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'History obligates us to do it': political capabilities of Indigenous grassroots leaders of health accountability initiatives in rural Guatemala

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ABSTRACT

Growing interest in how marginalised citizens can leverage countervailing power to make health systems more inclusive and equitable points to the need for politicised frameworks for examining bottom-up accountability initiatives. This study explores how political capabilities are manifested in the actions and strategies of Indigenous grassroots leaders of health accountability initiatives in rural Guatemala. Qualitative data were gathered through group discussions and interviews with initiative leaders (called defenders of the right to health) and initiative collaborators in three municipalities. Analysis was oriented by three dimensions of political capabilities proposed for evaluating the longer-term value of participatory development initiatives: political learning, reshaping networks and patterns of representation. Our findings indicated that the defenders' political learning began with actionable knowledge about defending the right to health and citizen participation. The defenders used their understanding of local norms to build trust with remote Indigenous communities and influence them to participate in monitoring to attempt to hold the state accountable for the discriminatory and deficient healthcare they received. Network reshaping was focused on broadening their base of support. Their leadership strategies enabled them to work with other grassroots leaders and access resources that would expand their reach in collective action and lend them more influence representing their problems beyond the local level. Patterns of representing their interests with a range of local and regional authorities indicated they had gained confidence and credibility through their evolving capability to navigate the political landscape and seek the right authority based on the situation. Our results affirm the critical importance of sustained, long-term processes of engagement with marginalised communities and representatives of the state to enable grassroots leaders of accountability initiatives to develop the capabilities needed to mobilise collective action, shift the terms of interaction with the state and build more equitable health systems.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Accountability initiatives that enable marginalised citizens to change the terms of interaction with the state are a critical driver for more equitable health systems.
⇒ Initiatives' potential to transform health system governance depends on the political capabilities of their participants.

WHAT THIS STUDY ADDS

⇒ The political learning of Indigenous initiative leaders began with actionable knowledge for defending the right to health.
⇒ Their networking strategies employed leadership and expanded collective action.
⇒ Interactions with a range of authorities to advocate for health system solutions indicated evolving capability to navigate the political landscape.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE AND/OR POLICY

⇒ Initiatives' impact can be strengthened through a citizen-centric focus on grassroots leaders' political capabilities to gain influence in health policy and practice arenas.
⇒ Enabling grassroots initiative leaders to develop the trust, collective agency and adaptive strategies needed to transform health systems requires long-term, sustained engagement.

human development index and most unequal distributions of wealth in Latin America.[1] It is simultaneously home to the highest concentration of private helicopters and planes per capita and the third highest rate of chronic malnutrition in the world.[2 3] Indigenous peoples of 23 predominantly Mayan ethnicities make up 46% of the country's population of nearly 17 million. Almost 80% of Indigenous people in Guatemala live in poverty, and half of these are extremely poor.[4] Inequity manifests most strongly in the health and education of the rural Indigenous population

INTRODUCTION

Guatemala is distinguished as one of the countries with the highest poverty rates, lowest

and the urban non-Indigenous population. Indigenous children in the rural area experience a stunting prevalence of 64% compared with 25% of urban non-Indigenous children, and only one decade ago, literacy rates among non-Indigenous urban men reached 91%, while only 35% of rural Indigenous women were literate.[5 6] These numbers attest to a profound ethnic and geographical division arising from deep roots of social exclusion in rural Guatemala.

The marginalisation of the rural Indigenous population results from many factors, including unequal access to land never alleviated by redistributive land reform and a 36-year civil war that ended in 1996 and killed over 200 000, most of them Indigenous.[7] The historical inadequacy of essential public services in rural areas with Indigenous populations reflects the weak state presence there and the smaller proportional allocations in the national budget, both of which contribute to the vicious cycles of poverty these areas endure.[8] Neither conventional development aid nor a string of national policies to combat poverty and hunger has been able to narrow the drastic disparities.[9 10] Inequities persist, in part, because programmes providing micronutrient supplements and conditional cash transfers address their manifestations but fail to challenge larger structural and social forces of marginalisation.

Likewise, internationally coordinated efforts to achieve Universal Health Coverage have placed primary emphasis on technical policy solutions, such as financing mechanisms, while neglecting the ways the health system itself reproduces social exclusion.[11] This is particularly visible in highly segmented systems like Guatemala's where the public health services attending disadvantaged populations are understocked, understaffed and provide inferior quality of care.[12] The public health system represents an important interface between the state and rural communities, and the interactions that occur there can either reproduce or combat the histories of disenfranchisement and discrimination that underpin the vulnerability and poor health outcomes these communities experience.[13 14] Recognising the health system as a site of state interaction with historically excluded communities implies that overcoming health inequities is primarily a political undertaking rather than a technical one.

