

**Social Accountability and Legal Empowerment for Quality Maternal  
Health Care**

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## ABSTRACT

### Social Accountability and Legal Empowerment for Quality Maternal Health Care

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Unacceptably high rates of maternal morbidity and mortality affect the Global North and the Global South. Among many challenges, policy-makers and researchers cite concerns about quality of care, respectful maternity care, and implementation of evidence-based strategies and national guidelines at the frontlines of the health system. Informal payments are one concern that cut across these three challenges; they represent poor quality care; they are often experienced as disrespect by patients; and, health care worker demands for such payments by definition conflict with national policy. Social accountability and legal empowerment are two approaches that are increasingly used to address quality of care concerns in maternal health and poor implementation at the frontlines of the health system.

This dissertation is comprised of three chapters (papers), all of which focus on these challenges in maternal health in low and middle income countries (LMICs). They apply concepts and methods from health policy and systems research (HPSR) to undertake theoretically-informed analyses that straddle two fields: (1) accountability, and, (2) global maternal health.

The first chapter is a critical interpretive synthesis that summarizes the evidence base on the prevalence, drivers, and impact of informal payments in maternal health care; critically interrogates the paradigms that are used to describe informal payments; and, finally, synthesizes the policy and funding debates directly related to informal payments. The paper finds that though assessing the true prevalence of informal payments is difficult given measurement challenges, quantitative and qualitative studies have identified widespread informal payments in health care in many low and middle income countries in Asia, Africa, and Latin America. Studies and conceptual papers identified both proximate,

immediate drivers of informal payments, as well as broader systemic causes. These causes include norms of gift giving, health workforce scarcity, inadequate health systems financing, the extent of formal user fees, structural adjustment and the marketization of health care, and patient willingness to pay for better care. Similarly, there are both proximate and distal impacts, including on household finances, patient satisfaction and demand for health care, and provider morale.

Despite the ground level relevance of informal payments, they are generally not adequately addressed in global policy frameworks and strategies, or in standard metrics of health system performance. Though this absence does not necessarily imply lack of financial or other attention to informal payments, it makes inattention more likely, and regardless, represents a notable silence.

Informal payments have been studied and addressed from a variety of different perspectives, including anti-corruption, ethnographic and other in-depth qualitative approaches, and econometric modeling. Synthesizing data from these and other paradigms illustrates the value of an inter-disciplinary approach. Each lens adds value and has blind spots. These attributes in turn affect the solutions proposed.

The paper concludes that the same tacit, hidden attributes that make informal payments hard to measure also make them hard to discuss and address. A multi-disciplinary health systems approach that leverages and integrates positivist, interpretivist, and constructivist tools of social science research can lead to better insight and policy critiques.

The second chapter is a descriptive case study of a social accountability project seeking to decrease health provider demands that women make informal payments in Uttar Pradesh (UP), India. Women in UP are often asked to make informal payments for maternal health care services that the central or state government has mandated to be free. The chapter is a descriptive, contextualized case study of a social accountability project undertaken by SAHAYOG, an NGO based in UP. The study

methods included document review; interviews and focus group discussions of program implementers, governmental stakeholders, and community activists; and participant observation in health facilities.

The study found that SAHAYOG adapted their strategy over time to engender greater empowerment and satisfaction among program participants, as well as greater impact on the health system. Participants gained resources and agency; they learned about their entitlements, had access to mechanisms for complaints, and, despite risk of retaliation, many felt capable of demanding their rights in a variety of fora. However, only program participants seemed able to avoid making informal payments to the health sector; they largely were unable to effect this change for women in the community at large. Several features of the micro and macro context shaped the trajectory of SAHAYOG's efforts, including caste dynamics, provider commitment to ending informal payments, the embeddedness of informal payments in the health system, human resource scarcity, the overlapping private interests of pharmaceutical companies and providers, and the level of regional development.

Though changes were manifest in certain health facilities, as a group, providers did not necessarily embrace the notion of low caste, tribal, or Muslim women as citizens with entitlements, especially in the context of free government services for childbirth. SAHAYOG assumed a supremely difficult task. Project strategy changes may have made the task somewhat less difficult, but given the population making the rights claims and the rights they were claiming, widespread changes in demands for informal payments may require a much larger and stronger coalition.

The third paper is an explanatory case study of a hybrid legal empowerment and social accountability effort led by the Mozambican NGO, Namati Moçambique. Established in 2013, Namati Moçambique runs a multi—pronged health paralegal and policy advocacy program that employs community paralegals as Health Advocates and trains Village Health Committees (VHCs). The study sought to uncover how the program affected the relationship between citizens and the health sector,

how the health sector and citizens responded, and what role contextual factors played. The case study had two components: 1) a retrospective review of 24 cases 2) qualitative investigation of the Namati program and program context. The cases came from a total of 6 sites in 3 districts. Program implementers, clients, Village Health Committee (VHC) members, and health providers were interviewed or participated in focus groups as part of the research.

The study found that though they are unable to address some deeply embedded national challenges, Health Advocates successfully solved a variety of cases affecting poor Mozambicans in both urban and rural areas. Health Advocates took a variety of steps to resolve these cases, some of which entailed interactions with multiple levels of the government. We identified three key mechanisms, or underlying processes of change that Namati's work engendered, including: bolstered administrative capacity within the health sector, reduced transaction and political costs for health providers, and provider fear of administrative sanction. In addition to case resolution, stakeholders highlighted individual satisfaction at having one's complaint remedied and individual empowerment among clients and Health Advocates as stemming from the project. Health Advocates and VHCs developed functional working relationships with providers, in part because they addressed issues that providers felt were important, and engendered community satisfaction with the Health Advocate, and ultimately, trust in the health system. The case resolution focus of legal empowerment brought procedural teeth, helping to ensure that new relationships result in immediate improvements, thus instigating a circle of relationship building and health system improvements.

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## **Dedication**

To Abigail and Rory, who support me even though I am always busy; to my parents, who demonstrated that busy people can parent and contribute to their communities; and to Professors Lynn Freedman and Ernest Benz, for whom I have great intellectual respect and admiration.

## Introduction

Unacceptably high rates of maternal morbidity and mortality affect the Global North and the Global South (Miller et al., 2016). Among many challenges in countries at all levels of income, policy-makers and researchers cite concerns about quality of care, respectful maternity care, and implementation of evidence-based strategies and national guidelines at the frontlines of the health system (Campbell, et al., 2016; Shaw et al., 2016; Koblinsky et al., 2016; WHO, 2016; Menard et al., 2015). Informal payments are one concern that cut across these three challenges; they represent poor quality care; they are often experienced as disrespect by patients; and, health care worker demands for such payments by definition conflict with national policy.

This dissertation is comprised of three papers, all of which focus on these challenges in maternal health in low and middle-income countries (LMICs). The papers apply concepts and methods from health policy and systems research (HPSR) to undertake theoretically informed analyses that straddle two fields: (1) accountability, and, (2) global maternal health. The first paper is a critical interpretive synthesis (CIS), a type of narrative literature review, and the second and third papers are case studies of existing NGO social accountability projects.

Accountability is increasingly invoked in the maternal health field, but the field of accountability addresses government and private sector behavior well beyond maternal health. There are several strands of accountability research and policy, including: (1) social movements, (2) human rights, and, (3) the field of transparency and accountability. Transparency and accountability is primarily concerned with efforts to enact the right to information, and then galvanize collective action to use this information as the basis for demands to promote governmental accountability (Houtzager and Joshi, 2008). The two case studies included in this dissertation fall primarily within this third category. Though there have been civil society and groups fighting for access to quality maternal and reproductive health

care for many years, the explicit application of the concepts of transparency and accountability to maternal health research, policy, and programs is much more recent.

The extant peer-reviewed literature on the explicit integration of accountability and maternal health is somewhat nascent and incomplete; it does not represent the universe of on-the-ground activities to foster accountability for maternal health. This ‘nascent-ness’ and incompleteness reflects five trends: (1) the fact that greater resources are allocated to researching and documenting externally-induced international NGO programs that are bounded in scope and timeframe, as opposed to ongoing, embedded efforts led by national NGOs and groups; (2) relatedly, the prevailing use of pre-post evaluation approaches that force programs, including those that are not bounded in scope and timeframe, into a limiting explanatory and conceptual frame (3) disproportionate focus on affecting global level policies – as opposed to national and sub-national developments – within the maternal and reproductive health advocacy community (Freedman and Schaaf, 2013); (4) the use of limiting conceptual lenses and lack of robust empirical research on some key issues that accountability efforts address, including informal payments for maternal health care (5) the fact that the purposeful integration of accountability and maternal health is relatively recent. Moreover, in general, approaches and research regarding accountability in maternal health have not yet integrated some of the rich conceptual and practical learning from the broader transparency and accountability field, though some recent studies do more rigorously apply social science theories and findings from the broader transparency and accountability field (*e.g.* Mafuta et al., 2017; Dasgupta, 2016).

Maternal health is frequently cited as one of the key aspects of the “unfinished agenda” of the Millennium Development Goals (MDGs), which served as the primary global framework for international development efforts from 2005 to 2015 (Graham et al., 2016). Among the many ongoing priority areas identified by the maternal health community in the Sustainable Development Goal (SDG) era (2015-2030), three are particularly relevant to the growing field of accountability. These include: (1) quality (2)

respectful maternity care (3) effective implementation of national programs at the frontlines of the health system.

## **Quality**

From 2005 to 2015, governments and international organizations focused on facility delivery as a proxy for skilled birth attendance; skilled birth attendance was an indicator of MDG Goal 5 on improving maternal health. To increase skilled birth attendance, governments and others implemented a wide-range of programs to encourage women to give birth in health facilities (Powell-Jackson et al., 2009; Witter et al., 2007; Randive et al., 2013; Elmusharaf et al., 2015). However, recent studies suggest that while these programs increased utilization, they had no impact on maternal mortality (Souza et al., 2013; Moyer et al., 2013; Randive et al., 2013). The 2016 Lancet Maternal Health Series evinced near consensus within the maternal health establishment in this regard; the opening editorials as well as several of the technical papers comprising the series identified improving persistent inequalities in access, as well as quality of the services provided, as germane to further progress (Graham et al., 2016; Miller et al., 2016; Campbell et al., 2016; Koblinksy et al., 2016; Freedman, 2016; Kinney et al., 2016). Key quality concerns include the clinical quality of both routine and emergency care, the enabling environment in the facility, and basic infrastructure in the facility (Campbell, 2016). Recent developments in global policy further demonstrate consensus and commitment to addressing quality challenges. In 2016, WHO issued standards for improving quality of maternal and newborn care in health facilities (WHO, 2016). In 2017, WHO and UNICEF supported the launch of a 9-country network that will serve as a learning platform for the implementation of the standards (WHO, 2017). Moreover, in 2017, *Lancet Global Health* launched a Commission on High-Quality Health Systems in the SDG Era (Kruk, Pate, and Mullan, 2017).

While the contours of many aspects of clinical quality are well-defined, patient-defined quality is more ambiguous. The relationship between patients and providers is characterized by information

asymmetry, in that patients do not have all the information or expertise required to make comprehensive, accurate judgments about *clinical* quality (Bloom et al., 2008; Tucker and Adams, 2001). But patients do make judgements about quality, and these judgments affect trust and future utilization, and bad experiences may be spread by word of mouth (Kujawski et al., 2015; Avorti et al., 2011; Bazant et al., 2009; Gilson et al., 2003; Hanefeld et al, 2017). Indeed, the most widely-cited definitions of health care quality include patient experiences of care as an integral element of quality (Valentine et al., 2008). When asked directly about quality, patients have said that they care about factors such as responsiveness, assurance, communication, informal payments, getting better, waiting time, drug availability, perceived technical competence of provider, politeness, and health providers' service orientation (Andaleeb et al., 2001; Atkinson and Haran, 2005; Bassett et al., 1997; Nabbuye-Sekandi et al., 2011; Piechulek and al-Sabir, 2000).

### **Respectful Maternity Care**

Respectful maternity care (RMC) is emerging as an increasingly salient aspect of maternal health care quality – including patient-defined quality - in both the Global North and South. Obstetric violence and the humanization of childbirth have long been priorities of women's rights activists in Latin America (d'Oliveira et al., 2002; Laako, 2017), but the issue was raised in mainstream global health discussions following the 2007 publication of a report documenting serious human rights violations in maternity wards in Kenya, and a 2010 landscape review on disrespect and abuse in maternity care, which was written with financial support from USAID (Center for Reproductive Rights and the Kenyan Federation of Lawyers, 2007; Bowser and Hill, 2010). These grey literature papers described embedded, near-routinized quality concerns, such as coercive informal payments and rude treatment, as well as egregious examples of rights violations, such as slapping, kicking, abandoning women while they deliver, and detaining women for inability to pay (Bowser and Hill, 2010; Center for Reproductive Rights and the Kenyan Federation of Lawyers, 2007).

Since these two reports, empirical research and literature reviews on respectful maternity care have proliferated (*e.g.* Warren et al., 2013; Miller et al., 2016; McMahon et al., 2014; Rosen et al., 2015; Bohren et al., 2015). Global efforts to improve policy have followed. WHO issued a statement on the topic in 2014, and the WHO standards for improving quality of maternal and newborn care in health facilities include respectful maternity care and other aspects of patient perceptions of care (WHO, 2014; WHO, 2016). These normative documents cite human rights, health service utilization and satisfaction, and health outcomes as justification for the import of RMC (WHO, 2014; WHO, 2016).

Thus, at the apex of the global health architecture, there is widespread agreement that RMC matters for intrinsic and instrumental reasons, and that it needs greater attention in program funding and implementation. However, it is important to note that the extent to which these RMC norms, as described in global policy frameworks, capture the range of concerns and aspirations of the most marginalized women remains an open question (Freedman, 2016).

Among the many manifestations of disrespect and abuse, informal payments are comparatively under-addressed in the emerging global quality standards, as well as in empirical research. Informal payments are defined as “a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services to which patients are entitled” (Gaal et al., 2006). The 2010 landscape study of disrespect and abuse mentioned informal payments, as did the most recent systematic review (Bohren et al., 2015) but in general, the issue appears rarely in the RMC literature. Moreover, even beyond the RMC literature, there are few papers focused entirely on informal payments, with the exception of a robust literature on the phenomenon in Eastern Europe and the former Soviet Union. Many papers on health systems in LMICs refer to the prevalence of informal payments in the context of a broader discussion on access to health services, but of these, few examine the mechanisms, social and bureaucratic norms, and power dynamics underlying demand for and

payment of informal payments. Thus, there is not a body of published literature to inform the design and assessment of efforts to decrease the incidence and impact of informal payments. Quantitative and qualitative studies have identified prevalent informal payments in health care (beyond just maternal care) in many low and middle income countries in Asia, Africa, and Latin America (Mæstad and Mwisongo, 2011; Vian et al. 2012; Stringhini et al. 2009; McPake et al. 1999; Lewis 2007; Pieterse and Lodge 2015; Riewpaiboon et al. 2005; Afsana 2004; Abdallah et al. 2015; Diarra 2012; Dasgupta et al. 2015; Coffey 2014).

### **Implementation at the Frontlines**

Some of the most significant gaps in maternal health stem not from lack of clinical evidence, but from failure to implement evidence-based guidelines and national policies (Campbell et al., 2016). This includes the “know do gap,” or failure to carry out clinical practices despite having been trained in them (Miller et al., 2016; Koblinsky et al., 2016). Single-minded dedication to top-down policy change, such as by developing global policy, disseminating that policy, and ensuring that supportive training and commodities are provided to health facilities has proven inadequate (Freedman, 2016). While failures in implementation as such is not a significant field of research, data from the MDG era reveal that women are not receiving the quality of care that is enshrined in global and national level policies. Indeed, the momentum for improved quality constitutes an implicit recognition that the clinical evidence base and respectful maternity care norms were not reflected in patient-provider interactions or health facility management at the frontlines of the system.

### **Accountability**

Greater accountability by governments, health systems, and donors is proffered as at least a partial solution to the 3 gaps above – poor quality, disrespectful care, and failure to achieve effective implementation at the frontlines of the system (Freedman and Schaaf, 2013; Lodenstein et al., 2016). The consensus definition of accountability encompasses answerability and enforceability. Governments

are obligated to provide information and justification regarding policy and practice (answerability), and sanctions must exist for failure to comport with policy (enforceability) (Schedler, 1999; Goetz and Gaventa 2001; Brinkerhoff 2004). This conceptualization based on answerability and enforceability was first elaborated by Schedler in 1999, and it has been used in several reviews of accountability and health (Lodenstein et al., 2016; Van Belle and Mayhew, 2015).

More normative approaches take a less actuarial approach narrowly focused on answerability and sanctions to explore how professional or social norms favoring accountability can engender compliance, and how these norms can be nurtured (O’Connell 2005; Bovens 2010; Freedman and Schaaf 2013). This broader conceptualization of accountability goes beyond “disembodied rules” (George, 2009) to promote responsive, transparent, and democratic service delivery cultures.

### **Social accountability**

Joshi and Houtzager define social accountability as the “ongoing engagement of collective actors in civil society to hold the state to account for failures to provide public goods” (Joshi and Houtzager, 2012 pg 15). Operationally, these efforts generally include “(a) an agreed set of standards against which conduct is assessed, (b) information about the public actions undertaken (c) justification for those” (Joshi and Houtzager, 2012, pg. 15). Common programs include social audits, community monitoring, and community score cards.

Though implementation of social accountability projects has jumped beyond the evidence base (Fox, 2015), it is an area of great interest in maternal health (Lodenstein et al., 2016). Several empirical articles and one review address the impact that social accountability efforts can have on maternal health and health more broadly. These articles report that social accountability efforts can spark improvements in quality, respectful maternity care, and program implementation at the frontlines. More specifically, researchers have found that in some contexts, social accountability campaigns can enhance knowledge and empowerment among community members; increase the quality of service

delivery, particularly in ways that the community can identify (patient-defined quality); enhance trust between communities and the health system; improve compliance with national guidelines regarding the availability of important inputs, such as drugs and maternity beds; and enhance the functioning of government- and community-supported institutions, such as Village Health Committees (Lodenstein et al., 2016; Papp et al., 2013; Schaaf et al., 2017; Wild and Harris 2011; Gullo et al., 2016; Ho et al., 2015). Specific improvements in patient-defined health service quality have included reduced demands for informal payments, more polite treatment, shorter wait times, reduced absenteeism among health providers, the transfer of unpleasant or incompetent staff, improved health staff adherence to policy, and the hiring of new staff (Lodenstein et al., 2016; Schaaf et al., 2017; Gullo et al., 2016; Ho et al., 2015; Maru, 2010). These changes may lead to improvements in intermediate and outcome indicators related to health status; two studies using quasi-experimental designs documented increased utilization, and one, reduced mortality (Gullo et al., 2017; Bjorkman and Svensson, 2009).

However, as alluded to earlier, these lessons learned may not reflect the totality of lessons learned by practitioners. It is important to acknowledge that the extant base of literature regarding social accountability and maternal health disproportionately describes bounded, project approaches, typically implemented on a 2-3 year timeline. This is presumably because international project-based funding and RCT and other dominant evaluation approaches are better suited to projects that are limited in timeframe and scope. Such projects comprise a part – but not the whole – of experiences related to social accountability for maternal health.

Social accountability efforts may be evaluated and documented in a format – such as an article in a peer-reviewed journal that cleaves to the standard of a scientific article as much as possible – in a way that makes them seem to be bounded local level projects, when the actual efforts on the ground are far more complex. There are few peer-reviewed articles in the social accountability literature that

use social science theory to richly describe projects in the context of a larger civil society effort to foster maternal health system accountability.

### **Legal empowerment**

The term 'legal empowerment' was first used in 2001 by Golub and McQuay, economists working in international development (Golub and McQuay, 2001). In 2008, the United Nations convened a High-Level Commission on Legal Empowerment and the Poor (United Nations General Assembly, 2009). Since then, the term has been used to describe efforts which focus on boosting citizen capacity to exercise and claim their rights, and which engage a wide variety of governmental bodies, as opposed to just the judiciary (Goodwin and Maru, 2017). Legal empowerment efforts aim to help marginalized people to use the legal system to obtain concrete improvements in a relatively short time frame. Such improvements may include increased access to public services or reduced inequality and exclusion (Domingo and O'Neil, 2014; Goodwin and Maru, 2017; Golub, 2010). Legal empowerment efforts generally address problems arising within the community, between citizens and traditional authorities, between citizens and the state, and between citizens and private firms (Maru, 2010). In the domain of health care, most programs and activities attempt to address citizen complaints about the state.

Like social accountability, legal empowerment programs are mostly implemented by NGOs (international and national) at the sub-national level. There are few examples of scaled programs. Legal empowerment has been used to tackle gaps in the health sector, though there are far fewer health program examples in legal empowerment than in social accountability. Existing research suggests that community paralegals in particular have great potential, but the number and scope of studies is limited (Goodwin and Maru, 2017). The impacts documented in the peer-reviewed and grey literature include personal empowerment, the confirmation and extension of formal legal rights, and policy change (Domingo and O'Neil, 2014). Thus, community paralegals, too, may address the maternal health priorities of quality, respectful maternity care, and implementation at the frontlines.

## **Social accountability and legal empowerment**

An increasing number of organizations are intentionally combining what are considered to be traditional elements of social accountability and legal empowerment. The rationale is that social accountability and legal empowerment have many similar tactics and approaches, but they also have some disparate approaches that can be complementary (Ezer et al., 2015). For example, social accountability programs are more likely to engage the media and to include community monitoring; legal empowerment is much more likely to provide support to individuals and to pursue litigation (Joshi, as cited in: Ezer et al., 2015). The chief rationale for a hybrid approach is that the social aspects of social accountability and the individual remedy element of legal empowerment would be synergistic in some contexts.

It is important to acknowledge, however, that the distinction between social accountability and legal empowerment is not always clear. Many organizations adopt strategies from each unintentionally; they are simply choosing and testing tactics based on the context and their past experiences (Ezer et al., 2015). Moreover, some definitions of legal empowerment include approaches and tactics that those working in social accountability would describe as social accountability, such as community monitoring and social audits (Goodwin and Maru, 2017).

There is some basic grey literature on this combined approach, donor interest in exploring it, and a peer-reviewed article that argues for combined approaches (Maru, 2010). However, at present, there is no empirical research on a combined approach – in any sector - in the peer-reviewed literature (Ezer et al., 2015).

Taking into consideration the context and lacunae described, these three papers have the following aims:

1. **Critical interpretive synthesis of informal payments for maternal health in low and middle income countries.** To assess the empirical evidence about informal payments for maternal

health care in low and middle income countries, and, to discuss the policy and program implications of prevalent conceptual approaches to gathering, understanding, and deploying this empirical evidence.

2. **Descriptive case study of a social accountability project.** To document the evolving strategy of an NGO's (SAHAYOG) social accountability efforts to reduce demands for informal payments for maternal health care in Uttar Pradesh, India, in the context of low state willingness and capacity to respond.
3. **Explanatory case study of a social accountability and legal empowerment project.** To assess the impact of an NGO (Namati's) hybrid legal empowerment and social accountability program on citizens and the problems they identify in Mozambique.

These three papers address emerging priorities in maternal health and a growing area of programmatic interest. They advance the field by addressing specific areas where further conceptual, theoretical, and empirical work is needed, namely:

- multi-disciplinary understanding of informal payments, and
- theory-based, contextualized research of strategic, embedded, long-term social accountability approaches, and
- theory-based, contextualized research of hybrid legal empowerment and social accountability approaches in health.

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## **Paper 1**

**A critical interpretive synthesis of informal payments in maternal health care**

## **ABSTRACT**

Introduction: Informal payments for healthcare are widely acknowledged as undercutting health care access, but empirical research is somewhat limited and located in disciplinary siloes. This paper is a critical interpretive synthesis that summarizes the evidence base on the prevalence, drivers, and impact of informal payments in maternal health care; critically interrogates the paradigms that are used to describe informal payments; and, finally, synthesizes the policy and funding debates directly related to informal payments.

