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ACCOUNTABILITY FOR HEALTH EQUITY: GALVANISING A MOVEMENT FOR UNIVERSAL HEALTH COVERAGE

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Health Accountability for Indigenous Populations: Confronting Power through Adaptive Action Cycles*

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Abstract Health-care providers are powerful figures in society. An informed service user may be able to identify regulatory non-compliance and abuses by these actors, but reporting them is not a mere administrative procedure. It is an act that stirs existing power relations and social hierarchies. This article argues that the essence of an accountability intervention is the process through which service users collect and analyse evidence that is then used to confront power at different governance levels. The response from authorities is assessed and strategies adjusted accordingly in adaptive cycles of accountability action. Based on ten years' experience supporting indigenous citizen-led accountability action in Guatemala, the authors describe how their approach evolved from an emphasis on technical components to a politically informed approach with interdisciplinary collaboration and explicit engagement with power. This article summarises lessons learned and their relevance for organisations working in health accountability in highly unequal settings.

Keywords: accountability, power relations, empowerment, indigenous populations, Guatemala, health, equity, power, marginalised populations.

1 Introduction

The medical doctor was loud and commanding: '*You will not be allowed to come here any more.*' Maria, a user of the local services, was banned from attending the local public health facility for showing '*no respect*' to a health official. Maria's disrespect was to ask questions about how public resources were being used in the health facility, and also asking for explanations as to why free medicines were not being provided to patients, despite being included in the national health-care delivery guidelines. Maria's questions shake up local power relations. Even her children at school felt the repercussions of their mother daring to question a government authority. The teacher called them '*the kids of the troublemaker*'.[1]

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Maria was one of over 50 people elected by their own communities to receive training about legal frameworks, their rights, responsibilities, and entitlements, and the basics of public health policy and public budgets. The role that Maria was playing – engaging in participatory monitoring and evaluation of local health-care services – was backed by a newly adopted health law that promoted citizen participation. Maria was banned afterwards from attending health-care facilities for her attempt to implement existing laws and regulations. Although public officials knew about these laws and regulations, they ignored them. In Guatemala, cases such as Maria's are frequent among rural indigenous peoples when they engage with public services.

The remainder of this article provides an overview of the historic and social context of exclusion in which this situation occurs, and how it has been addressed by a local civil society organisation (Centro de Estudios para Equidad y Gobernanza en Sistemas de Salud, CEGSS) in alliance with grass-roots indigenous organisations. Over the last decade, CEGSS has learned and adapted its approach to civic action and accountability: from an emphasis on technical components to a politically informed and participatory approach with interdisciplinary collaboration and explicit engagement with power. This article summarises our learning and presents the stages of an adaptive cycle of accountability action that characterise our current approach to enabling indigenous citizens to demand health accountability.

2 Social exclusion and inequities in Guatemala

Guatemala is one of the most unequal countries in the world. The country as a whole has one of the highest poverty rates in the region, with 54 per cent living in poverty (INE 2011). The unequal distribution of income is clearly linked to ethnicity. Among the indigenous population, poverty rates reach 73 per cent, compared to 35 per cent among the non-indigenous population (INE 2006; IWGIA 2011). Despite a decrease in the national poverty rate by 9 per cent from 2000 to 2006, indigenous poverty rose by 22 per cent during the same period (ICEFI and CESR 2009); and the most recent assessment showed that poverty rates were rising nationally (INE 2006, 2011).

Health and wellbeing are a privilege reserved for the few in Guatemalan society. Almost 50 per cent of children under five are chronically malnourished, which contributes to stunted growth, cognitive damage, and a higher risk of death due to a compromised immune system (MSPAS 2010). There are only three countries in the world with higher rates of malnutrition, and among indigenous children the rate is even higher (66 per cent) than in the most affected country (Afghanistan, 59 per cent) (ICEFI and UNICEF 2011). Death among children under five has decreased from 121 in 1987 to 45 in 2008/09 (deaths per 1,000 live births), yet the number rises to 55 among indigenous children, compared to 36 among non-indigenous children (MSPAS 2010).

Guatemala also has one of the highest rates of women dying from pregnancy- and childbirth-related causes in Latin America.