Social accountability is a critical driver for transforming the governance of health systems serving poor and marginalised populations to be more inclusive, participatory and responsive.[15] Social accountability initiatives actively involve citizens, communities and civil society in holding public officials and service providers accountable by expressing voice, claiming rights and influencing the decisions that affect their lives.[16] Interventions to support the development of such initiatives in the health sector have promoted a range of approaches that position citizens to redress health system deficiencies by strengthening their participation in governance, including village health committees, community-based monitoring and health advocacy campaigns. The potential of social

accountability efforts to transform governance depends in part on intent.[17] Accountability scholars distinguish between efforts that train citizens to project their voice as more educated consumers of services and those that deepen democracy by changing the terms of interaction between citizens and the state.[18 19] Deepening democracy implies accountability initiatives are oriented towards interrelated outcomes that work together to facilitate change, with improvements in health and service delivery in focus alongside changes in citizen empowerment and capacity for collective action.[16 20] Such initiatives have the potential to challenge social exclusion directly by supporting marginalised citizens to gain influence in policy and practice arenas that impact their lives.

Supporting initiatives of marginalised citizens to mobilise action for accountability and engage with the health system as collective actors is inherently political work. Shifting the terms of interaction with health workers and public authorities is a long-term, dynamic process that develops citizens' political capabilities to challenge exclusionary norms and advocate for their rights through sustained cycles of adaptive action.[21] Growing interest in how citizens and civil society can leverage countervailing power to reduce the power advantage of ordinarily powerful actors and make health systems more equitable points to the need for more politicised frameworks for analysing empowerment processes and outcomes.[22–24] Political capabilities are defined by Whitehead and Gray-Molina to include the resources and collective ideas available for effective political action.[25] They describe political capabilities as emerging through the 'cumulative and sustained interactions that socialise the poor into potentially constructive relationships with their social partners and with central or local agencies of the policymaking state'.[25] These political capabilities are manifested in their abilities to navigate and renegotiate political spaces as they participate in, influence and hold accountable institutions that affect their lives.[26]

Recent studies of accountability initiatives in India and Uganda have employed a political capabilities framework to better understand the impact of participatory accountability initiatives in marginalised populations and, thus, gain insight into their sustainability and longer-term political value.[27 28] Balestra *et al* found that engaging in the community-based process of health services monitoring developed political capabilities by fostering the collective agency of the lower-caste members of the Women's Health Rights Forum (Mahila Swasthya Adhikar Manch) in India and helped renegotiate their relationship with the state as citizens by providing grounds to conceptualise rights and challenge state representatives with evidence and demands.[27] By contrast, King's study of an initiative introducing a toolkit for monitoring public services in Ugandan communities attributed the limited, unsustainable outcomes to the programme's technical focus on disseminating the tool without analysing the local political economy or bolstering the capabilities of rural residents to challenge the entrenched power dynamics

of patronage politics.[28] Both studies emphasise that to understand and potentiate accountability initiatives' power to transform local governance, researchers and practitioners must attend to the shifts in collective agency and the dynamics of engagement between the state and disadvantaged groups that these initiatives foster. In Guatemala, studies of Indigenous-led initiatives have also highlighted capabilities for mobilising communities in collective non-violent resistance as well as building alliances to initiate legal action to seek accountability for grievous rights violations by extractive industries supported by the state.[29–31] Focus on political capabilities offers an invaluable lens for shifting from seeing marginalised groups as passive victims in need of intervention to deepening understanding of how to potentiate their actions as agents of change in the institutions that affect their lives.

This study explores how political capabilities are manifested in the actions and strategies of Indigenous grassroots leaders participating in health accountability initiatives in rural Guatemala as part of the Network of Community Defenders of the Right to Health (REDC-Salud). REDC-Salud's development began in eight municipalities in 2006 with the support of a Guatemalan civic organisation, the Center for the Study of Equity and Governance in Health Systems (CEGSS) and has grown to include over 160 defenders of the right to health in 35 municipalities. Qualitative data were gathered through group discussions and interviews with defenders, local collaborators and the CEGSS field staff who support the health accountability initiatives in three municipalities. By examining expressions of political capabilities developed through the defenders' work monitoring services and advocating for improvement of health system deficits, we aim to deepen understanding of citizen-led initiatives' potential to transform power dynamics and contribute to more equitable health policy and practice.

