

Poisedness for social innovation: The genesis and propagation of community- based palliative care in Kerala (India)

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Abstract. When and where do social innovations emerge? We address this question using comparative and historical analyses of organizing for palliative care in India. Although palliative care made in-roads into different parts of India in the 1980s, it evolved as a vibrant sector only in the state of Kerala, through a novel community-based approach. By examining historical and social conditions, we reveal how poisedness, and particularly political poisedness, of time and place manifests in the genesis and propagation of a social innovation. We contribute to the literature on macro-foundations of social innovations by illustrating how an array of organizations and individuals create the very conditions of poisedness that are thereafter leveraged by institutional actors for the construction of novelty and propagation. Moreover, we specify the conditions of poisedness that are conducive to propagation, thereby contributing to conversations on distinct phases of emergence.

Keywords: poisedness, institutions, social innovation, palliative care, Kerala, India

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INTRODUCTION

Organizational theorists are increasingly examining social innovations for complex societal challenges such as unequal market access (Mair, Martí & Ventresca, 2012), substance abuse (Huq, 2018; Lawrence, 2017), homelessness (Lawrence & Dover, 2015; Tracey, Phillips & Jarvis, 2011) and financial inclusion (Battilana & Dorado, 2010). Social innovation is understood here to be the creation and implementation of “novel solutions to social problems directed toward producing profound change in institutional contexts” (van Wijk, Zietsma, Dorado, de Bakker & Martí, 2018: 4; see also Tracey & Stott, 2017). Specifically, as a response to the crises of advanced capitalism, there is a growing imperative among academics to examine alternative organizational models – such as cooperatives, community organizations, and solidarity initiatives – as social innovations (Cheney, Santa Cruz, Peredo & Nazareno, 2014; Cruz, Alves & Delbridge, 2017; Daskalaki and Kokkinidis, 2017). However, the growing scholarship on social innovations emphasizes social innovators, their strategies and novel organizational models, obscuring wider institutional processes that may facilitate or constrain novelty (Dacin, Dacin & Matear, 2010; van Wijk et al., 2018).

Advancing an institutional perspective on social innovations, we suggest that it is not just that the institutional context matters, but that

certain social worlds are more “poised” than others to support novelty. Padgett and Powell (2012), and later Johnson and Powell (2015), define “poisedness” as the receptivity of a context to certain organizational inventions, and the readiness of the context to be reconfigured by the cascading effects of these inventions. Accordingly, the concept of poisedness carries analytic purchase to examine the configuration of social worlds, human agency and social innovation. Conceptually, we take seriously the assertion that contexts are not just backdrops or containers of institutional work within which action is meaningfully conducted (Lawrence & Dover, 2015). Rather, contexts are produced, imagined, interpreted and maintained (Gieryn, 2000). Thus, we move beyond an explanation of poisedness as a static feature of a social world that institutional entrepreneurs reap, to understand how multiple actors script contextual poisedness into social innovation.

In this article, we examine the specific historical and social processes favorable to the creation of a social innovation in the Indian palliative care sector. Palliative care is an approach to health care that attempts to relieve suffering and improves the quality of life of patients (and their families) facing terminal or chronic illnesses such as cancer, chronic respiratory disease and renal conditions, and HIV/AIDS (World Health Organization, 2016). Globally, palliative care is provided through hospital- and hospice-centric approaches, anchored around medical professionals. Aging populations and rapid increases in non-communicable diseases raise the imperative for palliative care, which can improve quality of life, ensure fewer and less intensive hospitalizations during end-of-life and reduce caregiver distress (Hughes & Smith, 2014). Yet, despite 60 years of the modern palliative care movement, less than 10% of those who require palliative care actually receive it (Economist Intelligence Unit, 2015).

However, in the south Indian state of Kerala, volunteers coordinated with medical professionals through community-based organizations to provide “total care”—financial, social, emotional and medical care—as well as rehabilitation and bereavement support to patients and families in their homes. This community-based innovation not only increased the scale of care provision to cover approximately 60% of the patient population in Kerala, but also expanded the patient categories within palliative care to include cancer, HIV/AIDS, chronic renal and respiratory conditions, paraplegia and geriatric conditions. Moreover, this innovation was institutionalized in 2008, when the Kerala state government introduced a palliative care policy mandating palliative care at primary health centers and collaboration between these centers and community organizations.

We present a historical and comparative account of how this novel and contextually appropriate innovation emerged in Kerala and expanded in scale (number of community organizations) and scope (number of diseases covered). Our comparative analyses highlight the limited success of palliative care in other parts of India. Further, community-based palliative care did not emerge elsewhere, despite available resources such as ideas, funds and skills. This research setting highlights how specific elements combine to make novelty possible *only* at particular points in time and place. We contend that this community-based approach emerged in Kerala because the appropriate place (where) and historical (when) milieu created certain conditions of poisedness.

We make the following contributions. First, we bridge the emerging literature on poisedness (Johnson & Powell, 2015) with institutional perspectives on social innovations (e.g. Tracey & Stott, 2017; van Wijk et al., 2018). In doing so, we advance an understanding of the institutional processes that enable social innovators. Second, we advance the

theorizing on political poisedness, which produces particular conditions amenable to social innovation. We compare the trajectories of palliative care in other parts of India with that of community-based palliative care in Kerala. In addition to providing analytical support to the concept of poisedness, this approach also illustrates how an array of organizations and individuals stitch together these very conditions of poisedness. Third, we provide insights into how social innovations propagate beyond their original geographical domains (Johnson & Powell, 2015). We conceptualize a propagation phase as one where elements constitutive of the social innovation form and circulate in different geographical domains. While propagation is constitutive of emergence, it is conceptually and empirically distinct from the earliest stages of the genesis of novelty. We elaborate on the conditions of poisedness that facilitate propagation.

THEORETICAL ORIENTATION

Social innovation increasingly elicits interest from a range of organizations spanning non-profits, for profits, public sector organizations and philanthropists (Phills, Deiglmeier & Miller, 2008). Accordingly, a burgeoning stream of organizational research examines social innovators and their specific organizational and social processes such as individual creativity or organizational models (Bacq & Janssen, 2011; Dacin et al., 2010; Mulgan, 2006; Tracey & Stott, 2017). Several scholars have called for integrating the “agentic-centered perspective”, which emphasizes social innovators and their actions, with the institutional processes that shape innovation (Cajaiba-Santana, 2014: 43; see also van Wijk et al., 2018). Social innovations contribute to lasting social change (Murray, Caulier-Grice & Mulgan, 2010; Phills et al., 2008), thus inhering contestations, negotiations and transformations in institutional orders. Of course, studies have investigated specific environmental characteristics that may support or inhibit social innovation. For instance, a localized small business system may be more resilient to economic shocks and amenable to the development of environmentally sustainable social innovations (Parker, 2017). Certain communities respond more proactively to emergent problems (Dutta, 2017) and may have more cultural competence for novelty because of past trajectories of civic engagement (Clemens, 1997). Thus, social innovations may arise from historical processes and are context dependent (Novy & Leubolt, 2005). However, as Castro and Ansari (2017: 1) contend, “contextual influences are often acknowledged but tend to be bracketed as precipitating factors or enabling conditions for agentic activities”.

Advancing a theoretical perspective on the configuration of agency and social worlds, Johnson and Powell (2015: 5) develop the concept of poisedness to examine when and why innovations emerge and persist “both cognitively and geographically”. Poisedness thus captures not just how certain contexts are more fertile for an innovation at a given time, but also how these contexts are amenable to subsequent reconfiguration by this innovation. This structural vulnerability to reconfiguration may have cascading effects for both the emergent innovation and the broader context (Padgett & Powell, 2012). Certain settings may be more hospitable to novelty: a setting can stand “ready and available to make a direct impact on beliefs and/or desires” (Tye, 2000: 62). Johnson and Powell (2012) describe transitions in the American civic, material and intellectual orders in the nineteenth century that generated a context that was “poised” for a new form—the modern American botanical garden. The authors describe poisedness as “circumstances that are rich with potential, in which

relations and trends at one level are available to be coupled with innovations at a different one” (p.1). By highlighting poisedness, the authors point to how structural availability is tethered to a specific time and place, revealing how some contexts may be more (or less) poised for an innovation.

However, extant conceptualization renders poisedness to an ontologically prior position to human action: the state of poisedness exists and skilled human action astutely draws upon it. Such a conceptualization reproduces problematic structural metaphors, like static “girders of a building”, that shape human action (Sewell, 2005: 125). But social worlds are doubly constructed: not only are they a given with a material form, meanings and values, they are also interpreted, imagined, transformed and malleable in the hands of people (Gieryn, 2000). Moreover, while humans have an inherent capacity for agency, it is formed by a specific range of contextually available schemas and resources (Sewell, 2005). Structures exist as “memory traces, the organic basis of human knowledgeability, and as instantiated in action” (Giddens, 1984: 377), with a multiplicity of structures influencing actors’ capacities to reinterpret and mobilize resources (Giddens, 1984; Sewell, 2005). Further, structural conditions influence actors’ capacities to shape and create new organizations (Stinchcombe, 1965).