The national maternal mortality rate was calculated at 140 deaths per 100,000 live births in 2011, and indigenous women were more than twice as likely to die in childbirth as their non-indigenous counterparts (163 vs 78) (MSPAS and Segeplan 2011). However, after adjusting for underreporting, UNICEF estimated that the actual national rate is 290 (compared to the estimated national rate of 153 in 2005), indicating an even more dire situation for indigenous women (UNICEF 2009). Overall, indigenous people in Guatemala are more likely to suffer poorer health and ultimately die younger – their life expectancy is 13 years less than that of non-indigenous Guatemalans (UN 2009).

These stark inequalities in income and health are the result of historical, social, and political processes that stem from European colonisation, decades of military dictatorships, the exclusion of poor and indigenous populations from development, and a 36-year-long internal war. The armed conflict from 1960 to 1996 was one of the most vicious and violent in the American continent. Guatemala's Historical Clarification Commission (CEH in Spanish) estimated that 200,000 people were executed or 'disappeared', and the number of orphans as a result of the armed conflict approached 150,000. The massacres and destruction of villages gave rise to the forced displacement of more than 1.5 million people. Although the political violence affected more than one third of the population, the largest burden of violence fell on the indigenous population – more than 80 per cent of all crimes verified by the CEH were on indigenous citizens. In addition to the violence, political instability and high levels of political repression characterised this period: in the years between 1955 and 1985, the government abolished all workers' unions and political organisations because they were perceived as dangerous. After several years of negotiations, peace was finally declared on 29 December 1996. According to the Peace Accords signed by the state and the guerrilla leaders, peace could only be achieved through the equitable social and economic development of the entire population. The Peace Accords specified the state's commitment to expand the tax base and progressively increase social investment in the most vulnerable sectors of society.

Despite modest increases in tax revenues and social spending since the 1990s, Guatemala is distinguished as the country with the lowest levels of tax collection and social spending in the world, relative to the size of its economy (World Bank 2014). Taken together, insufficient tax revenue and low social spending represents a major impediment to redressing inequities and attending to the urgent needs of the population.

3 Power: concepts and attributes[2]

At its core, this situation of social exclusion and the accountability failures it engenders reflect inequities in power. The first two entries in the *Oxford English Dictionary* define power as: (a) The ability or capacity to do something or act in a particular way, and (b) The capacity or ability to direct or influence the behaviour of others or the course of events (OED 2018). While these two definitions are sufficient to

understand what power is about, theoretical definitions of power are more complex, shedding light on different dimensions and sources, and there is no single concept that captures its full meaning. In our accountability work, we have found that instead of navigating the dense theoretical literature on power in detail, it is more useful to identify and understand power attributes and how they can help to explain social structures and interactions. The next paragraphs summarise some of the theories and attributes that have been influential in our understanding of power and its relevance in accountability work.

Power has the ability to produce changes in society, as much of these changes can be the result of conflict between individuals or, on the contrary, of consensus (Haugaard 2002). Many social processes and relations are determined by how some actors are able to manage social structures such as religion, education, formal and informal rules, the economic system, and even social class (Clegg, Courpasson and Phillips 2006). These different structures grant power resources to some actors, and create an environment that is more prone to staying the same and perpetuating the status quo than to promoting change. This is because powerful actors can use these social structures to mould relational processes and exchanges according to their needs and interests, without necessarily considering the position of less powerful populations. This describes the historical situation of Guatemala in which an economic elite with an ancestry of European colonisers have successfully created social, economic, and political structures that control and exclude indigenous populations who constitute about half of the total population in Guatemala.

Another theory of power poses that it is the result of building consensus among individuals: power is the result of the human capacity to act and work together. This means that power does not belong to one individual but to many, and that by creating more consensuses and including more people in a social process, the process itself becomes more powerful (Arendt 1970). Understanding power as consensus building is important to understand the relevance of agreeing on collective action, particularly in social movements. Consensus building is also important when service users and front-line health-care workers – particularly those allocated in deprived rural areas – are able to recognise each other's situations of exclusion within the broader health system and public services. Through this consensus, providers and users do not confront and fight each other but work together to demand changes higher up in the system.

Power can also be understood as 'latent' and expressed as 'influence' in decision-making. From this perspective, there are no powerless individuals, but only people who are yet to become conscious about, and activate, their hidden power in order to exercise influence (Morriss 2002). This perspective of power as a 'latent' force is useful in explaining social changes in several South American countries during the last decade, such as the *piqueteros* movement in Argentina

(Benclowicz 2006), workers' unions and peasants in Bolivia (Regalsky 2006), and indigenous movements in Ecuador (Pachano 2005). All are examples of how traditionally, socially excluded groups became 'conscious' through organising and political action, and activated their collective power to generate a shift resulting in a change of governments and social policies.