METHODS
Study context
The Guatemalan public health system is the predominant source of healthcare in rural areas with large Indigenous populations. Services are provided through a network of government facilities that are chronically underfunded and provide insufficient coverage of rural populations.[11] Access to quality services is further limited by linguistic barriers, discrimination and abusive treatment by health providers, despite policies guaranteeing linguistic access and intercultural care.[12 32 33] District health directors are responsible for managing service delivery at the municipal level, and administrative authority over the implementation of national health programmes and service delivery is largely decentralised to the provincial level and managed by a provincial health director.[34] Municipal governments also have responsibility for coordinating with the district director and allocating a portion of their budget to support the health district in needs such as

sanitation programmes, healthcare facility maintenance and hiring support personnel. Social participation in governance is guided by a legal framework that established the right and responsibility of citizens to participate in planning, monitoring and evaluating public services, as well as a decentralisation act that increased the power and responsibilities of municipal mayors and municipal councils.[35] These laws also specify that community authorities, including community development councils, should have a voice in the COMUDE, the municipal decision-making forum; however, de facto barriers often prevent access to and effective use of this space.[36]

CEGSS' approach to supporting citizen action for health accountability can be characterised as a deepening democracy strategy that focuses on strengthening the citizenship of the rural Indigenous population and collaborating with them in their efforts to influence public policy and services.[14] Their approach starts with individuals nominated by their communities to join the network of defenders. These individuals typically also have roles as community-level authorities, traditional healers and midwives and/or in grassroots organisations, while providing for their families through subsistence farming, migrant labour and the informal sector. The defender role is volunteer, and CEGSS provides resources for travel and meeting expenses as well as airtime for cell phones. CEGSS field staff, who are Indigenous activists and community organisers that speak the local languages, initially provide training in the right to health and the legal frameworks for participation as vehicles for addressing the needs of users of services and raising awareness of their rights and entitlements. Defenders also receive training in a variety of monitoring techniques to document health service deficiencies, including facility inspections, exit interviews with users of services, community assemblies and short message service (SMS) reports of user reports.[37] Equipped with knowledge of their rights and evidence of the service problems their communities experience, defenders interact with state authorities at different governance levels, including mayors, municipal councils, health district managers, regional health directors, Ombudsman, public prosecutors and provincial and national officials to solicit space, present their problems, and follow-up on demands for responsive action. Successive phases of capacity-building in these skills and ongoing support from CEGSS field staff enable socially excluded citizens to activate their latent power and shift the norms of interaction with authorities through cycles of analysis and adaptive action.[38] More information about the defenders and CEGSS' approach can be found in.[21 37–40]

In the 35 rural municipalities where this work is ongoing, teams of around five defenders plan and mobilise municipal-level initiatives by coordinating these actions together with local leaders they recruit as collaborators. The REDC-Salud links these municipal-level initiatives in a national network that serves as a platform for defenders to analyse shifts and opportunities in the

national political landscape and plan strategic action to influence systemic change. In the 15 years since this work started, CEGSS's support has evolved to increasingly focus on leveraging the power of these initiatives and equipping the REDC-Salud to mobilise coordinated responses to national political developments, monitor the implementation of new policies and promote more inclusionary national health reforms.[11 14 41]

Conceptual framework

This study is framed by focus on the political capabilities of Indigenous leaders of health accountability initiatives as a driving force for shifting power in marginalised citizens' engagement with the health system. The selection of this focus was informed by the position of the research team members who are non-Indigenous and based in Guatemala (AH, FJ and WF) and support the work of the defenders and REDC-Salud through their respective roles at CEGSS. As researcher-practitioners, we were able to draw on insights developed through long-term contact with the accountability initiatives as well as ongoing discussions and power analyses among the CEGSS team, half of whom are Indigenous, which pointed to the importance of initiative participants' political knowledge, skills and strategies for securing improvements in health services. The study design was further informed by the position of the Sweden-based members of the research team (A-KH and MSS), who have studied community-based accountability across high-income and low-income country settings and supported the relevance of focus on political capabilities to understand bottom-up change processes that strengthen health systems.

In the context of historic and current conditions that inhibit their participation in governance, grassroots leaders from marginalised communities face an uphill battle to attempt to hold the state accountable and attain solutions to health system failures. Our analysis of the political capabilities that enable them to confront power focuses on the micro-level of the actions and strategies these grassroots leaders use when interacting with their peers and the state.[40] In this sense, we take a citizen-centric approach that looks at what constitutes the last mile of service delivery from decision-makers and policy-makers' perspective as the first mile of interaction with the state from rural citizens' perspective.[42] This interface represents an important arena for the development of their capabilities to mobilise resources and collective action to push for state responses to their problems, and it is precisely through these micro-level interactions that inequity is experienced and must be reconstructed.

Our analysis is oriented by three dimensions of political capabilities proposed by Williams for evaluating the longer-term value of pro-poor participatory development initiatives.[26] In this study, we are interested in these dimensions as they relate to the longer-term value of health accountability initiatives that aim to deepen democracy by developing marginalised groups' capacity to exercise countervailing power. The first dimension

is political learning, which includes increased knowledge of rights and procedures for claiming rights as well as spreading political learning in the population. The second dimension is the reshaping of political networks through which marginalised groups can advance their interests, including brokering of strategic relationships in and beyond the local arena.[28] And the third dimension of political capabilities is seen in patterns of representation, which manifest in the language and tools of claims-making, shifts in norms of participation and local culture of governance and challenges to exclusionary norms. These three dimensions provide a relevant and useful structure for examining the actions and strategies grassroots leaders of accountability initiatives employ as they learn about health rights and skills for monitoring, seek allies to enhance the influence of their network and engage with state actors to represent their problems and advocate for solutions to health system deficits.

