

Understanding the Linkages between Governance and Service Delivery in Meghalaya: A Literature Review*

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MEGHALAYA INSTITUTE OF GOVERNANCE
INTEGRATED BASIN DEVELOPMENT AND LIVELIHOOD PROMOTION PROGRAMME



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Table 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 Centre
DEC	District Employment Council
FY	Financial Year
GDSP	Gross Domestic State Product
GoI	Government of India
GoM	Government of Meghalaya
HDI	Human Development Index
HMC	Hospital Management Committee
IEC	Information Education and Communication
MIG	Meghalaya Institute of Governance
MHDR	Meghalaya Human Development Report
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PHC	Public Health Centre
RKS	Rogi Kalyan Samiti
SDG	Sustainable Development Goals
SRS	Sample Registration System
US	United States
VEC	Village Employment Council
VHSC	Village Health and Sanitation Committee

Introduction

The Backdrop: Governance and Service Delivery Matter

Fostering development is a complex endeavor and there is now 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 developmental 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”*.

By the same token, there is a global recognition that ‘service delivery matters’ for achieving development outcomes. Whether this relates to reducing malnutrition, providing 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).

There is also a growing recognition that governance is critical in making or breaking service delivery. In many countries, service delivery outcomes have failed to achieve sustained and equitable improvements despite large-scale domestic and international resource investments. There is growing recognition that standard technical and financial measures to address service delivery have had limited effectiveness: they can fail to sufficiently take into account the reality of policy processes, the complexity of accountability and the motives and incentives that shape action (Harris et al, 2013; OPM, 2005: 8-9). A growing evidence base, instead, shows how governance factors can make or break service delivery. Such factors include: the nature and dynamics of political competition; the nature of elite incentives for delivery; relations between formal and informal sources of authority; the degree of capture and clientelism in the sector; citizen expectations and the ‘social contract’ for given services; the mode of service delivery;¹ the degree of effective oversight; or, the degree of collective capacities to address service delivery challenges (Batley and McLoughlin, 2012: 33; Foresti et al, 2013).

However, there are significant challenges in making progress on the governance of service delivery agenda. Three points are worth highlighting here. First, while there is a broad consensus that governance matters, there is much less consensus on how, precisely, governance 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, the evidence base on the nature and drivers of the governance of service delivery, albeit growing, is still very limited, with a dearth of detailed and comparative analyses. As Batley and McLoughlin (2013: 30) sum up, *“significant gaps in our understanding remain”*. This challenge is compounded by the fact that there is rarely a simple causal chain that can be established between governance and service delivery outcomes (Harris and Wild 2013: 4). Finally, many – although not all – development organizations tend to focus on narrower technical approaches and on resource transfers and shorter-term results, rather than the facilitation of longer-term institutional change (Andrews et al, 2012; Booth and Unsworth, 2014). In sum, there are knowledge and policy gaps in this field, as mentioned further below.

Zooming in: Meghalaya in India

Inspired by the above findings, the paper turns to the focus of this literature review – the governance of service delivery in Meghalaya, India. Meghalaya is an Indian state situated in the North East region, 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’² state.

The state has made progress in development, although a number of challenges remain. As elaborated in the following section, the state has made progress in economic growth and reducing poverty levels. However, major challenges remain and poverty levels remain high with a marked disparity between rural and urban poverty and dearth of economic opportunities in rural areas. Equally, the state's pace of progress in Human Development is also lower than the national average. The Government of Meghalaya (GoM) recognizes the bottlenecks in achieving greater progress in its Human Development Indicators (HDI), especially in education and health (12th Five Year Plan, 2012-2017).

Various observers note how the state's development progress and challenges can be explained, in part, by a range of governance and service delivery dynamics. A number of issues are cited but are not – as argued below – unpacked or analyzed in sufficient depth. These include the challenge of ensuring convergence and coherence between formal state structures and informal, tribal institutions in delivery; accountability and oversight deficits in terms of ensuring that resources are used as intended and that existing mechanisms for oversight and redress are used as effectively as possible; and, ensuring greater equity and inclusion in delivery decision-making and allocation.

One of GoM's key responses to these governance challenges was to establish the Meghalaya Institute of Governance (MIG) in 2013. The core aim of the MIG is to guide governance reforms in the state, by bringing together knowledge, people and technology to solve governance problems.³ However, MIG is a nascent institution and intends to strengthen its knowledge, capacity and organizational structures in order to fulfil its mandate over the coming years.

Rationale and Objectives of the Literature Review

The objective of this literature review is to explore how governance factors manifest themselves in, and shape the processes and outcomes of, the delivery of selected services in Meghalaya. Due to time and resource constraints, the review largely focuses on two service delivery programs: the delivery of social safety nets via the National Rural Employment Guarantee Act (MNREGA) and the delivery of health services via the National Rural Health Mission (NRHM). The selection of these programs is explained below. Specifically, the literature review attempts to begin filling three knowledge gaps:

- First, while there is a general recognition that governance matters to the delivery of services in Meghalaya, there is a dearth of knowledge about which aspects matter and how. As such, this literature review's key objective is to identify what is 'known' and is not known with a view to identifying areas for further research.
- Second, the literature review process and output is designed to build the capacity of the MIG in terms of identifying and assessing relevant governance and development issues. The review was conducted in close collaboration with MIG and some of the key gaps identified in this review has informed MIG capacity building activities and the piloting of primary research (see Lyngdoh et al, 2015; Output 2 of this NLTA).
- Third (and more broadly), the review attempts to make a contribution to some of the global knowledge gaps mentioned above. Specifically, it attempts to identify grounded analyses of service delivery implementation in Meghalaya to begin building a more grounded appreciation of the governance of delivery (Batley and McLoughlin, 2012: 30).

As such, the questions addressed in this literature review are as follows:

- What is known about the broad relationship between governance, development and service delivery in Meghalaya?
- What are some of the formal governance mechanisms 'on paper' associated with the delivery of MNREGA and NRHM?
- What are some of the governance processes/mechanisms 'in practice' associated with the delivery of MNREGA and NRHM? What factors explain this?

- How do such governance aspects appear to shape the processes and outcomes – for better or for worse – of the delivery of services?
- Based on the above, what are the gaps in our knowledge with regard to governance and service delivery in Meghalaya, more broadly, and governance in MNREGA and NRHM more specifically?

Methodology

The review attempts to answer the above questions via a qualitative desk-based analysis of available literature. Documentary research involved detailed examination of credible public and private documents on Meghalaya, including a range of academic, policy and donor literature. This included government publications (such as policy reports or departmental publications) and a range of other documentation such as academic articles and books, and non-governmental and civil society documentation, including newspaper articles. The information was identified via a range of databases (such as scholarly search engines, online research portals and online news portals) and via consultations with various experts in this field.

The two service delivery programs – MNREGA and NRHM – were selected for analysis based on a set of criteria. Due to time and resource constraints, a maximum of two service delivery sectors could be covered in any depth. A review of existing programs in Meghalaya was undertaken, and the two schemes were selected based on the following criteria: (i) whether the program aims 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 within the state and is extensive enough to enable us to cover a number of different governance dimensions (as opposed to a very small-scale initiative); and, (iii) whether there is, at least some, information available for the analysis.

Caveats

Before reading on, it is important to keep in mind two important caveats. First, there is a major paucity of literature on governance and service delivery in the state, more broadly, and governance of MNREGA and NRHM in Meghalaya, more specifically. Moreover, there is very limited rigorous research on the causal relationship between governance and service delivery outcomes in the state. As such, the points made below are tentative and represent hypotheses for further research. Second, the study does not claim to provide an exhaustive overview of the potential governance issues associated with the delivery of services; it focuses on the key areas that emerge from the available literature.

The review is divided into five main sections:

- Section 1, by way of contextualization, provides a brief snapshot of Meghalaya.
- Section 2 summarizes the key arguments in the literature regarding the broad linkages between governance and service delivery in the state.
- Section 3 then turns to a brief overview of MNREGA and NRHM, giving each programs’ institutional structure and formal governance mechanisms and provisions.
- Section 4 then turns to a review of what we know, and do not know, about how governance issues and service delivery interact in practice in the implementation of the two schemes.
- Section 5 concludes the review by summarizing the main findings and offering some questions and a framework for further research in the state on this topic.
- The Annexes provide further background information on relevant topics.

1. Background: Development and Governance in Meghalaya

This section provides a very brief snapshot of some development and governance characteristics in Meghalaya. It briefly provides an overview of Meghalaya's progress against various development indicators before giving a brief synopsis of its main governance arrangements.

Development and Service Delivery in Meghalaya

Meghalaya is an Indian state situated in the North-East of India 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'⁴ state. This means that it is the recipient of larger grants from the central government compared to the normal category states.⁵

The state has made progress in economic development although challenges remain. Its economy grew rapidly at an annualized rate of 7.8 percent during FY05-FY13 to US\$3.3 billion. However, the per capita income in the state is below the national average, and the gap between the state's per capita income and the national average has increased since 2005-06 (Rao et al, 2011: 5). Per capita Gross Domestic State Product (GDSP) of Meghalaya stood at US\$1,297 in FY12 – ranked 20 amongst the Indian states – and remained below the all-India average of US\$1450.⁶ The GoM Vision Document (Rao *et.al*, 2011: 17) notes that the state is struggling to achieve and maintain an adequate level of growth for various reasons mentioned below.

