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Community Action for Health in India's National Rural Health Mission: One policy, many paths

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ABSTRACT

Community participation as a strategy for health system strengthening and accountability is an almost ubiquitous policy prescription. In 2005, with the election of a new Government in India, the National Rural Health Mission was launched. This was aimed at 'architectural correction' of the health care system, and enshrined 'communitization' as one of its pillars. The mission also provided unique policy spaces and opportunity structures that enabled civil society groups to attempt to bring on to the policy agenda as well as implement a more collective action and social justice based approach to community based accountability. Despite receiving a lot of support and funding from the central ministry in the pilot phase, the subsequent roll out of the process, led in the post-pilot phase by the individual state governments, showed very varied outcomes. This paper using both documentary and interview based data is the first study to document the roll out of this ambitious process. Looking critically at what varied and why, the paper attempts to derive lessons for future implementation of such contested concepts.

1. Introduction

Community participation has been a key strategy in both the developmental and the health sectors for more than four decades now. Ever since the 70's, the idea of involving the community in projects aimed at their welfare, in the delivery of essential services, and in the governance of systems, has been a recurring theme (Cornwall, 2000; Rifkin, 2009). More recently the practice of community participation has been characterised by a number of 'new democratic spaces' (Cornwall and Coelho, 2006). These include the formation of various kinds of peoples' committees. These committees in different settings have been expected to contribute to priority setting planning implementation strategies and the monitoring and evaluation of implementation (Manor, 2004). This participation approach has also been characterised as 'co-production (Cornwall and Coelho, 2006). Despite the presence of many iconic success stories involving people's participation using this mechanism (Cornwall and Coelho, 2006; Cornwall and Shankland, 2008), the field is more littered with 'failures' and 'unexpected effects' of these interventions and spaces than with successes (Coelho et al., 2013; Cornwall and Coelho, 2006; Manor, 2004).

One of the key aspects of the gap between expectations from these processes and their outcomes has been the different ways in which participation is conceptualized. While the utilitarian approach to participation sees it more as a means to an end, the rights based approach implicitly includes a redistribution of power in the system. This clash has been pointed to by a number of authors reviewing community participation experiences over time (Cornwall, 2000, 2008; Rifkin, 2009).

The deployment of these mechanisms of participation and new spaces is happening at a time when there is a shift in the way the role of the state is being perceived. Unlike in previous decades, where the state was seen as a primary provider of welfare, today the state is seen more as a purchaser from and facilitator of the market in providing welfare (Comaroff and Comaroff, 2008). Thus while the state is continuing to invite communities to participate in various fields including health, the reasons for this are quite different from the more radical demands for participation. This results in what has been termed as a 'perverse confluence' of interests in community participation (Dagnino, 2011).

1.1. Community participation in health in India

Influential expert committee reports as well as policy

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statements in India ever since the pre-independence Bhore Committee have called for community participation to be a critical aspect of the development and strengthening of the health system (Indian Councial for Medical Research & Indian Coucncil for Social Science Research, 1981; Ministry of Health and Family Welfare, 1983, 2005b). This persistence of the concept in policy discourse is probably at least partly a reflection of the range of community based projects that have been tried by Non Governmental Organisations (NGO)s over the years. It was only in 1995 with the passage of the Panchayati Raj Bill 73rd and 74th amendment to the constitution that the concept of community participation got a legal basis. The early programs in 70s and 90s were largely community health worker programs (State Health Resource Center, 2003). Subsequent experiments of community participation around the country used the accountability and rights based approaches (Kakde, 2010; Pitre, 2003). However, barring the well documented examples of Kerala (Isaac and Heller, 2003) and Nagaland (Department of Planning and Coordination, 2011), the actual translation of these ideas by the government to a larger scale used more limited definitions of community participation, limiting it to symbolic events or merely to serve as means to predefined ends (Coelho et al., 2013; Murthy et al., 2009; Population Foundation of India, n.d.).

Thus while smaller community based projects have explored the more empowering and rights based approaches, bureaucratic attempts at upscaling seem invariably to invoke more limited utilitarian perspectives of participation.

