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DIVERGENCES, DISSONANCES AND DISCONNECTS

Implementation of Community-based Accountability in India's National Rural Health Mission

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Dedicated to my father…

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Abbreviations

ACF	Advocacy Coalition Framework
AGCA	Advisory Group on Community Action
ASHA	Accredited Social Health Activist now rechristened the 'ASHA worker'
CAH	Community Action for Health
NGOs	Non-Governmental Organizations
NHSRC	National Health Services Resource Centre
NRHM / NHM	National Rural Health Mission now rechristened 'National Health Mission'
SDG	Social Development Goals
VHSC / VHSNC	Village Health and Sanitation Committee later on rechristened 'Village Health Sanitation and Nutrition Committee'
WPR	What's the Problem Represented to be?

Glossary of Indian Administrative Terms

Indian Administrative Boundaries – States, Districts, Blocks – India is divided into a number of linguistically determined states. Each state has a number of districts initially divided based broadly on population parameters. Each district in turn consists of Community Development Blocks, which consist of a number of Panchayats. Each Panchayat has a number or wards.

Panchayat – When used alone the word Panchayat usually refers to the structure at the village level that represents local self-government. This is an administrative level which has a set of functions, funds and functionaries as laid out in the 73rd and 74th amendments of the Indian Constitution. Originally the word refers to a group of elders usually five in number (*Paanch* in Hindi) who used to form the elder's council.

Abstract

Accountability of health systems to the individuals and communities they serve is increasingly recognized as a key aspect in efforts at health system strengthening. This has led to a greater focus on efforts to evolve systems that enable communities to hold health systems accountable. In parallel with this change, the governance of public systems has been transformed under the influence of the neo-liberal paradigm of governance. India introduced the flagship National Rural Health Mission (presently termed the National Health Mission) in 2005, to bring about an architectural correction of the health system. One of the five key components of the mission was 'Communitization'. This component aimed to increase the ownership of the health systems by the communities they serve. As part of this a programme called Community Action for Health (CAH) was piloted in nine states and then rolled out nationally. The implementation diverged from the originally envisaged process in different states.

This PhD research aims to understand the institutional level influences that impact on the implementation of community-based accountability and governance mechanisms and the potential of integrating such processes in the public health system in India. I used qualitative methods to map out the divergences in implementation and sought to understand the reasons for these. Next, I conducted a case study of the southern state of Tamil Nadu, in which I focused on the processes within the apex administrative level of the state.

In addition to mapping two dimensions along which the policy seemed to diverge, I also documented three distinct perspectives on accountability among the key actors involved in implementing CAH. Overall there were three constructs that emerged from the research: 'Divergences', 'Dissonances' and 'Disconnects'. Divergences refer to the way in which policies and programmes shift from the original conceptualization. Dissonances points to the presence of multiple perspectives on the same concept in the same organizational setting. Disconnects represents the lack of spaces within the organization that enable processes of collective sense-making. The emergent understanding from the research is that the divergences in policy implementation may in fact reflect a deeper level of conflict at the level of belief and perspectives in different layers of the administration. In the absence of spaces and processes to facilitate collective sense-making, it is likely that policies, even when introduced with significant commitment from policymakers at the higher administrative layers, are likely to require systematic effort to sustain.

Keywords: Community Action for Health, Community-based Accountability, Policy Implementation, Problematization, Institutional Perspective, National Rural Health Mission / National Health Mission, Tamil Nadu, India

Original Papers

This Thesis is based on the following three published papers – referred to as Papers I, II and III

I. Gaitonde R, San Sebastian M, Muraleedharan VR, Hurtig AK. Community Action for Health in India ' s National Rural Health Mission : One policy , many paths. Soc Sci Med. 2017;188:82–90. Available from: http://dx.doi.org/10.1016/j.socscimed.2017.06.043

II. Gaitonde R, Muraleedharan VR, San Sebastian M, Hurtig AK. Accountability in the health system of Tamil Nadu, India: Exploring its multiple meanings. Heal Res Policy Syst. 2019;17(1):1–11. Available from: https://doi.org/10.1186/s12961-019-0448-8

III. Gaitonde R, San Sebastian M, Hurtig AK. Dissonances and Disconnects: the life and times of community based accountability in the National Rural Health Mission in Tamil Nadu, India. (Accepted for Publication in BMC Health Services Research on January 17th 2020)

These papers are reprinted as per licenses from the respective journals

Prologue

Community-based accountability is increasingly a key component of frameworks for health system strengthening. I was fortunate to be involved in various processes to implement this vision in India under the National Rural Health Mission (NRHM) launched in 2005 (now called the National Health Mission (NHM). I supported the national level planning of the process as well as the process of capacity building for implementation. I also led the process of implementation at the state level (in the state of Tamil Nadu). My experience as part of the implementation of the Community Action for Health (CAH) project showed me that there were multiple interpretations regarding the concepts of community participation and community-based accountability within the public health system. Similarly, there was a wide variation between the way Non Governmental Organizations (NGOs) were involved in various activities and in the national and the state governments. Thus, while the pilot project was implemented in nine states only two states continued the programme in the form originally envisaged.

In Tamil Nadu, we experienced the abrupt closing down of the project despite objective evidence of its success being demonstrated by two external evaluations, and the policy continuing to be on the national policy agenda.

The implementation of public policy, despite all the calls for it to be evidence-based, seemed a complex and messy affair. While the literature mainly spoke about the need for political commitment, resources and flexibility of the process to ensure implementation, the CAH project was abruptly stopped despite the presence of all of these. It seemed as though empiric and objective findings were not the only things that were driving the policy process.

These experiences were the basis of my aiming to map the diversity in implementation, understand its determinants, and further delineate institutional processes at the state level in Tamil Nadu that impacted on the implementation.

1. Introduction

The focus of this doctoral research study is the implementation of policies that aim to strengthen accountability of health systems to the communities they serve. Programmes and policies related to community-based accountability and community participation may be considered as 'social policies' (Brodkin, 2011). This highlights their inherently contentious nature as expert opinion engages with lay perceptions and historical contexts. Research shows that such policies are likely to be left vague by higher layers of the administration and policymaking, deflecting to lower layers the actual definition of the nitty-gritty. This vagueness in fact lends itself to contextual adaptation (Brodkin, 2011). The study of such policies thus, needs to factor in this process of 're-definition' that occurs as lower layers of administration attempt to implement these policies. This leads to an inherently complex and messy implementation processes.

This introductory chapter reviews the way in which community participation, a concept that has been around for decades in the health field, has increasingly begun to focus on accountability. It also summarizes the experiences of and challenges inherent in the implementation of such programmes both in India and in other developing countries across the world. The next chapter, describes the attempts in India by both civil society organizations and those of the Government of India to strengthen community participation and especially community-based accountability. More recently this has been through the introduction of the concept of 'communitization', as one of five 'pillars' of the National Rural Health Mission introduced in 2005 (Ministry of Health and Family Welfare, 2005b).

Subsequent chapters contain –the aims and objectives that guided this research (Chapter 3), the key theoretical underpinnings of this research (Chapter 4), the methodological and ethical issues (Chapter 5), the results (Chapter 6), a discussion where the results are placed in the light of current understandings of policy implementation, as well as provides answers to the research questions (Chapter 7), and some conclusions where I suggest areas for future research and recommendations arising out of this research (Chapter 8).

Community Participation, Community-based Accountability and Governance

Community participation has been a core feature of strategies for health system strengthening, especially since its rise to prominence as a core aspect of the Alma Ata declaration on Health for All in 1978 (Rifkin, 2009; Labonte *et al.*, 2017). Ever since that articulation, numerous attempts at its operationalization, at different scales, have taken place and have been documented and evaluated. By and large,

as numerous commentaries have pointed out, these experiences have belied their promise of empowerment and deepening of democracy. (Zakus and Lysack, 1998; Mosse, 1999; Rifkin, 2009). Despite these negative experiences, interest in community participation has persisted.

From the late 80s onwards, projects to increase community participation have occurred as part of the so-called Health System Reforms. As detailed elsewhere, this entails a significant change in the state-provider-citizen relationship (Ravindran and de Pinho, 2005; Lister, 2013).

Ever since the 90s, community participation has become more and more explicitly linked to health system accountability and governance (Cornwall, 2000). This is reflected in the fact that dimensions of participation, accountability and governance are present in almost all frameworks of health system strengthening. More recently these dimensions feature prominently as part of Universal Health Care and the Social Development Goals (SDGs), and the Astana Declaration (World Health Organization, 2007, 2018; Mikkelsen-lopez, Wyss and Savigny, 2011; Barbazza and Tello, 2014).

Community participation over the decades

It has been noted that in the decades of the 60s and 70s, the most common form of community participation was the community health worker (Molyneux *et al.,* 2012). In addition to this, there was widespread involvement of the community in terms of provision of resources, decisions regarding details or logistics of service provision, the development of community-based outreach programmes, health education, and attempting behavioural change and health promotion activities (Molyneux *et al.,* 2012).

The literature that describes this variety of approaches of community participation, notes that overall there were gains in the coverage of various essential services achieved by health systems. These consisted usually of preventive services like vaccination or antenatal care, and increasing awareness of these services and interventions among communities (Bhandari *et al.*, 2004).

Researchers have pointed to the fact that there was a deep-seated divide between the more biomedically driven approaches of state-led initiatives compared to the more social-justice driven approaches of civil society initiatives in community participation that probably explained the wide variation in outcomes as well as the limited successes of programmes at scale (Rifkin, 1996). A number of studies over the years and across geographies have described the limited nature of the achievements of these community participation-based projects (Manor, 2004; Murthy and Klugman, 2004; Rifkin, 2009). In sharp contrast to these examples,

experiences from Latin America have been more promising. The various reforms in Brazil, for example, have shown a lot of promise for the large-scale involvement of communities in the strengthening of public systems, holding them accountable as well as broadening their scope of services (Cornwall and Shankland, 2013).

There were questions raised regarding the 'depth' of community participation achieved in many of these programmes. Arnstein introduced the extremely influential "Ladder of participation" (Arnstein, 2011). This brought to the fore the diversity of ways in which communities were involved in health programmes, ranging from more 'superficial' forms which were coercive and manipulative to 'deeper' forms which included involvement and influence of community members at all stages of the programme cycle. Similarly, other frameworks such as those of Pretty (1995) which delineated a range of types of participation from manipulative, through consultation to self-mobilization, and White's (2000) matrix of typologies of interest, which highlighted the different perspective of the implementing agency and those at the receiving end of participation projects, were introduced. Their development and use reflect the existent variation in approaches to operationalize the concept.

Cornwall notes the influence of development thinking on the way participation and its outcomes have been framed. She points to the increasing impact of the marketization of the public services, including in health care. This is reflected in the way in which community members who participated were initially seen as 'participants', then as 'beneficiaries' and later as 'consumers' (Cornwall, 2000).

It is thus clear that the concept of community participation has been dynamic over time, and its present popularity is further complicated by the range of actors with widely differing perspectives calling for and supporting its implementation (Dagnino, 2011).

Governance, accountability and co-governance

Ackerman (2011) notes the shift in 'direction' of public accountability in the field of public administration. He points out that early public systems were run along bureaucratic hierarchies, where the direction of accountability was to superiors within systems. Increasingly there was an expectation that systems, and especially front-line workers of such systems, would be accountable to the citizens and the communities that they serve. This has led to a situation where providers and other front-line workers may need to be answerable both to communities as well as to their administrative superiors, who may both have quite different expectations of them.

Researchers and practitioners also point to the trend of moving from the concept of participation, to that of co-creation and further on to co-governance (Ackerman, 2011). In this conceptualization, the movement from co-creation to co-governance refers to increasing involvement in an increasing number of dimensions of governance. Co-creation refers to involvement in planning and provisioning, while co-governance refers to involvement in all steps of governance including prioritization and choice of intervention to be implemented (Ackerman, 2011).

One of the key theoretical supports for this shift towards co-creation and co-governance was, for example, the research of Elinor Ostrom. The central objective of this research was to investigate whether a community of users of common property overuse (referred to as 'tragedy of the commons') or manage to preserve these resources. In fact, her (and her team's) seminal work on the problem demonstrated conclusively, and in a wide range of settings, the fact that, groups of users were able to manage the consumption of these resources in a sustainable fashion, and in most instances much better than state-led initiatives (Ostrom, 2015). This highlighted the importance of the intimate knowledge of the local context carried by these local groups and its importance in the design of sustainable management. This research clearly bolstered the demands for the inclusion of local communities to play deeper roles in the overall governance of any development project.

Similarly, Ackerman (2011) and Fung and Wright (2003) describe examples of what has been described as empowered co-governance in a number of settings both locally and at scale. In these programmes, communities play increasingly important, key and powerful roles in the governance of public systems. Some of these initiatives have even tended to blur the boundaries between state and civil society (Ackerman, 2011).

The changing configuration of the state and implications on accountability

Accountability, at its core, is about answerability (George, 2009). In the now dominant understanding, it is the state that is answerable to its citizens for its decisions and actions (Cornwall, 2000). This direction of accountability developed as a norm, especially as the nation state evolved and began considering the welfare of its citizens as a core and legitimizing aim. This conceptualization of the responsibility of the state was further consolidated in the 'welfare state' paradigm, popular after the Second World War. Implicit in the welfare state perspective was the understanding that capitalist market mechanisms were bound to leave marginalized communities worse off, and the state provisioning of essential social services was required to counterbalance these negative effects

(Jayal, 1999). In this context, with the state directly providing a range of services, it was directly accountable to its citizens.

In the 80s (and even earlier in the 70s in the case of Latin America), a number of governments embarked on a range of health system level interventions collectively called Health Sector Reforms. These aimed at increasing the efficiency and quality of the health system. This slew of reforms was premised on the principles of competition, individual choice and the economic rationalization of planning and priority setting (Lister, 2013). As noted above the role of the government shifted from primarily that of provider to that of a 'steward' (Lister, 2013). Such structural transformations had an impact on the relationships between the state, citizen and provider, especially in terms of accountability.