In this study, we shift from an assumption of social worlds that are already poised. We posit that “things” as social poisedness come to be “constituted, reproduced, adapted and defined” (Langley, 2007: 2). We foreground attention to institutional structures and understand the construction of a social innovation as a process involving specific forms of institutional agency that are culturally and historically determined. As a consequence, we ask: *When and where are institutional contexts poised for social innovation? Specifically, what structural conditions constrain or enable institutional actors to engage in social innovation?* Building on the above theoretical insights, we examine individuals’ and organizations’ efforts at constructing a social innovation that was historically and geographically specific, as actors leveraged opportunities for organizing that were made available by certain historically specific configurations in a context that was “poised” for the innovation.

METHODS

A COMPARATIVE AND HISTORICAL PERSPECTIVE

We adopted a comparative and historical perspective (Suddaby, 2016) to examine both the emergence of community-based palliative care in Kerala and the limited success of any form for palliative care in other states. We proceeded in two stages. First, we studied the historical formation and propagation of community-based palliative care in Kerala. Second, we built upon comparative analyses of the forms, diseases, categories of patients, services provided and outcomes (coverage) of alternative models for palliative care across India. Comparative analyses are particularly amenable to uncovering conditions for the rise of new organizations (Lizardo, 2009) as they reveal and explain sources of enduring organizational heterogeneity and focus on contextual differences at different levels of analysis (King, Felin & Whetten, 2009).

The primary and secondary data sources for this study are derived from a larger research project on the evolution of the Kerala palliative care sector and translations of community-based palliative care to other geographies. Field work for this project occurred across multiple phases.

The first author conducted the first stage of field work, with a pilot phase in December 2009, followed by two months of field visits between August and October 2010. Both authors conducted the second stage of field work in December 2015, where we clarified early findings and sought clarifications from key stakeholders. In the interim, we closely traced the development of palliative care in India, and specifically Kerala, and participated in national palliative care conferences and workshops. This prolonged engagement alerted us to Kerala's contextual specificities that influenced community-based organizing.

Given our objective of examining why certain social contexts are more amenable to new forms than others, we proceeded in three stages. In the first stage, we built a chronological narrative of the genesis and propagation of community-based palliative care in Kerala. We discovered that while palliative care in Kerala started in 1993, it remained confined to Kozhikode city and the surrounding regions and only started to propagate after 1998. This finding was unintended and contributed a surprise element to our ongoing theoretical development (see King et al., 2009). Once palliative provision became a public policy by 2008, the nature of organizing altered to resemble diffusion processes that are already well-studied and understood (Strang & Soule, 1998). Consequently, we limited our analyses to the period between 1993 and 2012. By then, palliative care provision was firmly embedded in the state.

In the second stage, we conducted two sets of comparative analyses. In the first set of comparisons, we traced the earliest stages of palliative care across India, looking for sources of variation in terms of why and how palliative care emerged. Archival sources revealed that palliative care had made in-roads into different geographies of India, starting from 1986. Building on these archival records, we identified several comparative cases of delivery of palliative care outside Kerala. For the sake of parsimony, we present three cases where palliative care relied on different organizational forms, namely the first hospice (Shanti Avedna Hospice Mumbai, Maharashtra, 1986), a hospice with home care facilities (Karunashraya in Bangalore, Karnataka, 1994) and professional home care (CanSupport New Delhi, 1997).¹ We compared these three cases with the Kerala case and noted that the community model resulted in greater coverage, both in scale (number of community organizations, number of patients, number of districts in Kerala) and scope (spectrum of diseases). We illustrate how Kerala did not benefit from any particular advantage compared to other states in terms of initial awareness among medical professionals about palliative care or in terms of early access to funding. Given its visible success, several attempts at replicating community-based care outside Kerala occurred. We examined these efforts in a second set of comparisons. For brevity, we report data on two such attempts to replicate community organizing outside Kerala—in New Delhi and Tamil Nadu—neither of which achieved comparable scale or scope of organizing. The divergent outcomes of these cases pointed to the importance of social contexts.

As a consequence, in the final stage, we turned to a historical analysis of Kerala's social context. Following an inductive approach, we iterated between data, literature and emergent theory. We clustered our raw data into themes using axial coding and aggregated our findings into theoretical categories. We identified six conditions that made the state poised, that is, amenable to community-based palliative care provision. Our analyses reflect the linkages developed between these conditions of

1. Other organizations we included were Cipla Palliative Care and Training Center (Pune, Maharashtra) by Cipla Pharmaceuticals built around a short-stay model targeted at symptom control; Tata Memorial Hospital (Mumbai, Maharashtra) that provides hospital-based palliative care and has recently begun home-care programs; Jeevodaya (Chennai, Tamil Nadu) a hospice founded in 1995; DNipCare (New Delhi) that replicates the community-based approach and provides home care through volunteer-driven networks.

poisedness and how they manifest in social innovation.

FINDINGS

PALLIATIVE CARE IN INDIA

Palliative care coverage in India remains at less than 2%, despite the country having one-sixth of the world's population with a sizable burden of terminal and chronic illnesses (Rajagopal, 2015). In sharp contrast, the small south Indian state of Kerala, with 1% of India's land mass and 3% of its population (approximately 35 million people), provides palliative care across all its fourteen districts, covering over 60% of its patient population (Sallnow, Kumar & Numpeli, 2010). Kerala offers more palliative services than the whole country put together (Rajagopal, 2015). This specific empirical puzzle inspired our interest: *Why in Kerala and not elsewhere? When and where did community-based palliative care form and propagate?* Our comparison of the various palliative care models in India (see Table 1) with Kerala's community-based model, points to four organizational properties pertinent to our research question: *mechanisms of genesis, organizational boundaries, resource mobilization practices and regulatory environment.*

Mechanisms of genesis: Our analysis revealed that modern palliative care initiatives in India mimetically adopted globally prevalent hospice- and hospital-centric approaches. The first organized effort for modern palliative care was Shanti Avedna Ashram, a hospice founded in Mumbai in 1986 (Maharashtra state). It was modeled after and with inputs from the pioneering St. Christopher's Hospice, United Kingdom. Branches were added later in Delhi and Goa. The care teams included doctors, counselors, nurses, volunteers and spiritual advisors. Its services are varied (see Table 1 below), but the maximum capacity remains limited: a maximum of 100 in-patients in Mumbai, 40 in Delhi and 20 in Goa. Similarly, the Karunashraya Hospice in Bangalore (Karnataka state) was established in 1999 with assistance from the Shrewsbury Hospice, United Kingdom (Rao & Simha, 2011). Given the magnitude of the problem in India, scale was imperative and stand-alone hospices were insufficient to deliver solutions (Seamark et al., 2000). While India has more than a million cancer patients who need palliative care, each hospice barely reached 50 people. Besides, there was a cultural preference for caring for the aged and sick at home (Rajagopal & Kumar, 1999). Given strong family networks and the possibility of empowering relatives for patient care, home care was recognized as inexpensive and suitable for the Indian social and cultural milieu (Rajagopal, 2001). However, apart from a few isolated initiatives like CanSupport in New Delhi, we could not identify any noteworthy development of palliative care through home care. CanSupport, a non-profit organization founded by a cancer survivor in 1997, provides home-based palliative care for cancer patients through a team of trained medical professionals including doctors, nurses and counselors. As of 2012, CanSupport reached out to 80–85 patients per week in New Delhi (Khosla, Patel & Sharma, 2012).

Organizational boundaries: Medical professionals defined and controlled the organizational boundaries of the heterogeneous palliative care models in other parts of India. During the 1990s medical professionals from different Indian states (e.g. Assam, Karnataka, Kerala, Punjab, West Bengal) who were interested in palliative care received training at the International School for Cancer Care in Oxford, United Kingdom. The Indian Association for Palliative Care (IAPC) was founded in 1994 as a

national forum for palliative care practitioners and was housed at the Department of Anesthesia, Gujarat Cancer and Research Institute, Ahmedabad. Indeed, the Banaras Hindu University (Uttar Pradesh) organized and hosted the IAPC's first international conference. Delegates from across India presented scientific papers on pain relief and the role of alternative medicine in palliative care, indicating early engagement and exposure to palliative care discourse. The IAPC today has over 1,330 active members across India, conducts an annual international conference, certificate courses and workshops, and publishes three editions of the *Indian Journal of Palliative Care* annually. In sum, we identified that the Indian palliative care field was governed by professional actors who shaped care practices and legitimate modes of organizing.

Resource mobilization practices: Diverse palliative care initiatives followed resource mobilization practices predominantly driven by philanthropic support from domestic and international donors. For instance, for several years, Cancer Relief India—a non-profit organization—organized training for healthcare professionals throughout India in collaboration with the Cancer and Palliative Care Unit of the World Health Organization, the International School for Cancer Care, the MacMillan Cancer Relief Fund and Global Cancer Concern (Chaturvedi & Chandra 1998). Robert Twycross, Oxford, and Gilly Burn, Cancer Relief India, were regular educators and resource persons at various conferences, symposia, training courses and workshops conducted across the country during the 1990s. Further, professionals involved in palliative care had strong links with other international bodies such as the International Association for the Study of Pain, the Multinational Association for Supportive Care in Cancer, and the European Association for Palliative Care (Chaturvedi & Chandra, 1998).

