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ORIGINAL RESEARCH

Towards strengthening primary health care: Lessons from a government-civil society collaborative intervention in India

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ABSTRACT

Introduction: The need to strengthen comprehensive primary health care towards ensuring "Health for All" is well established yet operationalizing this has remained a challenge globally as well as in India. Based on a qualitative study of a collaborative initiative between the government and a civil society organization, this article discusses what factors and processes explain successful implementation of primary health care in a remote rural area in central India.

Methods: Data were drawn from in-depth interviews (n=27), observations of health facilities including outreach clinics as well as conversations with the staff during these visits (n=17 visits) and document analysis of Minutes of Meetings, Memorandum of Understanding, Project Reports and Government Circulars. Data were collected between December 2022- April 2023. Data were analyzed concurrently with data collection. Suitable themes and sub-themes were identified after juxtaposing different sources of data to construct a story of the initiative keeping a close eye and ear on the role of different actors, contexts, processes and their implications.

Results: Our findings show how policy actors' interpretation of the shared cause of the initiative, 'experiencing' contextual and feasible evidence, building and nurturing partnerships across different levels and actors were key to the implementation of this initiative. Additionally, values including equity, community participation, patient centered care and organizational culture were equally central to this effort.

Conclusion: Our findings reiterate the central role of the philosophy and values of primary health care in its implementation. These also resonate with the theoretical literature that draws attention to the need to investigate complex intersections of power, actors' interests, ideas, and contexts in the study of health system policy implementation.

Keywords: Primary health care, equity, qualitative, government, civil society, India.

Abstract in Español at the end of the article

INTRODUCTION

The need for strengthening comprehensive primary health care towards ensuring Health for All is a foregone conclusion. Yet many countries across the world including India have struggled to fully operationalize it. Debates around feasibility of comprehensive Vs selective primary health care, horizontal vs vertical and community and/or health facilities-based care are age-old in

the history of public health yet continue to be relevant in the current context [1]. In the light of the persistent concerns around health inequities across the globe, increasing burden of non-communicable diseases, existing and emerging infectious diseases and rising costs of hospital centered care, the need to revitalize comprehensive primary health care has been reiterated [1-6]. The WHO and UNICEF in a recent operational guidelines document on primary health care reinforce this need stating: "The demonstrated links of primary health care to better health outcomes, improved equity, increased health security and better cost efficiency make primary health care the cornerstone of health system strengthening" [7]. Scaling up primary health care interventions across low-and- middle income countries could indeed have a significant impact on saving lives and increase average life expectancy by 3.7 years by 2030 [8]. Some argue that the call for the Sustainable Development Goals and Universal Health Care offer important opportunities to reinvigorate primary health care and reinforce principles of equity, universality, comprehensiveness and intersectoral action [9-11].

There is enough evidence to suggest what and how primary health care has worked/not worked across different country settings [1,6,9,12-16]. More specifically, several experiments spearheaded by non-governmental organizations in India have demonstrated how comprehensive primary health care can be operationalized [17-19]. One constant lesson from this evidence is not to conflate primary level of care with primary health care. Further the provision of a range of services for example distribution of Iron supplements, deworming, immunization does not necessarily translate into comprehensive primary health care [20-21] Primary Health Care (PHC) as an approach that espouses principles of equity, universality, community participation, comprehensive care including curative, preventive, promotive, appropriate use of resources and intersectoral action remain central to its practice [15, 22-24].

Such an approach of PHC resonates with the conceptualization of health systems as core social institutions and 'not simply a mechanical structure to deliver technical interventions the way a post office delivers letters' [25]. Such a lens embeds health systems in the larger political and social structures and draws attention to the power structures, actors, ideas, values and interests that shape the way health systems function [26-28]. Scholars hence draw attention to the metaphors to argue why it is not only the 'hardware' (infrastructure, human resources, finance, technology, medicines etc.) but the software' (actors, ideas, interests, power, values, relationships) is critical to understanding health systems [29]. Nested within such a conceptualization of health systems, recent scholarship on health policy implementation demonstrates the usefulness of an interpretative understanding highlighting the role of different actors, micro-practices of power and contexts that shape both processes and outcomes of policy measures [30-31] including primary health care [13-14].

Drawing on this literature on health systems and policy implementation, we discuss here about a collaborative initiative towards strengthening primary health care named Pushparajgarh Health and Nutrition Initiative (PHNI). This was implemented collaboratively by the Government of Madhya Pradesh and a grassroots organization in central India - Jan Swasthya Sahyog (JSS).

The Pushparajgarh Health and Nutrition Initiative (PHNI): A background

PHNI was implemented in a district in the state of Madhya Pradesh in central India collaboratively with Jan Swasthya Sahyog (JSS). In terms of the size of the population, Madhya Pradesh is the fifth largest state in India with a population of 72.6 million (Census 2011). The share of the tribal (indigenous) population in the state is quite high with 21% of its total population and 14.7 % of the total tribal population of India. As per the recent National Family and Health Survey -5 data, the Maternal Mortality Ratio (MMR) in the state at 173/100,000 is higher than the whole of India figure at 113/100,000. The Infant Mortality Rate (IMR) and Under-5 (2019-2021) mortality stand at 33.9 and 38.2 respectively and 33% of children under 5 years of age continue to be underweight. There are significant variations among districts and social groups, specifically districts which have higher tribal population bearing a disproportionate burden of adverse health outcomes.