Historical and contextual factors had an important influence on the extent to which these reforms were actually implemented in each country setting. The larger context of these reforms and structural changes and consequent impact on governance, needs to be kept in mind, to contextualize this study, which focuses on the implementation of an initiative to strengthen community-based accountability.

In general, the operationalization of the health sector reforms envisaged that communities would hold public systems accountable in two ways – through 'exit' and 'voice' (Lister, 2013). While 'exit' strategies envisaged communities using their choice to indicate their displeasure or evaluation of a particular service, 'voice' referred to the 'holding to account' of service providers directly or indirectly (Lister, 2013). One of the more common forms to operationalize these voice-based strategies was the Village Health Committee – with the people now designated as 'clients / consumers' rather than 'citizens' (Manor, 2004) as members. These committees are either linked to institutions or based in communities (Molyneux *et al.*, 2012) and are meant to play a role in various aspects of overall governance as well as holding the institution or programme accountable. Thus, one can see that the practice and theoretical underpinnings of community participation demonstrate a move in two directions. More mainstream institutions invoke community participants increasingly as consumers in a market, while civil society groups push for increasing involvement of local communities not only in the facilitation of the provision of services, but in every step of governance. While there has been an opening up of spaces for more involvement of the community in governance, it is clear that the ways in which these are conceptualized and practiced by the different groups implementing these innovations is quite different (Dagnino, 2011).

2. Community Participation and Health in India

Community Participation and Community-based Accountability in India

Post-independence (in 1947), health emerged as an important aspect of state responsibility. The newly independent state saw the modernization and welfare of its citizens as a core responsibility (Amrith, 2007). This is reflected in the debates that occurred in the constituent assembly immediately after independence. It is also reflected in the direction and thrust of development policy in the early decades post-independence (Srivatsan, 2012). It was only in 1995 with the 73rd and 74th Amendment of the constitution that the promise of decentralization was formally fulfilled, with the panchayats (local self-government institutions) being recognized as a formal tier of government. With this, greater community involvement in a range of activities acquired a constitutional status.

In this overall scenario of economic developmental, the health sector evolved into a 'mixed' sector, with both the public sector and a largely unregulated private sector emerging over the decades. Within the health sector the importance of community participation has been underlined in a number of policy documents and reports concerning health in India (Indian Council for Social Science Research and Indian Council of Medical Research, 2002; Ministry of Health and Family Welfare, 2005a). This recognition of participation, builds on a number of experiments and initiatives in the NGO sector over the years (Pachauri, 1994).

Most early attempts at operationalizing the concept of community participation in health by the government translated into health worker programmes, or processes whereby communities donated land or chose the location of health institutions (State Health Resource Centre, 2003). It is only much later, in 2005 to be precise, that national programmes included community participation specifically as community-based accountability (Kakde, 2010; Gaitonde *et al.*, 2017).

However, the experiences with the implementation of community participation and community-based accountability in India over the decades has been mixed. Attempts at implementation by the government on a larger scale have translated into mostly symbolic events or merely as means to predefined ends (Population Foundation of India, no date; Murthy, Balasubramanian and Bhavani, 2009; Coelho, Kamath and Vijayabaskar, 2013). Studies of accountability in health

systems in India during this period point to the fact that, provision of health care to the poor was not considered as a duty of the government, but more as a favour (Khanna *et al.*, 2002 quoted in George, 2003). Further studies point to the fact that accountability of peripheral health workers is more towards their superiors (in highly hierarchical health systems) rather than to the people they serve (Meeta and Lochan, 2010). Research set in rural Indian health system settings noted that, review processes seemed to be more interested in apportioning blame than problem solving (George, 2007). Finally, research has noted that many formal processes of accountability built into health systems failed the most marginalized communities, who are unable to even demand entitlements (George, 2003; Sen, Iyer and George, 2005).

The literature also points to the limited capacity of public systems weakened as they are by structural readjustment, to engage with these newer forms of accountability. Moreover, in hierarchical public systems, encouraging such public accountability mechanisms leaves frontline workers particularly vulnerable, as they have extremely limited resources and capacity to actually respond to the grievances raised, despite wanting to do so (George, 2009).

In this disappointing scenario in India, the experience of decentralized planning in the south Indian state of Kerala, initiated by the then ruling Left Front Government stands out. It has been recognized as one of the key determinants of Kerala's success story in health and development (Isaac and Heller, 2003).

Community Participation in the National Rural Health Mission

Neo-liberal reforms were formally introduced in India in 1991. Thus, by the time the United Progressive Alliance (a coalition of centre and left parties) formed a government at the centre after the elections in 2004, India had had experience with neo-liberal policy reform for more than a decade. The election result was seen as a reflection of distress of rural and urban communities (Wilkinson, 2005; Shroff, Roberts and Reich, 2015). This framing of their electoral victory explains a slew of progressive laws like the Right to Information (National Informatics Centre, 2015), the Right to Education (Ministry of Human Resources Development, 2019), and the National Employment Guarantee Act (Ministry of Rural Development, 2014). In the field of health, the newly elected government launched the National Rural Health Mission (NRHM), which aimed to bring about an "architectural correction" in the national health system with an aim to increase the access and ownership of the public health system to the rural population (Ministry of Health and Family Welfare, 2005).

The new government also created a number of innovative spaces, such as the National Advisory Council, standing committees like the Advisory Group on

Community Action (AGCA), and quasi-statal bodies like the National Health Services Resource Centre. These enabled, through very different mechanisms and design, a greater involvement of academia and civil society representatives in setting policy agendas and guiding programme design (Singh, Das and Sharma, 2010; Donegan, 2011).

The National Rural Health Mission (NRHM) sought to ensure that everyone had access to essential and quality health care, especially in rural areas. This package of policy recommendations included a number of interventions in the key building blocks of the health system. These included investment in infrastructure, the setting of Indian Public Health Standards for each level of care, enhancing management capacity, financial flexibility and 'communitization' (Ministry of Health and Family Welfare, 2005). It can be seen that at least three of these key areas of focus – referred to in the mission documents as the pillars of the NRHM i.e. standards, management and community involvement and ownership were related to the governance building block. 'Communitization' was essentially about increasing the ownership of the public health system among the community. This included a number of components including the community health worker – called the Accredited Social Health Activist (ASHA, but generally referred to as ASHA worker), and the formation of Village Health and Sanitation Committees (VHSCs). The VHSCs were to lead a process known as Community Action for Health to enhance community-based accountability, which included both community-based monitoring of entitled services and community-based health planning. Another initiative was the introduction of 'untied funds' being provided to the VHSCs to be used after democratic decision-making, for issues chosen by the community to help in improving the health situation in the village (Ministry of Health and Family Welfare, 2005). This strengthening of accountability and securing of inputs for 'bottom-up' planning was expected to lead to an increase in the sense of ownership of the community over the public health system.

Despite a high level of political commitment, and support from various civil society organizations most of the programmes diverged from the original vision over time. Thus, there were increasing reports of 'untied funds' getting tied up by government diktats (Child In Need Institute - Jharkhand, 2010), the words 'social health activist' were quietly dropped from the name of the community health worker, calling her only an 'ASHA worker', reflecting the way the health department increasingly viewed her (National Health Services Resource Centre, 2011). I next describe in detail the broad contours of the CAH programme, the implementation of which is the focus of this research.

The Community Action for Health programme

The AGCA was tasked to operationalize the concept of communitization. The AGCA plan led to a pilot project, funded by the Central Ministry of Health, which was launched in nine states in 2008-09. This was led by civil society representatives, many of whom were members of the AGCA. These NGO representatives were also part of a larger national level coalition of NGOs (*Jan Swasthya Abhiyan,* the Indian chapter of the People's Health Movement) working towards the Right to Health. The idea of the pilot project was that individual states could learn from the pilot, adapt the design, and take the lead for the implementation of the process in subsequent years.

This programme consisted of the following specific components (Center for Health and Social Justice and Population Foundation of India, 2006; Singh, Das and Sharma, 2010):

- The formation of representative village level committees, termed the Village Health Sanitation and Nutrition Committees (VHSNCs), whose members were tasked with village level monitoring and planning functions, and deciding on how to spend the untied funds provided to each committee.
- A lead role for the NGOs in implementing these activities using funds provided by the government.
- Training of the committees on their role and on concepts of rights and accountability.
- A structured process of monitoring of entitlements in the public health system by committee members.
- The collation of the information from the monitoring process into village level report cards, and feeding these back to the local public health system.
- Evolution of a village health plan based on the gaps identified.
- Action by all concerned based on the plans developed.

The pilot project was evaluated by a team commissioned by the AGCA. The evaluation was largely positive and recommended continuing technical and financial support to enable continued implementation (Ramanathan, 2009).

The NRHM provided the opportunity for a number of radical ideas regarding community participation to emerge on the policy agenda. These had been advocated for a long time by civil society groups in India. The fact that the central government agreed to fund a pilot process to enable the states to learn from the pilot and own the subsequent roll-out was very promising in terms of the future

implementation of this policy. Yet, this set of encouraging circumstances for the introduction of a more 'empowering' definition of community participation failed to produce a buy-in from the governments at the centre and the state once it came to implementation beyond the pilot phase. There was very limited scaling up of the process, as witnessed by the extremely limited number of active programmes that are ongoing in the country today, ten years after its introduction, with only one of the nine states in which the original pilot was implemented having an active programme along the lines originally envisaged (Ministry of Health and Family Welfare, 2015).

This description of the roll-out / implementation of the CAH project leads to the following questions which form the starting point for this research:

1. What were the ways in which the CAH project changed from its original articulation as it was implemented?
2. What were the reasons for these changes in the CAH programme?
3. Why did a project that had so much support at the national level, and initially at the state level as well, fail to be adopted and sustained in its originally intended form, despite showing positive results in the early years of implementation?
4. How was the concept of accountability understood by those who were responsible for implementation?
5. How do these understandings influence the roll-out, adoption and sustained implementation of the CAH programme?

Summary

The implementation of initiatives operationalizing community participation in India followed the global trends described in the earlier chapter. The early programmes consisted largely of community health worker programmes. The later programmes, especially the CAH programme launched as part of the National Health Mission in 2005, were among the first to attempt to operationalize the concept of community-based accountability. Till then, the experience in India has been mixed, with initiatives launched by the public health system having shown very limited depths of accountability in practice.

3. Aims and Objectives

Overall Aim

To understand the institutional level influences that impact on the implementation of community-based accountability and governance mechanisms and the potential of integrating such processes in the public health system in India.

Objectives

- To map out and analyse the diverse pathways of the implementation of the Community Action for Health process. **[Paper I]**
- To analyse the divergences that occurred during implementation and to understand the determinants of these divergences as the policy was received and transmitted through different layers of government during implementation. **[Paper I]**
- To explore the different ways in which calls for increased accountability as a clear policy directive at the national level were interpreted at the state level by key actors in the context of the implementation of the National Rural Health Mission (NRHM). **[Paper II]**
- To explore the individual and institutional factors that contributed to the way in which the policy regarding community participation was formulated at the state level, as well as that impacted the way it was designed and rolled out. **[Paper III]**

4. Theoretical Underpinnings of the Research

Introduction

The focus of this research is on the processes within the organization, related to the implementation of policies after their emergence on the policy agenda. In this case I focus on the Community Action for Health project and its implementation. More specifically I am interested in the processes leading up to (or not leading) up to its final integration into the day-to-day functioning of the health system.

There are two main strands in this research:

- The implementation of a programme related to community-based accountability in the global context of a receding state and in parallel with increasing calls for accountability.
- Insights from various disciplines on how to analyse the dimension of 'meaning' different agents give to policy. This resulted in going beyond positivist approaches to study policy, policy change and policy failure and using post-positivist lenses.

As the PhD process evolved over the last five years, the research has been as much about specific research questions regarding an example of policy that failed to integrate into the health system, as it has been about methodological and conceptual approaches needed for the study of such problems. These two strands of the research process further drew upon my individual position in two ways: from the perspective of someone who was a part of the process that initially formulated the national and state level processes, and subsequently from the perspective of being in charge of the implementation of the project in one state. Thus, as I analyse the data, the insights from various disciplines intertwine with certain implicit understandings from my own implementation experience. The PhD process has been a time for me to stand back and make sense of the processes as they took place. Equally important is the attempt to derive lessons for future implementation efforts.

Prior to the start of my PhD, my experience with implementation showed me that there were multiple competing perspectives regarding the policy that were conflicting over time and across the layers of administration. This was also noted, for example, by Garn in her study of process (2010). This pointed me to the importance of disentangling and characterizing these processes in greater detail in order to have a more comprehensive understanding about policy

implementation. At the onset of my PhD, I therefore decided to map out the roll-out of the policy across the country to document the way in which its implementation diverged from what was originally intended. The later part of the PhD was built on the insights that I gathered from mapping the roll-out of the policy.

The Advocacy Coalition Framework (Jenkins-Smith *et al.*, 2014) – with its conceptualization of conflicting advocacy coalitions within a particular policy subsystem seemed to be an obvious frame to guide my initial inquiries into the implementation process. Further, mapping the CAH roll-out and exploring its determinants in the early stages of the research highlighted the importance of meaning and ideas to understand the roll-out. This pointed to the limitations of a positivist approach in describing and making sense of the findings that emerged during the research. This led me, to explore a range of approaches to the study of meaning and ideas in the field of policy and policy analysis, and use these insights to study the organizational level adoption of ideas using the insights from diffusion theory.

In this chapter I will first present the key theoretical underpinnings of the research as they emerged during the PhD process, followed by a section on the emergent conceptual framework that guided the research project.

