



LIST SESSION 5

On the Front Lines of Public Health

Positionality, street-level bureaucrats, and the case for community participation in public health

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Editorial Note

This article has been prepared by the Centre for Research in Schemes and Policies (CRISP) from the address delivered by Mr Rajeev Sadanandan to the CRISP team on 25 September 2026, the fifth session of the LIST – Lectures for India's Social Transformation series. It has been rendered in the speaker's own voice, revised into a more formal academic register, and organised for publication. It preserves in full the substance, the examples, and the evidence presented in the lecture, and arranges the argument thematically.

Abstract

Public health programmes in India are designed by people at the centre often based on available evidence. , They implemented by field workers whom the political scientist Michael Lipsky called street-level bureaucrats (SLBs). This article begins from the observation that those who implement a programme, and the communities it is meant to serve, are almost never consulted when it is designed, and asks what follows from that.

It examines how SLBs are tasked with objectives they do not have the resources to meet. They respond by using their discretion to select the objectives which are aligned to their perspectives and with that of the communities. But discretion exercised in the field is increasingly met with micro-targets and digital surveillance Also examined is why health, more than most sectors, depends on communities as partners rather than recipients and how the nature of health sector makes such partnerships difficult to realise. It draws on Sherry Arnstein's ladder of participation, on the idea of high rate of social discount of the future, the nature of health workers view of the community and vice versa, to argue that health is a weak entry point for community organisation.

It closes with the questions put by CRISP team, on scale versus local depth, tokenism, systemic constraint, and whether democratic governance can ever be proactive, and with an agenda for the organisation.

Keywords: *positionality; street-level bureaucracy; community participation; Arnstein's ladder; social discount rate; non-communicable diseases; targetitis; last mile*

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1. Where We Stand Shapes What We See

Every researcher, programme manager, and policy designer carries biases that come from their background, class, gender, culture, and belief. Two ideas help us take those biases seriously. The first is positionality: what we are in relation to the work or the study. The second is reflexivity: the discipline of continually asking how that positionality is shaping our conclusions and our day-to-day decisions.

I raise this at the start because in many ways we are of the same social class as the people who design public programmes in India.. However the people who implement the programmes they design and the community for whom these programmes are designed never have a voice at the design stage.

2. The Street-Level Bureaucrat

Michael Lipsky gave the implementers a name: street-level bureaucrats. They are the police constable, the field health worker, the rural development worker — the person at the counter or the doorstep where policy meets a citizen. There is a wide gap between the social background of those who write policy and those who carry it out, and in my experience neither communities nor field workers are consulted when a programme is first designed.

Street-level bureaucrats do not simply follow instructions. They use discretion, adapting a central policy to local restrictions, to what a community will accept, and to what is physically possible in a village. It is worth asking, of any programme, whether its validity is ever questioned, and whether an implementer's deviation is understood or simply dismissed as non-compliance.

3. 'Targetitis' and the Punishment of Discretion

Headquarters responds to this discretion with control. Programmes are divided into micro-defined tasks, each with a strict target, a pattern that has long been called 'targetitis'. More recently, digital applications monitor field activity in something close to real time. Field workers do not experience this as support. Some health workers I have spoken to described it, as digital terrorism.

I learned this by talking to field workers in my own village. Digital apps and micro-detail collection consume the time that should go to the actual work, and shift attention from what a programme is for to what can be reported. Workers are held to account for micro-activities rather than for broad outcomes, which leaves very little room for collaboration with the community. It also denies the opportunity for the field workers to modify the programme based on learning from implementation.

4. Monitoring Outcomes, Not Activities

I was asked how discretion can be built into implementation systems so that trust is possible. I told the fellows plainly that it is very difficult to do at the top, because the structure is rigid: the financial incentives paid to workers such as ASHAs and ANMs are tied directly to mandatory reporting, most of which are linked to activities and not outcomes.

A second question was how to balance monitoring through data against trust in grassroots workers, given that many lower levels have little access to data. My answer was to shift monitoring from micro-activities to outcomes. In Project SUHAAS, the final measure of success should be how many people control their hypertension and diabetes, not a record of every step of the process and every pill consumed. [Please take this box out. I can't correct it.]

5. Why Health Needs Communities

5.1 The insularity of medical expertise

The health sector has characteristics that make participation harder than in most others. Entry to the professions — doctor, pharmacist, nurse — is strictly norm based, and this fosters a culture in which the professional sees herself as the holder of exclusive technical knowledge and the community as a passive recipient. Communities, in turn, defer to expert medical opinion. This stands in sharp contrast to the Alma-Ata Declaration, which called for universal accessibility to essential healthcare and for the full participation of communities in it.

