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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

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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).

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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

been in place in Guatemala for over a decade, implementation and enforcement lag far behind (Flood & Rohloff, 2018).

2.2. Model of support for citizen-led accountability initiatives

The Center for the Study of Equity and Governance in Health Systems ('CEGSS,' by its initials in Spanish), a Guatemalan civil society organization, has supported the development of citizen-led initiatives for state accountability for the right to health in rural indigenous communities since 2006. This work began in eight municipalities and over the past decade has grown to include more than 30 municipalities. CEGSS fosters the mobilization of collective action through capacity building in human rights, the country's legal frameworks for participation, monitoring techniques, and negotiation and advocacy skills, as well as supportive accompaniment (Flores & Ruano, 2014). Their model is guided by the aim of activating the power of excluded, rural communities, their exercise of "citizenship", and their capacity to strategically engage with authorities to shift the power balance in public decision-making and lead to pro-equity policy and resource allocation. Participants in the capacity building sessions were volunteers nominated by their communities, motivated by their own experiences as users of public health services. By 2014, CEGSS was using the UN-based 'defenders of human rights' figure, so that the leaders who were engaging in monitoring and advocacy activities could be more formally recognized.

CEGSS' model includes successive phases of capacity-building and support to provide the nominated local leaders with the knowledge and skills to mobilize accountability action in three main domains. The first domain is grassroots network development, which consists in strengthening the ties connecting the core leaders involved in capacity-building to community authorities, such as community development council members, auxiliary mayors, and ancestral indigenous authorities, and other groups and organizations that can be mobilized in collective action. The second domain is monitoring of health facilities. Leaders are trained in a variety of techniques to collect evidence and document health service deficiencies, including health facility inspections, service user interviews, community assemblies, and SMS reports of user complaints. The third domain is engagement with authorities in advocacy to seek resolution of the deficiencies detected. Leaders' efforts to present problems and follow up on demands for responsive action typically focus initially on the district health authorities (district manager) and municipal authorities (mayor and municipal council), with further efforts to engage with health and government authorities and human rights institutions at the provincial and national levels. Implementation of strategic action in these domains, as well as others such as raising public awareness, is expected to activate citizens' power to collectively identify and act upon problems that infringe on their right to health. Furthermore, iterative action in these domains builds power through cycles in which the realization of previous actions builds recognition and self-efficacy, contributing to an enabling environment for further action. The expected outcome of citizen action is responsive action by authorities to redress the problems presented, which depending on the nature of the problem may take the form of administrative action with staff or allocation or improved coordination of resources.

2.3. Qualitative comparative analysis

Based on our interest in analyzing underlying change processes in a fairly large number of municipal cases, we identified Qualitative Comparative Analysis (QCA) as a complexity-sensitive method that permits study of an intermediate number of cases to identify patterns and causal connections (Rihoux & Lobe, 2009). QCA is both an approach, or research strategy, and a set of specific techniques. As an approach, it is case-oriented and comparative in nature, and it is based on a configurational view of causation. Rather than focusing on cross-case patterns in the relationships between variables (a correlational view), analytical focus is on discerning how different combinations of conditions produce an outcome with the goal of determining the "character of the different causal models that exist among comparable cases" (Ragin, 1987).

QCA's techniques are applied in a process that moves along a complexity – parsimony continuum (Rihoux & Lobe, 2009). Fig. 1 depicts the process we followed, which began with defining the set of conditions expected to influence the outcome of interest, drawing on theoretical and in-depth case knowledge. This set of conditions and outcomes provided a framework for engaging with the maximal complexity of the case information available and defining the case data to be collected. The complexity of the individual cases was reduced by synthesizing the data into a standardized template and then assigning numerical scores derived from the data to capture the extent to which each condition and the outcome were present in each of the cases (Schatz & Welle, 2016). At this stage, fuzzy set analysis was applied, using Boolean algebra to assess the extent to which different configurations of conditions led to outcomes. This analysis yields a solution formula that represents the point of maximal parsimony and consists of a causal recipe of the conditions and combinations of conditions that were sufficient and/or necessary to produce the outcome within the set of cases. The final interpretative phase of the analysis entailed re-engaging with the complexity of the cases by bringing the solution formula into dialogue with case data as well as theoretical knowledge, and identifying patterns in the change processes across cases with similar configurations of conditions and outcomes (Rihoux & Lobe, 2009). The steps we followed in our application of this method to deepen understanding of the causal pathways through which the collective action of citizen-led initiatives contribute to accountability outcomes are described below.