Findings and Discussion: Though assessing the true prevalence of informal payments is difficult given measurement challenges, quantitative and qualitative studies have identified widespread informal payments in health care (beyond maternal care) in many low and middle income countries in Asia, Africa, and Latin America. Studies and conceptual papers identified both proximate, immediate drivers of informal payments, as well as broader systemic causes. These include norms of gift giving, health workforce scarcity, inadequate health systems financing, the extent of formal user fees, structural adjustment and the marketization of health care, and patient willingness to pay for better care. Similarly, there are both proximate and distal impacts, including on household finances, patient satisfaction and demand for health care, and provider morale. Despite the ground level relevance of informal payments, they are generally not adequately addressed in global policy frameworks and strategies, or in standard metrics of health system performance. Though this absence does not necessarily imply lack of financial or other attention to the issue, it makes inattention more likely, and regardless, represents a notable silence. Informal payments have been studied and addressed from a variety of different perspectives, including anti-corruption, ethnographic and other in-depth qualitative approaches, and micro-economic modeling. Synthesizing data from these and other paradigms illustrates the value of an inter-disciplinary approach. Each lens has particular added value and blind spots. These attributes in turn affect the solutions proposed.

Conclusion: The same tacit, hidden attributes that make informal payments hard to measure also make them hard to discuss and address. A multi-disciplinary health systems approach that leverages and integrates positivist and interpretivist and constructivist tools of social science research can lead to better insight and policy critiques. With this, we can challenge “master narratives” and meet the universalistic, equity-oriented objectives enshrined in the SDGs.

## **INTRODUCTION**

At their most vulnerable moments, laboring women may be confronted with coercive, financially taxing demands for informal payments in order to receive the health care to which they are entitled (Mæstad and Mwisongo, 2011; Tibandebage and Mackintosh 2005; Vian et al. 2012; Lewis 2007; Pieterse and Lodge 2015; Riewpaiboon et al. 2005; Afsana 2004; Vian et al., 2015; Kruk et al., 2008). Despite significant financial and political investment in maternal health in the MDG era, informal payments continue to undercut ambitious plans to enhance access, utilization, and quality of prenatal and delivery care. Moreover, demands for payments are often experienced by poor women as yet another moment when governmental employees prey on them, rather than providing succor and reaffirming the entitlements of citizenship (Diarra 2012; Dasgupta et al. 2015; Coffey 2014). At the same time, the frontline health workers demanding these payments may be struggling to fulfill their professional mandate in a health system characterized by inadequate infrastructure and inputs, little or even punitive supervision, and poor morale and trust (Tibandebage and Mackintosh 2005; Aberese-Ako et al. 2014; Hahonou, 2015).

Researchers and program evaluators often identify informal payments as health system factors that make women less likely to deliver in a health facility (Dasgupta et al., 2015). Civil society groups and activists routinely decry their impact, and, in some contexts, informal payments are regularly discussed in the print media (Wojczewski et al., 201; Mudur, 2016; Karmakar, 2015; Chandra, 2010; Thampi, 2002; Gopakumar, 1998). Yet, given their primacy in the patient experience, informal payments

are comparatively under-addressed in research, policy, and programs, particularly in regards to sub-Saharan Africa (Kankeu and Ventelou, 2016). In brief, the ‘on the ground’ salience of informal payments to understanding both access to, and quality of, maternal health care is not matched by top down attention and action.

We use the term “informal payments” to describe “a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services to which patients are entitled” (Gaal et al. 2006a). This paper is a critical interpretive synthesis that summarizes the evidence base on the prevalence, drivers, and impact of informal payments; critically interrogates the paradigms that are used to describe informal payments; and, finally, briefly assesses the extent to which major policies and strategies actually attempt to tackle informal payments. This synthesis allows us to draw conclusions about the relationship between research, theory, and policy related to informal payments. Our key concern is maternal health. However, given the fact that there is relatively little on maternal health specifically and that most frontline providers and communities draw conclusions about the health system based on their interactions within and beyond maternal health, we often speak about informal payments and access to health care more broadly.

Critical interpretive synthesis (CIS) facilitates broad-based, multi-disciplinary exploration of topics of interest. In contrast to systematic reviews, CIS is inductive and iterative (Heaton et al., 2012; Wilson et al. 2014; Dixon-Woods et al. 2005), and it facilitates exploration of a heterogeneous body of literature (Moat et al., 2013). Though it is informed by interpretivist practices in qualitative research, CIS can include quantitative data (Dixon-Woods et al. 2006; Noblit-Hare 1988; Pope, Mays and Popay 2006; Wilson et al. 2014). Beyond aggregating and/or synthesizing data, CIS also presents new analytic constructs, synthesizing arguments, and questions (Ako-Arrey et al., 2016; Wilson et al. 2014; Moat et al., 2013; Flemming 2010). It has successfully been used to explicate health systems questions in high

income countries (Dixon-Woods et al. 2006; Entwistle et al. 2012; Flemming 2010), and on a limited basis, in reference to health systems in low and middle income countries (McFerran et al., 2016). Given the current state of knowledge on informal payments, CIS is particularly apt. There are several non-systematic, reviews of informal payments that focus on particular geographic regions or that appear in the grey literature; as well as published reviews of related issues, such as how to define informal payments, and the abolition of formal user fees (Gaal et al., 2006; Cohen, 2012; Lewis, 2007; Vian, 2008). CIS allows us to aggregate extant review data, examine more recent studies, and “make a case for the problem” by presenting a brief summary of the research on informal payment prevalence. At the same time, CIS facilitates exploration of the terminological and conceptual confusion that characterizes discussion of informal payments (Gaal et al 2006). To be sure, as a cross-cutting health systems and governance concern, informal payments have been described and addressed from a variety of different fields and paradigms. Respecting a “principle of pluralism” reveals how different approaches can illuminate the problem as a whole (Greenhalgh et al., 2005). Synthesizing discussions across these approaches and putting them in dialogue with one another in light of the empirical evidence highlights the contributions of each approach. Looking in turn at international agendas in light of the evidence and conceptual synthesis shows to what extent informal payments are a priority for the global health community and by which paradigms this policy is informed. Thus, this paper will make claims about research as well as policy. We will conclude by making propositions about informal payments as a ground level phenomenon and a global discursive phenomenon, and what this implies for further research and agenda setting.

## **METHODS**

This CIS was completed in a multi-stage process. The initial questions that guided our practice were:

- What empirical evidence do we have regarding the prevalence, drivers, and impacts of informal payments for (maternal) health in LMICs?

- What paradigms and approaches are used to assess and address informal payments?
- How are informal payments addressed in global strategies and policies?

Consistent with the CIS approach, these questions served as a compass, rather than an anchor, for the research; we followed relevant strands in the literature as they emerged, rather than establishing a priori areas of interest (Dixon-Woods et al., 2005; Eakin and Mykhalovskiy, 2003). The steps we took included the following:

The first phase employed diversity sampling; we sought to get an overall view of the empirical research, social science theory, and program types related to informal payments. Consistent with our cross-disciplinary interest and as per methodology for CIS, the criteria for paper inclusion related to relevance and the likelihood that the paper would contribute to theory development, not to study design or to a prima facie set of quality indicators (Ako-Arrey et al., 2016; Wilson 2014). All empirical studies from LMICs as well as from countries of Eastern Europe (EE) and the former Soviet Union (fSU) were included. EE and fSU countries were included because several of them are middle income, and because there has been a significant amount of scholarship on informal payments in these countries. While the post-Communist context is unique, there has been substantial conceptual insight and theorizing developed in the region. Finally, a few articles containing significant theoretical or conceptual discussion but with data from high income countries (namely Greece, Israel, and the United States) were included. Fifty-nine articles were identified for inclusion in this phase; there were identified by our existing knowledge of relevant articles, and complemented by searches on ScienceDirect, Pubmed and GoogleScholar.

Early findings were then used to identify new areas of research (Dixon-Woods 2006). A list of related maternal health and health systems issues was elaborated, including: satisfaction, disrespect and abuse, formal user fees, trust, and utilization. The objective of following these lines of enquiry was to place informal payments in a larger conceptual and policy context, rather than to exhaustively review the

literature in each of these areas (Moat et al., 2013). Thus, following a theoretical sampling approach, these terms were searched with “maternal health” and “reproductive health” in GoogleScholar. Based on the abstract, the 5 or 6 most relevant articles were chosen. A total of 19 articles were identified in this phase.

All 78 articles were then entered into an extraction tool that included fields for methods; data on fee prevalence, drivers, and impacts; and key conceptual points. The drivers, impacts, and key conceptual points then informed the structure of the paper. The citation list of all but the most tangential articles was assessed for additional relevant articles that may have been missed (snowballing). Twenty-seven additional articles were identified in this way and then also entered into the extraction tool.

As the writing process was near completion, we did a final search on GoogleScholar, Pubmed, and Science Direct for any new articles related to informal payments for health care in LMICs. Eight articles were identified in this way, and the findings were integrated. We also searched international donor strategies and funding frameworks and assessed to what extent they addressed informal payments. The first author conducted the substantive review and summaries, and discussed findings and interpretation with the second author.

The synthesis is grounded in a health policy and systems research framework, and adopts the premise that health systems are core social institutions. A health systems perspective entails exploring how practices at the frontlines are embedded within the larger system, including across levels of the health system and across health concerns (Gilson and Daire 2011). As such, this CIS relies on insights from more positivist approaches to describing and prescribing, such as classical microeconomics and epidemiology, but we also assume that more interpretivist and constructivist approaches from the social sciences, such as anthropology and sociology, are helpful to understanding “how health system actors understand and experience particular services or policies and what social and political processes,

including power relations, influence them” (Gilson et al 2011). Health systems research can also accommodate complexity by identifying feedback loops and emergent properties, such as trust and accountability (de Savigny and Adams 2009; Topp et al. 2015; O’Connell 2005). In brief, rather than understanding informal payments as a dependent variable that is shaped by independent variables, we looked at how these payments are rooted in an overall cultural, social, political, and economic system, and how this system iteratively interacts with informal payments. This approach to assessing informal payments across countries is unique in the literature.

## **RESULTS AND DISCUSSION**

### **Prevalence and types of informal payments**

Informal payments have been researched from a variety of perspectives, including global health, micro and institutional economics, corruption, public administration, political science, anthropology, and human rights. Quantitative and qualitative studies have found informal payments to be prevalent in health care (including but also beyond maternal care) in many LMIC countries, including Bangladesh, Burkina Faso, Burundi, Cambodia, Cameroon, China, Cote d’Ivoire, Egypt, Ghana, Guinea, India, Iran, Kenya, Liberia, Madagascar, Mali, Morocco, Mozambique, Niger, Nigeria, Pakistan, Senegal, Sierra Leone, South Africa, Tanzania, Thailand, Togo, Turkey, Uganda, Vietnam, many countries of EE, and all of the countries of the fSU (Mæstad and Mwisongo, 2011; Tibandebage and Mackintosh 2005; Arnold et al. 2014; Vian et al. 2012; Stringhini et al. 2009; Killingsworth et al. 1999; McPake et al. 1999; Lewis 2007; Stepurko et al. 2013; Human Rights Watch 2009; Tumilnson et al. 2013; Hunt 2010; Chuma et al 2009; Pieterse and Lodge 2015; Riewpaiboon et al. 2005; Afsana 2004; Abdallah et al. 2015; Diarra 2012; Dasgupta et al. 2015; Bangser and Mamdani 2010; Rai et al., 2011; Richard et al. 2003; Coffey 2014; Brody et al. 2013; Gao et al. 2010; Ith et al 2013; Vian et al., 2015; Aresenijevic et al., 2014; Kankeur and Ventelou, 2016; Kruk et al., 2008; Wojczeski et al., 2015; Paredes-Solis, 2011; Cockcroft et al., 2007; Bertone and Lagarde, 2016; Habibov & Cheung, 2017). Excluding EE and the fSU, of the 35 studies cited

above, 10 focused solely on informal payments. Of these, all were focused on secondary or tertiary care, though a few articles discuss informal payments in primary care settings (e.g. Gilson et al., 1994). As per our definition of informal payments, we only considered a payment to be informal if it was for a service that is part of the standard entitlement. In some countries, entitlements may include food and laundry in the health facility, support for transportation to and from the facility, and other such ancillary services. In the case of labor and delivery care specifically, patients report being asked to pay for drugs and other medical supplies; non-medical supplies; blood; laboratory tests; birth registration and other needed documents; to receive a facility delivery-related conditional cash transfer to which they were entitled; to see and hold their newborns; and for doctors, nurses, and other providers and health facility staff to provide medical care (Tibandebage and Mackintosh 2005; Arnold et al. 2014; Stringhini et al. 2009, Killingsworth et al. 1999; Lewis 2007; Stepurko et al. 2013; Human Rights Watch 2009; Tumlinson et al. 2013; Hunt 2010; Chuma et al. 2009; Afsana 2004; Dasgupta et al. 2015).

The percentage of patients being asked to make payments varies across studies and countries. In the countries listed above, the prevalence is generally quite high, with reported prevalence rates usually between 20 and 70%. These data are consistent with the findings from Transparency International surveys asking respondents if they paid a bribe for health services in the past year (Transparency International, 2011, 2013, 2015, 2016). Thus, there is ample evidence of informal payments being common. We do not report all these percentages, as our objective is not to establish a prevalence rate of making informal payments for (maternal) care. Studies use divergent definitions, making comparison and aggregation inappropriate. Moreover, through our readings, we identified significant reliability and validity challenges to the measures researchers use, as outlined below. First, many studies relied on patient self-report. Yet, several studies showed that patients were often unable to distinguish between official user fees and informal payments, so self-reported survey information may not accurately capture informal fee prevalence as distinct from formal user fees (Lewis

2006; Killingsworth et al. 1999; Falkingham 2004; Lewis 2007; Mamdani and Bangser 2004; Cherecheş et al. 2013; Gaal et al., 2006b). Often, patients pay a combination of both (Killingsworth et al. 1999; Afsana 2004; Perkins et al. 2009). They may also be deliberately misled about what they are paying for, such as being told that they are paying for necessary drugs when they are not (Sharma et al. 2005). Moreover, in some contexts, patients report that the fact of paying – rather than whether or not the payment is informal – is the most relevant attribute of the patient/provider interaction. We suggest that in these cases, it may be most appropriate to study out-of-pocket costs as a whole. Second, the distinction between gift giving and informal payments can be blurry. In surveys, patients report giving both, with the most widely accepted distinction being whether the money was provided prior to or after care was received, with money given before care being understood as a payment and money given after care understood as a gift (Cherecheş et al. 2013; Balabanova and McKee 2002; Tatar et al., 2007). However, there are reports of very forceful demands for informal payments being made after the provision of care, so this distinction between voluntary and involuntary and when the service is provided does not always hold (Afsana 2004). Moreover, some report giving “gift assurance” to improve the quality of care provided, suggesting that the gift is understood to be necessary in order to receive appropriate care (Ayanore et al., 2017).

Our review identified other measurement challenges related to prevalence in addition to inability to distinguish between informal payments and other types of financial outlays. Respondents – both patients and providers – may be reluctant to report engaging in practices that are not openly discussed and that may be associated with corruption (Vian 2008; Abdallah et al. 2015; Lindkvist, 2013). Also, informal payments may be so normalized that respondents do not mention them when they are asked about payments for health care as part of a wide-ranging household survey. Indeed, household surveys generally reveal lower informal payment prevalence rates than small, dedicated surveys, where

interviewees are asked multiple detailed questions about payments and their responses are probed (Lewis 2007; Balanbanova and McKee 2002).

Measurement challenges also reflect deeper conceptual and definitional challenges. Informal payments may or may not be illegal. Even if they are illegal, they could be widespread and considered to be legitimate (Gaal et al. 2006a). In the same facilities, there can be many types of informal payments. They can vary in terms of who is making the payment, to whom, how much they are giving, when the payment is made, where it is made, and for what reason (Gaal et al. 2006a; Sharma et al. 2005). Payments may be made to the treating doctor, nurse, or other medical professional; an administrator; pharmacist; janitorial or other facilities employee; or someone else. Many patients (and their families) make multiple payments to multiple people during an extended interaction with the system (Jeffrey and Jeffrey 2008; Mæstad and Mwisongo, 2011; Sharma et al. 2005). They may consider some of these to be gifts and others to be coerced. Data on how patients feel about the fees varies enormously within and across countries, and, again, assessing this is plagued by measurement challenges (Sharma et al. 2005). Patient and provider interpretations of payments vary enormously as well; patients and providers may reportedly have different interpretations of the same interaction as well as of the phenomenon as a whole. Moreover, practices and interpretations are embedded in the larger health system; “each transaction is thus understood, not as a one off market event, but rather as shaped by information, expectations, levels of trust, norms of behavior and incentives, all of which evolve over time through market and other social interaction” (Tibandebage and Mackintosh 2005).

Of those studies that differentiate among different types of services, most find that informal payments may be particularly prevalent in the obstetric care setting. First, studies have concluded that payments are more likely to be made – and are higher – for in-patient care and/or for specialist care, either or both of which are usually entailed in delivery care (Killingsworth et al. 1999; McPake et al. 1999; Lewis 2007; Aarva et al. 2009; Vian 2008; Baji et al. 2012; Nekoeimoghadam 2013; Stepurko et al.

2013; Joe 2014; Riewpaiboon et al. 2005; Miller et al. 2000; Mokhtari and Ashtari 2012; Perkins et al. 2009; Vian et al., 2015). Though few studies examine payments in such granular detail, it appears that even as compared to other reasons for in-patient care, obstetric care may be more likely to incur informal payment (Falkingham 2004; McPake et al. 1999; Aarva et al. 2009; Stepurko et al. 2013; Riewpaiboon et al. 2005; Mokhtari and Ashtari 2012). For example, a study on payments for healthcare in Hungary found that those receiving in-patient care were more likely to make an informal payment than those receiving out-patient care, and, of those receiving in-patient care, patients receiving labor and delivery care were even more likely than those receiving other services (Baji et al. 2012). There are obvious reasons for the higher informal costs of hospitalization and specialist care; both are more resource and time intensive. In addition, the dynamics of obstetric care delivery in particular may contribute to higher rates of informal payments. Women are often urgently in need of care and they and their families have insufficient time to negotiate, leaving them with little leverage. They are also concerned with the health of both the mother and the newborn (rather than just one person as in most interactions with the health system); some women are even asked to pay after delivery in order to see the newborn, often more for a boy (Holberg and Rothstein 2011; McPake et al. 1999; Sharma et al. 2005). Moreover, in some settings, obstetric care entails a long-term (6 to 10 month) relationship with the same obstetrician. Women may be willing to pay to achieve interpersonal trust and care, as they intend to rely on the same provider through the pregnancy and delivery (Stepurko et al. 2013; Riewpaiboon et al. 2005).

### **Drivers**

Studies and conceptual papers identified both proximate drivers of informal payments, as well as distal systemic causes. The drivers below are common to many studies, though some are more common in specific types of studies. For example, human resource scarcity is most often examined in economic analyses. Bringing together these analyses from different traditions helps us to arrive at a

richer and more profound understanding of informal payments, as well as of how they are understood (Gilson et al. 2011). We start with proximal causes and move on to systemic causes.

### *Norms of gift giving and reciprocity*

Patients and providers sometimes assert that gifts or payments are consistent with cultural norms of gift giving and reciprocity, particularly in the context of the government health system, where patients are usually receiving care from someone of a higher social status (Vian et al 2012; Cohen and Filc 2015; Nekoimoghadam et al. 2013; Gaal and McKee 2004; Mokhtari and Ashtari 2012; Chiu et al., 2007). The extent to which norms of gift giving and reciprocity drive informal payments is contested, and is very likely contextual (Bukovansky, 2006; Gaal et al. 2006a; Transparency International 2006). Some patients may consider that they are giving a gift or a tip, while another patient may consider a very similar transaction not to be tipping. These differences in interpretation can be seen in large scale surveys. For example, in response to a survey question in the 2008 round of the Vietnam Household Living Standards Survey about whether a government official receiving a “small gift or money after performing duties” was corruption, 45% said yes, 37% said no, and 18% were undecided (World Bank 2010b). Some argue that “the concept of ‘gratitude payment’ is no more than a convenient myth that has been used to make an unacceptable phenomenon acceptable,” (Gaal, 2006) though there are others who insist that norms of gift giving – such as in China – “cannot be reduced to a modern western notion of corruption because the personalistic qualities of obligation, indebtedness, and reciprocity are just as important as transactions in material benefit” (Yang 1994, pg. 108). There is variation in the extent to which researchers find support for the gift giving hypothesis, though it is fair to say that the notion of gift giving and tipping is evoked in nearly every global health article about informal payments. We did not find any papers or researchers who dismiss the entire phenomenon in a LMIC as patient-driven gift giving or tipping, and only one – from Iran – that concluded that expressing appreciation was the most important motive for making informal payments (Aboutorabi et al., 2016). Thus, among the research

and analysis focused on LMICs, there is widespread agreement that, while there may be a cultural element, the economy of informal payments also has structural drivers.

### *Scarcity of providers*

Scarcity of providers is often noted, though it is not extensively explored, as a cause of informal fee charges. Among other factors, scarcity is putatively caused by low salaries, maldistribution, and inadequate opportunities for medical education and training (Chen et al., 2004; Frenk et al., 2010; Rowe et al., 2005; Willis-Shattuck et al., 2008). The assumption is that there are too many patients for the number of health providers, so the 'market price' of seeing a health care provider is increased; providers hold a monopoly on service provision (Vian et al. 2012; Gaal and McKee 2004; Cohen and Filc 2015; Abdallah et al. 2015; Kaitelidiou et al., 2013). Informal payments thus fill a gate keeping function by deterring some patients from seeking care at all, and/or by creating multiple tiers of wait time and quality according to ability to pay (Abdallah et al 2015; Mæstad and Miwsongo, 2011). Some (though not all) evidence suggests that health providers of a higher professional status receive higher informal payments, buttressing a theory about there being a supply and demand-driven market clearing price (Bertone and Lagarde, 2016). On the other hand, it is also possible that providers purposely create scarcity in order to compel patients to make payments (Mæstad and Mwisongo, 2011). Research on scarcity generally focuses on the supply and demand for health care providers, with less attention to the systems determinants of informal payments, the quality of care provided, or the costs of drugs and other inputs.

### *Formal user fees*

In global health policy circles, prevailing opinion has mostly turned against formal user fees as an appropriate way to fund health services (Robert and Ridde, 2013). Almost all global health actors support the abolition of formal user fees, though some limit their calls for abolition of fees to populations or services that they think should be exempt; pregnancy care and pregnant women are

almost always among the groups that should be exempted (Robert and Ridde 2013). These global health actors widely cite inequities exacerbated by user fees as a key reason for ending them (Robert and Ridde 2013).

Yet, other researchers and policy makers have proposed formal user fees as a way of decreasing informal payments, suggesting that there is a direct relationship between the two, with informal payments decreasing as formal fees increase, and vice-versa (Sharma et al. 2005). The empirical data from different countries are mixed, giving credence to the notion that informal fees are often a racket, rather than a necessity. On the other hand, one problem may also be that formal fees are not channeled appropriately, such that informal payments are a remedial measure. A modeling study undertaken in Bangladesh found that it was “difficult to determine whether official user fees crowd in or out unofficial fees at Bangladesh health facilities” and another study found that informal payments appeared to always accompany official fees (Killingsworth et al. 1999). We propose that, since patients are often unable to distinguish between formal and informal fees, it seems likely that in some contexts, formal fees can create space for the charging of informal payments. If patients knew for sure that all care was mandated to be free, they may be less willing to make payments.

