medicus mundi international network
health for all

HEALTH COOPERATION BEYOND AID
PATHWAYS FOR CHANGE

A selection of essays from members and partners
of the Medicus Mundi International Network
Contributions to our Essay contest in summer 2017

Preface

In July 2017, the working group on Effective Health Cooperation of the Medicus Mundi International Network launched an essay contest among Network members, their partners and other organizations engaged in international health cooperation.

The aim was to reflect on different questions of *how to change health cooperation beyond aid,* taking the discussion paper on "Health Cooperation: Its relevance, legitimacy and effectiveness as a contribution to achieving universal access to health" as a basis. Contributors were asked to discuss their "theory of change" (if any) which defines how they expect social and health outcomes to be improved while reflecting on their organization's particular role and contribution. How do health development cooperation and the actors involved need to change to remain relevant and effective in the 21st century? How is their organization's or their local partner's structures and programs integrated in the national health policies and systems of the countries they collaborate with / work in? How do they handle the dilemma between working on a rights based approach to health while having to address institutional financial challenges?

The six essays selected for this online publication give answers to these challenging questions and provide "food for thought" in an exemplary way from both the personal and institutional perspective of the authors.

Natalie Sharples (Health Poverty Action), the winner of the MMI essay contest, has presented her essay today at a session organized by the MMI Network at the 10th European Congress on Tropical Medicine and International Health (ECTMIH 2017) in Antwerp, Belgium.

Enjoy! And thanks again to all who have contributed.

Mira Gardi, Secretariat
Medicus Mundi International Network
Basel/Antwerp, 17 October 2017

HEALTH CO-OPERATION BEYOND AID

By Natalie Sharples, Health Poverty Action

Winner Essay

Achieving health justice requires radical change. Change in polices that create poor heath, change in the global distribution of power and resources, and change within the health justice movement itself.

At Health Poverty Action there are a number of things we are proud of. We don't create parallel systems. We work closely with local authorities, district health committees and national governments to build effective health systems that are appropriate and accessible to those who need them. We look to challenge power imbalances from local to global levels. And we tackle the root causes of poverty without pretending that aid and charity are solutions.

There are a number of other areas to which we are committed, but require ongoing struggle and reflection.

Firstly, building solidarity between people in the Global North and South. The aid and charity narrative has presented citizens of the Global North as the generous saviours of the South. This has helped to cement power imbalances; fuel a right wing, aid sceptic agenda; and undermine solidarity. In this age of heighted inequality it is also irrelevant. When the UK NHS is chronically under-funded and facing increased privatisation, to talk about the need for strong health systems in the South, whilst ignoring the demise of one under our noses would be inconsistent. By equating health cooperation with aid, we have fallen into the typical neoliberal 'divide and rule' trap - as the growing hostility towards aid demonstrates. We won't overcome public scepticism by telling positive stories of aid. We need to stop pitting citizens of the North against the South, and engage people wherever they live, on the root causes of poor health that affect us all. This is of course easier said than done for organisations with remits and funding to work in the South. But through partnership and engaging with the campaigns of Northern organisations working on domestic issues, as well as seeking funding to work in the global north, we have begun to take steps towards it.

Stepping outside the charity frame requires us to tackle the root causes of poor health, not obsess about how to spend aid better. We know that universal access to health will not be achieved through aid. Health systems require the redistribution of wealth. Both through strong national tax systems, and the return of the resources stolen by the rich. Whether it is tax dodging, subsides to big corporations, the war on drugs or the impact of climate change that diverts resources from citizens to global elites and corporations, we need to shift the power back. This means cleaning up tax havens, ending illegitimate debt, making trade deals that promote rather than undermine health, and implementing drug policies that support health and livelihoods, not the failed war on drugs. It means taking that extra money and redirecting it to provide health and public services for all.

When we do talk about aid we need to reconceptualise it as one form of wealth redistribution among many, needed both within and between countries. We can start by being more honest about what it is. It isn't health 'cooperation,' it's justice. And it's not aid, at best it's compensation. As long as we continue to perpetuate the notion of aid as charity, we cannot achieve radical change. Whatever we should rename it - reparations, compensation, global solidarity, token gesture, or redistribution - we urgently need to decide and keep repeating it.

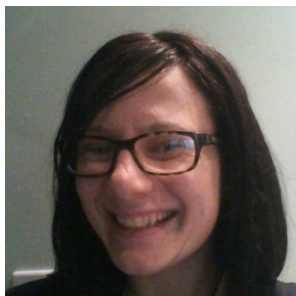
We also need to do more to link our programmatic work to the structural determinants of health. Those of us working with those on the sharp end of neoliberalism need to call it out for what it is. And every time we talk about our work providing services, articulate the political and economic climate driving the need for it. Political sensitivities in various countries often complicate -or in some cases prohibit - this, but the more we try to make the connections, the more we can reshape the picture of what health cooperation is, and situate our practical work in a wider narrative of change.

We could also be better about generating positivity. Our sector tends to be really good at pointing out the problems, less good at defining inspiring solutions. We make people feel overwhelmed and change impossible. By positivity I don't mean misleading claims about the effectiveness of aid, or 'inspiring' pictures of poor people working hard. I mean articulating a clear, bold and radical vision for the sort of world we want to see, with positive alternatives for change. There are plenty of examples to draw on. Take Cuba's health

system, Ecuador's rejection of neoliberalism and subsequent reductions in poverty, or the quality of public services across the Nordic countries. We need to stop making people angry and starting giving them hope.

Finally we need to tackle our privilege problem. We cannot reshape global power dynamics while replicating them within our own organisations. In the UK at least, the sector is noticeably dominated by the white, highly educated and middle class. This has resulted in situations in which groups of privileged people posit solutions to something they have never experienced. We need to put liberation at the heart of what we do. This requires genuinely getting out of our comfort zone and challenging our own perceptions, and our practices. Organisational structures and pay generate questions which we are yet to answer. Do we need to align with the pay of similar organisations to attract the best staff, or do we believe that comfortable salaries for Northern INGO management set us too far apart from the people we work with? Should we consider flat pay or management structures, or adjust our pay to take account of inherited wealth or caring responsibilities? If we believe in wealth redistribution should we be doing more to live it?

There are no easy answers. And with so many contradictions in this line of work, if we are feeling comfortable, there's probably something wrong. All we can do is feel into the discomfort, remain self-reflective and embrace external challenge. As Teju Cole has said: *If we are going to interfere in the lives of others, a little due diligence is a minimum requirement.*



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A UNIVERSAL HEALTHY SOLUTION FOR GLOBAL HEALTH

by Renée de Jong, Wemos

There have been many complaints in our sector about the unfairness in global health due to earmarked funding and a lack of accountability from big donors. This cycle can only be broken with independent funding for health. At the same time, we perceive a gridlock in global health while waiting for the next epidemic. Why not focus on the polluters? We might waste a 'good' crisis: climate change.

