Beyond normative technicism: institutionalist approaches to health systems governance in Tajikistan

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To Elsa and Lea

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List of abbreviations

AKDN	Aga Khan Development Network
BBP	Basic Benefit Package
FGD	Focus Group Discussion
GBAO	Gorno Badakhshan Autonomous Oblast (Region)
OECD	Organisation for Economic Co-operation and Development
PEA	Political Economy Analysis
SWAp	Sector Wide Approach
UTO	United Tajik Opposition
WHO	World Health Organization

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Summary

Health systems are the result of decisions on how resources are raised and spent, which groups in society are involved in the process of decision-making, or which needs and interests are responded to, and the incentives this creates for those delivering services. These decisions are shaped by the interests and convictions of those in power and depend on how they exercise this power. This puts governance at the centre stage of health systems research. Until recently however, health governance research was dominated by normative and 'technicist' approaches that focused on technical dimensions of health administration following the good governance paradigm and had limited empirical validation. Many low-income, fragile settings present a complex context for which frameworks based on an understanding of centralised and coherent health systems do not easily fit. This calls for approaches that allow for a more contextualised understanding of governance with an explicit focus on the way political, social and economic interactions in the health system are shaped by humanly devised constraints, also known as institutions. The primary aim of this thesis is to explore governance of the health system in Tajikistan with such a neo-institutionalist perspective, drawing on political economy analysis, principal-agent theory, collective action theory and the concept of social capital.

Tajikistan is a low income, post-Soviet and post-conflict setting with features of neo-patrimonialism and state fragility. The combination of a Soviet legacy, including a large public health infrastructure, fragile state capacity, a precarious power balance, partly stemming from a recent experience with conflict, and limited public resources available for health presents deep challenges to health service delivery. Little is known about what political factors have been inhibiting the introduction of health system reforms, and what these entail at the local level. The relationship between key governance actors and the role of political-economic interests, social norms and the wider political-economic context in the health governance process, including at district and community levels, have received less attention in scholarly debate. This includes attention to what citizen engagement in the area of health, and local governance structures at the community level actually entail in practice.

The research presented in this thesis draws on literature review and qualitative research conducted in Tajikistan at central policy level, district level and among communities and health workers. The thesis first of all sets out to develop an understanding of useful concepts to explore the governance of basic services in neo-patrimonial systems of governance in general; Secondly, it identifies the main governance constraints to the introduction and implementation of the Basic Benefit Package reforms and associated health management changes, by analysing the interactions of the main stakeholders with the political and socioeconomic context in relation to the technical dimensions of the reform. Third, it offers an analysis of meso-level accountability in the health system in terms of principal-agent relationships as a key process in district-level health governance; and lastly it explores how social capital facilitates the engagement with external development agents and local health governance actors, and fosters collective action around village organisations and community-based health funds.

With explicit attention to the political economy in which health policy changes and the interventions from development agencies take place, and the interconnectedness of central, local and community-level governance the research highlights the role of particular interests, resource-seeking motivations and entrenched power relations in shaping the health system. It shows how these result in and are affected by unclear mandates, policy incoherence and informal accountability mechanisms. The findings furthermore emphasise the precarious position that health workers as frontline bureaucrats in the system, and citizens find themselves in, in relation to government. Building on this, the study has provided new insight into important mechanisms that underpin the mixed results in engaging citizens through community-based health insurance for greater financial protection. Ultimately these insights serve to underline the relevance of contextualising health programmes and addressing the (informal) resource distribution mechanisms, power dynamics and collective action challenges that are so important in shaping health systems governance.

1. Introduction

Governance is considered as one of the core building blocks of health systems (de Savigny and Adam 2009) but its function and relation to the other building blocks has long been poorly understood or conceptualised, forming a blind spot in health systems research (Yazbeck 2009). Health system design, reform and operation – as well as it role in society – is not a merely technical question. Health systems are shaped by the interests and convictions of those in power and depend on how they exercise this power. Health systems are the result of decisions on how resources are raised and spent, which groups in society are involved in the process of decision-making, or which needs and interests are responded to, and the incentives this creates for those delivering services (Loewenson 2008). Particularly when aimed at Universal Health Coverage health reforms are fundamentally political as they affect the redistribution of power and resources between winners and losers (Participants at the Bellagio Workshop on Political Economy of Global Health 2015; Reich 2009; Fox and Reich 2015). These processes affect and are affected by particular (economic) interests, ideologies as well as trust and social networks. This thesis presents an exploration of health systems governance in Tajikistan with attention to these different dimensions at national, district and community levels.

Tajikistan can be characterised as a low income, post-Soviet and post-conflict setting with features of neo-patrimonialism and state fragility. The combination of a Soviet statist legacy, including a large public health infrastructure, fragile state capacity, precarious power balance, partly stemming from a recent experience with conflict, and limited public resources available for health presents deep challenges to health service delivery. By definition, governance and policymaking are of particular interest in such a setting. Yet they have received little attention in scholarly debate. The health systems literature on Tajikistan has largely been focused on central level reforms, such as the introduction of a Basic Benefit Package of health services (BBP) and the contribution provided by international aid. Ten years after the end of the civil war, Mirzoev, Green and Newell highlighted a number of areas in need of reform, such as the fragmentation across the health system, an oversupply of hospital services, and a lack of responsiveness to population and epidemiological needs in health financing, human resources for health distribution, and health service infrastructure (Mirzoev, Green, and Newell 2007). These health system characteristics are largely inherited from Soviet times, and are found across the Central Asia region, although Tajikistan stands out among its neighbours as particularly lagging in its reform efforts (Rechel et al. 2011). In response to these challenges, and to tackle the lack of donor coordination, a more comprehensive donor-government partnership and strategy for the health sector in the form of a Sector Wide Approach (SWAp) has been suggested, while recognising the governance weaknesses that could affect the operationalisation of a SWAp (Mirzoev, Green, and Newell 2010). A lack of donor coordination and weak technical and institutional capacity at Ministry of Health level were also identified as obstacles to the introduction of the BBP in Tajikistan (Rechel and Khodjamurodov 2010), although others have considered Tajikistan to stand out more favourably compared to its peers in this regard, based on its formal commitment to aid coordination (Ulikpan et al. 2014; WHO 2009). In sum, while the health system challenges in Tajikistan, and the direction of desirable reform are already well described from a central government perspective, little is known about what political factors have inhibited the introduction of health system reforms, and what these entail at the local level. The relationship between key actors and the role of political-economic interests, social norms and the wider political-economic context, including at district and community levels, have received less consideration. This includes attention to what citizen engagement in the area of health, and local governance structures at the community level actually entail in practice.

The overall aim of this thesis is therefore to increase the understanding of the ways in which key health system actors and stakeholders, including citizens, communities, health providers, local (health)

authorities, national government players and external development agencies relate to each other and the wider context in decision-making on the direction, performance and responsiveness of the Tajik health system. For this purpose, this thesis will draw on concepts and theories from the (new) institutionalist schools of political sociology and political economy, particularly structure-agency interaction, principal-agent and collective action theory, and social capital. In doing so it will demonstrate the use and limitations of these concepts and theories in analysing health governance at both macro, meso and micro scale -i.e. central, district and community level.

The field of health systems governance, or health governance, spans multiple disciplines and is interpreted differently depending on the discipline, making its definition, assessment and operationalisation elusive (Barbazza and Tello 2014). There is a need to more explicitly show what different theoretical perspectives on health governance can contribute to the scholarly debate, and how to use them for a contextualised understanding of health governance, providing lessons for academia, policy and practice. The results from this thesis should contribute to the emerging body of evidence on the political dimensions of health governance and power in health systems, particularly in fragile settings, and provide both this deeper theoretical understanding and entry points for change. Specifically, it can inform policymakers and practitioners about the power dynamics that need to be considered and help them more effectively navigate the challenges arising when seeking change through health programmes or reforms (Sparkes et al. 2019).

2. Research objectives, design and outline

2.1 Research aim and objectives

The primary aim of this thesis is to explore governance of the health system in Tajikistan in line with the theory and concepts advanced in chapter 3.

The specific research objectives are the following:

- To develop an understanding of useful concepts to explore the governance of basic services in neo-patrimonial systems of governance in general;
- To identify the main governance constraints to the introduction and implementation of the basic benefit package (BBP) reforms and associated health management changes, by analysing the interactions of the main stakeholders with the political and socioeconomic context in relation to the technical dimensions of the reform.
- To analyse meso-level accountability in the health system in terms of principal-agent relationships as a key process in district-level health governance;
- To explore how social capital facilitates the engagement with external development agents and local health governance actors, and fosters collective action around village organisations and community-based health funds.

To examine these issues empirical research in Tajikistan and from a distance was carried out between May 2010 and August 2012. An overview of the research objectives, questions and chapters is provided in table 1 below:

Table 1. Overview of research objectives, questions and annex organisation.

Research objectives	*Publication reference*	*Annex*	*Research questions*
To develop an understanding of useful concepts to explore the governance of basic services in neo-patrimonial systems of governance in general;	(Jacobs 2011)	A	• What are useful analytical tools to study the power context around basic service delivery? • What is the best way to analyse relations in the governance of basic service delivery while taking full account of the mix of informal and formal power that is so typical in these contexts?
To identify the main governance constraints to the introduction and implementation of the BBP and associated health management changes	(Jacobs 2019)	B	• What have been the main governance problems in the conception, development and implementation of the BBP and directly related health management reforms? • What are the main governance and health system structures, institutions and actors in Tajikistan • What are the main structure-agency dynamics in the BBP reform and implementation? • How do these mechanisms influence each other, and what lessons can be drawn from it?
To analyse meso-level accountability in terms of principal-agent relationships as a key process in district-level health governance;	(Jacobs and Baez Camargo 2020)	C	• Who are the main health system actors at district level? • How do the main health system actors relate to each other in terms of accountability? • What factors constrain or influence the accountability relationship between different actors? • What does the analysis of the accountability relationship imply in terms of where power lies in district level governance?
To explore how social capital facilitates the engagement with external development agents and local health governance actors and fosters collective action around village organisations and community-based health funds.	(Jacobs and Hofman 2020)	D	• What are the perceptions of Rushan communities towards externally induced community-based health funds and related community-based initiatives? • To what extent can external agents help to enhance inter-communal cooperation? • Do close inter and intra-group bonds (social capital) dis- or encourage collective action? • To what extent does social capital engender synergetic or antagonistic encounters?

2.2 Research design

The study design for the research reported on in this thesis consists of a combination of narrative review and embedded case study designs. Only qualitative methods were used for data collection. An overview of the different study types and data collection methods is presented in table 2 below.

Publication 1 (annex A) presents an argumentative thesis based on a narrative literature review and provides and institutionalist perspective for governance research. This established a theoretical framework and direction for the field research into health systems governance in Tajikistan. Publication 2 (annex B) studies the governance constraints to the BBP introduction in Tajikistan by means of a single case study embedded in its context. This approach allows for an exploration of a unique phenomenon, in this case the BBP design and implementation, in the context in which it is embedded, as the context is an integral component of the study (Scholz and Tietje 2002; Yin 2003). Case studies have been found to be particularly useful to understand and explain causal pathways in health policy developments and reforms (Crowe et al. 2011). For pragmatic reasons, and to allow for more in-depth exploration, the focus remains on health systems governance in Tajikistan exclusively, without a comparative case study of governance constraints around the introduction of benefit packages elsewhere.

The research designs for the studies reported on in publications 3 and 4 (Annex C and D) are embedded case studies as well, but with a comparative approach. This was expected to increase explanatory power and analytic generalisability compared to a single case study design (Gilson et al. 2011). For the local health governance study, two districts were chosen, representing cases with a different geography, socioeconomic and political context and different experiences with the introduction of the BBP. This context was assumed to shape health governance in the two settings to varying and distinct degrees. For publication 4, two villages were chosen as different cases for in-depth exploratory study and analysis because of the observed contrasting experiences.

Data collection methods and respondent types are summarised in Table 2. There is significant overlap in the respondents reported on in publications 3 and 4 (Annex C and D). Furthermore, although the study of governance constraints to the introduction and implementation of the BBP and associated health management changes (publication 2, annex B) mainly relied on data gathered among key informants at central level, data from interviews and focus group discussions (FGDs) held at local levels, as reported on in publications 3 and 4 (annexes C and D), provided essential contextual background.

A detailed description of the specific research methodologies including research site description, data collection and analysis for the different studies can be found in the publications (Annexes A – D).

Table 2. Overview of study objectives, design and methodologies

Research objectives	*Publication reference*	*Annex*	*Study type and data collection methods*	*Respondents*
To develop an understanding of useful concepts to explore the governance of basic services in neo-patrimonial systems of governance in general;	Jacobs, 2011	A	Narrative literature review	-
To identify the main governance constraints to the introduction and implementation of the BBP and associated health management changes	Jacobs, 2019	B	Single embedded case study Purposive literature review Open in-depth interviews Semi-structured interviews	Representatives from governmental agencies (Ministry of Health and Ministry of Finance), and bilateral, multilateral and non-governmental development organizations
To analyse meso-level accountability in terms of principal-agent relationships as a key process in district-level health governance;	Jacobs and Baez-Camargo, 2020	C	Comparative embedded case study Semi-structured interviews FGDs	Representatives from district and municipal government, health providers, development agencies, community groups. Citizens / community members
To explore how social capital facilitates the engagement with external development agents and local health governance actors, and fosters collective action around village organisations and community-based health funds	Jacobs and Hofman, 2020	D	Comparative embedded case study Purposive literature review Semi-structured interviews FGDs	Representatives from district and municipal government, health providers, development agencies, community groups. Citizens / community members

2.3 Thesis outline

The following chapter (three) provides an overview of the theoretical and conceptual tools used to address the objectives outlined above. Chapter four describes the study setting, including the socioeconomic situation in Tajikistan, the governance context and the state of its health system. Chapter five provides a summary of each research paper. The discussion, chapter six, is comprised of an overview, the main conclusions in relation to the research objectives, wider conclusions on health systems governance in Tajikistan, a discussion of the theoretical implications, research strengths and limitations and lastly recommendations for further research.

3. Theoretical background

This chapter presents the main theories and concepts used in this thesis to explore different dimensions and levels of health governance in Tajikistan.

3.1 The growing field of (health systems) governance

Responding adequately to the health needs of a population requires affordable and quality healthcare services. However, these services do not exist in isolation. They are part of, and embedded in, health systems (World Health Organization 2007). In health systems, different components (sub-systems or 'building blocks') interact with each other and produce a given outcome (de Savigny and Adam 2009). These include governance, financing, human resources for health, medical products and technology, and information in addition to service delivery. In turn, health systems can be viewed as complex social systems embedded in a wider context (Greenhalgh and Papoutsi 2018), which function to emanate prevailing societal values (Gilson 2003). This warrants explicit attention to the social, economic and political dimensions of health systems.

Governance has been seen as central and instrumental to health systems performance, in line with the 'good governance paradigm' whereby good governance is considered a prerequisite for sustainable development (Landell-Mills, Agarwala, and Please 1989). The emergence of this paradigm can be traced to a number of international developments in the 1980s and 1990s (Chhotray and Stoker 2009). The political dimensions of policymaking garnered increased interest because of frustration with the lack of success from the World Bank's and International Monetary Fund's Structural Adjustment Programmes in the 1980s, which was largely blamed on domestic political factors in partner (or 'recipient') countries (Walt and Gilson 1994). Although the Structural Adjustment Programmes were chiefly approached as technical economic interventions it became evident that their planning and implementation depended largely on political and bureaucratic commitment, skill, competence and capacity (Healy and Robinson 1992). The collapse of communist rule across central and eastern Europe and the rise of democratisation movements in the 1980s and early 1990s provided ammunition to the vindictive view of liberal democracy's superiority as a system of governance. It also gave more leverage to development agents from 'the West' over low and middle income country 'partners' because the fear of losing them to communism had dissipated (Leftwich 1994). This also explains the enduring equation of good governance with western liberal democracy, often officially shrouded in more 'technicist' terms to obscure its normative, political premise (Leftwich 1994).

This normative, technicist perspective was clearly apparent in the emerging literature on health governance, particularly from representatives of the World Health Organization (WHO) (Travis et al. 2002; Siddiqi et al. 2009) and the World Bank (Lewis and Pettersson 2009). They proposed conceptual frameworks to study how (health) governance ought to be in universal terms, and, in WHO's case, narrowed the focus on stewardship, and 'the state's [usually the Ministry of Health's] role in taking responsibility for the health and well-being of the population' (Travis et al. 2002, 289). These analytical approaches emphasised the existence of formal and codified institutions that are assumed to contribute to health service delivery performance, and focused on 'government' as a singular black box entity (Abimbola et al. 2017). These approaches however did not have much empirical grounding and were largely hypothetical or normative. More importantly even, they offered little insight into how governance actually takes place with its intricate power dynamics and informal rules and practices (Abimbola et al. 2017). Since these earlier publications, the field has continuously grown, with a plethora of new frameworks and perspectives on the topic. In this conceptual chaos it is possible to distinguish between two types of approaches: those with a predominantly normative view of governance, defined as an ideal- characteristic of a prefix before the terms such as good, good enough, democratic, effective, and so forth; and more descriptive interpretations of governance, defined by the structure of institutional relationships (Barbazza and Tello 2014). In a descriptive, relational and institutionalist sense, health governance is seen to concern the process of interaction between formal

(rules, laws, policies) and informal (customs, loyalties, social norms) institutions and the distribution of responsibility and power in the health system.

Despite the proliferation of frameworks and formulation of conceptual approaches to study health governance, they remained insufficiently tested in empirical terms (Pyone, Smith, and van den Broek 2017). Moreover, many, particularly low-income, neo-patrimonial and fragile settings present a complex context for which frameworks based on an understanding of hierarchical, centralised and coherent health systems do not easily fit. This calls for a flexible application of conceptual tools that are able to tease out these contextual nuances, while shedding meaningful insight into a health governance arrangement, so that it can be used for retroactive or prospective learning. This thesis will demonstrate an exploration of the application of such conceptual tools in a neo-patrimonial setting, that together could be grouped under the rubric of political economy analysis approaches derived from new institutionalism. The next section will provide an overview of these concepts and approaches.

3.2 Approaches to understanding governance

The fragile, neo-patrimonial state
Poverty worldwide is increasingly concentrated in settings described as fragile. The Organisation for Economic Co-operation and Development (OECD) estimates that by 2030, more than 80% of the world's poorest will be living in fragile and conflict-affected settings (OECD 2018). State fragility is a contested concept, but the consensus is that it denotes a situation in which the state is unable or unwilling to meet the basic needs of its population, including the poor (DFID 2005; Woodward et al. 2016). What complicates the understanding of state fragility is that this definition arguably applies to the majority of low income countries, and state fragility can be more pronounced in some territories than in others within the same nation state. This calls for a nuanced, contextualised understanding of these settings.

In understanding state fragility the concept of neo-patrimonialism can help elucidate the role of governance in it. Although criticised as a catch-all concept (Erdmann and Engel 2006), neo-patrimonialism provides a helpful, less normative understanding of governance settings (Booth 2009) in which legal-rational structures are permeated and shaped by more patrimonial, particularistic arrangements, norms and relationships (Eisenstadt 1973). In this sense it forms a hybrid between the Weberian ideal types of legal-rational and traditional authority (Erdmann and Engel 2006).

Legal rational authority, or 'domination by virtue of legality' can be characterised as being derived from the virtue of belief in the validity of impersonal and rationally created rules, while traditional (or patrimonial) authority is taken as wholly personalised, and not limited by formal rules and procedures (Gerth and Mills 1946). Obedience and control in patrimonial systems is maintained by devotion to the ruler (archetypically a prince or Sultan) because of historical convention and his/her personal distribution of spoils or rent. In legal-rational states on the other hand, authority is maintained by a hierarchy of administrative positions, grades and functions and loyalty to an anonymous state (Clapham 1985). Weber viewed these types of authority, in addition to charismatic authority, which stresses prophetic or demagogic leadership, as occurring in hierarchical and chronological sequence, with all societies eventually adopting legal-rational systems of governance. Yet, the concept of neo-patrimonialism suggests governance in any given setting can bear the characteristics of both types of authority. Another way to characterise these settings is therefore 'dual governance systems' (Brinkerhoff and Goldsmith 2002). In some cases this permeation of patrimonial, particularistic governance structures has largely turned the state and its structures into a vehicle for enrichment of the elite, known as elite capture, or even criminal enterprise (Bayart, Ellis, and Hibou 1999).

Although the concept of neo-patrimonialism was initially mainly applied to postcolonial African settings, which were dominated by such hybrid regimes, neo-patrimonial features can be found across the world. In the (post-)communist sphere the specific legacy of widespread statist intervention created a version that has been termed 'communist patrimonialism' (Kitschelt et al. 1999). In Central Asian countries dominated by authoritarian strongmen the phenomenon has been denoted as 'patronal presidentialism' (Laruelle 2012). To further understand the nature of power and authority in this setting it is helpful to refer to the governance typologies developed by Levy (Levy 2015). As illustrated in table 3 four typologies can be distinguished along two axes: the horizontal axis ranges from power being concentrated in the hands of a dominant leader or party to a more competitive power arrangement in which different groups have negotiated a settlement for the contestation of power. The vertical axis ranges from the presence of a highly personalised, or patrimonial state structure to highly impersonalised, legal-rational institutions. The role of rents, defined as 'returns that exceed the opportunity cost of resources which might otherwise be deployed in a competitive market' (Levy 2015) is different depending on the personalisation of institutions. Roughly speaking, rents are accessed (or sought) on the basis of more meritocratic principles, constrained by differentiated access to human and financial capital, in settings where institutions are more impersonal, while in personalised settings, rent-seeking and the discretionary allocation of rents is the main currency of politics (Levy 2015).

Table 3. Governance typologies.

		Organisational and institutional complexity	
Political settlement		***Personalised elite bargain***	***High impersonality***
	Dominant	Dominant discretionary	Rule-by-law dominant
	Competitive	Personalised competitive	Rule-by-law competitive

Source: (Levy 2015)

This typology highlights the importance of institutions and their use, application and meaning to governance, which will be described in the next section.

New institutionalism and political economy analysis

New institutionalism emerged in the 1980s as a reaction to the dominance of behaviouralist schools in sociology and political science, and hyper-individualism of classical economic theory (Chhotray and Stoker 2009, 53). It harks back to the theories espoused by institutional economists such as Thorstein Veblen and John Commons, and structural-functionalist sociologists Emile Durkheim and Talcott Parsons with their focus on structure-agency interaction and the role of (social) institutions in economic, social and cultural life (Powell and DiMaggio 2012). Its application of economics to the study of institutions broadly, is arguably an elaboration of public choice theory to realms beyond politics and bureaucracy (Kirchner 2007). New institutionalist approaches tend to explicitly view individuals' choices on the basis of their mental models, strongly influenced by values and norms. In other words, political, social and economic interactions are structured by humanly devised constraints that could be defined as institutions (North 1991). Institutions can be formal (laws, codes, regulations) or informal (customs, taboos, loyalties, traditions). Institutions should not just be seen as 'rules', but rather as rules in their practical application and enforcement (Kirchner 2007). Institutions help to reduce uncertainty in human exchange by limiting transaction costs, i.e. the costs that people or organisations incur when trying to overcome their information and capacity limitations when interacting with others (North 1990). In business, for example, the risk of investing in an unknown environment is deemed lower when relevant rules and mandates are clear and enforced.

The general application of this institutionalist perspective to the analysis of political and institutional behaviour and relationships has been referred to as political economy analysis (PEA) (Weingast and

Wittman 2006). PEA has been employed through different perspectives, dating back to works by Jean-Jacques Rousseau, Adam Smith and Karl Marx on the relationship between the state, the economy and society. As a methodological approach it is generally aimed at identifying actors, and their power, position and interests (Sparkes et al. 2019), as well as the barriers and facilitators to their cooperation (Pettit and Mejia Acosta 2014). PEA is multifaceted and can be applied to different sectors or phenomena. Commonly, its focus is on the interaction between the structural and institutional context on the one hand; and agency dynamics, i.e. relevant actors, their motivations interests, cooperation and contestation on the other (Harris 2013). PEA can help to explain the broader forces that affect the distribution of health and resources within and across populations (Participants at the Bellagio Workshop on Political Economy of Global Health 2015), which is what it is generally used for in this thesis. A wide number of concepts and theoretical tools are applied to do so, and could be grouped under the rubric of PEA, each lending a different insight into the analysis of institutional behaviour and relationships. In this thesis, a selected number of such concepts and tools have been explored, which will be elaborated on below. In addition to the application of PEA to central level policy reforms in terms of the general analysis of stakeholders and their interaction with the health system and wider political-economic context, these include principal-agent and accountability theory, collective action theory and its related concepts of social capital and trust.

Principal-agent relationships and accountability

Principal-agent theory, or agency theory presents a 'model of social relations involving the delegation of authority, and generally resulting in problems of control' (Kiser 1999), which has broad application. It is essentially concerned with the connection between incentives and performance (Stiglitz 1989) , and the tensions between the interests of the principal on the one hand and the agent - or multiple agents - on the other (Kiser 1999). Principal-agent theory can help uncover (institutional) incentive structures that reduce or facilitate problems associated with asymmetric information (Rauchhaus 2009). Closely linked is the concept of accountability, which 'concerns the obligation of one actor to provide information about and/or justification for his or her actions in response to another actor with the power to make those demands and apply sanctions for non-compliance' (Brinkerhoff and Wetterberg 2016). In other words, accountability is an ongoing dynamic principal-agent relationship characterised by an asymmetry of information and power focused on performance upon a mandate. This relationship is characterised by three core elements (Lodenstein 2019): Voice, interpreted as 'articulating an interest' (Hirschman 1970), answerability and enforceability (Brinkerhoff 2004; Newell and Wheeler 2006).

It is possible to further disaggregate this by assuming that it is only possible to speak of an ideal type accountability relationship in public governance when five components are present (Baez Camargo and Jacobs 2013): a mandate, resources, performance, information about performance, and enforceability. Although these elements are mutually reinforcing and dependent, it is useful to depict them in a sequenced order for clarity. These components are illustrated in figure 1. First, a clear mandate, in other words a voice focused at a task, specifying what is expected from the agent must exist and be known. Next, the agent needs to have access to the resources necessary to carry out the mandate. With a clear mandate and adequate resources the agent should perform upon the mandate. However, the essence of accountability resides in the fact that the principal retains the ability to follow up on the performance of the agent (answerability). Therefore, performance of the agent needs to be monitored vis-à-vis the original mandate and the potential to enforce sanctions (enforceability) in case of unsatisfactory performance needs to exist.

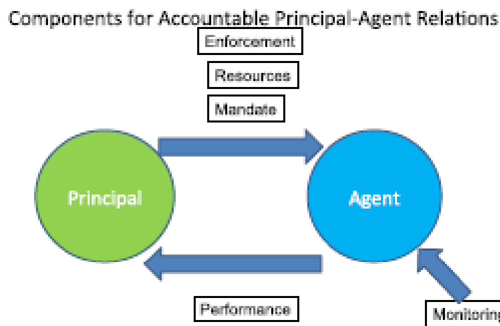

Figure 1 Ideal type accountability relationship and its components

Source: (Baez Camargo 2011) based on (World Bank 2004).

This ideal type of an accountable principal-agent relationship enables a better understanding of typical political economy dilemmas. In fact, Stiglitz argues that principal-agent problems are the central problems of economic incentives (Stiglitz 1989). Economists distinguish between two types of principal-agent problems: those resulting from *hidden information* and those resulting from *hidden action* (Rauchhaus 2009). Hidden action generates what is called a moral hazard. This is a phenomenon in which agents display risky behaviour once they lack incentives to guard against risk as the risk is borne by others. These incentives typically stem from contractual relations, such as health insurance, and arise when monitoring mechanisms are inadequate to capture the behaviour of the agent once the contractual terms have been settled and entered into- hence the term *hidden action*. *Hidden information* can generate a situation of adverse selection, in which the agent can perform in sub-standard ways because the principal has insufficient information to judge the quality of the performance and the poor quality delivered does not affect the agent, but only the principal (Akerlof 1978). This typifies the information asymmetry between patients and health providers, whereby (lay) patients cannot easily judge the quality and appropriateness of healthcare on offer and are sometimes provided substandard care or unnecessary medical interventions as a result.

In health systems, a focus on accountability has been seen as key to improving performance (Brinkerhoff 2004). The desire to improve accountability and responsiveness of health officials towards citizens has been invoked to push for decentralisation reforms that have swept through many low and middle income countries since the 1990s (Bossert 1998). This has led to the conviction that a health governance lens focusing on principal-agent relationships among actors in the health system helps to analyse and diagnose institutional incentive problems (Brinkerhoff and Bossert 2013). Accountability within health systems has originally been conceptualised by the World Bank (World Bank 2004), and later by Brinkerhoff and Bossert (Brinkerhoff and Bossert 2013) among others, as a triangular process between three main categories of actors: the state and its politicians and policymakers; providers; and citizens or clients. The character of these principal-agent relationships is illustrated in Figure 2

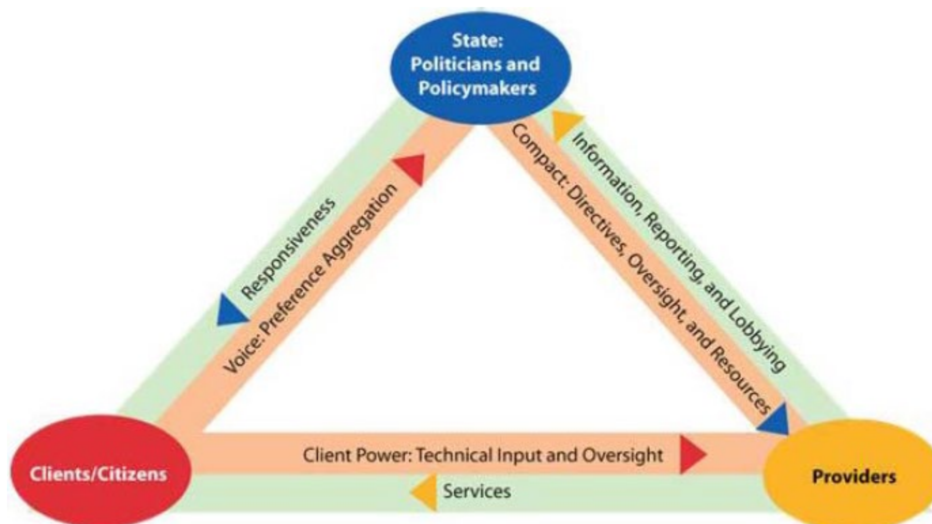

Figure 2 Accountability in health systems

Source: (Brinkerhoff and Bossert 2013)

In this model, and generally within international development citizens/clients are seen as representing the *demand side* of governance, while the state and providers represent the *supply side*. Citizens can demand provider performance through the state, who should act on their behalf and direct providers to deliver services, which is usually called the *long route of accountability*; or hold providers to account directly, i.e. through the *short route of accountability*. This model has been criticised for the assumptions it carries. A crucial but flawed assumption in many cases is that citizens, i.e. principals, naturally have an uncomplicated desire and ability to hold agents to account. They are, in other words, *principled principals* (Persson, Rothstein, and Teorell 2013) and collaborate if their interests align. Another questionable assumption is that governments are led by people who are principally and genuinely concerned with how to develop their country (Booth and Cammack 2013). Yet, in reality, despite this assumed commitment, principals and agents are unable to overcome their particular interest for the common good. To explain this dilemma, other conceptual tools, chiefly those derived from collective action theory, are needed.