2.4. Defining the conditions and outcome

Specification of the set of conditions and the outcome of interest to be analyzed was guided by CEGSS' model of support for citizen action and organizational learning. The process involved review of CEGSS' theory of change, frameworks of conditions and outcomes in accountability literature, and iterative refinement of model components based on review of monitoring data and

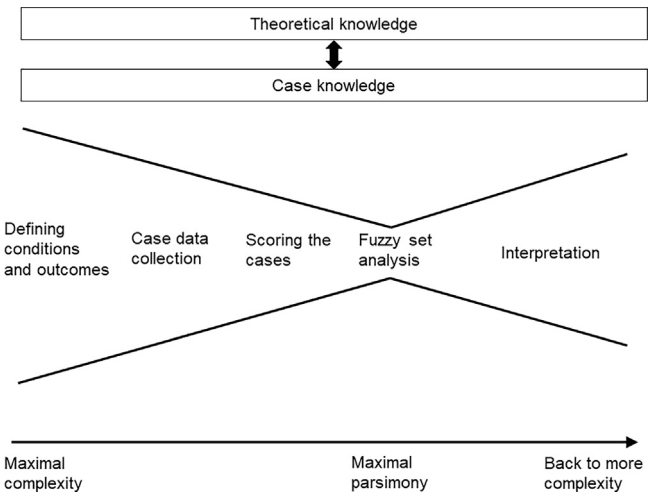

Fig. 1. QCA process followed and its correspondence with complexity – parsimony continuum. Adapted from Rihoux and Lobe (2009)

discussions among the research team. In addition to the three domains of citizen action described above (grassroots network development, monitoring of health facilities, engagement with authorities), the openness of municipal authorities and local health authorities at the beginning of leader capacity-building efforts were identified as the contextual conditions that most directly influence both the potential for citizen action to gain momentum, and the possibility of the outcome of responsive action by authorities to improve health services. Further description of the initiative-related and contextual conditions and the outcome is provided in Table 1.

In the process of defining relevant conditions, other domains of citizen action, such as raising public awareness, and context, such as leaders' previous experience, were considered. In selecting the conditions to include, we were guided by the principle of theoretical relevance as well as the feasibility of capturing the condition in a numerical score (Schneider & Wagemann, 2012). In the case of raising public awareness, we considered that the pathway by which information campaigns about the right to health contribute to the outcome of responsive action was less relevant because it was less direct than the other domains of citizen action, and the level of implementation was similar across cases. In the case of leaders' previous experience, despite its strong relevance to both the implementation and impact of citizen action, information about their socio-political positions was not readily captured in a numerical score.

2.5. Case data collection

Information about the level of implementation of citizen action in the three domains, openness of authorities, and responsive action achievements in the municipal cases was gathered from monitoring and evaluation data from the period 2013 to 2015. This included two data sets. The most extensive source was a database of structured qualitative information about the actions carried out in each municipality during this period, including description of participants, focus of meetings and activities, and authority responses when relevant. Description of initial activities included assessment of local health and municipal authorities' openness. The second source was municipal-level evaluations conducted at the end of 2015 to assess the capacities and achievements of citizen leaders active in the initiatives. These evaluations provided further information about their organizational capacity, alliances formed, monitoring efforts in health facilities and in communities, and dialogues with authorities. The information contained in both of these data sets was documented by CEGSS field staff and reviewed and verified by the technical staff in the central office.

The sample included all municipalities where citizen initiatives were active during the period from 2013 to 2015, for a total of 29 cases. A structured case report format was developed to gather data relevant for assessing the level of implementation of each of the domains of citizen action, the presence of contextual conditions and outcomes from the monitoring and evaluation sources. Case reports for each case were created by systematically reviewing the data available and recording pertinent information in the structured format.

Additional data was gathered through a questionnaire designed to triangulate the information reflecting each condition and outcome in the case reports and expand on some aspects that were not consistently captured in the monitoring data. This questionnaire was completed by the CEGSS staff member who had worked most closely supporting processes in each municipality and thus had in-depth knowledge of the activities, outcomes and local context.

2.6. Scoring the cases

A case data matrix was developed to facilitate the valuation of information from the case reports and questionnaires to arrive at numerical scores for each of the initiative-related and contextual conditions and the outcome of responsive action in the 29 munic-

Table 1
Description of conditions and outcomes used in the assessment of the citizen-led accountability initiatives and the criteria used to allocate the top score.