Regulatory environment: The Government of India initiated a National Cancer Control Program in 1975 and modified it in 1984 to make pain relief one of the basic services to be delivered at government-sponsored primary health centers. But, to date, this policy has not become reality (Rajagopal, 2015). One of the biggest challenges for effective palliative care delivery was the heavily regulated access to morphine. Morphine is one of the cheapest, and easily available pain-relieving drugs in India. India is also one of the largest exporters of raw material for morphine production, yet only a tiny fraction is used for domestic consumption. Moreover, distribution of morphine is heavily regulated under the Narcotic Drugs and Psychotropic Substances Act (NDPS) 1985, whose rules also vary across states. Based on a considerable amount of lobbying by the Pain and Palliative Care Society Kozhikode (Kerala), Indian Association of Palliative Care and the Pain and Palliative Care Study Group (Wisconsin), the Government of India directed state governments to amend the NDPS Act in 1998. Kerala state government promptly amended the NDPS Act in 1999. As of 2007, 13 other states had amended their provisions as well, although the material consequences were limited given the deep-seated prejudices and myths within the medical community over morphine prescription (Rajagopal and Joranson, 2007).

In sum, despite the prevalence of palliative care discourse for over two decades, long-standing collaborations with global institutions, early palliative training for professionals from different areas and the founding of a pan-India association, palliative care in India, as delivered through isomorphic hospital and hospice approaches, remained fragmented and limited in scale and scope. In spite of their early involvement in the genesis of palliative care in India or an early start with the hospice model, none of the abovementioned states—Maharashtra, New Delhi (National Capital

Region), Uttar Pradesh, or Gujrat—had any remarkable palliative care statistics to talk about as of 2015. This casts sharp relief on the novel community-based palliative care which emerged in Kerala. Table 1 provides a summary of several experiments in different geographies and at different points of time.

Form. City, State	Year	Focus	Organizational Form	Services	Reach
Shanti Avedna Sadan Cancer Hospice. Mumbai, Maharashtra, with branches in New Delhi and Goa	1986	AIDS and advanced terminally ill cancer patients	Hospice. Modeled after St. Christopher's Hospice, London. Care teams consist of doctors, counselors, nurses, volunteers and spiritual advisors	<ul style="list-style-type: none"> •Nursing •Medical, mental, social, spiritual, and financial care •Free care, preferences for poor and needy patients 	Mumbai: 100 in-patients New Delhi: 40 in-patients Goa: 20 in-patients
Karunashraya, Bangalore Hospice Trust Bangalore, Karnataka	1994	Advanced stage cancer and terminally ill patients	Hospice. Modeled after Severn Hospice, Shrewsbury UK. Supported by the Indian Cancer Society (Karnataka Chapter) and Rotary Bangalore Indiranagar	<ul style="list-style-type: none"> •Free in-patient care •Pain relief and symptomatic management. Symptoms may be physical, emotional, psychological •Nurse- and counselor-driven home care to provide medical and psychological support and enabling family 	Home care in and around Bangalore city; smaller palliative centers are set up in seven other cities. Approximately 15,000 patients including 2,900 in-patients over 20 years
Professional Home care (CanSupport) New Delhi	1997	Advanced stage cancer patients	Professional Home care. Founded by H. Gupta, Cancer Survivor	<ul style="list-style-type: none"> •Home-based care •Day care service for cancer patients •11 home care teams comprised of doctors, nurses and counselors 	80–85 patients per week in New Delhi
DNipCare	2008	Long-term, bed-ridden and terminal diseases	Home care. Multidisciplinary teams consisting of volunteers, doctors and nurses (Modeled around Kerala Palliative Movement)	<ul style="list-style-type: none"> •Home-based care •Psychosocial, emotional, medicinal, financial and logistical support •Rehabilitation for poor patients and families 	Restricted to the Keralite population and personal networks in New Delhi Limited evidence available
Community-based approach in Tsunami-affected regions of Cuddalore and Nagapattinam (Tamil Nadu)	2006	Chronically ill elderly	Community-based organization facilitated by HelpAge India, in partnership with the Institute of Palliative Medicine Kozhikode (Kerala). Funded by HelpAge India, Help the Hospices and Help the Aged	<ul style="list-style-type: none"> •Free Home Care by team of doctor, auxiliary nurse, physiotherapist, pharmacist, volunteer, social worker •Elderly's medical and social problems •Self-help groups of elderly to enhance mutual interactions and support •Counseling 	The project scaled from 10 to 52 villages during the three project years (2008–2011), then plateaued

Table 1. Comparative Analyses of Forms for Palliative Care across India

THE DEVELOPMENT OF PALLIATIVE CARE IN KERALA (1993–2012)

In 1993, M.R. Rajagopal, head of anesthesiology at Kozhikode Medical College (a government-funded teaching hospital), and Suresh Kumar, Rajagopal's then student, established the Pain and Palliative Care Society within the premises of the medical college in Kozhikode city (North Kerala). This was the first clinic in Kerala dedicated to pain relief, and in these early years the founding doctors focused their efforts on pain relief

for terminally ill cancer patients. The doctors enlisted three volunteers through their personal networks to support logistics and administrative activities such as maintaining patient records. Within a few months, about 400 patients thronged the clinic every month. The team raised funds primarily through donations from a few individuals by word-of-mouth and through international donors. During this period, the doctors recognized the challenges of getting access to morphine, one of the safest and most effective opioids for pain relief. Under the Narcotics and Psychotropic Substances Act 1985, originally introduced to prevent abuse, morphine was excessively regulated in India. A team of doctors, spearheaded by Rajagopal, formed a coalition with international bodies including the World Health Organization (WHO) and started an advocacy program to ease access to morphine.

A key problem with this clinic-based model was that patients had to travel to Kozhikode city from remote areas. This travel often meant loss of a day's wages for the patient's escort. Doctors recognized that care had to be delivered closer to patients' homes. In 1995, after a chance meeting with Rajagopal, Abdul Rahiman, a general physician at Manjeri (a town in a neighboring district in North Kerala), offered his clinic's premises and his volunteer support base for out-patient care.² By the end of 1995, a satellite center was founded in Manjeri with local community volunteers taking care of day-to-day operations. Over the next three years, a hub-and-spoke model emerged with twenty satellite centers in North Kerala, driven by the two founding doctors and supported by local volunteers. Doctors from Kozhikode traveled to the satellite clinics while local volunteer groups dealt with logistics, gathered administrative information, maintained patients' charts, followed up with patients' families and raised funds locally. In these early years, donors such as Cancer Relief India, Global Cancer Concern and the British Overseas Development Agency supported the Pain and Palliative Care Society Kozhikode (Rajagopal & Kumar, 1999). In 1996, the Kozhikode approach of satellite-linked palliative care was made a WHO demonstration project.

From the late 1990s, volunteer involvement increased and became central to palliative services. Through increased interactions with patients and their families, volunteers began to understand that patients faced non-medical problems. They framed the patients' problems as being "80% social and 20% medical". For example, patients' concerns included their families' well-being after their death, whether daughters would get married and how their children would continue their education.

In 1998, the Nilambur unit was founded by Basheer, a farmer with high school education who had worked with the home care unit at Manjeri. The Nilambur Pain and Palliative Care Society, registered as a charitable society, functioned as a community organization and was constituted entirely of non-medical professionals. The Manjeri and Kozhikode clinics provided external support to Nilambur for the first six months. Basheer is perhaps the first non-medical person in the world to have headed up a palliative care unit. Drawing on local resources, within a year the Nilambur community organization had trained 60 volunteers and the ranks subsequently swelled (*The Hindu*, 2008). Community members made decisions, raised funds and provided care, with doctors consulting on a needs basis.

In 2001, community organizations in Malappuram (a North Kerala district) and the Kozhikode clinic formalized this experimental model under the concept of Neighborhood Network in Palliative Care (NNPC). NNPC

2. Here, in-patient care refers to any medical service that involves admission into a facility; out-patient care implies patients visiting clinics for consultation with medical professionals but not for an over-night stay; home-care implies care for the patient at home—this could be provided by trained volunteers (basic relief from bed sores, wound dressing, changing catheters) or by medical professionals.

encompassed total care—medical, social and financial support—for terminal and chronically ill patients through community involvement. By the end of 2001, there were eight such organizations in North Kerala that were completely community driven. The genesis of the community organization was an inflection point for the trajectory of the Kerala palliative sector. By 2002, community organizing for palliative care had propagated beyond the northern belt where it had been concentrated to parts of central Kerala. In 2003, the Institute of Palliative Medicine was founded with the objective of furthering policy, research and training for palliative care. It was the first center in Kerala for formal palliative care training, and over the years it would train thousands of volunteers and hundreds of doctors and nurses.