JSS is a grassroot organization working in the neighboring state of Chhattisgarh in central India. Founded in 1996 by a team of socially conscious doctors, it is committed to providing low-cost high-quality care including surgical and obstetric care addressing the social determinants of health including poverty, nutrition and gender [32]. It caters to more than 250,000 patients from close to 2500 villages in the state of Chhattisgarh and neighboring districts of Madhya Pradesh. The larger principles of equity, community embeddedness, comprehensiveness and responsiveness guide all components of the work that the organization does. The work has shown how comprehensive primary health care could be operationalized through providing appropriate training and mentoring support to a cadre of village health workers in the communities, mid-level health care providers in the sub-centers (first level of formal health care system) and responsive referral services to the community hospital. The community hospital which is a 100 bedded referral hospital provides integrated care from diagnosis to follow up with suitable place for the patients and their families to stay during the period of consultation, diagnosis and treatment. Comprehensiveness in care is practiced not only to cover all aspects of care but to identify and respond to the health care needs of the communities through appropriate local epidemiological evidence. Provision of continuing mentoring support at all levels, use of appropriate resources (human, technology, data, finance) and people centered care are the pillars of JSS's

work [33]. The organization's model of comprehensive primary health care follows the institutional structure of the government and demonstrates the feasibility of primary health care in government settings. Hence PHNI was inspired by JSS which shows how sub-centers can be made functional with timely and adequate referral services on the one hand and strengthening community engagement through village level health workers and outreach clinics at the village level on the other.

In 2017, JSS got the opportunity to partner with the health department in the state of Madhya Pradesh to improve quality of maternal and newborn care in select public health facilities at the secondary care level. This was against the backdrop of the concern that while institutional deliveries had increased in the state, this had not necessarily resulted in a corresponding decline in maternal deaths. The project was titled Improving Government Facilities for New-Born and Maternal Health Care (IGUNATMAC, Memorandum of Understanding (MoU) 2017-2020, 2020-2023). This project, which was based on strengthening the quality of secondary hospital-based care, served as an entry point for the JSS to advocate with the state for strengthening primary health care that would include early detection of risks, provision of antenatal care as well as better referral linkages for IGUNATMAC to be effective. Further, the fact that many patients trekked to JSS to access care, often just to collect medicines for chronic diseases and follow up but were not covered under the host Government's insurance scheme added to the need for these advocacy efforts.

PHNI as a formal collaboration with the state government was initiated through a MoU to improve the quality of primary health care services including improving the nutritional status of children under three years of age (Government of Madhya Pradesh MoU 2017-2020). PHNI as per the MoU aimed to (a) strengthen primary health care by revamping sub-centers in specific areas through ANM (Auxiliary Nurse Midwife) mentoring, ASHA (Accredited Social Health Activist) refresher training, community engagement, and availability of dedicated ambulance at Primary Health Centers and Community Health Centers to ensure timely referrals; and (b) improve nutritional status of children under three years of age through *phulwaris* (hamlet based creches). *Phulwaris* are a community-based prevention and management of malnutrition program meant for children from six months – three years [34]. Hence while IGUNATMAC served as an entry point, the scope of PHNI was not limited to maternal health care but to strengthening primary health care through revamping the sub-centers.

Pushparajgarh block was selected for this effort as this was one of the remotest blocks with predominantly tribal communities with 74% of the total population in this block belonged to different tribal communities. The focus was on 75 villages in this block (of the total 250 villages) based on the situation analysis carried out by the JSS. A block in rural India is a sub-division within the district comprising of many villages (and village panchayats that refer to the village level local self-government units) that serves as an administrative unit for planning and implementation of development programs.

As part of PHNI, the focus was on rejuvenating the government sub-centers by making these functional. It is well established that a functional primary health care system has the potential to reduce health disparities by bringing care closer to the community with sub-centers (SCs) playing a critical role in the same. A sub-center in the Indian context is the first formal institutional point of contact with the health system for the local communities. It is supposed to provide a range of services including general outpatient and outreach services, maternal and child health services, immunization, family welfare and nutrition., control of communicable and non-communicable diseases. In India, the desire for a three-tier health care delivery structure closely connected with communities via the village level health workers and village health and nutrition days clearly exists in policy documents. This has received a boost through the National Rural Health Mission in 2005 (Figure 1), yet the functionality of the last mile connect has always been challenging.

The situation analysis carried out by the JSS in 2017 in Pushparajgarh block had revealed the dire state of primary health care system comprising of deficient infrastructure, inadequate human resources, unreliable transport service, and expensive and relatively absent or poor-quality private health care. It was found that less than 30% deliveries took place in public health care facilities with less than 40% of women availing two or more antenatal care. Problems with access to health care were accentuated due to the hilly terrains and dispersed hamlets in this block. Roads still remained absent at many sites with significant implications for access to routine and emergency care. This context had important implications not just for justification of the selection of the block but the components of PHNI. The study was carried out to understand what factors and processes allowed successful implementation of PHNI. Our intention was not to evaluate the intervention but to document the initiative including context, role of different actors, practices, processes and experiences to infer learnings for primary health care implementation specifically on where and how collaborative efforts with the government in implementation of health system policies could work.

METHODS

The study followed a qualitative method of inquiry drawing on the theoretical literature on health systems policy implementation [13, 21,31,40-41]. While the sub-centers were located in Pushparajgarh block, the team travelled to the state headquarters, the district collectorate as well as JSS field sites in Chhattisgarh for interviews and observations. Data were collected during December 2022- April 2023. Data collection involved

Figure 1. India's rural public health care delivery system (source: Azim Premji University 2023).

understanding the process of how and why the idea of the intervention began, who all were involved, the entire gamut of activities, processes, experiences and learnings.

Data collection was a collaborative process with faculty members from the University and the PHNI team at JSS. The faculty members were responsible for conducting the interviews. The PHNI team in JSS facilitated the data collection process apart from sharing their own journeys, experiences as well as regularly providing additional inputs for validation and interpretation when required.

