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The Dynamics of Accountability in Invited Spaces: A case study of Village Health and Sanitation Committees in Karnataka

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Abstract

This paper provides scope for learning about invited spaces as conduits for improving accountability in service delivery as a route to promoting development. Interpreting accountability as social process, we trace the cycles of learning that occur as these spaces serve as active sites for disseminating information, exercising discretion and building networks amongst state, political and civil society representatives. Over the past three years we have studied the Village Health and Sanitation Committees (VHSCs) which are invited spaces created under the auspices of India's National Rural Health Mission to increase community engagement in health service delivery. We focus our attention on the dynamics of accountability within these spaces as this holds important implications for selecting policies aimed to make primary healthcare more accountable to the community.

Introduction

Strengthening accountability has emerged as a key strategy for improving public service delivery through the creation of new democratic spaces to support increased citizen engagement in governance and overall development (World Bank, 2004). Created by governments to enable citizens to participate at various stages in the service delivery value chain, these 'invited spaces' have gained high priority within development agencies and governments as pivotal for enhancing accountability by changing the nature of interactions between service providers and citizens (Cornwall, 2004; Gaventa & McGee, 2013).

The growing number of studies on invited spaces show mixed results to date. Some report on the factors that limit the possibilities for citizens to participate due to lack of information or clarity about their purpose as well as power asymmetries and social exclusion (Mahanty *et al.,* 2008) while others reveal that spaces which began with a relatively restricted remit have gathered momentum over time (Bardhan *et al.,* 2008). However, current knowledge is lacking in terms of understanding the dynamics that exist within invited spaces and interpreting the extent to which this activity serves as a conduit for improved accountability in service delivery (Aiyar, 2010).

India's primary healthcare sector, notorious for its lack of accountability in terms of inadequate infrastructure, manpower shortages and lack of access to basic services (Choudhury *et al.,* 2006; Bhandari *et al.,* 2007), provides fertile ground to investigate this phenomenon. The National

Rural Health Mission (NRHM) was established in 2005 'to make the public health system fully functional and accountable to the community'. Early efforts by the Mission to audit performance targets through computerized monitoring were consolidated in 2009 with the launching of the NRHM's web-based health management information system (HMIS) intended to improve efficiency of the primary healthcare reporting function. However, when used as the exclusive measure of performance, hierarchical reporting systems have seldom led to systemic improvements in accountability (Brinkerhoff, 2004; Jacuzzi *et al.,* 2006; George, 2009). On the contrary, these systems have tended to serve as a defensive practice of achieving targets rather than as an opportunity for learning from the field by tapping the local knowledge base of health workers (Stoops *et al.,* 2003; Madon *et al.,* 2010).

Invited spaces constitute the latest in a series of initiatives undertaken by the NRHM in 2008 to improve accountability of primary healthcare through the establishment of VHSCs[i]. According to NRHM guidelines, these committees should convene monthly under the auspices of the Panchayati Raj Institutions (PRIs) to serve as a 'space for public participation' (GOI, 2005) with 15 members including 50% representation of women and significant participation from scheduled castes, scheduled tribes[ii] and other citizen groups. The regular conduct of VHSCs is intended to empower the community and local bodies to take leadership in local health and sanitation issues with support of a direct untied grant to each village from the central government. By 2011, 483,496 VHSCs were formed in the country covering about 76% of villages in India (NRHM, 2011) with studies focusing on how frequently VHSC meetings were held, who attended and howVHSC-active villages affected the health-seeking behavior of community members (Singh & Purohit, 2012; Malviya *et al.,* 2013; Kumar & Prakash, 2013).

Following the introduction of VHSCs throughout India, policy makers are increasingly interested to identify where the VHSCs work and where they do not. However, trying to answer such a question is premature as so far there is little understanding of how the VHSCs are actually being used and what we mean by 'success' in terms of their functioning and outcome. This paper contributes towards augmenting our knowledge of VHSCs as conduits for improving primary healthcare accountability through micro-level, longitudinal research in Karnataka. In the next section, we draw on ideas about participation, transparency and accountability in order to conceptualise invited spaces as local social processes that take place amongst members at village level. Next we describe our study methodology and present the results of our longitudinal study of VHSCs in Gumballi PHC, Karnataka. This is followed by an analytical discussion around the key cycles of learning that constitute our understanding of accountability improvements within the VHSCs. Finally, we consider the broader implications of our findings for theorizing invited spaces and for policy on primary healthcare reforms.

Conceptualising Accountability in Invited Spaces

The increasing momentum by governments towards creating invited spaces reflects the evolving discourse around citizen voice and accountability. Participation, once critiqued for its lack of engagement with processes of power and politics (Cooke & Kothari, 2001), became identified as an important conduit for holding service providers to account for the provision of public goods such as primary healthcare, education, sanitation and security through numerous examples of protests, petitioning, lobbying or direct citizen action (Hickey & Mohan, 2004; Houtzager & Joshi, 2008). A major focus in strengthening the capacity for interactions between citizens and

state to improve accountability in service delivery over the past decade has been through the enactment of policies and new technology solutions for increasing transparency of information (Brett, 2003; Houtzager, 2005). Numerous transparency initiatives in service delivery have been implemented in recent years to place information or processes that were previous opaque in the public domain, accessible for use by citizen groups, providers or policy-makers (Joshi, 2013). For instance, the World Bank Institute is one institute that has ongoing research dedicated to studying the usage of new information tools to enhance the delivery of public services to the poor through improved transparency and accountability (Gigler, 2014). At the same time, the preoccupation in contemporary organizations on making data visible for the sole purpose of comparing the work of individual employees and their activities has been shown to affect individual mentalities leading to the nervous preoccupation to meet targets (Power, 1997; Strathern, 2000; Smith *et al.,* 2010). There are numerous examples to show that transparency and accountability initiatives in the service delivery sector have resulted in a dysfunctional system of accountability in which the collection of performance data becomes a ritual that is decoupled from the very reality that it is trying to mirror (Bovens & Zouridis, 2002; Pina *et al.*, 2007).