There are three key aspects of the implementation process that emerged during my research. One is the deeper study of the process of implementation, especially framing it as a conflict between competing ideas the second is an approach that goes beyond a positivist approach to delve into 'meaning' in order to study the importance and influence of 'meaning' on implementation. The third is the exploration of the organizational processes that were part of integrating an idea newly emergent on the policy agenda into the day-to-day functioning of the system. The three theoretical frameworks that guided each of the above aspects of my research are listed below:

- The Advocacy Coalition Framework (Jenkins-Smith *et al.*, 2014) that guided my initial mapping and engagement with the implementation and rollout of the Community Action for Health project.
- The concept of problematization – as described in Carol Bacchi's approach to policy analysis (Bacchi, 2009) called 'What's the problem represented to be?' or 'WPR' for short, to explore the policy process and policy design using the post-positivist perspective.
- Atun's Framework (Atun *et al.,* 2010) for the integration of innovations into the health-care system which I used to study the integration of an innovation into the health system.

In the next part of the chapter I will briefly present some of the key insights with reference to the relevant aspect of implementation as noted above before following it with a subsection where I describe the relevant theoretical framework. Thus, I start with some key insights from the research on the implementation of public policy before proceeding to briefly describe the Advocacy Coalition Framework. Next, I briefly discuss the move towards post-positivist approaches in the analysis of policy before presenting Bacchi's 'What's the problem represented to be?' approach, focusing especially on the concept of problematization. I will finally describe a few key insights from the literature on organizational processes and institutional perspective relevant to the uptake and integration of a new policy before subsequently describing Atun's Framework for the integration of innovations into systems.

The Implementation of Public Policy

Among the key aspects of the literature on implementation germane to this research is the debate between the top-down and bottom-up approaches and the attempts at synthesizing these (Orgill and Gilson, 2018). Traditionally, the story of the evolution of and insights from the policy studies field also refers to the three generations of policy studies, and the conflicting top-down and bottom-up approaches (Orgill and Gilson, 2018).

A key outcome of these debates, in my reading, is the recognition of the importance of understanding the processes and actions of various actors contextually (Orgill and Gilson, 2018). This further shifted the concept of implementation from one that is merely conforming to orders from above to one that is a more collaborative process (Hupe and Hill, 2007). With the development of the concept of 'street-level bureaucrats' there was a highlighting of the discretion available to frontline workers during implementation (Lipsky, 2010). The research also pointed to the constraints under which these frontline workers work. There was thus an increased acknowledgment of the agency of the front-line workers in public systems, as they were the ones who actually 'enacted policy', by being the interface between the people and the government (Hupe and Hill, 2007).

The literature also points to the fact that after the policy is articulated at the apex by the policy elite, it has to traverse multiple layers of government. At each layer, the motivations of key actors and stakeholders and the opportunity structures within which they act are different. These factors influence the way in which a policy is received, interpreted and reinterpreted at that layer before it is transmitted down the administrative chain. Given this, I have applied this insight (of agency of street-level bureaucrats) not only to the front-line workers, but to officers in each of the administrative layers, as the policy is formulated and moves

down administrative layers on its way to being implemented. This has been documented for example in Exworthy (2002). It becomes crucial to take into account the multiple layers of administration, each with its own perspectives, motivations and capacities, and more importantly, with a unique and historically developed relationship with other actors at that level, including in the case of the front-line workers, the community itself. Thus, the policymaking process and its implementation could no longer be seen as a simple stepwise linear process in which the intent of a policy elite is faithfully put into action. Indeed, it is increasingly suggested that implementation no longer be considered as a separate, unique process that follows earlier processes in any set fashion (Hill and Hupe, 2003). It thus seems as if the implementation of policy is a process where policy is repeatedly interpreted and re-interpreted at each layer of administration, with the outcome at each layer constraining lower layers as they in turn proceed to interpret policy.

The Advocacy Coalition Framework (ACF)

The ACF contends that within a particular 'policy subsystem' there are two or more groups of individuals or institutions that hold conflicting views as to what the preferred policy solution to a given problem may be. These coalitions are themselves bound by a common set of beliefs and values, which are reflected in the policy articulations they espouse. Advocacy coalitions within a particular policy subsystem vie with one and another to make overall policy more in line with their belief structure. Towards this, they mobilize resources and use both long-term and short-term 'opportunity structures' to bring this change about (Jenkins-Smith *et al.*, 2014).

In the ACF, belief structures are considered to be hierarchically arranged. The deep core beliefs representing the most basic beliefs, pertaining to the normative and ontological level of beliefs, constrain the next layer referred to as policy beliefs. Policy beliefs that pertain to beliefs regarding the nature of the policy problem and the relative importance of various policy approaches in turn form the basis of the most superficial layer of beliefs known as secondary beliefs. These secondary beliefs refer to the instruments or tactics to bring forth the deeper beliefs (Jenkins-Smith *et al.*, 2014a).

While studying the implementation process, ACF points to the importance of studying the strength of various policy coalitions over time, their relative power and influence and adaptations to organizational contexts over the course of time and administrative level (Gupta, 2014), even as the policy is being adapted to these organizational contexts (Ellison, 1998). This particular insight of the ACF was key in focusing my attention on the dynamicity of power dynamics even after a particular idea comes on to the policy agenda.

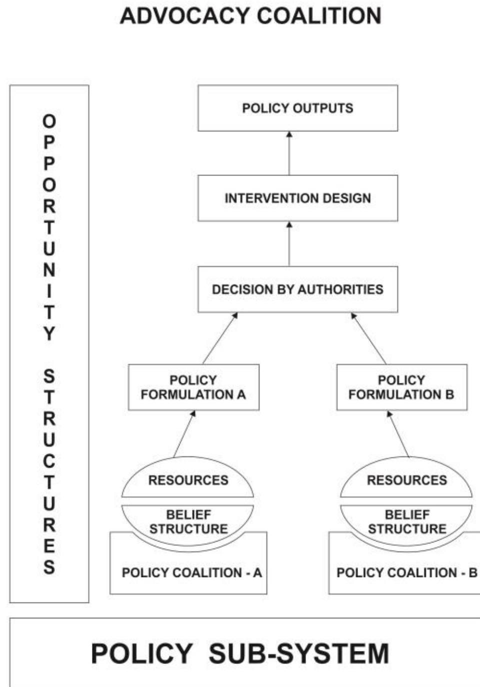

Figure 1. The Advocacy Coalition Framework – Schematic Representation (Source: Gaitonde *et al.*, 2017).

Emergence of the Post-positivist Approaches in Policy Studies

The rise in importance given to the agency of the implementers of policy, the so-called street- level bureaucrats, also opened up the discussion on the way policy intentions and policy articulations are actually interpreted, reinterpreted and used by different agents located in different layers of government. This development paralleled the increasing importance given to 'meaning' as a critical dimension of policy. The key aspect of 'meaning' is that it is not something inherent in any given policy intervention, but rather arises during an interaction between an agent in a particular context and the particular policy.

The focus of the post-positivist approaches, then, is no longer the veracity or effectiveness of a particular policy, but rather the question of how a particular problem is conceived of or framed in the first place, and the contextual factors that enable it to arise as legitimate. Thus, as Bacchi points out, there is a shift from seeing policy as a problem-solving approach, to a problem-questioning approach in post-positivist studies (Bacchi, 2016).

While the umbrella term 'post-positivist' can refer to a very wide range of research approaches, in the following sections, I focus on the concept of problematization as it is developed in Bacchi's WPR method.

These approaches are diverse, but generally accept that knowledge is a human construction. Hence, there is no outside or Archimedean point from which to offer policy recommendations. As post-positivists, constructionists start by questioning the nature of a policy 'problem' (Bacchi, 2009).

'Problematization' in 'What's the Problem Represented to be'? Approach of Carol Bacchi

The key point of departure for the approaches broadly under the post-positivist umbrella is the way they conceptualize the 'problem' 'out there' that policy attempts to solve. Positivist approaches conceive of an objective and single true problem that can be understood and 'solved', given adequate, obtainable and objective information. Post-positivists, however, claim that there is no one objective problem, 'out there', but rather hold that problems are socially constructed. While not denying the presence of a material reality, post-positivists point to the fact that reality is experienced essentially through the meanings events convey to agents. Thus, the meaning of a particular aspect of material reality, is not something inherent, but is something that arises from a number of social processes (Jorgensen and Philips, 2002).

Problematization refers to the way in which a particular problem has been defined. In other words, starting by questioning the taken for grantedness of the definition of what are considered as 'problems that need to be solved', problematizations point to the underlying assumptions, struggles and practices that have enabled the problem to be perceived as something real, or taken for granted.

Bacchi points out that policy interventions imply the presence of a problem that is to be changed, thus in fact endorsing particular framings of problems rather than responding to a unitary problem. This is the reason behind the call to scrutinize the implicit problems in public policy more closely (Bacchi, 2009). The concept of problematization, thus points to the ways that a particular problem is being represented, based on the assumptions that are inherent as well as the solution that is being suggested. In effect, we are governed through problematizations rather than through policies. Therefore, we need to direct our attention away from assumed 'problems' to explore, understand and engage with the underlying problematisations (Bacchi, 2009).

Put briefly, the argument is that, in order to understand how we are governed, we need to examine the problem representations that are implicit within policies and policy proposals. Rather than accepting the designation of some issue as a 'problem' or a 'social problem', we need to interrogate the kinds of 'problems' that are presumed to exist and how these are thought about. In this way we gain important insights into the thought (the 'thinking') that informs governing practices (Bacchi, 2009).

The 'What's the Problem Represented to Be (WPR)?' approach to policy analysis is not concerned with the policymakers intention to solve 'a problem', rather the focus is on identifying deeper assumptions operating within these problem representations.

These approaches make the case that, among the many competing constructions of a 'problem' that are possible, governments have a privileged role due to the power they wield that enables their understandings to 'stick'. Thus, their versions of 'problems' are formed or constituted in the legislation, reports and technologies used to govern. Hence, these versions of the 'problems' take on lives of their own, and go on to influence how 'reality' is experienced.

The approaches that take the post-positivist perspective as their starting point cease seeing policies as problem-solving interventions, but instead are more interested in asking what the circumstances were that led to the problem being framed in that particular way (among so many other potential representations) (Bacchi, 2009).

What emerges in this reading of the post-positivist literature is that policymaking is ultimately a discursive struggle. The ways particular problems are defined determines the policy response, the ways of assessment, and the public perception of that issue (Bacchi, 2009). Thus, we come to see policy as performance rather than prescription (Fischer and Gottweis, 2005).

The initial use of the ACF and its limitations in terms of contending with meaning, led me to the post-positivist approaches. I used the concept of problematization, derived from the WPR approach extensively in subsequent parts of my research.

The Processes at the Organizational Level after the Articulation of Policy.

Orgill and Gilson (2018) point out that additional insight into the implementation process may be got by using the research frameworks that arise in the field of research that study the uptake, adoption and internalization of various innovations into systems. While much of the research has been done in fields

other than health, it is pointed out that this body of research can contribute quite well.

In this body of literature, one of the findings is the presence of multiple meanings. Greenhalgh *et al.* (2004), quoting the developmental literature, points out that how implementing agencies see a particular innovation may be quite different from the way it was seen by policymakers. From the complexity perspective this is explained as being due to the differing perceptions of cost and benefit the different stakeholders may have as noted by Atun *et al.* (2010). It follows therefore that innovations stand a better chance of being adopted if they do not deviate too far from the perspectives of those in power (Atun *et al.,* 2010).

In sum, research using the institutional lens and focusing on the processes at a particular organizational layer of government points to the interplay between structure, culture and meaning in modulating the way in which individuals within these institutions respond to new ideas.

Atun's Diffusion of Innovation Theory

Atun's Framework on the integration of innovations into the health system draws on two broad areas of work – one is the conceptualization of the health system as a complex adaptive system (Plsek and Wilson, 2001), with its attendant aspects of interdependence as well as unpredictability, and the emerging work on innovations, including their uptake and sustenance within an organization or system (Greenhalgh *et al., 2004*).

The framework suggested by Atun to study the adoption and integration of innovations starts by framing the health system as a complex adaptive system (Atun *et al.,* 2010). It then postulates the interaction between five distinct dimensions which include the problem, the intervention, the adoption system, the broader health system and the larger macro context in which the health system is embedded (Figure 2).

In the framework, the 'problem' refers to the social narrative around the problem and the associated sense of urgency attached to the need for a solution. In this research the problem is access to quality healthcare, as stated in the founding documents of the National Rural Health Mission (2005). Atun's framework further talks about characteristics of the innovation such as relative advantage, compatibility (with the system), complexity, trialability, and observability. The framework emphasizes the issue of complexity, describing three axes. These axes describe the number of times the intervention is to be repeated, by how many stakeholders, and whether the innovation is largely technical or includes behavioural components. In our research, the innovation we study is the

'Community Action for Health project,' which aimed to strengthen community-based accountability.

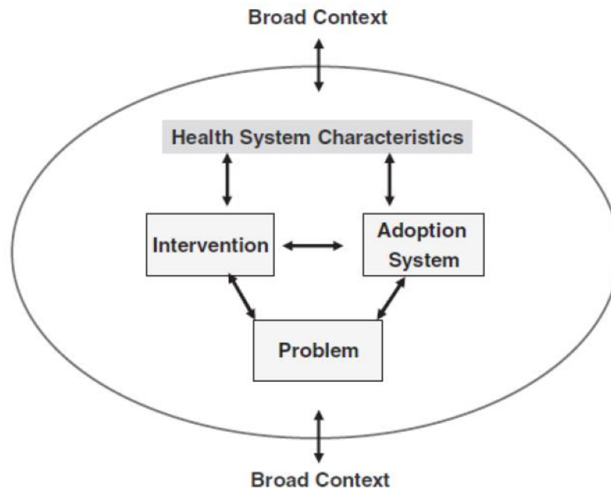

Figure 2. Atun et al.'s Framework for Adoption and integration of an innovation into the Health Care System (Source: Atun *et al.,* 2002).

With regards to the adoption system the framework points to dimensions such as perception of benefits by different groups of actors involved in the uptake and implementation, alignment of innovation with values in the adoption system, and the legitimacy of the intervention as perceived by those in the adoption system. The broader health system characteristics refer to regulatory and accountability frameworks, and integration with already existing management and financing mechanisms. The dimension of the broader context refers to various aspects of the context, including (and not limited to) the demographic, socio-political, legal, cultural and environmental, that characterize the context in which the adoption system is embedded.

