding of their health problems and their rights. It provided information about the various government schemes and challenged the authorities if they failed to reach the deserving people. It allowed different groups like men, women, youth, adolescents to form their interest groups and influence the decision-makers at another level and was not limited only to their context.

The Programme built a positive relationship with various health institutions such as primary health centres, sub-centre, ICDS centres, GP. These community groups were linked to available services and could also represent their concerns and demand for better care and services. Similarly, efforts were made to link with other civil society organisations operating at the local and national levels to facilitate service delivery and networking. The collaboration with public health and academic institutions helped the Forum inform higher officials about health needs and concerns at the grassroots. The interface meeting with subdistrict offices and GPs offered opportunities for disadvantaged people to communicate directly with leaders.

### *Live with dignity and hope (Power within)*

The power within (9) is related to a person's "sense of self-worth and self-knowledge; it includes an ability to recognise individual differences while respecting others". The power within involves people having a sense of their capacity and self-worth.

To live in a world of Power Over, the first step BHCSP took was to enable individuals, communities and institutions to recognise the power within(10). It also worked on engaging and networking with individuals, communities and institutions who appreciated Power With. The empowered local communities, VDC/VHSNCs, NGOs and CBOs found common ground among different actors and interest groups, built bridges with them for better health care and developed health programmes relevant to people's needs. The collective strength that evolved through collaboration, mutual support and solidarity (6)enabled the Forums and communities to transfer "power to" and move towards realising equitable relationships with those who have "power over". The power dimension was effectively used for collaboration and transformation rather than as a source of domination.

In the initial period, BHCSP came across many communities excluded from the health programmes for various reasons. The communities often expressed their helplessness when it came to accessing quality healthcare. They felt that the leaders and authorities took decisions and very seldom listened to their needs due to the prevailing socio-political and cultural context. They believed that they did not have any power to influence the ongoing schemes or health plans. Many were not even aware of the prevailing schemes and programmes planned and implemented in their areas.

The idea of forming the Village Development Committees/ Village Health Committees (VDC/VHC) in each village was to ensure that power was devolved to

the local level where people participate in health governance. Through the decentralisation process, the government has granted a certain level of power to the GP. However, it was difficult for the vulnerable and marginalised communities to influence decisions even at the GP level due to socio-cultural and political factors. The health interests of ordinary citizens often never reached or never got the attention of the local health leaders or the health bureaucracy. Hence, they developed the idea of establishing VDC/VHC at the village level consisting of people's representatives from different walks of life. The women and marginalised communities found a special place in these committees. In Diamond Harbour II subdistrict, AGP formed neighbourhood communities in the villages where they worked, bringing together 15-20 families of the same geographical area. Their representatives were nominated in the VHC/VDC. These units served as a platform for understanding, debating, and analysing their health issues and influencing local health authorities and institutions.

VDCs and CHCs provided people spaces to develop a shared understanding of their needs, critically reflect on the current realities, and engage constructively with the political and health leadership at the subdistrict and district level. Initially, these structures were outside the official decision-making process or remained parallel systems to the existing government system. The fourth Saturday meetings at the GP level functioned as political Forums where people learnt to collaborate and make decisions. BHCSP ensured the participation of many community groups and individuals in the decision-making structures at the local level. Enhanced political consciousness ensured community participation in these Forums and people exerted political pressure to access quality services.

BHCSP helped individuals and communities identify their "power within". The adolescents, women, elderly people, VDC/VHC and other similar groups recognised their self-worth, rights, and responsibilities through an Action-Reflection-Action

approach. Awareness generation, capacity building, community mobilisation, interface meeting with authorities, involvement with ongoing health programmes and participation in reflective meetings enabled them to imagine and develop hope for their future and their fellow community members. During fourth Saturday meetings at the GP, the community, local health leaders and local governing body representatives conducted case building exercises on specific health incidents in villages of South 24 Parganas. Such exercises helped the community critically analyse why such incidents happened to particular people or communities, what prevented them from accessing better services and how those constraints and impediments could be addressed in the future. The process empowered communities to plan, drive change and reinforce government responsibility to provide better services at the sub-centre and PHCs. Similarly, the demand of the elderly people in North 24 Parganas for health services at the PHC, resisting early marriage in South 24 Parganas, the anti-alcohol movement of women in Howrah, the demand for more untied funds for VHSNC and sub-centres from local government and PHC, and the demand for regular visits to the villages by the ANMs in South 24 Parganas are good examples to highlight the transformation of people from "I cannot" and "we cannot" to I CAN and WE CAN. These communities understood how power operates at different levels and developed alternative power sources by collaborating and aligning with similar interest groups, challenging those with "power over" them.

### *Altering destiny (Power To)*

The fundamental element of "power to" is based on the belief that individuals, groups and organisations have the power to make a difference, and they can achieve the change they want. BHCSP believes that people and organisations can make a

difference in matters affecting their health when supported with requisite skills, awareness and confidence. BHCSP developed and strengthened organisations of disadvantaged people and linked them at regional and sub-regional levels with similar groups. It played a facilitative role to help groups and individuals learn, share ideas, critically reflect, and act on issues affecting them. The process allowed individuals and people's organisations to participate in different platforms, interact with decision making bodies, network with similar groups and explore possibilities of joint action, "power with" others. At the same time, they had the opportunities to challenge and negotiate with the powerful. Many of these Community-Based Organisations (CBO) and Forums developed in-house capabilities, formed institutional mechanisms, challenged the authorities or leaders through collective actions to realise their rights. In Patharpratima subdistrict, the adolescent girls approached the officials for a regular supply of good quality sanitary napkins and also asked for toilet facilities in ICDS centres. In a similar context, the adolescent girls could ensure a regular supply of food from the ICDS centre in Baduria subdistrict, in North 24 Parganas, with the support of VDC. The women and girls influenced the Panchayats of Bhadura and Sarisha villages, of Diamond Harbour II, to allocate INR 2500 (35 USD) to build an incinerator in each of their villages so that they could easily and hygienically dispose sanitary napkins and other bio-medical waste.

The case study here gives a glimpse of another community initiative.

*BHCSP organised a Non-Communicable Disease (NCD) screening camp in 4 villages, namely Itarai, Khorda, Pancharul and Uttar Harishpur of Udaynarayanpur subdistrict in Howrah district, in collaboration with the government. They came across many elderly people suffering from physical and psychosocial problems that needed immediate attention.*

*The team helped the senior citizens to come together and form their groups to know each other and identify and address common problems. They convened a*

Figure 5. Graphical representation of the interlinkages and complementarity of different expressions of power to changing power relations

*meeting where senior citizens received information on different healthcare schemes and services for elderly people.*

*These villages had no medical facility. People had to travel to the subdistrict hospital, which was far and spend much time in the queue to access services. Often, they were forced to visit quacks. Most of the time, the nearby sub-centre lacked the appropriate medicines that they needed.*

*The members of the elderly people's groups submitted a joint petition signed by 326 members demanding the following: 1) Separate arrangements at BPHC for elderly patients. 2) Availability of prescribed medicines from the local sub-centre at a regular interval. The initial response was discouraging. However, struggle and sustained negotiations with the authorities over ten months gave positive results. The subdistrict hospital arranged a separate consultation queue for the elderly at the hospital.*

*Though the authorities could not arrange a regular supply of medicines at the sub-centre, they allowed representatives of the elderly persons to collect medicines from the subdistrict hospital on behalf of the elderly persons.*

*Elderly persons [IB7], who had felt powerless, organised themselves with the support of local self-help groups and. through collective action, they received their entitlements and rights.*

BHCSP strategically worked on two dimensions, 'power within' and 'power with', to realise the 'power to' dimensions. The exercise of 'power to' requires recognising the 'power within'. In most cases, people experience 'power with' other groups through collaboration and collective action. 'Power to' reinforce groups and members' self-confidence boosts the 'power within'. The opportunities to participate in decision-making processes and community building exercises enhanced their ability to influence 'power over' and increased people's confidence to promote transformational changes. The BHCSP made a combined effort to use their power to get things

done without exploiting their power over others but using it as an opportunity to make changes. Each expression of power is linked to another, has a positive influence over the other, and collectively contributes to the transformational changes.

BHCSP strategically worked on two dimensions, 'power within' and 'power with', to realise the 'power to' dimensions

## Coaching process to address the power imbalances within the Forum

Memisa and WBVHA, with the active involvement of an external consultant, played a facilitative role. Both Memisa and WBVHA hold power in developing partnerships with the local NGOs though the degree of leverage varied between Memisa and WBVHA. The local partners had strong relationships with the local community, though they had technical limitations in the health sector. WBVHA brought the technical capacity and Memisa the financial and complementary technical resources.

As facilitators, they created space, provided support and raised questions to enable the learning process, though partners came from different social and economic backgrounds. Some of them represented very established NGOs, while some were unsophisticated CBOs. The power dynamics among the partners and competition for resources was a constraint in the initial stage.

The facilitating team worked on the unevenness of power among the partners at different levels. This was managed and mitigated by strengthening the capacity of partner organisations, the local communities and community Forums, The importance of each partner was emphasised, as well as the strengths, resources and the added value they brought to the forum. During the workshops, the team helped the members recognise the different levels of influence and expertise and how each one complements the programme at the GP, subdistrict and district level.

The differences among the members were turned to strengths while working with communities through BHCSP.

The recognition and acceptance of SSDC in Pathar Pratima subdistrict helped other members to relate with the PRI and health institutions. Similarly, in Diamond Harbour 2 subdistrict, AGP helped other members from the subdistrict to connect with various departments. The quarterly peer reviews and cluster level meetings provided a deeper insight into each one's contribution to the Forum. The opportunity to challenge and provide feedback facilitated in improving the power equations. There was a shift in their approach while relating with the government or other actors. The members started to represent the Forum rather than connecting with these stakeholders as separate organisations. Such a process helped the smaller organisations feel equal within the platform.

As external actors and facilitators, the BHCSP team created space for engagement, sharing and learning among the Forum members and local communities. The team guided the forum and community to develop a longer-term vision and identified and promoted leaders like adolescent boys and girls who took up community issues with the political and administrative authorities. Some of them became ASHA workers and elected Panchayat leaders later. The facilitating team acted as a sounding board and provided technical inputs whenever necessary. It helped them open up, recognise the resources within the group and communities and promote peer learning.

Some partners still consider that Memisa and WBVHA hold more power due to their specific roles. The internal processes, however, promoted equality between the facilitating team and forum members. As they worked together, each of the parties considered themselves equal partners, jointly working together for a common purpose. The facilitators had their frustration with the local partners due to the slow process among the members to engage, open up and take ownership of the BHCSP

process and programme. The facilitating team sometimes expected more swift actions for social change without always fully understanding the local context and organisational environment in which the partners operated and the power imbalance they experienced with government institutions and leaders. There were times where the team expressed unhappiness about the outcome of certain activities.

However, the team ironed out these differences during the annual mission or the coaching workshops. As a strategy, spaces were created within BHCSP, where the management team including the facilitating team talked to each other whenever there was a communication gap. A community-first approach and community empowerment helped BHCSP minimise the power differences and imbalances among the key partners of the Forum.

A community-first approach and community empowerment helped BHCSP minimise the power differences and imbalances among the key partners of the Forum

## Did Changing Power Equations strengthen the local Health System?

Inter and intradepartmental collaboration for health at the micro and macro level were often limited due to poor communication, conflicting power relations, prevailing institutional structures, hierarchy and role confusion. Rivalries among the various professionals in decision making bodies contributed to the non-collaborative attitude in the health sector. The health providers believed that they had more power and expertise than health seekers, which was reflected in their approach and practices while developing policies or implementing health programmes. Often the approach was top-down, with very little expectation of involvement of ground-level actors. The clinicians felt superior to the local government authorities when it came to health matters and this led to friction while implementing health activities.

Similarly, the clinicians considered the public health team inferior to them. On the other side, the development leaders at the subdistrict level expected the biomedical /clinical team to follow them when overall developmental plans were initiated or implemented. Health is one of the components of the development agenda. There was a trust deficiency between the government health team and civil society groups. They were expected to support the government programmes without asking any questions.

The interface meetings among the various actors, the internal and public debates, negotiations, collaborative actions happening at Health Forums at multiple levels allowed different professionals and teams to recognise each one's contribution and their role in improving the health conditions [IB19]. It facilitated a change in their attitude towards the others and democratised interactions. It took time and effort, where each team had to invest a lot in understanding and relating to others for a common purpose. We have various examples where a change of mindset led to collaborative actions. The Block Development Officer and the elected leaders of Patharpratima Block (subdistrict) played the lead role in evolving the health plans for the subdistrict against the traditional backdrop, where the medical team used to be the key actors. The ANMs at the sub-centre respected and accepted the support of the health workers and intervisers of BHCSP to implement health programmes. They established links with the VHSNC and the ICDS programme. At the same time, there were difficult occasions and terrains where some wielded power, working against the concept of distributive governance. Though BHCSP made efforts and attempts while working on the quality of healthcare services, we had limitations in democratising the power relations between the health provider and seeker or even changing the mindsets of both parties. It was seen as a legitimate right derived over a while due to society's prevailing socio-economic and political culture. On many occasions,

the knowledge base, expertise and social status favoured the health providers in exercising "power over" others.

## Did the BHCSP programme facilitate social change in a community?

The BHCSP programme facilitated social change at multiple levels by creating opportunities for the local community to organise, voice their health needs and hold the health leaders accountable while implementing the national and state-level health programmes. It activated the existing institutional mechanisms at the subdistrict and GP level to be more responsive to the needs of people. The participation in the first Saturday meetings put pressure on the sub-centre and subdistrict health leaders to understand specific health needs of the people and provide quality services. Their collective strength provided opportunities for them to negotiate and dialogue or refer their requirements to higher level officials or similar institutions for action and support. More than that, people learned to collaborate and make decisions together.

*"You never change anything by fighting the existing reality. To change something, build a new model that makes the existing model obsolete ."*

(R. Buckminster Fuller)

Power is exercised through access to and control over decision making. The women who came together in SHGs organised themselves and gained economic autonomy mainly through savings schemes. They could reflect critically on the health issues affecting them at the local level, negotiate with the health leaders and service providers, and access services. Most of the women members of the SHGs developed confidence in dealing with authorities and handling family issues.

The women members from Howrah successfully fought to close the liquor shops, which led to a significant decrease in violence and increased availability of money for household needs. Working with the BHCSP enhanced the status of women at

the local level. The Programme focused on women's health at the family level, campaigned against violence and trafficking, ensured the participation of women in the VHSNC where more than 50% members are women, social movements and health programmes like nutrition, sanitation, Janani Suraksha Yojana (8) and health insurance, and supported them to gain economic autonomy through SHGs. It enabled them to recognise their self-worth and dignity and assert themselves within the family and community. The VHSNC offers an alternative social space for marginalised women to challenge power inequalities within the Forum and assert their rights by reviewing and monitoring AWWs and ANMs.

The BHCSP played a significant role in placing health as an agenda among the Local Governing Bodies (LGB) in the early period of the project. Health was linked with diseases and healthcare services. It was primarily associated with the medical team. However, there were administrative and political efforts to incorporate the health services in local governance under the decentralisation process. The N(R)HM policy later provided the impetus and acceptance for the health agenda among LGB. The BHCSP team worked with local authorities [IB13] to internalise the principles and policies and actionable agendas under NHM. The focus on health promotion, comprehensive and intersectoral approach, as well as participatory approach, helped Local Bodies at the GP and subdistrict level to incorporate health programmes in various departments and sectors, especially within the Ministry of Health and Family Welfare, Ministry of Women and Child Development and Ministry of Panchayat and Rural Development.

The increased interaction of elected members of the local bodies with the VDC/VHC and CHC members on healthcare, about specific diseases and their link with livelihoods, water and sanitation and accessing development schemes offered more significant space and avenues for health action. With new awareness of their responsibility to enhance people's health, the local authorities ensured increased

fund allocation and political support for availability of drinking water, toilets for the households, reduction of malnutrition among children and to provide broader coverage of ICDS programmes, especially to the most vulnerable areas and communities. The leadership of Gosaba subdistrict, with the support of RLSK and the local community, identified donated plots of land and constructed 23 ICDS centres ensuring a safe environment for children and mothers. A similar process was initiated in the Patharpratima subdistrict, where 8 ICDS centres were constructed. The local community and the local governance bodies collectively mobilised INR 1,86,00,000 (€2,18,823) from the government to construct the 31 ICDS centres. In Durbachati, the collective leadership of BMOH, subdistrict, Panchayat and ICDS, and Forum represented by SSDC addressed the high prevalence of malnutrition through a joint programme. The Forum's efforts helped all villages in Ramganga GP in Patharpratima and Kochukhali GP of Gosaba subdistrict become Open Defecation Free (ODF). In Diamond Harbour 2 subdistrict, the Sarisha and Bhadura villages received special funding to establish incinerators in the GP villages.

## Did the Programme address health inequities?

The Health Forum at South 24 Parganas was initially conceived as a space to share experiences, evolve a commonly shared health plan and build trust and a positive relationship among partners. However, it evolved as a learning forum where members engaged in critical reflection on the health condition of their area and discussed how the current health structures excluded the most vulnerable communities living in the far-flung and remote villages from getting health services. The communities started recognising the existing health inequities due to

their social conditions: their poor health status compared to others in the nearby districts and cities, the discrimination in distributing health resources in their villages compared to other places. The process helped members use new lenses to understand the prevailing inequities in health. It took time but was worth it. People started questioning why there was no regular supply of medicines to their health centres, why health personnel were not serving in their remote areas, why there were no medicines for snakebite in their islands or why they had to travel hours to access any health facilities and why they did not get sufficient resources, services and support from the government whenever they faced floods and cyclones. The communities started reflecting and questioning internally at the VDC, VHSNC and SHG level on the poor functioning of ICDS centres, health centres, and the absence of basic infrastructure and employment opportunities for people living in islands and mountainous areas. These concerns were brought up in the third and fourth Saturday meetings with authorities at the GP and subdistrict level for answers. The community pressure forced the officials with power and authority to find solutions and redress their grievances.

The BHCSP recognised community engagement [IB12] as an effective strategy for harnessing its potential in improving the health of the local communities right from its inception. The process allowed collaboration with local groups, for example, youth and adolescent groups, elderly person's groups and SHGs on issues affecting their health and well-being. These groups, often marginalised and at a disadvantage while living in inaccessible villages, had constraints in accessing health services due to structural, social and cultural factors. Strategically, we formed various groups based on their specific context and interest through an inclusive approach and strategy. The higher percentage of marginalised and disadvantaged members as part of the youth groups, adolescent groups, elderly groups, VDCs is a direct outcome of

the inclusive strategy. Their participation in these groups enabled them to interact and engage with health service providers and other health actors and access information and services. The community engagement process provided opportunities for these groups to voice their needs in the planning process at the VHSNC and GP level or provide feedback on the ongoing activities and schemes. The success of the immunisation programme among the minority communities had increased the reach of the CHCMI programme, increased institutional deliveries, led to positive changes in the health facilities, and improved water and sanitation in these remote villages, especially in the remote and marginalised areas. The success can definitely be attributed to the community engagement programme. The Forum mapped (see p416) out the schemes for the vulnerable population and linked them with the deserving persons/ families. The team assisted 10559 marginalised and vulnerable families to join Samajik Suraksha Yojana (SSY), making them eligible to receive a pension at 60. 13225 families are insured under Swasthy Sathi, a government health insurance scheme, enabling the family to access health care services up to INR 500,000(€ 5882) every year. More than 16420 vulnerable families ( elderly, disabled, widows) benefited from Manobik pension, Joy Bangla scheme, and widow pension schemes in the last four years. Though next to nothing, these benefits made much difference, contributing to their overall health.

The BHCSP can also be seen within the framework of rights-based approaches, which see rights being negotiated between citizens or rights holders and public functionaries or duty bearers. Through the BHCSP, various categories of rights holders were able to assert their rights and direct the duty bearers to take responsibility for respecting the rights of the people. Nevertheless, in the process, we realised that change must happen beyond laws and policies. There needs to be an attitudinal change among the duty bearers to understand the real felt needs of people and

In the process, we realised that change must happen beyond laws and policies

act accordingly. Both parties need to understand the other side while working on behavioural change.

Whenever the community exerted pressure on the health players whether it was an ANM or a public health official, or a doctor, the health personnel resisted those changes vehemently; hence our efforts were to reach out to their hearts, creating a positive relationship and an environment of collaboration. We tried to offer solutions and answers to their problems and day to day issues while they fulfilled their responsibilities. When we started collaboratively working with them, they realised that our agenda was not to confront them but to support their work for the more extensive interests of the community. Thus, they extended their cooperation. For some, it took more time to make that internal change due to external factors, such as lack of resources, policy limitation and political or economic pressure. Sometimes, it was due to personal issues or inner blockages such as fear, hatred or self-doubt.

## Conclusion

Mobilisation of communities, health promotion, campaigns and advocacy work for health policy changes or changing the local health system at different levels are all seen as challenging the prevailing power inequalities or, in other words altering the "power over" by the dominant groups through "power to" and "power with" actions.

Broadening and strengthening the Health Forum is about creating new power for the people and addressing the existing power imbalances

Broadening and strengthening the Health Forum is about creating new power for the people and addressing the existing power imbalances. These platforms provided information about the health policies and schemes, challenged its relevance, provided opportunities to suggest additions, deletions, and relevant amendments. These Forums enabled civil society and communities to alter the imbalances in the

existing power equation with health authorities and enhance their status with them as equals, especially at the GP and subdistrict level. With the given space, each Forum voiced their views and needs without fear, whether it was in the context of a Panchayat health plan, or allocation of quality food for women and children in the ICDS centres, or dengue prevention and response plan at the subdistrict level or implementation of the NHM schemes for pregnant women in their areas.

Currently, in most cases, the NGO partners steer the Forums in close collaboration with the communities and community-based organisations. Converting this Forum into a "people's health forum" is the next step. The people, especially the marginalised and excluded communities, have a space to voice their concerns now. They need better healthcare services to enhance their quality of life. The journey is long and challenging for BHCSP to take actions to the next level, where communities can strategically assert their inherent power, using their networks, relationships and resources, to make drastic changes in the existing power relationships at a larger scale and higher level and influence policies in their favour. With continued support, capacity building and a process of handholding, the BHCSP partners can sustain and strengthen the ongoing community partnership and empowerment processes and promote community leadership to challenge the existing power asymmetry.

These Forums enabled civil society and communities to alter the imbalances in the existing power equation

YOU NEED EVERYONE TO SOLVE THE POWER CUBE!
ROTATE HORIZONTALLY!
TRUST ME, I'M A DOCTOR!
VERTICALLY! NO... LEFT! NO... RIGHT! NO... BOTH!
I'M DOING THIS MY WAY!
TURN LEFT!
TURN RIGHT!
I CHOOSE MY COLOURS!
SV.

## Messages in a bottle

- Addressing health inequity requires understanding and addressing how power is held, manifested, and expressed in any community or society.

- Marginalised communities are those with the least social power. Empowering processes like promoting self-help groups, engaging in collaborative actions, inviting people to existing or new Forums from village up to district level, developing relationships with authorities, and self-reflection coaching at community-level, enable people to exercise their collective power to access their rights and be part of decision-making bodies.

- Capacity building goes beyond training people. It should primarily focus on reflecting on your own needs and actions in order to take well-informed decisions as an individual or in a group. This will stimulate an ongoing learning cycle which is the basic mechanism for development.

- While laws and policies provide frameworks for action, empowerment and collaborative processes can move beyond them especially at the local level. However, the potential for such expanded actions is often constrained by institutional authorities or power holders at higher levels and by bureaucracy in public administration.

- Confronting local power structures, both formal and institutional, as well as social and cultural, by marginalised communities, needs time as well as Coaching and Learning and support.

# Chapter 7

«I can do things you cannot, you can do things I cannot, together we can do great things.»

MOTHER TERESA

# Building boats and fleets

Meena Putturaj
Karel Gyselinck
Bart Criel
Aloysius James

## Designing Health Forums for stronger Local Health Systems

## ¿uestions

- ¿ Globally, district health systems are recognised as decentralised structures that are key in promoting bottom-up planning, community participation and social accountability. How did the BHCSP contribute to strengthen these important functions of districts?
- ¿ What lessons can be learnt from the design of Health Forums in the BHCSP?
- ¿ And what about your questions?

## The importance of the local health system

It always requires champions and visionary leaders on all sides to keep the momentum going

The District Health Forums emerged as key instruments for the communities to engage with the health policy framework that the Government of India was recrafting through the NRHM and NHM processes. These Health Forums allowed for a participation by the community, identification of locally relevant issues and opportunities for collaborative action, which together could be considered a kind of local health system. Before engaging with the rationale and description of the Health Forums, it is important to clarify the position of the BHCSP vis-à-vis the strengthening of local health systems. This rather generic phrase 'local health systems' is often referred to as *district health systems* in the world of public health. For the first time in 1987, the WHO made the concept and strategy of district health systems explicit. In practice, they had already existed for a long time. The Harare declaration (6) on Strengthening District Health Systems based on Primary Health Care where this concept was formally announced was a landmark event. It stated that "*a district health system is taken to mean a more or less self-contained segment of the national health system which comprises a well-defined population living within a clearly defined administrative and geographical area, either rural or urban, and all institutions and sectors whose activities contribute to improved health*". The roles and points for action of district health systems were clearly outlined. They ranged from adoption and decentralised implementation of national policies to strengthening community involvement and promotion of intersectoral action. This important declaration, however, was conceived at a time when public health services were dominant, with a relatively well-developed private not-for-profit health subsector, but with (still) a marginal private for-profit sector. The situation today, including in India, is quite different.

Most health systems in low and middle-income countries today can be described as mixed systems. Oxfam (2009) defined these as *"centrally planned government health services that operate side-by-side with private markets for similar or complementary products and services"*(1). Further the features of mixed health systems is elaborated as follows: diversity in health care provision; dominant, but poorly organised private markets; compromised public services; and, finally, a blurred public-private distinction (2).

In 1997 already, Giusti and colleagues (5) had argued that health planners should look at private facilities from another perspective than from its mere administrative status (i.e., governmental or non-governmental services) and focus on the finality or purpose of the service. They wrote: *"A different frame of classification between public and private health services is proposed: one which is based on the purpose the health service pursues and on the outputs it yields. A set of five operational criteria to distinguish between health services guided by a public or private purpose is presented. This alternative classification is discussed in relation to a variety of existing situations in sub-Saharan Africa (Mali, Uganda, Zimbabwe). It is hoped that it can be used as a tool in the hands of the health planner to bring more rationality in the current altercation between the public and the private health care sector."* Such a view opens a more productive lens to study the integration of private health services into a publicly oriented planning endeavour.

In October 2013, a regional conference on local health systems was organised in Dakar, Senegal (West Africa) (3), to reflect on the need to update district health systems in a dramatically changing world. As Meessen & Balamba (8) wrote: "*Much has changed over the past 25 years in Africa and a thorough update of the district health system seems warranted. First, many new contextual factors – including administrative decentralization, market liberalization, increasing urbanization and*

Focus on the finality or purpose of the service, whether public or private

*new technologies – must be considered. Second, needs have evolved. Those related to widespread poverty persist, while new ones have emerged or are emerging because of evolving epidemiologic trends.”*

India is of course not sub-Saharan Africa, nor vice-versa. The description of the district health system, as depicted above, corresponds in fact to the sub-district or block level in the architecture of the Indian public health system. The Indian district however has quite a large scale and huge population base, often exceeding more than a million inhabitants, and would therefore probably better fit the provincial level in most African health systems. But the analogy further holds local health systems, whether *blocks* in India or *districts* in Africa, constitute the level where top-down and bottom-up planification (need to) meet. And where the corresponding management teams face the challenge of optimising both dynamics and arrive at a more comprehensive and integrated vision and approach. In such a perspective, management teams of blocks/districts must do much more than merely executing programmes designed at higher levels of the health system. These teams must “customise” these programmes to local realities, transcending a bureaucratic attitude and standardised approach to health planning, but also channel up in the planning process the specificities of local needs and demands.

The BHCSP, without any ambiguity, opted from the start on to strengthen that “intermediate” level of management and planning – situated between the micro and macro levels – because that fit best its guiding principle to enable bottom-up planning of health and social services. The creation of Health Forums is a well-thought attempt to give the people, via the various civil society organisations that work for them, a genuine voice in the discussions on health planning and organisation of local health and social care delivery. Moreover, the multisectoral composition and scope of many of these Forums, with a significant number of their member organisations

The Health forum is an attempt to give the people a genuine voice and to address social determinants in health

focusing on social services and well-being – beyond health care per se – was and is a powerful opportunity to address social determinants in health and thereby, put into practice one of the core principles of Primary Health Care: i.e., multisectoral collaboration and action.

## Zooming in on the local health system in India

The public health care infrastructure in India consists of three tier system with the Primary Health Centres (PHCs) and health sub-centres at the grassroot level, the secondary health care system comprising Community Health Centres (CHCs),

Figure 1. Public health infrastructure in rural India

sub-divisional hospitals, rural hospitals and tertiary health care facilities with specialty and super specialty hospitals at the district and the state (provincial) level (7). See figure 1.

The flagship programme NRHM in 2005 paved way for community participation in the planning and organisation of public health services through the creation of various Forums for dialogue with the community. Emphasis was put on the promotion of intersectoral collaboration at different levels of the government system. The Community Health Care Management Initiative (CHCMI) of the Government of West Bengal, launched in 2005, further reiterated the convergent action of the Panchayat and Rural Development Department, that is, the department of local self-government with the health system. See figure 2.

Figure 2. Community engagement platforms in the National Rural Health Mission framework

## The link with the BHCSP Health Forums at different levels

Not all problems can be solved locally

In BHCSP, the idea of Health Forums started as a partnership between a limited number of CBOs and local NGOs active in a given district and collaborating with the NGO WBVHA. Though these CBOS/NGOs were supporting primarily the village level, it soon became clear that in order to tackle the needs of the local communities within the villages, the focus could not only stay simply at the grassroots. Not all problems can be solved locally. If one aimed at developing sustainable, structural solutions, some changes had to occur at the higher levels of decision-making as well. Therefore, it was necessary to look at the whole local health system, how actors in that system were connected to each other and how the behaviour of these actors could be influenced in order to contribute to solving some problems at the local level [IB9]. In practice the Health Forum in each of the districts involved in the programme, was composed of Forums at different levels as illustrated by the figure below (figure 3). It's like an atom. One atom appears to be one building block, but if you have a closer look it is composed of many sub-elements interacting with each other, each of them contributing to what an atom actually is.

The activities and advocacy work of Health Forums are typically complex and involve several players working in coalition from village to district level [IB13]. At the village level, the health forum supports the development of members of women's self-help groups, various community groups like the adolescent groups and elderly persons' groups, representatives from the community-based organisations, grassroot community health workers and a representative from the NGO partner of BHCSP. At the Gram Panchayat level, the representative of the self-help group clusters, Panchayat Raj institutions, NGOs and the Auxiliary Nurse Midwives constitute the forum. At the subdistrict level, the forum is composed of the NGO representative

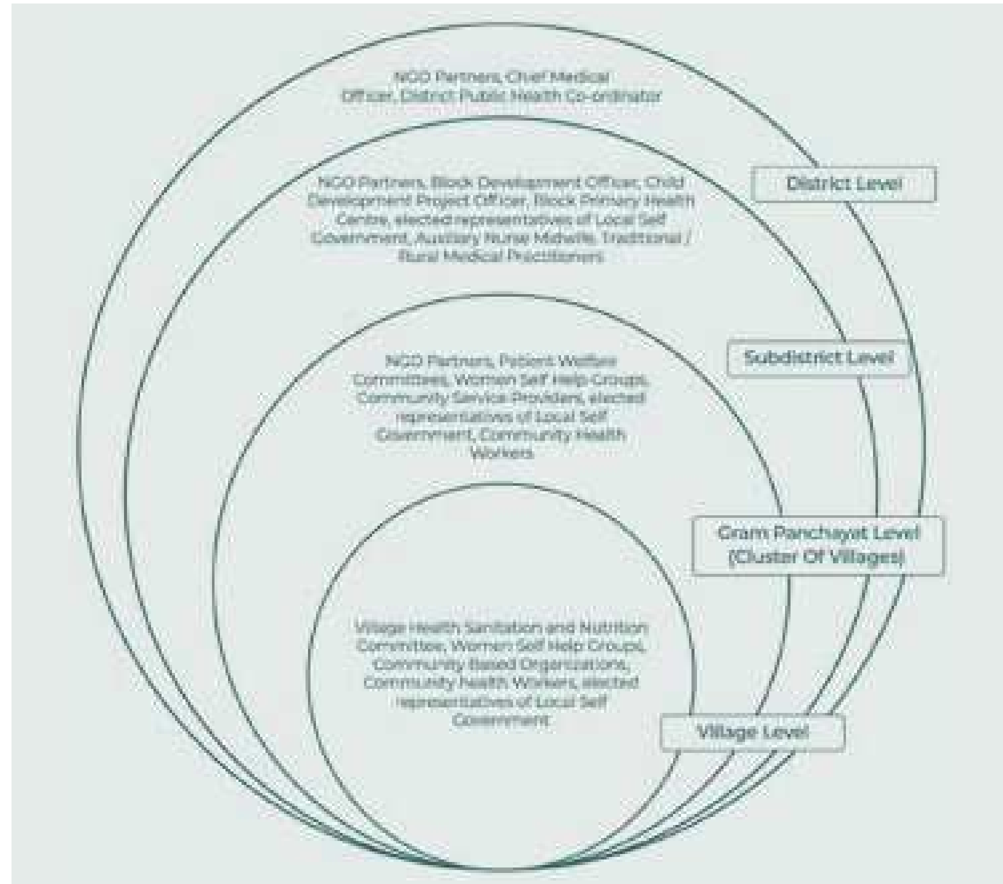



Figure 3. Key actors in the local health system of rural West Bengal with which the Health Forums of BHCSP worked

and government authorities from the child development project office, subdistrict development office and the subdistrict primary health centre. The district level forum in all the five districts mainly consist of different NGOs. But in some districts e.g., North 24 Parganas, the NGO partners were found to be closely working with the District Public Health Coordinator and the Chief Medical Officer of the district.

The Forum provides a collective identity to the members who come together for a common social aim of achieving wellbeing for all. This goal is the binding glue between the members of the Forums. The element of interdependence was found beneficial for both individual and collective efforts of the forum members. For instance, the government authorities in Durbachati Gram Panchayat, in South 24 Parganas district, felt that partnering with the local NGOs would improve the reach of the government services, especially to the marginalized communities. The NGOs felt that partnership with government authorities reiterated their legitimacy and provided a leeway for policy advocacy at different levels. For example, the District Health Forum in Darjeeling district collaborated with the government health service providers on a regular basis. This helped the Forum to effectively advocate with the higher-level government authorities and construct a new health subcentre [IB17] with all amenities in the Lamahatta Gram Panchayat. The Gorkha Territorial Administration (GTA) provided INR 2,397,482 (€ 28295) to construct the sub-centre. Furthermore, the Forum was able to persuade the authorities to recruit a medical officer in the Tadka PHC [IB18]. Thus, the Forum created a win-win situation for its members.

Given below (figure 4) is a graphical representation of the way the Health Forums of BHCSP operate at different levels.

At the subdistrict, GP and village levels, the NGO partners work through the various community groups like the women's self-help groups, adolescent groups, elderly people's groups and Village Health Sanitation and Nutrition Committee. They

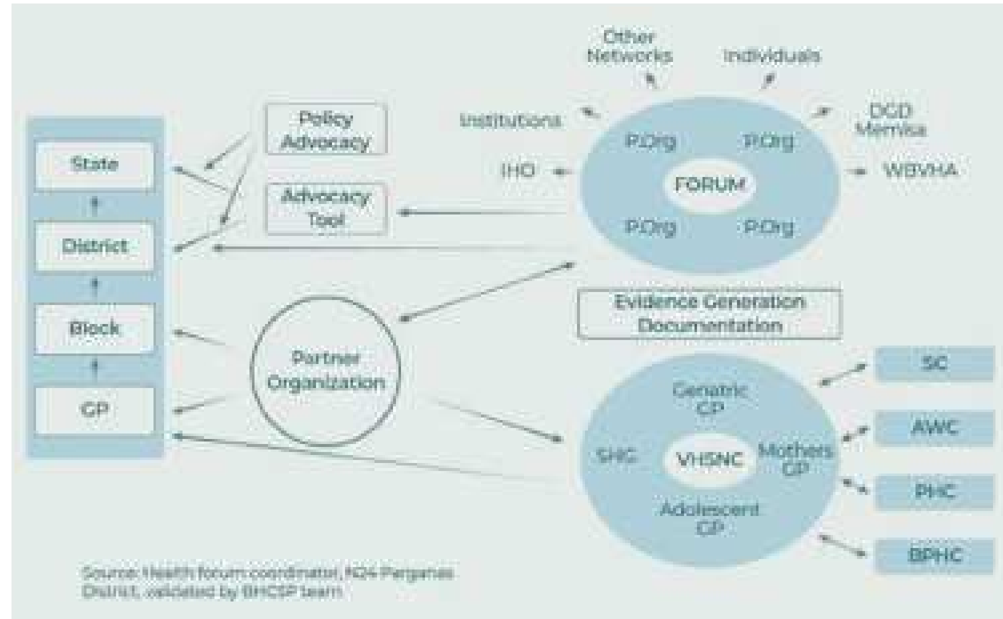



Figure 4. Scheme showing the facilitating role of the NGO partners of the District Health Forums in the BHCSP

also closely interact with the health sub-centre, Anganwadi centre, primary health centre and the subdistrict level hospital [IB6]. The district Health Forum intervenes for matters requiring an intervention from the higher levels in the system. With a constant iteration of action and reflection processes embedded within the BHCSP, the need for systematic documentation and institutional collaborations at national and international level was felt to support evidence-based policy advocacy at all levels of the health system.

## The emergence and design of Health Forums in the Basic Health Care Support Programme

The BHCSP processes allowed the local NGOs to gradually discover the benefits of being organised as a platform and work in a more structured way through the Health Forums [IB1, IB10]. In the beginning, the village development committees were formed in South 24 Parganas district which acted as a forum for ongoing dialogue and health action at the village level. Gradually, the idea of Forums was scaled up to Gram Panchayat level and community Health Forums were developed which had representatives from the various village development committees. The success of this dynamic was picked up by NGOs in the districts of Howrah, Darjeeling and North 24 Parganas in West Bengal and one district in Sikkim. The process led to the formation of five different kinds of Health Forums in these five districts.

With the advent of National Rural Health Mission (NRHM) in 2005, the village development committees at the village level and the community Health Forums at the Gram Panchayat level were merged with the governance structures e.g., Village Health Sanitation and Nutrition Committee proposed by NRHM. However, the Health Forums at the subdistrict and the district level persisted and operated independently with the mandate to strengthen the local health system and ensure overall wellbeing of the community. The BHCSP was implemented in four districts of West Bengal and one district in Sikkim. The Health Forums in the five districts had their own dynamic shaped by their local context. In this chapter we explain the structure and the functions of the Health Forums in the BHCSP towards strengthening of the local health systems. Figures 5,6,7,8, and 9 portray the composition and the dynamics of the Health Forums of the five districts where BHCSP was implemented.

The Health Forums in the five districts had their own dynamic shaped by their local context

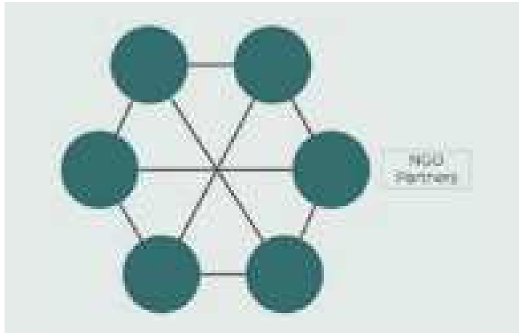



Figure 5. Health forum -
The South 24 Parganas model

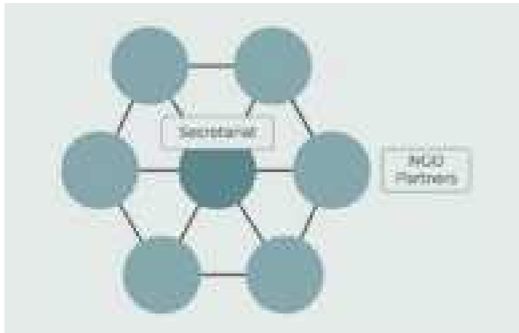



Figure 6. Health forum -
The North 24 Parganas model

# Description of the Health Forums

## *Health forum- The South 24 Parganas model*

The health forum concept was first piloted in South 24 Parganas district. The health forum at the district level mainly consists of NGOs. Gradually, other NGOs joined the district forum [IB1]: today the network has 16 NGOs. While the district forum is purely an NGO forum, the Forums at the subdistrict and Gram Panchayat level consist of a wide variety of actors like women's self-help groups, elected representatives, Panchayat officials, health service providers like ANMS, ASHAS, Anganwadi workers (AWW) and the community group members. The NGO partners facilitate the functioning of the Forums at the lower level. At the district level the Forum is mainly a platform for exchange of experiences between the NGOs. The NGO partners of the district forum coordinate and collaborate for joint action [IB21] at the subdistrict and Gram Panchayat level. However, district level policy advocacy is less prominent, probably because the NGO members of the district want to preserve their individual organisational identity.