1.2. Community action in the National Rural Health Mission

Buoyed by an electoral victory in 2004 that many interpreted as a rejection of the 'anti-poor' policies of the previous government, the newly elected United Progressive Alliance government in India took particular care to involve a number civil society groups in the design of their policies. As part of the recognition of the continuing gaps in service provision, inequity in health and the need to address the rural constituency after the electoral victory, the National Rural Health Mission was launched (Ministry of Health and Family Welfare, 2005b). NRHM aimed to bring about 'architectural correction' within the health system as well as making sure all who needed health care services, especially in the rural areas, got it (Ministry of Health and Family Welfare, 2005a). As per the NRHM Framework for Implementation the program included initiatives around greater financial flexibility at all levels, more management support, filling infrastructural gaps and evolving standards for the public health system (Ministry of Health and Family Welfare, 2005a). The NRHM also set up a number of advisory groups including the Advisory Group on Community Action (AGCA), where the voice and expertise of civil society could shape policy (Donegan, 2011; Singh et al., 2010). One of the key aspects of the NRHM strategy was 'communitization', the stated aim of which was increasing the ownership of the public health system by the people. Interventions for communitization included the introduction of village level Community Health Workers, flexible funds at the community level, village level committees and health care institution level committees to facilitate accountability (Ministry of Health and Family Welfare, 2005a). As part of this, a program called Community Monitoring and Planning, later called the Community Action for Health (CAH), was introduced. In this program which consisted of the following specific components (Center for Health and Social Justice & Population Foundation of India, 2006; Singh et al., 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 untied funds provided to each committee.
- A lead role for the NGOs in implementing these activities using funds provided by the government.
- A training of these committees on their role and on concepts of rights and accountability.
- Structured monitoring of entitlements in the public health system by committee members.
- Collation of this information into village level report cards, and feeding this back to the local providers.
- Evolution of a village health plan based on the gaps identified.
- Action by all concerned based on the plans developed.

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.

1.3. The community action for health program

Based on the plan evolved by the AGCA in response to the NRHM Framework of implementation, a pilot project, funded by the Central Ministry of Health was launched in nine states in 2008–09 led by civil society representatives in 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 was that individual states could learn from the pilot and take the lead for implementation of the process, in subsequent years. 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, advocated for years by civil society groups in India, to get into formal policy documents. 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 the implementation beyond the pilot phase. There was very limited scaling up of the process, as witnessed by the extremely limited number of active programs that are on-going 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 program along the lines originally envisaged (Ministry of Health and Family Welfare, 2015).

The aim of this paper is to map the roll out of the CAH process, an example of the implementation of an inherently contentious concept like community participation. We analyse the divergences that occurred during implementation and also attempt to understand the determinants of these divergences as the policy was received and re-interpreted by different layers of government during implementation. The study hopes to contribute to the literature on the implementation of health policy, focusing on the implementation of contested concepts like community participation.

2. Methodology

2.1. Conceptual framework

Recent discussions of policy implementation in the literature

point to more "argumentative" (Fischer and Gottweiss, 2012), 'discursive' (Yanow, 2007) and 'cognitive' (Spillane et al., 2002) aspects of policy, seeing it as depending on the interaction of institutions, interests and ideas (Gilson and Raphaely, 2008) and depending on how the problems are framed and by whom (Bacchi, 2009; Schneider et al., 2014). This then suggests that the study of policy implementation has to engage with what has been described as the 'multi-layer' problem, as researchers have pointed out, after the broad contours of policy intent have been set by the policy elite, the actual implementation of these objectives has to contend with competing goals and motivations at each layer of government. This leads to negotiation and thus adaptation and modification along the way (Hill and Hupe, 2003). We feel that this is particularly important in the implementation of contentious concepts like community participation.

Thus the issues surrounding the implementation of community participation should not be seen only in terms of the need for a clearer formulation, matching resources and the capacity to implement, but as a concept though much deployed is essentially contested.

Of the many frameworks for the study of public policy, we chose the Advocacy Coalition Framework (ACF) (Jenkins-Smith et al., 2014a) as it invoked the core ideas of contending coalitions, which seemed to fit the case we were studying.

The ACF (see Fig.1) contends that within a particular 'policy subsystem' there are two or more groups of individuals or institutions, that hold conflicting views as to what specific policy solutions that subsystem is interested 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 as well as short-term 'opportunity structures' to bring this change about (Jenkins-Smith et al., 2014a).

In the ACF, belief structures are considered to be hierarchically arranged. The deep core beliefs representing the most basic beliefs, which pertain to normative and ontological level of beliefs, constrain the next layer referred to as policy beliefs. Policy beliefs which 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., 2014b).

While studying implementation, the use of ACF leads to the following questions: "What happens to these alliances after public policies are made? Do the power relationships among coalitions that lead to the formulation of a public policy continue to exert a similar influence during implementation? How do power relationships change to address unanticipated complexity in implementation?", even as the original policy formulations are being "redesigned and reorganized in response to various implementation difficulties" (Ellison, 1998).