Conceptual Framework

Deriving from these three theoretical approaches described above, as well as the insights into implementation and the institutional perspective, I now present the conceptual framework that I developed for my research.

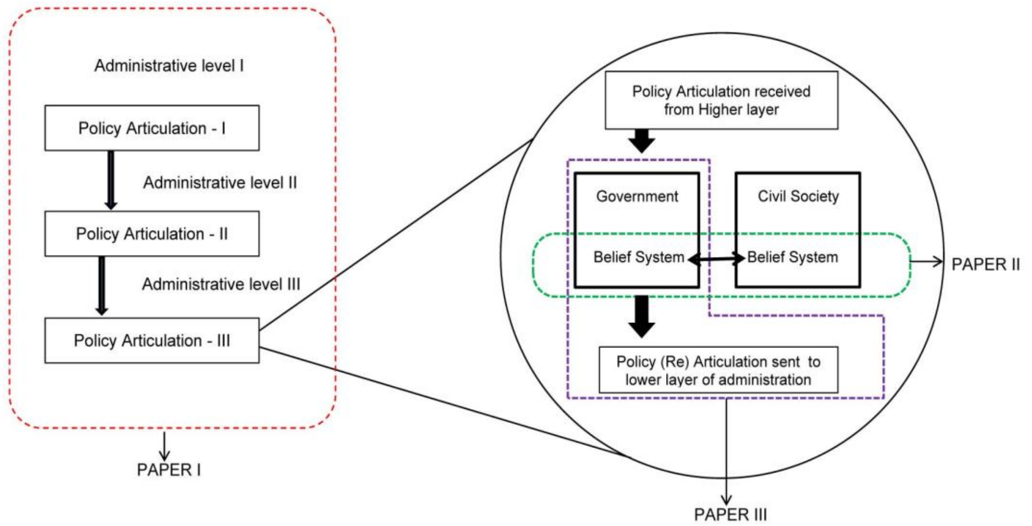

Figure 3. Conceptual framework of this thesis.

Broadly the key concepts presented in the diagram (and derived from the theoretical frameworks) are as follows:

- One is the multilayer process, which takes place within the government as an intervention that is already on the policy agenda moves towards implementation and the integration into the day-to-day functioning of the health system. Each administrative level of the government is conceptualized as having received, interpreted and rearticulated the policy (represented as Policy Articulations 1, 2 etc., in the conceptual framework).
- The second is the linkage between the underlying belief structures of various actors and the particular policy frames they prefer, with attendant impact on the design of programmes.
- The third is the inherently conflictual processes that these are - At each level there is a conflict between multiple groups holding different underlying belief structures. In the diagram this is represented by the Government and Civil Society boxes, each with their own belief system that interact and influence each other.
- And finally, the use of the institutional lens – by which I specifically mean unpacking the processes within the organization in terms of rules, processes and structures and the way these influence the policy process.

> These conflicts and negotiations entail the drawing on different institutional resources and structures for the dominance of one particular articulation over the other.

In essence, what the conceptual framework attempts to convey is that the policy process is a multilayered one, with multiple meanings conflicting, and the conflict and negotiation itself being mediated or embedded in a set of institutional patterns unique to organizational settings.

In Figure 3, I have also marked out the broad foci of the individual papers that constitute this thesis. As described in more detail in the next chapter, the three papers are divided into two phases of research.

Paper I – represents the output of the first phase of research and follows out the initial (national level) roll-out of the CAH project from its articulation in the National Framework of Implementation through the pilot phase in nine states and finally its roll-out at the state level.

Papers II and III represent the outputs of the second phase of the research, in which I decided to focus on the processes in one particular state, the South Indian State of Tamil Nadu. The choice of Tamil Nadu was also because of my personal involvement in the implementation of the programme, as well as my familiarity with the health system there.

Paper II – explores the belief structures of the participants / actors who were key in the implementation of the CAH project in the state of Tamil Nadu.

Paper III – explores the way in which the belief structures at that level (Tamil Nadu state level) interacted and resulted in the actual roll-out that took place post the pilot phase, in the state of Tamil Nadu.

5. Materials and Methods

This chapter presents the methodological aspects of the research, it covers the description of the research setting, the research design, sampling and analytical processes, and ethics approval.

Research Design

The research used a case study design for collecting and analysing the data. This study design, "is an empirical approach that investigates contemporary phenomena within a real-life context, where the boundaries between phenomena and context are not clearly evident and in which multiple sources of evidence are used" (Yin, 2003). In addition, Stake points to the importance of defining the context within which the case is embedded, as he contends that cases are complex entities embedded in their own unique contexts and historical backgrounds (2013).

I have divided my research into two phases: Phase 1, henceforth referred to as the 'National Roll-out phase', in which I focus on the national level roll-out of the CAH project, and represented by Paper I - henceforth referred to as 'CAH Mapping paper'; and Phase 2, henceforth referred to as the 'Tamil Nadu Case study', which focuses on the processes in the state of Tamil Nadu and which is represented by Paper II - henceforth referred to as the 'Multiple Perspectives paper' - and Paper III, henceforth referred to as the 'System Integration paper'. The relationship between the objectives, the phases and the individual papers is laid out in Table 1 below.

The National Rollout phase - The first phase sought to critically document the roll-out of the CAH project from its initial articulation in the Framework of Implementation of the National Rural Health Mission in 2005, through its articulation in the AGCA pilot proposal to the post-pilot phase, the latter phase being anchored by the respective state governments.

This phase of the research was designed to achieve a deeper understanding of policy roll-out and divergences, which could then be studied more in depth at the state level. This phase not only documented the ways in which the policy diverged from its original articulation as it moved down various administrative layers, but also discussed these findings in depth with a number of key actors to make better sense of the divergences documented. In addition to this, the study of the national level roll-out of the policy, meant that the findings from Tamil Nadu in the next phase could be placed in the larger national perspective.

Table 1: Relationship between Research Objectives, Phases of research and the individual papers that consititute the thesis.

Research Objectives	Phases	Paper	Method
1) To map out and analyse the diverse pathways of the implementation of the Community Action for Health process	Phase I National Roll-out phase	Paper I CAH Mapping paper	Document Review In-depth Interview
2) To analyse the divergences that occurred during implementation and to understand the determinants of these divergences as the policy was received and transmitted through different layers of government during implementation			
3) To explore the different ways in which calls for increased accountability as a clear policy directive at the national level were interpreted at the state level by key actors in the context of the implementation of the National Rural Health Mission	Phase II Tamil Nadu Case study phase	Paper II Multiple Perspectives Paper	In-depth interviews
4) To explore the individual and institutional factors that contributed to the way in which the policy regarding community participation was formulated at the state level, as well as that impacted the way it was designed and rolled out		Paper III System Integration paper	In-depth interviews

Tamil Nadu case study phase - The second phase of research focused specifically on the processes in the state of Tamil Nadu. This second phase was guided by the insights from the first phase. Since the aim was to focus on issues regarding the uptake and integration of the CAH project in the state, I focused on the state apex administrative level. This is especially because it is this level that received the policy from the central government, observed the pilot project and was to adapt the CAH project to the needs of the state. Further, the actions and perspectives of this level constrain to a large extent the way the lower layers of administration implement a policy. This focus on one particular layer is justified as being critical for enabling the systematic study of specific events and their internal and external determinants, thus contributing to the building of an overall understanding of implementation (Hill and Hupe, 2003).

The Research Setting - Community Action in the National Rural Health Mission – Implementation in the State of Tamil Nadu

The research covers the Pre-Pilot Phase, the Pilot phase and the Post-pilot phase of the CAH project, at both the national and the Tamil Nadu state level. This pertains to the following periods and key activities and should not be confused with the phases of research of this thesis, see Table 2:

Table 2: Phases in the implementation of the Community Action for Health Project at the National Level.

Pre-pilot phase	2005 – 2008	The phase from the appearance of the concept of communitization in the Framework for Implementation of the National Rural Health Mission to the formulation of the project proposal for the pilot phase by members of the AGCA
Pilot - phase	2008 – 2010	The period of the implementation of the pilot project in nine states (over a period of one year) and the external evaluation of the project.
Post – pilot phase	2010 – 2014	The period pertaining to after the implementation of the pilot project when the state of Tamil Nadu decided to implement the project after the pilot phase – this continued till 2012 when the project abruptly stopped in Tamil Nadu, while it continued in one other state.

The National Roll-out phase of my research covers the processes during the pre-pilot, pilot and post-pilot phases during the period 2005 – 2016 at the national level. The Tamil Nadu case study, focuses on the processes in the state of Tamil Nadu, India (Figure 4.) during the pilot phase (2008 – 2010) and subsequently during its implementation between2010 and 2012, when it was stopped.

India has a federal political structure in which health is constitutionally on what is known as the concurrent list. This means that some aspects are under the control of the central governments, while others are under the control of the individual state governments. Pertinent to the research, both planning and provision of health services, come under the control of individual state governments. In reality, however, the actual autonomy of individual state governments depends on their fiscal as well as administrative and planning

capacity. In this context, Tamil Nadu has historically been one of the leaders in the assertion of its autonomy from the central government.

In Tamil Nadu, the public systems are remarkable in their relative efficiency compared to the other Indian states (Muraleedharan, Dash and Gilson, 2011). Like the rest of India, Tamil Nadu has a multitiered public health-care set-up with a health sub-centre (HSC) with an auxiliary nurse midwife for every 5,000 population, a Primary Health Centre (PHC) with two doctors at the 30,000-population level and a First Referral Unit or Community Health Centre (CHC) at the 100,000 population level. Further referral is to the district hospitals and the medical college hospitals in urban centres. Tamil Nadu is the only state in India that has a separate department for public health at the primary care level which is staffed by a medically trained public health cadre. In Tamil Nadu, the state level Department of Public Health & Preventive Medicineis in charge of policy formulation and the subsequent monitoring of implementation of health-related policy delivered up to the CHC level. The district level unit of the department is in charge of the implementation. The implementation of public health policy in the state through this infrastructure, has been noted to be influenced by a hierarchical (Gaitonde, 2015) and coercive (Nagaraj, 2014) approach.

Another aspect of the functioning of the health department that is germane to the methodology is the way in which a newly introduced project is handled. Each new project is usually handled by one officer (usually a medically trained doctor with a training in public health). Until the incorporation of the components of the project into the day-to-day functioning of the health system throughout the state, all aspects of implementation, are taken care of by this individual, with support from a few general administrative support staff. This officer reports to one or two senior officers in the State Health Society / Department of Public Health and Preventive Medicine. Thus, for most new projects not more than four or five officers will have an in-depth understanding or knowledge of the processes in the early stages, before the programme is incorporated into the day-to-day functioning of the health system. This was also the reality for the CAH project, and this had an impact both on our sampling and ability to reveal too many details regarding the source of various quotes.

As noted in the earlier section on the processes in India (Chapter 2), the NRHM created spaces that enabled the civil society organizations (also referred to as NGOs) to take on leading roles in the implementation of the CAH project. This enabled NGOs to go beyond their typical role of service provision.

Apart from the above structures that form the service provision arms of the department, the State Health Society is in charge of planning and funding the

various programmes under the National Health Mission (NHM) formerly referred to as NRHM, at the state level.

In the next sections I will describe the data collection and analysis for each of the individual papers of the study, phase-wise.

Figure 4. Location of the state of Tamil Nadu in India (Source: http://mapsopensource.com/tamil-nadu-location-map-black-and-white.html)

Phase 1 – National Roll-out

Paper I – National Mapping paper

Data Collection

The CAH Mapping paper divided the CAH implementation process into three chronological phases (as detailed above). Key documents that pertain to the specific phases were collected and analysed. For the first two phases, these documents included the original policy proposals, the minutes of the meetings of the AGCA held to discuss and evolve these and the evaluations of the community monitoring and planning process. For details regarding the post-pilot process, the relevant sections of individual state annual plans submitted to the central government referred to as Project Implementation Plan, were referred to. Reports by the Common Review Mission, a system of annual multi-stakeholder rapid appraisals of the implementation of the programs under the state's Annual Health Plan under the NRHM were also used to gather more details of the state level processes. The data sources used are represented in Figure 5.

Once the documentary analysis was completed, interviews were conducted with key-informants who were actually involved with the roll-out of the policy at different levels. These included seven individuals at the national and state level from within the government and from the NGO sector.

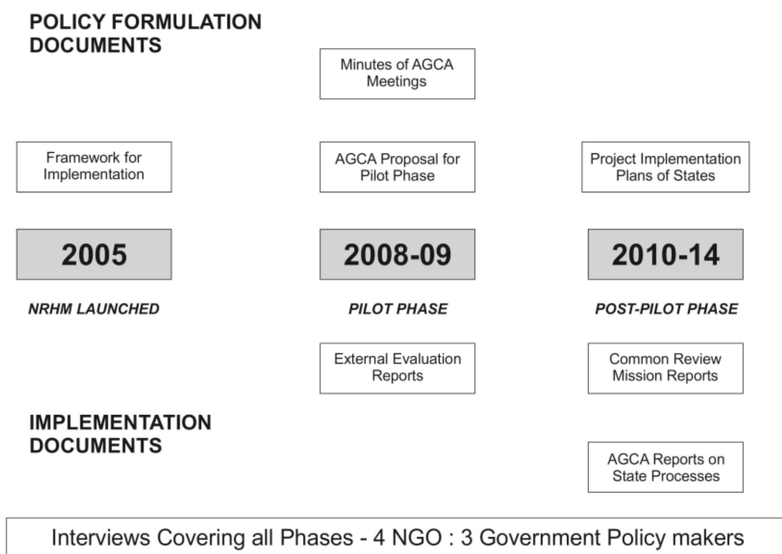

Figure 5. Data sources for CAH Mapping paper (Source: Gaitonde 2016).