In terms of poverty, a mixed picture emerges. The latest available statistics offer different interpretations of poverty in the state depending on the definition of poverty. One official source (2011-12 poverty rates) notes that around 12% of the population was below the poverty line. Another government source notes that 48.9% of the population is living below the poverty line (Rao *et.al*, 2011: 17). One source notes that urban poverty has witnessed a strong decline from 24.7 percent in 2004-05 to 9.26 percent in 2011-12; whereas rural poverty reduced by just 1.47 percent from 14 percent in 2004-05 to 12.53 percent in 2011-12.⁷ There is, as such, a high disparity between rural and urban poverty and about 80% of the Meghalaya population live in rural areas.

In terms of service delivery and human development outcomes, the pace of progress is deemed to be lower than the national average in various sectors. The GoM recognizes challenges associated with its ranking in the Human Development Index (HDI), especially in education and health. For instance, the GoM 12th Five Year Plan (2012-17) notes that urgent efforts are required to bring down alarming levels of infant and maternal mortality. In 2005 (the latest available data on HDI), the HDI ranked Meghalaya at 26 among 32 states with a 0.585 HDI value. One concern was the state's deteriorating human development performance; Meghalaya was ranked 21st in 1981, 24th in 1991 and 26th in 2005 (GoM, 2009).

The service delivery and development challenges are starkest in rural areas. The burden of poor levels of growth and development, as observed in the literature, is disproportionately borne by rural Meghalaya (GoM, 2009: 113). People in rural areas score worse on HDI indicators and have poorer access to services. According to one source, access to services including education, health, housing and roads is much more challenging in rural Meghalaya because: i) habitations in rural and remote areas are scattered therefore the cost of providing basic services in these areas is very high; ii) absence of local level institutions for planning and monitoring and, iii) there is limited political will on the part of the state government and absence of adequate demand from local communities (Rao *et.al*, 2011: 95, 126).

In short, the state faces a range of development and growth constraints. Some of the cited challenges include: low agricultural productivity, unsustainable cultivation practises resulting in ecological degradation, centralised systems of governance and planning, remoteness of the region,

absence of proper connectivity and transport infrastructure, lack of adequate flow of trade and investments, weak market infrastructure and institutions and insurgency amongst others (GoM, 2009: pp. 267-288; Rao *et.al*, 2011: 9). In all, the state is seen to be struggling to maintain a steady pace of growth and development.

Governance in Meghalaya

The state of Meghalaya has a complex governance structure. At the risk of simplification, the responsibility of governance and service delivery falls under the ambit of three centres of authority: (i) the State; (ii) the Autonomous District Councils; and, (iii) grassroots indigenous ‘tribal’ institutions.

State Government

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 Autonomous District Councils (ADCs), which are now described.

Autonomous District Councils

In 1950, the Constitution of India – under the so-called Sixth Schedule⁸ – 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. According to one source, the broader development goal of the ADCs is to facilitate the implementation of welfare and development activities at the village level without disrupting the structure of traditional institutions and to “initiate the traditional institutions’ gradual evolution to assimilate greater democratic attributes” (Rao *et.al*, 2011: 50).

Meghalaya has three ADCs called Khasi, Jaintia and Garo. A number of executive, financial, legislative and judicial powers are vested in the ADCs to maintain and manage traditional institutions. The ADCs are mandated with the power to appoint the heads of traditional institutions and to oversee the governance of a range of issues concerning the tribal population: namely, use of land and resources, inheritance and social customs.

Grassroots Indigenous Institutions

A third centre of authority derives its legitimacy from grassroots tribal institutions and practices. Grassroots indigenous institutions have significant power in Meghalaya’s society, which is rooted in a long history. Historically, power to govern at the village level 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).⁹ The elected members organised themselves into a village council or the *Dorbar Shnong*. It is headed by a chief (locally referred to as the *Syeim, Doloï or Wahadar*). The council has significant power and legitimacy, rooted in un-codified customary laws and practises (Joshi, 2004: 267). The primary function of the *Dorbar Shnong* is to undertake development works and to manage local assets such as roads or water sources. It also functions as a court, trying petty cases such as those related to land disputes. The decisions of the *Dorbar* are often considered as legitimate and are usually adhered to.¹⁰

2. Governance and Service Delivery Challenges and Linkages in Meghalaya

Having briefly given the big backdrop, this section summarizes what the literature tells us about the broad relationship between governance, development and service delivery in Meghalaya. More specifically, the section briefly summarizes what the literature reveals about: (a) the broad governance challenges and dysfunctions in the state; and, (b) the relationship between governance, development and delivery. Overall, the literature on this area is too generic and poorly substantiated; although, there are a number of pointers that can be extracted, as outlined now. The section is separated into the key sub-themes that emerged.

The Relationship between 'Formal' and 'Informal' Sources of Authority and Policy (In)Coherence

The most frequently-cited governance issue in Meghalaya relates to the relationship between formal and informal sources of authority. These are particularly salient given the nature of the society and governance system in Meghalaya, as mentioned above. This is also a cross-cutting issue – one that appears to pervade all governance and delivery issues in Meghalaya – although it is given separate attention here. Overall, the literature on this topic is somewhat contested – and sometimes polarized – providing different views of the institutions and their impacts on development prospects. The discussion on this area focuses on a number of angles, which are briefly summarized below.

First, certain observers suggest that the ADCs are no longer a body that legitimately represents the tribal constituents it was designed to protect. ADCs were originally viewed as institutions that preserved and protected the traditional customs and practices of the tribals. Over time, however, it has been suggested that this view has changed. One reason put forward for this change is that the functioning of ADCs has become more ‘modern’¹¹, thus contributing to a greater distance between ADCs and their tribal constituents (Rani, 2014). Another reason is that the ADCs are increasingly perceived, by some, to be somewhat clientelistic or ‘politicized’ as mentioned below.

Second, other literature looks at the changing relationship between the ADC and the state and the policy incoherence that this breeds. This literature suggests that the ADCs’ powers have progressively been reduced in relation to the state and that the two bodies have overlapping responsibilities and jurisdictions. Certain observers opine that the powers of the ADCs have been limited notably by major amendments to the Sixth Schedule. They point to the amendment (Para 12 (A)) of the Act which states that: in case a law made by the ADC conflicts with that of the state, the law of the state prevails. They argue that this has contributed to jostling for power, has strained the relationship between the state and the ADCs and has led to delays and policy incoherence (Institute of Developing Economies 2005: 130; Prasad & O’Meally, 2015).

A third body of literature points towards real and potential tensions between state and grassroots, traditional institutions. Joshi (2004) for instance notes that grassroots indigenous institutions in Meghalaya have felt threatened by state interference and ‘modernization’. He puts it that the, “principles of individual liberty, the rule of law and the expectation of competitive politics come directly in conflict with traditional values of tribal life, implying group assertion, kin-protection and collective effort”(Joshi, 2004: 7; also, Scott, 2009).

A final area of the literature looks at the linkages between formal and informal institutions in Meghalaya and the delivery of development services. At the risk of simplification, there is some noticeable contestation over whether the ‘informal’ institutions or the ‘formal’ institutions are the binding constraints to improved development and delivery outcomes. Each side of the argument is briefly summarized here.

On the one hand, traditional institutions are sometimes framed as barriers to development and improved delivery. For example, some bystanders suggest that traditional institutions have limited the

overall progress of the state, arguing that “what the state proposes, traditional institutions oppose” and such systems are “stubborn opponents of modern governance” (Mukhim, 2012). For instance; traditional institutions are opposed to the idea of civic elections in urban areas and the absence of elected civic bodies has made it difficult to access funds to improve civic infrastructure, cleanliness and waste management (Mukhim, 2012). More broadly, questions have been raised about the extent to which such tribal institutions are democratic or inclusive enough, given that women are often excluded or office can be inherited (Lyngdoh, 2015).

On the other hand, other diagnoses point to the ways in which formal institutions have hampered development. They argue that a major deficit hampering development has been the inability of formal systems to respond to local needs. The GoM Vision Document argues that a major constraint facing development in the region is the centralised nature of governance and planning which does not make adequate space for bottom-up, traditional processes (NIPFP 2011, 39). It is opined that this has led to the ineffective implementation of schemes marred by unaccountable spending and poor monitoring (NIPFP 2011:39). Indeed, certain literature points to the continued relevance of harnessing traditional institutions to ensure the effective functioning of local governance and planning (Rao *et.al*, 2011: 56).

In sum, the literature points to the tension between formal and informal institutions but more research would certainly be needed to unpack this. In sum, the literature points to a core governance challenge in the state: the need to balance pressures for a unified ‘formalistic’ Indian state with the imperative to include and preserve the customary tribal institutions of the majority tribal populations. As the GoM sums up, “the challenge in designing local planning approaches in Meghalaya lies in harmonising the functions and rights of traditional tribal self-governing village institutions with constitutionally approved institutional mechanisms designed for modern development and service delivery” (Rao *et.al*, 2011: 56). However, there are major gaps in the literature as summarized in Section 5.

Citizen Expectations and the ‘Social Contract’

Some literature also points to the potential role that citizen expectations might play in service delivery in the state, although this is weakly substantiated. Some studies have pointed to citizens’ perceptions of the formal and informal governance systems. It is opined that citizens struggle to combine their allegiance to the formal legal system of the Indian Constitution with adherence to their traditional or customary practices: Gassah, a well-known academician in the state, is of the view that the local community has not been able to accept modern political institutions completely or reject traditional institutions (Rani, 2014). However, there are major knowledge gaps: (i) citizens expectations are not systematically captured in the literature; and, (ii) the impacts of citizens expectations on service delivery processes and outcomes is not examined.