	Description	Criteria for top score
Initiative-related conditions		
Grassroots network quality	• Level of participation and internal coordination in core group of leaders • Communication with and involvement of other community leaders, organizations	• More than 4 active leaders, who meet and communicate regularly. • Strong communication with other leaders and organizations who occasionally participate in meetings and collective action with core leaders.
Monitoring of health facilities	• Level of participation in and continuity of collection of evidence through health facility visits, user interviews, community assemblies, SMS complaint platform	• Regular monitoring activities for more than 1 year, generating large amount of evidence
Engagement with authorities	• Frequency and focus of meetings with municipal, district health, and higher level authorities, including provincial and national level authorities, and human rights institutions • Signs of follow up with and active support (e.g. provision of meeting space) from municipal, district health, and higher level authorities	• Frequent interaction with municipal authorities with focus on action and follow up on problems presented • Frequent interaction with district health authorities with focus on action and follow up on problems presented • Audience with 2 or more higher level authorities or multiple interactions to follow up on problem presented
Contextual conditions		
Openness of municipal authorities	• Functionality of municipal governance spaces and openness to community participation • Openness of mayor to community interests at beginning of leader formation process	• Municipal council meets regularly with some attention to resolving problems presented by community groups. • Mayor gives audience to community representatives and is receptive to working on community problems.
Openness of health authorities	• District/provincial health authorities open to dialogue with communities at beginning of leader formation process	• District and provincial authorities give audience to community representatives and are receptive to community interests
Outcome		
Responsive action	• Actions by authorities to resolve problems presented by leaders	• Allocation of significant resources to improve health system deficiencies OR allocation of moderate resources and strong corrective human resources actions (e.g. transfers)

ipalities. In scoring, we chose to employ fuzzy set values, which capture the extent to which the conditions and outcome are present in each case, as opposed to crisp set values, which are dichotomous and only indicate presence or absence. This choice enabled us to better represent the variation across the cases.

The criteria for assigning scores corresponding to strong, moderate, weak and minimal/no presence for each condition and outcome were elaborated based on comparative assessment of the data summarizing how the conditions presented across cases (Basurto & Speer, 2012). In this sense, criteria for assigning scores were based on capturing the range of variability within the data set. For some of the conditions, we identified sub-domains that captured important dimensions that could not be easily reduced to a single score. For example, within the domain of engagement with authorities, the score consisted of a sum of three sub-scores reflecting the quality of their interaction with authorities at different governance levels (see Table 1). The outcome of responsive action was assessed based in the extent and value of the action (s) mobilized by authorities to resolve problems. As indicated in Table 1, cases with responsive actions that included allocation of resources and strong human resources action were assessed as having the strongest outcomes. Based on the variation within the sample, cases with achievements recorded as "user reports of improved service quality" alone were assessed as having lower value responsive action.

Case scoring entailed a three-step process. Initial scores were assigned by the study coordinator (AH) based on assessment of data reflecting the conditions and outcome in the case report and questionnaire. These scores were then reviewed in a workshop with the CEGSS staff that had completed the questionnaires. Through discussion and comparative assessment, some cases' scores were modified. Final scores were assigned by AH through review of the suggested modifications, and additional information to support modification of scores was recorded in the case data matrix.

2.7. Fuzzy set analysis

The data set of case scores was analyzed using the fsQCA software to assess the combinations of conditions that led to the outcome of strong responsive action (Ragin & Davey, 2016). To prepare the data set of case scores for fuzzy set analysis, the scores for each condition and the outcome were first calibrated to scales ranging from 0.0 to 1.0. To set the threshold for scores that represent strong presence of the conditions, we assessed the distribution of scores across the cases. For most conditions, the midpoint of the scale was found to be a meaningful point of distinction between strong and weak presence of the condition, and for some conditions the threshold was set over the midpoint to better capture the variation in the data.

A truth table was produced, which displays all possible configurations of presence and absence of conditions and outcome, and configurations that were not present in the data set were eliminated. Analysis of the truth table is based on the metrics of consistency, which is the degree to which cases with a given set of conditions display the outcome, and coverage, which is the degree to which a set of conditions is present among cases that display the outcome. Based on review of the presence of the outcome in the cases that corresponded to each configuration of conditions, the outcome was reset to 1 (present) if consistency was higher than 0.90. A standard analysis of the truth table was applied, and the intermediate solution formula was chosen. The intermediate solution formula reports the combinations of conditions, or causal recipes, that were sufficient to produce the outcome, based on logical reduction (elimination of configurations not observed) and retention of conditions that contribute theoretically to an explanation (Schneider & Wagemann, 2012).

2.8. Interpretation

The causal recipes identified in the solution formula, together with review of the truth table, provided a base for identifying groups of cases with similar configurations of conditions and the outcome. In the final interpretative phase of the analysis, we returned to the descriptions of activities in the case reports to better understand how these configurations took shape in practice and the processes through which they contributed to the outcomes of different levels of responsive action in these case groups. We sought to identify similarities and contrasts in how citizen action played out within and across the case groups with attention to how interaction among the conditions influenced the development of citizen power (Rihoux & Lobe, 2009; Fox, 2015). This retroductive process of bringing the solution formula into dialogue with the case knowledge and theoretical knowledge enabled us to identify three causal pathways that characterize processes of citizen action and authority responses observed in the case groups.