For our work in Guatemala, the three theories and attributes of power described above have been crucial to understand how power is expressed, not only at the macro or structural level (socioeconomic system) but also at the micro level, such as the relationship between a provider and a user of public services. The case of Maria described at the beginning of this article, when the medical doctor accused her of 'disrespect' and banned her from a public facility, despite lacking the authority to do so, shows how power can be abused at the micro level of a social relationship. At the same time, power can be built and expanded through dialogue and consensus between service users and front-line health-care workers when both actors recognise how the system is negatively affecting them, and, therefore, the need to work together to achieve systemic changes.

In our accountability work, while we always remind ourselves that our goal is to establish relations of dialogue and consensus, we must also be prepared to handle conflict. When working with grass-roots organisations, it does not help if we see them as powerless people, nor if they perceive themselves as powerless. For all of us, our work in accountability is driven by the consideration of ourselves as holders of power in latency, which needs to be activated through collective consciousness-raising and action. This view is very similar to the approach and practice of popular (Freirian) education and participatory action research, which have provided the core guiding values and principles of our work for the past decade.

4 Promoting accountability in rural indigenous municipalities

The CEGSS team began its first project in 2006, with the idea of promoting participatory planning and monitoring in local health services in six rural indigenous municipalities. From that initial experience, CEGSS expanded its work to cover a larger number of municipalities, reaching 35 by 2014, which represents about 10 per cent of the total number of municipalities in Guatemala, and about 22 per cent of the municipalities with a majority indigenous population.

When we started our work, we had a technical and linear view of accountability. There was a new law mandating citizen participation in the monitoring and evaluation of public services, and our project focused on providing training to both service providers and the communities that use those services. Once trained, both groups of actors would engage in participatory planning, monitoring, and evaluation. In our first project, the intervention seemed straightforward. Nonetheless, the results we obtained included many cases like that

of Maria, described at the beginning of this article. We did not take into account that a law ordering the participation of communities in the planning of public services was not sufficient to change the social hierarchy, racism, and discrimination embedded in the social relations between professionals, health officials (all of them non-indigenous), and the rural indigenous communities that use public services.

When our first project did not go as expected, we carried out in-depth interviews with community leaders who had had similar experiences to that of Maria. We wanted to understand what went wrong and to offer an apology to them. Although we were expecting that they would rightly hold us responsible for putting them in a vulnerable situation before health officials, this was not the case. Each of the community leaders we interviewed wanted to continue learning about their entitlements, how public services should work, and how to identify when services are not working well. All of the leaders interviewed were also aware that advancing in their desire to participate in the planning and evaluation of their local services would be difficult, and that they would receive more negative responses from authorities. They asked us to continue supporting them not only with training, but also with our support and solidarity.

The interviews with those community leaders were a breakthrough. They were basically telling us that although information and knowledge are important, they needed support to challenge the social hierarchy and unequal power relations in their municipalities. We at CEGSS reflected about this reality and decided to continue working in those municipalities. We refined our view of the driving force of our work, shifting from a central focus on the information, knowledge, and tools for participatory planning to explicit engagement with how power and power relations influenced access to public services in rural indigenous communities. For the next few years, CEGSS' work became embedded in ongoing analysis of how conflict and violence shaped existing power relations in those communities, including the distrust between communities, public officials, and service providers (Flores, Ruano and Funchal 2009). We also studied how existing public spaces for participation exemplified asymmetries of power between officials and rural indigenous communities (Flores and Gómez 2010). Through this specific study, we concluded that existing 'invited' public spaces were not responsive to communities' demands and that there was a need to pursue strategies to create new 'claimed' spaces.[3]

In line with our shifting focus towards understanding how power and power relations were expressed in these rural indigenous communities, we were also gradually diversifying the team within CEGSS. From an initial team of solely public health experts, we evolved into an interdisciplinary team that includes lawyers, political scientists, anthropologists, social workers, and journalists. Also, about 50 per cent of our team is of indigenous ethnicity. Collaboration with the grass-roots organisations that are at the forefront of accountability work

in rural municipalities has played a critical role in the development of strategies, actions, and tools to redress power asymmetries in these contexts. As such, the knowledge generated and learning acquired are a product of collective action between CEGSS and grass-roots organisations on the front lines of local accountability struggles.