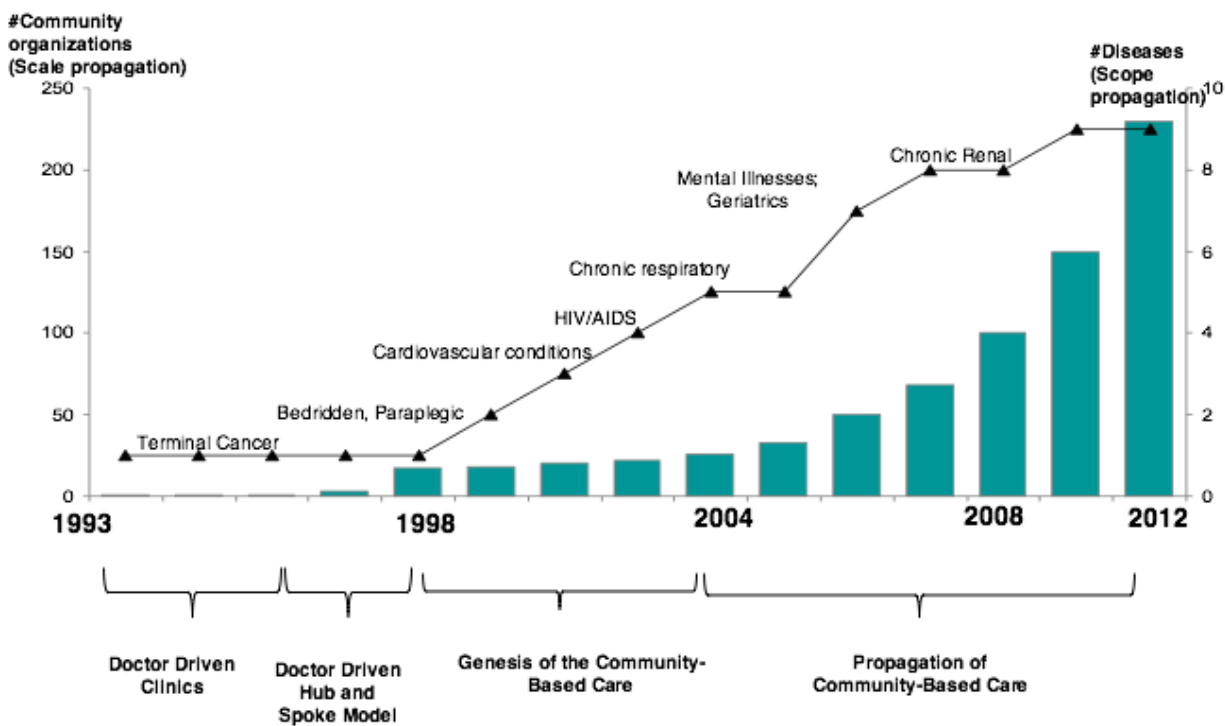


Figure 1. The Emergence and Propagation of Community-Based Palliative Care in Kerala (1993-2012)

Meanwhile, in 1999, the Supreme Court of India amended the Narcotics and Psychotropic Substances Act. Kerala was the first Indian state to amend its morphine distribution guidelines following the Supreme Court ruling to ease access to morphine. By 2012 (last official available figures in Kerala), over 230 community organizations constituted of 85 doctors, 270 nurses, over 15,000 community volunteers and 26,000 accredited social health activists provided palliative care to over 70,000 people living in 143 villages and towns spread over 39,000 square kilometers. Kerala moved toward an integrated health service delivery model with the incorporation of palliative care into the primary healthcare system (Kumar, 2013). Moreover, in response to the new policy, each of the 900 local self-governed institutions called ‘panchayats’³ (the administrative division within the district, in between the district and the

3. There are 990 village panchayats and 58 municipalities in Kerala with an average population of 29,580. Each Panchayat has ten to twelve wards, with a single councilor for each ward elected on a first-past-

municipality) had to employ at least one nurse trained in palliative care (Rajagopal, 2015).

Provisional summary. The Kerala case reveals a number of empirical characteristics. First, the community-based approach had strong efficacy. It solved three issues that other models of organizing could not: it ensured the spread of awareness about palliative care across Kerala; it mobilized non-medical professionals to undertake administrative and social care activities; and it provided regular micro funding from communities in lieu of uncertain big donations by international donors. It was not until the community-based approach supplanted the earlier clinic and hub-and-spoke models that palliative care spread throughout Kerala. Second, the genesis of the community organization in 1998 involved a marked shift in logic from an early doctor-centric approach to a community-centric approach. This is noteworthy given that the WHO had recognized the earlier hub-and-spoke model as a “WHO demonstration model for third world countries”. Thus, we see the dismantling of a model anchored around professional expertise and a shift to an approach that is more collective, action-based and bottom-up in nature. Finally, regulatory activism and the leverage of state resources appeared salient in the propagation of the innovation.

ATTEMPTS TO REPLICATE THE KERALA MODEL IN OTHER GEOGRAPHIES

With the growing scale and visible success of the Kerala experiment, there were attempts to replicate the model in other parts of India. For example, when informed in 2006 of the Kerala experiments, a group of Keralites residing in New Delhi formed an association called DNipCare with the intention of replicating the community-based organization (CBO) model. However, services have largely been limited in scope and restricted to the Keralite population in New Delhi. In another experiment, HelpAge India collaborated with the Institute of Palliative Medicine (Kerala) in establishing neighborhood networks based on the Kerala model in Tsunami-affected regions of Cuddalore and Nagapattinam in Tamil Nadu (the state neighboring Kerala). An evaluation indicated that the perceived physical quality of life and the psychological support in the project area were higher than mean scores in the control area. Yet, while the project scaled from 10 to 52 villages during the three project years (2008–2011), it has since largely plateaued (HelpAge India Report, 2011).

POISEDNESS FOR COMMUNITY-BASED PALLIATIVE CARE IN KERALA

In other geographies of India, actors followed a path of institutional mimesis, adopting either the hospice or the hospital model, or hybrids of these globally dominant models. In contrast, we see the construction of a novel community-based approach in Kerala. This innovation was constructed and propagated despite the presence of doctor-led clinics, a model that enjoyed legitimacy from professionals and technocratic experts such as the WHO. Thus, we asked: *Why did community-based palliative care emerge and propagate in Kerala?* Below, we contend that Kerala was poised for community-based palliative care. Specifically, six attributes of the place constituted a receptive milieu for actors to shift away from professionally driven forms and to experiment with care provision through an alternative, locally embedded form. Tables 2 and 3 present supporting data for our findings.

	Illustrative Evidence
Horizontal Associationalism	<p><u>Evidence of horizontal associationalism</u></p> <ul style="list-style-type: none"> ...the social and cultural heterogeneity of Kerala and its high-density citizenship have allowed for a vibrant and independent civic associationalism. This in turn has spawned many independent social movements including the fish-workers' movement and numerous KSSP [Kerala Sasthra and Sahithya Parishad]-initiated environmental and educational campaigns (Heller, 2001: 153) well-organized citizens movement may be a direct indication of the dialectical relationship between improved literacy... and other NGOs engaged in literacy promotion, environmental protection and rural development campaigns among the population, and the deepening of democratic traditions and values in the civil society of Kerala (Parayil, 1996: 946) <p><u>Evidence of horizontal associationalism as relevant to community organizing</u></p> <ul style="list-style-type: none"> I have a past. In 1952 I was part of the cultural resistance movement. Me and Gokul Das and others were part of it. A small group of us. There were 18 movements—literary movements etc....There was a lot of disappointment that there is no change in society. Around this time, was when this call came for this initiative [Palliative care CBO], I came (Interview with founder member, CBO Thrissur) I was the vice-president of another social organization. Every Sunday, there used to be a class for awareness on trauma care given by a doctor, a police officer, a fire fighter, or other related people. One regular doctor who used to come for this trauma class, you can say he taught everyone in Ernakulam district about palliative care (interview with founding member, CBO Aluva, October 2010)
Participative democracy	<p><u>Evidence of participative democracy</u></p> <ul style="list-style-type: none"> The institutional design of the Campaign's core institutions—grama sabhas, development seminars, task forces, and local governments—has self-consciously attempted to nurture and empower a model of democratic and participatory development planning [...] The participatory institutions of the Campaign are self-consciously deliberative—based on inclusion and reason-based decision-making—and directly empowered (Heller & Isaac, 2005: 413) Deliberative planning bodies in Kerala...retain the pragmatic, problem-centered concerns that enable ordinary citizens to engage in the decision-making processes...Citizens have incentives to develop their capacities and master the information necessary to making good decisions...These experiments also encourage the development of political wisdom in ordinary citizens by grounding competency upon everyday situated experiences rather than simply data mediated through popular press, television, or "book-learning". (Fung & Wright 2003: 23–28) <p><u>Evidence of participative democracy as relevant to community organizing</u></p> <ul style="list-style-type: none"> Weekly team meetings are conducted where open <i>discussions</i> among all categories of personnel are encouraged. This forum has proved to be an excellent one for thrashing out differences of opinion, airing grievances, identifying lacunae in services, and planning <i>strategy</i> (Rajagopal & Kumar, 1999: 7) Till now our view was that only professionals should be involved. Now, the society is involved in various government activities. Similarly, in every place where there is a palliative care society, there is a role for the volunteer. We have to develop this healthy politics. A lower medical officer should not think that higher officers are the ones who take decisions in the health field. He should think of the patient's problem at that level, discuss these problems with the people of that place and come up with a plan (interview with doctor, CBO Malappuram, September 2010)
Prevalence of community organizations (as decision-maker; fund-raiser; and organizer/ provider of free manpower)	<p><u>Evidence of availability of community organizations</u></p> <ul style="list-style-type: none"> The formation of Neighborhood Groups (NHG), consisting of 40 to 50 families—often initiated by KSSP activist—has been a response from below. Though not formally required, NHGs have been formed in around 200 panchayats. NHGs have also taken up other activities such as conflict resolution [...], health clinics. The crowding-in effect that the Campaign appears to have on associational life in Kerala is also evidenced in the proliferation of a variety of self-help groups (Heller & Isaac, 2005: 434) ...Many community-based programs elsewhere in developing countries do not invite sufficient local participation in defining problems, areas of action, and project goals...By contrast, the new Kerala model has already included increased allocation of funds for village development plans and has implemented a decentralized planning process that aims to involve the civil society at every stage. Ordinary citizens get a chance to express local development problems... Community-based sustainable development programs meet very conducive social conditions in Kerala. The population—in cities, towns and villages alike—is educated, informed, politically conscious and well organized to bring about necessary far-reaching social change (Véron, 2001: 612–614) <p><u>Evidence of transposing of community organization template</u></p> <ul style="list-style-type: none"> <i>Communities go beyond groups</i> (faith-based, Muslim, Hindu, etc.). <i>They pre-existed</i> and offered some platforms for action. They are also political groups. And doing good is very popular for politicians [...] And Kerala is evenly covered with communities of all kinds (interview with doctor and Director, Institute of Palliative Medicine, December 2015) Community is ready to accept anything. Community is everything. During the period of swine flu, at that time the community involvement was very high. Community used to participate by wheeling patients in, helping doctors out. Only in terms of medicine the government can help. Rest the community does. (Interview with volunteer, CBO Koyilandy, December 2009)