3. Results

Of the 29 municipal cases under study, citizen-led initiatives in 16 cases obtained strong responsive action, while 13 obtained lower level or no responsive action. Table 2 presents the case scores for each condition for the municipal cases with strong responsive action, while Table 3 presents the scores for the cases with lower level or no responsive action during 2013–2015, with conditions considered to be strongly present highlighted. Of the 16 cases with strong responsive action (Table 2), at least one authority was open to engage at the beginning of the process in 100%. In the 13 cases with lower level or no responsive action (Table 3), both municipal and health authorities were less open in eight cases and only health authorities were initially open in five. Among the 16 cases with strong responsive action, 13 cases also had strong presence of at least two initiative-related conditions, while only five of the 13 cases with lower level responsive action had strong presence of two initiative-related conditions, and four cases had strong presence of one.

The solution formula obtained from the fsQCA analysis of these scores and its coverage and consistency for the outcome of strong responsive action are shown in Table 4. The solution indicates that the presence of either initially open municipal authorities OR the combination of strong action in the areas of grassroots network, monitoring and engagement with authorities and initially open health authorities were sufficient conditions for the outcome of strong responsive action. Based on the solution formula and the patterns observed in the tables of conditions scores, it is evident that the presence of at least one initially open authority was a critical condition for strong responsive action. The second part of the solution formula (Network * Monitor * Engage * Open_health) further indicates that in cases where health authorities were initially open, strong responsive action also depended on strong implementation of grassroots networks, monitoring and engagement with authorities.

Further interrogation of the case data in light of the configurations in the solution formula enabled us to identify key insights into how citizen action took shape and contributed to different levels of responsive action. These insights provided the base for identifying three pathways that captured a richer characterization of how the conditions created and confronted by citizen-led initiatives interacted to bring about solutions to some of the health system deficiencies affecting indigenous populations. The components of the solution formula, groups of cases and key insights that provided the base for identifying each of the three pathways are shown in Table 5, though it should be noted that

Table 2
Strength of presence of conditions in cases with strong responsive action. Condition scores that were above the threshold to be "present" are bold.

		Initiative-related			Context		Outcome
		Network	Monitor	Engage	Open muni	Open health	Responsive action
Open municipal and open health authorities	San Bartolome	**0.95**	**0.73**	**0.95**	**0.95**	**0.95**	**0.95**
	Zona Reina	**0.95**	**0.95**	**0.89**	**0.52**	**0.95**	**0.95**
	San Marcos	**0.9**	**0.73**	**0.89**	**0.95**	**0.95**	**0.95**
	Tectitan	**0.81**	**0.95**	**0.95**	**0.88**	**0.95**	**0.95**
	San Pablo	0.49	**0.95**	**0.78**	**0.52**	**0.95**	**0.95**
	Ixtahuacan	0.34	0.27	0.43	**0.52**	**0.73**	**0.73**
Open municipal authorities	Santa Lucia	**0.9**	**0.73**	**0.61**	**0.52**	0.05	**0.73**
	Carcha	**0.67**	**0.73**	0.43	**0.95**	0.27	**0.73**
	Santa Barbara	**0.81**	**0.73**	0.43	**0.52**	0.27	**0.95**
	Concepción	**0.9**	0.27	**0.89**	**0.74**	0.27	**0.95**
	Chisec	0.34	0.27	0.43	**0.88**	0.27	**0.95**
Open health authorities	Jocopilas	**0.67**	**0.95**	**0.78**	0.05	**0.95**	**0.73**
	Cotzal	**0.81**	**0.73**	**0.61**	0.28	**0.95**	**0.73**
	Tamahu	**0.95**	**0.73**	**0.78**	0.12	**0.95**	**0.95**
	San Bartolo	**0.95**	**0.73**	**0.78**	0.28	**0.95**	**0.73**
	Santa Cruz	0.05	0.27	0.31	0.28	**0.73**	**0.73**

Table 3
Strength of presence of conditions in cases with lower level or no responsive action. Condition scores that were above the threshold to be considered "present" are bold.