A variety of other possible experiences of accountability have been discussed in the literature that focus on human and social factors. For example, while seemingly a mechanical exercise, data collection for routine reporting can be seen as a social process influenced by human motivation, which in turn depends on the ease with which the data can be collected on the ground and its relevance and utility for local work processes. From this perspective, those engaged in local work processes are assumed to build a common interpretation of reality that forms the basis for what Roberts (1991, 2002, 2009) calls 'socializing forms of accountability' in which

relatively unguarded regular dialogue creates the conditions for local discretion, knowledge-sharing and negotiation with other stakeholders . A similar conceptualization of accountability is expressed in the public administration literature through Lipsky's foundational work on 'street-level bureaucracy' where the focus of analysis lies in the actions of frontline public servants, the routines they establish and the devices they invent to cope with uncertainties (Hupe & Hill, 2007). A relative neglect in the literature has been on the social mechanisms in place for those being held to account to answer to those to whom they are held accountable, referred to by Fox (2007) as 'soft accountability. As opposed to 'hard accountability' which refers to the enforcement of sanctions for failure to perform, 'soft accountability' consists of a social process involving information exchange and dialogue enabling those held accountable to justify their actions (Goetz & Jenkins, 2005). A theoretical suggestion from the discussion above is that within any organizational setting, accountability as encoded through standard reporting procedures co-exists with accountability as embedded in practice (Yakel, 2001).

Interpretations of accountability which focus on local social processes are increasingly seen as a useful lens through which to study the opportunities created by invited spaces emerging in developing countries for enhancing accountability in service delivery. These spaces have been conceptualized as having a semi-autonomous existence in which a local, rather than hierarchical, accountability environment is established separate from the institutions of formal politics, bureaucracy and civil society although remaining influenced by them (Cornwall & Coelho, 2007). For example, Pare & Robles (2006) studied the establishment of invited spaces for watershed usage and management inn Mexico identifying the various strategies used by indigenous communities to realize their right to water in a situation where the formal system had failed. The case illustrated how the building of accountability and shared responsibility amongst

actors with different and contradictory interests requires an ongoing process of negotiation and engagement both within the committee and with the wider community it represents.

Other studies have focused on the interplay between multiple accountabilities as invited spaces are fashioned out of existing forms, resources and structures which re-inscribe relations, hierarchies and rules of the game yet also provide scope for new relations and activities (Cornwall, 2004; Newell & Wheeler, 2006). A case in point is a study of rural development programmes in Eastern India in which Veron *et al.*, (2006) show how systems of bureaucratic and political accountability are juxtaposed with a form of community accountability through which local state, political and citizen representatives recognize their allegiance to the village they belong to.

In this paper, we draw on an interpretation of accountability as social process to study invited spaces that have been created for strengthening primary healthcare accountability in India. We are interested to identify what communities can learn about primary healthcare through the VHSCs through the dissemination of information, the exercise of discretion and the building of networks at community level. This learning process, we postulate, provides an opportunity for building capacity through regular interactions between service providers, other community members and citizens as illustrated in Figure 1. The diagram shows VHSCs as semi-autonomous entities framed within the boundaries of existing forms, resources and structures, yet enabling new relations and activities to incrementally unfold and improve the quality of village health. In the next section we present our methodology as a precursor to describing how VHSCs are being used through our case study in Gumballi PHC, Karnataka.

Methodology

We adopt a qualitative case study approach informed by an interpretive philosophical position as an appropriate strategy for the early stages of research aimed at theory-building in order to strengthen our understanding of the dynamics of invited spaces (Eisenhardt, 1989; Myers, 2009). Our case is located in Chamarajnagar district of Karnataka 180 km south of Bangalore. Although better than many of its north Indian counterparts, Karnataka's performance in terms of primary health service delivery is mediocre with many of its rural villages struggling to meet the basic healthcare needs of its population, particularly women and children. Chamarajnagar district is classified as a 'C' district[iii] with poor overall health indices due its border area being tribal and remote. Our case was confined to Gumballi PHC which served 22,500 people in 12 villages and where approximately half the population belongs to scheduled caste and scheduled tribes with agriculture and animal husbandry comprising the main economic activity for many landless labourer families. There has been a strong NGO involvement in Gumballi PHC through the involvement of the Karuna Trust NGO as well as other local NGOs operating within Chamarajnagar district to promote capacity-building within VHSCs, particularly during their initial years of functioning.

Our study was longitudinal given our objective of identifying changes that were occurring over time in the 12 VHSCs within Gumballi PHC. We undertook a single case, multi-site study as appropriate for studying dimensions of interest within-case by identifying similarities amongst different villages (Yanow *et al.,* 2010). The primary data collection period was from January 2010 to May 2014. While we collected some quantitative data on VHSC frequency and membership and conducted some interviews with VHSC members, our main mode of data collection was through participant observation as our objective was to develop an 'inside view'

by experiencing and participating in the VHSCs (deWalt & deWalt, 2011). We found that participant observation was also the only practical approach to studying the VHSCs given the lack of initial awareness amongst members about the purpose of the committees. Fieldwork was carried out by two locally-based and experienced Kannada-speaking researchers who maintained regular contact with the VHSC members and other villagers in the study sites which helped to build up a rapport and gain the trust of villagers. The two researchers kept extensive field notes which were translated from the local Kannada language into English and discussed regularly with one of the authors based in Bangalore whose mother tongue is Kannada as well as with the other author remotely or during field trips to India.

Narrative accounts of each VHSC meeting were transcribed and entered into a file we created and called the VHSC log. Within about one year, a loose type of pre-structure emerged that guided subsequent fieldwork through the identification of categories of interest such as usage of the VHSCs for creating awareness or for identifying local health priorities. In each case, data obtained about the VHSCs was kept anonymous with only member roles disclosed. In total, 221 VHSC meetings were attended in the 12 villages of Gumballi PHC. Village-wise details of the number of VHSC meetings attended and interviews held are provided in Table 1. Analysis of data occurred alongside data collection as various themes began to emerge from our research – this was abductive in the sense that we periodically reoriented our analysis with emerging points of interest from the field.

VHSC Membership

In each village, the VHSC is composed of a mix of approximately 15 state, political and civil society representatives as depicted in Figure 2. To provide background contextual information, we summarize below some of the key aspects of the three main membership groupings:

Political representatives - The VHSC is constituted under the leadership of the gram panchayat (village council) - an institutional arrangement that was considered important for placing 'people's health in their hands' (NRHM, 2011). A gram panchayat member is designated as the VHSC president and as a joint account holder of the VHSC fund - an untied grant of Rs. 10,000 per year received in three installments from the state government. In addition, other gram panchayat members frequently attend the VHSC meetings.

State representatives - According to government guidelines, four members of the VHSC should be state employees. At least one member is the anganwadi worker who has a long tradition of providing basic healthcare, nutrition education and supplementation as well as pre-school activities for children. (Mahanty *et al.,* 2008). Another state member is an ASHA worker who is a local woman trained under NRHM to act as a health educator and promoter in her community and to serve as a crucial communication link between the health system and the rural population (GOI, 2005). As unsalaried government employees, ASHAs receive performance-based compensation from the gram panchayat for meeting quota-based targets such as motivating women to give birth in hospitals and escorting them to seek reproductive and child health services. State membership also includes the Auxiliary Nurse Midwife (ANM) – these are frontline community health workers who provide a crucial link between clinical healthcare providers and citizens with managerial authority over the ASHA worker's outreach responsibilities and joint control over VHSC's untied grant (Malik, 2009). Finally, state members can include the local school teacher supporting the NRHM's emphasis on addressing

non-medical determinants of good health and serves as a bridge between the VHSC and other village level committees like the Village Education Committee.