Collective action and social capital
Collective action theory is a related but distinct body of theory that enables a complementary understanding of governance relations from an institutionalist perspective. It stems from the observation that individuals with common interests often do not collaborate to further those interests (Olson 1965). Unlike agency theory, the focus of these approaches is not on problems arising from information asymmetry between actor groups that are assumed to be homogenous. Instead, it is primarily concerned with the (in)ability to overcome particular interests in order to further joint interests, and the role of civic engagement networks or reciprocal social relations based on shared norms, i.e. social capital. Increasingly, governance failure and bottlenecks in international development and aid are principally seen as collective action dilemmas (Gibson et al. 2005; Shivakumar 2005; Bano 2012; Booth and Cammack 2013). Social capital and collective action theory are particularly suitable to unpack governance relations at local level, with due attention to the role of the variety of formal and informal networks that matter in people's interactions. In the study of communities as micro-level agents and the focus on their shared and contesting rules, collective action and social capital as conceptual approaches can therefore be called micro-institutionalist (Earl and Potts 2011).

The principal collective action dilemmas revolve around situations where people fail to act collectively because 'the first-movers would incur costs or risks and they have no assurance that the other beneficiaries will compensate them' (Booth 2012, 12). This is especially pertinent in case of non-excludability from the collective good, once it has been produced. Rational strategies, from the actors' point of view, can lead to erosion of the public good (Bano 2012), or depletion of a common pool resource, also known as the tragedy of the commons (Ostrom 1990). Because of non-excludability the benefits of a public good are shared with those who have not contributed to it, which could encourage free-riders (the free-rider problem) and discourage the continued contribution of this good, or adherence to the rules of the game in case of common pool resource management. Collective action dilemmas can be overcome when a shared set of norms on access and management are set up and adhered to, which can be aided by the existence of reciprocal social networks or communities that already share a set of norms (Ostrom 1990). These 'norms and networks that enable people to act collectively' are also referred to as social capital (Woolcock and Narayan 2000).

Social capital is more than merely the existence of a social network. Rather, social capital is defined by its function (Coleman 1988). It should be understood as the aggregate of resources that are linked to membership of a group, which provides each of the members a type of reciprocal capital (Bourdieu 1986). In other words, it is a *resource for action*, in that the group membership facilitates certain actions of the group member or the group as a whole (Coleman 1988). An example of this is the trust between Jewish diamond merchants in New York City that facilitates a free exchange of diamonds for inspection in private before any deal is made, stemming from the fact that they live together in a close-knit community (Coleman 1988). In short, 'trust lubricates social life' (Putnam 1993).

In search of new answers after the frustration with the Structural Adjustment Programmes in the 1980s and the reduced role of the state, social capital came to be seen by some as the 'missing link' in development (Grootaert et al. 2003) and its relation to health has been extensively researched since then (Kawachi, Subramanian, and Kim 2008). This strong belief in the potential for civic life in addressing development problems has been criticised, contested and nuanced extensively (cf. (Harriss and De Renzio 1997)). In understanding (failures of) collective action it however continues to provide a useful analytical lens, although it requires a close contextual view on the relationship between communities and their leadership, other communities and external agents such as development NGOs. A useful distinction for this purpose is between the strong ties that bind close networks of friends, family and community together (i.e. bonding capital) and the weak ties (bridging or linking capital) with acquaintances or people outside their direct, close networks, that each have their own tight networks (Granovetter 1983; Gittell and Vidal 1998; Woolcock and Narayan 2000). In interaction with other communities the own bonds can thus function as a resource (Purdue 2001). As much as there are differences between communities in terms of how tight-knit and reciprocal their bonds are, i.e. how strong their bonding capital is, some communities are better able to establish or make use of these extra-communitarian links than others. In other words, bridging capital varies from community to community.

3.3 Conclusion

Understanding health systems governance at the multiple levels that it is being played out requires the use of a range of approaches, theories and concepts, especially in fragile settings such as Tajikistan. To increase the understanding of the ways in which key health system actors and stakeholders at these various levels relate to each other, and the wider context in decision-making on the direction, performance and responsiveness of the Tajik health system this thesis argues that the approaches provided by the new institutionalist schools of sociology, political science and economics are particularly useful. These include attention to political economy dynamics, summarised as political economy analysis, principle-agent theory and the concept of accountability, collective action and its associated social capital theory, as elaborated on in this chapter. To that end, this thesis will 1) provide

a discussion of useful concepts to explore the governance of basic services in neo-patrimonial systems of governance in general; 2) identify the main governance constraints to the introduction and implementation of the BBP reforms and associated health management changes with a political economy analytical perspective; 3) analyse district health governance in terms of principal-agent relationships; and 4) explore how social capital facilitates the engagement with external development agents and local health governance actors, and fosters collective action around village organisations and community-based health funds.

4. Context and study setting

4.1 The socioeconomic situation

Located in the heart of Central Asia, with a population of around 9 million inhabitants, the Republic of Tajikistan is bordered by Uzbekistan in the west, Kyrgyzstan in the north, China in the east and Afghanistan in the South, as shown in figure 3. Together with Turkic-speaking Central Asian neighbours to the north and the west it was one of the 15 Soviet Socialist Republics that together formed the Soviet Union (or Union of Soviet Socialist Republics - USSR) until its dissolution in 1991. Tajikistan is the only former Soviet republic in which varieties of the Persian language dominate, chiefly the Tajik and Pamiri varieties. In addition Russian is still widely spoken by members of the former *nomenklatura* (communist party elite) and higher educated groups in society.

Figure 3 Map of Tajikistan

Source: (UN 2009)

As the poorest of the former Soviet republics its economy, infrastructure and basic services, including healthcare, were further eroded by a civil war, which broke out shortly after the country gained independence, and lasted until 1997. It remains the poorest of the former Soviet Republics with a Gross Domestic Product per capita of around USD 3,520 at purchasing power parity, roughly on a par with countries such as the Republic of Congo, Yemen and Nepal (World Bank 2019a). At present just over 20% of the population falls below the international poverty line of US$3.20 a day and over 54% fall below the poverty line of US$5.50 a day (World Bank 2019c). Although the economy of Tajikistan has grown consistently since the end of the civil war and formal poverty rates have dropped, this has largely been fuelled by remittances sent back by Tajik workers abroad (Price 2018). A decline in income

from remittances, particularly for poorer households, directly related to the recent economic downturn in Russia where most Tajik labour migrant work, therefore largely explains the slowing of poverty reduction in recent years (Rajabov and Seitz 2018). The domestic private sector remains weak, and at 31% remittances in Tajikistan make up the fifth largest share of GDP worldwide (Knomad 2018). Survey results from 2010 suggest that for more than 60% of households remittances account for more than half of their income (ILO 2010). This reflects a lack of employment opportunities in the country and vulnerability to external shocks. Illicit drug trafficking is a large additional source of income, in which state actors are highly implicated, as Tajikistan functions as a key transit country for opiates from Afghanistan (De Danieli 2011; 2014; Engvall 2006; Paoli et al. 2007). Although it is impossible to assess its scale accurately, the share of proceeds from drugs in the total economy has been estimated to range from 30 to 50% (Paoli et al. 2007; Engvall 2006). In daily life most households are active in agriculture, in which cotton and fruit production dominate, and a relatively small industrial sector, with mostly aluminium and cement production. Altogether, the weakness of the private sector, dependence on remittances and the large size of the informal and criminal economy suggest the economic foundations of the country are precarious, leaving households highly vulnerable.

Although traditionally people mostly practised a nomadic lifestyle or relied on subsistence agriculture, cotton growing was heavily promoted by the imperial Russian government, and later Soviet authorities. Soviet central planning led to a massive collectivisation of agriculture and even greater focus on cotton as a monocrop (Hofman 2019). Particularly in the early Stalinist years, collectivisation was accompanied by forced resettlement of people from mountain areas, including Pamiri people from the (nominally autonomous) region of Gorno-Badakshan (GBAO) and Gharmis from the Rasht or Karetegin Valley, contributing to both the creation of new regional identities and feelings of resentment, later finding an expression in the civil war (Foster 2015; Tunçer Kılavuz 2009), which the following section will elaborate on.

4.2 Governance, conflict and statehood in Tajikistan

Governance in Tajikistan has long taken the form of co-opted local elites. As the Russian empire swept up the area of the later Republic of Tajikistan around 1865 its colonial rule was first of all limited to a military presence with many administrative features of pre-colonial rule still continuing (Collins 2006; Hirsch 2005; Roy 2000). This arguably continued and only slowly changed after the Russian empire went through a period of political-economic change following the 1917 Bolshevik revolution (Hirsch 2005). Despite the repressive and ideologically totalitarian nature of the Soviet regime, informal, localist networks continued to play a large role in Tajikistan through a sometimes planned, and often opportunistic, policy of co-optation, adaptation or modification. This already started in the 1920s and 1930s when the Soviet Commission for the Study of Tribal Composition successfully argued for the set-up of local soviets (governance councils) on the basis of traditional councils. Kolkhozes and sovkhozes (collective and state farms) were often formed around single clan identities and the Commission found that 'dekulakization' was largely unsuccessful in Central Asia because of loyalty within informal clan networks (Collins 2006, 89–101; Hirsch 2005; Slezkine 1994). In the following decades, 'party cadre policy, part consciously and part unconsciously, incorporated and reified pre-existing identity divisions' (Collins 2002, 98). Under Brezhnev, indirect rule with local elites continued as part of a strategy of stability through patronage (Bunce 1983). This situation has led Olivier Roy to argue that 'the Soviet System is more totalising (bringing everything within its order and registers) than totalitarian (gathering the whole of society into the state): [...] in the rural areas the party itself was entirely captured by traditional solidarity groups, as were the KGB and the militias' (Roy 2000, xiii). Nevertheless, or because of this 'totalising effort' the Soviet experience still profoundly impacted on Tajik society. The Soviet state has been considered to have born features of both a colonial empire and a modern developmentalist state (Kassymbekova 2016). Tajikistan was both used as a far-away territory from which resources could be extracted (mainly cotton harvested through manual labour) at a high human and environmental cost, particularly in the Stalinist era (Gleason 1991), and given

large investments in infrastructure, and basic services such as healthcare, which aided human development (Kalinovsky 2018). The continued importance of *dehqon* farms, the (often privatised) successors to the kolkhoz and sovkhoz, as units of social organisation and solidarity in society points to the impact of the Soviet socioeconomic model on society (Hofman and Visser 2014; Roy 2000). On the other hand, despite decades of statist ideology, a civil society and local governance structures independent of the (former Soviet) state, such as the *mahalla*, or neighbourhood council, have continued to exist and play a role in local collective action, which could be an entry point for locally grounded, community-based development initiatives (Cieslewska 2010).

Tajikistan was faced with severe economic crisis[1] as a result of the break-up of the Soviet Union in 1991. Independence itself came suddenly as a result of the dissolution of the union, rather than borne out of a strong independence movement. The complete withdrawal of subsidies from Moscow, and loss of a guaranteed market for its main export products as part of the centralised planned economic system, led to a drastic fall in living standards. In the wake of the power vacuum and harsh socio-economic consequences that ensued, a violent power struggle erupted, which has come to be known as the Tajik civil war. Lasting from spring 1992 to a peace agreement in June 1997, official reported casualties range from 23,500 (Nourzhanov and Bleuer 2013) to 157,000, with 700,000 internally displaced people and around 300,000 Russians fleeing the country (Matveeva 2009). The conflict mainly raged between the elite network from Khujand, which had long dominated the communist elite, allied with factions from the region around Kulob and Hisor, supported by Russia on the one hand and various opposition groups, loosely allied in the United Tajik Opposition (UTO) on the other. The Tajik civil war has often been portrayed as an ideological battle between hardline communists (the establishment) and Islamic extremists (the UTO). However, this severely overlooks the heterogeneous nature of the UTO, which included nationalist and liberal-democratic factions, and the fact that discontent can largely be traced back to the severe power imbalance after nearly half a century of Khujandi hegemony in government, propped up by Moscow, and the marginalisation of other regionalist factions. These included people from the Gharm, also known as Rasht or Karotegin valley, and Pamiris that had long felt isolated or had been forcibly resettled during the years of collectivisation. The view that the political turmoil and ensuing violent conflict was merely a result of rivalry between localist or kinship groups is contested because ideological differences, particularly on the secularist nature of the state, did play a role (Malik 1996, 211, 212). It is therefore widely acknowledged, albeit from different standpoints, that localist patronage networks, and the politicisation of regional and religious identities were key to political mobilisation in the process of civil unrest and state breakdown in Tajikistan (Roy 1997; Rubin and Snyder 1998, 152–53; Akiner 2001; Collins 2002, 192–208; Bleuer 2011, 219–90).

The fierce war not only severely damaged the already frail economy and basic services, which provoked a humanitarian crisis, but also saw a fragmentation of power, and near collapse of the state as a unitary entity across the country. Although a peace agreement was signed in 1997, whereby Emomali Rahmon(ov) came out as a victor, this fragmentation of power is still reflected in the governance situation today. The state and power-building strategy of Emomali Rahmon, who has remained president since, has been to either co-opt or neutralise political rivals and appoint fellow Kulyabis and family members to key positions (Buisson 2007). Through a combination of repression, and cronyism, including the distribution of toll positions from which rent can be accrued to cronies, he has strengthened his position in government and kept a relative, or *virtual* peace (Heathershaw 2009), although violent outbreaks have continued to take place since in the Gharm region and GBAO The regime's neo-patrimonial style of governance and continued political tension is characterised by a weak ability and capacity to deliver basic services and goods. Non-productive sectors such as

[1] Until 1991, the Soviet authorities in Moscow supplied 46.6% of the Tajik government budget (Collins 2002, 157), a loss of income from which it only very slowly recovered: 'In 2008 GDP per capita stood at $245 USD (in constant 2000 US$), almost 50% down from its 1989 level of US$ 440' (Rechel and Khodjamurodov, 2010: 1) from World Bank 2010).

healthcare and education remain deeply underfunded and its institutions are plagued by corruption and rent-seeking. In this sense Tajikistan bears the typical features of a fragile state (OECD 2018; Fund for Peace 2019).

4.3 Tajikistan's health system

Over the course of the 20th century large investments in basic services, including water, healthcare, education and energy resulted in a significant improvement of people's health across the Union of Soviet Socialist Republics, or Soviet Union, although regional inequities were high (Kazatchkine 2017). Despite the inequitable distribution of health improvements and questionable data quality, it is fair to assume these improvements were also felt in the 'southern tier' of the Soviet Union, i.e. Central Asia, since no modern medicine infrastructure existed there by the start of the 20th century (E. Jones and Grupp 1983). It was only under Soviet dominance that a large public healthcare system was established. Over time it came to be known as the Semashko system of healthcare, named after the first People's Commissar (Minister) of Public Health from 1918-1930, Nikolai Semashko, of which many basic features are still in place in Tajikistan today. The Semaskho system's main characteristics were its reliance on central provider-centric planning (as opposed to a patient-centric needs or a demand-based rationale), a high degree of specialisation at the expense of family medicine, public funding and ownership of facilities, and an oversupply of hospital beds and physicians compared to health systems elsewhere. As originally put in place, the health system in Tajikistan still features a duplication and fragmentation of health system functions across different agencies and administrative layers (Davis 2010, 29).

Similar to the situation elsewhere in Central Asia, health facilities have been set up at the republican, oblast (regional), rayon (district) and jamoat (municipal) levels and each different government level carries out similar and overlapping roles including revenue collection, provision of services, payment of salaries, maintenance of infrastructure, monitoring and enforcement (Ibraimova et al. 2011, 50). Vertical programmes exist for specific disease groups and some ministries, such as those for defence and internal affairs, own and manage their own healthcare services (Rechel et al. 2011, 3). Private service provision is limited and mainly confined to some providers in Dushanbe, the capital. As will be elaborated in this thesis, the fragmentation, duplication in and underfunding of the health system poses severe challenges to health service delivery and ultimately public health.

The economic and humanitarian crisis following Tajikistan's independence and civil war put a great strain on the health system. As resources dwindled, existing weaknesses of the system worsened, the quality of services declined and public health deteriorated. Although the system was originally envisioned to be wholly publicly funded, out-of-pocket expenditure has increased (Schwarz et al. 2013) and is now the largest source of health funding at 63% of total health expenditure. Health expenditure takes up a comparatively low share of total government expenditure at 7% (WHO 2019). These figures are at the extreme ends when compared to countries of similar income level from the former USSR. There is evidence that these costs are substantial for individuals (Ayé et al. 2010a) and form the biggest barrier to accessing healthcare, for example to drugs in general (Donadel et al. 2016), tuberculosis diagnosis and treatment (Ayé et al. 2010b) and family medicine (Tediosi et al. 2008). When incurred they form a substantial risk for impoverishment (Ayé et al. 2011). To regulate entitlements to a range of healthcare services and associated co-payments the country has been in the process of defining and introducing a basic benefit package. As this thesis will show this introduction has been hampered by a range of political economy constraints at both central and local levels.

As the poorest of the former Soviet republics, infant and maternal mortality remain one of the highest of the former USSR and wider WHO Europe region. Although a number of infectious diseases have successfully been reduced due to mass vaccination, the country continues to face a double burden of

both communicable and non-communicable diseases and a high burden of children's and nutritional diseases, as indicated by the causes of years of life lost (IHME 2018). Other basic health indicators show that the country fares relatively worse in several aspects as compared to its neighbouring former Soviet countries, as shown in table 4.

Table 4. Selected health indicators for Central Asian countries

Health indicators	*Tajikistan*	*Kyrgyzstan*	*Uzbekistan*
Life expectancy at birth (2017)	71	71	71
Under-five mortality per 1000 live births (2018)	35	19	21
Maternal mortality per 100,000 live births, national estimate (2012)	33	49	20
Stunting prevalence, height for age % of children under 5 (2012, 2014, 2006)	26.8	12.9	19.6
Unmet need for contraception, % of married women aged 15-49 (2017, 2018, 1996)	23	19	14

Source: World Bank Open Data (World Bank 2019b)

This section has elaborated on some of the key political, economic, historical and epidemiological contextual features of Tajikistan's governance set-up and its health system. The low income, post-conflict, post-Soviet, fragile context poses significant challenges to how the health system is shaped, funded and maintained and warrants the use of approaches that pay explicit attention to the governance incentives stemming from this political economy. The combination of a Soviet legacy in its health system, deep underfunding and resource scarcity and the conflict-affected, fragile context is almost unique to Tajikistan, although some settings in the Caucasus region could be expected to bear similarities in their challenges. This makes Tajikistan a particularly relevant setting for the exploration of health systems governance challenges in line with the theory and concepts elaborated it in section 3.

5. Overall contribution

This chapter introduces and summarises the studies conducted and resultant peer-reviewed published works that form the main pillars of this thesis (see appendixes A-D).

5.1 Publication 1

Eelco Jacobs, 'Basic public services and informal power: an analytical framework for sector governance' in Mansfeldova, Zdenka & Pleines, Heiko (eds.) (2011). *Informal Relations from Democratic Representation to Corruption: Case Studies from Central and Eastern Europe*. Stuttgart: Ibidem Verlag.

This book chapter, which is based on a narrative literature review, focuses on the question, 'what is the best way to analyse governance of basic service delivery while taking full account of the mix of informal and formal power?' It starts out from a conceptualisation of governance in terms of the formulation and operationalisation of rules and procedures that facilitate and constrain societal interaction. These rules and procedures, or constraints that human beings devise to shape interaction, can also be defined as institutions (North 1990), which can be both formal and informal. Informal and formal institutions co-exist and interweave with each other in all political and bureaucratic systems, albeit to varying degrees. Because of their large impact on the quality of human life, basic services such as water, education or health services are seen as a public good in most countries. In most low and middle-income countries universal access to these services is not a reality and they frequently fail to reach adequate quality standards. The book chapter contends that to understand this failure in the delivery of basic public goods attention needs to be paid to its governance, with due consideration for the importance of informal institutions and actors. The importance of informal institutions and their impact on governance in low and middle-income countries requires a closer look at the historical and structural development of their states. In doing so, the concept of neo-patrimonialism is invoked. Essentially the neo-patrimonial state possesses the basic structures of a modern bureaucracy (albeit often partly symbolic or redundant) but is strongly pervaded by informal networks and particularistic rather than legal-rational institutions (Eisenstadt 1973). Due to the influence of these personalistic institutions, *in lieu* of institutions based on principles of bureaucratic legal rationality, societal inequalities are reproduced, instead of mitigated in the public sphere. Clientelist relations and other personalistic modes of governance become essential for access to education, health care and clean water, leading to exclusion of groups who are not part of these networks, and a potential erosion of the state's legitimacy. The book chapter argues that this constitutes the heart of state fragility, which is conceptualised as a distortion of the 'social contract, i.e. the interplay between state capacity, will and legitimacy in relation to the delivery of basic services (B. Jones and Chandran 2008). An understanding of these mechanisms is therefore crucial to acquire a full picture of the challenges in the governance of basic services. In a discussion of different governance assessment frameworks the book chapter highlights the limitations of tools that take a one-size-fits-all gap-analysis approach, relying largely on quantitative indicators. Instead, the book chapter argues that any sector governance assessment needs to focus on in the dynamic interplay between institutions and agents, in a contextually flexible way, based on political economy and power and influence analysis approaches, questioning where and how power is exercised (Boesen 2008; Schiffer and Waale 2008). In this light the book chapter further discusses the potential contributions of stakeholder analysis, collective action and public choice theory can make to the study of sector governance with reference to Ostrom (Ostrom 2009), Becker (Becker 1993) and Varvasovsky and Brugha (Varvasovszky and Brugha 2000).

The discussion on sector governance and informal dimensions of power presented in this chapter represents an initial effort to sketch the contours for an analytical framework from an institutionalist perspective. The practical utility of such a framework in assessing governance-related problems in

basic service delivery requires empirical research, which will undoubtedly generate new hypotheses on the role of (informal) institutions and actors in different settings.

Own contribution to Publication (1): I am the single author of this book chapter and hence responsible for the complete contribution. I am indebted to Manfred Max Bergman, Claudia-Baez Camargo as well as Zdenka Mansfeldova, Heiko Pleines and the other organisers and participants of the Changing Europe Summer School on 'Informal Networks, Clientelism and Corruption. Case Studies from Central and Eastern Europe' held in Prague at the Institute of Sociology of the Academy of Sciences of the Czech Republic in August 2010 for their valuable critical feedback.

5.2 Publication 2

Jacobs, E. (2019). The politics of the basic benefit package health reforms in Tajikistan. *Global health research and policy*, 4(1), 14.

In line with the central argument of this thesis, this article starts out from the premise that health reform is a fundamentally political process. Yet, so far the political dimensions of health sector governance and reform in Tajikistan, and its interplay with its technical dimensions, has not received attention in the health systems literature in Tajikistan and Central Asia more broadly. In an effort to address this research gap, this empirical study set out to identify the main governance constraints to the introduction and implementation of the Basic Benefit Package (BBP) and associated health management reforms, which constitute the most fundamental policy changes to the governance and financing of Tajikistan's health system to date. The BBP regulates entitlements to a guaranteed set of healthcare services while introducing co-payments. In terms of management changes, the positions of primary healthcare (PHC) manager, and district health teams were institutionalised.

The design of this study is based on case-study design, which allows for an in-depth exploration of a phenomenon in its real life context. Data was collected from a purposive literature review and semi-structured as well as open in-depth interviews with key informants at central level and local administrators, managers and health staff in districts where the BBP was being piloted. For data collection and analysis an exploratory approach was used following principles of grounded theory. Through this approach data collection and analysis are seen as a dynamic and intricate process, whereby hypotheses and emerging themes are tested and adjusted throughout the data collection process until saturation. Data analysis was guided by a political economy framework exploring the interplay between structural and institutional features on the one hand and agency dynamics on the other. Based on an analysis of the relevant structure-agency dynamics, policy incoherence, parallel and competing central government mandates, and regulatory fragmentation emerged as dominant drivers of most other constraints to effective design and implementation of the BBP and associated health reforms in Tajikistan: overcharging and informal payments, a weak link between budgeting and policymaking, a practice of non-transparent budget bargaining instead of a rationalisation of health expenditure, little donor harmonisation, and weak accountability to citizens. The analysis suggests that policy incoherence and regulatory fragmentation can be closely linked to the neo-patrimonial character of the regime and donor behaviour, with detrimental consequences for the health system. The interplay between institutional/structural factors and agency is particularly highlighted in the way that policy incoherence and regulatory fragmentation around health financing and management was found to be largely a consequence of the combination of uncoordinated donor pressures for health financing and management changes, and the existence of governance actors with unclear, parallel and competing mandates at the central level. Situating the analysis within the wider literature on governance in Tajikistan it is possible to conclude that policy incoherence and unclear mandates, in combination with deep underfunding create an opportunity case for the widely reported rent-seeking phenomenon of bottom-up financing of health providers and authorities, partly expressed in the recorded high degree of overcharging of user fees and informal payments. In other words, policy incoherence, the lack of clearly defined mandates and lack of resources to carry out basic tasks of health provision, regulation and oversight at the local level are not only features of neo-patrimonialism but also create the conditions for patrimonial features of governance to penetrate legal-rational bureaucracies.

This study demonstrates that attention to the political and institutional constraints to health reform is key to better understand the incentives and motivations that further or block improvements in public health. It raises a number of previously under -researched health policy developments and implementation challenges in Tajikistan. In doing so it not only contributes to the small body of literature on public sector reform in Central Asia and Tajikistan in particular, but also to the growing literature on the political constraints to aid and health reform in general. The article points to the importance of considering the political-institutional context in which reforms and indeed donor

interventions take place. The findings raise pertinent questions on the unintended consequences of non-harmonised piloting of health reforms, and the interaction of health financing interventions with entrenched power relations. These findings can encourage reflection on the relevance of contextualising health programmes and addressing policy incoherence with long horizon planning as a priority.

Own contribution to Publication (2): I am the single author of this publication and hence responsible for the complete contribution. I am indebted to Manfred Max Bergman, Claudia-Baez Camargo, Kaspar Wyss, Don de Savigny and Benoit Mathivet for providing input and guidance to the study design and draft versions of the manuscript, and to Saidali Qodirov for research assistance in the data collection process.

5.3 Publication 3

Jacobs, E., & Baez Camargo, C. (2020). Local health governance in Tajikistan: accountability and power relations at the district level. *International Journal for Equity in Health*, *19*(1), 1-12.

This article is based on a premise that health governance is concerned with the institutions shaping accountability and power relations, responsibilities and accountability between health systems actors and their institutions that shape this are considered central to health governance. There has been increased attention to local governance from a decentralisation perspective, or in terms of accountability towards citizens and their participation. However, health systems governance at the district level in Tajikistan and Central Asia more broadly has so far not been analysed with consideration to the accountability links between all relevant actors and the influence of the wider political-economic context in this process. Using principal-agent theory to explore health governance in two purposively selected districts of Tajikistan this study aims to address this gap.

The study design is a comparison of two embedded case studies. This allows for the exploration of a phenomenon when context is integral part of the study, but increases explanatory power and analytic generalisability compared to a single case study design. The cases are two districts in two politically, culturally and socioeconomically distinct regions of the country, i.e. GBAO, and the Districts of Republican Subordination, where two different international development actors have lent support to the local health system. The districts were purposefully chosen for their difference in proximity and interest to the political centre Dushanbe and the fact that the RRP district featured as one of the pilot districts for the implementation of the BBP reforms, while the GBAO district was excluded from the BBP pilot at the time of research. Data collection consisted of semi-structured interviews, primarily with local health governance actors and health providers and FGDs with local citizens. Data analysis is driven by a framework that views accountability in health systems as a triadic principal-agent relationship process between three main categories of actors: the state and its politicians and policymakers, providers and citizens/clients (Brinkerhoff and Bossert 2013). Voice, answerability and enforceability were given particular attention in the analysis of the accountability relationships as they are considered to be central components of it.

The study has illustrated the key constraints to local health governance from an accountability perspective, such as unclear mandates, the ineffective voice for local citizens or client, and a rigid resource allocation rationale combined with underfunding restricting the possibility of health workers to address local needs and deliver on their task. The authoritarian political climate and bottom-up rent-seeking patterns have an important effect on the way accountability is exercised in practice. Citizens and health providers were found to be in a weak position vis-à-vis local government and development actors. Health workers in particular are subject to complex accountability demands from local government actors, development agencies. Development agencies established accountability relations with health providers running parallel to those between local government actors and health providers and little attention was paid by development actors to citizen participation in decision-making. Heterogeneity between individuals and groups was found to be particularly evident in the local government and health provider categories, in which in-group contestation over resources manifested itself.

The study points to the importance of informal accountability tools and the importance of the social, political and economic context in this. It showed how entrenched positions of power continue to shape governance despite efforts at reform. In its application of principal-agent theory to the analysis of local health systems governance this study has shown and discussed its use and limitations.

Own contribution to publication (3): As the first author of this publication I designed the study, carried out data collection, analysed the data and wrote the article, to which Claudia Baez Camargo gave feedback in successive rounds of review. In addition, Claudia Baez Camargo contributed to the conceptualisation of the study approach and its operationalisation through the research questions. I

am furthermore grateful to Kaspar Wyss, Don de Savigny, Manfred Max Bergman and Benoit Mathivet for providing input for the study design and to Saidali Qodirov for research assistance in the data collection process.

5.4 Publication 4

Jacobs, E., & Hofman, I. (2020). Aid, social capital and local collective action: attitudes towards community-based health funds and village organizations in Rushan, Tajikistan. *Community Development Journal* 55 (3): 399–418

Despite overwhelming interest in the role of social capital in international development, attention to the interplay of community-based development aid with local collective action dynamics in Central Asia and particularly Tajikistan has remained limited. This article investigates local governance institutions in rural communities in GBAO in Tajikistan and their linkage with community-based health insurance and its related village organisations, initiated by the Aga Khan Development Network (AKDN). The study used a comparative case study design. Two villages were purposefully selected as study sites for in-depth exploration because of the observed contrasting experiences. Data was collected through purposive review of literature and semi-structured interviews with village organisations, *mahallas* (local self-governing neighbourhood councils), community-based health fund leadership and members, AKDN representatives, district and mayoral (health) officials, health staff, and administrators from health centres in the two villages and the district hospital, as well as FGDs with three different groups of citizens in each village. Data analysis was guided by the interlinked concepts of social capital and collective action theories in recognition of the idea that dilemmas in international development and governance can be approached as collective action problems (Booth 2012; Gibson et al. 2005), whereby social capital is a *resource for action* in this (Coleman 1988), particularly at community-level.