Data collection

The present study is based on three cases of municipal-level initiatives selected to participate in a research project on leveraging the function of networks in citizen-led initiatives for health accountability. With the assistance of the CEGSS field staff and organisational monitoring data, we identified the municipalities with the strongest community involvement in each of the three main regions of the country where the initiatives were active. The lead defenders from the three municipalities selected were contacted by the field staff member who supports their municipality to invite their participation in a study about their initiative's network. After agreeing to participate, the defenders were asked to invite local actors whom they identified as their close collaborators in action for health accountability. In this way, invitations to participate in the study were extended and explained through gatekeepers who were trusted by the rural Indigenous community members.

Data collection took place in three phases, and the profile of participants in each phase, including their roles in their communities, is presented in table 1. In the first phase in early 2017, CEGSS field staff and the research team facilitated workshops on network strengthening where the defenders and their collaborators reported on relationships in their current network and brainstormed on contacts who represented potential resources for their work. The network analysis is reported elsewhere,[41] and the present study included the research team's field notes from these workshops and brainstorming sessions. In the second phase around 6 months later, participants were invited back, and the research team presented the network maps generated from the first phase and facilitated an interpretive discussion to deepen understanding of how the network works together. Discussions were conducted in Spanish, and CEGSS field staff supported interpretation to local Indigenous languages when needed. The discussion guide focused on the initiative participants' history of collaboration, how they

Table 1 Profile of municipalities where the accountability initiatives are based and participants in interpretive group discussions. Lead defender and field staff from each municipality also participated in follow-up interviews.

| Municipal profile | Participant profile | | | | | |
	Role in initiative		Sex		Role in community	
Concepcion						
Population: 7000 in 12 km^2	Lead defender	1	F	1	Women's CBO	1
	Defender	1	F	1	Women's CBO	1
Poverty: 81%	Collaborators	7	F	2	Municipal institutions	3
			M	5	Village leader	2
					Women's CBO	2
Health services: one health centre	Field staff	1	F	1		
	Total	**10**				
Santana						
	Lead defender	1	M	1	Village leader	1
	Defenders	4	M	4	Village leader	3
Population: 7000 in 12 km^2					Urban civil society	1
Poverty: 85%	Collaborators	3	M	4	Village leader	2
					Agricultural cooperative	1
					Urban civil society	1
Health services:	Field staff	1	M	1		
One health centre,						
Four health posts						
	Total	**9**				
Tolima						
Population: 27 027 in 196 km^2	Lead defender	1	F	1	Urban civil society	1
	Defenders	3	M	3	Urban civil society	2
					Indigenous authority	1
Poverty: 96%	Collaborators	9	F	3	TBA association	4
			M	6	Indigenous authority	1
					Village leader	2
					Urban civil society	2
Health services:	Field staff	1	M	1		
One district hospital,						
Two health posts						
	Total	**14**				

CBO, community-based organisation; TBA, traditional birth attendant.

communicate and organise action for health accountability and their interactions with authorities. It should be noted that the lead defenders and some of the collaborators who had recognised voices of authority in their communities were more vocal in the discussions, and the field staff and research team members sought to ensure all participant voices were heard by repeating the questions to less vocal individuals. Alongside the insights these group discussions provided into the resources that their networks offered, the research team and field staff identified that defenders' accounts also provided an inside view of their strategic learning and thinking around the right to health and how to influence the population and authorities. This observation led to a third phase of data collection, which consisted in six follow-up interviews with the lead defender from each of the three municipalities and the CEGSS field staff members who support their work. Follow-up interviews focused on local action and strategies for mobilising action and getting results for health accountability, and they allowed for member-checking of initial insights obtained in the group discussions as well as triangulation of the accounts of the field staff and lead defender for each municipal site.[43] Group discussions and follow-up interviews were audio recorded

Political learning	Reshaping network	Patterns of representation
• Story of network start • Health system problems • Communication to coordinate action	• Convening strategies • Networking strategies • Collaboration in defenders' work	• Interacting with authorities • Gaining recognition • Influence in political decisions

Figure 1 Correspondence between themes emerging from thematic analysis and the three dimensions of political capabilities.

and transcribed. Informed consent was obtained from participants at each stage of data collection by presenting the purpose and steps of the study to the group and facilitating a discussion in which each person had the opportunity to state their view on participating prior to providing consent. This procedure reflects CEGSS' organisational learning about the need for collective as well as individual deliberation in arriving to meaningful informed consent.