Consistent with this varying relationship between formal and informal fees, data are mixed on whether or how the institutionalization or abolition of formal user fees affects the likelihood of patients making informal payments. While a policy review found that efforts to substitute formal for informal payments and allowing health facilities to keep the revenues led to improved quality of care in Cambodia and the Kyrgyz Republic, a scoping study assessing 20 studies on the abolition of formal user fees found several examples of the commencement or the continuation of informal payments following the abolition of formal user fees (Akashi et al., 2004; Lewis 2007, Ridde and Morestin 2011). This occurred even in the Cambodia success story cited above (Akashi et al. 2004). Moreover, our ability to draw conclusions is limited by the fact that there are few longitudinal studies showing how the

institutionalization of formal user fees shapes informal payment prevalence in the long-run (Witter et al. 2007). However, the one study identified found that, when accompanied by adequate drug supply and financial transfers to the facility, the exemption of certain services from user fees in Ghana led to the disappearance of informal payments for these services, suggesting that ending formal fees can lead to decreases in informal fee payments in a context of strong health system governance (Aberese-Ako et al. 2014). Poorly implemented exemptions, on the other hand, can feed the further deterioration of morale and service quality, as demand increases (Witter et al. 2007; Aberese-Ako et al. 2014).

#### *Inadequate health system financing*

Other research looks at salaries and funding of the health system more broadly. In many contexts, funding is inadequate for the goods and services that are the subject of informal payments. This can stem from absolute resource deprivation in the health system, as well as challenges in ensuring timely and appropriate funds and supplies transfer from the central level to lower levels of the system. As a result, health providers claim that health facilities are not adequately resourced to provide the services they are mandated to provide, so patients must contribute (Stringhini et al. 2009; Nimpagaritse and Bertone 2011; Chuma et al. 2009; Falkingham 2004; Stepurko et al. 2013; Gaal et al. 2006a). When asked, providers refer in particular to low salaries, irregular salary payment, and frequent stock outs of drugs and other supplies as forcing them to demand payments (Nimpagaritse and Bertone 2011; Chuma et al. 2009; Miller et al. 2000; Gaal et al. 2006a).

The relationship between provider salaries and informal payments is not consistent. Focus groups conducted among providers in Tanzania found that doctors and specialists commanded higher informal payments than nurses and assistants (Stringhini et al., 2009), a finding that was confirmed in another study in Tanzania (Maestad and Mwisongo, 2011). In contrast, a regression analysis of data reported by providers and patients regarding informal payments in Tanzania found that providers earning relatively lower salaries were more likely to receive informal payments (Lindkvist, 2014).

Similarly, in-depth interviews among lay people and providers in Togo revealed much higher willingness to excuse demands for informal payments by providers with low salaries (Kpanake et al., 2014). Here too, there could be measurement challenges, as providers redistribute payments among themselves (Maestad and Mwisongo, 2011). Indeed, there may be a divergence between the amount different providers request, and the amount they ultimately receive. Moreover, as suggested by some researchers, a theory about salary relevance might be advanced by acknowledging that the notion of “adequate salary” and minimum standard of living are economically and socially governed, such that the relationship between provider salary and informal payments is contextually specific, and thus not comparable or meaningful across contexts (Transparency International 2006; Stringhini et al. 2009).

Some research has shown that informal payments can be well-implanted (routinized) in the system and described as “user fees.” In some contexts, informal user fees may comprise a significant portion of the operational funding for health facilities (Barber et al., 2004). Such fees are collected and spent at the facility’s discretion, rather than going entirely to individual providers. Facilities use the money to fund goods and services that go directly to the patient as well as necessary supportive inputs, such as petrol or phone calls to higher level facilities for patients who are referred (Falkingham 2004; Diarra 2012). Informal user fees might be considered to be a manifestation of what anthropologist Olivier de Sardan describes as “informal privatization” (Olivier de Sardan 2011). They may be one of few means at frontline providers’ disposal to *make the system work*, and they may help to keep providers from leaving a poorly resourced health system to seek employment elsewhere (Diarra 2012; Olivier de Sardan 2011; Gaal et al. 2006a). Yet, these payments can also very easily “become a racket, benefiting only the providers to the detriment of the users” (Olivier de Sardan 2011). The boundary between necessity and racket is hard to delineate. The difference is rarely researched or discussed in the peer-reviewed literature, especially regarding cases where informal fees fund health facility operations.

### *Structural Adjustment, New Public Management and Marketization*

Structural adjustment programs, the selective primary health care movement, the 1987 Bamako Initiative and its emphasis on cost recovery in health care, the institutionalization of so-called 'New Public Management,' and the associated focus on efficiency were part of a broader trend of drawing back the state in the 1980s and 1990s (Tendler and Freedheim, 1994; Storeng and Behague 2014; Pfeiffer and Nichter 2008; Janes and Corbett 2009). The institutionalization of formal user fees and decreased state investment in the health sector were part of this trend. Health systems researchers explain that these and other changes often undercut citizen and provider trust in the system and in each other, laying the groundwork for more transactional relationships (Songstad et al., 2011; Gilson 2003; Birungi 1998; Spangler 2011; Jeffrey and Jeffrey 2008; Mokhtari and Ashtari 2012; Gaal et al. 2006a; Janes and Chuluundorj 2004; Sadruddin and Heung 2015). For example, Birungi describes how, in Uganda, government disinvestment in health service inputs and in the health workforce pushed government health workers to adopt 'survival strategies,' including initiating their own private sector activities and levying informal payments on patients (Birungi 1998). Spangler contextualizes entrepreneurial behavior by providers in Tanzania in a "climate of federal deregulation that accompanied the nationalist goal to become a more capitalist democracy" (Spangler 2011). So, while absolute resource deprivation may be one cause, the concomitant transformation of the doctor-patient and government-citizen relationship to a provider-customer relationship may also be germane to understanding informal payments (Mokhtari et al. 2012, Riewpaiboon et al. 2007, Spangler 2011). Likely overlapping with the marketization dynamic, where studied, provider morale seems to relate to the likelihood that they ask patients to make payments. Studies of health providers in Ghana and Tanzania found that the providers who felt more abused by their supervisors and by the system and/or who lacked the basic inputs required to carry out their jobs were more likely to abuse patients, including pushing them to make informal payments (Tibandebage and Mackintosh 2005; Aberese-Ako et al. 2014).

Providers in Ghana explained that they were being asked to provide people-centered care while the health system employing them did not value them as professionals or people; there was a disconnect between their employment context and the performance expected of them (Aberese-Ako et al. 2014). The relationship among adequate infrastructure and supplies, quality, supportive supervision, and provider morale is well documented, with poor infrastructure, supplies, and supervision contributing to low morale and poorer performance (Willis-Shattuck et al. 2008; Purohit and Bandyopadhyay et al. 2014; Mbindyo et al. 2009).

### *Paying for better care*

By their own admission, many patients make informal payments in the hopes that they will receive better care. They may be paying to ensure a continuous, interpersonal relationship with the provider; for more personalized care; for higher quality clinical care; for shorter wait times; and for more comfortable care (Sepheri et al., 2005; Vian et al. 2012; Stringhini et al. 2009; Lewis 2007; Stepurko et al. 2013; Mamdani and Bangser 2004; Aarva et al. 2009; Nekoeimoghadam et al. 2013; Gaal and McKee, 2004; Riewpaiboon et al. 2005; Vaithianathan, 2003; Baji et al., 2017; Karibayev et al., 2016; Najar et al., 2017; Lindkvist, 2013). They may be more likely to make informal payments to health providers than for other government services because of their vulnerability and reliance on clinicians during a critical period in their lives (Miller et al. 2000), particularly in the context of childbirth. For example, Riewpaiboon et al. describe how Thai women select and pay an obstetrician to see them through their pregnancy and delivery, in the hopes that the money will transform an impersonal doctor-patient relationship to a trustful interpersonal relationship (2005). The imbalance of power between patients and providers may be relevant too. Research in the U.S. and Hungary suggests that gifts from patients to doctors may be a way for patients to redress the status imbalance between them and their doctors by redeeming their status lost by being ill and dependent, or by imposing a non-professional identity on the physician (Drew et al. 1983; Gaal et al. 2006a).

To unpack the exercise of patient agency in the structure of governmental health systems, Gaal and Mckee take economist Albert Hirschman's theory of 'voice and exit' and devised the concept of 'inexit' to describe informal payments. In many contexts, patients lack an "exit" option, as there are no alternative facilities (government or non-government) nearby. They may also have inadequate knowledge and opportunity to express "voice" (e.g. dissatisfaction or demands), and they can be dissuaded from voicing their opinions by the significant social risk inherent in alienating the health providers on whom they depend. 'Inexit' – or exercising choice within the same service by making informal payments – might be one of few means at patient disposal to influence the quality of health services, though, unlike voice, the positive results accrue only to the individual making the payment (2004). In fact, patients making payments could result in poorer quality of care for those who do not make payments (Mæstad and Mwisongo, 2011).

But, even if patients willingly pay to obtain better care, what other options do they have? Similar to the blurry boundary between necessary financial support and a "racket," the boundary between patient agency and obligation or coercion is nebulous and likely contextual. While patients with at least a minimal amount of disposable income may wish to make informal payments to reduce the opportunity cost of obtaining care (by cutting down on the time entailed) or to express their status and right to receive higher quality care, they may also feel that they have little choice, particularly in the obstetric context (Sepehiri et al., 2005). If the expected quality of care absent a payment is poor, or if they feel payment is required to receive any care at all, then from the patient perspective, informal payment is non-negotiable (Gaal et al. 2006a; Mæstad and Mwisongo, 2011). Moreover, if patients worry that the lives of their newborns are in the hands of the providers demanding payments, they are essentially coerced into paying (Spangler 2011).

Several other potential drivers and associated factors are raised in the literature, but they are mentioned rarely, making synthesis difficult. These include the relative size of the private sector, the

strength and detail of law and policy relating to informal payments, norms around physicians asserting their own professional status by demanding fees, the entitlements knowledge of the patient making the payment, SES or other characteristics of the patient, and larger questions about modes of health systems financing (Renfrew et al 2014; Stringhini et al. 2009; Mokhtari and Ashtari, 2012; Abdallah et al. 2015; Nekoeimoghadam et al. 2013; Arnold et al. 2014). There has also been some data from India showing that conditional cash transfers for facility-based delivery have resulted in demands for higher informal payments, as providers knew that women would be receiving a cash transfer following delivery (Coffey 2014).

Finally, some of the drivers can also be impacts, and vice-versa. Low levels of interpersonal and institutional trust, the marketization of the health system, and poor provider morale can both drive informal payments and result from them, again illustrating the appropriateness of a health systems lens that accommodates emergence and feedback loops (Gilson, 2003; de Savigny and Adams, 2009; Stringhini et al. 2009; Najar et al., 2017).

### **Impact**

Informal payments can have multiple immediate and distal effects on households, communities, and the health system. First, informal payments can form a significant part of a catastrophic out-of-pocket expenditure associated with an illness event, particularly in the event of labor and delivery complications (Tibandebage and Mackintosh 2005; Jeffrey and Jeffrey 2008; Perkins et al. 2009). Families may be forced to borrow money at high rates, solicit contributions from friends and family, or sell productive assets (Joe 2014; Kruk et al. 2008). The poorest are more likely to fall into this 'poverty trap' of debt and selling productive assets (Joe 2014; Kruk et al. 2008; Tambor et al. 2014; Commission on Macroeconomics and Health 2001). Moreover, as a generally flat fee levied on families regardless of their ability to pay, informal payments can be regressive, though whether or not the poorest are more or less likely to pay seems to vary among and even within countries (Killingsworth et al. 1999; Hunt

2010; Riewpaiboon et al. 2005; Cohen and Filc 2015; Nekoeimoghadam et al. 2013; Aarva et al. 2009; Kruk et al., 2008). Two recent analyses of secondary data from many countries in sub-Saharan Africa determined that informal payments were generally concentrated among the poorest, undercutting the theory that scarcity and absolute resource deprivation in the health system are the primary drivers, and suggesting that the social status of certain patients may prevent providers from asking them to make payments (Kankeu and Ventelou, 2016; Justesen, M. K., & Bjørnskov).

When patients anticipate having to pay, or have paid in the past, it can also erode trust and satisfaction with the health system, and ultimately, demand for services. Outcomes include women bypassing facilities known to demand informal payments or avoiding facility-based delivery altogether (Vian et al. 2012; McPake et al. 1999; Mamdani and Bangser 2004; Tibandebage and Mackintosh 2005; Uslaner 2004; Gilson 2003; Stepurko 2013; Birungi 1998; Hunt 2010; Riewpaiboon et al. 2005; Nekoeimoghadam et al. 2013; Mokhtari and Ashtari 2012; Janevic et al 2011; Coffey 2014; Jeffery and Jeffery 2010; Kruk et al. 2009; Otis et al. 2008; Mrisho et al. 2007; Brody et al. 2013; McMahon et al. 2014; Izugbara and Ngilangwa 2010). The relationship between satisfaction and payments can be dynamic, with poor satisfaction both driving and resulting from informal payments, consistent with recent empirical findings that repeated interactions, either positive or negative, can produce cumulative judgments and expectations of certain behaviors in health systems (Topp et al. 2015; Gilson et al. 2005; Tibandebage and Mackintosh 2005). Each instance of being asked to make an informal payment is thus one interaction among many that shape satisfaction and trust in the broader health system.

It appears that many women experience requests for payments for maternity care as extremely coercive and disrespectful, falling within the rubric of what has been recently described as disrespect and abuse in maternity care (Bowser and Hill 2010; Bohren et al. 2014; Bohren et al. 2015; Freedman and Kruk 2014; Coffey 2014; Jeffery and Jeffery 2010). Egregious examples of coercion and disrespect include threatening statements such as women being told they will die if they do not pay, being asked

repeatedly by different people working in the facility to make payments or risk negligence or worse, being denied pain relief during suturing unless a payment is made immediately, women being told they cannot see their newborn until they pay, and providers arguing with the family about a payment while the woman is in active labor (Afsana 2004; Mamdani and Bangser 2010; Coffey 2014; Ith et al. 2013; Sharma et al. 2005). In these cases, providers exploit women's vulnerability and sense of urgency, leaving patients and families with little room to negotiate. Moreover, they can impinge significantly on a childbirth event, changing the dynamics to be about power and poverty, rather than welcoming a new baby. Those who are ultimately unable to pay (or suspected of such) may face ongoing disrespectful treatment, poorer quality of clinical care, or outright denial of care (McMahon et al 2014; Coffey 2014; Izugbara and Ngilangwa 2010).

Informal fees can also negatively affect provider morale and behavior. Providers report that they feel forced into asking for payments as they otherwise would not have adequate salary or materials. Doing so, however, can make them feel like they are failing to fulfill their professional mandate; fearful of being caught; or, in some cases, that the balance of power has shifted in favor of the patient, who has essentially become a customer (Stringhini et al. 2009; Stepurko et al. 2013; Cohen and Filc 2015; Nekoeimoghadam et al. 2013; Human Rights Watch 2009; Najar et al., 2017). Moreover, the desire or the imperative to receive informal fees can drive providers and facilities to consider factors other than patient and population health in making clinical decisions. This may include pushing unnecessary clinical services that garner a higher payment, such as caesarian sections; providers competing for patients who are perceived to be more lucrative; and health workers deliberately providing poor quality of care or exerting less effort until a patient pays, or, until another health worker who has already accepted an informal payment from this patient shares that payment (Stringhini et al. 2009; Aarva et al. 2009; Vian 2008; Cohen and Filc 2015; Gaal et al. 2006a; Mæstad and Mwisongo, 2011; Lindkvist, 2013).

## Policy inclusion

The 2000 World Health Report stated that:

Health ministries sometimes turn a blind eye to the evasion of regulations which they themselves have created or are supposed to implement in the public interest. A widespread example is the condoning of illicit fee collecting by public employees, euphemistically known as “informal charging”... Though such corruption materially benefits a number of health workers, it deters poor people from using services they need, making health financing more unfair, and it distorts overall health priorities. In turning a blind eye, stewardship is subverted; trusteeship is abandoned and institutional corruption sets in (World Health Organization 2000).

Similarly, the World Bank’s Africa Indicators 2010 report refers to informal fees as a phenomenon that undercuts access (World Bank Group 2010), and the 2015 World Bank World Development Report stated that corruption can be a “social norm” (World Bank Group, 2015). Think tanks and institutes have highlighted the public policy relevance of “bribery for public services” (U4, 2015; Transparency International, 2011, 2013, 2014, 2015) and “health care corruption and governance woes” (Lewis, 2006). Yet, despite this rhetorical acknowledgement of the relevance of informal payments, recent relevant international strategies, action plans, and donor frameworks, including those related to maternal health, do not mention informal payments. Tables 1 and 2 summarize this.

While the absence of informal payments in global frameworks does not necessarily mean that governments are not addressing informal payments, the discursive absence of informal payments in these high profile documents is notable. We consider this to be part of a broader trend of ignoring “difficult” – but germane – challenges. Reflecting on years of research on health systems in Sub-Saharan Africa, Olivier de Sardan and Ridde write: “the quality of care leaves much to be desired: contempt for the anonymous user, the extortion of money from patients, a lack of professional conscience... These

problems are regularly reported by users and the press, but NGOs, international institutions and local politicians remain obstinately silent on the matter” (Olivier de Sardan and Ridde, 2015).

### **Lenses applied**

The evidence and policy synthesized above were influenced by different conceptual approaches to informal payments and to health systems governance. We synthesize the analyses within each conceptual approach below and offer counterpoints to each. We do not rehearse well-known strengths and weaknesses of each approach, such as the cost of research, required time investment, and ability to generate “thick descriptions” or population-wide data.

#### *Informal Payments as a Form of Corruption*

Currently, one of the most widely used definitions of corruption is the “misuse of entrusted power for private gain” (Mackey and Liang 2012). Informal payment requests are frequently described as a type of corruption in the health sector (Mackey and Liang 2012; Vian 2008; Lewis 2007). Researchers employing a traditional corruption lens based in classic economic theory posit that corruption stems from monopoly, discretion, and lack of accountability (Gebel, 2012; Klitgaard 1988). Service providers with a monopoly (in this case, the public sector) face little competition. Facing little to no credible threat of sanction for demanding payments (discretion), these providers make a choice to misuse their power for private gain (Mackey and Liang 2012). The assumption is that the incentive structure in the health system does not prevent corruption (Bukovansky, 2006; Gebel, 2012). As explained by Lewis, “informal payments...provide a means by which corrupt public servants can ensure or maximize their income, evade taxes, and effectively ‘beat the system’ and consequently are a form of systemic corruption” (Lewis 2000). Many patients experience demands for informal payments as provider corruption, as they explain that they are well aware that demands for such payments are illegal and they perceive the payments benefit the provider (Spangler 2011).

However, empirical evidence from several countries suggests that this classic corruption paradigm does not describe all instances of informal payments, and that the blanket deployment of corruption discourse can risk undermining research and action. Genuine gift-giving and informal payments that are considered absolutely necessary to keep the facility operating or to deliver a service, such as when providers ask a patient to purchase drugs that are part of the entitlement but absent a site level, can hardly be described as corrupt. There is no private gain in these instances. Also important to consider is the much larger grey area of payments that patients or providers consider to be necessary but others judge to be unnecessary, including those with some gratitude component. Too, patients may wish to make payments in order to reduce wait times and assert their status as being above the most poor, who cannot pay or who do not know how or when to pay. Finally, some argue that corruption flows partly from marketization, and that the concepts of monopoly, discretion, and accountability are insufficient to understand corruption; poor morale, insufficient funding, and acceptance of health care as a transaction engender corrupt practices (Gebel, 2012).

The classic corruption label may seem inappropriate to some providers and patients. The moral culpability and illegality it implies may be overly harsh, particularly in a context where informal payments are pervasive and considered to be legitimate (Vian et al., 2015). For these reasons, some researchers advocate understanding corruption as a collective action problem; the individuals most engaged in delivering care at the frontlines may be the least able to effect change (Persson et al 2013; Burns et al., 2013). Corruption continues unabated because individuals face strong pressures to continue; patients seek to obtain better care and providers face professional pressure to demand and share payments, just as their peers do. The opportunity cost for an individual being non-corrupt is quite high, unless everyone else becomes non-corrupt too (Persson et al 2013). However, this collective action approach cannot explain the entire ecology of informal payments. For example, it fails to consider the social norms inhering in the interactions between patients and providers, including gift

giving, as well as all of the health system challenges; for example, even if everyone at a particular health facility were to spontaneously agree to stop demanding informal payments, this does not mean that drugs would immediately become available (Menochal et al 2015). Moreover, many providers and patients may prefer that the system continue as is; there is no collective action problem from their perspective. Patients with more resources may prefer a two-tier system of quality that benefits those who can pay, and some providers may prefer a system that benefits them directly (Vian et al 2012; Walton and Jones, 2017).

Walton describes an “institutional decay” understanding of corruption. We propose applying this to informal payments. In keeping with the broader institutional turn in economics and public administration, the decay hypothesis is consistent with the proposition that we should focus on the “system in which professionals are working, rather than the persons themselves” when it comes to understanding corruption (Ferrinho et al 2004). It improves upon “thin conceptions of institutions as incentive structures” to look at political and normative underpinnings (Bukovansky, 2006; Brown and Cloke, 2004). Such underpinnings may be termed “the framework of cultures of entitlement,” including the socially constructed (rather than administratively determined) entitlements of different citizens and of the health providers who care for them (Akerkar et al., 2016). Walton developed hypothetical scenarios reflecting different understandings of corruption, and found that those matching the “institutional decay” approach resonated mostly strongly with survey respondents in Papua New Guinea; they considered the notion of moral atrophy of institutions to be especially harmful, and stated that it aptly described their experiences with the state (Walton, 2015). Though the low level of state penetration in Papua New Guinea is unusual, the broad notion of institutional decay is resonant with our synthesis of the systems drivers of informal payments.

The institutional decay understanding goes beyond a decoding of individual motivation and incentives to assess historical, social, and institutional norms and modes of operating. These modes can be described in different ways; we identified two lesser known constructs in the social sciences that have been applied to informal payments. Cohen puts forward the notion of “alternative politics” to describe how Israeli political history nurtured a norm of “self-supply of public goods and services illegally or semi-legally” that entails bypassing prescribed channels for obtaining goods and services, including health care (Cohen 2012). Patients making payments thus practice a form of alternative politics. From the provider perspective, Olivier de Sardan describes practical norms, which are contrary to official norms, but widespread and embedded in civil servant practice. These norms are generally implicit and consistent over time (Olivier de Sardan 2008; Olivier de Sardan and Ridde, 2015). Such norms may be accepted by patients who understand the providers’ plight. For example, qualitative research among providers and patients in Togo found that many patients approved of informal payments in contexts where the patients were wealthy and physicians were underpaid (Kpanake et al., 2014). The Togo study authors suggested that patients understood demands for informal payments to be a consequence of the health systems challenges present in Togo (Kpanake et al., 2014).

Research assessing the link between trust and corruption has found that higher levels of trust in institutions (and not just interpersonal trust) are associated with decreased corruption, suggesting that whole system concepts such as institutional decay or emergence are ripe for exploration (Sööt and Rootalu 2012). An institutional decay approach is not yet widespread in the literature, though it is increasingly visible. For example, Vian, a long-time researcher on corruption in the health sector, proposes that Olivier de Sardan’s notion of practical norms is an important area for future study (Vian 2008). Similarly, an analysis of the discourse within Transparency International (TI) - a global leader on anti-corruption discourse – stated that TI increasingly acknowledges the relevance of a more holistic, ethics-based approach, but that this approach is far from entrenched in their practice (Gebel, 2012).

Thus, global leaders in the corruption field suggest that institutional decay and similar concepts may be fruitful for describing and addressing informal payments.

### *Ethnographic and in-depth qualitative research*

Ethnographic research has shed light on the patient and provider experience of informal payments, the local institutional context, and the wider social and political structures that influence the local institutional context. Moreover, given some of the measurement challenges described earlier, observational and in-depth interview techniques are particularly suited to drawing out the implicit, hidden nature of informal payments. Anthropology “has a long and rich tradition for studying hidden practices and illegal or semi-legal exchanges” (Anders and Nuijten, 2007, pg. 4).

