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# Addressing Key Governance Challenges to Improve Service Delivery and Development Outcomes in Meghalaya

## Exploring the Governance of Service Delivery in Meghalaya: Findings from Piloting a Bottom-Up Approach

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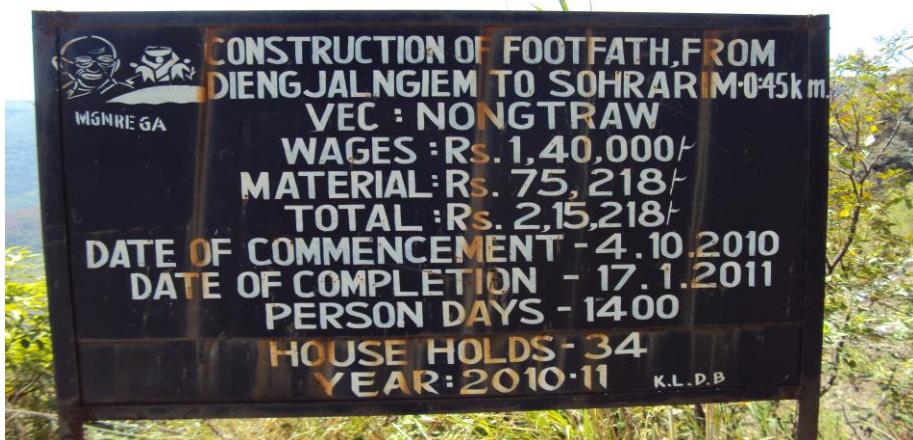
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# Exploring the Governance of Service Delivery in Meghalaya: Findings from Piloting a Bottom-Up Approach



**MEGHALAYA INSTITUTE OF GOVERNANCE**  
INTEGRATED BASIN DEVELOPMENT AND LIVELIHOOD PROMOTION PROGRAMME



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## List of Abbreviations

ADC	Autonomous District Council
AEC	Area Employment Council
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BDO	Block Development Officer
BEC	Block Employment Council
CHC	Community Health Center
CVC	Customary Village Councils
DEC	District Employment Council
DFID	Department for International Development (United Kingdom)
<i>Dorbar Shnong</i>	Village Council (local language)
ESID	Effective States and Inclusive Development Research Centre
FGD	Focus Group Discussion
GoI	Government of India
GoM	Government of Meghalaya
GP	Gram Panchayat
GRM	Grievance Redressal Mechanism
HDI	Human Development Index
HMC	Hospital Management Committee
IEC	Information, Education and Communication
INR	Indian Rupees
KII	Key Informant Interviews
MBDA	Meghalaya Basin Development Authority
MDC	Member of District Council
MHIS	Medical Health Insurance Scheme
MIG	Meghalaya Institute of Governance
MLA	Member of Legislative Assembly
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NGO	Non-Government Organization
NRHM	National Rural Health Mission
OPM	Oxford Policy Management
PHC	Public Health Centre
PRA	Participatory Rural Appraisal
<i>Rangbahshnong</i>	Village headman (local language)
SRS	Sample Registration Survey
VEC	Village Employment Council
VHSC	Village Health and Sanitation Committee
WDR	World Development Report

# Executive Summary

## Background, Objectives and Questions

There is a growing global consensus that governance and institutional issues are critical binding constraints to the achievement of better development and service delivery outcomes. However, there is a weaker consensus on *how*, precisely, governance matters; and, the evidence base is still relatively thin.

This report explores how governance issues shape the delivery of basic and poverty-reducing services in the Indian state of Meghalaya. It explores how services actually delivered on the ground in the context of a complex ecosystem of formalized modern institutions and informal, traditional and customary ‘tribal’ institutions. There is very limited documented evidence on this issue in Meghalaya.

Specifically, this exploratory work had two main objectives. The first objective was to develop and pilot a ‘bottom-up’ approach for better understanding the governance of service delivery in Meghalaya. The second objective was to build the capacity of the Meghalaya Institute of Governance (MIG). This was done through a ‘learning-by-doing’ approach, in which MIG staff were closely involved in designing, implementing and writing up the analysis. It focuses on two main sectoral programs: social assistance via the Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) and health services via the National Rural Health Mission (NRHM).

As such, the report attempts to answer the following questions:

- How do governance arrangements shape service delivery on the ground?
- What is the relationship between modern and traditional sites of authority in delivery?
- What are citizens’ perceptions, experiences and expectations of service delivery?
- How does accountability and oversight actually work on the ground?
- What are some of the implications of this analysis for further research, policy and practice?

## Approach, Methods and Caveats

To begin exploring these issues, an analytical approach was developed based on the latest thinking in this field. The approach can be characterized as ‘bottom-up’ in that it focused on the front-line implementation of service delivery and citizens’ experience with this. The approach gives special importance to the point of implementation:

*...where formal policies most often fail and where ‘real’ policies emerge from the interplay of interests and incentives... This [puts] the focus on those institutions, incentives and actors that are effective at the point of delivery – rather than on those that in the formal scheme of things are supposed to set the institutional and policy framework governing implementation* (Bately and McLoughlin, 2012: 30).

The main methods employed were: (i) a review of existing literature; (ii) key informant interviews; (iii) a household survey in three villages; (iv) focus group discussions; and, (v) ‘action-research’ methods to ensure the reflection and learning of MIG staff during and after implementation. Three villages were selected for piloting the primary research.

Before reading on, two caveats are worth flagging. First, the study scope does not claim to be exhaustive; it was designed as a ‘pilot’ to test some issues that were identified as most salient in the context. Due to time and resource constraints it focuses on two sectoral programs, as noted above. Second, the findings are preliminary and exploratory. The study does not attempt to be representative or generalizable across all areas of the complex state of Meghalaya. Further research would certainly be welcomed. These points are returned to in the conclusions of the report.

## The Main Findings

Here is a snapshot of the main findings. These findings are outlined in more depth in the report.

### *Citizens' Experience of Service Access*

- Overall access to services under MNREGA and NRHM was relatively good: the majority of respondents were accessing the core services under the programs.
- However, access to a range of specific entitlements within the programs was less strong: for example, in MNREGA, 16% of respondents had been issued a job card within 15 days or 32% had received a total of 100 days of work; in NRHM, 28% had access to a Primary Health Centre and access to health insurance was very low.

### *Modern and Traditional Institutions Co-Produce Delivery on the Ground*

- Both modern and traditional structures of governance are operational on the ground in the service delivery mechanisms.
- 'Modern' and 'traditional' actors play a role: in both MNREGA and NRHM, the modern implementation structure is, to a good degree, functional. At the same time, the traditional institutions play a central role as the village headman (who is largely responsive to the village council) chairs the local Village Employment Council and Village Health and Sanitation Committee.
- Formal administrative provisions and informal customary processes are also operational in providing mechanisms for accountability and oversight in service delivery. In terms of formal mechanisms, this includes 'good governance' provisions, such as pro-active disclosure and formal grievance redressal. At the same time, respondents made frequent references to the prevalence of informal mechanisms of redress, namely via the village council.

### *Who Really Matters for Delivery? Modern vs. Traditional Sites of Authority*

- Citizens were also asked to rate who they saw as 'important' for service delivery and to rate the 'performance' of service delivery actors. This provided some interesting insights.
- In terms of importance, the traditional body – the village council – emerged as the most important. 97% of micro-survey respondents said that the village council is important, and interviewees strongly substantiated this.
- In terms of 'performance', three main findings emerged. First, the village council was rated, by a long way, to be the highest performing body within the local service delivery chain. Second, with the exception of the village council, citizens saw service delivery actors as performing relatively badly. Finally, the most striking disconnect between importance and performance related to elected representatives: Members of the Legislative Assembly (MLAs) were rated by 72% of the respondents as important for delivery, but only 3% of respondents considered them to be a good performer; the Members of the District Council were rated by 62% of respondents as important, while only 2% considered the performance to be good.

### *Oversight and Accountability*

- In terms of 'transparency' and how information is accessed, two main points emerged: first, citizens' awareness of the programs, in general, was relatively high but awareness levels were much lower in terms of specific program entitlements; second, in terms of information preferences, people largely preferred to get their information via informal sources and face-to-face interaction (namely via village headmen and councils).
- In terms 'accountability' – that is, answerability and redressal in service delivery – two main findings also emerged. First, to some degree, formal and informal mechanisms for accountability intermingle, verging on 'hybrids'. For example, the same village-level functionaries are monitored by formal, state mechanisms (such as audits and site visits) as well as by the traditional customs of the village councils. Such functionaries appeared to have overlapping identities: as formal functionaries of the state, owing allegiance to the bureaucratic accountability mechanisms, *and* as tribal village community members, owing allegiance to the tribal village council. Second, while there is evidence of some hybridity, the bulk of the

evidence suggests that: (i) formal mechanisms of oversight – such as filing grievances, social audits or interacting with the Block Development Office on delivery issues – are, on the whole, under-utilized; and, (ii) traditional and ‘unofficial’ mechanisms of oversight – such as raising and resolving issues with the village headman – are highly preferred.

#### *Grassroots Inclusion/Exclusion Dynamics and Gender: Marrying the ‘Old’ and the ‘New’?*

- Provisions for gender equality in decision-making have led to increased participation of women. This stands in contrast to women’s position vis-à-vis the village council members: women’s membership in the village council remains restricted.
- However, traditional gender roles are perpetuated in other areas. Namely, traditional notions of gender-differentiated pay, such as in MNREGA, still prevail and, according to the data collected, such notions are widely perceived to be acceptable.

### **Towards Implications for Policy and Research**

The study attempts to, finally, offer some signposts for further reflection, research and policy actions. These are preliminary suggestions given the preliminary nature of the work. Moreover, few ‘magic bullet’ solutions are available.

#### *Cross-cutting Implications for Thinking about Governance in Service Delivery in Meghalaya*

- Traditional and informal institutions are critical. Modern and formalized institutional arrangements, alone, cannot explain delivery processes and outcomes.
- Modern and traditional bodies – and formal/informal processes – do not, however, always operate in isolation. There are points of co-operation, overlap and fusion that point towards ‘hybrid’ and ‘blurred’ institutional arrangements. This can lead to unclear understandings of who should do what, when and how. It also problematizes dichotomies between ‘formal/informal’, ‘public/private’ and ‘modern/traditional’.
- This said, the primary data and literature suggests that traditional and informal practices are the dominant institutional logic for delivering services in Meghalaya. Traditional arrangements were more frequently used, were perceived as more important to people and were perceived as higher performers compared to formal mechanisms.
- This suggests that there is a lack of fit between the formal ‘good governance’ ideas that dominate service delivery programs (and development discourses) and actual institutions that matter on the ground.
- These findings give weight to a growing evidence from other states in India and internationally (as noted in the conclusions of the report).

#### *Towards Policy Implications*

The below represents a short summary of some potential areas for policy debate and action. These tentative points, alongside some international examples and good practices, are outlined in Section 3.

Policy/Practice Area	Possible Actions
<b>Addressing Gaps in the Delivery of MNREGA and NRHM</b>	<p>The research identified some important gaps in delivery that could be further assessed and address going forward. Some suggested areas include the following:</p> <ul style="list-style-type: none"> <li>• MNREGA: (i) improve access to job cards within 15 days; (ii) improve the number of people accessing work within 15 days; (iii) taking measures to ensure that people work the full mandated 100 days; and, (iv) raising people's awareness of key provisions within the scheme, such as awareness of the unemployment allowance.</li> <li>• NRHM: (i) make greater progress on infant and maternal health, such as through ensuring greater field staff and trained attendants for home deliveries; and, (ii) ensuring greater awareness of and access to sub-provisions under NRHM such as the health insurance, clinic day and village health and nutrition day.</li> </ul>
<b>Building Greater Trust in the Formal System of Delivery</b>	<p>Given lack of buy-in to formal mechanisms, some measures might include:</p> <p><i>Shorter Term</i></p> <ul style="list-style-type: none"> <li>• Options: (i) demonstrate and popularize – through public outreach – the benefits and successes of the formal delivery mechanisms, to build greater trust in the system; and, (ii) raise people's awareness of the benefits of engaging with formal oversight and accountability mechanisms.</li> </ul> <p><i>Medium/Longer Term</i></p> <ul style="list-style-type: none"> <li>• Greater formal devolution of powers and resources to the level of the village could further strengthen the state's objectives of implementing welfare and development activities without disrupting traditional customs.</li> <li>• Further empowering local village councils to improve service delivery planning, management and delivery may be desirable.</li> </ul>
<b>Improving Information Outreach and Two-Way Communication</b>	<p>Engagement with citizens could be strengthened in ways that respond to local cultures. This could help build citizen trust, improve delivery and harness synergies between formal and informal:</p> <ul style="list-style-type: none"> <li>• Strengthen grassroots information provision, especially where there is low awareness. This would need to leverage citizens' preferred norms and channels for accessing information (such as via face-to-face meetings with the village headman, or during the village council).</li> <li>• Introduce mechanisms to collect citizens' expectations and satisfaction. There is a gap in knowledge in the state on how citizens really think and act on the ground. This could take different forms: (i) periodic perceptions/satisfaction surveys; (ii) localized citizen scorecards; or (iii) strengthening Management Information Systems to collect regular feedback.</li> </ul>
<b>Harness Informal Institutions: Foster Practical Hybrids</b>	<p>Experience suggests that informal and formal institutions can be <i>combined</i> into 'practical hybrids' that can improve service delivery and development outcomes. Some steps to do this could include:</p> <ul style="list-style-type: none"> <li>• Build on what is already working on the ground. This may include: (i) further harness village council in service delivery programs by expanding its role in decision-making and resource management; or, (ii) strengthen hybrid mechanisms for accountability, such as integrating certain principles of the social audit into village council meetings.</li> <li>• Build effectiveness of 'bridging' institutions – such as MIG – to bring together different actors from formal/informal, public/private divide to build trust and solve service delivery problems.</li> <li>• Create incentives for practical hybrids: allocate adequate funds for bearing transaction costs of local problem-solving, rather than funding inputs and outputs; (ii) use 'results-based' approaches to incentivize results but not determine the top-down solutions for getting there.</li> </ul>

### Towards Research Implications

Finally, further research would be required to substantiate, scale up and flesh out the research findings presented in this report. The sample size could be expanded and random sampling methods could be used across the three regions of Meghalaya to increase the representativeness and generalizability of the findings. Moreover, key policy research questions could be addressed: how do hybrid institutional arrangements work in practice and what lessons can be learnt for replicating them? What lessons can be learned from comparing and contrasting the governance of delivery in the different sectors in the state?

# 1. Background and Rationale

## The Backdrop: Governance and Service Delivery

**There is a global consensus that ‘governance matters’ for achieving development outcomes.** This is most starkly illustrated in the decision to have a governance target in the post-2015 global development goals known as the ‘Sustainable Development Goals’ (SDGs) (Bhargava, 2015). As Booth (2013: 2) puts it: “*The evidence is now overwhelming that most of the binding constraints in development are about institutions and institutional change.*”

**It is also widely recognized that ‘service delivery matters’ for achieving development outcomes.** Whether this relates to reducing malnutrition, enabling early childhood development, vaccinating against life-threatening diseases or ensuring basic social safety nets, the quantity and quality of public services are critical determinants of human, social and economic development (McLoughlin and Scott, 2014).

**At the same time, governance factors are critical in making or breaking service delivery.** In many countries, service delivery outcomes have failed to achieve sustained and equitable improvements despite sizeable domestic and international resource transfers. In fact, standard technical and financial measures to address service delivery have had mixed results: namely because they have failed to sufficiently take into account the reality of domestic policy processes, the complexity of accountability and the motives and incentives that shape action (Harris et al, 2013). Therefore, a growing stream of research has begun to explore how governance factors can make or break service delivery (as discussed below).

**However, there are significant challenges in making progress towards improving the governance of service delivery.** Three key challenges can be highlighted. First, while there is a broad consensus that ‘governance matters’, there is much less consensus on how, precisely, it matters; what aspects of governance are most important; and, what can be done (if anything) to foster developmental forms of governance (Levy, 2014; ESID, 2014). Second, evidence on the way different governance aspects impact on service delivery, albeit growing, is still limited. As Batley and McLoughlin (2012: 30) put it, “*significant gaps in our understanding remain.*” Finally, many, although not all, development actors tend to focus on narrower technical approaches, resource transfers and shorter-term results, rather than the facilitation of longer-term institutional change (Andrews et al, 2012; Booth and Unsworth, 2014).

## Zooming in: Meghalaya in India

**Inspired by these recent findings, we turn to the focus of this report – the governance of service delivery in Meghalaya, India.** Meghalaya is an Indian state situated in the North-East, bordering on the Indian state of Assam and the country of Bangladesh. It has a population of around 3 million. Given that the state is landlocked, hilly, has a large tribal population and is situated in the North-East, it is categorized by the Government of India (GoI) as a ‘Special Category’<sup>1</sup> state.

**The state has made progress in development and service delivery, although a number of challenges remain.** The state has made advances in economic growth and poverty reduction. For example, urban poverty has witnessed a strong decline from 24.7 percent in 2004-05 to 9.26 percent in 2011-12. However, challenges remain and poverty levels remain high with a marked disparity between rural and urban poverty and a dearth of economic opportunities in rural areas. Moreover, the state’s pace of progress in Human Development is lower than the national average, especially in education and health. For instance, the Government of Meghalaya (GoM) 12<sup>th</sup> Five Year Plan (2012-17) acknowledges that efforts are required to bring down high levels of infant and maternal mortality.<sup>2</sup>

**Against this backdrop, the state has a complex governance structure that combines modern, state-led institutions with traditional tribal institutions.** At the risk of oversimplification, the responsibility

of governance and service delivery in Meghalaya falls under the ambit of three centers of authority: (i) the State; (ii) the Autonomous District Councils; and, (iii) grassroots indigenous ‘tribal’ institutions. Each aspect is briefly outlined. First, the state of Meghalaya was created in 1972. The state was carved out of two districts of the state of Assam – the United Khasi and Jaintia Hills Districts and the Garo Hills. The state government is formally responsible for the delivery of services, although it is legally required to share part of this role with the Autonomous District Councils (ADCs). Second, in 1950, the Constitution of India – under the so-called Sixth Schedule<sup>3</sup> – established ADCs in the North-East region with a view to preserving and protecting tribal institutions. The rationale behind the ADCs was to set up a system of local administration to give greater autonomy to tribal societies, to preserve and safeguard tribal groups’ traditional practices and to act as a ‘meso-institutional’ linkage between the state government and ‘informal’ grassroots tribal institutions. Meghalaya has three ADCs called Khasi, Jaintia and Garo. Third, grassroots indigenous, tribal institutions are seen to be strong in the state. Historically, the power to govern at the village level rested in the hands of elected members of the village, and such members belonged primarily to the ruling clan and were known as *Ki Bakbhrav* or ‘the great ones’ (Joshi, 2004: 262).<sup>4</sup> The elected members organized themselves into a village council or the *Dorbar Shnong*. It is headed by a village headman (locally referred to as the *rangba shnong*).

## Challenges, Capacity Deficits and Knowledge Gaps

**Meghalaya faces certain governance challenges, which are thought to negatively impact on service delivery.** In brief, these challenges include: (i) the presence of multiple sites of authority and gaps in the policy and implementation; (ii) issues of incoherence between modern state structures and traditional tribal institutions; (iii) deficits in the effectiveness of accountability and oversight mechanisms; (iv) weaknesses in institutional capacities for delivery; (v) limited or skewed incentives for ensuring effective delivery; and, (vi) constraints in ensuring greater equity, grassroots participation and inclusion in delivery related decision-making and allocation (O’Meally and Vincent, 2015).

**However, the evidence base on governance and service delivery in Meghalaya is extremely limited.** Based on a review of existing evidence in Meghalaya and initial stakeholder consultations, a number of gaps have been identified. Overall, there is a major lack of rigorous and well-substantiated analyses, especially at the front-line of implementation. Some of the key gaps include: (i) the documentation fails to link, in any structured manner, governance dynamics with service delivery processes; (ii) there is very limited evidence on citizens’ actual expectations and allegiances regarding service delivery in the state and the degree of allegiance they owe to the different centers of authority; (iii) understanding of the relationship between formal/modern and informal/traditional sources of authority is broad, conflicting and poorly substantiated; and, (iv) the literature fails to analyze, in any depth, how and why oversight and accountability mechanisms are actually working on the ground (see O’Meally and Vincent, 2015). Policymakers recognize that this lack of knowledge limits the scope of policy debate and policy solutions.

**At the same time, the capacity of the state to identify, assess and respond to these important governance issues could be further built.** In recognition of the need to address such issues, the GoM established (in 2013) the Meghalaya Institute of Governance (MIG). A promising governance innovation, the MIG was set up to guide governance reforms in the state by bringing together knowledge, people and technology.<sup>5</sup> However, the MIG is a nascent institution requiring further strengthening in a number of areas such as designing and implementing action-research, strengthening its advocacy and negotiating skills, fostering change management and designing and supporting governance reforms.<sup>6</sup>

## Study Rationale and Objectives

**In order to address the above gaps, this study had two key objectives:** (i) to develop and pilot a ‘bottom-up’ framework for better understanding the governance of service delivery in Meghalaya; and, (ii) to build the capacity of the MIG in undertaking such analysis. Specifically, the objective of this analysis is to explore how governance factors shape the delivery of selected services

in rural Meghalaya. The study was also conceived as a means of building MIG capacity, via action-research ‘learning by doing’ (see Annexes).