		Initiative-related			Context		Outcome
		Network	Monitor	Engage	Open muni	Open health	Responsive action
Open health authorities	Cuilco	**0.81**	**0.95**	0.43	0.28	**0.95**	0.27
	Santa Maria	**0.67**	0.27	**0.61**	0.12	**0.95**	0.27
	La Tinta	0.23	**0.73**	**0.61**	0.12	**0.73**	0.27
	Soloma	**0.67**	**0.95**	0.43	0.12	**0.73**	0.27
	Cunen	**0.81**	0.27	**0.61**	0.28	**0.95**	0.27
Municipal and health authorities less open	Ixcoy	0.23	**0.73**	0.31	0.12	0.27	0.27
	Nebaj	0.08	0.27	**0.61**	0.28	0.27	0.27
	San Cristobal I	**0.81**	0.27	0.2	0.12	0.27	0.27
	Totonicapan	0.23	0.27	**0.78**	0.28	0.05	0.27
	San Cristobal II	0.05	0.05	0.2	0.12	0.05	0.05
	Lanquin	0.05	0.27	0.13	0.12	0.27	0.05
	Fray Bartolome	0.34	0.27	0.31	0.12	0.27	0.27
	Coban	0.34	0.27	0.13	0.05	0.27	0.05

the pathways were further refined through examination of their relevance to other case groups.

Pathway 1: Leaders gain leverage with initially open municipal authorities through community-generated evidence, alliances with community authorities, and persistent constructive engagement.

In cases where municipal authorities were open at the beginning of the citizen formation process, this did not translate to being immediately responsive. There was a common trajectory of collective efforts to gather evidence and involve community authorities in preparing demands to present to the mayor and in the municipal council. Involvement of community authority figures, including community development council members, auxiliary mayors, and ancestral indigenous authorities, helped the defenders extend their grassroots base of support in monitoring and leverage their influence in interactions with other authorities. Similar problems were identified across cases, including lack of emergency transport from remote villages or being required to pay for fuel, being given written prescriptions instead of medicines, and disrepair of health facilities. In processes of constructive engagement, leaders took various paths to having their problem heard. Some submitted letters with collected signatures of community members and community authorities to solicit an audience with the mayor and obtain a time to present in the municipal council meeting. Sometimes it was not immediately granted but required follow-up contact. After presenting the problem, even when immediate commitments were made, no action was taken right away. Leaders' persistence in bringing attention to their prioritized problems and collective demands through meetings with the mayor and participation in the municipal council was key to achieving responsive action. Examples of responsive action achievements included designated municipal funds for: ambulance fuel and maintenance, hiring a driver, purchase of an ambulance, filling prescriptions for medicines not in stock, and infrastructure repair for the health center.

Comparison of the cases of Chisec and Santa Lucia indicates that despite attaining similar responsive action, strong implementation of citizen action in Santa Lucia contributed to a more sustained shift in the accountability ecosystem than in Chisec, where citizen action was weaker. In Chisec, leaders' engagement with authorities was relatively brief and almost exclusively with the municipal council. Two leaders from a remote region of the municipality followed the general process described above to mobilize collective support across several communities to demand an ambulance to service their region. However, once the ambulance was granted, their efforts lost momentum. While they continued to engage in occasional monitoring, this did not become a regular activity due to the distance, lack of coordination with a broad community base, and the initial negative response from the district health authorities. In Santa Lucia, leaders also collected evidence documenting the problem of limited access to emergency transport and engaged with the municipal council to motivate the establishment of a fund for ambulance fuel and maintenance. However, higher scores

Table 4
Solution formula of conditions that led to strong responsive action. Solution coverage of 0.84 indicates that most of the cases with strong responsive action were represented by this combination of conditions, and consistency score of 0.95 means that it produced the outcome most of the time. The difference between the number of cases displaying the configurations indicated in the solution formula and the number of unique cases reflects the four cases that displayed both configurations (San Bartolome, Zona Reina, San Marcos, Tectitan).

	Consistency	Coverage	# of cases	# of unique cases
Open_muni	0.96	0.65	11	7
Network * Monitor * Engage * Open_health	0.96	0.61	8	4

Solution coverage: 0.84.
Solution consistency: 0.95.

Table 5
Origin of the three pathways.

Solution formula component	Case groups reviewed	Key insights	
Open_muni sufficient for strong responsive action	Open municipal and open health authorities Open municipal authorities (Table 2)	Leaders' persistence in constructive engagement key to strong responsive action	Pathway 1
Network * Monitor * Engage * Open_health sufficient for strong responsive action	Open municipal and open health authorities Open health authorities (Table 2)	Coordination of authorities at multiple levels key to strong responsive action	Pathway 2
Conditions present not sufficient for strong responsive action	Open health authorities Municipal and health authorities less open (Table 3)	Engagement with legal authorities key to building citizen power when facing less open local authorities, but longer time for response	Pathway 3

across initiative-related conditions reflected that leaders' actions also had a broader focus, including regular health service visits, involvement of community authorities in interactions to improve service in the rural facilities, and presenting reports of mistreatment of patients in the municipal council. On-going engagement with authorities to present collective demands enabled leaders to gain recognition and strengthen their voice in municipal decision-making.