The study's findings show that, despite the thin spread of a civil society that conforms to legal-rational Weberian principles, communities in rural GBAO are rich in social organisation, particularly centred around the *mahalla*. The study explored two cases with opposite experiences in how social capital is used for collective action. Successful cases of collective action can be seen as instances where communities could collaborate between and beyond *mahalla* level with external actors such as the AKDN and local authorities to better their common plight. The study's observations illustrate that where local structures for collective action, i.e. the *mahallas*, hold legitimacy among the population and thrive in their function, externally introduced community-based structures do not automatically take root. In other words, the existence of strong social capital does not automatically increase communities' willingness to join formal risk-pooling schemes.

Rather, this willingness, and the community's capacity to exercise a degree of accountability towards local governance and development actors depends on the community's capacity to reach beyond the intra-communal solidarity network through bridging and linking capital. The findings suggest this can be fostered by addressing trust, and the role of effective development brokers, with due attention to power relations within communities and towards external agents.

Own contribution to publication (4): As the first author of this publication I designed the study, carried out data collection, analysed the data and wrote the article, to which Irna Hofman gave feedback in successive rounds of review. In addition, Irna Hofman contributed to the conceptualisation of the data analysis and provided input for contextualisation of the study findings. I am furthermore grateful to Claudia Baez Camargo, Kaspar Wyss, Don de Savigny, Manfred Max Bergman and Benoit Mathivet for providing input for the study design and to Saidali Qodirov for research assistance in the data collection process.

6. Discussion

6.1 Overview of the discussion

The primary aim of this thesis was to explore governance of the health system in Tajikistan. It aimed to do so based on a range of interrelated theoretical and conceptual tools with a neo-institutionalist perspective, as outlined in chapter 3.

This study is based on the case for understanding governance as an interaction between institutions and actors, in which both can be informal in addition to the formal structures and actors. The thesis has explored the health systems governance context in Tajikistan at national/central, district and village/community level with the use of three interlinking theoretical perspectives and concepts: political economy analysis with a focus on structure-agency dynamics, principal-agent theory, social capital and collective action theory.

The use of these perspectives has shown how health governance in Tajikistan but indeed anywhere is shaped by the interaction between socio-political, historical and economic factors and the capacity or capital of actors to cope with these incentives. These factors include the recent experiences with violent conflict and authoritarian government, economic interests and logic of the political-bureaucratic regime with its high degree of elite capture. They also relate to the state's fiscal capacity to generate domestic resources for the health sector, fragmented donor interests and accountabilities and entrenched power positions dating from the Semashko model of health systems. Lastly, communities' degree of connection and collaboration, including the role of development brokers, past experiences with development initiatives, trust and expectations towards the state were found to play an important role in health governance at the most local level.

The findings generated through this research add to the growing body of evidence on the political dimensions of health governance, that, until recently was dominated by more normative, 'technicist' approaches with a heavy focus on formal positions, codes and regulations. It is so far the only exploration of the socio-political and political-economic dimensions of health systems governance in Central Asia.

The findings presented in this thesis serve two purposes. First of all, they add to the literature on health reform, health governance, socio-political organisation and aid in Tajikistan and Central Asia in general, bringing insight into the governance and financing of a health system in this post-Soviet, post-conflict, neo-patrimonial setting. Secondly, they highlight the use, nuances and limitations of a limited but diverse set of neo-institutionalist theoretical approaches and concepts in the study of health governance, principally political economy analysis, principal-agent theory, collective action and social capital.

This discussion will flesh out the main conclusions related to these purposes. This is divided in six parts. The first part will discuss the contribution to the specific research objectives of this thesis. The second part focuses on what can be concluded in terms of the main characteristics of health systems governance in Tajikistan. The third part offers a reflection on the more theoretical contributions of this thesis in terms of the theoretical and conceptual approaches it set out to test. Next it will discuss, the research strengths and limitations and will identify its implications for policy and practice. Lastly It will provide suggestions for future research.

6.2 Conclusions in relation to the research objectives

This section discusses the way the research responded to the four specific research objectives.

Objective 1: To develop an understanding of useful concepts to explore the governance of basic services in neo-patrimonial systems of governance in general

The first task this thesis set out to do is to explore a framework of useful approaches to the understanding of governance of basic services. Based on theoretical exploration and empirical research it found new institutionalist approaches to be offering a suitable starting point. Based on such an approach the governance of basic services is seen as the formulation and operationalisation of rules and procedures that facilitate and constrain societal interaction. These rules and procedures, or constraints that human beings devise to shape interaction, can also be defined as institutions. The thesis has worked from the assumption that institutional fragility is at the heart of the challenges to the social contract in settings where legal-rational structures of authority are permeated by more particularistic, personalised practices of power. For the analysis of the governance of basic services, including health, this thesis has therefore argued for and demonstrated that the dynamic interplay between institutions and agents can appropriately be explored, in a contextually flexible way, based on political economy, analysis, agency theory and collective action approaches.

Objective 2: To identify the main governance constraints to the introduction and implementation of the basic benefit package (BBP) reforms, which is one of the most fundamental health financing and governance reforms since independence, by analysing the interactions of the main stakeholders with the political and socioeconomic context in relation to the technical dimensions of the reform.

To reach specific objective 2 field work was conducted in Tajikistan with a political economy analysis approach, in line with the approach outlined in response to objective 1. The introduction of a BBP in Tajikistan, which regulates entitlements to a guaranteed set of healthcare services while introducing co-payments has been accompanied by management changes at the district level. As this was assumed to influence the BBP implementation the research focused on both reforms holistically. The main conclusions are that policy incoherence, parallel and competing central government mandates, and regulatory fragmentation are the dominant drivers of most other constraints to effective design and implementation of the BBP and associated health reforms in Tajikistan: overcharging and informal payments, a weak link between budgeting and policymaking, a practice of non-transparent budget bargaining instead of a rationalisation of health expenditure, little donor harmonisation, and weak accountability to citizens. The study suggests that policy incoherence and regulatory fragmentation can be linked to the neo-patrimonial character of the regime and donor behaviour, with detrimental consequences for the health system. These findings raise questions on the unintended effects of non-harmonised piloting of health reforms, and the interaction of health financing and management interventions with entrenched power relations. Ultimately these insights serve to underline the relevance of contextualising health programmes and addressing policy incoherence with long horizon planning as a priority.

Objective 3: To analyse meso-level accountability in the health system in terms of principal-agent relationships as a key process in district-level health governance

To reach specific objective 3 qualitative data was collected in two districts in Tajikistan and analysed following a principle-agent model for analysing health systems governance. This model focuses on the accountability relationships between three main groups of actors in the system: health providers, citizens and government actors. The research highlighted a number of key constraints to effective accountability relationships at the district (meso) level, including unclear mandates for both

government actors and health providers, little opportunity for citizens to voice their opinions and concerns around the health system and a rigid line-itemised budgeting rationale and underfunding that limited health providers' ability to deliver on their task and respond to local health needs and demands from citizens. The restrictive political climate and rent-seeking rationale in the bureaucracy, as described in response to specific objective 2, were found to have an important effect on the way accountability is exercised within the system. In addition to the three actor categories a fourth group of actors was found to exercise considerable accountability vis-à-vis providers, i.e. development agencies. This was exercised largely in parallel to those between local government actors and health providers, and included little citizen involvement in terms of strengthening their voice, or local government involvement. Health workers in particular are subject to complex accountability demands from local government actors, development agencies and citizens. The study also tested the applicability of the accountability framework, which assumes actors such as government or providers to be homogenous. Heterogeneity within these categories was however evident, particularly in the local government and health provider actor categories, in which in-group contestation over resources manifested itself. The study has highlighted the use of informal accountability mechanisms and the importance of the social, political and economic context in this. It showed how entrenched power continues to shape governance despite reform efforts. In its application of principal-agent theory to respond to objective 3 the use and limitations of this approach have been demonstrated.

Objective 4: To explore how social capital facilitates the engagement with external development agents and local health governance actors and fosters collective action around village organisations and community-based health funds.

To understand how social capital at community (micro-) level facilitated local governance and development efforts, such as community-based health funds, qualitative data was collected in rural GBAO. This is a region where the Aga Khan Development Network has long been active in supporting health services and fostering collective action at community level through its community-based organisations called village organisations. The interlinked concepts of social capital and collective action theories guided data analysis in recognition of the idea that dilemmas in international development and governance can be approached as collective action problems, whereby social capital is a resource for action in this, particularly at community-level. The study found that communities in rural GBAO organise themselves in neighbourhood councils called mahallas, which are seen as the most legitimate institution for local problem solving. Two distinct villages with different experiences in this area were purposefully selected as research sites. In one village the community was better able to collaborate between and beyond *mahalla* level with external actors such as the AKDN and local authorities to better their common plight. The findings suggest that the mere existence and thriving of a *mahalla* in a village is not sufficient for community buy-in to an externally induced community-based organisation (the village organisation) and community-based health insurance. In other words, the existence of strong social capital does not automatically increase communities' willingness to join formal risk-pooling schemes. This rather depends on the capacity to reach beyond the intra-communal solidarity network through bridging and linking capital. In this process trust-building, and effective development brokers play an important role.

6.3 A deeper understanding of health governance in Tajikistan

The main conclusions in relation to the characteristics of health systems governance in Tajikistan are summarised in Table 5 below in an overview with the relevant publications these conclusions are drawn from and the annexes in which they can be found. The following four sections elaborate on these conclusions in terms of their contribution within the wider field and literature on the governance of health systems and Tajikistan.

Table 5. Overview of main conclusions and relevant publications

Conclusion	Publication	Annex
1) *The interplay between donor behaviour and the dominant-discretionary characteristics of Tajikistan's political regime and bureaucracy are reflected in policy incoherence, the rent-seeking behaviour and resultant competition over resources at district level.*	1, 2 and 3	A, B, C
2) *Health providers are caught in a complex web with accountability pressures from different sides.*	2 and 3	B, C
3) *Local communities and citizens have little voice and exit options vis-à-vis health providers and state actors, and are therefore locked in a continuing loyalty of making do with available services and self-reliance through community councils.*	3 and 4	C, D
4) *The enrolment of community-based health funds in GBAO depends on overcoming local collective action challenges by linking to existing local governance structures and institutions, effective local leadership for development brokerage and creating 'buy-in' from communities.*	4	D

Conclusion 1: The interplay between donor behaviour and the dominant-discretionary characteristics of Tajikistan's political regime and bureaucracy are reflected in policy incoherence, the rent-seeking behaviour and resultant competition over resources at district level.

A central argument in this thesis is the key role of the political-economic and aid context in shaping health governance. Publication 1 provided an institutionalist perspective that is useful for the analysis of these settings. Publication 2 argued more specifically in relation to Tajikistan how policy incoherence and regulatory fragmentation can be closely linked to the dominant-discretionary character of the regime and donor behaviour. The interplay between institutional/structural factors and agency is particularly highlighted by the combination of factors that have contributed to policy incoherence and regulatory fragmentation around health financing and management. The thesis demonstrates how the inherited Soviet Semashko health system with its duplication of functions and vertical programmes suffered from a combination of uncoordinated donor pressures for health financing and management changes, and the behaviour of governance actors with unclear, parallel and competing mandates at the central level. Publication 3 demonstrated how ambiguity in health financing policy, unclear mandates and entrenched power structures create rent-seeking opportunities and lead to complex practices of power in which a contestation over these rents play a large role. The interplay between aid and the political-bureaucratic system and the centrality of rent-seeking had hitherto not been explored in relation the health system in Tajikistan. However, comparable phenomena have been described in studies on the political regime and public administration in Tajikistan and in the governance of basic services elsewhere. The existence of influential positions and structures that run parallel to the Ministry of Health and the rent-seeking rationale in public administration, including the health system, mirrors that of Cambodia for instance (Kelsall and Heng 2016). The role of aid in entrenching power and institutionalising exclusion in Tajikistan can be traced to the conflict over power and resources in the civil war, which has deeply embedded a rent-seeking rationale aimed at benefiting insiders in the post-war political settlement and public administration (Mitchell 2015; Buisson 2007), facilitated by patterns of aid allocation (Nakaya 2009b).

Conclusion 2: Health providers are caught in a complex web with accountability pressures from different sides

The analysis of local health governance in publication 3 can be seen as a deeper exploration of the effects that higher level governance, including the policy decisions and bureaucratic dynamics that publication 2 elaborated on, have on local accountability and power relations. The findings suggest that health providers are under duress and caught in a complex web with accountability pressures from different sides, exacerbated by different donor agendas, underfunding, an input-based resource allocation mechanism, rent-seeking pressures and resultant policy incoherence and regulatory fragmentation. In a sense, these are typical problems for 'street level bureaucrats', who are the ultimate implementers of policy with limited resources and conflicting expectations from their superiors and clients (Lipsky 2010). However, the practical meaning of it for health providers in Tajikistan, from an accountability perspective had so far not been documented. What is noteworthy, although not unique to Tajikistan, is providers' perceived lack of support for delivering services in line with the BBP, not only in monetary terms, and constrained by the line-itemised budgeting rationale, but also in terms of supervision from district (health) authorities. The more punitive (as opposed to supportive) leadership style that primary care providers reported on in these cases was suggested to also be a tool for rent extraction. Their irregular visits and punitive fines masked as supervisory work appear to be another expression of extortive and predatory rule, which has taken root in Tajikistan since the replacement of Soviet-era systems and institutions by informal and criminalised mechanisms of governance during the civil war (Mitchell 2015; Nakaya 2009a; Nourzhanov 2005). In that sense it mirrors the use of 'elastic debts' by local authorities as a means to extract rents from and discipline farm labour in Tajikistan, as observed by Hofman (Hofman 2017). This is an important tentative finding for any future effort to introduce elements of supportive supervision in this context.

Conclusion 3: Local communities and citizens have little voice and exit options vis-à-vis health providers and state actors, and are therefore locked in a continuing loyalty of making do with available services and self-reliance through community councils.

This conclusion is embedded in a close analysis of district-level health governance (publication 3) and community level governance institutions (publication 4), with due attention to informal institutions and networks for decision-making and collective action, as argued for in publication 1. Results from publication 3 suggest accountability between citizens and (local) state actors around health matters is limited by a severe power imbalance between them. This is expressed in disaffection among citizens with the severely limited opportunities for them to express their voice, demand answerability or enforceability, such as free and fair elections or a strong legislative body. This lack of voice is exacerbated by an erosion or lack of belief in the possibility of holding state actors to account and disillusionment with the welfare-provision role of the state, as seen elsewhere in Tajikistan (Remtilla 2012). The absence of voice in holding agents to account, and the lack of exit options in the form of a wide variety of other healthcare providers, lock them in a type of continuing loyalty of 'making do' with the limited services that are available and relying on community-level solidarity through the *mahalla*, i.e. community council.

The continuing loyalty of 'making do' mainly entails in-kind support to local primary care facilities. Examples include providing harvested produce to the health workers as a type of informal payment to supplement meagre health worker income, and repairs to the local health facility through the solidarity mechanism of '*hashar'*. The role of *mahallas* and *hashar* in rural life in Tajikistan has been described elsewhere (Boboyorov 2013, 24:151; Cieslewska 2010; Freizer 2005), but so far not linked to health systems governance. In absence of formal channels or platforms for 'social accountability' such as health facility committees, it is possible to interpret this behaviour as citizens engaging in an informal type of co-production (Joshi and Moore 2004) with primary care providers, with in-kind payments possibly functioning as a token in the creation of social bonds and reciprocity (Mauss 2002). In terms of accountability I claim this situation can be interpreted as a hypothetical inversion of Hirschman's theory that high loyalty to a company, organisation or state works to limit people's voice

and exit options (Hirschman 1970). In this case, it is not high loyalty necessarily preventing villagers from speaking up (using their voice) or seeking care elsewhere (using exit as an option). Rather, in absence of voice or exit options, they have no choice but to remain loyal to the suboptimal services available.

Conclusion 4: The enrolment of community-based health funds in GBAO depends on overcoming local collective action challenges by linking to existing local governance structures and institutions, effective local leadership for development brokerage and creating 'buy-in' from communities.

A comparative case study of two villages (publication 4) explored factors influencing the uptake of externally introduced community-based health insurance. It concluded that this depends on the degree to which the community-based structures put in place to facilitate it were linked to existing local institutions for collective action, and the extent to which citizens were equipped to overcome the risk of trusting an external intervention with their resources. The focus of this study was not on assessing the general success of community-based health insurance in terms of financial protection or its impact on the health of households. Rather, it was aimed at unpacking the socio-political dynamics around enrolment, so as to offer lessons for community development actors on the interplay between their potential interventions and local governance institutions that make sense for people.

Publication 4 showed that communities tend to see their own neighbourhood councils (*mahalllas*) as the only legitimate body for participatory decision-making. These are legally recognised but not formally integrated in the governance and public administration infrastructure of the state of Tajikistan. Membership and their activities are therefore not formally codified or regulated and receive no public funding. Despite the existence of these structures, AKDN introduced a new community-based organisation, the village organisation, after conclusion that no social structures existed at community level in GBAO to serve as a channel for community-based support. The village organisation subsequently functioned as the platform for the management of community-based health funds. A comparison of the experience of two villages in GBAO highlighted two contrasting experiences, despite the existence of strong bonding capital, expressed through the high level of *mahalla* activity, in both villages. The study showed that the degree to which village organisations and community-based health funds were used and subscribed to by village members, seen as a marker for externally-induced collective action, depended on the degree to which the village organisations were closely linked with the *mahallas*, and the role of trust and local brokerage in this process. The role of the village organisation leadership as a development broker stood out in this case.

6.4 Theoretical implications

Health governance research is interdisciplinary and can draw on a range of theories to make sense of governance at different levels or in relation to specific local phenomena (the unit of analysis): hierarchical levels in terms of health systems organisation at central, district and community levels; different units, e.g. a policy reform, local (district) incentives for healthcare provision, or community's buy-in to a community-based health insurance. This thesis answers to the need to explore what institutionalist perspectives can offer to a contextualised understanding of health governance and to draw concrete lessons from this, as tentatively outlined in publication 1. In doing so, this thesis has not only tested existing institutionalist theories and concepts to explore health governance, but has also expanded some of the theoretical discussions in the areas of health governance and related fields beyond the technicist, normative conceptions that have tended to dominate the discussion until recently.

In exploring health governance in Tajikistan this thesis has used different theoretical approaches and concepts to explore health governance at central, local and community levels respectively, as shown

in table 6. These theoretical tools and perspectives are seen as neither in competition nor on equal footing with each other. Rather, they are taken as complementary and interlinked. Chapter 3 discussed their meaning and theoretical interlinkages. This section will elaborate on the thesis' contribution in terms of their interconnectedness and application to the case of Tajikistan's health system, including their limitations.

Table 6. Overview of theories and concepts used at their level of analysis

Level	*Theory, concept or approach*	*Publication*
Central – local / macro – meso	Political economy analysis	2
Local (district) / meso	Principal-agent theory, accountability	3
Local – community / meso - micro	Collective action, social capital	4

Political economy analysis

The application of PEA to the study of an important health financing reform in Tajikistan was chosen to respond to a need to better understand shortcomings in Tajikistan's health systems governance and its goal to reach universal health coverage in its neo-patrimonial, authoritarian context. It is based on the premise that decisions about health financing alter the institutional mechanisms that guide the distribution of resources and their entitlements and responsibilities (Reich 1996). This affects stakeholders with varying interests, power and influence, creating political opportunities, challenges and tensions. The thesis has demonstrated how the political-economic and historical context still reverberates in the health system, characterised by policy incoherence, regulatory fragmentation, and a high reliance on out-of-pocket payments, and how this relates to the authoritarian, predatory nature of the state and its rent-seeking rationale, conforming to the dominant-discretionary regime ideal type (Levy 2015). The thesis results suggest that health reform and governance are mainly shaped by the interests of development agencies (both donors and implementing organisations) and different government and bureaucratic actors within the Tajik health system, which remains formally publicly owned and regulated. In line with the argument made in relationship to Zimbabwe (Witter et al. 2019), the findings from this thesis suggest PEA requires some adaptation in focus when applied to more precarious and closed political environments. While party and pork barrel politics, as well as patient, professional and industrial interest groups, i.e. *interest group politics*, play an important role in more middle or high income settings and competitive political environments (Reich 1996; Sparkes et al. 2019), in the fragile, low income, post-Soviet and dominant-discretionary political environment of Tajikistan these groups and mechanisms were found to play a less prominent role.

The application of PEA in this thesis has largely been directed at highlighting the relevant institutions and interests shaping agents' behaviour. The role of ideologies, values and ideas has been less prominent in this study. Although not directly surfacing in interviews or policy documentation, these variables are likely to have played an implicit role in legitimising government action, setting donor agendas and health policy implementation by street-level bureaucrats. The issue of user fees for example raises strong ideological sentiments, and there is a growing coalition in favour of abolishing formal user fees motivated by equity principles (Hercot et al. 2011) that regularly clashes with 'neoliberal' organisational cultures favouring a role for user fees in health financing (Dossou et al. 2018). In case studies of fragile settings where attention to values, ideologies and ideas has been explicitly incorporated, they were found to play an often unspoken but significant role in how health governance and financing interventions were framed by different donors or taken up by the health bureaucracy in which health system values were engrained (Witter et al. 2019). Any future use of PEA in the health sector would therefore be recommended to take up an explicit focus on this.

Principal-agent theory and accountability

The application of a principal-agent model to analyse local health governance in this thesis served to understand the incentive structures that shape the behaviour of local stakeholders, and ultimately the extent to which and issues around which they exercise accountability and wield power vis-à-vis each other. It gave insight into the internal divisions, power asymmetries and varying or sometimes competing interests, partly stemming from the inherited Soviet Semashko health system. This application showed the use and limitations of accountability, from a principal-agent perspective in analysing health governance. It should elucidate that, as opposed to the dominant interventionist perspective in international development, whereby accountability is seen as a tool or mechanism that can be implanted or facilitated by external actors, accountability should be seen as a relational concept (Lodenstein 2019). This relational conceptualisation of principal-agent linkages, which assumes that they exist in both formal and informal ways, helps to understand the fact that the way health systems actors interact in daily practice at the local level often deviates from the formal mandates and responsibilities that are expected from them in their professional or project role. Rooted in this understanding, this thesis showed how complex practices of power and contestation over resources within the bureaucracy are influential in shaping policy implementation. In doing so, it showed that the triadic model with its theoretically homogenous actors categories (World Bank 2004; Brinkerhoff and Bossert 2013) does not serve to fully understand these complex relations of power. Heterogeneity and competition within the actors categories was particularly evident in the 'state' and 'providers' groups. These examples confirm that the idea of holding a single agent category, such as 'the state', to account can be problematic in practice, summed up as 'the problem of many hands' that have contributed to any policy (outcome) (Thompson 1980). As discussed in publication 3, these limitations raise fundamental questions on the application of principal-agent theory to health systems governance analysis. In addition to the limitations of the triadic accountability model, the existence of rent-seeking patterns and activities that can be seen as expressions of co-production cannot be adequately understood or explained by accountability theory. A need therefore exists for other concepts and tools to explore these phenomena in (local) health governance. The principal-agent perspective has been criticised for 'theoretically mischaracterising' governance problems, assuming among others 'principled principals', who are naturally willing to hold agents to account in the public interest, and the main focus on individual incentive calculations (Persson, Rothstein, and Teorell 2013). These assumptions are not helpful to explain the implication of principals themselves in abuse of power for private gain, and the expectation of others to be implicated in such practices, creating 'corrupt cultures'. The existence of such cultures shows that rent-seeking is a collective phenomenon, instead of something purely based on individual incentive calculations, and highlights the importance of collective norms in perpetuating behaviour that is irrational from the viewpoint of the public good. This gives rise to the idea of governance as a collective action phenomenon, and casts a lens on which factors matter to overcome harmful equilibria of particularistic interests dominating in governance (Mungiu-Pippidi 2011; Booth 2011). Ultimately, however, the two approaches can also be considered complementary (Marquette and Peiffer 2015). As the study in publication 3 shows, the application of principal-agent theory can help to show the incentives guiding the behaviour of stakeholders in the local health system. It has provided insight into the challenges to the different components making up effective health governance at the local level, such as an unclear mandate, the lack of effective channels for voice or insufficient resources to carry out a mandate.

Collective action and social capital

In publication 4, the role of social capital as inter- and intra-group bonds in synergetic or antagonistic encounters, furthering or hampering collective action at community level and towards other health system actors was explored, with special attention to the extent to which, and how external agents can aide inter-communal cooperation. In combining and applying the concepts social capital, collective

action, trust, development brokerage and their interrelated theories from political sociology, political economy and community development this thesis has demonstrated the nuances of social capital theory in relation to collective action, and the way leadership matters in bridging and representing communities vis-à-vis external actors. The use of collective action theory and its related concepts in exploring governance at the meso-micro level was explicitly chosen to complement the principal-agent perspective explored in publication 3, and yield new insights into governance at this level.

The study is based on the basic assumption on local governance institutions that the presence of cohesive social groups can aid local problem-solving (Ostrom and Ahn 2009). This study gave evidence of how bonding social capital can have both isolating (i.e. distancing) as well as outreaching effects. It can aid collective action vis-à-vis (formal) local governance and international development actors or hamper it. The study findings suggest that it depended on the bridging capital of the different communities, and the way newly introduced community-based organisation linked up to existing local governance institutions that hold legitimacy for people. This finding is fully in line with the wider conclusions on the central importance of contextualising external interventions when attempting to fostering local governance institutions for collective action (Booth and Cammack 2013; Shivakumar 2005) and reconfirms the central tenet of this thesis.

The study also points to the important role of trust in overcoming the risk of loss in overcoming particular interests for the common good, and the key role of mediating agents in instrumentalising social capital for collective action. In the case where negative or confused attitudes prevailed around community-based health funds and related interventions linked to the newly introduced community-based organisation, a case of fraud had damaged the goodwill trust of villagers in the scheme and its proponents. In this case the institutional rules of the new intervention to which people were expected to sign up had clearly been too ineffectual and had not protected them from loss, undermining the further potential for collective action.

As this thesis explicitly looked at the relationship between different communities on the one hand and health providers, development agencies and local government actors on the other, little evidence was found of power differentials within communities. It can however be assumed, following Bourdieu's theory of social capital, that individuals and families who already have limited access to various forms of capital are disadvantaged to accumulate it further (Bourdieu 1986; Mladovsky 2014, 182). In other words, not only are some communities more disadvantaged than others in the way they have a voice towards local health authorities or provides, and in the way they can access resources, such as community-based health insurance, these power differentials also exist within communities. This limits the extent to which they can engage in collective action initiatives. In this light it is important to reiterate that the self-sufficiency paradigm underlying many community-based initiatives, including community-based health funds, does not resonate with or is not equally applicable to all citizens (Scott et al. 2017). As the study findings show one community was better able to 'buy into' this paradigm than another, aided by a development broker who had accumulated social capital with both the community and the external development and government actors. The development broker identified in this thesis (publication 4) occupied a role in which he carved out manoeuvring space for himself and is able to show results and give meaning to each community or 'universe' (Cohen and Comaroff 1976). Yet, working with people who hold locally powerful positions could exclude the voices of those marginalised in the process of representation. This suggests that aid-driven community-based associational models can create new forms of inequality and social exclusion (Olivier de Sardan 2011) and highlights the importance of explicitly considering power in the study of social capital and collective action.

6.5 Implications for policy and practice

The findings from this research carry several implications for how to rethink health policymaking and implementation and health governance in general. This section is focused on recommendations flowing directly from the main analysis for practitioners.

First of all, in line with the central tenet of this thesis, the findings underline the need for a serious consideration of the political-institutional context in which health reforms and externally-induced interventions take place, from those designed at central level, implemented at district level down to community-based interventions. This need for contextualisation is already well-known but too often its implications are not well considered in actual practice due to a need for hastily pushing reforms without sufficient attention to implementation challenges, divergent donor agendas and intricate power dynamics that are not immediately obvious to an outsider.

The study results suggest the need for long horizon planning and broad consensus among key stakeholders, including real donor harmonisation and alignment, in the direction and details of health policy, and in the implementation of basic packages for health services in particular. The existence of long-running BBP pilots with different eligibility requirements and unclear mandates for those involved, without clarity on the ultimate direction of reform, created a patchwork of entitlements and guidelines. This contributed to the ineffectual governance of health services and ultimately hampered citizens' access to care. In addition, the research findings suggest that uncoordinated piloting and the resultant policy incoherence and unclear mandates without central support can create or perpetuate power imbalances and rent-seeking patterns. Namely, informal payments at health facilities can be part of a larger system of rent-seeking leading to people in higher positions of power. This is crucial to consider in an effort to curb (informal) out of pocket expenditure and requires buy-in from the highest level of government to change.

When it comes to local governance of health services the findings suggest that accountability for delivering on a mandate for health workers and the implementation of a basic package of health services can be limited by a rigid line-itemised budgeting rationale. It would therefore be recommended to reform the purchasing rationale in a more strategic direction towards one that is more based on population needs and provider performance. Supervision tools that are focused on learning and support for improvement can be powerful motivators for health workers and lead to improvements in quality of care. However, it should be noted that a rent-extraction mechanism can form an important component of the oversight of health workers by district health authorities, leading to, as was found, punitive, instead of supportive supervision. Also, the introduction of a new local management positions or bodies such as health committees or PHC managers at the local level may be undermined by a lack of central-level support, an unclear mandate and lack of resources to carry out a mandate, perpetuating existing positions of power and competition over resources. Central commitment and clear mandates are therefore essential preconditions for such reforms to succeed.

The proposition of this thesis that a serious consideration of the political-institutional context is needed also holds for the introduction of financial protection mechanisms such as community-based health funds or micro-insurance. It warrants strong efforts to seek close collaboration with existing local institutions for collective action that hold widespread legitimacy, instead of setting up new structures in their place. In doing so, trust-building is essential for community members to overcome their risk of loss in furthering collective action through the engagement with external actors. This implies a need for long term investment in community engagement and inclusive leadership. More concretely, at the inception phase, community-based initiatives such as community-based health funds with isolated communities would therefore need to seek out effective and legitimate local brokers while paying attention to the voice of underrepresented groups of people who could be marginalised by the dominant local leadership. The strengthening of leadership capacities of such local representatives based on principles of inclusion might therefore be necessary.

Lastly, feelings of marginalisation of and disaffection by communities became apparent in the research, while competition over scarce resources by government actors and a health financing rationale that is de-coupled from population needs hamper access to quality services. In addition to strengthening inclusive local leadership it would therefore be recommended to create meaningful platforms for citizen dialogues, harnessing local norms and existing institutions for citizens representation and collective action to allow for greater responsiveness of the health system and in turn the services that are intended to serve citizens.

6.6 Research strengths and limitations

The overall research and specific studies presented in this thesis have their strengths, but they were also subject to several limitations. These pertain to all dimensions and steps in the research process. This section will discuss the main strengths and limitations. As the use and limitations of the conceptual approaches has already been discussed in the previous sections, this section will focus on the wider benefits and limitations of the research, as well as the practical, methodological challenges the study faced.

