

Can village committees improve primary healthcare accountability in India?

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LSE's Shirin Madon argues that healthcare accountability in India does not draw enough on health workers' capabilities to respond to local conditions and needs, and asks whether new democratic spaces can address the problem.

The primary healthcare sector in India is notorious for lack of accountability with frequent allegations of crumbling infrastructure, poor access to services, and absent doctors. In 2005, the National Rural Health Mission (NRHM) was established 'to make the public health system fully functional and accountable to the community'. Early efforts to improve accountability mechanisms were directed towards increasing the transparency of data through automated record-keeping. By 2010, accountability in this sector was formally exercised all over the country through NRHM's web-based health management information system (HMIS).



However, the various formal mechanisms – including health management information systems, staff meetings, and sanctions – have merely coalesced to perpetuate a system of accountability in which reports are seldom complete or accurate and where staff meetings involve numerical checking of reports according to predefined formulae. Hierarchy and reporting, when used as the exclusive measure for primary healthcare accountability as experienced in many developing countries, has tended to serve as a defensive practice of proving good performance rather than as an opportunity for supervisors to draw on health workers' constructive and creative capabilities to respond to local conditions and needs.

As field data is transmitted up the health administration through increasingly sophisticated technological interfaces, local knowledge needed to make sense of the data is very rarely sought, resulting in data becoming devoid of meaning. For example, data indicating a high incidence of malaria can mean either an outbreak of the disease in a locality or an increase in the efficiency of data collection depending on how data is interpreted locally by health workers. However, although studies have recommended that local health workers with knowledge about field realities use data as a source of 'information for local action', this has not been implemented in practice.

In recent years, policy focus towards creating '[short route to accountability mechanisms](#)' has resulted in the

emergence of new democratic spaces aimed at increasing community engagement in public service delivery. These spaces constitute the latest in a series of initiatives undertaken by the NRHM to improve accountability of primary healthcare primarily through the Village Health and Sanitation Committee (VHSC). The VHSCs are village-level bodies established in 2008 comprised of key stakeholders in a village and serve as a forum for village planning and monitoring of health referred to by the Government of India as a 'space for public participation'. This village-level organisation is encouraged to take leadership on health and determinants of health such as sanitation and nutrition for which it receives a direct untied grant from the central government.

Although VHSCs have been operational for several years, there has been a noticeable lack of academic studies undertaken to evaluate the extent to which accountability improvements have been achieved. My current research attempts to address this gap through a longitudinal study of VHSC formation and evolution in one primary health centre – Gumballi – in South Karnataka, which commenced in 2011. In collaboration with Indian Institute of Management, Bangalore, and supported by fieldwork carried out by two local researchers, I have been studying the functioning and dynamics of the VHSCs in 13 villages of Gumballi.

These committees consist of state, political, and civil society representatives totaling 15 members in all, many of whom belong to the village. As per government guidelines, no more than one-third VHSC members can be made up of state representatives and the committee has to be inclusive to all sections of society—at least 50 per cent participation should be female, and 30 per cent from the NGO sector. The VHSC is constituted under the leadership of the village council (*gram panchayat*), an institutional arrangement that was considered by NRHM as important for placing 'people's health in their hands'. State representatives include local health workers, school teachers, women and child workers while civil society representatives include villagers from minority backgrounds and castes. While most of the members of the VHSC are from the community and therefore feel moral pressure from below, at the same time many of them are also monitored by seniors and are therefore accountable to them.

What is of interest to me in this village forum is the extent to which this new democratic space provides an opportunity for a new kind of accountability to emerge—one which is not so much based on increasing the transparency of routine data, but that focuses instead on the emergence of an alternative form of local accountability amongst members; an accountability that encourages discretion in terms of usage of the untied fund, trust-building and negotiations amongst state, political, and civil society committee members, and scope for local planning and monitoring of health issues.

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