Social Science & Medicine 188 (2017) 82–90

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

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

Rakhal Gaitonde [a, b, *], Miguel San Sebastian [a], V.R. Muraleedharan [c], Anna-Karin Hurtig [a]

[a] Department of Public Health and Clinical Medicine, Umea University, Sweden
[b] Centre for Technology and Policy, Indian Institute of Technology Madras, India
[c] Department of Humanities and Social Sciences, Indian Institute of Technology Madras, India

ARTICLE INFO

Article history:
Received 6 December 2016
Received in revised form
26 June 2017
Accepted 30 June 2017
Available online 1 July 2017

Keywords:
Community action for health
National Rural Health Mission India
Policy implementation
Community participation
India

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

* Corresponding author. Centre for Technology and Policy, First Floor, IITM Research Park, No. 1 Kanagam Road, Taramani, Chennai 600113, India.
E-mail address: rakhal.gaitonde@epiph.umu.se (R. Gaitonde).

http://dx.doi.org/10.1016/j.socscimed.2017.06.043
0277-9536/

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