In this study we propose to investigate not only the changing opportunity structures during implementation, but also the way in which the differing belief structures of the groups influenced the implementation.

2.2. Data collection

We divided the CAH implementation process into three chronological phases (as detailed below). 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 individual state sections of the Project Implementation Plan (which is the annual health plan a state submits to the central government for funding under the NRHM) that dealt with the CAH process were referred to. Reports by the Common Review Mission (a system of multi-stakeholder annual rapid appraisals of the NRHM) reports were also used for more details of the processes. The data sources are represented in Fig. 2.

Once the documentary analysis was completed a series of interviews with key-informants who were actually involved with the roll out of the policy at different levels were conducted. These included seven individuals at the national and state level from within the government and from the NGO sector. At the national level, a senior bureaucrat and two members of civil society who anchored the pilot phase of the program were interviewed. At the state level, one NGO representative and three representatives of state public health systems were interviewed in total - one government official from a state that had discontinued the process immediately after the pilot another from one of the states that had continued the process, and the last from a state which modified the implementation. The NGO representative was also from a state that modified the implementation.

RG conducted the Interviews for each of these individuals. Signed consent for participation was obtained and the interviews were recorded. RG transcribed all the recordings and in the case of the interviews that could not be recorded, notes of the interview were written immediately after. The text of the interviews was then entered into OpenCode 4.2 for coding and subsequent analysis.

2.3. Data analysis

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 program, like training, NGO role, community based monitoring and planning were traced along the three 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 what 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.

2.4. Ethics

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 informed consent, and the interview transcripts were anonymized.

3. Results

Three distinct phases emerge in the implementation process: an initial 'policy formulation' stage, which resulted in the concept of 'communitization' entering into the National Framework for Implementation; the second phase of 'program formulation' by the AGCA, in which the Framework for Implementation was re-