## *Health forum- The North 24 Parganas model*

Inspired by the dynamics and the achievements of the South 24 Parganas district Health Forums, a pre- existing network of NGOs in the North 24 Parganas district approached WBVHA to form a district health forum in their district in 2009. Currently the district health forum has nine NGO partners and a strong secretariat. The district health forum here emerged from a pre-existing network of NGOs working on education. It is well organised with a strong leadership and has a good reputation and credibility

with the district administration. It is a platform for learning, exchanging experiences and an agency for policy advocacy, collaboration, and joint action [IB9]. This was evident during the Aila flood disaster in 2009 and the dengue outbreak in 2017 in the North 24 Parganas district. The Health Forums at the lower levels gather multiple stakeholders. Each NGO partner of the district forum has been linked to one or two subdistricts to facilitate the multi-stakeholder Health Forums at lower levels [IB13]. Such understanding enabled by the district health forum, avoids duplication, and promotes efficient organising of services rendered by the NGOs.

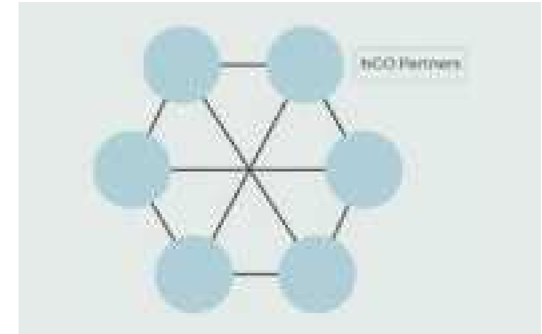


Figure 7. Health forum- The Howrah model

### *Health forum- The Howrah model*

The Howrah district health forum was established with the participation of 8 NGOs. What makes this Forum different from other district Health Forums is that it consists of NGOs working for specific population groups like people living with HIV or women fighting against alcoholism [IB4]. So, the forum is heterogeneous [IB14] in terms of mission pursued by the various participating NGOs. Over the period of BHCSP, it has been observed that this Forum is a bit unstable with frequent turnover of NGOs. The Forum started with 8 NGOs in 2008 but gradually dwindled to 4 NGOs. The main reasons for the frequent turnover were performance issues, legal problems, and incompatibility of the BHCSP principles with some NGOs. However, the more stable NGOs in the district forum were able to motivate and support the new NGOs to join the network. The Howrah district health forum is currently an established educational platform that offers information, tools, and resources for the member NGOs to undertake local policy advocacy and action through community engagement [IB15].

The forum is heterogeneous in terms of mission pursued by the various participating NGOs

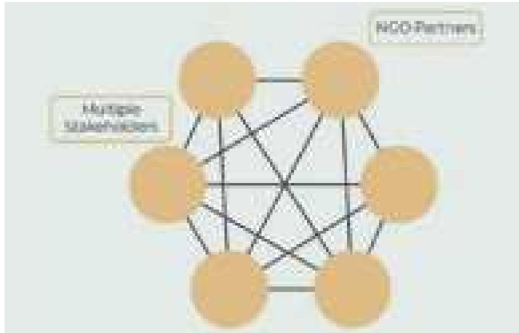



Figure 8. Health forum- The Darjeeling model

A crisis became an opportunity for the NGO forum to transform into a forum led by the community

## *Health Forum- The Darjeeling model*

WBVHA was already working with some NGOs in Darjeeling on issues like reproductive and child health, and in HIV. These NGOs became part of the BHCSP in 2008. In the beginning the district health forum was an NGO forum. Darjeeling district has seen political disturbances for a long time around the demand for a separate state called Gorkhaland. One such public agitation took place in 2013. Again in 2017 there was an indefinite strike and a complete shutdown of all the public services including health care services to the people in Kalimpong and certain other areas of Darjeeling district. NGOs, which are part of the BHCSP, along with other like-minded people made efforts to restore public health care services in the strike affected areas. Through their advocacy with the local government, they were able to increase the number of health personnel and ensure regular supply of medicines in the Primary Health Centre of Rangli Rangliot (also known as Takdah) subdistrict. Gradually the group which worked together during this strike began to function as a District Health Forum. This forum is proudly referred to as the people's health forum by the Forum partners as it has direct representation from the communities it works for. Currently, the People's Health Forum is actively involved in advocacy on a wide range of issues that affect the quality of life of people in Rangli Rangliot subdistrict e.g., road construction, town planning, welfare of persons with disability. Thus, a crisis became an opportunity for the NGO forum to transform into a forum led by the community [IB18]. Today there are around 50 members in the People's Health Forum. In their local language the Forum is referred to as "Jankalyan Samanwai Samity" or Public Welfare Coordination Committee. The members have strong and friendly relationships which make the Forum a closely-knit network.

### *Health Forum- The Sikkim model*

Sikkim is a small hilly state in Ind ia. Most of its population is scattered and resides in remote areas. The health service providers felt that collaborating with NGOs working in those areas might improve people's access to public health care services. They took the initiative to form the health forum at the Sombary subdistrict in West Sikkim. The NGOs saw this as an opportunity to promote community engagement in local planning and implementation of PHC services [IB2]. The Forum was thus seen as a win-win opportunity for both the NGOs and the health service providers. With the inclusion of community members, the forum consisted of multiple stakeholders with diverse backgrounds. Unlike the other Forums, the Sikkim model had a hierarchy in its structure. The health care staff of the primary health centre was steering the forum. But this forum became dysfunctional from 2017 because the NGO which was part of the forum did not fit the legal requirements to receive foreign funds.

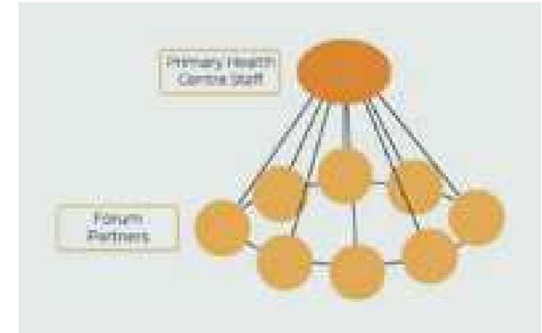


Figure 9. Health forum- The Sikkim model

## Role of West Bengal Voluntary Health Association and Memisa

The role that the West Bengal Voluntary Health Association and its international partner Memis a have established over the years can be best described as that of a mentor to the district Health Forums and the NGO partners of the BHCSP [IB9] (See figure 10). The mentoring was not episodic but consistent and organised since the beginning. WBVHA and Memisa played a crucial role in building the capacity of the NGOs to increase their organisational effectiveness and social impact. The capacity building interventions included trainings and workshops on various topics like

Coaching workshops became a platform for the district health forum members to reflect on their actions

project management, methods and techniques for community engagement, policy advocacy and others. The topics chosen for training and workshops emerged from the need assessment and the specific demands of the key stakeholders of the BHCSP since the beginning. The WBVHA organised coaching workshops for the district health forum members. The coaching workshops became a platform for the district health forum members to reflect together on their actions and observations in the field, decide on the working models and concepts, and craft compelling visions for the future. Sometimes it also meant designing and redesigning the organisational structures and processes. Regular handholding and overseeing the performance of the health forum partners was another key role of the WBVHA. It also helped the forum partners build their skills in creative thinking and innovation and to utilise the opportunities to do things in a new way. With the adoption of participatory and democratic methods, it was ascertained that the interactions between the WBVHA and the forum partners was guided by the core principles of the BHCSP and nothing was imposed on the Forums. A collaborative attitude and a shared purpose were nurtured within and between the district health forum partners. Through these processes, it was also possible to build genuine partnerships and promote linkages between the stakeholders.

The international development community should adopt a holistic approach to address structural inequalities in society

There is a rhetoric that the international development community rather than funding specific projects should adopt a holistic approach to address structural inequalities in society and enable social change. Memisa's role in the BHCSP for 20 years is a striking example of how international donors could support and create value in the long-term struggle for stronger health systems in a country like India. The hypotheses of the BHCSP were not cut in stone. They were tested and revised throughout the different programme cycles that Memisa co-funded in a flexible way. Memisa invested in ideas. It invested in broad coalitions of reform groups as

in civil society and district Health Forums. Therefore, it did not expect immediate results that could be easily captured with indicators within the given funding cycle. Instead, Memisa was open to support the district Health Forums to grab even the small windows of opportunity that emerged within the complex local health system. This helped the partnerships developed in BHCSP to grow from strength to strength. In the simplest terms, it can be said that WBVHA and Memisa were like a binding glue that held the district Health Forums together for all these years.

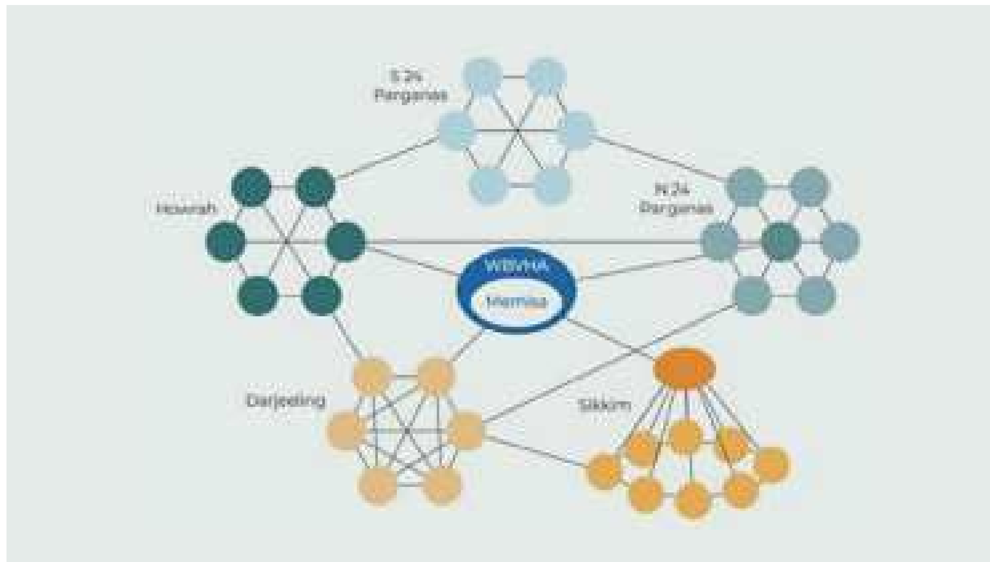



Figure 10. Networking of the district Health Forums of the five districts with WBVHA and Memisa under BHCSP

## Diversity in the characteristics of the district Health Forums

District Health Forums should not be uniform since they are closely linked to local communities and tackle the needs in the specific context

An important message is that District Health Forums should not be uniform since they are closely linked to local communities and tackle the needs in the specific context of those communities. They are diverse, be it in scope, in type of activities, in their composition and the way they are organised.

The scope of some Forums is primarily on health issues, while other Forums have a wider scope focusing also on the social determinants of health. Women's self-help groups, for example, may focus on health saving schemes but may also start saving to start a small business. Issues like water or road infrastructure required an inter-sectoral approach. Tackling early marriage and kidnapping of young girls need the involvement of many services and actors. There are many more examples like this.

In terms of type of activities there are also differences between forum partners and Forums. Some focused principally on health service delivery e.g., the Asha Kiran Hospital, while others were primarily engaged in advocacy e.g., fight against alcohol in Howrah district. The dialogue and action within each Health Forum varies depending on the local social, cultural, and political context.

Since the interests of the members of the Forum are not uniform, it's not possible for a Forum to speak with one voice

As illustrated above in the section describing the Health Forums, the membership and leadership also differ from forum to forum. Even if most Forums are composed on NGO partners, some include individual members or other institutional actors such as PHC staff in Sikkim.

Finally, the organisational set-up of the Forums is quite diverse. The Health Forums in the five districts vary in their degree of institutionalisation. Some district Forums e.g. South 24 Parganas and Howrah are a platform for exchange of ideas and learning. Other district Forums e.g., North 24 Parganas and Darjeeling have established their collective identity well as a forum vis-à-vis the district adminis-

tration. Some have formal structures e.g., secretariat of North 24 Parganas District Health Forum and explicit roles of the members. Some Forums are also only open to institutional members, while others are more open to individual members. Most Forums, though, have what we call 'Friends of the Forum ', to be a sounding board for the Forums, guide the forum members, reinforce their capacities, and sometimes, even play a knowledge broker role. They include representatives of government institutions, academicians, and individuals with specific skills in management, communication or social work. The Health Forums, however, have only voluntary members and no affiliations with political parties.

The Forums differ from each other in design and within each forum too there is great diversity. The membership of each forum may include representatives from civil society, government, public health institutions and the local community. The NGO members of the district Health Forums are also heterogeneous in terms of their organisational size, capacity, mission, vision, the sector they are involved in and their geographical location. Yet, despite this diversity, all forums work towards the same social aim, subscribe to a set of common principles, and commit themselves to strengthen the local health system. Though it has been difficult, they have, so far, succeeded in maintaining this open space considering the otherwise contested nature of local politics in West Bengal. Nurturing trust between the actors remains a key feature in developing and sustaining these Forums.

It is also important to note that the Health Forums within the BHCSP are not the same as the official District Health Advisory Committees (DHAC) at district level or the District Health Action Forum (DHAF). The BHCSP Health Forums are, in most cases, represented in these committees or Forums.

Despite this diversity, all forums subscribe to common principles, and commit themselves to strengthen the local health system

## Sailing is never as straight as a train journey

A first choice was between 'private versus public finality' of the Forums. Traditionally, most CBO/NGO partners were opportunistic

The question was whether a Health Forum should become a formally registered organisation or function as an informal platform

The sustenance of the Health Forums at different levels has not been an easy task. It encountered many challenges and choices had to be made. We have identified five choices.

The first was to choose between what we could call a 'private versus public finality' of the Forums. Traditionally, most of the CBO/NGO partners were opportunistic and centred towards themselves. Their interest was driven by survival of their organisation and securing finances for their projects to benefit the population in the villages they served. Initially, it was that same survival mode that convinced them to step into a partnership with other CBO/NGOs and form a Health Forum. However, in some district Health Forums (e.g., Howrah), the problem was a frequent turnover of the NGOs who no longer could align with the principles and goals of the Health Forum and shifted from a non-profit to a profit-making private organisation. Luckily, the open membership of the Health Forum and its networking efforts brought new NGOs on board.

A second choice was related to the management culture of the Health Forum: should it be 'bureaucratic or systemic', 'formal or informal'? NGOs in India are officially registered and comply with strict government regulations. This is also a precondition to be eligible to receive funds. The question was whether a Health Forum which in most cases brought together different NGOs should also become a formally registered organisation or function as an informal platform, representing the interests of their members and beneficiaries. It was a difficult choice. There is a tendency to choose formal registration to get official recognition and become sustainable. However, a Health Forum with a formal NGO status could be considered a rival by the individual NGOs of which the Forum is composed. Moreover, since

the interests of the members of the Forum are not always uniform as we already illustrated, it's not possible for a Forum to speak with one voice . The Health Forum is supposed to be the cement between the bricks which are the separate NGOs. That was the way to add value and build a house. But when a Health Forum becomes a formal NGO itself, it too becomes a brick and may not bring the complementary value of the cement role such as fostering collaboration amongst members, managing internal and external relations, creating external visibility, and raising issues at higher levels. Health Forums could also play an active role in developing a network of networks, which seems quite interesting from a systemic perspective. Nowadays, there are several parallel networks in the districts where the BHCSP is present, linked to a state or even national NGO. This has been an interesting debate throughout the course of the BHCSP and is not yet resolved.

Health Forums could also play an active role in developing a network of networks

A third choice concerned the membership of the Health Forums. Should they go for a 'technocratic or direct' membership? Most Health Forums are currently managed by the NGOs and their 'project experts', eventually backed by 'Friends of the Forum ' like government representatives, academics and professionals from the private sector. But to what extent did these people who were technocrats or bureaucrats really represent the population, especially the marginalised and vulnerable people? Were they ready to give them a direct voice? Were the Health Forums really empowering the people as they claimed? What did 'open membership' mean? Should membership of the Health Forum be open, and if yes, to whom? Only to other NGOs who want to join or to a wider range of institutional members as was already the practice in some Health Forums? Or should the Forums become open for individual members and include persons from the local communities or other persons who believe in the Health Forum goals and want to get engaged? Ultimately, should the Health Forums become a people's health movement or not, and join efforts with other

Should the Health Forums become a people's health movement?

like-minded networks? How is social accountability assured within the Forums, not only upward but primarily downward? There are no final answers to these questions, and it maybe be interesting to pursue further Action-research concerning these issues. At least the necessary ingredients are there. But those alone don't make a meal.

Should the relation between the demand-side and supply-side be that of a 'contractor and subcontractor' or a partnership?

A fourth choice concerned the relation between the demand-side or Health Forums and supply-side or the managers of the health system. Should that relation be that of a 'contractor and subcontractor' or a partnership? This depends on how the local health system should be managed. Traditionally, it's a hierarchical structure with the district / sub-district manager having the control and the decision-making power. The reality described earlier in this chapter, however, shows that there are parallel systems in place. Another reality is that health is not the same as healthcare. The social determinants of health require the involvement of many other actors working jointly to meet the common challenges of health. The notion of collaborative governance (4) is gradually being introduced. It's based on stewardship. Within the BHCSP stewardship was described as follows:

"*A mode of governance based on inspiring (value-based), supportive (accompanying) leadership (real authority) fostering an inclusive, flexible but yet coordinated environment where all stakeholders like citizens, government, and private stakeholders can dialogue, learn, engage, contribute, develop, increase mutual trust, and take lead in a distributive stewardship, responding and adapting to local needs of persons and communities, and systems, in a comprehensive way, thereby reinforcing their rights and autonomy, and enabling their human and social capabilities (public finality) and assuring information flows and all forms of public accountability, namely, upward, downward and horizontal accountability.*" [IB13]

Collaborative governance is based on stewardship

In such a governance model, partnership is key. It should be based on mutual respect, trust, and valorising comparative advantages. In building that relation,

there is nothing wrong with Health Forums assisting the health managers in some tasks like getting the health services to the most remote areas, or helping in capacity building, training, or on-site coaching. Some would call this *instrumentalisation*, threatening the civil society role of critical alignment and advocacy. However, reality is not black and white. An awareness of risks and suitable safeguards are needed to avoid problems. Walking on a thin line with a lot of pragmatism, can do both: making yourself useful in the eyes of the health managers, thereby building confidence, and at the same time using that credit of trust to secure a space to claim and develop your civil society role. Health Forums could in that way fill a vacuum and contribute to a 'go-between' role between supply, demand, and governance. The confidence at the level of Health Forums to take up that role is a slow process, especially beyond the subdistrict level. It always requires champions and visionary leaders on all sides to keep that momentum going .

Health Forums could contribute to a 'go-between' role between supply, demand, and governance

A last choice is the balance between action, documented reflection, and evidence-building. Many Health Forums tend to remain action oriented because that is their comfort zone. Ongoing quality data-collection of their experiences, analysing and organising it in a systematic way, constructing a case, engaging in a pro-active, evidence-based advocacy, managing the external relations, and building up an institutional memory remains the Achilles heel of most, if not all, the Health Forums. Dealing with the higher-level governance issues in the health system i.e., beyond the subdistrict level, at district and state level, and becoming a significant player in changing structures and policies towards social change at much higher levels, needs further professionalisation and strategic thinking on the part of the Health Forums [IB20]. In the light of shrinking policy space for civil society in the country, this is a huge challenge. The Friends of the Forum could leverage and galvanise the District Health Forums and reinforce collaboration between the different Forums.

Many Health Forums tend to remain action oriented because that is their comfort zone

Changing structures and policies towards social change needs further professionalisation and strategic thinking of the Health Forums

Given the diversity in the members of the Forums with the need of balancing different interests, searching a way forward regarding these challenges or choices is not an easy task. There is the dual challenge of building the boat while rowing it. It requires regular coaching and supportive supervision (InterVision) through WBVHA and Memisa.

## The Relevance of Decentralised Governance in Health

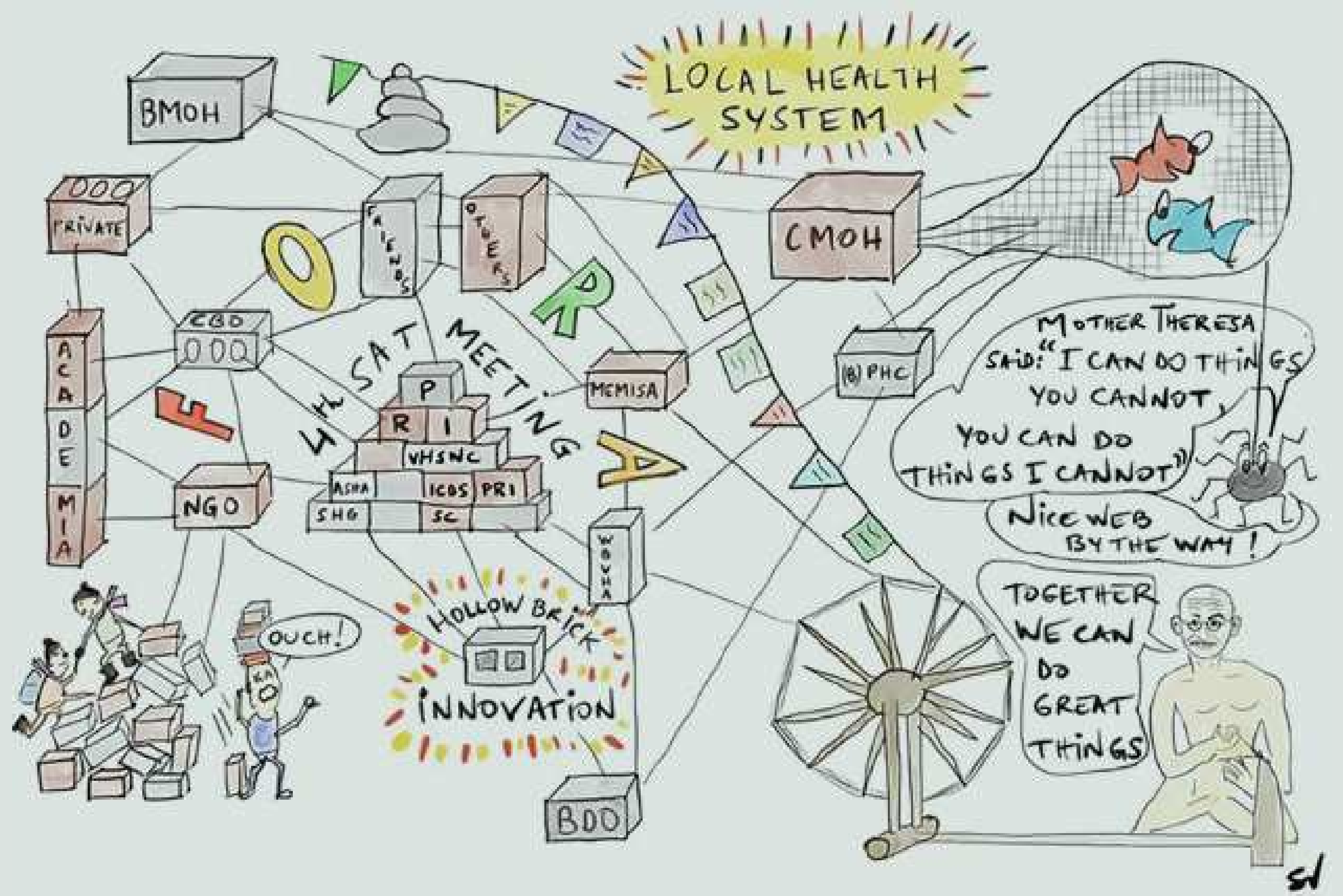
Are the Forums there to fill in the gaps in the delivery of social services or should the Forums also take up a more political role?

Universal Health Coverage (UHC) (9) by 2030 is an important target within the Sustainable Development Goals (SDGs). It includes as its core component the fact that individuals and communities will receive the full spectrum of essential and quality services without any financial hardship, along with necessary preventive, promotional, palliative and rehabilitative services. This means having an adequate number of competent health workers at all levels. But achieving UHC also demands broad coalitions of reform groups and partnerships between state and non-state actors. In these partnerships, the NGO sector plays a crucial role in building and catalysing the momentum for a people-led movement for UHC. The NGO sector is very diverse and has varied functions with a wide scope of work ranging from specific areas such as health, education, livelihood to much wider areas concerning the overall wellbeing of communities and individuals. Their approach ranges from delivering direct services to getting involved in policy advocacy. This raises a rather fundamental question: are the activities of the Forums there to fill in the gaps in the delivery of social services including health, but also beyond such a sectoral approach, and engaging in a wide range of welfare activities, which are supposed to be offered by the public health authorities to their people? In which case, one may

look upon these Forums as being instrumentalised. Or should the Forums also take up a more political role, confronting and pressurising the public authorities in the field of health but also beyond to fulfil their responsibilities, and possibly change policies for the better?

In reality, there is a continuum between these two poles and both have their legitimacy. The District Health Forums within the BHCSP illustrate that the mix between delivering services to people on the one hand, and being people's voice and advocate vis-à-vis the public health authorities on the other, appears to be contextual and therefore, a variable role from one Forum to the other. It is not without importance that the leadership of the various Forums are aware of this mix, and possibly deem it appropriate to actually recalibrate it. NGOs often compete for resources. However, there is a need for civil society to come together and collaborate with a shared sense of purpose to achieve UHC. Moreover, different NGOs have different strengths and thematic focus areas, for example, gender-based violence, water, health services, all of which are opportunities to collaborate towards a comprehensive health plan keeping in mind the social determinants of health. The BHCSP works closely with local communities through NGOs in the field of health and social development. The major principle of BHCSP is to ensure true partnerships between NGOs, service providers both public and private, local communities, government authorities and academia. The BHCSP provides an example of how communities and NGOs can contribute to the overall goal of achieving UHC in creative ways.

The mix between delivering services to people and being people's voice appears to be contextual and variable from one Forum to the other


LOCAL HEALTH SYSTEM
BMOH
PRIVATE
FRIENDS
OTHERS
CMOH
CBO
ACADEMIA
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O
R
F
A
MOTHER THERESA SAID: "I CAN DO THINGS YOU CANNOT, YOU CAN DO THINGS I CANNOT"
NICE WEB BY THE WAY!
OUCH!
HOLLOW BRICK
INNOVATION
TOGETHER WE CAN DO GREAT THINGS
BDO
SV

## Messages in a bottle

- The integrated District Health Systems approach adopted by WHO in 1987 which allows all institutions and sectors, whose activities contribute to improved health, to work together to strengthen local health systems is still valid for the contemporary goals of Universal Health Coverage. The district and subdistrict structures and roles within the National Health Mission (NHM) provide similar opportunities in India.

- The dramatic changes in context over the last three decades, however, required an update of the approach of Local Health Systems putting forward the principles of pluralism, empowerment of communities and individuals, social accountability, public-private partnership, multi-sectoral collaboration, equity, person-centred quality care, and continuous learning and adaptation.

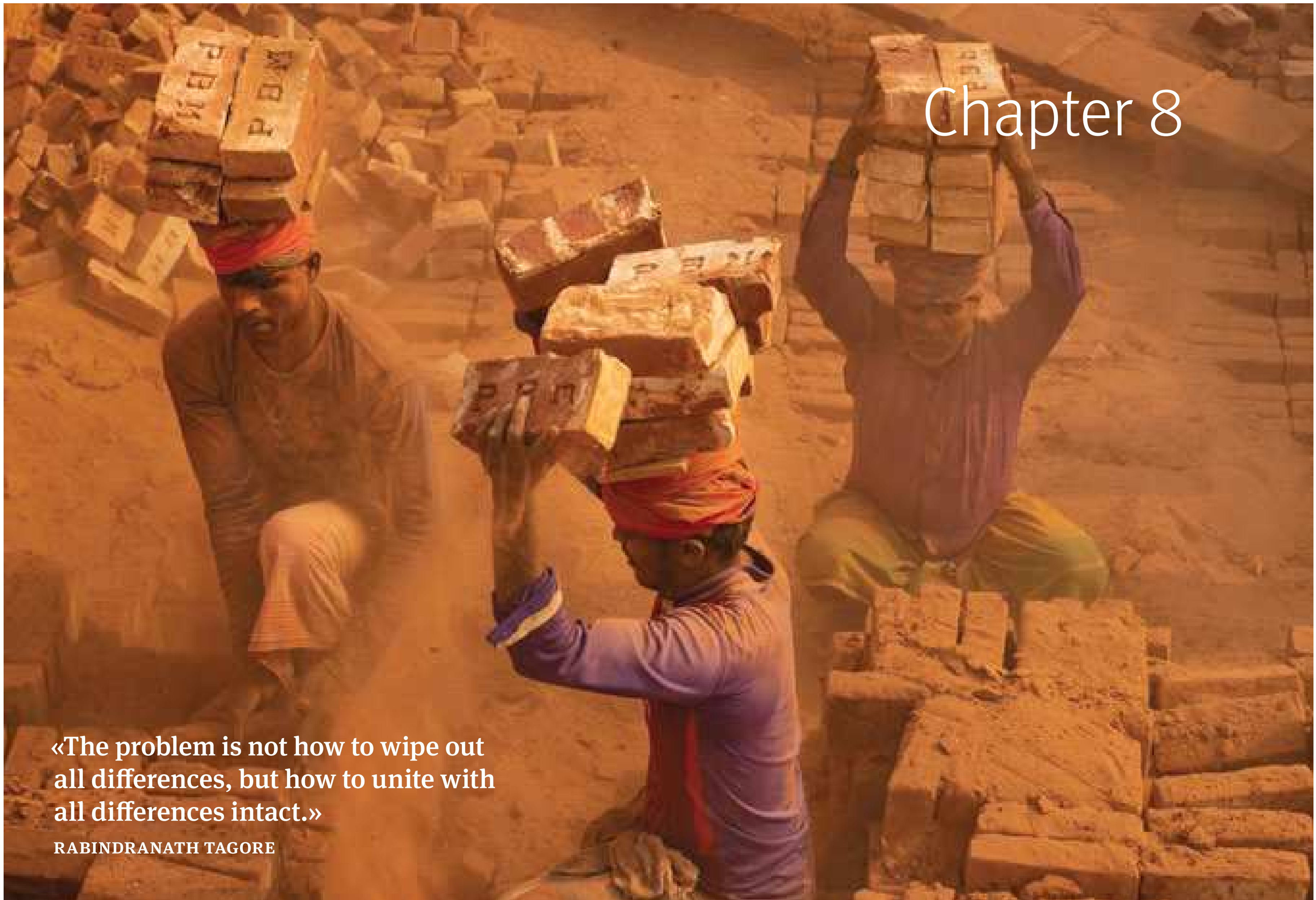
- The BHCSP was able to build upon this principle of collaborative governance by creating Health Forums at different levels within the district bringing together grassroot NGOs and community groups. Health Forums emerged as a promising model in the context of West Bengal in India. They nurtured a collaborative mindset and provided a common space for dialogue, mutual learning, and partnership between communities, NGOs, public and private health providers, the public health administration, policymakers, and researchers.

- Collaborative governance requires stewardship based on inspiring (value-based) and supportive (accompanying) leadership, valorising and coordinating the contributions of citizens and other public and private stakeholders, to provide strong and transparent public services that reinforce the rights and autonomy of people.

- Health Forums need not have a uniform modus operandi. Different districts within the BHCSP developed different Health Forum models in terms of composition, organisation, scope, and functions, adapting to the needs within their local context.

- A Health Forum should remain the cement linking the individual bricks, i.e., individual partners of a house and make it strong. It should not itself become a brick by over-institutionalising.

- Sustaining a network is not easy. It requires resources, and a strong internal or external leadership committed to pull the members together to achieve their collective agenda. Members, who are at different levels, learn from each other and grow individually and collectively. It is natural to have conflicts among members. However, collective reflection regularly will hold the members together, help to resolve issues internally and provide opportunity to attract more resources to play larger roles within the district and state levels.



# Chapter 8

«The problem is not how to wipe out all differences, but how to unite with all differences intact.»

RABINDRANATH TAGORE

# Building strong fishing crews

Meena Putturaj
Bart Criel

Contributing to a renewed public health governance framework

## ¿uestions

- ¿ How can local communities partners effectively participate in local health governance mechanisms?
- ¿ Are the District Health Forums developed in the frame of the BHCSP effective in improving local health system governance? If yes, how and why?
- ¿ Can we move from an NGO-led Health Forum to a People's Health Movement? And if so, under which conditions?
- ¿ What remains to be further investigated?
- ¿ And what about your questions?

The BHCSP is inspired by the philosophy of people-centred health systems. This is, amongst others, reflected in the multisectoral collaborative activities in the BHCSP at the local self-government and the subdistrict levels where local communities play a central role. Today's global aspiration is to achieve the Sustainable Development Goals (SDGs) by 2030. The SDGs are a set of interconnected goals and reaching them requires such multisectoral collaborations. At the same time, the global community is also committed to Universal Health Coverage (UHC) by 2030, with the promise that all people would have access to the health services they need, when and where they need them, without financial hardship. The BHCSP initiative also provides valuable lessons on how the agenda of UHC could be achieved through strengthening local health governance processes.

## Using Brinkerhoff & Bossert's health governance framework as a lens

Over the last two decades the idea that providing healthcare requires appropriate mechanisms and regulations and financing has been gaining ground. This needs both a policy framework as well as administrative arrangements all of which taken together can be called health governance. The BHCSP employed novel ways to strengthen local health governance. The Brinkerhoff and Bossert framework(1) refers to relationships [IB9] between the principal actors, namely, the state or policy makers, the providers, and the citizens who are potential patients. This framework is useful to identify the disconnects that constitute challenges to health system strengthening interventions such as the Health Forums in the BHCSP: (i) the gap between the good governance agenda and existing capacities (ii) the discrepancy between formal and

informal governance, and (iii) the lack of attention to socio-political power dynamics. This does not appear to be different in the Indian context and warrants therefore further exploration. The Brinkerhoff & Bossert framework more precisely points to connections between state actors (politicians, bureaucrats), service providers and clients/citizens that establish pathways through which health governance is exercised (see figure below).

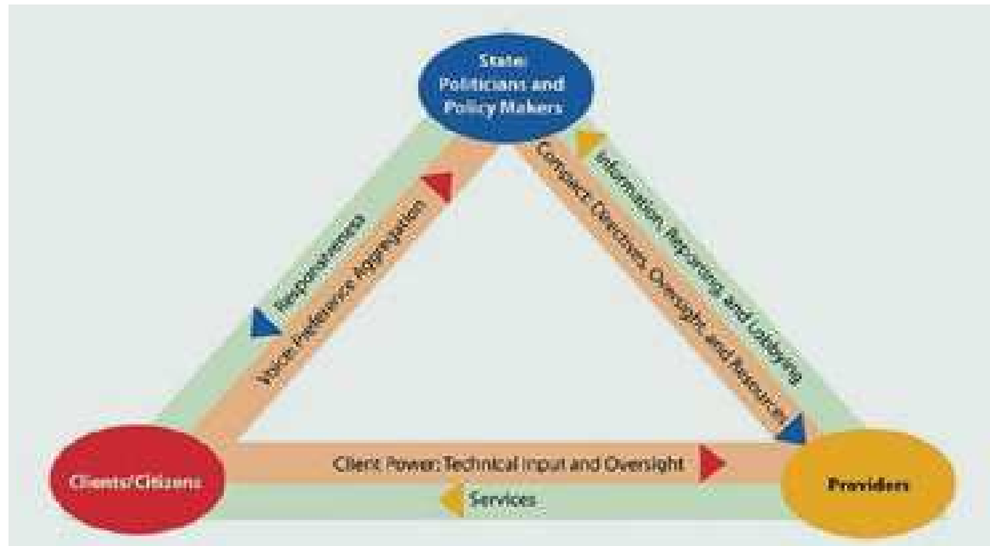



Figure 1. Health governance framework, Brinkerhoff and Bossert, 2008

This broad set of actors may include a number of other actors as its subset. The framework also indicates the direction and nature of the relationships between the actors. These relationships capture the different governance functions: e.g. service

Health governance is about optimal interaction between multiple and diverse actors

provision is the essential function of the relationship between the providers and the citizens. In turn, the public must have oversight on the services provided, but also provide technical inputs in organising the service delivery whenever relevant. Not all actors are equal in terms of power position. The existing power asymmetries between the actors obviously influence their relationships and therefore the governance functions. If the relationships between the actors in the system are functional and effective, then the guiding principles of good governance like equity, transparency, accountability, effectiveness, efficiency, exercise of citizens' voice and responsiveness will be evident in the system. Health governance is about optimal interaction between multiple and diverse actors. The principal health governance functions include: i) the provision of directives, oversight and resource allocation by the State; ii) information provision, reporting and lobbying by the service providers; iii) citizens providing technical input when relevant and overseeing the service provided to them; iv) enabling citizens to exercise their voice and express their preferences; and v) the State being responsive to the needs of the citizens.

In the BHCSP we adapted Brinkerhoff and Bossert's framework to the local context to understand the interactions of the District Health Forums – described in great detail in Chapter 7 – with the local health system actors in India [IB4, IB9]. Since the Health Forums of the BHCSP are embedded within the local health system, it became necessary to consider four actors instead of three as in the original framework. By doing so, it became possible to study the deep interactions between all the key actors relevant to the local health system. Owing to the complex nature of the interactions between the actors in the local health system which are often multidirectional in nature, instead of providing illustrations for each of the arrows in the framework, we explain the functions of these interactions such as providing directives, service provision, resource allocation, responsiveness to the needs of the community, local

policy advocacy, information provision and capacity building and oversight within the local health system.

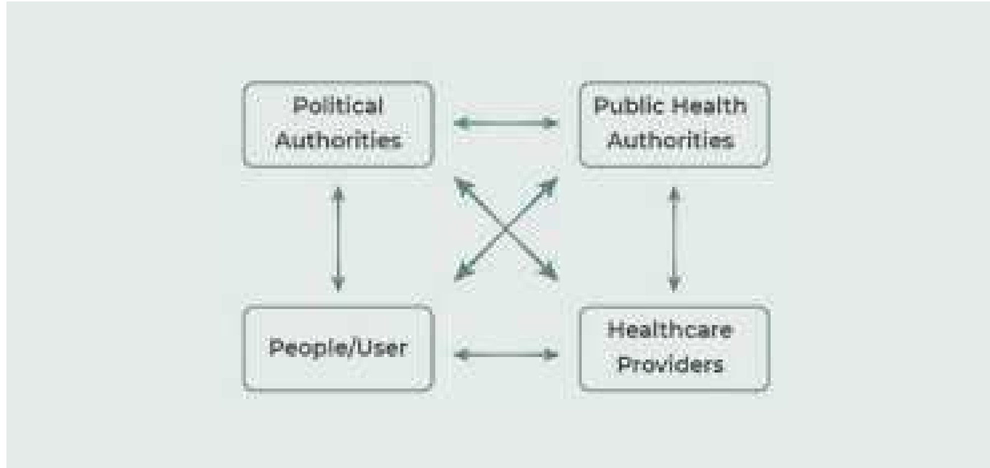



Figure 2. The Brinkerhoff and Bossert framework adapted to the BHCSP context

We used the BHCSP data to 'populate' the modified governance framework. This knowledge on how the Health Forums contribute to the local health system governance is not only useful and interesting for academia and the policy community, but also a priority internally for the BHCSP team as they envisage moving ahead with the Health Forums. This spirit of inquiry for better action is also the reflection of the inherent principle of learning by doing and the action-reflection processes embedded within the BHCSP.

The BHCSP was able to draw attention to health / health system related issues among the communities, elected members of the local self-government and public

authorities. The Health Forums which were formed under the BHCSP included individuals from these various actors to tackle broader issues and social determinants of health through a multisectoral approach and action. For instance, the People's Health Movement in Darjeeling was successful in advocating for link roads to the health subcentres, sewage disposal, town planning and ensuring presence of Medical Officers in PHCs [IB18].

## Contributions of Health Forums to local health governance functions

In this section, we present a number of examples from the BHCSP pertaining to the contribution of Health Forums to the following seven domains: i) formulation of directives issued by government and public health authorities; ii) mobilisation and allocation of resources; iii) promotion of more responsive health systems and services; iv) provision of specific health services; v) provision of information, reports and strengthening of capacity in local communities vi) engagement in lobbying and policy advocacy and vii) strengthening of oversight and accountability [IB15].