**Due to time and resource constraints, the analysis focuses on two service delivery programs in the social safety net and health sectors.** The two programs are the Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) and the National Rural Health Mission (NRHM). MNREGA (2005) is one of the world’s largest social safety net programs for the rural poor. It mandates 100 days of unskilled manual wage employment to adult members of every rural household in a financial year. In addition, it aims to create durable assets so as to enhance service access and the livelihood security of the rural poor. In terms of health, the NRHM is a national program designed to improve a number of health outcomes. The Government of India (GoI) describes NRHM as a national effort “to provide effective health care through individual, household, community and health system level interventions”.<sup>7</sup> Further details of the programs are outlined in the annex.

## Analytical Framework and Research Questions

**In order to guide the analysis, an analytical framework was developed and piloted.** The framework was designed to help address key governance gaps and issues in Meghalaya (see O’Meally and Vincent, 2015; Stakeholder Meetings, 2015). It also integrated the latest, and most relevant, international thinking in this domain, as outlined below. The main aspects of this approach were as follows.

**First, the framework can be broadly characterized as a ‘bottom-up’<sup>8</sup> approach to governance in service delivery.** This means exploring governance by examining the ‘front-line’ and ‘actual implementation’ of service delivery, and citizens’ experiences with these issues. This is opposed to more traditional, ‘top-down’ analyses that tend to focus on formal service delivery policies and rules. This approach is explained thus:

*...research needs to give special importance to the point of implementation, where formal policies most often fail and where ‘real’ policies emerge from the interplay of interests and incentives...and adopt an essentially ‘bottom-up’ approach to the field research...This would put the focus on those institutions, incentives and actors that are effective at the point of delivery – rather than on those that in the formal scheme of things are supposed to set the institutional and policy framework governing implementation* (Batley and McLoughlin, 2012: 30).

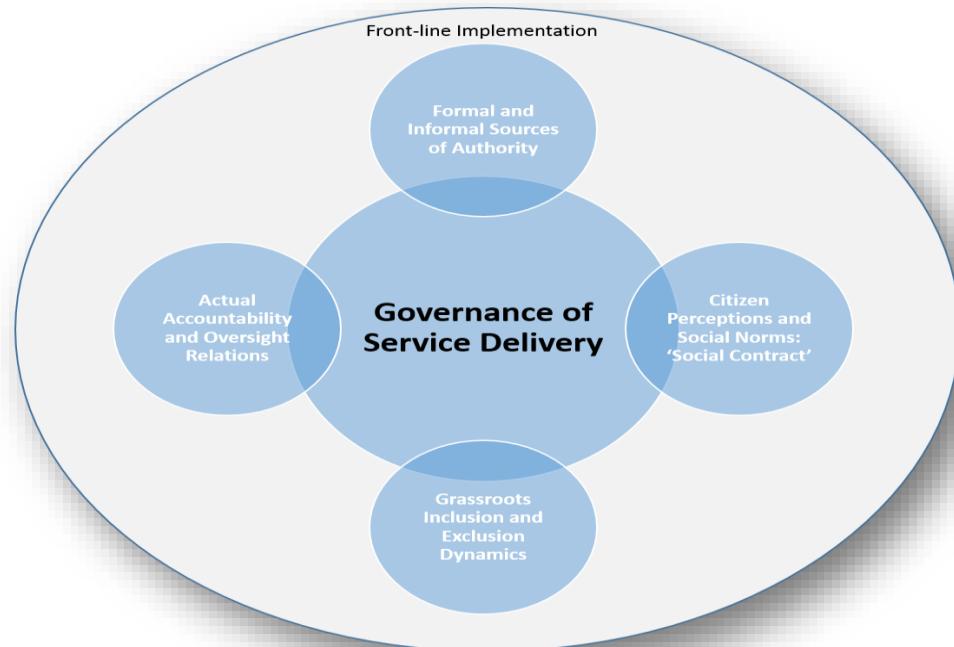
**Second, the approach takes seriously both modern/formal and traditional/informal institutional arrangements.** On the one hand, a *formal institutional perspective* tends to see governance and accountability as ‘enshrined in the legal and institutional foundations of state sovereignty and written rules at the various levels of governance’ (OPM, 2005:16). Formal institutions have been described as rule-based, rational-legal systems that reflect a clear distinction between public and private spheres of life.<sup>9</sup> On the other hand, the *informal institutional perspective* puts an emphasis on whether formal ‘political and administrative institutions are legitimized by, and accountable to, the social foundations of social and economic elites’ (OPM, 2005:16). Informal institutions are understood to be rooted in practices of indirect rule with authority concentrated in the hands of socially dominant groups – such as via kinship, caste-based groups or tribal chiefs – and are organized along patrimonial, customary or traditional lines. Typically, formal institutions are framed as more plural, democratic and inclusive in nature while informal are associated with more repressive and exclusionary practices (IDS, 2010). Ultimately, the approach adopted here recognizes that in practice, “[service] delivery is often facilitated through...arrangements that rely on relationships of reciprocity and alliances across blurred public-private boundaries” (Batley and McLoughlin, 2012: 30). It, as such, recognizes that *formal* rules, alone, rarely explain implementation processes and outcomes (Bukenya and Yanguas, 2013).<sup>10</sup>

**Third, the approach recognizes that there may be a tension or ‘misfit’ between informal and formal arrangements.** In other words, the study “does not presuppose that formal institutional arrangements are automatically corresponding with informal institutions” (OPM, 2005: 16). Moreover, there are likely to be blurred boundaries ‘modern’, ‘formal’, ‘traditional’ and ‘informal’ forms of governance. The approach, as such, shares similarities with an analysis conducted in Tanzania:

*...[this research in Tanzania] recognised that it was important not only to identify the institutions and channels through which local people sought to secure accountability, but also to understand the language in which they thought and talked about accountability. It accepted that there might be some lack of fit, or problem of translation, between the way donor agencies and central government officials thought about accountability and the way local people did* (Kelsall et al, 2005).

**Fourth, the approach seeks to assess citizens' expectations and social norms, which form part of the 'social contract'.** This has various dimensions. First, one should not take the 'poor's' values and ways of thinking about governance as a given. As World Development Report (2015: 3) puts it: "Individuals are not calculating automatons. Rather, people are malleable and emotional actors whose decision making is influenced by contextual cues, local social networks and social norms, and shared mental models". The WDR (2015) goes on to argue that "development professionals are not always good at predicting how poverty shapes mindsets", so policymakers should always check their assumptions with actual analysis of what is happening on the ground.<sup>11</sup> Second, the nature of the 'social contract' around different services – that is, people's perceptions of who should get what, when, how and from whom – can impact on service delivery, especially by shaping the way people are likely to respond to failings in delivery. Moreover, the social norms underpinning a social contract can differ significantly according to contexts: people can be more interested in 'getting things done' than perfect transparency and accountability standards; favoritism in public services may have wide social legitimacy; notions of moral reciprocity, even in patron-client relations, may have significant sway; or, patronage and corruption – rather than signifying an absence of rules or an aberration – can actually be supported by widely held *de facto* norms (Booth, 2012; DFID 2015).

**Figure 1. A 'Bottom-Up' Framework for Understanding Governance in Service Delivery**



**Fifth, the form and degree of oversight mechanisms can be important in shaping delivery processes and outcomes.** This study examines if, and how, such mechanisms actually work on the ground and why. It also unpacks accountability along its typical constituent elements: (1) *transparency* – degree to which decisions are taken openly and sufficient information is available; (2) *answerability* – denotes idea that power-holders need to answer for and justify their decisions and actions to so-called 'constituents'; and, (3) *enforcement* – existence of mechanisms to sanction actions and decisions that run counter to given mandates and procedures (e.g. Foresti et al, 2013; Brixi et al, 2015).

**Finally, a less prominent aspect of the study is to look at how grassroots inclusion/exclusion dynamics might shape, or re-shape, delivery processes and outcomes.** This emerges as an area of potential importance as per the review of the evidence (O'Meally and Vincent, 2015), and also emerges as a policy priority in the state (Rao et al, 2011). The framework is summarized in Figure 1.

**In sum, the study attempts to answer the following questions:**

- What are citizens' perceptions, experiences and expectations of service delivery?
- What is the relationship between modern and traditional sites of authority in delivery? What are citizens' expectations and perceptions of modern and traditional sites of delivery?
- How does accountability and oversight actually work on the ground? What are citizens' understandings and expectations of oversight and accountability?
- What are some of the grassroots dynamics of inclusion and exclusion in service delivery?
- What factors explain the 'real-world' governance of delivery on the ground? How do such governance aspects appear to shape service delivery?
- What are some of the implications of this analysis for further research, policy and practice?

## Methodology

**The method involved a combination of desk-based analysis and qualitative and quantitative primary research.** Two service delivery programs were identified for the study: MNREGA (social safety net program) and the NRHM (sub-sectoral (health) intervention). The programs are not identical in structure, but were selected according to three main criteria: (i) whether the program seeks to provide for the basic needs of the poor and is, therefore 'pro-poor' to a degree; (ii) whether the program has a relatively large footprint, impacting the majority of the citizens within the state, and is extensive (as opposed to a small-scale initiative); and, (iii) whether the program involves interface between the government and citizens. Two programs, as opposed to one, were selected so the approach could be piloted in more than one sector, thus maximizing learning. It was not the intention to conduct a comparative analysis of the programs.

**The next step was to undertake qualitative desk-based analysis of the available literature.** This involved a detailed examination of credible public and private documents on Meghalaya, including a range of academic, policy and donor literature (See O'Meally and Vincent, 2015). In so doing, key knowledge gaps and key research questions were identified. Next, an analytical framework was developed, as discussed above.

**Three study sites were selected for the primary research.** Given time and resource constraints – and the 'pilot' nature of this study – three villages were selected for primary data collection.<sup>12</sup> The villages chosen for the study were Laitsohpliah, Mawstep and Nongtraw (Table 1). These villages fall under the Khatarshnong Laitkroh Development Block in the East Khasi Hills District. The study is not attempting to make statistically significant generalizations and the sample was not intended to be representative.

**Table 1. Field Data Collection Sites**

		<b>Laitsohpliah</b>	<b>Mawstep</b>	<b>Nongtraw</b>
Approx. distance from Shillong		39 kms	44 kms	48 kms
Households		54	45	41
Population		101	232	198
Male/Female		57/44	118/114	105/93
Well Being Ranking	Poorest	-	-	4
	Poor	52	45	35
	Moderate	2	-	2

**Three main methods were employed for the primary data collection.** A lead researcher, assisted by a team of field researchers, undertook the field data collection:

- *Household ('micro') Survey.* This aimed to capture citizens' perceptions, experience and expectations in terms of delivery. In the three villages, 135 respondents (just over one respondent from each household) provided information on the administered questionnaire (see Annex). The data gathered fed into and informed the key issues identified for deeper ethnographic research via Key Informant Interviews and Focus Group Discussions.
- *Key Informant Interviews (KII).* KIIs were conducted with selected stakeholders.<sup>13</sup> For this, semi-structured questionnaires were developed and used (see annex). The findings were captured via field notes and/or transcripts.
- *Focus Group Discussions (FGD).* This allowed for a richer discussion of the issues as different citizens corroborated or contradicted others, resulting in rich (but sometimes ambiguous or contradictory) insights. This was moderated by facilitators and captured via audio recordings.

**Following the data collection, the data was purposively codified and analyzed.** The micro-survey data was coded and entered into Excel. Then analyses were run to draw out trends. The detailed qualitative data was examined via a number of qualitative techniques for treating interview data, including clustering, ranking and triangulating. 'Windows' (or boxes) were also developed: these are short summaries from field notes, which are designed to 'show' (not just tell) the reader about how governance and delivery is actually unfolding on the ground.

**However, this method was not 'pure' research in the academic sense: it integrated elements of an 'action-research' and 'learning-by-doing' approach.** As mentioned above, a core objective was to build the capacity of the MIG via action-research and a 'learning by doing' approach. In other words, MIG staff was intimately involved in designing the research and led its implementation with constant technical support and backstopping. See Annex 3 for a summary of these aspects.

## Caveats

**Before reading on, it is important to keep in mind a number of important caveats.** First, the study scope and framework does not claim to be exhaustive. It focuses on some key issues of relevance to current knowledge gaps and policy debates.<sup>14</sup> Second, the study was designed as a 'pilot', which involved designing new research instruments, testing the approach, evaluating its usefulness and building the capacity of MIG. Third, the findings are preliminary and it does not attempt to be representative or generalizable; further research would certainly be welcomed. Finally, research does not attempt to test direct *causal* relationships between governance and service delivery outcomes, although it is possible to draw inferences about the relationships.<sup>15</sup>

**The remainder of the report is separated into two main sections.** The next section summarizes the main findings from this pilot approach. The second section summarizes the main findings and then explores some possible implications for future research, policy and practice in this area.

## 2. Main Findings

This section briefly presents the main findings from the primary data collection. The discussion is separated into five main sub-sections based on the key findings: (1) the first sub-section sets the scene by giving a snapshot of the results on citizens' experience of service access; (2) the next sub-section explores whether formal *and* informal governance dynamics are, in practice, operational in actual service delivery; (3) next, the discussion unpacks the relationship and hierarchy between modern and traditional institutions in delivery; (4) the fourth sub-section, where the bulk of the findings lie, examines the nature and actual functioning of oversight and accountability mechanisms; and, (5) the final brief sub-section explores inclusion/exclusion dynamics. Given the preliminary nature of this research (as flagged in the introduction), areas for further research and substantiation are also briefly flagged in this section.

### 2.1. Citizens' Experience of Service Access

The data suggests that the delivery programs were providing an appreciable level of services, although a number of gaps emerged. These findings, to some extent, resonate with secondary data available on service access in the two schemes. The points are briefly outlined by program.

#### Social Safety Nets: MNREGA

Survey findings suggest that villages are accessing services under MNREGA. For example, all surveyed households were registered under the scheme and owned job cards; almost 96% of the respondents had received work under MNREGA; and, 61% of the respondents surveyed claimed that work was provided to them "on demand" (Table 2). Respondents spoke about several program benefits, including access to work and wages, participation of women in decision making, and improved infrastructure such as roads and footpaths.

However, citizens' experience of accessing specific entitlements within the service delivery program was not found to be uniform. For instance, only 16% of the respondents stated that they were issued a job card within 15 days from the time of registration. Out of the 61% that received work on demand, only 36% accessed work within 15 days. Similarly, in 2014, only 32% stated they received 100 days of work as per the MNREGA entitlements. In response to the question on whether they made payments to access job cards, only 4 respondents (3%) claimed that they were required to pay Indian Rupees (INR) 3 to 30. This points towards a low incidence of bribery or reflects an unwillingness on the part of respondents to admit to such acts (this would need further examination).

Table 2. Social Safety Net (MNREGA) Service Elements and Access Responses

Service Elements and Entitlements	% of Respondents answering yes	
Households registered	100%	
Job Cards	100%	
Access to Work	96%	
Access to Job Card within 15 days	16%	
Access to work on demand	61%	
Access to work within 15 days	36%	
100 days work	32%	
Community level planning of type of work	92%	
On site facilities (crèche, drinking water, first aid kit)	No service	27 %
	1 service	16%
	More than 1 service	26%

When compared with the official data on Meghalaya, these findings support certain received beliefs and question others. The findings resonate with the aggregate data on Meghalaya, which finds that a significant percentage (98%) of citizens in Meghalaya who demanded work were provided employment in 2014 (GoM, 2015). However, when one digs deeper and examines the delivery of sub-

provisions and entitlements within the program, as per this survey, the picture is less positive and less uniform (we return to this point in the conclusion).

## Health: NRHM

**The survey on NRHM also paints a mixed picture on service access.** Survey results show a high level of access to key services, with 84% of the respondents indicating they could access a sub-centre, which is the first point of contact between the Primary Health Centre (PHC) and the community (Table 3). Also, almost 81% could access a PHC. On the other hand, 46% of respondents had ‘rare’ access to a trained community health worker. Only 27% of female respondents delivered in a health institution; most had home deliveries without any skilled care.

**Table 3. Health (NRHM) Service Elements and Access Responses**

Service Elements and Entitlements	% of respondents		
	Yes	No	No Response
Access to health care infrastructure (Sub Centre/PHC)	84%(sub-centre) / 81% (PHC)	4% (sub-centre)/3% PHC	12%(sub centre)/16% PHC
Availability of basic drugs at Sub Centre	70% (Sub Centre)	6%	24%
Access to trained community health worker (ASHA)	41% (Regular access) 46% (Rare access)	-	13%
Availability of doctor at PHC	64% (Always)16% (Rarely)	-	20%
Access to medical health insurance (MHIS) –Out of the 43% enrolled	4% (received benefits)	38% (not received benefits)	1%
Access to institutional delivery	17% (Health institution) 64% (home) 10% (Both)	-	9%

**Available secondary data similarly paints a mixed picture.** While the state-level data is patchy, it does suggest improvements in access to basic sub-centres via the creation of health infrastructure: according to a study in 2009-10, access to health care facilities had improved with the creation of 420 sub-centers at the village level, 108 PHCs and 29 Community Health Centers (CHCs) at the block level (NRHM Evaluation Report, 2009:12). On the other hand, the secondary data reports drug shortages, low availability of doctors at PHCs and very poor indicators in terms of maternal and infant health. For example, the Infant Mortality Rate of the state is at 47, which is higher than the national average of 40 (SRS 2013); 71% of home deliveries are undertaken in the absence of skilled care; or, almost 35% of the women in Meghalaya do not have access to family planning (Oosterhoff *et.al.*, 2015; SRS, 2013). The following sections explore some of the ‘governance’ aspects of this mixed picture.

## 2.2. Modern/Formal and Traditional/Informal Institutions Co-Produce Delivery on the Ground

**The data suggests that both modern and traditional structures of governance and service delivery are, to a degree, operational on the ground.** The service delivery landscape was found to be made up of a diversity of traditional and modern providers, and these institutions are functional – sometimes operating in parallel, sometimes overlapping – in the delivery of MNREGA and NRHM. The extent to which such mechanisms are actually ‘effective’, in practice, is discussed in the following sections.

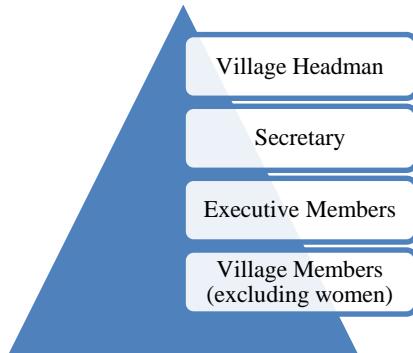
## Social Safety Nets: MNREGA

### *The Service Delivery Chain*

**The main aspects of the ‘modern’ and ‘formal’ delivery system are in operation for MNREGA.** The primary data confirmed that the formal implementation structure is operational and is made up of a four-tier arrangement at the main administrative levels in the state, which are: (i) the district level (District Employment Council (DEC)); (ii) the block level (Block Employment Council (BEC)); (iii) the cluster level, above the village (Area Employment Council (AEC)); and, (iv) the village level (Village Employment Council (VEC)) (Figure 3).<sup>16</sup> A more detailed outline of the formal ‘written’ roles and responsibilities of such bodies are provided in the annex.

**At the same time, traditional institutions, rooted in informal and customary practices, have a central place in delivery, primarily because the ‘village headman’ plays a central role in the VEC.** The findings confirm that the village headman is widely viewed as responsible for the implementation of all welfare and development schemes at the village level. The headman is appointed in principle and in practice as head of the VEC, which is also perceived as a key implementing body for MNREGA (see below). As such the village headman is supposed to assume the formal roles and responsibilities prescribed under the program. At the same time, the local authority of the village headman is rooted in historical, tribal traditions. For many years, the power to govern at the village level has rested in the hands of elected members of the village, and such members mainly belonged to the ruling clan and were known as *Ki Bakbhrav* or ‘the great ones’ (Joshi, 2004: 262). These elected members organized themselves into a village council (known as the *Dorbar Shnong* in the local language) (Figure 2). The council has significant power and legitimacy, rooted in non-codified customary laws and practices. The decisions of the council are often considered as legitimate and are usually adhered to (Joshi, 2004; Lyngdoh, 2015). The village council is headed by the village headman (*rangbahshnong*) who is elected by adult male residents of the village. Women are not permitted to participate in the village council.

**Figure 2. Village Council Structure (Retains Central Relevance in Social Safety Net Delivery)**



#### *Governance Mechanisms Built in to MNREGA*

**Formal mechanisms of governance and accountability – built into MNREGA by the ‘modern’ state system – appear to be functional at the local level.** MNREGA has, on paper, a number of mechanisms to facilitate ‘good’ governance and accountability in delivery. Our primary data suggests that a number of such mechanisms, at least to some degree, are in operation (Table 4). In terms of transparency, some main activities include: program-related information is disseminated to local functionaries through government sponsored trainings, official meetings, mobile technology and so on;<sup>17</sup> record keeping and expenditure tracking has been adopted in a number of cases (including public availability of muster rolls and job card records); and pro-active disclosure activities have been undertaken such as posting information on public notice boards and other Information, Education and Communications (IEC) activities. Oversight and answerability mechanisms include field inspections, social audits and ‘time-bound’ grievance redress mechanisms.