In this essay I will discuss how health development cooperation could adopt a 'health in all policies' approach by linking climate change to health and health systems. I am interested in how actors in health development cooperation should change in order to remain relevant and effective in the next century. Firstly, we might have to question how much health development cooperation in its current form can do to improve health or reach the 'right to health'. Why? Because the social and environmental determinants of health are exceptionally important. We do repeat 'Health in all policies' over and over again, but this should nudge us to move outside our health sector bubble too. Other SDGs might be just as important for health, and we need to get more actively involved in those policy areas as well. It seems unjustifiable that the environment and climate change receive so little attention compared to 'curative services' in health.

A carbon tax for health

We have a climate problem. Besides the many disastrous effects for the environment, it poses a big threat to human health. For example, it creates beneficial effects for infectious diseases, increases heat waves and extreme weather events and can cause malnutrition and undernutrition[1].

Climate change could be addressed by taxing those who produce carbon dioxide and pollute the environment. The idea is simple, it creates a financial incentive which makes it attractive to go green while it is a relatively easy tax to administer[2]. Nevertheless, currently 85% of the carbon dioxide emission is

not subject to tax and the sector still receives up to US$5.3 trillion of subsidies[3]. Besides that, existing carbon cap-and-trade schemes such as the EU's are unambitious and ineffective[3]. While only reassigning the 'polluting' subsidies could make a huge difference, a carbon tax could reverse this trend with very positive side effects, including for health.

Economists agree that a tax ofUS$50increasing to US$100 per ton carbon dioxide emission in 2030 is necessary to halt the current emission of carbon dioxide. If we would globally collaborate, this would provide us with US$4trillion[3,4].In comparison, according to WHO, US$1 billion to US$3 billion is needed to reach the health SDGs[5]. The tax could (progressively) increase over the years[4]. Besides, this might exactly target the sectors WHO mentions as problematic with regard to climate change, and thus for our health: energy, transport and food systems[6].

A good example of how 'the polluter pays' is the case of carbon emission from China compared to the US and India. China produces the most tons of CO2worldwide (6800 million tons CO2 in 2009). Second is the US (5185) and third is India (1564). However, when we look at how much CO2 is related to the consumption pattern of these countries' citizens, we get an entirely different picture. China consumes 5836 million tons CO2, the US 5685 and India 1506. Already China and India appear to consume a little less than they produce, but a factor is missing. When you divide the total consumption by the population of a country, an entirely new distribution appears. Namely, a US citizen 'produces' on average 18.532 tons CO2 per head of the population. For a Chinese citizen, this amount is 4.372 tons CO2 per capita, while an Indian citizen produces 1.247 tons per capita[7].

This is a consequence of our globalized world where we outsource the production of goods to lower-income countries. While factories in China make a product and get taxed, it might be a US consumer who buys the product. With a carbon tax, it is likely that the costs of the carbon emission are added to the price of the product. This would then mean that the polluting consumer pays the additional costs for the carbon emission. This way, funds are globally redistributed and those who pollute the most will pay the most or the 'true' costs. Because our world has become so globalized, it could already be an effective climate change measure, even if not all countries implement the tax.

How could a carbon tax link with health (systems)?

If we truly want to realize 'the right to health' and Universal Health Coverage, we might have to critically rethink how we want to fund it. There is no lack of literature on how to gather the funds. Many academics argue about how to develop the best community-based health insurance or the most efficient social health insurance system. However, small pools are inefficient and in low-income countries with a large informal sector, mandatory social health insurances are unlikely to raise sufficient funds soon. Loans are offered, but have shown to be risky in the past, e.g. the problems related to the structural adjustment programs. Similarly, while philanthropy and donor funding have benefited many countries, they have shifted accountability to the (international) donors and philanthropist rather than to the (poor) population affected.

This leaves a final resort: taxes. But again, how can it be raised in poor countries? Well. Firstly, large-scale tax avoidance by international corporations must stop and cannot be facilitated any longer by high-income countries. This is a no-brainer. Other taxes suggested are the 'sin taxes' on individual behavior for using tobacco, sugar and alcohol. This might be a good start for additional independent funding for health ministries.

Currently, the main focus for tax lies on taxes gained from labor by the population. However, taxing corporations, the industry and the financial sector-based on their environmental and social impact globally- remains undiscussed in health financing literature, while their impact is tremendous. A 'sintax' for polluting corporations makes sense. The collected funds could be used for social and environmental benefits. The general idea of 'the polluter pays' could be a way to raise more money for public goods, and now - as weather records are broken year after year and the evidence for climate change keeps piling up - I think it is justified to add a carbon tax to the list.

In practice, a carbon tax should be nationally collected and partly earmarked for the health sector[8]. This way, a globally justifiable measure to halt climate change could contribute to better health outcomes directly. In countries where currently the health sector budget largely depends on international donor support, these earmarked funds from a carbon tax could increase their power in a currently distorted power balance. Besides, it would shift accountability slightly to the ministry of health. Together with the tax's effect on climate change, this also means a win-win for the public sector.

The challenges

Investment in social benefits with the collected carbon tax is crucial because the poorest people might have to be compensated. A carbon tax could increase the costs of living but does not have to lead to larger inequalities. Besides an earmarked part for the health sector, the collected tax should go to determinants of health, such as education, housing, health and other social investments. It is important that money is earmarked for these purposes to make a positive difference via (global) public goods, rather than that the funds disappear into the national budget. We need to make sure that governments see the potential of using this tax for social investments. Of course, there is a chance that governments choose not to invest the money in the health sector, but if it reduces or mitigates the impact of climate change, I think it is still a win for health.

By all means, a race to the bottom should be avoided! In the past, industries have shown that they would move their factories to avoid salaries, regulation and basic human rights. Possibly, they might also move to avoid a carbon tax. Therefore, global collaboration is a precondition. The more countries join, the bigger the effects of the tax will be and the harder it becomes to escape the tax.

Industrialized middle-income countries could benefit from the tax as in the case of China. For high-income countries it is an attractive measure to implement, as it can foster investment in the development of new technologies and does not hamper economic growth. This has made Sweden, with the highest carbon tax in the world (137 euro per ton CO2!), a global advocate for the tax [2].Where does this leave low-income countries? When there is little industry, there is less to gain. However, to avoid this race to the bottom their participation is crucial. It will not be the solution to fund the entire gap in the health system, but the additional tax incomes could help governments gain ownership over their health sector budget.