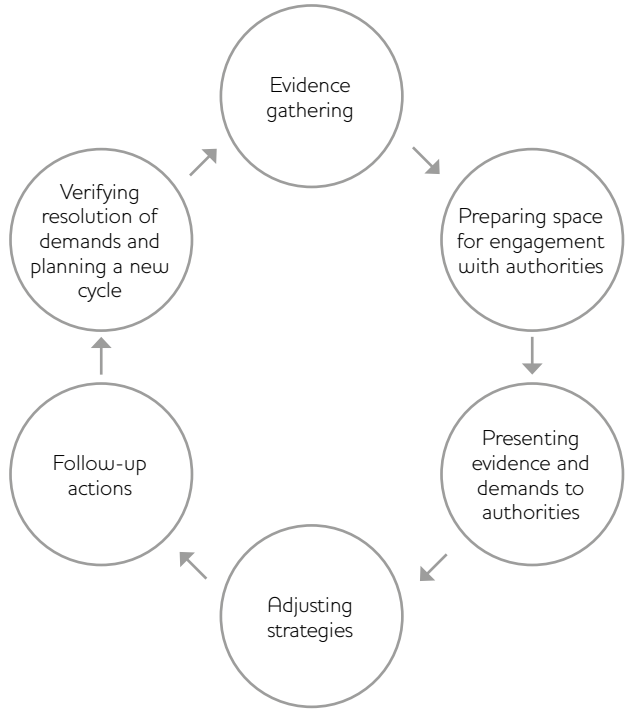
In 2013, our collaboration with communities evolved to working with citizen leaders mobilised in the role of Community Defenders for the Right to Health (from now on referred to as 'defenders' in this article). There are currently over 120 defenders (about 60 per cent male and 40 per cent female) elected by their own communities to (a) defend them from abuses by officials and providers of health services, (b) act on their behalf to dialogue and engage with officials to improve the responsiveness of local services, and (c) to inform and educate communities about their rights, entitlements, and obligations. The defenders are all volunteers who receive ongoing training and support to develop and implement their knowledge of human rights, legal frameworks, evidence-gathering techniques, public policy and services, advocacy, negotiation and conflict resolution, and the basics of public budgets.

In the past couple of years, CEGSS' work has also focused on the integration of the defenders from different indigenous municipalities across the country in the Network of Community Defenders for the Right to Health (REDC-SALUD as per its name in Spanish). This network serves as a platform for the municipal-level grass-roots networks to link up at a national level and develop consensus regarding their common struggles and interests. This consensus provides a base for identifying collective goals regarding the problems they will seek to influence. The network elects a group of 'regional coordinators' who are in close and constant communication with CEGSS staff and who also coordinate collective actions such as campaigns, and represent the network at meetings with provincial- and national-level authorities. The details of our approach and the work of the defenders are described in Section 5.

5 Adaptive cycles of accountability action

Our work towards accountability is approached as an action–reflection–action process in which service users collect and analyse evidence that is then used to confront and engage with power at different governance levels. The response from officials is assessed (e.g. commitment to resolve problems, denial of problems, hostility towards community leaders) and strategies are adjusted accordingly. The strategies may involve the implementation of a plan when there is willingness and collaboration by officials, or a confrontational approach when an official is in denial or hostile towards communities. We follow up on the implementation of agreed action plans and verify the resolution of problems and complaints that were put forward by service users. Once resolution is confirmed, we plan a new cycle. Figure 1 presents the six stages in the cyclical action–reflection–action process, and the remainder of this section describes each of the stages in detail.

Figure 1 **Stages in the adaptive cycle of accountability action**



Source Authors' own.

5.1 Evidence gathering

In our approach, evidence is not understood as an academic construct according to the hierarchy of scientific evidence, but as information gathered collectively with communities which contributes to opening channels of engagement with officials. Defenders receive verbal complaints from service users about problems at health-care facilities, such as not receiving the required medicines, opening hours not being respected, the ambulance service not being available, or a service provider that is disrespectful or abusive towards patients. The defender obtains as much detail as possible about the complaint and then classifies it based on a catalogue of 23 different types of complaint.[4] Once classified, the defender sends a coded SMS message to an electronic platform that converts the SMS message into an individual complaint that is geo-referenced on a digital map.[5]

Depending on the type of complaint, the defender may also take photographs or video recordings of infrastructure, shelves inside health facilities showing stock-outs of medicines and medical supplies, or verbal testimonies from service users about their complaints. By analysing the complaints received, the defender identifies whether a recurrent problem is emerging: several patients not receiving the required medicines, reports of abuse and disrespect by the same health-care worker, the local ambulance not transporting patients, etc. In coordination with CEGSS advisors, the recurrent problem

is identified, and all evidence related to this problem (individual complaints in the electronic platform and any audiovisual evidence) is compiled in a report to be presented to public officials.