Data analysis

Analysis of the data gathered was guided by thematic analysis.[44] After initial familiarisation with the data, the first author (AH) developed an index of thematic codes and applied it to segments of text using NVivo V.11.0 software. The index was continually refined to incorporate emerging themes that captured different aspects of the analyses, actions and strategies that initiative participants described in discussing their work defending the right to health, and the code book, coded text sorted by theme, and initial summaries were shared with WF and FJ for review and refinement. To deepen our insight into how the actions and strategic approaches described represented expressions of political capabilities, we then examined the themes through the lenses of political learning, reshaping network and patterns of representation and identified points of intersection, shown in figure 1. Data from themes in the same dimension were reviewed together and the coding continued to be refined as segments of the data more relevant to another dimension of political capabilities were reclassified. This analytical process was supported by discussing emerging insights with the field staff who had been part of each stage of data collection and were able to corroborate our interpretations of the connections between the actions and strategic thinking that reflected political capabilities. We then iteratively reviewed the data related to each dimension to refine our interpretation of the political capabilities manifested in the defenders' action and strategic thinking as they engaged in and spread political learning, expanded their network and represented their interests with authorities.

Patient and public involvement

This study analyses insights into the political capabilities of Indigenous leaders of health accountability initiatives that emerged through a participatory action research project focused on their network resources.[41] As such, patients and the public were not involved in the design, conduct or reporting of this study.

RESULTS

In the context of a history of territory disputes and land seizures, armed conflict and even massacres, there have always been contentious relationships between authorities and communities. The grassroots leaders participating as defenders of the right to health had chosen from before to position themselves in roles where they could look out for the needs of local communities. They were members and leaders in community development councils, health commissions, civil society and agricultural organisations, women's community-based organisations as well as traditional healers and Indigenous ancestral authorities. Their goals related to the health system included ending discrimination and abusive treatment and getting the services stocked with medicines for common illnesses, basic equipment and supplies. These goals arose from 'seeing the terrible state of healthcare' through their own experiences and those of their neighbours. Learning about rights and defending the right to health in places that the government has 'forgotten' is something that they started doing 'not because we wanted to, but because the same need from history obligates us to do it'. This quote reflects how the health system problems of being treated poorly by health workers and the lack of medicines and supplies to attend patients are not new, but part of the history of marginalisation that they want to change. The following sections present our findings on the political capabilities that the defenders expressed and developed as they worked to shift power and challenge the history of marginalisation by defending the right to health in remote rural municipalities of Guatemala.

Applying political learning to mobilise monitoring

Political learning about health and participation rights and strategies for claiming rights was the catalyst for

mobilising rural grassroots leaders to get involved in the health accountability initiative. Through their learning about the tools of monitoring and their work raising awareness about health rights and mechanisms for reporting problems, the defenders made important advances in activating rural users of services and their leaders to help make health service problems visible.

With the support of CEGSS field staff, the defenders had learnt about how to use monitoring as a starting point for defending the right to health and had gained skills to document problems, present them with authorities and advocate for solutions. Some defenders were not familiar with use of mobile phone technology to gather evidence, such as video recording and sending SMS reports of the reports. In these situations, beyond the support of the CEGSS field staff, the defenders themselves supported each other's political learning through mentoring relationships between older and younger leaders. While older leaders shared experience in community organising, some younger defenders took more responsibility with tasks using the cell phone and supported other defenders to become proficient as well. These learning exchanges among the defenders illustrated how their political learning was facilitated by integrating new actionable knowledge about the right to health into existing knowledge and experiences of community organising.

Defenders used their positions in their communities to share their political learning by raising awareness and involving more people in their work to monitor for violations of health rights. They described it as activating the people and working to change mentalities of low expectations, as many people felt that 'the health workers were doing them a favour and you should not say anything against them'. They responded by encouraging them 'to act and file a complaint to make the problems visible so there can be change'. By spreading the knowledge that they had gained about rights, responsibilities and the importance of reporting problems, the defenders were able to motivate the community to shift their expectations of the health services and get involved in monitoring with them.

Through their approach to sharing their political learning, the defenders were not only generating awareness but were also attentive to building people's trust in themselves as actors for change. They described 'gaining trust to have influence' through the way they presented themselves with health workers, leaders with community influence and users of services. This was particularly important with health workers because:

> …there is always new personnel. We go to the health post to monitor, and the nurse says 'Who are you? We are going to sue you because you don't have permission to come in here.' So as REDC-Salud, we have to keep introducing ourselves to have influence.

They recognised that the health workers were also learning about the right to health, and they sought to explain the legal basis for monitoring and their motivation to hold the government accountable for its responsibilities. In presenting themselves, they said it was important to talk about the REDC-Salud and identify themselves as part of a network of defenders in different parts of the country so 'the people see that we are not alone'. Representing their connection to a larger initiative for accountability helped them convince community authorities to accompany them to visit services for monitoring and encourage community members to report problems. The defenders' efforts to orient users of services to their rights and support them to report problems also reflected their approach to gaining trust. In their interactions with users of services, the defenders' own experience as users of services and members of rural Indigenous communities provided the starting point for building trust through their sensitivity to local norms and concerns. In cases where they would travel to a remote village to interview someone about a health service problem reported, they described contacting the community authorities to receive them and meet the family together with their local leaders. These kinds of considerations reflected their understanding that the rights violations that users of services experienced were not just individual problems but community problems.