Let's dream big. The ideal system would work globally, redistributing the money to rectify harm done by polluting industries. The redistributed money would be exclusively reserved for global public goods. However, despite the Paris Agreement countries have done fairly little to halt climate change. A national carbon tax would already be a tremendous improvement.

The future of health development cooperation

I am convinced that health cooperation will always be indispensable. However, our focus might be too narrow. It appears as if we are waiting for the next epidemic, but so much more is affecting our health, whether it is climate change, or our problematic monetary system and related global inequalities. We repeat 'Health in all policies' and 'SGD3'over and over, but nevertheless we remain quite reserved about getting involved in the other SDGs. In the end, what is the point of building strong health systems in a place where people will leave due to climate change?

Even though the link between health (systems) and climate change is not always as clear as the link between a weak health system and health, I believe that the public or preventive part in health development cooperation is as important. This is not to say that we should all change our mission, but a start would be to recognize wider problems and actively speak up and get involved in these broader issues. We should collaborate with other sectors to get each other's message across.

Climate change could be the crisis needed to change the world for the better if we want to move from aid to global solidarity (for health). Advocating for new resources for taxes such as a carbon tax (or other polluting emissions), financial transaction tax[8], a tax on natural resources or the capital of the 1%, could be a start to move to a fairer global system while producing global public goods. Not engaging in other policy areas is not an option, there is way too much at stake for the health sector.

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60 YEARS AFRICAN PIONEERS IN HEALTH COOPERATION

by Mirre van Veen, Amref Flying Doctors

"...we might need to accept that a paradigm shift is required that breaks with the continuum process of development cooperation for health as it has been conducted during the last 50 years."

A paradigm shift that moves health cooperation beyond aid; it is definitely not something that happens overnight. The above quote illustrates how the discussion paper by Medicus Mundi International (MMI), "Health Cooperation: Its relevance, legitimacy and effectiveness as a contribution to achieving universal access to health", is urging the need for real change in the health cooperation sector. This year, Amref Health Africa celebrates its 60th birthday. It is a festive moment, which is being used to proudly look back on the past 60 years, but - more importantly - it is a moment for reflection and looking forward to the future. In MMI's discussion paper, institutions engaged in international health cooperation were invited to reflect on their particular role and contribution in the transition towards better social and health outcomes globally, and to submit their answers on how to actually change health cooperation beyond aid.

When I think about the need for structural change - a real transition - I start feeling small. Where does change start? Where does the power to change come from? Literature studies and desk reviews can tell us a lot about what kind of change is needed. For example, it is clear to all of us that we need to move health cooperation beyond aid. However, change is supposed to be made, yet it is much more difficult to understand from literature and research how to bring about change. In order to gain some understanding regarding the "how" question, this essay invites you to look beyond literature and global aid debates, beyond whatever paradigm you might currently hold with regard to health cooperation. This essay aims to provide some insight in how change in African health systems is driven forward and how Amref Health Africa, the

largest African health organisation, has been contributing to lasting health change in Africa over the past 60 years. Why? For the reason that I feel that the approach Amref adopts in health cooperation can teach us something about how to realise the paradigm shift that MMI is calling for.

A multi-level perspective on health systems in transition

During my studies in global health, I got fascinated by the "multi-level perspective" on system innovations and transitions. It is a concept that can be applied onto any given complex change process. It explains change processes as the result of interactions at three different levels: landscape developments (long-term, external trends), regimes (dominant structure, culture and practice) and niche experiments (innovative practices). Have a look at the health system of Kenya. Firstly, current developments in the health system are influenced by landscape developments: for example, the incredible boom of mobile phone use over the past decade has influenced all aspects of daily life in Africa, including people's access to health information. Secondly, it is straightforward that the way the health system is organised and how health, disease and illness are culturally understood influence practices that are carried out in the health system, including how human resources are being trained, how medicines are being supplied, and how Kenyan communities access health care services. Thirdly, niches refer to the experimental, innovative practices, that do not necessarily fit the dominant culture and structure. These niches put the regime, the dominant structure, culture and practices, under pressure. It is this pressure that functions as a catalyst in systemic change processes.

Over the past fifty years, all health systems in the world have been in transition, because of new, innovative practices demanding structural and cultural change. This paper would take more than ten pages to describe what transitions African health systems are currently going through, but at least the multi-level perspective offers us some understanding of how change processes in health systems are driven forward. That brings us to the second question: how does Amref Health Africa contribute to lasting health change in Africa? Where does the power to change come from?

Firstly, Amref strategically connects dynamics at all three levels (landscape, regime, and niches) of African health systems, in order to pave the road for

unconventional solutions towards better health in Africa. Secondly, Amref contributes to the creation of niches: new, innovative, ground-breaking alternatives for existing structures, cultures, and practices. Solution pathways require pioneers, fire starters, who dare to take the first step. These pioneers can be found in any community; they can be men, women, youth, elders, community leaders, health workers or government officials. Therefore, niches need to be locally owned. Amref collaborates with local communities, civil society, public and private sector on the basis of shared African values, in order to guarantee that development and implementation processes are always steered by the "users". The following two examples illustrate these three "talents" in practice.

Using mobile technology to train health workers

Amref Health Africa has always been an innovator in African health systems. When founded in 1957 as the Flying Doctors of East Africa, Amref was the first to organise flights specifically to bring medical staff and commodities to remote areas without access to healthcare. Soon it became clear that one-off medical outreaches were not sustainable. For lasting health change in Africa, it had to be followed up by well-trained health workers on the ground. Training for human resources for health and continuous professional development became a key pillar of Amref's work.

Initially, education was being organised in class rooms. This approached needed to be better contextualised, given the health worker crisis in Sub-Saharan Africa - 36 countries in Sub-Saharan Africa meet the WHO definition of "critical shortage" with less than 2.28 doctors, nurses and midwives per 1000 population - and the fact that many health workers work in isolated settings in remote areas. When health workers need to leave their communities to receive training, communities are left behind without the crucial expertise and knowledge that their health workers would normally provide. The solution was found in distance education.

In 2007, when the number of people in Africa with a mobile phone grew beyond the number of African people with access to clean water, Amref started to explore the new opportunities that this technology offers. Together with business partners and national governments in Kenya, Uganda and Tanzania, Amref developed training curricula for health workers via mobile phone. Of course, it requires time and efforts to show governments as well as health workers what

the possibilities are with mobile technology, but it resulted in - amongst others - Leap, a mobile learning platform. More than 40,000 health workers have been trained since then: a real lasting health change. Moreover, it is a promising tool in case of disease outbreaks, like cholera. In the blink of an eye, tailor-made training content can be shared with huge numbers of community health workers, so that they are always up-to-date while serving the people in their villages, also in case of emergencies.