5.2 The epidemiological transition

The case for participation has become stronger, not weaker. With the demographic and epidemiological transition and the rise of non-communicable diseases, the health department alone cannot improve a population's health. Reducing smoking, managing diet, exercising, cutting alcohol, and ageing healthily are behaviours that people practise, or do not, in their own homes. Community partnership is therefore indispensable, not optional.

6. Arnstein's Ladder of Participation

To assess how much participation a programme actually has, I use Sherry Arnstein's ladder. It runs from the lowest rungs, where participation is a form of manipulation or therapy, through informing, consultation, and placation, to partnership, delegated power and, at the top, citizen control.



Figure 2. Arnstein's ladder of participation, from manipulation to citizen control.

Most of what is called community participation in our programmes sits on the middle rungs and is, in practice, tokenistic. Climbing higher requires organised community structures, leadership and capacity, but also something less often discussed: a willingness among those who hold power to negotiate with the community rather than dismiss what it says.

7. The Social Discount Rate

Why is community interest in health programmes so often low? The answer lies in what economists call the social discount rate. People discount future health risks heavily against the costs and pressures of today. When I worked on HIV prevention with sex workers and truck drivers, an abstract threat years away failed to move them. What worked was addressing something immediate that affected daily earnings, such as sexually transmitted infections.

Health education must therefore aim to reduce the discount rate by making the benefit immediate and concrete. Controlling hypertension and diabetes matters to a family when it is linked directly to avoiding dialysis or reducing the probability of stroke.

8. Three Approaches to Health

I distinguish three approaches. The medical approach treats health as the absence of disease. The health service delivery approach uses community groups as channels for services designed elsewhere. The comprehensive approach recognises that social, economic, and political determinants shape health.

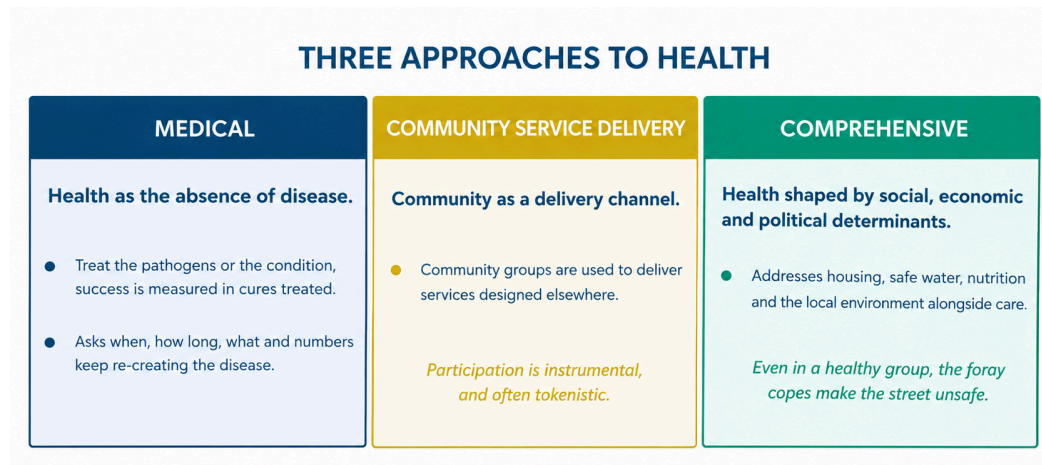


Figure 3. Three approaches to health.

Medical interventions for tuberculosis or for the prevention of non-communicable disease fail unless the underlying determinants are addressed: housing, safe drinking water, nutrition, and even the environment. I have seen a walking group for hypertension fail because stray dogs made the street unsafe. No clinical protocol anticipates that.

9. Health as a Weak Entry Point

A common assumption is that health is a natural door through which to organise a community. I have found the opposite. People treat health services transactionally, as something to consume once they are ill, and so health is a poor entry point for collective action.

In Bangalore, we worked with sex workers who had little interest in a conversation about safe sex. Their priorities were ration cards and housing. Working on those led, over time, to Swathi Mahila Sangha, a community-based organisation and micro-finance bank run entirely by the women themselves. The health outcomes followed from the organisation, not the other way around.