For the CAH Mapping paper, the primary data was obtained through the document review – with individuals from the state and NGOs involved in the implementation providing confirmation of the interpretation of the findings from the document review, as well as providing insights into the patterns that were discerned from the document review.

For the national level (2) – I chose one representative (a former bureaucrat) of the body that developed the project, and one NGO representative who was a key stakeholder of the project, both at the project development and subsequently at the state level implementation phases. In addition, one of the state NGO representatives interviewed also had extensive involvement with the CAH project, having played key roles at both the state and the national levels. For the state government (2) I chose officials who were representative of one state where the project was abruptly stopped after the pilot phase and one state in which it was continued. (2) For the state – NGOs (3) – I interviewed one senior implementer from a state in which the CAH project was continued, and two from states in which it was modified significantly.

Analysis

For the initial mapping exercise of the roll-out of the CAH project - the data analysis was done using the thematic analysis approach (Attride-Stirling, 2001; Braun and Clarke, 2006) in two stages. In the first stage, after reading and familiarization with the documents, the various stages and components of the CAH programme, like training, NGO role, and community-based monitoring and planning were traced through the formulation, pilot and post-pilot phases, to discern key divergences as they emerged from the documents.

In the second stage the transcripts of the interviews were coded using both pre-decided and emergent codes focusing on the interviewees' explanations of the divergences. These codes were then arranged into categories corresponding to the main components of the Advocacy Coalition Framework, concerning beliefs, resources, external factors and internal factors to make sense of the overarching narrative that emerged.

Phase II – Tamil Nadu Case Study

In the Tamil Nadu case study or Phase (II) – representing the second and the third papers - the primary mode of data collection was in-depth interviews. Given that the project had been implemented for only two years (after the pilot phase till the time it was abruptly terminated), there were only a very small number of officers actually dealing with the implementation, as described in detail in the section on settings. Further, given that the main aim of this research was to study the processes that occurred at the state level during the course of the implementation and subsequent and the abrupt cessation that took place between 2008-2012, the total number of those who had any knowledge of the project as well as being familiar with the internal discussions and feedback received at the state level was, in fact, quite limited. Given my intimate involvement in the processes over both the conceptualization, and the planning as well as the implementation during both the pilot and subsequently the post-pilot continuation phase in Tamil Nadu, I was able to use the knowledge of the process and those involved to guide my choice of key informants.

Paper II – Multiple Perspectives paper

Data Collection and Research Participants

For the Multiple Perspectives paper, I included five government officials (four from the state level and one from the national level) and four civil society representatives (two from the state and two from national level). The main criteria of their choice at the state level was the fact that they were involved in the

implementation of the NRHM projects, including those for community-based accountability. Three of the government officials had more than 30 years of experience, while the other two had approximately 15 years' experience. All civil society representatives had over 15 years' experience. Thus, they all had experienced the changes in the health system post the introduction of the neo-liberal reforms in 1991. Thus, some were even able to contribute a historical perspective to the research.

Data Analysis

For the first stage of the analysis we used grounded theory (Charmaz, 2006) to explore the various meanings that emerged from the interviews. All transcripts were shared with my supervisors and after multiple rounds of discussion between ourselves, I proceeded to code the data. After an initial line-by-line open coding, which was close to the data, a set of key categories describing various aspects of the definition of accountability and highlighting various aspects of programmes emerged. Analysing the interviews led to the emergence of a number of specific aspects of the process of implementing the project that were repeatedly highlighted by the participants. These included aspects such as the overall role of the health system; the overall outcomes of programmes aiming to increase system accountability; the role of training / capacity building of the community in such programmes; the role of community-based monitoring of the availability and quality of entitled services; and the role of external agencies, especially civil society groups in the implementation of programmes. Further, I read closely within the material describing specific aspects of the programme to discern any contradictions between participants or contrasting assumptions. I then repeated the exercise for each of the aspects of the programmes described above. I analysed each of these specific aspects of the programme through the lens of 'problematization'. I use the technique of 'retroduction' in order to 'read-off' the deeper beliefs from the way a particular problem is represented. This process is described as follows: "To begin with, a surprising, anomalous, or wondrous phenomenon is observed. One then proceeds 'backward' to furnish an account of how and why this is so". (Hanson, 1961 in Howarth and Griggs, 2012). After repeated iterations of these steps, one was able collect these assumptions / perspectives into three emergent groups of perspectives.

Paper III – System Integration paper

Data collection and Research participants

The System Integration paper was based on the data collected during the interviews that formed the basis of the second paper. While in the second paper we focused on the way the individual actors conceptualized accountability in the

setting of a community-based accountability project, in the third paper we focused on their description of the processes that took place in the state with reference to the implementation of the CAH project.

Data Analysis

In the System Integration paper, we analyzed the data thematically (Attride-Stirling, 2001; Braun and Clarke, 2006), coding into the various dimensions of the Atun's framework (Atun *et al.,* 2010) and further trying to understand the sub-themes under each of these. After familiarizing myself with the data, I proceeded to do an initial coding remaining close to the data. Further steps included arrangement of these into the various dimensions of the framework and discerning the emerging narrative with reference to the actual implementation process. At each step the evolving analysis was discussed among all the authors.

Table 3. summarizes the participants interviewed during each phase and study and their backgrounds

Table 3: Summary table of interviews conducted during each phase of research.

Phases	**Paper**	**Method**	**No Interviewed** (Total number of interviews used)	**Rationale**	**Others quoted**
Phase I National Roll-out phase	Paper I CAH Mapping paper	Document Review In-depth Interview	7	National Gov: 1 National NGO:1 State Gov: 2 State NGO: 3	
Phase II Tamil Nadu Case study phase	Paper II Multiple Perspectives Paper	In-depth interviews	6 (9)	State Gov: 4 State NGO: 2	Drew on 3 interviews from the first round
	Paper III System Integration paper	In-depth interviews	6 (9)	State Gov: 4 State NGO: 2	Drew on 3 interviews from the first round.

Ethics Clearances

This study received ethics clearance from the Institutional Scientific and Ethics committee of the Society for Community Health Awareness Research and Action (SOCHARA) – School of Public Health Equity and Action (SOPHEA) based in Bangalore, India. All documents were accessed from public domains. All interviewees provided full written informed consent. The interview transcripts were anonymized, and stored in a pass-word protected drive, only accessible to me. Further all the papers were shared with key interviewees to ascertain adequacy of anonymity, and were submitted only after they were fully satisfied.

6. Results

National Roll-out Phase Summary

The research mapped the various axes along which variations from the originally articulated policy on Community Action for Health (CAH), occurred. This was studied as the policy was first articulated by the Central Ministry of Health in the Framework of Implementation of the National Rural Health Mission, and subsequently traversed a number of layers of government on its way to actual field level implementation. This phase of the research led to the construct 'divergences', detailed below.

Tamil Nadu Case Study Phase Summary

The second phase focused on an in-depth case study of the process of implementation of the CAH project in the state of Tamil Nadu. An exploration of the importance of perspectives and meanings in the understanding of policy implementation defined the second phase of my research. The outputs of this phase consist of two parts.

The first paper in this phase is referred to as the 'Multiple Perspectives paper' in which I conducted an exploration of underlying perspectives among the key actors involved in the implementation of the CAH project at the state (apex administrative) level in the Department of Health and the State Health Society in the state of Tamil Nadu, revealing three distinct perspectives on accountability, which I have described as reflecting 'dissonances' among the key actors responsible for the implementation.

Subsequently in the second paper of this phase referred to as the 'System Integration paper', I focus on the actual processes and decision-making around the CAH project in Tamil Nadu, after the centrally sponsored pilot project and during the period where it was sought to be integrated into the day-to-day functioning of the public health system and upscaled to involve the whole state. This research led to the definition of a third construct, which I have identified as 'disconnects', which contribute to understanding the processes around implementation.

Taking all the papers of the two phases together –three constructs - 'divergences', 'dissonances', and 'disconnects' emerged.

National Rollout Phase

CAH mapping paper (Paper I)

The emergence of the idea of community-based accountability on the policy agenda – the organizational setting.

A space for an innovative idea related to community-based accountability in the public health system arose thanks to the unique political situation in the country at the time. The emergence of the idea (which was one of many innovative and pro-people policy interventions) followed a hard-fought election in 2004, where the previously ruling right-wing party was voted out of power. The incoming coalition government (referred to as the UPA) brought in a number of innovative and pro-people policies during their rule. The ruling coalition included the Left parties – both the Community Party of India (Marxist) (CPIM) and the Community Party of India (CPI). Further, the creation of new spaces in the government and the invitation of a number of civil society groups into these spaces, as described in the introduction, infused a number of new ideas into the policymaking process. These new ideas found resonance among several senior officers. These officers had all worked with NGOs and international development agencies. This had exposed them to the latest thinking and practices related to governance and accountability. They were considered boundary spanners, and now occupied key positions of authority, at both the central and the state levels (at least in the case of Tamil Nadu). Finally, the civil society representatives who were involved in the policy formulation, through their involvement in the AGCA, had a lot of experience of working on various models of community-based accountability, especially from a Right to Health perspective. As one of the participants noted,

> *There were different ideas floating around, and when there are different ideas floating around, it is sometimes easy to steer in a particular process…. So, between these cracks NRHM emerged with civil society space on the drawing board".* [National NGO representative]

However, when interviewed themselves, these individuals who were identified as being CAH's policy 'champions', pointed out that it was not enough just to be in a position of power to bring something new to the policy agenda. They pointed to the importance of supportive senior officers, and a healthy and respectful and, most importantly, trusting relationship with the individual or group who were advocating for a new policy. In the case the CAH project, this was the NGO in charge of implementation. This support, they pointed out, was especially important for agenda setting when it came to policies like CAH, which the government has not traditionally implemented and that had uncertain outcomes.

The divergence of policy

This research has documented the ways in which the Community Action for Health project diverged from its originally articulated design through the course of implementation. In Paper I, I traced the way in which the conceptualization, emphases and programme design and implementation of the CAH process changed as it moved down the various levels of implementation, and in the various states after the completion of the pilot project.

Community-based monitoring of the entitled health services by members of the Village Health and Sanitation Committees (VHSCs) was the core feature of the project. The research identified at least two ways in which the policy varied as it was transmitted down the layers of administration as part of its implementation.

The most obvious form of divergence was the way in which this AGCA model was actually taken up after the pilot phase (2010–2014).

It was noted that in one pattern the process was abruptly terminated after the initial central government sponsored pilot project, despite a positive end line external evaluation of the project. This happened in three states. I have termed this the 'model rejected' outcome. In another pattern, the process continued as originally envisaged. This occurred in two states. This I have termed the 'model accepted' outcome. And in the third pattern, the process continued with a significant change in some key components of what was originally envisaged. This happened in five states. I have termed this the 'intermediate' outcome (see Paper I for more details).

However, more detailed document reviews revealed that another way in which the project varied was by a shift in the emphasis given to various components of the project as it moved down through different administrative layers. The components that seemed to have varied the most were: the role of the NGOs in implementation; the role of the panchayats in implementation; and the relative balance between monitoring and planning in the programme. My focus on these particular components emerged from a reading of the documents (listed in detail in Figure 5) relating to the roll-out. The table below highlights the way in which the emphasis on each of these components changed during the various phases of implementation. In the policy formulation phase, the central government articulated the policy as part of the Framework of Implementation. In the programme formulation phase (referring to the implementation of the pilot project), the Advisory Group of Community Action (AGCA), a committee of the Central Ministry re-articulated this vision into the pilot phase proposal, and in the programme roll-out phase, the responsibility of the implementation moved to the individual state governments.

Table 4: The Changes in the Emphasis in various components ofthe CAH Process (Source Gaitonde *et al.,* 2017).

	Phase in Implementation	Role of NGO	Role of Panchayats	Relative importance of monitoring	Relative importance of planning
1	Policy formulation (2005)	+	+++	++	++++
2	Program formulation (2006-2010)	++++	+	++++	+
3	Program roll-out in the post-pilot phase (2010-2014)	+	Varies by state	+	+

As seen in the table above (Table 4), while the original policy document – proposed a project anchored in the panchayat structures with the NGOs supporting, subsequent discussion in the AGCA led to a model in which the NGO was the lead implementer, and there was more emphasis on monitoring than on the planning component. This was the model implemented in the pilot phase. However, after the pilot phase, when the implementation responsibility (and lead) moved from the Central Ministry to the state governments – there was again a shift in the emphasis away from the NGOs, and a moving back towards the panchayats. Similarly, there was a relative downplaying of the component of monitoring, with overall more emphasis on education and awareness building of the entitlements among the community.

Multi-layer origin of these divergences

The research reveals that these changes took place as the project traversed different layers of government during implementation. At each layer the CAH project seemed to undergo a rearticulation, as it was passed on to the lower layer for implementation.

Determinants of variations at each layer

What also emerges from the research is that the variations identified at each level could be linked to the identity of the actors who were dominant in that administrative layer, in that particular context.

> *...because of the change in the whole power equation....between the pilot phase and the post-pilot phase ... the way in which the process rolled out in different states became extremely differentiated and diverse...then depending on the complexion and the attitude of the health department in each state...that became the key determinant in each state.* [National NGO representative]

One of the important re-articulations of the project occurred as the project was operationalized by the Advisory Group on Community Action (AGCA). Through this process of operationalization, civil society representatives in the AGCA along with progressive senior government officials were able to introduce aspects of the programme that differed from the original articulation. This included components like the significantly enhanced role for civil society organizations, a diminished role for panchayats, and an increased role for monitoring as compared to planning (Table 4). These changes reflected the perspective of the civil society groups, who played an important and deciding role within the AGCA, given the support they received from 'champion' bureaucrats. Similarly, the way in which the project continued in individual states after the pilot project could be attributed to the presence of networks of NGOs, and their ability to influence the processes at the state levels. However once state governments agreed to support implementation, their influence invariably overrode that of the national level civil society organizations. This was especially seen with regards to the role of NGOs in implementation, with state governments reducing the role of the NGOs significantly compared to the AGCA pilot project.