Civil society representatives - In order to ensure that citizens with the least power and voice are represented, NRHM guidelines indicate that representatives from marginalized groups should serve on the VHSC (GOI, 2005). These include mainly female representatives of self-help groups that comprise of below-poverty-line women working to establish income-generating activities. Other marginalized group representatives who are encouraged to become members of the VHSC include representatives from the SC, ST and other backward classes. Since 2013, the VHSC routinely includes participation of between 4-10 pregnant/lactating mothers.

The frequency of VHSC has changed over the duration of our research. During the initial years of functioning, there were frequent delays in the conduct of meetings partly as a result of delays in the release of the untied grant from the government and the consequent lack of interest shown by members in attending meetings when there was no fund available. Figure 3 shows that in our twelve study villages there has been a continuous increase in the frequency of meetings. This increase has been influenced by the recruitment of large number of ASHA workers and the time and energy they invest to organize the meeting and to actively persuade members to attend each month. This has coincided with repeated reminders by VHSC presidents for members to attend regularly with threats of replacing non-attendees. Attendance at VHSC meetings since 2010 has tended to fluctuate between 8 and 10 members of which the president, ASHA, anganwadi worker and ANM are regular attendees. Figure 4 depicts an increasing representation of marginalized groups at VHSC meetings. However, while there is a high presence of female health and community workers, we found that regular attendance of SC/ST and self-help group representatives has been somewhat hampered because of poverty and social exclusion.

Attendance of these groups at VHSC meetings is often precluded as a result of the costs they would incur to travel to the VHSC meetings and the potential loss of a day's wage. From our interviews, we also found that these marginalized groups also felt that they lacked voice and often felt intimidated to attend the meetings.

Describing VHSC Processes

In this section we describe how the VHSCs are actually being used identifying similarities in five key processes across the twelve study villages.

(i) Raising health awareness

In all villages of Gumballi, VHSCs are emerging as important conduits for information dissemination about health awareness and disease prevention. Talks are routinely given in all VHSCs by ASHA workers, ANMs and anganwadi workers on the merits of obtaining health services rather than depending on traditional medicines and remedies. In particular, talks are held on the prevention of diseases such as leprosy, dengue fever, dysentery and cholera as well as on importance of neatness and hygiene in the village. In all villages, numerous such health awareness sessions have taken place to encourage cleanliness and sanitation in the household and emphasizing the importance of footwear for pregnant women to avoid the risk of bacteria caused by solid waste entering the body and leading to infection. The talks are followed by question and answer sessions in which health workers answer questions from committee members on particular diseases as well as on overall sanitation and nutrition such as how to take precautions against catching infections. Apart from health awareness sessions conducted within the VHSCs, for example about the precaution that can be taken against dengue fever, in all our study villages,

the ASHA worker also routinely visited surrounding houses to disseminate messages about health and sanitation issues such as keeping drains unblocked and using mosquito nets.

In all VHSCs, we found that health awareness sessions are also devoted to informing members about government schemes such as immunization programmes, free emergency ambulances 108 services and information about hospital facilities and health camps. Special sessions were held targeted at antenatal and postnatal cases providing information about various government maternal health schemes. From 2012 onwards, in all villages of Gumballi, health awareness sessions have been used to disseminate information about the increasing number of government health surveys being commissioned through the VHSCs and to cross check PHC data. For instance, in our study villages, VHSC meetings have been used to verify the accuracy of various village health data sets kept at the PHC such as antenatal reports, immunization data of mothers and children, total births and deaths in the village, and lists of low income pregnant women who are eligible for assistance.

A major focus of all the VHSCs has been to create awareness amongst members about the purpose and organization of this forum. Consequently, our data shows that in all the study villages, a lot of time has been spent by the VHSC President and Secretary to inform members about the important role of the committee and of the ASHA worker in providing information and counseling on various aspects of community health. More recently, all VHSCs have gained prominence as central points for village health through display of health information posters in prominent locations within the village such as outside the anganwadi centre and the village school, and by distributing hand bills to villagers. By way of illustration, most VHSCs have focused on creating awareness about leprosy and dengue fever by displaying boards at strategic locations in the village such as in the colonies where lower caste villagers reside.

(ii) Prioritizing village needs

In all study villages, a prioritization of village needs has occurred following a process of discussion and deliberation that has taken place between VHSC members resulting in decisions to purchase items from the NRHM untied grant. In the initial years of functioning, the majority of decisions were taken by the ASHA workers and the ANM with essential health items identified for purchase such as a first aid box, a thermometer, weighing scales and a water filter for the anganwadi centre and the primary school in the village. These items were unanimously deemed necessary by health staff for maintaining good health as well as for providing safe drinking water to children. Health staff also identified furniture such as a table and chairs for the anganwadi centre and VHSC meetings as essential.

We observed that in all villages, the purchase of footwear for eligible pregnant women was identified by VHSC members as essential items of expenditure. In all villages, members sanctioned the routine purchase of accessories for the ASHA worker to support her field visits which included stationery, uniform, mobile phone and accessories such as a watch, torch, storage box, a blood smear machine and a hot water bag. VHSC members also unanimously agreed that funds should be allocated towards an emergency fund that each ASHA worker could use for expenditure incurred related to treating and supporting destitute women during pregnancy.

From 2011, there has been a noticeable trend towards balancing expenditure on health-related items with other aspects of village health such as sanitation, nutrition and poverty alleviation, particularly with the input of the gram panchayat members of the VHSC. For example, we noticed that in all our study villages the untied fund was increasingly used for the spraying of disinfectant to reduce mosquitoes, purchase of chlorination powder for water tanks and for the

repair of taps, the village hand pump, bore wells and water pipes. A particular need articulated during VHSC meetings has been to keep the anganwadi centre and drains clean as unsanitary conditions were found to affect children's health. Also repairing bore wells in the village to prevent mosquitos from entering the water storage area was noted. A recent recurrent expenditure prioritized in all VHSCs during the course of the past few years, particularly since 2011, has been the purchase of bleaching powder for clearing blocked drains in the village as well as paying for the clearing of garbage and the purchase of dustbins to be placed in strategic locations within the marginalized colonies. Some VHSCs use funds to help support destitute villagers purchase vital medicine.

A more recent prioritization of village health needs at VHSC meetings relates to the involvement and payment of the ASHA worker in conducting government health surveys. In all villages, the VHSC committee sanctions an amount from the untied grant for the conduct of a household survey by ASHA workers. A related priority sanctioned by all VHSCs has been the purchase of protein supplements for children identified as malnourished from the surveys.