Using surveys to understand individual motivations related to informal payments may be particularly ineffective in contexts where respondents associate lists of close-ended questions with governmental data collection, and thus fail to provide honest responses (Sessener 2001). In contrast, one-on-one in-depth interviews and observations may allow researchers to ascertain what informal payments mean from the actors’ own point of view (Sessener 2001), and how informal payments are related to a “configuration of broader practices” that illuminate the relations between patients and the health sector and relationships within the health sector itself (Blundo & Olivier de Sardan, 2006, pg. 87). While ethnographic approaches do not communicate the scale of informal payments, understanding the meanings attached to informal payments is essential to establishing if they do in fact have an impact that is on balance negative in a given context, and if so, how they might be changed. For example, Spangler recounts the statement of a Tanzanian woman: “You don't have the power to refuse. What will happen when your child gets malaria? Or the next time you go to deliver. No, No. This you cannot refuse” (Spangler 2011). The inability to refuse and fear of future contact with the health system may not be easily discerned in a survey, yet these factors are essential to understanding the larger impact on

trust and citizenship informal payments can have. Similarly, learning through a health system –based ethnography that informal payments are shared among several providers or that informal payments lower provider morale may be key to ascertaining how informal payments may be disrupted (Pfeiffer and Nichter 2008; Aberese-Ako et al. 2014; Hoag & Hull, 2017). The fact that providers may feel their professional role is compromised by these payments is an important “hook” for efforts to reduce informal payments.

### *Micro-economic*

Economists have used a willingness-to-pay framework or econometric modelling to understand some of the immediate causes and impacts of informal payments. The concept of scarcity and much of the theory and data on the relationship of formal user fees and provider salaries to informal payments come from this tradition (Baji et al 2010).

To unearth the prevalence, drivers, and impact of fees, researchers have conducted original surveys, analyzed large household survey data sets, and proposed econometric models of factors associated with informal payments. Though this approach can make a focus on systems and complexity difficult, and are limited by measurement challenges, these studies provide the most complete data on the frequency and geographic scope of informal payments, including on the higher rates of payment by obstetric patients (Mokhtari et al 2012). Moreover, they have played a key role in elucidating economic impacts at the household and facility levels, such as when and where informal payments are regressive, how informal payments and other out-of-pocket payments can have a catastrophic effect on household economic stability, and how the existence of payments creates a two-tiered (or even a multi-tiered) system of quality, with those who can pay receiving better quality care (Killingsworth et al. 1999; Hunt 2010; Joe 2014; Abdallah et al. 2015).

Synthesizing data from these and other paradigms illustrates the value of an inter-disciplinary approach. Each lens has particular added value and weaknesses. These attributes in turn affect the solutions proposed.

#### *What to do?*

Proposed ways of reducing the harm of informal payments have run the gamut from general civil service reform to narrow efforts to change the ‘incentives’ providers and patients face to health system improvements, such as reducing stock outs. A discussion of all of these proposed interventions is beyond the scope of this paper, but a brief summary elucidates how theoretical orientation, policy pragmatism and expediency shape some of the solutions proposed.

Global health experts and economists often suggest addressing the putative proximate determinants of provider incentives, such as raising their salaries, allowing private sector moonlighting, instituting formal fees and stronger sanctions for demands for informal payments, and state provision of bonuses based on the number of patients served (Gaal and McKee 2004, Lewis, 2007). There are multiple examples of these policies being implemented in isolation, or without attention to practical norms and larger issues such as trust (Stepurko et al. 2013; Cherecheş et al. 2011; Lê 2013). There are also examples of reforms being implemented partially, such that achieving the intended impact is unlikely (Witter et al. 2007; Aberese-Ako et al. 2014). Even if new policies are implemented with full fidelity, they may be unable to change the broader dynamics, such that informal payments persist (Lewis, 2007). Some suggest ‘working with the grain’ by acknowledging practical norms and attempting to shift them; a group of anthropologists working in West Africa described a successful effort led by a ‘reformer midwife’ to cut the average daily health care worker income from informal fees in half. The fees could not be eliminated absent significant structural change, but the harm associated with them

was lessened by a single person's efforts to effect progress from the starting point of practical norms (Olivier de Sardan, Diarra and Moha, 2017).

Many researchers and advocates explore citizen ability to contest informal payments. They recommend rights claiming through the individual and collective expression of voice or dedicated monitoring efforts. The implicit assumption is that increased citizen and policy-maker knowledge, collective action, and opportunities to dialogue with local providers and officials will lead to greater accountability regarding informal payments (Schatz 2013; Pieterse and Lodge 2015; Vian et al. 2012; Vian 2008; George et al. 2005; Molina et al., 2016). Groups of citizens and/or local organizations can spearhead these social accountability efforts. There are some examples of local level health facility responsiveness, including regarding informal payments, stemming from community monitoring and other social accountability efforts (Dasgupta et al. 2015; Molina et al., 2016).

However, there are several caveats in the empirical literature. First, women and communities need to be aware of their rights in order to claim them (Mamdani and Bangser 2004; Spangler 2011; Chuma et al. 2009; Mokhtari and Ashtari 2012; Dasgupta, 2011). They also need to feel safe claiming them; as described, poor women may be reluctant to alienate providers at the only health facility in their area, particularly because they and their families will rely on them in the future (Spangler 2011; George and Branchini, 2017). Women and communities attempting to monitor and describe health system deficiencies can be subject to retaliation (Dasgupta et al., 2015).

Second, to address some of the institutional decay at issue, frontline monitoring efforts might need to move beyond the most sensational examples of health provider abuse to challenge the underlying system wide failures (George et al. 2005). This is harder to do with scattered efforts at community monitoring. An integrated, scaled up accountability effort that addresses multiple levels and agencies of the government, communities, and institutional capacity may be needed (Fox 2015; Halloran

2015). Building alliances between providers and community members on shared priorities – such as lack of adequate drugs and supplies - holds potential as part of a larger strategic approach (Fox 2015).

Others have proposed ways of addressing broader factors that can both be drivers and impacts of informal payments, such as levels of institutional and interpersonal trust. This might be accomplished through enhanced quality accreditation; changing the cost and reimbursement structure in hospitals; greater engagement of professional associations and training bodies; and greater attention to health system governance (Riewpaiboon et al. 2006; Piroozi et al., 2017).

## **CONCLUSION**

Critical interpretive synthesis entails moving beyond aggregation and breaking new ground in synthesis. We have accomplished this by interrogating a heterogeneous literature, in a way that has not yet been done in discussions of informal payments. Our review of high profile global policies and strategies elucidates the needs - and to some extent, the limited decision space - of a key group of end users of research, policy-makers. Synthesis of lenses applied to informal payments further shows how these paradigms inform empirical work on fee prevalence, and we suggest ways in which approaches from outside the traditional global health literature can productively be applied to unpacking and addressing informal payments.

Informal payments are a manifestation of health system dysfunction. Their most negative effects are on those who are the most disempowered in under-resourced and poorly governed health systems – frontline providers and their patients. Recent conceptual work asserts that disrespect and abuse in maternity care should be defined by both patients' subjective experiences and provider intent (Freedman et al. 2014). This approach can be applied to informal payments. As learning from several disciplines shows, the harm in informal payments is located in subjective patient experience of coercion, disrespect, fear, or economic damage as well as provider intent to take advantage of patients and

provider sentiments that the health system does not give them the resources required to realize their professional mandate.

Payments may allow some patients with adequate capital to bypass the most egregious manifestations of health system dysfunction, but they do nothing to mitigate that dysfunction. In fact, informal payments may feed dysfunction by perpetrating clientelism and corruption in the allocation of postings to health care workers (Schaaf and Freedman, 2015). Thus, harm goes beyond the individual. Informal payments can undercut trust beyond those people implicated in any given encounter, and contribute to health services being provided and received as a commodity, rather than an entitlement. This has implications for community willingness and capacity to access services, the quality of communication between patients and providers within the service, and community trust in the government.

Our chosen definition of informal payments includes all payments that are beyond entitlement; some of these payments may neither hurt patients nor stem from provider avarice. While this definition is conceptually clear-cut, it is empirically difficult to assess, challenging research and policy related to informal payments. There are advantages and disadvantages to the various approaches in which any definition is embedded. Like many health systems issues, it appears that different lenses each tell only part of the story. The appropriateness of an approach depends partly on contextual factors and the questions we seek to answer. For example, analysis of provider incentives might be more apt in settings where corruption is not endemic. The ultimate objective of any research should be to tell as much of the story about the practice and its meanings as possible, without getting lost in a hall of postmodern mirrors that offers few possible solutions.

The everyday relevance of informal payments to both maternity care providers and patients is at odds with the research base, which privileges EE, fSU, and analysis of proximate determinants. Micro-

economic analyses of these proximate determinants may lead to overly narrow solutions, but even here, we have little long-term data or fully implemented programs on which to judge the efficacy of solutions. In any case, the seeming importance of concerns of trust, provider morale, institutional determinants of corruption, and the social construction of rights revealed in qualitative analyses suggest that a multi-disciplinary health systems approach that leverages and integrates positivist, interpretivist and constructivist lenses of social science research can lead to better insight and policy critiques. Among other questions, the boundary between informal payments as palliative mechanism and exploitation, the power and equity determinants and outcomes of payments, and the interplay between local and global (translocal) constructions of corruption and informal payments merit exploration. With this, we can challenge inadequate “master narratives” and strive to meet universalistic, equity-oriented global health objectives.

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## Tables and Figures

**Table 1: Inclusion of informal fees in global strategies**

Strategy	Mention of Informal Fees	Reference to other relevant issues (corruption or out-of-pocket payments)
2012-2015 Partnership for Maternal and Newborn Health Strategic Framework	No	Indicates that out-of-pocket payments adversely affect demand for care
2014 Every Newborn Action Plan	No	Describes need to reduce out-of-pocket payments for health care and eliminate corruption
Draft 1.0 of WHO's Health Workforce 2030 and accompanying document from the Executive Board	No	Note the need to improve the governance of human resources.
The Every Woman, Every Child global strategy on Women's, Children's and Adolescents' Health	No	No
WHO global strategy on people-centered and integrated health services: interim report 2015	Yes, but in the context of a criticism of excessive stakeholder attention to informal payments, rather than to the purported underlying drivers of health system governance overall	Refers to corruption as part of the same critique at left

Source: World Health Organization 2014; The Partnership for Maternal, Newborn & Child Health, 2011; World Health Organization Executive Board 2015; World Health Organization 2015; Every Woman, Every Child 2009, World Health Organization 2015

**Table 2: Inclusion of informal fees in donor strategies**

<b>Donor and strategy</b>	<b>Mention of Informal Fees</b>	<b>Reference to other relevant issues (corruption or out-of-pocket payments)</b>
Japan International Cooperation Agency (JICA) Operation in the Health Sector: Present and Future	No	No
USAID Global Health Strategic Framework	No	Mentions the need to reduce the negative impacts of out-of-pocket payments and the need to reduce corruption
Responding to the challenges of globalization: The EU Role in global health	No	Notes the importance of universal access and eliminating financial barriers to health care
Strategy for Denmark's Development Cooperation	No	Fighting corruption is a key goal
Health is Global: an outcomes framework for global health 2011-2015 (UKAID)	No	No

Sources: Japan International Cooperation Agency 2013; USAID 2011; European Commission 2010; DANIDA 2012; UKAID 2010

**Paper 2: “Our fear is finished,” but nothing changes. Fomenting accountability for informal payments  
for maternal health care in a context of low state capacity**

## **Abstract**

Women in India are often asked to make informal payments for maternal health care services that the central or state government has mandated to be free. This paper is a descriptive, contextualized case study of a social accountability project undertaken by SAHAYOG, an NGO in Uttar Pradesh, India. The project sought to decrease health provider demands that women and their families make informal payments for maternal health care. The study entailed document review; interviews and focus group discussions of program implementers, governmental stakeholders, and community activists; and participant observation in health facilities. The study found that SAHAYOG adapted their strategy over time to engender greater empowerment and satisfaction among program participants, as well as greater impact on the health system. Participants gained resources and agency; they learned about their entitlements, had access to mechanisms for complaints, and, despite risk of retaliation, many felt capable of demanding their rights in a variety of fora. However, only program participants seemed able to avoid making informal payments to the health sector; they largely were unable to effect this change for women in the community at large. Several features of the micro and macro context shaped the trajectory of SAHAYOG's efforts, including caste dynamics, provider commitment to ending informal payments, the embeddedness of informal payments in the health system, human resources scarcity, the overlapping private interests of pharmaceutical companies and providers, and the level of regional development. Though changes were manifest in certain fora, providers have not necessarily embraced the notion of low caste, tribal, or Muslim women as citizens with entitlements, especially in the context of free government services for childbirth. SAHAYOG assumed a supremely difficult task. Project strategy changes may have made the task somewhat less difficult, but given the population making the rights claims and the rights they were claiming, widespread changes in demands for informal payments may require a much larger and stronger coalition.

## Introduction

Gender and other social hierarchies shape vulnerability to ill health, as well as the quality of health care one receives (Marmot et al., 2008). Building the community consciousness, confidence, coalitions, and know-how for low status women to effectively claim maternal health and citizenship rights is the work of long-term, broad-based social movements. We examine the contribution of one campaign to this movement in Uttar Pradesh, India.

Despite high-level rhetorical commitment to improving maternal and child health in India, in many contexts, the quality of care in the public system can be quite poor (Dasgupta et al., 2017; Seth et al., 2017; Raj et al., 2017; Sridharan et al., 2017). Central and state level governments have put enormous effort into encouraging and incentivizing women to give birth in government health facilities, under the assumption that higher rates of institutional delivery would lead to decreased maternal and neonatal mortality rates (Jha et al., 2016). However, overwhelmed health facilities are not necessarily able to provide quality healthcare to all women seeking it. Despite increased rates of institutional delivery, the maternal mortality rate has not changed significantly (Elmusharaf et al., 2015; Coffey, 2014; Randive et al., 2014). In the extreme, disproportionate emphasis on institutional delivery can yield “safe, yet violent” deliveries, where women experience disrespect and abuse during labor and delivery, and health care workers strain to fulfill their professional mandate in facilities with poor infrastructure, frequent stock outs, and punitive management (Chattopadhyay et al., 2017; Coffey, 2014; Das and Dasgupta, 2013).

In this context, women in India are often asked to make informal payments for maternal health care services that the central or state government has mandated to be free. Informal payments are defined as “a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services to which patients are entitled” (Gaal et al., 2006). These payments can be financially

significant for poor women and their families, and payments may be demanded in a coercive manner that undercuts satisfaction, future utilization of the health system, and health citizenship (Dasgupta et al., 2015; Nair and Panda, 2011; Coffey, 2014; Sudhinaraset et al., 2016).

Policy-makers, activists, and donors proffer social accountability efforts as at least a partial solution to demands for informal payments (Lodenstein et al., 2016; Freedman and Schaaf, 2013). Social accountability entails collective action among civil society actors to hold the state to account for failures to provide public goods, such as health care (Joshi and Houtzager, 2012).

This paper is a descriptive, contextualized case study of a social accountability project undertaken by SAHAYOG, an NGO in Uttar Pradesh, India. The project, called My Health, My Voice (Meri Swatshya, Meri Awaz in Hindi, or MS, MA) ran from January 2012 to June 2016, and sought to decrease health provider demands that women and their families make informal payments for maternal health care. Because women in labor are especially vulnerable, and because they are concerned with their own health as well as that of their newborn, compared to other health services, maternal health care may be particularly fraught with informal payments (McPake et al. 1999; Lewis 2007; Vian 2008; Riewpaiboon et al. 2005; Holmberg and Rothstein 2011; Sharma et al. 2005; Harris, Bately and Wales, 2014).

### **Social Accountability**

Social accountability builds on the longstanding field of participation in development, including in primary health care, by linking participation to the accountability principles of answerability and sanctions (Brinkerhoff and Wetterberg, 2016; Schedler, 1999; Goetz and Gaventa 2001).

Several empirical articles and one review address the impact that social accountability efforts can have on maternal health and health more broadly. Researchers have found that in some contexts, social accountability campaigns can enhance knowledge and empowerment among community members; increase the clinical and interpersonal quality of service delivery; enhance trust between

communities and the health system; improve health system compliance with national guidelines regarding the availability of important inputs; and enhance the functioning of government- and community-supported institutions, such as Village Health Committees (Lodenstein et al., 2016; Papp et al., 2013; Schaaf et al., 2017; Wild and Harris 2011; Gullo et al., 2016; Ho et al., 2015). Program implementers and researchers have documented reduced demands for informal payments as a result of social accountability efforts, but there has been very little research on social accountability and this particular topic. The degree to which social accountability activities affect empowerment and governance depends in part on intent; some efforts simply seek to teach citizens to be more educated consumers of services, whereas others seek to “deepen democracy” by changing the terms of citizen and state interactions (Joshi, 2013; Gaventa and McGee, 2013). Deepening democracy requires supporting inclusive, deliberative processes and the development of leaders from marginalized groups (Halloran, 2015).

Jonathan Fox and Anuradha Joshi, two influential accountability researchers, make an important distinction within social accountability efforts addressing health and other service delivery areas. Fox describes the differences between strategic and tactical approaches, and Joshi and Houtzager, between widgets and watchdogs. Tactical approaches are bounded and are limited to “society-side” efforts to gather and project citizen voice. In contrast, strategic approaches entail multiple tactics, seek to foster an enabling environment for collective action, and coordinate with synergistic efforts to improve state capacity to respond to citizen voice (Fox, 2015).

Joshi and Houtzager describe widgets as “labelled mechanisms” which have been introduced by external actors. They differentiate these labelled mechanisms from watchdogs; civil society functions as a watchdog when there is ongoing “political engagement by social actors with the state as a part of a long-term pattern of interaction shaped both by historical forces and the current context” (Joshi and Houtzager, 2012, pg. 146).

Fox and Joshi and Houtzager conclude that the transformative potential of social accountability efforts is much greater when strategic, watchdog approaches are adopted, a conclusion that has been supported by other empirical work (Holland et al., 2016).

### **Study Context**

India has a recent record of state-mandated, institutionalized processes to foster citizen participation; some of these processes are specific to the health sector. For example, the National Rural Health Mission (NRHM), a national effort to improve health care in rural areas, included community monitoring of service quality. This large-scale effort contributed to increased health provider and administrator acceptance of community monitoring and engagement (Shukla et al., 2011). However, within India, North India, including Uttar Pradesh, stands out for especially entrenched patriarchal, religious, and caste hierarchies (Pankaj, 2016; Scott et al., 2017; Dasgupta et al., 2015). Poor women have limited decision-making power, access to education, and freedom of movement (Scott et al., 2017; Dutta, 2015). Many social and economic indicators are significantly worse in Uttar Pradesh than the median levels in India; maternal mortality is no exception, with an overall rate of 258 maternal deaths per 100,000 live births, as compared to the overall rate of 178 per 100,000 live births (Government of India, 2013; Coffey, 2014). These indicators also differ significantly across axes of inequity, with low caste, Muslim religion, lower education levels, and rural residence associated with worse maternal health outcomes and quality of care (Seth et al., 2017; Raj et al., 2017; Sridharan et al., 2017). Caste divisions can be at the core of political discourse and public sector operations. Political reputations are often based not on the delivery of services, but on the delivery of the fruits of patronage politics, such as employment, to one's fellow caste members and political allies (Rajan et al., 2014; Dutta, 2015; Shah and Rani, 2003). These factors make participatory processes based on the premise of universal, quality service delivery quite challenging.

SAHAYOG began working in Uttar Pradesh in 1992. An intermediate level organization, SAHAYOG 'brings the state to the grassroots' by educating women about their entitlements and political processes, and they bring the 'grassroots to the state' by facilitating women's input into monitoring, agenda-setting, and policy-making forums. SAHAYOG maintains a participatory governance structure; they have 22 members drawn from various stakeholder groups who in turn elect a 7-member governing body. The 12 organizational staff are based in Lucknow, the capital of Uttar Pradesh, and Delhi, the capital of India.

SAHAYOG has adapted its approach over time, strategically employing more or less adversarial or collaborative tactics at various levels of the government (Dasgupta, 2011). In addition to grassroots change, SAHAYOG seeks to impact policy at the state, national, and global levels through participation in both government-led and civil society led forums.

MSAM (Mahila Swasthya Adhikar Manch or the Women's Health Rights Forum), has been a fulcrum of SAHAYOG's work since 2006. MSAM is comprised of approximately 12,000 largely illiterate, Muslim, scheduled caste, or tribal women from eight districts of Uttar Pradesh. In partnership with Community-Based Organizations (CBOs), SAHAYOG provided MSAM with training and facilitation support for regular member meetings at both block (a block is an administrative designation below the level of district in India) and district levels. Consistent with theory and program experiences on politically marginalized women, SAHAYOG and the CBOs expected that MSAM members would learn about rights and entitlements and reflect on their own experience - conscientization, in Freirean terms – and ultimately become more vocal and assertive and collectively engage the state to demand greater accountability (Cornwall, 2003; Das and Dasgupta, 2013; George and Branchini, 2017). MSAM members monitor public services and entitlements related to priority issues they themselves have identified, collate their findings into reports, and present these reports at district and state level dialogue events.

They also participate in official NHM mechanisms for citizen input. By creating new expectations and avenues for interface between marginalized women and the state, these efforts would empower MSAM members, lead to enhanced service quality, and contribute to deepened democracy.

In 2012, MSAM identified informal payments for maternal health care as a priority issue. SAHAYOG, CBOs, and MSAM members then conducted a survey in 11 districts, where women who had given birth in the past 6 months reported paying an average of 1277 rupees (approximately \$24 at the time the data were collected) for maternal health services that were mandated to be free. In response, SAHAYOG and the CBOs launched Meri Swasthya, Meri Awaz (MS, MA or My Health, My Voice in English). It was a 4-year project wherein women used interactive voice response (IVR) on mobile phones to call a hotline and report having been asked to make an informal payment for maternal health care. The complaints were categorized by type and amount and were mapped and displayed on a website in real time. The project was started in 4 pilot districts and eventually scaled up to 8 districts.

SAHAYOG, the CBOs, and MSAM believe that informal payments are a systems problem. Thus, the intent of the project was to demonstrate the scope of the phenomenon, as well as patterns associated with particular geographic areas and facilities, rather than to punish any particular provider or obtain remedy for a particular patient. The project was enabled in part by the Government of Uttar Pradesh asking SAHAYOG and other civil society groups to monitor the implementation of Janani Shishu Suraksha Karyakaram (JSSK), a scheme ensuring free comprehensive maternity care, as well as by NRHM's participatory mechanisms.

## **Methods**

The research question we sought to address in our case study was: How does SAHAYOG aim to reduce informal payments as part of a larger strategy for promoting women's health rights? How do they implement and adapt strategic social accountability approaches in a context of low state capacity and commitment to respond?

We undertook a descriptive case study, aiming primarily to answer “what” and “how” questions. This approach is justified partly by the fact that much of the extant research on social accountability in the health sector has focused more narrowly on interventions and outcomes without attendant exploration of program context and evolving program strategy. SAHAYOG and researchers from Columbia University studied the impact of the first two years of this project using Most Significant Change methodology. Through this, we identified specific contextual and organizational factors for further investigation. These factors included state willingness and capacity to respond; SAYAHOG’s evolving reputation and relationship with the state; MSAM relationships with health facilities; and health provider perceptions of informal payments (Dasgupta, 2011; Dasgupta et al., 2015).

We collected data from two project districts: (1) Azamgarh, with an approximate population of 2.3 million women, and, (2) Mirzapur, with an approximate population of 1.2 million women (Government of India, 2011). The criteria for choosing these districts were: MSAM active in the site, high rates of reporting over time, and anecdotal reports of decreased frequency in informal payments. Mirzapur and Azamgarh differ in that Mirzapur is more geographically remote and has poorer socio-economic and gender equity indicators (Government of India, 2013).

