HHR Health and Human Rights

DREXEL UNIVERSITY Dornsife School of Public Health

FXB Center for Health & Human Rights at Harvard University

VIEWPOINT

# Fragile Gains, Shifting Mandates: Civil Society, State Synergy, and the Future of Health Accountability in Maharashtra, India

DHANANJAY KAKADE

## Introduction

The Community-Based Monitoring and Planning (CBMP) initiative emerged in 2007 as a collaborative effort between the government of India and civil society organizations under the framework of the National Rural Health Mission (NRHM). Rooted in the long-standing advocacy of the People's Health Movement, CBMP seeks to institutionalize "communitization" in public health governance by creating formal spaces for citizens to monitor services and hold the health system accountable. The initiative was initially rolled out in nine states, including Maharashtra, covering 324 primary health centers across 36 districts.

Since then, Maharashtra's CBMP has gradually evolved into one of the more sustained and collaborative efforts between civil society and the state in India's health sector. It has reached approximately 1,000 villages across 17 districts. Using community scorecards, social audits, and public hearings, CBMP helps communities assess how well services are being delivered, engage directly with officials, and secure commitments to improvements, embedding a culture of accountability and community participation in the public health system.

This CBMP involves four broad interlinked elements: monitoring, review, remedial action, and local planning. Monitoring, through scorecards and social audits, has generated evidence on whether power holders (frontline doctors and outreach workers) uphold their obligations; reviews, through public hearings and facility-level dialogues, have interpreted this evidence to assess performance; remedial action, such as commitments to time-bound improvements in service delivery, has ensured that gaps and failures are acknowledged and rectified; and local planning, such as a plan to utilize village-level health funds based on

Dhananjay Kakade is director of SATHI (Support for Advocacy and Training to Health Initiatives), Pune, India.

Please address correspondence to the author. Email: dhananjay.kakade28@gmail.com.

Competing interests: SATHI is one of the state nodal organizations for the implementation of the Community-Based Monitoring and Planning (CBMP) initiative in Maharashtra, where the author is director.

local priorities, has led to community participation in local health decision-making.

Though accountability is a conceptually fuzzy term, this viewpoint aligns with the idea that power holders must justify their decisions and actions and take remedial measures when they fail to fulfill their duties.

Jonathan Fox conceptualizes multiple accountability pathways in governance: vertical accountability entails bureaucratic answerability through established hierarchies; horizontal accountability prioritizes institutional oversight among government bodies; and diagonal accountability emphasizes participatory processes that connect citizens' voices with state decision-making. Located within the broader framework of diagonal accountability, this essay illustrates how the CBMP initiative in Maharashtra, India, has combined bureaucratic compliance with citizen empowerment to develop a more effective rights-based accountability system.

For pragmatic reasons, this viewpoint does not address the element of local planning, as it requires a different analytical framework.

## Foundations and enabling conditions for Maharashtra's CBMP

CBMP was designed to enable local communities to monitor health service delivery and participate in health planning at the village and the primary health center level.

Implemented across multiple districts through a network of nodal civil society organizations, the process institutionalizes community feedback as part of the functioning of health facilities. While most implementing organizations are Indian nongovernmental organizations funded under NRHM's community processes component, they vary considerably in scale and orientation—from small local groups embedded in rural communities to professionalized nongovernmental organizations that provide technical support and policy dialogue.

Several enabling factors have contributed to the effectiveness of CBMP. To start, the state has provided much-needed legitimacy and dedicated budgetary support to the program through government orders and CBMP's formal inclusion in the NRHM's Programme Implementation Plan. Further, a broadly supportive political and bureaucratic environment—shaped by reform-oriented officials and a history of rights-based activism—facilitates constructive state-civil society engagement. In addition, the presence of experienced civil society partners and state-level nodal agencies ensures that accountability dialogues are systematically implemented and scaled across districts. CBMP strategies such as systematic capacity-building through training and exposure to the functioning of the public health system enables grassroots accountability actors—including community-based organizations, village health and sanitation committees (VHSNCs), and local elected representatives—to monitor health services. They regularly engage with frontline health workers through structured accountability dialogues such as public hearings (Jan Sunwais) and social audits.

Since its inception, the CBMP initiative in Maharashtra has expanded from a 2013 pilot covering 13 districts and 615 villages to nearly 1,000 villages across 17 districts in 2018. Participatory oversight bodies such as VHSNCs and Rogi Kalyan Samitis are more active in CBMP areas, contributing to the improved resolution of problems.

Between 2014 and 2015, 2,446 community-raised concerns regarding the functioning of the local public health services—ranging from basic health service improvements to shortages of human resources—were tracked, demonstrating CBMP's growing role in institutionalizing accountability within Maharashtra's public health system.

Civil society organizations' strategies of local mobilization, combined with advocacy and the presence of a reform-oriented higher bureaucracy, have created a favorable environment for grassroots participatory spaces to thrive.

## Intersecting powers: Mandate, solidarity, and knowledge

At a conceptual level, CBMP illustrates how three interdependent yet distinct forms of power—

mandate power, solidarity power, and knowledge power—intersect to generate a meaningful accountability culture within public health systems from a community perspective. Both the reach and depth of CBMP in Maharashtra are influenced by how these forms of power simultaneously operate across state and community spaces.

### *Mandate power*

Although the social foundations of CBMP predate the NRHM, the reform-oriented environment after 2007 provided the necessary institutional mandate for participatory accountability. The bureaucratic "buy-in" and formal recognition of civil society organizations as implementing partners through budgetary provisions and government orders has given the process bureaucratic legitimacy. The mandate power works as a bulwark against administrative resistance and positions accountability as a legitimate function of health governance.