### *Formulating directives*

In the beginning, the government officials had a lot of reservations on the role of NGOs. They were seen as irritants challenging government actions and motives. The government health services did not reach out to many of the island villages due to resource constraints. In some places, the officials used local NGOs as their extended arms to carry out their activities in the field. However, their roles were restricted

to merely conducting those activities assigned to them. Most of our partners were initially happy to fill these gaps and complement government programmes. Trust between both parties was limited due to historical reasons and misconceptions. But, gradually, the non-confrontational approach and supportive role of NGOs generated political and programmatic support to the partners and the District Health Forums. Regular interactions and engagement with the government authorities, especially with local governance institutions [IB10, IB13], ensured participation in the Health Forums, searching and finding solutions or developing policies for enhancing the community's wellbeing.

The non-confrontational approach and supportive role of NGOs generated political and programmatic support

At least 24 NGOs collaborating with the BHCSP are part of the various subdistrict level committees: the subdistrict health task force, child protection committees, disaster management committees and so on. This was possible because of the goodwill and the confidence gained by the NGO partners with the subdistrict administrative officials and the elected representatives. This is illustrated by several experiences shared by government authorities and elected representatives where the Health Forums are operational:

*"SEVA has a good reputation among the government officials." (Subdistrict Development Officer, Bahduria Subdistrict, North 24 Parganas)*

*"Itarai Asha Deep works closely with us. They are very much focused on health and work consistently unlike some NGOs which are seasonal." (Subdistrict Disaster Management Officer, Udayanarayanpur subdistrict, Howrah)*

*"RLSK gives us information on the field realities. For example, they informed us about the issues with the untied funds for the health subcentres. They are very supportive and we work together." (Subdistrict Medical Officer of Health, Gosaba Subdistrict, South 24 Parganas)*

*"NGOs like INSS , HDC, SSDC complement our work. Every six months they submit reports*

*on the activities they did in the subdistrict. They also provide inputs in the planning processes at the GP and Subdistrict level." (Elected representative, Patharpratima Sub-district, South 24 Parganas)*

The analysis of the minutes of the fourth Saturday meetings of 10 GPs for the years 2017 and 2018 revealed that the NGO partners of the Health Forums regularly participated in these meetings. They were held at the local self-government level to ensure convergence between the different line departments of the local self-governments and the public health facilities in the organisation and delivery of health care services to the rural population. In these meetings, the NGO staff raised several issues regarding the functioning of Village Health Sanitation and Nutrition Committee (VHSNC), MCH services offered by the public health facilities, measures to curb child trafficking, malnutrition in under-five children, poor conditions of the roads leading to some of the public health facilities and enrolling of beneficiaries in various social welfare and health insurance schemes.

### *Resource mobilisation*

There were a few examples showing that the health forum partners led the resource mobilisation efforts directed towards the achievement of public health goals. Resources could be both financial and non-financial in nature, e.g., volunteering could provide a great resource. The forum partners motivated community members to volunteer for some public health activities like pond cleaning, environmental sanitation drives, road shows and campaigns on health issues. Health of adolescents and that of the elderly population were some of the common focus areas of work across the NGO partners in BHCSP. In this regard, adolescent groups and elderly persons' groups were formed at the GP and subdistrict level. The leaders of these

groups shouldered responsibilities to maintain group coherence and engaged in a variety of social issues that affected them. For example, an elderly people's group in Pancharul GP, Howrah district, was successful in streamlining some services for the elderly like OPD consultations and drug dispensing at the subdistrict PHC. The adolescent groups formed in South 24 Parganas district actively engaged in advocacy against child trafficking and early marriage.

Another example was the introduction of community health funds in the women's SHGs in the BHCSP districts. In the BHCSP areas 21% of the SHGs in South 24 Parganas, 10% of the SHGs in North 24 Parganas, 35% of the SHGs in Howrah and 41% of the SHGs in Darjeeling district had utilised the community health funds [IB16]. Women in Durbachati GP, South 24Parganas who utilised the fund reported that it reduced their financial burden during health emergencies. However, further analysis of the community health fund utilisation data indicated that for 75% of the women, community health funds did not take care of all the healthcare expenses they incurred during an illness. For 25% of the women, the community health fund covered expenses related to primary care. But the community health fund was insufficient to help the women meet financial expenses related to secondary and tertiary care.

The SHGs also volunteered to work on malnutrition prevention and management and on sanitation because these were strong felt needs in their villages. At times, the community members also undertook joint ventures with government stakeholders to solve their problems. For instance, in Pancharul GP, Howrah district, the SHGs joined hands with the local self-government and provided manual labour support to the construction of the wall of the garbage pit. In Gosaba sub-district, RLSK, the NGO partner in BHCSP identified and motivated community members to donate land for construction of Anganwadi centres (AWCs). These are ICDS centres of the government at the village level and each centre caters to a population of one thousand. By

The NGOs were able to tap local resources for activities to strengthen the health system

playing an enabling and facilitating role, the NGOs were able to tap local resources for activities to strengthen the health system e.g., advocacy for streamlining the untied funds for health subcentres in Gosaba subdistrict and training programmes for VHSNC and members of local self-government.

### *Responsiveness to needs of the community*

Responsiveness refers to the extent to which the health system meets the expectations of the community. Responsiveness can be fulfilled only when health systems are competent in terms of human resources, funds, and materials. This kind of ideal situation has not yet been reached in the areas where BHCSP is implemented. Despite that, there were several examples to show that the Forum members were helping managers of local health systems during health emergencies. For instance, when there was a dengue outbreak in North 24Parganas district in September 2017, the health forum partners collectively facilitated the dengue awareness campaigns and cleared the mosquito breeding sites by involving the local community. Another example of how local priorities were addressed in BHCSP is the case of malnutrition among the under five children, a widespread problem in South 24 Parganas district. The NGO members of the district health forum were able to influence the local governments to allocate resources in their annual budget for nutrition programmes. The establishment of a nutrition rehabilitation centre in the premises of Sundarbans Social Development Centre, an NGO partner in the South 24 Parganas District Health Forum, was an outcome of the consistent advocacy activities of the Forum. At times when concrete policy action towards healthcare of elderly persons was lacking, the BHCSP took it up as a major area of work. The elderly people's groups facilitated by the NGO partners of the district health forum are another example of the priority accorded to elderly care in BHCSP [IB7].

The partner organisations along with the government responded to annual flooding and recurring cyclones in the Sundarbans areas that affected the local community. Specific needs of the communities were identified and responded to. The NGO partners played a facilitative role, and the community approached the authorities with demands and got positive responses. The forum partnered with other civil society actors in South 24 Parganas, mobilised resources and responded collectively.

## *Service provision*

The health forum partners also complemented the government programmes and delivered direct healthcare services in the most unserved and underserved areas of Sundarbans. Some of the NGO partners felt that direct service delivery was essential to gain the trust of the community and the government authorities. Also, it positively influenced their local policy advocacy activities with the government. But some government authorities and elected representatives where the Health Forums are active, felt that the role of NGOs should be limited to helping the government in the implementation of government schemes and that NGOs do not have the legitimacy to engage in the governance or administrative functions of the government.

Two grassroot NGOs, SSDC and the HDC in Patharpratima subdistrict organise mobile clinics by boats. SSDC organises camps for pregnant women on a regular basis to provide antenatal care and postnatal care and general health check-ups at their doorstep. Pregnant mothers receive health check-ups by experienced doctors and a technical support team with motivation and advice for institutional delivery. SSDC has extended eye care services to hard-to-reach areas in South 24 Parganas. Its base hospital, which was awarded the National Eye Award in 2007 and the Eye

Health Hero Award in 2017, is well equipped with modern instruments and state-of-the-art facilities in a patient friendly environment. SSDC has been running a Nutrition Rehabilitation Centre (NRC) since 2011 at its campus. Severe Acute Malnourished (SAM) children are usually admitted and provided with 14-21 days of nutritional care by the medical team of the Nutrition Rehabilitation Centre. Mothers also learn about child nutrition care with practical exposure. Apart from that, SSDC provides home-based management on growth monitoring, counselling, follow up and awareness for complete care of children. This is coordinated with the work of the AWC workers and the ANMs in the villages.

### *Providing information and building capacity*

A key concern of any programme manager is to ensure better services in the project that they are involved in implementing. The BHCSP through the active engagement of its NGO partners was able to identify, advocate, develop solutions and fill in the gaps in the implementation of national health programmes. The Table below shows the change in uptake on key services in the district of South 24 Parganas and provides a comparison with the regions in the same district where the BHCSP was not implemented.

The following Table 1 clearly shows that the uptake of government healthcare services is better in the BHCSP areas when compared to non BHCSP areas. We, however, cannot entirely attribute this success to BHCSP, but we believe that the BHCSP may have contributed to the success by creating an enabling environment where the possibilities for better implementation of the national health programmes thrive. An enabling environment refers to a set of interrelated political, social, and economic conditions that facilitate development planning and implementation to be more

| Subdistricts (in covered villages) | Diamond Harbour II | | | Mathurapur II | | | Patharpratima | | | Kakdwip | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Complete Immunization Coverage(%) | Ante-natal Care(%) | Institutional Deliveries(%) | Complete Immunization Coverage(%) | Ante-natal Care(%) | Institutional Deliveries(%) | Complete Immunization Coverage(%) | Ante-natal Care(%) | Institutional Deliveries(%) | Complete Immunization Coverage(%) | Ante-natal Care(%) | Institutional Deliveries(%) |
| Data from the subdistricts where BHCSP is implemented | | | | | | | | | | | | |
| 2008 | 68 | 28 | 62 | 68 | 28 | 50 | 77 | 79 | 48 | 48 | 64 | 50 |
| 2009 | 76 | 31 | 65 | 71 | 25 | 63 | 82 | 88 | 56 | 71 | 63 | 50 |
| 2010 | 80 | 63 | 69 | 80 | 31 | 67 | 78 | 82 | 59 | 73 | 68 | 56 |
| 2011 | 78 | 61 | 73 | 96 | 31 | 72 | 80 | 93 | 68 | 73 | 70 | 67 |
| Data from the subdistricts where BHCSP is not implemented | | | | | | | | | | | | |
| 2011 | 25 | 44 | 60 | 20 | 26 | 29 | 26 | 53 | 50 | 18 | 33 | 40 |

Table 1. Comparison of the selected health indicators between the BHCSP implemented areas and non BHCSP implemented areas

These village information boards act as one-stop sources for all kinds of information

inclusive and participatory. The community awareness generation activities under the BHCSP created much of the enabling environment. Community awareness raising activities impacted on the demand for and utilisation of services. These efforts complemented government efforts and allowed for government health services and programmes to extend to the difficult and hard to reach areas.

One of the important functions of the health forum members is to empower the citizens, service providers and the policy community with relevant information. The concept of the **village information board** emerged in the BHCSP as early as 2004 in South 24 Parganas district. These village information boards act as one-stop sources for all kinds of information to the village people and are displayed in public spaces such as markets, schools, and common drinking water points. Various people such as healthcare providers, local self-government officials, health forum members, community groups contribute to collect the data. Various community awareness raising activities to SHGs, elderly people's groups, adolescent groups, and the public are aimed at fostering community participation in the health planning processes and implementation. Awareness generation on various schemes, PRI services and health issues are routinely done by the health forum partners of the BHCSP. These activities are consistently appreciated by the local government leaders and health authorities. In their opinion, such activities improve the utilisation of schemes and services provided by the government. The BHCSP partners essentially act as a channel for information from the community to the panchayat/subdistrict/district but also vice versa. Often, updates on various government programmes reach the officials through BHCSP partners in a bottom-up fashion. These complement government efforts and allow for government health services and programmes to extend to the difficult and hard-to reach areas (Report of Midterm Evaluation of BHCSP, 2016).

The NGO partners of the district Health Forums organised several training programmes for various community groups, VHSNC members, frontline health workers such as the ANMS, ASHAS, elected representatives in the PRI and the RMPS. The idea was to support and empower these stakeholders with the required information and skills to perform their role effectively for the betterment of all.

The programme was able to harness the energy and enthusiasm of women, youth, and even elderly people as agents of change. For women members of the SHGS, vocational training programmes were conducted with the support of the government (e.g Itarai Asha Deep trained the SHG members on organic farming and poultry). Kautala Friends' Sporting Club in Mathurapur II subdistrict trained the SHG members in preparing prepackaged nutritious food for children and sanitary napkins for women and adolescent girls.

Adolescent health was one of the focus areas of the BHCSP . Accordingly, several adolescent groups consisting of boys and girls were formed. These groups were provided orientation about various health and social issues concerning adolescents. The group members come together once a month to discuss various social and health issues that affect their community: for instance topics like early marriage, human trafficking, menstrual hygiene, healthcare services available for adolescents at PHCS and subcentres etc. Over time, some of these groups also engaged in advocacy at the subdistrict level. For example, one of the adolescent groups in Diamond Harbour II subdistrict held a discussion on the problems faced by adolescents in their area and then compiled the findings and submitted a report to the BMOH. They also indicated the need for distribution of sanitary napkins at a subsidised rate by the ASHAS as many adolescent girls in their villages could not afford to buy expensive sanitary napkins. The adolescents reported that being part of the group had enhanced their

Adolescents reported that being part of the group had enhanced their leadership qualities and communication skills

leadership qualities and communication skills. Now they were also aware of their local government system and about their role in the development of their village.

Community groups like the adolescent groups, self-help groups, mothers' groups were an integral part of advocacy activities of the BHCSP partners. For example, in Bhaduria subdistrict, North 24Parganas adolescents engaged in advocacy for improving the amenities in ICDS centres; the elderly people's groups were involved in advocacy to improve the geriatric health care services at the BPHC in Udayanarayanpur subdistrict, Howrah; the mothers' group in Patharpratima subdistrict, 24 Parganas South successfully advocated for good quality food in the ICDS centres.

The SHG members now feel more confident and empowered to raise their concerns in meetings. Many women actively participate in the gram sabhas and in other meetings. Political leaders also have noticed this change and appreciate it.

### *(Local) Policy advocacy*

Many of the health forum members were directly or indirectly engaged in various advocacy activities at the GP and the subdistrict levels. Some of the issues taken up for lobbying include streamlining of untied funds meant for the health sub-centres (Gosaba subdistrict, Udayanarayanpur subdistrict), ensuring spot feeding of the children attending AWCs, customised care for elderly people at the subdistrict PHC and distribution of sanitary napkins for adolescent girls. For advocacy, the health forum members adopted different strategies like interface meetings of service providers and authority figures with citizens, petitions, signature campaigns and presenting a charter of demands. Community members like women's self-help groups, mothers, adolescents, members of the elderly people's group played a pivotal role in advocacy activities. For example, in the Durbachati GP, the mothers' group used community

score cards and interface meetings with elected representatives of the village and the anganwadi worker, to improve the quality of food provided to children in the ICDS centres. The people's health forum in Darjeeling advocated at several levels of the government and finally succeeded in getting a new building for a health sub-centre in the Lamahatta GP [IB17].

The adolescent groups in Baduria subdistrict of North 24 Parganas district and Diamond Harbour II subdistrict of South 24 Parganas district petitioned the Child Development and the Project Officer (CDPO) seeking measures to improve the infrastructure of the ICDS centres in their villages. However, not all policy advocacy activities of the Forums were successful. For instance, while the official in one of the subdistricts in North 24 Parganas acknowledged the petition by the adolescent groups and forwarded it to the district level, he expressed doubts whether any action to rejuvenate many such dilapidated ICDS centres in his subdistrict would be initiated from the district level owing to a lack of funds.

From field reports of staff and reports of external evaluators, we know that Health Forum members ensured that issues taken up for advocacy were discussed elaborately in various platforms like the VHSNC, fourth Saturday meetings at the GP, mothers' meeting at the Anganwadi centre, subdistrict level development meetings, and task force meetings. Quality data is crucial for evidence-based advocacy activities. While some practical data relevant to the advocacy issue has been used by the forum partners, the full potential of documentation and thus evidence generation is yet to be tapped.

The people's health forum in Darjeeling succeeded in getting a new building for a health sub-centre

## *Oversight*

Oversight of public systems is a key element of governance but seldom do users or citizens get an opportunity to provide direct feedback in a systematic manner. In the BHCSP the health forum partners were also able to foster social accountability by attempting to put in place a community monitoring system. BHCSP introduced the idea of village development committee which used a monitoring matrix for public health services long before the launch of NRHM. Later, with NRHM, these village development committees were merged with the VHSNCs which are now mandated to monitor the services provided by the subcentres, anganwadi centres and primary health centres. N(R)HM emphasises the community-based monitoring processes through the formation and strengthening of committees at village / subdistrict / district level and the creation of community awareness of NRHM entitlements. Some of the forum partners are part of Patient Welfare Committees of the Primary Health Centre e.g. AGP and district health committees e.g.,SSDC. Some of the forum partners are also district trainers for capacity building of VHSNCs e.g. AGP.

Ensuring that information boards in the subcentres and the Anganwadi are regularly maintained and updated was a key concern area for the forum partners. However, efforts to assure downward accountability using such information boards met with varying success. While there was compliance in some GPs e.g. Udayanarayanpur subdistrict, Howrah, it has been a constant struggle in other GPs due to the local political dynamics where the BHCSP is implemented. Community monitoring mechanisms through the village level child protection committees have been functional at the GP level in most of the villages in South 24 Parganas district, Howrah, and North 24 Parganas district mainly to prevent child trafficking. Some members from the adolescent groups and also the health forum members are part of

these committees. The tubewell monitoring committees in Patharpratima subdistrict are another example of a community monitoring mechanism promoted by the health forum members. The health forum NGO partners capitalised on their collaborations with other national and international aid organisations outside BHCSP to strengthen community monitoring mechanisms such as the formation of water user committees. In Patharpratima subdistrict alone, there are 250 water user committees. Out of these, 75 % of the water user committees were handling minor repairs of tubewells without financial support from the local panchayat. Community monitoring of ICDS and Health subcentres at the village level in the BHCSP were routine. But at the district level, such community monitoring efforts were scarce. Interviews with government officials at subdistrict levels where BHCSP was implemented indicated rampant political interference and corruption in the tendering processes of medicine and supplies to the BPHCs, in bulk purchases of pulses and grains for the Anganwadi centres and also during recruitment of Anganwadi workers to the ICDS centres.

Other aspects of creating an enabling environment included community empowerment, as well as understanding and addressing local power relations through informal networks and relationships. Over time, the BHCSP developed and supported various interfaces at the village/GP and subdistrict level through the Health Forums. This created a dialogue between the demand and the supply side of care, which was embedded within a climate of trust. For instance, one of the innovative methods are the interface meetings where the community, service providers and decision-making authorities meet to deliberate on specific issues. These interface meetings enabled the community members to openly discuss and question the power holders/service providers on the issues that affected them. It reinforced accountability within the government system. Experimenting with such innovative methods was possible only because of the trust and goodwill gained by NGO partners of BHCSP with the

One of the innovative methods are the interface meetings where the community, service providers and decision-making authorities meet to deliberate on specific issues

government stakeholders. Several government officials. elected representatives and community members appreciated the contribution of the BHCSP partners in the development planning and action.

Interface meetings demanded transparency and accountability of the state actors vis-à-vis their citizens. Such meetings could cause heartburn to some people in

| Functions of governance | N24P Forum | S24P Forum | Howrah Forum | Darjeeling Forum |
|---|---|---|---|---|
| Directives | * * | * * * | * * | * * |
| Resource mobilization | * * * * | * * * * | * * * * | * * * * |
| Responsiveness to the needs of the community | * * * | * * | * * * | * * * |
| Service provision | * | * * | * * | * |
| Information provision and capacity building | * * * | * * * * | * * * * | * * * * |
| Local policy advocacy | * * * | * * * | * * | * * * * |
| Oversight | * | * * * | * * | * * * * |

Table 2. Performance of the Health Forums based on their contribution to the governance functions

authority when they were challenged with facts and figures. We had to cancel one such meeting when the findings from the descriptive analysis were critical of the actions of certain people in authority. Furthermore, questions about the political motives and affiliations of community leaders were asked when uncomfortable issues were raised. West Bengal is a politically polarised state and there were some occasions when representatives of the local government, ignoring the merit of the issue under consideration, delayed, or stopped local actions because they suspected that the community groups aligned with the political ideology of their opponents.

Table 2 above summarises the contribution of the four different health forum models to the governance of the local health system. A host of contextual factors influenced the structure and the functions of the Health Forums in the four districts covered by the BHCSP. Hence the variation in their contribution to the governance functions. The factors included, but are not limited to, forum leadership, turnover of NGOs in the forum, organisational diversity of the NGOs, individual attributes of the forum members, geography of the working areas, social capital of the individual forum members and the changing socio-political dynamics within the districts.

## Some challenges

It has to be remembered that joining forces for collective action through district Health Forums was not always an easy task. The annual missions of Memisa and the ongoing supportive supervision and periodic coaching from WBVHA staff helped the forum members with diverse perspectives to overcome their ego and come together for the larger social goal of achieving Health for All. Sometimes the forum members had to invest heavily in the relationship building process with government staff. The

The NGO partners found it difficult to challenge the decision-making process

frequent transfer of government officials was a constraint, as it takes time to build rapport with an official. The new officials, not familiar with partnership processes or the health forum activities, took time to internalise them, which in turn slowed down the routine health actions at the forum level. On certain occasions, highlighting individual organisations over the collective Forums created some embarrassing moments crippling the engagement with other actors. It should be acknowledged, however, that changing the mindset of both parties has been very challenging. The government officials had difficulties to come out of their hierarchical mindset and engage with the forum and its members as partners. The NGO partners of the Health Forums sometimes found it difficult to challenge the decision-making process fearing backlash to their ongoing activities other than related to the BHCSP. The varied capacity of partners in health matters was a constraint for many in the beginning. They were unable to engage equally in some of the activities or in playing an active guidance role or to get agreement among the health experts. It also took some time for many NGOs to align with the partnership values of the BHCSP.

## What's left to explore about Health Forums?

A lot about the Health Forums remains to be better understood. There are a number of issues that are not readily apparent and that could constitute the basis for more research.

We need to more systematically collect data

We need to more systematically collect data to know the impact of the Health Forums on health system performance and health outcomes. Further, there is a need to dive deeper into the contextual factors that led to the variation in the performance of the Health Forums within and between the districts. More specifically, there is a

need to explore the underlying mechanisms such as the socio-political dynamics of the relationships between the various actors in the local health system in relation to the Forums. We also found that the contribution of Forums to the governance functions varies between the Forums in a district and between the districts. This indicates the influence of the varied contexts of the districts on the activities and the modes of operation of the Health Forums. Therefore, an in-depth contextual analysis of districts in which the Forums are functional will enable us to better understand what works for whom in which context. In addition, a critical examination of both successful and failed policy advocacy activities of the Health Forums will offer useful lessons for future action within a multilevel governance system. Furthermore, it is important to identify the necessary conditions required for the district Health Forums to engage in and contribute to policy changes at much higher levels such as State and federal levels.

Finally, it is important to systematically reflect on the following questions pertaining to the Health Forums:

Is the health forum approach relevant for other districts and states in India and beyond?

– What are priority areas in terms of deepening and broadening the operation of the Health Forums? For instance, should membership for the Health Forums be entirely open or restricted to members meeting particular criteria?
– What are the experiences with such Health Forums elsewhere? And what are the opportunities for Health Forums to align with other existing networks or social movements serving the same purpose of defending people's rights in terms of health?
– Should the institutionalisation processes of the district Health Forums be more formalised than is the case now? What are pros and cons? And should there be

A critical examination of both successful and failed policy advocacy activities of the Health Forums will offer useful lessons for future action

Is the health forum approach relevant to other districts and states in India and beyond?

better coordination between Health Forums and local administrative district structures e.g. District Health Committees?

## Lessons for the Health Forums, BHCSP and beyond

One might argue that by filling in the gaps in service delivery, Health Forums allow authorities to shun their responsibilities of protecting, promoting and fulfilling the rights of the people

Health Forums in the four districts have made contributions to the specific governance functions as identified through the Brinkerhoff and Bossert framework. One might, however, argue that by filling in the gaps in service delivery, Health Forums allow government authorities to shun their responsibilities of protecting, promoting and fulfilling the rights of the people. But in a context where governance systems are not functioning effectively, infusing social accountability into the systems through the engagement of communities and civil society in governance processes proves to be useful. In this respect, the Health Forums in the BHCSP appear to be relevant structures.

We also find that much of the action of the Health Forums has been confined to the subdistrict level. The collective action of the forum at district and higher levels in the health system has been limited. This could be because of the limited technical, organisational and financial capacity of grassroot NGOs to effectively engage with these bodies. In a context of legal restrictions on civil society imposed by State, the fear factor could be another reason that deter Health Forums from publicising their work.

It was found that at least 24 NGO partners of the Health Forums were part of the various committees constituted by the government at the subdistrict level. One of the possible explanations why the NGOs found a place in these committees could be related to trust. Trust is imperative for enduring partnerships but building trust

takes time. Frequent turnover of officials is unfortunately a strong feature of Indian bureaucracy. In that context, building trust is even more challenging. But, over 20 years of BHCSP operations, the credibility of grassroot NGOs and their consistent engagement with the government machinery have helped the Forums earn some level of trust. However, the specific contribution of the NGO partners of the Health Forums to these government committees is something to be explored more systematically. This would demand more structured research.

One of the key functions in terms of governance is to ensure the flow of information from government to people and vice versa. The Health Forums made sure that this information flow was not disrupted and carried out activities such as campaigns and roadshows and utilised tools such as village information boards [IB3] to reach out to the communities. On the other side, the Health Forums were also providing data based on the community needs assessments to the government. With personnel shortages in government offices at the village and GPs, the efforts of the Health Forums to provide data on community needs were welcomed. Citizens, especially the socially disadvantaged population, when equipped with the right information, find it easier to claim their rights and benefits from the various welfare programmes and schemes implemented by the State. It was also evident in some subdistricts that awareness generation on specific health/welfare programmes had indeed motivated people to approach the concerned authority at the subdistrict level to also themselves be recipients of existing welfare schemes rolled out by the State. But the authorities at the subdistrict level were not able to resolve the issues brought to their notice and to respond adequately to the petitions made by the people because of the administrative issues and problems with programme planning and implementation at the higher levels.

Furthermore, it must be noted that various community groups were capacitated by the grassroot NGOs to engage in local policy advocacy issues such as improving the infrastructure of ICDS centres, ensuring quality in the meals provided to the children attending the ICDS centres, ensuring good quality sanitary products for adolescent girls in the villages and so on. The advocacy activities of Health Forums were mostly limited to the subdistrict level. While there were a few success stories, most of the issues remain unresolved because of the need of intervention either by the district or the State authorities. This is a stark reminder for the Health Forums to actively engage with the higher levels if they want to ensure sustainable and effective solutions for the systemic problems that the government health system faces.

## Conclusion

One of the important challenges for the Health Forums is to deal with higher-level governance issues in the health system

The case of the District Health Forums in the BHCSP demonstrates how the creation of platforms for dialogue at various levels in the health system can contribute to empower local communities to engage in health governance processes. Furthermore, these platforms of dialogue and action can take varied forms depending on the local context. Notwithstanding the diversity of contexts, nurturing trust between the actors remains a key feature for these Forums. However, one of the important challenges for the Health Forums is to deal with higher-level governance issues in the health system i.e., beyond the subdistrict level, at State and federal levels. If Health Forums aspire to become a significant player in changing structures and policies at much higher levels, there is a need for them to strategise their thinking and actions beyond the subdistrict and district levels.

The accomplishments of the BHCSP indicate that amidst the complexities of the health system there lie many possibilities to breed ideas for social change. The district Health Forums are one of the possible avenues to promote collective thinking and action around health. Further, the BHCSP illustrates the importance of an integrated approach [IB6, IB13] in addressing the social causes of ill health in the community. Building bridges between different people, organisations and institutions within the BHCSP created synergies towards achieving the sustainable development goals through a primary healthcare approach. The BHCSP clearly showcases that stitching a network of diverse actors and organisations towards a common goal, even though riddled with challenges, is by no means an impossible endeavour.

The BHCSP illustrates the importance of an integrated approach

I LOVE THIS!
I DON'T!
FRIENDS OF THE FORUM
GUIDING STAR
GOVT
OUR COLLABORATION IS GIVING THE BEST RESULTS!
I'M IN TROUBLE!
WHEN CAN WE VISIT?
I'M SAFE
SV.

## Messages in a bottle

- Trust-building between governmental and non-governmental actors, and finding champions within the public system, are necessary not only to address gaps in access for all to quality services, but also to make progress on health rights.
- Supporting authorities and functionaries to fulfil their objectives and targets regarding the implementation of national schemes is a good starting point to build that trust. It may create a space to solve problems, innovate, foster mutual accountability, discuss sensitive advocacy issues later on in the process, and finally shift some decision-making power to the people.
- The soft power approach of the Health Forums allows for more substantive community engagement and decision making. This would not be possible through the NHM mandated structures.
- Health Forums provide opportunities for mutual learning, identifying appropriate development initiatives, shared decision-making, mobilising resources up to grassrool-level, making health systems and services more responsive, improving coordination and cooperation with the local government, harmonising approaches to development, pursuing effective local advocacy based on documented experience and evidence, and strengthening social accountability.
- More research is needed about the challenges linked to the internal organisation of Health Forums and about the mechanisms through which Health Forums can strategically impact governance.

# Chapter 9

«Innovation is not so much about creating new things, but about making things work.»

HANS VERVENNE

# Catching some fish

Meena Putturaj
Ketaki Das
Aloysius James
Madhumita Dobe
Sandip Bagchi
Bart Criel

Local solutions to local problems

## ¿uestions

- ¿ Was the BHCSP able to develop 'new' or 'innovative' practices to support the unique and practical needs of the community that they were serving?
- ¿ The BHCSP has invested a great deal of energy and time in developing and accompanying processes whereby people are empowered and engage in a culture of reflexivity concerning the work they are involved in. But does it lead to tangible changes in people's day-to-day lives?
- ¿ On the basis of a sound knowledge of the problems that people face in terms of health and healthcare, the BHCSP aims to go beyond "merely" facilitating the implementation of existing programmes designed at the higher levels in the health system. The BHCSP also nurtures the ambition to customise existing programmes to local realities and launch innovative experiences. What are the examples available?
- ¿ And what about your questions?

The BHCSP nurtures the ambition to fine-tune existing programmes, to customise them to local realities, and to possible launch innovative experiences

In earlier chapters we have discussed the iterative processes as well as the flexibility and space for adaptive learning that BHCSP tried to create. In this chapter we will discuss some noteworthy initiatives that were developed through these processes to address local challenges and opportunities.

The specific initiatives we will describe are building capacity of the Village Health Sanitation and Nutrition Committees (VHSNC); streamlining the programme of untied funds for the health sub-centres; engagement with Rural Medical Practitioners (RMPs); and the launching of Community Health Funds (CHF).

## Building the capacity of Village Health, Sanitation and Nutrition Committees (VHSNC)

### *Context*

The National Rural Health Mission (NRHM) was rolled out in 2005 by the federal government and created different platforms of community dialogue at various levels of the health system. These included the Village Health Sanitation and Nutrition Committees (VHSNCs) earlier known as Village Health and Sanitation Committees (VHSC), Patient Welfare Committees, the Subdistrict (Block), District and State Health Committees. However, the need for such structures had already been articulated by the BHCSP before the launch of the NRHM.

For instance, the idea of a Village Development Committee (VDC) with representatives from various government mandated development schemes was introduced in 2004. VDCs had a system of monthly meetings to identify health-related issues and problems that need attention and action. These VDCs, along with the members

of the women's Self-Help Groups in the villages, were also involved in community monitoring of the public health services. The VDC also collected some funds from the community and an equal matching amount up to a ceiling of Rs 2000 or about 40 USD was given to these village development committees through the BHCSP. Later, the Central Health Committees at the subdistrict level were formed as most of the problems in the villages demanded intervention by the subdistrict authorities.

During the coaching workshops, the NGO partners of the BHCSP realised that the VHSNCs proposed under N(R)HM policy were very much in line with the spirit of the BHCSP. Furthermore, around the same time in 2005, the Department of Panchayat and Rural Development of West Bengal government with the help of UNICEF, introduced the Community Health Care Management Initiative (CHCMI) in rural areas. The main aim was to ensure convergence between the different line departments of the Gram Panchayats (GP) in the organisation and delivery of health care services to the rural population. On the 4th Saturday of every month, the GP functionaries and the health care service delivery workers met and deliberated on health issues and planned actions on the priority issues. This provided an opportunity for BHCSP partners to train GP functionaries on health issues and develop a community monitoring system at village level for the health services.

Following the launch of the NRHM by the central government and the CHCMI by the West Bengal government, the NGO partners of BHCSP realised there were many opportunities that could be tapped by the BHCSP. It was expected that platforms like the VHSNC and the fourth Saturday meetings at the GP level would facilitate people-centred health governance through the following mechanisms:

- Inform the community about health programmes and other government initiatives;
- Enable the community to participate in the planning and implementation of these

VHSNC facilitate the community to voice health needs, experiences and issues related to access of health services

programmes and take collective action to improve the health status of the village;
– Take action on social determinants of health that directly or indirectly affect health and health outcomes;
– Facilitate the community to voice health needs, experiences and issues related to access of health services such that the institutions of local government and public health service providers can take note and undertake appropriate action;
– Equip GP with the understanding and mechanisms required for them to play their role in governance of health and other public services and provide leadership to the community for collective action to improve health status;
– Provide support and facilitate the work of community health workers like ASHAs and other frontline healthcare providers, who form a crucial interface between the community and health institutions.

The district health forum partners of the BHCSP were aware that the VHSNCs and the fourth Saturday meeting platforms were more legitimate governance structures [IB9] and therefore integrated the village development committees within the VHSNCs. They did not wish to create parallel systems but wished to facilitate the effective implementation of government initiatives at the grassroots level. When BHCSP partners started working with the VHSNCs and participated in the fourth Saturday meetings, they found that these platforms for community dialogue were facing several challenges:

District health forum partners did not wish to create parallel systems

– According to government norms, all VHSNC members had received one day's training on their roles and responsibilities. However, knowledge and awareness of the members of VHSNC was found to be deficient. Knowledge about the objectives, role and responsibilities of VHSNC was comparatively better among ASHAs than among GP members. Other members of the committee who represented the community were unaware about their roles and responsibilities;

– Irregular meetings and poor attendance were another major problem faced while working with the VHSNC. High levels of absenteeism of official members like the ASHA and the Gram Pradhan (village chief) meant that meetings were rarely held. The Chair of the committee rarely participated in training programmes and meetings;
– To adequately reflect the aspirations of the local community, especially of poor households and women, the NRHM guidelines outlined several equity measures like inclusion of women, ensuring participation of vulnerable social groups and local CBOs. However, the final detailing was left to the State Governments. These committees operated within the umbrella of PRIS.Initially, the composition of VHSNCs did not reflect the the expected diversity. However, with the interventions of BHCSP partners, this changed, and the representation of women and vulnerable social groups increased;
– According to the norms of the newly formulated NRHM every VHSNC was entitled to an annual untied grant of INR.10,000/- (approximately 140 USD). This money was to be used for local public health activities and to support referral care for the poor. Decisions regarding the use of these funds were to be taken by the VHSNC. However, many problems were observed while using them at the sole discretion of the GP chairperson or through official orders, thus, defeating the very purpose of the untied fund.

## *Strategic actions and key achievements*

### *Training and mentoring*

The stakeholders of the district health forum felt that there was need for strengthening VHSNCs and building the capacity of the GP functionaries to effectively perform their roles. Accordingly, the BHCSP NGO partners held several training programmes for the VHSNC in three districts, namely, South 24 Parganas, Howrah and North 24 Parganas. A total of 498 out of 615 VHSNCs from the BHCSP working areas from these three districts received training to make them functional. We adapted the training design, contextualised it, and conducted training in small groups using participatory and interactive methods of teaching and learning. This programme added value to their existing knowledge and skills. The Government identified five of our partners, AGP, KFSC, BFCWS and SSDC from South 24 Parganas and IAD from Howrah as resource organisations for VHSNC training. They also trained GP members in districts where BHCSP was not present.

### *Accompanying VHSNCs*

Besides conducting two or three-day training programmes for VHSNCs, the district health forum partners provided regular handholding support with specific orientation sessions, participating in VHSNC meetings and guiding their plans and action. ASHAS in BHCSP areas received additional training from partners. The health facilitators, "intervisors" (a designation developed within the BHCSP to emphasise supportive supervision) and the coordinators of BHCSP supported the VHSNC on a regular basis and coached them on using tools like resource mapping and focus

group discussion to identify health needs, to conduct health planning and implement activities.

The BHCSP partners facilitated interface meetings and district level conventions so that VHSNC members could directly interact with high officials at the subdistrict and the district levels. These interface meetings were a crucial platform for VHSNC members to highlight problems that hampered optimal functioning of the VHSNCs. Subdistrict and district conventions of VHSNCs and other CBOs got attention of the authorities at higher levels and their participation put pressure on subdistrict and GP level leaders to constructively respond to local issues.

The VHSNCs monitored the health services offered to people. They assessed the quality of food provided in ICDS centres, the use of ICDS facilities by children and mothers. They raised concerns with ICDS officials about poor services but, at the same time, encouraged parents to use ICDS services. They monitored cleanliness activities in the villages, quality and availability of drinking water sources and functioning of subcentres.

The ANMs, who were overburdened with the additional mentoring role in VHSNC, welcomed the support from BHCSP. It helped in strengthening the programme as well as building collaborative relationships in all spheres of work.

*Community mobilisation for health action*

In the BHCSP villages, the VHSNC served as a platform to ensure community participation in the health planning process and provided feedback to the various health service providers on the gaps existing in the services. The members lived in the same geographical area, had representation of the various strata of the community especially from the marginalised communities and women. Based on the issues iden-

tified and prioritised, VHSNC members organised the community and took up action by themselves or with the support of Forum partners, PRI and health institutions. They collected information related to the gaps in health services and specifically the nutritional status of women and children, which got discussed during the second and fourth Saturday meetings at the subdistrict and GP level. They led the processes of constructing toilets and kitchens for the ICDS and health centres, repaired roads, took measures about garbage management at the local level, repaired and maintained tube wells, improved the road leading to the subcentres, developed disaster management plans in disaster prone areas. VHSNCs ensured that pregnant women from the most vulnerable communities received transportation costs so that they could access health services. The members took the responsibility of informing the community through public announcements or graffiti. The community and VHSNC raised INR 324,755 (€ 3820) as a local resource to implement 126 initiatives out of INR 844,635 (€ 9963) to address the specific needs that emerged at the community level.

The Forum developed multiple strategies so that Panchayat members and the Pradhan or chief got involved in strengthening VHSNCs. The Forum organised specific sensitisation programmes for the Pradhans and GP members with the support of district and state level authorities. The Forum had one-on-one discussions with the GP members highlighting the importance of their role and the support needed for VHSNC. Digambarpur GP of Patharpratima, which had received support and guidance from the Forum was given the best GP award by the President of India.

*Accessing untied VHSNC Funds*

Though the government guidelines allocated INR 10000/- (140 US$) for each VHSNC, most of them did not receive these funds. Often ANMS or the PRI members took deci-

sions according to their own priorities without considering the local context. But with the intervention of the BHCSP, the members better understood the policy guidelines. They identified priority health issues through a collective decision making process, maintained proper records, followed the procedures, and claimed the untied funds from the government. The VHSNCs utilised a major part of the funds for sanitation and cleanliness of the village. Dengue awareness and prevention, cleaning up of water sources and drains, and campaigns on cleanliness consumed the rest of the funds. Some of the VHSNCs of Patharpratima and Diamond Harbour 2 blocks received additional funds of INR 2500-3000 (35-42 US$). In some instances, the community added additional funds to construct toilets for the ICDS centre.