A key challenge related to many mHealth innovations is the inability to break out of pilot stage. “Pilotitis” refers to the current epidemic of new niches that are developed successfully, but never implemented at larger scale. Without scaling up, niches are not empowered to put pressure on existing structures, culture and practices, hindering them in finding their way into mainstream. Pilotitis can be cured by flexible programme designs that enable niches to adapt easily to external influences, resulting from landscape developments and the resistance to change at regime level. Moreover, successful scaling up depends on close collaboration between mHealth developers, implementers and users. By working in partnerships, the diversity of perspectives can inform which activities to pursue and which ones to drop. “Fail fast, scale smart” should be the motto for any niche in the health system.

An alternative rite of passage to combat female genital mutilation

Ten years ago, Amref started a project in Kenya, Ethiopia and Tanzania focusing on ‘reproductive health for nomadic youth’. In Kenya and Tanzania, the project initiated dialogues with the Maasai communities touching upon issues such as unintended pregnancies and HIV, but also subjects like adolescents’ freedom of choice. In 2009, Amref realised that this dialogue did not result in behavioural change. We were not aware that the project posed a potential threat to the communities’ initiation rite, of which female genital mutilation (FGM) is an important aspect. FGM is deeply rooted in the Maasai community as it is the first and the most important step for a girl to transit from childhood to adulthood. Any endeavor to stop this rite of passage is a threat not only to the girl who would risk missing a husband, but also to the household who would lose wealth in form of cattle.

Yet, it appeared that both the Maasai communities and Amref Health Africa hold the same vision: realising a promising future for the Maasai girls. For the

Maasai, that is the reason behind FGM: the future of girls can only be sustained when they develop themselves as women and reputable candidates for marriage. For that you need to be circumcised as girl. Once Amref realised that, a dialogue was initiated about alternative rituals that could at some point replace FGM in the rite of passage. Together with Maasai community leaders, the elders and the youth, Amref started the development of an alternative rite of passage. It had to be a ceremony attended by the community, morans and elders. Over the years, Amref learned that FGM is not a stand-alone tradition. It is linked to so many other traditions and beliefs that the Maasai hold strongly to, including food beliefs during pregnancies and myths related to child deliveries. Understanding the full picture and all the consequences of FGM allowed Amref to help the Maasai to understand the historic development of their rite of passage, and therewith, to unlearn the harmful aspects of the tradition. Since the start of this approach, 15,000 girls have become women through the alternative rite of passage, without being circumcised.

Creating African solutions

The above two examples show how Amref Health Africa works continuously to build innovative and sometimes unconventional roads towards an autonomous, self-conscious and healthy African continent. Amref is capable of creating opportunities in health systems to initiate, strengthen and support niche experiments that challenge the dominant structure, culture and practices in African health system to continuously renew and optimise. In the first example, the landscape trend of increasing access to mobile technology provided the opportunity to improve the structure for health worker education by developing m-learning platforms, thereby connecting health workers from all over the country in digital classrooms. In the second example, Amref Health Africa successfully established a niche around the alternative rite of passage, which saved many girls from FGM as essential part of initiation rites into adulthood. The future of this initiative looks promising, given the recent "landscape trend" related to the adoption of Sustainable Development Goal 5.3 (elimination of all harmful practices, including FGM), resulting in increasing global attention for the issue.

Yet, this is not the full answer to the question "where does the power to change come from?". That power comes from within. Clearly, African health problems need African solutions. Amref Health Africa is an African organisation

with almost exclusively African employees, who know their African societies and cultures. On this basis, Amref Health Africa always develops and implements interventions in close collaboration with local experts, communities and government officials. This focus on local ownership is a central principle in both the Paris Declaration on Aid Effectiveness, the Busan Partnership document, and the Doing Development Differently manifesto. Yet, is it sufficient to move health cooperation beyond aid?

Paradigm shifts require pioneers

Health cooperation remains a balancing act. The challenge within Amref Health Africa remains to find a balance between donor driven agendas and local needs and priorities. Still, accountability structures are complex, as the organisation needs to balance upward accountability relations, in terms of measuring results and reporting to the donor, with downward accountability towards the communities. Amref Health Africa is well aware that it is often not the only organisation working towards certain programme goals and that coordination between health cooperation initiatives is insufficient.

While reflecting on the tensions that often come along with the balancing act of health cooperation, Amref Health Africa can definitely learn something from the insights presented in the discussion paper by MMI. At the same time, we believe that the health cooperation sector can learn from Amref if it really aims to realise the paradigm shift and move health cooperation beyond aid. A structural change requires pioneers, who do not get lost in discussions about the desired change, but start creating it. Steve Jobs strongly pointed out that “only the ones who are crazy enough to believe they can change the world, are the ones who do”.

Developments at landscape level will continue to put pressure on the existing structures, culture, and practices in systems, creating windows of opportunities for innovative niches. It is up to us to keep our eyes open and remain flexible enough to take advantage of these opportunities and create novel structures and practices that provide an alternative. Amref Health Africa’s expertise, built on 60 years of health cooperation, shows three key ingredients for pioneering: the courage to take the first step, to choose the unconventional and innovative pathways, and build on local expertise and solutions. Regardless of how we might finding ourselves feeling small sometimes, here we all have a role to

play to preserve and increase the relevance, legitimacy and effectiveness of health cooperation.

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Stewardship role of health forum in strengthening local health system, West Bengal, India

by Dr. Ketaki Das, West Bengal Voluntary Health Association (WBVHA)

Introduction

The Indian health system is pluralistic with financing and provision of care by both government and private sectors. The government health service is organised through a 3 tier system with primary health centres at village level, a referral centre (30 beds) at block level and a 200 bed district hospital. It is commonly acknowledged that the government health services have failed due to various reasons, including poor governance and inadequate financing. Social determinants of health contribute further to this (Radwan, 2005; Rao et al 2011; Rao and Choudhury, 2012; Rao 2015). High absenteeism; poor service quality; low level of peoples' satisfaction and rampant corruption lead to mistrust of the system. Weak voice and low accountability are yet other constraints for effective healthcare delivery. A major health system reform in India occurred in last 10 years: the National Rural Health Mission (2005-2013) to strengthen the rural primary health care system. It specifically acknowledged the importance of communities in the healthcare process and formalised structures at village level to raise citizens' voice. In 2013, the National Health Mission, an over-arching programme for rural and urban areas was approved and launched by The Union Cabinet.

The National Health Policy 2017, for the first time, explicitly addresses the issue of governance of health systems, acknowledging the multi-layered local health governance structures in rural India, and the availability of limited public resources for the health system with unclear mandates and roles for various players. However, governance in India is complex and poorly understood and effective governance and accountability in the health sector remains a major challenge. Systemic governance failures afflict the healthcare sector across modes of governance (Bali & Ramesh 2015).