**At the same time, people were more predisposed to talking about traditional mechanisms of oversight.** It was regularly indicated that information is also disseminated via informal methods such as conversations with the village headman and members of the village council. Similarly, grievances

are regularly raised via the village headman.<sup>18</sup> These aspects are unpacked in more depth in the following sections.

**Table 4. Monitoring and Grievance Redress ‘Functional’ under MNREGA**

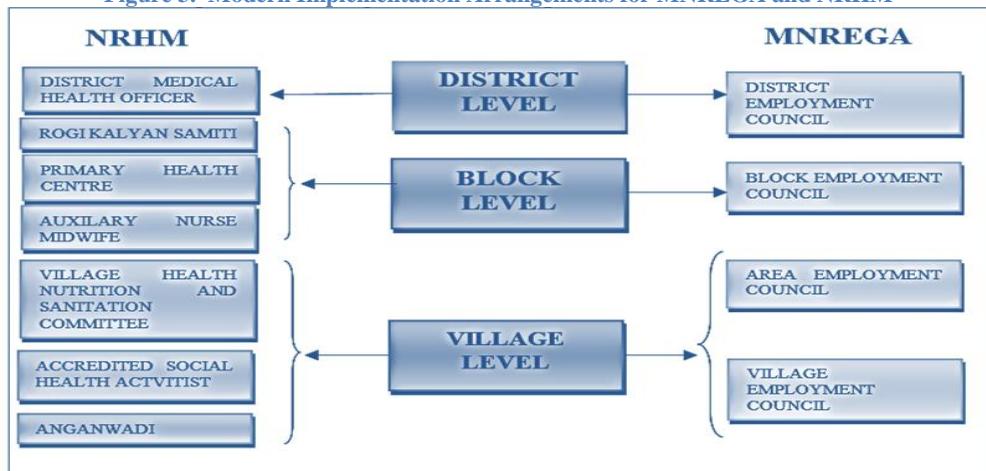
Governance tier		Formal/Informal
<b>Monitoring</b>		
<i>Block</i>	<ul style="list-style-type: none"> <li>• Field inspections to assess work implemented by VEC</li> <li>• Periodic audits/evaluations at village (including social audits)</li> </ul>	Formal
<i>Village</i>	<ul style="list-style-type: none"> <li>• Monitoring by community coordinator at the village level</li> <li>• Maintenance of records and books of accounts.</li> <li>• Monitoring of work order by Village Monitoring Committee.</li> <li>• Inspection of work by Gram Sevak and Engineers</li> </ul>	Formal
	<ul style="list-style-type: none"> <li>• Raising and discussing issues at the Village Council</li> </ul>	Informal
<b>Grievance Redressal</b>		
<i>Block</i>	<ul style="list-style-type: none"> <li>• Grievances submitted to the Block Officer</li> <li>• Citizen informed about GRM via awareness activities</li> </ul>	Formal
<i>Village</i>	<ul style="list-style-type: none"> <li>• Grievances submitted to the Program Officer</li> <li>• Reporting issues verbally to the Block officer</li> </ul>	Formal
	<ul style="list-style-type: none"> <li>• Grievances discussed with the village headman</li> </ul>	Informal

## Health: NRHM

### *The Service Delivery Chain*

**A number of formal and informal NRHM implementation mechanisms appear to be working.** At the Block level there are the Community Health Centres (CHCs) and the Public Health Centres (PHCs); at the Cluster level are the sub-centres; and, at the Village level, there are the Accredited Social Health Activists (ASHAs) – village level trained health outreach workers – and the Anganwadis (Figure 3). In terms of planning, two main bodies operate at the Block and Village level. At the Block level, there is the *Rogi Kalyan Samiti* (Hospital Management Committee (HMC)), which is responsible for the maintenance and quality of health service facilitation. At the village level, the Village Health and Sanitation Committees (VHSC) undertakes the planning and monitoring of health care activities. Traditional institutions are also included in the planning and delivery arrangements; namely by appointing the village headman as the VHSC chair-person. Also, the HMCs included the involvement of diverse stakeholders from ‘modern’ state structures and ‘traditional’ tribal structures.

**Figure 3. Modern Implementation Arrangements for MNREGA and NRHM**



### *Governance Mechanisms Built in to NRHM*

**A range of formal mechanisms for governance and accountability in health service delivery are in place on the ground.** As with MNREGA, formal provisions (based on ‘good governance’ principles) have been built into the NRHM. With regards to transparency, a number of mechanisms were cited by respondents, including: regular ‘village health days’ involving IEC; information provision via posters, pamphlets and door-to-door visits; and making NRHM records available to villagers for scrutiny.<sup>19</sup> In terms of oversight and accountability, a number of measures have been implemented. This includes the establishment of records, which are reviewed by PHC doctors during field checks and presented to citizens during meetings organized by the VHSC. Additionally, citizen charters – outlining service delivery standards and commitments – have been adopted in the sample area. For example, one of the PHCs visited during field research displayed a citizen charter. In addition, a number of social audits and public hearings – *Jan Samwad* – have been conducted and led by an NGO called ‘Grassroot’ (based in Shillong, the State capital); a point returned to below.

**Informal transparency and accountability mechanisms also seemed to play a role.** Frequently cited mechanisms for informing citizens about NRHM services were the traditional village announcements and community meetings. Further, the village council also seemed to monitor the overall functioning of the VHSCs (even if this is not mandated by the scheme; a point returned to below).

## 2.3. Who Really Matters for Service Delivery? Modern vs. Traditional Sites of Authority and Legitimacy

The above findings point to the parallel functioning of modern and traditional institutions, but this tells us very little about the way such institutions interact or are used, and how effective they are in shaping service delivery. The following sections, where the data permits, explores a number of these aspects. Specifically, this sub-section turns to questions of how important, effective and legitimate the various delivery actors and governance mechanisms are perceived to be. It explores the perceptions of both modern and traditional sites of authority. The discussion is organized by three key themes: (i) the perceived importance of service delivery actors; (ii) the perceived performance of such actors; and, (iii) the blurred boundaries between different forms of delivery.

### Who is perceived to be ‘important’?

The micro-survey and qualitative methods probed citizens’ perceptions of the importance of various delivery actors, and various key inferences could be drawn. This is also a useful proxy for understanding local notions of who is considered to be the most legitimate service providers. Table 5 summarizes some of the main findings. Two key findings are summarized here:

- Both modern, governmental bodies and traditional, tribal bodies were locally regarded as important. For example, the front-runners were the village council (97%), the Members of the Legislative Assembly (MLAs) (72%), who are elected representatives, and the state-formed VEC (71%). The qualitative data also points to the fact that the BEC and the VEC are viewed, by many, as important: the BEC is headed by the Block Development Officer (BDO), a government employee; and, the VEC is headed by the village headman and composed of members selected by traditional, village mechanisms. Moreover, the results also show the perceived performance of both bureaucratic functionaries – such as the BDO (58%) – and elected representatives, such as the MLA (72%) and the Member of the District Council (MDC) (62%).
- Ultimately, the traditional body – the village council – emerged as the most important. It was rated by 97% of respondents, as the most important body. KIIs substantiated this finding, with the village council being referred to as the most important vehicle for local welfare. Field data also showed that VECs play an important role in delivering services at the local level. However, the probing of interviewees quickly showed that they saw the village headman, and VEC, as largely synonymous. By a similar token, the data shows that citizens perceive the village headman to be the actor that is most ‘*responsible*’ for addressing their service delivery needs and concerns, underlining the nature of the local social contract (see the following sub-section).

**Table 5. Rating NREGA Service Delivery Bodies and Actors by Importance and Performance**

Actors/Body (in descending order of importance)	% of respondents rating the actors/body as important	% of respondents rating the performance of actors/body as good, average, and bad (out of those who rated the institution as important)			
		Good	Average	Bad	No Response
Village Council	97%	55%	40%	-	1%
MLA	72%	3%	40%	14%	14%
VEC	71%	25%	40%	1%	4%
MDC	62%	2%	41%	5%	12%
BDO	58%	16%	34%	1%	6%
Gram Sewak <sup>20</sup>	51%	13%	30%	2%	6%
AEC	17%	4%	11%	1%	1%

### How is their performance perceived?

**Respondents were also asked to rate these key actors based on their performance.** The following inferences can be drawn from the survey and qualitative data:

- *The village council was rated as good by the highest percentage of respondents.* In effect, the village council clearly emerged as the most important and best performing service delivery actor according to interviewees. Interviewees said this was because of the village councils' role in improving village welfare and in assisting villagers to access various schemes. This suggests that the legitimacy of the council is based, at least in part, on its ability to serve local interests. It is interesting to note, however, that the *village council* has no formally mandated role in the delivery of services under MNREGA or NRHM (we return to this point in the conclusion).
- *With the exception of village councils, most respondents perceived the performance of delivery agents as 'average' or 'bad'.* This hints towards a relatively widespread perception that service delivery actors are not meeting citizens' expectations. For example, in terms of the NRHM, interviewees pointed to a range of service delivery problems such as a lack of local funds, delays in disbursement, shortage of drugs and essential medical equipment, the over-working of community-level health workers, or poor health infrastructure. These issues and perceptions, and their underlying drivers, need to be assessed in further depth.
- *The most striking disconnect between perceived importance and performance related to the formally elected representatives – that is, the Members of Legislative Assembly (MLAs) and Members of the District Council (MDCs).* MLAs were rated by 72% of the respondents as important, but only 3% of those considered MLAs to be a good performer; the MDC was rated by 62% of respondents as important, but only 2% considered it a good performer. The KII and FGDs gave some cues as to why this is the case: they suggested that both had failed to deliver on their promises, that there is limited involvement of such actors in delivery and that they preferred to not take their grievances to local MLAs and MDCs.<sup>21</sup> More broadly, this suggests that there is a negative perception of formal/vertical accountability mechanisms (via the electoral channel) and reinforces the notion that traditional bodies and informal processes are considered to be better performers than those associated with the modern and formalized systems. This is certainly worth exploring further in future research.

#### Box 1. Window on Actual Delivery Performance: A PHC Doctor's Perspective

A PHC doctor explained that there are not adequate efforts to understand the actual needs of the community in health service provision. He drew attention to the role of traditional birth attendants – also known as *Ayas* – who helped women go through safe deliveries in the absence of availability of timely medical services and care. Earlier, *Ayas* were trained by the state to conduct deliveries. However, it was decided later that only ANMs (Auxiliary Nurse Midwife) will be authorised to conduct deliveries. According to the doctor, ANMs are overburdened and find it difficult to visit all villages especially those located in hard to reach areas. As a result, women, especially those inhabiting remote villages, are forced to opt for unsafe home deliveries in absence of medical care and trained attendants.

**...but the boundaries appeared to be blurred**

**While our findings underline the perceptions that ‘traditional’ institutions are higher performers and of higher importance, the data also suggest that the lines between the formal and informal are – in practice – somewhat blurred.** For example, a number of citizens do not strictly differentiate between the functions of the village headman/council and the state-created VEC. In various instances, the functions of the VEC and the VHSC were described as the function of the village headman. They also used the term VEC interchangeably with the village headman. For instance, 80% of respondents identified the village headman as their primary source of information (even if that information often flowed via the VEC). At the same time, only 8% of the respondents claimed that they relied on the VEC for information. This suggests, as found in other studies (Cleaver, 2012), that the distinctions between modern and traditional can become quite blurred in practice. We return to this point later.

## 2.4. Oversight and Accountability

**Rich findings emerged on the way in which oversight and accountability work, in practice, at the local level.** There were two main overlapping aspects to this: (i) transparency and information access; and, (ii) answerability and grievance redress. The points are now briefly summarized.

### Transparency and Access to Information

#### *Awareness of Service Entitlements*

**In terms of citizens’ level of awareness of relevant service delivery information, the primary data paints a mixed picture.** On the one hand, overall awareness of the programs and their main entitlements appeared to be relatively high. Awareness of MNREGA was high (almost all people were aware of the scheme). Also, 55% of respondents were aware of NRHM and a number of its services, with 83% of respondents aware of its ‘universal immunization’ drive. On the other hand, in terms of specific services and provisions, awareness levels were more varied. For example, for MNREGA only 3% (4 out of 135) of the respondents were aware of the unemployment allowance entitlement under NREGA. Similarly, only 21% and 23% respectively were aware of NRHM’s ‘clinic day’ and ‘village health and nutrition day’.

**Another example of major gaps in awareness related to the health insurance provision under NRHM.** During FGDs, citizens repeatedly emphasized that it was difficult to access details about the state government’s health insurance scheme and were of the view that the BDO does not know much about the subject, and the insurance company does not disclose information easily. Other interviewees corroborated that the state’s insurance outreach strategy had limitations: a doctor at a PHC stated that the block office organised registration camps for the insurance scheme but did not make sufficient efforts to inform all villagers. KIIs and FGDs suggested that a lack of proper information is one of the reasons why scheme enrolment is low. Indeed, our micro-survey showed that more than 50% of respondents are not enrolled on the scheme and of the 58 (out of 135) respondents enrolled, only 10% claimed they had received benefits.<sup>22</sup>

**Although gaps in awareness were identified, the present study did not attempt to assess, in detail, why this was the case.** Nonetheless, some useful inferences could be drawn: (i) the high levels of awareness of the overall programs suggest that outreach mechanisms on core services are relatively strong in our sample area; and, (ii) the lack of awareness on specific provisions, within the programs, indicates failings in the outreach mechanisms.

#### *Information Sources and Preferences*

**Another aspect of the analysis attempted to understand how, in practice, citizens prefer to access information on service delivery.** Overall, in spite of the fact that modern channels for information are functioning to different degrees (as above), citizens preferred ‘traditional’ sources of information and interaction. The data demonstrates that village headmen and village councils are the primary and preferred sources of information for villagers. For example, under MNREGA, approximately 80% of

respondents identified their primary source of information as the village headman, whereas 1.5% of the respondents (2 out of 135) reportedly accessed service delivery information from mass media sources. In NRHM, 66% of the surveyed respondents accessed information about NRHM via ASHAs, followed by the village headman and the council.

**Face-to-face modes of communication were also repeatedly referred to as the preferred ways of accessing information.** For example, face-to-face visits to PHC doctors or ASHAs were cited as the preferred means to access information. Similarly, village level meetings, which have high attendance levels, were cited as one of the popular ways of outreach<sup>23</sup>

**Box 2. Window: A Village Headman's Perspective on Information**

I received training on government schemes at the Block Office. I receive information related to schemes, work order and so on from the Block office through phone calls, SMS, and letters. I approach the Block Office for seeking information/clarifications as and when necessary. Information is then disseminated to the people at the village council meeting. The village announcer makes the announcement for the meeting in the village. At the village council meeting, which is attended by both men and women, information is shared among the members, discussions take place and decisions are taken. No notice board is put up on government schemes or entitlements. Office bearers provide information to citizens on request. However, after completion of the planned work, information related to budget, expenditure and so on are displayed in the village.

Betsing Rynjah's Account (Village Headman)

## **Answerability, Redressal, and Enforcement: Hybrids or Misfits between Design and Reality?**

**The findings also pointed to a range of issues on answerability, redress and enforcement.** The findings suggest a degree of overlap, even cooperation, between formalized and 'modern' governmental systems and traditional and informal societal institutions of oversight. This problematizes simple dichotomies of formal/modern vs. informal/traditional, as the conclusions discuss. However, our findings still suggest that, ultimately, informal and traditional mechanisms for oversight and accountability are the preferred mechanisms for accessing services and resolving grievances. These points are briefly outlined.

### *Towards 'Hybrid' Forms of Accountability*

**The findings suggest that formal and informal accountability are intermingled, to some degree, which verges on so-called 'hybrids'.** Notably, the study revealed that the performance of village level functionaries was monitored by formal mechanisms – such as periodic site visits from the BDO or modern audits – alongside traditional rules of compliance rooted in tribal customs. For instance, under NRHM, if citizens found any problem in the working of the village health workers (ASHAs or ANMs), complaints were sometimes channeled via the modern formal system *and* via the village council. Moreover, the VHSC – with upward accountability responsibilities to higher tiers of state government – is also downwardly accountable to the village council insofar as VHSC members are locally required to present details of activities undertaken and funds utilized via public village meetings (*jingialangpaibah*), on a regular basis.

**The field data also suggested that local service delivery functionaries were perceived to have two overlapping identities.** They were referred to as formal functionaries of the state, owing allegiance to the bureaucratic accountability mechanisms, *and* tribal village community members, owing allegiance to the tribal village council.

### *Traditional Oversight Preferred Over Modern*

**Although some 'hybridity' appears to be evidence, the data suggests that citizens have a significant preference for traditional mechanisms of oversight.** Specifically, the data suggests two

main findings: (i) formal, modern mechanisms of oversight are poorly utilized; and, (ii) traditional mechanisms are more frequently utilized and preferred.

**There is some uptake of the new, modern approaches to oversight.** Two thirds of the respondents stated that social audits were conducted in their village. 49% of respondents stated that they participated in a social audit and 63% stated that they were aware of the Muster Roll (the document for recording allocations and entitlements) (Table 6). 25% of citizens participated in public hearings (*Jan Sumvad*) formally introduced under NRHM wherein PHC doctors and the BDO interface directly with citizens to hear their grievances.<sup>24</sup>

**However, overall, the formal mechanisms are under-utilized or not utilized for the intended purposes.** Take the social audits as one example. 49% (66/135) of the respondents participated in social audits. Out of the 66 respondents who participated, 50% did so out of a sense of duty and the other 50% considered it as a socially acceptable thing to do: this implies a weak understanding of the scope and purpose of the auditing process, which is designed to verify information and heighten the accountability of service providers. Indeed, the village headman from Mawstep suggested that it is challenging to ensure the participation of villagers in such forums and to ensure the intended type of participation. Other KIIs and FGDs also suggested that the audits are, largely, not being used as intended mechanisms for identifying discrepancies and activating remedial actions.

**A similar story emerged with regards to public hearings.** Participation in public hearings under NRHM was found to be low (25%), with only 12% of those lodging a grievance reporting it being resolved via the public hearing mechanism (Table 7). The NGO ‘Grassroot’ – involved in organizing such hearings at the PHC level since 2011 – reported that it has been challenging to engage citizens in this because it is a ‘new’ initiative and that villagers are yet to engage in this formal mechanism to hold service providers accountable.

**Table 6. Formal Social Audits under MNREGA**

Question	Answer	% of respondents
Was social audit was conducted in the village?	Yes	65% (89/135)
Did you participate in the social audit?	Yes	49% (66/135)
Why did you participate in the social audit?	Duty to participate in social audit	33/66
	Participated because everyone participated	32/66
	Participated to register grievance	6/66
What activities were undertaken in the audit?	Raise issues relating to wages & work	32/66
	Paper work	3/66
	No response	23/66
Are you aware of the Muster Roll?	Yes	63%
Are details entered daily in the Muster Roll?	Yes	46%

**Table 7. Formal Public Hearings (Jan Samvad) under NRHM**

Question	Answer	% of respondents
Do you participate in the Jan Samvad?	Yes	25% (34/135)
	No	72% (97/135)
	No response	3% (4/135)
Were your grievances resolved via the Jan Samvad?	Yes	12% (4/34)
	No	26% (9/34)
	No response	62% (21/34)

**Other formal channels for grievance redressal – filing and registering complaints – are also under-utilized.** In Meghalaya, a person has a number of formal channels for raising complaints: for

instance, under MNREGA a person can submit a written complaint to the Programme Officer or the District Coordinator, submit a grievance in a complaint box, or raise grievances at public VEC forums or the social audit forum. While these formal channels of redress exist ‘on paper’ and function (to a degree), the data suggests that people do not use them. For instance, 84% of respondents noted that they do not complain to higher-level government authorities (Table 8). Similarly, an example of PHC complaints boxes is also indicative. Only 8% of respondents were aware of the complaint boxes, and only 9% of those who were aware actually used them; in other words only 1 of the 135 respondents (0.7%) had actually used the complaint box (Table 9). Indeed, one KII – a PHC doctor – drew attention to a complaint box kept at the centre and noted that the PHC had never received a complaint via this mechanism.

**Table 8. Citizens use of formal complaint mechanisms**

Question	Answer	% of respondents
<i>Do you complain to higher level/government authorities?</i>	Yes	13% (18/135)
	No	84% (113/135)
	No response	3% (4/135)

**Table 9. Use of PHC Complaint Box**

Question	Answer	% of respondents
<i>Awareness of complaint box</i>	Yes	8% (11/135)
	No	77% (104/135)
	No response	15% (20/135)
<i>Citizens that have used it (those citizens who are aware of it)</i>	Yes	9% (1/11)
	No	91% (10/11)

**Instead, the findings overwhelmingly suggest that citizens prefer to use informal oversight and accountability mechanisms.** In spite of there being a larger number of ‘state-led’ mechanisms for oversight compared to traditional mechanisms (see Section 2.2 and the Annex), people still prefer to rely on informal mechanisms. Citizens most often raise service delivery issues through the traditional channels of the village headman and village council. More often than not, matters of non-compliance are taken up at village level public meetings and resolved by community members collectively and consensually. For example, in the KIIs and FGDs, it was noted that if citizens find any problem in the working of the village health workers, they complain to the village council and the council often convenes a meeting to address the complaint. In case an incumbent is found guilty, he or she is removed from office and the villagers collectively select a new member from the village in his/her place.<sup>25</sup> Furthermore, our data suggests that villagers are discouraged from filing formal complaints without the prior approval of the village council. Similarly, in FGDs villagers noted that they communicate with higher authorities, such as the BDO *via* the village headman or VEC secretary: the villagers expect the headman to approach the BDO for clarifications or reporting of grievances.