In cases where municipal authorities were not initially open, leaders faced barriers to following similar paths of constructive engagement at this level. There were several cases where the mayor inhibited the process of forming the core group of leaders by blocking the participation of members of the community development councils. These cases were characterized by a more contentious environment where leaders had to navigate political rivalries to develop a network of community support. There were also several cases with less open municipal authorities where the municipal council meetings were held irregularly and/or did not provide space for participation of community representatives. The condition of less open municipal authorities thus implied that leaders should pursue alternative pathways to obtain strong responsive action.

Pathway 2: Regular monitoring of health facilities, communication channels with community authorities and health authorities provide a base for engagement with authorities at multiple governance levels.

In the cases where district health authorities were open from the beginning and the three initiative-related conditions were strongly implemented, leaders established regular visits to health facilities to interview service users, document inventories and discuss problems with district managers. These efforts were supported by coordination with various community authorities, such as auxiliary mayors and ancestral indigenous authorities, as well as traditional birth attendants and health promoters, who helped to disseminate messages about users' rights and served as contact points for service users who wanted to report rights' violations. The involvement of members of existing networks of community authorities, health promoters and traditional birth attendants, both in the core group of leaders and as collaborators, contributed to the recognition and legitimacy of their work in the eyes of other authorities as well as service users. In these cases, they also collectively identified the urgency of problems with emergency transport and lack of medicines, as well as problems with closed and unattended rural health facilities, lack of equipment and reports of poor quality of care and mistreatment.

Building on this base of sustained collective action, leaders engaged with authorities at diverse governance levels to bring more attention to the problems documented and seek solutions. Regular interaction between leaders and district health authorities contributed to responsive action in the form of improved service delivery through better supervision and corrective action. In several cases, leaders formed collaborative relationships with the district manager, such as in San Pablo, where he included leaders in performance evaluation meetings. However, leaders' relationships with open district managers varied, even over time within the same case, as their capacity for and interest in addressing the problems raised was not always strong. Engagement with the director of the provincial health authorities to report and provide documentation of personnel problems and follow up on the response played a critical role in generating support and authorization for stronger human resources actions, such as transfers and firing. Other structural problems related to resource constraints also negatively affected district health authorities, and they encouraged leaders' efforts to engage with municipal authorities as well as provincial health and government authorities. These interactions gave greater visibility to the problems they wanted resolved, enabling leaders to leverage their influence with municipal authorities in cases where they were open. In Zona Reina and San Marcos, these multilevel interactions also facilitated coordination of municipal, provincial health and government resources to strengthen emergency transport and improve infrastructure. In cases where municipal authorities were not responsive, improvements in the supply of medicines in and funds for fuel and maintenance for the ambulance were attained through enhanced coordination between provincial and district health authorities that was facilitated by the leaders.

Cycles of mobilizing collective action in monitoring and advocacy also included engagement with authorities beyond the local level that did not lead to specific responsive action during the timeframe under study. In Jocopilas, initial interactions with the director of the provincial health authorities to present the work they were doing led to the establishment of regular meetings. Citizen representatives from other municipalities in this province also

participated, and the director formed commissions to investigate some of the problems presented. In Tectitan, leaders took similar action to present problems with the provincial health authorities director, but the initial response was that they already knew about these problems and did not have adequate budget to address them. However, the leaders persisted and, along with representatives from other municipalities, obtained spaces in meetings with provincial health and government authorities and congressional representatives to present demands for solutions to prevalent structural problems of medicine and vaccine shortages, inadequate budget for emergency transport and shortage of health workers. Even while these interactions did not generate immediate responsive action, they reflected strengthened exercise of citizen voice with higher level authorities and a growing level of recognition of the leaders' work as defenders of the right to health in the eyes of authorities.

Pathway 3: Legal action to seek redress for individual and collective grievances enables leaders to build their credibility and power when local authorities are not responsive.

In the cases with low level or no responsive action (Table 3), leaders did not manage to convince municipal authorities or coordinate multiple authorities to mobilize higher value resources to resolve problems during the time period under study. Lack of interest or even resistance from authorities served as a deterrent to further action for accountability in some cases, such as Lanquin and San Cristobal II. In other cases, including some cases with strong responsive action, leaders confronted the lack of local response to some problems with alternate strategies of pursuing more adversarial legal avenues. Even in some cases where health authorities were open to monitoring and discussing service problems, including La Tinta (Table 3) and Zona Reina (Table 2), leaders also filed legal complaints regarding violations of some users' rights that were not redressed locally. In most cases, the complaints filed with the public prosecutor, human rights ombudsmen, and other indigenous rights institutions were not resolved during the period under study. But these actions demonstrated to authorities that leaders were knowledgeable about the legal basis of their work and enhanced their confidence and credibility in further interactions with authorities. In Nebaj (Table 3), one of the cases with less open health and municipal authorities, a leader sought and received protection from the human rights ombudsmen after reporting threatening phone calls related to her work defending patients' rights at the regional hospital. In this case, the leader's engagement with the ombudsmen helped her to gain the recognition and sanction of the hospital director, who with time established regular collaborative interactions with the leader to review patient complaints and took action to improve service quality,