A different process of evidence gathering occurs when a defender receives a complaint about a case that needs urgent action (based on medical grounds stated by a provider, or a blatant violation to the right to health care). For instance, a patient referred by doctors to a higher resolution facility due to his/her condition who is not transferred because the ambulance driver is demanding an illegal payment, or cases in which a patient is refused care because he/she does not speak Spanish. In these cases, the defender gathers as many facts as possible and then communicates immediately by phone with the official in charge of the facility where the problem occurred. If there is no response from the official, the defender communicates with CEGSS advisors, who contact or advise defenders on contacting higher level officials at provincial and national level.

5.2 Preparing the space for engagement with authorities

Once the report on recurrent complaints is ready, the defenders, together with CEGSS advisors, analyse what would be an adequate space of engagement for the type of complaints that will be brought to public officials for their resolution. In Guatemala, there are several institutionalised spaces for engagement at different governance levels (local, regional, and national). However, many of those 'invited' spaces (e.g. municipal council meetings, local health committee meetings) are not effective in the resolution of community demands, due to *de facto* barriers restricting access or voice. Defenders have been more successful in 'claiming'[6] spaces of engagement with officials at local and regional level (e.g. monthly or quarterly meetings between defenders and officials specifically set up to review and plan actions to resolve complaints by service users, officials providing their phone number to defenders to establish direct communication, etc.). However, some problems such as infrastructure deficits require engaging in other spaces where resource allocation decisions are addressed (e.g. municipal development council). Also, if the complaint directly involves officials at the local or regional level (e.g. engaged in illegal charges or abuse towards patients), then the complaint must be brought to a higher level of government to avoid conflict of interest by the corresponding official. To aid the identification of an adequate strategy and space for engagement, CEGSS developed a decision tree that is used by defenders and CEGSS advisors.

5.3 Presenting evidence and demands to officials

When defenders present the evidence and concrete demands for a resolution, officials usually react in any of the following ways:[7] (a) acknowledge the problem and commit to an action plan to resolve it; (b) show politeness but unwillingness to commit to a resolution; (c) deny that the problem presented exists and refuse further engagement; (d) show open hostility towards defenders that may include implicit or explicit threats. The engagement may involve one or several face-to-face

meetings. Once defenders feel the engagement stage is over (e.g. because there is an agreed action plan; the authority continues being polite but no commitment to an action plan; or hostility does not warrant additional meetings), defenders consult with CEGSS advisors to analyse the next steps and adjustments to the strategy that may be required.

5.4 Adjusting the strategy

The adjustment to the strategy depends on several factors such as the type of complaint (e.g. illegal charges and corruption are more serious than medicine stock-outs), the level of collaboration and communication at higher governance levels at a given time (which fluctuates between low and high and is influenced by external political factors), and the strength of the community grass-roots network and their mobilisation capacities. Some examples of adjustments to the strategy follow. For an authority that collaborates and commits to resolution, the defenders organise their schedule to participate in the implementation of the agreed action plan. When the authorities refuse to commit to a resolution, the strategy will involve requesting the mediation of the Ombudsman office and engaging with officials at a higher level of government. If the higher level of government is also non-responsive, the defenders will request the involvement of parliamentarians who represent the geographical district where the complaint occurred, or who are members of the Human Rights and Indigenous Population Commissions within Parliament.

In those cases where the authorities deny the problem and refuse to engage, the defenders call for press conferences in which the evidence is presented, and naming and shaming occurs if deemed as needed. The defenders will also seek alliances with other civil society organisations and may decide to mobilise their communities in a civic protest outside the official's office. A situation of hostility and threats requires immediate legal assistance. CEGSS deploys its legal advisors and at the same time requests the engagement of the Ombudsman. It supports the defenders to present a formal complaint at the local court of justice or the nearest public prosecutor's office. Defenders are also networked with other civil society organisations that specialise in the legal defence of Human Rights Defenders. The latter type of cases that involve threats by an official are not common. However, CEGSS keeps specific protocols in place to act whenever such cases occur.

5.5 Follow-up actions

This stage involves implementing actions after adjusting the strategy. Actions may include municipal-level activities to inform communities about the resolution process or preparing a civic mobilisation. Travelling to the regional and national capital cities to meet up with Ministry of Health officials, parliamentarians, the Ombudsman, and other actors is also a common activity at this stage.