The Effectiveness of Oversight Mechanisms

Other observers point to weaknesses in oversight and accountability mechanisms, which hinder development progress. They suggest that there are gaps and weaknesses in various accountability and transparency mechanisms in the public management of resources, which poses a challenge for development in the state (Institute of Developing Economies, 2005; Lyngdoh, 2015). Accountability deficits are also compounded by the overlapping formal and informal institutional structures. For instance, municipality of toll gates on National highways has been established by traditional chiefs, ADCs and the government. This can lead to conflicts between lorry drivers and toll-gate employees. Similarly, irregularities related to the issuance of trading licenses in urban centres have also been highlighted as a problem resulting because of the presence of multiple administrative structures (Institute of Developing Economies 2005: 135). Citizens, some suggest, suffer the most in such situations because they do not know who to hold accountable for the failure in service delivery (Mukhim, 2004).

Elite Incentives for Delivery

Some of the literature also hints, albeit partially, towards the role of elite incentives in helping or hindering delivery. One report (Rao et al, 2011: 126) argues that poverty and weak service access in rural areas is caused, in part, by a lack of political will on the part of the state government and the absence of bottom-up pressures from local constituents. The report, however, only makes fleeting reference to this point and does not explain why this ‘will’ is limited. Other literature implies that certain institutions’ incentives are not aligned with pursuing improved delivery. One analysis of the ADC suggests that ‘politicking’ has become common in the ADC, as political parties are seen fielding party members as candidates for ADC membership (Rani, 2014). This has led to some seeing the ADC as more of a political springboard than an agent of tribal welfare and development or as seeing it as a vehicle for controlling – rather than protecting – traditional institutions and interests (Rani, 2014).¹² These points, however, are poorly substantiated or unpacked across the range and levels of service delivery institutions.

Institutional Capacity

Another cited constraint to delivery is ‘weak institutional capacity’. This is broadly defined in terms of limited human, technical and financial resources to address the range of development and service delivery challenges. For instance, one report points to a number of development constraints in Meghalaya such as low agricultural productivity, unsustainable cultivation practises, lack of adequate flow of trade and investments or weak market infrastructure. It goes on to argue that the state has not been able to fully address these constraints due to its weak institutional capacity (Rao *et.al*, 2011: 9). However, the term ‘capacity’ is often used broadly and there are limited analyses to unpack the different dimensions of capacity and their underlying drivers (a point taken up throughout this review).

The Broader Nature and Dynamics of Political Competition

Some documents also point to the relationship between political ‘instability’ and development program implementation. According to some sources, Meghalaya is a politically unstable state. From 1990 to 2000 nine governments have come to power (Press Trust of India, 2009). The state has also been under President’s Rule twice; in 1991 to 1992 and 2009. It is opined that political instability has constrained programme formulation and implementation (Rao *et.al*, 2011: 44). In 2012, for instance, funds had to be returned to the Development of North Eastern Region Ministry owing to the non-implementation of almost 40 schemes in the absence of stable rule (Lim, 2012). In this regard, the current Chief Minister of Meghalaya is cited as drawing broad linkages between the broader context and the poor implementation of development schemes. He ostensibly referred to, ‘absence of interest, connivance at different levels, no political will from successive chief ministers and the lack of moral courage to hold anyone accountable’ (Mukhim, 2011). However, these issues – and their relationship with service delivery outcomes – are not unpacked or substantiated in systematic depth in the available literature. The above points are returned to in Section 5.

3. Social Safety Net (MNREGA) and Health (NRHM) Delivery in Meghalaya: Governance ‘On Paper’

Having discussed some broader governance, development and service delivery issues in the state, the discussion now focuses on governance in two specific service delivery programs: MNREGA and NRHM. The purpose of this section is three-fold: (i) it provides a brief introduction to the delivery programs by outlining their objectives and delivery structures; (ii) it summarizes the in-built ‘formal’ governance provisions that are part of the delivery scheme; and, (iii) it summarizes some of the outcomes associated with the programs. In short, this section focuses on the formal structure of the schemes as per their written design; that is, ‘governance on paper’. The next section unpacks actual governance dynamics in implementation; that is, ‘governance in practice’.

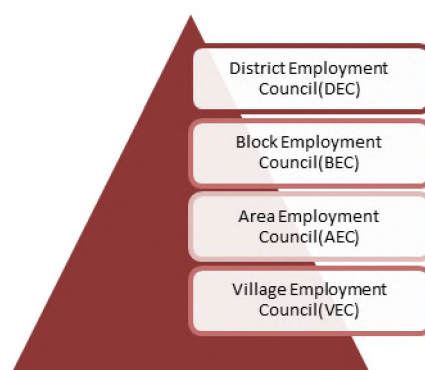
Social Safety Net Delivery via MNREGA: A Profile

Program Objectives and Modes of Delivery

The Mahatma Gandhi National Rural Employment Guarantee Act (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, via this wage employment, it aims to create durable assets so as to enhance service access and the livelihood security of the rural poor (Official Website of MNREGA).

The structure for the delivery of the program is briefly described here. Since 2006, MNREGA in the state has largely been implemented via a four-tier arrangement as summarized in Figure 1. It has set up delivery bodies at the main administrative levels in the state, which are: (i) the district level; (ii) the block level; (iii) the cluster level, above the village; and, (iv) the village level (Official Website of SRES). Further details on the role and responsibilities of each actor is provided in Annex I.

Figure 1: Implementation Structure of MNREGA (Source: State Rural Employment Society)



‘Formal’ Governance Arrangements in MNREGA

MNREGA has a number of in-built provisions, on paper, for addressing governance issues in program implementation. As a right-based Act, it prescribes legally mandated mechanisms that cover three main areas: inclusiveness/citizen engagement, transparency and accountability. Annex II lists the key service elements and the in-built governance mechanisms. The main elements are briefly summarized here.

In terms of ‘inclusiveness’, the implementation arrangements envisage combining elements of the modern ‘formal’ and traditional ‘tribal’ systems. Unlike the local governance arrangements in other parts of India (known as the Panchayati Raj Institutions (PRIs)), members of the MNREGA village-level implementing body are not elected. The village headman is directly appointed as the Chairman

of the Village Employment Council (VEC) and takes on formalized roles and responsibilities under the program, in addition to his traditional role. The selection of two other members of the VEC is undertaken based on village consensus. Furthermore, the Act stipulates mandatory representation of women in the VEC and AEC, which differs from the traditional *Dorbar* where women are excluded.

In terms of ‘transparency’, MNREGA envisions a number of measures. It envisages a transparent system insofar as systematic record keeping and expenditure tracking is mandated, and citizens have the right to scrutinize this information, such as via public scrutiny of muster rolls and the maintenance of job cards. Moreover, the MNREGA supports measures for pro-active disclosure such as posting information on public notice boards and undertaking Information, Education and Communications (IEC).

In terms of ‘accountability’ – answerability and enforcement – various measures are envisioned. First, as a rights-based approach, the Act envisages a number of rights and entitlements for wage demanders with liabilities for failing service providers (Table 1). Second, citizens also have the right to monitor the flow of public funds. Most notably, periodic social audits are mandated under the MNREGA. Finally, there are in-built ‘grievance redressal mechanisms’. A person has a number of channels for raising complaints: a person can submit a written complaint to the Programme Officer or the District Coordinator, submit his or her grievance in a complaint box, or raise his/her grievances at public forums organised by the VEC/AEC and the social audit forum. The Act stipulates that all complaints must be addressed within 7 days from the time of their receipt.

Table 1. Rights and Entitlements under MNREGA	
Application for work	Every adult named in the Job Card is entitled to apply for unskilled manual work
100 days of work	All persons belonging to a household and registered shall be entitled to employment under the Scheme for as many days as each applicant may request, subject to a maximum of one hundred days per household in a given financial year.
Access to work within the village	The applicant shall be provided work within the village. If an applicant is provided employment outside a radius of five kilometres where he/she resides at the time of applying he/she shall be paid an extra 10% of the prevailing wage rate.
Unemployment Allowance	If an applicant is not provided with such employment within 15 days of receipt of his/her application or from the date on which the employment has been sought in the case of an advance application (whichever is later), he/ she shall be entitled to a daily unemployment allowance.
Right and entitlements of women	Priority shall be given to women in such a way that at least one-third of the wage seekers shall be women who have registered and requested for work.
Timely payment of wages	If wage payment is not made within a fortnight, the workers shall be entitled to receive compensation. Compensation Cost shall be borne by the State Government.
Access to just and favorable conditions of work	Workers are entitled to work site facilities like safe drinking water, shade for children and periods of rest, first-aid box with adequate material for emergency treatment of minor injuries and other health hazards connected with the work.

Outcomes

The available data is patchy but suggests that MNREGA in Meghalaya has been relatively successful in achieving some of its desired outcomes. As per official figures in Meghalaya, in 2014-15, out of the total number of households who demanded work (357604), almost 98% were provided employment.¹³ Furthermore, other outcomes have been documented. For example, according to a sample research study conducted by IIM Shillong (Panda, B *et.al.* 2009: 77-87), the major outcomes of the scheme in Meghalaya were: the creation of supplementary income; enhanced food security; creation of local assets specifically roads; and, the empowerment of rural women because of their active involvement in activities.¹⁴ In fact, literature evaluating the performance of MNREGA across India indicates that the North-east region are “leaders” insofar as the goal of employment generation is concerned (Drèze, *et.al.*, 2009). One key question, as mentioned again below, is *why* the scheme has been successful in Meghalaya and what governance factors explain this ‘success’.