**In sum, formal oversight mechanisms are not preferred, are under-utilized or wrongly utilized.** This suggests a certain level of disinterest and disengagement of the local citizenry towards the modern and formal governance and delivery arrangements. This also suggests that formal oversight mechanisms can only partially explain delivery processes and outcomes in the sample areas.

### What Explains this Misfit Between ‘Formal’ Design and ‘Informal’ Practice?

**So what explains this divergence – or ‘misfit’ – between modern oversight design and actual implementation?** Given time and resource constraints, we were unable to explore these questions in depth. However, the primary data does give some hypotheses and questions for further research.

*Traditional Actors are seen to be Accountable?*

**One reason may be because people perceive the village headman and village council (as opposed to the ‘state’) as being accountable for delivery.** In this case, though MNREGA and NRHM are

state-provisioned services, our data suggests that people expect the village headman to be responsible for delivering their services and addressing their concerns. Most villagers held the view that, as a member of all committees at the village level, the village headman plays the most important role in addressing village matters. In case the village headman is unable to resolve their concerns; they turn to the village council. Indeed, modern notions of accountability do not necessarily reflect localized and traditional notions of public responsibility.

#### *Informal, Traditional Mechanisms are seen to ‘Work’?*

**Another possible explanation is that informal mechanisms are preferred because they are (at least perceived to be) more effective.** While certain explanations may focus on deep-rooted cultural and social norms (see below), a more straightforward answer could be that people are more inclined to use the informal mechanisms because they perceive them to actually work in serving their own and the village’s interests. For example, some villagers stated that traditional authorities were accessible and available at all time. The Village headmen of Laisohpliah and Mawstep were of the view that villagers do not have major complaints regarding service delivery because all decisions related to welfare schemes at the village level are taken collectively at the village council meetings: in case members do not abide by the decisions of the council they are fined (women are charged INRs. 100 and men are charged INRs 200). The field interviewees cite various examples of how ‘functionaries’ have been scrutinized, reprimanded and or sanctioned via the village council.

#### *There is a Different Culture of Accountability?*

**Another possible explanation resides in the different ‘culture’ of accountability in operation on the ground.** Local norms, values and other cultural factors appeared to partly explain low levels of uptake of formal mechanisms. First, the field findings suggest that the type of behaviours required by formal modern mechanisms – such as speaking up in public meetings, filing ‘official’ complaints to make governance ‘answerable’ – are not widespread and are relatively ‘new’ to the tribal population. People instead noted that the local people are less outspoken, and may not speak out due to shyness, lack of confidence or illiteracy.<sup>26</sup> Second, the formal delivery mechanisms may not reflect the dominant values and norms of governance present at the local level. Traditional norms can take precedence over modern ones. Often, these norms revolve around patriarchal and familial authority – centred on the village headman – whose legitimacy is drawn from traditional customs. Meghalaya’s Khasi people also hold beliefs in consensual decision making and in notions of the common good and fairness (e.g. Joshi, 2004), which helps explain the continued relevance of the village council.<sup>27</sup> In short, these traditional norms do not easily align with the ‘good governance’ notions of accountability, which focus on: individuals regularly scrutinizing power-holders’ decisions; ensuring power-holders are answerable to their constituents and take ‘rational’ decisions; and, regularly checking power-holders’ behavior. That said, the findings are in some way ambiguous: modern forms of governance appear to have some traction at the local level and can even intermingle with traditional practices (a point returned to in the conclusion).

#### **Box 3. Window on Local Governance: Different Culture of Accountability**

Issues raised by citizens are mainly about access to services. They do not raise questions related to accountability and transparency. They are yet to develop that level of confidence. Also, culturally people have a tendency not to speak up in public platforms. Officials and citizens are at times also related to one another or are familiar with each other. Citizens also don’t question because of the personal relationship they share with the officials. But those citizens who are educated are more likely to question.

Source: NGO, Grassroot

## **2.5. Grassroots Inclusion/Exclusion and Gender: Marrying ‘Old’ and ‘New’?**

**A final main finding related to issues of inclusion and how they impacted on the governance of service delivery and its outcomes.** The evidence on this area was particularly thin and focused mainly

on inclusion of women in decision-making processes. Specifically, the main findings relate to two areas: (i) how modern notions of ‘gender equal’ participation have been taken up at the local level; and, (ii) how notions of ‘gender equal’ access to services have been taken up at the local level. Each aspect is briefly described in turn.

### **Modern vs. Traditional Notions of Equal Participation?**

**Both the social safety net delivery and health delivery programs envisage the inclusion of women (and other groups) based on modern, liberal notions of equality.** MNREGA mandates representation of women in the VEC and AEC. Similarly, NRHM promotes greater ‘inclusiveness’ as per two key operational guidelines: (i) at least 50% of VHSC members should be women; and, (ii) every hamlet within a revenue village should be represented on the VHSC to ensure that the needs of the weaker sections of the society (notably Scheduled Castes or Scheduled Tribes) are included.

**The findings suggest that these ‘modern’ provisions are operational on the ground and that they have led to increased participation of women in delivery decision-making.** The collected data suggests that women are actively involved in the functioning of the village-level bodies set up under MNREGA and NRHM. For instance, interviews with both male and female VEC functionaries suggested that women are proactively involved in the VEC. They recounted that, as VEC members, women are involved in taking decisions, providing suggestions, and supervising and monitoring the implementation of MNREGA.<sup>28</sup> A range of interviews also suggested that women actively participated in the functioning of the VHSC. Participation of women in the VHSC is perceived to be higher as compared to men; in Mawstep village, for instance, 12 out of 13 members of the VHSC are women. The VHSC was found to be operational in fulfilling various functions, such as developing health plans that were deliberated at village meetings, monitoring delivery and taking part in cleanliness and sanitation drives at the village level.

**More broadly, survey data points to inclusiveness in decision making.** In MNREGA, 92% of the respondents claimed that the type of work to be undertaken is collectively decided; almost 86% were involved in this collective decision-making process; and, 93% of the villagers surveyed stated that work undertaken benefited the village as a whole. Out of those respondents who were involved in the collective decision-making process, 65% were women. These findings on women’s involvement stand in contrast to women’s position vis-à-vis the village council: women’s membership in and involvement in the decision-making processes of the village council continues to be prohibited according to tradition. As noted below, this presents an interesting research puzzle.

### **Modern vs. Traditional Notions of Equal Access?**

**The schemes also formally envision gender-equal access to services, but it appears that traditional norms superseded such provisions.** While it was not possible to explore this issue in depth, the data pointed towards the continued prevalence and legitimacy of more traditional gender norms. Take, for example, the ‘equal pay’ provision under the MNREGA. While the Act mandates equal pay, we found that men and women do not receive equal wages. Men tend to receive INRs.300 while women receive around INRs.150. More broadly, villagers claimed that different wage rates for men and women are not just fixed for MNREGA works but other schemes as well.

**These differences in service access, interviewees recounted, were rooted in local decision-making processes and accepted social norms.** Many KIIs and FGDs argued that these decisions were made via the village council, and received broad assent in the village. Interviewed women appeared to support this, giving a variety of reasons. For example, a VEC female functionary at Mawstep village stated that women do not feel discriminated against when they are paid lesser wages because men undertake tasks that are more intensive. Similarly, in Liasohpliah, a village member stated that women take more time to complete work as compared to men. Another woman argued that such an arrangement accommodated their requirement to work for fewer hours in order to fulfil their additional household responsibilities. In sum, all respondents (male and female) argued that a woman earning lower wages as compared to men was acceptable.

**The findings, however, also generate questions for future research.** For example, given the continued prominence of the headman, how has women's participation in the VEC re-shaped local governance and the social contract in service delivery (if at all)? Also, given that the VEC and VHSC are closely linked to, and overseen by, the male-dominated village council (as noted above), has this created challenges for women's empowerment via the VEC and VHSC?

### **3. Conclusions and Implications**

#### **3.1. Summary of the Main Findings**

##### *Citizens' Experience of Service Access*

**The data suggests that overall access to services is relatively good.** In terms of social safety net delivery, the vast majority of respondents had received work under the scheme and referred to a number of its benefits. In terms of NRHM, a similar picture emerged, with the vast majority of respondents having access to a health sub-centre.

**However, access to specific entitlements within the programs was less strong and painted a more mixed picture.** For example, in MNREGA a small percentage of respondents had been issued a job card within 15 days (16%) or only 32% of respondents stated they had received a total of 100 days of work. In NRHM, only 28% had access to a PHC, 47% of respondents had 'rare' access to a trained community health worker and access to health insurance is very low.

##### *Modern and Traditional Institutions Co-Produce Delivery on the Ground*

**The findings suggest that both modern and traditional structures of governance and delivery are, to some degree, operational on the ground.** This has two main aspects:

- *First, in terms of the service delivery chain, both modern and traditional actors play a role.* In MNREGA, the modern implementation structure is operational via a four-tier arrangement at the main administrative levels in the state. At the same time, traditional institutions have a central place in delivery as the 'village headman' plays a central role, who in turn is accountable to the traditional village council. In NRHM, the main state-formed bodies are operational and the village headman plays an important role, mainly via his position heading up the VHSC.
- *Second, both formal administrative processes and informal customary processes are also operational in governing service delivery.* In MNREGA, a number of mechanisms to facilitate 'good' governance and accountability, such as pro-active disclosure and formal grievance redressal mechanisms (like complaints handling and auditing) were found to be functioning at the local level. Similarly, in NRHM such mechanisms were operational. At the same time, respondents made frequent references to the prevalence of informal mechanisms of governance and redress, namely via the village headman and village council.

##### *Who Really Matters for Delivery? Modern vs. Traditional Sites of Authority*

**The report reveals some interesting findings in terms of how important, effective and legitimate the various actors in the service delivery chain are perceived to be:**

- *In terms of 'importance', two main findings emerge.* First, both modern governmental bodies and traditional bodies were locally regarded as important for service delivery. Second, the traditional body, the village council, emerged as the most important body – 97% of micro-survey respondents said that the village council is important, and interviewees strongly substantiated this.
- *In terms of 'performance', three main findings emerged.* First, the village council was rated, by a long way, to be the most important and highest performing body within the local service delivery chain. Second, with the exception of the village council, citizens' overall perception of service delivery actors was relatively negative. Most citizens implied that service providers were performing relatively badly. Finally, the most striking disconnect between importance and performance related to elected representatives: Members of the Legislative Assembly (MLAs) were rated by 72% of the respondents as important for delivery, but only 3% of respondents considered them to be a good performer; the Members of the District Council were rated by 62% of respondents as important, while only 2% considered the performance to be good.

- Yet the boundaries between ‘traditional’ and ‘modern’ were somewhat blurred. For example, the data also indicated that a number of citizens do not strictly differentiate between the functions of the village headman/council and the state-created VEC.

### *Oversight and Accountability*

#### **In terms of access to information, two main points emerged:**

- First, in terms of citizens’ awareness of available services, a mixed picture emerged: overall awareness of the programs was relatively high but awareness levels were much lower in terms of specific program entitlements.
- Second, in spite of the fact that formal channels for information are functioning to different degrees, people largely preferred to get their information via informal sources of information and face-to-face interaction (namely via village headmen and councils).

#### **In terms of answerability and grievance redressal, there were also two main findings:**

- First, to some degree, formal and informal mechanisms for accountability intermingle, verging on ‘hybrids’. For example, the same village-level functionaries are monitored by formal, state mechanisms (such as audits and site visits) as well as by the traditional customs of the village councils. Indeed, such functionaries were perceived to have overlapping identities: as formal functionaries of the state, owing allegiance to the bureaucratic accountability mechanisms, and as tribal village community members, owing allegiance to the tribal village council.
- Second, while there is evidence of some hybridity, the bulk of the evidence suggests that: (i) formal mechanisms of oversight – such as filing grievances, social audits or interacting with the Block Development Office on delivery issues – are, on the whole, under-utilized; and, (ii) traditional and ‘unofficial’ mechanisms of oversight – raising issues with the village headman – are highly preferred.

### *Grassroots Inclusion/Exclusion Dynamics and Gender: Marrying the ‘Old’ and the ‘New’?*

#### **While the evidence is limited in this area, the findings point to different dynamics of the inclusion of women in governing service delivery:**

- First, provisions for gender equality in decision-making have led to increased participation of women, namely via the VEC and VHSC. This stands in sharp contrast to women’s position vis-à-vis the village council members: women’s membership in the village council remains restricted.
- Second, traditional notions of gender-differentiated pay, such as in MNREGA, still prevail and, according to the data collected, such notions are widely perceived to be acceptable.

## **3.2. Implications and Directions for Future Research**

**The report now concludes with a brief discussion of some of the implications of this study for thinking, policy and research.** While the report findings are tentative (as explained in the introduction), a number of preliminary ideas and implications can be identified. This final section is split into three parts: (i) part one extracts some of the broad implications for thinking about governance and service delivery in Meghalaya and relates this to broader global knowledge on these issues; (ii) part two identifies some *tentative* policy implications of the findings; and, (iii) part three outlines some potential issues and questions for future research.

### **(i) Implications for Thinking about Governance in Service Delivery in Meghalaya**

**The findings show just how important traditional and informal institutional arrangements are in shaping service delivery.** The findings, time and again, pointed to the fact that modern and formalized institutional arrangements, alone, cannot explain delivery processes and outcomes. This resonates with global findings in this field (Batley and McLoughlin, 2012; Bukenya and Yanguas, 2013).

**However, ‘modern’ and ‘traditional’ processes and bodies did not always operate in isolation: there were points of overlap and fusion pointing to ‘hybrid’ or ‘blurred’ arrangements.** Both formal and informal practices had some traction at the local level and appeared to simultaneously apply pressures on the same service delivery actor or process. Extensive research in Africa identifies these types of ‘hybrids’ (Booth, 2012); a point returned to below. Moreover, certain findings point to the ‘blurred’ nature of the formal/informal or public/private boundaries, as service users fail to distinguish between one and the other. This can actually lead to somewhat ambiguous understandings of who should do what, when and how and problematizes dichotomies between ‘formal/informal’, ‘public/private’ and ‘modern/traditional’. This suggests that we may need to go beyond these dichotomies as Kelsall et al (2005) put it: “the language of “traditional” institutions/authority is counterproductive...it elicits prejudices for or against the opposed concepts of “tradition” and “modernity.”<sup>29</sup>

**At the same time, the data suggests, on balance, that governance mechanisms associated with traditional, customary and informal practices are the dominant institutional logics shaping service delivery.** Overall, traditional arrangements were more frequently used, were perceived as more important to people and were perceived as higher performers compared to formal mechanisms. On the other hand, formal and ‘modern’ mechanisms were largely not preferred, are under-utilized or are not utilized for the intended purposes. Village councils were a key mechanism for service delivery planning and redress, even if they had no formally mandated role in the programs. This, as per findings from other states in India and internationally, underlines that customary institutions can make or break formal governance and delivery arrangements (Ananthpur and Moore, 2010; Mohmand, 2012).

**The data, as such, points to a ‘misfit’ between the ideas of governance embodied in the formal service delivery programs and the actual culture on the ground.** What explains this? Further research is required. However, this study points to a number of factors. First, citizens tended to view the village headman as accountable for service delivery, so they were much more inclined to turn to him when there were problems. Second, people tended to perceive traditional mechanisms (as opposed to government mechanisms) as more effective and accessible, thus explaining their preference to use them. Third, and more broadly, there appears to be a lack of fit between the norms, values and social contract prevalent in traditional arrangements in Meghalaya, and those underpinning the formal governance system. ‘Good governance’ notions of accountability focus on: individuals regularly scrutinizing power-holders’ decisions; ensuring power-holders are answerable to their constituents and take ‘rational’ decisions; or resolving complaints in a ‘written’ and ‘transparent’ manner. Local norms, instead, revolve around patriarchal, tribal and familial authority and legitimacy, centred on the village headman, and are rooted in ideas of consensual, collective decision-making. The types of behaviours required by formal mechanisms are not widespread and are relatively ‘new’ to the tribal population.

**Notably, this finding on a ‘misfit’ is not just peculiar to Meghalaya.** This evidence points to three key points: (i) one certainly should *not* assume that formal institutional arrangements correspond with informal institutions or explain outcomes (Moore and Unsworth, 2011); (ii) social norms underpinning a social contract can differ markedly within and across different contexts and these different norms ‘matter’ for explaining outcomes and policy responses (DFID 2015; Woolcock, 2014); and, (iii) people’s values and perceptions – embedded in local social networks and shared mental models – matter for the types of actions they are willing to take (WDR, 2015). The conclusions from study in Tanzania (Box 1) exemplify these points quite well.

**Box 4. Lack of fit between ‘good governance’ paradigm and institutions on the ground**

In concluding their analysis of governance and accountability in Tanzania, Kelsall et al (2005) find that the findings on the ground do not correspond with received notions of ‘good governance’ and ‘formal’ accountability. They sum up their findings thus: “[we originally] argued that all effective accountability mechanisms operate ‘according to a logic based around three criteria’: Transparency: Answerability and Controllability. The findings of the ethnographic data sit uneasily with this schema for understanding accountability. If people draw their ideas of accountability from different traditions, the ‘mandate’ given to leaders, and the type of transparency required to achieve it, can be unclear. Local people had an idea of transparency, for instance, but it was an imprecise combination of ideas of ‘financial transparency’ with ideas of ‘visibility’ or ‘tangibility’. Second, a leader who draws legitimacy from a patriarchal tradition, a tradition

*which views the family as a template for government, need not necessarily justify his decisions on grounds of reasonableness or rationality. While not entirely absent from familial governance, reasonableness and rationality are not at its core. Talk of controllability, checks and balances, and enforcement mechanisms, seems slightly misplaced when there is so much overlap and sharing of personnel between institutions. Using the above concepts to capture the experience of accountability locally is like trying to nail jelly to the wall; the concepts pin down the reality with great difficulty. Reality at local level is a fluid field of interpenetrating institutions and actors, informed by co-mingling cultures of accountability which place rather loose, and not always consistent, restraints on the actions of leaders”.*

## (ii) Towards Policy and Practice Implications

*“In reality, it doesn’t matter how we think of informal institutions. Regardless of our opinion, they will continue to exist” (Mohmand, 2012).*

**Based on the findings, it is possible to identify some tentative policy implications and recommendations.** One should be clear from the outset that there are few ‘magic bullet’ solutions: given the limited scope of this research and the complexity of the governance landscape in Meghalaya, few clear-cut solutions are evident. Moreover, thinkers and practitioners are yet to come up with solid answers as to how to balance traditional and modern institutions, and respond effectively to deep-rooted local customs (Mohmand, 2012; Woolcock, 2014: 16-17).<sup>30</sup> Nonetheless, there are emerging and good practice ideas that could be piloted in the Meghalaya context, as briefly outlined here.

### *Address Identified Gaps in the Delivery of MNREGA and NRHM*

**The findings identified certain gaps or failings in service delivery, which could be reviewed and addressed.** These include the following:

- In MNREGA, the following issues could be addressed: (i) improve access to job cards within 15 days; (ii) improve the number of people accessing work within 15 days; (iii) taking measures to ensure that people work the full mandated 100 days; and, (iv) raising people’s awareness of key provisions within the scheme, such as awareness of the unemployment allowance.
- In NRHM, the following issues could be addressed: (i) making greater progress on infant and maternal health, such as through ensuring greater field staff and trained attendants for home deliveries; and, (ii) ensuring greater awareness of and access to sub-provisions under NRHM such as the health insurance, clinic day and village health and nutrition day.

### *Build Greater Trust in the Formal System*

Given the apparent lack of buy-in to formal mechanisms of delivery, the GoM may want to put in place further mechanisms for strengthening buy in. Some options for doing this:

- In the shorter term, some options: (i) GoM may want to demonstrate and popularize – through public outreach – the benefits and successes of the formal delivery mechanisms, to build greater trust in the system; and, (ii) GoM may want to actively raise people’s awareness of the benefits of engaging with formal oversight and accountability mechanisms.
- In the longer term, greater formal devolution of powers and resources to the level of the village could further strengthen the state’s objectives of implementing welfare and development activities without disrupting traditional customs (Rao et al, 2011). This would need to take into account key lessons from devolution experiments in India and internationally.

### *Improve Information Outreach and Two-Way Communication*

**Engagement with citizens could be strengthened in ways that respond to local cultures and information preferences.** This could integrate key lessons citizen engagement from international experience (Box 5). Some ideas in this regard:

- Strengthen grassroots information provision, especially where there is low awareness (as outlined above). This would need to leverage citizens’ preferred norms and channels for accessing information (such as via face-to-face meetings with the village headman, or during

the village council) and could integrate some of the international good practices in this domain (see Box 5).

- Strengthen mechanisms for communication, dialogue and collective problem-solving between state and traditional actors. This could involve organizing a series of multi-stakeholder meetings to discuss specific service delivery issues and develop action plans.
- Introduce mechanisms to more systematically collect citizens' expectation and satisfaction. There is a gap in knowledge in the state on how citizens really think and act on the ground. This could take different forms: (i) periodic perceptions/satisfaction surveys; (ii) localized citizen scorecards; or (iii) strengthening existing Management Information Systems to collect more regular citizen feedback.