We followed a purposive sampling to identify actors who were involved in PHNI from the decisions making (eg: MoU) to implementing the intervention at different levels – state, district, block and the villages. For the village level health workers and representatives of self-government, we sampled purposively (for the purpose of in-depth interviews) considering the criteria of timeline (mix of those who were involved in different phases of PHNI), years of experience and remoteness of villages. With the help of JSS, we did this mapping of different government officials (state and district levels and different departments), community health workers, representatives of self-government and representatives of the grassroot organization who were directly involved in PHNI. We conducted in-depth interviews with all of them (n=27). Many officials who were involved then at the district level were transferred and hence we reached out to them in their new job sites and roles for the interviews. Apart from interviews, we visited 10 government sub-centers which were part of the revamping effort, the referral hospital and the model sub-center in JSS (that had shaped PHNI), creches as well as Village Health and Nutrition Days (outreach clinics). We made 17 such visits and made detailed notes of what we observed including the nature of facilities, activities including interactions among the staff, patients and others who were part of these sites. Apart from these observations, we had conversations with the staff, patients and family members at these sites which were important to supplement as well as contextualize our observations. The detailed interactions (in the observations sites) with the community health workers including ANMs, ASHAs, ASHA supervisors, ANM mentors in the context of their everyday work during these visits were crucial to juxtapose the data from the interviews. We also had several informal conversations with the JSS staff during our bumpy rides to the villages and health facilities. These conversations have further enriched our understanding of the context and people involved in PHNI and beyond. We did a document analysis of the Minutes of Meetings, MoU, project reports and all the relevant government circulars pertaining to PHNI as well as photos of differ-

ent activities of PHNI that were documented in detail by the team. Photos were used as evidence and formed an important part of the periodic review and implementation of PHNI. Table 1 summarizes the data collection methods used.

Table 1. Summary of the data collection methods used.

Methods	Field site	N=Total
In-depth Interviews	PHNI • Government representatives (state and district level) • Representatives of self-government • Representatives of the grassroot organization (PHNI team)	N= 27
Visits, observation and interactions	• Government sub-centers • JSS sub-center and referral hospital • Village health and nutrition days (outreach clinics) • Crèches Observed the facilities, activities and interacted with the staff on these sites	N= 17 field visits
Document analysis	• Minutes of review meetings • Memorandum of understanding • Government circulars pertaining to PHNI (between 2018-2022) • Photos pertaining to different activities of PHNI	NA

Data analysis

Our analysis drew on data collected through all these methods and done iteratively along with data collection. It followed a thematic analysis identifying themes, interpreting key events, constructing the timeline of activities (sequential as well as parallel), juxtaposing and triangulating insights from different actors as well as different methods (eg. observations with interviews). A constant process of reading transcripts, interpretation and validation took place among the authors individually and collectively to construct the story of PHNI including why and how it worked. The analysis was led by the faculty team with constant sharing and validation of insights and interpretations with the partner organization team. Further external validation was done by having the findings peer-reviewed both by a practitioner who had experience of working in the state health system and an academic background.

Ethics

Ethical approval for the study was obtained from the Institutional Review Board in Azim Premji university (2022/SOD/Faculty/6).

RESULTS

PHNI: The hardware and the software

As discussed in the introduction section, PHNI resonated with the conceptualization of health system comprising of the hardware (infrastructure, human resources, medicines etc.) as well as the software (social and relational aspects through a focus on the actors, their values, interests) [29]. PHNI entailed strengthening primary health care in a material sense of repairing the buildings of sub-centers including improving road connectivity, power supply as much as strengthening the social and relational aspects of the system in providing continuous mentoring support, building trust with and empowering the communities as well as navigating through structures and practices of power to identify creative opportunities for its implementation.

Figure 2 summarizes the key activities including the timeline of these activities, Figure 3 cites the key components of the initiative and Figure 4 notes the actors involved as part of the rejuvenation of sub-centers as part of PHNI.

The activities began with repairing of physical buildings of the sub-centers. Assessment of such repair jointly by the JSS and civil engineering personnel from the Government that preceded it followed the norms of physical infrastructure as laid down in the Indian Public Health Standards (IPHS) of the Government of India (2012). Apart from fixing the broken windows/doors to the buildings, a boundary wall was erected for safety for each of the sub-centers. Other related facilities for outpatient services including bio-medical waste management, water and electricity supply drawing on support from many of these departments beyond health were