Within the districts of Azamgarh and Mirzapur, we intended our sampling strategy to result in the selection of typical (“common,” in case study terms), successful cases. We chose sites that would be representative of those places where the project was taken up by the population (women made reports), and where at least some minimal governmental buy-in was in evidence (anecdotal reports of response to the project, CBO has a functional relationship with the government health authorities, and the Medical Officers in Charge of the relevant facilities were willing to participate.)

Analysis of strategic, watchdog approaches requires research that accommodates complexity and that is attentive to explicit and implicit power by addressing the macro and the micro context that comprise the ‘accountability ecosystem’ (Halloran, 2015). We accomplished this by exploring a wide

range of questions via several different qualitative tools and several days of observation. More specifically, we undertook:

- Key informant interviews (KII) of program implementers (n=4).
- In-depth interviews (IDI) with governmental stakeholders at health facility and district levels (n=7).
- Focus group discussions about experiences as a professional/community activist with MSAM members and with CBO staff (2 FGDs with the CBOs, and 6 FGDs with MSAM women, with a total of 68 people).
- Participant observation in healthcare facilities. Participant observation was carried out for 3 days in a primary health center in Mirzapur, 1 day in a district hospital in Mirzapur, 4 days in a primary health center in Azamgarh, and 1 day in a district hospital in Azamgarh. All of these facilities provide prenatal care and labor and delivery services. The actual observation entailed observing public areas of hospitals and having informal conversations with staff, providers, and patients to understand the norms guiding formal and informal financial transactions for maternal health care. Participant observation is particularly suited to this context as it allows for exploration of the “socially acquired and shared knowledge” of different stakeholders, thus facilitating understanding of the day-to-day realities and challenges of care-giving (Woodside, 2010, pg. 325). Participant observation also provides some corrective to the reporting bias inherent in interview methods; it “can help to overcome the discrepancy between what people say and what they actually do” (Mays and Pope, 1995, pg. 183; Yin, 2014; Woodside, 2010).
- Document review. Documents included government orders related to informal payments in the past 5 years from district/state health offices, official government comments/press releases available in the public domain, project documents and meeting summaries from SAHAYOG, and data from the My Health, My Voice website.

KII, IDI, and FGD guides were developed based on the social accountability, participation, and informal payment literature (deductive) as well as the research questions. Representatives of SAHAYOG commented on the tools. All tools were pre-tested and revised as needed. The participant observation, IDIs, KII, and FGDs with MSAM women were conducted by SC, an Indian physician and doctoral student in socio-medical sciences. The FGDs with CBOs were led by JD, who was the Founding Director of SAHAYOG, and, at the time the research was conducted, a Strategic Advisor to SAHAYOG. Though JD's engagement raises some concerns about bias, JD's experience and commitment to organizational learning has enriched the research; she has considered the research questions from both a theoretical and an experiential perspective.

KII, IDI, and FGD transcripts were transcribed, translated, and saved in Nvivo 11. A native Hindi speaker checked the quality of the translations. Detailed notes were written in English about participant observation. These were also saved in Nvivo 11.

The transcripts and notes were analyzed using thematic coding. The initial list of analytic thematic codes was based on relevant theoretical and empirical literature related to social accountability, participation, and informal payments. Codes were modified following close review of all transcripts and discussion with JD, such that the final list included inductively and deductively derived codes (Attride-Sterling, 2001; Fereday and Muir-Cochrane, 2006). MS coded the data. Once the data were coded, MS developed thematic memos exploring the range and number of exemplars for the same codes, illustrating dimensions of the phenomena of interest (Gibbs, 2012; Becker, 1970)

MS then discussed conclusions with JD, triangulated the emerging findings among different theories and past empirical findings, and triangulated among methods, assessing to what extent to the participant observation, project reports, and FGDs suggested similar conclusions (Yin, 2014).

Institutional Review Board approval was obtained at Columbia University Medical Center as well as Sigma IRB in Uttar Pradesh.

## Findings and Discussion

### Project implementation

A description of the pilot phase of this project has been presented elsewhere (Dasgupta et al., 2015), and other papers discuss the ICT component of the project in depth (Chhabra et al., submitted; AMDD & SAHAYOG, 2014). In this paper, we focus our project implementation discussion on the ways in which SAHAYOG and partner CBOs adapted the project strategy over time. These changes were based on regular reflection and discussion about what activities engendered greater empowerment and satisfaction among MSAM members, as well as greater impact on the health system. SAHAYOG and the CBOs perceived low state capacity or willingness to address informal payments; they tried multiple approaches to shift the knowledge and incentives facing providers and managers. In addition to internal learning about what works, the implementers also responded to the changing context, such as the political stance of the party in power at the state level, and the political salience of public sector health care quality and corruption.

- **Functioning and accessibility of ICT:** SAHAYOG made several changes to make the hotline easier to use and to manage. These included decreasing the number of interactive voice response options so that women were less overwhelmed by options when they called, obtaining more than one line so that women never heard a busy signal when they called, and hiring an Indian (rather than a foreign) firm to manage the ICT component. SAHAYOG and CBO staff also noted that mobile phone penetration and network coverage had improved since the project began; initiatives starting now and into the future will likely have fewer problems related to tech literacy and access.
- **Increased campaigning:** The initial number of reports to the MS, MA hotline was fewer than expected, so SAHAYOG and the CBOs enhanced campaigning and outreach, consisting of pamphlets, community lectures and community theater, hoardings, and radio. They also hired

campaigners. These campaigners (and CBOs) targeted large gatherings of people, including cultural events, markets, monthly meetings of community health workers (ASHAs), colleges, schools, and other CBOs. The impact of this campaign was visible in disparate reporting rates; communities without campaigners had significantly fewer reports to the hotline. Importantly, campaigning also entailed directly supporting MSAM women to use phones to navigate the IVR system.

- **Feeding data and information back to the community:** Most MSAM women do not have internet access, and lack the literacy and numeracy required to read the project website. However, the entire MSAM project depended on MSAM women and other women from their communities providing data regarding their experiences with the health system. To contribute to further conscientization among MSAM women, and in order to maintain community engagement in reporting, SAHAYOG and the CBOs started to produce quarterly newsletters. These newsletters described the data, explained what the data showed, and summarized how SAHAYOG and the CBOs used the data for advocacy. CBOs and MSAM women presented and discussed these newsletters at MSAM meetings. The newsletters were shared with MSAM women, as well as with Medical Officers in Charge of the health facilities concerned, district officials, state officials, and the media.
- **Engagement with the Rogi Kalyan Samiti (RKS):** RKS Committees, an initiative of the NRHM, are hospital level committees comprised of health system stakeholders, including health facility staff, local elected officials, civil society representatives, and members of the media and the community at large. Among other functions, they are mandated to ensure the accountability of providers and health facilities to the community. The RKS Committees in most of the MS, MA catchment area appeared to be inactive at the beginning of the project. As the project scaled up, SAHAYOG worked to activate these Committees and to educate them about the MS, MA

data. Activating the Committees often entailed significant effort, including filing right to information requests to learn who the members were, contacting these members, and educating them about their role. SAHAYOG also filed right to information requests to learn about when and where RKS Committees met, what complaints the RKS Committees received, and how they addressed these complaints. To promote RKS Committee consideration of MS, MA data, SAHAYOG and the CBOs facilitated MSAM attendance at quarterly RKS meetings, where MSAM members presented the data to the entire Committee.

- **Proactively giving MS, MA data to health sector stakeholders:** Over time, it became clear that providers and managers rarely – if ever – consulted the MS, MA website. Thus, the CBOs began to publish quarterly facility-specific report cards summarizing the calls made to the hotline about the facility over the previous three months. CBOs shared these report cards with providers, with RKS members, and with District Health Society members. District Health Societies are responsible for coordinating the implementation of NRHM activities at district level; they include representatives of the health sector and the Indian Administrative Service, the permanent, professional bureaucracy of India. In addition to facility report cards, CBOs sent monthly district level data on complaints to district officials, RKS members, and the media, via SMS.
- **Media outreach:** SAHAYOG deepened media engagement by holding workshops with reporters and consistently inviting the media to block and district events, and, as noted, sharing the MS, MA newsletter and district data with them. In addition to data, SAHAYOG and the CBOs shared stories about informal payments with the media, as they felt testimonials were important to sway public opinion. In interviews, SAHAYOG staff suggested that they felt that media coverage created additional pressure on facility staff, district officials, and politicians. This pressure was

helpful even if it was not specific to informal payments, but regarding the broader issue of maternal health.

- **Institutionalize block level dialogues in the project:** SAHAYOG and the CBOs inconsistently held block level advocacy dialogues during the earlier phases. Later, these dialogues, which involved district level health officials, health providers, and community members, were held regularly. During the dialogues, the CBO would share the recent MS, MA data and explain the website, and then MSAM women would present recent cases of demands for informal payments as well as other maternal health challenges they faced. Health providers and decision-makers were asked to respond publicly.

SAHAYOG and the CBOs continuously changed their strategy to promote understanding of MS, MA data and its use in debate and policy-making; the utility of adaptive approaches has been well-established in the literature (O'Meally, 2013; Fox, 2015; Joshi 2013; Halloran, 2015; Holland et al., 2017).

After conducting an analysis of project costs, the number of complaints generated, and the seeming impact on the incidence of demands for informal payments, SAHAYOG discontinued the hotline in December, 2015. They decided that further investment was not efficient, particularly given the fact that the state government had started their own hotline relating to informal payments. The government explained that this hotline was inspired in part by MS, MA. Since SAHAYOG and the CBOs had conclusively established the problem of informal payments, they decided that further data collection would not necessarily be helpful. They continued to try to influence state and local level policy and practice by discussing the data at various official fora in which they participated.

As the MS, MA project wound down, SAHAYOG and the CBOs started to publicize the government hotline; the CBOs continue to do so. We are not able to track the functioning of the government hotline, as they do not release data regarding the number of calls made or the remedies provided.

## Project Impact

SAHAYOG and the CBOs adapted their strategy in order to better empower MSAM women and shift state willingness and capacity to respond. In keeping with SAHAYOG's and the CBOs' goals and our research questions, we group our findings and discussion into three broad categories: (1) impact on empowerment, (2) impact on the incidence of informal payments and related issues, and, (3) macro- and micro-contextual determinants of health system responsiveness.

### (1) Empowerment

We use Kabeer's concept of empowerment, "the process by which those who have been denied the ability to make strategic life choices acquire such an ability" (1999, pg. 1). Making choices entails exercising three inter-related capacities: resources (preconditions), agency (process), and achievement (outcomes) (Kabeer, 1999). For the purposes of this study, we focus on the knowledge components of resources, and the negotiation, voice, and mobility elements of agency. Achievements refers to the accomplishment of desired goals, namely the cessation of demands for informal payments and other improvements in the inter-personal and clinical quality of care. We address resources and agency here, and describe achievements in the section describing MS, MA's impact on the incidence of demands for informal payments.

Over the course of their up to 20 year engagement with MSAM, MSAM women, particularly those who had been members for a long time, have gone through repeated consciousness raising processes, as they learned about their rights and entitlements and successfully addressed priorities in multiple domains, such as ration distribution and the minimum rural employment guarantee. As low caste, poor women, new members often initially did not think of themselves as rights holders, or as having the "right to have rights" (Kabeer, 2002 pg. 12; Dasgputa, 2011). This self-perception evolved over time as MSAM women came to believe that health and social outcomes are not due to chance, but are matters of social justice which the state has the responsibility to address (Dasgputa, 2011). In

interviews, SAHAYOG and CBO staff emphasized how long this process of consciousness raising was; they continuously provided MSAM women with information, opportunities for discussion and reflection that translated into new resources. MSAM women leveraged these resources to exercise agency in their interactions with the MS, MA hotline, health providers, and the state more broadly.

In interviews and FGDs, SAHAYOG and CBO staff and MSAM women themselves emphatically communicated the multiple ways that their resources and agency had increased. They described a general sense of empowerment and loss of fear from their involvement in MSAM, as well as gains in knowledge and confidence specific to the health sector. Sometimes, they discussed MS, MA specifically, but more often, they referred to their engagement in MSAM in more general terms (i.e. not limiting themselves to the life of the MS, MA project).

*We have abandoned our fear from the day of joining the Forum [MSAM]. We were afraid of speaking out in the past. Now, we can talk to the Chief Medical Officer and speak from the stage using a microphone... our fear is finished now. (FGD with MSAM, Mirzapur).*

Women generally attributed their increased agency to the resources they had gained through MSAM.

*When they demand money, we say that it is against the rules. Then, they realize that we are the members of MSAM. Those who are not the members of MSAM cannot speak. They do not have information (FGD with MSAM, Azamgarh).*

Many women exhibited agency in their willingness to put themselves in uncomfortable, adversarial, or risky situations to assert their knowledge and claim rights. Several CBO staff and MSAM members described situations where women faced down threats in their refusals to make informal payments. MSAM women reported a variety of menacing situations, including providers threatening physical violence; mobilizing political allies against the family making a complaint; filing a false complaint

against the woman concerned; being rough with the laboring woman and/or the newborn; and, denying the woman care.

*Since they have to take money from us, they behave properly. They misbehave only if you refuse to give them informal fees. The enmity starts when we refuse to bribe them. They refuse to prepare a record of treatment if we do not pay informal fees... People do have a fear that if they refuse to make informal payments, doctors may kill our patients by poisoning them (FGD with MSAM, Azamgarh).*

Our data did not reveal any allegations of actual poisoning (just the fear of it), but we did hear multiple stories of women who identified as MSAM members being denied care, suggesting that providers punished those who tried to claim their rights. Sometimes women were able to negotiate to receive care anyway, sometimes not. For example, an MSAM leader accompanying her laboring daughter-in-law was recognized as an MSAM leader by the Medical Officer In Charge. He refused to provide care, and the MSAM leader countered that she was going to call his boss, the Chief Medical Officer.

Many women referred to this access to frontline providers' "bosses," whom they had met at dialogue events or contacted in the process of making complaints. This increased access to the state apparatus served as a resource, increasing MSAM women's negotiating leverage. They utilized this resource in public dialogues, where they interacted with "bosses" and provided personal testimony regarding demands to make informal payments and other negative experiences with the health system. Thus, despite threats, many MSAM women persistently engaged the health system and demanded responsiveness. Such persistent engagement was enabled in part by public dialogues. Public dialogues were structured according to rules that tried to minimize the relevance of embedded hierarchies; women of all castes and classes were theoretically able to speak to providers and district officials. For women, these facilitated interactions constituted a new 'social space,' wherein marginalized women

could enact new identities nurtured by MSAM (Scott et al., 2017; Nagar, 2000). Over time, repeated interactions such as these can “socialize the poor into potentially constructive relationships with...the policymaking state” (Whitehead and Gray-Molina, 1999, pg. 5; Bulestra and Dasgupta, forthcoming).

MSAM members understood changes in their resources and agency in the context of their longer-term engagement with MSAM.

*It has been ten years since we are associated with the organization. It was essential to join it.... We learned how to register our complaint in Lucknow through mobile phones. We also learned about human rights. Initially, we were fearful but now we can threaten the ASHA [CHW] and ANM [frontline midwife who supervises the ASHA] in the name of registering a complaint (FGD with MSAM, Mirzapur).*

Empowerment does not occur solely in relation to the health system; MSAM women claimed their rights in a dynamic context of gender, caste, religious, and political relations. There is widespread agreement in the empirical literature on social accountability and participation that women’s political capabilities are mediated by gendered social norms within the household and the community (Holland et al., 2016; Bulestra and Dasgupta, forthcoming; George and Branchini, 2017). Although most of the discussions in our interviews and focus groups centered on interactions with the health system, MSMA women regularly referred to these wider social norms. They indicated that the empowerment they felt was not just vis-à-vis the health system. Some – though not all - noted that they felt liberated from husbands and/or mothers-in-law who were opposed to their mobility and to their engagement in political matters outside the home.

*Family members discourage us. When I came to the meeting for the first time, I had informed my husband. But, when I went back, he slapped me. When I argued, he started beating me, and kicked me out of the home. Then some of the members went to my home and convinced him. (FGD with MSAM, Mirzapur)*

In sum, in our research sites, MSAM women manifest increased resources and agency; they developed this over a time frame well before MS, MA began, and they sometimes fought to claim their rights despite significant opposition.

(2) Impact on the incidence of informal payments and related issues

Kabeer describes resources, agency, and achievement as indivisible components of empowerment (Kabeer, 1999). SAHAYOG and CBOs felt that increased knowledge and opportunities to use that knowledge were important goals, but they also realized that failure to impact the incidence of demands for informal payments (achievement) would undercut community engagement, and ultimately empowerment.

MSAM women described being asked to make informal payments to receive care, to see the newborn, to be discharged from the facility, to take the ambulance to the facility to deliver, to receive the JSY check (a conditional cash transfer for giving birth in a facility) and for the labor room to be cleaned. Many were asked to procure from outside pharmacies the medicines that the health facility was mandated to provide. SAHAYOG and the CBOs believe that in many of these cases, private pharmacies provide kickbacks to the prescribing providers, though in some cases the health facility may actually be stocked out of the drug in question.

SAHAYOG, the CBOs, and MSAM women successfully educated or convinced some state, district, and facility staff about the frequency and impact of informal fees. As a result of what they learned and/or the pressure SAHAYOG and the CBOs brought, these officials made administrative allowances to address informal payments, such as issuing orders mandating discussion of MS, MA data in regular meetings, and mandating CBO participation in various forums. For example, the Uttar Pradesh NRHM Mission Director issued a letter asking that RKS Committees discuss MS, MA data at their meetings. Chief Medical Officers reissued this letter to Medical Officers in Charge of health facilities, asking them to ensure implementation at facility level. One District Program Manager reported that the facilities in

his jurisdiction outsourced diagnostic tests to prevent demands for informal payments for laboratory tests. Many interviewees mentioned that some health system managers asked frontline health providers to explain why MS, MA data showed persistent demands for informal payments.

According to CBO and MSAM women, district and block level dialogues resulted in short-term (2 week -3 month) reductions in demands for informal payments from MSAM and non-MSAM patients, as well as improvements in other domains that had been raised at the dialogue. These changes were more likely to occur when many women attended the dialogue, as well as when higher-level officials attended. Improvements included better ambulance service in rural areas; the installation of solar lights and generators in remote facilities; cleaner facilities; new equipment in maternity wards; the provision of conditional cash transfer checks to maternity patients without their paying a bribe; and the provision of food to in-patients, as stipulated by policy. In some cases, hospital staff returned money to patients. Due in part to the public nature of the dialogues, the CBOs explained that they could shame providers into participating and to following through on commitments made during the dialogues.

The hotline also included an emergency number for urgent cases; this emergency line resulted in immediate aid for callers. The emergency number was staffed 24 hours per day by CBO employees. There were many examples of emergencies being addressed, often because the CBO representative on call contacted someone above the offending provider in the hierarchy. For example, a woman being denied a blood transfusion, a skeptical woman being told she needed an urgent cesarean section and she needed to pay for it, and multiple women being denied care because they were allegedly presenting at the health facility “too late” in their deliveries had their problem addressed immediately. This immediate responsiveness helped to maintain community support for the project.

As a result of regular interactions with health sector officials at block, district, and state level, the CBOs and SAHAYOG enjoyed greater visibility and cooperation vis-à-vis official structures. SAHAYOG input was regularly solicited by state level entities. SAHAYOG employees reported that they felt that

most policy-makers perceived SAHAYOG as an organization providing relevant, authentic data from the grassroots.

Against this backdrop of increased knowledge and commitment at the mid and upper levels of the state health system, public dialogues, and increased SAHAYOG and CBO engagement in policy-making and policy monitoring, MSAM women were able to use their resources and agency to avoid making informal payments. Women who asserted their rights were mostly able to avoid making payments, though some faced retaliation.

*When I took my daughter in law to the hospital... the staff demanded 500 rupees and I was asked to go and buy a medicine from outside. When I scolded them, the Auxiliary Nurse Midwife [ANM] started arguing and said that things may go out of stock anywhere. Then I replied that you should take care of the things going out of stock and should bring them before they are finished. I also made a telephone call to the CBO... [the ANM] refused to talk [to the CBO] but she also abandoned her demand for money.*

Non-MSAM women accompanied by MSAM women (or by a representative of the local CBO) were also largely able to avoid payments. These changes spilled over to the general population in limited contexts; for example, FGD participants reported that lower caste women – MSAM members or not - were now less likely to be asked to pay for the cleaning of the labor room after delivery, a practice that had been routine. As testament to MSAM's informal regulatory power, in some facilities, health facility staff tried to obtain explicit MSAM member support for urgent patient referrals, in order to show that the transfers were needed and consensual.

However, despite the facility-level changes following dialogues and SAHAYOG and the CBOs' increased participation in policy discussions, MSAM, CBO, and SAHAYOG representatives agreed that demands for informal payments from non-MSAM women did not decrease over the long term; there

was little system change. The CBOs and MSAM reached this conclusion in part by informally asking women about payments after they left health facilities.

In an FGD, an MSAM member described this lack of progress:

*Many of us went to the hospital, we demanded that informal money should not be taken from us. We had several meetings on these issues. Staff say that they will not take money again but things go back on the same track once again. Doctors have assured us many times that they will punish those who demand money. But, everyone is a culprit there. (FGD, MSAM members, Azamgarh)*

Participants summarized the situation similarly at an FGD for CBO members in Azamgarh. Those who know their rights can sometimes avoid paying, but others can not:

*Interviewer: Is there any change in the situation? Do such incidents occur less now?*

*Respondent 1: Staff cannot take money from those who know their rights and entitlements. Such people fight and do not pay informal money. Otherwise, they demand [money] in the name of celebration...*

*Respondent 2: Those who fight until the end can save their money, but not all of us are able to do that.*

As a result of this lack of progress, reporting to the hotline went down. The campaign was based on the premise that the data could foment system level change. Not seeing improvement, women were less motivated to report, and were less optimistic about their ability to effect change. Many expressed the following sentiment in interviews and discussions:

*We are now tired of attending dialogues and complaining. Everything becomes the same after a temporary change. (FGD with MSAM, Azamgarh).*

As SAHAYOG and CBO staff explained in interviews, decreases in reporting gave the government an excuse to claim that demands for informal payments had decreased. The hotline began to slide into

irrelevance, as fewer women reported or were motivated to do the hard, risky work of complaining about informal payments. Lack of achievement did indeed undermine resources and agency.

### (3) Macro and micro contextual factors shaping state responsiveness

Despite their increased resources, agency, and achievements in many domains, such as in securing better access to rations for the poor and the minimum employment guarantee, MSAM women had fewer achievements in the domain of informal payments. Health providers and the system overall were responsive to demands regarding informal payments on a limited basis.

The contextual factors shaping state responsiveness are less explored than the community dynamics of social accountability, though response is germane to the success of an effort and to continued engagement from the community (Joshi, 2014; Fox, 2015; Lodenstein et al., 2016). In this section, we discuss macro and micro features of the context that influenced health system responsiveness related to informal payments. The contextual factors that arose from our data are broadly similar to what has been identified as contextually relevant in other settings, including “broad features of the political economy,” (Joshi, 2013, pg. 7; Grandvoinet et al., 2015). We examined how they are manifest at national and subnational levels, including caste, provider commitment to ending informal payments, the embeddedness of informal payments in the health system, human resources scarcity, the overlapping private interests of pharmaceuticals and providers, and regional development. Because they offer insight into how to foster success, we also examine a few examples of individuals who influenced health systems responsiveness.