Table 2. Poisedness for the Genesis of Community-Based Palliative Care in Kerala

	Illustrative Evidence
Political capacity	<p><u>Evidence of political capacity</u></p> <ul style="list-style-type: none"> • What made the development [of the state of Kerala] so possible was the harmony between a compulsive public demand and a willing state supply in a democratic environment. The former came naturally from a people, reared in a most conducive historical stage that grew them politically better conscious of their rights and socially enlightened of potential opportunities...The marriage of the two in fact stood to institutionalize the development process (Kannan & Pillai, 2004: 40) • It is well known that Kerala today has attained rather high levels of health and literacy, and fairly low birth rates as a result of relatively radical social policies on the part of a government with strong left-wing tendencies and support at the local level (Mencher 1980: 1781) <p><u>Evidence of political capacity as relevant to palliative care sector</u></p> <ul style="list-style-type: none"> • In 2004–2005 village panchayats entered palliative care. Even before this, many panchayats were supporting palliative clinics in different ways by providing medicines, water beds, or conducting training programs by including them in their projects. In 2004–2005 panchayats prepared a project to function like palliative clinics even without a government circular. The project was sanctioned and they started to visit patients once in a week just like in palliative clinics. The team includes a doctor from primary health centers, a panchayat member, a trained volunteer from the same panchayat. Panchayat members started to enjoy a type of satisfaction they did not enjoy before (interview with volunteer, CBO Edakkara, September 2010) • In Kerala, there are 16 coordinators under National Rural Health Mission, one for each district. Their responsibility is to inform the public about palliative care. This is the government's initiative. So in every Zilla, every panchayat, it has initiated activities in palliative care, publishing brochures and pamphlets. Another initiative is Jana Maitri police. Wherever there are police stations they are giving training in palliative care (interview with volunteer, CBO Aluva, October 2010)
Health-seeking behaviors	<p><u>Evidence of health-seeking behaviors</u></p> <ul style="list-style-type: none"> • The Communists' anti-cholera campaign showed that some people were no longer prepared to suffer illness in silent acceptance [...] People knew about, and wanted, medical care.... By the 1970s, the western-style system of medicine treated the equivalent of the entire population each year, and Kerala's medical facilities had the highest rate of use in India (Jeffrey 2011, p.192). • Many developments outside health, such as growing literacy, increasing household incomes and population aging... probably fuelled the demand for health care already created by the increased access to health facilities (Kutty, 2000:103). <p><u>Evidence of health-seeking behaviors as relevant to palliative care sector</u></p> <ul style="list-style-type: none"> • Kerala has a long tradition of social activism and many groups already involved in community service were interested in helping deliver palliative care services in their area. In many gramsabhas (local government meetings) they have begun to hear raised voices not only about the state of the roads and electricity but of the care for the terminally ill (Sallnow et al., 2010). • We adopted the [CBO] model. To run such a center effectively the most essential requirement was a team of ordinary people who can feel the sufferings of others, think and respond. There was an existing team who were bothered about the lapses in health care and looking for an alternative. Writers, teachers, singers, socially active doctors joined hands to form this society (interview with founding doctor, CBO Thrissur, August 2010).
Availability of infrastructure and competences	<p><u>Evidence of availability of infrastructure and competences</u></p> <ul style="list-style-type: none"> • Hospitals in Kerala are evenly distributed throughout the state. The easy access to medical facilities, the relatively low cost of medical services and the high demand for them are important reasons for the better health conditions in Kerala than in other states of India. The high density of population and even settlement pattern has made health services easily available to most of the people in the state (Zachariah, 1998). • High literacy levels have also resulted in a more systematic exploration of alternate and cheaper forms of medicine such as Ayurveda and homeopathy in Kerala. The state government runs institutions which cater not only to allopathic medicine, but also to these alternate forms of medicine. Kerala, in particular, has a rich tradition of Ayurvedic medicine...The region also has four Ayurveda schools that offer a 5–6-year degree program in medicine (Varman, 2012: 89). <p><u>Evidence of availability of infrastructure and competences as relevant to palliative care sector</u></p> <ul style="list-style-type: none"> • We first started a clinic in one of the private hospitals. Later, Government permitted us to shift the to the medical college with the joint support of the medical college, district hospital and the society (interview with founding doctor, CBO Thrissur, August 2010) • We started a basic course in auxiliary nursing. We find youngsters who have done their basic education—10th or 12th standard—and some nursing experience. After selection, we give them a structured training for 3 months, purely on basic stuff, not advanced. They work in remote palliative care units where they can give good quality palliative nursing care. (interview with doctor and head of training, Institute of Palliative Medicine, September 2010)

Table 3. Poisedness for the Propagation of Community-Based Palliative Care in Kerala

POISEDNESS FOR THE GENESIS OF COMMUNITY-BASED PALLIATIVE CARE

In this section, we identify three characteristics of the Kerala state that impelled community-based palliative care: horizontal associationalism, participative democracy and the availability of the community organization template in other domains. We view these constitutive elements of poisedness as social processes (see Langley, 2007) that contribute to social innovation.

Mobilizing horizontal associationalism. Secondary associations or non-familial organizations, such as volunteer groups, self-help groups, trade unions and religious organizations, play a constructive role in civil society by shaping the “beliefs, preferences, self-understandings, and

habits of thought and action” that individuals bring to public arenas (Cohen & Rogers, 1992: 393). Throughout India, the associational field is primarily *vertical* and marked by direct barriers to participation, such as enforced social exclusions, and indirect barriers, such as group-bound distributions of social, cultural and educational capital (Heller, Harilal & Chaudhuri, 2007). In contrast, Kerala has a higher degree of *horizontal associationalism* with high rates of unionization, the most extensive network of co-operative bodies and a high density of non-governmental organizations. Apart from a quantitative supply of associations, there is also a high quality of associational autonomy reflecting the inclusion of various groups including minorities, castes, classes and genders (Heller, 2006). Horizontal associationalism facilitates the inclusion and plurality of representation of different communities in public places. Below we explain how horizontal associationalism as a social process manifests in the constitution of social innovation.

Community-based care drew upon existing secondary associations to solve the issue of severe resource constraints. For instance, at Manjeri, the first satellite clinic, Abdul Rahiman drew upon the volunteers of a Muslim religious network that was active in social services. With expanding services, the Kozhikode and Manjeri teams tapped into this religious network in neighboring villages to provide local support. Basheer, the farmer who founded the first community organization in Nilambur, shared the following:

Before coming into this I was interested in social activities in my place, like the various activities of a Muslim organization called Mujahid Muslims which was into social work. I was a part of a palliative care class which was conducted by that organization—that is how I came into palliative care.

While the Mujahid Muslims organization was not formally affiliated with palliative care, like many similar religious and political groups, its members were actively involved as caregivers and fundraisers in spreading awareness and expanding the volunteer base (Sallnow & Chenganakkattil, 2005). Basheer, a member of this secondary association, first volunteered with the Manjeri unit. As the patients in Nilambur increased, Basheer was encouraged by the Manjeri and Kozhikode units to start an organization in Nilambur which they would support in the early days. Like Basheer, other volunteers were mobilized from the numerous secondary associations that dotted Kerala’s civic society, such as Kudumbashree groups (state-sponsored poverty alleviation program for women), self-help groups, sports clubs and once-active older social movements such as the People’s Science Movement of Kerala (a state-wide popular movement for popularizing science and literacy). These dense networks also enabled actors to shift dependence for fundraising away from large donors toward community ownership. Therefore, the mobilization of horizontal associationalism as a feature of poisedness gradually evolved as the novel innovation faced new constraints and challenges.