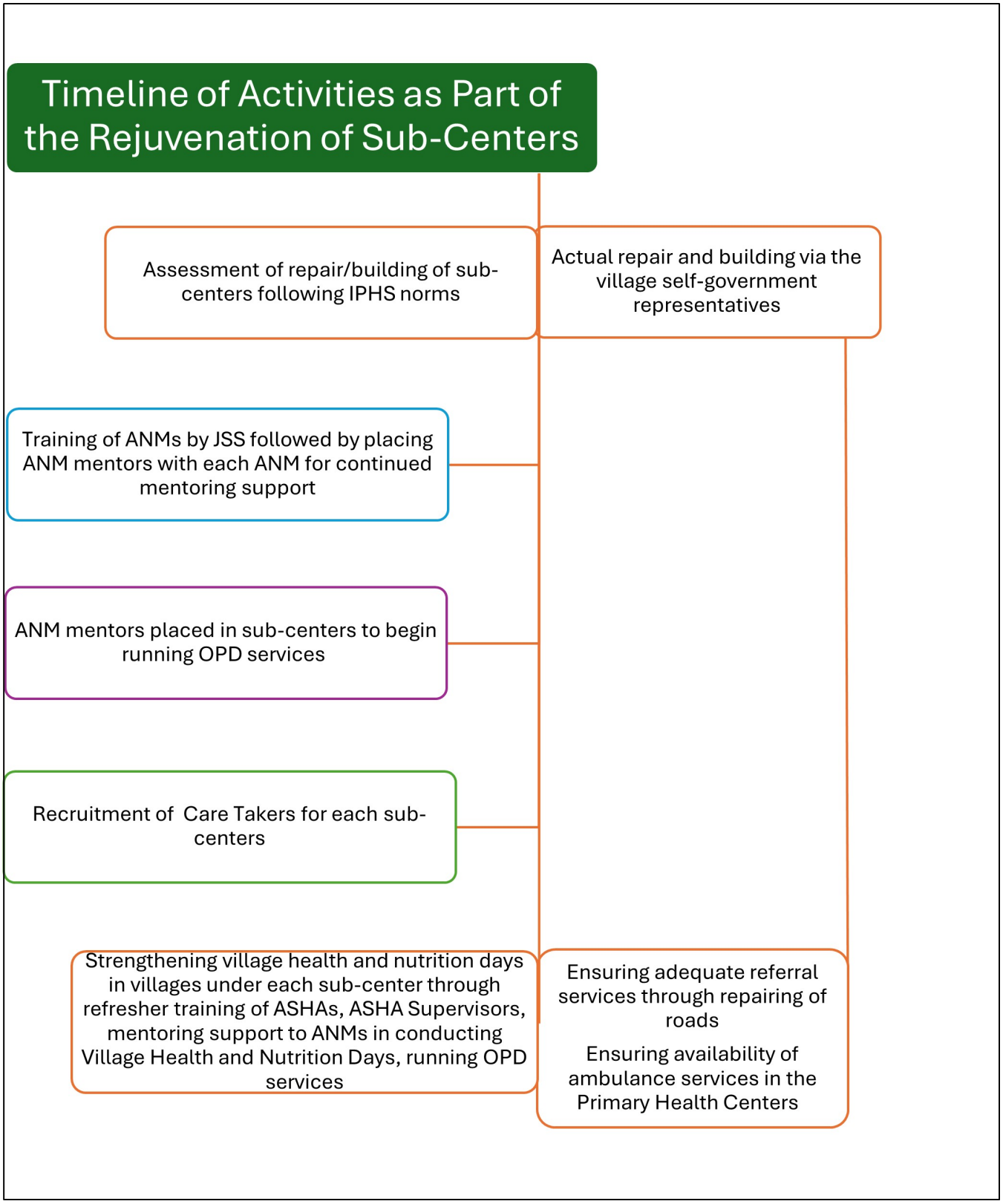

Figure 2. Timeline of activities as part of rejuvenation of sub-centers.

Figure 3. Components of the PHNI.

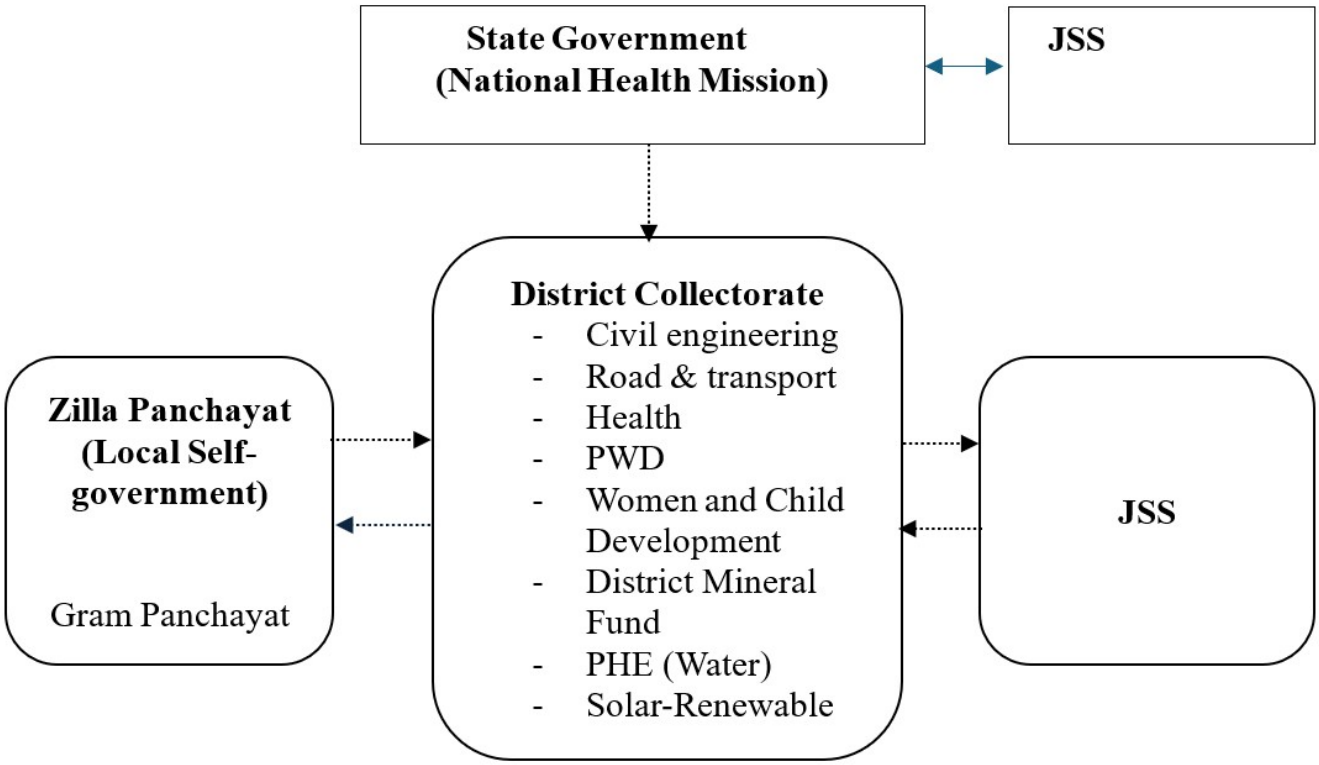

Figure 4. Actors involved in PHNI.

Figure 5. Rejuvenation of sub-centers in progress.

taken up. These departments included road and transport, water, civil engineering, Public Works Department (PWD) and Solar energy-renewable (Figure 5).