Reshaping network through leadership practices

The defenders knew the value of developing their networks through their own experience in community leadership. Their approach to reshaping their network to strengthen their work for health accountability focused on exercising good leadership practices to bring in different kinds of resources, including networks of community support, strategic local allies and expanded contacts with activists and organisations beyond the local level.

Convening power was considered critical for mobilising community networks, and participants described that such power was gained through experience of the people's needs and actions that correspond to them. One participant who was a collaborator with the defenders indicated:

> (The lead defender) has convening power because people see she is serious in what she does. They see the commitment and the action. If you just talk and don't act, the next time people won't come hear you talk.

Exercising this kind of power was different from political influence, which they differentiated as being based on convincing with words and a prepotent, charismatic demeanour. By contrast, having influence as a community leader depended on 'being humble' and 'bringing development to the community'. They further described that maintaining convening power required being clear about why you are convening by informing about the agenda when inviting and fulfilling the expectations you give people in the meeting by not introducing new topics and following through on plans. This kind of thinking reflected that a conscious approach to developing their

own leadership was also central to their strategies for growing a network of support from communities.

The defenders' criteria for seeking allies reflected strategic thinking about qualities of an effective participant and the resources they offered through their connection with communities as well as their potential influence with authorities. While influence was a valuable quality in an ally, the defenders clarified that the most important consideration was that the potential ally shared their vision so that his or her participation would be effective for their goals.

> It is not just going and taking the mic and saying everyone is invited. As a good leader, I have to identify… who is going to be active, offer proposals…and be willing to participate in promoting the process.

Leaders whom they had gotten to support their work were characterised as having a voice of authority with the people, for example, through roles in community organisations, activism in other movements or as ancestral authorities. The defenders' allies helped them get messages to the rural population, taking advantage of their lines of communication with different groups of people, such as established person-to-person chains of communication created to reach those without cell phones. They also supported the defenders by accompanying them in engagements with local authorities to present demands or proposals for solving problems identified through health service monitoring. By going with others known to be well-connected and influential with the people, the local authorities were more likely to take seriously their petitions for supplementing medicine supplies, repairing and expanding health infrastructure and sanctioning discriminatory treatment.

The defenders and their collaborators discussed seeking new contacts beyond their existing local network who might offer different strategic resources. They were interested in strengthening ties with journalists to increase the visibility of their work and with human rights lawyers and educators to be able to represent their problems more effectively. Defenders had also experienced the benefits of preparing for audiences with regional and national authorities together with defenders from other municipalities and provinces about their demands in relation to systemic problems, like medicine stockouts. They described how working with the REDC-Salud network was a resource because together they had more strength and potential influence with authorities. They also discussed the strategy of linking up with other organisations with a shared interest in defending rights to advocate for solutions at the provincial and national levels. Some of the defenders had experience representing demands related to women's rights and environmental destruction at the provincial and national levels through their leadership in other organisations. They saw potential for forming alliances with regional organisations and networks of activists like the Mayan Peoples' Council as a strategy to take advantage of their broader networks of contacts and their experience engaging in higher-level political arenas. However, opportunities for recruiting potential allies varied by municipal context, as the more remote and sparsely populated municipalities had fewer contacts with institutionalised organisations.

Representing problems and rights in governance spaces

Advances in educating communities and mobilising networks of allies in action for health accountability helped prepare and provide the defenders with resources for representing their problems and their rights in different governance spaces. With both receptive and non-receptive authorities, the defenders exhibited confidence in their right to participate and be heard as well as knowledge of the norms and mechanisms of governance. Their gains in shifting the power balance in their interactions with state representatives were seen in their collaborative relationships with health authorities, their capacity for navigating the municipal political space and their strategic responses to barriers.

In two of the three municipalities under study, the defenders had a regular audience with the district director to present and discuss the problems detected in monitoring. They described having a good rapport and collaboration in correcting problems with personnel and documenting and seeking solution to problems that required action at a higher level. In the case where a regular audience with district health authorities was not possible, the director denied the existence of severe discrimination problems and blocked the defenders' access to the hospital. The defenders shifted strategies to represent their problem with provincial and national authorities charged with protecting human and Indigenous rights. Some defender groups had also made progress in establishing channels of communication with provincial health authorities. A CEGSS field staff member described that 'since they have been relating with (the provincial director) for a long time, even if it is a vertical relationship, there is respect…he calls (the defenders) in to discuss (situations) in the ministry and encourages them to continue their work'. They attributed the respect they had gained in part to their way of 'working without conflict' and the strategy of seeking the right path of action according to the situation:

> Maybe (the problem) requires filing a complaint—there is the labor union, the regional Indigenous authority, the director of the provincial health office, the district director. If it can't be resolved internally, we can follow other processes.