#### **Box 5. Lessons on the Role of 'Information'**

A range of lessons has been learned in terms of the use and deployment of information for development progress. In brief, good practice lessons on information include the following:

- (1) information needs to be 'actionable', 'targeted' and 'relevant', i.e. triggering existing capacities, perceptions and interests of targeted actors. However, information, alone, may be necessary but it is rarely sufficient;
- (2) information needs to be 'user-centered' and 'user-friendly' and thus appropriately 'framed' i.e. providing information that is useful from the user perspective. As such, information provision would need to fully recognize 'informal' norms and beliefs, as it is unlikely that such beliefs can be bypassed or replaced.
- (3) information needs to be 'available' i.e. accessible via culturally and technologically appropriate and used channels;
- (4) information needs to be 'high quality' and 'trustworthy' i.e. containing factually correct information so as not to further confuse or obfuscate;
- (5) information needs to be 'sandwiched' i.e. information gaps exist on both the state and society side; and,
- (6) information provision needs to be 'flexible' and 'adaptive' i.e. we still do not 'know' what forms of information will unlock behavior change so we need to experiment and adapt.

*Source: O'Meally et al, Forthcoming*

#### **Box 6. Lessons from Citizen Engagement Experience**

The evidence on citizen engagement points to a number of important lessons, with applicability to bridging the formal/informal or modern/traditional divide in Meghalaya. In brief, three lessons are highlighted here:

- The state needs to actually *respond* to citizen engagement to build trust. Incentives for citizens to act increase when they believe the state will actually respond to citizens' voices. If citizens receive no response, trust and engagement are likely to decline, and participation may not be sustained.
- Local voices that question powerful state/traditional authorities may be ignored. Citizen action that has the backing of government allies who are both willing and able to get involved, has a greater chance of addressing impunity.
- Mechanisms and pro-active measures are needed to actively encourage the voice and representation of those citizens who normally would be excluded because of gender, ethnic, or class bias.

*Sources: Fox, 2014; Bixi et al, 2015; O'Meally et al, Forthcoming*

#### *Find Ways to Foster 'Practical Hybrids'*

**The findings suggest that we need to look for opportunities to build 'practical hybrids' via 'institutional bricolage'.** Two approaches have been developed internationally – 'practical hybrids' and 'institutional bricolage' – which offer cues for bridging some of the divide between traditional and modern practices.<sup>31</sup> Some examples are provided in Box 7 and they are briefly defined here:

- Booth (2012) identified a range of '*practical hybrids*' in Africa. He defines them as institutional arrangements that combine modern bureaucratic standards and approaches to development with locally-accepted cultures and practices. Specifically, '*practical hybrids*' are institutional arrangements that are: (i) 'locally anchored' insofar as they are locally-driven initiatives that make use of local resources and derive their legitimacy from 'local cultural repertoires' and 'local views on what is important and how to get things done' (Booth, 2012:19); and, (ii) 'problem solving' insofar as the arrangements respond to solving 'problems' that are perceived to be locally important, build on what already exists and facilitate collective action to address such problems.
- Cleaver (2012), related to this, finds multiple cases of '*institutional bricolage*'. She argues that attempts to graft formal 'good practice' models onto different contexts rarely work. In reality,

what tends to happen, and work, is incremental bricolage where ‘people consciously and unconsciously draw on existing social and cultural arrangements to shape institutions in response to changing situations’ (Cleaver, 2009). Institutions are formed through the uneven ‘patching together’ of old practices and norms with new arrangements. In practice, this requires: the constant renegotiation of norms; the reinvention of tradition; the identification of legitimate forms of authority; the facilitation of cross-cultural borrowing and multi-purpose institutions; and, the fostering of mutual cooperation and respect (Cleaver, 2012).<sup>32</sup>

**Box 7. Brief Examples of Practical Hybrids and Institutional Bricolage**

- In Nagaland (India), a study of co-productive relationships between the state and traditional authorities in the provision of public goods and services found arrangements worked because they combined strong state-level backing and an enabling legal framework with local customs of consensus-building around collective problems.
- In Karnataka (India), Customary Village Councils (CVCs) influence the functioning of the Gram panchayat (GP) – local government bodies – in many ways: they have a say in the choice of candidates for GP; they influence the developmental projects/programs run by the GP, and they influence the way the GP functions.
- In the Western Balkans, a municipal official explained: “If we could work more formally with these [traditional] institutions we could use them to negotiate with communities [such as on paying taxes], raise awareness on issues [such as health issues and environmental protection], facilitate the implementation of projects [such as waste management], and help the municipality manage inter-community relations”.
- In Malawi, local traditional bodies like the village council face challenges like they are prone to be captured by vested interests or local political power; however, abolishing such bodies can lead to weakening people’s participation and restricting their voice. Moreover, flows of funding to build local associations in such contexts have failed to build on local practices, resulting in increased competition for resources and ‘development rents’, corroding the willingness of public servants right down to the local level to do anything without inducements.
- In Uganda, a music band is being used to alert people of meetings and a puppet show is staged to communicate key messages. This is then worked into a formal meeting that local government officials attend to discuss citizen issues.
- In Nigeria, the use of forum theatre provided a unique opportunity for villagers to express their grievances about divisions arising from traditional community hierarchies and wealth inequality in the public sphere.
- In Niger, a number of mayors have begun collecting a few additional centimes from all users of primary healthcare facilities to fund the fuel and staff costs associated with emergency evacuations of pregnant women; these collections are outside the national regimes of user charges and free care, but it enables a solution to an otherwise difficult problem.
- Experience in some areas of rural China demonstrate that citizens rely on informal solidarity groups, such as temples or lineage groups, rather than formal frameworks in order to exact accountability from otherwise unwilling public officials, because such face-to-face solidarity groups often impose reputational costs on the officials.

*Sources: Batley and McLoughlin, 2012; Booth, 2012; Cleaver, 2012; Mohmand, 2012; O’Meally, 2013.*

**These approaches provide broad principles, but further work would be needed to put these principles into practical action in the context of Meghalaya.** Some suggested actions over the short-to-medium term could include:

- Build on what is already working on the ground. This may include: (i) further harnessing the power of the village council in service delivery programs by expanding the formal space for the village council in decision-making and collective action, and devolving greater resources for their control; or, (ii) identifying and strengthening hybrid mechanisms for accountability, such as integrating certain principles of the social audit into village council meetings.
- Build the capacity and effectiveness of ‘bridging’ institutions – such as MIG – to bring together the different stakeholders to build trust and to solve service delivery problems. This would involve key principles of adaptive management, such as:
  1. focusing on solving locally-nominated and defined problems (as opposed to transplanting preconceived ideas of how things should work);
  2. seeking to create an authorizing environment for decision-making that encourages experimentation (as opposed to designing projects and programs and then requiring agents

- to implement them exactly as designed); and,
3. actively engaging broad sets of agents to ensure that reforms are viable, legitimate, relevant, and supportable (as opposed to a narrow set of external experts promoting top-down diffusion of innovation) (Andrews et al, 2012).<sup>33</sup>
  - Create incentives for developing practical hybrids. This may involve: (i) allocating adequate funds for bearing transaction costs for enabling bottom-up local problem-solving, rather than funding inputs and outputs; and, (ii) use 'results-based' approaches to identify and incentivize results and learning but not determine the top-down solutions for getting there.

### (iii) Potential Avenues for Policy Research

**More comprehensive and comparative research would be welcomed to substantiate, scale up and flesh out the research findings presented here.** Box 8 gives a summary of some of the key research questions that have emerged. Also, some lessons on strengthening the study's pilot analytical framework are mentioned in the annex.

#### **Box 8. Policy Research Questions Emerging from this Study**

Overall, further research would be recommended. This could: (1) substantiate further if this report's findings are replicated across the state - the sample size could be expanded and random sampling methods could be used across the three regions of Meghalaya to increase the representativeness and generalizability of the findings; (2) more directly unpack the causal relationships between governance and service delivery outcomes; and, (3) probe more deeply – via more intensive ethnographic research – the drivers of people's perceptions and motivations. Additional (and by no means exhaustive) action-research questions could include:

- How do hybrid institutional arrangements work in practice and what lessons can be learnt for replicating them?
- What lessons can be learned from comparing and contrasting the governance of delivery in the different sectors in the state?<sup>34</sup>

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# Annexes

## Annex 1: Sample of Micro-Survey, KII Questionnaire and FGD Questionnaire

### Sample of the Micro-Survey Questionnaire

#### Mahatma Gandhi National Rural Employment Guarantee Act

[Investigator: Please remember that the questions below are addressed to an individual respondent. Make sure that the concerned person answers himself or herself (especially if the respondent is a woman). Before starting the interview, introduce yourself carefully and check that the respondent is willing to spare up to an hour or so for this discussion. If any question is not applicable, write "NA" in the relevant space]

Date: /\_\_\_\_\_ / District: /\_\_\_\_\_ /  
Block: /\_\_\_\_\_ / Village: /\_\_\_\_\_ /  
Investigator's name(s): /\_\_\_\_\_ /  
Name of the respondent: /\_\_\_\_\_ /

#### PART I GENERAL QUESTIONS

##### A. Respondent's Details

1.	Age (years)	/_____/
2.	Gender [ 1= Female; 2=Male]	/_____/
3.	Education Level: [1=illiterate; 2=Literate (below primary); 3= Primary (Class V complete); 4=Upper Primary (Class VIII complete); 5= Secondary (Class X complete); 6 = High School (Class XII complete); 7=Above High School]	/_____/
4.	Marital Status: [1=Married; 2=Widowed; 3=Separated; 4=Unmarried]	/_____/
5.	Category: [1=ST; 2=SC; 3=Other (Specify)]	/_____/
6.	Religion: [1=Indigenous; 2=Christian; 3=Hindu; 4=Muslim; 5=Others (specify)]	/_____/

##### B. Household Details

7.	Number of household members: <i>[Investigator: Fill all entries in this table and make Sure that the row total is the same as the column total.]</i>  <table><thead><tr><th></th><th>Female</th><th>Male</th><th>Total</th></tr></thead><tbody><tr><td>Children (below 18 years)</td><td>/_____/</td><td>/_____/</td><td>/_____/</td></tr><tr><td>Adults (aged 18-65 years)</td><td>/_____/</td><td>/_____/</td><td>/_____/</td></tr><tr><td>Aged persons (above 65 years)</td><td>/_____/</td><td>/_____/</td><td>/_____/</td></tr><tr><td>Total</td><td>/_____/</td><td>/_____/</td><td>/_____/</td></tr></tbody></table>		Female	Male	Total	Children (below 18 years)	/_____/	/_____/	/_____/	Adults (aged 18-65 years)	/_____/	/_____/	/_____/	Aged persons (above 65 years)	/_____/	/_____/	/_____/	Total	/_____/	/_____/	/_____/	
	Female	Male	Total																			
Children (below 18 years)	/_____/	/_____/	/_____/																			
Adults (aged 18-65 years)	/_____/	/_____/	/_____/																			
Aged persons (above 65 years)	/_____/	/_____/	/_____/																			
Total	/_____/	/_____/	/_____/																			
8.	Type of household [1 = Nuclear family; 2 = Nuclear family with dependent(s); 3 = Joint family; 4 = Other (specify)]	/_____/																				
9.	Monthly income Status (Mark ✓ wherever applicable) i. Rs 10,000- 20,000 ii. Rs 20,000-50,000 iii. Above 50,000 (Specify)	/_____/																				

10.	Does the household have a Ration Card? [1=Yes; 2=No]	/ ____ /
11.	Type of Ration Card (Investigators needs to check the Ration Card) [1= APL; 2 =BPL; 3 =Antyodaya; 4 = Annapoorna; 5 = Other (specify)]	/ ____ /
12.	Type of dwelling: (Investigators to observe the type of dwelling) [1 = Kachha; 2 = Semi-pukka; 3 = Pukka]	/ ____ /
13.	Electricity supply [1=Yes; 2=No]	/ ____ /
14.	Drinking water source [1=tapped water;2=well;3=pond;4=others(specify)]	/ ____ /
15.	Toilet facility [1=Yes; 2=No]	/ ____ /
16.	Main occupation(s) of the household: [Investigator: Enter two codes (one in each box) if necessary, starting with the main occupation.] [1 = Self-employment (agriculture); 2 = Self-employment (non-agriculture); 3 = Casual Labour; 4 = Regular Employment; 5 = Other (specify)]	/ ____ / / ____ /
17.	Whether the village is connected by an all weather road (tarred road) ? [1=Yes; 2=No]	/ ____ /

**PART II**  
**MNREGA QUESTIONS**

**C. List of key government and societal institutions according to the interviewee:**

Sl.N o	<b>Government Institutions</b>	1.Aware 2.unawa re	1. Important 2. Not so important 3. Unimportant	Rate the Performance level on a scale of 1 to 10.  1-3=Bad 4-6= Average 7- 10=Good	Give Reasons/ Remarks
A.	Block Development Officer/Program Officer				
B.	Gram Sevak				
C.	Area Employment Council(AEC)				
D.	Village Employment Council (VEC)				
E.	Public Health Centre( PHC)				
F.	Sub Centre				
G.	Village Health & Sanitation Committee(VHSC)				
H.	Accredited Social Health Activist(ASHA)				
I.	Government School				
J.	Member of Legislative Assembly (MLA)				

K.	Member of District Council(MDC)				
L.	Bank				
M	Police				

19.					
Sl. No.	Societal Institutions	1.Aware 2.Unaware	1. Important 2. Not so important 3. Unimportant	Rate the Performance level on a scale of 1 to 10.  1-3=Bad 4-6= Average 7-10=Good	Give Reasons/ Remarks
A.	Rangbah Shnong/ Secretary Shnong				
B.	Village Executive Committee				
C.	Women Organisation				
D.	Youth Organisation				
E.	Private School				
F.	Clan Organisation				
G.	Religious Organisation				
H.	Self Help Groups				

#### D. Information access

20.	Are you aware about MNREGA (100 Days Scheme)? [1=yes; 2=no; 3=others (specify)]	/_____/
21.	If yes, who provided you information about MNREGA? (Mark ✓ wherever applicable) ( Note that the interviewer should not read out the following points)  A. Village council B. Village Headman C. Villagers D. Block officer E. Gram Sevaks F. NGOs G. MDC H. MLA I. TV/Radio/Newspaper J. Campaign/street plays K. Posters at government office L. Others (Specify)	/_____/

#### E. Job Cards (Interviewer to see and take photo of the job card)

22.	Is your household registered under MNREGA? [1=Yes; 2=No; 3=Don't know]	/_____/
23.	Do you own a job card? [1=Yes; 2=No; 3=Don't know]	/_____/
24.	What information is provided in the Job Card?	/_____/
25.	Where is the job card kept? [1=at home; 2=village headman; 3=others (specify)]	/_____/

26.	If the job card is kept with others, why?	
27.	Did you pay any fees or charges to get a job card?  [1=Yes; 2=No; 9=Don't know]	/ _____ /
28.	If yes, how much did you pay?	/ _____ /
29.	After registration, in how much time were you issued a job card?	/ _____ /
30.	How many days of work did you receive under the scheme last year?  <i>[Investigator: After careful discussion with the respondent, and examination of the Job Card(s), write below your best estimate of the number of days of NREGA work done during the last 12 months by all household members together. You can enter a range (e.g. 60-80 days)]</i>	/ _____ /  / _____ /

#### F. Application for work

31.	How do you receive work under MNREGA? (Mark ✓ wherever applicable)  A. Submit a written application to the VEC B. Personally request the village headman to provide work C. Pay money or fees D. Approach middlemen E. Approach MLA/MDC F. Other (Specify)	/ _____ /
32.	If you submitted a written application, did you get a dated receipt for the application? [1=yes; 2=no; 3=others (specify)]	/ _____ /
33.	After applying for work, in how many days did you actually receive work?	/ _____ /

#### G. Access to work and wages

34.	Who do you think is responsible for providing you work?	/ _____ /
35.	Have you received work under MNREGA? [1=yes; 2=no; 3=others (specify)]	/ _____ /
36.	If no, are you aware about the unemployment allowance? [1=yes; 2=no; 3=others (specify)]	/ _____ /
37.	Do you receive work every time you make a demand? [1=yes; 2=no; 3=others (specify)]	/ _____ /
38.	What type of work have you received under MNREGA?	/ _____ /
39.	Is the type of work collectively decided by the village members? [1=yes; 2=no; 3=others (specify)]	/ _____ /
40.	If yes, did you participate in this collective process? [1=yes; 2=no; 3=others (specify)]	/ _____ /
41.	If no, who decides the type of work to be undertaken in the village?	/ _____ /
42.	Did the work undertaken benefit the village as a whole or just a few members?	/ _____ /
43.	If the work only benefited few members in the village, who did it benefit and why?	/ _____ /
44.	How do you procure raw materials for MNREGA works?	/ _____ /

45.	Have machines been used for the implementation of work? [1=yes; 2=no; 3=others (specify)]	/ ____ /
46.	Were contractors engaged to supply raw materials and implement work? [1=yes; 2=no; 3=others (specify)]	/ ____ /
47.	Is your work inspected before wages are allocated? [1=yes; 2=no; 3=others (specify)]	/ ____ /
48.	Who inspects your work upon completion?	/ ____ /
49.	Is the inspection of work undertaken in your presence? [1=yes; 2=no; 3=others (specify)]	/ ____ /
50.	Are you required to maintain a cordial relationship with the inspectors to ensure that your work is properly measured and wages are allocated to you on time? [1=yes; 2=no; 3=others (specify)]	/ ____ /
51.	Are you aware about Muster rolls? [1=yes; 2=no; 3=others (specify)]	/ ____ /
52.	If yes, what kind of information is entered into the muster roll?	/ ____ /
53.	Who is responsible for entering your information in the muster roll?	/ ____ /
54.	Are details of your work entered into the muster roll on a: A. Day to day basis B. Weekly basis C. Yearly basis D. Other (Specify)	/ ____ /
55.	Are you allowed to check the muster rolls and the details entered? [1=yes; 2=no; 3=others (specify)]	/ ____ /
56.	Do you receive wages on time? [1=yes; 2=no; 3=others (specify)]	/ ____ /
57.	Do some villagers receive higher wages than others? [1=yes; 2=no; 3=others (specify)]	/ ____ /
58.	If yes, who in the village receives higher wages and why?	/ ____ /
59.	What is the wage rate fixed for men and women respectively?	Men- Women-
60.	Are men willing to work at this wage rate? [1=yes; 2=no;]	/ ____ /
61.	Are women willing to work at this wage rate? [1=yes; 2=no;]	/ ____ /
62.	If men/ women are/were not willing to work at this wage rate, was the issue ever raised in a village meeting? [1=yes; 2=no;]	/ ____ /
63.	If yes, how was the issue resolved in the village meeting? What decision was taken?	/ ____ /
64.	How do you access wages? (Mark ✓ wherever applicable) A. Wages are manually distributed B. Through your personal bank C. Through the post office D. Other ( specify)	/ ____ /

#### H. Access to benefits under the scheme

65.	What facilities are available to you at the worksite? (Mark ✓ wherever applicable)	/ ____ /
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	A. Creche B. Drinking water C. Shade D. First aid E. Others (Specify)	
66.	In case of injury at the worksite, are you entitled to any benefits? [1=yes; 2=no; 3=others (specify)]	/ ____ /
67.	If yes, what kind of benefits did you receive?	/ ____ /

### I. Grievance Redressal

68.	Have you ever complained to higher authorities? [1=yes; 2=no; 3=others (specify)]	/ ____ /
69.	If yes, who did you complain to and on what matter?	/ ____ /
70.	If no, why don't you complain?	/ ____ /
71.	What methods do you use to submit or register your complaint?	/ ____ /
72.	Was your complaint addressed? If yes, were you satisfied with the way it was resolved? If no, why not?	/ ____ /
73.	Who do you think is responsible to listen to and resolve your grievances? (Mark ✓ wherever applicable) A. Village council B. Village headman C. Block officer D. Others (Specify)	/ ____ /
74.	Are you aware of Social audits? [1=yes; 2=no; 3=others (specify)]	/ ____ /
75.	Was a social audit conducted in your village? [1=yes; 2=no;]	/ ____ /
76.	If yes, how many times in the last one year?	/ ____ /
77.	When was the last time a social audit was conducted in your village?	/ ____ /
78.	Did you participate in the social audit? [1=yes; 2=no; 3=others (specify)]	/ ____ /
79.	If yes, why did you participate? A. Forced to participate by the village headman B. To register my grievances C. Everyone in village participated D. Other (Specify)	/ ____ /
80.	What activities are undertaken in social audits?	/ ____ /
81.	Do you raise your grievances during social audits? [1=yes; 2=no; 3=others (specify)]	/ ____ /
82.	If yes, what types of grievances did you raise and to whom during social audits?	/ ____ /
83.	Were your grievances resolved by the officials present at the social audit? [1=yes; 2=no; 3=others (specify)]	/ ____ /
84.	If no, did you take any action?	

