World Development 113 (2019) 392–401

Contents lists available at ScienceDirect

World Development

journal homepage: www.elsevier.com/locate/worlddev

Pathways to accountability in rural Guatemala: A qualitative comparative analysis of citizen-led initiatives for the right to health of indigenous populations

Alison Hernández [a,*], Ana Lorena Ruano [a,b], Anna-Karin Hurtig [c], Isabel Goicolea [c], Miguel San Sebastián [c], Walter Flores [a]

[a] Center for the Study of Equity and Governance in Health Systems (CEGSS), Guatemala, Guatemala
[b] Center for International Health, University of Bergen, Bergen, Norway
[c] Division of Epidemiology and Global Health, Umeå University, Umeå, Sweden

ARTICLE INFO

Article history:
Accepted 24 September 2018

Keywords:
Accountability
Health system
Indigenous peoples
Qualitative comparative analysis
Guatemala

ABSTRACT

Strengthening citizen-led accountability initiatives is a critical rights-based strategy for improving health services for indigenous and other marginalized populations. As these initiatives have gained prominence in health and other sectors, there is great interest in how they operate and what makes them effective. Scholarly focus is shifting from measuring the efficacy of their tools and tactics to deepening understanding of the context-sensitive pathways through which change occurs. This paper examines how citizen-led initiatives' actions to strengthen grassroots networks, monitor health services and engage with authorities interact with local sociopolitical conditions and contribute to accountability achievements for indigenous populations in rural Guatemala. We used qualitative comparative analysis to first systematize and score structured qualitative monitoring data gathered in 29 municipal-level initiatives, and then analyze patterns in the presence of different forms of citizen action, contextual conditions and accountability outcomes across cases. Our study identifies pathways of collective action through which citizen-led initiatives bolster their power to engage and negotiate with authorities and bring about solutions to some of the health system deficiencies that they face. While constructive engagement is widely advocated as the most effective approach to interaction with authorities, our study indicates that success depends on wider processes of community mobilization. To overcome the power asymmetries that marginalized groups face when engaging with authorities, iterative processes of network building and participatory monitoring as well as persistence in their demands are critical. These processes further provide an enabling environment for moving beyond the local and projecting indigenous voices to engage with authorities at higher governance levels. Initiatives also applied adversarial legal action as an alternative engagement strategy that contributed to bolster citizen power. Our findings indicate the potential of collective power generated by the actions of citizen-led initiatives to enable marginalized populations to hold authorities accountable for health system failures.

1. Introduction

Medicine stock-outs, crumbling infrastructure, missing health workers, and disrespectful and abusive treatment are experienced by millions of users of health facilities every day (Freedman & Kruk, 2014; Travis et al., 2004). These health system deficiencies represent accountability failures that violate the right to health and perpetuate stark inequalities. For indigenous peoples, who bear a disproportionate burden of disease, mortality and poverty, these inequalities are compounded by historical processes and current practices of sociopolitical exclusion (Castro, Savage, & Kaufman, 2015; Kirmayer & Brass, 2016). Strengthening citizen-led accountability initiatives is a critical rights-based strategy for promoting better health system governance, particularly in contexts of deep-rooted marginalization. Citizen-led accountability refers to on-going collective efforts to hold public officials to account for the provision of public goods and make them

* Corresponding author at: 11 calle 0-48 Zona 10, Edificio Diamond, oficina 504, Ciudad de Guatemala, Guatemala.
E-mail addresses: alison.hernandez113@gmail.com (A. Hernández), ana.lorena.ruano@cih.uib.no (A.L. Ruano), anna-karin.hurtig@umu.se (A.-K. Hurtig), isabel.goicolea@umu.se (I. Goicolea), miguel.san.sebastian@umu.se (M. San Sebastián), waltergflores@gmail.com (W. Flores).

https://doi.org/10.1016/j.worlddev.2018.09.020
0305-750X/

responsive to their needs (Lodenstein, Dieleman, Gerretsen, & Broerse, 2013). Initiatives have taken diverse forms, employing different tools and approaches to mobilize citizen monitoring and oversight and to strengthen community participation in decision-making via mechanisms such as village health committees, community score cards and community defenders of health rights (Flores, 2018; Molyneux, Atela, Angwenyi, & Goodman, 2012). These initiatives engage with the sociopolitical causes of health inequalities in indigenous populations and other marginalized groups, enabling them to be agents in processes of redressing health system deficiencies and strengthening their influence in the decisions that affect their lives (Hernández et al., 2017; Freedman & Schaaf, 2013).