Many MSAM, CBO, and SAHAYOG interviewees indicated that lower caste women had fewer opportunities to exercise agency and to realize achievements than higher caste women, as their rights and opinions were not held in the same regard as those of others. As explained by a Dalit MSAM women in Azamgarh:

*If N [a higher caste woman] complains about something, people are not going to say anything. But, if I make the same complaint they will call me all sorts of names and hurl abuses at me (MSAM woman, informal discussions in Azamgarh)*

No one suggested that caste make up *per se* explained differences between project sites. However, CBO and SAHAYOG staff explained that lower caste and scheduled tribe women were at a disadvantage in all arenas of rights claiming, and were potentially more likely to be asked to make informal payments. Moreover, it appeared that some heterogeneous MSAM groups may have been less durable. Members of one MSAM group we visited explained that they no longer met without explicit CBO facilitation and support. The elected head of this group was lower caste, and upper caste women would not attend meetings she called absent the external coordination and legitimacy conferred by CBO engagement. In other words, the meeting no longer served as an alternative 'social space' where new terms of engagement could be tested.

As noted, there was some evident high-level commitment to decreasing informal payments at the state level, as NHM leadership expressed their support for the project and asked for SAHAYOG input into multiple policy-making processes. This commitment was buttressed by changes in the political context, as, shortly after the project began, new policy-makers relaxed restrictions on NGOs and focused more resources on fighting corruption. When district officials were asked why this central level commitment did not engender commitment among frontline providers, they referred to technocratic and logistical barriers, such as lack of required computer skills to look at the MS, MA website and lack of time. District officials, SAHAYOG, and the CBOs also cited poor communication between the central level of the state and districts. However, some frontline providers and medical officials did not change their behavior because they did not agree that informal payments were deleterious. About half of the district officials and senior managers disagreed with the premise that informal payments were problematic, stating that it was acceptable for service providers to demand informal payments, as poor

women received a conditional cash transfer if they delivered their baby in a health facility, and, if women were not asked to pay, they would overuse medical care. Some claimed that women's expectations were too high, or, that if women did not want to make informal payments, they should simply refuse to pay them.

Interviewees and focus group discussion participants offered many more reasons, with many converging on one key point: there is a complex "nexus" of financial exchanges that few providers and managers are motivated to change. The word "nexus" was used frequently by health providers, health managers and officials, CBO staff, and MSAM women. Informal payments are deeply embedded in the health system, such that it may be more difficult to obtain responsiveness in this domain than in others. The nexus presents a collective action problem: individuals face strong pressures to continue demanding informal payments, as these payments are a central part of the way the health system functions (Persson et al., 2013). Providers faced few incentives to be one of few who do not demand payments, and they may upset colleagues who expect spoils to be shared. Women may face pressure to continue to make payments, as those who do pay receive better quality care more quickly. This segmentation of the market between those who can and those who cannot pay has been well documented in the empirical literature globally, with those making payments often feeling they have little choice but to pay (Schaaf & Topp, submitted).

Among providers, several phenomena feed the nexus. First, as has been detailed in the peer-reviewed literature, interlocutors of various types explained that many providers pay for their position (La Forgia et al., 2015; Purohit et al., 2016; Schaaf and Freedman, 2013). Providers thus wanted income from informal payments in order to pay to stay where they are, or to pay for a more desirable posting. Second, some interviewees speculated that providers who levied informal fees were indebted to their superiors or to other decision-makers, perhaps for obtaining a post or for superiors' overlooking transgressions. Third, the nexus could expand, neutralizing potential whistle blowers or opponents. For

example, SAHAYOG and the CBOs initially assumed that ASHAs would be natural allies of MSAM and MS, MA. This was rarely the case, and some SAHAYOG and CBO staff concluded that the principals of the nexus co-opted ASHAs by allowing them to charge their own informal fees. We did hear scattered reports of ASHAs preventing CBOs from entering villages to conduct awareness raising on entitlements and the MS, MA project. ASHAs may have been more vulnerable to co-optation because the amount of compensation they received from the government had decreased in recent years, so several interviewees reported that they became more willing to seek payments directly from women.

Mid and senior level managers claimed that because of the nexus, their ability to sanction the providers demanding payments was limited. The nexus was not confined to a health facility; financial relationships often related to broader political dynamics in the community. Thus, political power could be deployed to maintain the status quo. Indeed, political patronage was ubiquitous in discussion, with managers claiming that they were unable to sanction many employees who were below them in the hierarchy because these individuals had political connections they could use to get the manager transferred. Providers who had lived in a region longer reportedly had stronger political connections, making them more impervious to discipline. The nexus seemingly had the effect of flattening the hierarchy for most (not necessarily for those with the least power, such as ASHAs) such that everyone owed everyone something; as one district official in Azamgarh described, “everyone has a jack” he can deploy to avoid accountability. Managers reported disciplinary workarounds, such as “managing on the inside,” or resolving the problem by reaching a compromise with the employees concerned – sometimes by dividing up the spoils.

MSAM women, in contrast, had few political connections, and few “jacks” to deploy.

*Q: Is it more important to have a good connection with some influential people than complaining?*

*A: Yes. Nothing is possible when you do not have a strong connection*

*(Azamgarh FGD with MSAM women)*

Officials and managers stated that the nexus was even stronger in a setting of very limited human resources. For example, one district official explained that he was not in a position to punish a doctor who violated policies in the understaffed hospital. Providers in such contexts are in a strong negotiating position. A District Program Manager from Azamgarh elaborated more fully:

*We cannot take direct action against the staff, as the number of staff is already less than what we require. If we did [take action], the services which are available today would not be available tomorrow. They have built up a strong nexus among themselves. We cannot take any action against any of them; if they are suspended for even two three days then we won't be able to provide even basic facilities to our clients. We could have taken action only if there were a good number of doctors available there. (IDI, District Program Manager, Azamgarh)*

While there was widespread agreement among different types of interviewees and FGD participants that a nexus existed and that this nexus nurtured informal payments, we interpret manager explanations of why they were unable to address informal payments with some skepticism. SAHAYOG and CBO staff speculated that managers try to attribute informal payments solely to lower level staff in order to obscure their own role in it. Some managers may benefit from informal payments indirectly or directly, or they may engage in their own corruption that health providers know about, so they do not dare to stop frontline providers. A limited number of managers substantiated this view, as they explained that demands for informal payments at the point of service was a visible form of corruption that patients saw, but that it was the last link in a long chain of corruption.

The nexus also applied to the prescription of medicines from outside pharmacies, which was one of the most ubiquitous forms of informal payments. To decrease patient opposition to purchasing these drugs, it appears that providers fed widespread myths that government-supplied generic

medicines are of poorer quality and less effective. Patients would thus be more willing to purchase 'quality' medicine from the outside. While we did not explore this angle in our research, recent research in India suggests that pharmaceutical companies also propagate this false narrative, while independent testing reveals that government supplied generics are of comparable quality to branded medications (Aivalli et al., 2018). The myth seems to have penetrated the community; many MSAM women reported that government medicines were of lower quality.

Thus, in confronting informal payments, MSAM women were confronting a practice that is closely related to the dynamics of economic and political power in Uttar Pradesh. We do not mean to suggest that health system employees have no professional or moral values or that formal rules are of no consequence. Rather, we learned how informal rules are also quite salient. Social accountability efforts often occur "not in the absence of the 'standard model' of bureaucratic and political accountability, but among its ruins and/or in the gaps it leaves" (Nisbett et al., 2017, pg. 13). In a context where many providers may disagree that the stated target of the campaign – informal payments – are a problem, most people working in the system are unwilling to use their "jack" to address this particular issue. This is apiece with empirical literature concluding that the nature of the challenge to be addressed by social accountability efforts shape health system responsiveness and willingness to engage in the project (Lodenstein et al., 2016; Feruglio, 2017; O'Meally, 2013).

Some successes were partly attributable to individual people. As described in a recent synthesis of ethnographies of bureaucracy, government and non-governmental organizations are comprised of people who differ by more than "simply their hierarchical position" (Hoag and Hull, 2017). The Director of the CBO in Azamgarh developed a reputation as being very honest and dogged, in part by investing enormous time in building relationships with providers and managers. When a committed IAS officer realized how much the CBO Director knew about ground realities, he invited the Director to become a permanent member of the District Health Society, and to attend the District Nutrition Meeting, The

District Quality Assurance Committee, the ASHA Mentoring Group, the RKS meetings, and, the Maternal Death Review Committee. This gave him more opportunities to share data, to advocate, and to build pro-accountability coalitions. Similarly, at a Primary Health Center in one project site, the MOIC made ANMs rotate in and out to provide midwifery services, never long enough that they could build up the political capital necessary to demand informal payments. These individuals shaped the context and trajectory of MS, MA in their sphere of influence.

Finally, SAHAYOG staff repeatedly emphasized the differences in project uptake, buy-in, and impact in Mirzapur and Azamgarh. The geographic remoteness of Mirzapur, as well as its generally lower level of education and wealth, meant that it was more difficult for the CBO to keep MSAM women engaged, and more difficult for the CBO to travel to those villages to educate and support MSAM. This remoteness also affected NRHM ability to improve the quality of care, as training and supervision were more difficult in this geographic context, and perhaps because NRHM staff tried to avoid postings in Mirzapur. The impact of this was visible to the CBO, which, for example, attended the ASHA training and support meetings to assist because government facilitation was inadequate. Azamgarh, in contrast, is easier to navigate, facilitating the Azamgarh CBO's ability to forge the strong relationships that enhanced the project.

## **Conclusion**

SAHAYOG and two CBOs launched MS, MA to address an intransigent problem that MSAM women had identified as a priority. Over the life of the project, SAHAYOG and the CBOs adapted their strategy to enhance project impact. MS, MA engendered greater resources and agency for MSAM women; women learned about their entitlements, had access to mechanisms for complaints, and, despite risk of retaliation, many felt capable of demanding their rights in a variety of fora. MSAM women did achieve successes in that they were mostly able to avoid making informal payments to the

health sector, but they largely were unable to effect this change for women in the community at large. MSAM women and the CBOs perceived their work on informal payments to be somewhat unsuccessful.

In the context of increasing focus in global health and development on how civil society and advocates can create and leverage countervailing power to make health systems more accountable, the MS, MA experience offers important lessons and questions. Some of these lessons are consistent with the emerging evidence base on social accountability. A recent synthesis of health provider responsiveness to social accountability efforts in health in low- and middle-income countries found that corruption and quality of care for poor women was a common domain of failed responsiveness (Lodenstein et al., 2016). Among other attributes, failure was more likely in contexts where providers: view patients as users, rather than citizens; do not fear repercussions from important third parties; and do not feel morally obligated to address the issue at hand (Lodenstein et al., 2016). These are all general trends across countries and contexts, but it is noteworthy that they were largely corroborated in our research.

As we and others have found, in the case of social accountability for health, contextual factors – which are often set aside as “noise” in evaluations of health programs - can be at the heart of the social accountability project. The specific tactics groups take matter of course, but the real question is how and when these tactics stimulate change in the context, including power dynamics among state actors, political actors, and civil society actors. How can the alternative social space enacted at public dialogues contribute to sustained change and deepened democracy without outside CBO engagement?

Beyond the extant evidence base, our study proffers new questions and propositions for further research. First, MS, MA was embedded in a long-term effort to increase poor, low caste, Muslim, and Tribal women’s empowerment. Almost all interviewees reported that resources and agency had improved over time, and that there had been greater achievements in domains other than informal payments. Thus, rather than thinking of MS,MA as a failed project, we can think of it as a less successful

component of a much larger effort. Second, SAHAYOG employed a vertically integrated approach, and they were arguably fairly successful in their state and district level efforts. Yet, some SAHAYOG staff mentioned that their increasing success in state government engendered resentment at the facility level. To be sure, the rich descriptions of the informal payment nexus suggested that the problem was felt at the frontlines, but shaped by the accountability ecosystem within the larger health system and political economic context. How to generate countervailing power for such issues – particularly when they affect a politically marginalized segment of the population – is not apparent. It is possible that more of the same – more media coverage, more dialogues to share experiences with providers and to enact new identities, and more pressure on decision-makers – would generate more change. It is also possible that particular strategies for embedded collective action challenges such as informal payments are needed. This might include specific efforts to support labor organizing and alliances with frontline providers, broad-based campaigns to fund the health sector appropriately, and, in the case of electoral democracies such as India, broad-based electoral campaigns.

Third, social accountability has been criticized for elite capture (Joshi, 2013). There is little literature in social accountability about the distribution of the benefits to various groups, but much of the literature describes general community processes that may exclude just the type of women who join MSAM. Community level processes are often dominated by village leaders and others with more power, with those filling gender and other quotas often accorded little more than a token role (Nesbitt et al., 2017). MS, MA avoided this problem, in part by explicitly targeting the most marginalized, and by focusing on violations (i.e., being asked to make an informal payment) rather than a list of priorities identified through community deliberation, which is much more vulnerable to capture. This focus on the non-elite may explain some of the particular challenges MS, MA faced and suggests that the project may be somewhat distinct from much of the growing evidence base on social accountability for health. Fostering increased resources and agency was a long process, with many women not perceiving

themselves as rights holders. Changes were manifest in the social space of public dialogues, and powerfully in patient assertions of rights in interactions with providers. Yet, providers have not necessarily embraced this notion of low caste, tribal, or Muslim women as citizens with entitlements, especially in the context of free government services for childbirth.

In brief, SAHAYOG assumed a supremely difficult task. Project strategy changes may have made the task somewhat less difficult, but given the population making the rights claims and the rights they were claiming, a strategic, watchdog approach may require a much larger and stronger coalition, thus generating more than rhetorical commitment and scattered genuine commitment among health system actors.

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**Paper 3: The patient and provider are friends: a case study of Namati’s legal empowerment program  
in Mozambique**

## ABSTRACT

This paper is an explanatory case study of a hybrid legal empowerment and social accountability effort led by the Mozambican NGO, Namati Moçambique. Established in 2013, Namati Moçambique runs a multi—pronged health paralegal and policy advocacy program that employs community paralegals as Health Advocates and trains Village Health Committees (VHCs). The study sought to uncover how the program affected the relationship between citizens and the health sector, how the health sector and citizens responded, and what role contextual factors played. The case study had two components: 1) a retrospective review of 24 cases 2) qualitative investigation of the Namati program and program context. The cases came from a total of 6 sites in 3 districts. Program implementers, clients, Village Health Committee (VHC) members, and health providers were interviewed or participated in focus groups as part of the research. The study found that though they were unable to address some deeply embedded national challenges, Health Advocates successfully solved a variety of cases affecting poor Mozambicans in both urban and rural areas. Health Advocates took a variety of steps to resolve these cases, some of which entailed interactions with multiple levels of the government. We identified three key mechanisms, or underlying processes of change that Namati’s work engendered, including: bolstered administrative capacity within the health sector, reduced transaction and political costs for health providers, and provider fear of administrative sanction. In addition to case resolution, stakeholders highlighted individual satisfaction at having one’s complaint remedied and individual empowerment among clients and Health Advocates as stemming from the project. Health Advocates and VHCs developed functional working relationships with providers, in part because they addressed issues that providers felt were important, and engendered community satisfaction with the Health Advocate, and ultimately, trust in the health system. The case resolution focus of legal empowerment brought procedural teeth, helping to ensure that new relationships result in immediate improvements, thus instigating a circle of relationship building and health system improvements.

## INTRODUCTION

By the close of the MDG era, health care in low- and middle-income countries (LMICs) had improved in ways that affect millions of people. Between 1990 and 2015, there had been significant gains in maternal mortality, HIV, TB, vaccination coverage, and treatment of childhood illnesses (Alkema et al., 2016; WHO & UNICEF, 2014; Prendergast et al., 2015; Sidibe et al., 2014; UNAIDs, 2015; WHO, 2015a; Raviglione and Sulis, 2016; Liu et al., 2017; Bustreo et al., 2015). Despite this progress, the global health project is far from complete. MDGs and other consensus objectives related to maternal mortality, water and sanitation, TB, and other areas were not met (Satterthwaite, 2016; Alkema et al., 2016; Raviglione and Sulis, 2016; WHO 2015b). In some contexts, health management information system data suggested that services were available and utilized, but outcome data and on the ground observations revealed that the quality of clinical and interpersonal care was abysmally poor (Campbell, 2016; Kruk, Pate, and Mullan, 2017; Bohren et al., 2015). Moreover, many of the upstream social determinants of ill-health – from race, gender, ethnic, and caste hierarchies to generalized exclusion of the poor – persist; these are increasingly the topic of explicit research and programming (Kapilishrami et al., 2015; Patil, 2014; Mumtaz et al., 2014; Arcaya et al., 2015).

In this context, health and development funders and implementers seek, fund, and study strategies that 2017; Hankivsky et al., 2017; Shelton et al., 2017). Legal empowerment and social accountability are two such approaches. This paper is an explanatory case study of a hybrid legal empowerment and social accountability effort led by the Mozambican NGO, Namati Moçambique.

### Legal Empowerment

Legal empowerment grew in part out of the recognition that top down efforts to build the capacity of the legal system may be insufficient to effect change in people's lives. Legal empowerment consists of bottom up efforts to help marginalized people to learn about law and policy, and to use this knowledge to obtain concrete improvements in a relatively short period (Goodwin and Maru, 2017).

Legal empowerment activities can address individuals or collectives (Domingo and O’Neil, 2014; Maru, 2006).

Training and deployment of community paralegals or ‘barefoot lawyers’ are one of the most common legal empowerment tactics. Often, paralegals come from the very communities they serve (Domingo and O’Neil, 2014). They function essentially as problem-solvers; they try to bring the remedies enshrined in law and policy closer to marginalized communities by working with clients to shepherd complaints through the formal or informal administrative or legal system (Joshi, 2017; Feinglass et al., 2016; Maru 2006). Community paralegals may also engage multiple elements of the state apparatus (e.g. ombuds office, Ministry of Health, Ministry of Social Protection) at multiple levels (e.g. local facility, district, national).

Existing research suggests that community paralegals have great potential, but the number and scope of studies is limited (Goodwin and Maru, 2017). The impacts documented in the peer-reviewed and grey literature include client empowerment, the confirmation and extension of formal legal rights, and policy change (Domingo and O’Neil, 2014). Findings on legal empowerment and the health sector specifically comprise increased entitlements knowledge, more polite treatment, improved functioning of health clinics, and gains in physical health (Goodwin and Maru, 2017; Feinglass et al., 2016). However, there are few peer-reviewed studies of legal empowerment overall, and even fewer discussions of community paralegals as agents for legal empowerment for health (Joshi, 2017).

#### Hybrid legal empowerment/social accountability approaches

An increasing number of organizations intentionally combine elements of legal empowerment and social accountability approaches. Joshi and Houtzager’s definition of social accountability includes the major attributes described in the literature; social accountability is: “ongoing engagement of collective actors in civil society to hold the state to account for failures to provide public goods” (2012 pg 15). Common tactics of social accountability efforts include organized public dialogues with decision-

makers, service providers, and community members; community scorecard programs; and community monitoring of government services.

Legal empowerment and social accountability share similar principles and objectives, including long-term community empowerment, raising awareness about rights and entitlements, and action to demand responsiveness from the health system (Joshi, 2017). The tactics of each approach are slightly different, however, and together, may work in synergy. Social accountability brings collective mobilization, while legal empowerment brings concerted focus to resolution and remedy (Joshi, 2017; Maru, 2010). Social accountability may include efforts to proactively address underlying governance challenges, while legal empowerment – particularly paralegal programs - is usually understood to reactively address violations that arise.

There is some basic grey literature on this combined approach, donor interest in exploring it (Ezer et al., 2015; Abdikeeva, 2016), a peer-reviewed article that argues for combined approaches (Maru, 2010), and a peer-reviewed article that synthesizes program experiences in several countries (Joshi, 2017). In-depth research is timely (Ezer et al., 2015; Abdikeeva, 2016).

#### Paper objective

Established in 2013, Namati Moçambique runs a multi—pronged health paralegal and policy advocacy program in Mozambique.

Our case study sought to answer the following questions:

- How does Namati Moçambique’s combined community paralegal and social accountability project affect the relationship between citizens and the health sector? How does the health sector respond? How do citizens respond?
- What organizational and contextual factors facilitate or hinder positive change in the health sector in response to the program, particularly at facility and district level?

In exploring these questions, we intended to draw preliminary conclusions about legal empowerment as a means to improve healthcare quality, and to propose avenues for future research.

## **STUDY CONTEXT**

### Mozambique

After enduring a civil war from 1977 until 1992, Mozambique has achieved significant progress in human development and public health, including maternal and child mortality and HIV treatment scale-up (Bailey et al., 2015; Milagre, 2016; Feinglass et al., 2016; Rodriguez Pose et al., 2014). Nonetheless, the current situation in several domains is bleak, as the continuing HIV/AIDS epidemic, structural adjustment, and other factors undercut investment and progress made in the early 1990s (Maes and Kalofonos, 2013). Mozambique is ranked 181 out of 188 countries on the Human Development Index (UNDP, 2016).

At present, the number and distribution of health care workers is insufficient to serve the country, and many Mozambicans must travel long distances to reach a health facility (Schwitters et al., 2015; Rodriguez Pose et al., 2014). Patients who do access care often experience poor quality of care, including provider absenteeism; demands for informal payments; poorly trained and supervised providers; frequent drug and supply stock outs; inadequate infrastructure; and disrespectful, discriminatory care (Wagenaar et al., 2014; Feinglass et al., 2016; Madede et al., 2017; Betran et al., 2018; Rodriguez Pose et al., 2014). Such care can affect clinical outcomes, patient satisfaction, community willingness to use the health system, and trust in government services (Bohren et al., 2015; Feinglass et al., 2016). National data bear out the repercussions of poor quality; for example, adherence to HIV treatment is low and maternal mortality remains stubbornly high (Blevins et al., 2015; Groh, 2011; WHO, 2015b). There are few structured opportunities for patients and communities to provide feedback or to demand more from the health system. The Ministry of Health has created Village Health Committees (VHCs), but reportedly, these Committees do not meet regularly, if at all. Suggestion boxes

exist but are rarely consulted, and the poor generally lack awareness about their health rights and entitlements (Feinglass et al., 2016).

### Namati

Namati Moçambique's overall objective is to build community capacity to demand access to quality healthcare and governmental capacity to design and implement policies to provide that care. The program strategy involves: (1) increasing community awareness of health policy, (2) strengthening community involvement in health facility governance, (3) pursuing solutions to specific breakdowns in health care delivery, and (4) using grassroots data to impact national policy and practice. By design, this includes a downstream approach of reacting to problems that arise at the local level, and proactively engaging at the national level to address the upstream causes of these problems. Namati also intends for local level solutions to prevent further cases of a similar nature.

Namati implements their strategy through a cascade of paid staff working at multiple levels of the health system. The organization currently has 32 Health Advocates posted in 18 of Mozambique's 128 districts. Health Advocates are hired and trained to work as community paralegals. Advocates focus on the first three activities above, and they base their work on the Mozambican Charter on Patients' Rights and Obligations; the Law on Protection of the Individual, the Worker, and the Candidate for Employment Living with HIV and AIDS; particular articles in the Constitution, and, Ministry of Health policies and protocols. Namati has created a Health Advocate guide that describes these laws and policies and specific tactics Health Advocates can employ to achieve their objectives. Advocates conduct information sessions regarding basic health literacy, health rights and entitlements, patient responsibilities, and the Namati program. They educate groups of patients in health facility waiting areas; students in schools; and, members of VHCs, grassroots organizations, and community-based HIV treatment support groups. They also go door-to-door to educate community members at large. Each Health Advocate is responsible for between one and three health facilities, depending on patient

volume and geographic coverage. Health Advocate catchment areas range from 10,000 to 120,000 people, with larger catchment areas in urban and peri-urban areas.

In addition to awareness raising, Health Advocates also work directly with various health sector governance committees. Of the existing committees, Health Advocates spend the most time working with VHCs; Namati now works with 57 VHCs on an ongoing basis. Specifically, Advocates provide training and ongoing support to VHCs so that they host community and health facility dialogues, play a more active role in monitoring system performance, and advocate for community health priorities. They also work with VHCs to conduct bi-annual health facility assessments. These assessments, which have been formally recognized by the Ministry of Health, include an objective assessment of facilities, as well as subjective input from health facility staff and the community.