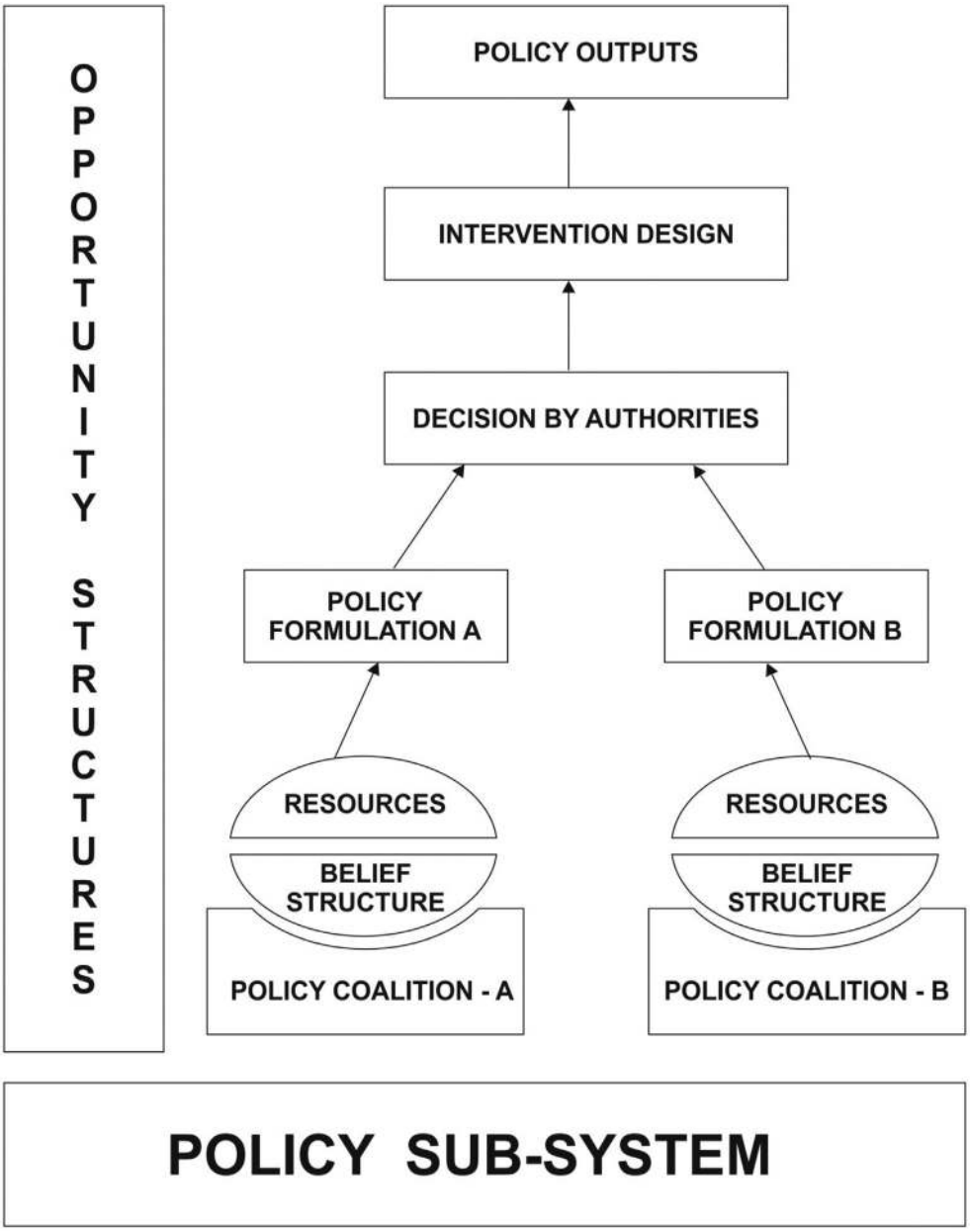

Fig. 1. A generic representation of the Advocacy Coalition Framework.

articulated into a 'program' which was pilot tested in 9 states; and the third phase of state level 'program roll-out' after the pilot process, when the individual states took on the implementation of the project. Briefly, we show that the divergences observed were underlined by the differing (and even conflictual) views of at least two contending advocacy coalitions – the NGOs and the government ministry and departments of health, and the varying opportunity structures obtaining at each level during the implementation.

4. Phase I: policy formulation (2005)

The interviews revealed that the space for the appearance of multiple perspectives on Community Action for Health, emerged in the NRHM thanks to a confluence of various factors. These included moves within the Ministry of Health as part of the Reproductive and Child Health II program with its component of Community Needs Assessment, as well as pressures from civil society for the adoption of a more rights and social justice based version of community participation (IDI 1,2 and 4). This was facilitated particularly by the presence of a newly elected government, and especially the fact that this government had the two main left leaning parties as part of the coalition. In addition, there were spaces created for closer interaction with NGOs, as represented by the AGCA. As one of the persons interviewed 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" (IDI 2, National NGO representative).*

In this initial articulation, the processes envisaged under 'communitization' were firmly embedded in the panchayat system. It