*Case Study of VHSNC, Khordanahala, Subdistrict Diamond Harbour Block2II, South 24 Parganas*

*Khordanahala village of Khorda GP, in Diamond Harbour Block2 subdistrict, is economically better off than other villages in the district and 80% of the people is literate. Villagers work mainly in agriculture or small-scale businesses. They however appeared rather indifferent to water, sanitation and hygiene issues.*

*After their training, the VHSNC members of Khordanahala realized they should prioritise water, sanitation and hygiene issues. They better grasped the harmful effects of vector borne diseases like dengue and malaria in their area. Since dengue and malaria were spreading in different districts of West Bengal at that time, they organised a community level meeting in their area to prevent vector breeding and reduce the spread of dengue and malaria.*

*The women's self-help groups in the village attended the awareness meeting in Khordanahala primary School, where they discussed the harmful effects of poor*

*environment and unhygienic conditions. They adopted WASH strategies to keep their surroundings clean. The participants organised mass campaigns in the village to raise awareness on the issue. They wrote graffiti, organised rallies, and safai (cleaning) campaigns in their locality. The village was cleaned to control vectors. The campaign was steered by the local government with the active collaboration of the VHSNC. The VHSNC met the expenses for distributing insecticides. And so, they were able to control the dengue outbreak.*

## Conclusion

Local people are best positioned to communicate directly with local health actors on their specific needs

The BHCSP is an example of how local processes of empowerment can ensure better quality of health services for socially and geographically marginalised communities [IB12]. Local people are best positioned to communicate directly with local health actors on their specific needs, challenge them for service inadequacies, and offer collaborative support to reach out to the most marginalised groups in their area. Government mandated structures like VHSNCs provide an opportunity but their capacities and support mechanisms are limited. The presence and support of institutions/ community platforms like BHCSP, add significant value to and can transform government mandated exercises into truly people-centred grassroot initiatives.

## Streamlining the use of untied funds for the health subcentres

### *Context*

In India, fund allocation for public expenditure has traditionally been in the form of tied or earmarked funds for implementing a particular activity or scheme. Often there are hardly any funds for emerging priorities or even for routine upkeep costs, which are different for facilities facing different circumstances. This centralised management and poor flexibility in the use of funds does not provide much scope for context-specific initiatives and flexibility for local action at subdistrict level and below, even in the health sector. Under the National Rural Health Mission (NRHM), a major reform was introduced to increase functional, administrative and financial decentralisation and strengthen the autonomy of the field health units. In this reform, every Primary Health Centre was provided INR 25,000 (about US$ 350) and each health sub-centre INR 10,000 (about US$ 150) every year as untied fund for local health action.

Poor flexibility in the use of funds does provide little scope for context-specific initiatives

### *The relationship of BHCSP with the health subcentres*

Community involvement for development is a key concern for the BHCSP. The health facilitators of the NGO partners of the district Health Forums complement the role of the ANMs of the health subcentres. They conduct joint planning of local health activities [IB6] together with the ANMs. They stand by the ANMs for advocacy with local policy makers for issues like improving the infrastructure for health subcentres, regular medicine supply for health subcentres, reaching the unreached for health

service delivery and so on. The health facilitators also share information with regard to the performance of the health subcentres in platforms like the fourth Saturday meetings held at the GP level every month.

### *Learnings during the reflection processes*

During their work with the health subcentres, NGO partners in the BHCSP areas realised that the processes related to untied funds for health subcentres were not transparent. The decisions were often ad hoc and lacked accountability for outcomes and fund management. The community voices were not considered. Further investigations revealed that not only were disbursements irregular, but the ANMs themselves were not familiar with the guidelines. They brought up these issues at the NGO partners' meetings at the subdistrict level, labelled 'cluster meetings', district forum meetings and the coaching workshops at the WBVHA. They realised that they needed more data on specific gaps.

### *Using data to monitor and adapt untied funds*

Collecting financial data was an arduous task for the NGO partners in the BHCSP. Despite the long working partnerships with the government actors, the NGOs faced resistance from health service providers and subdistrict authorities in collecting financial data related to the untied funds. It was also challenging because it was an unfamiliar domain for the NGOs. Once the data was collected, WBVHA helped them to assess the knowledge of ANMs regarding the purpose and procedures, and the process of decision-making regarding expenditures and the actual fund flows.

## *Analysis of the data*

### *Disbursement and use of untied funds*

The analysis of the data on untied funds for health subcentres collected from one subdistrict in South 24 Parganas district and another subdistrict in the Howrah district in 2017 for the period 2014-2017 revealed interesting discrepancies. In South 24 Parganas district, the ANM and the Panchayat Pradhan were signatories for the untied funds of the health subcentre, but in Howrah district it was that the block (subdistrict) account manager. This was an example of "street level bureaucracy" (3) where guidelines were modified to suit local bureaucratic conveniences. However, such discretionary practices of implementers were rarely done in the interest of the community.

### *Nature of expenses covered by the untied funds*

In both districts, the untied funds were spent for minor repairs of equipment and furniture, purchase of new equipment, house-keeping expenses, purchase of supplies, stationery, carpentry work in the subcentres and referral of poor patients. In some cases, financial assistance was provided to poor patients from untied funds. From the comparative analysis on the use of untied funds from the two subdistricts, it emerged that untied fund in subcentres of the Udayanarayanpur subdistrict in Howrah district had been used for a variety of reasons and followed the guidelines, but the utilisation of the untied funds was very limited in Gosaba subdistrict in South 24 Parganas district. Possible explanations are the following: in the subdistrict in

Howrah district, two thirds of all subcentres were in government owned buildings while in the subdistrict in the South 24 Parganas district this was only the case in one in four. In addition, the national guidelines do not allow the use of untied funds for any repair works in rented buildings assuming that such repairs are the responsibility of the owner. Also, the ANMs in the subdistrict in Howrah district had a better knowledge of the guidelines than the ANMs in the subdistrict in South 24 Parganas district.

*Decision-making on the use of untied funds*

In both subdistricts, the spending of the untied funds was at the discretion of the ANMs of the health subcentres. This matter was rarely discussed in platforms like the fourth Saturday meetings where Panchayat members and the health service providers came together. The subdistrict officials usually approved the requests made by ANMs. While the guidelines stated that the decisions related to the untied funds were to be approved in fourth Saturday meetings, they hardly deliberated on their use.

## *Course correction at policy level*

*Sharing and dissemination of the evidence on the use of untied funds*

Ramakrishna Lok Seva Kendra (RLSK), a BHCSP partner and member of the District Health Forum in South 24 Parganas district, shared the outcome of the assessment of untied funds with the elected representatives of 14 Gram Panchayats in January 2017. During the sharing meeting it was observed that most of the Panchayat rep-

resentatives did not have any knowledge of the utilisation of untied funds and consequently were not clear about their role in the process. *"Swasthyar beparta ANM-rai dekhe, amra ote naak golai na" (health issues are taken care by the ANMs, we do not interfere in that)*-they said. They were also not aware about the guidelines regarding utilisation of untied funds and therefore not bothered about delays or decreases in disbursement of untied funds. The NGO partner RLSK of the BHCSP highlighted the roles and potential benefits of untied funds. Following this meeting three PRI members raised this issue with the government authorities and other elected representatives at the subdistrict level. Subsequently the fund allotment from the subdistrict to the subcentres increased for most of the health subcentres in this district. The change was quite remarkable. In 2014 – 2015, none of the 50 subcentres received the allotted 10,000 rupees and only 19 received 5000 rupees. In two years in 2016 – 17, 29 health sub-centres received the allotted amount of 10,000 rupees. "*The RLSK raised the issue on untied funds allotted for the health subcentres, I think we have addressed that issue to some extent,*" said a subdistrict level official.

The fund allotment from the subdistrict to the subcentres increased

### *Challenges faced: overcoming systemic barriers*

Despite requisite permissions, some ANMs were not ready to share information with the assessment team. Even when information was shared, details were not provided. Only after repeated attempts by the BHCSP staff, was it possible to get the data. Written permission to conduct the assessment was given in South 24 Parganas but in Howrah district the higher officials were hesitant and only gave verbal consent for the assessment of untied funds. While sharing the evidence was possible in South 24 Parganas district, it was not possible in Howrah district because the bureaucracy was not cooperative.

The NGOs formed alliances with champions within the subdistrict administration to access sensitive financial data to streamline the use of untied funds

To overcome these difficulties, the NGOs in the two subdistricts formed alliances with local policy champions within the subdistrict administration and worked with them to access the sensitive financial data which was then used as evidence for advocacy to streamline the use of untied funds.

## Engagement with Rural Medical Practitioners

### *Context*

It has already been mentioned that the Sundarbans region, a BHCSP intervention area, is one of the most challenging places for human survival. The weak public health system in this inaccessible region often leave poor people with no option but to seek care from unqualified practitioners. These unqualified medical practitioners are referred to as "Rural Medical Practitioners" (RMPs) (7). BHCSP engaged with these practitioners since they were part of the day-to-day reality of people's lives.

An estimated 2.5 lakh (0.25 million) RMPs (2) practise medicine in West Bengal with little or no formal training. Most of them had earlier worked as assistants to doctors. Some inherited traditional medicine systems such as Ayurveda from their parents, and some were homoeopathy practitioners. For most people of West Bengal, in the rural areas, these healthcare providers are the first point of contact. Even though they operate outside formal regulatory oversight, they often have earned the respect and trust of the communities they serve. They are present in remote places, are available when needed and they charge very little.

Maternal and child health indicators of the Gosaba subdistrict of South 24 Parganas district, when the BHCSP was launched (between 2003-2004), was one

of the worst in the state. Some mention of the BHCSP's interactions with RMPs has already been made in Chapter 2. The NGO partners of the BHCSP working in this subdistrict observed that the communities preferred the services of the RMPs for their easy accessibility and affordability. There were hardly any qualified doctors in these villages. Most villages in the interiors of Gosaba subdistrict or Patharpratima subdistrict lacked functional health centres or even subcentres. People had to walk or use cycle van or boats to take a patient to the nearest hospitals 30-40 kilometres away. So, when people fell sick, the villagers consulted these untrained health workers, sometimes referred to by the (rather pejorative) term of 'quacks'. These health workers were available, whenever they were in trouble, even in the dead of night. Interacting with them was always non-threatening, as they were quite familiar with the users' culture and belief systems, often unlike the urban trained medical doctors. For the poor, the RMP are a significant source of relief as their service charges were low and people did not need to pay immediately for the services. The fees could be paid in kind or cash or even in instalments.

The RMP are a significant source of relief as their service charges were low and people did not need to pay immediately

### *Sensitisation programmes for RMPs*

In the period 2007-08, the BMOH in Gosaba was concerned about the high proportion of home deliveries in this region and therefore partnered with the grassroots NGOs of the BHCSP and explored the idea of engaging with the RMPs to improve the MCH status of the population. It was indeed observed that RMPs tend to delay in referring complicated cases to the subdistrict hospital or the private health centres. The engagement started with a training programme organised by grassroots NGOs in partnership with the BMOH. The RMPs had limited knowledge and skills and were sometimes causing harm to their patients. "*Our motto is risk reduction*", says the Gosaba BMOH.

*"Our motto is 'risk reduction"*, says the Gosaba BMOH

The focus of the training was on first aid, treatment of minor ailments, sensitising RMPs about possible harmful practices, their limitations, and the need for timely referrals of patients to the nearby primary health centre. The training discouraged the use of antibiotics, encouraged early referrals of complicated cases to the government/private health facility, and suggested that RMPs keep their treatment restricted to minor ailments. The trainers discussed some of the complicated cases in their locality, critically analysed the situation and suggested practical measures to save lives. RMPs were also given information about the various health programmes/government schemes available for the communities they serve. There was an overwhelming response from the RMPs for such training. RMPs felt that such types of training would help them to get recognition from the government. The grassroots NGO partners strategically made alliances with the subdistrict authorities for the RMP sensitisation programmes. For maximum coverage of RMPs, they also involved the RMP associations at the subdistrict level.

This experience of RMP training was shared by the RLSK, the grassroots NGO in the Gosaba subdistrict, with NGOs of other districts in the coaching workshops held by the WBVHA. Other NGO partners like AGP in the Diamond Harbour 2 subdistrict and IITD in the Kakdwip subdistrict conducted similar sensitisation programmes for the RMPs in 2007-08 and 2008-10 respectively in the South 24 Parganas district. Later, in 2017, the North 24 Parganas district health forum partners actively engaged the RMPs in dengue outbreak management (see Table 1). A district-level convention was held, and RMPs were trained to generate community awareness and action to eliminate the mosquito breeding sites and organise early referrals of the dengue affected patients to appropriate places of treatment. They were able to identify early symptoms and referred patients for testing. They sent complicated cases to government hospitals or to other qualified medical practitioners.

The forum regularly organised quaterly meetings and provided technical inputs to improve their knowledge and skills. Some of the PHC and subdistrict level doctors interacted with them during such meetings.

The RMPs now demanded regular quarterly meetings with the government authorities to update the government programme regularly. However, the response from the authorities was mixed. In some areas, the authorities were open to such regular training for the RMPs but in a few other areas they were concerned that such training programmes would be a step towards legalising "quackery" in health care.

| Year | District | No of training Sessions | No of RMPs trained | The proportion of RMPs in the BHCSP implemented areas involved in the training programme |
|---|---|---|---|---|
| 2007-08 | S24P | 10 | 305 | 14% |
| 2017 | Howrah | 4 | 165 | 70% |
| 2017 | N24P | 6 | 191 | 26% |
| 2016 | N24P | 1 (convention) dengue outbreak | 90 | |
| Total | | 21 | 751 | 24% |

Table 1. Details of the training sessions held for the Rural Medical Practitioners in the BHCSP

The RMPs demanded the inclusion of clinical aspects in the training programmes. It is likely that the RMPs believed that the training conducted in the government premises was an indication of the state's willingness to legitimise their practice.

## *Changes on the ground*

These rural practitioners maintain a close relationship with the government doctors in the BHCSP working areas. In many villages, we have seen the collaborative work of these informal providers with Government health officials to implement government health schemes or organise campaigns on health. Many vaccinations campaigns are now organised with their support. The government planned many such camps next to their clinics. The government utilised their services in polio eradication, family planning programme, TB and AIDS awareness and control programme, building awareness on institutional delivery and maternal and child health care.

PHC doctors in the BHCSP area have mixed reactions to the outcome of the training. Most of them agreed that there is a positive relationship with these informal practitioners, facilitating early referrals. They co-operated with the government schemes and campaigns. Working with RMPs helped them in identifying cases early and controlling the spread of disease, e.g. the dengue prevention and response programme in North 24 Parganas jointly organised by the BHCSP and district health team.

The RMPs utilised these training opportunities to grow, improve their knowledge and skills. They cultivated a positive relationship with the health authorities and NGOs operating in their area, which resulted in increased income, visibility, and social acceptance. The RMP associations have articulated their expectation of being formalised within the government framework.

There is a positive relationship with these informal practitioners, facilitating early referrals. They co-operated with the government schemes and campaigns

## *Many challenges remain*

Since such training of RMPs is still not part of the existing health policy, it provokes intense debate. Some argue it creates double standards of care from an equity perspective – qualified professionals for the urban people and underqualified/unqualified practitioners for the rural population. However, this argument does not address the unwillingness of most trained health professionals to go and work in rural areas. Some believe training informal healthcare providers is a potential solution to address the shortage of trained doctors in rural areas (Das et al., 2016). Others like the practitioners of modern medicine hold that a few training sessions to the RMPs cannot replace the years of experience gained in the medical schools by qualified professionals. Doctors who are part of the IMA (Indian Medical Association) (9) oppose any effort at enhancing the status of RMPs or organising training programmes for them. IMA has been trying to bring an anti-quackery legislation, arguing that the practice of RMPs violates existing regulatory provisions around health professionals. They have also halted many government initiatives to mainstream RMP services within the rural family programme and schemes which aimed to upgrade their skills and competencies.

Another challenge is to have conceptual clarity on the notion of "quackery", in a country with a diversity of medical disciplines. According to the IMA, practice of modern medicine by unqualified people including those who may have been trained in Ayurveda or Homeopathy, or any other formally recognised discipline also amounts to quackery. However, the AYUSH (an integrated term which include the Ayurveda, Yoga, Unani, Siddha and Homeopathy) fraternity feels that legitimising integrative medical practitioners is a potential solution for India's primary health care woes (10). For the AYUSH practitioners, the definition of quacks

includes the herbalists, hakeem, bonesetters, folk healers, alternative medicine practitioners and so on (5).

Earlier, there was a move from governments in different states, including West Bengal, to formalise the services of these rural practitioners by building their capacities and skills over some time. Telangana government approved a state-wide training – the 1000-hour training, for the rural practitioners (6,8), managed by the Telangana Para Medical Board. However, due to the strong opposition from the IMA, vehemently arguing that such a process would affect the health of patients and public health, the governments, both state and central had to drop such initiatives. The Liver Foundation (6,7), a non-government organisation in West Bengal, conducts a seven-month training programme for RMPs since 2007. They train 60 participants in each batch against all opposition including that from the powerful IMA and provides them with a "Rural Healthcare Provider" certificate.

## *Our plans for the future*

The BHCSP is committed to train and develop these informal rural medical practitioners to address the immediate gap in healthcare. Even with policies in place and the advancement of communication and technology, these quacks as health providers have much relevance in the present context. They are still playing a positive role and their absence would deny basic treatment facilities in many interior villages.

BHCSP will continue to advocate for policy changes in the health sector for an inclusive approach to different medical disciplines

The BHCSP will continue to advocate for policy changes in the health sector for an inclusive approach [IB21] to different medical disciplines. At the same time, BHCSP supports the government in developing a long-term strategy and plan to train more and more qualified and skilled health personnel who would then be deployed in the most needed rural areas, thereby ensuring universal access to quality Health for All.

Simultaneously, the BHCSP will educate people and empower them to promote their health and prevent disease by following healthy lifestyles. The ordinary person must have sufficient capacity to discern and choose appropriate disciplines relevant to her/his health and community. The BHCSP will continue its facilitative role and enable the community to make choices in accessing proper cost-effective medical care.

## The Community Health Fund

### *Context*

Global evidence shows that prepayment mechanisms for accessing healthcare do better than direct payment mechanisms. In India, however, approximately three fourths of the healthcare payments are met through out-of-pocket (OOP) expenditure at the point and time of service delivery. It is estimated that around 46 million households in India would have experienced catastrophic health expenditure and 8% of India's population is pushed into poverty because of healthcare expenses every year (4). When compared globally, India's public health spending is one of the lowest when compared to countries with similar economic indices or even with countries poorer than India like Bangladesh, Sri Lanka, Indonesia, and Bhutan (1). This leads to poor accessibility of public health care facilities and, even if available, often providing poor quality of services to the population. The government spending on public healthcare has never exceeded 1.3% of Gross Domestic Product (GDP) since many years (WHO, Global expenditure data base, 2014) (11) even though the government has promised, several times, to raise this to at least 2.5%.

In India three fourths of the healthcare payments are met through out-of-pocket payments and 8% of India's population is pushed into poverty

To achieve universal health coverage and ensure social protection of health, there have been some moves to adopt prepayment mechanisms. Since 2008, several social insurance schemes like Rastriya Swasthya Bima Yojana (RSBY) and currently the Ayushman Bharat scheme have been rolled out with the hope to improve financial access to healthcare. However, these were not there at the time when the BHCSP was started.

## *The beginning*

In the BHCSP area when people fall sick and need money they borrow money from local money lenders at very high rates of interest. This was catastrophic for poor people in the BHCSP intervention area. In 2005, a decision was taken to introduce a health fund for the women's self-help groups through the Village Development Committees. The VDC collected an amount of money from the community members and a matching grant was provided to them through the BHCSP to support them. The primary purpose of the fund was to support the poor families in cases of any health emergency. Women's SHGs were identified as the critical stakeholders as they were involved in all the key activities of the BHCSP, and they were familiar with health-related activities.

Women's self-help groups were an established community-based income supplementation group created through the government. In 1999 the government of India had introduced Swarnajayanti Gram Swarojgar Yojana (SGSY), which was replaced by National Rural Livelihood Mission (NRLM) in 2013 (Reserve Bank of India 2019). In West Bengal NRLM was renamed Anandadhara programme in 2012 (West Bengal State Rural Livelihoods Mission). All rural women (18-60 years) were eligible to be members of SHGs. A self-help group usually comprises 10-12 members. SHGs also

promote women's empowerment and thus address the deep-rooted gender inequalities in the country. As a strategy, BHCSP had decided to build upon this existing community-based group of women.

### *Seizing the opportunities*

Having known about the engagement of BHCSP with women's SHGs, Freedom from Hunger (FFH), an American NGO, approached WBVHA in 2012 to introduce the concept of community health fund among the women's SHGs. Health promotion through the women's SHGs was one of the working strategies of the FFH. The FFH provided technical support and training modules focused on issues related to health and healthcare. Thus, the concept of health fund was promoted as "integration of health and microfinance" [IB16] in the self-help groups, re-oriented as "Community Health Fund" (CHF) in 2012 and was piloted in South 24 Parganas district through the women's self-help groups in the villages.

### *Some operational details on the community health funds*

The CHF was a fund pooling and risk pooling mechanism at a very small scale through the women's SHGs in rural areas. Each group consisted of 10-12 members. Each member contributed a small amount which could range from INR 5 to INR 60 (0.05 – 0.75 US$) every month in addition to the normal monthly savings. One member in each group would take the responsibility to manage the health fund. The fund was deposited in a common bank account of the SHG. The member who managed the funds would keep some cash in hand, so that it was available immediately in case of emergencies. The norms for the contribution and utilisation were very flexible

QR code of the movie on Community Health Fund

and determined by the group itself. During health emergencies, any member could take a loan to meet their need.

### *Scaling up the idea of Community Health Fund*

Initially, out of the 1700 SHGs functional in the BHCSP areas in 2012-13, the CHF was planned for 341 SHGs in the districts of South 24 Parganas, North 24 Parganas and Howrah through 30 NGO partners of the BHCSP. However only 124 SHGs initiated health funds and at the end of 2013 only 104 groups continued. The team realised that was due to inadequate efforts and poor follow-up. In 2014 the team revised the strategy to promote CHF, with additional training and increased follow up. The SHGs responded positively, and they increased CHF savings. The CHF is different from the classic community-based health insurance. Indeed, in the CHF model the borrowers must reimburse the amount with a maximum interest rate of one percent. The members are free to choose the repayment period of up to two years. Some SHGs allowed their members to take interest free loans and while others let the borrower decide the interest rate according to her convenience.

The revised approach had a snowballing effect and 46 women's SHGs beyond the BHCSP areas adopted the CHF concept. The government authorities and the elected representatives also appreciated the concept of CHF and some SHGs received support from government. Eighteen community service providers, and a designated functionary responsible for promoting the SHGs under NRLM, launched in 2011 by the Government of India, extended their support to the CHF concept. In recent years, with the involvement of community service providers at the Gram Panchayat level, more SHGs initiated CHF in their groups. By 2014, FFH realized that the NGO partners

in the BHCSP were adequately supported to scale up and sustain the CHF concept and gradually tapered their support to BHCSP.

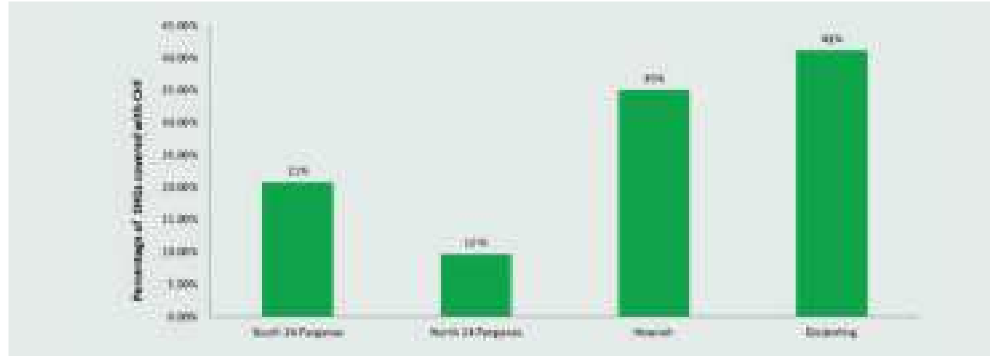


Figure 1. CHF coverage in the women's SHGS in the BHCSP implemented areas (Source: Routine programme data)

Strategic partnerships were made to scale up the initiative. The NGO partners of the BHCSP secured the support of community service providers of leaders of the SHG clusters. As of December 2021, 5910 families contribute to the CHF programme. They have a financial resource of INR 3,044,956 (€ 35823) at their disposal to meet any emergencies.

Elected Panchayat representatives, Panchayat officials, BMOH and members of SHGs appreciated the CHF idea [IB4].

*"T he community health fund is available for us to use in case of health emergencies. It is preventing us from incurring huge debts because of healthcare expenses." (KII-Self-help group leader, Durbachati GP, South 24Parganas )*

*"Government schemes like the RSBY are not enough to cover all the expenses (direct*

*"The community health fund is available for us to use in case of health emergencies. It is preventing us from incurring huge debts because of healthcare expenses."* (SHG leader Durbachati)

*and indirect) during an illness. In such situations the community health funds come as a respite."* (KII *self-help group member, Durbachati* GP).

The utilisation of the CHFs was evaluated through a survey conducted in four subdistricts from two BHCSP implementing districts. The data was collected during the period July 2017 to June 2018. In the two districts, 17 % (264/1560) of SHGs have CHF.

## *Utilisation of CHF by the SHGs*

In 32% (84/264) of the SHGs with a CHF, at least 240 women members utilised the funds at the time of illness in their family.

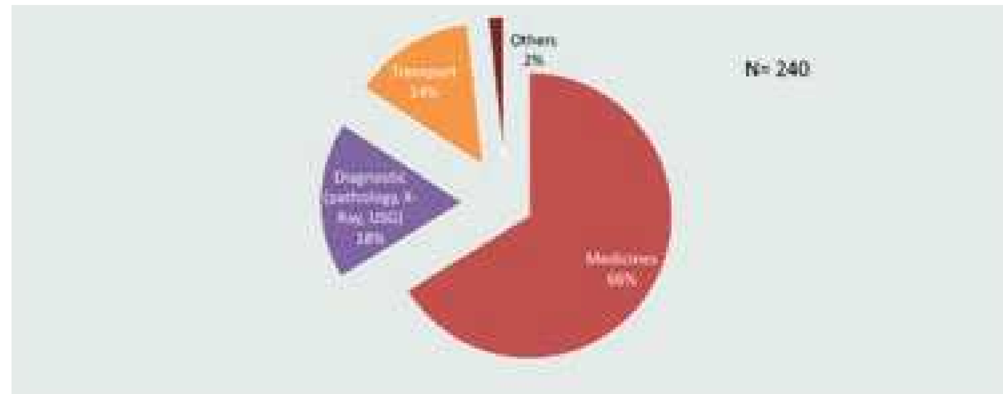



Figure 2. Utilisation of CHF by the SHGS

Out of the 240 women who used the CHFs, 66% of them utilised the money for buying medicines, 18% for medical tests and 14% to cover transportation charges pertaining to the care of the sick person.

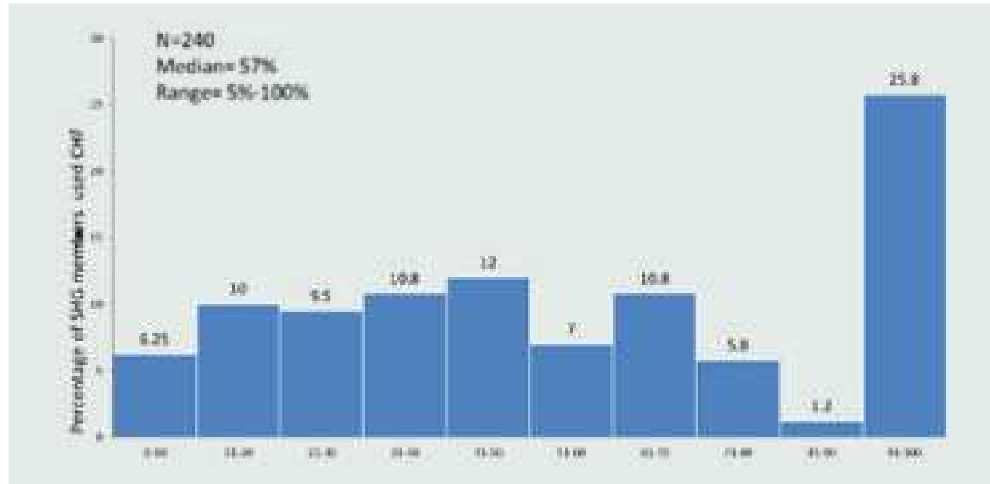



Figure 3. Percentarge of the healthcare expenses of SHG members covered by CHF

Further analysis of the data showed that the CHF was most often used for minor illnesses, and that in about a quarter of these cases (see the graph above) the CHF support was sufficient to meet most of the costs involved. For the 6 % of the women who utilised the CHF to manage major illnesses, it covered only 5-10% of their healthcare related expenses. Around 75 % of the women who used the CHF reported that the funds were not sufficient and that they still borrowed money from moneylenders/ relatives or mortgaged their property to pay the full-cost of healthcare bills.

This data emphasises the point that social health insurance schemes should also cover the costs of first line care and not only, as is so often the case, tertiary and high-end super speciality care.

## *Limits and potentials of the community health fund initiative*

High out-of-pocket expenses for healthcare has been a serious concern in India for some time now. Despite promises, the government has not allocated enough financial resources to the health sector. In addition, the large existing social protection schemes face problems in terms of design and implementation and normally do not cover any out-of-pocket expenses during treatment. CHF can be seen as a partial and incomplete response, at best.

- The current CHF actions are SHG focused, and risk pooling and resource pooling is very small. It cannot cover major healthcare expenditures e.g., chronic illnesses or hospital admissions. So, complete financial protection cannot be ensured;
- Some degree of "anonymity" is essential in risk/resource pooling which cannot be ensured in small-scale community health funds where "everybody knows everybody". Since it is a small group, decision on whom to support or what can be supported with the CHF could possibly be influenced by moral standards and normative beliefs within society in general and the SHG in particular (e.g. care of HIV positive person, or care for drug addicts...);
- CHF are intrinsically gathering people, on a voluntary basis, who have a similar background and share a common 'identity'. They will, therefore, also tend to exclude households/individuals who do not share similar social, cultural, religious and economic characteristics. However, this critique does not mean that the women's SHGs could not constitute a sort of "apprenticeship" in terms of solidarity.

Community Health Funds are intrinsically gathering people who share a common 'identity'

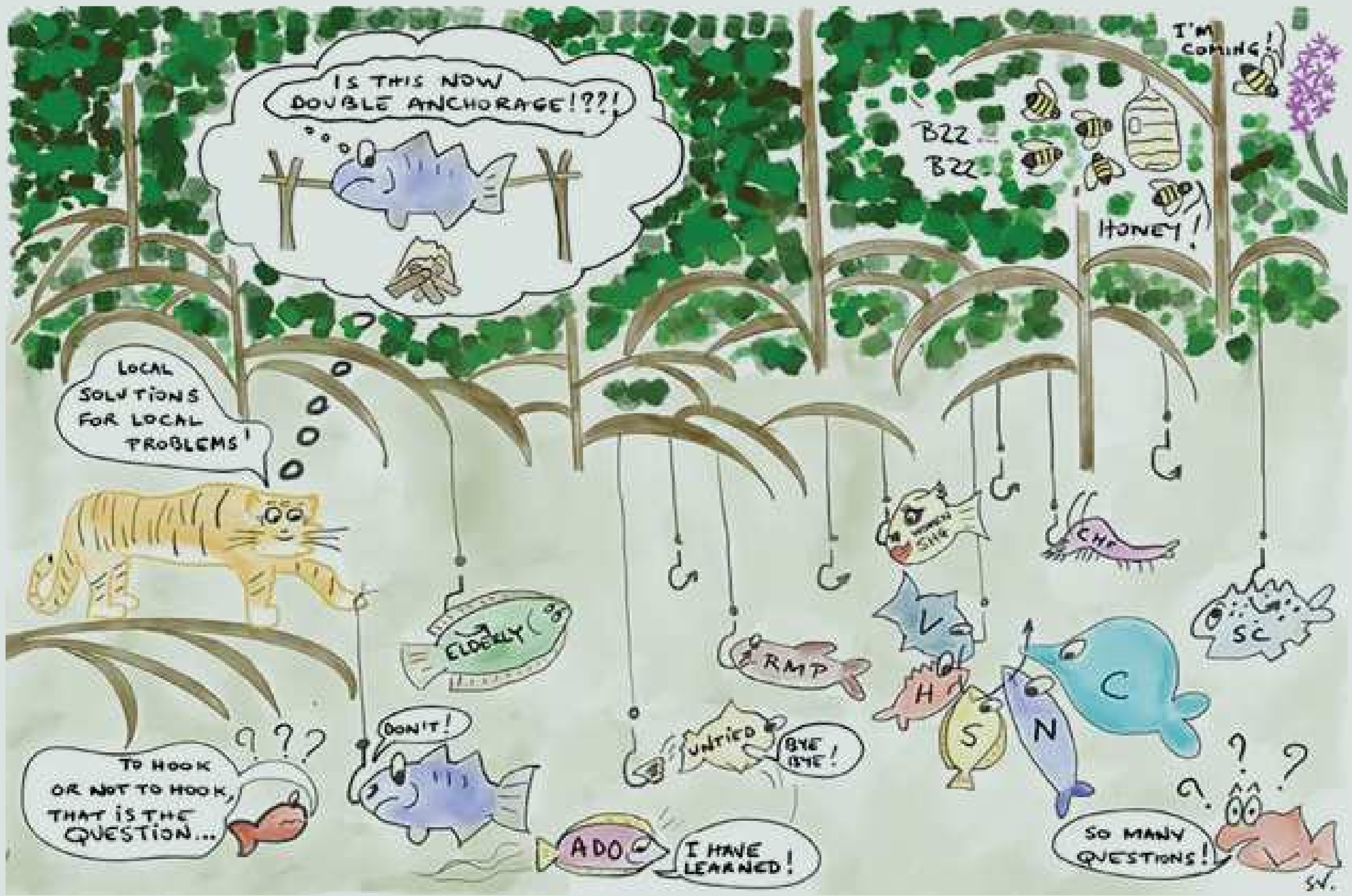
The BHCSP's experience with CHFs indicates that they may be helpful in complementing existing health insurance schemes in addressing the high burden of out-of-pocket payments, including at the level of the first line of the healthcare delivery system.

## Moving ahead: stepping out of the comfort zone

This initiative so far has been limited mostly at the local and subdistrict levels, and rarely beyond. This is beneficial to the local communities but does not address the considerable design and implementation challenges in terms of social health insurance programmes. There is need to scale-up the scope of activities of social health insurance programmes, and give special consideration to the inclusion of the most vulnerable households. This implies an engagement with policy-makers beyond the subdistrict level. Without such linkages at the higher level, the BHCSP will not succeed in introducing structural reforms in the health system, and many ongoing actions may not be sustainable. Hence there is a need for the BHCSP to go for strategic objectives at the policy level, rather than only acting at the operational level [IB20,22,27].

There is a need to scale up social protection schemes for the most vulnerable beyond the subdistrict level

A more structural solution demanding rethinking and redesigning of the BHCSP is therefore crucial if the programme intends to build on its valuable achievements on the ground through a process of "empowering the communities". Such restructuring of the BHCSP will necessarily have implications on the organisation, functioning and human resources policy of the BHCSP. A two-pronged approach might help the future of the BHCSP: firstly,maintain and consolidate the action at community level and secondly, build a new pillar of strong monitoring and evaluation capacity of the stakeholders at various levels that contributes to evidence-based policy action within the BHCSP and beyond.


IS THIS NOW DOUBLE ANCHORAGE!??!
BZZ... BZZ...
I'M COMING!
HONEY!
LOCAL SOLUTIONS FOR LOCAL PROBLEMS!
ELDERLY
RMP
CHP
SC
V
H
S
N
C
UNTIED
BYE BYE!
DON'T!
TO HOOK OR NOT TO HOOK, THAT IS THE QUESTION...
ADO
I HAVE LEARNED!
SO MANY QUESTIONS!
SV.

## Messages in a bottle

- The BHCSP succeeded in developing fruitful learning cycles going from contextual problem analysis, reflection on possible solutions, implementation of changes, and their monitoring and evaluation.

- Several innovations were developed within the BHCSP. They emerged as locally relevant solutions to problems that local communities identified and agreed to address with the support of the BHCSP team.

- Innovation is not so much about creating new things, but about making things work. Local innovations can work effectively if they build on existing government schemes or establish linkages with the local government bodies with relevant innovative community programmes, for example, untied funds and CHF. Additional inputs in terms of capacity building of both government providers and community leaders as well as some additional financial resources are important.

- Scaling up of local innovations can happen through word-of-mouth diffusion and peer-to-peer learning in adjoining areas with similar conditions.

- Small scale innovations, rigorously documented and shared with policy makers, can help build new policy approaches and support larger policy reform [IB26]. But an 'innovation' from one place may not be a 'universal' policy solution.

- The space for 'innovating' needs to be incorporated into public systems.

- The BHCSP engages with policymakers at district and State level to present their work with the purpose of translating their findings into policy and practice. For that kind of an impact, several deep organisational changes need to be conducted at the level of the BHCSP partners.

# Chapter 10

> «If we knew what it was we were doing, it would not be called research, would it?»
>
> ALBERT EINSTEIN

# How did we sail below the waves?

Karel Gyselinck
Ketaki Das

## Methods and tools to manage complex social development programmes

### ¿uestions

- ¿ How to make sense of 'change' and 'success' of development interventions in a complex social environment?
- ¿ How to transform management tools and leadership styles to manage a development support programme in a complex and dynamic social environment?
- ¿ How to structure learning for results in development support programmes?
- ¿ How to innovate?
- ¿ What are useful practical methods and tools to document experiences, build and share evidence, and interpret success and failure in a complex, dynamic context?
- ¿ How to use programme funding creatively to support such processes?
- ¿ How to connect with the policy level?
- ¿ And what about your questions?

## Reminding the scope

Before we dive into the methods and tools of the BHCSP, it is good to remind ourselves of the scope of the programme. The following picture illustrates this well.

The BHCSP is not about giving people fish, which often tends to be based on charity thereby making people dependent on aid. It is neither about teaching local communities how to fish. This is what vertical programmes are tempted to do: reinforce specific capacities according to a specific focus. These programmes however do not take into account all factors which determine whether fisherfolk will be able to live the lives they want to live. That is a far more ambitious goal, which is called development. Development and related social change are complex endeavours. The focus of the BHCSP is managing this complexity and choosing approaches, methods and tools that are useful for the process.

## Documenting the how, not only the what

Doing ‘activities’ and making individuals and communities benefit is obviously important for development programmes. However, it is also important to understand the overall change process in terms of the goals and objectives that are set and revised for such activities. It is also important to distill lessons from such pioneering efforts, not only for the ongoing improvement of the programme itself, but for the benefit of the larger development community. The BHCSP yielded some valuable lessons on how to deal with complex interventions, and some of these have been described in earlier chapters. This was possible thanks to a range of processes, methods and tools which were introduced. These not only helped the team to understand the

change pathways, but were also useful in documenting the innovation strategies. Therefore it is important to document, beyond the content of the BHCSP, the way we introduced and worked with these processes, methods and tools in practice. How did we manage to sail below the waves [IB28]?It is important to understand how the programme was set up and managed, and explore if this has contributed to success. A compass can be a guide but you need boats, crews, nets and many other tools to be able to sail to the ocean and catch some big fish. The five guiding principles had to be practised, using a value-driven, participatory, system-oriented, reflective, innovative, evolving and flexible way of working based on trust and fostering change. We can take a closer look at the processes, methods and tools used by the BHCSP and put them in a framework of thinking about complexities. We will not deal in detail with the application of all this material in the BHCSP. This has already been largely illustrated in previous chapters.

For all those wanting to sail towards the open sea, it's good to be prepared and ensure that you have the necessary tools and techniques [IB26] to catch big fish – either in the coastal areas or in the deep sea – and deal with unforeseen circumstances.

## Doing Development Differently

Before talking about the approach and methods used in the BHCS itself, let's put them in a wider context. In October 2014, the Centre for International Development at Harvard University organised a workshop with development practitioners and researchers to look at new experiences and efforts of improving service delivery by the state. The result of this workshop was the 'Doing Development Differently' Manifesto which emerged from this exercise. BHCSP can also be seen as an effort in this direction.

# THE DDD MANIFESTO

## ON DOING DEVELOPMENT DIFFERENTLY

Too many development initiatives have limited impact. Schools are built but children do not learn. Clinics are built but sickness persists. Governments adopt reforms but too little changes for their citizens.

This is because genuine development progress is complex: solutions are not simple or obvious, those who would benefit most lack power, those who can make a difference are disengaged and political barriers are too often overlooked. Many development initiatives fail to address this complexity, promoting irrelevant interventions that will have little impact.

Some development initiatives, however, have real results. Some are driven domestically while others receive external support. They usually involve many players – governments, civil society, international agencies and the private sector – working together to deliver real progress in complex situations and despite strong resistance. In practice, successful initiatives reflect common principles.

- They focus on solving local problems that are debated, defined and refined by local people in an ongoing process.
- They are legitimised at all levels (political, managerial and social), building ownership and momentum throughout the process to be 'locally owned' in reality (not just on paper).
- They work through local conveners who mobilise all those with a stake in progress (in both formal and informal coalitions and teams) to tackle common problems and introduce relevant change.
- They blend design and implementation through rapid cycles of planning, action, reflection and revision (drawing on local knowledge, feedback and energy) to foster learning from both success and failure.
- They manage risks by making 'small bets': pursuing activities with promise and dropping others.
- They foster real results – real solutions to real problems that have real impact: they build trust, empower people and promote sustainability.