The buildings themselves could not ensure provision of care unless the road situation was improved. Hence provisions for repairing of roads leading up to the sub-centers were made capitalizing on other existing schemes of the government (Prime Minister Village Road Construction Scheme). Such opportunities were identified and facilitated by the district collectorate. Recruitment of ANMs (filling up the vacancies) and care takers (responsible for maintaining cleanliness of the sub- health centers) was done through Government circulars in each of the 10 sub-centers that were part of PHNI. Such recruitment was accompanied by adequate training both in technical skills as well as an overall orientation of patient centered care. The Government ensured that the ANMs were trained by the JSS on their campus in Chhattisgarh. JSS's pedagogy in facilitating learning is laden by their value system of serving the underserved in a non-judgemental manner. The quality of training through hands on experience as well as helping ANMs see their own strengths, listening to their own challenges and helping navigate these was critical. What the organization attempted to infuse via the trainings was not just technical skills but motivation and leadership. Such values followed an appreciative inquiry approach. The training made the ANMs, and village health workers (ASHAs) feel that they were critical to the system, and their work was valuable. One of the Government ANMs shared about this training:

> *"It was a very different experience. The ambience itself was so non-judgmental and non-threatening, something which we have not been used to. Everyone is so committed. Doctors in JSS were sitting with us on the floor. They were trying to understand our stories and appreciating what we could bring to the table and what more we can do. They showed us practically how to do OPD services, Village Health and Nutrition Days better."*

Another Government ANM added:

> *"I have learnt many new skills such as how to recognize and manage a critical pregnancy case, how to suture wound properly. My fourteen days of training at JSS hospital has helped me finetuning my skills."*

However, training cannot just be a one-time event. Enough evidence shows the importance of continued mentoring support which is well demonstrated in JSS's work. Hence, ANMs from JSS were appointed in the government sub-centers to provide regular mentoring

support on the job. Efforts were made to ensure that the village outreach clinics (Village Health and Nutrition Days as it is called in India) take place regularly by visiting the communities in the villages, building their trust on the system through the functional sub-centers, appointment of ANMs as well as garnering support from the self-government representatives (gram panchayats). In this context, the training of ASHAs and ASHA supervisors became critical. While the Government has an elaborate training manual, JSS adapted this manual to make it more hands on with several relatable examples. What is important to mention here is that none of these were just a series of technical activities, but built on the needs, strengths and contexts of the participants, which in this case were the village health workers.

PHNI led to 10 sub-centers being functional in providing services as per norms of IPHS. Six of these sub-centers were delivery points where normal deliveries could happen while four remained available for regular OPDs as well as outreach services. At the community level, the regularity and effectiveness of Village Health and Nutrition Days sought to be strengthened through mentoring support of ANMs, refresher training of ASHA and ASHA supervisors. Our visits to these sub-centers witnessed how patients were admitted for normal deliveries, high risk mothers were visited for their post-natal checkups in their homes or others came to the OPDs for a range of ailments. We met adolescent girls coming to consult the ANMs for their menstruation related concerns as much as the elderly people for their skin related ailments. Community members shared how they knew the exact days when ANMs were supposed to run the OPD services, when they would visit their villages for the outreach clinics. This helped them to know when to access different kinds of services. As one of the villagers who accompanied her husband for a major wound on the leg shared:

> *"We could see from a distance that the gate of the center was open. We knew ANM sister was there and would take care of this wound. It was worth walking from our village to come here."*

The newly built gate (that remained open during the day) symbolized the gradual restoration of a relationship of trust with and expectation from the health system through different services. In few sub-centers which never functioned in any capacity before PHNI, the trust in the center was however mediated through the trust in JSS ANM mentors. Villagers were familiar with the JSS referring to them as *Ganiyari* (the name of the place where JSS community hospital is based) staff as many from different villages had sought care from the hospital run by the JSS. Hence, the process of building and maintaining trust in the system via the sub-centers and the Village Health and Nutrition Days needs to be carefully nurtured beyond PHNI. This would also be dependent on the sub-centers to be able to cater to the existing and emerging local health needs including non-communicable diseases. At the time of the study, a new Government cadre of Community Health Officers (CHOs) was recruited in the sub-centers. With a B.SC nursing degree, the CHOs are supposed to man the sub-centers which have been renamed as Health and Wellness Centers implementing different national programs but more importantly the non-communicable diseases. Many of them who we met were new and the study could not capture their role in the sub-centers. More evidence would be needed on their role within the primary health care context specifically for responding to the changing disease burden including non-communicable diseases.

Explaining factors that shaped the collaborative implementation of PHNI

PHNI showed how different factors, which we describe below, facilitated this collaboration effort including how different actors navigated the systems to introduce innovations using their discretionary power for a shared cause – to rejuvenate sub-centers towards strengthening primary health care.

'Seeing and experiencing is believing': Evidence on comprehensive primary health care

The fact that evidence matters is beyond contestation. The need to strengthen primary health care through community ownership via village level health workers, bottom- up planning as well as functional community health facilities clearly exist in policy documents more explicitly in the National Rural Health Mission of the Government of India (2005). This is reiterated in the National Health Policy 2017 too. However, operationalizing primary health care has been a challenge for several reasons. These include bureaucratic functioning of the government systems, global prioritization of vertical targets, inadequate training support, resource constraints etc. [35]. "Many of these factors lead to hopelessness and frustration among frontline health workers who question the feasibility of operationalizing primary health care" as shared by a senior district level official. In this context, the visit of the district and state health officials (under the directive of the state) to witness the practice of comprehensive primary health care in JSS became significant. This visit, where officials spent a few days, helped them 'see in their own eyes' how primary health care could indeed be made feasible with similar social, community, geographical contexts, epidemiological burden, infrastructure and resources.