What seems to be emerging thus is that the particular way in which the emphasis on different components of the overall project varied from layer to layer was linked to who was the dominant actor at that particular stage of the implementation process. This included both the government officials at that administrative layer and the NGOs involved.

Tamil Nadu Case Study phase

Multiple Perspectives paper (Paper II)

The presence of divergent perspectives on accountability

One of the key findings of this research (and presented in detail in Paper II Gaitonde *et al.,* 2019), was the discovery of at least three distinct perspectives on accountability among the key actors who were involved in the implementation of CAH, and two of these within the health system itself.

I have named these three as 'Accountability as Targets'; 'Accountability as Efficiency'; and 'Accountability as Transformation'.

The main intention of the research for the Multiple Perspectives paper on which these results are based was to explore the presence of and attempt to delineate distinct perspectives on accountability present among the key actors of the implementation of the CAH programme. There was no attempt to define the composition of the groups exhaustively.

From the interviews there emerged three distinct problematizations of the current situation of access to health in the state, which the CAH programme was introduced to tackle. In the following paragraphs, I delineate the distinct perspectives on accountability that arise from these distinct problematizations.

Accountability as Targets – In essence the 'Targets' perspective considers being accountable as meaning the accomplishment of targets for service coverage. These targets are based on expert-defined 'needs' of the community. According to those who espoused this perspective, the consumption of appropriate health-care services was enough to lead to an increase in welfare. The lack of consumption of particular services was explained as a reflection of 'ignorance' among the community, and training was equated to awareness building. Thus, any gaps in services could be identified and filled with adequate funding and awareness building among the community. NGOs were seen as 'irritants', and 'distracting' from the government-led provision of services.

The problematization that seemed to be implicit in this perspective held that the issue of availability and access to services and the lack of communities approaching the government for services (especially among the marginalized) was an issue of inefficiency of the public sector, which could be overcome by better management (capacity of the officers) as well as increased accountability to the people they serve. This, according to those who held this perspective, could be further improved by increasing the capacity of the community to understand the logic and rationale behind the services. This perspective was mainly held by the bureaucrats interviewed and the more junior officers.

Accountability as Efficiency - The 'Efficiency' perspective also saw accountability as being about the reaching of technically set targets. Like the 'Targets' perspective, these targets and the associated plans are also defined by experts. However, the difference between this and the 'Target' perspective was that there was recognition of the need for community feedback. There was an element of moving away from strictly expert-set targets to what may be termed the 'community needs assessment' approach. Yet the overall content and priorities of the services were, according to this perspective, still to be set by the system. Given the overarching focus on the management component, there remained a focus on quantitative targets. Nevertheless, this perspective allowed for the concept of triangulation, introduced by the NRHM, for the framing of accountability as the

correlation between multiple sources of information. Thus, community-based monitoring was seen as a way of cross-checking information available through the routine health system. According to this perspective, the training component of a programme, went beyond awareness building and was equated with the community's capacity building. Those holding this perspective believed that the community needs training and capacity building in order for it to understand the logic and rationale behind the various services being provided by the system. This training and capacity building were to be done by external agents such as NGOs, as they will do so more efficiently and with greater reach. At the end of such trainings, the community was expected to make demands that are more in line with what the department is providing, thus increasingly sharing / internalizing the logic and rationale of the experts. External agencies like NGOs were seen as playing a crucial part in implementation, especially of non-routine programmes like those trying to implement community-based accountability. Left only to the government such processes, these participants felt, would never have even been implemented. This was attributed to the fact that the NGOs have more flexibility in functioning than the government.

The problematization that seemed to be implicit in this perspective blamed the current situation in the health system as being due to interference with the autonomy of the public health department, and the constraining of funds available for public health activities. Thus, the way to improve it is not through the involvement of NGOs but with increasing funding to the department, and letting the experts within the department have a free hand in planning and managing the public health system. While this perspective was held by senior technical officials, it was also identified as a distinct perspective by all government officials interviewed.

Accountability as Transformation - According to this perspective, the key feature of an accountable system was not only meeting the needs of the community, but also their aspirations, thus clearly expecting the community to play a greater role in defining the objectives of the system than the prervious two perspectives. Those holding this perspective felt that the services should be provided in such a way that the various social determinants, such as caste, class and gender, which are key axes along which inequity arises, are taken into account. They thus went beyond just the provision of services, and expected an accountable system to engage with the larger structural determinants of health. This was thus a radically different conceptualization than the earlier two. According to this perspective, the community was an equal partner as a consequence of 'citizenship' and 'rights'. Thus, this perspective criticized the experts and the managers for ignoring key dimensions of various services / interventions that were important from the community's point of view. Thus, accountability programmes were seen by this group as being all about altering the power balance, between the system and the

community, in favour of the community. This would also enable the community to gain in confidence while interacting with the authorities and deepen the democratic process. More importantly, this perspective pointed out that any process of training had to be sensitive to the unique socio-economic-political and cultural context in which the particular programme was being implemented. In other words, the training is about laying bare the larger structural issues and creating an awareness and demand for structural change. This concept of training goes beyond 'awareness' and 'capacity building' articulated in the earlier two perspectives to the concept of 'structural competence'. This perspective saw accountability as the building up of more equitable relationships between the public health system and the communities they serve. It holds that in an unequal situation, such as obtained between communities and the public health system, it was crucial for there to be an external agency to help the community negotiate these power differences as they gradually gained confidence and were empowered in the process. The external agencies were not only to conduct the training and capacity building of the community but were also crucial in supporting the community's empowerment.

The problematization that seemed to be implicit in this perspective saw the fundamental reason for the services not reaching groups of the community as being due to the unequal power distribution between the community and the system, and further within the community itself. For those who held this perspective, the key aspect of the CAH project was the mobilization and the organization of the community to hold the health services accountable for their actions (and inactions). This perspective was clearly animated by concepts of deepening democracy and citizenship. Further, this group also recognized that the peripheral workers themselves could not be blamed (unlike the other two groups), and any gaps in services need to be seen systemically rather than as individual service provider related flaws. In addition, it called upon the public system to acknowledge the power differentials within communities and respond appropriately. This perspective was held mainly by NGO participants, but was also acknowledged by a few government officials. These differences are summarized in Table 5 below:

Impact of different perspectives on program design

Using the components of the programme that emerged in the mapping of divergences in the National Roll-out phase, I documented particular programme design elements that were emphasized by each of the perspectives.

Table 5: Summarizing findings on different dimensions of accountability according to the three emergent groups from the study (Source: Adapted from Boven et al. 2014 & van Belle 2016).

S. No	Dimension of Accountability	TARGETS	EFFICIENCY	TRANSFORMATION
1	Who is accountable?	Health system officials / front-line providers	Health system officials / front-line providers	The health system as a whole in addition to individual providers and officers.
2	To whom?	Mainly to superiors	Superiors / community	Primarily to the community.
3	For what?	Targets / specific outputs Primarily process accountability	Outputs primarily	Outcomes individual as well as distributional.
4	By which standards?	Bureaucratic standards of rules / protocols	The interventions set by experts, but quality standards in terms of where, when and how etc., of the interventions in discussion with the community	Democratic standards Rights Social justice
5	Why?	To ensure that possibly wayward providers stick to the agreed upon targets.	To ensure the reaching of system set goals. To be efficient in spending the taxpayers money. By involving community resources.	In order to bring about the experience of true democracy and thus lead to an alteration of power balance. Structural change.
6	Causal model – Expected outcomes	Improvement of service coverage	Improvement of quality of services, making them more relevant to the community.	Services' quality improve. More importantly the power differential between community and system changes, and communities become more equal partners in governance.

The officers holding the Accountability as Targets perspective considered NGOs as irritants, with community monitoring only providing information of existing gaps that can be corrected by the appropriate activity of the department. Those

holding the Accountability as Efficiency perspective on the other hand saw the NGOs as a valuable allies to train and bring the community ‘up to’ the level needed to understand the rationale of the programmes (especially when these were being provided under increasing fiscal constraints); monitoring was seen as a way for the ‘clients’ of the programme to hold frontline workers accountable for the provision of entitlements. The Accountability as Transformation, however, considered NGOs as support to the community in their struggle against the power of the health system officials and thus saw monitoring as a valuable tool to strengthen the community voice in negotiations with the health system in altering the power balance.

As pointed out above, the differences in the differing perspectives on accountability tended to reflect themselves in particular aspects of the programme design. Thus, we were able to demonstrate the link between different perspectives and different programme design principles.

Systems integration paper (Paper III)

Characterizing the mechanisms at each layer of government

What emerges from the findings the Multiple Perspectives paper is the presence within the same department, of two of the three divergent perspectives on accountability: Accountability as Targets and Accountability as Efficiency. This led to different assessments by these participants of the relevance and importance of CAH in dealing with the issues the Tamil Nadu health system is facing.

Thus, for the Efficiency group the NGOs were seen as partners to fill in the lack of capacity of the government, especially as they had a good presence in the field and a rapport with the community. The Targets group on the other hand, saw the NGOs (who were leading the CAH project) as an irritant. They were upset with what they termed as the disruption of the natural relationship between the community and the health system with the advent of the NGOs on the scene.

In the early phases of the CAH project, i.e. during the pilot phase and immediately after the pilot phase – the policy champions, and those espousing a particular perspective of accountability were in key positions of power, both in the Central Ministry and at the state level. This meant that the project was implemented, with particular design features, despite antagonism from members of the other group. Given the hierarchical nature of the health system in Tamil Nadu, it was not surprising that the officials in charge of implementation followed the line of the officer in the senior position.

However, with time, when the officers at both the central as well as the state level shifted from their positions, the balance of forces changed. At this time the group that was resistant to the idea of community monitoring and the active involvement of NGOs could dominate, and the project was discontinued despite it being provisioned for in the state budget and all formalities for its implementation having been completed.

Another dimension along which there seemed to be a change in the balance of forces was during different stages of the life cycle of the project. Thus, in the initial stages of the project when the main aim was to establish a proof of concept there was little opposition to the project. Subsequently after the pilot project it was implemented in a few districts in the state and there was little opposition even then. It was only when the project was to be expanded to cover larger areas, and when the project required bringing about structural changes in the governance of the public health system that the opposition to the project peaked.

Though the aspect of the NGO perspective was not actively pursued in this research, those interviewed for the first paper pointed out that the project seemed to have continued in the form originally envisaged only in those states where the civil society groups were united in a common front and were able to put forth the argument for the need for such a project strongly. The research for the first paper supports this, and showed that in those states where the civil society groups were not as strong, the government either shut down the programme or continued it in a modified form.

Thus, what emerges consistently over the research is the importance of the balance of opposing forces for the project and its components to take on a particular emphasis.

The nature of the decision-making space in Tamil Nadu

One of the key determinants of the various stages of adoption and institutionalization of the project that were highlighted in the discussion of governance in Tamil Nadu (from the Systems Integration paper) was the hierarchical nature of the system. This was a feature not only of the public health department, but of the larger governmental system as a whole.

A number of points emerged from the interviews in this connection. First, interviewees talked about the impact of increasing political interference and pressure of fiscal constraints on their functioning (described above). However, their response to this was to work within these constraints rather than take these up for discussion or debate within the system.

Another aspect was the concentration of decision-making power with the person at the apex. Thus, it was pointed out that even if there were innovations, their uptake and integration into the system depended on the apex official. Similarly, it was pointed out that whatever the apex official wanted went unchallenged. Some of the participants went to the extent of pointing out that the system 'moulded' itself to the perspectives of the person occupying the apex position.

> (Referring to an officer at a lower administrative level) ... *he is interested in improving. But who is going to support? He can do the work but unless you are financed for it nothing happens.... ultimately the guy at the top should actually decide what is to be done. So, there is always a disconnect. ...Attitude-wise [sic] there is a disconnect, political-wise [sic] there is a disconnect...it is not only community monitoring, all the programmes which we launch and everything, there is always disconnect from the top.* [State Government Official]

These points reflect the nature of the decision-making space at the state level in Tamil Nadu in which the complex and conflictual policy relating to community-based accountability was received from the central government, and rearticulated into the CAH project at the state level.

7. Discussion

Community participation, and community-based accountability are recognized as core strategies for health system strengthening towards the achievement of Universal Health Coverage (World Health Organization, 2007, 2018; Mikkelsen-lopez, Wyss and Savigny, 2011; Barbazza and Tello, 2014). The demand for increasing community involvement is happening in parallel with larger macro level changes brought about by the neo-liberal paradigm of governance. This context is especially important for my research due to the implications of these changes on the conceptualization and the implementation of accountability of public systems (Haque, 2007).

This research was triggered by the observation that a policy with a specific component of community-based accountability took very different paths as it traversed layers of government, as well as while it was rolled out in different states across the country. Even within a particular state, the support for it waxed and waned over time (Gaitonde 2020). This research aimed at understanding the institutional influences that impacted on the implementation of the CAH project by first mapping, and then analysing the variations, as the implementation process moved down through various administrative layers of the government. The research further sought to understand the reasons for, and the mechanisms through which these divergences took place, focusing on the processes taking place at a single administrative layer in the state of Tamil Nadu. Subsequently, in-depth interviews with key actors at the state level in Tamil Nadu involved in the implementation pointed to the underlying differences in 'meaning', as well as the changing balance of powers between different groups of actors involved in the implementation.

An analysis of documents and interviews led to the development of three constructs – Divergences, Dissonances and Disconnects. As mentioned in Chapter 4, the theoretical and conceptual frameworks drew from a number of disciplines, as well as from the experience of my deep involvement with the conceptualization and implementation process of the CAH project, both at the national and the state level. In this chapter, I will discuss the way in which the three emergent constructs described in the Results chapter contribute to an understanding of the research questions.