### NATIONAL RURAL HEALTH MISSION

[Investigator: Please remember that the questions below are addressed to an individual respondent. Make sure that the concerned person answers himself or herself (especially if the respondent is a woman). Before starting the interview, introduce yourself carefully and check that the respondent is willing to spare up to an hour or so for this discussion. If any question is not applicable, write "NA" in the relevant space]

Date: / \_\_\_\_\_ /

District: / \_\_\_\_\_ /

Block: / \_\_\_\_\_ /

Village: / \_\_\_\_\_ /

Investigator's name(s): / \_\_\_\_\_ /

Name of the respondent: / \_\_\_\_\_ /

**PART I**  
**GENERAL QUESTIONS**

**A. Respondent's Details**

1.	Age (years)	/ _____ /
2.	Gender [ 1= Female; 2=Male]	/ _____ /
3.	Education Level: [1=illiterate; 2=Literate (below primary); 3= Primary (Class V complete); 4=Upper Primary (Class VIII complete); 5= Secondary (Class X complete); 6 = High School (Class XII complete); 7=Above High School]	/ _____ /
4.	Marital Status: [1=Married; 2=Widowed; 3=Separated; 4=Unmarried]	/ _____ /
5.	Category: [1=ST; 2=SC; 3=Other (Specify)]	/ _____ /
6.	Religion: [1=Indigenous; 2=Christian; 3=Hindu; 4=Muslim; 5=Others (specify)]	/ _____ /

**B. Household Details**

7.	Number of household members: <i>[Investigator: Fill all entries in this table and make Sure that the row total is the same as the column total.]</i>	
	Female      Male      Total	
	Children (below 18 years)      / _____ /      / _____ /      / _____ /	
	Adults (aged 18-65 years)      / _____ /      / _____ /      / _____ /	
	Aged persons (above 65 years)      / _____ /      / _____ /      / _____ /	
	Total      / _____ /      / _____ /      / _____ /	
8.	Type of household [1 = Nuclear family; 2 = Nuclear family with dependent(s); 3 = Joint family; 4 = Other (specify)]	/ _____ /
9.	Monthly income Status (Mark √ wherever applicable) A. Rs 10,000- 20,000 B. Rs 20,000-50,000 C. Above 50,000 (Specify)	/ _____ /
10.	Does the household have a Ration Card? [1=Yes; 2=No]	/ _____ /
11.	Type of Ration Card (Investigators needs to check the Ration Card) [1=APL; 2=BPL; 3=Antyodaya; 4=Annapoorna; 5=Other (specify)]	/ _____ /
12.	Type of dwelling: (Investigators to observe the type of dwelling) [1=Kachha; 2=Semi-pukka; 3=Pukka]	/ _____ /
13.	Electricity supply [1=Yes; 2=No]	/ _____ /
14.	Drinking water source [1=tapped water; 2=well; 3=pond; 4=others(specify)]	/ _____ /
15.	Toilet facility [1=Yes; 2=No]	/ _____ /
16.	Main occupation(s) of the household: <i>[Investigator: Enter two codes (one in each box) if necessary, starting with the main occupation.]</i> [1= Self-employment (agriculture); 2 = Self-employment (non-agriculture); 3 = Casual Labour; 4 = Regular Employment; 5 = Other (specify)]	/ _____ / / _____ /

17.	Whether the village is connected by an all weather road (tarred road) ? [1=Yes; 2=No]	/_____/
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**PART II**  
**NRHM QUESTIONS**

**C. Availability of health facility:**

85.					
Sl. No.	<b>Health Facility</b>	Available in the village [1=yes; 2=no;]	How far is the Distance to the nearest health facility in K.M		Whether health facility accessible throughout the year [1=yes; 2=no;]
			Mode	Time	
1	ICDS (Anganwadi)				
2	Sub-Centre				
3	PHC				
4	CHC				
5	District/Govt. hospital				
6	Private clinic				
7	Private hospital/Nursing home				
8	Ayush Health facility				

**E.Availability of health workers in the village;**

86.			
Sl. No.	<b>Health Facility</b>	Available in the village [1=yes; 2=no;]	If yes, how many?
1	Anganwadi worker		
2	ASHA		
3	ANM		
4	Lady Doctor		
5	Male Doctor		
6	Untrained Aaya		
7	Ayush Doctor		
8	Traditional Healers		
9	Other (Specify)		

**D. Awareness about NRHM scheme**

87.	Are you aware of National Rural Health Mission? [1=yes; 2=no; 3=others (specify)]	/_____/
88.	If yes, what is the scheme about? (Mark √ wherever applicable) A. Providing effective healthcare services to all	/_____/

	B. Providing healthcare services to only women and children C. Do not know D. Others (Specify)	
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#### E. Information dissemination

89.	How did you come to know about the health and medical schemes and services in the village? (Mark ✓ wherever applicable) Interviewer not to read out the given points. A. ASHA/Anganwadi/VHSC B. Village headman/ Village council meeting C. ANM D. PHC/Sub-Centre E. Block F. Others (Specify)	/_____/
90.	Do you read the health scheme and services related posters/wall paintings/pamphlets at the PHC? [1=Yes; 2=No]	/_____/
91.	If yes, do you find the health scheme and services related posters/wall paintings/pamphlets at the PHC a useful source of information? [1=Yes; 2=No]	/_____/

#### F. Availability of community workers

92.	Does the ASHA visit your house? (Mark ✓ wherever applicable) [1=Regularly; 2=Rarely; 3=Never]	/_____/
93.	For what purpose does she visit your house?	/_____/
94.	What services is the Anganwadi worker delivering at the village level?	/_____/
95.	Is the ANM available at the sub-centre? [1=Always; 2=Rarely; 3=Never]	/_____/
96.	Are you aware about the responsibilities of the ANM? [1=Yes; 2=No]	/_____/
97.	If Yes, what kind of services does the ANM provide? <ul style="list-style-type: none"> <li>• maternal and child health family welfare</li> <li>• nutrition</li> <li>• immunization</li> <li>• diarrhea control and control of communicable diseases programmes</li> </ul>	/_____/

#### G. Health infrastructure and facilities

98.	When was the last time you visited a sub-centre? For what purpose?	/_____/
99.	How many hours does the sub centre remain open?	/_____/
100.	Are basic drugs (common and minor ailments) for ailments available to you at the sub centre? [1=yes; 2=no; 3=others (specify)]	/_____/
101.	When did you visit the PHC the last time? And for what purpose?	/_____/
102.	Is the Doctor available at the PHC? [1=Always; 2=rarely; 3=never]	/_____/
103.	Did you delivery in the house or at an institution? (Incase interviewing lady member) [1=yes; 2=no; 3=others (specify)]	/_____/

104.	Did you receive any monetary benefit from the government for : A. Institutional delivery B. Home Delivery [1=yes; 2=no; 3=others (specify) If yes, how much did you receive?	/_____/
105.	In case of home delivery, who conducted the delivery?	/_____/
106.	Which health worker was available at the time of delivery?	/_____/
107.	Are basic drugs and medicines easily available in the village? [1=yes; 2=no; 3=others (specify)	/_____/

#### **H. Village Planning and Monitoring**

108.	Are you aware about the VHSC? [1=Yes;2=No]	/_____/
109.	If yes, what do you know about the VHSC?	/_____/
110.	Who are the members of the VHSC?	/_____/
111.	How did you come to know about the VHSC?	/_____/
112.	Are you aware about Village health and nutrition day? [1=Yes;2=No]	/_____/
113.	When was the last time it was organised in the village?	/_____/
114.	Is immunization day organised in the village? [1=Yes;2=No]	/_____/
115.	Have you approached the VHSC for any medical or health service? [1=Yes;2=No]	/_____/
116.	If yes, what kind of services did you avail through the VHSC?	/_____/
117.	Are you aware of Clinic Day? [1=Yes;2=No]	/_____/
118.	If yes, have you attended the clinic day and for what purpose?	/_____/
119.	When was the last time it was organized?	/_____/

#### **I. Access to benefits under specific programmes**

120.	Are you enrolled under the state government medical insurance scheme? [1=yes; 2=no; 3=others (specify)]	/_____/
121	If yes, how did you come to know about the scheme?	/_____/
122.	Have you received any insurance benefits? [1=yes; 2=no; 3=others (specify)]	/_____/
123.	Are you aware of schemes targeting mother and child health needs? [1=yes; 2=no; 3=others (specify)]	/_____/
124.	If yes, can you name the scheme?	/_____/
125.	Have you received the following services under the JSSY? Mark ✓ wherever applicable  A. Free and Cashless Delivery B. Free C-Section C. Free treatment of sick-new-born up to 30 days D. Exemption from User Charges E. Free Drugs and Consumables F. Free Diagnostics G. Free Diet during stay in the health institutions – 3 days in case of normal delivery and 7 days in case of caesarean section H. Free Provision of Blood I. Free Transport from Home to Health Institutions J. Free Transport between facilities in case of referral as also Drop Back from Institutions to home after 48hrs stay.	/_____/

	K. Free Entitlements for Sick newborns till 30 days after birth similarly include Free treatment, Free drugs and consumables, Free diagnostics, Free provision of blood, Exemption from user charges, Free Transport from Home to Health Institutions, Free Transport between facilities in case of referral and Free drop Back from Institutions to home	
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#### J. Community Monitoring

126.	Have participated in a Jan Sanvad ( Public Hearing)which organised in the block? [1=yes; 2=no; 3=others (specify)]	/_____/
127.	If yes, Did you speak about your grievances in the Jan Samvad?	/_____/
128.	Which official did you share your grievances with?	/_____/
129.	Were you grievances resolved by the officer?	/_____/
130.	Are you aware about the complaint box at the PHC?	/_____/
131.	If yes, what is the purpose of the box?	/_____/
132.	Have you ever used the box to put in your complaints?	/_____/
133.	Have you ever complained?	/_____/
134.	If yes, on what issue did you complain?	/_____/
135.	Who did you approach to complain?	/_____/
136.	Who do you think is responsible for resolving your complaints?	/_____/

#### Sample of the Micro-Survey Questionnaire

##### A. Village Employment Council (VEC)

###### Implementation Arrangement

- What is the organizational structure of the VEC/PIC? Who are the key functionaries? What is the procedure you follow to select the Secretary and other Office bearers of the VEC?
- What is your specific role and responsibility as the Secretary of the VEC?
- Do you receive any formal training? If so, what kind of training do you receive? Where do you receive the training and what is the duration of the training?

###### Delivery of Services

- What are the key provisions of the MNREGA? What role does the VEC play in the delivery of these services?
- Who is eligible to seek employment under MNREGA? How many members within a household can apply for work?
- How does a citizen apply for employment under MNREGA? What processes and procedures is he required to follow?
- Do all villagers own a job card? If no, why?
- Have villagers received 100 days work under MNREGA last year?
- After making an application for work, in how much time does a citizen receive work?
- Are you aware about the unemployment allowance?
- What kind of work is available to citizens under MNREGA? How is this work decided?
- What is wage rate under MNREGA? Do men and women receive the same wage rate?
- Are wages received on time? If no, what factors are responsible for delay?
- How do villagers access their wages? What is the existing mechanism?
- What kind of facilities is available at the worksite for the workers?
- Have you receive any kind of medical treatment in case of injury in the course of employment including cost of hospitalization if required and ex-gratia payment in case of disability or death in the course of employment?

###### Governance Mechanisms

#### *Transparency*

17. As a VEC member, how did you receive information on MNREGA and from whom? Can you share any information material that you may have received?
18. Are you involved in disseminating information on MNREGA? If yes, what methods do you employ to disseminate the information to the public?
19. Whom do the villagers approach to seek information related to MNREGA?
20. Do you maintain a Notice Board at the VEC office? If so, what kind of inputs and information it contains?
21. Do you maintain a Citizen Information Board at the worksite? If so, what kind of inputs and information it contains?
- 22.** Do you display Photographs of the Work before, during and after to the public?
23. Are you aware about the RTI? If yes, please provide details.
24. Have you ever utilized RTI? If so on what basis?

#### *Convergence*

25. On what matters do you engage with the Block office?
26. Is the block officer available to meet you? Always/ frequently/rarely
27. In addition to the Block Office do you engage with any other state or non-state institutions? If so, what are the institutions and what kind of engagements do you hold with them?
28. How do you disburse payment of wages to the Job cardholders?

#### *Answerability*

29. Do you report to your higher authorities? If yes, on what matters do you report to your higher authorities and how?
- Monitoring and Supervising*
30. Who maintains the Muster Roll? What kind of information is maintained in muster rolls?
  31. Do you maintain any other books of account/registers and papers as a part of your responsibility? If yes, what kind of records/documentation do you maintain?
  32. Do the job cardholders have the right to check the Muster Roll?
  33. Has there been any inspection from the Block Office or from any other Organization? If so, what is the frequency of the visit?
  34. Do you conduct social audits? How do you conduct the Social Audit? How often does it happen?
  35. What kinds of issues are discussed during social audits?
  36. Is there a Vigilance and Monitoring Committee (VMC) at village level?

#### *Grievance Redressal*

37. Have you ever received any complaint from job cardholders? If so, what kind of complaints do you receive?
38. What mechanisms are available to workers under the scheme to file a complaint?
39. Do you adopt any formal process/mechanism to redress grievances? If yes, what are these mechanisms? Are you able to respond to all cases of complaints that come to you? If no, why?

#### *Inclusion*

40. Are women involved in the functioning of VEC/PIC? If so, in what way?
41. Do women participate in the selection of the type of work to be implemented in the village?
42. On what grounds is an applicant denied work under MNREGA?  
(Incase interviewing a female VEC member)
43. Do you actively participate in the functioning of the VEC? If yes, what kind of work have you undertaken as member of VEC?
44. Are you consulted at the time of decision-making? How do you participate in the process?
45. Do you think your views/opinion are heard seriously and adhered to by other members?
46. Do you witness any difference in the way men and women participate in the decision-making process? if yes, what kind of differences do you notice?

### **B. Block Development Officer (BDO)**

#### **MNREGA**

## **Implementation Arrangement**

1. Can you please describe the organizational structure set up for the implementation of MNREGA? District/Block /Village level.
2. Please identify the key functionaries at each level and describe in detail their primary roles and functions?
3. Can you provide in detail the key services citizens are entitled to under MNREGA? (Include a checklist)

## **Delivery of Services**

4. Please provide in detail the process of availing employment under MNREGA? What are the key requirements of this process?
  - ✓ Can you provide us latest data on the number of households registered (in Laitsohpliah, Mawstep & Pyrda villages) under MNREGA?
  - ✓ Can you please provide us latest data on the total number of job cards issued (in Laitsohpliah, Mawstep & Pyrda villages) under MNREGA?
  - ✓ Can you provide the latest data on the number of households who have received worked under MNREGA? How many households have completed hundred days of work
  - ✓ Can you please provide us the latest data on the total number of workers (in Laitsohpliah, Mawstep & Pyrda villages)? What is the proportion of male and female/SC and ST workers?

### *Access to work*

5. Upon registration, in how much time is a citizen provided work?
6. In case of a delay in providing work, are citizens entitled to compensation? If yes, how does a citizen avail his/her entitlement to compensation? What are citizens entitled to receive in the form of compensation? Can you provide us the latest data, if any on the compensation claimed by citizens?

### *Shelf of work*

7. What have been the major works undertaken so far?
8. How do citizens know about the nature of work they must undertake? How is the nature of work decided and by whom?

### *Wages*

9. What is the wage rate at which employment is provided to citizens? Is there a difference in wages provided to men and women?
10. How are the wages paid to a citizen? Can you elaborate the process in detail?

## **Governance Mechanisms**

### *Transparency*

11. How are citizens made aware about the MNREGA and its provisions?
12. If a citizen needs specific information on MNREGA, what mechanisms are available to him/her to access the information?
13. What are the common methods citizens avail to access information on MNREGA?

### *Monitoring and evaluation*

14. What are the monitoring and evaluation mechanisms built into the project? If yes, what are these mechanisms?
15. Are you involved in any form of monitoring and evaluation role? If yes, please provide details?

16. Are citizens involved in any form of monitoring and evaluation of the scheme? If yes, how are the citizens involved in the process?

*Grievance redressal*

17. If citizens have grievances, what formal mechanisms are available to citizens to articulate their grievances?
18. How do you address these grievances? What is the process of grievance redressal?
19. What kind of common complaints do you receive from citizens?
20. What are the most common methods citizens use to articulate their grievances?

*Convergence*

21. Do you directly engage with the beneficiaries of the scheme? If yes, what is the common method of engaging with them and on what matters?
22. For the purposes of implementation of MNREGA at the village level, who do you engage with on a regular basis?
23. Do you engage with village level functionaries such as the VEC/AEC or any other directly? If yes, what is common method of engaging and interacting with them and on what matters?
24. What has been your general experience of engaging with village level functionaries? (if required, probe further into accomplishments/challenges/roadblocks)
25. What is your experience in engaging with village level committees in implementing MNREGA? Accomplishments/Challenges/Remarks
26. What is your experience as a service provider? Accomplishments/Challenges/Remarks

## **NRHM**

### **Implementation Structure**

1. Are you involved in the implementation of the NRHM scheme? If yes, can you provide details about your primary role and responsibilities?
2. You are also the Chairman of the Rogi Kalyan Samiti. Can you please provide details about the main objective behind setting up of the RKS and what is the main function of the RKS?
3. Please provide us details about the organizational structure?
4. Who are the key members of the RKS? Please provide details about their specific roles and responsibility?
5. You receive grants in the form of untied funds and annual maintenance funds. Please provide us details about the total grant that you receive for functioning? Do you receive this amount annually?
6. What was the total grant that you received last year? Can you provide details about how much money was spent from the total budget?
7. Are there any delays faced in the release of the funds? What are main reasons for the delays?
8. What kind of activities is undertaken using these funds? What kind of activities cannot be implemented using these funds?
9. How are these activities planned and decided?
10. Upon finalizing the activities, how and to whom do you disburse the money?
11. Do you keep a register of the funds received and spent? Is this information accessible to the public?
12. How do you monitor the expenditure of these funds and the activities undertaken?
13. Are you also involved in the functioning of the VHSC? If yes, in what capacity? What are your main roles and responsibilities?
14. Have you receive any grievances from the PHC? If so, what kind of grievances do you receive and in what way do you receive it? How do you redress these grievances?
15. As the Chairman of RKS do you also have to attend the Public Hearing Committee Meeting (Jansamvad)? If so, what are the issues that you discussed and for what purpose?
16. Based on our interactions with the ASHA members at Mawstep, we learnt that there is a sectoral meeting at PHC (Laitryngew) once a month, who organized this meeting and what is the purpose of the meeting?

*Meghalaya Health Insurance Scheme*

1. What are the criteria that citizen needs to fulfill to access benefits under the scheme?
2. How does a citizen enroll herself under the scheme? What are the main process and procedures?
3. Once a citizen is enrolled, how is the citizen informed about her selection and how does the insurance money reach the beneficiary? What processes and procedures are involved?
4. How often are the enrollments for the scheme conducted? By whom?
5. Based on our interactions with villagers in Mawstep, we learnt that the BDO prepares a list of selected beneficiaries after the enrollment. How do you select the beneficiaries from the enrolled citizens? Is the selection based on any criteria? If yes, what are the criteria for selecting a beneficiary?
6. How many citizens have you covered under the scheme? Can you provide us the total population of rural citizens who have accessed the scheme? Please provide us relevance documents, if any.
7. How do rural citizens come to know about the scheme? How do you disseminate information related to the scheme?
8. What are some of the common constraints rural citizens face in getting themselves enrolled?
9. What challenges do you face in reaching out to citizens in rural areas?

### **Primary Health Centre (PHC)**

#### **Implementation Structure**

1. Can you provide us details about the organisational structure/composition of the PHCs<sup>35</sup>, CHCs and sub-centres in the state?
2. Can you provide us details about the total number of PHCs, CHCs and sub-centres in the state?
3. What is the total population covered under this particular PHC?
4. Do you engage with the CHCs, sub-centres and community level workers? If yes, on what matters do you engage with these institutions?

#### **Delivery of Services**

5. What kinds of facilities are available to citizens at the PHC?
6. Under the NRHM, PHCs are entitled to funds for local health action. How much funds do you receive?
7. What are the key activities that are implemented at the local level using these funds?
8. How and by whom are these activities planned?
9. What is the role and responsibility of the Rogi Kalyan Samiti? Can you please provide us details about its organisational structure?
10. For how many hours does the PHC remain open to citizens?
11. What is the status<sup>36</sup> of health facilities and the delivery of health services at the village level?

#### **Governance Mechanisms**

##### *Transparency*

12. Have prepared a citizen charter? Is this available to the public? If yes, in what form?
13. Are you involved in any form of information dissemination at the local level? If Yes, what kind of information is made available to citizens? What kind of mechanisms do you use for information dissemination?

##### *Grievance Redressal*

14. Incase a citizen is dissatisfied with medical facilities at the PHC, what mechanisms are available to the citizen to register/articulate his/her grievance?
15. Who, at the level of the PHC is authorized to hear grievances of citizens?
16. Are there mechanisms to redress citizen grievances? If yes, what are the mechanisms in place?
17. What are some of the common issues citizens complain about?

##### *Accountability*

18. Are there any monitoring mechanisms in place to ensure timely delivery of medical services to citizens? If yes, what are these mechanisms and how do they function?
19. Do you maintain a register of the funds received and utilized? Is this available to the public?