However, this does not negate the fact that there are challenges associated with delivery. As discussed in Section 4, it would not be convincing to argue that it is an unmitigated success. Moreover,

further research would be required to examine the extent to which the above-mentioned outcomes have been reproduced across the state.

Implementation Status of MNREGA in Meghalaya, 2014-15¹⁵

State MECHALAYA												
District	No. of Registered		Job Card Issued	Employment demanded		Employment offered		Employment Provided			No. of filled Muster Roll	No. of Families Completed 100 days
	Household	Persons		Household	Persons	Household	Persons	Household	Persons	Persondays		
EAST GARO HILLS	30320	64650	29872	25431	34975	25408	34952	25245	34662	1036345	18277	4
East Jaintia Hills	23345	38024	22639	13609	17502	13608	17501	13566	17312	593865	8607	379
EAST KHASI HILLS	81503	142898	79842	52680	62641	52680	62640	50721	59547	2473710	31999	5007
JAINTIA HILLS	45096	84446	43208	26944	34532	26941	34527	26404	33848	780000	9731	779
NORTH GARO HILLS	29750	77290	29580	28129	51364	28128	51361	28092	51284	1197840	14698	333
NI BHOI	52049	102279	47108	31642	50192	31642	50191	30397	47921	1289270	12999	2058
SOUTH GARO HILLS *	30025	62850	29650	23348	30302	23316	30237	23194	29895	1404465	13310	6799
SOUTH WEST GARO HILLS	32094	72325	32090	29860	31890	29858	31888	29368	31176	1292503	11207	627
SOUTH WEST KHASI HILLS	20023	40271	19955	15195	16606	15195	16685	15082	16566	671750	3250	290
WEST GARO HILLS	86332	183678	86142	79696	93523	79682	93504	78474	92029	4425776	34494	13341
WEST KHASI HILLS	53659	128574	53281	31670	49877	31068	49873	30581	48669	1537687	11399	2559
Total	404196	997205	473367	357604	473404	357526	473359	351124	462909	16703211	169979	32176

Source: Official Website of MNREGA

Health Service Delivery via NRHM: A Profile

Program Objectives and Modes of Delivery

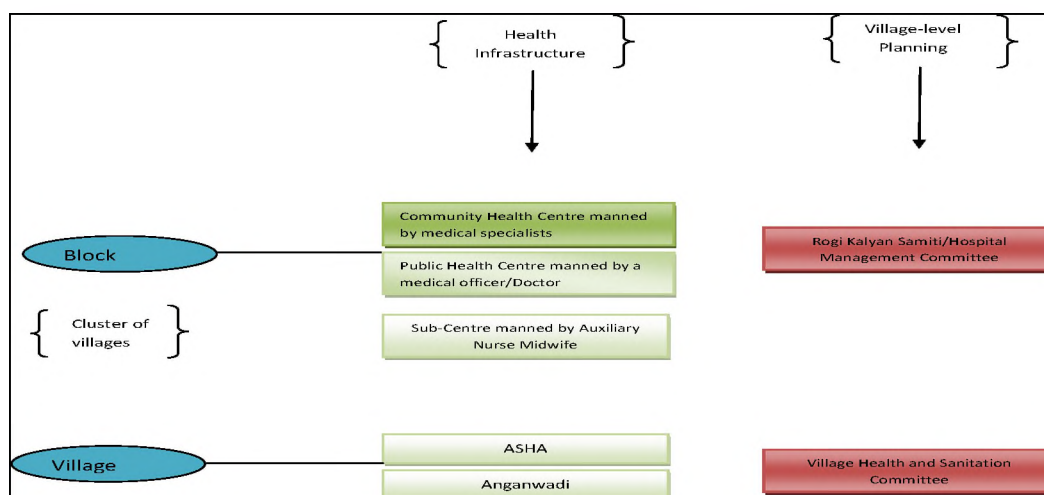
The National Rural Health Mission (NRHM) is a national program designed to improve a number of health outcomes. The GoI describes NRHM as a national effort, “to provide effective health care through individual, household, community and health system level interventions. It mainly targets the rural population, especially marginalised groups including women and children by improving access, enabling community ownership and demand for services, strengthening of public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralization” (Official Website of NRHM, GoM). It the front-line, NRHM aims at achieving the outcomes summarized in Box 2 (Official Website of NRHM, GoM)

Box 2: NRHM: Key Targeted Outputs and Outcomes at the ‘Front line’

- Availability of trained community level workers at village level, with drug kit for generic ailments
- Health Day at Anganwadi¹⁶
- Availability of generic drugs for common ailments at Sub-center and hospital level
- Assured hospital care
- Improved facilities for institutional delivery
- Assured healthcare at reduced financial risk
- Provision of household toilets
- Improved outreach services through mobile medical unit at district-level

Under the main implementation arrangements, a multi-tier delivery system has been developed. As summarized in Figure 2, 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 Activist (ASHAs) – village level trained health outreach workers – and the Anganwadis. 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, Village Health and Sanitation Committees (VHSC) for planning and monitoring health care activities. Further details on the roles and responsibilities of the different tiers and actors is outlined in Annex I.

Figure 2: NRHM Main Implementation Arrangements



‘Formal’ Governance Arrangements in NRHM

NRHM, like MNREGA, has a number of in-built provisions, on paper, for addressing governance issues in program implementation. NRHM is not as strongly rooted in a ‘rights-based’ approach like MNREGA, although it does include a number of provisions in terms of inclusiveness, transparency and accountability. Annex III lists these elements, which are also briefly summarized here.

In terms of ‘inclusiveness’, it envisages mechanisms to foster a more inclusive planning and delivery process. It has established the VHSCs and HMCs which envisage involvement of diverse stakeholders in the service planning, delivery and monitoring. Membership includes groups from ‘formal’ state structures and ‘informal’ tribal structures, such as village headman. NRHM also directly 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.

With regards to ‘transparency’, the scheme has two main elements. First, a network of community health workers (i.e. ASHAs) is required to reach out to the households via door to door visits and outreach programmes. Second, IEC activities are supposed to be undertaken, such as the distribution of posters or leaflets, advertisements in newspapers or the holding of street plays.

In terms of ‘accountability’ certain mechanisms are foreseen. As per the state programme implementation plan 2012-13, top-down incentives are in place to determine budget allocations, as briefly summarized in Box 3. Furthermore, NRHM envisages improved monitoring via the establishment of ‘community monitoring mechanisms’ such as Jan Samvad and the establishment of monitoring committees linked to the VHSC and HMC, amongst others.

Box 3: Budget Allocation Conditions and Incentives under NRHM

Some of the conditions that will draw additional allocations or reductions are:

- Non-compliance may translate into a reduction in outlay up to 7 ½%¹⁷
- Gaps in implementation may lead to a reduction in outlay up to 10%¹⁸.
- Responsiveness, transparency and accountability (up to 8% of the outlay)
- Quality assurance (up to 3% of the outlay).
- Recording of vital events including civil registration of births and deaths (up to 2% of outlay)
- Policy and systems to provide free generic medicines to all (up to 5% of the outlay)

Outcomes

The available data paints a mixed picture on the outcomes. Certain reports illustrate a range of improvements in health care infrastructure and certain outcomes. For example, according to a study in 2009-10, access to health care facilities had improved with the creation of 420 sub-centres at the village level, 108 PHCs and 29 CHCs at the block level (NRHM Evaluation Report, 2009:12).¹⁹

Meghalaya, however, has not performed well on a number of health indicators. Due to its lagging indicators, it has been categorised as a high focus state under NRHM (Official Website of NRHM, GoM). Notably, health indicators for women and children are seen as particularly alarming: the Infant Mortality Rate of the state is at 47, much higher than the national average of 40 (SRS 2013); the Maternal Mortality Rate is 264.87 (Nongkynrih, 2013:2) as against the national average of 212 (SRS 2011); 71% of home deliveries are undertaken in the absence of skilled care (Oosterhoff *et.al.*, 2015: 8); 64% of pregnant women are anaemic as against an all India average of 12.8 %; and, almost 35% of the women in Meghalaya do not have access to family planning (Oosterhoff *et.al.*, 2015: 8). Indeed, the extent to which such statistics can be attributed to NRHM and its related governance factors would be an important matter for further research. These points are returned to in Section 5.

4. Implementing MNREGA and NRHM: Governance ‘in Practice’

This section now reviews how governance factors manifest themselves in actual implementation and how such factors are documented to shape delivery processes and outcomes. Specifically, it attempts to address the following key questions outlined in the introduction: what are some of the governance processes/mechanisms ‘in practice’ associated with the delivery of MNREGA and NRHM? What factors explain this? How do such governance aspects appear to shape the processes and outcomes – for better or for worse – of the delivery of services? However, the literature on these issues is very ‘thin’, so the following discussion largely presents tentative pointers and hypotheses.

MNREGA Delivery and Governance in Practice

Institutional Capacity

Issues of institutional capacity are often cited to explain problems in MNREGA delivery. A number of pieces highlight these issues and focus on different dimensions of the capacity question. For instance, Feroze et al (2012: 32) argue that a lack of ‘technical’ capacity has limited the scope and effectiveness of delivery. Other pieces focus on weaknesses in local or ‘front-line’ capacity. They point to the fact that local systems for administration and implementation are relatively weak, with traditional institutions as the primary front-line delivery vehicles. They contend that it is a major challenge to capacitate these institutions to manage the formal system and to fulfil their planning and implementation requirements (Benbabaali, 2009; Mukhim, 2012; Umdor, 2014). More broadly, another observer suggests that MNREGA could perform better if the utilization of funds were improved and human resource capacity strengthened. Specifically, Banerji (2011) argues that Meghalaya has failed to improve its performance in effectively utilizing funds and that there is a major human resource constraint at the level where money needs to be channelled, with local functionaries unable to manage large amounts of funds.