Finally, Health Advocates identify and address individual and collective patient complaints, or cases. Collective complaints, defined as issues affecting more than ten people, are often identified in conjunction with VHCs. Namati seeks cases that constitute examples of state failure to meet standards, which is a reactive approach. However, in some contexts, Health Advocates and VHC members almost recruit collective cases, such that they end up addressing the needs of individuals who had not intended to come forward with a complaint. For example, they VHC members might take an issue identified through the bi-annual health facility assessment and make it a case, with the designated client being a VHC or community member. This more proactive approach goes beyond traditional reactive grievance redress strategies.

Advocates work with the complainant or the VHC to shepherd these concerns through the administrative system, ranging from dialogue at the health facility concerned to seeking redress from a range of institutions. Table 1 shows the breakdown of cases from March 2013 to November 2017. While the percentage of collective cases has increased over time (going from 36% in 2013 to 89% in 2017), the distribution of cases among the various domains has remained roughly static.

The Health Advocate determines when a case is officially resolved. Depending on the nature of the case, the Advocate verifies that a case is resolved through observation, informal patient exit interviews, or discussions with the Director of a health facility.

Infrastructure and equipment cases encompass instances where critical inputs or health facility requirements, such as working toilets, running water, gloves, ambulance service, or general cleanliness, are lacking. Medicines denotes stock outs and inadequate allocation of medicines to a particular facility or to a patient. Provider performance refers to clinical and interpersonal issues that patients and Health Advocates can assess, such as provider demands for an informal payment, provider absence or tardiness, disrespectful or abusive treatment, failure to provide a patient with information, or refusal to provide services.

Health Advocates who are unable to resolve cases within a specified period (the timeframe varies according to the category of the case) seek assistance from one of the three Namati Program Officers. Program Officers build relationships with MoH staff at the district and provincial levels. They in turn are supported by senior Namati program staff in Maputo. Senior staff provide ongoing support and bi-monthly training to Health Advocates, and create new tools based on field data and experience. For example, given widely voiced concerns about informal payments and the difficulties encountered in documenting these, Namati created a brief guide for Health Advocates on how to detect and address bribery in healthcare. In addition, national staff use learning from field programming to draft and disseminate policy briefs and lead ad hoc civil society coalitions at national level. This has in turn led to Namati providing technical assistance to the Ministry of Health in developing new policy, in operationalizing existing policy through the development of practical tools, and in developing training curricula for pre-service and in-service education. Thus, Namati's national level work uses field learning to address the upstream determinants of quality of care challenges. At present, Namati Moçambique employs 59 staff, including the Health Advocates.

The current study focuses in particular on the work of Health Advocates, but their work is inseparable from the larger context of Namati's strategy.

### Conceptual approach

Namati Moçambique and other legal empowerment programs aim to effect immediate, concrete change through the resolution of cases, and to parlay case related changes into wider improvements in governance at local and national level. Very little research has been undertaken on legal empowerment for health, so we lack evidence about exactly how cases are resolved, as well as how the resolution of cases might contribute to broader changes in a health system. Moreover, legal empowerment research has also barely considered the impact that legal empowerment might have on state-society relations, though this might be an integral element of organizations' theory of change, including Namati Mocambique's. The older fields of participatory development and social accountability have long theorized and explored the impact that these efforts can have on governance, including state-society relations (Gaventa & Barrett, 2012; Joshi, 2014; Gaventa and McGee 2013). In fact, assessing changes in state-society relations may be key to understanding the potential of hybrid legal empowerment/social accountability approaches, as strengthened relationships between the health system and citizens can shape the sustainability and transformative potential of immediate changes in service coverage and quality. Combining relationship building with procedural or legally-based institutional accountability in the way that legal empowerment does may help to ensure that this relationship building works in the interest of the poorest (Tembo, 2015). Thus, relationship building may enhance the impact of case resolution and vice-versa.

To contribute to the empirical literature on how legal empowerment works in health systems, we examine the mechanisms of case resolution. By mechanisms, we mean the underlying processes operating to produce an outcome (Dalkin et al. 2015; Astbury and Leeuw 2010). We also describe the proximal impact of case resolution and discuss how the project affected state-society relations. The

concept of “linking social capital” is apt to describe and understand how project activities led to case resolution and improved state-society relations.

Linking social capital is defined as “norms of respect and networks of trusting relationships between people who are interacting across explicit, formal or institutionalized power or authority gradients in society” (Szreter and Woolcock, 2004). As elaborated by Szreter and Woolcock, power differentials are particularly pertinent to public services that are delivered through in-person interactions where hierarchies can be enacted and reinforced (2004). In settings of rigid inequities, linking social capital must be consciously built, so that marginalized individuals and community-based organizations can meaningfully participate in public policy and hold officials accountable in day-to-day interactions (Szreter and Woolcock, 2004; Titech and Vervisch, 2008). Moreover, a few new trustful relationships does not constitute linking social capital; changes may be comprised of individual relationships and interactions, but linking social capital must encompass community trust and democratized access to institutions. Indeed, lack of power and access to decision-making structures is a defining feature of marginalization; these same dynamics make it quite difficult for the most marginalized to express voice and demand accountability (Ayliffe et al., 2017). The significance of linking social capital (and lack thereof) is evinced by the multiplicity of studies showing that in poorly governed health systems, poor quality clinical and interpersonal care is often meted out to “anonymous users” who have no relationships or specialized knowledge on which to draw in negotiating health care (e.g. Olivier de Sardan and Ridde, 2015; Behague et al., 2008; Spangler, 2011).

This notion of creating links characterized by trust is not new to the development project (Ogden et al., 2013). Moreover, there are extant empirical analyses of intermediaries and their role in promoting accountability for service delivery, though the concept of linking social capital is not explicitly employed. For example, based on extensive social accountability program experiences in Africa, Fletcher Tembo articulated the concept of “interlocutors” to describe individuals and organizations that

help representatives of the state and society to identify and enact mutually beneficial changes (Tembo, 2013). Similarly, patient navigators, and other paraprofessionals liaise between the health system and communities to demystify the health system for marginalized groups, thus filling something akin to a linking social capital role (Schaaf et al., 2018).

Finally, the notion of linking social capital is also apt for the Mozambican context; Namati sought to build on governmental efforts to construct functional working relationships across institutionalized authority gradients in society, including VHCs and other health governance committees.

### Methods

In designing this study, we used Yin's definition of a case study: "an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-world context, especially when the boundaries between the phenomenon and context may not be clearly evident" (Yin, 2014, pg. 16). This is an explanatory case study, seeking to answer "what," "how," and "why" questions. Answering "why" questions is more challenging absent a comparison locality, but comparing the findings from this study to the existing literature enabled us to undertake some cross-unit analysis building (Yin, 2014; Collier, 2011). Yin explains that case studies are suitable for studying interventions with no single set of outcomes (Yin, 2014). An ongoing NGO legal empowerment and social accountability program fits into this category, particularly when we seek to understand the impact of the project on relationships between the health system and the community, rather than just the individual Health Advocate case outcomes. A successful case study should yield a deep understanding of the phenomenon of interest, including of the "subjective significance" of the project activities and impact, and the program causal pathway (Woodside, 2010, pg. 6).

The case study had two components: 1) a retrospective review of 24 cases 2) qualitative investigation of the Namati program and program context. The case review entailed the selection of 24 cases by area of focus (infrastructure, performance, medicine) with a disproportionate number of

performance cases, as these cases have the greatest variation in terms of issues addressed. Successful cases were purposely sampled to achieve maximum variation. We defined variation in terms of the area of focus, the route to resolution, and whether it was a collective or an individual case. The cases came from a total of 6 sites (each site is a health facility) in 3 districts – Marracuene, Maputo Cidade, and Namaacha. The Namati program started in 2013 in four of the sites, and in 2014 in two of them. Nine different Health Advocates worked on these 24 cases.

The case reviews were accomplished by conducting structured in-depth interviews (IDIs) with those directly involved in the case: the Health Advocate who managed the case (9 total interviews); the client(s) (22 total interviews); and, a representative of the health facility (13 total interviews), preferably who was involved in the case. In three cases, there was no provider who could be interviewed; in two cases the client could not be found; and, in one case the Advocate was no longer available.

The second component was a broader assessment of the program and the program context. It included semi-structured Key Informant Interviews (KIIs) with district, provincial, and national health managers (5) and Namati staff (4). In addition, focus group discussions (FGDs) were held with Health Advocates (2 FGDs with a total of 7 participants) and 6 FGDs were held with a total of 31 VHC members. We also asked questions about unresolved cases, since our sampling did not include such cases.

All interviews were conducted in Portuguese. Occasionally, clients sought clarification in Changana or preferred to express a particular thought in Changana. These were transcribed in Changana, and translated into English by the Portuguese to English translator.

The interview guides were developed collaboratively by MS and the Namati team in Mozambique; they were based on literature regarding legal empowerment and social accountability, as well as Namati's program theory. Transcripts were transcribed, translated, and saved in Nvivo 11. A native speaker of Portuguese checked the quality of the translations. MS and JF collaboratively developed thematic codes. The initial list of thematic codes was based on relevant studies and program

theories. The theory reviewed ran the gamut from tentative specific program theories (e.g. Feinglass et al., 2016) to propositions that developed following an extensive literature review of legal empowerment and social accountability (e.g. Fox, 2015; Lodenstein et al., 2015; Goodwin and Maru, 2017). We then modified the codes based on the transcripts; thus, the ultimate code list included both inductively and deductively derived codes (Attride-Sterling, 2001; Fereday and Muir-Cochrane, 2006). MS coded the transcripts, with substantial input from JF, who discussed coding of ten initial transcripts.

In addition to coding, the authors built explanations by developing a data display showing similarities and differences among stakeholder (Health Advocate, client, and provider) perceptions of each case. This facilitated comparison across cases and across type of stakeholder (Glaser and Strauss, 1967; Gibbs, 2012; Brooks et al., 2015).

MS then developed thematic memos including exemplary quotes. The memos explored the range of exemplars for the same codes, illustrating dimensions of the phenomena of interest (Gibbs, 2012). To support accuracy (internal validity), MS compiled “quasi statistics” (Becker, 1970, pg. 81) including regarding both majority and minority opinions. MS then discussed conclusions with other members of the study team. All study team members commented on and contributed to multiple drafts of the paper.

Institutional Review Board approval was obtained at Columbia University Medical Center as well as the National Bioethics Committee of the Mozambican Ministry of Health.

## **RESULTS AND DISCUSSION**

We begin with a summary of the cases, the practical steps Health Advocates took to solve the cases, the mechanisms of case resolution, and the proximal impact of case resolution. To explore broader outcomes in community relationships, we move on to examine how Namati intentionally created linking social capital. We also discuss how these relationships can foster broader change.

### Cases studied

Health Advocates learned about these cases by encountering the complainant at a health facility, through their door-to-door visits or education sessions in communities, or through VHCs. Some problems affected individual patients; some affected large groups of patients. Each case was associated with a health facility. The cases are summarized in Table 2.

Though these problems were manifest at the client's local health facility, many of them were shaped by multiple levels of the health system. For example, drug stock outs at facility level can reflect problems higher up in the supply chain, such as leakage or inappropriate projections at the national level. Even if the stock out originated at the facility, ensuring strong stock management is a national level responsibility. Such problems have been described as necessitating a "vertically integrated" response that engages multiple levels of governance (Fox, 2015; Benequista and Gaventa, 2011).

#### Case resolution

Health Advocates took a variety of steps to resolve these cases, some of which entailed interactions with multiple levels of the government. Frequently cited approaches included educating health workers and administrators about how to solve a certain problem and assisting them to do it; facilitating a dialogue among the Health Advocate, the client, and the offending provider; supporting the process of putting new health facility procedures in place; holding meetings with facility staff; helping the health facility to submit a formal request to the district or province; submitting a letter and/or a petition with community signatures to the district; and advocacy at the district or provincial level. In most cases, the Advocate indicated that at least one VHC member participated in each step as well. Resolving a case often entailed more than one of these actions, often comprising what Fox has described as "partially vertically integrated;" it connects the local to the district level (Fox, 2016).

The creation of a new waste pit was a typical, multi-step, multi-level case:

- The Health Advocate met with the VHC and the health facility management to discuss the problem

- The health facility management formally contacted the municipality
- Not receiving a response, the health facility management suggested that the Health Advocate raise the issue with the district health authorities and the municipality
- The Health Advocate worked with the VHC to draft a petition, which the VHC then submitted to the district health authorities and the municipality
- The Health Advocate followed up with the municipality, which explained that they were aware of problem but prioritizing other facilities
- After more follow-up, the municipality sent an excavator to close the old waste pit and to dig a new one
- The VHC began to monitor the health facility staff to ensure that waste was being disposed in new pit

Interviewees reported that Health Advocates monitored the progress of each case, visiting regularly, or remaining in phone contact with the client and the health facility if the Health Advocate was not physically present. To ensure that the problem had not re-emerged, the Health Advocates and the VHC continued to directly observe and monitor many cases, including conducting informal patient exit interviews.

#### Mechanisms for case resolution

We identified three key mechanisms: increased administrative capacity, reduced transaction and political costs, and fear of administrative sanction.

In many situations, Health Advocates directly bolstered facility level (and sometimes, district level) administrative capacity to address and prevent the type of problems identified. This mechanism is not prominent in either the legal empowerment or social accountability literature, though the frequency and impact of poor state administrative capacity at the local level is well documented in many contexts (Smoke, 2015; Welham et al., 2017), as is the fact that weak state response undermines many

accountability efforts (Ayliffe et al., 2017). Political scientists studying participatory councils and the water sector in Brazil found that participatory fora can improve the state's ability to provide public goods, so there is limited evidence on how civil society can help to create the conditions for state responsiveness (Abers and Keck, 2009). The Namati Health Advocate worked with health facility providers and administrators to learn about new protocols or about lesser-used processes for fixing problems, such as referring adherent HIV patients to a rapid flow for anti-retroviral treatment or asking the municipality for funds for infrastructure repairs. Health Advocate experiences in addressing similar cases in multiple settings enhanced their ability to identify and remedy problems. In the context of decentralization and rapid HIV scale-up, mastering administrative procedures and fast-changing protocols may be unfeasibly time consuming for overwhelmed frontline providers and managers working in understaffed facilities. They may also lack the administrative know how to seek assistance from the district. In some cases, Advocates worked with VHCs to create a new management system, thus likely improving health facility capacity on a longer-term basis. For example, several VHC members reported proactively reaching out to the pharmacist every 15 days to check on stock levels of key medicines. The VHC members had decided that identifying and addressing each case of a stock out post hoc was insufficient to fix the underlying problem; the health facility required ongoing support to prevent stock outs. Some providers mentioned such new systems in interviews, noting that their facilities were now better able to manage drug stocks. Health Advocates also described some similar changes in facility level management stemming from cases, such as health facilities starting to routinely post information about service availability when a health provider was on an approved leave.

In addition to addressing administrative capacity gaps, Health Advocates' accompaniment of frontline providers and managers through administrative processes appeared to decrease the transaction and political costs of solving problems, a finding that has been identified in other social accountability projects (Wild and Harris, 2011; Joshi and McCluskey 2017). For example, one of the

cases reviewed was brought to a Health Advocate by a provider; when interviewed, Namati staff and Advocates confirmed that this happens with some regularity. “A lot of times the health providers have said that they made the request [to address a problem]... and they give up because they don’t want to pressure their supervisors” (IDI with Namati staff). This suggests that providers believe the problems to be important, but feel that the Advocates are better able to solve them. Pointing out uncomfortable truths about colleagues – particularly about one’s superior - may also be politically costly. A Health Advocate recounted:

*[A health provider] said, "It's true that my colleague overreacts, he overreacts a lot and really needs to be called to account, but we can't do this, we are his direct colleagues, but you can do it, you are the community, you are partners, you can." (IDI, Health Advocate)*

Thus, in the context of a hierarchical system that does not allow for much initiative by providers, the Health Advocate or the VHC’s mandated role to identify and address problems provide an opportunity for providers to channel problems to an entity that can solve them.

Our data suggested that administrative accompaniment and decreased political and transaction costs may be the most salient determinants of state responsiveness to Namati Moçambique, as interviewees mentioned these frequently during the case review discussions. These findings highlight the potential utility of a hybrid legal empowerment and social accountability approach. Numerous empirical analyses have identified state capacity to respond to social accountability efforts as a central concern (Fox, 2015; Grandvoinet et al. 2015; Gaventa, 2006; Joshi, 2013; Ayliffe et al., 2017; Schaaf et al., 2017). Demanding more from the state may be futile and demoralizing in environments where the state does not have the resources or wherewithal to respond to those demands (Domingo, 2014; Fox, 2015). Through its focus on facilitating case resolution, Namati Moçambique builds state capacity to

respond to citizen demands by increasing administrative know-how within the facility, and decreasing the transaction and political costs associated with responding.

However, in addition to improved state capacity, it is also clear that the mechanism of feared administrative sanction played a role in case resolution, particularly in cases related to provider performance. In some of the cases we reviewed, the providers acknowledged wrongdoing. Most immediately tried to make amends; a few asked the Advocate not to inform their supervisor. In other cases, the provider denied that an offense had occurred, even though others corroborated the complaint. Provider behavior in the face of these allegations of poor performance suggest that the providers wish to avoid sanctions. While providers unsurprisingly did not point to fear of sanction as a mechanism of change, VHC members did. For example, one VHC member explained that the health providers felt that the case being discussed served as:

*a reminder and a warning... we had seen this problem and... they would run the risk of being expelled because the community is getting empowered; they [the community] are able to take a case until the district headquarters. But when we tackled it, in fact they resolved things, they [the providers] accepted the blame (VHC FGD).*

Similar to other social accountability efforts, Health Advocates provide “eyes and ears,” by reporting problems to those who are mandated to address them and to levy sanctions where appropriate (Westhorp et al., 2014; Joshi, 2017). District and provincial officials confirmed that problems are solved by “calling attention” to them, and, that egregious cases of poor performance raised by Health Advocates have led to disciplinary measures against providers. Many VHC members expressed similar sentiments. One noted, “The Advocates are the ones that can help us in this fight because nurses work without supervision and they do what they please.” As described by another Advocate, lack of accountability becomes routine; the government “employ[s] someone without supervising the person; the person gets

accustomed to [lack of supervision] and thinks that this is his [right];” the Health Advocate and VHC impose some supervision. One VHC member described how their ‘eyes and ears’ “guard” role enables better relations between communities and the health facility, as it keeps the providers ‘in line’ and provides assurance to the community. “The patient and the provider are friends because of the meetings of the Committee and [because of] Namati.” Credible threat of litigation has been identified as a key ingredient of legal empowerment (Maru, 2006). Namati Mocambique has never pursued litigation, but the credible threat of administrative sanction may fill the same role of compelling compliance. Though our data are insufficient to say so with confidence, it may also be that the presence of the Health Advocate and the invigorated VHC improves state capacity to administer sanctions. Health Advocates and VHC members stressed that providers violated rules with impunity, yet, these same Advocates and VHC members were apparently able to successfully leverage threat of sanction. Advocate and VHC knowledge of sanction processes as well as their mandated role to address problems may mean that the application of sanctions is more likely when Namati is involved than it is in communities where Namati is not present.

#### Proximal outcomes of case resolution

According to the Namati case database and the interviewees, all of the cases we reviewed were resolved. Stocked out drugs became available, providers agreed to discontinue certain behaviors and they did so for at least 30 days, mobile brigade service was re-initiated, and infrastructure was improved. In FGDs, VHC members explained that the resolution of collective cases immediately affected many patients. For example, a functioning toilet that does not stink affects patient experience, provider working environment, and potentially, infection control. We probed interviewees about whether or not changes were sustained. We did not hear of any of the cases recurring, though a few of the resolutions were temporary. For example, the health facility might use materials that are on hand to fix an infrastructure problem, while awaiting funds from the next budget cycle to construct a more permanent structure. In the context of the much-lamented gap between health policy and practice, these

performance improvements at the frontline of the health system can be significant to both patients and providers (Schaaf et al., 2017; Adams et al., 2015). Moreover, the resolution rate appears to be quite high. For example, assessments of grievance redress mechanisms in social protection programs have found much lower rates of redress (Ayliffe et al., 2017). The Health Advocate and VHC members facilitated the improved implementation of governmental procedures and protocols in a variety of domains, ranging, for example, from drug supply to patients' rights to funding and implementing infrastructure improvements. Moreover, multiple cases of the same kind can have a proximal impact beyond the resolution of the case in question. For example, providers facing multiple complaints of poor performance were reportedly transferred. Facilities with constant challenges in provider performance were sometimes allocated an additional health provider. Others obtained needed equipment, such as a CD4 machine, so that individuals could receive HIV care locally.

Such visible improvements in quality of care are common in studies of successful legal empowerment and social accountability efforts (Lodenstein et al., 2013; Goodwin and Maru, 2017; Schaaf et al., 2017; Gullo et al., 2016). However, based on the literature, it seems that Namati Moçambique tracks these outcomes more closely than most social accountability projects, facilitating organizational learning, as Namati regularly compares the strategies employed in resolved and unresolved cases. This reinforces organizational focus on resolution and remedy, potentially resulting in a higher rate of case resolution. It also potentially enhances Namati's capacity to act proactively (rather than just reacting to violations), as the data are used to inform Namati's advocacy and policy support at national level, as well as the broader solutions they propose at the facility and district levels.

#### Empowerment outcomes

In addition to case resolution, clients, Health Advocates, and VHC members discussed other outcomes of the project, including individual satisfaction at having one's complaint remedied, and individual empowerment among clients and Health Advocates.

When asked to reflect on their case, most clients expressed appreciation that they had been able to raise an issue that affected them, and, that someone had taken this issue seriously and addressed it. Those who did not express appreciation were largely unaware of the steps Namati had taken to tackle their case, though their cases had been determined to be resolved by the Health Advocate. Some clients who were more involved in resolving their own case explained that they felt a sense of individual empowerment.

A VHC member described this sense of empowerment, framing it explicitly in rights terms.

*Because before, a patient didn't know what his rights are, but now he already knows how to demand his rights, is able to see that when I do this, I am not committing indiscipline, this is part of it, I am demanding my rights as a patient, as a user. (IDI with client)*

Health Advocates noted that lack of entitlements knowledge, illiteracy (and thus inability to file a written complaint), the normalization of poor service, and fear of retaliation shaped patient desire and willingness to make a complaint. As a Namati staff member explained, there is a “culture of silence” about rights violations and poor quality healthcare (IDI with Namati staff). The client empowerment engendered by the project appeared to lessen some barriers to rights claiming. Several VHC members and Namati staff explained that entitlements education and the successful resolution of a case helped to ‘de-normalize’ poor quality services, thus instigating a virtuous circle of community engagement.

*[Once the Health Advocate had solved a few cases] the community began to express thanks and had more courage to come to present more problems. (IDI with client who is also a VHC member)*

These findings regarding individual empowerment are common in the legal empowerment and social accountability literature; individuals who are not punished for raising a concern and/or who see benefit from an effort start to feel as if they have the right and capacity to speak and ‘make a difference’

(Lodenstein et al., 2016; Papp et al., 2013; Schaaf et al., 2017; Wild and Harris 2011; Gullo et al., 2016; Gulob, 2010; Feinglass et al., 2016; Goodwin and Maru, 2017; Wetterberg and Brinkerhoff, 2016).

#### State-society relational outcomes: Health Advocates construct linking social capital

In educating the community, leading the mapping, and resolving cases, Health Advocates constructed linking social capital. Advocates developed functional working relationships with providers, in part because they addressed issues that providers felt were important, and engendered community satisfaction with the Health Advocate, and ultimately, trust in the health system.