Governance is increasingly recognized as an important factor in health system performance (WHO, 2000, Siddiqi et al. 2009). A health governance lens focusing on principal–agent relationship among health system actors, can provide useful insights into the dynamics of health system performance and can contribute to identify underlying institutional problems. Effective interventions to improve health governance can potentially lead to a better performing, sustainable and country-owned health system.

Basic Health Care Support (BHCS) program is implemented by West Bengal Voluntary Health Association (WBVHA) - a Non-Governmental Organization (NGO) Federation, to strengthen the local health system. The program works closely with the local communities through local health and social welfare NGOs, thus creating a network among NGOs, service providers and local authorities. This has evolved an enabling environment for the people to access and afford the pro-people quality healthcare services.

More explicitly, in 2003-2004, WBVHA in collaboration with the Memisa – a Belgian NGO, organised the demand-side actors and created a Health *Forum movement* in the district of South 24 Parganas, the southern-most part of the Ganges-delta in the State of West Bengal, India. Starting with 9 grassroots healthcare NGOs active in 5 blocks within the district, the forum gradually evolved into a health platforms at community, Panchayat (the local government body) and block level (with its health authorities). Two major challenges of *Forum* are: (1) the governance of health system and the strengthening of health systems (health governance); and (2) the joint action of health/non-health sectors, public/private sectors and of citizens for a common interest (governance for health).

The *Forum* provided an opportunity for these grassroot NGOs to come together and understand each other's needs, demand and experiences; identifying gaps in the health services; improving their institutional capabilities; and engaging in dialoguing with service providers and political decision makers to obtain better quality health services. This allowed the health platform to become a catalyser for assuring that government schemes and resources related to the NRHM/NHM have successfully arrived and utilized at local community level, especially in the remote island areas of the Ganges-delta in South 24 Parganas.

Instead of looking for funding for their individual micro-projects, the NGOs of the platform bit by bit discovered the benefits of being organised as a platform and work in more structural way. This means i) strengthening collaboration with

various stakeholders in local health system, ii) sharing responsibilities towards health within the local health system (distributive stewardship), iii) improving upward but-more important-also downward accountability mechanisms, and iv) engaging in advocacy to tap more effectively and potentially available resources in the system and to bring to the attention of decision makers about the successes and challenges experienced at grass root level, in order to better adapt the policies to the community needs and claim their right to health. Examples of involvement of civil societies/communities are Creation of a Community Health Fund in health emergencies; Community Monitoring of the Sub Centre/Primary Health Centre/Block Primary Health Centre and other local initiatives (installation of incinerators, repairing of Sub Centre etc).

The program is successful today with five *Forum*s in 4 districts (Darjeeling/Howrah/North & South 24 Parganas) in West Bengal and 1 district (West Sikkim) in Sikkim that bring together 40 NGOs and cover 1.5 million people in remote rural areas.

This program has been supported by the MEMISA, Belgium since its inception. The Institute of Tropical Medicine, Antwerp; Institute of Public Health, Bangalore; All India Institute of Hygiene & Public Health and Indian Statistical Institute, Kolkata have been providing technical support over the last three years.

Theory of change

The theory of change underlying this process is to develop the health system and the health services by reinforcing a learning cycle (Action-Reflection-Action) aiming at i) facilitating the implementation of government schemes, ii) adapt them to local circumstances, iii) share the learnings at grassroot level, iv) provide a feedback to the decision makers at Panchayat and Block levels. This process has organically grown, starting from Panchayat level, mapping and linking up with all types of health service providers at primary level and with the Panchayat leaders. It has led to a more prominent place of health within the Panchayat Development Plan, as well as a regular dialogue and monitoring between grassroot NGOs, service providers and Panchayat members at monthly "Fourth Saturday Meeting" at the Panchayat office. In a next phase, a link with the block level and to some extent at the district level was established with more attention for first line referral health services, as well as on specific themes and advocacy issues.

The success of this dynamic motivated NGOs from other districts, led to formation of five *Forum*s, each has developed its own dynamic, emerging from the local context: i) some are primarily concentrating on facilitating service delivery, while others engage more in advocacy; ii) some are focusing on health, while others have a wider scope and concentrate on welfare. In addition to a rich collection of data (including case-stories coming from the grassroot partners eg., community health fund/community monitoring etc at Panchayat and block levels), the changes or 'mind-shifts' at the level of the key actors have been monitored and documented, using the methodology of Most Significant Changes during the quarterly coaching workshops, held since the start of the program.

Relevant and effective changes in 21st century

In the 21st century, health is mainly about people and how they live and produce health in the context of their everyday lives. This requires a new perspective on the governance of health and well-being as key features that constitute a successful society and grounds policies and approaches in values such as human rights and equity. Governance for health promotes joint action of public-private actors in health/non-health sectors, and of citizens for a common interest, requires a synergistic set of policies.

Despite India's impressive economic performance, slow progress in improving access to health care, large inequities in health and access to health services continue to persist and have even widened across states.

Forum strengthens local leadership and cooperation at all levels: communities/ civil societies/management teams at local and intermediate level; document changes introduced to capitalize the experience and influence the decision making level.

In many areas, the inactive Village Health Sanitation & Nutrition Committees–a community–based monitoring team created by government, became effective after the intervention of *Forum* partners.

Various gaps were identified and prioritized at Sub Centres/Primary Health Centres/Block Primary Health Centres by *Forum* Partners and were shared at various levels. Health plans prepared by Village Health Sanitation & Nutrition

Committees, were sent to block level for consolidation and submission at higher level.

Synergic and collaborative actions were undertaken with PRI, public/private and civil society actors to implement and influence various State/National health programmes at Panchayat /block/district levels.

Forum along with Civil Society Organisations and Community Based Organisation understands that an effective and strong local health system requires local ownership, networking, flexibility and adaptability to the local context.

The involvement and cooperation of the community promotes successful governance for health. Working directly with the public can strengthen transparency and accountability, which become engines for innovation in the complex relations between govt. and society. Communities are at the centre of concerns for sustainable development.

Many corporate companies are showing interest to provide support to health and health care access, though they do not have enough skills and expertise to empower the community. In such cases, *Forum* can take the initiatives of capacity building, project monitoring etc.

The major challenges of *Forum* are: recognition from government departments, visibility, ensuring community ownership, participation in health system, facilitating in developing health plan, advocacy for improving health utilization, ensuring political will for health system development; expansion of Forum in broader area with financial stability.