As one of the senior state level officials succinctly puts it:

> *"Our officers spent a few days to see how the team in JSS provides health care, how the sub-center Bamhani is running. What struck all of us was the way a health worker could manage the first level of care in the sub-center so effectively including treating snake bites (which are very common in this area). Once someone goes there and sees the work that the organization does with humility*

> *and dedication, one cannot afford not to notice it. The value system with which the entire team works and provides care convinced us for a collaboration with JSS to work on PHNI. It also gave us the confidence that if things could work here with similar resources as that of the government and with related social and geographic contexts, it could very well work in our settings."*

Reiterating the value of such evidence, a district official shared:

> *"In most cases NGOs work like journalists and keep pointing out problems only without suggesting or contributing to the solution. JSS is different. It has understood the problem and has come up with a feasible solution – of providing quality care in remote, rural and tribal areas. It has come up with an evidence-based solution that can be scaled up, for example a simple solution of providing accommodation for ANMs in the sub-center indeed made a difference in making the sub-centers being functional."*

Hence it is not just evidence per se but three points about evidence mattered here. The first, the evidence was relatable and spoke to the context - both the social and geographical (similar geography, similar social composition with predominantly tribal communities with related challenges and resources) and health system contexts. Second, such evidence was seen and experienced by the government officials who visited JSS. This added credibility to the evidence. Third, the fact that the JSS's model for operationalizing primary health care was not really resource intensive nor unsustainable was important. It was done with a similar institutional structure as in the Government. Hence relatability, feasibility and experiential learning of what and how such evidence did matter in this context.

Building relationships and nurturing partnerships

PHNI efforts showed how relationships among different actors at different levels needed to be mindfully and meaningfully built and nurtured. The MOU had stated the role and responsibilities of the Government and the JSS which was important. However, in actual implementation, the ways actors involved in these partnerships interpreted, made sense of and operationalized such collaboration was equally critical. The government and the JSS have different sources, forms and extent of power and legitimacy. The formal bureaucratic authority of the state is paramount. Many officials both at the state and district level explained why the Government gets suspicious of civil society organizations – 'many NGOs have intellectual arrogance 'we know things better than you kind of attitude, 'play more of an activist role pointing out the problems in the government' and 'not all NGOs have a deep social orientation like JSS'. Even when socially oriented NGOs partner with the state, it is important to understand what roles they could play. Explaining this a district official remarked

> *"No organization can run parallel to the government. It should work in close partnership with the government. Government has the capacity to do things at a scale. No matter how well-meaning NGOs like X, Y, Z, they cannot scale up. Leadership should remain with the government and NGO should be in an advisory and facilitating role."*

Explaining further, other officials clarified that:

> *"While the Government has all the resources in terms of programs and schemes, it lacks the skills to effectively engage with local communities. Officials at the local level get frustrated as much as the communities too. Organizations like the JSS have a long-standing experience of engaging with communities, they understand the needs of the community and respond to it accurately. So, in this case, JSS played an important role in strengthening the community connect with the system while the government played a facilitator/enabler role."*

Officials further explained what such enabling/facilitating role meant. This included helping the JSS navigate the state bureaucracy, easing paperwork, ensuring smooth fund flow, ensuring cooperation of all relevant departments but more importantly creating innovative opportunities within the system shaping PHNI process and outcomes. For example, while all other cadres like the ANMs, ASHAs, ASHA supervisors are prescribed human resource norms by the government, ANM mentors were not an existing cadre. JSS's experience demonstrated the value of continued mentoring support. Hence even if the provision did not exist within the Government system, state officials created such a provision. As the state and district officials explained:

> *"The government has a nursing mentoring system though not an ANM mentoring system. The suggestion from JSS for ANM mentors to provide continued support to the ANMs in the sub-center was not a difficult one and we thought we should be able to create such provision. Yet we needed a stronger rationale within the system. So, we randomly called a few ANMs and assessed their skills. We realized that they did not even have basic skill. One could not have sent them back to the college for reskilling them. So, when the idea of the mentoring system was proposed by the organization where an experienced ANM from JSS would be with ANMs in the government sub-centers to spend dedicated time and mentor them on the job, the government was ready to try this out."*

> "*As a senior official in the district, I helped JSS staff navigate the system. The government apparatus is mammoth. I ensured that there is no unnecessary paperwork and fund flow happens in a timely manner as this becomes an integral bottleneck.*"

Financing of resources was critical to the entire effort. While the government provided resources from the National Health Mission, it also played an important role in harnessing additional financial resources from the District Mineral Fund which has the mandate to provide funds for developmental activities of the district including health. The role of such opportunities for financial resources ensured that PHNI was implemented smoothly. Similarly, instead of advertising for tenders to do the civil work of repair of sub-centers, the Government officials decided to entrust this responsibility to the village panchayat (local self-government). This could ensure community ownership of health and hence sustainability beyond the PHNI. Village panchayats, despite a formal mandate, have played a minimal role in health. However, PHNI through the civil work provided a concrete opportunity for them to strengthen their role in health as the outcome of the effort was visible – functional sub-centers. This garnered additional legitimacy for the village panchayat. One of the village panchayat leaders shared:

> "*We know what JSS has done for our children through phulwaris. People usually do not understand the difficulties of our geography with such limited access to transport. Availing health services that are far away are extremely difficult. Hence when this opportunity came for us to participate in repairing and building the sub-centers for our people, we gladly cooperated.*"

While PHNI offered an important opportunity to strengthen the involvement of the village panchayats in health, not all of them were equally invested in this initiative. In few cases (two cases), the work had to be stalled due to corrupt practices, in another the panchayat leader took it up more as a routine construction activity with little or no appreciation of the potential long-term implications of the functional sub-center for the villagers. Many factors led to such varied investments including their own trajectories of leadership, dynamics with different groups within the villages, prior interactions (and experience) with the Government as well as the extent of familiarity with JSS's work.