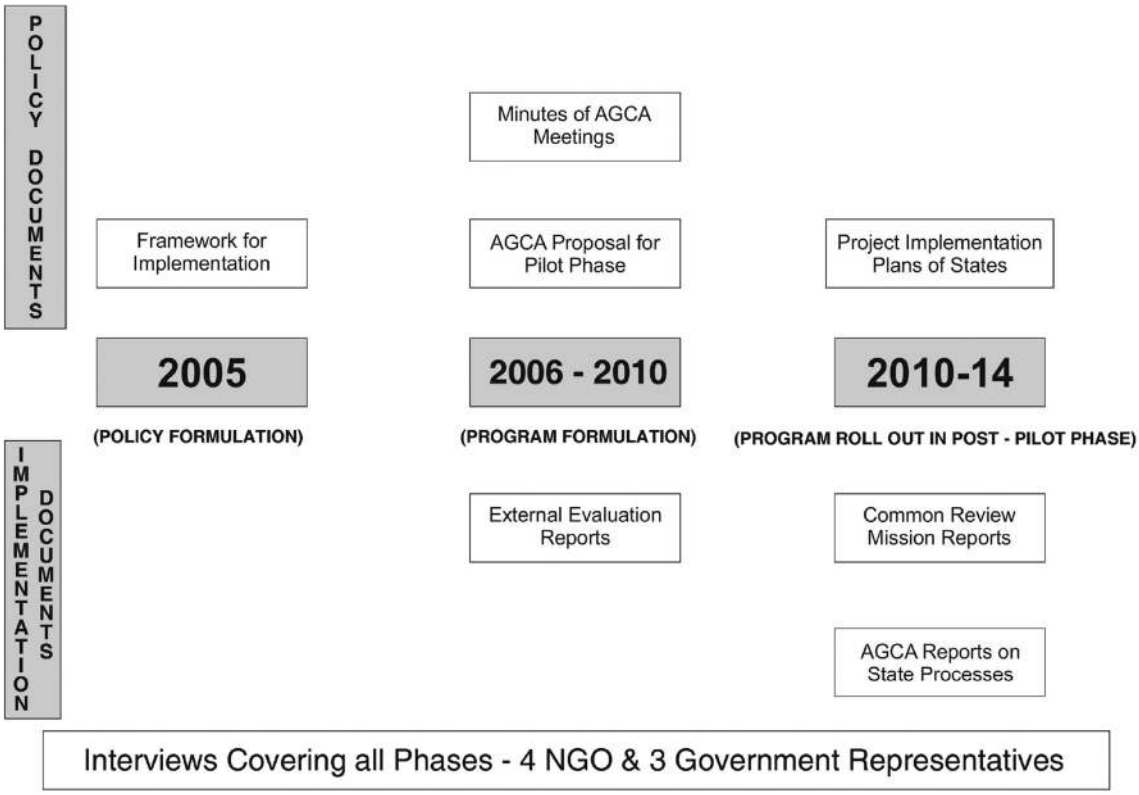

Fig. 2. Data sources for the study.

was expected that the panchayat members in each village would take a lead in the implementation and sustenance of the program at the village level.

4.1. Phase II: program formulation (2006–2010)

Phase II saw two main developments – one is the clear emergence of two contending advocacy coalitions, the second is the reconfiguration of the NRHM Framework of Implementation into an 'AGCA model' that was the basis of the pilot.

4.1.1. The contending belief structures

While the Government initiated the process of community based monitoring and planning, it was a coalition of NGOs that took the lead in the further formulation and implementation of the process during the pilot phase and subsequently at the state level. This was facilitated by the presence of officials familiar with and who had recent exposure to, international and local thinking on accountability, in key positions at the national level (IDI 4, National Government Representative).

While both groups agreed on the institutional structure of the Village Health Committee as well as the basic intervention of community based monitoring and planning, differences in the underlying belief structures became clear when one looked at the way they defined the outcomes of the process.

The bureaucrats saw the process more in terms of information gathering and gap-filling. The government policy makers both at the central and the state level, expected the communities to monitor the performance of institutions using agreed upon parameters and saw the main outcome as increased availability of services to communities. As one of the persons interviewed noted,

> " …. What will be good is for the committee to make a list of all eligible people who should get services and make sure that they get their services" (IDI 5, State Government representative).

The NGOs on the other hand, saw the outcome of the process as "enabling a shift in the balance of power in the health sector, in favour of people" (Center for Health and Social Justice & Population Foundation of India, 2006). They contended that the collection of information would only have meaning if they, "gain a degree of authority to identify gaps and correspondingly propose priorities and influence decision making regarding the Health system" (Center for Health and Social Justice & Population Foundation of India, 2006).

In reality the neat distinction into conflicting policy coalitions was made somewhat fuzzy by the presence of bureaucrats who actively engaged with the NGOs and who engaged with their framework of action.

During the policy-formulation phase the NGOs were envisaged as additional and flexible resources for the implementation of the project. NGOs were called to be involved in capacity building, delivery of services, and the development of innovative approaches. However, no clear guidelines were given to the state governments regarding this aspect. As one of the state level officials said,

> *"The entire NRHM suffers from this design error that NGOs are nowhere there, they have been mentioned … they say you should do your work through the NGOs, but how do you actually bring the NGOs [is not clear]" (IDI 3, State Government representative).*

4.1.2. The pilot phase and the emergent AGCA model

Subsequently within the AGCA, however, as one of the senior civil society representatives noted that what emerged was,

"… a different scenario. Now the baton passes to a group of national level civil society activists. The agency shifts" (IDI 1, National NGO representative).

This change in opportunity structures enabled a radical shift in the role of the NGOs, in the way the policy was interpreted, and in the progam that was formulated and became the basis of the pilot. A more significant role for the NGOs was justified as follows,

"It is difficult to imagine that this significant shift in balance of power – which involves making health officials and functionaries directly accountable and answerable to people – can be carried out exclusively by the agency of the Health department without any additional facilitation, although their central involvement at every stage would of course be essential" (Center for Health and Social Justice & Population Foundation of India, 2006).

During the program formulation there was also a shift in the emphasis of the role of the Panchayat's in the process. While the policy talked about the process being "embedded" in the Panchayat system of local government, under the legal mandate of the local government on health (73rd and 74th amendments to the constitution), the program formulated for the pilot significantly reduced the emphasis on the panchayats. As one of the civil society interviewees described it:

"In our personal experience …. the panchayats were part of the vested interests. So while we never said no to the panchayats we said that the panchayats alone should never be considered the people's representatives" (IDI 2, National NGO representative).