Learning about the legal basis of the right to health provided the defenders with tools to represent the health system deficits they faced with municipal authorities and convince them to take action. One defender stated:

> Before we didn't know which articles…now I have more empowerment to advocate with authorities…and I can explain that health is a right and the state has an obligation to give better health to the population.

They were also familiar with their rights to participate in municipal decision-making spaces as citizens and representatives of their communities. The municipal council, or COMUDE, was a space where many defenders and their collaborators had participated through different roles. Despite variations in authorities' openness to community participation, the defenders were experienced in exercising with their right to be heard in the COMUDE, and they knew how to present formal documentation of a problem or demand in the form of 'actas', which enabled them to demonstrate the support of community authorities and the weight of community interest through signatures. However, they also acknowledged that presenting the *acta* did not guarantee their problem would be resolved: 'If they don't fix it, we have to see where we go to create pressure'.

The legal framework for social participation grants community representatives the right to an official position in the COMUDE, but in practice, meaningful participation was not always possible. In one municipality, the defenders' position in the COMUDE was recognised, and their strategy was to use it to express health service needs and gain influence by 'present(ing) clear proposals. If not, you will not achieve anything…If you don't take answers, proposals, demands that respond to the needs, nothing will happen'. While in the other two municipalities in this study, the defenders had participated in the COMUDE but expressed that they were not included: 'No one does anything. They just listen and don't say anything'. Where the municipal political space was more contentious, clientelism and political divisions against the mayor impeded meaningful participation. In those cases, the defenders described themselves as performing their function as civil society. They emphasised their role in 'watching' the authorities who discussed projects to address the needs but did not act: '(they) make plans to support communities, but where does the money go?' In this role, they did not stay in health. One defender described convening his network because a representative from the Ministry of Education was in town to initiate a project to build a school. He stated: 'The mayor was all, 'of course' since everything is already arranged… But we are there making sure it is seen—not just by a few people'. Defenders in these less-open municipalities did not give up on gaining space to participate in the COMUDE and generate support. Their strategies focused on involving other actors and reflected confidence in their right to participate: 'Once we have a group, we'll go directly to the muni—if not with this mayor, then the next one—and fight for a space so that the REDC-Salud will be recognized in Santana'.

DISCUSSION

In this study, we examined the political capabilities of Indigenous grassroots leaders defending their right to health on the frontlines of health service delivery and local governance in rural Guatemala. Our findings indicated that the defenders made important advances in leveraging countervailing power as they activated tactics and strategies in their engagement with their peers and the state to push back against rights violations and abuses of power in the health system.

Political learning began with actionable knowledge about defending the right to health and citizen participation, transmitted with the support of CEGSS field staff and mutual cooperation among leaders. The defenders' approach to spreading the knowledge and applying the monitoring tools with users of services, communities and their local leaders exhibited understanding of the need to shift the entrenched mindsets of low expectations of public services, which has been recognised as a significant barrier to bottom-up initiatives' capacity to improve service quality.[45 46] Their positions in and understanding of the norms and problems in the remote communities they aimed to involve enabled them to cultivate trust in their message about the right to health as well as their capacity to act for change on their behalf. Beyond the political knowledge itself, our findings point to the importance of the defenders' capability to cultivate trust in enabling them to influence marginalised communities to participate in monitoring and attempt to hold the state accountable for the discriminatory and deficient healthcare they received. Other studies have highlighted elite capture as a key factor inhibiting efforts to catalyse participation in community-driven initiatives for accountability, particularly in communities that are poor, remote from centres of power and have low literacy, like those in the municipalities in this study.[47 48] One common problem identified across settings, such as users' associations in Colombia and health management committees in Uganda, was that the individuals responsible for receiving marginalised communities' reports and representing their interests lacked channels of communication with them.[28 49] By contrast, our findings illustrated how initiative leaders who were socially embedded in rural Indigenous communities used their capability to interact with communities and generate trust in their message and themselves as agents of change to activate marginalised users of services to report their experiences and demand better healthcare.