The emerging community model drew not only upon the density but also on the quality of horizontal associationalism, characterized by the plurality of participation. Volunteers asked: “*If a cancer patient receives care, why should a paraplegic patient not receive it? He also suffers*”. Services also went beyond medical relief to financial and emotional support. Therefore, as the novel innovation faced new challenges, it mobilized different facets of horizontal associationalism and community ties.

Embedded in these communities, volunteers had a different vantage point from visiting medical professionals. Volunteers noticed absentee patients and were more cognizant of patient issues such as social isolation or financial destitution. In the absence of such density and quality of associations, there would be a reproduction of inequalities (such as gender, caste, class) that hinder inclusion and representation (Rao & Sanyal, 2009). The diversity of groups involved in palliative care provision represented the diversity of the communities served (Sallnow & Chenganakkattil, 2005). Therefore, we posit that this context, marked by horizontal associationalism, was poised for an innovation constructed by members who were not excluded socially on the basis of class, religion, political convictions or educational or professional capital. The mobilization of such multivocal groups afforded unique frames (as compared to more homogenous groups of medical professionals) that had implications for the construction of the innovation

Reproducing participatory democracy. Participatory democracy elicits the efforts of ordinary people to solve their own problems and engage with public decision-making and state resource allocation through deliberative practices and by tying action to discussions (Fung & Wright, 2003). Deliberation provides information about issues and others' preferences, increases the legitimacy of political processes, encourages members to reconstruct their preferences and facilitates group coordination through an endogenization of preferences (Cohen, 1997) and is therefore particularly geared to addressing plural values. Effective participation can be transformative, enhancing the capacity for collective action and harnessing a community's capacity to manage its own affairs (Goodin, 2003).

Unlike other parts of India that are characterized by exclusions (e.g. caste, class, gender) in the public sphere, Kerala has for decades been the site of broad-based mobilizations and state responsiveness toward reducing social inequalities and increasing civic participation (Heller et al., 2007). In Kerala, past movements, notably working-class mobilizations, have made repeated attempts to decentralize government and effect a participatory democracy whereby the state is brought closer to the people (Heller et al., 2007). These pressures for decentralization reached a critical point in 1996 (contemporaneous with the emergence of palliative care), when the ruling government rolled out the People's Campaign—globally recognized today as the largest, unparalleled case of empowered participatory governance (Isaac & Heller, 2003). The campaign was a state-led effort to build local participatory democracy institutions with a planned devolution of state decision-making powers to the lowest levels of government (Heller, 2006), making it cognitively acceptable to politically participate and reducing inequalities of representation in public spaces (Isaac, 2001).

Community-based palliative care drew upon the participatory practices of citizens such as local information gathering, public debates, discussions and collective decision-making. This had strong implications for the constitutive norms and practices of community ownership including planning, evaluating, monitoring and modifying programs. Volunteers who could spare up to two hours a week regularly underwent basic volunteer training in palliative care, including aspects of communication, catheterization and dressing of wounds and bed sores. On completion, they formed groups that were supported on a needs basis by medical professionals. Volunteer groups visited families in their respective neighborhoods to identify patients and the problems they faced, and to collectively review and discuss potential solutions. For instance, volunteers

identified that a house was reeking of urine and needed to be disinfected or that a family did not have money for food or medicines. During review meetings after a home care visit, volunteers discussed and identified possible solutions. Typically, community organizations conducted monthly review meetings where all members—doctors, nurses and volunteers—together reviewed fundraising requirements, patients and their families' status, and deliberated over future courses of action.

Critical to the participatory process in this community-based approach was egalitarian participation. As early as 2002, the community-based approach had become synonymous with “for, with, and through the people” (Stjernsward & Clark, 2003). A member of one community organization in Tirur shared his simple advice about starting a new community organization: “There is no point using the words ‘we can make them do it’. Those who are ready, find out those people”.

Community-based organizing drew not only upon participatory democracy as a condition of poisedness but also further engendered it as an organizational practice. A volunteer noted with satisfaction that although he was a wage worker at a local hotel, in his spare time, he was part of a community organization where his decisions positively affected his community. A physician at the Manjeri unit clarified how having a voice and participating in decision-making attracted more volunteers as they experienced a sense of ownership:

We have to solve the things from the grassroots level, with the patient and family. We have to take the support of surrounding families, neighbors and people of that place. We have to discuss the problems at every level. There is nothing centralized...We have to discuss with them, keep transparency and democracy, and move forward. In this type of clinics, there will be lots of volunteers.

Participants recounted how gatekeeping and hierarchy within an organization, where one or few individuals determined its functioning, were not a key to success for community forms. With greater community participation and voice, more patient categories were included.

Transposing community organizing templates. Community organizations in the design and implementation of health policies and programs are not alien to Kerala's development paradigm (Kannan & Pillai, 2004). Kerala had been experimenting with community-based programs for nutrition and urban and basic services during the late 1980s and early 1990s, with considerable impact and widespread recognition. For example, as early as 1993, a *panchayat* in Malappuram district had experimented with an integrated healthcare program in collaboration with government departments and various civil society organizations. Two hundred “barefoot doctor” community volunteers were trained to tackle basic healthcare problems and led to total vaccination programs and implementation of health surveys to identify public health issues (Isaac & Franke, 2002). Other successful initiatives like the state-sponsored Kudumbashree program for women also relied on neighborhood formations of women. The availability of community organizations as an organizational template is evident in the following observation by a National Rural Health Mission officer:

It is the community that can solve its many problems. The community is actually what is powerful...When there is an earthquake, then many people unite, form camps, provide food. This is because the community realizes that it is a natural calamity, we need to be together, show interdependence...Similarly, in the case

of such patients, if you treat it like a natural calamity and stand together then you can tackle it...They work together and get that awareness.

This account illustrates how community as a social order has shared frames of references and traditions and an underlying logic and structure that may be mobilized for organizational action (Marquis, Lounsbury & Greenwood, 2011). Elaborating on such views, Kumar, co-founder of the first palliative clinic, noted:

It could be the social reform background that we have. People are used to this community organizing. It is not something new to them. Sometimes, I think working in communities transcends boundaries – caste, religion etc. People are used to working while keeping other differences aside.

Typically, in unorganized domains, although people may have mutual interests, there is relatively little coordinated action given the paucity of taken-for-granted symbolic and material resources (Maguire, Hardy & Lawrence, 2004). However, the poisedness of the Kerala context, with its history of community formations that mobilized large numbers into habits of public discussions, fundraising and collective action (Jeffrey, 2011), provided fertile ground for transposing community forms from other domains to palliative care. Transposition, or movement of a template from one domain to another and its re-use for a new purpose, is consistent with Padgett and Powell's (2012) mechanisms for organizational genesis.

POISEDNESS FOR THE PROPAGATION OF COMMUNITY-BASED ORGANIZING

In this section, we describe three characteristics of the Kerala state that were conducive to the propagation of this social innovation: political capacity, health-seeking behaviors and the availability of infrastructure and competences.

Integrating political capacity in healthcare. Political capacity refers to the ability of a government to penetrate society in order to extract and distribute resources (Rouyer, 1987). Kerala had developed a strong political capacity in health-related issues (Jeffrey, 2011). Prior to independence, Kerala was under the rule of the princely states of Travancore and Cochin whose rulers invested extensively in both western medicine and the indigenous Ayurvedic system. Post-independence, the state government preserved this legacy and made health services available to larger numbers (Jeffrey, 2011). During the 1970s, despite low economic growth, low per capita income, and stagnancy in productive sectors, Kerala had the highest social development indicators in India. Kerala state's development approach with high social indicators despite low economic growth gained the epithet of the "Kerala model of development" (Center for Development Studies Report, 1975). By 2011, Kerala's Human Development Index was 0.79, the highest in India, with high life expectancy, low infant mortality rates and exemplary literacy levels (highest in the country) that were comparable with many developed countries. Kerala also had the best public health system in the country (Government of India, 2011). The high literacy levels achieved in Kerala contributed significantly toward raising awareness for health care issues (Drèze & Sen, 1995). Importantly, healthcare achievements transcended caste, religion, rural/urban divide and gender (Franke & Chasin, 1994).

Kerala is one of few states where the *panchayat* system has been successful (Heller, 2006). In later years (2004 onwards), communities leveraged funds available from the respective panchayats and district administration to drive palliative projects. In response to sustained lobbying by community organizations, Kerala was the first state to formulate a palliative care policy which not only mandated that state-funded primary health centers to provide palliative care, but that these centers also had to collaborate with community organizations. This political poisedness is further affirmed by the eventual integration of palliative care into the public health system by 2008. As of 2015, the Kerala government was the largest player in palliative care in terms of expenditure and the number of organizations providing care.