A general strength of the research presented is the conscious application and integration of theories and concepts from sociology, political science and economics into the health systems debate that has hitherto been largely dominated by perspectives from public health. This interdisciplinary angle and approach has increased the understanding of the mechanisms that contribute to the challenges that are witnessed in executing health policy, allocating resources to health, engaging communities in improving financial protection or improving health service provision in Tajikistan and beyond. This interdisciplinary approach was facilitated and strengthened by the collaboration between researchers from both public health and the social sciences in the design of the research project, but also the involvement of local specialists in public health and community development in the data collection process. The interdisciplinary nature of the research project also posed challenges to the main researcher. In terms of data collection methods and the presentation of results a choice had to be made on which disciplinary customs to follow and consideration needed to be paid to the prospective audiences.

In terms of study design, the research was originally set out to also include quantitative methods aimed at recording the experiences of households with (informal) payments for healthcare. This would have been a potentially useful complement to the qualitative research that captured multiple accounts of informal payments and the contours of a more institutionalised mechanism of rent-seeking through 'ascendant financing' as described in publication 2 and 3. It could have yielded more robustly representative data on these experiences, in addition to laying bare the potentially catastrophic effects on household income. Despite the engagement with a local research partner and the development of a survey tool for this, the plan did not gain political approval, possibly due to the sensitivity of informal payments, and was therefore aborted.

A related limitation concerns the topic of inquiry itself. Exploring power relations is sensitive in any setting, but particularly in an authoritarian environment with a legacy of large statist dominance of basic services, and a reliance on external support for the health sector. This poses challenges in terms of how the research is presented, how to deal ethically with sensitive data obtained through the interviews, and the personal biases of the main researcher. A strong effort was therefore made to triangulate data from different sources and analyse the findings in relation to studies on the wider societal, and political-economic context. In addition, feedback from other specialists on multiple dimensions of the research was sought. These included researchers familiar with the socio-political and economic context in Tajikistan beyond the health sector, public health specialists (on Tajikistan and beyond) and locally embedded professionals. Together with constant critical reflection on the part

of the main researcher this helped to maintain integrity in the study conduct, and interpretation and analysis of the data.

The results presented in this thesis are highly time-bound. Policy and organisation details have changed since data collection, and will continue to change as lessons are drawn, priorities shift, funding cycles change and new reforms are piloted or implemented. This is exacerbated by the long period between data collection and final analysis. The time-bound nature is a clear limitation of study but is essentially inevitable when it comes to the study of health policymaking and governance, which is by definition always in flux. The main lessons that can be drawn from it therefore pertain to uncovering the mechanisms that shape health governance in Tajikistan in the broad sense, rather than explaining policies in their technical detail, and demonstrating the use of the theoretical approaches in doing so.

One of the main limitations in data collection concern the relatively short periods in which data collection took place, and the limited number of interviews and FGDs with citizens. These are the result of limits in resources, linguistic capacity of the main researcher and logistical limitations, but are also a limitation of the approach in general. A reliance on more ethnographic methods such as longer-term immersion and participant observation would have yielded a richer body of data on the perceptions and experiences of ordinary Tajik citizens in relation to the health system, although these methods come with their own challenges.

Furthermore, respondent selection bias cannot be ruled out as AKDN, project Sino (funded by the Swiss Agency for Development and Cooperation) and WHO facilitated entry to the study settings, although their representatives were largely excluded from interviews and FGDs with other stakeholders. Together with the closed political environment this may have biased respondents' answers. In terms of selection bias, a conscious effort was made to include the views of women and less well-connected citizens, to avoid disproportionally capturing the views of prominent (male) community members and leaders. Lastly, the study faced some linguistic challenges. Although the main researcher reached a reasonable command of Russian at the time of field research, most interviews with Tajik respondents were conducted together with a research assistant who is a native speaker in both Russian and Tajik. This could have led to a selective interpretation of responses by the main researcher, but this was mitigated by the fact that both researchers took notes during interviews that were compared and discussed afterwards. Participants in GBAO often spoke their second language (Tajik), which may have inhibited respondents from fully expressing their opinions.

6.7 Recommendations for further research

This thesis has explored various institutionalist approaches to the study of health governance, but the focus of this thesis is limited to one country, Tajikistan, and a range of qualitative research methods. Building on the initial insights of this thesis, further research on health systems governance could therefore be carried out in other settings with the aid of different research methodologies.

First of all, as discussed in the research limitations, using ethnographic methods such as longer-term immersion and participant observation could yield a richer body of data on the perceptions and experiences of both health workers and citizens in relation to other actors in the health system. It could provide deeper insight into the complexities of agent's motivations, strategies and practices of power. Power dynamics within communities and power inequities between different citizens and government or development actors should be part of such research. As discussed in this thesis, individuals and families who already have limited access to various forms of capital, including social and human capital, are disadvantaged to accumulate it further. This counts for community-based health insurance initiatives, which can perpetuate existing patterns or generate new patterns of inequities and social exclusion. Yet it also extends to the ability to take part and express voice in social accountability initiatives and related governance initiatives such as the implementation of health

facility committees. This attention to the experiences and perceptions of vulnerable individuals and households within communities is often lacking in the study of communities that are seen as homogenously vulnerable or marginalised. A more nuanced and intricate power lens is therefore warranted.

The prevalence and function of informal payments should be an area of particular attention in future research. This includes the normative expectations or organisational culture around it, and its role as a rent-seeking mechanism by government officials at different levels, in exerting accountability and control, supplementing health workers' income from other sources and facilitating reciprocal exchange between health workers and their clients. Quantitative methods, particularly in the form of household surveys, can complement this to assess the scale and breadth at which informal payments make up out-of-pocket health expenditure, so as to refine BBP entitlements and regulations around co-payments or user fees.

Next, based on the assumption and confirmation that the context in which health policy development and donor interventions take place matters, it is valuable to see how such initiatives, particularly when driven by external aid actors, are adapted to the (fragile) contexts in which they take place, and integrated with national structures and policies in practice. In collaboration with others I have made a first attempt at that in the analysis of the way performance-based financing interventions are adapted to fragile and conflict settings, and the extent to which they are integrated with essential health packages and national user-fee exemption regulations (Bertone et al. 2018; Jacobs et al. 2020). Further research in this direction could help to understand what works and what does not work in terms of donor harmonisation and alignment, how health systems can durably be strengthened and what drivers and facilitators matter in aiding this process.

As discussed, health (financing) reforms inevitably alter the distribution of resources and its associated institutional arrangements, affecting the interests and power of the stakeholders involved. To motivate and legitimise reforms and interventions ideological and normative frames are therefore used. Future research could more explicitly lay bare these ideas and values in any future political economy analysis of health financing reforms such as benefit package design, user fee regulation or purchasing reform, as they can be powerful drivers of opposition or support and sometimes override individual interests.

7. Conclusions

This research presented in this thesis has provided insight into health systems governance in Tajikistan with the use of a range of new institutionalist theoretical approaches and concepts in an attempt to go beyond a normative, technicist review of health governance. The research contribution is twofold. It has first of all responded to the research gap on Tajikistan's health system, and its unique low resource, conflict-affected, fragile context with a health system that was originally designed in accordance with the Soviet Semashko model, which has so far received little attention. Secondly, in doing so it has demonstrated the use and limitations of the aforementioned new institutionalist theoretical approaches to understand health systems governance in fragile settings. This has been done in recognition of the fact that many low-income, fragile settings present a complex context for which frameworks based on an understanding of hierarchical, centralised and coherent health systems do not easily fit. With explicit attention to the political economy in which health policy changes and the interventions from development agencies take place, and the interconnectedness of central, local and community-level governance it has highlighted the role of particular interests, resource-seeking motivations and entrenched power relations in shaping health systems governance and policy implementation. It has shown how these result in and are affected by health systems governance constraints such as unclear mandates, policy incoherence and informal accountability mechanisms. The findings furthermore emphasise the precarious position that citizens and health workers, as frontline bureaucrats in the system, find themselves in. Building on this, the study has provided new insight into important mechanisms that underpin the mixed results in engaging them through community-based health insurance for greater financial protection. Ultimately these insights serve to underline the relevance of contextualising health programmes and addressing the (informal) resource distribution mechanisms, power dynamics and collective action challenges that are so important in shaping health systems governance.

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ANNEX A: Publication 1

Eelco Jacobs, 'Basic public services and informal power: an analytical framework for sector governance' in Mansfeldova, Zdenka & Pleines, Heiko (eds.) (2011). *Informal Relations from Democratic Representation to Corruption: Case Studies from Central and Eastern Europe*. Stuttgart: Ibidem Verlag

Eelco Jacobs

2. Basic Public Services and Informal Power: An Analytical Framework for Sector Governance

2.1. Introduction

Since the 1980s, increasing awareness of the severe governance challenges that exist in the public sectors of many developing countries and their effect on human development have thrust state capacity into the spotlight as a new sphere of interest in research.[1] This has provided new ideas of *what* is required to strengthen basic service delivery[2] in specific areas in terms of information transparency, expenditure tracking, management capacity and oversight control. However, the question of *why* these improvements frequently fail to appear, even when seemingly straightforward solutions are available, needs to be further explored. Often these shortcomings are attributed to the black box of political will, but what precisely constitutes this *will*, i.e. the power context[3] that affects public sectors, needs further research in relation to sector governance. This article will seek to offer analytical tools to study this power context with explicit consideration of the role of informal institutions and networks.

This paper argues that informal dimensions of power need to be included in the analysis of sector governance, especially—but not exclusively—in developing countries. An exclusive focus on state structures and bureaucracy, based on the classical Weberian[4] framework of governance with its strict distinction between public and private spheres, cannot address many of the challenges facing the delivery of basic public services. In many developing countries, states lack the institutional and operational

1 Evans, Peter B./ Rueschemeyer, Dietrich/ Skocpol, Theda (eds.): Bringing the State Back in. Cambridge: Cambridge University Press, 1985.

2 This paper is concerned with basic services that are partly or wholly delivered, financed or regulated by public agencies. The theory and methodological tools provided therefore mainly, but not exclusively, apply to the water, education and health sectors, which are commonly understood to be the most crucial services for human welfare.

3 Unsworth, Sue: Understanding Pro-Poor Change: a discussion paper. London: Department for International Development, 2001

4 Based on Max Weber's legal-rational ideal type of authority, whereby the public and private realms, with their own guiding principles, are strictly separated. Weber's other ideal type of authority, patrimonialism, which is based on a pre-modern model of power, is heavily dependent on one person in power rather than officeholders. It assumes the presence of a personal, patriarchal ruler whose authority over his followers is unlimited by formal rules and procedures but based on tradition. In contrast to the legal-rational bureaucracy no distinction between private and public domains with due roles or responsibilities exists: 'the system is held together by the oath of loyalty or by kinship ties (often symbolic and fictitious) rather than by a hierarchy of administrative grades and functions'. Clapham, Christopher: Third World Politics: An Introduction. London: Routledge, 1985.

capability to consistently and effectively enforce policy decisions and, more generally, the rule of law throughout the entire national territory.[5] In these cases, there is no sharp distinction between public and private roles.[6] This is a cause for concern because not only does ineffective public, or formal, governance affect the performance of service delivery and ultimately human welfare, but the absence or poor quality of services can also undermine a state's legitimacy in the long term.[7] Given the great significance for both human welfare *and* state legitimacy, the case for a governance approach that incorporates those dimensions of power beyond the formal structures is strong.

This article uses the definition of governance put forth by Brinkerhoff and Bossert[8], who argue that 'Governance is about the rules that distribute roles and responsibilities among societal actors and that shape the interactions among them'. These rules can also be understood as institutions as defined by Douglass North: any form of constraint that human beings devise to shape interaction.[9] It is essential to understand that the rules that shape the game can be both formal(ized) and informal, public or private. Informal and formal institutions co-exist and interweave with one another in all political and bureaucratic systems, albeit to varying degrees. Based on North's definition, institutions shape power relations and their consequences, including '*will*'. This article views accountability as central to power relations. Following this interpretation, formal and informal normative frameworks, to which institutions can be reduced, provide incentives and constraints on action that influence to whom accountability is exercised.

To understand the core of what constitutes accountability, this article uses Kelsall's definition,[10] which implies a relationship between two actors in which A is accountable to B if A takes into account B's wishes, while B can hold A responsible if A ignores B's wishes. This occurs when B relinquishes some degree of power, status or resources to A, which B may withdraw in order to enforce A's responsiveness. Accountability, just like the institutions that guide it, can be formal or informal. Based on this premise, accountability within an ideal type legal-rational institutional framework can be understood along the pillars of delegation, answerability and enforceability. This can be further disaggregated by considering the adequate financing that comes with delegating

5 The World Wide Governance Indicators give a good indication of this: Kaufmann, Daniel/ Kraay, Aart/ Mastruzzi, Massimo: Governance Matter VIII: Aggregate and Individual Governance Indicators, 1996–2008. World Bank Policy Research Working Paper 4978, 29 June 2009.

6 Rose-Ackerman, Susan: Corruption and Government: Causes, Consequences and Reform. Cambridge: Cambridge University Press, 1999: p. 91.

7 OECD DAC: Service Delivery in Fragile Situations. Key Concepts, Findings and Lessons, in: Journal of Development, 2008, (vol. 9), no. 3.

8 Brinkerhoff, Derick W./ Bossert, Thomas J.: Health Governance: Concepts, Experience, and Programming Options, Bethesda: Abt Associates Inc. 2008, p. 3.

9 North, Douglass Cecil: Institutions, institutional change, and economic performance. Cambridge University Press, 1990, p. 4

10 Kelsall, Tim: Going with the grain in African development? Africa Power and Politics Programme, 2008, Discussion Paper 1, p. 3

tasks and performance monitoring to judge responsibility.[11] Part of the social contract that defines the cadre mediating accountability between state and society is the delegation of decision-making powers and tax money to politicians with the expectation that basic services are provided. Citizens can sanction their governments—by voting them out of office or, in more extreme cases, by withholding tax payments—in the case of non-compliance.

By definition, the governance of public service delivery in those states where the government is not able or willing to deliver basic public goods and services,[12] despite citizens' expectations and promises in national poverty reduction strategies or during elections , does not conform to this legal-rational ideal type. In fact, in such cases the social contract is broken. This does not imply that governance in the wider definition ceases to exist but rather that informal and often more particularistic governance institutions play a stronger role. Understanding the influence of the accountability relationships that arise from these informal institutions helps to identify stakeholders in sector governance and can explain why people behave differently than what might be expected in ideal type formal governance settings.

An exclusive focus on institutions, however, is not sufficient to explain accountability relations. In cases where (formal and informal) normative frameworks overlap or compete, the mere existence of different institutions does not explain their degree of influence on human action. Institutional and stakeholder analysis should therefore be complemented by the analytical perspective that choice theory offers.[13] This gives insight into the motivation for the choices of norms that humans make.

The central question of this article is therefore: what is the best way to analyse accountability relations in the governance of basic service delivery while taking full account of the mix of informal and formal power that is so typical in these contexts?

To address this question, the article first sketches out the structural features of many developing countries with special reference to the concepts of neo-patrimonialism and clientelism. The role of basic service delivery, which is key to the social contract between the state and society, is given particular consideration with regard to these concepts. Second, suggestions for a model to assess the governance of public services are given. The contours of a multi-step assessment framework involving institutional and stakeholder analysis are drawn and consideration is given to the insights that rational choice theory offers to come to a closer understanding of stakeholder behaviour.

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11 Baez-Camargo, Claudia. Accountability for Better Health Care Provision: a framework and guidelines to define, understand and assess accountability in health systems. Forthcoming.

12 OECD DAC: Service Delivery in Fragile Situations. Key Concepts, Findings and Lessons, in: Journal of Development, 2008, (vol. 9), no. 3.

13 Booth, David: Elites, Governance and the Public Interest in Africa: Working with the Grain? Africa Power and Politics Programme, 2009, Discussion Paper 6, p. 15.

2.2. Understanding Informal Institutions in Sector Governance

While the fields of political sociology and economy recognize the importance of informal institutions and actors, the nascent health systems literature,[14] as an example of one of the most crucial basic services, has been predominantly concerned with (good) governance, defined in terms of the formal rules and procedures that are associated with effectively carrying out health policy. The literature has provided sophisticated and detailed knowledge of the ways in which the various levels of formal governance can be analysed. With an instrumental perspective on governance mechanisms, it has refined the conceptualization of formal health governance. In addition, serious attention has been paid to the diverse manifestations of corruption that plague the sector, and possible ways to address corruption in terms of technical solutions. Brinkerhoff and Bossert[15] rightly note that the role of non-state actors needs to be considered more closely in the governance of health systems, particularly in contexts where the state fails in its task of providing, regulating or financing basic services. Nevertheless, what is often termed the *political context* (versus the technical dimension) of sector governance remains to be further explored, as an evaluation of donor good practice highlights.[16] This paper attempts to fill that void by outlining an analytical framework that explicitly considers the role of informal institutions, networks and actors in sector governance.

Understanding the importance of informal institutions and their impact on governance in developing countries requires a closer look at the historical and structural development of their states. Without delving into the various ways in which colonization took place across the world, it can be generalized that the process of decolonization in much of the developing world in the past half-century—from Ghana in 1957 to the former Soviet republics in 1990–1991—opened up the state as a prize for domestic political competition. With either a scant industrial base or a state monopoly on much of the economy, state control became the quickest route to wealth accumulation. In

14 Ruger, Jennifer Prah: Global Health Governance and the World Bank, in: The Lancet, 2007, (vol. 370), no. 9597, pp. 1471–1474; Savedoff , William D.: Transparency and Corruption in the Health Sector: A Conceptual Framework and Ideas for Action in Latin America and the Caribbean. Inter-American Development Bank. Health Technical Note 03/2007; Lewis, Maureen: Governance and Corruption in Public Health Care Systems, Working Paper 78, Center for Global Development, Washington, 2006. Lewis M./ Pettersson, G.: Governance in Health Care Delivery: Raising Performance, Unpublished draft, July 2009; Roberts, Marc, J. et al. Getting Health Reform Right, Oxford: Oxford University Press, 2002; *De* Savigny, Don/ Adam, Taghreed, (eds.): Systems thinking for health systems strengthening. World Health Organization, Geneva, Switzerland, 2009; Brinkerhoff, Derick/ W, Bossert/ Thomas, J: Health Governance: Concepts, Experience, and Programming Options. Bethesda: Abt Associates Inc., 2008; Vian, T.aryn: Review of corruption in the health sector: theory, methods and interventions. Health Policy and Planning, 2008.

15 Brinkerhoff, Derick W./ Bossert, Thomas J.: Health Governance: Concepts, Experience, and Programming Options. Bethesda: Abt Associates Inc. 2008.

16 VIan, Taryn. Corruption in the Health Sector. U4, 2008, no. 10, pp. 31–41

this process of elite state capture and the *de facto* privatization of many state institutions, the boundary between state and society became largely blurred;[17] this nebulousness has since become a common feature in many developing countries.

Migdal's categorisation of strong societies and weak states[18] captures the seemingly paradoxical situation in many low-income countries effectively. While many states do not effectively enforce their own legislation, their societies (or elements thereof) have strongly resisted state domination or have even managed to infiltrate the state with institutions based on particularism. In effect, the situation can be described as a conflict between (elements of) the state and societal institutions. This leads to a situation characterized as 'dual governance systems'.[19] While the formal system is based on legal-rational provisions, such as judicial structures and constitutions, the informal system is 'based on implicit and unwritten understandings'.[20] Some of the characteristics of this informal system are captured by the concept of 'economy of affection',[21] which highlights the particularist and reciprocal nature of the system:

> Because governance there is extensively reliant on informal relations [...] power does not stem from occupying official positions alone. It comes from the ability to create personal dependencies, from mastering a clientelist form of politics.[22]

Chabal and Daloz reason that because the state in Africa has never actually been institutionalized, 'its formal structure has ill-managed to conceal the patrimonial and particularistic nature of power'.[23] Some even contend that in some African countries the state is not only infiltrated by informal institutions that promote illegal behaviour, but has itself become a vehicle for organized crime.[24] Although much of the relevant

17 Clapham, Christopher: Third World Politics: An Introduction. London: Routledge, 1985.

18 Migdal, Joel S.: Strong Societies and Weak States: State–Society Relations and State Capabilities in the Third World, Princeton: Princeton University Press, 1988.

19 Brinkerhoff, Derick W. and Goldsmith, Arthur A. Clientelism, Patrimonialism and Democratic Governance: An Overview and Framework for Assessment and Programming. Prepared for USAID by Abt Associates Inc. December 2002.

20 Ibid.

21 Hyden, Goran: Informal Institutions, Economy of Affection, and Rural Development, in: Tanzanian Journal of Population Studies and Development, Special Issue: African Economy of Affection, 2004, (vol. 11), no. 2.; Hyden, Goran. Beyond Governance: Bringing Power into Development Policy Analysis, paper presented to the Danida/GEPPA Conference on Power, Politics and Change in Weak States, Copenhagen, 1–2 March 2006, online at www.geppa.dk/files/activities/Conference%202006/Goran%20Hyden.pdf ; Hyden, Goran: African Politics in Comparative Perspective. Cambridge: Cambridge University Press, 2006; Hyden, Goran: Governance and Poverty Reduction in Africa, 2007, PNAS, (vol. 104), no. 43, pp. 16751–16756; Hyden, Goran: Institutions, Power and Policy Outcomes in Africa. Africa Power and Politics Programme, 2008, Discussion Paper 2.

22 Hyden, Goran Governance and Poverty Reduction in Africa. 2007 PNAS 104 (43): 16751–16756.

23 Chabal, Patrick/ Daloz, Jean-Pascal: Africa Works: Disorder as Political Instrument. Bloomington, Indiana University Press, 1999.

24 Bayart, Jean Francois/ Ellis, Stephen/ Hibou, Beatrice: The Criminalization of the State in Africa. Bloomington: Indiana University Press, 1999.

See also: Bayart, Jean Francois: The State in Africa: The Politics of the Belly. New York: Longman, 1993.

literature is centred on Africa, examples can also be found across the newly independent countries of the former Soviet Union as well as in other parts of the world. The predatory elite behaviour and the strong influence of patronage networks on governments found across Central Asia[25] are exemplary.

This brings the argument to the concept of neo-patrimonialism, or modern patrimonialism, which has become commonly used in political science over the past three decades to denote the nature of many contemporary states in the developing world, particularly in Africa.[26] Derived from Weber's ideal types of authority, the term refers to the coexistence of patrimonial and legal-bureaucratic elements constituting the state. Its manifestation can take different forms depending on the local context and is not a typology of political freedom, yet its character typically excludes most liberal democracies. Many neo-patrimonial features can also be found in the large gray hybrid zone of political systems, including many of the 'new polyarchies', but also in some long-enduring polyarchies in Asia, Southern Europe and Latin America.[27] Due to this broad applicability, the term is often criticized for being too much of a catch-all concept. However, in this framework it serves to describe a general state of politics in which informal power, often defined by clientelist relations, thrives.[28] Essentially, a neo-patrimonial state possesses the basic structures of a modern bureaucracy (albeit often partly symbolic or redundant) but is strongly pervaded by informal networks and traditional rather than legal-rational institutions. The term also helps to explain how

25 Buisson, Antoine: State-Building, Power-Building and Political Legitimacy: The Case of Post-Conflict Tajikistan, in: China and Eurasia Forum Quarterly, 2007, (vol. 5), no. 4, pp. 115–147; Ilkhamov, Alisher: Neopatrimonialism, interest groups and patronage networks: the impasses of the governance system in Uzbekistan, in: Central Asian Survey, 2007, (vol. 26), no. 1, pp. 65–84; International Crisis Group 2009, Tajikistan: On the Road to Failure. Asia Report 162; Matveeva, Anna: The Perils of Emerging Statehood: Civil War and State Reconstruction in Tajikistan. An Analytical Narrative on State-Making. Crisis States Research Centre 2009, Working Paper 46; Radnitz, Scott: It takes more than a village: mobilisation, networks and the state in Central Asia. PhD Thesis Massachusetts Institute of Technology February, 2007.; Radnitz, Scott/ Wheatly, Jonathan/ Zürcher, Christopher: The Origins of Social Capital. Evidence from a Survey in Post-Soviet Central Asia, in: Comparative Political Studies, 2009, (vol. 42), pp. 707–732.

26 Bratton, Michael/ Van de Walle, Nicolas (eds.): Democratic Experiments in Africa: Regime Transitions in Comparative Perspective, Cambridge: Cambridge University Press, 1997; Brinkerhoff, Derick W./ Goldsmith, Arthur A. Clientelism, Patrimonialism and Democratic Governance: An Overview and Framework for Assessment and Programming. Prepared for USAID by Abt Associates Inc. December 2002; Clapham, Christopher: Third World Politics: An Introduction. London: Routledge, 1985; Eisenstadt, Shmuel N.: Traditional Patrimonialism and Modern Neopatrimonialism. Beverly Hills: Sage Publications, 1973.

27 O'Donnell, Guillermo: Illusions About Consolidation, in: Journal of Democracy, 1996, (vol. 7), no. 2, pp. 34–51; O'Donnell, Guillermo/ Schmitter, Phillipe C.: Transitions from Authoritarian Rule: Tentative Conclusions about Uncertain Democracies. Baltimore: Johns Hopkins University Press, 1986. OECD DAC: Service Delivery in Fragile Situations. Key Concepts, Findings and Lessons, in: Journal of Development, 2008, (vol. 9) no. 3.

28 Brinkerhoff, Derick W./ Goldsmith, Arthur A.: Clientelism, Patrimonialism and Democratic Governance: An Overview and Framework for Assessment and Programming. Prepared for USAID by Abt Associates Inc. December 2002, p. 6

formal rules and procedures in the public sector do not always lead to the predicted outputs relevant to human welfare. In many societies based on strong interpersonal relations, the very idea of separating public roles and responsibilities from private obligations—which involve ties of loyalty, friendship and kinship— seems unnatural and impractical.[29] Understanding this challenge is essential because it underpins one of the basic problems that characterises service delivery in many developing countries: weak formal governance.

Because the state and its institutions were originally imposed on many colonized countries from outside and mainly used for the benefit of a small elite group, no 'merging between state and society as common expressions of a set of shared values'[30] took place. The assumption that state institutions such as health systems 'are not only producers of health or health care but they are also the purveyors of a wider set of societal values and norms'[31] therefore does not hold in these contexts. Ideally, 'people value health and welfare systems both because they satisfy their own interests through them and because such systems allow them to contribute to the social good'.[32] However, in a context where the state is viewed with suspicion and (the revenues for) its institutions are regularly manipulated by private interest, entities such as health or water systems lose their role of a cherished public service. This scenario is especially common in states where the government seriously lacks legitimacy among and accountability toward the general population and service delivery is grossly inadequate.[33] These shortcomings also constitute the heart of state fragility, which 'arises primarily from weaknesses in the dynamic political process through which citizens' expectations of the state and state expectations of citizens are reconciled and brought into equilibrium with the state's capacity to deliver services'.[34] Jones, Chandran et al. argue that this social contract, i.e. the interplay between capacity, will and legitimacy, is the key to understanding state fragility. Basic services are a chief component of this social contract. It therefore stands to reason that governance concerns in this field have wider implications for the resilience of states, as failing public service delivery may serve to further undermine trust in formal institutions and thus perpetuate a downward spiral of deteriorating state performance and legitimacy.

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29 Rose-Ackerman, Susan: Corruption and Government: Causes, Consequences and Reform. Cambridge: Cambridge University Press, 1999, p. 106.

30 Clapham, Christopher: Third World Politics: An Introduction. London: Routledge, 1985, p. 42.

31 Gilson, Lucy: Trust and the development of health care as a social institution, Social Science & Medicine, 2003, (vol. 56), no. 7, p. 1461.

32 Ibid.

33 Conversely, one could argue that improving basic services can contribute to state-building and the enhancement of state legitimacy. See: OECD DAC: Service Delivery in Fragile Situations. Key Concepts, Findings and Lessons. Journal of Development, 2008, (vol. 9), no. 3.

34 Jones, B./ R. Chandran, et al. Concepts and Dilemmas of State Building in Fragile Situations: From Fragility to Resilience. OECD/DAC, 2008, Discussion Paper.

As 'clientelism is indeed the application of the principles of neo-patrimonialism to relationships between superiors and inferiors',[35] this particular phenomenon requires extra attention. The concept of clientelism implies dyadic, inherently unequal but reciprocal relationships between public office holders and followers, supporters or dependents. They may be legal or not, may involve more dynamic and complex networks with more than two actors involved, may be semi-institutionalized and strictly clan-based, or may be merely motivated by political and/or economic interests. However, according to Kaufman,[36] clientelist relations always exhibit the following characteristics:

> (a) the relationship occurs between actors of unequal power and status;
> (b) it is based on the principle of reciprocity; that is, it is a self-regulating form of interpersonal exchange, the maintenance of which depends on the return that each actor expects to obtain by rendering goods and services to the other and which ceases once the expected rewards fail to materialize;
> (c) the relationship is particularistic and private, anchored only loosely in public law or community norms.

In essence, clientelism and accountability share a strong element of reciprocity in power relations. Therefore, some clientelist relations can be considered to contain elements of informal and particularistic vertical accountability. In line with the basic definition of accountability in this article,[37] the degree of accountability in patron-client relationships depends on the degree of extortion and space for withdrawal or choice on the side of the client (the exit option in accountability[38]). Clearly, many clientelist relations that are unequal by definition, merely function under heavy intimidation and the lack of choices on the side of the client. Still, cases of competitive clientelism,[39] whereby clients 'choose' their patron and patrons compete for client support, suggest that clientelist networks can be centred around principles of accountability. Seeing clientelism as a potential form of vertical accountability can serve to explain how accountability can be skewed beyond relations that are formal, public and for all to see. The inherently unequal relationship between the (potential) user and provider makes public services especially vulnerable to the influence of clientelist networks, often described

35 Clapham, Christopher: Third World Politics: An Introduction. London: Routledge, 1985, p. 55.

36 Kaufman, Robert: The Patron-Client Concept and Macro-Politics: Prospects and Problems, Comparative Studies in Society and History, 1974, (vol. 16), no. 3, p. 285.

37 A relationship between two actors in which A is accountable to B if A takes into account B's wishes, while B can hold A responsible if A ignores B's wishes. This occurs when B relinquishes some degree of power, status or resources to A, which B may withdraw in order to enforce A's responsiveness..

38 For an excellent conceptual analyses on accountability and its voice and exit options, see: Paul, S.: Accountability in Public Services: Exit, Voice and Control, in: World Development, 1992, (vol. 20), no. 7, pp. 1047–1060; Baez-Camargo, Claudia: Accountability for Better Health Care Provision: A Framework and Guidelines to Define, Understand and Assess Accountability in Health Systems. Publication forthcoming.