The defenders' orientation towards network building was focused on building associations that broadened their constituency of grassroots support and contributed to a 'thickening' of civil society. Their leadership strategies enabled them to interact constructively with other grassroots leaders and access resources that would expand their reach in collective action and lend them more influence representing their interests beyond the local level. They viewed the power to communicate with and convene remote, vulnerable communities as well as a shared vision of the work to be promoted as vital criteria for assessing potential allies' capacity to support their action for the right to health. For work beyond the municipal level, they were interested in allies, including regional activist organisations, human rights lawyers and

defender peers from different regions, who offered experience, knowledge and support to navigate regional and national political arenas and represent their interests. These kinds of strategic approaches reflect capabilities for developing a thickened associational network, which Fox[50] and Walker[51] describe as a key power resource that allows social accountability initiatives to overcome obstacles to autonomous collective action and lends them more 'teeth', or capability to prompt government responsiveness. The defenders' networking strategies sought to combine the clout gained by scaling up connections with regional civil society actors with the representative and mobilisation power lent by expanded ties to marginalised communities served by the rural public health system.[42] These kinds of capabilities for building associations and organising with other leaders working for marginalised communities' interests are critical in enabling citizen-led initiatives to overcome exclusionary norms and work collaboratively toward shared goals, such as improving rural health services.[16 28]

The defenders' approach to representing their problems and interests with a range of local and regional authorities indicated they had gained confidence and credibility through their evolving capability to navigate the political landscape and seek the right authority based on the situation. In each of the three cases, the defenders faced differing levels of receptivity with the health and municipal authorities. By employing the language of health and participation rights, seeking to build rapport and work without conflict and bringing clear proposals, they were able to shift the terms of engagement with authorities as they opened spaces for dialogue about problems with local and regional health officials and gained recognition to participate in municipal governance spaces. While the defenders were not always able to shift exclusionary dynamics in these spaces, their efforts to participate and claim their rights through adaptive responses to resistance and opportunities represent strategic actions in a process of renegotiating their citizenship and exerting their latent power. Focus on this long-term, iterative trajectory of state-society relations at the local level is central to understanding the emergence of social accountability.[18 52] Our findings align with those of other studies in pointing to knowledge of rights and governance procedures, collective identity as REDC-Salud and collective agency to advocate for health system improvements as important resources for gaining recognition and exerting influence in interactions with state representatives.[17 27 51 53] Indigenous communities experience the repercussions of historical social exclusion on multiple fronts, and the capabilities that the defenders developed through their engagement with authorities were not only applied for health. As seen in other initiatives in low-income, rural contexts,[17 54] the defenders were also exercising their citizenship and participation rights to seek accountability in other domains, including 'watching' authorities' implementation of an education project as civil society. Even when state actors did

not respond to their claims, their continual efforts to access, create and participate in spaces for state-citizen engagement indicate the development of capabilities to generate gradual, sustainable shifts in power by claiming their rights as citizens.[47]

The findings of this study should be interpreted with the following limitations in mind. Our framing focus on Williams' three dimensions of political capabilities was selected post-hoc, and thus, the interviews did not fully engage with the participants' views on political learning, reshaping their network and patterns of representation with authorities. However, the dimensions were well-matched with the main aspects of CEGSS' approach for supporting the defenders to lead local accountability initiatives,[38] and our analysis adds to a growing literature responding to calls for more politicised assessments of initiatives' contribution to sustainable shifts in power dynamics.[16 55 56] Additionally, expressions of countervailing power vary widely by context, and our interpretations were guided by the defenders' perceptions of what constituted gains. Gains in empowerment were seen in how they mobilised the population in monitoring, exercised their rights to participation in governance spaces, expressed their right to health and pursued different audiences when their problems were not resolved. However, while their accounts of actions and strategies suggest that the norms and power dynamics of local governance are shifting, further study using longitudinal, process-tracing techniques is needed to understand the impact of their actions in constraining abuses of power.

CONCLUSION

The Indigenous grassroots leaders participating as defenders of the right to health have made important achievements in mobilising remote marginalised communities to participate in health service monitoring, expanding their network of allies and influencing municipal and health authorities to resolve local health system problems. Our findings highlight the context-adapted political capabilities that facilitated these achievements and provide key insights into the qualities of the defenders' strategic approaches and actions that enabled them to leverage their own power as they sought to redress the health system injustices their communities experience. Raising awareness of rights among marginalised users of services and involving them in monitoring was aided by the defenders' understanding of norms and communication channels in rural communities that supported their ability to gain trust as agents of change. Their leadership experience led them to focus networking efforts on allies who would be effective in helping them achieve their goals based on their capacity to convene communities and influence authorities as well as their alignment with the defenders' vision of action for health. Navigating interactions with different state representatives enabled the defenders to open paths of action through collaboration with responsive health and municipal authorities

and develop adaptive strategies to put pressure or seek other channels when authorities did not respond.

This paper demonstrates the value of a citizen-centric focus on the political capabilities of the leaders on the frontlines of initiatives for health accountability. The dimensions of political learning, reshaping network and patterns of representation were highly relevant for providing insight into Indigenous grassroots leaders' resources for shifting the terms of interaction between historically excluded communities and the state. Our results affirm the critical importance of sustained processes of engagement with marginalised communities, civil society leaders and representatives of the state to enable initiative leaders to develop the trust, collective agency and adaptive strategies needed to transform power dynamics and build more equitable health systems.

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