However, reflecting on the experiences in the post-pilot phase, and the fact that the role of the other stakeholders like the panchayats came out more strongly during the implementation, one of the senior NGO representatives concluded,

"We may need to sit back and think that what we started and did in 2006–2007 did not manifest in the way we planned …how can it be re-configured? Perhaps a much stronger role of panchayat members? Much more focus on orienting them and involving them? (IDI 1, National NGO representatives).

The third significant shift in the emphasis was the balance between monitoring and planning. The policy discusses both community based monitoring and village level planning, while it underlines the importance of household and facility surveys as being the basis for community action. The link between these and the Village Health plan was less well defined. While it does clearly state that individual village health plans would be collated at sub-districts and districts and fed into the state level health plans, there was no detailing of the process. Monitoring was seen more in terms of "assessing the gap" or "coverage of entitlements".

In the AGCA model, however, there was much more emphasis on monitoring as a tool for community empowerment. Critically, the information collected during the monitoring aimed to help improve the community's negotiating space with the health system, leading to potential shifts in the hierarchy between the community and the health system. In the pilot proposal, an almost complete absence of discussion or guidelines with respect to the concept of planning can be found. The link between monitoring and planning was not discussed at all. In fact, only one state had attempted to link the processes organically, but even this state found it a challenge to merge the plans evolved through this process to the state level annual health plans as envisaged (Ramanathan, 2009). Serious work on planning emerged much later in the project, but that too at a small scale (Shukla et al., 2014). Thus up tillthe pilot process even the NGO groups seems to have underplayed the importance of planning in the overall process.

5. Phase III: program roll-out in the post – pilot phase (2010–2014)

With the responsibility for implementation moving from the central ministry to the state departments in the post-pilot phase, however, the opportunity structures found at the central level during the early policy and program formulation and pilot phases were altered. While at the central level, the NGO coalition had access to policy making through the forum of the AGCA, at the state level, a State Mentoring Committee was to play the same role. The actual relationship between the various states and their State Mentoring Committees varied quite widely.

"What I am trying to say is that the power equation in the pilot phase and the power equation in the post-pilot phase …. .there is a qualitative change … then depending on the complexion and the attitude of the health department in each state …it became a key determinant of the way in which the Community Based Monitoring and Planning process subsequently rolled out" (IDI1, National NGO representative).

The opportunity structures in each of the states were determined by a number of factors including – the signals being sent from the central to the state government regarding the priority of the process, the evolution of state specific rapport with NGOs, the previous policy trends in the state, the space for innovation available for bureaucrats, and the characteristics of the NGOs themselves.

In the roll out of the program, three broad types of outcomes emerged, based on the process that occurred immediately post pilot. The first type of outcome, termed "model accepted" outcome, was that the process was implemented in the original model (with adaptations) and progressively scaled up to cover more and more parts of the state (two states). The opposite outcome, termed the "model rejected" outcome, was where the process came to a complete halt (three states) immediately after the pilot phase. The "intermediate" outcome type was when the implementation occurred but with only particular components of the original model (four states). One of the states in the first outcome category completely stopped in 2012, after a change of bureaucrats. According to the most recently available reports (2014–15), all except two of the pilot states, one from the "model accepted" and one from the "intermediate" outcome had active programs on the ground. A few newer states were in very early stages of initiating the process. In addition, there were significant shifts in the emphasis of various components of the program that took place in each of these phases.

While the pilot process had NGOs in the lead role working to implement a more empowering accountability, after the pilot phase, the majority of the states decided to take over the lead role from the NGOs, or agreed to work with NGOs, but within a framework more aligned to a utilitarian form of accountability. As one of the key NGO implementers at the national level notes,

"the NGO has gone ahead and accommodated the government to a great extent … where the vision of a citizenship or an active governance model emerging has disappeared" (IDI 2, National NGO representative).

With regards to the role of the panchayats in the system, the states implemented this aspect in a varied fashion that was highly

dependent on the historical relationship between the state and local governments. For instance, while in one state a senior bureaucrat mentioned that,

> *"So in a way in [state name] we have kept the panchayats out of most of the programmatic interventions, so it was logical, whatever was the discussion elsewhere that [state name] would not ride on the Panchayat Raj" (IDI 3, State Government representative).*

In another state the key informant noted how that the CAH project was actually merged and helped further strengthen an already on-going process that was anchored in the panchayat system, rather than the health department. As one of the officials in the state noted,

> *"the NRHM CAH process provided a forum and some continuity at the village level to implement the earlier program developed by the state. So the spaces created by the NRHM have been used to consolidate the earlier program"* (IDI6, State Government representative)

Thus the role of the panchayats emerged more clearly only during this phase. Further at the state level there was a lot of resistance to monitoring by the community in any form and if at all acceptable it was to be seen only as a feedback process.