The construct of Divergences refers to the differing ways in which the programme was implemented in different states after the pilot project. While the state-wise variation may be attributed to the relative influence of the different actors involved at the state level, the changing emphasis on different components of the project as it traversed different administrative levels can be traced to different

conceptualizations of what the programme meant to different actors who were involved. This is enlivened by the concept of 'chains of equivalence' which further nuances our understanding of these variations.

Next, I discuss the construct Dissonances, which refers to the fact that there are multiple perspectives on the issue of accountability. When analysed through a post-positivist lens, these different perspectives seem to arise from different problematizations, which in turn seem linked to different governance regimes.

I finally discuss the construct of Disconnects, which highlights the processes and spaces (and in this case the lack thereof) needed when new ideas are introduced into a system. It highlights the consequences of a lack of these spaces and processes of sense-making for the integration of a new policy into the system.

Divergences - The Many Paths Followed by the Same Policy in Different Settings

The emergence of the space for a new radical articulation of community-based accountability was made possible by a host of factors including a newly elected government, officials with diverse experiences who were both boundary spanners as well as champions for this project, spaces to formally interact with civil society organizations, and trusting relationships between officers and NGOs. It is obvious that this set of circumstances, or 'opportunity structures' as they are termed in the Advocacy Coalition Framework, while enabling such a policy at the central government during the articulation and pilot phase, could hardly be expected to persist as the implementation moved down the layers of the government after the pilot.

With the responsibility for implementation moving to the states, it emerged that the balance between the NGO network in the state (the equivalent of the civil society representatives in the AGCA at the central government), and the particular state governments, seemed to determine the mode of continuation of the project beyond the pilot phase. As noted in the results section, this balance led to three types of overall outcomes in terms of continuation.

While the state-wise pattern of roll-out may be explained as above, the pattern of changing emphases at different layers of government during the implementation process could be explored effectively through the use of the concept of 'chains of equivalence' (Laclau 1996).

Chains of equivalence – linking divergences to policy implementation

Cornwall and Brock invoke discourse to discuss the way in which the same terms come to mean different things (2005). They point to the fact that terms may acquire different meanings as they are combined with others when they are deployed in different policies (Cornwall and Brock, 2005). In fact, with regard to buzzwords like 'participation', 'empowerment' and 'accountability', they note that the possibility of deriving different interpretations of these concepts leads them to be useful in managing diverse political perspectives during the policy process (Cornwall and Brock, 2005).

'Chains of equivalence' is a concept initially elaborated by Laclau (1996). It refers to the way in which a particular discourse brings sets of seemingly disparate concepts together in particular ways, and with particular meanings, to animate certain constructs - in the case of my research, accountability. This bringing together of disparate concepts results not only in the inclusion of certain concepts as a unified 'chain', but also the exclusion of some concepts from this 'chain'. These chains of equivalence thus redraw boundaries and structure commonalities (Jorgensen and Philips, 2002).

Applying this concept, Cornwall points out that when concepts like participation and empowerment are used in a 'chain of equivalence', with terms infused with meanings from the neo-liberal paradigm like 'governance' and 'efficiency', certain meanings of the concepts are "stripped away to ensure coherence" (Cornwall and Brock, 2005). She further points out that when instead they are used along with concepts like social justice, redistribution and solidarity, "some of these meanings may be recuperated" (Cornwall and Brock, 2005).

The ability to take on different meanings by the same concept draws on discourse theory, and the work of Saussaure and others who pointed out the way in which language and discourse, concepts are dependent on each other for their meaning (Laclau 1996; Jorgensen and Philips, 2002; Cornwall and Brock, 2005). 'Chains of equivalence' suggests a way of understanding why programmes that work in small and circumscribed settings, usually led by charismatic and committed leaders, fail when systems attempt to upscale them. Chains of equivalence point to the fact that particular concepts, and by extension, interventions attempting to operationalize them, derive their expressed meaning (or social effectiveness) in a given context from the various practices along with which they are deployed. Thus, community monitoring will be 'liberatory' and 'change power hierarchies' only in a situation where the training component of the envisaged programme is of the same nature, the implementation follows democratic principles, and there are countervailing forces to enable the more marginalized communities to stand

up to traditional power hierarchies. In the absence of these, community monitoring can lose its liberatory potential and is reduced to a dead routine.

Creation of these differences in emphasis among the various components of a programme, leading to a difference in the impact of the overall programme, may thus be considered as ways in which different actors or groups of actors could impose their particular perspective on the programme.

The CAH Mapping paper points out that at the national level (in the AGCA proposal), there was a clear dominance of the Rights Based Civil Society perspective. This influenced the particular design of the project that emerged. This included a significant role for the NGOs, elaborate rights-based trainings for the community, and community-based monitoring. However, when implementation was taken over by the individual state governments and the balance of power shifted to individual departments of health, the dominance of the NGOs was reduced. This led to the emergence of programme designs that sought to minimize or eliminate the role of the NGOs and of community monitoring, with an emphasis on awareness building during the training of the community. The research thus suggests that the divergences were more linked to the underlying belief structures of the actors (or groups of actors, to be more precise) involved, and their problematizations of the issues involved. The implications of this are that the presence of such variations seen through the conceptual apparatus of the chains of equivalence suggest the presence of multiple discourses. This informed my research in Phase II.

This discussion on changing emphases of components and chains of equivalence also has some implications with regards to the discussion on flexibility and adaptation of a programme or policy in local contexts. When would one consider divergence of a programme from the originally articulated programme document as a legitimate adaptation, and when an unacceptable one? This is particularly important given the fact that most theories of implementation do recognize that some form of local adaptation is necessary and legitimate in order to make the programme relevant to the context. In fact, some theories point out that the more 'flexible' a programme is, the more likely it is to be adopted and integrated into a system (Greenhalgh *et al.,* 2004). One way of engaging with this question is to use the insights provided by Rod et al when they invoke the concept of the "spirit of an intervention" and "its social effectiveness" (Rod *et al.*, 2014).

One may argue then that implementation is not merely a faithful repetition of a given number of specific steps of a particular intervention. It is in fact an attempt to bring about 'social change'. This social aspect is what is captured by the concept of spirit of intervention by the authors (Rod *et al.,* 2014). What follows is the need to go beyond literal understandings of fidelity, and to instead gauge the spirit

behind the intervention, and the requirements of the implementation of this ‘spirit’ (referred to in the previous paragraph) in a given context. Thus, it is the impact of the totality of interventions that needs to be explored, rather than the ‘efficacy’ of individual components. Also, equally important is that this points to the importance of uncovering the underlying ‘spirit’ of the intervention, and by extension the underlying ‘problematization’, rather than restricting analysis merely to the performance of particular components of a programme. This moves the discussion from an abstract notion of efficacy to a contextually relevant “social effectiveness” (Rod *et al.,* 2014).

The discovery, and the exploration of these divergences thus point to the importance of exploring implementation from a more post-positivist perspective, bringing to the fore the ideational and meaning components of policy.

The divergences emerged at every level as the policy was transmitted along the administrative and organizational hierarchy towards field level implementation. This led to a questioning of what aspects or features of each ‘level’ led to the divergences. While I initially used the concept of belief structures as presented in the ACF to look at the divergences, I found the approach of discourse with the concepts of ‘problematizations’ and ‘chains of equivalence’ more useful to develop a nuanced picture of the divergences, especially one that seemed to resonate with my experience. The key difference in the latter approach was that it enabled the opening up of the ‘problem’ through the concept of problematization, instead of treating it as a given.

The next part of the research, Phase II, focused on the journey of CAH from its implementation as a pilot project, its continuation on a small scale in Tamil Nadu, and attempts at upscaling and integrating it into the public health system. This phase focused on the state level administrative layer and the processes within it. The two constructs that emerged from this phase are ‘Dissonances’ and ‘Disconnects’, discussed next.

Dissonances – The Multiple Perspectives Within the Same Level of Government

The research during the Tamil Nadu case study, which focused on the state of Tamil Nadu, revealed the presence of three distinct perspectives on accountability among actors who played a key role in the implementation of the CAH project. There are a number of theoretical approaches to understanding the presence of divergent perspectives with regard to key policy concepts. The bottoms-up perspective on policy implementation draws attention to the agency of front-line workers in the way they interpret and implement a particular policy that has been articulated at a higher level. Extending this, I argue, following Exworthy and

others (2002), that these insights could be applicable to individuals working in any layer of government that receives a policy from a layer above it in the hierarchy for implementation. Further, research like that of Exworthy and colleagues (2002) points out that different layers of government have different motivations and priorities. Therefore, they may or may not implement policy received from higher layers in exactly the way it was intended. The perspectives referred to above are those of an individual (or group of individuals) working within a particular organization.

While the above two insights from the literature were explanations of diversity, they refer to 'external' factors leading to a divergence in implementation; other theories sought to explore explanations that were more 'internal' (to the individual and institution). The approaches like that of the Advocacy Coalition Framework (Jenkins-Smith *et al.*, 2014) and Halls conceptualization of 'paradigmatic change' (1993) started exploring these more ideational explanations. In the ACF, policy was seen to be a reflection of an underlying belief structure, while in Hall's conceptualization, a policy paradigm was seen as an "interpretive framework for understanding policy goals and the instruments to achieve them, but even more importantly it offers a framework for understanding the nature of the issues to be dealt with" (Hall, 1993). In approaches that are positivist, like advocacy coalitions and the paradigms approach, the key aspect or determinant of diverse 'interpretations' or 'paradigms' leading to divergent implementation is largely the interplay between individual and institutional paradigms and belief structures. Here, there is a clear recognition of 'intent', in that the individual is seen as having agency to choose between paradigms and perspectives. This clearly differentiates these approaches from those invoking various discourse analytic approaches, discussed next.

From a discourse approach, the starting point is that no discourse is ever completely closed (or fixed). Thus, there is always the possibility of invoking other competing discourses, and therefore an inherent instability of any discourse as it were (Jorgensen 2002). However, the essential difference between discourse theory and the concept of the belief structure as described by Hall and Hall (1993) and Sabatier and Jenkins (1988) respectively, is the question of intent. In more critical policy analysis, including in frameworks like the ACF, a link is made with particular interpretations and underlying belief structures (Jenkins-Smith *et al.*, 2014) or paradigms (Hall and Hall, 1993). However, these are supposed to arise through processes of socialization or other social / relational processes, but are essentially internal to the individual. While these may be hard to overcome, in theory it would be possible, given their locus within individuals. Discourse, however, essentially posits that there is no independent agency and belief of an individual outside discourse (Hajer, 2002).

The sources of multiple perspectives and the implementation of policy

The presence of multiple conflicting perspectives can be explained by both positivist and post-positivist approaches, as shown above. One of the key questions that arises however is the origin of these diverse perspectives. The interviews that form the basis for papers II and III offer some clues in this regard. In these interviews, one group of respondents (who were classified as holding the Accountability as Targets perspective, see above) described a gradual erosion of the autonomy of public health officials. They specifically mentioned the increasing dominance of the financial and managerial logic over their technical authority. Further, they alluded to an overall trend in the stagnation of funding for public health services. All these trends were reported as having been recognizable since the 90s. This is also precisely the period when India began the process of structural adjustment under pressure from the International Monetary Fund (Pal and Ghosh, 2007).

Other respondents (who were classified as belonging to the Accountability as Efficiency perspective, see above), on the other hand, focus more on the inefficiency of the public sector. They call for civil society and community-based action to hold the system to account and thereby increase efficiency, seemingly naturalizing the fiscal situation referred to prominently by the other group.

These two rather distinct patterns discernible in the interviews represent, in my opinion, the two distinct governance regimes that have dominated India since independence – the expert-driven welfare model and the manager-driven neo-liberal model (Saxena, 2011; Sivaramakrishnan, 2011).

In post-positivist approaches, these meso-level constructs (the governance regimes referred to above) are referred to as “storylines” (Hajer, 2002). These constructs in discourse theory connect the larger macro level discourse with the individual level.

This meso-level construct called ‘storyline’ by Hajer is described as “narratives on social reality through which elements from many different domains are combined and that provide actors with a set of symbolic references that suggest a common understanding” (Hajer, 2002). Thus, “story-lines are essential political devices that allow the overcoming of fragmentation and the achievement of discourse closure”, which in time, “become tropes, or figures of speech that rationalize a specific approach to what seems to be a coherent problem” (Hajer, 2002). The storyline is essential for the creation of coalitions among actors in a given domain.

The second middle-range concept introduced by Hajer is the 'discourse – coalition'. Hajer defined discourse-coalitions as, "the ensemble of (1) a set of story lines; (2) actors who utter these story lines; and (3) the practices in which this discourse activity is based… as the discourse cement that keeps a discourse-coalition together" (Hajer, 2002).

Assuming that the different governance regimes could represent the different storylines that were described by Hajer (2002), provides one an explanation of the origins of these different perspectives. However, it still needs to be explained how these came to be co-existing at the same time, in a given institution. The setting (in my research) of the multiple discourses in organizations that have undergone transition in governance regime points to one probable cause for the presence simultaneously of multiple discourses.

It may be argued that the presence of the different perspectives is a reflection of the incomplete transition from being a welfare state to a neo-liberal state that Tamil Nadu has undergone. It may be argued that the neo-liberal governance regime has not completely replaced the older welfare regime. Such processes have been described as partial de-institutionalization (Chaudhry and Rubery, 2017). What is relevant in this concept is that not only is there a simultaneous presence of multiple discourses, but that the existent consensus is relatively unstable and requires continuous effort and resources to be sustained (Chaudhry and Rubery, 2017; Hudson *et al.*, 2017).

Dissonance talks about the presence of different perspectives on a particular problem. While one is very likely to find this in any organizational setting, the concept gains significance when seen through the problematization lens. Thus, the importance of the construct of dissonance in policy implementation lies not in the different 'solutions' that individuals are suggesting, but in the fact that the problem itself is being defined differently. This links to alternative 'storylines', and in the specific case being discussed, of transitioning governance regimes.