### *Solidarity power*

Nodal organizations facilitate grassroots mobilization and solidarity among VHSNCs and local communities, catalyzing the creation of a local network of accountability seekers. These empowered accountability seekers effectively utilize civil society-led and state-sanctioned forums such as public hearings, audits, and planning dialogues to present grievances and demand redress. These forums also provide a nurturing space for community solidarity, which translates into collective voice and moral authority, thereby anchoring accountability in democratic participation rather than administrative compliance.

### *Knowledge power*

Communities acquire key skills such as the ability to understand data generated through score cards, identify service gaps, and use evidence to seek transparency and accountability from government health functionaries through context-specific trainings. This process builds what may be termed "knowledge power": the authority that emerges when citizens can engage the health bureaucracy using its own informational logic. Knowledge thus becomes a tool not only for advocacy but for redefining relations of expertise and legitimacy within the system.

Together, these intersecting powers generate a change cycle: mandate power opens institutional space for community participation, solidarity power sustains grassroots mobilization, and knowledge power lends credibility and negotiation strength to communities. Effectively, CBMP's success is achieved through the strategic interplay and configuration of institutional sanctions, collective action, and communities' knowledge-based agency.

## State-society synergy and challenges

CBMP's success is predicated on the delicate balance between state-civil society partnership and community-led oversight of public health systems. The state recognizes that community engagement and participation not only help improves service quality but also serves as an essential strategy for strengthening grassroots accountability; with this in mind, the state gives a formal mandate to nodal organizations to implement CBMP. For civil society organizations, participation provides an opportunity to institutionalize community-led accountability approaches within the health system and foreground community aspirations in health planning.

Predictably, public officials sometimes perceive community monitoring as surveillance or undue criticism, while civil society actors are cautious of being co-opted. Despite occasional flare-up tensions between the bureaucracy and civil society organizations, through years of negotiation, both sides have developed a stable operating balance. The government provides resources, a mandate, and continuity, albeit sometimes with significant delays, while civil society organizations sustain community action and the program's credibility.

## Shifting policy context: From CBMP to Jan Arogya Samitis

Under the Ayushman Bharat program, a nationwide scheme for universal health care launched in 2018,

the government has introduced Jan Arogya Samitis ("people's health committees") at the sub-center and health and wellness center levels. These committees are envisioned as a participatory platform to promote preventive and promotive health services. While their design is based on four core functions—quality service delivery, health promotion, grievance redressal, and social accountability—and ostensibly retains participatory elements, their underlying orientation diverges sharply from the rights-based framework that shapes CBMP.

In practice, the provider-centric composition of Jan Arogya Samitis limits the scope for independent community oversight. Civil society facilitation—a cornerstone of the CBMP program's functioning—is de-emphasized. Although community monitoring as a strategy is retained, the institutional mandate for crucial accountability tools such as scorecards, public hearings, and audits is watered down.

The evolution of Jan Arogya Samitis typifies the co-option of accountability discourse—where policies appear to promote transparency and participatory language is retained but its transformative potential is weakened. It also signals a broader policy drift toward technocratic efficiency over deliberative, rights-based governance, eroding the CBMP program's gains to date in fostering trust and downward accountability.

## Conclusion

The CBMP experience in Maharashtra has demonstrated that deliberative convergence among institutional mandates, community solidarity, and community knowledge-building can profoundly impact unaccountable hierarchical health systems. Through sustained dialogue and mechanisms of interface at various levels of the health system—from the village to the state—the accountability culture within public health systems can be enhanced and nurtured.

It also illustrates that meaningful accountability requires more than participation—it demands sustained dialogue, institutional openness, and mechanisms for remedial action. CBMP's success over the years has relied mainly on sympathetic reform-oriented officials, resulting in inconsistent institutionalization and weak translation of community evidence into systemic reform. Higher-level policy issues, such as staff shortages and public health funding, have remained largely beyond the program's sphere of influence. There is limited integration of community-level evidence generated through accountability processes, such as scorecards and hearings, with state-level policy decisions and planning. The recent policy trajectory, exemplified by the rise of Jan Arogya Samitis, signals a shift from empowerment-oriented accountability to program-oriented participation. This is also indicative of a broader depoliticization of community engagement, in which citizens are repositioned as supporters rather than as watchdogs of public systems. CBMP's survival over more than 15 years underscores the resilience of collaborative models that link rights-based advocacy with institutional reform. Yet its current vulnerability reminds us that accountability, once institutionalized, is never permanently secured—it must continually be renegotiated and defended against shifts in political intent and institutional design.

## References

1. Government of India, *National Rural Health Mission: Framework for Implementation* (2005).

2. A. Kapilashrami, N. Quinn, and A. Das, *Advancing Health Rights and Tackling Inequalities* (Policy Press, 2025), ch. 7.

3. M. Bovens, "Analyzing and Assessing Accountability: A Conceptual Framework," *European Law Journal* 13 (2007).

4. State Health Resource Center, *Evaluation of Community Based Monitoring and Planning of health care services under National Rural Health Mission (NRHM) [Pilot phase] in Maharashtra* (2013), pp. 8–9.

5. SATHI and Accountability Research Center, *Activating Spaces, Scaling Up Voices: Lessons from the Community-Based Monitoring and Planning Process in Maharashtra* (SATHI and Accountability Research Center, 2023), pp. 14–15, 24–25, 32–35.

6. National Health Resource Center, *Jan Arogya Samiti Handbook for Members* (2022).

7. J. Fox, "Accountability Keywords," Accountability Research Center Working Paper No. 11 (2022), pp. 74–75.