As an emerging community of development practitioners and observers, we believe that development initiatives can – and must – have greater impact.

We pledge to apply these principles in our own efforts to pursue, promote and facilitate development progress, to document new approaches, to spell out their practical implications and to foster their refinement and wider adoption.

We want to expand our community to include those already working in this way.

We call on international development organisations of all kinds to embrace these principles as the best way to address complex challenges and foster impact. We recognise the difficulties, but believe that more effective strategies and approaches can generate higher and lasting impact.

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Visit http://doingdevelopmentdifferently.com/the-ddd-manifesto/ to see signatories and sign up

Figure 1. The DDD Manifesto developed at Harvard University in 2014

The processes of BHCSP can be considered in line with the recommendations of the DDD Manifesto (5) as it is also about 'tackling local problems through locally owned processes, with local conveners and stakeholders engaging in action-reflection-action cycles, blending design and implementation, making small bets, leading to incremental change'. All this with the vision not only to improve local service delivery through 'small changes' but also to learn from these changes for other contexts so to prepare and catalyse 'bigger change', that is, 'go for the bigger fish', changing the policies and strategies at the higher level. This double anchorage of a development support programme, where the scope of work has meaning both at the operational and the strategic level, is an essential condition for sustainability. It embeds the changes emerging in a programme within the wider system.

## Face to face with complexity: the limits of traditional methods

A development support programme like the BHCSP is not operating in a vacuum. Even if the initial ambitions were modest and the programme focused on a selected number of isolated villages supported by 8 NGOs in South 24 Parganas, it found itself in a very dynamic environment – at different levels – which influenced what happened in those 51 remote villages. It's like jumping on a running train or jumping on a sailing boat. The programme is like a boat in the sea, where wild winds, waves and currents rule and tend to take the boat in all directions. A project logframe might create the illusion that we control to a large extent the expected results, but reality proves otherwise. We cannot deny the reality of rapidly evolving policies, power dynamics at all levels, the social tissue at village level, the doings and beings

A project logframe might create the illusion that we control the expected results, but reality proves otherwise

of individuals and communities, just to name a few. Yet, the ambitions were high: contribute to change in the lives of the people. Change but no control. How could we manage to sail in the desired direction in a wild sea?

Ambitious programme managers will tell you that change is not about outputs like 'number of people trained' but about outcomes as in 'how do people change their behaviour following those trainings'. If sustainable change is the big fish you want to catch, it's about changing behaviour. Behaviour of individual people, of groups, of organisations, of complex social systems. The word has fallen: complexity! The word alone makes programme managers feel a shiver run along their spine. Looking down the abyss at the edge of chaos is frightening. The greater the fear of uncertainty the more impressive are the rituals trying to exercise control. Such rituals have been there since the stone age. Led by the high priests of programme management, at best, participative SWOT analyses, project designs summarised in logframes – in particular intended for the decision-makers who have so little time being busy with far more important things – and sophisticated M&E dashboards with Objectively Verifiable Indicators predicting the unpredictable are developed to keep calm the gods, donors and decision-makers. Thanks to the communication gurus, a virtual reality with ever ascending lines on the graphs is created to keep everybody happy. Sometimes we still appear to linger in the industrial age where everything was formatted to 'production'; we are still sticking to our old habits and hesitating to enter the information age.

Back to 'real reality' now. Where were we? Oh yes, complexity. Do we like it? Not as such, although those who accept and even embrace it may enter a fabulous world, rich, diverse and unpredictable, some 20000 miles below the sea. Those who survived the journey of complexity can tell you the fascinating story. So, did we want more complexity then? Certainly not, but using the wrong methods and tools, linear

and apparently simple, would certainly have made things even more difficult. So, we just accepted complexity. Arguably, complexity is not a choice. It's recognising reality as it is: recognising the underlying processes playing below the surface [IB28], often uncertain, poorly predictable and rarely prone to control. How to deal with that complexity in practice is a messy process, a process of muddling through.

With such a 'weather forecast', we had to decide whether to sail out or stay in the safety of the bay [IB23]. We hoped that with the right attitude and the right equipment we could make the journey even in stormy weather and take useful decisions which would lead us in the right direction. And why should we be afraid of taking a bad decision from time to time? Better a bad decision than no decision, as long as you learn from it. Because no decision would have paralysed us, leaving us adrift and helpless in the middle of the ocean.

Better a bad decision than no decision, as long as you learn from it

## The steps towards a Realist Approach

The BHCSP didn't really escape from the straitjacket of the logframe and related logbooks, but somehow the programme started in the right mode, with not only attention for activities or implementing the logframe, but also for reflection on these activities. It seemed as if the programme benefitted from a rare, magic moment where not only the stars but also the hearts and minds were aligned at that particular time, back in 2003 in South 24 Parganas, creating an opportunity to go beyond 'business as usual'. Or was it just pragmatism?

The BHCSP partners – initially the 8 NGO partners, WBVHA, and Memisa – realised that continuing to do what grassroot NGOs are used to do, 'doing things for the people' or 'merely implementing existing health schemes', wouldn't lead to the

If sustainable change is the big fish you want to catch, it's about changing behaviour, not merely about implementing health schemes

desired change, and certainly not if that change was to last. But what was then the alternative, and even more, how to proceed? We were deep inside Plato's cave, where it was dark and we were blind. Our eyes had to adapt to the darkness so that gradually we could at least see some shapes. So, we were compelled to start this programme by jointly scratching the first layer of the complexity of this context, by trying to have an initial understanding of each other and insight in what's moving people, what's moving inside and around them, what's moving below and above them. Instead of starting with clearly defining 'what are the expected results' of this programme, we needed to answer questions 'what works, for whom, in what circumstances, in which way, over which period and why?' A first step in sense-making about people and their relations, interests, and context. Without explicitly framing it as such, we stumbled onto a Realist Approach (4).

The Realist Approach is internationally recognised as an important way of looking at changing complex social systems, permitting to learn from change experiences in complex environments. Looking back at the 20 years of the BHCSP journey, a Realist Approach in the strict sense of a prospective theory-driven inquiry has not been used throughout. Only from 2016 onwards, attempts were made to make theories related to innovative strategies more explicit through Action-research. Nevertheless, the essence of the Realist Approach, which is understanding why something does work or not, has implicitly been there from the start. The involvement of relevant stakeholders in the planning, the internal inter-vision mechanism of WBVHA, the coaching during the quarterly reflection workshops with all the NGO partners, the participative monitoring and external evaluations mainly focused on learning, are all in line with the reflective spirit of Realist Approach. Even if theories were not explicit from the start, the principles and Mind-shifts were made explicit. And finally, the rare privilege of having continuous support for over 20 years, with four consecutive

programme cycles without interruption, has been a major asset favouring a robust understanding of how change emerges through the interplay between context, mechanisms and outcomes.

Trying to have a wider and deeper understanding of people, institutions and their relations and making sense of systems they are embedded in, the mechanisms and multiple determinants is commendable but tough. Even more tough is to act within that complex, unpredictable system. There is no 'fast and easy' way, no 'quick and dirty' way. Such a systemic approach raises more questions than answers. But there was no way back because solving isolated problems cannot lead to sustainable results. Systems resist change and have the tendency to fall back to their previous 'steady state'. Negative feed-back loops are inherent to complex systems. Structural changes are needed, tipping points where changes in behaviour of individuals, organisations and institutions have to become irreversible. This is beyond the scope of timebound and regimented programme cycles and needs interventions like BHCSP which are focusing on a subsystem embedded in a much wider system.

Systems resist change and have the tendency to fall back to their previous 'steady state'

To engage in complex systems thinking, we needed diving goggles to see below the surface and maps to sail in the right direction. The logframe didn't provide the answers, but conducting the programme management cycle in line with the Realist Approach helped a lot.

## The consequences for the programme management cycles

Management is about making useful decisions. The implication is that those decisions are informed, which is possible through systematically monitoring and evaluating earlier decisions, as in a management cycle. This also happened throughout the BHCSP.

### *Overlapping design, implementation and M&E phases*

*“The plan is nothing, planning is everything”*
(Dwight D. Eisenhower)

To orient their decisions, the BHCSP partners needed a framework. This process has already been described in Chapter 5. Having in mind the change they imagined through the BHCSP, the actors attempted to develop an initial Theory of Change. The purpose was to find out how change could occur in the lives of people in the selected villages in South 24 Parganas, taking into account the context in terms of policies

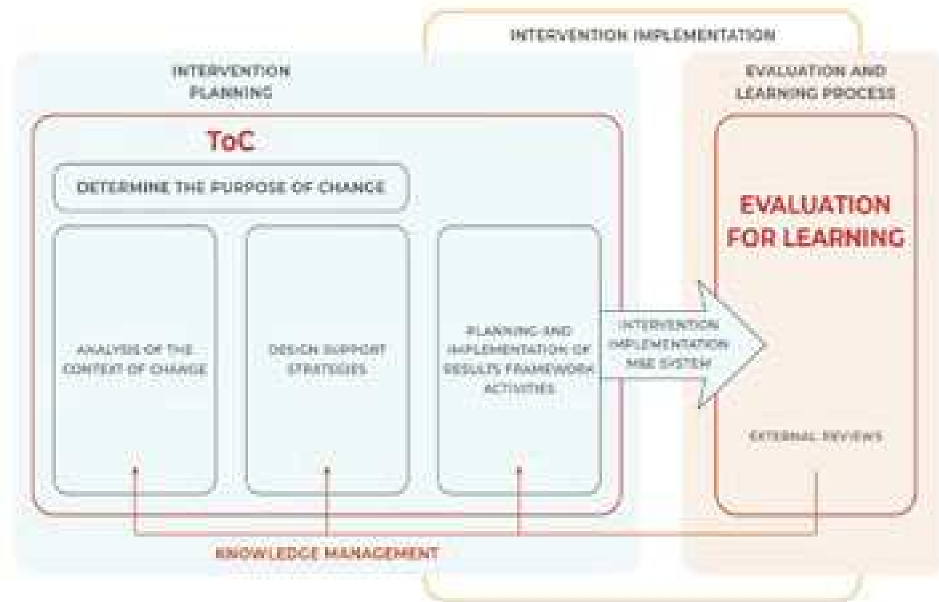



Figure 2. The transition between planning, implementing and evaluating processes (Enabel policy note on learning, 2020)

and actors with their networks and interests, as well as the underlying conditions and evidence to make it possible. Based on that analysis, the actors agreed on a set of common values and principles for the programme and developed initial strategies and related operational plans in line with them. Although their strategies were well-founded, they were based on a theory, a mental construction with a related set of working hypotheses, with no absolute proof that the theory was 'correct'. Given the fact that social change processes are complex and characterised by considerable uncertainty, this initial design process could only be but incomplete. The lesson learnt was that the transition between design, implementation and Monitoring & Evaluation (M&E) is not clear-cut in complex development programmes, as illustrated in Figure 2.

### *Action-research as motor for adaptive management*

All the actors in BHCSP were compelled to review their design throughout the whole lifecycle of the programme. They did this jointly, pooling their experience and expertise to make the design guiding their practice more robust. The motor for this iterative design and adaptive management was Reflective Action, putting people in an action-reflection-action mode. This involved rapid cycles of planning, action, reflection, and revision, drawing on local knowledge to foster learning from actions, both successes and failures. Action-research does the same, but it adds a systematic scientific dimension as illustrated by Figure 3. By explicitly formulating learning questions and related working hypotheses, and making use of documented experiences and evidence from other contexts, it generates its own model and evidence. Action-research can take different shapes, but it is based on four fundamental characteristics: social change, participatory approach,

Action-research is an attitude, not a study

empowerment of participants and acquisition of new knowledge on an ongoing basis through critical analysis.

Figure 3. Reflective Action and Action-research
(adapted from Nitayar Nitayarumphong S et Mercenier P, 1992)

## *Coaching and continuous learning for continuous learning: not a luxury*

To start this motor and keep it going, continuous 'coaching and learning' was key. This was explicitly organised at different levels. The WBVHA intervisors, the external BHCSP facilitator, the quarterly peer reviews among the operational managers,

the annual Memisa coaching and the supporting academic institutions, all played a key role in this. They helped the programme to learn, as well as monitor and self-evaluate its actions. Regularly, during the monthly or quarterly meetings, the BHCSP teams presented to each other their stories and pictures, qualitative and quantitative data, activities and results, successes and failures, as well as their concerns and challenges. These were followed by discussions to make sense of things, 'deepen and widen the perspective' as it was called, and to orient future action. The most significant changes were highlighted. The 'Mind-shifts' constitute a particular case, as they monitored, the 'how', the way the NGO partners were working.

### *Monitoring and Evaluation using the Reality lens*

The M&E system of the BHCSP monitored 3 dimensions of 'change' (see Table 2) allowing the programme to take useful decisions in this adventurous journey. Firstly, the 'outcome' monitoring or the 'what' captured both the progress of verifiable indicators as well as behavioural changes of actors and their relations. Of course, we had to keep a critical look because not all changes were necessarily attributable to the programme. Secondly, the understanding of the underlying mechanisms the 'how, why, for whom...', that is, opening the black boxes to go from situation A to B (see Figure 8). And finally, we systematically had the context on the radar and the way it was influencing change and the underlying mechanisms. This allowed the programme to identify opportunities which could be used to achieve better results, as well as manage risks.

External evaluations in the BHCSP were principally done from the perspective of learning, although there always is an accountability dimension, not only towards the donor but also towards the local stakeholders. By putting participative learning

It was easier for the community to express itself by drawing pictures and telling stories rather than reviewing a logframe

at the centre, these evaluations were conducted in the spirit of the fourth generation evaluations (Patton) and in particular Realist Evaluation (Pawson & Tilley) (4). They were focusing on 'what works, for whom in what circumstances, in which way, over which period and why' instead of just 'what are the results (outcomes)'.' Even if the theory building and developing working models of interventions through these evaluations were not that robust, the sense-making of reality was captured in an organic way, especially when an external evaluator in 2012 introduced a very inspiring tool: the Rich pictures. The use of Rich pictures helped us understand the underlying representations of stakeholders. It contributed also to the empowerment of community stakeholders in particular since it was easier for them to express themselves by drawing pictures and telling stories rather than reviewing a logframe.

### *Digging up, capitalising and sharing the gold in the mountain*

It has been said that the BHCSP is sitting on a mountain of gold, with such rich information and experiences to share. The process of capitalisation of all this knowledge, i.e. the systematic iterative and participatory learning process through which an experience is analysed, documented and turned into shareable knowledge which can be used to generate change, was not a piece of cake, as the BHCSP actors were very much focusing on action. Capitalisation products such as 'on the wall' displaying of pictures including Rich pictures, stories and Mind-shifts, producing BHCSP flyers and 'info-rama' type of documentation, organising theatre performances about the Mind-shifts, videos like the one on the Self-Help Groups in South 24 Parganas, or the one on the fight against alcohol in Howrah, sharing knowledge through the Village Health Boards were all still within the comfort zone of the BHCSP partners. However, the next level capitalisation with products like policy briefs, case-building

for advocacy, a conference, a write-up of a programme theory, scientific publications, training modules based on the five guiding principles and programme theories, or a book like this one proved to be hard.

Capitalising and sharing knowledge at different levels is nevertheless necessary for both horizontal and vertical scaling-up for sustainability [IB8]. This requires a system of managing that knowledge. It encompasses the initiatives, methods, and techniques that promote an integrated approach to identifying, creating or acquiring, storing and organising, sharing and using knowledge generated within the programme. External support from academic institutions and other 'Friends of the

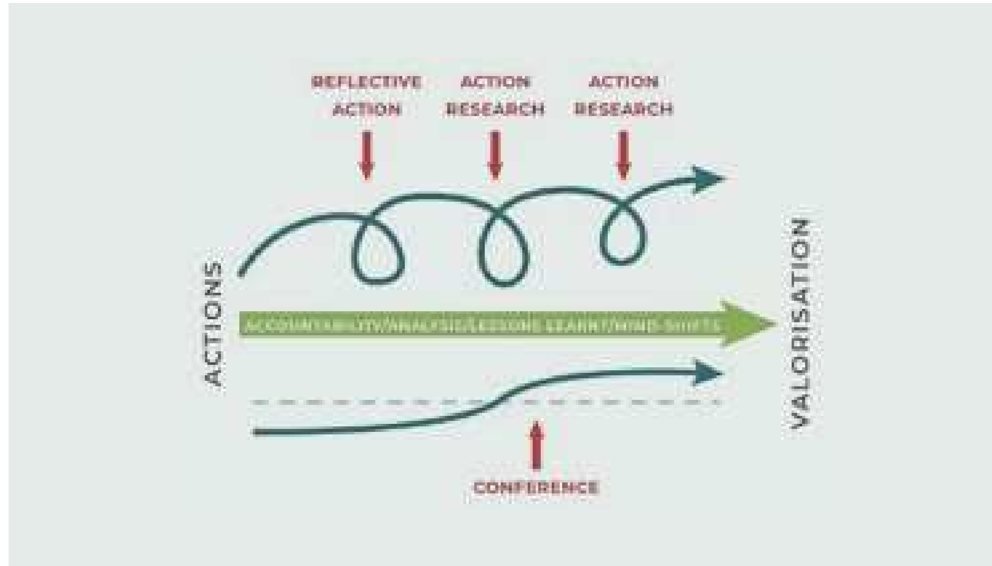



Figure 4. The continuous process of learning (adaptation from V Ridde)

Capitalisation and knowledge management should be organised from the start on

Forum ' helped a lot. But still it remained – and remains – a challenge for the NGO partners to plan and conduct the knowledge management process in a systematic way. A lesson learnt here is that capitalisation and knowledge management should be organised from the start of the programme cycle. It can be done by developing working models or a theory of change of what will possibly work and then support it through a comprehensive yet flexible documentation plan and systematic proactive qualitative and quantitative data collection mechanism. This documentation needs to be reviewed along with the communication of results throughout the programme cycle, not only at the end. In that way, it can be the fuel to boost the learning process and build up an institutional memory at the level of each of the stakeholders, which may serve beyond the scope of the programme.

### *Long-term support for long-lasting results*

It has been amply demonstrated that sufficiently that theories and models need to be gradually co-constructed and adapted with all stakeholders and the constantly refined. That needs time and patience. Time to let change emerge in an organic way. Time to avoid biases linked to deadlines, in most cases becoming 'dead-ends'.

In that perspective, it's worth highlighting what an exceptional privilege it was to have an uninterrupted development support programme for 20 years. A rare opportunity in a world governed by the fast and the furious, a world of short project cycles focusing on 'quick wins' and very much focused on often limited short-term results. As BHCSP partners, we didn't control the time-span. We were bound by the rhythm of 4 year project cycles. Our only merit was to have the long-term mind-set and commitment. Recognition is growing that any development programme should

Change needs time to avoid biases linked to deadlines, in most cases becoming 'dead-ends'. Slow cooking makes tastier food

not be short term or time bound and should be grounded in the local context and engage with politics and policy to bring in sustainable social change (3).

In the BHCSP, the opportunity of long-term support has been one of the conditions of success. Slow cooking makes tastier food. Changing the behaviour of people, organisations and systems in a sustainable way requires time. Although success is not guaranteed in dynamic environments, even if one has the time, such a long journey at least allowed us to build positive relationships, mutual respect and trust. People had to become comfortable with each other, and learn to understand and listen to each other. It also allowed us to develop locally adapted operational strategies over time and, in the best case, demonstrate their potential.

## *'Sustainable' versus 'sustained' strategies*

With the privilege of time comes the responsibility to develop potentially 'sustainable' strategies, and systematically document and communicate them, and to share the experience with others and influence policy.

The BHCSP could have limited itself to a compilation of 'low hanging fruits above the surface', such as building a tubewell for safe drinking water or specific small-scale studies. These changes at micro-level within the comfort zone of the NGO partners may have brought valuable changes [IB16] in the lives of the people but would not have been enough. We needed more if we wanted a more sustainable change by contributing to the functioning of the local health system as a whole. Therefore, we needed to go into a 'Realist Approach' mode, diving below the surface, for a closer look at the issues that mattered to people, the causes behind them, the underlying relationships and processes and possible drivers of change. These needed to be better understood, documented and communicated.

Understanding the mechanisms that hide under the surface within any socio-political context is important if any change process has to be locally grounded, owned and made sustainable in the longer run. A programme like the BHCSP gains immense value for those wanting to strengthen the health system if it can provide any such lessons. They can potentially provide guidance and examples into ways that help avoid further privatisation of the healthcare system. This is a major risk when the public health provision doesn't provide the required access and quality; when trust between patients and doctors breaks down; when health regulation, especially of the private sector is weak. In such situations, market principles dominate and the space for civil society tends to shrink.

Documenting experiences and evidence which reinforce health as a public good was therefore a major responsibility of all those directly involved in this programme, and in particular the Health Forums and West Bengal Voluntary Health Association. There was particular attention to systematically connect the experiences of local actors with broader global health policies such as Universal Health Coverage, and vice versa. This dynamic sharing of insights and information between the local and global can be seen as a contribution of a development support programme towards sustainable change. However, 'sustainable' is different from 'sustained '. Attaining sustainability is neither a spontaneous process nor is it a 'destination'. In this case it can be seen as the ability to interpret and act in a way that healthcare is strengthened as a public good. Ultimately, it's up to the 'indigenous actors' at the different levels, from community up to national level to really sustain something which has the potential of being sustainable. It's their choice since they are the owners of the learnings and doings which emerged in this programme.

A programme can develop sustainable strategies, but it's finally the choice of the local actors whether to sustain them or not

## *Breaking out: towards strategic management*

This approach of the programme management cycle helped to muddle through, and to make decisions towards change in an uncertain context. In dynamic contexts, it is good to bear in mind not to limit ourselves to static, quantitative data analysis and research on confined topics 'under the dictate of the P-value', as one participant at the international BHCSP conference in 2019 put it. A 'SMART' approach cannot capture reality and changes within the programme. It's the complementarity of tools and methods which provides a deeper and more realist understanding of the

It's the complementarity of tools and methods which provides a deeper and more realist understanding

| TARGET CHANGE | Traditional Planning ➡ | Strategic Management |
| --- | --- | --- |
| Key Element | Planning focusing on quantified objectives | Decision-making process, value-driven and involving stakeholders |
| Capacity Developement | Focused on "tool boxes" | Strengthening institutions and "systems" |
| Evalutation methods | Control of Performance | Focused on learning |
| Information | Objective, verifiable indicators | Information about perceptions, positions and commitments of stakeholders |
| Competences | Specific, technical | Technical and emotional intelligence competence mix |
| Management of performance | Performance based contract | Promotion of professionalism and trust (ex-post control) |
| Organisational model | Bureaucratic mechanism | Learning organisation |

Table 1. Adapted from 'Defining strategic management', Jean Macq (UCL)

underlying mechanisms and context related to this programme. To allow this to happen, managing the programme cycle requires a set of characteristics compatible with the way Jean Macq (UCL, 2011) described strategic management (see Table 1). This is totally different from a bureaucratic approach of managing a programme. The latter is based on keeping as much as possible control. In this programme we 'plan for sailboats not for trains'(3). Earlier chapters in this book illustrated how the BHCSP attempted to put strategic management in practice.

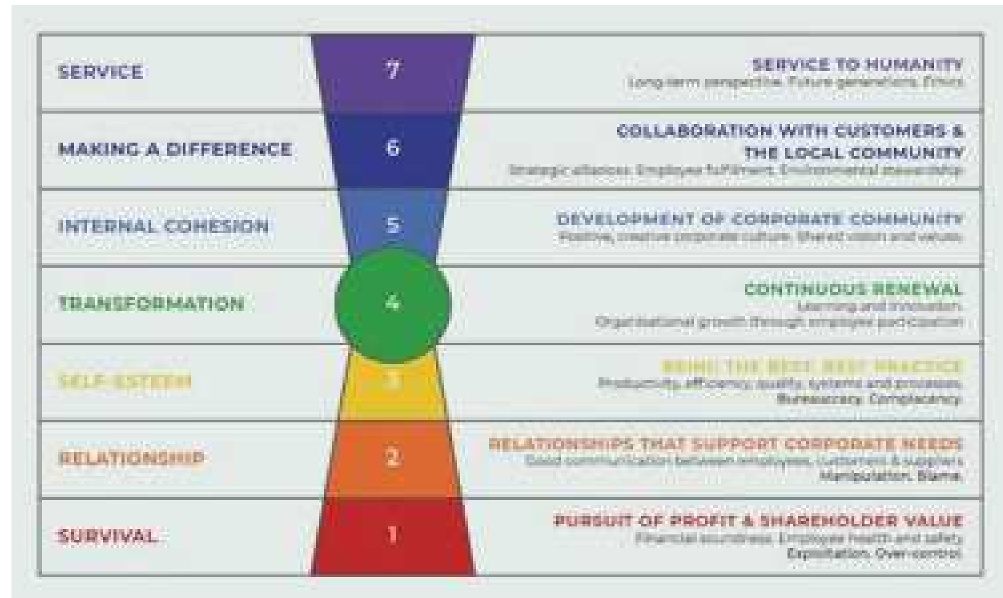



Figure 5. The '7 levels of organszational consciousness'
(Richard Barrett, 1998, Liberating the corporate soul. Building a visionary organisation)

This strategic management was not only a mind-shift to make at programme level but also at the level of each individual organisation. Each of the partners was challenged to make changes in their organisational culture taking the five guiding principles as compass. Evolving from organisations which are traditionally 'action-oriented' to learning organisations with a better balance between action and reflection was not easy. For each of the NGO partners the current position on the scale of what Richard Barrett (2) calls the '7 levels of organisational consciousness' (see Figure 5) was different. Organisations achieving to put learning at the centre of their functioning have the potential to be successful and create added value for the people they serve and for their own staff.

## What is in our toolbox?

'Doing Development Differently' meant that our toolbox was adapted. Even if the BHCSP couldn't escape from usi ng classic project management tools, it enlarged its toolbox gradually with tools adapted to deal with complexity. Mixing tools helped to capture not only the technical and management dimensions of the programme, or the way BHCSP actors dealt with the changing power equations and politics within their context, but also the underlying streams of the mind and heart in a more comprehensive way. It's like learning to dance: you don't learn it using your head only but putting your whole mind and heart to it. Tools like story-telling and Rich pictures helped to capture this dimension in particular.

### *The inevitable but useful classic project management tools*

The logframe remains an obligatory but also useful tool for planning, provided you don't use it as a prescriptive and strict set of instructions. It should reflect the decisions and translate them into expected results. This helps to structure things and to communicate clearly about the programme with internal and external stakeholders. The BHCSP programme learnt that such logframes don't need to be too detailed. That could be counter-productive. It was used strategically, providing an initial 'backbone'. We felt there was no need to put too much flesh from the start. We planned only for what could be truly foreseen. As we know that in complex environments most of the things are unpredictable. When critical monitoring during implementation revealed that the planned-for activities did not lead to the expected result, activities and related working hypotheses were adjusted or even completely revised. In other words, the results framework was regarded as a very dynamic tool adapting action following new insights. This flexible compliance with the logframe was important. The programme reporting tried to go beyond 'logframe activity' reporting as well and invited actors to report on the decisions they took to sail in a certain direction.

In our 'classic' toolbox there were other tools which served their purpose. During participative planning sessions in the consecutive programme cycles, we made use of tools like SWOT-analysis, problem tree analysis, and CPPE (Comprehensive Participatory Planning and Evaluation). This was done either as stand alone or in combination. To support the management skills and organisational culture of the NGO partners, tools like partner scan and/or performance assessment were also applied.

## *The ‘must have’ tools to deal with complexity*

It has already been explained how the BHCSP programme cycles were made ‘fit’ to deal with complexity by adopting a Realist Approach. This approach orients the mindset of the stakeholders in the programme towards the questions ‘what works, for whom, in what circumstances, in what respects, over which duration, and why …?’

The Realist Approach makes clear that in order to understand change and therefore to learn from experience, three dimensions have to be considered (see Figure 6).

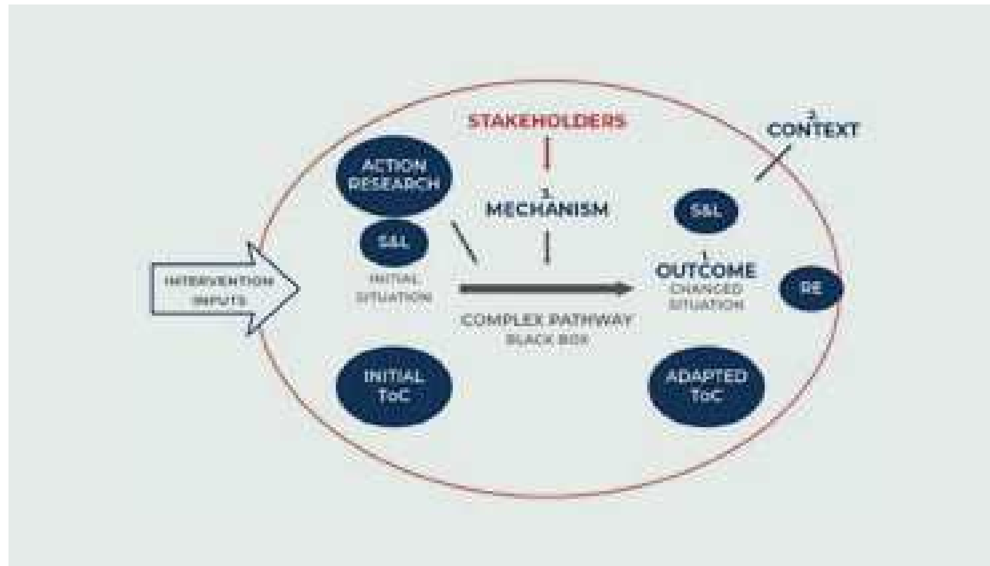
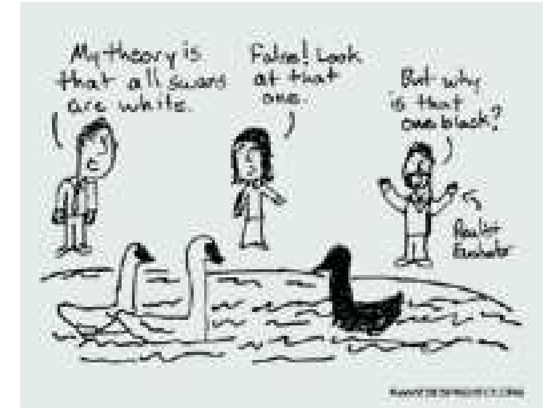



Figure 6. Realist Approach integrating Theory of Change (ToC), Action-research, Support & Learning (S&L) and Realist Evaluation (RE)



Firstly, it looks at outcome. Outcome means a sustainable change of behaviour of persons, institutions and systems. The inputs of a development support programme, whether financially or in terms of expertise, are supposed to change a given situation A and transform it to a significantly changed situation B. Secondly, it looks at how and why things happened under the influence of the context, and more specifically which context factors were essential in the change or non-change. It keeps opportunities and risks in the context on the radar. Finally, it studies the mechanisms that triggered the change. It allows us to comprehend the complex pathway or "black box" in which the configuration of actors (some in favour of, others in opposition to change), intervention, context and mechanisms explain the observed results. Mechanisms are underlying drivers of processes of change, which lead to outcomes in specific conditions.

To put this Realist Approach into practice, the BHCSP experience essentially promoted four complementary instruments that facilitate the learning process while focusing on change processes as illustrated by Figure 7. In this section, we briefly come back to the theory behind these tools and the complementarity between them.

The first instrument is the Theory of Change (ToC). This was initially developed as a participatory planning and evaluation tool for community level interventions. The BHSCP designers used this instrument because it helped to understand what change could be possible in a given context, and why and how. It helped to make an initial plan for the programme as the contribution to this change which was regularly adapted through continuous learning. As shown in Chapter 5 the Theory of Change of related models evolved in the course of the programme. Testing the theory and models is about identifying possible explanations rather than trying to confirm the preferred hypothesis. The BHCSP learned that complex development support

Figure 7. Realist approach integrating four instruments to support learning from interventions

programmes should replace 'programme' (management-oriented) by 'programme theory' (content-oriented) as the unit of analysis.

The second instrument is Action-research (AR). It is a prospective approach useful for those pathways of change identified in the initial ToC where there is a lot of uncertainty which makes explicit learning necessary to guide decision making. Initiated at the appropriate time, it allows to design and monitor specific change processes in a systematic and well-argued way. This can help to collect all the necessary data to respond to all the questions the Realist Approach proposes in order for an intervention to become relevant for policymakers.

The third instrument is Support & Learning (S&L). It implies a process of strengthening a programme by continuous external technical/scientific and strategic coaching on demand of the stakeholders. The objective is to reinforce the local process

of ongoing joint reflection and exchange, with a perspective of achieving specific development results; reinforcing technical, methodological, managerial and systemic capacities; promoting mutual learning, strategic steering, improving quality and bringing behavioural change; capitalising experiences and facilitating dialogue both with peers, providers and policymakers. Needless to say, the profile of the coach is key.

The fourth instrument is Realist Evaluation (4). The BHCSP used this method for its evaluations. In line with the ongoing learning process during programme implementation, this evaluation method focuses on sense-making and learning ('What worked, for whom in what circumstances, in which way, over which period and why?') rather than on judging ('What are your results, and can you prove it with hard data?'). It makes use of both qualitative data including stories and Rich pictures and quantitative data to cover the three dimensions of the Realist Approach: outcome, context and mechanisms of change. The method valorises evaluation questions formulated by the programme stakeholders themselves. This combination of instruments and approaches created the necessary space to put the five guiding principles into practice.

## *Promoting 'eclectic methodological pluralism'*

Reproducibility and replicability or a concern for consistent results with the same data and methods for the same question are extremely important in field of 'scientific' research. However, the 'social' world is complex and often unpredictable and different results may be obtained in different situations. In such cases ensuring validity and reliability become more important and this can be achieved by usingmultiple methods drawing sometimes from different theoretical backgrounds. This is called

‘triangulation’, or ‘methodological pluralism’ (1) or ‘ecelectism’ by academics. The Realist approach is in a similar frame and allows practitioners and researchers to gain new knowledge and insight into the process of change using a wide range of tools. It’s important to note that those tools can show their potential and added value only when embedded in the process of continuous learning based on developing and testing programme theories. Like stalactites and stalagmites, they only reveal their beautiful shapes and colours when surrounded by light. The learning process, responding to the needs of the BHCSP actors to understand and make useful decisions to improve the life of people, was at the centre, and the tools were useful to the extent that they fed this process and reinforced the five guiding principles. The peer-to-peer learning at the level of the SHGs illustrates how choosing the right method can reinforce self-confidence and autonomy.

Tools and procedures were adapted to needs and not vice versa. Methodological dogmas and their instruction guides were left behind. On the contrary, the tools were kneaded and adapted according to the needs of the programme, and even more, to the diverse needs of the stakeholders involved at different levels. The practice of systematically identifying ‘Mind-shifts’ for example was an adaptation of the Most Significant Changes tool. Another example was the Fishbowl technique which was adapted depending on the context in which it was used. Adapting existing tools is one thing. Cherry picking by taking a few elements from an existing tool is another. The ‘story-telling’ tool, for example, took some elements from outcome-harvesting; the idea of ‘boundary partners’ and progress-arkers (must have, like to have, love to have) were borrowed from Outcome-Mapping without ‘buying’ the whole package.

In the same logic, these tools were introduced at the time they were needed. The last chapter of this book briefly describes these tools and how they have been used in the BHCSP.

Tools and procedures were adapted to needs and not vice versa

To demonstrate the link between the information needs of a complex development programme such as the BHCSP, the most important tools which were used have been linked to the three dimensions of the Realist approach (Figure 8) as shown by Table 2. There was a willingness to work with imperfect data. The M&E system used a range of tools to collect relevant information on the change process, triangulate information (resulting from practical and theoretical knowledge and qualitative and quantitative data), interpret information, make sense of it, reduce uncertainty and take the best possible decision in a given context.

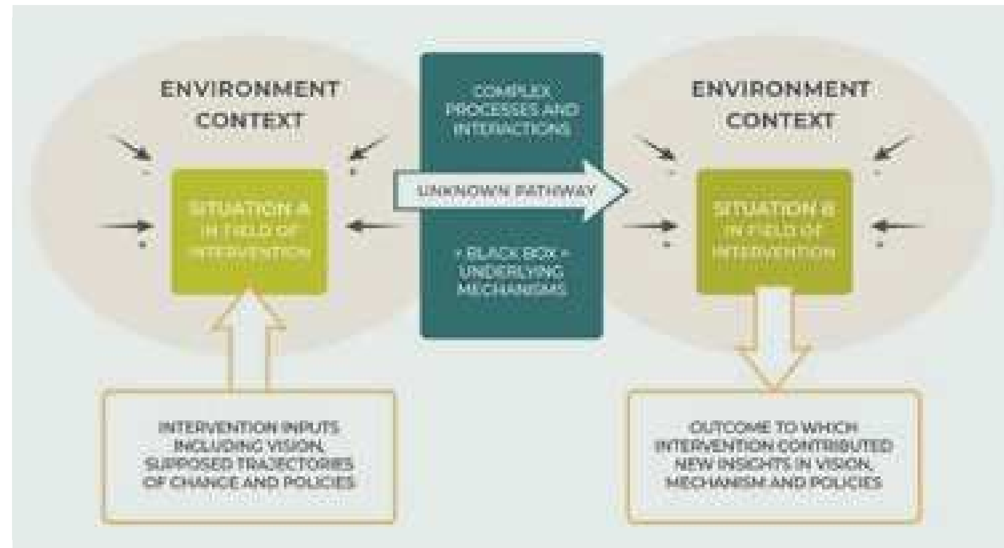



Figure 8. The Realist Approach principles (Enabel policy note on learning, 2020)

| Dimensions of Realist Inquiry | Most important data collection tools & methods used in the Basic Health Care & Support Programme M&E system |
|---|---|
| ***Outcomes: the 'desired' change in people's life (from situation A-> B)***<br><br>The WHAT question | • The (SMART) indicators in the BHCS logframe<br>• Specific indicators arising from Action-research in the course of implementation<br>• Progress markers linked to behavioural change (Outcome-mapping, Most Significant Changes, Mind-shifts, policy-changes…)<br>• Satisfaction surveys, focus-group-discussions<br>• Story- telling, RICH pictures<br>• Direct observational studies<br>• Community Score Cards |
| ***Understanding the mechanisms of change***<br><br>The WHY, HOW and FOR WHOM-question | • Comprehensive Participatory Planning and Evaluation, SWOT-analysis, problem-tree analysis<br>• Horizontal analysis (pathway of care)<br>• Evolution of the intervention: Theory of Change<br>• Evolution of the model and working hypothesis in the Action-Research process<br>• Quarterly coaching workshops, Focusgroupdiscussions, Fishbowls, Cluster meetings, Interface meetings, …<br>• Community monitoring and planning process at the local level<br>• Realist Inquiry type of evaluation<br>• RICH pictures, Story-telling, Critical incidents (case-building exercises)<br>• Satisfaction surveys and other studies<br>• Peer to peer learning<br>• Partner scan, Performance assessment<br>• Village Health Boards |
| ***Evolution of the context (outside the sub-system)***<br><br>External favourable factors and constraints to success | • SWOT analysis of the wider context<br>• Policies and institutional changes<br>• Changes at the level of the stakeholders in the wider system (stakeholder analysis)<br>• Risk analysis<br>• Monitoring of new opportunities |

Table 2. data collection tools and M&E methods used in the BHSCP

## Follow the money

Last but not least, it is important to talk about money which is a powerful tool for steering a programme, even when the funding is modest, as in the case of the BHCSP.

The funding strategy of a programme has a great impact on its design and the type of results. The modest funding compelled the BHCSP deisgners to be strategic. The funding of the BHSCP was very different from the funding mechanisms of the specific health schemes the NGO partners were used to implementing earlier. The BHCSP guiding principles determined the way the programme and its activities were funded in order to achieve results in a cost-effective and sustainable way. How did this work in practice?

The choice to 'link up actors' and build a strong local health system implied that funding separate, small-scale NGO projects, as was done by donors in the past, was replaced by a funding mechanism rewarding collaboration and joint results. Therefore only 50% of the budget allocation was reserved for activities under the leadership of the individual NGO partners, while the other 50% (25% for subdistrict or block and 25% for district level) for activities of the Health Forum.

Complex development programmes require budgetary flexibility in the budget guided by continuous learning. You cannot simply implement a predesigned and budgeted results framework. As the programme actors gradually understood their reality better and encountered opportunities and obstacles along the journey, there was a need to continuously adapt their activities to a constantly changing context and reallocate resources accordingly, whilst keeping in mind the guiding principles and overall programme objectives. Contrary to micro-management, this strategic budget management facilitated subsidiarity or decentralisation of decisions regarding content and budget. It also contributed to the autonomy of the local actors and

allowed them to use the budget based on emerging needs rather than on preplanned activities of a logframe.