The link to problematizations as well as meso-level storylines suggests the need to go beyond 'evidence' when one wants to bring about policy change. Considering evidence as being enough to bring about policy change means considering the problem as single and unproblematic. However, if the problem itself is differently thought about, it stands to reason, that even the best evidence will not make sense to some of the actors. This is not because of anything inherent in the evidence, but simply because that is not the question that is considered relevant to answer in the given situation!

Disconnects – The Lack of Spaces and Processes for Collective Meaning Making

The research also engaged with the contested and 'brittle' nature of CAH's presence on the policy agenda in the state. In the context of a hierarchical system in which there were a number of competing perspectives, the emergent construct of disconnects draws attention to the lack of, and consequently the need for, spaces for sense-making within organizations, especially when new interventions (or innovations) are introduced. The third construct that emerges from the research is thus an insight into the importance of organizational structures and systems and cultures for the adoption and sustenance of newly introduced innovations. It may be helpful to break this discussion down into two parts – the process of the adoption of a new policy, and the process of internalizing the new process into day-to-day functioning.

The policy implementation literature points to the relative neglect of the period called the "bit-in-the-middle" (Berlan *et al.*, 2014). This refers to the processes that follow the emergence of a particular intervention on to the policy agenda up to when it is actually implemented. One review of this period in the implementation of policy, notes that these processes include phases of "generation of policy alternatives, deliberation and/or consultation, advocacy of specific policy alternatives, lobbying for specific alternatives, negotiation of policy decisions, drafting or enacting policy and guidance/influence on implementation development" (Berlan *et al.*, 2014).

Various processes of transformation of the original innovation have been described as occurring during the process of uptake and internalization. Some authors consider interventions as consisting of central cores that are critical, and peripheries that are more fuzzy or flexible (Jenkins-Smith *et al.*, 2014). This flexibility is what is considered to allow interventions to adapt to the specificities of an organizational context (Greenhalgh *et al.,* 2004). The importance of this adaptability is also highlighted in other frameworks, such as the i-PARHIS (Harvey and Kitson, 2016). This adaptability is considered a crucial aspect of the innovation's chances of being adopted (Harvey and Kitson, 2016).

Highlighting what is termed as 'absorptive capacity' of an organization, it has been noted that the adoption of any innovation is negotiated and depends on various formal and informal networks within a given organization that help in the evolution of shared meaning (Greenhalgh *et al.,* 2004).

The literature further demonstrates how any idea that is introduced into a system is not automatically followed as is. It has been shown that there are a number of processes during which the idea is 'translated' or 'adapted' before being taken up

in an organization (Orlikowski, 1992). This is true even for clinical guidelines, where research on their adoption point to the existence of 'mindlines' which in a way 'adapt' the guidelines to the local context (Gabbay and May, 2004; Wieringa and Greenhalgh, 2015).

Similarly, the innovation uptake literature speaks of various processes whereby an organization engages with new ideas. One of the key steps in this process is what has been termed 'sense-making' (Maitlis and Christianson, 2014). This speaks about the processes by which the differences within the organization about the assumptions regarding the new idea are engaged with, and a consensus is reached. Some other terms used for this process in the literature include "learning organization" (Greenhalgh 2004) and "absorptive capacity" (Zahra and and Gerard George, 2002). Further research using the framework of Discursive Institutionalism also point to the interplay of ideas and the importance of this in bringing about change (Schmidt, 2010). Further, the literature on adoption and diffusion of innovations refer to "translation" (Chaudhry and Rubery, 2017), "sense-making" (Greenhalgh 2004), "meaning-making" (Gabbay and May, 2004), "re-creating" (Wierenga and Greenhalgh, 2015), and "tinkering" (Harvey and Kitson, 2016), which refer to the processes whereby interventions being introduced undergo clarification and 'fitting' with the local realities, priorities and understandings.

Drawing on the above list of processes, it is obvious that the incorporation of a new idea or an intervention into a system is not simple and straightforward, but complex. By highlighting the hierarchical nature of decision-making and the decision-making space in the Tamil Nadu, where, as one of the respondents noted, "the system moulds to the person on top" (Gaitonde 2020), the construct of disconnects highlights the lack of the requisite space and process of engagement that is essential for this complex process of sense-making in the health system in Tamil Nadu.

Thus, all approaches to policy studies point to the crucial nature of the effect of institutional structures on the way a particular policy is adopted and integrated into the day-to-day functioning of a given organization. One of the important processes seems to be the negotiation of meaning at different layers of government.

Thus, in a hierarchical system, there is likely be very little scope for respectful and participatory discussion and there is likely to be an adoption of a particular perspective that is unstable, with the domination of one over the other paradigms, rather than consensus or any other form of integration evolving. In a system with space for collective sense making on the other hand, there is the possibility for innovations to be integrated into the system at a much deeper level due to the

possibility of negotiating a consensus and addressing differences in perspective and meaning. This would probably lead to a relatively stable learning system. This points to the futility of engaging solely at the level of "evidence", without first clarifying whether everyone is trying to answer the same question in the first place. Thus, while all efforts towards policy change are focused on presenting better and more convincing evidence, assuming that all actors are clear about the problem and have similar motivations regarding solving that problem, in reality, however, there may be no consensus on the problem definition itself.

Disconnects and its impacts on the policy process

One other important insight of the literature that has also come up in my research has been the importance of factoring in the stage of the life cycle of the intervention / innovation being studied. Thus, despite lack of agreement on problem definition, many solutions are acceptable when they are seen only as pilots or demonstrations, and thus, unlikely to cause major shifts in the status quo (Greenhalgh *et al.*, 2004). It is only when these move from being demonstrations to being sought to being institutionalized, and thus likely to cause a shift in the status quo, that the differences in the problem definition become more acute. This may explain why even despite the disagreements, groups that opposed the CAH ignored it when it was implemented in only a few areas in the first few years after the pilot project, but resisted its implementation when it was sought to be upscaled. The argument arising out of the discussion around disconnects is that if there had been adequate discussion and engagement with the diverse ideas, this sort of brittleness would not have ensued.

Thus, in Tamil Nadu, it seems that the dissonances that resulted from a transitioning of governance regimes, in the presence of a disconnect between the key decision-makers and implementing officers at various levels, made the process of adoption and incorporation of innovative interventions into the day-to-day functioning of the system particularly vulnerable to challenge from those within the system who problematized the situation differently. The routine processes of transfers of officials was enough to alter balances quite significantly. This led to the abrupt stopping of a process that seemed to have got a lot of support as well as funds allocated for it in the early stages of its implementation.

Summing Up

Thus, the overall emergent understanding from the research is that the divergences in policy implementation from the originally envisaged and articulated policy may be due to more than mere lack of capacity, and may in fact reflect a deeper level conflict at the level of belief and perspectives in different layers of the administration. The presence of these divergences is thus essentially

reflective of underlying dissonances. These dissonances arise, following an understanding emerging from post-positivist and especially discourse based approaches, from the distinct and now transitioning regimes of governance in the post-colonial country settings. Thus, these dissonances point to different problematizations inherent in these conflicting paradigms. Given this, in order to maintain and integrate a new idea in the face of this dissonance points to the need for work to be done to ensure and facilitate collective sense-making. In the absence of spaces and processes to facilitate this, it is likely that policies, even when introduced with a lot of commitment from policymakers at the top, will be unstable and unlikely to be sustained.

Trustworthiness

I was involved in the conceptualization as well as the implementation of the CAH project both at the national and at the state level. This personal involvement was both an asset in terms of gaining immense implicit knowledge regarding the process, as well as a liability given the possibility of my personal biases creeping in. The issue of personal investment in the process was overcome by having a research team and set of co-authors who were both removed from the setting (my Main Supervisor and Co-Supervisor) and based in Sweden, and another Co-Supervisor who has deep understanding of the Tamil Nadu health system, but had not actively participated in the CAH project. Thus, I made sure that multiple perspectives were invoked during the interpretation of the data. I feel that this process of discussion of the interpretations among researchers with multiple perspectives helped interrogate my conclusions and ability to reflect on them, including seeing them from different perspectives. In addition to this, I actively discussed my findings with a group of three individuals who were senior academics in the field of political science, philosophy and health systems; this enabled me to keep my analysis grounded in the Indian and Tamil Nadu context. Further, I shared my final papers (before submission) with key participants who were involved in the processes, to see whether the way I had interpreted and theorized the findings made sense to them. Their acceptance of the interpretations and constructs of the various research papers was indeed a great affirmation to the trustworthiness of the research process.

This paper is based on interviews with individuals who were actively involved in the implementation of the community-based accountability components of the NRHM in the state of Tamil Nadu. The nature of the implementation in the Department of Health means that in the initial stages of implementation (before an intervention is fully upscaled and integrated), it is the responsibility of only one, or at the most two junior officers at the state level, who report to the senior policymakers. Thus, those who were involved in the actual implementation of the CAH project and who could provide insights were very small in number, all of

whom we interviewed. We had to be sensitive to the nature of the hierarchy of the health system and limit our description of all those we interviewed in order to maintain anonymity. Moreover, the main intention of this paper is to highlight and attempt to delineate the presence of distinct perspectives on accountability among the key actors of the implementation of the CAH programme. The attempt was not to define the composition of the groups exhaustively. Thus, we have refrained from drawing conclusions as to the composition or the extent of support of the groups, but have merely defined the differing perspectives. While the small numbers may be seen as a shortcoming of the study, given the particular setting of Tamil Nadu, as well as the type of conclusion we draw in this paper, we feel we have done justice in the circumstances.

8. Conclusions

This study focused on the implementation of a policy to enhance community-based accountability. More specifically, I studied the implementation of the CAH project, focusing on the part between the emergence of a policy intervention on to the policy agenda, up to its integration into the system (or not). The research used an analysis of divergences of policy, observed as it traversed various layers of government and across multiple states after the pilot project, as an entry point. Using a post-positivist and institutional lens, this research was able to provide a fine-grained understanding of a few aspects of the implementation process.

One of the key findings of the study was the identification of differing problematizations with regards to the underlying situation of health in rural India, and consequently as regards accountability and its role in health system strengthening. The research demonstrated the possibility that these conflicting problematizations in the institutional context of transitioning governance regimes and hierarchical decision-making, along with lack of spaces and processes for sense-making were key determinants for the divergences observed during implementation and the abrupt termination of the project in Tamil Nadu. Further, the research highlighted the importance of these influences and processes at each administrative layer (the multi-layer problem) as well as during the course of the life cycle of the project.

Framing the CAH project as an innovation that was sought to be institutionalized into the health system in Tamil Nadu, I was able to highlight the fragility of the emergent programme design at any given point of time, and especially depending on the point in the life cycle of the innovation one is considering. This I have pointed out, stems from the lack of sense-making and even possibility of sense-making in the public health system of Tamil Nadu. In such a situation it is likely that those in authority can impose certain interventions on the organization and expect to get the cooperation of all involved in the implementation. However, this is brittle, as shown in the case studied, as the moment the person in authority changed, the process collapsed.

Ultimately my research also points to the limitations of positivist approaches that frame the ‘policy-implementation gap’ as one of rationality, understanding and information, one that is effectively solved by access to better and more robust information.

Implications of this Research

In this chapter I discuss the implications of this research for three areas. First, I will discuss the implications for the field of policy studies that focuses on implementation, which was the primary academic field in which I located my study. Next, I will discuss the implications of this research on the process of health systems strengthening, especially in the state of Tamil Nadu Finally, I present some implications for civil society advocacy for policy change.

Implications for future research

This research highlights the importance of problematization and its potential contribution to the study and understanding of the processes by which a policy may be integrated into day-to-day functioning of the health system (or not), and the determinants of these processes.

More specifically for research on contested concepts like community-based accountability, my research points to the need to document the various problematizations with regard to reasons for lack of access to health care and the implications of these differing problematizations for health system strengthening and the role of accountability, and the sources of these different problematizations, at different administrative layers. Further there is a need to map out and delineate various institutional processes during the period from the emergence of an idea on to the policy agenda to its integration into the system, more systematically, especially against the background of and engagement with transitioning governance regimes in LMICs. My research points to importance of the need to explore further structural and institutional determinants of policy implementation, in the light of the contributions of a concept like problematization to the understanding of the implementation process. Finally, my research points to the potential need to study processes among civil society and government, as well as at lower layers of government using the three constructs that have emerged in this research. This research further underlines the importance of the need for multidisciplinary approaches to the understanding of policy.

Methodological implications

One of the key implications of my research is the importance of using post-positivist approaches in policy studies. This enables one to tap into deeper level determinants of the way in which policy is interpreted and implemented by both individuals and organizations. A second aspect is the potential of the concept of 'chains of equivalence' in the engagement with policy, and especially with policy divergence during implementation. Essentially, it calls for the broadening of our

gaze while performing policy analysis to the larger policy environment in order to fully appreciate the findings in a particular area. Similarly, the use of the concept of 'problematization' afforded me a very useful and productive entry point into policy, which further enabled me to engage with a much deeper level of politics and meaning. By flipping the question from 'is this the right solution?', to asking 'what is the problem represented to be?' following Bacchi, we are able to enter into levels that are emerging as crucial to understanding the life of policies in the real world. One particularly interesting line of research would be the application of the concept of problematization to the various frameworks of innovation integration, and to study the implications.

Implications for health system strengthening

One of the most important implications is the recognition of multiple (and many times conflicting) perspectives within a given department. Obviously, this has a lot of implications for how newly introduced programmes and innovations are perceived, evaluated and acted upon. The second key implication is the importance of spaces and the evolution of processes for collective sense-making. The environment in any learning system needs to acknowledge the diverse viewpoints within the department, and enable these to be discussed and clarified before the emergence of an organizational consensus.

Implications for civil society advocacy

My research underlines the need for civil society organizations to understand the importance of acknowledging the differences in problematization even as they advocate for policy change. Further it underscores the importance of recognizing that the accumulation of evidence is not enough for policy change, especially in situations where the underlying problematizations and the discourses from which they are derived may be different. Finally, it points to the need to evolve strategies that will enable engagement with various policy actors at the level of belief structures and problematization.

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