JSS representatives on the other hand highlighted how an overall approach of an appreciative inquiry helped nurture the relationships across state, district and village level government staff strengthening and reiterating the shared and collaborative nature of the work. While appreciative inquiry has been widely used in organizational behavior, evidence on how this unfolds in different contexts and settings specifically in the context of health care is rare [36]. In this context, three important aspects of such an inquiry of affirmation, appreciation and dialogue were important. The first, PHNI remained a shared vision among different stakeholders involved specifically between the government (state and district) and the JSS. Hence it was important, as one of the PHNI team members shared to 'give the confidence to the government that we are there with them', 'we don't intend to find faults but be part of the solution process'. The second is nurturing the appreciative eye be it in training and mentoring the ANMs, ASHAs or working with other departments. The third referred to the need for granular attention to facts on the ground. One of the project staff in JSS explained these further:

> "*During the district review meetings, I realized that one needs to know one's facts very well. It conveys our serious intention and conviction in the shared cause. Our tone cannot be that of blaming the other person be it the government or any other and hence when one is conveying the problem (eg: an ANM not staying on campus, repair could not be completed on time), it is important to show what could this problem lead to in concrete terms, why and how we should address it instead of blaming the other person. This avoids the systems officials to get defensive.*"

A community mobilizer from the JSS expanded further to say why an approach of *dostana* ('friendship') to convey that 'we are together in this instead of us trying to find fault is important". Such a *dostana* approach is operationalized through accompanying the Government community health workers, sharing vehicles during their mandatory visits to villages, helping them in their mobilization work, helping officials drafting letters to other departments or sometimes even mundane activity like the community health workers learning to ride the scooter together. All these activities helped to build trust and bonding among the government and JSS staff at the block and community levels.

The Government's overall trust in JSS emerged from a) the evident social purpose of the organization through long years of work in remote tribal areas for more than two decades b) the institutional backup of the founders adds to their credibility. The fact that all the founders are from the premier institute of All India Institute of Medical Sciences in the national capital and had come to work in remote villages showed their commitment to the cause of public health c) and JSS's approach of 'being there' for the government. PHNI did not operate in a narrow project mode. The organization's staff (those who were clinicians) were quick enough to be there in the government health facilities to attend to patients when the government health workers went on strike. They also provided necessary support during a sudden malaria outbreak in one of the villages. Trust and partnerships also were established during village/block meetings where the district collector introduced JSS members and talked

about the collaborative work adding further legitimacy to the shared purpose of PHNI. While the formal MOU helped establish the formal intent of partnerships, these had to be carefully nurtured in the everyday context of PHNI implementation through a range of practices.

'Health is a service sector, and the humane touch is critical here': Values and organizational culture matter

A PHC approach essentially espouses values of equity, community participation and social justice. The importance of such values was reiterated during our interviews with the stakeholders. Government officials shared how such values are critical to the health sector and patient/people centred care should drive everyday decision making. They clearly acknowledged how such values explicitly guided JSS's work. A state official shared:

> *"After seeing the work of JSS, a special drive was done to send the ASHAs, ANMS from the tribal districts of Madhya Pradesh to Ganiyari in Chhattisgarh. What was distinctive about the training is the pedagogies they used but also the values they impart. … Health is a service sector, and the humane touch is critical here. Unfortunately, training in the government is done in a mechanistic way. Trainers treat this exercise as 9am-5pm day of activities only."*

While everyone acknowledged that value orientation was critical, government officials also admitted how such value orientation was at odds with the bureaucratic organizational culture of the government which was deeply hierarchical. While accountability is clearly defined in the health bureaucracy, often it serves limited purpose as negative sanctions are difficult to implement in the case of lack of any such accountability. Many block and district level officials articulated the differences in work and organizational culture of JSS and the government. A block level supervisor explained his constraint to ensure accountability of his staff:

> *"I have seen how JSS works differently. We had the malaria outbreak in a village, and we needed more ANMs. Even if all the ANMs report to me, it is difficult to ask ANMS of one area to join another to address a crisis because they will turn around giving the rationale for 'jurisdiction'. While penalties are there for non-accountability, one must look at many things including political connections to operationalize such penalties. While for JSS, they do not bother who is responsible for which area and ensure that the final work gets done. All have the same objective. They take responsibility of the work till the end."*

Senior government officials explained why innovations or stretching oneself beyond the routine mandate needed to be incremental (than radical) in a government system. A state official explained:

> *"The government system works in an equilibrium, so a tendency of some kind of lethargy sets in where everyone is comfortable with the status quo. In a scenario like this, no matter how committed you are, you cannot rock the boat through system shattering changes but find smaller spaces and opportunities to make incremental changes. When I joined then as a district collector, I was briefed by the previous collector of the noble intentions of PHNI and the role of JSS, so it was not difficult for me to support it from day 1 onwards."*

Such an equilibrium often leads to a fatalistic attitude towards problem solving. As evidence in other contexts shows, a positive problem-solving attitude and skill of primary health care staff can indeed make a huge difference to health outcomes [14]. Even with the constraints of complex state bureaucracy, policy actors sought to create spaces and opportunities (that are not system shattering yet correcting) shaping the PHNI work. This included instituting an accountability mechanism through adding PHNI agenda in the existing district level timeline meetings. PHNI found a regular space during district level weekly Timeline (TL) meetings that had representatives from all the departments. TL meetings are conducted by the district collector to regularly follow-up the most important activities of the district. Further, another innovative way the accountability of all actors was instituted was through a WhatsApp group with all the stakeholders involved in PHNI implementation across hierarchy both within the government, self-government representatives and JSS. JSS took the responsibility for day-to-day managing and overseeing the activities while the district collectorate facilitated this. Regular updates including bottlenecks with evidence (including photos, for example of repair work, status of the sub-centers etc.) were shared by the JSS in the WhatsApp group for prompt attention and action by the district collectorate. PHNI had to confront several challenges of meeting deadlines for repair work, willingness of ANMs to start living on their accommodation in these difficult geographies or cooperation of Panchayats. These were navigated through close monitoring and follow-up by the JSS including figuring out local strategies and action together with the district collectorate to mitigate these. For example, JSS ANM mentors continued to man few sub-centers providing all services till the government ANMs were appointed or where there was initial hesitation of ANMs to stay in these remote locations.