Integration in National health policies and systems

The BHCS program of WBVHA is explicitly in line with the NHP and local health system. It contributes to the objectives of NRHM/NHM by bridging gaps in access to services by vulnerable populations in remote areas. The resources are available in theory but still inaccessible for unreachable population. *Forums* helped the service providers to reach services to people and integrated all stakeholders at various levels. In that way a multi-stakeholder dynamic is developed to strengthen local health system. Presently *Forums* are interacting with the existing decision makers at community to district level.

Forum network promotes linkage, both within and among communities/organizations/societies. It also focuses on the multiplicity of societal actors in local health system at various levels, the distribution of roles and responsibilities among them, their ability, power and willingness to fulfil their roles and responsibilities, leading towards distributed stewardship and ensures that all *health system* actors including *stewards* are held accountable to their actions. The mechanisms and dynamics promoted by the BHCS program, promotes Panchayats and service providers to greatly engage in health concerns of their citizens, by way of identification/analysing the local health situation, need assessment, prioritization and plan of action.

This *Forum* assists government in fulfilling its commitments to people by identifying gaps (operational & policy) and providing services in un-served/under-served areas. Forum can also support the Ministry of Health and Family Welfare by identifying the operational gaps at various levels, in joint movement on various health related issues, training, facilitating health plan (involving stakeholders) at Panchayat level. Forum members are representing in various patient welfare committees at Panchayat/Block/District/State by raising voices on behalf of community, and also advocate for policies that promote and support the public sector.

Forum can further contribute at fostering the relevance and effectiveness of the research, priority setting, and translating knowledge to action. It can play a key role in stewardship (promoting health evidences and advocating on issues which are relevant for national health policies and system research; resource mobilization; generation, utilization and management of knowledge, capacity development). *Forums* can initiate partnership with academic institutions or dedicated research agencies with their knowledge/innovative ideas, expertise, community mobilisation and empowering skills, social legitimacy, implementation capacity and ability to attract external donors (CordAid, Misereor, Memisa) and corporate funding (PepsiCo India Holding Private Limited, Indian Oil Corporation Limited) to address diverse health needs in under-served or un-served geographical areas or communities, which government did not provide or least prioritised in its public health agenda.

Handling dilemma in working on a rights-based approach:

The NGO partners engaged in health program want to access the funds available through NRHM/NHM to improve the accessibility of healthcare services to their target population. On the other hand they are engaged in advocacy to improve the policies and strategies, based on their experiences. This role of advocacy may indeed create tension with the aim to access the funds. The dilemma is managed by building trust between *Forum* and service providers in the first place: by engaging in dialogue, by helping public health providers to implement the goals of the NRHM and to reach the vulnerable population, by offering complementary expertise to the providers. The demand-side actors also gain credibility and become strong partners of the health providers and decision-makers. This facilitates access as implementers of the health schemes launched by government and the related resources. The relation of trust allows the *Forum* to provide advice and to make proposals which defend the health rights of the population.

Finally, their credibility as operational actors also attracts partners other than government, such as international groups/NGOs/agencies and corporates. *Forum* builds strong, trusting relationships with their communities by breaking barriers and optimising the use of diverse and valuable resources embedded in local community settings and on the strengths of social interaction and local ownership as drivers of change processes. This integrated approach is also participatory, empowering, context-sensitive and knowledge-based. Integrated efforts and long-lasting partnerships promote an effectiveness of strengthening of LHS involving a diverse range of actors in public/private institutions, NGOs, Civil Society Organisations and Community Based Organisations.

The forum activities focused not only on raising community awareness (demand-side) but also on empowering providers (supply-side) by co-hosting values-clarification workshops on health system strengthening. *Forums* run cooperatively with government health services to maximize the opportunity to provide for better access to healthcare and for the realization of health rights.

Forums are facing difficulties in finding sufficient, appropriate and continuous funding for Forum activities.

Budget analysis of allocated funds to various patient welfare committees at Panchayat /block/district levels was done for monitoring gaps between policies

and action at Sub Centre/Primary Health Centre/Block Primary Health Centre/District hospitals, followed by advocacy at State level. Another way is by scaling down expenditures on unproductive activities and increase social spending on activities those benefit the poor and vulnerable groups.

Forum felt the need for the security of the distressed and vulnerable people and link with concern departments to avail the benefits of various social security/health schemes of State/National Government. Initiatives are taken for awareness generation, facilitating the process of enrolment and disbursement of National/State level insurance schemes.

The BHCS is a unique program of WBVHA mainly focuses on strengthening local civil society. The intervention is focusing on how to minimize inequity in society. There is an opportunity to evidence that peoples' awareness on their right to health can help them identifying what exists and what doesn't, but should. This is a bottom-up approach that can influence policy. Consequently this will lead to expansion of the role of *Forum* in social, community and sustainable development.

Dr. Ketaki Das *is working in the Basic Health Care and Support (BHCS) Programme, West Bengal Voluntary Health Association (WBVHA) as a Public Health Research Officer since 2009. "It gives me the opportunity to work directly with the community- a People centre approach programme, which focuses on improving local communities' self reliance, health rights, social justice and participatory decision making".*

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Health Cooperation Beyond Aid: Empowering Countries to Achieve Universal Access to Medicines

by Manusika Rai, i+solutions

Changing global health landscape

When the UN 20 by 20 initiative was announced back in early 2015, it seemed like the perfect opportunity for i+solutions to expand our services beyond the traditional supply chain strengthening work. This initiative aims to supply 20 billion condoms by 2020 to African countries by creating a vigorous and sustainable market in this continent. Seizing the opportunity of this momentum, i+solutions has since been leading the private sector condom group which was formed to foster multi-stakeholder engagement for achieving the very ambitious target of 20 by 20 initiative.

The message is loud and clear. Funding streams for donor assistance are changing. As countries transition into higher income levels, they are asked to take ownership and be responsible for their own health systems. Donor-driven procurement of health commodities and vertical supply chain systems are no longer sustainable. Various mechanisms to increase efficiencies and ease the burden on public sector are being tried and tested. This has several implications not only for countries and their health systems but for the private sector including non-profit organizations like i+solutions. The pharmaceutical industry and private wholesale distributors will no doubt have to rethink their strategy and approach when it comes to supplying health commodities to developing economies. There needs to be clarity on regulatory mechanisms, visibility on demand and a conducive business environment to foster private sector engagement. Issues like affordability will continue to pose challenge not only for new treatment and diagnostic technologies but also for those commodities with limited scale-up at country level.