(iii) Self-organizing

A third key social process relates to the organization and management procedures put in place for the functioning of VHSCs. One aspect of this relates to the serious attitude towards attendance taken by the Chair and Secretary of all the VHSCs in Gumballi. When the VHSCs were first established, Presidents and Secretaries were preoccupied with assigning membership roles. Once the committees were set up, however, we found that in all villages the VHSC office bearers spent time during the meeting to emphasize to members the importance of regular attendance at meetings and their obligation to take an interest in village development. In all villages, members

were regularly reminded about which day every month the VHSC would convene and we began to witness the taking of signatures and thumbprints of attendees at the end of every meeting as a routine. All villages recorded non-attendance and members who were frequently absent were replaced with new members.

A key aspect of VHSC organization and management related to the physical distribution of purchased items. In all villages from 2011, we observed how the VHSCs were used to disseminate purchased items such as health equipment to school teacher or anganwadi worker, footwear to eligible pregnant women, or stationery items and sari uniform to the ASHA workers. In some cases, items were not only distributed but also demonstrated. This is the case particularly for health equipment such as a water filter in order to ensure that the recipient has understood how it is to be used and its functionality. A further aspect of VHSC organization in all villages and at all meetings was the recapping of the previous meeting's discussions and decisions in order to ensure continuity of process and to ensure that items that had been prioritized by the committee but not yet purchased due to non-availability of funds at the time would be carried over to the next meeting.

Finally, good accounting practices developed within all the VHSCs. During the early years of functioning, blank cheques were signed by the VHSC President for purchases to be made from the account. This system was replaced in 2011 by one in which quotations first needed to be obtained for sanctioned items with the onus placed on the ASHA worker to ensure that receipts were kept and that the committee was kept informed about NRHM fund release and the current balance. Indeed, we observed that VHSC members routinely asked the ASHA worker, as Secretary, to present receipts for all purchased items. Once approved, the purchased items were then scrutinized by the committee before reimbursement of expenditure to whoever purchased

the item and distribution to the relevant VHSC member or beneficiary. In some VHSCs such as Dasanhundi, Vadagere, Krishnapura and Uppinamole, a recent practice has been to take photos and obtain signature of pregnant women who have received protective footwear in order to ensure that they do not claim again.

(iv) Planning and monitoring

The VHSC plans and monitors various aspects of village health. In all villages, we found basic health equipment to be routinely monitored by health staff and anganwadi workers who informed the committee when equipment was needed or when old equipment needed replacing, for example, items in a school's first aid box. The VHSCs provide a regular venue for monitoring PHC records such as immunization records, birth and death registers and lists of low income pregnant women. More recently, in some villages, the VHSC has emerged as a space for local monitoring of water quality. Once every three months a health worker from the village takes a sample of water from the overhead water tank, mini water tank, bore wells and open wells and this sample is taken to the laboratory at Gumballi PHC for a chemical contamination test to determine whether the water is fit or unfit to drink. If the result is that the water is unfit to drink, the health worker gives a letter to the gram panchayat requesting that the water source is cleaned and the VHSC meeting is informed so that it can follow up with the panchayat. This village-level monitoring is complimented with annual fluoride, mineral and chemical tests conducted by the taluk panchayat. Increased vigilance is also observed amongst VHSC members when reporting problems such as broken water pipes at specific locations in the village or missing covers from drinking water tanks resulting in a greater chance of water getting polluted and unsafe to drink.

The VHSCs are routinely used for forward planning of government health surveys such as the annual pulse polio programme[1], other health camps and village festivals where large numbers of people gather. In all our study villages, VHSC members checked to ensure bleaching powder was placed in village drains, chlorination power in water tanks to ensure that safe drinking water was available and that garbage was cleared to avoid communicable diseases. In 2012, many villages in Gumballi PHC identified a bad smell coming from the village drains and a consequent breeding of mosquitoes near the vicinity. In some villages, the VHSC has provided an impetus for monitoring a particular local issue such as the health issues facing adolescent girls in the village. An example is the setting up of a helpline for adolescent girls by placing a box in the government higher primary school so that girls can discretely disclose their problems and seek confidential advice from the ASHA worker.

(v) Networking with other agencies

From our observations, all the VHSCs in Gumballi have been forming linkages with the gram panchayat, particularly in matters related to sanitation and cleanliness. The prioritization of larger expenditures such as the construction of toilets in the village and drainage repairs has resulted in the Chair of the VHSC, a gram panchayat member, communicating this need to the panchayat. By way of illustration, communication with the gram panchayat has taken place in some villages due to VHSC members prioritizing the need for a toilet to be constructed in a PHC subcentre. All VHSCs we observed have also reported increasing support from the gram panchayat for village clean-up operations in preparation of events such as festivals as well as support for the periodic dumping of rubbish from the bins outside the village.

[1] Pulse Polio is an immunization programme established by the Government of India in 1995-1996 to eradicate polio by vaccinating all children under the age of five years against the polio virus

There are also linkages being formed between the VHSC and the PHC due to the fact that health workers play a dual role of raising health awareness amongst VHSC members and providing front line healthcare to the community. For example, in all VHSC meetings we observed that the identification of pregnant women eligible for the purchase of footwear from the VHSC fund by the ASHA worker went hand-in-hand with ensuring that these women were aware of the need for good hygiene and nutrition. From our observations, all villages in Gumballi show an increasing number of linkages forming between the VHSC and higher levels of the health administration. For instance, there has been an increase in the involvement of VHSCs in health surveys conducted by the District Family and Health Department in Chamarajnagar. Two members of the VHSC play an important role in the implementation of health surveys. First, the ASHA worker has been designated by the health administration to conduct the survey and therefore plays a crucial role in obtaining the data at source from households. Second, the anganwadi worker plays an important role in coordinating with the taluk health department to identify the names and addresses of malnourished children from the village offering them protein supplements purchased from the VHSC untied fund. In other ways, there are routine linkages between all VHSCs and the health department as VHSC meeting reports are Xeroxed and sent to taluk level for scrutiny and as VHSC members offer assistance to the government in the implementation of annual events such as pulse polio or the malaria programme.

VHSC Accountability as a Virtuous Cycle of Learning

Our empirical data reveals the key social processes that characterize how the VHSCs of Gumballi PHC are being used. Our focus now is on identifying associations that have emerged

between two or more processes which in turn appear to have a catalytic effect on other processes. We describe this complexity as a virtuous cycle of learning about accountability as it emerges from the routine practices that have unfolded within the VHSCs as illustrated in Figure 5.