39 Denissen, Ingeborg: New Forms of Political Inclusion: Competitive Clientelism. The case of Iztapalapa, Mexico City. MinBuZa: A Rich Menu for the Poor: Food for Thought on Effective Aid Policies Essay Series, 19 June 2009, no. 33.

as corruption.[40] In fact, clientelist networks can so deeply pervade politics and society that they often come to be regarded as the only means to access supposedly public services. In an ethnographic study[41] on the effect of clientelism on basic service delivery in Argentina, Auyero described how urban slum dwellers depend on their clientelist relationships for physical survival. State provisions, such as the *Programa Materno-Infantil*, are interpreted as a favour granted by benefactors or a tool through which to win support rather than a rights-based service for which officeholders can be held accountable based on their position. The expectation that personal ties are indeed crucial for meeting even basic needs helps to explain the resilience of such clientelist networks.

The impact of clientelist networks on the governance of basic services can have a substantial effect at all levels. At the macro level, an example would be the allocation of more spending for basic services to a particular district in which an important official has a strong constituency or political interest. This type of clientelism, which concerns the more general implementation of policy, can distort the allocation of resources according to national poverty reduction strategies or stand in the way of public sector reform. At the micro level, clientelism could take the form of preferential access to a health facility or school as a result of good relations with the relevant doctor/teacher in exchange for support in the community. In this case, those involved aim for direct private gain and a one-on-one link between patron and client can be discerned. Taking into account these and other examples given later, it becomes clear that clientelist networks can pervade democratic procedures and negatively affect basic services' influence on responsiveness, efficiency and equity. In addition, these networks can play a crucial role in explaining specific sector outcomes that are governance related. For instance, although there have been several studies on informal payments or other manifestations of corruption in water, education and health, relatively little attention has been paid to clientelism as an underlying mechanism. Various types of informal payments could be a possible manifestation of a patron–client relationship. Because informal payments are at the discretion of the service provider, variation can take the form of who is charged and by how much. A long-term doctor–patient or student–teacher relationship may lend itself to a more subtle type of reciprocity that is common in clientelist relations. This could help to explain how those who cannot afford informal or co-payments in regular healthcare, education or water services are still able to obtain access to medical help, education or water; conversely, those who might have the financial means for treatment might lack the proper connections and thus fail to gain adequate access to the best doctors, schools or water

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40 For a good analysis of the reasons for the high corruption vulnerability of the Health Sector, see: Vlan, Taryn. Corruption in the Health Sector. U4, 2008, no. 10, p. 5.

41 Auyero, Javier: The Logic of Clientelism in Argentina: An Ethnographic Account, in: Latin American Research Review, 2001, (vol. 35), no. 3, pp. 55–81.

resources because patron–client relationships are ultimately more important than money. Clientelist networks can also underlie corruption in drug procurement, tendering, payment and supply,[42] as a case study in China illustrates.[43] In education, licensing, grading, passing and even entry to schools are often dependent on informal relations.[44] Another way in which informal networks can facilitate corruption or infringe equity of access to health care for patients is through referral by health workers to benefactors within the network, as witnessed in a Kazakh case.[45] In the water sector, comparable phenomena have been observed in terms of informal payments and illegal connections[46]

Although informal institutions in neo-patrimonial states can be very influential, this does not dictate whether their aggregate effect on basic service delivery is positive or negative per se. In fact, informal institutions are oftentimes deeply rooted in local values and can be more acceptable and hence effective in reaching societal goals. Despite their shortcomings, the traditional reconciliation rituals that have followed many of the civil wars in Sub-Saharan Africa constitute cases of informal institutions offering a framework for justice, peacemaking or addressing war trauma that is often more effective and acceptable than formal channels such as the judiciary or investigative committees.[47] Donor agencies have even started to use mahallas, traditional community councils in Tajikistan, to strengthen governance of basic services at the local level from the bottom up.[48] As extensive research in anthropology suggests,[49] the custom of gift-giving can play an important role in human interactions across different societies. Its exact implications for the functioning of the public sector

42 Lewis, Maureen: Governance and Corruption in Public Health Care Systems, Center for Global Development, 2006, Working Paper 78.

43 Bloom, Gerard/ Han, L./ Li, X.: How health workers earn a living in China, Brighton: Institute for Development Studies, 2000, IDS Working Paper 108, p. 24.

44 Heyneman, S. P.: Education and Corruption, in: International Journal of Educational Development, 2004, (vol. 24), no. 6, pp. 637–648.

45 Thompson, R./ Rittmann, J.: A Review of Specialty Provision: Urology Services, in: Thompson, Ensor, Tim/ J. Rittmann (eds.): Health Care Reform in Kazakstan, compendium of papers prepared for the World Bank Health Reform Technical Assistance Project, 1995–1996, 1997.

46 Davis, Jennifer: Corruption in Public Service Delivery: Experience from South Asia's Water and Sanitation Sector, in: World Development, 2004, (vol. 32), no. 1, pp. 53–71.

47 Huyse, Luc/ Salter, Mark: Traditional Justice and Reconciliation after Violent Conflict: Learning from African Experiences, Stockholm: IDEA, 2008.

48 For one of the longest lasting and most intensive projects with community development in Tajikistan, see: Aga Khan Development Network. Rural Development Activities in Tajikistan. http://www.akdn.org/tajikistan_rural.asp accessed 30 November 2010. Freizer, Sabine. Tajikistan local self governance: a potential bridge between government and civil society. In di Martino, Luigi (2004) Tajikistan at a Crossroads: the Politics of Decentralisation. Cimera: Geneva.

49 Komter, Aafke: Social Solidarity and The Gift, Cambridge: Cambridge University Press, 2004; Lévi-Strauss, Claude: The Principle of Reciprocity, in: Komter, Aafke (eds.): The Gift: An Interdisciplinary Perspective, Amsterdam: Amsterdam University Press, 1996, (Orig. pub. 1949.); Mauss, Marcel: The Gift: The Form and Reason for Exchange in Archaic Societies. London: Routledge. 1990 (Orig. pub. 1923.).

are varied; in the private sector, gift-giving and the cherishing of important relations that it symbolizes is common and often well accepted.[50] In the often partly privatized health, education and water sectors, the same activities are therefore often not questioned, even when the sector is publicly regulated. One of the commonly used words for bribe in Tanzania, *asante*, sums up the confusion: the word also means 'thank you' in Kiswahili. Ultimately, distinguishing between a gift, a bribe and a tip depends considerably on how explicit or direct the reciprocity is in the relationship; the implications may be very subtle. The appeasement of diverse groups in a country and communication between 'centre and periphery' or a powerholder and his base can be seen as the positive effects of clientelism, as a classic case study in Senegal shows. [51] Moreover, clientelism does not necessarily exclude legal-rational or democratic institutions from having voice and participation. In its essence, constituent services performed by congressmen in the United States are an example of *de facto* institutionalized clientelism. Informal institutions and networks operating within them can, however, challenge the democratic principles in decision-making by virtue of their exclusive, particularistic and parochial character. Such institutions are based on personalist or parochial interests rather than universal principles and are less clear, transparent and reliable. Because of this, clientelist relations are easily manipulated and the client can suffer exploitation.[52] Informal institutions should therefore be taken into account in efforts to strengthen basic service delivery as intervening variables that can offer alternative routes for accountability; however, they may also skew existing formal channels of voice and participation. In any case, it must be recognized that informal institutions are part of the governance mechanism in many developing countries and are often very persistent and durable. While recognizing their importance, it might also be possible to find informal institutions that are conducive to development;[53] building upon their potential might be the most productive approach to strengthening the public sector in these contexts.

50 Rose-Ackerman, Susan. Corruption and Government: Causes, Consequences and Reform. Cambridge: Cambridge University Press, 1999, p. 91

51 Coulon, Christian/ Cruise O'Brien, Donal B.: Senegal, in: Cruise O'Brien, Donal B./ Dunn, John/ Rathbone, Richard (eds.): Contemporary West African States, Cambridge: Cambridge University Press, 1989, here: p. 150.

52 Brinkerhoff, Derick W./ Goldsmith, Arthur A.: Clientelism, Patrimonialism and Democratic Governance: An Overview and Framework for Assessment and Programming. Prepared for USAID by Abt Associates Inc. December, 2002, pp. 5, 9.

53 Booth, David: Elites, Governance and the Public Interest in Africa: Working with the Grain? Africa Power and Politics Programme 2009, Discussion Paper 6; Kelsall, Tim: Going with the Grain in African development? Africa Power and Politics Programme 2008, Discussion Paper 1; Kelsall, Tim: Game-theoretic Models, Social Mechanisms and Public Goods in Africa: A Methodological Discussion. Africa Power and Politics Programme 2009 Discussion Paper 7. De Sardan, Olivier/ Pierre, Jean: Researching the Practical Norms of Real Governance in Africa. Africa Power and Politics Programme 2009, Discussion Paper 5.

It should be clear that in many developing countries, governance does not solely take place through formal institutions. Neo-patrimonial forms of governance often have a considerable and distorting impact on the functioning of bureaucracies and the delivery of basic services. Informal institutions and networks are relevant to the assessment of the quality of governance because they may adversely affect the equity, responsiveness and efficiency of basic service delivery by reproducing societal inequalities within the public sector, which is officially designed to work in an anonymous, egalitarian way. Clientelism is one of the more pronounced manifestations of neo-patrimonialism, especially in the case of basic services, where unequal relations are inevitable and the costs—both human and financial—are high. Clientelist relations are often behind many symptoms of problematic governance, such as informal payments, false accreditation, drug leakages, overprescription in health care and procurement fraud. To address these challenges, it is therefore crucial to be aware of these underlying, informal networks of reciprocity to which clientelism can be reduced. Moreover, understanding the interplay between formal and informal power institutions, networks and actors yields insight into the dynamics of accountability in the public sector; this information can be useful for designing interventions. However, the question remains: what the best way is to assess the quality of sector governance?

2.3. Assessing Sector Governance and Informal Dimensions of Power: A Discussion of Methodology and Approach

Institutions and actors beyond those that are formal(ized) matter greatly, but they are by definition difficult to assess openly. Not only is their place in society not formally regulated, but it is also fluid, dynamic and particularistic. Informal power institutions, actors and networks are best mapped in combination with their formal counterparts because the two inevitably interact with, pervade or serve as alternatives for each other. This approach yields a more comprehensive picture of governance challenges than does an analysis that merely concentrates on capacity gaps. More practically, this paper suggests an approach using institutionalism combined with rational choice to gain insight into the crucial interplay between social structures and human actions in the field of sector governance.

By considering the strengths and weaknesses of different perspectives, each of which places a different emphasis on institutions and agents, it is possible to capitalize on the value that they can bring to an understanding of governance in practice. This ultimately requires a multi-step process that recognizes the different analytical loci of each approach. Such a multi-step assessment framework would enable an understanding of institutions that either guide or constrain behaviour; it would also provide insight into the motivation of different actors for the choice of particular norms/

rules/institutions in the governance of basic services, including their variation across time and space. This combination of approaches can ultimately provide the points of entry for strengthening the accountability relations that are productive in the delivery of basic public services such as education, health care and water.

Governance and accountability in settings where the legal-rational concept of the state does not apply, can be analysed from different perspectives. The frameworks that are used in such analyses in political sociology typically emphasize social structures and functions, such as 'institutions', or individual actions and agency, captured in methodological individualism and choice theory. Many scholars, for example Parssons[54] (1951) and Giddens[55] (1984) to name just two, have attempted to overcome this dichotomy, and the debate will continue to develop in sociology.[56] For the study of governance, it is important to consider the differences in the theoretical traditions if methodological inconsistency is to be avoided. Likewise, a clear conceptual delineation must be made between institutions, stakeholders and actors—along with an understanding of the connections between them.

Referring back to North,[57] an institution can be defined as a framework that places normative constraints and incentives on the behaviour of agents. Agents, in turn, can be human individuals or organizations/networks pursuing particular interests.[58] If decision-making on a particular issue concerns them, agents can become stakeholders—literally, agents who hold a certain interest (stake), big or small, in the issue. One institution can theoretically be dominant in constraining and incentivizing the behaviour of a whole organization and thereby set the norms for accountable behaviour in a certain setting. However, as has been argued before, in reality the variation within organizations is often large and multiple, formal and informal institutions play a role in the variety of accountable relations between people.

Attempts at constructing more comprehensive governance mapping tools have come from both academia and the donor community, with varying degrees of practical applicability. With different purposes in mind, the premises, emphasis, focus and scope of the given analytical frameworks differ, as well as the degree to which they

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54 Parssons, Talcott/ Shills, Edward E.: Toward a General Theory of Action. Theoretical Foundations for the Social Sciences. New Brunswick, NJ: Transaction Publishers, Abridged edition, 2001.

55 Giddens, Anthony: The Constitution of Society, Cambridge: Polity Press, 1984.

56 This article does not aim to explicitly position itself in this debate, nor re-evaluate Emile Durkheim's structuralist-functionalism, Weber's social action theory or the large body of sociological theory that these classics in sociology have inspired. However, the continuing, albeit often latent, influence of their approaches must be recognized and considered in the search for theoretically consistent tools to assess governance of basic services in general and health systems in particular.

57 North, Douglass Cecil: Institutions, Institutional Change, and Economic Performance. Cambridge University Press, 1990.

58 Warrener, Debbie: The Drivers of Change Approach. Overseas Development Institute. November, 2004, Synthesis Paper 3, p. 8.

strive at an objective or normative assessment. Lastly, the use of these tools for comparative or case study research also varies.[59]

A distinction between mapping tools for entire countries and those that are more applicable to sectoral analysis can be made, although some tools can be used for both purposes. Examples of the tried and tested tools best equipped for country-level analysis are USAID's Governance and Democracy Assessment and the World Bank's Governance Matters, CPIA and Country Diagnostic Tools. These provide valuable insight into a country's structural situation, within which basic service delivery functions, and into the institutional features that shape the rules of the game. Their methodology is fixed and systematic, which yields results on institutional patterns that are easily comparable.[60] However, because the results are so broad, further research is needed to answer in greater detail the questions of *why* sectors operate the way they do and *who* holds influence over this process. This requires a closer look first of all at the character of institutions and secondly at the positioning of stakeholders in relation to the institutions as well as to each other.

Examples of analytical tools from the donor community that pay specific attention to the functions of institutions, both formal and informal, include DFID's Drivers of Change,[61] the EU's Sector Governance[62] and SIDA's Power Analysis.[63] The analytical frameworks of these tools are methodologically flexible, incorporating relevant results from different types of studies; this approach increases the understanding of specific contexts but can hinder comparative analysis.[64]

A common feature of many institutional approaches is a functionalist interest in the sources of power. Where and how is it exercised?[65] It takes governance functions as its starting point, which facilitates an analysis of the role that different, state and non-state, actors play in fulfilling them. Furthermore, there is recognition that governance functions are contested, specifically when it comes to public services, even

59 Nash, Robert/ Hudson, Alan/ Lutrell, Cecilia: Mapping Political Content: A Toolkit for Civil Society Organisations, Overseas Development Institute, 2006.
60 Schiffer, Eva/ Waale, Douglas: Tracing Power and Influence in Networks, IFPRI 2008, Discussion Paper 00772, p. 2.
61 Warrener, Debbie: The Drivers of Change Approach. Overseas Development Institute, November 2004, Synthesis Paper 3, p. 9.
62 Boesen, Niels: Analysing and Addressing Governance in Sector Operations. European Commission, November 2008, Tools and Methods Series. Reference Document 4.
63 Bjuremalm, Helena: Power Analysis—Experiences and Challenges, Swedish International Development Agency (SIDA), Stockholm, 2006.
64 Schiffer, Eva/ Waale, Douglas: Tracing Power and Influence in Networks, IFPRI 2008, Discussion Paper 00772 , p. 2.
65 Boesen, Niels: Analysing and Addressing Governance in Sector Operations. European Commission, November 2008, Tools and Methods Series, Reference Document 4.

within Europe and North America. This leads to the case for a view of non-state governance actors as equal to state actors in fulfilling governance functions.[66]

In the study of informal institutions, there is a risk of falling into the primordialist, culturalist or traditionalist trap[67] by generalizing about a whole region or viewing institutions as hereditary, fixed and constant over time. In reality, institutions are not static, but vary across time and space. Even though institutions centred on ethnicity, family and religion play a large role in many societies and have proven durable over time,[68] their degree of construction and instrumentalization by elites[69] must also be considered. Accordingly, some scholars use the distinction between official and practical norms to analyse the situation being studied with a greater sensitivity to the normative diversity that can exist in societies.[70] While official norms are based on formal institutions, practical norms can be ther particular applications of informal institutions to any decision that an agent encounters in a situation. Interestingly, however, even intricate knowledge of the character of institutions does not fully explain its influence or the ultimate normative choices that agents make and neither does it yield an understanding into the ways in which the agents' actions have shaped the character of the institutions. Ultimately, an analysis of institutions tends to remain largely descriptive. The central questions remaining beyond this analysis are therefore: what motivates actors' choice of norms and how do their actions shape institutional outcomes?

Any attempt to answer the question of why actors choose to follow particular norms needs to be grounded in an understanding of individual behaviour, or *action*. Stakeholder mapping and analysis can help to illuminate the foundations of this action. This approach can be described as a set of tools to discover who the most relevant formal and informal actors are with regards to a specific situation or issue by carefully considering their interests, intentions and inter-relations. This mapping allows one to 'develop an understanding of—and possibly identify opportunities for influencing—how decisions are taken in a particular context'[71] and thus provides insight into actor behaviour. Choice and political economy theory exercises, such as game-theo-

66 Draude, Anke: How to Capture Non-Western Forms of Governance. In Favour of An Equivalence Functionalist Observation in Areas of Limited Statehood, SFB Working Paper Series 2, January 2007, pp. 1–16.

67 Booth, David: Elites, Governance and the Public Interest in Africa: Working with the Grain? Africa Power and Politics Programme 2009, Discussion Paper 6, p. 15.

68 Kelsall, Tim: Going with the grain in African development? Africa Power and Politics Programme 2008, Discussion Paper 1.

69 Chabal, Patrick / Daloz, Jean-Pascal: Africa Works: Disorder as Political Instrument. Bloomington: Indiana University Press, 1999, p. 2.

70 De Sardan, Olivier/ Pierre, Jean: Researching the Practical Norms of Real Governance in Africa, Africa Power and Politics Programme 2009, Discussion Paper 5.

71 Brugha, R./ Varvasovsky, Z.: Stakeholder Analysis: A Review. Health Policy and Planning, 2000, (vol. 15), no. 3, p. 239. Brugha, R./ Varvasovsky, Z.: How to do (or not to do)… A Stakeholder analysis, in: Health Policy and Planning, 2000, (vol. 15), no. 3, pp. 338–345.

retical models, can be included in order to examine the choices made by stakeholders more closely.[72] The element of perceived costliness in choices, whether material, psychological, social or moral, is at the heart of choice theory in the social sciences, which assume that individuals will always choose the least costly route to maximise their perceived self interest.

The element of perception in the definition of self-interest and the possibility of self-interest involving more than just material gain necessarily complicate the applicability of the theory. Furthermore, the rational choice assumptions that 1) individuals are forward-looking in their behavioural choices and 2) individuals act consistently over time[73] can be challenged in some instances, as can all general approaches to human action. Nevertheless, when complemented by a thorough understanding of the relevant normative frameworks, careful consideration of choice theory's underlying principles regarding human action can yield deep insight into power relations.

Stakeholder mapping and analysis can help to gain firsthand insight into the relevant power relations at play. This approach can be described as a set of tools to discover who the most relevant formal and informal actors are with regard to a specific situation or issue by carefully considering their interests, intentions and inter-relations. This mapping allows one to 'develop an understanding of—and possibly identify opportunities for influencing—how decisions are taken in a particular context'[74] and thus provides an insight into actor behaviour. Oft-used elements of stakeholder mapping are game-theoretical models. Game-theoretical analysis has its origin in applied mathematics and is part of choice theory in social science research. The value of applying mathematical models in an effort to understand societal phenomena is that they can map strategy based on the combination of choices that exist for a variety of agents. For example, in Nash equilibriums, one of the classic game situations, the goal of achieving maximum gain is a choice between competition or cooperation with trust as an important element.

However, many real-life situations are too complex to map in a mathematical model, particularly when the situation concerns a choice for rules or institutions.[75] This is the paradox of game theory, which ultimately wants to understand how a game works given a variety of structural rules. Still, it is possible to put some of the underly-

72 World Bank website, On Stakeholder Analysis. Last Accessed 31 May 2010: http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPUBLICSECTORANDGOVERNANCE/EXTANTICORRUPTION/0,,contentMDK:20638051~pagePK:210058~piPK:210062~theSitePK:384455~isCURL:Y,00.html

73 Becker, G.: Nobel Lecture: The Economic Way of Looking at Behavior, in: The Journal of Political Economy, 1993, (vol. 101), no. 3, p. 402.

74 Brugha, R./ Varvasovsky, Z.: Stakeholder analysis: a review, in: Health Policy and Planning, 2000, (vol. 15), no. 3, p. 239. Brugha, R./ Varvasovsky, Z.: How to do (or not to do)… A Stakeholder analysis, in: Health Policy and Planning, 2000, (vol. 15), no. 3, pp. 338–345.

75 Ostrom, E.: Understanding Institutional Diversity. Princeton, NJ: Princeton University Press: 2005.

ing principles to use in the analysis of power relations. In short, the argument is that the degree of difficulty of exclusion of use and the subtractability of a good are the axes along which four types of goods can be classified: toll goods, private goods, public goods and common pool resources.[76]

Subtractability refers to the extent to which one person's use of a good or resource limits its use by others. If a good or resource is scarce, its subtractability is generally higher than when it is seemingly abundant or unlimited. Excludability is the extent to which people can be prevented from using a good or resource. These two factors largely determine the stake that people perceive themselves as having in a given situation as well as the extent to which they (can) compete for influence. For example, official positions high up in the hierarchy of a low-income country's bureaucracy allow for potentially greater access to scarce financial resources. If internal, or managerial, accountability within a sector is weak, it becomes easy to withhold these resources from the public, i.e. to adhere to the official institutional norm, but to reserve the public resources for personal or parochial use.

Given the high excludability and subtractability of financial resources in a low-income country, competition for (access to people in) high official positions is intense. This not only explains elite state capture, and the subsequent organization of state apparatuses as milk cows, but also sheds light on society's perceptions of clientelism and patronage, which can even take on a formally institutionalized shape. In the case of water services, their high subtractability but low excludability leads to the free rider or tragedy of the commons problem that is associated with common-pool resources. Unless strict monitoring and enforcement systems, in other words elements of excludability, are built in, it remains more beneficial to free-ride than to follow the formal regulations and pay for a service or good. A factor heavily influenced by excludability is the direction in which accountability is exercised. On the assumption that people faced with multiple choices would opt for the one that maximizes their own perceived self-interest, it follows that people exercise accountability to those who hold most power over their status, career, access to resources or remuneration in a job, which does not necessarily need to be their official boss or the primary stakeholder. A doctor whose salary and position depends on the patient's satisfaction is more likely to be responsive to their needs than one whose salary and position is unquestioned and secured by a political friend in the ministry of health. Similarly, if child benefits depend on school attendance, teachers acquire a very strong position, and parents will be willing to relinquish power or resources to them in exchange for access to the benefits. This element of excludability also highlights the importance of clientelism, potentially skewing accountability away from those formally outlined. The actor with

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76 Ostrom, E.: Understanding Institutional Diversity. Princeton, NJ: Princeton University Press: 2005: p. 24.

the power to exclude potential (groups of) care seekers or users from accessing a service holds great power. In turn, clients can also lever their power, especially when political competition is at stake.[77] The potential 'excluder' should therefore be considered as the strong power wielder, especially in cases of conditional cash transfers that are gaining in popularity among donors and policymakers. These examples illustrate how subtractability and excludability can help identify stakeholders in a given situation, including how they exercise accountability with each other, and facilitate an understanding of the prominence and character of the relevant institutions.

Stakeholder mapping and analysis has its roots in management and programmatic decision-making[78] and is applied in a wide variety of disciplines and situations. Because of the consequent absence of a single methodology, its results can be mixed and greatly depend on the purpose, time and context. A good research design needs to clarify these factors from the start, however. Because institutions and stakeholders cannot be strictly separated, their mappings and analyses should complement one another. Networks or organizations that function within institutional norms as a unit can, especially in an analysis with a large scope, be considered stakeholders. However, it must be stressed again that individual actors working within the normative framework of a single formal institution often still respond to other, possibly informal, institutions. In sum, an awareness of the normative frameworks at play is crucial because it sets the parameters within which stakeholders act.

The composition of a definite framework for a stakeholder analysis will have to depend on the institutional mapping that needs to be included and, most importantly, the precise issue under scrutiny. In this kind of problem-driven research, methodological adaptability is always a must.

2.4. Conclusions

Many developing countries do not approximate the ideal type of legal-rational governance. However, many donors working on sector governance continue to merely focus on formal governance institutions and actors in their attempts to understand the existing challenges in the governance of basic services. Informal dimensions of power remain under-researched and are insufficiently recognized in donor policy. This article constitutes an attempt to contribute to this debate with a framework of the analysis of sector governance.

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77 Denissen, Ingeborg: New Forms of Political Inclusion: Competitive Clientelism. The case of Iztapalapa, Mexico City. MinBuZa: A Rich Menu for the Poor: Food for Thought on Effective Aid Policies Essay Series, 2009, no. 33.

78 Nash, Robert/ Hudson, Alan/ Lutrell, Cecilia: Mapping Political Context: A Toolkit for Civil Society Organisations. Overseas Development Institute, 2006.

As governance can be conceptualized in terms of the formulation and operationalization of rules and procedures that facilitate and constrain societal interaction, it should be clear that governance can be both formal and informal. Because of their large impact on the quality of human life, basic services are seen as a public—and therefore formal—good in most countries. Since states in many developing countries fail in the governance of this basic service, the importance of informal institutions and actors is even greater. In these cases, neo-patrimonial forms of rule dominate, which reproduces societal inequalities in the public sphere. Clientelist relations and other personalistic modes of governance become essential for access to education, health care and clean water. An understanding of these mechanisms is therefore crucial to acquiring a full picture of the challenges in the governance of basic services.

Any sector governance assessment needs to focus on both institutions and agents, with the recognition that these can be both formal and informal. Formal and informal dimensions of power are best analysed in combination because both kinds of institutions often interweave or compete, and agents can perform different roles at the same time. An understanding of the relevant informal institutions in addition to the formal rules and procedures reveals much about the underlying causes for the performance of systems set up for basic service delivery, but ultimately does not suffice to explain fully the behaviour of actors in different settings. Therefore, a consideration of the principles of choice theory can be instrumental in analysing the composition of stakeholder networks and the nature of the individual relations within them.

The discussion on sector governance and informal dimensions of power presented in this article represents an initial effort to sketch the contours for an analytical framework. The practical utility of such a framework in assessing governance-related problems in basic service delivery requires empirical research, which will undoubtedly generate new hypotheses on the role of (informal) institutions and actors in different settings.

ANNEX B: Publication 2

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The politics of the basic benefit package health reforms in Tajikistan

Eelco Jacobs[1,2]

Abstract

Background: Health reform is a fundamentally political process. Yet, evidence on the interplay between domestic politics, international aid and the technical dimensions of health systems, particularly in the former Soviet Union and Central Asia, remains limited. Little regard has been given to the political dimensions of Tajikistan's Basic Benefit Package (BBP) reforms that regulate entitlements to a guaranteed set of healthcare services while introducing co-payments. The objective of this paper is therefore to explore the governance constraints to the introduction and implementation of the BBP and associated health management changes.

Methods: This qualitative study draws on literature review and key informant interviews. Data analysis was guided by a political economy framework exploring the interplay between structural and institutional features on the one hand and agency dynamics on the other. Building on that the article presents the main themes that emerged on structure-agency dynamics, forming the key governance constraints to the BBP reform and implementation.

Results: Policy incoherence, parallel and competing central government mandates, and regulatory fragmentation, have emerged as dominant drivers of most other constraints to effective design and implementation of the BBP and associated health reforms in Tajikistan: overcharging and informal payments, a weak link between budgeting and policymaking, a practice of non-transparent budget bargaining instead of a rationalisation of health expenditure, little donor harmonisation, and weak accountability to citizens.

Conclusion: This study suggests that policy incoherence and regulatory fragmentation can be linked to the neo-patrimonial character of the regime and donor behaviour, with detrimental consequences for the health system.. These findings raise questions on the unintended effects of non-harmonised piloting of health reforms, and the interaction of health financing and management interventions with entrenched power relations. Ultimately these insights serve to underline the relevance of contextualising health programmes and addressing policy incoherence with long horizon planning as a priority.

Keywords: Health governance, Health financing, Health policy, Health reform, Tajikistan, Political economy

Background

Over the past fifteen years, reform processes in the health sector have been launched in Tajikistan to overhaul the inherited Semashko[1] health system and address the high level of out-of-pocket payments on health. Among these reforms is the introduction of the Basic Benefit Package (BBP). The BBP, the first pilots of which started in 2004–2005, regulates entitlements to a specific, guaranteed set of healthcare services through a set of rules with pre-determined levels of co-payment charges and exemptions for categories of the population and patients. Supported by a constitutional amendment removing the right to free healthcare, the BBP reforms allow for an increase in revenues for the health system by formalizing informal payments and inverts the health system service delivery pattern relying heavily on the hospital level by redirecting resources to primary health care (PHC). However, its implementation has remained challenging.

Many of the policy details and organizational flaws of the health reforms in Tajikistan have been discussed from a variety of approaches [1–5]. The literature has exposed the main technical weaknesses of the system

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and its symptoms, including oversupply of specialised care at the expense of PHC; inefficient budget formulas; weak information systems; and its outcomes in the areas of epidemiology, quality of and access to health care. External assistance has come into the country to address many of these challenges in a slow process of moving from relief to development aid in the first decade after the end of the civil war [6]. However, despite progress in some areas there has been insufficient consideration of the fact that" long-term results are contingent upon the murkier, less measurable and less manageable realm of political and power dynamics" [7]. Health reform, particularly when aimed at enhancing universal health coverage, is a fundamentally political process with major collective action challenges, as it entails the redistribution of power and resources with inevitably winners and losers [8].

Consideration for the 'enabling environment', or political context in which technical health policy is conceived and implemented is therefore essential [9–11], especially given the situation of precarious statehood in Tajikistan. The leading research question of this article is therefore 'what have been the main governance problems in the conception, development and implementation of the BBP and directly related health reforms?' More generally, the Tajik case can help to answer questions such as: which institutional constraints can be identified to be standing in the way of health policy development and implementation? How do these mechanisms influence each other, and what lessons can be drawn from it?