Also crucial was the commitment of the donors to principally go for long term support without short funding cycles. There is a huge difference between a scope of 3 years and one of 20 years. At best, a 3-year project may lead to interesting, focused results and innovations, but it cannot lead to sustainable results and change of behaviour of people and systems.

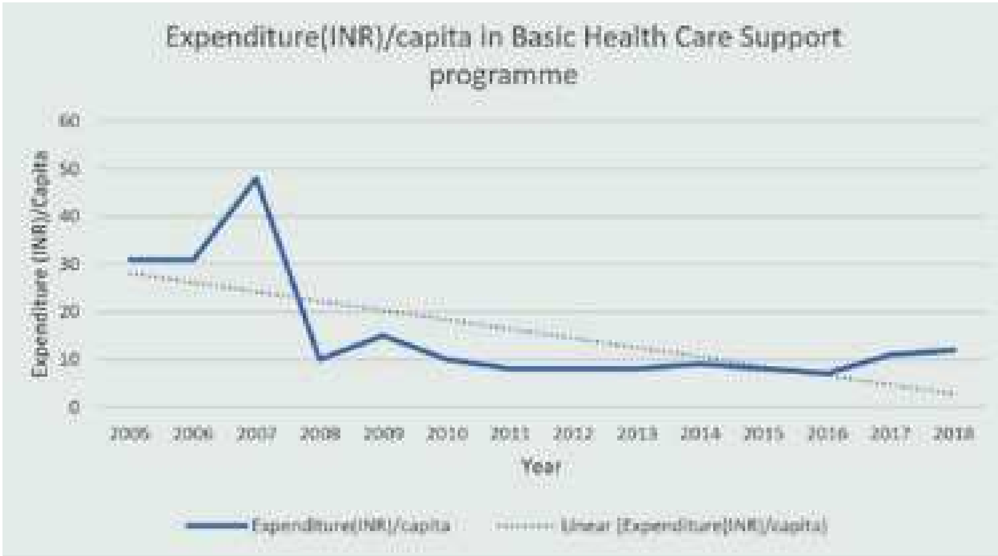
The added value of programme funding was to create space for exploring new pathways and fostering innovation instead of financing routine activities. It's like a company investing seed money in its R&D department. It was a deliberate choice. Of course, given the amount of funding available, one could say there was no other option for the BHCSP but to invest foremost in 'how to' rather than in 'what' or 'how much'. This approach mitigated the risk of high dependence on external funding. It empowered local actors to reduce the gap in policy implementation, to push for public funds (such as health schemes to specific population groups) and to maximise the benefits resulting from this funding. Figure 9 illustrates this. It shows a decreasing trend in the per capita total expenditure of the BHCSP over the period of time, despite the extension of the BHCSP to five districts and the overall exponential increase in the volume of activities. While in Indian Rupees this decline in per capita expenditure was from around INR 30 to about INR 10 (about one third) this was more dramatic in USD terms from about 67 cents to 15 cents (less than one fourth) as the exchange rates changed in the intervening period.

This rapid decline in per capita cost was not only due to the increase in scale, but could also be attributed to factors such as community ownership of 'actions', increased capacity of the NGO partners to mobilise domestic (and external) resources e.g. mobilising funds for RMP sensitisation training and VHSNC, PRI

At best, a 3-year project may lead to interesting, focused results and innovations, but it cannot lead to sustainable results and change of behaviour of people and systems

training programmes, shifting the focus of the NGOs from service delivery to a facilitating, enabling and advocacy mode. The institutional transformation of the NGO partners over the past 20 years prepared them to better face these tasks and challenges. The Mind-shifts and the organisational scan tool allowed them to monitor their progress.

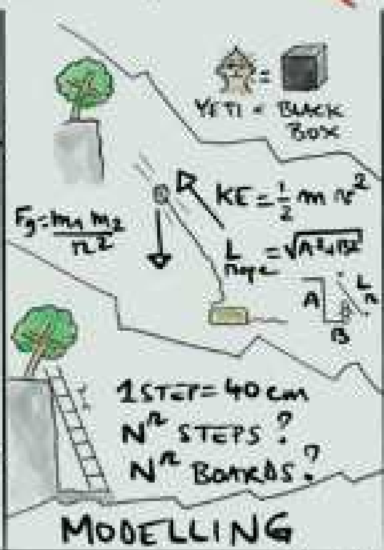
It remains to be seen how transformative the funding strategy remains in the longer term. It would be useful to assess to what extent the 'external funds' channeled through Memisa, and used as seed money to catalyse changes at the level of the grassroot NGOs and the local sub-system, have been a lever to attract more domestic funds throughout the programme. For example, we know that funds have come through the health schemes and specific investments such as the government contribution for the construction of a new health sub-centre. It would be even more interesting to see how this flow of funds towards the grassroot level will evolve when the BHCSP is no longer there. The table on p416 gives a glimpse of the efforts taken by the local community and partners to mobilise additional resources leveraging the BHCS programme. The partners enabled people to utilise the government fund allocation for various schemes to the maximum for the benefit of the vulnerable and marginalised communities advocated for additional funds against specific needs identified by the community. They raised INR 89,062,193.00 (€1,047,790.51) during the project period taken into consideration (from 2004 up tot 2020), reaching out to 192370 vulnerable people. The total amount of incoming project funds via Memisa during the same period was 2,465,321 euro (INR 180, 38 million).




Note: Expenditure/capita based on the actual expenditure made under BHCSP and GP wise population was calculated based on the 2001 and 2011 census data.

Figure 9. Per capita total expenditure (INR) in Basic Health Care Support Programme

# ACTION-RESEARCH



## Messages in a bottle

- Complexity is not a choice, it's accepting a reality. Development support programmes need to acknowledge complexity. This starts by understanding the various human, social, cultural, economic and political realities of different contexts ('project areas') as a condition to imagine change.

- Complexity also requires stakeholders to adopt a 'Realist Approach'. This approach aims at understanding reality, i.e., how and why the context and the underlying mechanisms are leading to sustainable outcomes. It implies jointly learning during the whole programme cycle using multiple tools and methods.

- A pre-fixed design with rigid implementation of a logframe is not appropriate in complex development support programmes. Change is a process of ongoing cycles of action and reflection allowing key actors to re-examine and redefine their positions and actions keeping the guiding principles in focus. This requires flexibility and adaptability of the overall planning and budgeting process. Design, implementation, monitoring, evaluation and capitalisation of experiences are not distinct phases in a programme management cycle but overlap and are intertwined.

- Instruments like Theory of Change, Action-research, Coaching and Learning and Realist Evaluation are key to engage in complex change processes such as the BHCSP.

- Action-research is an attitude, not a study.

- External evaluations should not judge and limit themselves to asking, 'what are the results' (accountability) but focus on trying to increase understanding amongst stakeholders about 'what works, for whom, in what circumstances, how and why' (learning).

- Documenting experiences and sharing lessons learnt should not be done only at the end of a programme cycle but from the start and should be organised explicitly. Specific expertise and skills need to be built amongst partners to generate evidence for policy and share it with other operational actors as well as higher level decision-makers.

- Rigorous documentation can potentially help scale up the 'solution' to the larger policy space.

- The use of the programme funds should be designed in a strategic and flexible way, adapting to need, reinforcing decentralised decision making, promoting collaboration between actors, fostering innovation, and leveraging the mobilisation of domestic funds.

# Chapter 11

«The real voyage
of discovery
consists not in
seeking new
landscapes,
but in having
new eyes.»

MARCEL PROUST

# Bits and bobs for beachcombers

Karel Gyselinck
Aloysius James
Biswanath Basu

Zooming in on additional tools

## ¿uestions

- ¿ What range of tools has proven useful in a complex development support programme like the BHCSP?
- ¿ How to work with these tools in practice?
- ¿ And what about your questions?

Almost twenty years of BHCSP have yielded a rich collection of material. It was not possible to share everything in detail in the previous chapters. After reading this book, those who are still strolling around the beach might find some exciting stuff lying around. Rather than cleaning up the beach, we left it there and let the beach-combers themselves discover these things and pick up what may be of use for them. .

## Taking a closer look in the toolbox on board the BHCSP boat

Do not be surprised to find a toolbox while strolling along the shores near the Bay of Bengal. It might have drifted along the river Ganges from the Himalayas to the Bay of Bengal. Or it might have fallen from a BHCSP boat and washed up on the beach. Those seeking methods and tools to act in a complex, uncertain environment might find it interesting. These methods and tools are embedded in a specific approach, which puts learning at the centre to achieve development and behavioural change..

These methods and tools are embedded in a specific approach, which puts learning at the centre

### *Working with metaphors*

In the BHCSP context, metaphors have been used to illustrate concepts and changes in but mind-set. These metaphors should be close to the context of people. In this case we used boats, which was illustrated throughout the book, but also bicycles, which we briefly explain here. Using the history of the bicycle as a metaphor illustrates how to operate in complexity.

Bicycles through the centuries developed because of systematic reflection on the practice of using the bicycle. This reflection led to improvements in the model of a bicycle. These were, in most cases, small changes, with significant design shifts

from time to time. According to the context, the model was adapted; a mountain bike is different from a road race bike. This process is ongoing and will continue in future, valorising the contributions of many other actors.

Just like the development of a bicycle is a continuous learning process, in the context of this programme, social change in the areas covered by the BHCSP didn't start with the programme and won't stop at the end of it. It's embedded in a much longer, endogenous process. The BHCSP may only have triggered it a boost.

Social change is also the result of a collaborative process of reflecting on our actions and decisions. The design of a bike and its performance doesn't only depend on the person riding it. It results from the interplay between the rider, the mechanic, the trainer, the manager, the team doctor, the sponsors and others.

Another dimension is that changes processes can only happen when the learning takes place at different levels. Innovations in bicycle technology cannot be triggered by individual learning only. You need a cycle team and cycle federation committed to joint learning and continuous research; you need investors, a regulatory framework, and many other things. A key result is the synergy between both the operational and strategic levels.

In top bike races, riders and their bicycles are tagged from all sides to monitor all kinds of quantitative parameters. But also, the mental condition and the tactics – more qualitative parameters – are followed closely. All that data are put in databases and explicitly documented to take tactical decisions along the way or for evaluation purposes later on. These data, together with experience, build up an institutional memory that may also serve future innovations. BHCSP also documented its experience, though it could have been more systematised. We acknowledge that the lack of comprehensive information is one of the weaker points of the programme.

The change process can only happen when the learning takes place at different levels

Like the BHCSP, a race is about managing a complex system. There are multiple determinants to consider if you want to win. There is also the human factor, where the mental state plays an important role. Cycle teams use different theories and models (bicycle models, physiological models and so on) and a racing strategy that needs to be tested and, if necessary, adapted during the race depending on the context of the race. Despite all these factors, however, victory is not guaranteed. In the BHCSP, the Theory of Change and its various representations, Action-research, Coaching and Learning and Realist Evaluation have been key instruments to achieve the goals. Still, just like in the bike race, there is no guarantee of success at the start. In line with the Realist Approach, the Theory (or Theories) of Change and related representations try to simulate how and why the change could happen over time within the BHCSP, considering the context, actors, and underlying mechanisms. Even if based on sound principles and arguments, it remains a theory that needs to be tested and fine-tuned in practice. That is why it's helpful to engage in Action-research helping to take the best possible decisions in practice, based on the theory, and evaluate those decisions regularly. Coaching and Learning supports this complex process because it may bring valuable experiences and insights from other contexts and promote joint learning. Realist Evaluation boosts this learning process by trying to better understand better the changes, context, and underlying mechanisms (starting from questions from the various stakeholders) instead of focusing only on results or failure, as frequently happens in classical evaluations.

These instruments were complemented in the BHCSP by a diverse mix of qualitative and quantitative methods and tools, just as cycling teams try to optimise their performance using a range of complementary approaches and tools. They were being introduced at different moments in the programme cycle and tailored to the needs. However, all these tools were embedded in participatory principles, adhering

to BHCSP core principle of "people centredness." Some tools were handy in mobilising and empowering communities, advocating for health rights, establishing and strengthening networks and building teams. Some helped us to challenge the health system and offer new directions to the local health team. In the BHCSP there is no room for dogmatically following instructions guides and we tried moulding or even blending methods and tools to make them fit for managing a complex environment. The remainder of this chapter is dedicated to illustrating this. An overview is given alphabetically to all complexity-fit approaches, methods and tools used in the BHCSP.

We tried moulding or even blending methods and tools to make them fit for managing a complex environment

### *Action-research and reflective action*

There is no universal definition for Action-research. Still, there are four key ingredients: acquisition of knowledge ('research'), social change ('action'), participation of local stakeholders (with eventual support of external stakeholders), and empowerment of local stakeholders. As for any research on change in social systems, it is based on the classical management cycle (Deming cycle) and the principle of "muddling through", an eternal search for improvement.

The approach considers the complexity of the reality in which processes take place. It is a learning and reflection process with explicit working hypotheses, models useful to guide, monitor and evaluate decision-making for those pathways of change identified in the initial Theory of Change.

Action-research (Grodos) (4) looks at the change in a complex reality from 2 angles: firstly, did the decisions, based on an explicit working hypotheses, produce the expected results and why (not)? And secondly, what were the environmental conditions that allowed or inhibited positive results?

Action-research has the ambition to contribute to general knowledge relevant for actors operating in different contexts, in contrast with locally relevant knowledge. Conclusions are based on systematic data collection, documentation and monitoring..

### *Case-building exercise based on 'system analysis'*

The BHCSP wanted to understand how the local health system did work (or did not work) by telling stories of people (people-centredness).

The first step in this case-building exercise was collecting stories of both good practices and critical incidents, striking events for the observer that demonstrate the system's (non) functioning. The aim was to illuminate the 'general' by looking at the 'particular'. The BHCSP actors started collecting stories from pregnant mothers from Gosaba, a remote island in the Ganges delta. These local stories, together with existing data and evidence, allowed us to make a system analysis.

This system analysis attempted to get a better view of the needs and the health seeking behaviour families with regard to reproductive health, taking into account the context with its opportunities and barriers. In the case of BCHSP, social determinants were taken into account to have a comprehensive view. Then, both current and potential options for promotional, preventive, curative, rehabilitative or palliative healthcare adapted to the local context were listed. The difference between the two (existing and potential) gaps in the actual local healthcare pathways, related to maternal and reproductive care in the Ganges delta in South 24 Parganas district [IB1], were identified. Gaps in terms of availability of services, accessibility, accommodation (operational organisation of provider to meet preferences and constraints of people), affordability and acceptability of services were listed. The BHCSP discussed these gaps and critical incidents due to these gaps and identified action points at

their level and issues for advocacy towards the Gram Panchayats, the subdistrict and district authorities. The assumption was that advocacy would be more robust by systematically building such cases based on relevant experiences and evidence.

### *Comprehensive Participatory Planning and Evaluation (CPPE)*

CPPE is more of an approach than a method, facilitating collective reflection to tackle complex development problems. It sees planning and evaluation as a continuum and an integrated and flexible process (5). The emphasis is on collective reflection and planning. The CPPE approach can easily be adapted. It can be used in a complementary way to some of the more standardised formats like a logical framework. It facilitates to generate learning questions by all stakeholders involved in a development support programme and subsequent sense-making during participatory evaluations. The BHCSP applied the principles of the CPPE but adapted it to the local needs.

### *Community Score Cards (CSC)*

The Community Score Card (CSC) is a participatory, community-based monitoring and evaluation tool that enables citizens to assess the quality of public services. The BHCSP partners facilitated community feedback regarding access and quality of the public health services in their area (e.g., quality food of the ICDS centre, services at subcentre up to Block level). It informed community members about available services, provided an opportunity for direct dialogue with the service providers and supported their entitlements.

CSC requires good preparation to inform people about the purpose and benefits, the scope, data collection and facilitation. Facilitators organise and support

community focus groups to identify performance/quality indicators (e.g., staff attitude, affordability of services, availability of medicines, geographical accessibility, equal access) for the public service in question, give a score on a five point scale and reasons for that score and provide suggestions to improve the service. A similar exercise was done with the service providers, which resulted in an interface meeting between them and the community discussing the scores and possible solutions. Systematic documentation of the process and the scores allowed to dialogue with the actors and use it for policy and advocacy at higher levels.

The community feedback process helped strengthen people's voices and capacities, build trust between users and service providers, and benchmark the quality of services. It is, however, a delicate process since providers and policymakers may feel threatened by the CSC holding them accountable or may not be receptive to community suggestions. Expectations must also be kept realistic as service providers do not control most of the decisions regarding their service. Such a process needs competent facilitators.

### *Developmental Coaching*

In our context, developmental coaching covers the process of accompanying a development support programme and the teams, various groups and organisations involved at different stages of the programme. The coaching is intensive and continuous, where it offers technical/scientific and strategic coaching on-demand to one or multiple actors directly involved in the programme. The coaching process builds on the principles of adult education, recognises the diversity of the team and organisations and operates in action reflection – action mode. The objective is to reinforce the ongoing local process, joint reflection and mutual exchange starting

with the needs at the local level. The Coaching and Learning is with the perspective of achieving specific development results, facilitate mutual learning, strategic steering, promoting behavioural change, changing mind sets, ensuring quality improvement, and scaling up of the programme.

In the BHCSP, this coaching took place principally through quarterly workshops and annual reviews with all the local partners with their management team, and operational leaders associated with the programme.

## *Fishbowl*

The fishbowl technique is used to manage group discussions. The general idea is that rather than a large group having an open discussion about a particular issue, which can be challenging to handle and often only benefits a few active participants, a smaller group (the 'fish', ideally 3 – 6 people including the debate facilitator) sits in the middle of the circle (the 'bowl'). In contrast, the rest of the participants sit around the outside and observe and listen without interrupting.

First, explain to the group how the process will work, open the floor with a provocative question, and invite the discussants in the inner circle (fishbowl) to comment. The inner circle includes an empty chair inviting observers from the outer circle to join the discussion. When a new discussant enters the fishbowl, someone else has to leave the fishbowl, so the group remains small, and all those who wish to particpate in the discussion can do so. It's advisable to note down the key discussion points, or you might end up with a rich but undocumented discussion.

Fishbowls are useful for ventilating "hot topics", brainstorm or sharing ideas and information from a variety of perspectives. It helps to increase understanding of complex issues. It is an alternative to traditional debates or panel discussions, avoids

lengthy presentations, and fosters active participation. We used it extensively in the BHCSP: with larger groups in conferences [IB22] to generate ideas and know the views of the participants. But also, with smaller groups during our annual reflections, peer learning exercises and retreats.

## *Interface Meetings*

Interface meetings are a powerful tool for advocacy with government departments or offices directly linked with the communities. Interface meetings bring the different stakeholders on a platform where they can interact in a facilitated environment. The process is non-threatening and not confrontative. The meetings were organised in such a way that the officials were comfortable with the issues discussed and the facilitation process in an atmosphere of emerging trust. The interface meeting provided a safe environment for both officials and communities. However, a lot of homework had to be done behind the scene. The issues or concerns of the people were studied in detail, supported with data and evidence. We followed different processes and used a range of tools to collect data and evidence to facilitate interface meetings at various levels.

At GP and Block Level, we identified the beneficiaries of health services, sensitised them on ICDS/Subcentre/PHC/BPHC services and the roles and responsibilities of service providers. We also conducted Focus Group Discussions (FGD) with the community and identified issues and gaps using specific indicators. Later both community and service providers rated the different dimensions and gaps in services using the Community Score Card. These findings and observations were presented to the community service providers, government officials and decision-makers as part of the interface meetings to explore solutions and policy changes.

At State Level, a study was conducted amongst 468 elderly people to compare the health status between rural and urban elderly men and women in West Bengal. Based on the findings, recommendations were made and shared in the interface meeting where State level officials from various departments (Health, Panchayat & Rural Development, Women & Child Development and Social Welfare), academia, local service providers, community people and Forum members were present as well.

During interface meetings, various findings generated through different methods were brought to the attention of the concerned officials along with the community representatives. Solutions were identified and sometimes referred to the higher levels for action. A recommendation on supplementary food support for the elderly was included in the draft State Elderly Health Policy 2019.

### *Most Significant Changes (MSC) and storytelling*

MSC (3) is a Monitoring and Evaluation (M&E) method used for learning from complex interventions based on a qualitative, participatory approach. It involves the generation of significant change stories by various stakeholders involved in a development support programme. Storytelling is a way to apprehend in more depth what people really think and perceive as their reality, and helps to provide culture-specific explanatory pathways. Attention needs to be paid to assure that the stories are representative and inclusive, incorporating particular stories from marginalised people. All these stories are then discussed to make sense of them and identify the most significant effects on the lives of the beneficiaries. MSC can be very helpful in explaining how change comes about (processes and causal mechanisms) and when (in what situations and contexts). For more details see https://www.mande.co.uk/wp-content/uploads/2005/MSCGuide.pdf.

In the BHCSP, changes were labelled as Mind-shifts. Stories were collected and discussed at different levels on a monthly (e.g., VHSNC, 4th Saturday meetings) or quarterly basis (BHCSP workshop with the NGO partners). We used the five guiding BHCSP principles to analyse the stories and identify the changes in people's lives and the way of working of the NGO partners. A flipchart displayed at every workshop listed the Mind-shifts to be documented and to be gradually completed and used as a reference and guide in the discussions. The methodology and process contributed to the appropriation of the outcomes and internalisation of the Mind-shifts.

### *Outcome-Mapping (OM) and Outcome-Harvesting (OH)*

Outcome-Mapping is a methodology for planning, monitoring and evaluating complex development initiatives in order to bring about sustainable social change. It aims at understanding the mechanisms behind outcomes like changes in behaviour, relationships, and functioning of people, groups or organisations, the so-called 'missing-middle' or 'black box'. It takes into account the numerous stakeholders who often have contradictory agendas and personal motivations and encourages intervention stakeholders to recognise spheres of control, of influence and of interest. By doing so, stakeholders might purposely address new commitments and approaches to problem solving. The Outcome-Mapping method acknowledges that the path to the solutions is tricky and uncertain and that "muddling through" and jumping on opportunities is critical for success. This entails more emphasis on flexibility and reflectivity than on strict planning. The link to the Outcome-Mapping learning community is https://www.outcomemapping.ca/.

Outcome-harvesting (7), like OM, is also actor-centred, defines outcomes as behavioural change, focuses on contribution to results and puts the information and

learning needs of the primary users at the centre of an evaluation. OH collects ("harvests") evidence of what has changed ("outcomes") and then, working backwards, determines whether and how an intervention has contributed to these changes, what has been the contribution of context (positive or negative) and which social mechanisms were at play. OH, however, is more of an M&E tool than a planning instrument per se. The method is also less delineated than OM and is open to direct and indirect stakeholders.

The BHCSP adapted these tools to its needs and mixed the two approaches. The way the programme worked with stories was borrowed from outcome-harvesting. The ideas of 'boundary partners' and 'progress-markers' like 'must-have', 'like to have', 'love to have' were borrowed from Outcome-Mapping without 'buying' the whole package.

## *Partner-scan*

It is a tool designed by Memisa to assess a partner's ability to carry on the project activities entrusted to them. The tool is straightforward and user-friendly. A partner can also use it on its own as a self-assessment. It is always communicated a few days in advance for the partner organisation to prepare.

A partner-scan is divide into four categories to assess the partner's operational, administrative, financial and governance abilities. The result should never be considered as a scientific truth but have to be considered within the local context of the region and the nature of the partnership and activities carried on by the partner. For example, a partner may have limitations in some respects, but the partnership remains relevant as the activities entrusted do not require any skill on those particular aspects.

It is not meant to halt partnerships or to avoid starting new ones. The purpose is to identify strengths and weaknesses and to use the results as a starting point to draw a road map for improvement or to share good practices and skills identified with a partner organisation with other Memisa partners.

### *Peer-to-peer learning*

It is a two-way, reciprocal learning process where people learn from and with each other by sharing knowledge, ideas, and experiences. The BHCSP took place at different levels, most prominently at the level of SHG groups and the NGO partners.

Peer-to-peer learning in the BHCSP reinforced self-esteem and autonomy of people at the community level and developed their oral communication and leadership skills. It was an essential strategy in the horizontal scaling-up of the programme.

Peer-to-peer learning reinforced self-esteem and autonomy of people

*Pentagram Model*

The spider-gram model developed by Susan Rifkin in 1988 (1) is a helpful starting point for assessing community participation and developing recommendations for empowering people in health care programmes. It is based on five dimensions: needs assessment, resource mobilisation, organisation, management, and leadership. The participatory tool helped the BHCSP actors (like AGP in 2011) promote community ownership and strengthen the sustainability of actions.

### *Realist Evaluation*

Realistic evaluation (Pawson & Tilly) (6) belongs to the family of approaches aiming to understand and act in a complex reality. The word 'realist' refers to the view that most of reality is below the surface. The mechanisms of change are often invisible

and difficult to predict. It's like a volcano where most of the dynamics are happening under the ground. Though an eruption cannot be controlled, we can try to understand it, monitor volcanic activity, predict eruptions to a certain extent and mitigate their effects.

The central attitude is an attitude of joint learning. It focuses on questions like 'what works, for whom, in what circumstances, in which way, over which period and why' instead of merely looking at results (outcomes)'. Realist Evaluation looks at the outcome and simultaneously investigates the causal mechanisms and context including the actors and their relations in the setting in which the action occurs. Negative experiences are at least as interesting as positive ones. One should not be ashamed of failing but instead of not trying to understand the lack of success.

The approach uses a mix of qualitative and quantitative data feeding a process of joint analysis to make sense of reality.

Most of reality is below the surface. The mechanisms of change are often invisible and difficult to predict. It's like a volcano where most of the dynamics are under the ground

## *Rich pictures*

Rich pictures [see 'Image Book'] are a visual participatory methodological tool. Drawings and pictures can reveal issues and links between different ideas living in a community. Adapted from the soft systems methodology (2), they offer an opportunity to seek a deeper understanding of the situation from multiple perspectives, identify different dimensions of a problem situation, capture messy, complex processes of programme implementation (including flows, activities, and connections among other activities; dynamic interactions among actors, changes that have taken place and conflicts that need to be resolved), facilitate open discussion and shared learning.

The Rich pictures tool was first used in the BHCSP in 2013 during an external evaluation. Groups of 5-8 stakeholders were asked to draw and share with other

groups their dream about the programme, the way they understood the programme and the changes it had brought (or not). This exercise promoted a constructive and iterative process of joint reflection, learning and action. The team picked up the tool immediately and and used it in a different context and levels regularly. The RICH Picture book illustrates this.

The Rich pictures are an empowering tool as they allow community members and others involved in the programme to express themselves in a natural and comprehensive way that appeals to the mind and the heart, eschewing a more intellectual and academic approach.

The Rich pictures are an empowering tool as they allow community members to express themselves in a natural and comprehensive way

### *Stakeholder analysis*

Stakeholder analysis is the process of assessing a system and system changes, taking into account the power relations between relevant and interested parties (stakeholders). The BHCSP team used this information to determine how they could work with the different stakeholders in the context of the programme.

### *Theory of Change (ToC)*

The ToC is the argued theory on how (and why) change could happen over time within a given social domain of intervention, considering the influence of context, the characteristics of the actors, the existing evidence on the change process and the underlying assumptions.

The ToC is a mental construction. There is no proof that the theory is correct, even if it is coherently argued. The stakeholders need to monitor the hypotheses underlying the ToC, and whenever appropriate adjust them based on regular reflec-

tion by the different stakeholders upon their actions. It speaks for itself that a ToC developed in the design phase of an intervention cannot be final. This has been extensively illustrated in chapters 5 and 10 in this book.

### *Village Health Information Boards*

The concept of the "village information boards" emerged in the BHCSP in 2004 in South 24 Parganas district [IB3]. These boards act as a one-stop source for all kinds of information for the village people and are displayed in public spaces such as markets, schools, health centres, common drinking water sources and others. Various people such as healthcare providers, local self-government officials, health forum members, and community groups collect the data. It generates awareness on multiple schemes, local self-government institutions and health issues, and fosters community engagement in health planning processes and implementation. In some places, it acted as a community monitoring mechanism, where the information board mentioned the availability of the health personnel in the villages for immunisation or maternal care. It put pressure on the health personnel to be present on those days. Whenever people found health personnel missing, they reported them or confronted them on the next occasion.

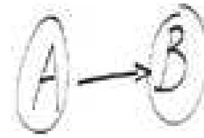
These boards act as a one-stop source for all kinds of information for the village people. In some places, it acted as a community monitoring mechanism

*To conclude*

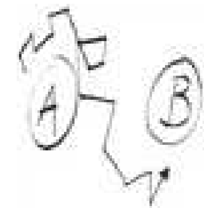
All these methods and tools contributed to the pathways of change in the BHCSP. As we have learnt, these pathways are not like railways with clear, linear paths where most things are foreseeable and planned for in advance.

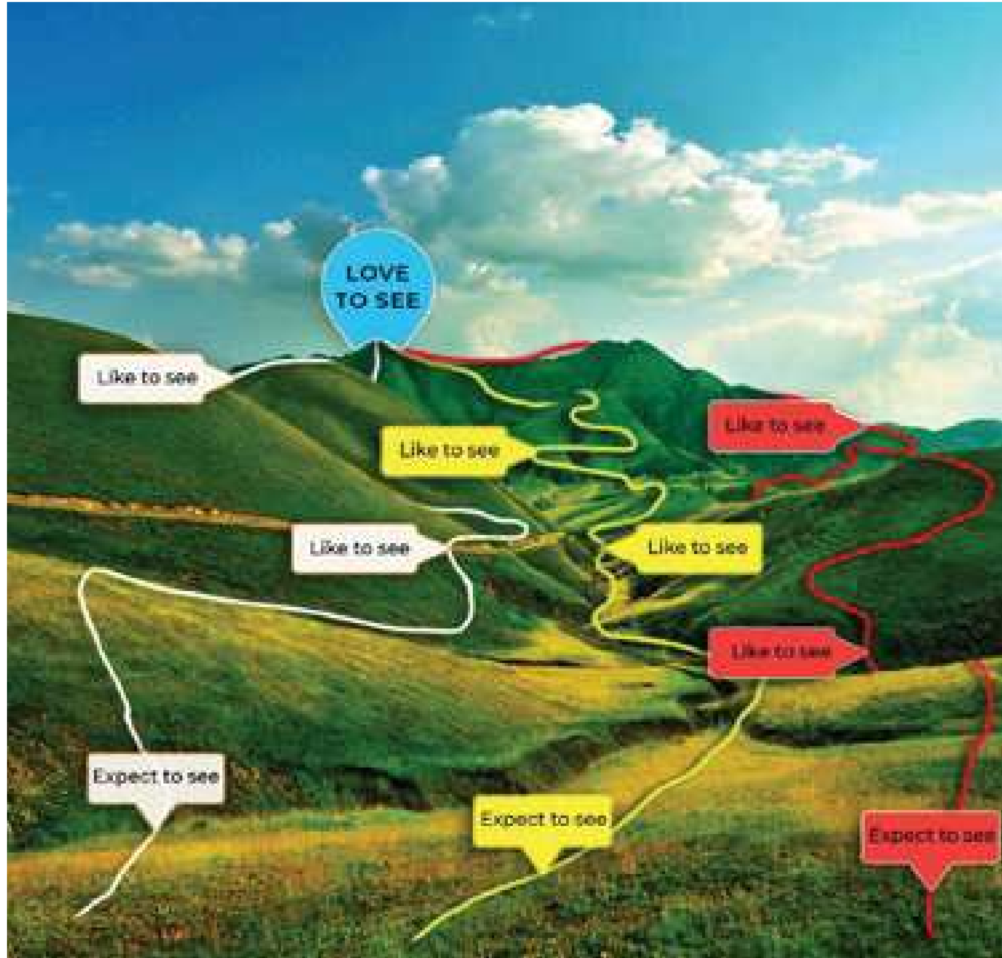
On the contrary, social change pathways are like sailing journeys, where the exact route cannot be predicted in advance but is based on constant analysis and adaptation.

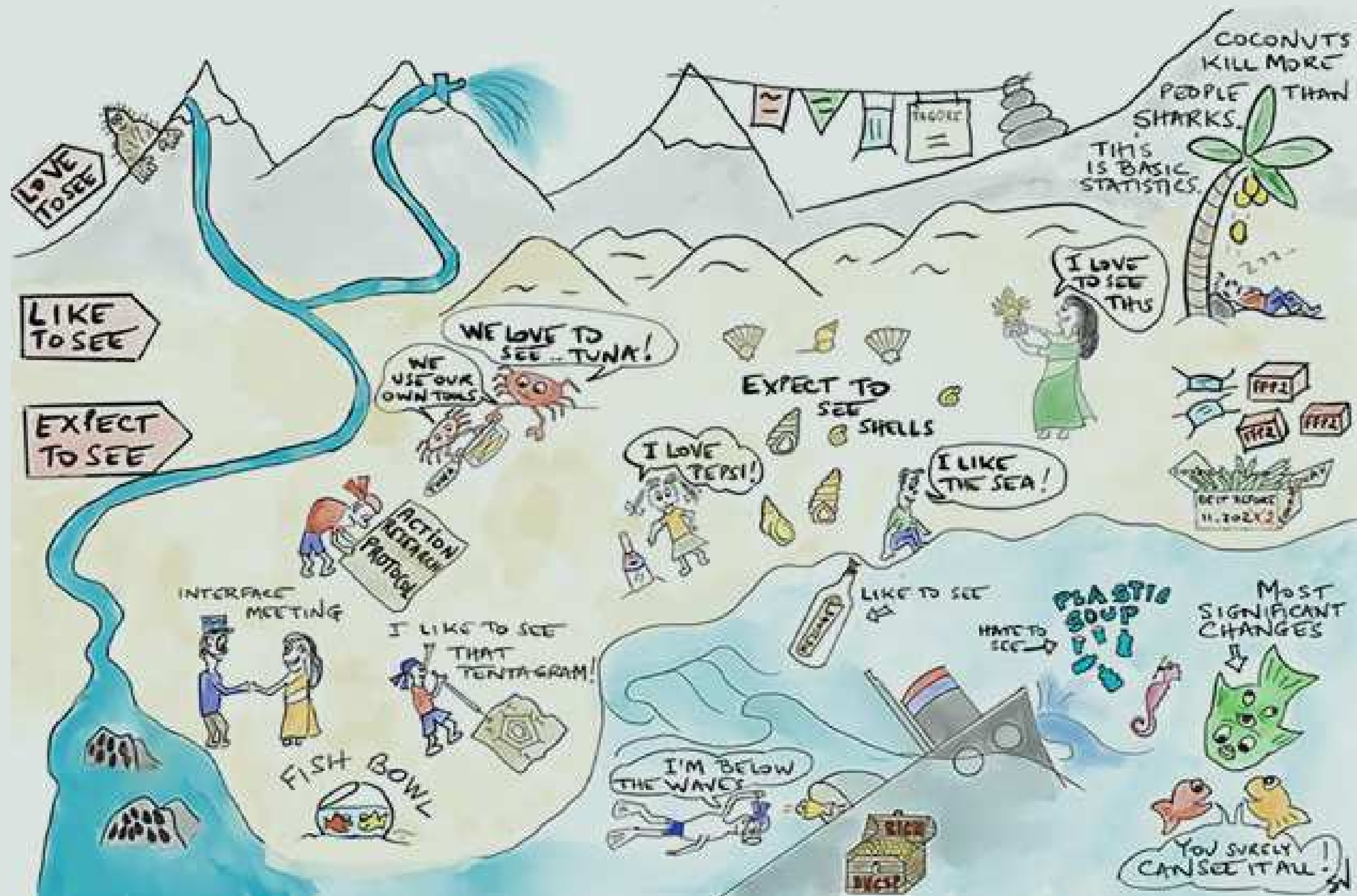
Or, expressed in the context of the mountain communities: there are several




pathways to get to the top, as the next picture illustrates.




LOVE TO SEE
Like to see
Like to see
Like to see
Like to see
Like to see
Like to see
Expect to see
Expect to see
Expect to see



LOVE TO SEE
LIKE TO SEE
EXPECT TO SEE
COCONUTS KILL MORE PEOPLE THAN SHARKS.
THIS IS BASIC STATISTICS.
I LOVE TO SEE THIS
WE LOVE TO SEE...TUNA!
WE USE OUR OWN TOOLS
EXPECT TO SEE SHELLS
I LOVE PEPSI!
I LIKE THE SEA!
ACTION RESEARCH PROTOCOL
INTERFACE MEETING
I LIKE TO SEE THAT PENTAGRAM!
FISH BOWL
LIKE TO SEE
HATE TO SEE
PLASTIC SOUP
MOST SIGNIFICANT CHANGES
I'M BELOW THE WAVES
YOU SURELY CAN SEE IT ALL!

## Messages in a bottle

- Complex development programmes can use a diverse mix of complementary qualitative and quantitative methods and tools which may be introduced at different moments in the programme cycle, and which may eventually be tailored to the needs of the programme. Tools and procedures should adapt to needs and not vice versa. This mix should facilitate and/or capture change in a comprehensive way.

# Chapter 12

«The true measure of any society can be found in how it treats its most vulnerable members.»

MAHATMA GANDHI

# Sailing on big ocean waves

Felipe Sere
Abhijit Das
Meena Putturaj
Bart Criel

Connecting local work with public health trends in India and the global level

## ¿uestions

- ¿ How does BHCSP relate to larger developments in the field of global health?
- ¿ What lessons does the BHCSP have for the contemporary health policy framework in India?
- ¿ How does BHCSP draw from and contribute to the emerging understanding of Universal Health Coverage and the Sustainable Development Goals?
- ¿ And what about your questions?

## Big waves in the world of public health and development

While people go about their lives in places like the Sundarbans struggling against natural disasters, diseases, and poverty, many plans are made to improve the material conditions of such communities far away in the corridors of power. This is the world of global development and international aid in which multilateral UN agencies, governments, philanthropies, and many others are involved in the complex task of improving the lives of poor and disadvantaged people. At the same time, the world of trade and commerce has created new globalised business opportunities and we live in an interconnected world where our futures are intertwined in many more ways than we properly understand.

Public health has been an arena of international cooperation for many years. After World War II ended, the World Health Organisation (WHO) was established on April 7, 1948 as a specialised agency of the United Nations (UN) to support the attainment of the 'highest possible level of health' for all people. WHO represented a global solidarity, a joint commitment among all nations, rich and poor, the erstwhile imperial powers, as well as the newly independent nations, so that all people in the world could have similar aspirations to the highest attainable standard of health.

On the December 10, 1948 the UN also adopted the Universal Declaration of Human Rights where all member nations pledged to promote and uphold the human rights of all people (22). In December 1966, the UN adopted the International Convention of Economic Social and Cultural Rights (ICESCR), a multi-lateral treaty that included the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health', also known as the 'right to health' as an explicit human right (24). These rights including the 'right to health' were to be achieved through affirmation, commitment, and cooperation between all countries, but remained the

obligation of member states to their people. The ICESCR came into force in 1976, and in 1978 WHO and UNICEF organised the Conference on Public Health Care in Alma Ata (Kazakhstan, in the then USSR). Leaders and experts from 134 countries around the world came together to declare 'Health for All by 2000', energizing the world of global health.

In the last 50 years, the global health aspirations have evolved in response to the emerging evidence and changing politics in the international arena. There have been at least four big ideas for global health which need to be considered to contextualise the BHCSP. These include the following:

In the last 50 years there have been at least four big ideas for global health

Firstly, the Alma Ata Declaration in 1978 with its aspiration of 'Health for All' by the year 2000 and emphasis on Primary Health Care as a key strategy to achieve this goal has remained a key driver of global health agenda (33). It pushed the then member countries of the World Health Organization to commit themselves to strengthen primary health care in their nations. The Declaration called for addressing social injustices especially in the developing countries so that people could accomplish a level of health that would enable them to lead a socially and economically productive life. A comprehensive multi-sectoral approach, integrated systems including traditional practitioners along with community participation were seen as hallmarks of primary health care.

Secondly, while the Alma Ata Declaration remained a key aspiration, the idea of comprehensive 'primary health' was soon undermined by 'selective primary health' and an emphasis on disease specific interventions. While this was taking place in the eighties, another global trend that emerged and found full expression in the nineties was that of 'rights-based approach' to development. The World Conference on Human Rights in Vienna (1993) (25), the International Conference on Population and Development in Cairo (1994) (23, 29) and the Fourth World Conference on Women

in Beijing (1995) (26) provided an added impetus to this new approach. The ideas of entitlement of citizens, duty bearers' obligations, accountability and transparency became new programmatic elements of development projects, including health projects.