Raising health awareness amongst VHSC members and more widely throughout the village has created a second-order effect of influencing decisions about usage of the untied fund within the village. While early usage of VHSC funds was directed almost exclusively towards the purchase of health equipment for the PHC, anganwadi centre or local school, local priorities have also increasingly included expenditure related to sanitation and nutrition. Today, all VHSCs routinely prioritize and sanction the purchase of footwear for pregnant women and protein supplements for mothers and children. Greater health awareness amongst VHSC members has also been a trigger for addressing village infrastructure needs such as building toilets and village clean-up programmes through networking with the gram panchayat as well as encouraging greater vigilance amongst villagers to plan for and monitor the availability of safe drinking water for village events such as festivals. Increasing health awareness amongst VHSC members and dedicating funds for the dissemination of information at community level has had a wider networking effect involving local schools, the PHC and the gram panchayats in the holding of street processions. For example, between 30th January to 13th February 2014, a leprosy awareness procession was led by government school children, health workers, the school teacher and panchayat members in Y.K. Mole village.

The ability of the VHSC to prioritize items of expenditure from the untied fund has resulted in new forms of transparency and accountability within the VHSC. Once an item has been sanctioned for purchase by the committee, the ASHA worker has to produce an estimate for the item(s) for approval before purchase. This estimate is obtained from the local shoe store and

presented to the committee before purchasing footwear for eligible pregnant women. In many cases, however, our data found that there were insufficient funds to purchase priority items which impacted the capacity of the VHSC to manage its affairs. When the item is eventually purchased, it is then brought to the committee for inspection before money is reimbursed to the purchaser. Finally, the process of distributing the item is made transparent as the Chairman of the committee officially hands over the item to the recipient during the VHSC meeting. An increasing capacity to self-organise within the VHSC also creates new channels of community accountability. As a case in point, the increasing capacity of the VHSC to distribute vital health items such as footwear to pregnant and lactating mothers has created greater confidence amongst villagers that the VHSC is accountable to them. Building capacity at village level also results from the VHSC having discretion to allocate funds for overall community development such as to help destitute villagers purchase medicine and from an increasingly blurred boundary between service providers and citizens. For example, there is an increasing obligation of VHSC members, themselves citizens of the village, to attend meetings and to actively contribute towards improving village health.

An increased ability to prioritize needs and administer procedures at VHSC level has resulted in more regular and transparent networking with other agencies. By way of illustration, when a need is identified for a village clean-up programme or for the building of a new toilet at the anganwadi centre, earlier contact between VHSC and gram panchayat was sporadic while today more sustained communication by letter or phone takes place between the two entities in order that an agreement can be reached about how to fund the project. The details of the communication and subsequent action points are reported back to the committee. The increasing autonomy and self-organising capacity of the VHSC has also been an important catalyst for

networking with various levels of the health administration. A crucial catalyst for this interaction has been the ASHA worker as VHSCs increasingly find themselves interacting with the PHC through her. A case in point is the pressure exerted on the ASHA worker by VHSC members to ask the PHC Medical Officer why NRHM funds have not been released on time. The increasing autonomy of the VHSC has enabled a closer coupling between different arms of the health administration enabling issues such as cleanliness, immunization and nutrition to be addressed together at local level. District and taluk health officers now routinely have confidence in the ability of VHSCs in Gumballi to conduct health surveys and to provide support services for administering the surveys such as data entry and photocopying. The ability to prioritise and purchase footwear from the untied grant necessitates also demands greater transparency of PHC records as VHSC members have the ability to cross-check that the list of eligible beneficiaries, for example eligible pregnant women for receipt of footwear or eligible malnourished children for receipt of protein supplements from the VHSC fund.

Linkages between the five key social processes described above constitute a virtuous cycle of learning about accountability in primary healthcare. Before the VHSCs were constituted, each of the three member groupings – state, political and civil society representatives – were subject to a hierarchical system of accountability. Local health workers were accountable first to the PHC, then to taluk, district and higher levels of the government health administration. Similarly, the gram panchayat members would answer first to the gram panchayat which in turn was accountable to the taluk and district panchayats. Civil society representatives could belong to self-help groups and minority groups with upward affiliation to NGOs operating at community, taluk and district level. These accountability affiliations remain but at the level of the VHSC, we find that accountability emerges through a process of socialization that takes place between

members with different formal and informal affiliations at the village level. For example, the school teacher or the anganwadi worker while a representative of their own parent department, serves on the VHSC as a knowledgeable and socially-connected villager. The regular process of socialization during meetings enables a form of 'soft accountability' to emerge as VHSC members are more easily able to justify their actions in an environment where there is a mutual understanding of the local context. For instance, while a shortfall in the registering of malaria cases can be seen as a sign of underachievement, the building of capacity at VHSC level now enables discussions about malaria prevention to revolve around issues of disease surveillance identifying the causes of malaria outbreaks and using the untied fund to mitigate against its consequences.

Discussion and Conclusion

The NRHM has been instrumental in the constitution and design of VHSCs as invited spaces for improving primary healthcare accountability in India. However, beyond the launching and design process, this paper has shown that it is through the routine practices that have unfolded within the VHSCs themselves that members have come to understand the possibilities afforded to them and work out tactics that make sense for improving village health. Our study shows that the participation of local state and civil society representatives in the planning, implementation and evaluation of their own health services is a cumulative process that cannot be enforced from above. Usage of the VHSCs in Gumballi supports not only a curative primary healthcare service but also a preventive and educative one that relates to the original Alma Ata principle of primary healthcare as a social welfare function. Yet it cannot be taken for granted that community

participation grounded in the normative principles of equality, justice and empowerment will occur merely as a result of the government providing invited spaces. A subcategory of invited spaces is referred to by Mohanty (2007) as 'empty spaces' referring to a context where marginalized groups may fail to sufficiently populate an official invited spaces due to poverty, social exclusion and practical considerations. For example, marginalized groups may feel intimated to attend invited spaces or they may not be able to attend due to costs of travel and loss of daily wage as our study has shown. In some cases, marginalized groups are represented but they may still not have a voice if decisions are taken by other groups.