This literature, however, has various gaps here. First, while the term capacity is used regularly, there are limited analyses that unpack the different dimensions of this capacity in depth or that offer diagnoses of the underlying drivers of this (lack of) capacity. Second, there is something of a contradiction in the available literature: on the one hand, MNREGA outcome data in Meghalaya paints a quite positive picture (see Section 3), which implicitly suggests that implementation capacity is quite good; on the other hand, a number of observers bemoan the weak local capacity. This puzzle would need further investigation.

Elite (Dis)Incentives for Delivery

Other literature suggests that delivery performance is hindered by weak incentives for delivery. Various reports suggest that there are cases of ‘skewed’ flow of funds wherein resources are diverted at different levels. This has included cases of misappropriation of funds, bribery, delays in release of wages or irregularities involving members of the VEC and AEC (Feroze, S.M et.al 2012: 32; MNREGA Annual Report, 2011-12; Umdor, 2014). Another observer has pointed to the challenge of bureaucratic interference or capture in scheme delivery. In some cases, it is reported that bureaucratic interference – from the Block Development Officer (BDO) – is high, with the BDO going through muster rolls and sanctioning work and wages instead of the mandated VEC (Benbabaali, 2009: 5-6). Looking at the question of incentives from another angle, Lyngdoh (2013) argues that AECs and VECs are expected to work on a voluntary basis and are thus not incentivized to fulfil their functions properly: he is of the view that, in the absence of incentives, occurrences of malpractice are more likely. Overall, this body of literature points to some weak or skewed incentives to follow the prescribed scheme guidelines, which reduces performance (Umdor, 2014).

In sum, this literature points to the problem of weak incentives in delivery, though further research would be needed. Overall, these points require further substantiation. Deeper analysis would

be needed to understand the drivers of the observed practices, what levels they take place at and how they have impacted on service delivery outcomes.

Effectiveness of Oversight Mechanisms

Related to the previous point, some literature points to weaknesses in oversight mechanisms, which hampers delivery. One review argues that program monitoring mechanisms are relatively poor (Feroze, S.M *et.al* 2012: 32). Another observer argues that local accountability mechanisms are weak because most village headman are unaware of modern accounting procedures and that there is an absence of proper accounts and clear oversight (Mukhim 2012). Umdor's analysis of the implementation of social audit processes in Meghalaya similarly points to oversight deficits: his review of 55 VEC documents suggests that the process was undertaken to fulfil the formal requirements but did not engender deep scrutiny of records (Umdor, 2014: 15). However, the analyses on this sub-theme are partial and not systematically or rigorously documented.

The Relationship between 'Formal' and 'Informal' Sources of Authority and Policy (In)Coherence

Some sources hint at the challenging relationship between formal and informal sources of authority in MNREGA delivery. Some sources point to how weak local administrative autonomy and the over centralisation of formal systems has undermined performance (Banerji, 2011; Mukhim, 2012). It is opined that despite increased devolution of funds and functions at the village level in the program, the prerogative of taking key decisions remains in the hands of the centre, which has limited grassroots ownership (Benbabaali, 2009: 5-6).

This aspect, however, is surprisingly weakly documented in the literature. Although this issue emerged as critical in relation to governance and delivery in the state (Section 2), it is scarcely covered in the literature on MNREGA. The extent to which the interactions between formal and informal sites of authority shape delivery outcomes is hardly assessed.

Citizen Expectations and Societal Capacity for Collective Action

The literature also hints towards the issue of societal capacity in taking collective action to influence service delivery. The global literature suggests that the degree to which societal actors can organize, articulate their interests and take action can shape service delivery processes and outcomes. The literature on this area in Meghalaya on MNREGA is limited and inconclusive. There are, however, some examples that hint at growing 'bottom-up' pressures to improve MNREGA delivery. In North Garo Hills, for instance, functionaries from 21 VECs opposed the engagement of contractors for the material component of the scheme and sought government intervention to revoke such a practise (OhMeghalaya, 2015). More broadly, some sources point to the increasing role of non-state actors in the state mobilizing to improve delivery and accountability (Choudary 2005; Nongkynrih, 2013: 6). However, there are gaps in this area. The degree to which societal actors can organize and influence MNREGA outcomes is not well documented. Moreover, the literature does not say much about the extent to which the state responds to such bottom-up pressures.

Inclusion/Exclusion Dynamics

Finally, the literature suggests that program provisions have made governance more 'inclusive' yet this is poorly substantiated and its impact on delivery outcomes is not measured. Under MNREGA, one mechanism for inclusion has been the stipulation to include women in the AEC and VEC. Certain literature claims that women have been involved on better terms in decision-making via the AEC and VEC (Lyngdoh, 2013). Some literature also suggests that women are treated relatively equally in delivery: for instance, a study conducted by IIM Shillong on MNREGA in 2009 suggested that men and women were paid equal wages (Panda, B *et.al.*, 2009:69). The literature, however, tells us very little about how, if at all, the 'improved inclusion' of women has impacted on delivery processes

and outcomes; or the degree to which women have influence in such settings. This may warrant further attention as in traditional practices women tend to be excluded from decision making and management.

NRHM Delivery and Governance in Practice

Institutional Capacity

The literature throws up the issue of capacity constraints. Namely, it reveals that village-level bodies such as the VHSC and RKS have been performing poorly. As per the NRHM evaluation study commissioned by the GoM (2009:89), almost 50% of total sampled villages felt that VHSC had a limited contribution to make at the village level. The study highlighted that citizens perceived the VHSC and RKS as ineffective, and a number of citizens were unaware that such institutions constituted a part of the health system (NRHM Evaluation Report, 2009:87). Other major ‘capacity’ challenges that have been identified in the literature include poor health care infrastructure, rugged topography making it difficult to reach out to everyone, and poverty which prevents people from seeking timely health care (NRHM Evaluation Report, 2009-10: 12). This issue of capacity – as mentioned above – would need further unpacking.

Elite (Dis)Incentives for Delivery

Certain literature suggests that some elites – in bureaucratic and political circles – may not have strong incentives for delivering services as per plans. Some studies suggest that health service delivery has experienced a number of irregularities pointing to the presence of incentives and interests that run counter to improved delivery outcomes. For instance, one study found that 75% of doctors were running private clinics in their allotted resident quarters (NRHM Evaluation Report, 2009:86). Another example relates to access to drugs. Reportedly, PHCs and CHCs often complain of shortage of generic drugs, which forces citizens to buy drugs at higher rates from the market (Lim, 2012). Related to this, it is reported that Meghalaya is currently faced with a ‘scandal’: allegedly large amounts of medicines were procured under NRHM, were kept unused until their expiry and were disposed of (Shillong Times, 2015)

Effectiveness of Oversight Mechanisms

Some sources also identify poor monitoring and oversight mechanisms as limiting access to basic health care services. Various reports point to ‘weak’ monitoring and oversight, mechanisms which enable certain malpractices (NRHM Evaluation Report, 2009; Nongkynrih, 2013; Choudary, 2005). Moreover, while the scheme provides for the involvement of citizens in monitoring, the actual implementation is called into question. For example, some sources suggest that grievance redressal mechanisms – such as the use of suggestion boxes at CHCs and PHCs – are not functional. One reason cited for the limited effectiveness of the grievance redressal mechanism is lack of ‘will’ (NRHM Evaluation Report, 2009-10:74-75). This, yet again, is poorly substantiated. First, it is not documented how the range of community monitoring mechanisms actually work on ground. Second, there has been limited analysis of the existing oversight mechanisms and how they could be strengthened; for instance the so-called ‘lack of will’ for the enforcement of grievance redressal is not assessed or explained.

The Relationship between ‘Formal’ and ‘Informal’ Sources of Authority and Policy (In)Coherence

Some sources suggest that certain implementation challenges in NRHM are related to the fact that it has not struck the right balance between formal, centralized delivery and tailoring to informal, local realities. For example, Oosterhoff et al (2015: 17) claim that the NRHM planning processes have failed to recognize the contextual realities of the region and ‘bottom-up’ planning of health schemes has been prioritized on paper but not in practice. They cite the example of ‘institutional deliveries’, arguing that such births are not necessarily preferred by local women because of the time and money involved and because they do not want to spend a lot of time in hospitals. NRHM in Meghalaya fails to recognise these issues and encourages institutional deliveries rather than

encouraging traditional birth attendants. They describe this as a “cut and paste policy” (Oosterhoff *et.al*, 2015: 18).²⁰

Moreover, some reports suggest that NRHM in Meghalaya has not connected adequately with ‘informal’ institutions in delivery, which has hampered performance. It is suggested in some sources that NRHM has failed to fully ensure embeddedness within the informal tribal system, and that NRHM needs to be better rooted in local languages and meanings to enhance community ownership (NRHM Evaluation Report, 2009-10: 26). Similarly, other studies have argued that modern frameworks of practising accountability envisaged under NRHM are either absent at the local level or are still at a very nascent stage of their development. They point to a lack of clarity about the ‘modern’ health system at the local level and the absence of mechanisms to engage with service providers. This has, apparently, hindered the achievement of intended results (Oosterhoff *et.al*. 2015: 26). These issues would warrant further attention and substantiation.