This study aims to offer an insight into the interplay between the technical and political dimensions of health reform. The case of Tajikistan and the BBP reform provides an illustration of the way political dynamics in a fragile, post-conflict environment affect the design and implementation of a health financing reform. With a focus on the political economy dimensions of health governance, policy formulation and implementation the analysis is embedded in the wider debate on the drivers and spoilers of change in development policy, political economy of reform and generally the political dimensions of governance. Health governance in this study is defined as a process in which institutions, understood as the both formal and informal norms, rules and laws that shape the actions, and particularly the authorities, roles and accountabilities among societal actors in a health system [12–14]. These institutions influence the way a variety of state and non-state actors 'make policy' i.e. conceive of, formulate and implement it. The gap between agenda-setting and policy formulation on the one hand and policy implementation on the other is often striking, and has been the focus of a number of studies, albeit usually in more high income settings [15]. The former (agenda-setting and policy formulation) is here understood as the process in which various actors push their policy options and are ultimately adopted in formal laws, codes or rules, albeit in sometimes incoherent terms. The latter (implementation) can be defined as the way these codified practices are actually carried out by 'street-level bureaucrats' [16]. It is important to emphasise the heterogeneity of actors in this process, each influenced by different (formal and informal) institutions and networks with sometimes competing agendas as a result. This institutionalist perspective on governance and policymaking deviates from the 'good governance' or 'best practice' paradigm in which governance is viewed in a priori universally normative terms that are largely shaped by the experiences of legal-rational bureaucracies in high income settings, and tend to be more focused on the technical rather than the political dimensions of governance [7, 9, 17].

The debate on governance has diversified in recent years, and an increasing number of case studies from different sectors have enriched the body of evidence on the political economy of policy planning and implementation. However, this lens could be more applied to the field of global health to get a fuller understanding of policy processes and outcomes in the drive towards Universal Health Coverage [8, 18]. Particularly in Central Asia and Tajikistan, the political dimensions of health policy and governance remain underexplored. This research therefore contributes to the still limited body of evidence on the politics of health reform, and fills a gap in the literature on health governance in Central Asia.

The article is organized as follows. The next section describes the methods used to undertake the research in Tajikistan, which includes a discussion of the basic political economy analysis framework used for the combined process of data collection and analysis. The results section starts by describing the institutional and structural context, including some of the main characteristics of the Tajik political regime that shape the health system and its functioning. With this background the overall structure of the system and its associated challenges, including underfunding and fragmentation are outlined. The following section presents the findings on the structure-agency dynamics that form the main health governance constraints to the BBP reform in Tajikistan. The discussion attempts to synthesize the findings with the emerging theory on what the most pertinent constraints to effective health reform are. Lastly, the paper concludes.

Methods

Research design

The study design for this research is based on a case study design [19] allowing for in-depth exploration of a contemporary phenomenon in its real-life context, whereby the boundaries of the phenomenon are not nessarily evident. Case study approaches have been found

to be particularly useful to understand and explain causal pathways in health policy developments and reforms [20].

Data collection

Data for this study was collected through literature review as well as semi-structured and open, in-depth key informant interviews (KII). The review included grey literature retrieved through contacts in country and targeted internet searches from the websites of relevant organisations and institutions, as well as literature from a range of disciplines on Tajikistan's political system, economy and health sector, identified through targeted internet searches and snowball sampling.

Purposive snowball sampling techniques [21] were used to identify key informants in the Tajik health governance context. The key informants were selected according to their expertise and level of involvement in the basic benefit package reforms, at both design and implementation levels. A total of 31 informants from governmental, bilateral, multilateral and non-governmental organizations, based in Dushanbe and various other parts of Tajikistan over the course of May 2010– December 2011 were conducted to gain insight into the governance, policy-making and reform context. Interviews with 23 local administrators, managers and health staff during the same time period in one BBP pilot district, as well as interviews with an additional five key administrators in two other BBP pilot districts were conducted for a detailed insight into the practical implementation of health policy. The purpose of the research was explained before each interview. References are not named in order to protect informants.

For data collection and analysis an exploratory approach was used following principles of grounded theory [22, 23], which in essence treats data collection and analysis as an interrelated process, as social phenomena are understood to be naturally dynamic and actors respond to changing conditions and the consequences of their actions and those of others. A topic guide was used for interviews that was focused on the main design and implementation challenges of the BBP reforms, key stakeholders in the health sector and their influence and accountability relations vis-a-vis each other. However, as data collection and analysis were undertaken in the same process, and an analysis of each interview was made before the next interview, the topic guide was updated and adjusted depending on the type of source and new insights gained during the process of data collection. Based on this approach, a number of themes on key governance constraints to health reform and implementation in Tajikistan emerged and hypotheses developed on their relations. These themes and hypotheses were in turn tested and adjusted during the course of data collection until sufficiently confirmed or 'saturated' [24].

Data analysis

This study uses the basic features of political economy as a starting point for data analysis. Political economy analysis can broadly be defined as a set of methodologies based on economics applied to the analysis of political behaviour and institutions [25]. An important assumption underlying political economy analysis is that the governance context in which reforms of basic service sectors take place is shaped by formal and informal institutions, behavioural patterns, networks and agents which in turn influence the design and implementation of policies. In other words, the way policymakers and implementers act and perform is dependent on the, often heterogeneous, institutional environment in which they are embedded [26]. Within the given context individuals are assumed to act in their perceived best interest and form occasional coalitions with those who have similar interests [27] that may not be aligned with the goals of a given reform. As informal institutions shape behaviour and reproduce power, weak legal-rational bureaucratic structures can be pervaded, replaced and modified by more particularistic normative frameworks and relations, leading to what Eisenstadt termed neo-patrimonialism [28]. Although often criticized as being too broad of a concept without much explanatory power, neo-patrimonialism is here used to enable an understanding for the personalised type of political-bureaucratic constellation and authority that also characterizes the situation in most Central Asian countries, including Tajikistan [29]. A neo-patrimonial institutional setting is usually seen to be discouraging rigorous performance management or equitable public service delivery, and instead to be encouraging corruption and clientelism [9, 30, 31]. Political economy analysis is multifaceted with a wide array of approaches. However, common features include a focus on structures and institutions on the one hand, and agency dynamics, i.e. relevant actors, their interests, motivations and processes of cooperation and contestation on the other hand [27, 32]. These features formed the basic framework for the the first level of analysis in this research.

The following results section presents the main themes that emerged from the research in the following order. First of all, the relevant governance and health system structures, institutions, and actors are discussed. Secondly, the main structure-agency dynamics are presented that form the key governance constraints to the BBP reform and implementation.

Results

Governance and the health sector in Tajikistan: the institutional and health system context

Governance background Tajikistan

Partly as a consequence of the national state's lack of resources to organize local systems, and partly as a legacy from the political settlement that ended the violent

conflict in the 1990s informal power relations in Tajikistan have shaped the implementation of governmental policy [33–39]. In fact, since the period of Russian colonialism in the nineteenth century and even the Soviet period the direct influence of the state beyond the district level is limited, merely taking the shape of co-opted local elites [34, 40–42].

Political power is highly centralized in the position of President Emomalii Rahmon, while his domination of the political landscape depends on his ability to pacify a fragmented set of groups through the distribution of spoils and 'virtual politics of peace' [43]. In the face of the near-collapsed condition of the unitary state apparatus after the war, the power-building strategy of Rahmon, who has remained in power until this day, has been to either co-opt or neutralize political rivals through cronyism and repression [33, 44]. Ethno-regional identities and loyalties play a key role in this process [45]. Public services such as the security forces are not only attractive to work in because they provide access to a toll position, they also function to make people complicit in the system of rent-seeking and through that as an arena of acquiescence and political control [38, 44–46].

The relative, virtual peace that has prevailed in the country, save for sporadic violent outbreaks in the Gharm region, Gorno-Badakhshan and around Dushanbe, has as a result come at the detriment of legal-rational institution-building [43] and basic service delivery. Although corruption and cronyism certainly were not absent during Soviet times (e.g. as *blat*, as elaborated by Ledeneva [47]) a quarter of a century after its demise, the Soviet experience still stands in positive contrast to the current life conditions for a majority of the population[2] [48]. Tajikistan remains the poorest of the former Soviet republics and that with the lowest Human Development Score. Its score trend over the period 1990–2015 in the Human Development Index suggests it is one of the countries with the most stagnant human development [49]. Moreover, positive economic growth since the end of the civil war is largely remittances-fuelled as they are estimated to make up 52% of the country's GDP, the highest share of any country globally [50].

With a rent-seeking logic pervading the bureaucracy that is primarily aimed at short term patronage [37, 38, 44], non-productive sectors such as health face neglect and underfunding. Because of the intense personalization, and de facto patrimonialization of power, the Tajik state remains institutionally weak and operates under top-down rationale with limited bureaucratic capacity at the lower levels of government [51]. As a partial consequence, Tajik public function is characterized by little vertical accountability towards citizens, and top-down decision-making that is driven by political need and power dynamics at the top rather than evidence based-policymaking [1]. This authoritarian, personalised leadership with weak legal-rational institutions conforms closely to the dominant-discretionary ideal type, as developed by Levy [52], contrasting with more competitive and rule-of-law based political arrangements.

In the interaction with external donors, the Tajik government has become trained in adapting to the symbols and language of the international community [43] and has acquired an ability to instrumentalise assistance for its own goals [53] that has only been further refined over time. The interaction between this neo-patrimonial regime and a group of donors that have not closely harmonised their agendas and efforts has affected the state of the health system and the implementation of reforms, as this study suggests.

Health sector governance

The Tajik health system continues to formally resemble the Semashko organisational model put in place during Soviet times, with publicly owned, and -financed service providers wholly dominating the health sector. As originally devised the Tajik health system is still characterized by a frequent duplication of functions among agencies and administrative levels and a fragmented institutional setup [54]. Similar to the situation in other Central Asian countries, health facilities exist at the republican, oblast (regional), rayon (district) and jamoat (municipal) level and each different level of government performs similar and overlapping roles including revenue collection, provision of services, payment of salaries, maintenance of infrastructure, monitoring and enforcement [55]. Additionally, specialized health services for specific disease groups exist through vertical programmes, while some employers, including the Ministries of Defence and Internal Affairs run their own health services [4]. Private service provision is mainly limited to a few health providers in the capital on the other hand. Such a bureaucratically fragmented health system with duplication of functions not only leads to wastage of scarce resources, it also poses severe challenges in a context such as the one prevailing in Tajikistan where, as described above, the implementing capacity of the state is limited, especially at the local level [56].

The Tajik health sector continues to suffer from a lack of adequate public or risk-pooled funding as well as inequitable and inefficient financing practices. As Table 1 shows a comparison of Health Expenditure (HE) patterns in other low- and lower-middle-income post-Soviet countries suggests that public resources for health are comparatively limited in Tajikistan, have little priority in the government budget, and, probably as a result,

Table 1 Health expenditure in Tajikistan and a selection of post-Soviet low- and and lower-middle-income countries

	Tajikistan	Kyrgyzstan	Uzbekistan	Moldova
Government HE [1] as % of total government expenditure	7	10	9	13
Government HE as % of total HE	28	45	53	46
OOP [2] expenditure as % of total HE	63	48	43	46

[1] Health Expenditure
[2] Out-of-pocket
All data from the WHO Global Health Expenditure Database, latest available data (2015)
Sources: Global Health Expenditure Database (WHO, latest available data)

out-of-pocket HE is comparatively high. As suggested by Xu et al. [57] this directly correlates with a high incidence of catastrophic and impoverishing HE by households. At 6.8% general government HE as a percentage of total government expenditure in Tajikistan is the third lowest of the WHO Europe region after Azerbaijan and Georgia.

As a non-productive sector, the Soviet health system already chronically suffered from the symptoms of a shortage economy: high shortage intensity, harder-than average budget constraints, and chronic under-fulfilment of supply, investment and output plans [58]. Financing of the healthcare system today remains largely input-based: although originally the infrastructure and resources for the health system were calculated upon basic population norms, the norms and subsequent line items were never adjusted [59] and had not been adjusted until the time of research. Since April 2014 Performance-Based Financing (PBF) has been piloted in Sughd oblast, followed by Khatlon oblast since early 2015. PBF complements and might partially replace the non-transparent input financing mechanism for health that is described in this study. However, due to its piloting nature in a limited part of the country it remained beyond the focus of this study.

In terms of system output, a pressure to 'produce' in Soviet times, based on quantity indicators, lead to a legacy of extensive coverage on the one hand but a surplus of narrow specialists and hospital infrastructure on the other hand. This has come at the expense of overall quality, efficiency and technological innovation; and PHC in particular [3, 4, 58, 60].

Following Tajikistan's independence, a combination of a sudden stop of subsidies from Moscow, severe economic shock and civil war put a great strain to the state budget and subsequently the health system. As resources dwindled, existing weaknesses of the system worsened, and the quality of services deteriorated. Although informal out of pocket payments were certainly not absent in Semashko systems during the communist period, as studies in European countries suggest [61, 62] and reliable private HE data on Tajikistan from the 1980s and early 1990s is scarce, the large drop in public health spending,[3] combined with evidence of big increases in out-of-pocket expenditure from studies in the Central Asian region suggests out of pocket payments, of which a substantial amount appears to be informal payments, came to increasingly fill this gap [1, 3, 58, 63–65]. A time-trend analysis of household surveys conducted in Tajikistan between 2005 and 2011 suggests the median amount of OOP, adjusted for inflation, doubled in that period [66].

To address the underfunding of the system, formalize informal payments and strengthen PHC, co-payment or user fee reforms have been initiated over the past decade. These include the co-payment regulations that are central to the BBP reform, which by 2011 had been piloted in eight districts[4] with support from development partners, and the co-payment policy as outlined in governmental decree no. 600 (Decree 600), for which the Tajik government takes full responsibility. As analysed by Rechel and Khodjamurodov [2, 3]. The BBP guarantees a defined set of health services at no official charge for a limited number of population and patient categories.[5] For all other care-seekers the BBP obliged to cover between 50 and 100% of ambulatory and diagnostic services costs depending on availability or not of referral from a PHC practitioner (50%) and place of residence (80% is charged to residents while 100% payment applies to those who seek care in rayons (districts) in which they are not a resident). In PHC consultations and treatment are provided free of charge apart from ambulatory services and diagnostic tests.

First introduced under Government resolution 237 ("on approval of the BBP for citizens of the Republic of Tajikistan and guidelines for the provision of medical and sanitary services by the state") and implemented nationwide in 2005 the BBP was suspended within months after heavy criticism from development partners and healthcare professionals. The criticism centred around the lack of accompanying financing mechanisms to rationalise and increase funding for PHC, the unpreparedness of all affected by the implementation of the reform including lack of capacity-building of health workers and administrators to implement the provisions of the reform and the complexity and lack of standardisation of co-payment categories and rates (KII and [2]). Following extensive consultations between the Ministry of Health

(MoH) and development partners, a revised BBP was introduced in pilot districts in 2007.

The new payment structure aims to realign the financial incentives for patients to increase the use of PHC facilities in their own jurisdiction and reduce incentives to use hospital level care as the entry point to the health system. The introduction of exemption categories has the goal of preserving and even enhancing affordability of health services for certain vulnerable groups. The introduction of the BBP has been accompanied by two other relevant reforms. Under governmental decree No. 665 that was passed in 2009, district health departments (RaZdrav or GorZdrav) were established, formally shifting coordination of health service delivery at this level away from the previously responsible chief physician of district hospitals. In some districts in which the district's capital authorities are tasked with the coordination of health care services this committee is usually referred to as GorZdrav. Its purpose is however identical and the body will therefore be referred to as RaZdrav in the rest of the article.

Governmental decree 600, passed in 2008, introduced a separate set of user fees for 1200 different services, with much similarity to the failed 2005 BBP policy. The fee levels and categories were not synchronised with the newly revised co-payment regulations under the BBP and no fee exemption mechanism was in place, the levels and rates were not transparent for patients and were too complicated to manage without risks of supplier-induced demand. After intensive discussions, the MoH, together with USAID's ZdravPlus II project, worked to simplify the co-payment structure and started piloting it in 13 hospitals around the country [67]. The co-payment structure and regulations on the use of user fee revenue was however still not synchronised with that of BBP at the time of research. Given the limited scope of Decree 600 at the time of research this article is focused on the BBP and its related changes to the health governance structure, i.e. the introduction of a PHC manager and the RaZdrav committee as introduced under Decree 665.

Main formal actors in the system

Apart from the MoH, as the formal steward of the health system, the most influential actors in the health system in terms of political power at national level are the Ministry of Finance, the president and his shadow administration, made up of advisors who remain beyond legislative control as Abduallaev already found [68], and bilateral and multilateral donors that have funding leverage, but whose efforts have since the end of the civil war not been strongly coordinated or harmonised [1, 2, 69, 70]. The main international donors have been represented in a donor coordination council that has officially been chaired by President Rahmon. As will be elaborated later, the council has not functioned as a body to actively coordinate or collaborate on incorporating lessons learned or using common guidelines in piloting the BBP either between donors or with the government. Rather, it remained a body that merely served the purpose of information sharing [1]. At the district level, formally the main actors are the District Hospital Director, the district health committee *RaZdrav*, the PHC manager, and the district's financial department (*GorFin*). In the BBP pilot districts different development agencies, through their relevant health programme staff, assist in the implementation of BBP and related reforms.

BBP's key governance constraints: an exploration of structure-agency dynamics

The next section presents the main factors impeding the policy development and implementation of the BBP and related reforms at different interconnected levels in Tajikistan that emerged as themes from the field research findings. It attempts to highlight the interplay between the institutional/structure and agency dimensions of health policymaking and implementation as exemplified by the case of the BBP and associated changes in district health management.

Parallel and competing central government mandates, policy incoherence and regulatory fragmentation

A leading overarching concern on the BBP implementation, coming out of most KII, that affects all other governance constraints is the lack of adequately defined and understood policies, rules and mandates. A lack of clarity on which national government actor is primarily responsible for different decision-making and implementation processes, leads to policy incoherence, duplication and fragmentation of responsibilities at governmental level [71]. This is exemplified by the existence of parallel and competing government structures with unclear attributions and mandates. The roles of ministries, such as those for health and finance that fall under the prime minister's office are often duplicated by sector heads and specialists under the President's executive administration, whose authority is beyond legislative control. Most of these actors are represented on the coordination council that has existed since 2011, in which government actors and donors meet to discuss health initiatives, while their exact responsibilities and powers remain unclear. The lack of collaboration in the relationship between these segments of the government became evident during discussions on reform implying a purchaser provider split. Despite this being an agreed-upon goal in the national health strategy to which the MoH subscribed, the Ministry of Finance was strongly

opposed as it meant devolving its purchaser-role to the regional level. Only after a donor appeal to the Presidential administration the Ministry of Finance ultimately agreed (KII).

Overcharging and informal payments

Policy incoherence has had a marked influence on the extent to which implementation of BBP payment schedules and exemption guidelines is non-arbitrary, leading to an increased opportunity space for actors to use their public office for private gain (KII). Combined with the general scarcity of resources this fragmentation and vaguely, sometimes contradictorily formulated rules and procedures were perceived to facilitate the rent-seeking behaviour of staff in key positions, expressed in informal payments for patients, and the ensuing power-play between them over their mandates (KII). The documented variation across facilities and rayons in which co-payments are charged under BBP supported by the SDC-funded Project Sino[6] [66, 72, 73] indeed suggests erratic enforcement of BBP guidelines, possibly facilitated by a lack of awareness on behalf of both patients and providers. Exemption and co-payment categories have been reformulated in a short space of time, and have been piloted by different donors with their own variations on the programme leading to additional confusion for health staff and patients. As documented this erratic implementation of BBP payment guidelines in practice means there is a tendency for excessive charging, including 100% fees for district residents, who are entitled to reduced rates [73], and payment for nominally free PHC services [74]. The general situation of underfunding in the health system has not helped to reduce informal payments substantially. Rather, the intense financial constraints serve as a powerful incentive for the responsible administrators to acquire income through a system of upward channelling of proceeds from informal payments at health facility level (KII).

Weak budgeting practices

An important factor intensifying the fragmentation is the weak link between budgeting and policymaking at the republican level government of Tajikistan. KII with respondents from development agencies, the ministries of finance and health indicated that this regularly resulted in the development of strategically formulated policies for which no adequate or sustainable sources of funding existed. The lack of an implementation budget for the BBP and the lack of an independent budget for the RaZdrav to conduct monitoring and regulatory work are examples of this policymaking – budgeting rift. This is aggravated by the Ministry of Health's lack of budgetary autonomy as the vast majority of funds for healthcare is directly channelled from the Ministry of Finance to local levels of government, as explained below. The government's adaptability to the language of the donor community and the donors' pressure to execute funding often led to these gaps being compensated for with external funds, which would usually be committed only ad-hoc or for a few years (KII). Although weak technical and institutional capacity at the MoH plays an important role [2], the practice can also be sustained by continuing donor commitment without large costs for the government following the principles of moral hazard. In the absence of a functioning formal mechanism of budget allocation, bargaining power towards the political-administrative capital Dushanbe has become and remains an important determinant in budgeting (KII), resulting in inequities between rayons. Consistent with the political regime analysis discussed above, KII with financial and health administrators from three different districts confirm previous observations [1, 3], that although local budget requests are sent to Dushanbe, decisions on budgetary allocations are ultimately taken following a non-transparent logic at the Ministry of Finance. The MoH is effectively sidelined in this process, with rayons in practice bargaining for their health funding directly with the Ministry of Finance (KII).

Little donor harmonisation

The behaviour of development agencies in the BBP reforms has further contributed to policy incoherence and regulatory fragmentation. Objectives, perspectives and modes of operation and evaluation have varied considerably between donors in Tajikistan. Until the establishment of the Health Coordination Council in 2011 there had not been a formal body for aid coordination in the health sector between donors and the government, as donor-government contact mainly took place on an ad-hoc or bilateral basis (KII). Aid coordination has in practice mainly implied the sharing of information on aid activities under the auspicies of the Ministry of Finance [6]. Development partners, of which the most important actors have been SDC, USAID, DfID, WHO, EU, the WB and ADB have often emphasized different elements of health reform and some ran only short-term pilots, adding to the lack of clarity for providers and patients on co-payment policies (KII). Although the National Health Strategies have helped to formulate a direction, which could function as a basis for some level of accountability, an agreed timeline for piloting reform initiatives and scale-up or a systematic effort at monitoring and evaluation for these pilots has never existed.

Weak accountability to citizens

As [2] have outlined, national health governance and in particular the development of the BBP reforms has been

characterized by a lack of participation of non-state actors or lower levels of government. This is matched by the lack of a strong legislative at district level of government. KIIs suggested decision-making at rayon level, where health reforms are implemented, is dominated by the district chairman, or *rayon rais*, who is appointed by the president's office, and in turn appoints municipal mayors. Although an assembly of deputies exists in every rayon, it was considered to hold merely 'consultative status' by local government officials (KII). Furthermore, the President's People's Democratic Party has held absolute majorities in parliaments since the end of the civil war, and according to human rights watchdog Freedom House political rights have been severely curtailed by the government, "sustaining a campaign of repression against opposition, dissent, and criticism" [75]. The absence of competitive electoral politics is a possible explanation for the lack of pork-barrel politics observed. Rather than such a prototypical clientelistic setup, where benefits are delivered to constituencies of citizens in exchange for political support, a system of pervasive bottom-up rent extraction in the Tajik health sector was a widespread perception surfacing in KII. This is in line with the fact that, despite the direct appointment of cronies from Dangara and Kulyob, the president's home base, to powerful government positions, the districts themselves remain poor and badly serviced [37]. Similarly, health facilities in Tursunzade, one of the BBP pilot districts, is just as poorly equipped, with a patchy supply of electricity and water, despite its economic importance for the political centre, as that in the rest of the country (KII and personal observation).

Discussion

This study has provided an insight into the relevance of the political-institutional context to health reforms by analysing the governance constraints to the BBP reforms in Tajikistan. The findings from desk research and KII suggest that little donor harmonisation, policy incoherence, parallel and competing central government mandates, and regulatory fragmentation, stand out as dominant drivers of most other constraints to effective design and implementation of the BBP and associated health reforms in Tajikistan: overcharging and informal payments, a weak link between budgeting and policymaking, a practice of non-transparent budget bargaining instead of a rationalisation of health expenditure, and weak accountability to citizens. Beyond identifying these governance constraints per se the findings serve to illustrate the complex and interlinking structure-agency dynamics that impact health sector reforms in neo-patrimonial settings. In this section, the findings are synthesised with the existing evidence from other cases to draw conclusions on the institutional constraints to effective service delivery reform and their interlinkages, and provide recommendations.

The interplay between institutional/structural factors and agency is particularly highlighted in the way that policy incoherence and regulatory fragmentation around health financing and management was found to be largely a consequence of the combination of uncoordinated donor pressures for health financing and management changes, and the existence of governance actors with unclear, parallel and competing mandates at the central level. The role of aid in health systems strengthening in particular and public sector reform in general has been widely discussed (e.g. [76–80]). In line with the wider literature the findings from this study illustrate how a lack of donor harmonisation can create and exacerbate fragmentation of the health system. The finding that external pressure for health reform from different development actors without central prioritisation or sufficient engagement with implementing actors nor a realistic timeframe has impeded a coherent introduction of the BBP, mirrors health reform processes in other fragile and post-conflict settings [81, 82]. Different waves of piloting the BBP concept, executed by different development agencies have produced a landscape of incoherent mandates for new positions and guidelines for fee-charging. Harmonising the technical and political objectives behind development cooperation carries an inherent challenge [7]. The incentives that different development agencies face with their own programming cycles, policy agendas, domestic constituencies and deliverables are not always conducive to donor harmonisation [78, 83, 84]. Furthermore, as a study of health policymaking in Cambodia and Pakistan demonstrates, power between donors and government actors is asymmetrical and exercised not only through financial resources, but also technical expertise and evidence-generating capacity, thereby setting the agenda for policy reform [85]. In a fragmented aid landscape this highly complicates the possibility of keeping health financing policies coherent. What this study additionally shows, is that support for health reform that is not sufficiently coherent, harmonised and focused on the long term not only leads to moral hazard, but affects the power balance between governance actors (inter-departmentally and between ministries and the presidential cabinet), echoing findings from Uganda [79].

The findings from this study suggests that policy incoherence and unclear mandates, in combination with deep underfunding creates an opportunity case for the widely reported phenomenon of bottom-up financing of health providers and authorities, partly expressed in the recorded high degree of overcharging of user fees and informal payments. This corresponds to rent-seeking phenomena in other neo-patrimonial settings, such as

the 'ascendant financing' mechanism (referred to as 'the pump') in Democratic Republic of Congo [86, 87], and the low adherence to fee exemption rules in Burkina Faso [88]. The bottom-up financing mechanism may suggest that management positions in the health sector can function as toll positions from where rent can be accrued, similar to rent-seeking patterns in the wider bureaucracy and land governance in Tajikistan [33, 46, 89, 90]. In other words, policy incoherence, the lack of clearly defined mandates and lack of resources to carry out basic tasks of health provision, regulation and oversight at the local level are not only features of neo-patrimonialism but also create the conditions for patrimonial features of governance to penetrate legal-rational bureaucracies. This highlights the dilemmas that aid can perpetuate or entrench power relations and control of resources, as Nakaya found in the phase of early recovery Tajikistan [37] and that the ideal of national ownership can in practice imply control by authoritarian elites in closed political environments, as found in Rwanda [91]. As North et al. (2006) observe, rent-seeking is inherent to all political systems but as rent-seeking and limiting of privilege increases, the economy generally shrinks and with it the possibility of broad tax-based developmental programmes. In recent years, the negative correlation between neo-patrimonialism and development has been nuanced with analyses of the varying performance of neo-patrimonial settings depending on the extent and type of rent-seeking behaviour [92–94]. Rent management through personalised top-down patronage can work out in both predatory and developmentalist ways [52]. Rather, what appear to be decisive factors is whether these rents are accrued from productive or unproductive sectors, centralised, and geared to long or short term interests [95]. What sets Tajikistan apart from the more developmentalist cases (e.g. Rwanda, Ethiopia and China) is the combination of weak bureaucratic capacity with short term, fragmented developmental planning and management by the elite, as findings from this study suggest. Quick overturn of staff at the central level, often for the purpose of political neutralization [33, 37], further contributes to the loss of institutional memory, strategic vision and commitment to carry out previously-agreed reforms. Neo-patrimonialism and associated patterns of rent-seeking can thus be a cause and a consequence of policy incoherence.

Lastly, accountability from civil society organisations and citizens is often seen as crucial to strengthen more equitable and responsive health services [96]. However this study has posited that a lack of bottom-up bargaining power or limited ability to demand accountability on performance is a central feature of the political arrangement in Tajikistan, where patronage finds expression in appointments of cronies to key positions in public service to accrue rent, rather than clientelist relations between 'big men' and their constituents [97]. The findings suggests that in this context opportunities for citizen involvement in policymaking are very limited in general. This speaks to the findings from three other post-Soviet republics that a hostile political and economic climate limits the potential for civil society advocacy [98]. In such a context fear for personal safety, losing out on contracts or other types of exclusion is a dominant disincentive for civil society engagement and government criticism. In terms of policy development and implementation it risks marginalizing the voice of underrepresented and vulnerable professional or patient groups but is also an impediment to understanding local public health needs.

As with any policy reform analysis this study has been subject to limitations and its results are highly time-bound to the period of field research. Policy details have changed and will continue to change as new reforms are piloted, terminated or altered. Some of the limitations to this research are inherent to its approach and focus. Exploring the 'murkier realm of politics' in a neo-patrimonial, closed and authoritarian political setting is delicate as it touches upon often conflicting interests and therefore requires provisions in the presentation of results to protect informants. Further research in this area is therefore warranted. This includes a deeper exploration of de facto health financing arrangements, such as the health funding allocation mechanisms, and the dynamics around informal payments and their perceived channelling upwards, but also more in-depth research into accountability relations between providers, regulators and citizens at the local level of implementation.

Conclusions

Studying the political and institutional constraints to health reform is key to better understand the incentives and motivations that further or block improvements in public health. This study raises a number of previously under -researched health policy development and implementation challenges in Tajikistan. In doing so it not only contributes to the small body of literature on public sector reform in Central Asia and Tajikistan in particular, but also to the growing literature on the political constraints to aid and health reform in general. Based on the example of the BBP reform this study has found that health reform in Tajikistan suffers from a combination of policy incoherence, parallel and competing central government mandates, and regulatory fragmentation. This finds an expression in weak budgeting practices and overcharging of user fees. Rent-seeking patterns were widely reported to play a role in this, and poor coordination between external development actors has added to these

challenges. The article points to the importance of considering the political-institutional context in which reforms and indeed donor interventions take place. The findings raise pertinent questions on the unintended consequences of non-harmonised piloting of health reforms, and the interaction of health financing interventions with entrenched power relations. These findings can encourage reflection on the relevance of contextualising health programmes and addressing policy incoherence with long horizon planning as a priority.

Endnotes

[1]This health system model is named after Nikolai Semashko (1874–1949), the Soviet Union's first 'People's Commissar of Public Health' (Minister of Health) who laid the foundations of the Soviet health system, which also served as a blueprint for health systems in most socialist economies. Common characteristics are the publicly funded financing model, with no formal charges at the point of service delivery; public ownership and management of health facilities in cascading levels of specialization from municipal, district, region and state level; and relatively high levels of specialization, human resources for health and hospital infrastructure.

[2]In a Gallup poll undertaken in Tajikistan in 2013 only 27% of respondents replied they think the breakup of the Soviet Union benefited the country, and 52% said it harmed the country. This confirms personal observation from the vast majority of respondents who reminisce positively about life in Soviet times.