5.6 Verifying resolution of demands and planning a new cycle

During the follow-up actions, an official may inform defenders that the problem has been resolved. Defenders then visit the site where

the complaint originated to verify such information and to gather a means of verification that could be: a photograph or video of repaired infrastructure, medicine shelves fully stocked, an official letter informing that an abusive and disrespectful health-care provider has been removed from post, or the testimony of service users that emergency transport was allocated without out-of-pocket payment. The verification is sent to the electronic platform (which is administered by CEGSS staff) and the status of the original SMS complaint is changed to 'resolved'. The cycles that are still ongoing are assessed and planning for a new cycle may commence.

It is important to note that at any given moment, the Network of Community Defenders and CEGSS are engaged in several simultaneous and parallel cycles of accountability action. For instance, a cycle related to continuous stock-outs of medicine in several municipalities in a specific geographical region runs in parallel to another cycle tackling illegal charges for emergency transport in a particular municipality. Also, some problems may require different strategies with more actions at local level with health and municipal officials, versus actions engaging with higher levels of government. Whether action occurs at local or regional or national level also implies different time periods. Usually, engagement at the national level with parliament and the Ombudsman takes several months, whereas actions at the local level can be carried out over shorter periods.

6 Changes in rural health-care facilities as a result of adaptive accountability action

Adaptive cycles of accountability action have led to a range of changes in rural health-care facilities. As a result of defenders' monitoring and advocacy, local officials in many municipalities have taken responsive action to address some of the pressing problems affecting service delivery (Flores 2016). Municipal officials have mobilised funds to improve emergency transport, by paying for fuel and maintenance for the district ambulance, hiring drivers, and coordinating vehicles. Some mayors have designated funds for a municipal pharmacy, enabling service users to obtain free medicines when they are not available in the health facilities. Projects to repair and improve infrastructure and purchase equipment have been implemented with municipal and provincial funds. Engagement with local and provincial health officials to present problems reported by service users of mistreatment and discrimination has led to improved quality of care through corrective action, including transfers and firing, and changes in provider attitudes (Hernández *et al*. forthcoming, 2018). These examples of responsive action represent important achievements in contexts of extreme inequalities and marginalisation.

7 Contribution to citizen empowerment in accountability ecosystems

We consider these to be short-term changes that address problems infringing on the right to health, but that would likely not be sustained by the next local authority if they are not accompanied by the changes in active citizenry that adaptive accountability action cycles also

engender. The role of accountability cycles in activating marginalised indigenous citizens' power to collectively identify and act upon rights violations has been observed in their enhanced participation in local decision-making spaces, both in the health system and municipal governance (Hernández *et al*. forthcoming, 2018). Iterative efforts to mobilise the community in demands for accountability further build power through virtuous cycles in which the realisation of previous actions builds recognition and self-efficacy, contributing to an enabling environment for further action. Defenders are increasingly engaging with authorities beyond the local level to voice their problems and demands with provincial and national officials with greater capacity to address the systemic root causes. Even while they continue to face strong power asymmetries and lack of political will in these spaces, this participation represents a significant gain in light of their historic socio-political exclusion. These incremental advances demonstrate the internal changes and political capabilities developed through adaptive accountability cycles that provide the grounds for activating latent power, and generating greater collective power to influence the decisions and policies that affect citizens' lives.

8 Conclusions and lessons learned

Systematic exclusion and discrimination against indigenous communities in Guatemala results in very unequal relationships. When marginalised populations confront embedded power structures to demand their rights, overcoming the socio-political forces that perpetuate the status quo is a major challenge. Through our experience over the past decade, CEGSS has learned that even when we aim for dialogue and constructive engagement, sometimes conflict is unavoidable in these situations. Organisations pursuing accountability in unequal contexts should be aware of this.

The need to navigate between constructive engagement and adversarial strategies to pursue health accountability for marginalised populations has recently been observed and documented in other unequal settings in Africa, Asia, and Eastern Europe (Joshi 2017). The technical teams that support citizens and public officials should look beyond expertise in monitoring tools to include legal and anthropological advisors, and develop strategies and protocols to handle conflict and cases of serious abuse of power uncovered by accountability action. In practice, this means applying strategies and expertise from both legal empowerment and social accountability fields (Joshi 2017; Feinglass, Gomes and Maru 2016).