5. Summary and Research Implications

The purpose of this review was to assess existing knowledge on how governance factors shape service delivery processes and outcomes in Meghalaya. Focusing primarily on two selected services, the review had three core objectives: (i) to address and identify knowledge gaps in this area in Meghalaya; (ii) to build the capacity of MIG by involving them in ‘learning by doing’ governance analysis and by helping them define and pilot innovative primary research (see Lyngdoh et al, 2015); and, (iii) to make a broader contribution to global debates on this important issue. As noted in the introduction, it is now globally recognized that governance factors can make or break service delivery, yet much more needs to be known about how, precisely, this happens.

The findings are tentative and preliminary given the weakness of the available evidence. Nonetheless, it is possible to *begin* identifying and unpacking some important factors that impact on service delivery processes and outcomes. This section, as such, is broken down into two sub-sections: (i) the first sub-section briefly summarizes some of the main findings; and, (ii) the final sub-section identifies some interesting avenues for further analysis and policy debate.

Summary of Key Messages

The Meghalaya Backdrop

The review reveals a number of development and service delivery challenges in Meghalaya. Some of the cited challenges include: entrenched poverty especially in rural areas, difficulties in sustaining growth, low agricultural productivity, unsustainable cultivation practises, remoteness, limited connectivity, lack of adequate flow of trade and investment, and weak market infrastructure. Moreover, the review points towards service delivery deficits. These relate, mainly, to weak and uneven access to an adequate quantity and quality of services. In particular, observers are alarmed by limited progress in various human development and service delivery outcomes; with certain education and health indicators being of the greatest concern.

Against this backdrop, the state has a complex governance structure. At the risk of simplification, the responsibility of governance and service delivery in the state falls under the ambit of three different centres of authority: (i) the State; (ii) the ADCs; and, (iii) grassroots ‘tribal’ institutions.

Broad-brush Linkages between Governance, Development and Service Delivery in the State

The literature, see Section 2, gives some tentative cues towards thinking about the overall linkages between governance, development and service delivery in the state. It points towards a number of ways in which governance issues *may* impact on service delivery processes and outcomes, summarized below. These issues are interlinked and overlapping but separately discussed. Overall, the issues are somewhat broad-brush and poorly substantiated; they are further unpacked in the below discussion on MNREGA and NRHM.

The Relationship between ‘Formal’ and ‘Informal’ Sources of Authority and Policy (In)Coherence

Perhaps the most prevalent issue is the presence of – and complex relationship between – multiple centres of formal and informal authority. Meghalaya’s service delivery landscape comprises a diversity of providers, representing ‘modern’ and ‘traditional’ governance arrangements. Overall, the literature is somewhat contested and inconclusive on this area, yet it points to the following key issues: (i) how ADCs may not be perceived as legitimate representatives of tribal groups; (ii) how ADCs have lost certain powers relative to the state and this has led to strained relations and policy incoherence in program delivery; (iii) tensions between state institutions and grassroots indigenous institutions; and, (iv) contested views over whether the formal *or* informal institutions are the major barriers to development in the state.

More specifically, the nature of engagement between formal ('modern') and informal ('traditional') sources of authority points to areas of policy and delivery incoherence. Certain examples suggest that indigenous 'local' institutions struggle to exert their autonomy and authority in the presence of what is claimed to be an overly 'centralised' governance arrangement. This is further compounded by the lack of clarity over who is responsible for what in service delivery. At the same time, the State Government explicitly recognizes that the planning process has to be taken forward in harmony with the traditional system.

The Effectiveness of Oversight Mechanisms

Some observers point to weaknesses in oversight and accountability mechanisms which potentially limit service delivery outcomes. The broader literature hints towards deficits in the general oversight and monitoring mechanisms within the state. They also suggest that the quality of implementation of 'modern' accountability mechanisms, such as record-keeping and accounting, is relatively poor. This problem is, some argue, compounded by fragmented and overlapping lines of accountability and an inability to connect adequately with traditional systems of accountability, as discussed below.

Institutional Capacity

As is common in the global literature, institutional capacity deficits are referred to as one key way in which governance aspects affect service delivery outcomes. A number of sources broadly identify the capacity constraints in terms of human, financial and technical capacity. They also underline that local level bodies, in particular, lack the capabilities to effectively manage services; a point which re-emerges in our sectoral review below.

Citizen Expectations and the 'Social Contract'

The literature hints towards the potential role that citizen expectations might play in service delivery in the state. The literature broadly suggests a degree of citizen disinterest in, and disengagement from, the 'formal' or 'modern' system, which impacts on service delivery. It has been contended that this is, in part, because the modern practices of governing service delivery are not well rooted in local language, values, understandings and practices, which hints towards something of a 'misfit'. This misfit may help explain why modern practices of accountability and transparency are not fully effective at the 'grassroots' level. However, these conclusions are not yet convincing, because there is very little evidence available on citizens' *real perceptions* of modern and traditional governance structures and the degree of allegiance that they owe to these different centres of authority.

Elite (Dis)Incentives for Delivery

The broader literature alludes towards the role of elite incentives in helping or hindering delivery. It refers to the broader issue of a lack of 'political will' in improving certain service outcomes or the 'politicization' of certain governance and delivery institutions. This ultimately points to weak or skewed incentives for furthering broad-based service delivery goals. This area, however, is weakly substantiated.

The Nature and Dynamics of Political Competition

A final broad area relates to the potential linkages between the nature of political competition in the state and delivery design and implementation. This is particularly poorly substantiated, but one observer does suggest that political instability – namely short tenure for governments – has constrained program formulation and implementation.

Governance and Social Safety Nets (MNREGA)

The summary now turns towards governance in specific sectors: one overarching finding is that there is a gap between governance of service delivery ‘on paper’ vs. ‘in practice’. This big finding is supported by a growing global literature, as mentioned in the introduction, which argues that formal and written rules tell only part of the story in explaining service delivery processes and outcomes. While there are points that are common across MNREGA and NRHM, they are distinct programs so they are summarized separately here.

The literature provides tentative pointers and hypotheses on a number of governance and MNREGA issues. Each main theme that emerged is briefly summarized:

- *Institutional Capacity.* Weaknesses in institutional capacity are regularly cited to explain areas of under-performance in MNREGA delivery. The literature focuses on a lack of capacity in terms of technical knowledge, ability to manage financial resources and human resource availability. Most prominently, the literature suggests that limited ‘local’ or ‘front-line’ capacities are a major barrier to improved social safety net employment implementation.
- *Elite (Dis)Incentives for Delivery.* Some sources underline that MNREGA delivery performance is hampered by weak or skewed incentives. This relates, particularly, to the incentives of actors who hold positions of power and control in the service delivery chain. Certain sources refer to cases of misappropriation of funds, bribery, delays in release of wages or irregularities at different levels. Also, some sources specifically suggest that local level MNREGA functionaries – in VEC and AEC – have been involved in mismanagement, which they attribute to three factors: 1) their lack of proper understanding of modern mechanisms of governance; 2) their limited incentives to perform as planned given the voluntary nature of the work; and, 3) their lack of ownership of these mechanisms and processes given that the overall design is not embedded in local culture and values.
- *Effectiveness of Oversight Mechanisms.* Related to the previous bullet, the literature points to weaknesses in oversight mechanisms which hampers delivery. This points to weak capacities for accounting and oversight at different levels, but particularly at the local level. It also hints that monitoring mechanisms – such as social audits – have been implemented in a partial manner.
- *The Relationship between ‘Formal’ and ‘Informal’ Sources of Authority and Policy (In)Coherence.* Perhaps unsurprisingly, the literature flags a tension between formal and informal sources of power. They suggest that weak local administrative autonomy and the over centralization of formal systems has undermined performance; a point returned to below.
- *Citizen Expectations and Societal Capacity for Collective Action.* Some sources also point towards changing citizen expectations matched by growing ‘bottom-up’ pressures and organization in the state focused on MNREGA improvement and other areas. This, however, would need further unpacking as noted below.
- *Inclusion/Exclusion Dynamics.* A small number of sources also suggested that the dynamics of inclusion and exclusion – and namely the formal inclusion of women in the MNREGA governance systems via the AEC and VEC – had impacted upon service delivery processes and outcomes. The literature is, however, inconclusive about whether this has impacted positively on delivery outcomes. This point – like much of the other claims in the literature – is poorly substantiated.

Governance and Health (NRHM)

The literature also provides tentative pointers and hypotheses on a number of governance and NRHM issues. The main points raised include the following:

- *Institutional Capacity.* As in MNREGA, institutional capacity constraints are regularly cited to explain under-performance in NRHM. Alongside basic financial, administrative and

infrastructural capacity, the literature also points to the relatively weak effectiveness of key planning bodies, namely the VHSC and RKS.

- *Elite (Dis)Incentives for Delivery*. Some studies suggest that health service delivery has experienced a number of irregularities, pointing to the presence of incentives and interests that run counter to improved delivery outcomes. This challenge is identified both at higher levels of government – such as in terms of the alleged medicine scandal – or at the front-line – such as in terms of doctors’ running of unauthorized clinics.
- *Effectiveness of Oversight Mechanisms*. Various reports point to ‘weak’ monitoring and oversight mechanisms which creates some space for certain malpractices. This includes examples of poorly functioning grievance redressal mechanisms.
- *The Relationship between ‘Formal’ and ‘Informal’ Sources of Authority*. Reinforcing the points raised previously, some sources suggest that there are implementation challenges in NRHM because it has not struck the right balance between formal, centralized delivery with responding to informal, local realities on the ground. Moreover, some reports suggest that the program has not connected adequately with ‘informal’ institutions in delivery, which has hampered performance.