[3]By 1994 real per capita public health expenditure had dropped to 46% of its 1990 levels [63]

[4]The first four plilot rayons from 2007 onwards were: Dangara, Spitamen, Tursunzade, Rasht. In 2009 BBP piloting was extended to the districts of Shahrinav, Varzob, Sarband, Nurek town.

[5]Twelve social groups (such as veterans, elderly, infants) and fifteen disease groups (including TB, HIV/AIDS, leprosy, malaria) are exempted from these co-payments

[6]These were the districts of Tursunzade, Shakhrinav, Dangara, and Varzob at the time of research.

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Author's contribution
EJ designed the study and carried out data collection, analysis and writing. The author read and approved the final manuscript.

Ethics approval and consent to participate
The study was approved by the Health Policy Analysis Unit of the Ministry of Health of the Republic of Tajikistan. All persons and authorities in this study were informed of its objectives, the freedom to opt out anytime and gave their informed consent. All research procedures were in accordance with the Declaration of Helsinki.

Consent for publication
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The author declares that he/she has no competing interests.

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ANNEX C: Publication 3

Jacobs, E., & Baez Camargo, C. (2020). Local health governance in Tajikistan: accountability and power relations at the district level. *International Journal for Equity in Health*, *19*(1), 1-12

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Local health governance in Tajikistan: accountability and power relations at the district level

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Abstract

Background: Relationships of power, responsibility and accountability between health systems actors are considered central to health governance. Despite increasing attention to the role of accountability in health governance a gap remains in understanding how local accountability relations function within the health system in Central Asia. This study addresses this gap by exploring local health governance in two districts of Tajikistan using principal-agent theory.

Methods: This comparative case study uses a qualitative research methodology, relying on key informant interviews and focus group discussions with local stakeholders. Data analysis was guided by a framework that conceptualises governance as a series of principal-agent relations between state actors, citizens and health providers. Special attention is paid to voice, answerability and enforceability as crucial components of accountability.

Results: The analysis has provided insight into the challenges to different components making up an effective accountability relationship, such as an unclear mandate, the lack of channels for voice or insufficient resources to carry out a mandate. The findings highlight the weak position of health providers and citizens towards state actors and development agents in the under-resourced health system and authoritarian political context. Contestation over resources among local government actors, and informal tools for answerability and enforceability were found to play an important role in shaping actual accountability relations. These accountability relationships form a complex institutional web in which agents are subject to various accountability demands. Particularly health providers find themselves to be in this role, being held accountable by state actors, citizens and development agencies. The latter were found to have established parallel principal-agent relationships with health providers without much attention to the role of local state actors, or strengthening the short accountability route from citizens to providers.

Conclusion: The study has provided insight into the complexity of local governance relations and constraints to formal accountability processes. This has underlined the importance of informal accountability tools and the political-economic context in shaping principal-agent relations. The study has served to demonstrate the use and limitations of agency theory in health governance analysis, and points to the importance of entrenched positions of power in local health systems.

Keywords: Health governance, Accountability, Principal-agent theory, Tajikistan, Political economy, District level

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Background

Local health governance, and particularly accountability towards citizens has been an object of study and debate since the global health community shifted attention to primary healthcare, and engaged with the good governance and decentralisation paradigms. Already the 1978 Alma-Ata declaration espoused people's "right and duty to participate individually and collectively in the planning and implementation of their health care" [1]. The Bamako initiative operationalised the declaration by promoting decentralisation of health service financing and management and universal access to health [2]. Around the same time the view that decentralisation of public services, and good governance of these services, including health was essential for their enhanced performance, gained wider traction [3, 4].

Despite increasing attention and the development of multiple analytical frameworks for health governance a need remains to empirically test and validate existing frameworks [5]. Relationships of power, responsibility and accountability between health systems actors and the institutions that shape this are considered central to health governance. Yet, the functioning of local governance is often studied from the perspective of decentralisation or provider accountability towards communities [6–8], while a gap remains in understanding how accountability relations between the multitude of governance actors shape local health systems, particularly in the former Soviet Union and Central Asia. Furthermore, a need for a stronger consideration of the political and contextual factors influencing accountability relations remains [9].

This study aims to address this gap by offering an analysis of principal-agent linkages in the local health system of two districts in Tajikistan. Health governance in Tajikistan, or Central Asia in general, has received little attention, and has mainly been focused at central level reforms, such as the introduction of a Basic Benefit Package of health services (BBP) and the role of international aid in this [10–15]. Fragmentation in health financing regulations and stewardship functions coupled with insufficient donor coordination, leading to a proliferation of vertical and pilot programmes suggests the existence of a patchwork of different health governance arrangements across the country [14]. Closer insight into the way local stakeholders in the health system relate to each other, and how the local context shapes these patterns of power is therefore warranted. To analyse governance relations at the local level in Tajikistan a triadic principal-agent framework is used. This framework allows for an exploration of principal-agent linkages between three sets of actors that are considered to form the heart of health governance: government, providers and citizens. Particular attention is paid to the core components that have been identified to contribute to accountability as a principal-agent relationship.

This paper proceeds as follows. The next section outlines the methods used for this qualitative study, and an elaboration on the choice and assumptions underlying the principal-agent analytical framework of this paper. The following section presents the main health system actors in two distinct districts in Tajikistan and an exploration of their accountability relationships. The implications of the key findings are next discussed in light of the wider literature on accountability and governance, both in terms of the lessons from the Tajik experience and the use of agency theory for health governance analysis. Lastly, the paper offers some concluding thoughts on future entry points for policy, practice and research.

Methods

Study design and setting

The study design for this research is a comparison of multiple, embedded case studies [16, 17], which has the potential to explore a phenomenon in the context in which it is embedded, particularly when the contexts is integral component of the study, increasing explanatory power and analytic generalizability compared to a single case study design [18].

Field work was conducted in two districts: one of the Districts of Republic Subordination (*Rayoni Respublikanskogo Podcinenja* or *RRP* in Russian), a region encompassing the former Karotegin or Gharm Oblast (Region) in the East and the Hisor valley in the West, and one district+ in Gorno Badakhshan Autonomous Oblast (Region), commonly abbreviated to GBAO. More detail on the political and socioeconomic context of these study settings is provided in Table 1. The districts are not specifically named to protect informants. Instead the districts will be denoted as the RRP district and the GBAO district.

The districts were purposefully chosen for their difference in proximity and interest to the political centre Dushanbe and the fact that the RRP district featured as one of the pilot districts for the implementation of the BBP reforms, while the GBAO district was excluded from the BBP pilot at the time of research. A key element of the reforms is the introduction of co-payments, with the exemption of vulnerable social and disease groups, which is intended to generate extra revenue [12, 14]. In addition, health service delivery in the two districts was supported by two different external development partners, as will be elaborated in the results section, which was assumed to influence local accountability relations in distinct ways.

Data collection

This research was part of a wider power and influence study of stakeholders in the health system of Tajikistan

Table 1 Study Settings

The Gorno-Badakhshan Autonmous Region (GBAO) is the largest region of Tajikistan in landmass but the smallest in population. It is dominated by the Pamir mountains, known as 'the roof of the world', which have contributed to the region's historical isolation and the development of a distinct regional identity [19] in linguistic, cultural and religious terms. The majority of the population adheres to the Ismaili faith and speaks one of the Eastern Iranian (Pamiri) languages as opposed to the Western Iranian Tajik, with a Kyrgyz minority in the East of the region. Partly as a result of this isolation, low population density and mountainous geography, the region is less developed socioeconomically compared to the central regions of Tajikistan. Most households rely on subsistence agriculture and remittances from migrated family members for their livelihood. During Soviet times tens of thousands of Badakhshanis, also denoted as Pamiris, were forcibly resettled to the cotton growing plains in the southwestern Qurqontheppa south-region, while positions of authority were mostly filled by non-Badakhsanis, which fostered local resentment towards central authorities [20]. This marginalisation was part of the reason for Pamiris to ally with Gharmi and other regional and ideological groups against the government in Dushanbe and form the United Tajik Opposition during the civil war (1992–1997). Given this historical background, the geographical isolation and cultural distinction from the rest of the country, the region remains more distant from the political centre up to this day. However, key positions continue to be filled through appointment from the centre, ensuring a degree of political control.
The districts of republican subordination (usually denoted by its Russian acronym RRP) are a collection of districts that are governed directly by the central government. The area stretches horizontally across the middle of the Republic of Tajikistan from the Hisor valley at the border with Uzbekistan around 70 km west of the capital Dushanbe, to the Rasht or Karotegin valley in the east, bordering Kyrgyzstan, hemmed in by mountain ranges in the north and southeast. The region has historically never been a unified territory. Rather, it encompasses mountainous areas in the east that were strongholds of the United Tajik Opposition (Karotegin / Gharm region), and more populous plains in the west that have remained under firm control of the central administration in nearby Dushanbe. The district that forms one of the two study sites in this paper is located in the Hisor valley in the western part of the RRP. Due to its proximity to Dushanbe, intensive cotton production on the irrigated plains, and the presence of the largest aluminium manufacturing plant in Central Asia, Tajikistan's main industrial asset, the area has been of vital interest to the political and economic elite, receiving most of its capital investments. As an expression of that the Hisor elite was closely allied with those from the Khujand/Leninobod north and the Southern Kulobis that dominated the government by the end of the Soviet period and throughout the civil war in the 1990s [20].

at central, district and village levels that took place between May 2010 and December 2011. It is based on primary data collected through key informant interviews (KIIs) and focus group discussions (FGDs) in the two study settings between June and August 2011.

KIIs and FGDs were carried out in person and through telephone/Skype and were conducted in Tajik, Russian or English. A total of 23 KIIs were held in the RRP district, and 17 KIIs in the GBAO district. In addition, 6 FGDs were held with villagers in the GBAO district, and 2 FGDs in the RRP district. An overview of respondents is provided in Table 2. The study further draws on the contextual insights gained from 31 KIIs conducted among governmental, bilateral, multilateral and non-governmental organizations, primarily at central level, which were used for another study [14]. Participants for KIIs were purposefully selected, focusing on those involved in the regulation, supervision, financing and provision of health services in the two districts. A snowball technique was used by asking interviewees to suggest the most relevant stakeholders in the local health system. Health providers were mostly interviewed at the health facilities where they worked. This allowed for visual capture of the conditions in which they operated and observation of interactions with patients and co-workers.

As FGD participants were identified through the main organisations implementing health service delivery programmes in the two districts a certain degree of respondent bias is possible. The cases are therefore not taken as a sample representing community views in the district. Rather, each case is taken to provide insights into the contextual factors, processes and mechanisms underpinning actors' interactions, which can be used for middle range theory-building and further testing [16, 18, 21].

Data analysis

A topic guide was used for interviews and FGDs, including questions on the organization, financing and provision of health services, as well as the main challenges and responsibilities in these areas. Detailed notes were taken during each interview by each interviewee and compared afterwards on the same day, which allowed for triangulation and the elaboration of more comprehensive field notes. These notes were used for preliminary analysis during the course of the research. This revealed emerging themes and aided the refinement of interview questions in the process to further explore these themes.

Data analysis, which took place shortly after conclusion of the field work, was based on a framework approach [22], guided by the model for analysing accountability processes as principal-agent relationships between three main health system actors that has been developed and refined by Brinkerhoff and Bossert [23, 24] as an application of agency theory to health systems research. This model allows for an analysis of health system governance actors and their relationships of power, responsibility and accountability, based on an understanding of health governance as a process of principals delegating authority to agents, as shaped by the formal and informal institutions and behavioural patterns. Originating from new institutional economics, agency theory essentially forces a lens on the relationship between incentives and performance [25], and the tensions between the interests of the principal and agents, allowing for the existence of multiple agents in the state-policy implementation [26]. Brinkerhoff and Bossert have distinguished between three main groups of actors in their model for health governance: the state, providers and citizens/clients that act as principals and agents to each other in more or less effective ways. To

Table 2 Overview of KIIs and FGDs

District	Method	Type of interviewees / participants	Number of KIIs / FGDs	Total
RRP district	KIIs	District and municipal level government actors	5	KIIs = 23 FGDs = 2
		Health providers	10	
		Development agency	6	
		Community groups / community leaders	2	
	FGDs	Citizens	2	
GBAO district	KIIs	District and municipal level government actors	5	KIIs = 17 FGDs = 6
		Health providers	4	
		Development agency	5	
		Community groups / community leaders	3	
	FGDs	Citizens	6	

generate greater understanding of these relationships this article firstly describes the local governance actors in the two districts following the actor categories, and subsequently analyses each dyadic relationship in terms of separate dimensions of accountability, captured in the questions. In terms of citizens' relationships to the state or providers three core elements, which together form the principal –agent process of citizens' accountability, will be explored: voice, interpreted as 'articulating an interest' [27], answerability and enforceability [23, 28, 29]. These core elements can in themselves be considered an aggregate of five steps in any effective accountability process: delegating a mandate (or voice focused at a task), providing resources, performing on the mandate, providing information and being monitored on the performance, and enforcement of the mandate [30]. These five components will be used to guide the analysis of the principal-agent relationship between state and providers for a more detailed understanding. From the findings a fourth actor category was found to exercise significant power as a principal: development agencies. Their role and relation to the other actor categories is therefore discussed separately.

Results

Main actors in the local health system

The state

In both districts, formally the most important actors in the health sector are state actors, i.e. the district hospital director, who by definition also manages the most important health provider in the district, and the head of the district financial department. Both in turn are selected and appointed by the district chairman (*Rayon Rais*), who is indirectly assigned to his or her post by the Presidential administration in Dushanbe. Budget allocations to health facilities follow from their joint decisions, based on how much funding has been secured from the Ministry of Finance at the central level. Other important actors that surfaced from interviews were the primary healthcare (PHC) manager, responsible for PHC in the district and the district health team (for which the Russian portmanteau *RaZdrav/GorZdrav* was commonly used), de jure responsible for health planning and supervision in the district. In both districts, as was reported to be not uncommon around the country, the deputy hospital director was appointed as PHC manager at the insistence of the hospital director. This was alleged to foster a sense of loyalty and obligation from PHC manager to hospital director. To facilitate the distribution of funds to health facilities in the mountainous area, municipal mayors in the GBAO district have a responsibility in this, acting as a middle man, but hold no further mandate. Local legislative councils, (*Majli*, or assembly of people's deputies), exist but although legally endowed to approve budgets and policy, they were not indicated by respondents, including council members (referred to as *deputat* by respondents), to exercise any meaningful authority over the financing or management of local health services.

Although initiated to be fulfilling a central role, the position of the district health team, whose members usually consist of a chairman and an accountant, following appointment by the hospital director, was found to be remarkably weak in both districts. Its authority vis-à-vis the other state actors was found to be low, as its mandate is only vaguely defined, overlapping with the roles of district hospital manager and PHC manager, and it cannot lay claim to its own operational budget. In both districts, district health team representatives claimed to receive no funding to carry out their monitoring, supervisory and planning activities apart from a below-subsistence level salary, which was confirmed by KII at central level. District health team staff indicated that this means that independent travel for monitoring and oversight to rural health facilities is impossible, and even a workspace or office equipment is not covered and up to them to negotiate with the hospital director. Lastly, the district health team does not have any authority on budget planning, which is generally a process of negotiation between PHC manager, hospital director and the rayon's financial department.

This combined picture illustrates how the district health team's role as a coordinating body balancing the needs of primary and specialized health care is undermined. Reports from health staff and administrators in both districts suggest rivalry between the district health team, PHC and hospital managers over mandates between the different rayon level administration officers. One example that surfaced during interviews with district officials and health staff in the RRP district, was a dispute over the management of ambulances. The PHC manager, hospital director and the district health team all laid claim to this role that was traditionally reserved for the hospital director. In separate interviews the different parties covertly expressed that the other actors were merely interested in this management role as it provided a toll position, i.e. the fee patients pay for the service is creamed off by those who manage the ambulance staff.

Providers

The most important health providers in both districts are the district hospital, including its policlinic, and the PHC centres: rural health centres and health houses. The district hospitals also contain a chemist. All facilities are publicly owned and receive most of their highly limited income from public sources, although formal user charges for diagnostic tests and pharmaceuticals exist. There were no formal private providers of care in either district at the time of research, and no informal care providers were mentioned by respondents, which leads to the assumption that private providers play no significant role in health service provision. Health centres are generally staffed with multiple personnel, including a physician, and theoretically better equipped. Health houses would typically be staffed by a nurse only, although in practice the observed difference in terms of equipment and infrastructure between the two types of PHC centres was marginal, particularly in the RRP district. A difference could be observed between the degree to which health providers were equipped and the state of infrastructure between the RRP and health providers in the GBAO district were generally better equipped and in a better infrastructural state. This is probably mainly due to the large investments by the Aga Khan Development Network (AKDN), as described in the sections describing the role of development agencies.

Citizens - users

The district citizens are considered the main users of the health services in the two districts, although seasonal workers from other districts might make up a small additional group of users. No activity from formal patient groups was found in the districts, but other associations for collective action were found. Two types of relevant organizations for collective action could be discerned: NGO-induced community-based groups (as explained below) and neighbourhood committees, or mahallas. Although citizen respondents generally expressed closer identification with their mahalla, the community-based initiatives were the only groups that could be found to be playing a meaningful role in exerting citizen influence on the health sector, although this role is limited by the restrictive political environment.

Development agencies

A fourth relevant actor category in the local governance of health services emerged from the findings, given their relative weight of their involvement in local health services: external development agencies. In the RRP District a Swiss Development Corporation funded project, project Sino, was operational, and in the GBAO district the Aga Khan Development Network (AKDN) through the Aga Khan Health Services (AKHS) and the Mountain Societies Development Support Programme (MSDSP) provided extensive support. In both cases this support included the rehabilitation of health centres, provision of equipment, awareness-raising activities for citizens around health issues, health staff training, technical support for health facility management and limited monthly health worker salary supplementations (officially termed incentive payments). In addition, the AKDN had instituted a revolving drug fund and community based health funds (micro-insurance) through their own community-based organisations, the Village Organisations (VOs).

Principal-agent relationships between the main actors

This section elaborates on the principal-agent relations between the main actors that establishes the process of local health governance in the two districts.

State –providers

Health providers in the two districts are all state-owned, receive most of their budget from the district's allocations and its employees are civil servants. Formally, the district's hospital director, PHC manager and the district health team practice regulatory oversight and supervision over the health providers. The district health team's lack of means to exercise oversight means the hospital and policlinic directors, i.e. the hospital director and PHC manager, practice oversight over their own management. The lack of separation between funding, purchasing, regulation and provision functions that flows from the diverse functions of hospital directors and PHC managers observed in the two districts and the resultant blurring of the principal-agent relationship between state and providers, appears to benefit the district hospital and policlinics over rural PHC facilities.

In terms of a mandate, a BBP defines the formal scope of services provided in the public facilities, with

commensurate co-payment rates. In practice the degree to which this mandate could be performed upon was found to be limited by a severe lack of financial resources, impacting equipment, drugs and skills shortages, albeit to uneven extents.

Although formally 40% of health funding is reserved for PHC in the two districts, the budget is so small that staff from rural health centres and health houses reported neglect by district authorities in terms of funding at the expense of the district's hospitals and policlinics, which was confirmed by visual observation. Budget allocations follow a line-itemised input logic without flexibility to shift funds between budget lines in case of changing needs or priorities. In practice 80 to 90% of allocated funds for rural PHC centres is used to pay for salaries that are below subsistence level[1] [31]. In the RRP district the use of co-payment revenue, generated under the BBP regulations, was a source of contention. Because BBP co-payments were limited to diagnostic tests and ambulatory surgery for district residents in PHC, the extra resources these user fees generate were limited. The PHC manager gave the example of an ECG device that could be acquired for the polyclinic after saving up the resources for three months. Rural health facility staff on the other hand consistently complained they saw very little to nothing back of the co-payment revenue that they channelled to the PHC manager on a monthly basis. This could be confirmed when analysing the available information on collected co-payments. As was shown in the PHC financial records, the monthly revenue varied from 0 to 150 TJS per rural health facility, with the district capital's polyclinic generating over 500 TJS monthly. Due to the budgetary split between PHC and hospital care there was no compensation through monies from co-payments in hospital care, where revenues were much greater. One of the other effects of the low level of funding is that although doctors have been trained to operate various types of medical equipment they reported that they lose those skills because the equipment is not available. This effect was however much more widely reported in the RRP district, due to the greater lack of equipment and general lack of running water or constant electricity supply in the PHC centres, which is necessary to run or maintain the technology.

In terms of provision of information on, monitoring and enforcement of performance, rural health workers from both districts showed extensive paperwork for record-keeping of client visits, but claimed supervisory visits were erratic and, when conducted, largely punitive in character, focused on opportunities for rent-seeking. In the GBAO district rural health workers claimed that the district financial authorities or the mayors only come for inspection with the purpose of checking new equipment given by the AKHS, and demanding a share of revenue, even though formally co-payments are not charged at rural health centre level. When supervisory visits were undertaken by district authorities, rural health centre staff from two health centres reported sanctions they experienced as extortionate (twice a nurse's monthly wage) for missing equipment, which they claimed to be the result of underfunding from the same district authorities. District authorities claimed lack of funds for transport hampered the conduct of regular supervisory visits, and confirmed applying fines in case of 'wrongdoing'.

Citizens – providers

Health providers in the two districts were found to be strongly positioned towards those seeking care, as public providers hold monopolies in care provision and citizens have little capacity to judge the necessity or quality of clinical practices. In addition, particularly in the GBAO district, health centres are sparsely distributed across a highly mountainous landscape, leaving communities with few other options than their local rural health centre or health house. Although the relationship between providers and citizens is marked by great power asymmetry, which applies to some degree to all health systems, a clear difference could be observed in relation to local primary health care providers versus the district hospital and policlinic. Respondents from FGDs and interviews with village representatives in both districts reported relatively higher appreciation for services delivered by their local PHC centre or health house, compared to the district policlinic and hospital, where informal payments were reported to be rife and experienced to be at extortionate levels. In both cases no formal direct voice mechanisms or institutions between citizens and providers, such as report cards, or village health teams were found or reported on. However, villagers expressed much greater trust in the staff of rural health centres and showed understanding for their underfunded position. Health staff in rural health centres and health houses were more perceived as 'one of them', particularly in the GBAO district. As opposed to the informal cash payments in the district policlinics and hospitals, village residents in the GBAO district reported giving products from their plots, such as potatoes, to rural health facility staff as gratitude payments, and in some cases lending a hand in small repairs to the clinic's building in recognition of the lack of resources these health facilities reportedly receive from the district authorities. Although an element of extortion by health

[1] Between TJS 200 for a nurse and TJS 400 for a head doctor according to their own reports. At the time of research TJS10 = EUR 1.49, GBP 1.29, and US$ 2.12

providers in demanding these in-kind payments from patients cannot be ruled out, it appeared that these contributions also formed an informal tool of enforceability and contributed to a greater sense of answerability by rural health centres and houses towards citizens as compared to the district hospital and policlinic.

State – citizens

KIIs and FGDs with village residents and representatives suggest the relationship between local district government and the district's inhabitants, who can be assumed to all be potential users of the health system, is marked by low trust and negligible citizen participation in decision-making. Voice is limited by the lack of an electoral process for key positions in local government and the Soviet legacy of authoritarian leadership. The only participatory governance structure that citizens perceived to play a functional role in their lives is the mahalla, or neighbourhood council. In the absence of effective formal channels of citizen participation, the mahallas and AKDN's community-based organisations in some cases function as a channel to voice needs and concerns towards and mobilise citizens collectively pool or provide resources for healthcare provision or financing, as documented elsewhere [32].

The position of development agencies

Although omitted from the triadic health accountability model, development agencies were found to play an influential and distinct role in local health governance. Through their in-kind contributions to local service delivery and health workers, as well as their community activities they occupy a central position towards health providers and citizens. As a bilaterally funded project and a private, faith-based international non-governmental organisation the most significant development actors in the project cannot be considered local civil society or groups of direct citizen representation (conforming to the category of 'citizens'). They therefore merit separate consideration.

AKDN's presence in the GBAO district is in part motivated by the presence of a predominantly Ismaili population in the region, for whom the Aga Khan is their main spiritual leader. Combined with their continuous presence since the years of severe food insecurity and conflict in the mid 1990s, and the wide range of other activities it employs in rural, economic and cultural development this lends the organisation a basic level of cultural-religious legitimacy for people in the region. As a channel and platform for community-based support MSDSP set up VOs across GBAO, and later also elsewhere in the country. Although they can serve to channel people's concerns to the MSDSP, VOs hold no serious leverage to demand answerability from it.

Project Sino's intervention in the RRP district started in 2004 with tuberculosis control work and soon after broadened its scope to strengthening primary healthcare and public health sensitisation among communities [33]. In other words, community-based groups were not encouraged to function as platforms for citizen's voices vis-à-vis either providers or state authorities.

Both project Sino's and AKDN's interaction with local (health) authorities takes place through regular meetings (in case of AKDN involving either AKHS or the MSDSP depending on the issue), at which local authorities are consulted on local needs in the health sector and they are informed of the projects progress and new initiatives. Similar to project Sino's involvement with local health authorities this process is merely consultative or informative in character, as other accountability dimensions were found to be weak or non-existent. No financial resources were reportedly being provided directly to local government actors, they were not found to be active participants in AKDN or Sino activities, and no specific performance agreement or reporting obligation between the two actors was found.

The engagement between AKDN and Project Sino with health providers on the other hand bears strong features of a principal-agent relationship. The resources (monetary, in-kind and through capacity-building) provided by the both agencies are directly linked to the general objective and mandate to strengthen primary healthcare and reward health workers, and their use is monitored in relation to provider performance. However, the large dependence of health facilities on this support, implies the external actors have come to compete with the state authorities as their most important principal. This was perceived more strongly in the case of the AKDN in GBAO, where even the interviewed mayors and district administrators considered the AKDN to have partly replaced the state in its role of providing basic services. The consensus was that although basic salaries of health staff are paid by the state the AKHS provides most of the public health campaigns, infrastructure maintenance, retraining of staff, and supply of medicines and technology. One top-level official of the GBAO district even went so far as to call health staff 'volunteers' since they perform their duties for a below subsistence-level wage.

Discussion

This study has provided an understanding of the nature of principal-agent relationships in the local health sector of two districts in Tajikistan and their underlying power dynamics. Beyond that the findings from the two settings can serve to yield insight into the complexity of accountability relations and the way the different components in the process of accountability

can relate to each other. The application of agency theory to two cases in this study has also served to highlight its use and limitations. These insights will be discussed and elucidated below in the context of study findings from other settings and relevant conceptual tools and theory.

Despite their different socio-economic, historical and political contexts the qualitative data suggests that in both districts relationships between key governance actors are fraught with generally similar constraints on accountability for equitable and quality service provision as proposed in the triadic accountability model. This however does not exclude the existence of accountability relationships with a different nature. In the face of weak or absent formal accountability mechanisms it appeared that informal interpersonal and inter-organisational behaviours play an important role in establishing an accountability relationship, which confirms theoretical reflections in the field of (health) governance and accountability [23, 34–36]. These formal and informal accountability relationships form a complex institutional web in which agents sometimes also act as principals and vice versa. Particularly health providers, as street-level bureaucrats [37], find themselves to be in this role, being held accountable "from bottom-up, top-down as well as sideways" [38] as they face (sometimes conflicting) demands from state actors, citizens and development agencies.

In the relationship between health providers and state actors the findings suggest accountability for the delivery of the BBP is limited by insufficient resources to carry out this mandate, a rigid resource allocation rationale that is de-coupled from population needs or provider performance and monitoring activities that appear more aimed at finding faults in record-keeping and opportunities for resource-extraction through fines and (informal) co-payment revenue than at support for service delivery. This rent-seeking behaviour, which was reported in both districts irrespective of the co-payments associated with the BBP pilot, is in line with patterns in the wider bureaucracy as documented in a related study [14]. It is important to recognise that the negative, punitive character of this supervision style was found to be an important factor in health staff demotivation and attrition elsewhere and stands in contrast to the more supportive or coaching supervision approach by managers, which has been identified as a strong motivator for health workers in a broad variety of low and middle income settings [39–43]. The lack of decision space, limited resources and capacity to exercise effective accountability has also been found to be critical in other rural low resource settings [44, 45]. Its combination with a bureaucratically-engrained rent-seeking rationale, which turns monitoring and supervision into a power tool to incentivise the agents (health providers) to serve in the principal's interest, particularly skews internal accountability away from provider performance, as has been documented extensively in India as well [46].

According to Hirschman [27] voice is one of the two important ways, together with *exit,* in which people respond to inadequate services. By extension Paul [47] considered them the two main factors that influence accountability. The findings of this study suggest that accountability between state authorities and citizens in the two districts is hampered by a disaffection among citizens with the severely limited opportunities for them to express their voice and the lack of effective formal enforceability mechanisms accessible to a wider public, i.e. a strong local legislative power that is chosen through free and fair elections. The lack of voice towards government actors resulting from a lack of belief in the possibility of answerability in Tajikistan corroborates findings from elsewhere in GBAO [48] and also echoes findings from other settings with recent experiences of authoritarian government [49]. This could also be a factor in explaining the lack of 'rude accountability' [50], found in this study. The instrumental use of threats through shaming or violence as a mechanism for frontline negotiations by citizens towards service providers, constituting this 'rude accountability', appears to be going hand in hand with a greater awareness of rights and rising expectations on social service provision in Bangladesh, where this was found [50]. Tajikistan markedly contrasts with this setting, as expectations of what the state is able or willing to deliver have massively reduced [51] and bureaucratic and democratic legitimacy have significantly eroded since the short-lived period of openness in the Soviet Union's last years [52].

Based on the recognition that the 'long route of accountability' is often insufficient or ineffective in incentivising services to be more responsive (international) non-governmental organisations in comparable contexts have over the past decade initiated social accountability mechanism aimed at strengthening the 'short route of accountability' between citizens and health providers [6, 8]. In the two districts of this study however, the primary focus of the community-based organisations that have been formed, particularly in the GBAO district, is not on promoting active decision-making with state authorities. The degree to which they can enforce providers to be answerable appears to depend largely on 'weak' or 'bridging' social capital ties [53] that some community representatives manage to establish or nurture to voice their expectations and concerns [32], whilst information asymmetry between providers and citizens hampers the ability of the latter to do so. The in-kind 'payments' or support provided to local rural health facilities, in the

GBAO district particularly, can be interpreted as a token in the creation of a social bond, or debt, with an obligation to reciprocate, as elaborated by Mauss and others [54], or as a limited form of co-production [55]. As Abimbola noted, this type of collective action by non-state (community) actors to keep primary healthcare services afloat can be found across LMICs, and can be seen as an informal example of collective governance [56].

The lack of strong or formal channels for citizens to voice their expectations or concerns around health services is particularly significant given the severely limited 'exit options' for people, particularly the poor [57]. Widespread poverty, geographical isolation, bad road infrastructure and a lack of private healthcare provision in addition to a limited network of public facilities contribute to this. The observation that both exit and voice options are severely limited can perhaps explain citizens' efforts to contribute to the functioning of their local health centres. In other words, the lack of exit and voice options lock them in a type of continuing loyalty of 'making do' with the limited services that are available. This is a hypothetical inversion of Hirschman's theory that high loyalty to a company, organisation or state works to limit people's voice and exit options [27].