In the case of Maria, support from the Ombudsman, her own community, and the wider network of community defenders enabled her to continue monitoring health services, and in time she developed a collaborative relationship with health officials once they better understood her role. It should also be noted that many providers and health officials that defenders have engaged with perceive their work as a support, bringing attention and, in some cases, solutions to the deficits that they face in delivering rural health-care services (Hernández and Sebastián 2017).

From our initial technical approach to accountability through supporting implementation of a legal mandate for participatory monitoring and planning of health services, CEGSS' support has evolved to focus on adaptive cycles of accountability action. Through close engagement with the indigenous citizens, communities, and grass-roots organisations on the front lines, we have observed that it is not the information generated by monitoring that influences accountability, but the process through which citizens gain and confront power. With a central focus on activating citizens' latent power and their power as a group, reading the response in the political context and adjusting strategies accordingly guides adaptive cycles of gathering evidence and advocating with public officials.

In addition, throughout the years, CEGSS as a team have expanded their expertise to support the engagement of defenders at different governance levels (municipal, provincial, and national). This kind of engagement reflects the recent call for vertical integration of accountability actions (Fox, Aceron and Montero 2016) to achieve systemic and sustainable change. We at CEGSS feel that together with the network of defenders, we have only partially achieved such integration, so our current work plan and strategies are aiming to advance in that direction.

Notes

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1 The information in this paragraph is a reconstruction of an in-depth interview carried out by CEGSS in 2010 with a community leader after she experienced hostility from health authorities. Maria's real name has been changed to preserve her anonymity.

2 This section is partially based on Flores (2016).

3 Invited and claimed spaces for social participation are key concepts in the power cube framework. An 'invited' space is an institutionalised setting in which people are consulted or invited to give opinions. The invitation to participate may be a one-off event or a continuous attendance such as a health committee at local level. A 'claimed' space is a setting which excluded groups create for themselves in which to address their own concerns, including planning social actions to engage and influence public officials or any other actor. For more information, see Veneklasen and Miller (2007); Gaventa (2006).

4 The list of 23 different types of complaint are organised around seven category groups: (1) lack of medicines and medical supplies; (2) corruption and illegal charges; (3) denial of rights to health-care service users; (4) users' lack of satisfaction with services provided; (5) providers not following rules and regulations; (6) obstructing access to information by providers; and (7) any other type of complaint. This list was compiled after 18 months of consultations about the most

common problems and barriers that rural indigenous communities experience when seeking health-care services. The consultations were carried out in ten different communities and in four different indigenous languages. CEGSS, together with community leaders, agreed a final list of the most common complaints, which was later validated with the same ten communities. The technical team at CEGSS converted the final list into a text that would reflect the existing legal framework in the country.

5 See the electronic platform at: http://vigilanciaysalud.com/plataforma.

6 As it is understood by the power cube framework.

7 These four different reactions from officials were summarised by CEGSS staff after reflecting about the experience of both defenders and CEGSS field staff while engaging with the authorities.

References

Arendt, H. (1970) *On Violence*, New York NY: Harcourt

Benclowicz, J. (2006) 'La izquierda y la emergencia del movimiento piquetero en la Argentina. Análisis de un caso testigo', *Espiral* 13.37: 123–43, www.scielo.org.mx/pdf/espiral/v13n37/v13n37a5.pdf (accessed 6 February 2018)

Clegg, S.R.; Courpasson, D. and Phillips, N. (2006) *Power and Organizations*, London: SAGE Publications

Feinglass, E.; Gomes, N. and Maru, V. (2016) 'Transforming Policy into Justice: The Role of Health Advocates in Mozambique', *Health and Human Rights* 18.2: 233–46

Flores, W. (2016) 'Public Health for Indigenous Peoples in Guatemala: Monitoring from the Bottom Up', in D.A. McDonald (ed.), *Making Public in a Privatized World: The Struggle for Essential Services*, London: Zed Books

Flores, W. and Gómez, I. (2010) 'La Gobernanza en los Consejos Municipales de Desarrollo de Guatemala: Análisis de Actores y Relaciones de Poder', *Revista de Salud Pública* 12.1: 138–50

Flores, W.; Ruano, A.L. and Funchal, D.P. (2009) 'Social Participation within a Context of Political Violence: Implications for the Promotion and Exercise of the Right to Health in Guatemala', *Health and Human Rights* 11.1: 37–48