10. Reaching the Last Five Per Cent

A programme can report 95 per cent immunisation coverage and still leave behind exactly the people who most need it. The last five per cent are rarely reached by the methods that reached the first ninety-five. Reaching them means mapping marginalised groups by name and place, holding meetings close to where they live, at times when they are not engaged in farm labour, and designing the programme so that engaging them takes precedence.

This is what the Sustainable Development Goals mean by leaving no one behind. It is a discipline of design, not a slogan.

11. From the Discussion

11.1 Scale versus local depth

Asked whether a project can be scaled up without first mastering it in one place, I said the opposite is true: if a project has not worked well in one place, scaling it is counterproductive. Fellows should understand thoroughly what makes a programme work in a single community, and earn its trust, before thinking about scale. I would rather CRISP concentrate resources in a few regions than spread them thinly.

11.2 Tokenism and the sarpanch

A fellow observed that participation is often dominated by local figures such as the sarpanch, while the vulnerable stay silent. I agree, and I do not think the answer is procedural. Even a structure like the Gram Sabha can include excluded voices if someone makes an active effort to invite them. That effort has to be deliberate, and mapping the vulnerable is where it begins.

11.3 Constraints, and refusing to conform

Colleagues described how programme reviews rush multi-year plans through a ten-day window without consulting local availability, producing resistance, lack of trust and lethargy. These are real constraints. But I advised the fellows not to grow comfortable inside an imperfect system. An organisation like CRISP should retain a questioning mindset, and treat bureaucratic inconvenience as something to be examined, not accepted.

11.4 What is monitored is what gets done

A fellow working with the government to reduce maternal mortality in the Bundelkhand region described field workers focusing on heavily monitored, incentivised tasks such as immunisation, while health and nutrition education went undone and high-risk mothers missed their folic acid tablets. She also described workers managing six or seven registers while being criticised for missing counselling.

I agree on both counts. What is monitored is what gets implemented, and field staff spend most of their time entering data into separate systems. What can be done at the field level is to integrate health education into the antenatal care teaching that ANMs and ASHAs are already trained to deliver. If the indicator accurately reflect the outcome of a cumulative set of activities, rather than reporting on each activity, such monitoring would be effective and much less arduous.

11.5 Can governance be proactive?

A participant compared governance with firms that solve problems customers have not yet recognised, and argued that the government is too reactive. My response is that an electoral democracy must respond to demand that already exists, since that is where political mileage lies, and unarticulated future needs rarely win votes. Governance in a democracy is therefore reactive by structure. That does not make attention to the future unimportant; it makes it harder, and more deliberate.

Table 1. Constraints raised in discussion, and the responses offered.

Constraint raised	Response offered
Discretion is hard to embed; incentives tied to reporting	Shift monitoring from micro-activities to macro-outcomes
Participation dominated by the sarpanch	Map vulnerable groups; invite them deliberately
Scaling before mastering one place	Do not scale what has not worked locally; build trust first
Ten-day reviews of multi-year plans	Retain a questioning mindset; do not conform
Only monitored tasks are implemented	Fold health education into ANM and ASHA antenatal modules
About nineteen applications for field staff	A top-level problem; cannot be solved from the field
Governance reacts to existing demand	Structural to electoral democracy; plan for the future deliberately

12. An Agenda for CRISP

The lecture and discussion point to a practical agenda, some of it already taken up by the group at the session:

- Explore whether project coaches can find and implement workarounds within existing system constraints.
- Concentrate effort in a small number of regions, and involve implementers and communities in programme design from the start.
- Treat communities as monitoring agents whose feedback can change an intervention, and map the last five per cent before designing outreach.

Conclusion

I would like the fellows to leave with a questioning attitude rather than acceptance. Programmes will keep being designed by people who may not have the same attitude and approach as those who implement them, and communities will keep being invited to endorse decisions already taken. Our task is to notice where we stand, to ask who was not in the room, and to keep asking, even when the system offers good reasons to stop.

About the Author

Mr Rajeev Sadanandan is a former officer of the Indian Administrative Service, Kerala cadre. He served as Health Secretary of Kerala for eleven years, as Additional Chief Secretary for Health and Family Welfare, and as Chief Executive Officer of the Rashtriya Swasthya Bima Yojana. He was also the founding CEO of Health Systems Transformation Platform, supported by Tata Trusts, and has advised the state government in Kerala on major public health responses, including the 2018 Nipah virus outbreak and the COVID-19 pandemic.