### *Inclusion*

20. Do think there are communities or section of the population who find it difficult to access health facilities? If yes, who are these communities or sections of the population? What kind of difficulty do they face in accessing health services?

### **Auxiliary Nurse Mid-wife (Sub-centre)**

#### **Implementation Structure**

1. Can you provide details about the organizational structure and composition of the sub-centre?
2. How many sub-centres are available at the village level?
3. What is the main role and responsibility of a sub-centre?
4. What is the total population covered under this sub-centre?

#### **Delivery of Services**

5. What kinds of facilities are available at the sub-centre?
6. What is the status of delivery of health services at the village level?

#### **Governance Mechanisms**

##### *Transparency*

7. Are you involved in any form of information dissemination? If yes, what kind of information is made available to citizens? What mechanisms do you use to avail this inform to citizens?

##### *Accountability*

8. Are you involved in any form of monitoring and supervision activities? If yes, please provide details?
9. Do report to higher authorities? If yes, on matters to do you report to the higher authorities and specifically to whom do you report?
10. How do you report to your higher authorities?
11. Are these reports of activities available to the public?

##### *Grievance redressal*

12. In case a citizen is dissatisfied with medical facilities at the Sub-centre, what mechanisms are available to the citizen to register/articulate his/her grievance?
13. Who, at the level of the Sub-centre is authorized to hear grievances of citizens?
14. Are there mechanisms to redress citizen grievances? If yes, what are the mechanisms in place?
15. What is some of the common issues citizens complain about?

##### *Citizen engagement/inclusion*

16. On matters of delivery of health services, are you required to directly engage with citizens? If yes, on what matters do you directly engage with citizens?
17. Do citizens directly participate in deciding how health services need to be delivered at the village level? If yes, how?
18. Are there communities or sections of the population in the villages who find it difficult to access facilities at the sub-centre? If yes, who are these communities or sections of the population? Why do you think they find it difficult to access services?

### **Village Health and Sanitation Committee (VHSC)**

#### **Implementation structure**

1. What are the organizational structure and the composition of VHSC? What is its key role and function?
2. Do the VHSC members receive training? If yes how often? Who imparts training to them? What are the topics included in the training programme?

#### **Delivery of Services**

1. What is the total amount of grant that you receive for your activities? What type of grant do you receive?
2. How do access this grant? What is the process involved?
3. What kind of activities do you undertake using these funds?
4. The grant is a resource for community action at the local level and is used for community activities. Can you provide in detail how community level activities are planned? What kinds

of mechanisms are in place to facilitate community action? Who are the key stakeholders involved in the process?

5. Do members of the village community contribute additional grant towards the committee? If yes, what mechanisms are in place to collect financial resources at the village level?

## **Governance Mechanisms**

### *Transparency*

6. Are you involved in any form of information dissemination? If yes, what kind of information is made available to citizens? What mechanisms do you use to avail this inform to citizens?

### *Accountability*

7. Who maintains the village health fund? Is there any register to keep track of the funds received and the funds spent? Is this available for public scrutiny?
8. Is the community directly involved in monitoring the flow and usage of funds? If yes, in what ways?
9. Who supervises or monitors the activities of the VHSC and how?

### *Grievance redressal*

1. Incase a citizen is dissatisfied with medical facilities at the Sub-centre, what mechanisms are available to the citizen to register/articulate his/her grievance?
2. Who, at the level of the Sub-centre is authorized to hear grievances of citizens?
3. Are there mechanisms to redress citizen grievances? If yes, what are the mechanisms in place?
4. What is some of the common issues citizens complain about?

### *Citizen engagement*

10. The VHSC is involved in preparing health plans for the village. How are the plans prepared? Who are the key stakeholders involved?
11. Do you conduct household surveys to enable need-based interventions? If yes, how regularly are these conducted? Can you provide us a copy of the survey?
12. How do you use information gathered through these surveys to plan interventions? Please provide details of the process.

### *Inclusion*

13. Are there women members in the VHSC? If so how many?
14. Are citizens provided any form of monetary assistance from these funds? If yes, what is the process in place? What are some of the common needs of citizens for which they require monitory assistance?

## **Grassroots NGO-Community Monitoring (NRHM)**

### **Implementation arrangement**

1. Are you the district cum block nodal NGO responsible for community monitoring under the NRHM scheme in Khasi region? If yes, please provide details about the primary focus area of your work as the Nodal NGO and your specific roles and responsibilities?
2. Can you explain the community monitoring component of NRHM scheme? What are its main objectives?
3. Is there an implementation arrangement set up at the state, district, block and village level under NRHM to undertake community monitoring activities? Please provide details about the organizational structure?
4. What is the total population you cover as the nodal NGO?
5. How many blocks and villages do you cover in the Khasi region as the Nodal NGO?

### **Delivery of Services**

6. How is community monitoring of NRHM conducted? Can you share related documents/manuals, if any?
  - Key processes
  - Key activities
    - i. At the service provider/government level-
    - ii. At the service beneficiary/citizen level-
  - Methods/tools

7. How many times do you conduct these activities in a year?
8. From our interactions with Medical officer at xx PHC we got to know that your organization is involved in conducting Jan Sanvad. What is the objective behind conducting jan sanvad?
9. How do you conduct Jan Samvad? Please provide about the key processes and activities.
10. How is the information and data collected through these activities used and for what?
11. How do ensure the participation of the government officials and citizens in jan samvad? What mechanisms of information dissemination do you use to facilitate community participation?
12. Jan samvad facilitate interface between the service providers and citizens. What are the issues that are discussed during jan sanvad?
13. What are some of the common concerns that citizens raise during jan sanvad? Do they raise concerns related to accountability and answerability of the service providers, transparency etc.? If yes, please provide details.
14. Do you think government officials are responsive to the concerns of the citizens? If yes, are there instances where government officials have acted upon citizens concerns and resolved issues? Please provide details.
15. Do citizens proactively participate in these forums? If yes, why do think so? If no, then why not?
16. Do government officials proactively participate in these forums? If yes, why do think so? If no then why not?
17. Do you find it difficult to engage specific communities or sections of the population in such forums? If yes, which are these communities or sections of the population? Why is it difficult to engage them in these discussions?
18. What is the ratio of men and women who participate in these forums?
19. Do women actively participate in the forums in terms of raising grievances, questioning officials etc.?
20. What has been your overall experience of conducting community monitoring activities in the khasi region, specifically engaging with the citizens and government officials?

## **Social Audit Facilitator**

### **Implementation Arrangement**

1. Can you please discuss the governance arrangement of the social audit system for MGNREGS in Meghalaya? What is the organizational structure, District/Block/Village?
2. Our research reveals that you are the social auditor for the Khadarshnong Laitkroh Block area. How long have you served as a social auditor? Please provide details of your role and responsibilities.
3. How is a social auditor appointed? Which government department is involved in selection?
4. Have you received any formal training for social audits by the government? If yes, what kind of training did you receive? What was the duration of the training?
5. Does the state of Meghalaya have a Social Audit Unit? What are the functions of the SAU? Please provide details about its organizational structure?

### **Delivery of Services**

6. What are the key objectives that social audits are designed to fulfill under MNREGA?
7. How do you conduct social audits? Please provide details about the processes and procedures you follow? Can you provide us copies of the tools used, if any?
8. Who are the key stakeholders involved in the implementation of social audits? Please provide details about their specific roles and responsibilities?
9. How many times are you required to conduct social audits in a year?
10. What are some of the common issues related to MNREGA that are reviewed during social audits?
11. What happens to information/data that is collected through social audits? How is the information and data used?
12. Do you think social audits impact the delivery of MNREGA? If yes, in what ways. Please provide examples. If no, then why not?

13. Do government officials participate in social audits? How is their participation in social audits ensured? If no, why do think government officials avoid or hesitate to participate in social audits?

### **Governance Mechanisms**

#### *Transparency*

- 14.** How do you disseminate information on Social audits? Are there any formal mechanisms in place for information dissemination?

#### *Convergence*

15. Have social audits facilitated government and citizen interface? If yes, can you throw light on the nature of this interface? (Do citizens proactively engage in discussions with officials? Are officials willing to respond? Do they have conflicts?)
16. Do you engage with state and non-state institutions as a part of the requirement of your work? If yes, please provide details.
  - a. State Institutions: Name/Kind of engagement/How is the engagement?
  - b. Non-state Institutions: Name/Kind of engagement/ How is the engagement?

#### *Accountability and answerability*

17. How do service providers respond to the grievances of citizens, raised during social audits? Are they responsive?
18. Are there any instances where government officials have successfully redressed citizens' grievances? Please provide details.

#### *Grievance Redressal*

19. What are the common grievances citizens talk about during social audits?

#### *Citizens Engagement*

- 20.** What has been your experience of engaging with citizens as social auditor?
- 21.** When was the last time you conducted a social audit? Laitsohpliah/Mawstep/Rngi Jingsai
- 22.** How many social audits have you conducted so far? Laitsohpliah/Mawstep/Rngi Jingsai
- 23.** Can you provide data on the number of citizens who enrolled and participated in social audits from Laitsohpliah/Mawstep/Rngi Jingsai
- 24.** Do community members actively participate in social audits? If yes, why do think they choose to participate in such activities? If no, what are main reasons according to you?
- 25.** Enrollment of citizens is an important component of social audit, what formal and informal mechanisms do you use to ensure maximum enrollment of citizens?
- 26.** Do you think social audits are a useful exercise? If yes, why? If No, why not?

#### *Inclusion*

27. Do women participate in social audits? What is the ration of men and women who participate in social audits?
28. Are women proactively involved in articulating their grievances during social audits?
29. Do women participate in the social auditing in the village? If yes, on what activities are they actively involved?
30. Is non-participation in social audits specific to certain communities or groups in the village? If yes, which are these communities and what do you think are the reasons?

### **Sample of the FGD questionnaire**

#### **A. Citizen engagement**

1. The delivery of schemes such as MGNREGA and NRHM depends on active involvement of citizens' in planning and decision-making.What has been your experience of participating planning/decision making processes of MGNREGA & NRHM?
2. Do you think citizens should have a role in the decision-making and delivery of services under MGNREGA and NRHM? If yes/no, why?
3. The state government has put in place mechanisms such as the Jan samvad, social audits etc to seek citizens' feedback in improving service delivery. How have these mechanisms enabled you to participate in decision-making and service delivery?
4. What changes do you think should take place to give you more influence in taking decisions?

**B. Accountability**

1. When services under MGNREGA and NRHM are not delivered in the village, who do you think is primarily responsible for it and why do you think he/she is responsible?
2. What do you think are the challenge he/she faces in delivering services in the villages?
3. What are the obligations of the service providers? How do you ensure that the service providers fulfill their obligations? What mechanisms do you use?
4. What do you think the government ought to provide (obligation) its citizens?
5. What do you think ought to be the responsibility (obligation) of citizens to the government?

**C. Transparency**

1. Does information about the schemes help you access services? If so, how?
2. What kind of information do you think you are entitled to receive? What has been your experience in accessing this kind of information?
3. What has been your experience as a beneficiary of the services you received under MGNREGA/NRHM?
4. Can you give any suggestions to improve the delivery of services by the government to the community MGNREGA/NRHM?

**D. Inclusion**

1. Women- Does the exclusion of women in the village council meetings impact the way they access services? if so, how?
2. Do you think women like men should participate in the village council meetings?
3. Do you think some members of the village are able to access more services than the others? If so, why?
4. Through our survey we have come to learn that the wage rate at the village level is different for men and women. Can you explain a little about this?
5. What role do women organizations play in the village?
6. What role do youth organizations play in the village?

**E. Grievance Redressal**

7. Who do you prefer to discuss your grievances with?
8. What are your reasons for choosing this person/office?
9. If your grievances are not addressed at the level of this person/office, how do you take them forward? If you do not take them forward, then please tell us why?

## **Annex 2: Formal Responsibilities and Governance Mechanisms in MNREGA and NRHM**

### **MNREGA: Delivery structure**

MNREGA was implemented in the state in three phases; in 2006, the scheme was implemented in West Garo Hills and South Garo Hills Districts, in 2007, East Khasi Hills, Jaintia and Ribhoi Districts were covered under the scheme and in 2008, implementation of the scheme East Gharo Hills and West Khasi Hills was completed. West and South Garo Hills were among the 200 districts that were selected for the nation-wide implementation of the MNREGA in 2006. However, the state government failed to roll out the scheme because of the absence of Panchayati Raj Institutions in Meghalaya. Over a period of six months, the state government developed an alternative implementation structure -a four tier arrangement functioning at the village, cluster, block and district level for the seamless operationalisation of MNREGS at the village level.

**Village Employment Council**-The VEC performs all functions of the Gram Sabha. All male and female-headed households in the village constitute the VEC. Each VEC is headed by three elected members including the Village Headman, a male and a female member. The members elect the secretary of the VEC from among themselves excluding the village headman. The office bearers of the VEC function on a voluntary basis. The VEC is assisted by the Gram Sevak and a community coordinator, who is responsible for identification, execution and supervision such works.

**Area Employment Council**-One or more VECs may fall within the area of jurisdiction of an AEC. The AEC functions at the cluster level, covering all villages that fall within the radius of 2 Kms. It comprises of three elected representatives from each VEC, a male and a female member in addition to the village headman. A minimum of 20 members constitute the AEC, 30% of its membership is reserved for women. The AEC fulfills the responsibility of the Gram Panchayat. The AEC is responsible for receiving applications for registration and for issuance of Job Cards

**Block Employment Council**-The BEC constitutes the third level of implementation. Like the block panchayat, its primary responsibility is finalizing and approving block level plans, mainly consisting of the consolidated shelf of projects taken up under MNREGS.

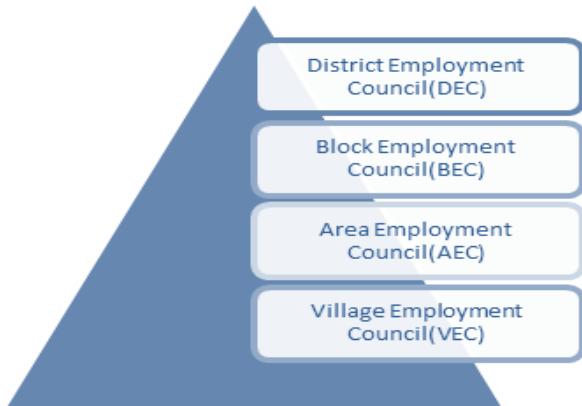
**District Employment Council**-The DEC is an equivalent of the Zilla Parishad. It is responsible for finalizing and approving district level plans

### **Pattern of funding**

MNREGS is implemented on a cost-sharing basis between the centre and the state. Central funds are utilized for bear the costs of wages, 3/4<sup>th</sup> of the material cost, administrative costs, capacity building costs and establishment of programme officer and supporting staff such as community coordinators. State funds are allocated to pay 25% of the material and wages of skilled and semi-skilled workers, unemployment allowance, administrative expenses of the state EG council and expenses related to implementation of the scheme.

The state government also established the Meghalaya State Rural Employment Society (SRES). It is entrusted with the responsibility of managing the state corpus fund that meets the requirements of the districts facing acute shortage of financial resources.

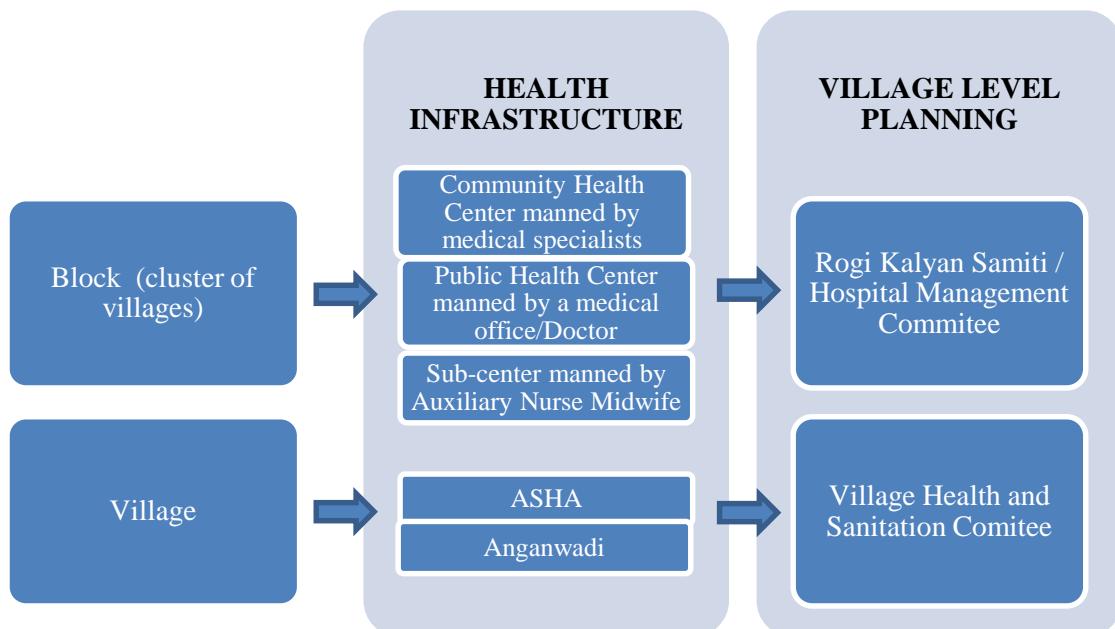
**Figure 4. Implementation Structure of MNREGA (Source: State Rural Employment Society)**



### **NRHM: Delivery Structure**

With the objective of widening access to quality health services, a three tier health care system has been developed under NRHM comprising of Sub centres, Public Health Centres and Community Health Centres. The Sub-centre is the primary unit for accessing health care services at the village level. It is manned by an Auxiliary Nurse and Midwife, a female health worker and a male health worker. Sub-centres are responsible for providing citizens with basic drugs and medicines for minor ailments. The Public Health Centre operates at the block level. PHCs are also referral units for 6 sub-centres. It is the first point of contact between the community and the medical officer. It is manned by a doctor, supported by paramedical and other staff. The referral unit for PHCs (4) are Community Health Centres. These are also set up at the block level. A CHC may comprise of four medical specialists; Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. CHCs are equipped with facilities like 30 in-door beds with one OT, X-ray, Labour Room and Laboratory and etc.

**Figure 5. NRHM Main Implementation Arrangements**



The community at the village level drives the implementation apparatus of NRHM. Key stakeholders include:

#### *ASHA-Community level Health Workers*

At the village level, the primary unit for accessing health services is the Accredited Social Health Activist (ASHA). NRHM reaches out to all villages through the ASHAs. They work mainly on a voluntary basis, the scheme however provisions performance-based compensation to them for undertaking specific activities. ASHAs play an important role in spreading awareness about the scheme and improving access to health care services at the village level.

#### *VHSC-Village Health and Sanitation Committee*

It is a community led forum for planning and monitoring health care activities at the village level. It is comprises of members of village council. The main functions of the VHSC are to ensure no member of the community remains excluded from health services, all health service providers are available during immunization day/village health and nutrition day, local transport arrangements are available for pregnant women, especially for those with complications and sick newborn to reach the referral facility, and that in an emergency, this transport is available on a cashless basis with reimbursement later and nutrition supplement and food security programmes reach the pregnant and lactating woman. The Village Health and Sanitation Committee of the village would prepare the Village Health Plan, and promote intersectoral integration.

**Table 10. Total Number of VHSC in Meghalaya. Source: NRHM Official Website**

District	No. of VHSC
East Khasi Hills	1033
West Khasi Hills	1070
Ri Bhoi District	570
Jaintia District	422
West Garo Hills District	1617
East Gari Hills District	952
South Garo Hills District	586
<b>Total</b>	<b>6250</b>

#### *RKS-Rogi Kalyan Samiti/Hospital Management Committee*

RKS is responsible for the functioning and maintenance of the quality of services in health facilities. It functions at the block level. RKSs utilize government assets and services to generate and use funds for health care activities and related improvements. It consists of members of local village councils, NGOs, local elected representatives and officials from government sector. RKS are set up in district hospitals, Community Health centres and public health centres.