Making ourselves future-fit

The restructuring of the organization to become future fit reflects our efforts to remain relevant and reorient ourselves in this changing global health landscape. Besides advising countries on procurement and supply chain management, we are actively engaged in studying and understanding markets and forces that influence access to medicines. We see ourselves filling in the gaps by bringing our knowledge and experience of supply chain systems and generating critical evidence that will allow and empower countries to make smarter investments. We will strive to be the bridge between governments and private sector actors by cultivating partnerships and synergistic relationships so that best practices can be adopted and adapted to solve supply chain challenges and overcome barriers to reach the un-reached. Acknowledging that our work at both global and local level is impacted by policies beyond the health sector, i+solutions is looking at describing and understanding the policy landscape across all sectors in all our work. Our operating principles are founded on making countries more resilient by putting them in the driving seat and at the forefront of designing their health programs thus enabling them to adopt a rights-based approach to access to medicines. Our projects are led by local organizations with whom we engage right at the project design phase. We see merit in collaborating with organizations that focus on other building blocks of the health system such as health financing, service delivery, leadership and governance. A good example is our collaboration with Oxfam Novib, Rutgers WPF and their local partners on the Universal Access to Female Condoms (UAFC) joint programme who were focused on advocacy, linking and learning at global and local level. Our work on manufacturing & regulatory support and improving national female condom supply chains was an important contribution to the partnership which demonstrates how these diverse activities had a synergistic effect on improving availability and ultimately access.

Our vision: how do we contribute in this changing landscape?

Recently as i+solutions embarked on the journey to revisit and rethink our strategy for the coming years, it was clear that to become future-fit we must constantly evolve to remain agile and responsive to the changing needs of the global health community. Besides defining our value proposition under each of our core service areas, we have set out to unpack what this means for countries. Whilst our level and type of engagement will differ depending on their economic status, one of the key objectives will be to empower countries so that they can take ownership of their procurement and supply chain systems across both public and private sector. In doing so, we see the value in

remaining a lean organisation reinforced by local and regional offices in strategic locations to support operations and relationship management. There is no doubt that in this journey, issues around financing and affordability of healthcare will continue to dominate the conversations. Public-private partnership proved successful in addressing last mile distribution challenges by drawing on the strengths and comparative advantages of its stakeholders. Built on a similar principle, the Global Financing Facility is an innovative financing model that combines resources from multiple sources and operates under the leadership of national governments thereby reaffirming the principles of rights-based approach i.e. participation, equality, inclusion and accountability. These trends will fundamentally shape our business and financing model and therefore we see ourselves reacting and responding increasingly to country investment cases.

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Bridging Six Degrees of Separation:

Measuring the Small World Phenomenon to help Activate International Cooperation in Public Health —

A global health influence discovery project

By Bill Jeffery, Centre for Health Science and Law (CHSL, Canada)

In the years after the second world war, United Nations diplomacy pressured a handful of European nations to release the shackles of colonial rule, but the dominance of rich countries and the paternalism and disruption of the aid and global trade regimes still impede development and state sovereignty in important ways. Maps changed and old cultures flourished once again, but economic divides persist.

Putative engines of global public health—especially, the World Health Organization—are largely funded by a small number of wealthy nations and foundations funded by non-arm's length global commerce. Obstacles remain to achieving meaningful redistribution, regulation, and citizen-enforceable rights in relation to the right to health, especially at the international level where individuals and non-governmental public interest organizations likely have no legal standing at, for instance, the International Court of Justice, and little real sway in international institutions, even where some such organizations officially recognize NGO participants (such as the WHO, the United Nations, and Codex).

Truly grassroots movements have self-evident input legitimacy, but, individual citizens may have more proximate influence over national and international political decision-makers than they realize because their position in the global social network is not obvious to their casual, socially embedded observations. Correspondingly, wealthy and politically powerful decision-makers may presently pay a disproportionately small amount of attention to the situations of geographically distant foreign citizens on the mistaken belief that their social distance is greater than their physical distance and, furthermore, that that social distance is vastly greater than the social distance to their own citizens.

Perceived close social distance is the foundation of trust, and caring, both vital precursors of sound and accountable governance. Accordingly, we should generate empirical evidence to better understand the social networks that global citizens share with key government and international decision-makers.

I want to make the case for potentially paradigm-changing and activity transforming community-based research with health advocacy purpose.

Many people, worldwide, are familiar with the notion of six degrees of separation: that every global citizen is connected to each other by a paltry six intermediaries, each knowing the other on a first name basis. What many do not know is that this notion is not aspirational fiction, but a surprising conclusion of a real-world social experiment conducted in the United States in 1967. The original small world study conducted by American sociologists Stanley Milgram and Jeffrey Travers selected two target people in Massachusetts, the spouse of a student and a stock-broker, then 162 "starter" people in Nebraska as follows:

> *...an arbitrary "target person" and a group of "starting persons" were selected, and an attempt was made to generate an acquaintance chain from each starter to the target. Each starter was provided with a document and asked to begin moving it by mail toward the target. The document described the study, named the target, and asked the recipient to become a participant by sending the document on. It was stipulated that the document could be sent only to a first-name acquaintance of the sender. The sender was urged to choose the recipient in such a way as to advance the progress of the document toward the target; several items of information about the target were provided to guide each new sender in his [sic] choice of recipient. Thus, each document made its way along an acquaintance chain of indefinite length, a chain which would end only when it reached the target or when someone along the way declined to participate. Certain basic information, such as age, sex and occupation, was collected for each participant.*

Travers's and Milgram's small-world study sparked a high amount of cultural interest, including a Hollywood feature film in the 1993 called "Six Degrees of Separation" (with an award-winning performance by Stockard Channing, and stars Will Smith and Donald Sutherland) based on a play by John Guare who probably originated the "six degrees of separation" catch-phrase. This notion was also popularized in North America by a spontaneously disseminated parlour game for movie buffs, "Six Degrees of Kevin Bacon,"

which rewarded players for naming the shortest path between any actor and Kevin Bacon through the intermediary actors in other movie casts.[1]

The small world phenomenon also subsequently spurred several mostly small-scale empirical studies to examine the largely non-social structure of ownership of German banks, interlocking directorships in Fortune 1,000 companies, electric power grids, neurons in animal brains, pages on the Internet, co-authorship collaborations among scientists and mathematicians.[2] However, researchers have typically relied on (conveniently) pre-existing datasets to study abstract theories about social structure or test mathematical proofs against messy social realities. In many of these cases, network analysis was applied to reveal the extent to which wealthy individuals impose their views on financial systems, or scholars idiosyncratically collaborate to discuss ideas. Social networks could be studied in a way that informs techniques for achieving health governance that is more accountable to citizens and global citizens.

Milgram's social network study has only been replicated a handful of times since 1967, and only twice (to my knowledge) in an international context: the first involving Canadian targets with a handful of American starters, and the second using email only targeting 18 persons in 13 countries with 60,000 starters (e.g., several summarized by Garfield, 1979). This gap in the research presents an unparalleled and unique opportunity for MMI to create some new knowledge with health advocacy relevance to better understand the reach and features of real social capital to provide unique new insights on social bonding- and bridging-capital.