Despite their limitations, invited spaces have created opportunities for local communities to play a part in primary healthcare. At the village level, this space represents a collective and shared resource of common concern to state, political and civil society representatives and is typically populated by those who have local knowledge, ability and are willing to contribute time and energy towards addressing community development issues. In this paper, we have suggested that accountability should be thought of not simply as an outcome of a report that has been generated, but as a social process – something which stands in stark contrast to conventional arguments with their focus on the efficiency and transparency of organizational reporting structures. Yet, the apparent collision between these two forms of accountability masks a variety of subtle interdependencies as the effects of socializing forms of accountability have a significance beyond the invited space as they form an important basis for selecting policies, standards or design solutions. One key factor in the success of invited spaces as a propagator for improving accountability in service delivery is finding the right incentives to mobilize citizen voice. The untied fund, although a small amount of money, has already gone a long way towards addressing a variety of important village health and sanitation issues. An underlying

structural issue to be addressed relates to continued timely disbursement of the untied fund. In India, intergovernmental transfers, even when meant to be untied or flexible, have often failed to be so in practice. A possible solution for the future could be to transfer funds electronically to the VHSC account via mobile or by linking to the UID project. A second factor that is important for invited spaces to improve accountability relates to the attendance of the poorest and disadvantaged members of the VHSC. While cash incentives may be prone to misuse, linkages can be made with other programmes targeted towards poor sections of the community. For example, attendance at VHSC meetings may be considered equivalent to one day's work under the National Rural Employment Guarantee Act (NRGEA).

With the VHSC emerging as an intermediate space between the community and the government, policies are needed to create incentives for incorporating intelligence from the VHSC into PHC, block, district and state health planning mechanisms, perhaps also by educating doctors on village health and sanitation issues. Linkages are being forged between the VHSC and the health administration which were not apparent during the early years of VHSC formation. For instance, the PHC showed little interest in the VHSCs during their early years of formation – their main preoccupation being the routine monitoring of targets and achievements related to various health programmes. More recently, however, an agenda item at monthly PHC meetings and quarterly taluk meetings relates to scrutinizing the proceedings and expenditure of the VHSCs within the village cluster. The VHSCs are also beginning to be recognized as important for reducing the burden of diseases. By way of illustration, in Yelandur taluk, senior health officers commented that the VHSCs are making a big difference to acute outbreaks of dengue fever and gastro enteritis by promoting awareness about hygiene and sanitation resulting in a reduced number of cases being reported over the last two years.

Apart from the formal health planning apparatus, linkages are also being strengthened between other government agencies. The name change from VHSC to VHSNC has brought about changes to the scope of these committees to include issues related to nutrition during pregnancy, after delivery and for children. These committees now provide a forum for the discussion of these issues by health workers, the anganwadi worker and by a wider participation from the community, typically including 15-20 pregnant women and mothers at each meeting. Our study has also identified that important linkages are being forged between the VHSC and the gram panchayat in order to address more large-scale health and sanitation issues in the village. Higher level support for integrating the VHSC into these existing structures and also for cross-learning between VHSCs will lend legitimacy to arguments about the role of invited spaces in improving governance and development.

To conclude, as India has climbed rapidly up the ladder of economic growth rates, it has fallen behind in the most basic of health measures such as maternal and child mortality (Dreze & Sen, 2013). Lack of awareness of health and sanitation issues remains a serious contributing factor for poor health indices, for example approximately 60% of villages in Chamarajnagar district still have no latrines and 30-40% of villagers in Yelandur taluk lack awareness of the need for latrines and practice open defecation. Our findings are exploratory and there are methodological limitations in our approach of relying on participant observation as the main means of data collection. A key limitation is that the insights we have gained about the dynamics of invited spaces is based primarily on what it has been possible to observe. Indeed, there are other aspects to life both within the cluster of villages within Gumballi PHC as well as outside the local community which are important, such as taluk and district level meetings, which are important to understand the wider context within which the VHSCs exist (deWalt & deWalt, 2011)

While the VHSC has emerged as an important forum for promoting village health and sanitation with potential to make primary healthcare more accountable to the community, much more micro-level research is needed to understand who participates and why, which forms of participation work and in which contexts and perhaps most importantly, how invited spaces affect service delivery and accountability. We point to four research avenues that deserve attention. First, there is so far only anecdotal evidence about the VHSCs having a positive impact on reducing the incidence of acute outbreaks of diseases calling for a more systematic analysis to correlate PHCs where VHSCs are working well and not working well with health indicators on diseases that are specifically affected by poor sanitation such as water-borne diseases like diarrohea and dysentery. A second line of inquiry could be to explain why in some of the neighbouring PHCs to Gumballi, decisions regarding usage of the untied fund are typically made by health workers without holding VHSC meetings. One hypothesis to be tested is that VHSCs function better in locations where there has been a strong legacy of NGO involvement in community development such as in Gumballi PHC. Third, economic and social divides at village level can affect equity in health access and need to be investigated through ethnographic study as exclusions due to class, gender, age and ethnicity can affect the impact of the VHSC. Finally, a comparative study to look at VHSC functioning across PHCs in different regions of Karnataka and other states within India is important in order to address the influence of social and economic variables on VHSC formation as the local knowledge base within any particular PHC is highly context-sensitive.

The essential message we have tried to convey in this paper is that accountability is a complex issue that cannot be handled only from a distance by designing and implementing mechanisms to increase the transparency of reporting data. Indeed, this point refers not only to the primary

healthcare sector but speaks to broader debates in development about technical/managerialist approaches to enhancing accountability. Accountability must be accepted on a much deeper procedural level with a commitment to study the unfolding of socializing processes or cycles of learning that take place between civil society, political and state agencies. The success of these spaces is highly dependent on their continued bargaining and negotiation with government administration for access to power and resources (Tembo, 2012). Invited spaces are part of a shifting landscape in which longer term changes in the way citizens are involved in processes of governance may be taking root. In many cases, these initiatives have little or no immediate policy efficacy but patience is needed because tactics are being tried, alliances are being built, and what participants bring into and take from these spaces may have many possibilities for them as actors in other spaces and more broadly for the practice of democratic accountability.