Legal action based on collective grievances provided leaders with an additional means of advocacy for resolution of problems that they knew to be beyond the capacity of local authorities to act upon. This strategy did lead to strong responsive action in the case of Tamahu (Table 2), where a national health policy change resulted in the closing of remote community clinics managed by contracted non-governmental organizations. Leaders in Tamahu filed a complaint based on the violation of the right to access to health care in the 38 communities where clinics were closed. Through a process of gathering signatures in the 38 communities and sending a delegation of leaders and community authorities to the provincial capital to submit the demand to the ombudsmen and follow up on two occasions, a resolution was reached that resulted in the reopening of the clinics. In another province, leaders from Totonicapan and Santa Maria (Table 3) presented a petition to the human rights ombudsmen for the director of the provincial health authorities to be removed from his position based on documented corrupt hiring practices. The leaders obtained an audience with a commission from the ministry of health at the provincial and then at the national level, with mediation by the ombudsmen. During the period under study, the ministry did not yet take any action against the director, as these forms of legal action often have a long timeframe for resolution. Even when engagement with legal authorities did not directly contribute to strong responsive action, the action was significant in its contribution to building recognition of the legitimacy of the leaders' work and developing their capacity to advocate for problem resolution, particularly when local authorities were less open.

4. Discussion

This study indicates that citizen-led initiatives were substantially effective in generating some form of responsive action by authorities to redress community-identified health system deficiencies across varying municipal contexts in rural Guatemala. Through processes involving networking, monitoring and strategic engagement with authorities, 16 of 29 municipal-level initiatives generated strong responsive action including mobilization of resources to alleviate structural deficits, such as lack of medicines or emergency transport, during the period 2013–2015. Among the other 13 cases, many had forms of responsive action that were assessed as weak based on variation within the sample, which included achievements such as user reports of improved service delivery. These findings are in line with the results of recent reviews that show that initiatives mobilizing citizen engagement for accountability are widely successful at the local level in generating improvements in health services and other sectors (Holland et al., 2016; Lodenstein et al., 2016). Even while accountability experts point to the difficulty of scaling local results to attack systemic problems (Fox, 2015; Joshi, 2013), such responsive improvements represent significant advances for communities whose relationship with authorities is characterized by historic distrust and social exclusion, and they contribute to a sense of empowerment and fuel motivation for continued action (Samuel, 2016). However, the value of these responses should be interpreted within the context of the processes that precede and follow them. As the case of Chisec illustrates, short term gains in obtaining an ambulance do not necessarily translate to shifts in the accountability ecosystem in the absence of sustained cycles of strategic citizen action.

The conditions that were sufficient to generate stronger responsive action in 16 of 29 cases included either open municipal authorities, or strong implementation of all domains of citizen action and open health authorities. Review of case data to understand the pathways behind these patterns indicated that while open municipal authorities provided a starting point, the leaders did not simply ask and receive. Instead municipal governments that had a functional council and had been previously receptive to community interests represented a slightly open door. At least some presence of iterative processes of engagement, strengthened by the backing of network connections with other recognized community leaders and community-generated monitoring evidence, enabled them to have influence on municipal authorities' decisions. These wider processes of community mobilization and collective action to document and demand resolution of health system deficiencies were important for leveraging the power of indigenous leaders so that they could take advantage of the slightly open door. This finding is relevant to the on-going discussion of constructive or collaborative approaches to citizen engagement with authorities, which are generally promoted as being more effective than adversarial approaches (Grandvoinnet, Aslam, & Raha, 2015). As Fung & Wright (2003) highlight, even in contexts where authorities are open to dialog with citizen groups, constructive engagement does not imply a level playing field. Our findings

reinforce the case for explicit attention to processes of citizen action, including network-building and participatory monitoring, that bolster the collective power of disadvantaged groups and enable constructive engagement between citizens and authorities in political contexts where it is feasible (Joshi & Houtzager, 2012; King, 2015; McCoy, Hall, & Ridge, 2012; Speer, 2012).