As citizen-led accountability has gained prominence over the last decade, there is great interest in distilling evidence about how initiative processes operate and what makes them effective. Accountability researchers, practitioners, and policy stakeholders emphasize the need to clarify pathways to change rather than the efficacy of a specific tool that initiatives employ, such a report card or social audit (Lodenstein, Dieleman, Gerretsen, & Broerse, 2016). While many have highlighted that the evidence of the effectiveness of accountability initiatives is mixed, a recent meta-analysis of program evaluations indicated that initiatives with stronger impact in development outcomes were distinguished by the strategic nature of their approach (Fox, 2015). Approaches focused on deployment of specific tools were less successful than strategic approaches that employed multiple, coordinated tactics and built an enabling environment for collective action for accountability. This finding resonates with calls for approaches guided by system-wide thinking and grounded in attention to the embedded power imbalances that give rise to accountability failures (Halloran, 2015; Joshi, 2017). Particularly in societies where representative government is weak or non-existent and marginalization is deeply entrenched, there is a need for long-term, iterative approaches that enable countervailing citizen power (Fox, 2015; Schaaf, Topp, & Ngulube, 2017).

While there is growing agreement about the value of strategic accountability approaches that build citizen power, there are few empirical studies of how such approaches operate and influence health system responsiveness in practice (Freedman & Schaaf, 2013). Recent studies of citizen-led efforts to improve health system accountability have increasingly employed complexity-sensitive methods to analyze underlying change processes and the influence of context (Lodenstein et al., 2016; Schaaf et al., 2017; Abimbola et al., 2016). Results shed light on strategies for information gathering, presentation with providers and government officials, negotiation and follow-up, and highlight the role of trust-building, dialogue, and co-production in changing provider attitudes and generating improved service provision. While important insights are emerging, significant gaps remain. In particular, there are few studies of health accountability initiatives led by indigenous peoples in Latin American contexts (Samuel, 2016). Furthermore, given the importance of context and adaptation, there is a need for studies that enhance understanding of how strategic approaches enable different forms of citizen action and unfold in diverse ways across subnational settings (Fox, 2015; Joshi & Houtzager, 2012).

This study contributes to this evidence base by identifying and comparing pathways connecting actions implemented by initiatives for health system accountability led by indigenous populations in Guatemala, the local political context, and outcomes of responsive action. The study includes initiatives developed in 29 municipalities in the rural highlands of Guatemala with support from a local civil society organization and employs a qualitative comparative analysis (QCA) approach to examine how interaction among different forms of citizen action and openness of local authorities lead to accountability achievements in these municipal-level cases. In the following sections of the paper, we present the Guatemalan context, the model of support for the initiatives under study, and the process followed in applying the QCA method. Our results identify key pathways through which citizen actions to strengthen grassroots networks, monitor health facilities and engage with authorities interact to bring about solutions to some of the health system deficiencies affecting indigenous populations, and how they contribute to an enabling environment for further collective action for accountability.

2. Methods

2.1. Study setting

Indigenous peoples of 23 ethnicities make up 46% of Guatemala's population of 15.6 million. The indigenous population is concentrated in the rural highlands in the north of the country, with 79% living in poverty and 40% in extreme poverty (INE, 2015). Guatemala has the fourth highest rate of chronic malnutrition in the world, and this rate is nearly twice as high among indigenous children compared to non-indigenous children (61% vs. 34%) (ICEFI & UNICEF, 2012). These indicators reflect social and political processes of marginalization that stem from decades of economic exploitation, military dictatorships and a 36 year-long internal war that ended in 1996. This conflict left 200,000 dead or disappeared, most of them indigenous, and contributed to the deterioration of already weak public services. By the mandate of the 1996 peace agreements, Guatemala passed a progressive legal framework for social participation that established a structured scheme of development councils from the community to the national level, alongside a decentralization act transferring increased powers and responsibilities to municipal mayors and municipal councils (Ruano, 2013). Even while the law specifies that community-level authorities within the municipality, including community development council members and auxiliary mayors, should have a voice in the municipal decision-making forums, the capacity of representatives from indigenous communities to participate and advocate for their interests and rights is limited by many *de facto* barriers (Flores & Gómez-Sánchez, 2010). These barriers are heightened when municipal authorities are non-indigenous, but even when authorities are indigenous, corruption and clientelism often play a role in municipal decision-making.

In rural municipalities, the public health sector is the predominant source of health care. Administrative authority in the public sector is largely decentralized to the provincial level, where responsibility for coordination, execution, supervision and evaluation of health services and national programs is managed (Hernández Mack, 2010). Each municipality within the province typically corresponds to a health district, where service delivery via a central health center and peripheral health posts is directly managed. Municipal governments are also responsible for coordinating with district health authorities and allocating a portion of their budget to health programs such as water and sanitation, refurbishing of healthcare facilities, ambulance and support personnel (drivers, auxiliary nurses) if needed. Public health services in rural Guatemala are marked by regular stock-outs of medicines and supplies, health worker shortages, and organizational deficiencies, and reform efforts have been chronically underfunded and mismanaged (Hernández Mack, 2010). Indigenous people's access to quality health care is further inhibited by linguistic barriers and discrimination and disrespectful treatment by non-indigenous health providers, which contribute to widespread distrust of health services (Cerón et al., 2016; Berry, 2008). Even while policies guaranteeing linguistic access and intercultural care have