Figure 1: Conceptualizing Accountability in Invited Spaces

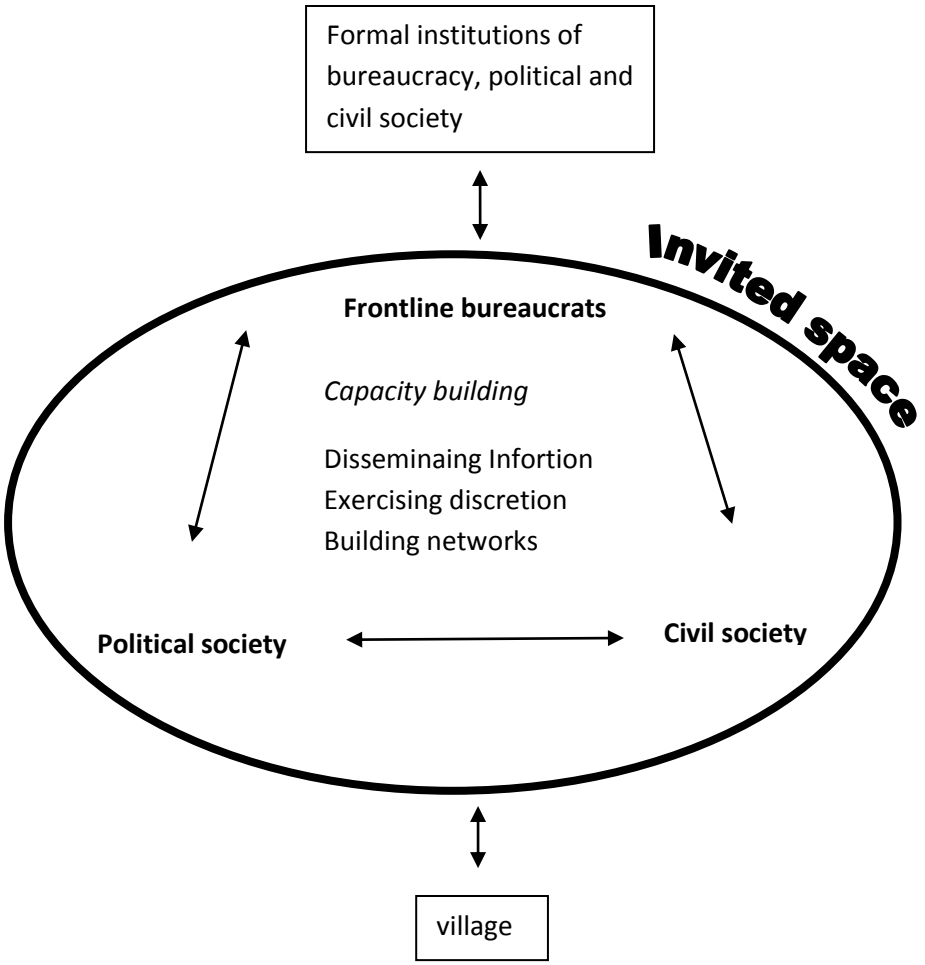


Table 1: Data collection in the 12 villages of Gumballi PHC

Village	**Total VHSC meetings attended in study period**	**Total interviews with VHSC members held/focus groups during study period**
Changachalli	19	5 interviews with VHSC members
Dasana Hundi	24	Focus group with 7 ASHA workers
Gangavadi	10	4 interviews with VHSC members and attendance at Jan Samwad
Ganiganur	16	5 interviews with VHSC members
Gumballi	15	Focus group with 12 ASHA workers
Hegade Hundi	16	
Komanapura	19	6 interviews with VHSC members
Krishnapura	18	Jan Samwad and 3 interviews with VHSC members
Uppinamole	18	4 interviews with VHSC and community members
Vadagere	26	
Y.K. Mole	25	6 interviews with VHSC and community members
Yargamballi	15	3 interviews with SC/ST members
TOTAL	**221**	**36 interviews, 2 focus groups**

Figure 2: VHSC membership

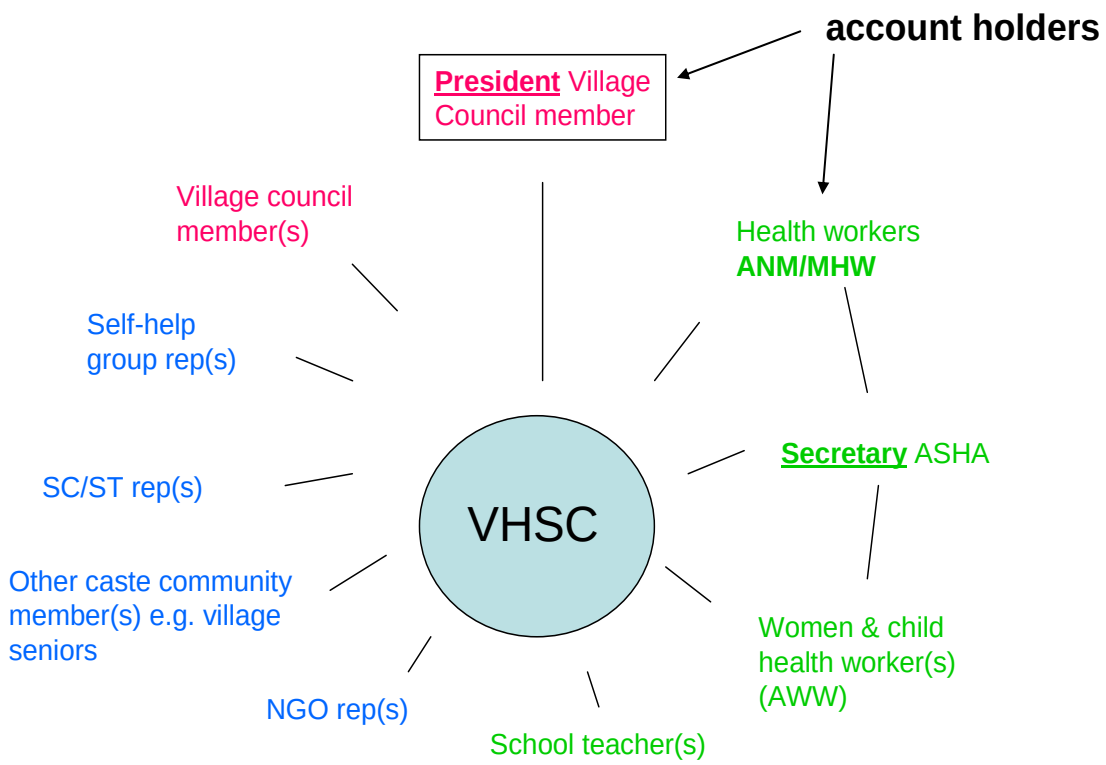


Figure 3 – Frequency of VHSC meetings in the 12 study villages

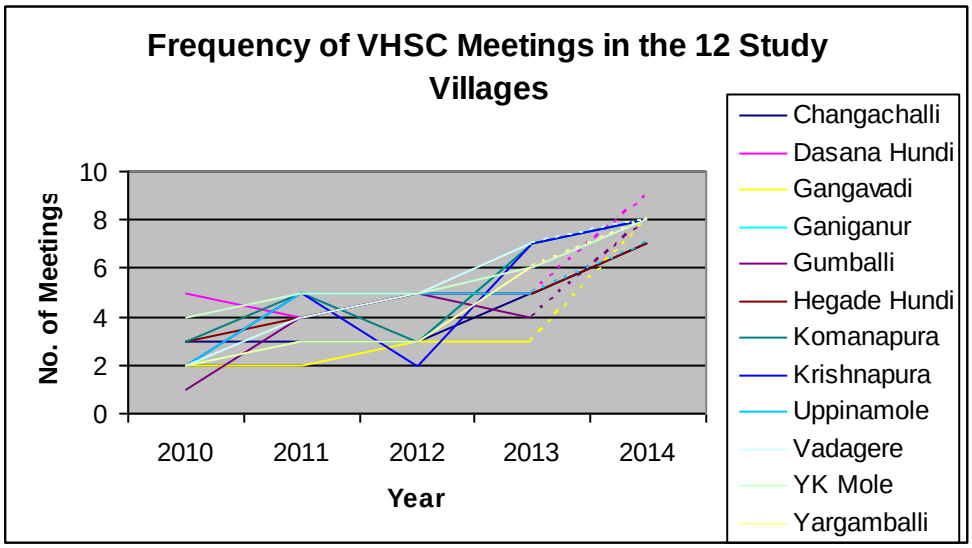


Figure 4 – Attendance of Women/Marginalised Members as a Percentage of Overall Participation at VHSC Meetings in the 12 study villages