Health NGOs are not alone in wanting to better understand the constituencies they serve. But, governments may be too fearful of running afoul of their own privacy laws, and too reluctant to vet individuals living outside of their own borders, especially in a manner that could give rise to citizens becoming more adept at leveraging health law reforms by their own and foreign governments. Likewise, commercial companies are focused on generating profits for their owners, so have strong incentives to keep secret any lucrative methods they uncover for tapping into social networks. The WHO, rather than mobilizing

1 See: https://en.wikipedia.org/wiki/Six_Degrees_of_Kevin_Bacon
2 In fact, an on-line tool based on a database of peer-reviewed publications in the field of mathematics allows published researchers to compute their degrees of separation from Paul Erdős , a Hungarian mathematician who co-wrote some 1,500 papers with colleagues in many disciplines with a very diverse group of collaborators accumulated over a lifetime of scholarship, whose media degrees of separation is five and, though only 5% (268,000) of mathematicians have calculated their Erdős number, it has been estimated that 90% of the world's academic mathematicians have Erdős numbers of less than 8.

large global networks, may be geared more to discouraging mass mobilization by erecting pre-registration and vetting protocols than inviting grassroots input.

While the small world phenomenon is not exclusively relevant to health cooperation, it has enormous potential for making seemingly remote health law- and policy-makers care more about global health issues and health reform advocates more effective at promoting beneficial change.

One or more national and international pilot research projects could be conducted very inexpensively. However, the multi-disciplinary[3] nature of research conducted to date, and the socially existential, and politically profound implications of the research could stimulate interest from variety of non-commercial funding sources, including e.g., national postal services, member states with thoughtful and reflective attitudes toward international affairs, international development foundations, non-commercial private foundations, and government health and social science research granting agencies. If so, more comprehensive, illuminating, and reliable research re be commissioned.

Studies could involve two different complementary methods: (1) a focused, targeted technique (similar to Milgram's) which invites 100 or more starters to move information packages to targets each through a single tunnel of intermediaries each, and (2) a strategic hybrid broadcast/flooding technique which invites 10 starter participants to recruit subsequent intermediate recipients to send his/her package to three further intermediaries using a recruitment strategy that combines the person's judgement with evidence-based tips from the principal investigator for finding the shortest path.[4] Assuming 100% completion, and an average of five intermediaries, these two strategies would generate 700, and 7,290 letters, respectively, only one-third of which would require postage (or pre-paid metered postage stickers, 728 per initial package[5]) if the ultimate destination were an elected official. (Many countries allow citizens to correspond with

3 Recent reviews have listed collaborations with sociologists, mathematicians, physicists, statistical physicists, oceanographers, anthropologists, psychologists, political scientists, computer scientists, biologists, and engineers, with hard scientists bringing mathematical rigour and computation muscle to the analysis and social scientists reminding them that social identity remains an important determinant of social networks.

4 While a more comprehensive broadcast approach is financially more viable using email address books or Internet-based social media, unmanageably high volumes of communications could be expected within a very small number of intermediaries and give rise to very high numbers of interactions to count. For instance, an email-based chain-letter initiated by a Janet Forrest's grade six class in Taylorville, South Carolina led to 450,000 email confirmations within a few weeks before the project had to be shut down.

5 Intermediary participants would need to find three envelopes and make three duplicates of the chain letter to complete their part of the mission.

their elected officials postage-free.) Communications by email would be much less expensive, but possibly much less likely to be completed.

The backbone of these network linkages relies on the "strength of weak ties," a concept developed by sociologist Mark Granovetter (1973)—in one of the most influential sociological papers ever published—to explain the important contributions of personal relationships outside of an individual's tight-knit inner circle of relationships. Linking the study (and participant-target mailings) to fundamentally and universally interesting and concrete health policy reform issues[6] could also help increase the effectiveness of participant recruitment and task-fulfillment. Likewise, inviting university-based social network researchers to provide technical assistance to fine-tune the research methodology (esp. finding and fixing completion bottlenecks) and data analysis in exchange for assistance with data analysis could help ensure success.

While some have raised questions about the methodology of the original Milgram study, some mathematicians are confident that, despite its flaws, it likely under-estimated the true number of intermediaries (Watts, 2004 at loc 991).

This research could also help illuminate the extent to which and the manner in which key network hubs (e.g., opinion leaders or socially plugged-in individuals) are featured in social networks typified by the so-called power-law[7] in social network linkages, especially when a social system is undergoing a transition phase (as opposed to a bell-curve distribution that govern the distribution of most other features of the social and physical world). The mechanics of power laws in phase transitions in physical phenomena were first described in 1971 by Nobel Prize-winning physicist (in 1982), Kenneth Wilson,[8] in a process called re-normalization. Re-normalization is tightly analogous with the aim of political, cultural and legal changes that health advocates seek to bring about, e.g., for changing dietary, alcohol, tobacco consumption patterns.

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6 For instance: conflict of interest safeguards in national and global health policy decisions, protection of children's health, improving access to healthcare, and universal access to health (if this notion is not too abstract for a concise action-oriented missive.

7 Power, in this sense, refers to a mathematical quantity, not political or economic clout. Here, even assuming the assuming the average person has only 100 friends unduplicated in a chain of peer networks, five intermediaries would reach out to a population of 10 billion people (100 to the power of five) with optimally selected intermediaries.

8 The late Wilson is, coincidently, is in two degrees of separation (both "strong" ties) from the Geneva Global Health Hub.

Choosing politically meaningful and willing targets would also be important for such national and international community-based small-world studies. Assuming global pathways of six links are typical, it could be fascinating to invite two or more entire chains of intermediaries to a future Medicus Mundi International conference to describe their networks to the group, for them to meet their more distal compatriots in person (and possibly identify more efficient shortcuts), and to share their experiences with the broader public via webcast.

Establishing empirical evidence of a small "global village" could be an effective impetus for expanding the circle of caring of health policy makers, and importantly, with the publics that political officials are answerable to. Researchers might also learn the special benefit of MMI networks to shorten the pathways and may gain insights into ways to more effectively methods to promote the mobilization of social movements in aid of beneficial health policy ends in what economists call "information cascades," epidemiologists call "percolating beahviours," and marketers calls "going viral."

Overall, carrying out this research could be a measure of the global community's partly untapped potential to collectively solve problems (Easley and Kleinberg, 2010 at 252) and the potential for MMI and other health activists to use its credibility and activism (albeit possibly not as a network node *per se*[9]) to activate such networks.

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