Major Knowledge Gaps and Avenues for Research

The overall evidence base on governance and service delivery in Meghalaya is extremely limited. The literature provides useful pointers but, across the board, there is a lack of rigorous, well-substantiated or comparative analysis on these topics. The literature does, however, point towards linkages and themes that, if better understood, could inform and improve policy and delivery interventions. To conclude, some key areas and themes for further research and policy debate are outlined.

Linking Governance with Delivery Processes and Outcomes

The literature fails to link, in any rigorous manner, governance dynamics with service delivery outcomes. In many areas it simply ‘hints’ at the linkages between governance and service delivery but stops there, and it is difficult to prioritize issues or untangle the complex picture being offered. There is, overall, a paucity of data, particularly at the ‘local’ or ‘front-line’ level. Further comparative research would be required to explore such linkages in more depth. Some more specific aspects could also be addressed, as outlined below.

Grounding Evidence of Citizens Perceptions, Expectations and the ‘Social Contract’

There is ambiguity in the literature about citizens’ real expectations and allegiances regarding service delivery in Meghalaya. The literature points up possible disinterest and disengagement of citizens towards the formal system as well as poor alignment between modern implementation systems and values with traditional ways of doing things. However, these points are inconclusive as they are not rooted in a bottom-up analysis of citizens’ actual expectations or perceptions of modern and traditional governance structures and the degree of allegiance that they owe to these two centres of authority. In sum: (i) the literature does not attempt to systematically capture citizen’s expectations; and, (ii) it does not look at how citizen’s real expectations shape service delivery processes and outcomes. This is a potentially important area for policy debate too; there is limited evidence to suggest that the state’s delivery modalities are currently informed by a grounded assessment of citizens’ expectations.

Better Understanding the Role of Formal and Informal Sites of Authority

In terms of the relationship between formal and informal sources of authority, the literature makes claims that are too broad, conflicting or poorly substantiated. Overall, the available evidence does not explore, in depth, the relationship between formal and informal institutions in

delivery and how this impacts on service delivery processes and outcomes. For example, it would be useful to explore the areas where there are overlaps in the functioning of formal and traditional political and administrative systems and then examine: (i) if and how formal processes of governance override the traditional or vice versa and what different this makes; and, (ii) how this impacts on citizens' ability to 'demand' or access services. Moreover, the literature offers polarized and inconclusive views of 'formal vs. informal'. Some observers are overly critical of all that is 'traditional' and others critical of what is 'modern'. Based on the global literature (see Booth, 2012) one should resist this dichotomy and, instead, to try to form 'practical hybrids' between the modern and traditional. We suggest that research could look at how productive 'hybrids' of formal and informal mechanisms have formed or could be fostered to improve delivery processes and outcomes.

What Modes of Delivery Might Work Better?

Related to the above, more could be learnt about which modes of delivery appear to show most promise in this context. With regard to the mode of delivery and service delivery strategy, it may be useful to explore how different modes of governing delivery have impacted on processes and outcomes. The review finds that the programs in question have integrated a range of mechanisms to address governance bottlenecks, such as the relationship between formal and informal forms of authority, strengthening oversight mechanisms or creating new incentives. However, there are few analyses that actually assess the extent to which such mechanisms 'work' on the ground as intended and what effects they have on delivery outcomes (if any). For example, by appointing the village headman (who exudes significant local power) in MNREGA as the frontrunner of local activities, has this increased local 'buy-in' and legitimacy? Has improved or hindered different aspects of delivery? In short, while GoM appreciates that the planning and implementation process has to be taken forward in harmony with the traditional system, it would require more detailed and granular information on these issues in order to take evidence-based policy decisions.

Making Sense of 'Institutional Capacity'

'Institutional capacity' is often referred to as a major challenge, but it needs further attention. In the broader literature and the sector-related literature, weak institutional capacity is frequently referred to as a reason for delivery under-performance. However, two major gaps are evident here. First, the term capacity is often used without being clearly defined or disaggregated. Second, the underlying drivers of weak capacity are not diagnosed. The reasons for persistent weak capacity can be many and weak capacity is rarely due to just limited resources or know-how; it is often linked to the broader political economy (Sen et al, 2014). Further research could be conducted into how and why capacity deficits persist and how this could be built more effectively.

Unpacking Elite Incentives for Delivery

The factors that shape the incentives of various elites in the service delivery chain are also poorly unpacked. While it is suggested that there are incentives that run counter to improved delivery (in both MNREGA and NRHM), this is not disaggregated. Moreover, the broader literature refers to issues of weak 'will' or politicization but it does not really unpack the origins of this 'will'. Further research would be helpful to develop more granular responses to this problem. This could include analysis of: (i) the different constellation of elites in the service delivery chain; (ii) the underlying drivers of (dis)incentives; (iii) the levels and loci where bottlenecks and leakages occur; and, (iv) how these factors all impact on delivery processes and outcomes.

Diagnosing and Strengthening Oversight Mechanisms

Related to the last point, existing oversight mechanisms are poorly understood. The literature points, overall, to weak monitoring and oversight but it fails to analyse this in any granular depth, or provide a solid analysis of 'why' this is the case. Indeed, both NRHM and MNREGA have in-built monitoring and accountability mechanisms. The literature on this suggests that they are relatively weak

in practice, but grounded analysis of this is sparse. First, it is not well documented how the range of local monitoring mechanisms actually works on ground and why. Second, there has been limited systematic analysis of how oversight mechanisms could actually be strengthened.

Sector-Specific Governance and Delivery Issues

Drilling down into the specific sectors, some other areas of research emerge as potentially fruitful:

- *Using governance to explain what works, what does not work and comparing them.* The review raises some important questions about governance and service delivery related to the two schemes. At least three areas would be useful for exploration: (i) given the relatively positive outcomes under MNREGA, it would be useful to better understand the governance dynamics that explain this relative delivery ‘success’²¹ and what lessons could be drawn for replication elsewhere; (ii) given the mixed, and sometimes very poor, results in the health sector in Meghalaya it would be helpful to assess the extent to which such challenges can be attributed to NRHM and its associated governance factors, and what could be done to ‘fix’ them; and, (iii) given that the programs have different modes of delivery, different objectives and differing outcomes it would be useful to compare and contrast the programs in terms of how governance factors shape their delivery processes and outcomes.²²
- *Further unpacking issues of ‘capacity’.* As mentioned above, this aspect needs further unpacking. Specifically, there is something of a contradiction in the available literature: on the one hand, MNREGA outcome data in Meghalaya paints a quite positive picture; on the other hand, a number of observers bemoan the weak local capacity. This puzzle would need further investigation.
- *Getting a better sense of citizen expectations and societal capacity to mobilize and shape service delivery.* Both schemes point to the role of citizen expectations and societal organization in shaping delivery processes and outcomes. However, the literature on this area in Meghalaya on MNREGA and NRHM is sparse and inconclusive.
- *Understanding how ‘inclusion’ reshapes governance processes and delivery outcomes.* Both MNREGA and NRHM have provisions for including women and this has had some impacts according to the literature. However, the impact of this on delivery processes and outcomes is weakly assessed. Further research could be undertaken to understand how, if at all, such provisions interact with existing formal and informal power relations to (re)shape delivery processes and outcomes.

In Sum: Towards a ‘Bottom-Up’ Approach

In sum, it is clear that one could take a more systematic and bottom-up approach to understanding the governance of service delivery in Meghalaya. This could take the form of a grounded, bottom-up approach that would enable us to get to better grips with a number of the issues outlined above. A more grounded analysis could integrate the issues outlined above and integrate the findings and concepts of the most relevant literature in this field (e.g. Batley and McCloughlin, 2012; Foresti et al, 2013; Kelsall et al, 2005). In essence, this review supports the conclusions of one recent review that puts it this way:

Future 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, working upwards in order to identify the key political factors that underpin performance... This approach would be particularly appropriate and timely given the growing recognition that, in practice, delivery is often facilitated through informal, ad hoc arrangements that rely on relationships of reciprocity and alliances across blurred public-private boundaries (Batley and McCloughlin, 2012: 30).

Indeed, a better understanding of these linkages could equip those aiming at service delivery improvements with more suitable and realistic policy options.

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Annex I

MNREGA and NRHM: Overview of the Delivery Structure

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 in East Garo 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 operationalization 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 of 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 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 fulfils 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 responsible for finalising 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 utilised for bearing the costs of wages, 75% 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.

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, Gynaecologist and Paediatrician 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 so on.

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 comprised 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 immunisation day/village health and nutrition day. Local transport arrangements are available for pregnant women, especially for those with complications or with sick new-born to reach the referral facility. In an emergency, this transport is available on a cashless basis, with reimbursement later, to ensure that nutrition supplement and food security programmes reach the pregnant and lactating women. The Village Health and Sanitation Committee of the village would prepare the Village Health Plan, and promote inter-sectoral integration.

Total Number of VHSC in Meghalaya
Source: NRHM Official Website

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

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 utilise 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.