Thirdly, the new millennium brought the Millennium Development Goals (MDG), a set of eight goals and the era of targets and indicators (27). By this time, the aspirations of rights and justice had started declining as global aid from developed countries. The international financial institutions such as the World Bank and the International Monetary Fund played a dominant role in setting the development agenda. Through more than two decades of global economic policies like 'structural adjustment', global poverty had not reduced and the MDGs were directed towards the Low and Middle Income Countries (LMIC) and aimed at reducing in-country disparities. Even though the targets were modest, they remained mostly unachieved by 2015, the goalpost for MDGs. Now a more comprehensive process of global goal setting is embarked upon which included all countries. The focus of the new global aspiration is 'Sustainable Development' and the Sustainable Development Goals (SDGs) include 17 goals and 169 targets to be accomplished by 2030 (28). In addition to the more traditional development issues like poverty, health, education, water and sanitation and gender equality, SDGs include goals related to urbanisation, consumption, ocean and marine resources, climate action and inequality. The idea of universality is emphasised through its central promise of 'leaving no one behind'.

Lastly, while the idea of 'highest attainable standard' of health for everyone has remained a global ambition, the pathways to this goal have been uncertain. In 2000, the Committee on the ESCR through its General Comment No 14, provided certain guidance on how the 'right to health' may be achieved. It clarified that this right did not imply the right to be healthy, but rather referred to a set of freedoms and

entitlements (32). While freedoms included the right to be free from torture and on non-consensual treatment, the entitlements included facilities, goods, and services. These needed to be Available, Accessible (without discrimination), Acceptable (respectful and culturally appropriate) and of Quality. This is often referred to as the AAAQ framework of health services (32). Once the right to health was better defined, the discussions started on how health systems could be developed to provide these. Discussions were launched on the financing of such health systems for 'Universal Health Coverage (UHC)' when WHO published the *World Health Report 2010*, entitled *Health systems financing: the path to universal coverage (36)*. Quality, access, and financial protection is at the heart of UHC. Recently, the Astana Declaration in 2018 exhorted the WHO member countries to make bold political choices to revamp health systems and use Primary Health Care as a proven strategy to accomplish UHC (37).

## The supportive currents of civil society action

To understand the relevance of BHCSP within this global scenario, it is imperative to consider civil society efforts which evolved in parallel to the global development agenda. At the Alma Ata Conference in 1978, along with representatives from 134 countries, experts from more than 64 organisations including Non-Government Organisations had come together making the conference an interesting example of the global collaboration between the more formal state and international sectors and the civil society or citizen sector. In fact, the participation of civil society members had started right from the start of setting up of the UN and the drafting of the UN charter. The role of NGOs and civil society as alternative actors in the development process further strengthened since the 1980s. NGOs and civil society actors became

involved in diverse activities like research, implementing projects, as well as advocacy for development agenda setting, better public policies, improved funding, and more effective implementation of development projects. Advocacy for rights-based approaches has been an important area of civil society actions and there was large participation from civil society in the human rights related conferences of the 1990s. In this overall landscape, NGOs in the global north included organisations which facilitated the development process through funding and technical support to implementing organisations, as well as research organisations which provided research and knowledge management inputs. As the deadline for 'Health for All by 2000' was coming close, many organisations across the world which had been working towards this agenda felt it was time to review progress. Civil society actors from many countries came together at the People's Health Assembly at Dhaka, Bangladesh in November 2000 and adopted the People's Health Charter. The People's Health Movement was established and a new call of 'Health for All – Now' was adopted (16).

The key partners of BHCSP – Memisa, WBVHA and the Institute for Tropical Medicine (Antwerp) – can be seen as constituents of this 'supportive current' and worked closely together with the community and other local public and private actors to bring about the changes that have been described in earlier chapters.

## Thinking globally and acting locally: experimenting with district health planning in India

Community participation and the use of local resources to provide a comprehensive and integrated set of services including curative as well as preventive and promotive services is at the heart of the Primary Health Care approach. Even though this

approach lost favour to the selective primary health care approach globally, it was revisited in 1987 at the Harare Conference, Zimbabwe where 22 countries of Sub-Saharan Africa came together to review appropriate approaches for communities in this resource poor continent (35). The Harare Declaration stated that the district provides the best opportunities for identifying the underserved and for integrating all health interventions needed to improve the health of the entire population '. Following this declaration, the 'District Health System' approach was adopted in many countries in Africa as an optimal organisational platform to implement PHC. Twenty-five years later, in 2013, the Harare Declaration was revisited at a regional conference in Dakar, Senegal (8). Much had changed by then. Countries in Africa had been ravaged by HIV and AIDS, the MDGs had come and gone, and the idea of Universal Health Coverage within SDGs were now the global aspiration. After many deliberations the 170 participants (from 20 countries) at the conference felt that the 'health district' strategy remained as compelling as before.

*"The district provides the best opportunities to improve the health of the entire population."*
(Harare Declaration)

While districts have been important administrative divisions, they were not key to health planning in India[1]. India was a founding member of WHO and was represented at the Alma Ata Conference. India also formulated its first National Health Policy soon after that in 1983 (7). However, since the formation of the first Five Year Plan in 1951, India has been overly concerned with population growth and family planning – by no means an illegitimate choice given the demographic pressure in the country (17). The Department of Family Planning was created in the mid-sixties, and it soon became the single most important programme of the Ministry of Health and Family Planning. After the Janata Party government came into power at the national level in 1977 the name of the concerned government department changed to Family Welfare, but population control continued with the setting of nationally determined method specific targets. In 1996, after India became a signatory to the International

1 Districts in the Indian administrative system are much larger (in terms of geography and population) than was proposed in the Harare declaration. Conceptually speaking, Indian sub-districts or blocks better match WHO's definition of 'district health systems'.

Conference on Population and Development Programme of Action (ICPD POA), the Government of India adopted the Target Free Approach in family planning because of dissatisfaction with over-emphasis on demographic targets. The emphasis of the health programme shifted slowly from Family Planning to include Maternal and Child Health and became the Reproductive Health and Child (RCH) programme in 1997 (12). The emphasis of planning and monitoring had by now shifted from the national to the state level. India adopted a District level mode of planning only after the National Rural Health Mission was adopted in 2005 (11).

The BHCP is an excellent example of cross fertilisation of global knowledge with local initiative and experimentation

This partnership between Memisa and ITM, Antwerp on the one hand, and the WBHVA and AIIH&PH, Kolkata on the other, and with various community-based partners, provides an excellent example of cross fertilisation of global knowledge with local initiative and experimentation. BHCSP was able to bring together members of Memisa and ITM who had experience in working with decentralised and community supportive health planning and implementation in other countries and members of WBVHA who had long experience of working with community-based organisations in rural West Bengal. The changes that were taking place in the health policy paradigm through the adoption of NRHM provided a perfect platform of finding ways in which decentralisation could be rooted in a unique way suited to the conditions in West Bengal. The CBO partners across the different districts and blocks provided leadership to negotiate the local realities. The results of this unique experiment have been described in earlier chapters.

## Shifting tides of national policy and local contexts

While the first national health policy (NHP) (1983) in India, had emphasised the provision of primary health care to all by 2000, subsequent revisions to the national health policy in 2002 and 2017 indicate a gradual transition from a tax-based public health system to insurance-based health care financing mainly through private health care establishments (13). With the recent endorsement of the SDGs by India, the renewed NHP (2017) aims to deliver quality health services at affordable cost for the achievement of UHC (14). It also envisages increasing public health expenditure to 2.5 per cent of GDP to achieve its intended objectives. In this spirit, the Government of India recently rolled out the 'Ayushman Bharat' (National Health Protection Scheme) in 2018 which is touted to be one of the largest social health insurance programmes in the world (Ministry of Health and Family Welfare, India). However, such social health insurance schemes are widely criticised for their poor design and implementation given the lapses in the health care regulatory architecture (18).

The health policy of independent India was guided by the Bhore Committee Report of 1946 (1). The report had recommended the integration of preventive and promotive services along with curative services and called for the setting up of decentralised Primary Health Centres across rural areas. Overall, this phase can be considered aligned with the philosophy and the strategy of primary health care for all. The government health system expanded into the rural areas through its network of Auxilliary Nurse Midwives (ANM) and Primary Health Centres (PHC) with an emphasis on family planning and immunisation. Based on the population norms, the public health care infrastructure consisted of a three-tier system with the primary health care facilities and the health subcentres at the grassroot level, the secondary health care systems comprising the community

health centres, sub divisional hospitals, rural hospitals and the tertiary health care facilities with the specialty and the super-specialty hospitals at the district and the state (provincial) level (5). Due to the paucity of health facilities and the difficulty in retaining qualified health workforce specially in the rural areas, the existing public health infrastructure is overburdened catering to a population often exceeding the stipulated norms. Curative care related outreach thus remains primarily linked to informal and private sector practitioners in rural areas.

To understand the health sector in India, it is also necessary to understand the division of responsibility between the federal or central government and the provincial or state governments. Health, including public health, is considered a 'State' subject, which implies that provision of curative care services, and running of hospitals is the responsibility of the provincial government. However, family planning and population control are part of the concurrent list or is a joint responsibility of both the federal and the provincial governments. Through the mechanism of national programmes, the national government provides a common platform and financial support for the public health priorities of the country. These have been related to blindness, malaria, tuberculosis, filariasis, leprosy, iodine deficiency and so on, each managed separately through a vertically organized programme.

Public health spending of India is one of the lowest in the world. It never exceeded 1.3 % of GDP

Fundamentally, public health spending of India is one of the lowest in the world. Indeed, it never exceeded 1.3 % of GDP and it is questionable whether there is genuine political will, today and in the past, to go beyond the usual lip service and indeed increase public funding. This is exceptionally low compared to the world average of 6.5%. Only one third of the total health expenditure in India is devoted to public health expenditure which means that the Indian health system is highly commercialised with high out of pocket expenditure (as high as 75%) for the people seeking healthcare (34). With such low investment on health, public

health infrastructure is weak in India. For instance, a survey on the public health facilities in India in 2006 revealed that only 69 % of the primary health facilities had at least one bed, only 20 % had a telephone and 12 % of the primary health facilities were regularly maintained. Since health is a 'state' subject, much of the public financing for health comes from the provincial budget, and the resources are thus different in different states. In the poorer states of India such as Bihar, where the overall health budget is also very low, the condition of public health facilities is very poor. Most of the public health facilities lack basic amenities such as electricity, toilet and essential equipment such as weighing machine for patient care. High absenteeism of health workers ranging between 35-58% in different Indian states as per a study in 2002-03 presents a chilling picture on the state of public health in India as cited by World Bank, 2008 (30).

The NHP 2017 highlighted the need for increasing the state's health spending to more than 8% of the total budget, however many states in India are yet to achieve this target (22). In the state of West Bengal, the allocation for health during the financial year 2018-2019 was only 4.5% of the total budget (19). It is not surprising that there are critical shortages in the health workforce in West Bengal. According to the Rural Health Statistics 2018, 64.4% of the primary health centres in the state function with only one doctor and 85 % primary health centres are run without a doctor. There was a shortage of 348 surgeons at the Community Health Centres (secondary level health care settings), and a shortfall of 290 obstetricians and the gynaecologists in public health facilities, even though maternal health was a programme of the highest priority. There were 348 general physicians needed but just 42, or only 12% positions were filled. There were shortages in other cadres of the health workforce as well. It is not surprising that healthcare providers are overburdened and violence against doctors is increasing in recent years (6). With poor infrastructure and depleted health

workforce, people are either forced to opt for expensive private healthcare providers or bypass the first line public healthcare facilities and visit informal providers (21).

India also has a pluralistic and mixed health system. Pluralistic in terms of the availability of modern and traditional systems as well as formal and informal systems of medicine. The mainstream traditional systems also called non – allopathic systems of medicine in India are Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH). Apart from these, there is a huge informal healthcare sector comprising the traditional medicine practitioners and unqualified practitioners especially in the rural areas who often practise a wide range of systems of medicine. The mixed nature of the health system is mainly because of the presence of the private healthcare system alongside the public healthcare delivery system. Reference to the mixed nature of health systems and the role of informal practitioners and how the BHCSP included these valuable resources within its ambit have been mentioned in earlier chapters.

High dependence on privately paid services led to impoverishment with a wide disparity in health outcomes

The growth of the formal private health sector took place in India after the introduction of neoliberal economic policies in the early 1990s. Its growth further accelerated since 2004 with the government's approval for 100% foreign direct investment in the hospital sector. Currently 75 % of the inpatient care and 25 % of the outpatient care is offered by the private healthcare enterprises (9). This high dependence on privately paid services, especially at the point of service delivery, has led to health becoming an important cause for impoverishment with a wide disparity in health outcomes. In the last 30 years, the economic status of India has improved significantly. However, this economic growth has not reflected in the lives of all citizens especially the poor and the marginalised. A range of health inequalities with respect to socioeconomic status, caste, education, gender, geographic location has been reported. Despite the economic growth, India's record

on human development has remained poor. More than half of India's children are stunted mostly due to undernutrition and half of India's women are anaemic (31).

In the late nineties, several factors influenced the way health related policy making proceeded in India. Mention has been made of the global and national push to revisit the population control focused family planning programme and introduce a more rights based reproductive health approach. The MDGs focused attention on several indicators related to all round development. On the other hand, attention was drawn to the issue of health sector financing and several states started Health Sector Reform projects. The system of National Health Accounts was initiated and drew attention to the high levels of out-of-pocket expenses and indebtedness due to health-related costs. At the same time, large corporate sector hospitals were being set up and India was emerging as a centre for specialised medical care for many other countries of the global south. The schism between the levels of care available to different sections of the population was becoming increasingly evident and several states started insurance-based programmes for secondary and tertiary care, but not for primary care.

Several states started insurance-based programmes for secondary and tertiary care, but not for primary care

As the country was grappling with the issue of affordable and comprehensive care, two key innovations were introduced in the last fifteen years. One of them is the National Health Mission and the other the Ayushman Bharat Jan Arogya Yojana. Of these two, the National Health Mission provided opportunities to BHCSP to 'ride the waves' [IB27] of change.

## Riding the NHM wave to strengthen health systems

Most programmes were nationally planned and rolled out with vertical management systems

The National Rural Health Mission sought to promote intersectoral action for health and decentralisation

As mentioned earlier, there is a significant rural-urban divide in the Indian healthcare system. About 75% of the healthcare facilities in India, accounting for the lion's share of infrastructure and human resources, are in the urban areas, but serve only 27% of the country's population. At the same time, there was little integration between the family planning and several other national health programmes. Most programmes were nationally planned and rolled out through the three-tier health system, each with its vertical management systems. To integrate the delivery of health systems the Government of India rolled out the National Rural Health Mission (NRHM) to bring about the "necessary architectural corrections" in the system in April 2005. The NRHM, subsequently renamed National Health Mission (NHM) – a merger of the National Rural and the national Urban Health Missions respectively – provided a strategy for integrating ongoing vertical programmes of Health and Family Welfare, and addressing issues related to the determinants of health such as sanitation, nutrition, and safe drinking water. The NHM also had a mechanism through which the national government would provide increasing financial support as the state government increased its own contribution to the programme.

The National Rural Health Mission sought to promote intersectoral action for health, which is in line with the philosophy and the strategy of PHC. Decentralisation was a major thrust under the NRHM and included several initiatives. The first was the introduction of a cadre of grassroot healthcare workers known as Accredited Social Health Activists (ASHAs) in every village. Each village was also expected to have a Village Health and Sanitation Committee (VHSC) and was provided a small, untied fund to support decentralised planning. Each public health facility from

the health sub-centre upwards was expected to have a patient welfare committee or Rogi Kalyan Samiti and each of these was provided an additional budget for improving the facility. At the district level, a District Health Society was constituted, and a District Project Manager was appointed to ensure that district level planning and programme implementation could happened through the District Programme Implementation Plan (DPIP). The state PIP was supposed to be a collection of DPIPs developed according to the local priorities and realities of each district.

The Panchayat Raj political-administrative system in India is a three tier structure for decentralised administration. It extends upward from the village level (Gram Panchayat) and through the Block Panchayat at it goes up to the district level (Zilla Parishad). This system is very robust in West Bengal. It has provisions for interacting with the health system but in actual practice the linkages are weak. The Panchayat and Rural Development Department, Government of West Bengal, started a special initiative to promote awareness on several health issues called the Community Health Care Management Initiative (CHCMI) in 2005 (3). This provided a unique opportunity for the BHCSP partners to interact with the public systems. As discussed earlier, the BHCSP partners collaborated with the various committees that were created at the subdistrict and district levels like the subdistrict health task force, child protection committees and disaster management committees. This was possible because the opportunity existed and the partners were able to generate goodwill and gain the confidence of subdistrict administrative officials and the elected representatives.

In many ways the district-based planning system introduced the 'health district' concept in India, even though there has been no direct reference to the concept in any official document. This is in alignment with the international understanding that local health systems extend up to the district level. Local health systems

At the level of local health systems, policies, plans and practical realities can meet, and feasible solutions can be developed

provide an excellent organisational framework within which to introduce changes in the health system. At this level, policies, plans and practical realities can meet, and feasible solutions can be developed. NRHM, as mentioned earlier, paved way for mainstreaming community participation in the planning and organisation of public health services through the creation of various Forums and opportunities for dialogue between the community, civil society, and the health system at different levels of the government system.

The three main goals of a health system are to meet people's expectations, achieve better health outcomes and ensure fairness in financing

The three main goals of a health system are to meet people's expectations (responsiveness), achieve better health outcomes for the population in a fair and equitable manner, and ensure fairness in financing (10). Achieving these goals is an ongoing struggle for national health systems and the struggle is more for Low- and Middle-Income countries (LMICs) owing to the increase in disease burden, resource constraints and ineffective governance systems. It is widely acknowledged that Health Systems Strengthening (HSS) is about political choices; hence the emphasis on the relationships between the diverse actors in the political and social makeup (10). The BHCSP, using a diverse range of decentralisation processes, was able to intervene in this political process using opportunities as they presented themselves to achieve better and equitable health outcomes for very marginalised communities.

## Local actions and global relevance

The BHCSP was born in the age of the MDGs, and its objectives and strategies were in line with objectives related to gender equality and women empowerment, reduction in child mortality, improvements in maternal health and combating HIV/AIDS,

malaria, and other diseases. The age of MDGs is now over and we are all working towards achieving the Sustainable Development Goals by 2030. Health lies within SDG 3 which is related to ensuring healthy lives and promoting well-being for all and at all ages. In addition to reducing mortality and morbidity related to specific conditions as in the MDGs, the SDGs also call for achieving Universal Health Coverage (UHC) which relates toaccessing essential and quality healthcare services as well as financial protection. The results of BHCSP show that the multi-stakeholder engagement, decentralized stewardship (as described in chapter 7) and the leverage of existing policy opportunities provides a unique and contextually relevant approach to develop effective plans to move towards the SDGs. And this is not restricted to SDG 3, which directly concerns health, but also to the SDGs related to gender equality (SDG 5), water and sanitation (SDG 6) as well as partnerships (SDG 17).

Achieving any of the targets relating to the SDGs demands community empowerment and engagement of various stakeholders in the governance processes at all levels. Governance is increasingly recognised as an important factor in health system performance and it is one of the six pillars of health systems (2). Earlier governance was thought to be consisting of technical functions. The World Bank for instance defined governance as the design and enforcement of economic policies, organising service delivery, responsible use of public resources and regulatory capacity of the state (35). Later scholars realised that power is a central concept to understand governance and that there is a political dimension to it. Accordingly, Brinkerhoff and Bossert reiterated that governance is all about the relationships between the different societal actors. These relationships are determined by the power, the formal and informal rules that shape the relationships between the different actors. Furthermore, governance is not only confined to the higher levels of the health system but also to the structures operating at the decentralised level. Broadly speaking, governance is

about how the state relates to non state actors (31). Health system governance refers to the various institutional arrangements that are necessary to effectively carry out the public health functions in order to achieve health system goals.

Health governance in India is complex and poorly understood and systemic governance failures are a matter of grave concern (20). In that line, the BHCSP created or utilised the opportunities for civil society organisations and the local communities to get involved in health governance processes, especially using soft governance approaches such as building trust and collaboration with various stakeholders on the ground.

Strengthening institutional mechanisms for improved accountability is also key to achieve the SDGs

Further, strengthening of the institutional mechanisms for improved accountability is also key to achieve the SDGs. The BHCSP attempted to work on the mechanics for infusing social accountability into the system with people-centredness as the key organising principle. The BHCSP stands as a testimony for possible local action targeting the global development goals. As we have seen, the BHCSP never isolated itself from the context and, on the contrary, sought ways to be articulated around it.

Achieving the SDGs and UHC by 2030 demands broad coalitions of reform groups and partnerships between state and non-state actors. In these partnerships, the NGO sector plays a crucial role in building and catalysing the momentum for a people-led movement for UHC. The NGO sector is so diverse and has varied functions with a wide scope of work ranging from specific areas such as health, education, livelihood to much wider areas concerning the overall wellbeing of the community/individuals. Their approach ranges from delivering direct services to getting involved in policy advocacy. Often, they compete for resources. However, there is a need for civil society to come together and collaborate with a shared sense of purpose to achieve

UHC. Moreover, different NGOs have different strengths and thematic focus areas (gender-based violence, water, health services) which is an opportunity to collaborate towards comprehensive health, keeping in mind social determinants of health. The BHCSP worked closely with local communities through the NGOs in the field of health and social development. The major principle of BHCSP was to ensure true partnerships between NGOs, public and private service providers, local communities as well as the academia and government authorities.

At the practical level, BHCSP was focused on instituting specific changes in India in the states of West Bengal and Sikkim. However, keeping an eye on the global relevance of this experiment there was always a concern for the key implementing partners, and it is hoped that these lessons will be useful for practitioners elsewhere.

## Lessons in sustainability

The international partnership between WBVHA in India, Memisa and the Belgian Development Cooperation was crucial in developing and steering this programme. Indeed, a large portion of Memisa's financial support is provided by the Directorate General for Development Cooperation and Humanitarian Aid of the Kingdom of Belgium. A question that needs attention after 20 years is whether the BHCSP promoted processes have led to more financial, social, and technical sustainability.

While the BHCSP did bring in additional funds to stimulate many of the key processes related to planning, capacity building and developing collaborative

The programme was built with the purpose to be able to function 'as it is' within the limits of existing funds

relationships, the programme was built with the purpose to be able to function 'as it is' within the limits of existing funds. The Community Health Funds are self-sufficient, the Forums do not depend on the programme's finances to work and the VHSNCs are functional without the BHCSP. We can, therefore, presume that some level of financial sustainability has been reached. Additional financing, however, is needed for geographic upscaling, achieving deeper levels of advocacy and reach higher decision-making levels as envisaged in SDG 17.

The community level processes fostered through the programme have largely integrated into existing institutional practices and have led to some form of social sustainability. Local stakeholders, including members of the community, as well as community level service providers, feel that the social processes stimulated through the BHCSP will go on because this is 'how they do things now'. The results may vary among the villages, but the core of the programme now has strong roots in the community .

Local stakeholders feel that the social processes stimulated through the BHCSP will go on because this is "how they do things now". The core of the programme now has strong roots in the community

The trickiest aspect of sustainability and the most challenging one is that of technical sustainability. A test of technical sustainability is to see whether the results pass the test of time. But what does this mean? In a programme that is so complex and that has evolved over a long period of time, technical sustainability would not only mean developing the technical capacity of the beneficiaries on a wide range of topics, but also developing their ability to share methods and tools with others so they can live on. It would mean that the community eventually acquires the technical capacity to innovate and mobilise the resources needed. Achieving sustainability through repetitive actions is relatively easy for vertical programmes where it is possible to organise a set of training sessions for a particular disease. However, it is something completely different for a 'horizontal' integrated programme like the

BHCSP. In this case, technical sustainability would mean that communities need to share, innovate as well as remain resilient so that the key principles that have been imbued during the programme remain embedded as the community negotiates progress and change. This kind of change remains a challenge for the future, and it would be important to continue studying the BHCSP process as it evolves.

NHM
SDG
UHC
WE'RE STUCK! WE NEED YOUR HELP!
HEALTH POLICY
THIS LOOKS LIKE A CIRCULAR PROCESS
CONDOMS
I HAVE SOMETHING TO SHARE
ACTION RESEARCH
OK!
POLICY 2020
PROTO COLS
I'M SENDING THE GREETINGS FROM BHCSP!
HEALTH FORUM
I CAN EAT & DIGEST ANY RULES, NORMS & PROCEDURES
THOSE PROCEDURES CAN MAKE YOU SICK!
SW.

## Messages in a bottle

- Addressing social determinants and including citizen engagement are key to achieving the overall SDG goal of 'leaving no one behind'.

- In addition, there is a clear need for more public resources (financial, human…) to strengthen the underfunded Indian health system.

- BHCSP provides a beautiful illustration of how multiple actors at the local level, i.e., citizens, civil society organisations, frontline health workers and local authoritiescan come together and join forces in a creative partnership to determine how local priorities can be addressed within the larger policy framework.

- Local engagement of health system actors, the community, as well as other stakeholders associated with local governance mechanisms and public service delivery, allows for devising relevant and context specific solutions. However, these can only be achieved with trust in the overall process and within a sufficiently long-term time perspective.

# Chapter 13

«Success is not final, failure is not fatal, it is the courage to continue that counts.»

WINSTON CHURCHILL

# Are we ready to face future cyclones and tsunamis?

Karel Gyselinck
Aloysius James
Bart Criel
Felipe Sere

Musings on BHCSP's capacity to cope with current and future systemic challenges

## ¿uestions

- ¿ What is the BHCSP legacy?
- ¿ How does the BHCSP legacy help us to face current and future systemic challenges?
- ¿ How can we sustain the assets and learnings of the BHCSP?
- ¿ How do we integrate lessons learnt over the last two decades in the BHCSP's organisational culture and activity portfolio?
- ¿ And what about your questions?

A common philosophical thought experiment is framed as follows: 'If a tree falls in a forest and no one is around, does it make a sound?' We could all agree that it hardly matters to anyone even if the tree would make a sound. Unless someone was there and started telling people about it, no one would know the impact the fall of that specific tree would have on the landscape, fauna and flora around it.

Undocumented actions lose part of their meaning. Not to the direct beneficiaries, of course, but to everyone else, and they fade into oblivion once some time has passed, without leaving any meaningful trace. After a journey of twenty years, we should look back and ask ourselves whether the stories of trees falling have been adequately documented and shared? Will the BHCSP pass the test of time? Let us not allow changes in our forest to go unrecorded.

## What is the main BHCSP legacy?

The main legacy of the BHCSP is to have developed a 'software'

The main legacy of the BHCSP is to have developed a 'software.' It is not the number of Panchayats and themes it has covered, nor the number of community groups it has initiated, nor the number of services it has improved in a joint effort with many other actors. At the core of this software are the five guiding principles of the BHCSP. The Mind-shifts emerging through the BHCSP and the key messages at the end of each chapter of this book reflect the learnings when working with that software. It has been developed with a lot of muddling through and like any software, it is not perfect. It's a version 4.0 because in 20 years of the BHCSP, the software has already been revisited several times and customised according to changing needs. But like any software it needs to be continually refined to meet evolving demands. And

since it's an open source software, the aim is that the reader becomes a user and contributes to improving and updating it.

An appropriate name for this software could be Compass 4.0. Appropriate because it has been guiding the BHCSP actors. It acted as a compass to orient them in taking decisions in a complex environment, a compass to sail below the waves and deal with reality invisible to a large extent.

The word 'compass' is also part of the word 'compass-ion'. Compassion has a link with empathy and 'people-centredness' which is the central principle of the BHCSP. Rather than people having to conform to or adapt to schemes, services, results, frameworks, strategies, and policies managed by others, the BHCSP aimed to reverse the logic. How can services, programmes, processes and policies adapt to people and their needs, so that they can better address people's priorities, not only at a particular time but throughout their life (1)? It's about enabling people, both as individuals and as communities, to undertake 'valuable doings and beings' in life. Without that there is no equity. Who should finally be in control: the managers and political leaders or the people they serve? Not managing but serving. Isn't that the intention behind words like 'civil servants' and democracy?

This principle of people-centredness encompasses the four other principles of the compass: being comprehensive (holistic), decentralising decision-making by people and local stakeholders, linking up actors and adopting a learning mode [IB24].

If health is no longer simply the 'absence of disease' but 'well-being' as WHO promotes, or 'promoting human and social capabilities' as Amartya Sen puts it, then a health system can no longer confine health to the biomedical model focusing on specific parts of the body and specific disease conditions. It goes beyond providing curative and preventive services, focusing on the social determinants of health,

Human beings need cure and care, compassion, consolation, and coaching

mental health, and promoting healthy lifestyles, with an inclusive approach. In that way the health system goes beyond the mere service provider and user relationship. It becomes a companion, again bringing to mind the word 'compass'. A compass orienting and supporting people and providing them with a continuum of care across their lifespan [IB7]. In that paradigm, people are no longer merely users. Health services are not like any other business. Human beings need cure and care, compassion, consolation, and coaching regarding their health. Where hospital-ity is put again at the centre of our hospitals, there is a ray of hope. Is it a coincidence that the grassroot level health workers connecting the marginalised communities to the Indian healthcare system are called ASHA ( which means hope)? Did they have a holistic model in mind? What a wonderful world it would be!.

In such model – embraced by the BHCSP software – health technicians and managers no longer just look at their computers collecting data of patients to make the best decisions for them, or just look at their bank accounts, but look people in the eye and listen to them, supporting them to take the best possible decisions regarding their health from cradle to coffin. As the saying goes, people know best where their shoes pinch on their feet.

Software Compass 4.0 is also anchored in a Realist Approach with learning as the main driver. Sustainable change can only happen if you understand the underlying mechanisms and work on the broader context because most problems cannot be solved in isolation. Systematic reflection on options and actions, and learning from them to make better decisions regarding one's health is the way forward. The BHCSP has attempted to develop attitudes, strategies and tools to deal with such situations in a better way.

And this can't be done all alone. We depend on so many other people. Compass 4.0 is about linking up actors, too. Rather than working in competition and opposition,

a culture of mutual trust, partnership, and collaboration needs to be nurtured. And that will determine the performance of Panchayats, blocks and districts. Without that spirit, there will be no change, only sterile bureaucracy. Rather than administering fragmented health schemes, BHCSP is about building robust and integrated health systems. The assumption is that solid local health systems create a better environment responding to people's needs. The WHO integrated district model (a vision launched at the Alma Ata conference in 1978 but reiterated later in Harare, Dakar and Astana) and its values are still valid, but needs to be tailored to the context of West Bengal. The BHCSP attempted to contribute to this process by exploring new forms of multi-stakeholder governance together with partners from grassroot level up to international level.

The software embraced by BHCSP raised the interest of actors beyond the programme's scope, like Self-Help groups from other Panchayats, NGOs in other subdistricts, subdistrict and district health authorities. Even a private actor like the management of the Pepsi plant in Howrah came to know about this approach and contacted WBVHA to assist them in redesigning their HIV initiative. Though it's not simply pressing the copy-paste button, the Compass software can be run on every system and is easily adaptable. And on this software, many programmes can run.

## How may the BHCSP legacy help to face current and future (health) challenges?

The COVID-19 pandemic, the super cyclone Amphan ravaging the Ganges delta in 2020, the melting Himalayas resulting in huge floods, the privatisation of healthcare, the gap between policy and practice are just a glimpse of the many challenges

> These challenges are just symptoms of more profound system failures

West Bengal and India are facing, and by extension the whole world. These global challenges have multidimensional domino effects, and act like several tsunami waves affecting people's lives, livelihoods, and the global economy, resulting in increasing inequality.

But just like tsunamis, these challenges are just symptoms of more profound system failures : failing health systems where fragmentation rules; failing global eco-systems with global warming; failing market economies where even financial bubbles can't hide the fact that we have come to the end of the present neoliberal growth model; and failing political systems out of touch with people's reality and taken as a hostage of that same market economy. Pilots know their aeroplane is in serious problems when three systems fail at the same time. So we may be near to a crash. We need to be realistic but not fatalistic despite the odds. So let's act within the frame of the doughnut economy (Kate Raworth) (2): assuring people's basic needs and rights with a growth scenario within the limits of what our planet can bear. What does this mean for West Bengal and India?

The Indian NHM may be one of the answers in the right direction. At a local level, the BHCSP compass may contribute to tackling those challenges, at whatever level these challenges present themselves, be it at grassroots level or more strategic level.

## *Addressing a failing health system*

> Pilots know their aeroplane is in serious problems when three systems fail at the same time. So we may be near to a crash

Covid-19 revealed the fragility of health systems everywhere in the world, also in West Bengal in India. There is, of course, a lack of adequate capacity in terms of hygiene, testing, oxygen supply, hospital admission, intensive care facilities and vaccination just to name a few. But there is also a substantial financial burden

on those seeking treatment in the for profit private sector with high out-of-pocket costs, illustrating the inequity in access to quality services. And what can we say about the incapacity to deal with domestic violence or mental health issues? The failure of the Indian health system to cope with those COVID-19 related challenges goes beyond the lack of insufficient resources. The deeper causes are related to the fragmentation in the health system (with many schemes and even more actors), poor health governance, myopic vision of political leaders on health, bureaucratic and prescriptive approaches, commercialisation of health care, and a dominant biomedical vision on health.

It is an excellent opportunity to test the BHCSP software and assess whether it helps people and institutions be more resilient during this crisis. COVID-19 has surprised people and forced them to take decisions without a clear plan, take steps in the dark not knowing whether there would be light at the end of the tunnel, and readjust continuously when necessary. The given context is a concrete example of an uncertain, complex situation where learning by doing, step by step, has proved to be the only way forward. The BHCSP has gained experience in this approach, guided by its compass. The programme has developed instruments, tools and in-house capacities to deal better with such situations. This may have served the BHCSP actors to better cope with the COVID-19 situation at their level.

During the ongoing COVID-19 pandemic, the existing BHCSP culture of collaboration and partnership among the various actors in the local health system was an asset to mitigate the risks. It facilitated a better information flow in both directions, ranging from information regarding the evolution of the pandemic in the field– even in remote areas – to the communication of the official COVID-19 measures which changed from day to day. The forum members were part of the various task forces at the district, subdistrict and GP level, influencing policy decisions, complementing

the response programme, supporting the local health systems to act swiftly, organising prevention and vaccination campaigns and quarantine centres. It contributed to more concerted and efficient actions in mobilising people, community groups, NGOs, health providers, Panchayats, subdistrict and district health authorities to contain the pandemic. They reached out to the affected vulnerable families and communities in the districts of North 24 Parganas, South 24 Parganas, Howrah and Darjeeling, providing medical support, relief materials and food kits. The forum was instrumental in organising GP level response interventions against the initial government approach of subdistrict level interventions. As part of the community managed the covid response, the Darjeeling forum organised and managed 19 quarantine centres in Takdah block as a first-level response centre.

The forum partners also ensured that the government health system reached out to the excluded communities and families who could not use the government services schemes. In some places, like Teesta valley and Takling GPs, they organised transportation for the government health team. Many healthcare workers had to go through anxiety, fear, depression due to the heavy workload and pressures from family. They supported the families of ASHA and GP level health workers to perform their roles. Similarly, they equipped and helped the RMPs with the West Bengal government covid response policy for early referral and surveillance.

'Never waste a good crisis' is a widely held belief. Crises like the COVID-19 pandemic are a threat, indeed, but at the same time an opportunity to strengthen the local health system and build resilience. A health system performing despite the challenging circumstances will increase people's confidence in the existing health services and system. Even a COVID-19 crisis should not be addressed by setting up another separate, vertical health scheme but using and further strengthening the potential within the existing health system. Shouldn't we overcome the binary Dr Jekyll and Mr Hyde

logic of turning into a humanitarian aid worker when an emergency arises, and then returning to the longer term development mode once the crisis is over? Isn't it more a continuum (3), with the same actors in the health system being adaptive to short term needs, but keeping the longer term needs on the radar?

The COVID-19 pandemic illustrates that a mere top-down approach in emergencies has many flaws. Decisions made by politicians, health managers and technicians regarding issues like hygiene measures, lockdowns, testing and vaccination strategies or intensive care should be complemented by local measures and solutions. It concerns decisions at the level of every person, every household, every village, every Panchayat community to adapt general, nation-wide measures to their context to make them work, as the BHCSP attempted to do. COVID-19 measures declared by national or state authorities, even if they are very rational, are to some extent always unfair, inequitable or unpractical when you have to apply them in a specific, local context. A certain degree of flexibility and autonomy in applying general measures is therefore necessary to mitigate such effects.

Finally, the comprehensive and people-centred approach embedded in the BHCSP software helps the actors, amongst all other needs, to pay attention to the psychological needs of people and specific mental health issues related to the COVID-19 pandemic. It also helps to keep other health needs of people on the radar. On the news, you get the daily COVID-19 infection, morbidity and mortality rates. But who monitors the collateral damage linked to this pandemic? Who communicates on the effect of COVID-19 on the morbidity and mortality rates of other health conditions?

Shouldn't we overcome the binary Dr Jekyll and Mr Hyde logic of turning into a humanitarian aid worker once an emergency arises, and then returning to the longer term development mode when the crisis is over?

## *Addressing a failing eco-system*

In dealing with emergencies like the Amphan super cyclone in May 2020 and Yass, another cyclonic storm in May 2021, the BHCSP software added value as in the case of the COVID-19 pandemic. After the Aila cyclone 2009, the forum members were part of the Inter-Agency Group (IAG) primarily formed to coordinate the disaster preparedness and response plans of the districts. The BHCSP actors have gone beyond solidarity during the emergencies by investing in short term and longterm strategies and mitigation measures to deal with such disasters.

The collective effort of the forum in Hingalganj block of North 24 Parganas, Gosaba and Pathar Pratima Blocks of South 24 Parganas helped the community adapt itself to the new situation and recover fast. The forum members took the leadership in North 24 Parganas and South 24 Parganas. They mapped vulnerable areas and families, streamlined their communication with the authorities, identified resources for relief and early recovery, developed disaster preparedness plans, strengthened community and system resilience, implemented evacuation and mitigation plans, and trained response teams by mobilising the local community in coordination with GP, subdistrict and district level leadership. The ANMs and ASHA workers reached out even to the cyclone shelters and safe areas to address specific health problems. The Block and GP leadership, in active collaboration with civil society organisations assisted many community members to restart their livelihood activities. The district health system got a boost through such collaboration. It led to more robust district disaster preparedness and response plans.

The efforts of 20 years of BHCSP with improved community resilience, existing social protection measures through the SHG and CHF, and social infrastructure, reinforced community capacities and a stronger local health system contributed to

anticipating risks, absorbing and adapting to recurring disasters and rebuilding their lives at the earliest. Most of the NGO partners also took up actions beyond health, ensuring intersectoral collaboration. Mainstreaming agricultural innovations (i.e. floating rice) or the protection of land and mangrove forests, risk proofing of water and sanitation are some examples to note. Thus, they contributed on a local scale to mitigate the risks of climate change in the long run. Tackling climate change requires a broad coalition between players to create the conditions for multi-actor collaboration and collective intelligence. Programmes like the BHCSP may help reach both the first and the last mile in translating international or national policies into practice.

Tackling climate change requires a broad coalition between players

## *Addressing a failing market economy*

The dominating neoliberal paradigm in the Indian health sector has led to the increasing commercialisation of healthcare. Health in India shifted further from a public to a private good, leading to growing inequalities. Neighbouring Bhutan chose a different leading paradigm and in 2008, integrated the Gross Domestic Happiness (GDH) Index in its constitution.

Let's act within the frame of the doughnut economy

The logic of competition and growth still prevails to some extent amongst the BHCSP NGO partners. Nevertheless, the BHCSP put a lot of effort into promoting a mind-shift where people and their health needs are put at the centre. It created space for initiatives in that direction with some success, particularly at the community level, focusing on health promotion and prevention, community healthcare, and Community Health Funds. It led to models and ideas which can be scaled up. At the level of the rural hospitals and higher level referral hospitals, assuring people-centred services was more of a challenge due to many reasons.

Health in India shifted further from a public to a private good leading to growing inequalities

And there is also this… In a world ruled by the quick, the dirty and the short-term, with quarterly result bulletins promoted by the gurus of capitalism and the daily sensations of media, it's a statement to have a development support programme that embarked on a journey of 20 years, that is still ongoing. Giving things time, isn't that one of the premises to achieve sustainable change? It is a message in a bottle for the donors and the whole development business, who embrace short-term project cycles, quick results and simplified, yet dramatic stories.

## *Addressing a failing political system*

Last but not least, how did the BHCSP software play a rol e in counteracting the failings of the political system? Modestly, the BHCSP has taken initiatives helping to bridge some gaps.