Based on the review of the individual state level evaluation reports as well as the interviews, it could be observed that in states that showed the "model accepted" outcome there seemed to be a combination of strong NGO coalitions, which were able to build relationships of trust with key officials, while at the same time pushing beyond a utilitarian form of accountability. Describing the continuation of the process in one of the two states showing this outcome, a senior bureaucrat noted that,

> *"the belief in the purpose, the trust in the NGO and the flexibility on both sides to take it forward …. these three help these kinds of programs"* (IDI 3, State Government representative)

In states showing the "model rejected" outcome, strong NGOs could also be found but there was a lack of a trusting environment, especially an absence of supportive bureaucrats. One state level bureaucrat interviewed referred to a "lack of trust and misunderstanding" between the government and the NGO (IDI 5, State Government representative) as being one of the key reasons for the discontinuation of the process.

In the "intermediate" outcome states, a combination of NGO coalitions that were weak or that worked along with the governments without challenging them could be observed. In such states, only parts of the overall model were implemented in the post-pilot phase. While in one state there was more emphasis on mobilization and public hearings, in another more on monitoring, and in some states there was only an effort to spread the component of training and information regarding entitlements (IDI 2, National NGO representative; IDI6, State Government representative, IDI7, State NGO representative).

To summarize (Table 1), there were a number of key shifts in the emphasis on various components of the CAH process as the implementation moved from the policy formulation, through the program formulation and the program roll-out phases. While in the initial policy formulation phase the process was envisaged as being embedded in the panchayats, with the NGOs playing a supportive role, this was shifted significantly during the program formulation stage with the AGCA pilot process envisaging an NGO led process, with a minor role, if at all for the panchayats. Post pilot phase roll out was state specific, with the state departments invariably taking the lead in implementation, relegating the NGOs and panchayats to secondary positions. In terms of the relative importance of monitoring and planning, while the policy expected community based monitoring to highlight gaps and feed into the planning process, in the program formulation phase the AGCA proposal conceptualized monitoring as a tool for empowerment, with little emphasis on the planning phase. Subsequent state led program roll-out downplayed these aspects, except as feedback.

5.1. Discussion

A particular set of circumstances at the central level in 2005 enabled the emergence of the concept of accountability to feature prominently in the NRHM Framework of Implementation. This space was used effectively by members of a coalition of NGOs to articulate and implement a process based on a 'collective action' perspective on accountability, compared to the 'institutionalist' perspective characteristic of the government departments of health (Van Belle et al.,2016). In the subsequent phases of the project following the pilot process, the driving force for the implementation of the process moved to a different layer of government (from centre to state). Under these circumstances, the NGO coalitions at the national level had to re-establish the rapport they had achieved at the central Ministry in each of the states, each with very different opportunity structures. These changed opportunity structures meant that the subsequent implementation (except in two states) was more within the 'institutionalist' perspective, with a consequent change in the emphasis of the different components described above.

Another aspect that emerges from this study with respect to the implementation of such contentious policies, is the way competing coalitions use the ambiguity inherent in these concepts to push for the implementation to be based on their perspective. In the case of community participation this inherent ambiguity has been documented during the decades' of attempts to implement it. As one author puts it, "It can be said that participation is a politically desirable development idea to which institutions will sign up for different reasons; that its ambiguities allow contradictory objectives to persist within projects" (Mosse, 2007). While the ambiguity inherent in the concept allowed the NGOs to stretch the definition in the context of a particular set of opportunity structures at the central level and in a few states, these spaces rapidly closed as the opportunity structures changed in the states or over time.

One way of understanding this link between ambiguity and implementation is to invoke the concept of "chains of equivalence" (Laclau, 1996). This refers to the fact that the meanings of concepts emerge from the other concepts along with which they are used. Thus, the use of particular concepts in particular chains, also in a way, restricts their meanings to what the rest of the concepts, along with which they are being used, allow. In the present case - while there was agreement on the concept of community monitoring through a village committee for increasing accountability, there was conflict over other the accompanying aspects of the model, like the lead role for rights based NGOs, and the usage of community monitoring to contribute to altering the power differential between the system and the community rather than just for the system to identify gaps and fill them. The conflict over these, we suggest, were crucial in the way the implementation finally panned out. In terms of the Advocacy Coalition Framework this points to the way in which the agreement on one aspect of the secondary belief structures (however specific), while ensuring its implementation, may not necessarily lead to the specific outcomes expected by the different coalitions, unless there is agreement on related interventions as well.