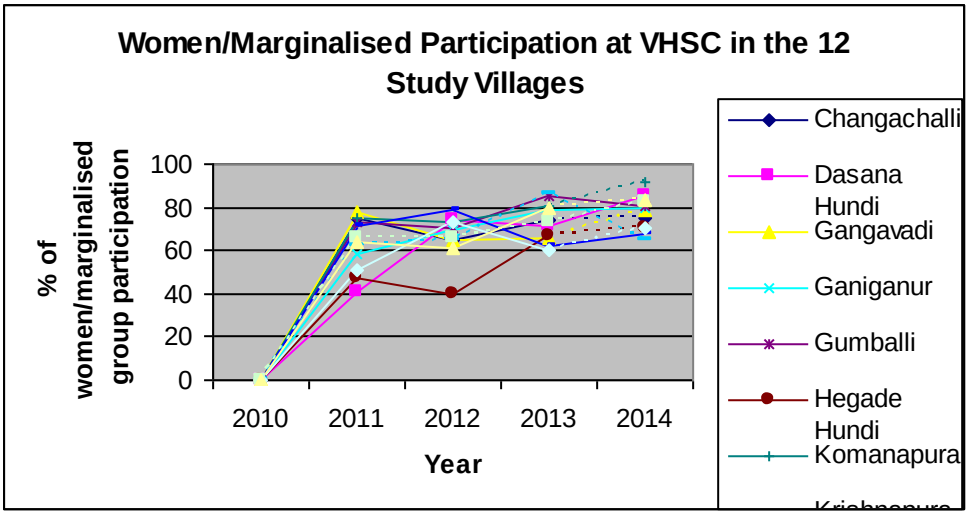
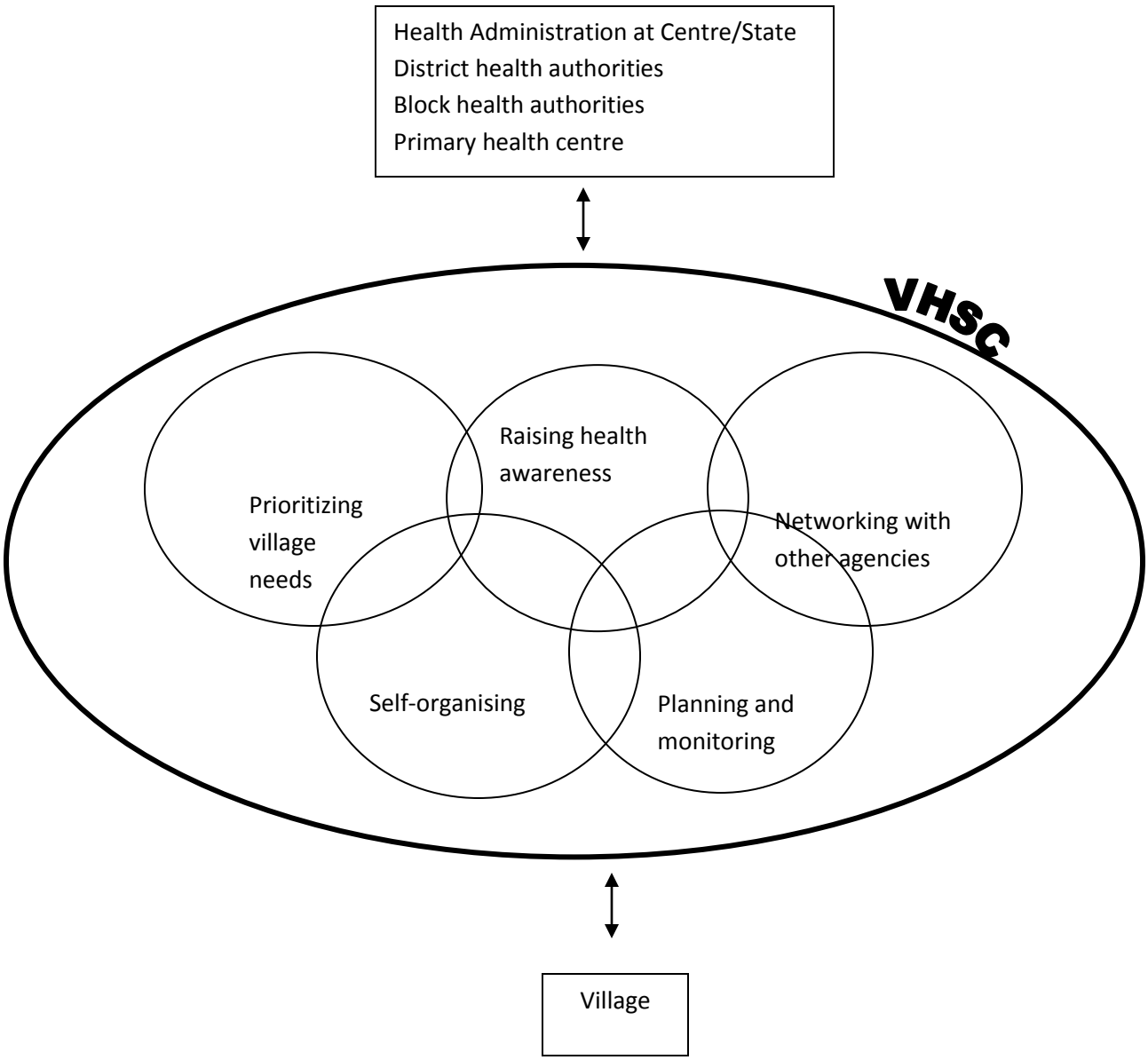


Figure 5 – VHSC Accountability as a Virtuous Cycle of Learning



[i] The VHSC is now called the VHSNC – The Village health, Sanitation and Nutrition Committee

[ii] Scheduled caste/scheduled tribes are recognised as two historically disadvantaged groups in the Constitution of India

[iii] There are 8 'C' districts in Karnataka which are very poor in terms of health indices

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