The political capacity of the state is manifest across the trajectory of propagation of community organizing. The bureaucratic red-tape around morphine prescription was one of the biggest deterrents to the spread of pain relief practices (Rajagopal, 2015). Kerala was the first state to amend the Narcotics and Psychotropic Substances Act, which facilitated easier access to opioids for community organizations. In addition, the propagation of palliative care was increasingly coupled with wider formal institutions. Consider how the chairman of a local Municipal Corporation's committee for health and education spoke about incorporating political mobilizations for the local palliative care project:

...the members of the working class, Kudumbasree volunteers and Anganwadi workers would be involved in a big way in developing the project so that it would be able to reach out to the entire group of patients who needed its services. (The Hindu, 2007)

Kerala, with its history of social movements and an electorally successful communist party, has a politically conscious working class that has helped in the propagation of this innovation. Not only did state agencies use their political capacity to mobilize resources but they were also responsive to community demands. Palliative care was a ubiquitous need that cut across political divides and it helped the state to support political mobilizations. As a result, emergent innovation not only draws upon political mobilizations for its propagation, it is also an effective means of reinvigorating such political initiatives. Therefore, poisedness as a social process dynamically shaped propagation of the innovation and was shaped by it.

Leveraging health-seeking behaviors. Documenting community involvement in the evolution of palliative care, Sallnow and Chenganakkattil (2005: 10) noted:

The state of Kerala is known for its political vitality and social awareness. It has the highest newspaper consumption per capita of any state in India and each morning, animated discussions are heard in tea shops and buses as the daily news is reflected upon. It comes as no surprise that palliative care services too have been infused with this political fervor. They are firmly enmeshed in Kerala's social, political, and religious framework.

This politically assertive culture was particularly charged around the issue of health (Jeffrey, 2011). The efficacy of Kerala government programs has been attributed to the demand-side dynamics of a vibrant civil society (Drèze & Sen, 1995). People in Kerala are politically organized and have been demanding services from governments that confront an intensely competitive electoral system: "politicians came to believe, with good reason, that voters judged them partly on the basis of whether they

improved medical care in their area” (Jeffrey, 2011: 192). Kerala also had the highest per capita health consumption expenditure (2009–2010) in India at INR 1,835 per month in rural areas and INR 2,413 per month in urban areas compared to an average of INR 1,054 in rural and INR 1,984 in urban areas in India (Drèze & Sen, 2013).

Across social strata, public action was necessary and desirable. As a residue of past health campaigns, people knew about health care and refused to suffer illness silently (Jeffrey, 2011). Basheer explained the need for a lay person’s involvement in palliative care:

If ordinary people receive health education, we can get rid of much exploitation. That change we can make by giving ordinary people health education through palliative care. That is our aim. It’s not in the buildings or facilities or funds they raise, it’s all in the capabilities to make more number of people understand what to do and how to do.

According to Basheer’s account, access to palliative care takes on a political fervor as an issue of exploitation, elimination of isolation and suffering, and as a basic human right that ordinary people can mobilize for, deliver and expect. Thus, health-seeking behavior is a condition of poisedness for the propagation of social innovation. At the same time, the propagation of the innovation is expected to further engender the condition of health-seeking behavior, forming a recursive social process. Indeed, a patient and Suresh Kumar petitioned the State Human Rights Commission to recognize palliative care as a human right as a result of which the commission directed the state government in 2006, among other provisions, to include palliative medicine in the curriculum of nursing and medical students, thus further facilitating propagation.

Utilizing available infrastructure and competences. For decades, the Kerala government has dedicated a significant proportion of its budget to healthcare. Consequently, hospitals are evenly distributed throughout the state. In the years preceding the emergence of palliative care in Kerala, approximately 90% of Kerala’s villages were within two kilometers of a dispensary, and approximately 78% were within five kilometers of a hospital, while the rest of India languished at 25% within two kilometers of a dispensary and 35% within five kilometers of a hospital (*Economic and Political Weekly*, 1985). Kerala’s successful health transitions were built on the foundations of public health services developed by the state, on top of which private services have developed (Drèze & Sen, 2013). Further, competition between public and private delivery services had a crowding-in effect and increased overall efficiency (Parayil, 2000). Kerala’s medical facilities have the highest rate of use in India across socio-economic strata (Jeffrey, 2011).

The dense distribution of primary health centers and hospitals is important for understanding palliative care propagation. Founders of community organizations codified and circulated, through media articles, scientific journals, manuals and training programs, the need to utilize existing infrastructure—whether a government or private hospital, or non-governmental organizations (e.g. Majeed, Basheer, Numpeli, Mol & Kumar, 2002; Neighbourhood Network in Palliative Care Kerala, 2001; Rajagopal & Kumar, 1999). For instance, while the Manjeri and Tirur units started from pre-existing general clinics, the Thrissur unit started from the premises of an old district hospital. Actors framed the use of existing infrastructure as an important way to achieve cost-effective and socio-economically appropriate solutions for better coverage. Eventually, the Kerala government’s Pain and Palliative Care Policy in 2008 drew upon

these very community organizations to complement palliative care activities at the state's primary health centers.

In community-based palliative care, nurses are key care providers, with doctors—the relatively scarce resource—providing secondary support on a needs basis. The availability of a pool of trained nurses is not assured in other parts of India. For decades, Kerala has produced the highest number of nurses in India, reflecting again the expansion of training and medical facilities. During the 1980s, Kerala had the best nurses-to-people ratio in India, about 1: 5,200, and was a net exporter of trained nurses both to the rest of India and the rest of the world (Jeffrey, 2011).

Finally, in Kerala, both the state and the people were able to handle competing health systems in a compatible way. Ayurveda, an ancient Indian system of medicine, was widely practiced in Kerala, often in conjunction with modern medicine (Jeffrey, 2011). For example, a group of Ayurvedic and palliative practitioners collaborated to conduct a controlled trial of a liquid Ayurvedic preparation (Misrakasneham) in the management of opioid-induced constipation:

Misrakasneham is a centuries-old combination used in Ayurveda as a purgative in constipated patients. Our scientific aim was to compare the efficacy of Misrakasneham with that of a conventional laxative, Sofsena tablet, in the management of opioid-induced constipation in patients with advanced cancer. We tentatively concluded from this study that Misrakasneham has the potential to be used as an alternate therapeutic tool for managing morphine-induced constipation as a part of palliative care of patients with advanced cancer (Ramesh, Kumar, Rajagopal, Balachandran & Warriar, 1998: 240).

The results of this collaboration were published in *Palliative Medicine*, an international peer-reviewed journal, and led to the establishment of a cancer palliative care unit at a leading Ayurvedic Hospital and the development of a two-day palliative care course for Ayurveda doctors. As a cascading effect that reconfigures the context, in December 2015, the Kerala state government piloted the Snehadhara Project in three panchayats, which linked Ayurveda doctors (who arguably occupy another organizational domain) to existing palliative services in primary health centers.

Summary. Similar conditions of poisedness were absent in other states such as Karnataka (where the Karunashraya hospice is located), Maharashtra (where the Shanti Avedna Hospice is located), Tamil Nadu (where there were attempts to replicate community organizing) and New Delhi (where CanSupport is located and where attempts to replicate community organizing occurred). The Indian human development index (Government of India 2011), which encapsulates human development outcomes as a function of economic growth, social policy and poverty reduction measures, places Kerala at the highest (0.79), followed by Delhi (0.75), Maharashtra (0.572), Tamil Nadu (0.57) and Karnataka (0.519). On the matter of associative and participative democracy in India, the conditions in which voice, opinion, aspiration and participation are extended to marginal groups have generally been adverse. Kerala has been an exception (Heller et al., 2007). Individuals are also three times more likely to attend local self-governing institution meetings in Kerala than in Karnataka or Tamil Nadu (Besley, Pande & Rao, 2007), indicative of greater participation in public spheres and belief in political capacity of state institutions.

DISCUSSION

Our comparative and historical analyses of palliative care in Kerala provide insights into how conditions of poisedness engender the genesis and propagation of social innovations. We identified the genesis of a novel community-based organization in 1998 in Kerala and its subsequent propagation. In the rest of India, forms for palliative care developed along conventional paths of institutional mimesis (DiMaggio & Powell, 1983) but did not achieve similar scale or scope. Our study has implications for theory building and research on the poisedness, emergence and propagation of social innovations.

First, we contribute to the research on social innovations by highlighting the role of political poisedness, understood here as the political conscientization by actors at a given time and place. Our findings illustrate political poisedness as directly manifest in the participatory democracy practices and political capacity of the state government. Moreover health-seeking behaviors and available healthcare infrastructures are derived from institutional actors' political claim making as well as political capacity of the State. Here, poisedness is not only about making certain material and symbolic resources available; it also affects how actors perceive themselves and others (Baillargeon, 2018). We posit that social innovators and their actions are profoundly governed by political poisedness, which creates subjectivities that shape and constrain whether and how social innovators subsequently engage with social issues. This political poisedness enables volunteers to call for the inclusion of wider categories of patients, and to push for a greater role for themselves. Volunteer involvement subsequently changed the collective action frame from a medical frame to a social justice frame (Vijay & Kulkarni, 2012). Non-medical professionals are likely to occupy lower power structures in an issue field where there is greater authority and legitimacy for medical professionals (see Heimer, 1999). In a domain that valorizes medical expertise, how does an alternative template of bottom-up organizing emerge from non-medical professionals? We illustrate that political poisedness shapes this actorhood to contend for frames in a field where actors have less power. Additionally, political poisedness shapes the framing of the innovation within a social justice frame.