DISCUSSION AND CONCLUSION

It is a foregone conclusion that strengthening primary health care towards the goal of Health for All continues to be an imperative. Yet as global experience has shown, such operationalization has not been consistent. In many cases PHC has remained isolated and scattered and/or has been implemented merely as a technical program with delivery of certain select services leading to

sub-optimal outcomes. Our findings offer three important learnings broadly on implementation of policies including the primary health care.

First, evidence on operationalization of primary health care need not be restricted to smaller experiments in the non-governmental organizational set ups. JSS's learnings on comprehensive primary health care formed the backbone of PHNI in government set ups. PHNI showed what mattered in the implementation of primary health care. These included a) exclusive focus on strengthening the institutional structures (sub-centers, VHNDs) and mechanisms (referrals) instead of specific services b) adequate training and mentoring support to the primary health care staff that focus not just on technical skills but that acknowledges their role and contributions and build on/respond to their contextual challenges. This has an important impact on motivation and finally c) embedding and reinforcing a value orientation of equity, community ownership (in this case role of the self-government became important) and inter-sectoral action (as relevant to the context, here child nutrition was critical). The findings also signify why teamwork is critical to primary health care where teams refer to different stakeholders in the government, self-government and in this case facilitation by JSS [24].

Second, PHNI drew attention to several factors that could explain why a collaboration between a government and a grass root NGOs possibly worked. These factors include a) a broader appreciative inquiry approach adopted by the NGO partner b) contextual and grounded evidence (hence pragmatic solutions) c) relevant technical expertise of the NGO d) 'being there' beyond a project mode of working d) formal clarity in roles and responsibilities but also investing in nurturing and building partnerships through some of the practices discussed e) acknowledgement of complementary strengths and f) sustained demonstrated commitment to the cause of public's health. Some of these factors resonate with few existing studies [40].

Third, the study reiterates the methodological literature on PHC implementation that draws attention to the everyday realities of health systems including organizational culture, values, contexts, leadership practices and actors' interests [9, 13, 40]. Echoing this literature yet adding to it, our findings show how policy actors including senior policy makers, program implementers made sense of the organizational culture(s) of a health system that is deeply hierarchical, more or less self-sustaining (major innovations are difficult) with values and cultures of a partner organization that has shared leadership practices where power is distributed than hierarchical. In such a different yet collaborative space, state and district leadership teams created several opportunities which were not necessarily radical to challenge the system yet could have an important impact for PHNI. These ranged from arranging financial resources from the District Mineral Fund or resources from other existing schemes (Prime Minister Road Construction Scheme to repair the roads for referral services), giving tenders for civil work to the self-government representatives instead of an open tender to outside contractors, training opportunities for the ANMs, creating cadres of ANM mentor in the line of existing nurse mentors etc. Hence while the power hierarchy within the health system bureaucracy remains and several provisions/decisions remained top down, yet policy actors in the state, district and block levels used their discretionary power to create more positive spaces and outcomes. This was also made feasible because of demonstrated relatable evidence on operationalization of primary health care (through the visits to the grassroot organization), building relationships of trust and partnerships among different cadres between the health system and the JSS through several formal and informal practices. Studies in other contexts show how a collective (and shared) meaning making of programs/innovations becomes difficult in a hierarchical health system and hence diverse perspectives of the problem and the solutions pose major hindrance to the implementation [41]. In the case of PHNI, the framing of the 'problem' – people are unable to access health care and sub-centers need to be made functional is not a new framing. Sub-centers are meant to be functional and the policy directive on the same is clearly stated. Yet this framing needed a boost, fresh evidence (to see and feel), right opportunities and a sense of optimism that this could be done with dedicated and continued support from a trusted partner organization. PHNI shows how government officials, whether at state or block levels, exercised discretionary power to bring about positive results thus facilitating strengthening primary health care [31, 41]. Implementation research needs to capture such everyday contexts of power as well as formal and informal practices that shape policy process and outcomes.

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AI utilization

None reported.

Competing interests

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ABSTRACT IN SPANISH

Hacia el fortalecimiento de la atención primaria de salud: Lecciones de una intervención colaborativa entre el gobierno y la sociedad civil en la India

Introducción: La necesidad de fortalecer la atención primaria de salud integral para garantizar la "Salud para Todos" está bien establecida, pero su implementación sigue siendo un desafío tanto a nivel global como en la India. Basado en un estudio cualitativo de una iniciativa colaborativa entre el gobierno y una organización de la sociedad civil, este artículo analiza los factores y procesos que explican la implementación exitosa de la atención primaria de salud en una zona rural remota del centro de la India.
Métodos: Los datos se obtuvieron de entrevistas en profundidad (n=27), observaciones de centros de salud, incluyendo clínicas móviles, así como de conversaciones con el personal durante estas visitas (n=17 visitas) y del análisis documental de actas de reuniones, memorandos de entendimiento, informes del proyecto y circulares gubernamentales. Los datos se recolectaron entre diciembre de 2022 y abril de 2023, y se analizaron de forma simultánea a la recolección. Se identificaron temas y subtemas pertinentes al confrontar diferentes fuentes de información para construir la narrativa de la iniciativa, poniendo especial atención en el papel de los distintos actores, los contextos, los procesos y sus implicaciones.
Resultados: Nuestros hallazgos muestran que la interpretación de los actores políticos sobre la causa compartida de la iniciativa, la vivencia de evidencia contextual y factible, y la construcción y mantenimiento de alianzas en diferentes niveles y entre diversos actores fueron claves para su implementación. Además, valores como la equidad, la participación comunitaria, la atención centrada en el paciente y la cultura organizacional fueron igualmente fundamentales en este esfuerzo.
Conclusión: Nuestros resultados reafirman el papel central de la filosofía y los valores de la atención primaria de salud en su implementación. También coinciden con la literatura teórica que subraya la necesidad de investigar las complejas intersecciones entre el poder, los intereses de los actores, las ideas y los contextos en el estudio de la implementación de políticas en los sistemas de salud.
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Palabras clave: Atención primaria de salud, equidad, cualitativa, gobierno, sociedad civil, India.

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