Total Number of RKS in Meghalaya

Source: NRHM Official Website

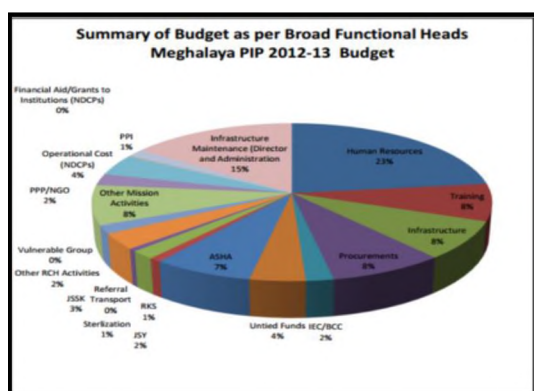
District	District Hospital	CHC	PHC
East Khasi Hills District	1	6	23
West Khasi Hills District	1	5	19
Ri Bhoi District	1	5	8
Jaintia Hills District	1	3	18
West Garo hills District	1	7	18
East Garo hills District	1	2	16
South Garo hills District	1	1	7
Total	7	29	109

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:

NRHM Budget allocations for Meghalaya, 2012-13

Source: NRHM Official Website



Annex II

Governance and Service Delivery Matrix for MNREGA²³

Table. 1 GOVERNANCE AND SERVICE DELIVERY MATRIX, MNREGA						
Key Service Elements	Accountability		Transparency		Inclusion and Citizen Engagement	
IEC activities for awareness generation on MMNREGA			Awareness generation through IEC drives, CSOs, door to door campaigns, mass media etc.	✓		
			Disclosure of information through citizen information boards at work site and offices of service providers			
Registration of the Household					Any adult member of a rural household willing to undertake unskilled work can register under MMNREGA	✓
Issuance of Job cards	Job card should be available free of cost	✓				
	Job card is kept with the worker					
			All entries in the job card is made in the presence of the worker	✓		
Application of work and recording of demand			Access to and submission of application must be kept available through multiple channels	✓		
Dated receipt ²⁴ upon submission of application.			Access to a dated receipt every time an application is for work is submitted			
Timely allocation of work (within 15 days from the time of submitting an application)			The information on work requested and work allotted is required to be mentioned in the Job card			

Unemployment Allowance	Access to unemployment allowance if applicant does not receive work within 15 days from the time of submission of application	✓				
Work-site management and attendance	Recording of attendance in the muster roll	✓	Access to muster roll for public inspection	✓		
Worksite facilities					Worksite facilities (Medical aid, drinking water and shade) are to be provided at the worksite.	✓
Monitoring	Weekly measurement of works should be undertaken by measurement officers (Technical Assistants/ Overseers/ Junior Engineers). Measurement officers should ensure that all measurements are taken within 3 days after close of weekly muster	✓				
Timely payment of wages			Wage disbursement agency is different from the implementing agency-Banks and Post office	✓	RBI had permitted banks to use intermediaries as BCs, to conduct banking business as agents of the banks at places other than the bank premises	✓
					Special awareness and outreach activities should be conducted to ensure that all wage-seekers (including women) are able to handle bank procedures, especially in areas where they are unfamiliar with the banking system	
					In Districts/Blocks/GPs, where the penetration and network of banks and post offices is weak, PIAs may disburse wages in cash	
	To ensure timely payments to the workers for the work done, State shall fix up maximum time limits for each completing process resulting in payment of wages to the wage seekers, in such a way that each wage seeker gets the wage payments for the work done in the week by the end of the subsequent week.	✓				

Maintenance of records by GP/VEC	Maintenance of range of activity registers, financial records etc.	✓				
Social audits	Public vigilance and auditing of the scheme	✓	Transparency in decision-making and implementation of the scheme	✓	Public participation in the implementation of the scheme	✓
Grievance Redressal	All complaints must be entered in complaint register. Aggrieved party must be given redressal within 15 days or less.					

Annex III

Governance and Service Delivery Matrix for NRHM

Table. 2 GOVERNANCE AND SERVICE DELIVERY MATRIX, NRHM						
Key Service Elements	Accountability		Transparency		Inclusion and Citizen Engagement	
Availability of trained community level worker at the village level			Create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services.	✓		
Outreach activities-Health day, immunization day, clinic day etc.						✓
Good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level		✓				
Access to generic drugs at the sub-center						✓
Facilities for institutional delivery through provision of referral, transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families		✓				

Free and cashless delivery for pregnant women		✓				
Availability of assured healthcare at reduced financial risk through pilots of Community Health Insurance under the Mission		✓				
Community level planning and decision making					Setting up of the VHSC and RKS led by members of the community	✓
Community monitoring	Monitoring and supervision of the scheme by the community	✓				✓

¹ 'Mode of Delivery' may include the public/private aspects of delivery, the degree to which delivery is decentralized or the degree of policy coherence in the sector.

²The 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.

³ As such, according to the MIG mission statement, it 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 reform agenda; (iii) create a repository of best 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, <http://mbda.gov.in/>

⁴See endnote note No. 2.

⁵Meghalaya enacted a Fiscal Responsibility and Budget Management Act in 2006, which helped curb its fiscal deficit from 4.8 percent of GDP in FY04 to 2.3 percent of GDP during FY12. Overall, barring one deviation in FY11 due to additional expenses incurred to honour the revised pay scales announced by the 6th Pay Commission, the state's finances have improved over the last five years and have remained within thresholds recommended by the 13th Finance Commission.

⁶The services sector – particularly trade, hotels and public services – accounts for around 54 percent of total economic output. Agriculture and mining sectors account for 12 and 6 percent of total GDP respectively, compared to 15 percent and 3 percent at the national level. While the manufacturing sector in Meghalaya performed well and grew at 20 percent during FY05-FY13, it remained small and contributed 6 percent to total production, compared to 14 percent across all states.

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- ⁷The majority of Meghalaya's population belongs to the Scheduled Tribes (STs)⁷ and in 2011-12, 12.5 % of STs were below the official poverty line.
- ⁸In 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).
- ⁹According to Joshi, the geo-political context, lack of access to communication and isolation, necessitated the need for self-governance (Joshi, 2004: 265).
- ¹⁰The implementation and administration of the rules and regulation legislated by the *Dorbar* is the responsibility of the *Rangbashnong* or the village headman. Decision-making in the *Dorbar* is a broadly collective exercise, although women tend to be excluded. General meetings are conducted where villagers put forward their grievances and seek clarifications from the council and the village headman.
- ¹¹Usage of the term 'modern' is with reference to the understanding that ADC is not based on customary practices of the people. It is based on the modern lines of public administration and justice along with the presence of democratic electoral politics contested on party lines.
- ¹²One of the criticisms levelled against the nature of functioning of ADCs is that they are interfering in the activities of traditional institutions with the intention of subordinating the latter to a status where these function as powerless agents of the councils (Rani, 2015). The article "Autonomous District Councils in Meghalaya: Fifth Wheel" captures a perception of ADCs that appears to prevail in some circles today: *Councils...are modern institutions based on western democracy are being implanted to preserve traditional institutions in Meghalaya...ultimately all evils of the democratic system have crept into Meghalaya's traditions* (Rani, 2014).
- ¹³Employment was generated through works involving rural connectivity, restoration of traditional water bodies, rural sanitation and water conservation.
- ¹⁴The research study conducted in 5 districts of Meghalaya namely East Khasi Hills, Ri Bhoi, East Garo Hills South Garo Hills and West Garo Hills covering a sample population of 580. Key stakeholders included workers and service providers at the village, block and district level.
- ¹⁵What is the difference between employment offered and employment provided? A reference with these concepts definitions may be useful.
- ¹⁶Anganwadi is a government sponsored child-care and mother-care centre in India. It caters to children in the 0-6 age group. The word means "courtyard shelter" in Hindi. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition.
- ¹⁷The condition mainly applies to health institutions. The state grades institutions based on poor performance. The health institutions are required to ensure that services are available at all delivery points and data on HMIS portal on a regular basis amongst others.
- ¹⁸Gaps in implementation is based on two criteria: Policy criteria which ensuring state-wide coverage of free delivery, free treatment to sick new born and grievance redressal system with specified redressal timelines. The implementation criteria mainly includes state-wide dissemination of information about the scheme, operational grievance redressal system, access to assured and cashless means of transport to pregnant women and such.
- ¹⁹The Directorate of Programme Implementation and Evaluation, Government of Meghalaya entrusted AMC Research Group, New Delhi to carry out an evaluation study on "National Rural Health Mission (NRHM)" in the state of Meghalaya to assess the impact of National Rural Health Mission (NRHM) initiatives in the intervention districts. All the seven districts of Meghalaya were covered under the study. From each district minimum three blocks were selected for detailed survey and field visit. The survey was conducted during September-November 2010 using different category of schedules. Attempt was made to cover the beneficiaries for five years period i.e. 2005-06, 2006-07, 2007-08, 2008-09, and 2009-10. This is latest evaluation study available of NRHM in Meghalaya.
- ²⁰They argue that national programmes are designed on the national level data, which represent states like Uttar Pradesh, Bihar and Rajasthan. They argue that such large states are contextually very different from smaller states like Meghalaya (Oosterhoff *et.al.*, 2015: 17).
- ²¹As mentioned above, the North-East has been a high performer in MNREGA implementation relative to the rest of India
- ²²It would be great to compare the findings on Meghalaya with the wider India literature on governance issues in MNREGA and NHRM from India (such as the Effective States and Inclusive Development Consortium studies).
- ²³Revise this further in the final draft to make it smaller. Also, do the colors mean anything?
- ²⁴The dated receipt is an acknowledgment of the received application. The receipt mentions that the applicant will receive work within 15 days and in case work is not provided to the applicant within 15 days, he/she is entitled to an unemployment allowance.