Firstly, it focused on bridging the gap between people and politicians. Most politicians are out of touch with people's reality. There is a need to invest in a new partnership between the people and those who govern them. The BHCSP has invested in building relations with the subdistrict and Gram Panchayat representatives, motivating them to follow the principle of convergence and make decisions for the wider good of the people. The joint development and implementation of a Gram Panchayat development plan in line with the priority needs of people is a nice achievement of this partnership. Such a process also helped to create downward accountability.

Secondly, it bridged the existing gap from policy to practice. The National Health Mission (NHM) is a good example. Through the Health Forums at different levels, and the collaboration between the actors in the local health system, The BHCSP contributed to adapting the national and state health schemes to the local context and needs, and extending the health services promoted by NHM up to the most remote

areas. Creating a supportive work environment for ASHAs, other community health workers and health staff at sub-centres and PHC level has been important. More importantly, the programme allowed people and institutional leaders to meet and relate to one another, reflect and search together for solutions, develop a common ground, and work together, giving a redeeming effect to all concerned. It created synergy among local governing bodies and the healthcare system.

Thirdly, there is bridging the gap from practice to policy. By organising the community, organising Health Forums, participating in dialogue platforms at the different levels, building trust with higher level decision makers, increasing people's confidence to speak up, slowly issues and proposals for solutions are raised by the grassroot level and start influencing decisions by the authorities. Sustainable change at the local, operational level can only happen with the involvement of decision makers at the higher, strategic level. This 'double anchorage' principle is based on system-thinking, where influencing your context is key. This is a slow process. It is still a challenge for many BHCSP partners to go out of their comfort zone, raise their voices and defend health rights strategically. As the external evaluator Dr Raoul Bermejo highlighted in the 2016 external review of the BHCSP : '[While] there is some evidence of influence on health planning at the village, Panchayat, and Block levels, but [there is] less so at the District and State levels'.

There is a need to invest in a new partnership between the people and those who govern them

### *Two Achilles-tendons*

The first Achilles-tendon of the BHCSP is insufficient experience-based and evidence-based documentation. This twin-publication of the Story Book and the Image Book is a step in the right direction. We are sharing experiences candidly. Describing a process of people-centred health governance for twenty years – which in itself

is exceptional – is worthwhile. There are also some results which look promising. Circumstantial evidence is there but, if we want our falling trees to be heard, we need more substantial evidence for those results, certainly when entering global arena debates. We need critical data to demonstrate that the BHCSP compass helps realise some of the SDGs, especially SDG 3 (Good Health and Well-Being), SDG 5 (Gender Equality); SDG 6 (Clean Water and Sanitation), SDG 10 (Reduced Inequalities) and SDG 17 (Partnerships for the Goals). However, apart from small-sized local accounting/evaluations of field activities and qualitative monitoring focused on the Mind-shifts, the BHCSP lacks a comprehensive, robust, effective and efficient monitoring and evaluation system of whether the programme is reaching its objectives. This is not really part of the organisational culture of the BHCSP , and the necessary capacity and human resources basis for that purpose is grossly lacking.

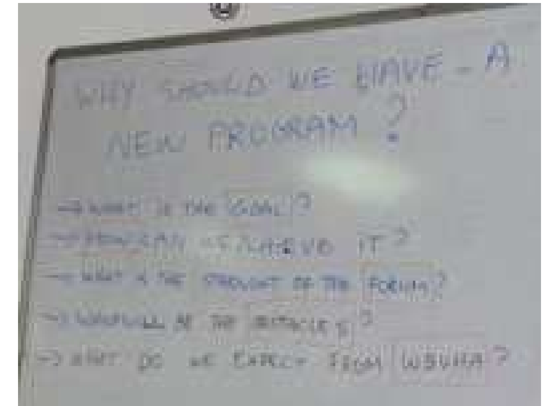
We need more substantial evidence for those results, certainly when entering global arena debates

The second Achilles-tendon is the poor performance of the BHCSP in actually "weighing" on health policies, except perhaps at the local level of the health system. The reasons for that are multiple: having impact on policy-making it is not ingrained in the vision, culture, design/architecture, human resource basis and functioning of the BHCSP.

Both weaknesses need to be overcome by increased professionalisation, specifically in the two domains mentioned above. This cannot happen without a profound rethinking of the managerial and organisational architecture of the programme, and attracting new human resources to fill in these gaps.

All these global challenges seem as vast as an ocean for a small programme as the BHCSP. However, such a programme may be significant, not in terms of coverage but in terms of mindset and methodological approach. This is a good time to remember the quote from the preface: "*If you think you are too small to make a difference, try sleeping with a mosquito*". (Dalai Lama)

## How can we sustain the assets and learnings of the BHCSP?




What next? How can we take this further? Does our software have a future? Will there be a version 5.0 after Compass 4.0?

*During a meeting in Howrah, the project coordinator of WBVHA asked the community members the following: 'What would happen if tomorrow we stop coming here, if we just leave?' After a first round of light, humorous reactions like 'no worries, we can go to your place in Kolkata and have our meetings in your living room', a spokeswoman for the ASHAs said, 'more seriously, I would be sad because we appreciated everything you brought, but it wouldn't change how we do things now.'. A member of a Self-Help Group continued, 'It would be a shame because of all the new things we would be missing, but we would keep the community health funds, we would keep fighting against early marriage and we would still work for better sanitation in our village.'*

A programme like the BHCSP can develop sustainable concepts, strategies and instruments in the sense of 'having the potential to be sustained'. However, it's finally up to the endogenous actors (whether local communities, local authorities, health providers and managers, academia and politicians) to choose whether to sustain the assets of the BHCSP or not. Using Outcome-Mapping language: "*What does each of them expect to see, like to see and love to see?*" The programme cannot make firm commitments by itself. We can only put forward some questions to each category of actors to reflect on and determine their future commitment. These questions take into account four dimensions: social sustainability (how the change in the lives of people, households and communities can be sustained); the 'technical' sustainability (how the Mind-shifts and skills in relation to the concepts, strategies and instruments can be sustained), the institutional sustainability (how structures, organisations and institutions integrate the BHCSP guiding principles and related strategies and

A programme can develop sustainable strategies, but it's finally the choice of the local actors whether to sustain them or not

instruments in their vision, mission and values as well as in their structures and functioning) and the financial sustainability (how domestic resources can be used in the most strategic way to assure the autonomy and health rights of people and equitable access to quality health services).

Our sailing continues. But as we move forward, we would like to place our reflections and learning as suggestions and questions to our stakeholders and key players to sustain our learnings and assets, both software and hardware of the BHCSP.

### *To the local communities:*

– Can community-based groups (self-help groups or VHSNC) continue to share their experiences with neighbouring communities, through peer-to-peer mechanisms?
– Can local communities continue to support the work and contribute to working conditions of grassroot health workers?
– Can community champions and leaders continue to raise their voices and bring their challenges to the attention of decision makers?

### *To the BHCSP NGO partners and WBVHA:*

– Can we imagine that the Health Forums have an open structure and organisational flexibility vis-à-vis emerging internal rules, and a clear vision and mission?
– Can we move from NGO-based Health Forums towards People's Health Movements where community people take up leadership and the NGOs adopt a supportive role?
– Can each NGO integrate the guiding principles and Mind-shifts of the BHCSP and use it as a reference to implement all their projects or schemes ?
– Can we take a life-course perspective towards health and see our role in supporting people in their choices regarding their health during their lifetime?

- Can we set up training programmes and practical internships to share the BHCSP vision and related guiding principles, the strategies associated with strengthening a local health system, and the instruments of working in complex environments?
- Can we consolidate the partnerships with decision makers in the local health system and claim the spaces of dialogue at different levels – from fourth Saturday meetings at the Panchayat PRI up to subdistrict (block), district and eventually state level – based on trust, critical data and creative and constructive proposals?
- Can we systematically incorporate evidence-based advocacy focusing on the structural changes – 'from the low-to the high-hanging fruits' – moving beyond operational work at micro-level?

### *To the NGO WBVHA in particular:*

- Can we expand our network of strategic partners and join forces with policy influencers and academia, particularly at the state, national, and international levels?
- Can WBVHA strengthen its internal capacity and organisation system, mobilise (preferably domestic) resources to strengthen and build capacities of the network of strategic partners and assure the continuity of the BHCSP?
- Can Action-research and related systematic data collection become common practice in the programmes of WBVHA and be better connected to the organisation's strategic objectives?
- To narrow the gap between research and field work, can WBVHA facilitate the creation of a structured platform for academia to interact with the various operational actors? This platform would facilitate win-win situations, help to improve routine data collection, strengthen the Monitoring & Evaluation (M&E) system, and create a space to conduct Action-research.

*To the NGO Memisa Belgium:*

– Can Memisa move beyond a partnership with WBVHA and other actors in India based on programme funding and focus on the added value of this partnership on the broader framework of SDG, UHC and the 'Health for All' vision? Can Memisa invest in creating the conditions (tools, processes, funds) to make this concrete?
– Can Memisa further strengthen its capacity to work in complex contexts and advocate at the level of our donors, networks and (inter)national Forums and engage in flexible, creative, long-term programmes owned by local stakeholders geared towards sustainable change and system strengthening?

*To the government actors and Panchayats in the supported districts:*

– Can government decision-makers reinforce their role as leaders and stewards of the local health system at different levels, valorising the contribution of multiple stakeholders towards health?
– Can government actors and Panchayats leaders continue and strengthen their dialogue with the Forum partners and the local communities, and develop health plans jointly through regular interactions?
– Can they contribute to bridging the gap between NHM guidelines and policies and the operational challenges at the implementation level, take up such concerns with the decision-makers at the higher levels?

### *To the private health providers in the local health system:*

- Can private health providers participate in the dialogue with the other actors of the local health system to reduce gaps and overlaps in the health care system?
- Can they develop partnerships that help to improve equitable access to quality health services?
- Can they share their expertise and experience with other health actors regarding health care and management?

### *To the policymakers and influencers:*

- Can policy-makers and influencers at state, national and international levels take the lessons from the BHCSP?
- Can they facilitate WBVHA and its partners to access and participate in policy dialogues?
- Can policymakers orient funds for health services more efficiently and equitably?

### *To the a cademia:*

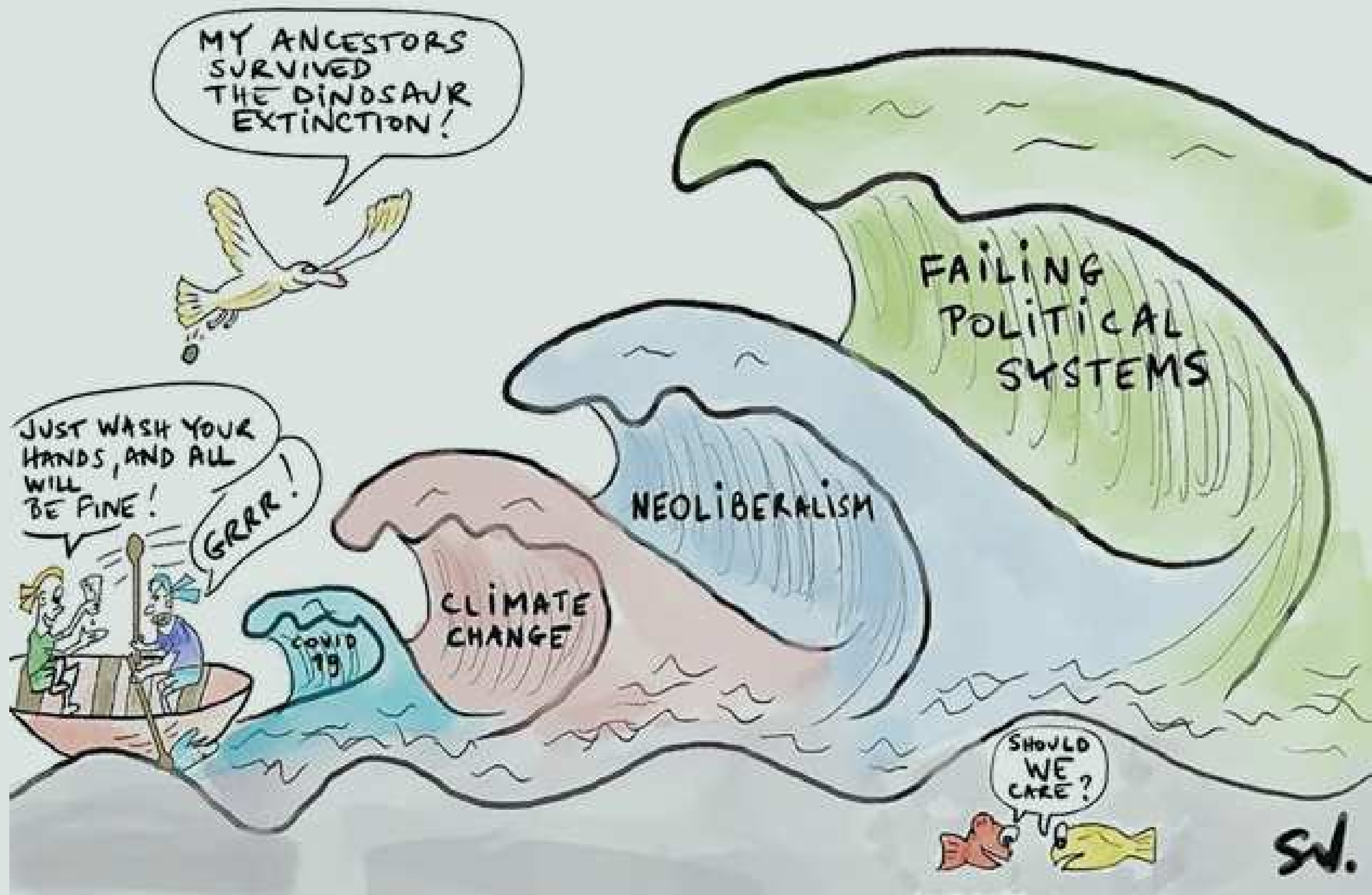
- Can academia provide opportunities for scientific exchange and teaching opportunities for the BHCSP to share their learnings from the programme?
- Can the BHCSP become a field for traineeships, internships or postgraduate research?
- Can academia promote the strategies, qualitative and quantitative methods and tools adapted to the running of complex social development programmes and integrate them into their curricula?

– Can academia build up the skills of students and health actors related to Action-research by integrating the approach in both their theoretical training and internships, coaching operational actors engaged in Action-research, and facilitating the capitalisation and dissemination of the results emerging from Action-research?

## *A tree that survived cyclones*

Some trees don't fall easily. The 250-year-old world's widest banyan tree at the Acharya Jagadish Chandra Bose Indian Botanic Garden in Kolkata is such a tree. This tree is quite interesting because it has survived without its main trunk of 50 feet wide. In 1925 it got infected by a fungus but it survived because of thousands of roots protruding out of the branches. Calling it a 'banyan forest' would be more appropriate as it is spread around four acres of land, like a forest. The banyan tree is another appropriate metaphor for the BHCSP [IB3,4,12,15,19, 20]. Even if the programme funding stops, its spirit will survive thanks to so many offspring and the many minds it has influenced.

Figure 1. The 250-year-old world's widest banyan tree at the Indian Botanic Garden in Kolkata


MY ANCESTORS SURVIVED THE DINOSAUR EXTINCTION!
JUST WASH YOUR HANDS, AND ALL WILL BE FINE!
GRRR!
FAILING POLITICAL SYSTEMS
NEOLIBERALISM
CLIMATE CHANGE
COVID 19
SHOULD WE CARE?
SW.

## Messages in a bottle

- The potential added value of an international cooperation programme is more than merely providing financial and technical support. It goes beyond project cycles. It is about a long-term partnership nurturing spaces to exchange global experiences relevant to local health systems and about connecting to a wider national and international network and movement for social justice.

- The added value of a development programme should not be measured by its coverage or by picking the 'low-hanging fruits' (like building tubewells) or by the number of research papers on confined topics ('under the dictate of the P-value'), but by its understanding of the broader determinants of change and by trying to tackle them structurally.

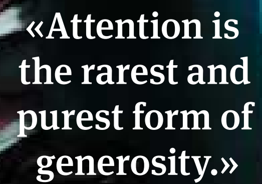
- A development support programme may demonstrate that the operational strategies developed within the context of the programme have the potential to become sustainable. But it is up to the local system to decide whether it will sustain these strategies.

- The ultimate indicator of the programme is that people themselves become in charge and not the NGO partner ('from Forum to movement').

- This programme is about attitude ('it's the attitude stupid'): radically accepting reality, making sense of it, giving perspective to people's autonomy, seeking options to move forward and embracing setbacks as part of growth. This will yield wise leaders, whether they manage a family, a health centre, a district, an NGO or a district forum.

- Healthcare is a right, social protection is a right, ability to make informed choices is a right. There is no equality without such rights. Hence, there is a need to go beyond service delivery and engage in advocacy work based on evidence and detailed documentation of experiences.

- By taking a life-course perspective regarding health, it would make sense that health actors may take up a role of accompanying people in the choices they make during their life concerning their own health or the health of their family.



«Attention is the rarest and purest form of generosity.»

SIMONE WEIL

# Statements of BHCSP actors

*"Like other projects, BHCSP does not build a parallel or alternative system, it strengthens the existing health system. It takes time but brings sustainability."*

*Mr. Govind Pradhan, President, Peoples' Forum, Darjeeling*

*"Through BHCSP, we have been able to gain credibility with the government and as a result, we have been given the responsibility of running 'patient support centers' in several government health centers."*

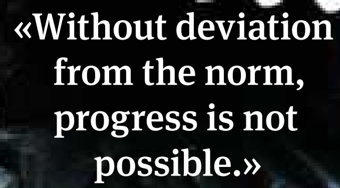
*Niranjan Paik, Coordinator, Swanirvar, North 24 Parganas*

*"Women are spontaneously demanding health services. This has never been seen before and so, has increased the interest and dedication of healthcare providers to work."*

*Sankari Bera, Health Facilitator, IITD, South 24 Parganas*

*"The programme helped us build strong partnerships with Government and other stakeholders."*

*Mr. Gautam Chakraborty, Secretary of Itarai Asha Deep*


«Without deviation
from the norm,
progress is not
possible.»
FRANK ZAPPA

*"BHCSP will not only limit itself to healthcare but will continue to be involved in other community development activities."*

*Suchita Das, Secretary, Suchetana, South 24 Parganas*

*"People have realised that health is equally important like food, clothes and shelter."*

*Minakshi Gayen, Coordinator, SSDC, South 24 Parganas*

*"We, the Darjeeling partners, can go together to the district level to advocate for uninterrupted health services and ensure the safety of service providers."*

*Shikha Khawas, Coordinator, Seva Karya, Darjeeling*

*"The politics of giving things away for free creates challenges for BHCSP and its ideology."*

*Bhabani Mal, Health Facilitator, INSS, South 24 Parganas*

«Speed is irrelevant if you are going
in the wrong direction.»
MAHATMA GANDHI

*"The thematic groups created by this programme will carry forward their activities through building a working relationship with the service providers."*

Sushanta Mondal, Coordinator, PSJS, North 24 Parganas

*"I understand the importance of adolescent healthcare and do not hesitate to discuss the issue with authorities."*

Sanchayita Khan, Adolescent Group, AGP, South 24 Parganas

*"Due to political changes, it sometimes takes a long time for some newly elected leaders and members to understand BHCSP."*

Manoj Porel, Coordinator, IAD, Howrah

*"As members of self-help groups, we can now incorporate our needs into government health plans."*

Divya Gurung, SHG Member, Darjeeling

«Kindness is the language
which the deaf can hear and
the blind can see.»
MARK TWAIN

*"The programme has transformed me from a housewife to a skilled health worker. I can take the problems of the villagers to a higher level on their behalf."*

*Tanusri Ghosh, Health Facilitator, KFSC, South 24 Parganas*

*"For the first time in my life, I have found a place where I can share my pain and my worries with everyone and get advice on how I can have a better life."*

*Asmatara Begum, Member, HNP+ Howrah.*

*"Women are spontaneously demanding health services. This has never been seen before and so, has increased the interest and dedication of healthcare providers to work."*

*Sankari Bera, Health Facilitator, IITD, South 24 Parganas*

*"The health fund is our strength. When I fell ill, I did not have to borrow money with a high rate of interest from a moneylender for my treatment."*

*Shibani Samanta, Member CHF, SSDC, South 24 Parganas*

«A good leader inspires people to have confidence in the leader,
a great leader inspires people to have confidence in themselves.»

**ELEANOR ROOSEVELT**

*"BHCSP is an Action-research work. People understand how to exercise their basic right to health. They believe in learning by doing."*

*Mahbul Baidya, Coordinator, SEVA, North 24Parganas*

*"Despite having good relations with government authorities, it is often difficult to get official praise from them."*

*Gour Mondal, Secretary, The BVNEWS, North 24 Parganas*

*"Frequent transfers of government officials and building relationships with new officials is a major challenge of the programme."*

*Basudeb Mondal, Coordinator RLSK, South 24 Parganas*

*"The financial documentation system of BHCSP has impressed other donors to work with PPUS."*

*Hassan Zaman, Coordinator, PPUS, North 24 Parganas*

«If you want to go fast go alone.
If you want to go far go together.»

**AFRICAN PROVERB**

# Milestones and partners

BHCSP is one of the rare programmes that has been implemented for 20 years and evolved. Here is a factual account of the various phases in the lifecycle of the BHCSP up to now. Hopefully, this will allow the readers to understand the evolution of the BHCSP more tangibly and operationally.

| *Year* | *Milestones* |
|---|---|
| 2002 | The first workshop in Kolkata with WBVHA, Partners and Memisa is held, exploring a partnership on health for West Bengal. |
| 2003 | Eight grassroots NGOs in South 24 Parganas form a platform with the support of WBVHA and Memisa and start working together to develop a joint project focusing on improving the public health services. |
| 2004 | A need assessment involving the community and stakeholders is conducted, including the government healthcare providers, on the existing public health services in 41 villages of five subdistricts in South 24 Parganas in West Bengal. |
| 2005 | The BHCSP is officially launched to improve the quality of public healthcare services and strengthen the local health system in 41 villages of 5 subdistricts in South 24 Parganas in West Bengal. |
| 2006 | The focus of the target areas is shifted to GPs and Subdistricts (Blocks) rather than working in isolated villages in a GP and working collectively in prioritised subdistricts. The decision was to cover all the villages of each GP identified for support. |

| *Year* | | *Milestones* |
|---|---|---|
| 2006 | | The performance of Village Health Committees (VHC) formed by the BHCSP is reviewed, using a set of indicators and assisting the VHC to enhance their competencies and starting a health forum in a selected village on a pilot basis in some GPs. |
| 2007 | | The concept of Social Mobilisers in villages is introduced in the BHCSP to support the Primary healthcare services (later on the ASHAs took over this role). |
| | | A collaboration with the traditional healers like RMPs, Traditional Birth Attendants (Dais) and others is started in South 24 Parganas, including training. |
| | | The NGOs from North 24 Parganas and Howrah spontaneously come to a BHCSP workshop to know more about the programme. |
| 2008 | | There is a strategically focus on cross-cutting issues such as gender, environment, multi-sector approach, HIV/AIDS |
| | | There is a collaboration with the ICDS to initiate growth monitoring, focusing on Weight for Height. |
| | | The BHCSP expands to the districts of Darjeeling and West Sikkim. |
| | | There is an engagement of the VHCs in the Village level health planning through a participatory process. |

| Year | Milestones |
|---|---|
| 2008 | The PRIs co-opt the members of the village development committees as members of Village Health and Sanitation Committees (VHSNC) introduced under the N(R)HM, which avoids duplication of the group within the community. It is also a recognition of the ongoing activities. |
| | A district level convention of Central Health Committees of the GPs is organized where the members can interact with the concerned government officials on various ongoing health schemes, services and issues concerning its accessibility. It provides visibility to the BHCSP. |
| | The BHCSP Team leader attends the course on strategic management of local health systems in ITM Antwerp as part of Human Resource Development. |
| 2009 | NGO partners are invited to join GP/Subdistrict level health and other committees of the Government. |
| | The first district level adolescent convention on Reproductive and Sexual Health and the role of Adolescents in Basic Health Care Programme in South 24 Parganas is held to highlight its relevance and importance and evolve policies and activities supporting them. |
| | There is a collective Health Forum response to the AILA cyclone in North 24 Parganas and South 24 Parganas during May – October 2009. It helps in evolving joint planning with Government and community and deepening the relationships and building trust among them. |

| *Year* | *Milestones* |
| --- | --- |
| 2010 | The Forum engages with Ram Ganga, Kautala, Durbachati and Manmathapur Gram Panchayats to develop GP health plans on a pilot basis, which encourages other members to associate with health planning in their respective GPs in the programme area. |
| | The BHCSP decides to support the Government to implement NRHM policy at the grassroots level and rectify gaps in its operational policy. |
| | The BHCSP expands its partnerships to North 24 Parganas and Howrah districts. The total number of NGO partners of BHCSP grows to 42. |
| 2011 | The Theory of Change of the BHCSP is formalized. |
| 2012 | The District Health Forum members are involved in the implementation of the Community Health Care Management Initiative (CHCMI) and intersectoral coordination for public health at the GP level. |
| | A BHCSP representative becomes a member of the State ASHA Mentoring Group. |
| | There is a collaboration with Chittaranjan National Cancer Research Centre, Government of India, in community level screening, prevention and control of cervical cancer. |
| | A private company requests that BHCSP help them with setting up a HIV care and response programme in Howrah. |
| | Self-help Groups initiate Community Health Funds within their groups. |

| Year | Milestones |
| --- | --- |
| 2013 | Rich Pictures are used for the first time in BHCSP. It's a powerful tool to express the different dimensions of the programme. The partners and community members start using rich pictures widely as part of their reflections and reviews. |
| | The BHCSP introduces the process of action-reflection at all levels (System approach with double anchorage). |
| | A NGO Partner's convention is held on redefining the role of NGOs in strengthening the local health system and making it responsive to the emerging challenges at the District, Subdistrict (block), and Panchayat level. |
| 2015 | There is a specific focus of the Forum on Advocacy and Policy aiming to influence the following areas: enhancing accountability and transparency mechanisms at local health institutions, facilitating community monitoring of health activities at the community level by VHC, advocating on -spot feeding at the Integrated Child Development Centres and streamlining the untied funds for the health subcentres. |
| | The peer-to-peer learning from SHG to neighbouring SHG (outside the BHCSP) starts with a focus on the Community Health Fund. |
| | Community members are donating land to construct ICDS and subcentres in several GPs due to the forum's advocacy initiatives. |
| | The concept of cluster meetings between the NGO partners of the District Health Forums for sharing, learning and nurturing joint action is introduced. |

| *Year* | | *Milestones* |
|---|---|---|
| 2015 | | The Forums start to work on four thematic working areas: Malnutrition, Adolescent, Women's Empowerment and Geriatric Care. |
| | | A state-level consultation on the draft National Health Policy is organised with various stakeholders, including community representatives. The recommendations are shared with the National Ministry of Health and Family Welfare |
| | | One of the senior leaders of the BHCSP team completes a Master's in Public Health from ITM Antwerp. |
| 2016 | | The Theory of Change and principles of the BHCSP are revisited leading to a new framework for programme interventions. |
| 2017 | | The Forums expand their partnership with the state, civil society, academia, and public and private practitioners to strengthen the local health systems. |
| | | The capacity and credibility of the Forum are recognized. The health authorities of Howrah and South 24 Parganas entrust the Forum to build the capacity of the VHSNC in all the villages. |
| | | The field level partners of Sikkim have to step out of the BHCSP as they don't have official registration for accepting foreign donations. |
| 2018 | | The Forum enhances the capacity of ANMs in four districts in the areas of managing VHSNC, establishing transparency and accountability, providing counselling support, and managing stress. |

| *Year* | | *Milestones* |
|---|---|---|
| 2019 | | The International Conference on Primary healthcare and People-centred health governance in West Bengal is organized, sharing experiences of 17 years of building partnerships to strengthen health systems in India.<br><br>A state-level interface meeting looking into the needs and concerns of elderly people is facilitated, bringing together the state-level health leaders and NGOs. The State Government of West Bengal includes the recommendations in the draft state-level health policy. |
| 2020 | | There is a collective response to Covid-19 in collaboration with the Government in all the districts. The Forum becomes part of the district task force on COVID -19 Management. |
| 2021 | | The experiences of the BHCSP are written down by a group of 10 co-writers. |
| 2022 | | The Story and Image book twin-books Sailing below the waves: A 20 years journey of Primary Health Care in India and a RICH Picture book |

## Who were the crews embarking on the sailing journey?

The following contains a list of partners we worked with in the BHCSP for more than three years.

*WBVHA*
WBVHA TOWER, 580 Anandapur,
3rd Floor, Kolkata, West Bengal, India
Email: wbvha 1974@gmail.com
Website: www.wbvha.co.in

*Memisa België*
de Meeûssquare 19 – 1050
Brussels, Belgium
Email: info@memisa.be
Website: www.memisa.be

### *The NGO partners in South 24 Parganas District*

*Ashurali Gramonnayon Parisad (AGP)*
Chittraranjan Das. Secretary
Block: Diamond Harbar-II
Email: agpamrita@gmail.com

*Human Development Centre (HDC)*
Atiyar Rahaman Sardar, Secretary
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Email: humandc@gmail.com

*Ramakrishna Loka Seva Kendra (RLSK)*
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*Bhetkipur Family & Child Welfare Society (BCFWS)*
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*Arpan Mahila Samiti (AMS)*
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*Suchetana*
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## *The NGO partners in North 24 Parganas District*

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*SWANIRVAR*
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Email: swanirvar446@gmail.com

*The Basirhat Vidyasagar New Educational & Welfare Society (BVNEWS)*
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*Community Health & Environment Conservation Society (CHECS)*
Pemba Sherpa, President
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## Friends of the Forum

They are strategic partners of the BHCSP coming together once or twice a year to give advice from multiple perspectives and act as a mirror. They are composed of academic groups, government people and people from the private sector.

- Institute of Public Health, Bengaluru, India
- All India Institute of Hygiene & Public Health, Kolkata, India
- Institute of Tropical Medicine, Antwerp, Belgium
- Calcutta Metropolitan Institute of Gerontology, Kolkata, India
- Indian Statistical Institute, Kolkata, India
- Tata Institute of Social Science
- Indian Institute of Health Management and Research, Joypur, India
- Indian Institute of Health Management and Research, New Delhi, India
- Azim Premji University, Bangaluru, India
- Centre for Health and Social Justice, New Delhi, India
- S.P. Jain Institute of Management and Research, Mumbai, India
- Ministry of Health & Family Welfare, Govt. of West Bengal
- Ministry of Panchayat & Rural Development, Govt. of West Bengal
- Ministry of Women and Child Welfare, Govt. of West Bengal
- Ministry of Social Justice and Empowerment, Govt. of West Bengal

## LOCAL RESOURCE MOBILISATION OF COMMUNITY AND PARTNERS THROUGH BHCSP

| Activity | No of families benefited | No of people benefited | Total resource mobilised (INR) | Total resource mobilised (Euro) | Remarks |
|---|---|---|---|---|---|
| Installation of low cost sanitary toilets in collaboration with PRI | 425 | 2125 | 425,000 | 5,000 | The government contributed 80%. The total cost was Rs.1000/- per toilet. |
| Linking with disability pension scheme (Manobik Pension) | 884 | 4420 | 24,180,000 | 284,470 | The scheme provides Rs. 1000/- per month to people with a disability of more than 50%. 884 people have received the benefit since 2018. |
| Old age pension scheme (Joy Bangla scheme) | 751 | 3755 | 12,200,000 | 143,529 | Launched in April 2020. It is a pension plan for the underprivileged (Scheduled caste and Tribe). Each month, each beneficiary receives Rs. 1000/-. |
| Old age pension scheme for general population | 1407 | 7035 | 18,710,000 | 220,117 | Each BPL family over the age of 60 receives Rs. 1000 per month. |
| Widow pension | 308 | 1540 | 9,180,000 | 108,000 | Widows from the BPL category are entitled to Rs. 1000/- per month. |
| Construction of 31 ICDS centres with the donation of land by community | 3100 | 15500 | 18,600,000 | 218,823 | The community donated land for the construction of the ICDS centre. The government provided a grant of INR 6,00,000/ per building. |
| Mobilizing govt. fund for construction of sub centre (Darjeeling) | 600 | 3000 | 2,397,482 | 28,205 | They recieved a grant of Rs. 23,97,482 from the government for construction of the Sub centre. |
| Local initiative at the village level | 126 | 6525 | 324,755 | 3,820 | They mobilised resources to construct garbage pits, incinerators, a water tank and repaired the road to the sub-centre. |
| Community Health Fund (CHF) in 591 SHGs | 5910 | 29550 | 3,044,956 | 35,823 | Every month, SHG members contribute to the CHF, which is distributed to members in times of health crisis. |
| Linking community with Social Security Scheme (SSY). | 10559 | 52795 | | | At 60, each SSY member will begin receiving a pension of INR 9,000 (Euro 105) per year. |
| Linking with government health insurance scheme (Swasthya Sathi) | 13225 | 66125 | | | Each registered family receives insurance coverage worth up to INR 5,00,000 (EUR 5882) per year. |
| | 37295 * | 192370 * | 89,062,193 | 1,047,790 | * Various schemes would have benefited the same families or individuals |

«In theory, theory and practice are the same. In practice, they are not.»

ALBERT EINSTEIN

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## Preface


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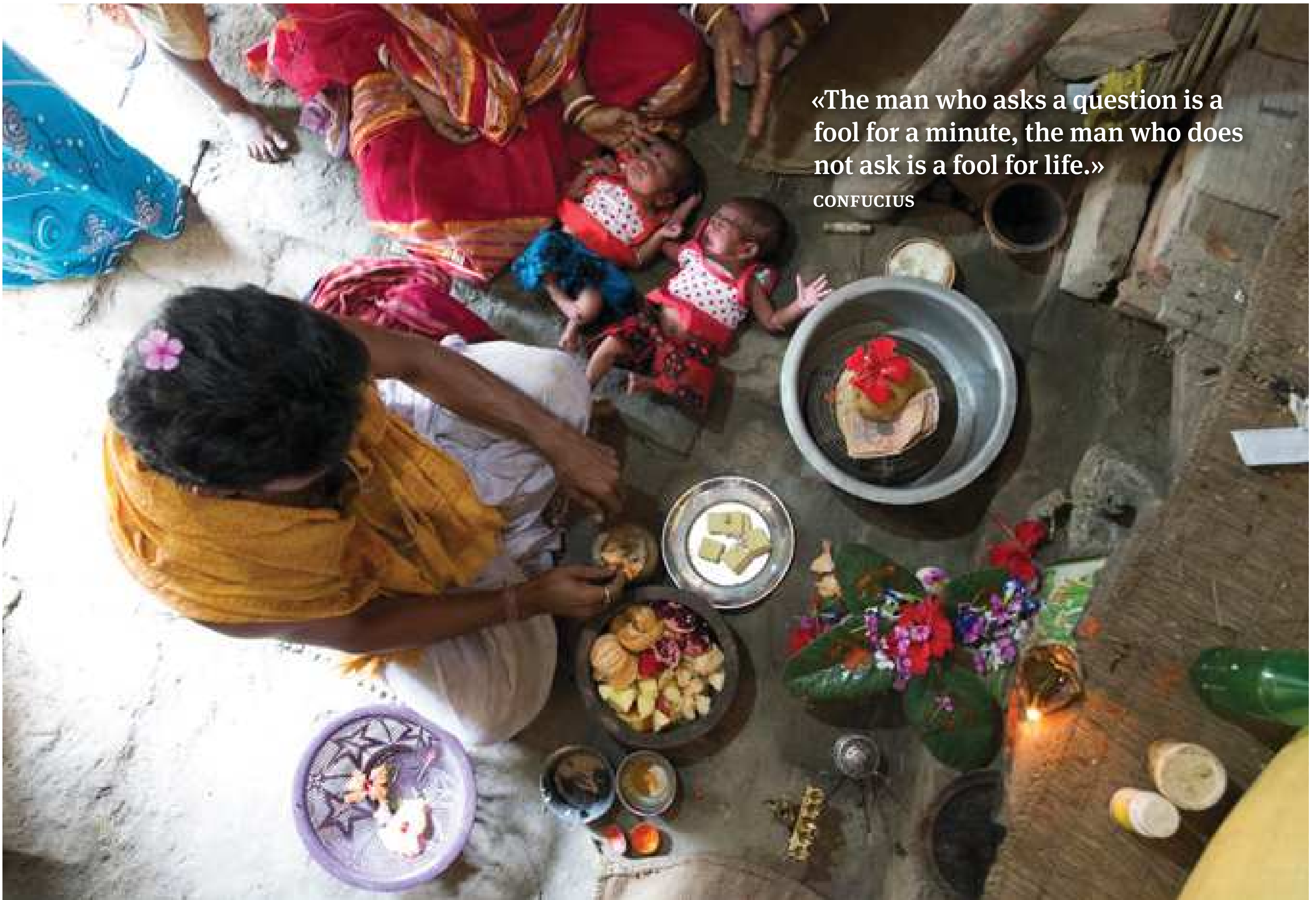
«The man who asks a question is a fool for a minute, the man who does not ask is a fool for life.»
CONFUCIUS

# Reflections and notes from the reader

POVERTY IS NOT JUST THE LACK OF MONEY; IT IS NOT HAVING THE CAPABILITY TO REALIZE ONE'S FULL

INNOVATION IS NOT ABOUT CREATING

EXPLORING THE BOUNDARIES

LOCAL SOLUTIONS TO LOCAL PROBLEMS

PLAN FOR SAILBOATS, NOT FOR TRAINS

I CAN DO THINGS YOU CANNOT, YOU CAN DO THINGS I CANNOT

WITHOUT DEVIATION FROM THE NORM, PROGRESS IS NOT POSSIBLE (FRANK ZAPPA)

MAHATMA GANDHI

OUR GREATEST ABILITY AS HUMAN BEINGS IS NOT TO CHANGE THE WORLD BUT TO CHANGE OURSELVES

DESIGNING A COMPASS TO SAIL BEYOND THE WAVES

SAILING TOWARDS THE OPEN SEA

WINDS AND CURRENTS

WE'RE CAUGHT IN A WORD NET!

THIS IS THE END!

POTENTIAL AS A HUMAN BEING (AMARTYA SEN) - SUBSIDIARITY & EMPOWERMENT

STORIES OF SOCIAL CHANGE AND ... CHALLENGING CONTEXTS

PEOPLE, JOURNEYS AND DESTINATIONS - A FEW STORIES

ORIES AND PRACTICES OF CHANGE USING ACTION-RESEARCH - WITHOUT DEVIATION FROM THE NORM, PROGRESS IS NOT POSSIBLE (FRANK ZAPPA)

LIVING IN THE HIMALAYAS AND THE GANGES

TONOMY. THE MOST COMMON WAY PEOPLE GIVE UP THEIR POWER IS BY THINKING THEY DON'T HAVE ANY (ALICE WALKER)

I CAN DO THINGS YOU CANNOT, YOU CAN DO THINGS I CANNOT; TOGETHER WE CAN DO GREAT THINGS (MOTHER TERESA)

BUILDING BOATS AND FLEETS - WITH DESIGN OF HEALTH FORA FOR STRONGER LOCAL

LINKING UP ACROSS AND STRENGTHENING CURRENTS, EXPLORING THE BOUNDARIES

A PICTURE IS WORTH A

BUILDING STRONG FISHING CREW AND CATCHING SOME FISH

THE PROBLEM IS NOT TO IRON OUT ALL DIFFERENCES, BUT HOW TO UNITE WITH ALL DIFFERENCES

INTEGRATING STUFF FOR BENCHMARKERS IS A

THE TRUE MEASURE OF ANY SOCIETY CAN BE FOUND IN HOW IT TREATS ITS MOST VULNERABLE MEMBERS (MAHATMA GANDHI)

THE MAN WHO ASKS A QUESTION IS A FOOL FOR A MINUTE, THE MAN WHO DOES NOT ASK IS A FOOL FOR LIFE (CONFUCIUS)

IF YOU THINK YOU ARE TOO SMALL TO MAKE A DIFFERENCE, TRY SLEEPING WITH A MOSQUITO

LINKING UP ACROSS AND STRENGTHENING CURRENTS

SV

If you think you are too small to make a difference, try sleeping with a mosquito. – DALAI LAMA

How to deal with complex environments?
How to put people's needs, autonomy and rights at the centre of development?
How to bring together the actors of the local health system?
How to connect the grassroots and the policy-level?
How to sustain change?
How to do development differently?

This book doesn't provide the answers but shares the lessons and challenges of a 20-year experience. It's part of a twin-book-publication: a Story book and an Image book. Together they tell the remarkable story of the Basic Health Care Support Programme, a development support programme intended to improve the health and well-being of people living in close to 2000 villages of West Bengal and Sikkim, two states in eastern India. A journey of muddling through.

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