The ACF contends that deeper beliefs are more difficult to

Table 1
Changes in the emphasis in various components of the CMP process during the implementation.

	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	+	+

Note: the magnitude of the signs (number of plus signs) was arrived at based on the relative importance given to the particular aspect in the documents reviewed of the particular phase.

change than more superficial ones (Jenkins-Smith et al., 2014a,b). What emerges from the interviews analysing the ability of NGOs (in two states) to implement the 'collective action' perspective, even after the pilot phase, was the ability to engage at the level of these deeper beliefs. This was possible, however, only under particular circumstances. This was reflected in the interviews with senior bureaucrats when they referred to the newness and unexpectedness of the whole process. What seemed to be essential were strong NGO coalitions willing to engage with the government, and officials within the government who were working in supportive environments who had a good rapport with the NGOs. The word used in the interviews to describe this was 'trust'.

This study has several implications for future programs. The WHO has made a call for the establishment of a people-centered health care system as an essential component of the effort to establish a Universal Health Care system (World Health Organization (WHO), 2015). In India the right-wing national government elected in 2014 has taken more than two and a half years to articulate a coherent national health policy. This delay and uncertainty in the intervening years has meant that they were unable to take advantage of and build on the momentum of ten years of implementation of the NRHM. While both the previous as well as the present governments espouse the neo-liberal framework of governance, the previous government had the left-leaning parties as coalition partners, thus potentially having to include space for more people centered and rights based aspects in policy. More recently Rights based NGOs perceive increased restriction of functioning by the government (Khullar, 2016). These factors, the delay in articulation of National Health Policy, the political make up of the present government and the response to Rights Based NGOs, suggest a set of opportunity structures which will provide insignificant space for NGO led 'collective-action' perspective of community based accountability to emerge.

6. Conclusion

In our opinion, three things emerge from this study.

The first is that while certain opportunity structures enable a policy intervention to come on to the policy agenda, the subsequent implementation depend on the ability of the policy coalition that brought this particular policy intervention to continue to influence the policy process under changing opportunity structures as the implementation moves through different levels of government.

Secondly, while there was broad agreement on certain policy interventions, like "community monitoring", the perspective from which the different groups approached the concept varied. Their perspective is revealed we argue by the importance given by them to other actions accompanying the implementation of the specific agreed upon intervention. Thus the ambiguity of contested concepts arise from disagreements on various aspects of the overall program, while agreeing on certain specific interventions. This, we suggest, calls for going beyond the study of an isolated intervention; it calls for an attempt to study the effects of a set of interventions as a whole, as it is these broader sets of interventions that reveal the underlying aims of the implementers.

Thirdly, we also point to the fact that the implementation of such contentious policies like community monitoring that challenge long standing institutional norms requires not only strong coalitions but also spaces for and relationships of trust where newer institutional norms may be built. In the particular situation of India this calls for all groups interested in the implementation of community participation and accountability initiatives with a collective action and social justice perspective to understand the dynamics within the department as well as the importance of building trusting relationships with officers in charge of implementation. In such situations trusting relationships require the civil society groups to understand the sources of concern of the officers within the context of the bureaucracy, and make attempts to address them. At the same time it calls for these groups to maintain the pressure for change and be wary of co-option.

We believe that apart from contributing to the literature on policy implementation, the study also draws attention to key themes for the study of policy in situations of "perverse confluence" where as in the present neo-liberal times community participation is becoming fashionable once again, but not necessarily for the right reasons.

6.1. Trustworthiness

The first author (RG) was deeply involved in various stages of the evolution, piloting and post-pilot implementation of the CAH process at the national level and particularly in one of the states. While this closeness with the process and its implementation may have influenced or biased the interpretation, we used a number of steps to increase the trustworthiness of the overall process. Each of the conclusions which came from a reading of the documents was confirmed with all the interviewees, which included a range of key-informants from both the government and the NGO sector at both the national as well as the state levels. Secondly working in a multi-author team with two of the authors (AKH and MSS) familiar with similar processes in a number of developing country settings, but not directly involved in India, and having another author (VRM) very familiar with the Indian situation but not directly with the CAH project, further in our opinion, reduced any biases.

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