Both Health Advocates and providers explained that their relationship with the other improved over time. For their part, Advocates explained that provider circumspection generally gave way to a constructive working relationship, once providers understood that the Advocate and the providers shared goals. A Health Advocate described this evolution:

*I can say that when I started working as an Advocate, it is always like that, when you start working at a health facility, you are frowned upon, you are frowned upon by the providers, only when they understand what the objective is, what the role of the Advocate is, that is when they get closer to you. (IDI, Health Advocate)*

Several providers and district officials echoed the sentiment of initial mistrust giving way to trust. They stated that many Advocates began their work with an overly adversarial outlook, but once they grew to understand the obstacles health sector employees faced, they became more collaborative.

Namati training and the meaningful support Health Advocates provided to the health system fostered these functional relationships between Health Advocates and providers. Namati trained Health Advocates in an overarching framework of entitlements and right to health care, but they also taught Advocates to approach health providers as allies and fellow professionals with shared goals. A Health Advocate described this approach:

Interviewee: *Namati taught me how to follow up, how to deal with the nurses, how to speak like that.*

Interviewer: *Like that, how?*

Interviewee: *Knowing how to connect with the nurse, have manners, good language, not to judge, not to police the nurse, knowing how to connect with them. (Health Advocate, IDI)*

Another Advocate expressed similar sentiments.

*I will start as I was taught in Namati, I began to follow the steps and then I saw that after all it is not that hard...not to go in there and act as if you were police, or go in to judge, no, you go in as if you were working with them, seek to know what it is like here. (Health Advocate, KII)*

Similar to findings from other settings, health managers and providers were receptive to this collaborative approach because they felt Health Advocates addressed important problems (Lodenstein et al., 2016; Feruglio, 2017). This congruence in interests is not minor; erroneous assumptions about shared priorities between the public sector and citizens have plagued many development efforts (Evans, 1995). A small minority of health providers opined that they would prefer that Namati work only on health promotion and not on rights and entitlements, and a few providers and officials said that Namati should work exclusively on educating patients about their responsibilities, as further education on rights was not needed. Overall, however, these sentiments were seemingly offset by widespread appreciation of Health Advocates' work addressing patient health literacy, drug stock outs, infrastructure, and selected aspects of maternal and child health and infectious disease.

Providers explained that Health Advocates educate patients about health system protocols and entitlements, such that patient expectations better matched health system obligations. Several providers said that Namati's lectures for the community and the Health Advocate and VHC member work in bringing patients who had discontinued TB or HIV treatment made providers' job easier and fulfilled an important public health task.

When asked directly during the case review interviews, most providers agreed that the case under discussion did indeed relate to an important problem. As compared to drug stock outs and infrastructure gaps, providers were less likely to be concerned about performance cases related to the quality of interpersonal care. On the other hand, providers unequivocally stated that drug stock outs and infrastructure gaps undercut their work as medical providers. They explained that stock outs of ARVs and antibiotics, including TB drugs, threatened patient outcomes and potentially contributed to the spread of drug resistant illnesses. For them, stock outs had a clear clinical and public health impact. Moreover, they noted that they did not feel good explaining the clinical and public health importance of adherence to patients when stock outs made adherence impossible. Similarly, when discussing infrastructure cases, such as the effort to improve infection control by creating a segregated area for TB patients, a doctor explained:

*For me as a clinician, we knew we were exposing the providers and patients to a range of diseases. Maternal child health, weight control, physiotherapy, pregnant women were all receiving care in the same place. It [resolving this case] was a great victory. They [non-TB patients] were removed from danger, it was indeed a great relief*  
(IDI, health provider)

Finally, maternal and child health are clear governmental priorities, so managers were committed to improving service quality, even when not all providers were. For example, a health provider described that district health staff had contacted their facility and specifically asked them to make sure there were no more unattended births in the health facility, so a Namati case related to an unattended birth was addressed quickly. Several Advocates and health providers mentioned that health facility managers saw the role that Health Advocates played in improving facility performance vis-a-vis national priorities, and that these managers in turn encouraged and supported frontline health providers to work with Advocates.

Health Advocate relationships with clients and the community, too, were germane to Health Advocates' ability to construct linking social capital. Knowing how to navigate the health system and what one's entitlements are, knowing a trusted intermediary (Health Advocate), and knowing a provider within the health facility are all forms of capital that one can leverage in the future.

Most clients expressed general sentiments that Health Advocates listened to them, educated them, and helped them. This excerpt from a client interview is emblematic.

*My impression was of having a refuge, of having someone who cared about the patients...I felt at ease, she offered security so that I could tell her these things (IDI, client)*

Health Advocates then worked to parlay patient trust in the Advocate to patient trust and comfort in the health facility. As a VHC member explained:

*NAMATI also helps... in disseminating the rights of the users in the health facilities... Patients should feel like they are at home when they are in the hospital, to express themselves freely about their health concerns.*

Patients were then more willing to access health care. Multiple Health Advocates spoke about bringing sick patients who had lost trust in the health system to a facility for care. Moreover, given that trust in the health system is often shaped by word-of-mouth, good experiences by Namati clients can contribute to increased utilization by the broader community (Kujawski et al., 2015).

However, our data also indicated that Health Advocates did not always "close the loop" with clients, missing opportunities to cement the relationship among the client, Namati, and the health system. Thus, though their cases were resolved, of the clients interviewed for the case review, almost half indicated that they wished they had more follow up from the Health Advocate. Some did not know that the Health Advocate had resolved their cases. Bringing a problem to a Health Advocate and not hearing from that Advocate again does little to build linking social capital.

Through ongoing monitoring and evaluation, Health Advocates had become aware of this interruption in the feedback loop. One Advocate describes the impact of inadequate follow-up:

*When the burglar bars were put at the health facility and the other windows were repaired... there was no demonstration to the patients that this is the result of the complaints, of empowerment on the right to health (IDI, Health Advocate)*

Providing feedback is not simple; clients often live far from the facility and/or they do not have phones. A small number of those interviewed expressed fear of retaliation for having lodged a complaint and did not wish to be involved in the case resolution. To track the quality of case resolution, including how well Health Advocates follow up with clients, Namati has recently instituted a spot check, whereby a randomly selected 10% of all clients are interviewed following the closure of a case. Namati's growing commitment to reporting back to individuals and communities promotes stronger linking social capital.

#### State-society relational outcomes: VHCs construct linking social capital

When Namati began its work, the VHCs in their program catchment areas did not meet or rarely met; members had not been trained and were not aware of their remit; and, there were generally no formal processes in place to support VHCs to accomplish their stated goals of improving health system responsiveness and individual health behaviors (Feinglass et al., 2016). These challenges are common to many VHCs in LMICs (Scott et al., 2017; George and Branchini, 2017; George et al., 2015; Loewenson et al., 2014). Namati trained VHC members on the patient bill of rights, other relevant health policies, advocacy strategies, and conflict resolution. Namati also trained and supported VHC members to undertake the bi-annual health facility assessments, community/health facility dialogues, and to monitor the implementation of resultant action plans.

VHC engagement with Namati's work was significant in scope. In most cases, VHC members were present for almost every step of problem resolution for cases that the Committee identified;

indeed, they increasingly spearheaded case resolution. At the time this research was conducted, about 50% of all cases were identified by the VHC. However, similar to Health Advocates, VHC members described having to overcome circumspection and even disrespect by frontline health providers; over time, trust and a working relationship developed. A VHC member explained:

*What I have to say is that, [at] the start of our work, the hospital workers didn't like our work. When we reached the hospital, we were isolated, but now we enjoy strong cooperation and mutual assistance...[the nurses] realized that the Health Committee is not against them but that we are there to collaborate for the good functioning [of the health facility]."* (VHC, FGD).

VHC members developed relationships with the health facility and the community, facilitating collaboration, including on potentially sensitive challenges. Similar to Health Advocates, VHC members explained that they tried to balance rights claiming with empathy for the providers' position. As explained by a VHC member, their goal is not to "damage the nurse's career," but to improve the quality of services.

Namati assistance and collaboration with VHCs built the collective efficacy of VHCs, thus fostering the Committee's ability to achieve its goals. As described as a VHC member:

*The health committee became more motivated by Namati's presence, because Namati gave us experiences that we didn't have before. So we became more composed with the experience of Namati, we have more strength, more will because of Namati (FGD, VHC).*

This strength, coupled with Namati's reputation in health facilities, facilitated VHC work.

*We are no longer afraid to enter the offices of the nurses, we have access to any office, there is no fear of the providers making [ugly] faces when we enter their wards*

*because NAMATI taught us and NAMATI is respected by the providers and that respect extends to us (FGD, VHC).*

Similar to Health Advocates, our transcripts suggest that these working relationships between health providers and VHC members were enabled by the perception that VHC members addressed health system priorities.

Many VHC members described educating patients about expected behavior in the health facility, sometimes at the request of nurses. One VHC member stated:

*[M]any people [now] know that when they go to the hospital, it is to be well attended and they know how to behave themselves. Patients know that when they go to the hospital, they do not go to a bar, but to a Health Facility (FGD, with VHC members).*

In addition, again at the request of nurses, VHC members located TB or HIV patients who had interrupted treatment, and encouraged and accompanied them to seek healthcare at the health facility. VHC members explained that their work facilitating health care gave them a sense of personal accomplishment; several described great personal satisfaction at watching a thin TB or HIV patient become “fat” once s/he was put on treatment.

Finally, VHC members also reported directly supporting health facilities, including by cleaning, packaging pills, and cooking meals for patients, thus providing concrete services that improved both patients’ experiences and providers’ working environment.

Similar to Health Advocates, VHC members were perceived by the community to be a trusted intermediary between the community and the health system; VHC members described this function as patient accompaniment; demystifying, democratizing, and monitoring the health system; and, resolving conflicts or misunderstandings arising between patients and providers. For example, VHC members worked to triage and organize the queue at health facilities, introducing transparency and rules to a system that patients often perceived as disfavoring those lacking linking social capital. As a VHC

member explained: “those cases can’t happen that this one is [a health provider’s] neighbor and he should be the first to be attended to, because we all have the same right to have the service.” One interviewee noted that some Namati cases regarding informal payments were raised by patients who had been skipped in the queue because they were unwilling to pay, underlining the point that VHC engagement could democratize the system by making at least the process of seeking care more transparent and equitable.

### Outstanding questions

Our research surfaced the process and mechanisms of Namati case resolution, and illustrates how the project builds linking social capital between communities and the health system, with the Health Advocate or the VHC playing an important intermediary role. Bridging the dichotomy between ‘outside’ and ‘inside’ approaches, this NGO-led project built the capacity of a state led bridging organization – the VHC – to promote state capacity and responsiveness.

However, our research also raises several questions that merit further research. In particular, we highlight four questions that merit further investigation, both to inform Namati’s internal learning and the growing field of legal empowerment for health. These include:

- 1) **How vertically integrated is Namati’s impact?** Jonathan Fox has described “accountability traps,” wherein service delivery improvements remain localized and short-lived in the absence of multi-level and multi-actor engagement (Fox, 2015). Namati attempts to avoid such traps by using learning from their health facility and district level work to inform their national level policy advocacy and support, and by taking steps to make their reactive violations-based approach to be more proactive. This includes creating broad-based solutions to cases that should prevent future problems, and proactively seeking out collective cases. Whether this kind of national level – local level integration is effective depends in part on the character of decentralized health and administrative governance (Joshi, 2017). In this study, we investigated

the links among community members, VHCs, Health Advocates, and the local and district levels of the health system. Investigating how governance at central, provincial, and district level is affected by the Namati program would further illuminate the impact of the program and to what extent activities at all levels interrelate and promote sustainable change.

2) **To what extent does the nature of the cases shape Namati's short and long term**

**effectiveness?** Within the limited research on legal empowerment, there has been discussion about the use of adversarial versus collaborative approaches at various levels of the state. Most efforts employ more collaborative approaches at the local level, with organizations that are perceived as legitimate by the state having more options to use both adversarial and collaborative approaches at all levels of the health system (Joshi, 2017; Feruglio, 2017). We learned that Health Advocates and VHCs addressed issues that patients and providers agreed were problems, built state capacity to solve these problems, and reduced transaction costs. In other words, they largely used collaborative approaches at the local level. This created linking social capital that likely helped Health Advocates to address more challenging issues, such as provider performance. The way this "case mix" of more politically sensitive cases, such as unattended delivery, and less sensitive cases, such as broken toilets, influenced health system responsiveness at all levels requires further exploration in Mozambique and beyond.

3) **Do VHCs build social cohesion within communities?** Some research has shown that linking social capital can, over time, be turned to negative ends in the absence of strong social cohesion in the community (Titeca and Vervish, 2008). We know little about VHCs' position in the community, including how representative the membership is and how these committees are perceived by the community. We had some evidence to suggest that, at least in the context of their work with Namati, VHCs represented the needs of marginalized individuals, but we have little idea of power dynamics internal to VHCs; and of what, if any, gatekeeping role the VHC as

an entity and/or the VHC Secretary plays in identifying cases. In other settings, ‘infomediaries’ were unable to overcome entrenched hierarchies in communities and households and ensure the equitable dissemination of information and resources (Ayliffe et al., 2017). Yet, in the case of Namati, we did see that VHCs were able to serve a true two-way ‘linking’ role. Rather than just diffusing information ‘down’ to the community, they represented community needs ‘up’ to the health system. This suggests that VHCs can be effective at addressing community goals. Understanding the relationship among VHCs, communities, and health workers is integral to understanding how accountability is shaped by power dynamics in the community (Molyneux et al., 2012).

- 4) **How sustainable is case resolution in the long-term?** Increasing reliance on VHCs for case resolution makes Namati’s work more sustainable and amenable to scale. However, deeper investigation into the durability of case resolution, the long-term functioning and utility of linking social capital, and how far and deep the impact of case resolution extends beyond the individuals concerned would better illuminate the potential long-term community level impact of Namati’s work. VHC members complained about the common challenges of volunteer fatigue (Brunie et al., 2014), raising issues about sustainability. Interviewees frequently referred to changes and improvements resulting from Namati’s work, but comparative observations or longitudinal follow up would provide more rigorous evidence of sustainable impact.

Our study used retrospective interviews and FGDs, with a focus on cases. These methods are not particularly sensitive to changes in district level governance, explicating changes in the relationship between facilities and the district, national level policy change, or changes in community level dynamics. Prospective, comparative, and observational (ethnographic) methods could shed light on these questions.

## Conclusion

Though they are unable to address some deeply embedded national challenges, such as lack of adequate human resources in the health system, Namati Moçambique's Health Advocates successfully solved a variety of cases affecting poor Mozambicans in both urban and rural areas. Some of these cases were resolved within the health facility; others required intervention at the district level. In resolving these cases, Namati bolstered individual and health facility capacity to provide quality services, and relieved some of the transaction and political costs that may prevent health providers or administrators from addressing the problems by themselves. Health Advocates' success, particularly as related to frontline provider performance, relied in part on a functioning system of sanctions and administrative redress, a system that Advocates and VHCs potentially enhanced through their 'eyes and ears' function. Providers feared and responded to dictates from their supervisors, providing the legal empowerment program with leverage. Health Advocates built a base of trust within health facilities as well as within the VHCs and among the community members who availed themselves of Namati's services. The Health Advocates resolved visible problems that community members themselves had identified, leading to individual client empowerment, and to some extent, instigating a virtuous circle of rights claiming via linking social capital. The construction of linking social capital was aided by Advocates' collaborative approach, and by the fact that Health Advocates addressed many challenges that health providers agreed were priorities. Health Advocates' role was increasingly buttressed by VHCs, which, over time, assumed greater responsibility for case identification and resolution. Namati – an independent NGO – strengthened the existing state apparatus for participatory governance.

Research on legal empowerment does not always explicitly engage questions of trust, relationship building, and state-society relations (Goodwin and Maru, 2017). Our research suggests that legal empowerment efforts can establish and nurture lines of communication and cooperation where there were few. Benefits accrue to the clients of individual and collective cases, to other users of the health system, and, potentially, to community members in VHC catchment areas. When their jobs are

made easier and/or more pleasant, benefits also accrue to providers, managers, and officials. The project serves vulnerable people – as opposed to the village ‘elite’ - insofar as individuals experiencing violations are the focus.

This study contributes to the limited literature regarding the mechanisms of legal empowerment case resolution in health systems, and, the impact that legal empowerment and social accountability hybrids may have, particularly on state-society relations. Community paralegals may be well-placed to build linking social capital, especially when they work with existing community-based entities that bridge hierarchies across the state-society divide, such as VHCs. The case resolution focus of legal empowerment brings procedural teeth, helping to ensure that new relationships result in immediate improvements, thus instigating a circle of relationship building and health system improvements.

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Tables and Figures

Table 1: Namati cases March 2013 – November 2017

Namati cases March 2013-Nov 2017			
Domain of Case	Status of Case		
	Resolved	In Process	Total
Equipment	84	142	226
Infrastructure	472	295	767
Medicines	171	55	226
Provider Performance	1321	231	1552
<b>Total</b>	2048 (74% of total)	723	2771

**Table 2: Description of Namati cases studied**

Case No.	Category	Description
1	Medicine	Stock out of a TB drug
2		Stock out of cotrimoxazole syrup (antibiotic used chiefly as prophylactic treatment for opportunistic infections among HIV+ children)
3		Stock out of a malaria drug
4		Stock out of injectable antibiotics
5		Stock out of a TB drug (expired drugs on site)
6		Stock out of cotrimoxazole
7	Infrastructure	Lack of appropriate space for TB services
8		Overflowing clinical waste pit at health facility (staff continued to dispose waste there even though full; terrible smell)
9		Lack of warehouse for drugs
10		Facility doors do not have locks, windows do not have screens, broken glass; threat of theft of medicines & lack of security in maternity ward
11		Toilet broken in men's ward
12	Performance	Mobile clinic interrupted service for 4+ months w/out explanation to community
13		Pharmacist told patient seeking ART drugs to come back the next day
14		Government-employed HIV activist breached confidentiality by disclosing the health status of ART patients to others when drunk
15		Clinician only observed & gave paracetamol, would not administer malaria test to a sick child
16		Pharmacist seemingly discriminated against certain patients, not giving them medications. Underlying issue was stock out of required drugs.
17		Clinician told patient seeking wound dressing that facility was too busy & that she should come back at noon
18		Client not recommended for rapid flow ART even though eligible
19		Clinician requested bribes for labor and delivery services
20		Clinician made ART patients wait while allowing other patients (family/friends) to skip the queue
21		Untrained service agent in maternity attending births b/c nurse on duty did not know how
22		Patients on hospital beds w/out sheets b/c technician was tired of changing sheets
23		Mother left alone on a bed w/ no sheets after delivering in the middle of the night
24		Clinician left a laboring woman alone in the maternity ward; she delivered w/only her mother-in-law & a service agent (not a qualified provider) present, & w/out proper hygiene (gloves)

## **Conclusion**

These three papers address multiple components of the accountability research agenda: disciplinary siloes, program implementation, policy-making, and agenda-setting. Synthesis of the conclusions of all three papers suggests some overarching conclusions as well as some unanswered questions.

### **Nature of the problem to be addressed**

Informal payments appear to be a crucible for assessing the possible effectiveness of social accountability and legal empowerment. While the social accountability literature is rife with examples of program impact on multiple domains, Namati faced more challenges in cases of provider performance, particularly informal payments, and SAHAYOG struggled with affecting the frequency of demands for informal payments. Deliberative processes for identifying issues for social accountability efforts to address may yield more ‘low hanging fruit,’ such as lack of particular equipment. In contrast, approaches starting from violations may better target the most marginalized and the issues that matter to them most; these issues may be anything but ‘low hanging fruit.’ Further research on the social accountability or legal empowerment “case mix,” on social accountability and embedded governance challenges, and on provider perceptions of the issues addressed by social accountability and legal empowerment may shed further light on these dynamics.

### **Elite capture**

Elite capture is frequently described as a pitfall of social accountability programs. Deliberative mechanisms can be dominated by community leaders, and even if the most marginalized participate, their ability to shape the debate can be negligible. Elite capture was very clearly a non-issue in the SAHAYOG project, and seemingly not an issue in the case of Namati. This is likely because both organizations started with an affected population, rather than gathering a group of “community members” and asking them to come to a consensus regarding priorities. Yet, several researchers and

theorists have pointed out that in order to achieve success, some degree of elite engagement may be impossible to avoid. This raises questions for the SAHAYOG project in particular, where providers and decision-maker feelings about the “deservedness” of the population making rights claims may have played a role in their lack of responsiveness to those claims. SAHAYOG and the CBOs felt that prejudice about low caste women and Muslims and childbirth in particular, were relevant, explaining in part why MSAM had more success in other domains. This could extend to Namati too, where starting from those experiencing violations – which a barefoot lawyer approach inevitably does – could have implications for the development of collective consciousness and action, particularly when clients fear retaliation or a program is focused overwhelmingly on case resolution rather than community processes.

### **Social cohesion**

Namati did not particularly consider social cohesion in communities. The role that the VHCs play in identifying and addressing community priorities merits further exploration. While SAHAYOG explicitly targeted the lowest status populations, it seemed that in some contexts, collective action required ongoing outside facilitation. Women in one community described that inter-caste dynamics limited their ability to meet and continue without the CBO. As a result, after the CBO had stopped working with MSAM, the remaining MSAM group represented a much more limited constituency.

### **Vertical integration**

On the face of it, both Namati and SAHAYOG tried to undertake vertically integrated efforts. SAHAYOG had regular contact at the state level, occasional protests at the state level as part of the larger MSAM work, and frequent interactions at the district level. At the district level in particular, decision-makers described that they had little ability to address informal payments, though some took administrative steps to address them. At the state level, decision-makers regularly professed commitment and agreement with SAHAYOG and they took administrative steps, but to little end. The

CIS on informal payments suggested that informal payments cannot be addressed without broad changes in the health system. Generating adequate countervailing power at all levels of the health system on this particular issue may thus require significant and sustained efforts, or efforts that are embedded in larger campaigns to reform health care. SAHAYOG was aware of these challenges and dynamics, but the case also raises the importance of not approaching vertical integration as a box checking exercise. Namati intervened at the district level to solve problems that could not be addressed at the facility level. They also used the data they collected and the lessons they learned to advocate at the national level. The key question is whether and when this engagement might have an impact beyond the cases that Health Advocates solve.

### **Impact on state society relations**

Both the SAHAYOG and the Namati studies highlight the significance of the project's impact on state society relations. While there is significant conceptual and empirical work related to state-society relations in the development field, this can be overlooked in health, where the focus is on changed health service coverage and health outcomes. Yet, as the failures of the MDG era described in the CIS on informal payments illustrate, health systems' support of quality interpersonal relations, health provider morale, and community trust influence utilization, and arguably the effectiveness of program implementation and population health outcomes. Within public health in the global North and South, there has been longstanding attention to CHWs, patient navigators, and other efforts to create links between the community and the health system; in some ways, legal empowerment and social accountability can be more macro approaches to the same general problem of lack of linking social capital that these well-established efforts in global health try to address. Identifying the long-term impact of such changes in state-society relations - rather than focusing exclusively on health coverage

and outcomes - might help to create a different frame for evaluating health accountability efforts, and standards for deciding what and how to scale up.

### **Importance of understanding lived experience**

Together, the papers also suggest the primacy of lived experience at the frontlines of the health system, as well as the fact that the experiences of both providers and patients are not always considered in program models and research. For example, short-term approaches to ‘educating consumers’ and ‘shifting incentives’ do not resonate with low caste, Muslim, and tribal women in Uttar Pradesh, who have spent years coming to believe of themselves as rights holders and iterating approaches to changing provider and policy-maker behavior. Similarly, in the context of informal payments, it appears that understanding the meaning and intent of the actors involved in the exchange is germane to changing practice.

To maximize the relevance and impact of efforts to affect changes in patient experience, understanding the lived experiences of patients and providers – and the structural drivers of these - should be our starting point. This insight has important implications for conceptual work, empirical research, and program support. Individuals coming from the communities we seek to support are in the best position to describe their experiences as well as what matters most to them, but authentic collaboration with these groups can slow down the traditional gears of intervention focused development work.