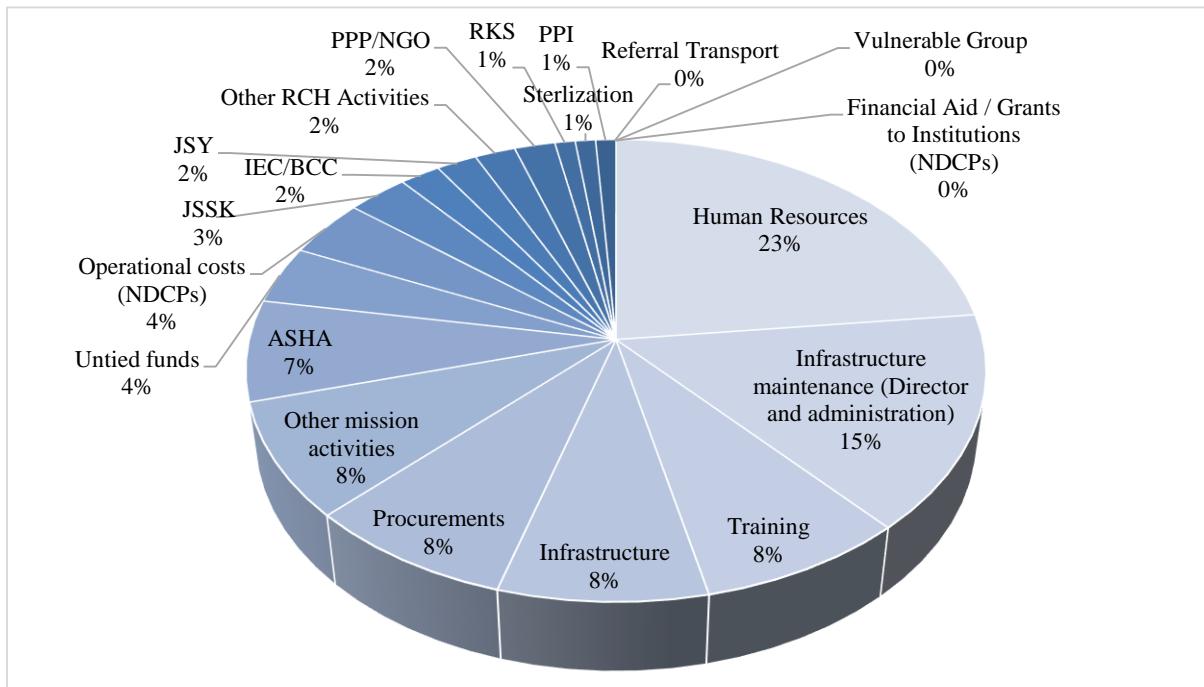
**Table 11. Total Number of RKS in Meghalaya Source: NRHM Official Website**

District	District Hospital	CHC	PHC
East Khasi Hills District	1	6	23
West Khasi Hills District	1	5	19
Ri Bhoi District	1	5	8
Jaintia District	1	3	18
West Garo Hills District	1	7	18
East Gari Hills District	1	2	16
South Garo Hills District	1	1	7
<b>Total</b>	<b>7</b>	<b>29</b>	<b>109</b>

## Pattern of Funding

The centre provides 90% of the funds while the state invests 10% of its funds on the implementation of NRHM. Summary of the budget as per broad functional heads under NRHM, Meghalaya:

**Figure 6. NRHM Budget allocations for Meghalaya, 2012-13 Source: NRHM Official Website**



## The role of the village headman in the implementation of MNREGA and NRHM:

The village headman is mandated to play an important role in the implementation of MNREGA and NRHM as the chairman of the VEC and VHSC. The field findings reveal that the citizens' interface with the VEC under MNREGA is greater than the VHSC. This is because of the nature of the role and functioning of the two bodies at the village level. The VEC has a key role to play in allocating work, wages, determining beneficiary eligibility. It does not have control over financial resources given that beneficiaries are now equipped to withdraw their wages directly from the bank as per the scheme. The VHSC is mainly involved in planning and monitoring, less in implementation. They receive an annual grant of INR 10000/- for their activities. The nature of the functioning of the two bodies does not however, impact the power and authority of the village headman. As the head of both the VEC and VHSC, functionaries of the two respective bodies are answerable to the village headman; he has the final decision-making authority. The members of the VEC and VHSC are likely to owe allegiance to him not only as the formal authority of the bodies but because of his position as the traditional head in the village.

### **Annex 3: A Summary of the Learning-By-Doing Approach**

**Capacity building was one of the key objectives of the NLTA.** The client clearly articulated the need to initiate capacity-building interventions at both individual and institutional levels as a part of the NLTA. Accordingly, the World Bank task team, in consultation with the client, integrated capacity building into the bottom-up study of governance.

**Capacity building steps were incorporated in all the three main stages of the study: design, implementation and write-up.** Beginning with the research design document, the study had data collection and report writing as the second and third stages. While the research design document was led by the World Bank task team (to facilitate knowledge transfer), the local consultant and the designated MIG team were actively involved in the discussions and its finalization. The data collection, analysis, and report documentation were mainly led by the local consultant and the MIG team; with extremely regular interaction.

**The study was not aiming to be pure ‘research’ in the academic sense: it integrated a range of actions and principles of qualitative research methods with a clear “learning-by-doing” approach to capacity building.** At each stage of the effort, as mentioned above, various aspects of the methodology were implemented. Design of the survey instrument and the various nuances of survey methodology, understanding the concepts and processes of Focus Group Discussions (FGD), techniques for and pitfalls while undertaking key informant interviews (KII) were some of the aspects of data collection that were discussed for enabling learning transfer. Coding and analyses of data collected using survey instruments, FGDs, and KIIs were the key learnings that went into the third stage of data analysis and documentation.

**Multiple measures were adopted for facilitating capacity building at the individual and institutional levels.** Learning-by-doing was the most significant aspect of the capacity building effort. However, to kick start the use of some of techniques face-to-face interactions between local consultants, MIG staff and the World Bank task team lasting half-a-day to one full day were held many times. These interactions also included mock FGD sessions and trials for administering the survey instruments. To ensure that some of the concepts and techniques are internalized and available for reference, a number of guidance notes were delivered in writing and in person. Finally, to enable the research team (local consultant and the MIG team) to concretize its learnings at each stage, it asked to summarize the findings and reflect on what it had learned (e.g. after the framework was designed, after the primary research was conducted, after the first cut of analysis, and so on).

**Some key takeaways on capacity building can be highlighted.** Insofar as capacity building is concerned there are some noteworthy processes and outputs both at the institutional and individual level:

*Process Aspects.* Some take-aways include:

- Testing the survey instrument within the team with a view to anticipating possible conversation blocks at the field level helped the research team appreciate the nuances in administering the instrument. It also helped ensure, to a large extent, uniformity in data collection by different groups of the research team.
- Similarly, discussion about the FGD with the Bank task team helped in making the research team more sensitive to the nuances of collecting data through a FGD.
- Data coding and analysis was preceded by a one day discussion on the techniques of coding and basic descriptive statistics, which enabled the team to codify large quantities of raw field data into meaningful and usable tables.

*Output Aspects.* The main ‘training’ outputs that would qualify as institutional ‘capacity’ as they can be used over time by any team that would want to replicate this study include the following:

- Documented research design framework that provides an approach and methodology for undertaking a bottom up governance study in the context of service delivery in the context of tribal society such as Meghalaya.

- A 135-item survey instrument, in Khasi (one of the three tribal languages of Meghalaya) covering basic household demographic data, dimensions of governance related to delivery of service in the context of MNREGA and NRHM.
- An operational note on Focus Group Discussion—concept and basic inputs for observing a FGD
- A note providing guidance for analytically documenting report of a field study such as the present one.

**The capacity building effort through a learning-by-doing approach requires ongoing technical backstopping with sensitivity to the context.** The main challenge is the trade-off between task accomplishment, in this case completion of the study, and capacity building. A tough rope to walk!

#### Annex 4: List of KIIs and FGDs Undertaken during the Study

Date	Village	Distance from BDO	Activity	Remark
26.02.2015	Mawstep	12 kms	Preliminary visit interview of Headman	Completed
27.02.2015	Laitsohpliah	8 kms	Preliminary visit interview of Headman	Completed
18.03.2015	Laitsohpliah	8 kms	Interview of KIs	Completed
24.03.2015	Mawstep	12 kms	Interview of KIs	Completed
1.04.2015	Mawstep	12 kms	Household Survey	Completed 27 HHs
8.04.2015 & 9.04.2015	Nongraw	18 kms	Interview of KIs HH Survey	Completed (Total 36 out of 40 HHs)
11.04.2015	Laitsohpliah	8 kms	Household Survey	Completed 37 HHs
14.04.2015	Mawstep	12 kms	Household Survey	Completed 13 HHs (Total 40 out of 47 HHs)
15.04.2015	Laitsohpliah	8 kms	Household Survey	Completed 20 HHs (Total 57 out of 63 HHs)
30.04.2015	Laitsohpliah	8 kms	Focus Group Discussion	Completed (10 participants)
1.05.2015	Nongraw	18 kms	Focus Group Discussion	Completed (12 participants)
2.05.2015	Mawstep	12 kms	Focus Group Discussion	Completed (14 participants)
Date	Key Informant	Distance from BDO	Activity	Remark
13.03.2015	BDO	0 kms	KI interview	Completed
23.03.2015	Doctor - PHC	20 kms	KI Interview	Completed
26.03.2015	Facilitator, Social Audit	1 km	KI Interview	Completed
27.03.2015	ANM – Sub Centre	10 kms	KI Interview	Completed
27.03.2015	Grassroot - NGO	Shillong	KI Interview	Completed
27.03.2015	BDO	0 kms	KI Interview	Completed

## Annex 5: Lessons Learned on the Analytical Approach

The study's analytical framework could be further fine-tuned. The framework has usefully enabled the research team to address identified knowledge gaps and to unpack – in granular depth and in a participatory manner – some of the critical governance issues at the point of implementation, particularly from the citizens' perspective. That said, some modifications could be made going forward based on the piloting experience. First, 'top-down' governance factors – the impacts of top-down oversight mechanisms, the system of elite (political, bureaucratic and societal) incentives and disincentives for delivery and the different dimensions of institutional capacity (see O'Meally and Vincent, 2015) – could be integrated with the bottom-up perspective. This could provide a more holistic overview. One potential framework to explore and adapt could be from Batley and McLoughlin (2012) (see annex), although that is perhaps overly ambitious in its scope. Second, some reflections on lessons learned and how to improve the roll-out of the approach are given in box 3.

### **Some Lessons from Piloting the Study Approach and Methodology**

The MIG discussed and internalized a number of lessons, which would contribute to improved implementation in the next phase of activities. If indeed, the MIG is to develop into a premium 'think' and 'do' organization on governance issues in the state, these lessons may need to be addressed. The lessons can be briefly clustered and summarized as follows.

#### *Research Design*

- The development of a detailed research design framework became a critical 'living document' for the MIG team as, during the implementation, they could go back to it to re-orientate themselves. The fact that the MIG was involved in the development of this framework increased ownership.
- The shortage of local experts trained in these types of issues contributed to delays. The lead consultant dropped out at the mid-point leading to delays in finding someone new. MIG could build a stronger base of local experts to assist their work to reduce such blockages.
- The formal training of MIG staff in designing and conducting such analyses could be further strengthened. Prior formal training in these fields has been relatively limited.

#### *Implementation*

- A key learning for MIG was just how much time and 'manpower' are required to conduct such analytical work properly. Delays emerged from a range of logistical issues but also because team members had other work commitments that were prioritized. If MIG is to lead on governance analysis, it would require dedicated staff with adequate time.

#### *Data Collection Tools*

- The Data Collection Tools were extremely helpful in identifying and generating relevant information. Some areas for further strengthening the tools before the next phase include the following: (i) some questions in the micro-survey were repetitive or vague; or, (ii) methods of encouraging rolling questions during KIIs/FGDs and thus sparking greater respondent discussion could be strengthened.
- Mock tests of the tools within the team helped identify gaps, foresee implementation challenges and familiarize team members with 'dos and don'ts'.
- There were language barriers in translating the tools into the local language (Khasi). This was particularly challenging in ensuring the governance constructs (such as governance, accountable, answerable, grievance, redressal) were adequately captured in the local language. This points to the need to take a great deal of time in understanding what people actually mean by certain aspects.

#### *What Aspects could be Strengthened?*

- Some other areas identified for strengthening by the action-research participants included the following: (i) more time could be given to digesting all the micro-survey findings before conducting KIIs and FGDs so that the KIIs and FGDs could be more 'gap-filling'; (ii) the survey required quite a bit of the participants' time so there is a need to make it less cumbersome; (iii) team members could be trained further in FGD members to ensure a more vibrant discussion and break down people's apprehensions in sharing information; and, (iv) it was found that more females responded over males because the surveys were conducted mainly during the day when certain males were unavailable.

## Endnotes

<sup>1</sup>The Indian National Development Council gives Special Category Status to States based on certain parameters such as low resource base, hilly and difficult terrain, low population density or sizeable share of tribal population, or strategic location.

<sup>2</sup>See the 12<sup>th</sup> Five Year Plan – Meghalaya.

<sup>3</sup>In cognizance of the specific needs of the tribal society, the Sixth Schedule was inserted into the constitution and a separate political and administrative arrangement was granted constitutional legitimacy to govern the tribal state—the Autonomous District Councils (ADCs).

<sup>4</sup>According to Joshi (2004: 265), the geo-political context, lack of access to communication and isolation, necessitated the need for self-governance.

<sup>5</sup>According to the MIG mission statement, the MIG is envisioned to play a number of key functions: (i) act as the apex level resource institute for development of democratic governance; (ii) work with government departments to identify governance issues and implement a reform agenda; (iii) create a repository of good practices; (iv) support change management; (v) build capacity of local governance institutions and community based organizations; and, (vi) empower communities through participatory approaches Meghalaya Basin Development Authority. See: <http://mbda.gov.in/>

<sup>6</sup> These objectives for MIG were identified in the GoM TA proposal to the World Bank.

<sup>7</sup> From the official website of NRHM <http://nrhmmeghalaya.nic.in/>

<sup>8</sup> Note that the term ‘bottom-up’ is not referring to ‘society-side’ or ‘demand-side’ approaches to governance (a term commonly used in the literature). It is simply referring to the *methodology* of unpacking aspects of governance and service delivery, as outlined in the main text.

<sup>9</sup> For example the formal state is constituted by public institutions such as an elected executive and legislature, a rule-based bureaucracy, an independent judiciary, a security apparatus and a regulated market economy.

<sup>10</sup> The paper recognizes that the dichotomy between formal/informal or traditional/modern is not straightforward, although it maintains this in large part. While traditional institutions remain accountable to social structures and norms, they too function formally, albeit based on unwritten norms and customs. The functioning of traditional institutions can thus combine both formal and informal characteristics. In order to address the ambiguity and variability of the constructions of traditional, modern, formal and informal and to better understand service delivery in Meghalaya, the interface between multiple sites of authority could finally be classified: 1) *Governance structures*; both modern and the traditional: the modern stands for the state government and bureaucracy and the traditional stands for the village council and village headman; 2) *Governance mechanisms*; both modern and traditional; in this case, formal refers to commonly held written rules, processes and procedures and informal that refers to rules, processes and procedures rooted in social norms and practices. For example, the judicial system set up in Meghalaya functions as a hybrid entity with overlapping structures and formal and informal mechanisms. The Village Courts are constituted for the trial of suits and cases in the village with the Headman, Sirdar, Syiem Raid, Basan, Lyngdoh, Lyngskor and other members elected by the village adults to try minor cases at different level when litigation is within the tribal areas and party or parties involved are tribals. The Additional Subordinate District Council court was constituted for the trial of suits and cases within the Syiemship, Lyngdohship, Sirdarship, Wahadadarship that cannot be tried by village courts, and to be presided over by the Syiem, Lyngdoh, Sirdar, Wahadadar, as the case may be with such number of Myntris or customary elders and for hearing appeals from the decision of the village courts, both civil and criminal.

<sup>11</sup> This underlines the importance of taking an ‘ethnographic’ approach to governance analysis; that is, taking local cultures seriously and understanding how contextual narratives can shape thought and action (Woolcock, 2014).

<sup>12</sup> This was not intended to be a representative sample. The criteria for selection of the three villages were based on: their distance from the Block Office, their distance from all-weather roads, and the acceptance of our field data collection request by the village authorities.

<sup>13</sup>Before going to the field, the secondary analysis helped identify a range of actors engaged in delivery of services under MNREGA and NRHM. Respondents representing state institutions included Member of AEC, Members of VEC, Block Development Officer, District Collectors, and Members of the ADC. Respondents representing informal or indigenous institutions may include members of the Village council. Service beneficiaries comprises of mainly recipients of government schemes and services; citizens.

<sup>14</sup> While the focus is on a bottom-up methodological approach, this does not mean that the ‘top-down’ aspects – such as top-down incentives and sanctions, or public financial management – are not important. In fact, such top-down mechanisms are critical determinants of improved delivery and development (Booth, 2012).

<sup>15</sup> There is rarely a simple causal chain between governance and delivery outcomes (Harris and Wild 2013: 4).

<sup>16</sup>MNREGA was launched in the country on February 2, 2006. The implementation of the programme in Meghalaya was not, however, initiated immediately. This was because the State of Meghalaya fell outside the purview of Part IX of the Constitution. Panchayati Raj Institutions/local councils/authorities were not a part of state apparatus at the time of implementation of MNREGA. In the absence of these institutions, the State created its own institutional arrangement resembling Panchayati Raj Institutions, constituted from the scratch to facilitate

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the implementation of MNREGA. The preparatory entailed formation of the Village Employment Councils and Area Employment Councils which were empowered as village institutions for implementing the Act in the State and were equipped, over a period of time to function like a formal system not only for execution of MGNREGA works but also as planners, record keepers and vigilance and monitoring units.

<sup>17</sup>KII with Block Officer.

<sup>18</sup>KIIs with VEC members.

<sup>19</sup>KIIs with ASHAs

<sup>20</sup> Gram Sewak is secretary of the village panchayat. He/she is appointed by the government.

<sup>21</sup>Focus Group Discussion, Mawstep village, May 2, 2015.

<sup>22</sup>Service providers envisaged the role of VHSC in enabling health care activities via active community participation. However, survey results show that almost 60% of the respondents were unaware about its presence in the village. On being asked about the services citizens avail via the VHSC, 86% provided no response. Only 7% stated they received information about health and sanitation and could access medicines with the help of the committee.

<sup>23</sup>One PHC doctor stated that citizens prefer to approach him personally and clarify issues they are facing. The ASHAs and ANMs also shared that in the case where citizens have grievances related to health care; they directly approach them for resolution. According to a medical officer at a PHC, essential medical equipment could not be purchased on time due to lack of funds. Such problems, he stated, have been raised during block level meetings but remain unaddressed. Block officials usually blame it on delayed approvals by the centre.

<sup>24</sup> While the participation rates are relatively low, KIIs suggest that they have incrementally increased over time.

<sup>25</sup>Various FGDs. Also KII, Anganwadi worker, Nongtraw village, April 8, 2015. KII, VEC member, Laitsohpliah village, March 18, 2015.

<sup>26</sup> From the micro-survey data and field interviews.

<sup>27</sup> So, holding the village headman accountable – in the formal ‘good governance’ sense – may not be applicable as citizens are not likely to question him freely as his legitimacy derives from his position and the council.

<sup>28</sup> KII, lady member VEC, Nongtraw village, April 8, 2015.

<sup>29</sup> Discussions in popular media in Meghalaya tend to emphasize at least two points: (i) views can be somewhat polarized between whether traditional institutions are ‘good’ or ‘bad’ for development; and, (ii) people can tend to set up a dichotomy between the ‘modern’ and the ‘traditional’ (see O’Meally and Vincent, 2015).

<sup>30</sup>As Woolcock (2014: 16-17) reminds us: “*A central virtue of this [type of] approach is less the broad policy prescriptions to which it gives rise...than the emphasis it places on making intensive and extensive commitments to engaging with, if not always fully understanding, the idiosyncrasies of local contexts...Cultural analyses should help us to appreciate the distinctive kinds of phenomena to which culture draws attention, and to humbly, incrementally, illuminate them*”.

<sup>31</sup> These approaches have been developed in light of the growing belief that the ‘good governance paradigm’ – attempts to adopt formal institutional arrangements akin to modern OECD institutions – has not been a useful roadmap for explaining or supporting institutional change in many countries.

<sup>32</sup> Bricolage is not always benign and may reproduce inequalities (such as continued exclusion of certain groups)

<sup>33</sup> Practical steps for integrating adaptation into planning and implementation include:

1. Build in inclusive locally-driven consultative processes to define the ‘problem’, to design the intervention and to monitor impact.
2. Identify realistic incremental and intermediate changes and use them as milestones for periodically revisiting (and revising) the intervention’s theory of change.
3. Enable informed risk taking and deviation from rigid project design. For this, avoid overly rigid log-frames: use process and outcome mapping tools (Tembo, 2012).
4. Integrate mechanisms for regular learning and adaptation. For example, establishing ‘real-time’ management information systems (Rao, 2014).

<sup>34</sup> Other potential questions in this context could include:

- What explains the diverse performance within each scheme in terms of the delivery of the full range of program entitlements (i.e. why was the delivery of some entitlements much worse than others)? Why did citizens’ awareness of different entitlements differ?
- Why is there such a gap between the perceived importance and performance of elected representatives (MLAs and MDCs)? In other words, why are vertical/electoral accountability channels seen to deficient?
- Why, if at all, are citizens relatively dissatisfied with the performance of formal service delivery channels?
- Why are traditional governance mechanisms and arrangements preferred over more formal state-led mechanisms? Is it because they are perceived to work more effectively? Is it because of very different cultures of accountability at the local level?
- How, if at all, do hybrid institutional arrangements work in practice and what lessons can be learnt for replicating them? In other words, how can the state promote and implement its welfare and development activities at the village level without disrupting the structure of traditional institutions? For instance, how

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did the involvement of both traditional and formal arrangements under NRHM and NREGA help or hinder the delivery of services?

- How do governance factors explain the progress in achieving key sector delivery outcomes in the state? What lessons can be learned from more systematically comparing and contrasting the governance of delivery in the different sectors?
- How has the integration of formal provisions for inclusion really impacted on local power relations and service delivery outcomes given that some elements of the ‘modern’ and ‘traditional’ aspects (for instance on gender inclusion) are both in operation? How have local actors adapted to the inclusion of women in formal mechanisms while still excluding them from the village council leadership?