In cases with strong implementation of all domains of citizen action and open health authorities, the pathway to responsive action involved engaging with authorities beyond the local level. Closer examination of the cases with this configuration of conditions indicated that the strong base of sustained cycles of collective action in monitoring and local advocacy enabled the pursuit of new channels of engagement with provincial, and in some cases national, level authorities. These interactions with higher level authorities contributed both directly and indirectly to outcomes of strong responsive action, particularly through enhanced coordination between provincial and local authorities. It is noteworthy that progressive multilevel engagement is also an important intermediate outcome that reflects strengthened exercise of voice by indigenous leaders and provides a base for further coordinated efforts to seek redress of the upstream, systemic causes of health system deficiencies. This pathway is relevant to Fox's proposition that scaling local accountability initiatives is not so much a matter of getting bigger as "strategizing at multiple levels to get more leverage over powerful institutions" (Fox, 2016). As part of iterative cycles of citizen action, engagement between indigenous leaders and authorities beyond the local level reflects an incremental gain towards generating demand from below that can lead to pro-equity health policy and resource allocation (Grandvoinnet et al., 2015). Given the political terrain in highly unequal societies like Guatemala, furthering the pathway of multilevel engagement requires bolstering the capacity of municipal-level initiatives to link up with each other and with other pro-reform associations in strategic efforts to represent their collective demands in national arenas (Gaventa & Barrett, 2010; Hernández et al., 2017; Flores, 2018).

In addition to constructive engagement with local and higher level authorities, citizen-led initiatives also pursued legal action with the human rights ombudsmen, public prosecutors and indigenous rights institutions in several municipal cases. Through this more adversarial approach, citizen leaders acted on the legal rights bases of their reclamations against the state in relation to health system deficiencies, particularly those that were beyond local capacity to address. Even while this pathway was not directly implicated in the solution formula results from the QCA, upon reexamination of case data it was evident that these strategies contributed to the progressive empowerment of citizen action both in cases where authorities were initially less open, such as Nebaj, and in cases where authorities were already open, like Zona Reina. Leaders gained confidence in expressing their legal rights and greater recognition of the significance of their work from other authorities. In this way, their engagement in legal processes indirectly helped give them leverage in other interactions, reflecting Grandvoinnet et al.'s (2015) assessment that action in one pathway of citizen-state engagement can catalyze progress along another. Even though this path of engagement did not directly yield responsive action in the time period under study, except in the case of Tamahu where community clinics closed by a policy change were re-opened, findings indicate that legal action strategies have a useful place on a menu of advocacy options for citizen initiatives (Fox, 2016). Navigating between constructive engagement and adversarial legal action strategies in pursuit of health accountability for marginalized populations in other settings has enabled moving focus between both end of the pipe delivery issues and upstream bottlenecks (Joshi, 2017). Such integrated approaches evolve in response to the local and national environment rather than evidence of "best practices" in isolation from context.

5. Conclusions

When citizen-led initiatives tackle the stark deficits in health service delivery that indigenous peoples experience in rural Guatemala, they are confronting the embedded socio-political forces that perpetuate the status quo of health workers who mistreat them and lack basic supplies for delivering care. In this study, we identified pathways through which the actions implemented by these initiatives challenge the status quo and lead to change. Our findings respond to calls for empirical evidence of how strategic approaches operate to generate countervailing power and address health system accountability failures (Joshi, 2017; Freedman & Schaaf, 2013). Through comparative analysis of 29 municipal cases, we gained key insights that contribute to on-going discussions of the centrality of citizen power and socio-political context in accountability change processes.

Firstly, in highly unequal contexts, even constructive engagement with open authorities does not imply a level playing field. Obtaining a response to the health system problems presented depended on pushing up against power asymmetries, and making iterative demands backed by a base of mobilized community support. This finding affirms the importance of looking beyond the monitoring tools used and directing focus to the processes through which marginalized citizens gain and confront power when they gather and present the information (Flores & Hernández, 2018).

Secondly, iterative, bottom-up processes facilitate the projection of indigenous voices into spaces of engagement with provincial and national authorities. Efforts to scale accountability approaches beyond the local should be approached with attention to ensuring that the voices of indigenous and other marginalized citizens are at the center. As seen in this study, multi-level engagement occurred through the long-term process of joining up with other indigenous leaders and communities in cycles of collective action for health system accountability. In this way, citizen leaders interacting with authorities at higher levels are there not as individuals but as representatives of organically developed grassroots networks mobilized for the right to health.

Finally, legal action against rights violations can contribute to an enabling environment for citizen engagement with authorities. While legal action approaches are most often seen as adversarial and discouraged by proponents of purely collaborative engagement, we observed that legal action was a useful alternative route for advocacy that reinforced leaders' knowledge and confidence in the legal base of their work. However, legal action alone did not offer a viable route to transformative change in this setting due to excessively long processes of resolution.

While the goal of achieving health equity for indigenous populations in Guatemala is an uphill battle, the pathways identified in this study highlight the political nature of this struggle and demonstrate the potential of collective power generated by citizen-led initiatives to hold authorities accountable for health system failures.

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Declaration of interest statement

No conflict of interests to declare.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.worlddev.2018.09.020.

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