Institutional legacies of communities can shape civic capacity—or the general capacity to explore and act upon the community's interests and social challenges (Rao & Greve, 2018). These institutional legacies are reproduced and perpetuated by organization building (Greve & Rao, 2014). Consistent with Johnson and Powell (2015), our study highlights the importance of civic institutional arrangements – exemplified by the symbolic and material resources made available by horizontal associations and community templates - that create conditions for poisedness. We expand our understanding of communities' capacity for addressing social challenges by attending to political poisedness. We postulate that it is not just any collective civic engagement that matters. Rather, processes of political engagement - such as participative democracy, political capacity of the state, and political claim-making by actors - shape future social innovation in definitive ways. In the absence of participative or associational democracy and political capacity, a community-based approach that involves mass mobilization and claim-making for palliative care as a human right that the state must guarantee, may not be an obvious choice for institutional entrepreneurs.

Second, and relatedly, political poisedness nuances our understanding of agency in social innovation. We know that norms for

mobilizing and organizing do not emerge from a vacuum but are derived from the larger institutions we inhabit (Hallett & Ventresca, 2006). Participation in such collectivist forms is shaped by historical outcomes of mobilization and associational life whereby social structure becomes congealed (Chaudhuri & Heller, 2003). Thus, the propensity to collectively engage in community organizing is arguably positively influenced by prior mobilization capacities. Hence, instead of starting with entrepreneurs as a given (e.g. Tracey et al., 2011), our study illustrates how agency is acquired through certain social–historical processes. We highlight the structural opportunities to exercise agency of a particular kind, i.e. the construction of a new social innovation that displaces the professional hospice or hospital model and legitimizes a community-based approach.

Third, we contribute to the nascent study of poisedness. Like the poisedness of nineteenth-century New York for the botanical garden form that Johnson and Powell (2015) describe, Kerala's poisedness provided fertile conditions for the genesis and propagation of community-based palliative care. Political capacity, horizontal associationalism and participatory democracy in Kerala were constitutive of this "density of social life, including an already rich organizational life" (Stinchcombe, 1965: 150). The concept of poisedness captures the concatenation among the macro- and meso-level social processes (here political capacity, health-seeking behaviors, etc.), resulting in lateral and vertical spillovers to other geographies and related organizational domains and an amplification of individual efforts at innovation (see Johnson & Powell, 2015). Thus, the Kerala context in the late 1990s was not just a good receptor for the innovation, but the context itself was transformed. In particular, *experiments and learning, spillovers and cascading effects* were salient processes in the reproduction of poisedness. Experiments to seed palliative care prior to 1998 through satellite-link centers were a precedent to the eventual invention of the community-based care. The two founders made sense of the limitations of their early initiatives, such as patients' low awareness of pain relief solutions or travel costs for beneficiaries. This process of experimentation and reflexive learning over time led the founding doctors to shift to the community-based approach that culturally resonated with Kerala's social structures. Volunteers and doctors narrated that they had learned along the way through trials, experimentations and learning-by-doing. Spillovers and cascading effects refer here to consequences of organizing both in and outside of the domain of palliative care. For instance, as well as including different patient categories and different services atypical of conventional palliative services, the Kerala palliative sector also evidenced horizontal interactions with other health initiatives such as community mental health programs and drug abuse awareness programs. Today, the community approach is globally cited as an exemplar of the "public health approach to palliative care" (Sallnow, Kumar & Kellehar, 2013) indicating transformations in global discourses.

We advance the extant conceptualization of poisedness by illustrating a dynamic production and reproduction of the context intertwined with social innovation. Shifting from an account of how conditions of poisedness may be leveraged by institutional entrepreneurs (Johnson & Powell, 2015), our study shows how an array of organizations (such as state agencies and various secondary associations) and individuals stitch together the very conditions of poisedness that engender innovation. For instance, mobilizing extant secondary horizontal associations was integral to constructing the innovation: associations' members constitute the resource base for emergent community organizations and their shared understandings and social capital derived

from prior mobilizing activities provided the “seedbed of collective action” in a new domain (Davis, McAdam, Scott & Zald, 2005: 7). Subsequently, palliative care organizations began to comprise the rich tapestry of organizational life that reconfigured the palliative care domain as well as other overlapping domains of healthcare or community mobilization (as illustrated by the spillovers and cascading effects described earlier).

The conditions of poisedness are continually made and remade. For instance, as community volunteers encounter the social suffering of their patients and families, they respond by drawing on existing structures, invoking participatory norms and political capacity, thus reproducing regularities, albeit in novel ways, in the new palliative care domain. By doing so, multiple and distributed actors attempt to make structural sense out of an unprecedented situation. In short, the conditions of poisedness we identify do not just create a fertile ground for social innovators but they are incorporated into and further reproduced in the innovation. Eventually, our case provides a counterfactual insight into past studies which postulate that high ideological and social heterogeneity leads to challenges of mobilization and coordinated action (Costa & Kahn, 2003; Rao, Yue & Ingram, 2010) and results in fragmentation of emergent organizing (e.g. McKendrick & Carroll, 2001; Putnam, 2000). Rather, we see that the heterogeneity of actors becomes the very context in which structural transformation occurs and social innovations emerge. As Sewell (2005: 196) contends, “it is precisely in these various episodes of confusion of tongues—where social encounters contest cultural meanings or render them uncertain—that cultural systems are transformed. Once we admit social diversity, we can no longer see cultural systems as always reinforcing: they must also be seen as sites of conflict, dialogue and change”. Our insights also shed light on how relatively powerless actors can challenge and redefine the “iron cage” of a highly institutionalized discipline like medicine.

Fourth, we also contribute to the scholarship on propagation. By propagation, we mean the travel of an object—a form, category, or practice—to other geographies and cultural domains (Johnson & Powell, 2015), while the object is still emergent. Propagation processes are distinct from diffusion processes. In a diffusion process, the innovation has an objectified, assumed reality as a social category, and studies of diffusion have focused on aspects such as how the object gains legitimacy and is institutionalized (e.g. Greenwood, Suddaby & Hinings, 2002). Our study shows that the Kozhikode clinic experimented with community volunteers’ involvement in 1993. In 1998, the first palliative care organization entirely run by community volunteers was formed at Nilambur. Till that stage, care provision focused on terminal illness and a few related conditions. Yet, as the innovation propagated, care was redefined to include different patient categories, and eventually, total care. This redefinition process was based on experiments and feedback loops from different geographies. The decipherable institutional work on the social innovation had plateaued out by 2008 and we saw the innovation being institutionalized in the state policy that mandates state health agencies to work with community organizations. One may argue, as a working hypothesis to be further examined, that the post-2008 spread of the innovation followed a path of diffusion.

By contrast, propagation merits separate attention as a stage within the possible trajectories of innovations. A close examination of the trajectory of palliative care in Kerala suggests that the founding of a community organization in Nilambur and the founding of similar community organizations in neighboring towns do not suggest an inevitable

propagation path across the rest of Kerala. Indeed, till 2005, community organizations in palliative care were perceived to be predominantly a North Kerala phenomenon (see Paleri & Numpeli, 2005). The state's political capacity was a strong mediator in terms of providing access to resources through panchayats and district-level bodies. Future research could explore the different mechanisms by which social innovations - in this case, the community-based organization for palliative care - propagate across different geographies. Researchers could also consider the configurations of time, place and human agency by which an innovation does not propagate beyond a geographical locale. For instance, we see the case of stalled propagation of doctor-led satellite clinics which were seeded but did not transform the organizational landscape in scale and scope. Cumulatively, these critical junctures also highlight how genesis and propagation of novelty rest on whether actors realize and leverage the fertility of the situated conditions. This being said, let us clarify that the dichotomy between the genesis of novelty and its subsequent propagation, as well as the separation of conditions that engender the two stages, are for analytic convenience. We do not suggest that the two are necessarily distinct stages. Rather, our findings illustrate emergence as "thick and tangled" (Padgett & Powell, 2012: 2).

CONCLUSION

As Padgett and Powell (2012: 2) note: "organizational genesis does not mean virgin birth". We traced the origins of palliative care in Kerala back to 1993 and examined how a novel community-based model for palliative care emerged as a deviation from the prevailing, legitimized professional-driven approaches. We explained how poisedness is instantiated in emergence and how the very conditions of poisedness are created by an array of organizations and individuals. Our research calls for explicit attention to socio-historical processes, often absent from studies of social innovations. Our comparative historical analyses of attempts at replicating the innovation outside Kerala highlight how equality of agency may be a problematic assumption and how equality of opportunity needs to be examined to understand actors' organizational capabilities across social contexts.

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