Fox, J.; Aceron, J. and Montero, A.G. (2016) *Doing Accountability Differently. A Proposal for the Vertical Integration of Civil Society Monitoring and Advocacy*, U4 Issue 2016.4, Bergen, Norway: U4 Anti-Corruption Resource Centre, Chr. Michelsen Institute, www.u4.no/publications/doing-accountability-differently-a-proposal-for-the-vertical-integration-of-civil-society-monitoring-and-advocacy (accessed 31 January 2018)

Gaventa, J. (2006) 'Finding the Spaces for Change: A Power Analysis', *IDS Bulletin* 37.6: 23–33, http://bulletin.ids.ac.uk/idsbo/article/view/898 (accessed 31 January 2018)

Haugaard, M. (2002) *Power: A Reader*, Manchester: Manchester University Press

Hernández, O.J. and Sebastián, S. (2017) 'Los vigilantes de la salud', *elPeriódico*, 11 June, https://elperiodico.com.gt/

domingo/2017/06/11/los-vigilantes-de-la-salud/ (accessed 15 January 2018)

Hernández, A.; Ruano, A.L.; San Sebastian, M.; Goicolea, I.; Hurtig, A.K. and Flores, W. (forthcoming, 2018) 'Pathways to Health System Accountability in Rural Guatemala: A Qualitative Comparative Analysis of Indigenous Citizen-Led Initiatives for the Right to Health'

ICEFI and CESR (2009) *Rights or Privileges? Fiscal Commitment to the Rights to Health, Education and Food in Guatemala*, Guatemala City, Guatemala: Instituto Centroamericano de Estudios Fiscales and Center for Economic and Social Rights

ICEFI and UNICEF (2011) 'El remedio de nuestros males: Un análisis sobre los mecanismos, costos y formas de financiamiento para mejorar el sistema de salud pública en Guatemala, 2012–2021', Documento de análisis ¡Contamos!, *Boletín* 6, Guatemala City, Guatemala: Instituto Centroamericano de Estudios Fiscales

INE (2011) *Encuesta nacional de condiciones de vida*, Pobreza y desarrollo: Un enfoque departamental, Guatemala City, Guatemala: Instituto Nacional de Estadística

INE (2006) *Encuesta nacional de condiciones de vida*, Guatemala City, Guatemala: Instituto Nacional de Estadística

IWGIA (2011) *The Indigenous World 2011*, Copenhagen: The International Work Group for Indigenous Affairs, www.iwgia.org/iwgia_files_publications_files/0454_THE_INDIGENOUS_ORLD-2011_eb. pdf (accessed 15 January 2018)

Joshi, A. (2017) 'Legal Empowerment and Social Accountability: Complementary Strategies Toward Rights-Based Development in Health?' *World Development* 99: 160–72

Morriss, P. (2002) *Power: A Philosophical Analysis*, 2nd ed., Manchester: Manchester University Press

MSPAS (2010) *Encuesta Nacional de Salud Materno Infantil 2008–09*, Guatemala City, Guatemala: Ministerio de Salud Pública y Asistencia Social, Instituto Nacional de Estadística, Centers for Disease Control and Prevention

MSPAS and Segeplan (2011) *Encuesta Nacional de Mortalidad Materna*, Guatemala City, Guatemala: Ministerio de Salud Pública y Asistencia Social/Segeplan

OED (2018) *Oxford English Dictionary*, https://en.oxforddictionaries.com/definition/power (accessed 8 January 2018)

Pachano, S. (2005) 'Ecuador: Cuando la inestabilidad se vuelve estable', *Íconos: Revista de Ciencias Sociales* 23: 37–44, www.flacso.org.ec/docs/i23pachano.pdf (accessed 8 December 2008)

Regalsky, P. (2006) 'América Latina: Bolivia indígena y campesina. Una larga marcha para liberar sus territorios y un contexto para el gobierno de Evo Morales', *Herramienta* 10.31: 13–38

UN (2009) *State of the World's Indigenous People*, New York NY: United Nations, www. un.org/esa/socdev/unpfii/documents/SOWIP/en/SOWIP_web.pdf (accessed 6 February 2018)

UNICEF (2009) *The State of the World's Children*, New York NY: UNICEF, www.unicef.org/sowc09/docs/SOWC09_Table_8.pdf (accessed 6 February 2018)

VeneKlasen, L. and Miller, V. (2007) *A New Weave of Power, People & Politics: The Action Guide for Advocacy and Citizen Participation*, Rugby: Practical Action Publishing

World Bank (2014) *Guatemala Economic DNA*, Guatemala City, Guatemala: World Bank Group