A number of limitations to the application of the triadic principal-agent model to the study of health systems of low-resource settings have surfaced in this study. First of all, the triadic model does not take account of the influence of the main external development agencies on citizens, providers and state authorities and the relationships between them in such settings. The findings from this study suggest the AKDN and project SINO have mainly dealt directly with health providers, establishing a principal-agent relationship parallel to that between state actors and health providers. This fits a pattern that donors in Tajikistan have mainly worked directly with beneficiaries instead of trying this through the government [58]. This pattern, although highly time-bound and likely to evolve, is unlike other fragile settings or areas of precarious statehood where external development actors and local health authorities engage in an unbalanced mutual dependency relationship [45] or networked governance of the health sector [59] in an imperfect attempt to foster local ownership and systems strengthening.

The cases explored in this study give insight into the internal divisions, power asymmetries and varying or sometimes competing interests, partly stemming from the inherited Soviet Semashko health system. It shows how complex practices of power and contestation over resources within the bureaucracy are influential in shaping policy implementation, mirroring the contestation over resources among local governance actors in South Africa [60]. The triadic model with its theoretically homogenous actors categories does not serve to understand these complex relations of power. Heterogeneity and competition within the actors categories was particularly evident in the 'state' and 'providers' groups. The competing interests of the Hospital Director, PHC manager, district health team and the district financial department revolved largely around access to and autonomy in decision-making over the allocation of scarce funds. The side-lining of the district health team in both districts, which was facilitated by the elusive formal mandate of this body and the double hat worn by the Hospital Director, as head of the most important health provider in the district, and key local government health official are the most striking examples of this. These examples confirm that the idea of holding a single agent category, such as 'the state', to account can be problematic in practice, summed up as 'the problem of many hands' that have contributed to any policy (outcome) [61].

Altogether these limitations throw up some fundamental question on the use of principal-agent theory for analysing health governance. Not only are the relations between actors more complex than suggested in the triadic model, the uncovering of rent-seeking rationales and co-production initiatives at community level suggest a need for other concepts and tools to explore practices of power, contestation and collaboration in local health governance. The application of principal-agent theory to governance has been criticised for 'theoretically mischaracterising' governance problems assuming the existence of 'principled principals', who are willing to hold agents to account whilst embodying the public interest, and the emphasis on individual incentive calculations [62]. This fails to recognise the implication of principals themselves in abuse of power for private gain, which is suggested in this study, and the expectation of others to be implicated in that. This influence of the (expected) behaviour of others on individual behaviour highlights the collective, rather than individual nature of rent-seeking and the importance of collective norms in perpetuating behaviour that is irrational from the viewpoint of the public good. Approaching governance as a collective action phenomenon, centred around the question what factors can help to overcome harmful equilibria of particularistic interests dominating in governance has therefore been seen as a more useful approach [63, 64]. Ultimately, however, the two approaches can also be considered complementary, as Marquette and Peiffer argue [65]. As this study shows, the application of principal-agent theory in the study of local health governance helps to unpack the incentives under which key stakeholders in the system relate to each other. It has provided insight into the challenges to the different components making up an effective accountability relationship, such as an unclear mandate, the lack of effective

channels for voice or insufficient resources to carry out a mandate. Future research could help to further explore the phenomena found in this study, with attention to the function and the role of norms in rent-seeking behaviour, as well as the use of collective action theory to understand the role of (mis)trust in governance relations.

Research limitations

This study has been subject to several limitations and its results are time-bound to the period of field research. Policy and organisational details have changed since data collection, and will continue to change as lessons are drawn, funding cycles change and new reforms are piloted or implemented. The limitations in data collection pertain to the relatively short period in which data collection took place, and the limited number of FGDs with citizens. Future studies could rely more on longer-term immersion and participant observation to better flesh out the complexities of agent's motivations, strategies and practices of power. Respondent bias cannot be ruled out as AKDN, SDC's project Sino and WHO facilitated entry to the study settings, although their representatives were excluded from interviews and FGDs with other stakeholders. Together with the closed political environment this may have biased respondents' answers. Some limitations pertain to the topic of inquiry itself. Exploring power relations is sensitive in any setting, but particularly in an authoritarian environment with a legacy of large statist dominance of basic services, the economy and society [66] that has been penetrated by a more patrimonial type of governance by central elites [52, 67]. This requires provisions in the presentation of results to protect informants. Lastly, quantitative methods could have helped to gather more representative views on the daily practices of health workers and citizen's voice.

Conclusions

This qualitative study has presented an analysis of health governance at the district level in Tajikistan through an exploration of the way in which the main health system actors engage in a principal-agent relationship. In the application of the principal-agent model of health governance to district level Tajikistan, it has explored the previously understudied area of local health governance in post-Soviet Central Asia. This has highlighted the weak position of health providers and citizens vis-à-vis state actors and development agents and the prevalence of parallel lines of accountability towards health providers from development agents next to those assumed by the triadic accountability model. With consideration for the political and economic context the study also reveals the contestation over resources and resultant power play among local government actors and the existence of informal enforcement tools shaping de facto accountability relations. It thereby also served to demonstrate the limitations of this model in the study of health governance. This encourages further reflection on the complementarity of analytical concepts and tools from power and collective action theory and their application to the health system. More concretely, the study shows that particular attention needs to be paid to the importance of entrenched positions of power when introducing a new governance structure such as a district health team.

Abbreviations

AKDN: Aga Khan Development Network; AKHS: Aga Khan Health Services; BBP: Basic Benefit Package; FGD: Focus group discussion; GBAO: Gorno Badakhshan Autonomous Oblast; KII: Key informant interview; MSDSP: Mountain Societies Development Support Programme; PHC: Primary healthcare; RRP: Districts of Republic Subordination (*Rayoni Respublikanskogo Podcinenja)*; VO: Village Organisation

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Authors' contributions

EJ designed the study. CBC contributed to the conceptualisation of the study approach and its operationalisation through the research questions. EJ carried out data collection, analysed the data and drafted the first version of this manuscript, which was commented on by CBC. All authors read and approved the final manuscript.

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Availability of data and materials

Not applicable.

Ethics approval and consent to participate

The study was approved by the Health Policy Analysis Unit of the Ministry of Health of the Republic of Tajikistan. All persons and authorities in this study were informed of its objectives, the freedom to opt out anytime and gave their informed consent. All research procedures were in accordance with the Declaration of Helsinki.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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ANNEX D: Publication 4

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Aid, social capital and local collective action: attitudes towards community-based health funds and village organizations in Rushan, Tajikistan

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Abstract Despite overwhelming interest in the role of social capital in international development, attention to the interplay of community-based development aid with local collective-action dynamics in Central Asia and particularly Tajikistan has remained limited. This paper investigates donor-induced local institutions for collective action in rural Tajikistan with a focus on the introduction of a community-based health insurance. Social capital and collective-action theories are used to interpret results from qualitative research in two Rushan District villages in the Gorno-Badakhshan region. By highlighting the role of donor embeddedness, and the perceived legitimacy of different decision-making structures, the article contends that the perception of such externally-induced change depends on the community's capacity to reach beyond the intra-communal solidarity network through bridging and linking capital. The findings suggest this can be fostered by addressing trust, and the role of effective development brokers, with due attention to power relations within communities and towards external agents.

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Introduction

Tajikistan, the poorest country of former Soviet Republics, has witnessed an influx of donor assistance since the end of its civil war (1992–1997). As post-conflict humanitarian aid dried up and development assistance got under way, many donors were in active search for a civil society associated with pluralism, good governance and participation in line with the principles underlying the New Policy Agenda of the time (Edwards and Hulme, 1996). The New Policy Agenda for post-Soviet transformation departed from the idea of a reduced role of the state. This would require a more active attitude by non-state civil actors around basic services hitherto provided by the state.

For long the assumption prevailed that, because the Soviet Union's ideology was totalitarian, and statist, no meaningful civic life was left and rebuilding civil society had to start from scratch upon the independence of the Central Asian countries (Babajanian, Freizer, Stevens, 2005). However, the existence of a rich social fabric, perhaps not conforming to Weberian notions of civil society but rather based on more personal and functional relationships, and kinship ties (Roy, 2002: 127; Akiner, 2002; Freizer, 2005) suggests otherwise. Although these non-state institutions were considered to 'represent collective identities that could be a basis for maintaining a civil society' (Roy, 1999, 110), a search for civil society organizations that could satisfy donor agendas and conditions led to the rapid emergence of a new local scene of non-governmental organizations (NGOs) that relied on foreign assistance. Potentially in an effort to prevent elite co-optation or patronage, in the spirit of the good governance development paradigm, aid agencies tried to set-up institutions that paralleled, rather than were based on existing solidarity groups (Akiner, 2002; Roy, 2002; Freizer, 2005; Kandiyoti, 2007).

Since the 1990s, the Aga Khan Development Network (AKDN[1]) has emerged, as one of the dominant development NGOs in Tajikistan, relying partly on its cultural-religious legitimacy among the Ismailis in the mountainous Gorno-Badakhshan Autonomous Region (Oblast). Akiner (2002, 179) applauded AKDN's set-up of the participatory community-based platforms, called Village Organizations (VOs) to enhance community empowerment as a welcome contrast to more top-down interventions. She argued that the cultural-religious legitimacy combined with its integrated approach was effective in nurturing social capital and strengthening local

1 The Aga Khan Development Network is a network of private development agencies founded by the Aga Khan, including those discussed in this study: the Aga Khan Foundation, Aga Khan Health Services and the Mountain Societies Development Support Programme.

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institutions for participatory collective decision-making. The VOs formed the basis for the AKDN's community development work, including the piloting of community-based health funds (CBHF) to improve financial access to healthcare.

CBHFs or community-based health insurance (CBHI) is a popular risk-pooling mechanism to reduce catastrophic health expenditure, which is usually a result of high out-of-pocket expenditure[2]. As a share of total health expenditure out-of-pocket payments in Tajikistan are one of the highest of the former Soviet republics at 63 percent (World Health Organization, 2015). Yet, risk pooling in Tajikistan is limited and mainly piloted by NGOs – with the AKDN as the dominant actor in the country. Although CBHI is often studied in terms of financial sustainability, an understanding of drivers of its uptake requires a closer look at local socio-political dynamics. Emerging evidence suggests that solidarity, trust, extra-community networks, vertical civil society links, and state-society relations at local level affect outcomes in CBHI approaches (Jowett, 2003; Zhang *et al.*, 2006; Schulze, 2012; Mladovsky *et al.* 2014; Fenenga, 2015). However, the evidence mainly rests on case studies outside Tajikistan and Central Asia in general, and have often not considered pre-existing, local, and informal institutions for collective action, which justifies a closer look at the socio-political context in place.

To address the research gap on the interplay between community-based aid and local collective action in Central Asia, this paper attempts to bridge insights from research on CBHI with evidence from studies on social capital, collective action, and community development. It offers an in-depth account of two villages from Rushan District, Gorno-Badakhshan. The study's aim is twofold. First, it contributes to the discussion on the use of collective action and social capital literature in analysing community-based donor interventions, both in the post-socialist setting and beyond. Second, it offers some lessons for community development actors on the interplay between their potential interventions and local institutions for collective action.

AKDN's approach to community development has received both praise (Akiner, 2002; Freizer, 2005; Rahman, 2007; Holloway *et al.*, 2009) and criticism (Settle, 2011). The positive assessments of its work centre on the set-up of formal mechanisms for participation in authoritarian political contexts (Holloway *et al.* 2009), its cultural-religious legitimacy for the Ismaili communities (Akiner, 2002), its effort to use local capabilities (Rahman, 2007), and embed its activities locally (Freizer, 2005). Other evidence on AKDN's work in the region highlights the lack of sustainability

2 Out-of-pocket health expenditure is defined as direct payments made by individuals to health providers at the time of service delivery.

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of NGO-induced participation without enhanced government accountability (Settle, 2011). In a study of VOs in Rasht, Freizer (2005) claims that the VO is generally perceived as a continuation of pre-existing forms of community organizing, which is supported by examples of successful VO activities. This study, conducted hundreds of kilometres South of Rasht nuances Freizer's findings.

This paper is structured as follows. In the following, second section of this paper we provide the theoretical underpinning of this paper in which we discuss the concepts of collective action and social capital. In the third, we describe the research methodology employed. The fourth section presents the results from the case study, after which the main findings are discussed and embedded in the available evidence in the area. Lastly, the article offers conclusions and recommendations.

Social capital and collective action

Identifying a group of people as community generally implies they share a common interest or bond and engage in regular social interaction for that purpose, leading to social cohesion, and intimacy (Hillery, 1955; Nisbet, 1967; Taylor, Barr, West *et al.*, 2000). However, this is never a flawless process, and community life is rife with collective-action problems. The principal collective-action dilemma revolves around the paradox that individuals with common interests often do not collaborate to further those interests (Olson, 1971). This is especially the case when individuals cannot be excluded from using or benefiting from the collective good once it has been produced. Examples of such public goods that people cannot be excluded from include clean air or herd immunity due to high vaccination rates. Strategies that are rational from an individuals' point of view (e.g. continuing to slash a forest for firewood) can lead to outcomes that erode the collective good (Bano, 2012: 15). Typical examples include the tragedy of the commons (complete destruction of the productive forest) and the free rider problem (e.g. foregoing vaccination whilst benefiting from herd immunity).herefore, the main question for any community development donor or practitioner is: what conditions can help to overcome these individual short-term interests? As Gibson *et al.* (2005: 220) explain, 'aid projects must address the underlying collective-action problem if they are to be effective and sustainable.'

In line with Olson (1971), Bano (2012) has observed that the free rider problem is overcome when a group, seeking collective action, organizes itself in a small enough unit to build close social networks. This increases accountability and local ownership, enhancing people's motivation to act

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in socially responsible and desired ways. Community ownership over resources and collective action ties into the debate about social capital, where the latter tends to be regarded as a *resource for action* (cf. Coleman, 1988, 95), or a *vehicle for change*. Social capital can be understood as the presence of civic engagement networks, or reciprocal and trusting human relations based on shared norms. As a catalyst for local action, it may refer to local synergies (bonding capital) as well as to local actors' abilities to reach out to external resources (bridging or linking capital). Whereas 'bonding' refers to social integration and (strong) ties within (homogeneous) groups, 'bridging' relates to the effect that strong intragroup cohesion can serve as a linkage to contact and establish 'weak' ties with other (heterogeneous) groups or actors (Granovetter, 1983; Woolcock, 2001; Mladovsky and Mossialos, 2008). In this regard, social capital has implications within and beyond specific groups. Through bridging, social capital communities may be effective in obtaining support to solve problems or cooperate on a wider spatial level with other communities. In situations where this involves interaction with formal institutions across vertical power lines, this is also referred to as linking capital.

Since the popularization of the concept (Bourdieu, 1986/2011; Coleman, 1988; and Putnam, 1993), social capital has come to be seen as beneficial to development. Strong social cohesion among groups would stimulate cooperative behaviour as it is often assumed that norms and obligations within groups, i.e. social capital's base, limit deviations from the norm. Social capital can also be seen as a compensation or stimulus for other types of capital. The risk of community exclusion in case of defection can for instance limit formal transaction costs (and thus a need for much financial capital). Similarly, it can aid the formation of human capital by, e.g. supportive (groups of) parents stimulating children to remain in education instead of dropping out (Coleman, 1988). However, investing in community cohesion does not always directly benefit the individual and has an insecure rate of return. Individuals may consider that deviating from collective expectations brings greater individual benefits. This sets social capital apart from other kinds of capital, e.g. physical, financial or human capital, with which one can appropriate other goods that can strategically be invested in or built up (Coleman, 1988).

As the social capital paradigm entered the mainstream, and austerity measures in the 1990s shrunk many countries' public sector, the belief took hold that civil society was a key to development, and aid for non-governmental and community-based organizations increased. The World Bank even came to view social capital, and by extension civil society, as 'the missing link' in development (Grootaert, 1998, Woolcock, 1998). This arguably served a tendency to depoliticize development dilemmas, or even

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distract attention away from a need for state accountability towards communities (Gaynor, 2011).

However, social capital's use as a concept and evidence for the popularized claim that it has a positive effect on development outcomes is contested (Harriss and De Renzio, 1997). The strongest critique centres around the stretch of the concept from the individual to regional or even country level; the lack of attention to unequal power dynamics in communities; and, the disregard for evidence of the negative aspects of social capital, such as exclusion and distrust towards outside actors, organized crime, *downward levelling pressures*, and restrictions on individual freedom (Harriss and De Renzio, 1997: 926). In other words, social capital can both help and hinder economic advancement (Woolcock, 1998, 154). A contributory role in this process can arguably be attributed to mediating agency, i.e. the ability of capable actors in activating bridging and linking social capital and overcoming the negative constraints of (bonding) social capital (Krishna, 2002).

Despite social capital's limitations as a 'key for development', it remains a useful analytical lens in the study of community dynamics. It has given rise to a more nuanced view on the role of human relations and their inherent power dynamics in development. With evolving insights from the *good governance* debates (cf. Grindle, 2007; Booth, 2012) came an increasing recognition that development efforts need to positively address these informal networks, because they are often more resilient and locally anchored than weak formal structures.

Community development's tenet to engage with communities for empowerment towards authorities and other development actors, however requires a need for analysis of how communities differ and relate to other actors (e.g. Gilchrist's, 2009; Kenny, 2016). In other words, it is imperative to analyse both the localized notions and characteristics of societal actors – as the micro-level agents – and the behaviour of external actors to understand how interventions unfold, and how these encounters may vary across settings.

Many questions remain, particularly in the post-Soviet Central Asian context. To what extent to can external agent help to enhance intercommunal cooperation? Do close intragroup bonds discourage or encourage collective action and to what extent do these engender synergetic or antagonistic encounters?

Methods

The research methodology for this paper relied on extensive literature review as well as qualitative field research. Field research centred on VOs and CBHFs in two villages in Rushan district, Tajikistan in July 2011: Khuf

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and Vamd. These sites were purposefully selected for an in-depth exploratory study because of the observed contrasting experiences, as described in the following section. This paper is embedded in a larger study, aimed at investigating the power and influence of different actors in the health system of Tajikistan. As part of this study, villagers' perceptions of, and interactions with local governance actors and organizations emerged as such a relevant theme that it was developed into a separate research question. Focus group discussions (FGDs) with three different groups of citizens in each village (total $N = 6$), and a total of 17 semi-structured interviews were conducted with VOs, *mahalla* (local self-governing neighbourhood councils), CBHF leadership and members, AKDN representatives, district and mayoral (health) officials, health staff, and administrators from health centres in the two villages and the district hospital. The number of participants in each FGD ranged from seven to eleven, and women constituted around 40 percent of participants. A total of fifty-three people participated in FGDs. Verbal informed consent was obtained from every interviewee and FGD participant. This was done by describing the study objectives and offering the possibility to refrain from answering or withdraw from the interview/discussion at any point without further consequences. Purposive snowball sampling techniques (Atkinson and Flint, 2001) were used to identify participants, key stakeholders, and informants. For the FGDs with villagers, a strong effort was made to include both women and men, and participants with different wealth status. Inductive reasoning allowed for identifying patterns in the relationship between local institutions for collective action and the newly introduced CBHF.

Local governance, the AKDN and Community-Based Health Funds in Rushan district, Tajikistan: a comparative case study

This section presents the findings from interviews and FGDs. First, an overview is given of the formal and informal structures for governance and collective action in Rushan. Second, it presents the findings on people's perceptions of these structures and interventions, with special attention to the variation between the two villages.

Governance background Rushan

Rushan is a district (*rayon* in Russian, *nohiya* in Tajik) in Tajikistan's Gorno-Badakhshan, bordering Afghanistan. Just like much of Gorno-Badakhshan region, the population of Rushan is religiously and linguistically distinct from the rest of the country with a large Ismaili population and the widespread use of Rushani, one of the Eastern Iranian (Pamiri) languages

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dominating in Gorno-Badakhshan. Due to its historical political isolation, low population density and mountainous geography, the region is less developed socio-economically compared to the central regions of Tajikistan, and faced a threat of famine during the civil war. Subsistence agriculture is the main economic activity and many households additionally rely on remittances from migrated family members.

Politically the region has been isolated since pre-Soviet times, and forced relocation of large parts of the population from Gorno-Badakhshan to cotton growing districts in south-western Tajikistan contributed to resentment among its people towards central authorities. After the dissolution of the Soviet Union, Pamiri secessionist forces briefly proclaimed independence for Gorno-Badakhshan, and sided with the United Tajik Opposition during the country's civil war, in which massacres and ethnic cleansing against Pamiris was widespread (Foster, 2015). Today, the region remains more distant from the political centre, although the central government has tightened its grip on the region through the direct appointment of key decision-makers in local governance: the district's head (*raisi hukumat*), and indirectly, municipal mayors (*raisi jamoat*) ruling over a collection of villages, who dominate local decision-making in the absence of de facto legislative powers for elected deputies at the district level. In the study sites, both citizens and executive authorities considered the deputies to hold only 'consultative status' with Rushan district authorities (*hukumat*) and convene only biannually.

Asked which organization, network or leaders communities relied upon for addressing their daily problems, villagers held widespread consensus that the only functioning participatory governance structure is the legally recognized but unregulated *mahalla*, or neighbourhood council. These sub-municipal councils typically represent around thirty-five households in Rushan and are bodies for addressing local problems through collective action, ranging from local disputes to collective labour (*hashar*). This phenomenon captures a broad variety of laborious tasks that are undertaken collectively, and for which the community has a duty to show up. Examples include road and bridge repairs, the cleaning of irrigation canals and agricultural work. Decision-making in these councils can vary slightly but usually takes place through consensus between household representatives, coordinated by the *raisi mahalla* (*mahalla* leader), who is also elected through consensus. Although men are often overrepresented several active women were also encountered, including a female *raisi mahalla*. The *mahalla* leadership was generally perceived to be legitimate in the communities that were studied. For specific affairs – land use and cultural-religious life – the collective (*dehqon*) farm, (which functions like an association), and the

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religious leader, *khalifa*, were also mentioned to play a role of importance in people's lives, but not for such wide-ranging purposes as the *mahalla*.

Village Organizations and the Aga Khan Development Network's involvement in Gorno-Badakhshan

The dissolution of the Soviet Union led to a severe neglect of public services, which was exacerbated by the Tajik civil war of the 1990s. The presence of the AKDN through the Mountain Societies Development Support Programme (MSDSP) has since been vital to the rural development of Gorno-Badakhshan and the sustenance of public goods and services since the 1990s, boosted by its religious-cultural legitimacy for the predominantly Ismaili population in the region.

As the dominant and longest-running external assistance programme in Rushan, the MSDSP and its community-based structures, require closer attention. The MSDSP is a semi-autonomous arm of AKDN, and was formed as the successor to the Pamir Relief and Development Programme, the AKDN's first engagement in Tajikistan and Gorno-Badakhshan in the early 1990s. At its inception, it focused on food relief and agricultural development in the face of severe food insecurity, which combined with its cultural-religious connection to the Ismaili population helped to establish its place in Gorno-Badakhshan.

In search for a community-based organization through which to channel its aid, the MSDSP established its first VOs in the second half of the 1990s, after an analysis of existing social structures in Gorno-Badakhshan and concluding that none were suitable as channels for community-based aid (Tetlay, Jonbekova, 2005). VOs were and still are meant to serve as an institution for decision-making around MSDSP-initiated, development-related activities. By 2011, VOs had been established throughout Gorno-Badakhshan, numbering around 500 (AKDN, 2011) and typically span across one to four *mahalla*s. The MSDSP has stressed its intention for VOs to be participatory, democratic structures that empower and represent communities and are inclusive towards women (among other groups). The MSDSP also employs mainly local people with a large share of women. The process of establishing a VO has been consultative and voluntary according to MSDSP/AKDN.

CBHFs in Rushan district

In Rushan MSDSP and the Aga Khan Health Services cooperate in the health sector, linking VOs with the provision and financing of health services. Initiatives include CBHFs in nine communities, health facility renovations, supply of equipment, and public health information, the establishment of a not-for-profit chemist and retraining of primary healthcare staff.

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As one of the first risk-pooling interventions in health, AKDN started piloting CBHFs in Rushan district in 2009. The CBHF assumes that VO members contribute voluntarily towards the pool. The money can be used for diagnostic tests, transport to health facilities, or medicines for unaffordable emergency cases. Funds pooled by community members were matched by the Aga Khan Foundation's to build-up a substantial pool of money. Matching ranged from 50 percent to 75 percent (AKDN, 2011), in effect making the CBHFs largely dependent on external funds.

After technical and financial support for the fund's set-up, communities were encouraged to define the regulatory framework for the CBHFs themselves. For example, the level of contributions to the common pool, whether enrolment is per household or per individual, and the maximum amount of money that can be claimed from the pool for health-related expenditure is decided by VO members themselves by consensus. In Vamd, they decided on one Tajik somoni per individual a month, and in Khuf 1.5 Tajik somoni per household per month.[3] In both villages, they agreed on a ceiling of 100 Tajik somoni for claims. Checks and balances were established through a practice of transparent bookkeeping, which MSDSP encouraged and verified, and the collected funds are kept in a box with three locks, the keys of which are held by three different VO members. Apart from the deputy structure, a representative body for VO heads called SudVO was established to facilitate communication between VOs and municipality (*jamoat)* and to a lesser extent district administration. In addition, those VOs with CBHF pilot schemes are represented through a district-wide CBHF committee.

Villagers' perceptions of VOs and their collective risk-pooling activities

VO and MSDSP

VOs and the other MSDSP bodies SudVO and the CBHF district committee were viewed with greater distance than the *mahalla*s. A marked difference was however observed between the village of Vamd and the village of Khuf.

In Vamd, VO activity was high and its function as a structure for local collective action was considered meaningful, exemplified by various achievements, strengthened through strong coordination with *mahalla*s. However, in Khuf VO activity was low and coordination with *mahalla*s very limited.

3 TJS1 equalled around USD 0.22 in July 2011.

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The Vamd VO acted as a catalyst that, depending on the needs and project, engaged with relevant interest groups and players to achieve common goals. The VO spans four *mahalla*s, and the majority of local people, including the *mahalla* leadership, are VO members. VO and *mahalla* leaders indicated that the close engagement of the *mahalla*s was key in fostering a sense of common purpose, which they upheld by calling weekly meetings between them.

VO engagement in the interest of collective action, i.e. in terms of producing or strengthening public goods and services, extended beyond the *mahalla* leadership to the local religious leader (*khalifa*) and the collective (*dehqon*) farm, local clinic, or school, depending on the need. When resources were required from donors or the municipal or district administration, a concerted effort of lobbying appeared successful in various cases, resulting in, for instance, new equipment for the local clinic as well as the district hospital. Community saving through semi-organized pools and cooperation with the *dehqon* farm, the district authorities, donors and the *khalifa* ensured the construction of a small hydropower station, the repair of pumps and water pipes for farmland irrigation, and other agriculture-related activities such as fruit conservation.

The Vamd VO leader stood out for his activity, visibility and drive to voice his community's problems to higher levels of authority. Although relatively young in a society where seniority holds high esteem, Vamd´s village FGD respondents, *mahalla* leaders, as well as local health workers and authorities expressed widespread appreciation for the chairman's activities and leadership. As the founder of his own health NGO in the district capital, he appeared better connected than other VO leaders with local authorities and public service providers.

In contrast, the VO leadership of Khuf felt they could not influence decision-making of local authorities, and could not provide examples of successful lobbying on their communities' behalf. Trust in district and municipal governments was low, and although villagers generally held the authorities responsible for the poor quality of healthcare and road infrastructure, expectations towards these actors were low, and a sense of disempowerment towards them prevailed.

In this way, Khuf represents a village where people expressed relatively more frustration about their experience with the lack of responsiveness of public services, and research participants indicated that there was a disconnect between the local, participatory problem-solving institutions (primarily the *mahalla* and to a lesser extent the mosque), and the external efforts aimed at addressing their problems. In FGDs, villagers largely considered CBHF to be 'yet another scheme'. As FGD participants expressed it (11 July 2011):

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> 'they [MSDSP] are only welcome if they bring money, otherwise it is not necessary'
>
> 'we [*mahalla*] are family, we can help ourselves'
>
> 'the VO is not helpful in solving our problems'

CBHF

The prevailing wary attitude in Khuf towards the MSDSP was reflected in CBHF enrolment. According to the VO leadership around 70 percent of the village was a VO member, and around 40 percent of VO members was enroled in the CBHF. This was approximated in FGDs with villagers. AKDN's statistics however differ from the community reports, and claim 100 percent of VO members to be CBHF enroled (AKDN, 2011).

Reasons given for their lack of enrolment, elaborated in more detail below, include: (1) confusion by the various community saving funds; and, (2) distrust caused by one case of mismanagement or fraud in the use of community savings by the old VO leader. These combined factors formed a powerful incentive to disengage from the VO and its schemes, and confirmed villagers in their preference to keep addressing their local problems through the *mahalla* structures.

Although the CBHF scheme had been recently introduced, the variety of other saving activities was considered highly confusing. Some of these activities were organized across villages (community-based saving groups) while others aimed to address only certain sectors (the village social fund) in addition to the general village development fund. Confusion centred around the conditions of use of these funds, the different purposes, and the use for this variety of schemes. The Khuf rural health centre staff, and *mahalla* leaders in the village also recognized and expressed this confusion, and the latter indicated this prevented them from convincing 'their' villagers to sign up to the new MSDSP-led institutions.

As inclusion and participation in the VO structure was greater in Vamd, so was participation in the CBHF scheme. In FGDs with the VO leadership, all villagers were reported to be a VO and CBHF member, which was approximated in discussions with villagers. Paired with 100 percent of VO members participating in the CBHF scheme (AKDN, 2011), this implies near total coverage. Remarkably, the mayors and the deputy head of Rushan district were dismissive about the use of the CBHF committee and SudVO, and villagers reported little awareness of the existence of inter-VO MSDSP institutions such as the SudVO and the CBHF district committee.

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Discussion

Despite the decades of Soviet rule, and even though civil society organizations in the legal-rational sense are thinly spread in Gorno-Badakhshan (and particularly Rushan), this study confirms that communities are rich in social organization, as elaborated in the literature on civil society in Central Asia. Yet, their experiences in organizing collective action differ.

These study findings show two cases with opposite experiences in harnessing social capital for collective action. From the research findings, successful cases of collective action can be interpreted as examples where communities could collaborate between and beyond *mahalla* level with external actors such as the community development workers from MSDSP and local authorities to better their common plight. The observations are summarized in Table 1.

The more positive experience of the Vamd community has been analysed in contrast to the more negative experience of Khuf. These observations serve to demonstrate that, where local structures for collective action hold legitimacy among the population and thrive in their function, externally-introduced community-based structures do not automatically take root. The variation in attitudes towards the VO, the newly introduced community-based structures and pooling schemes witnessed between the two villages in Rushan nuances claims that community-level social capital increases communities' willingness to pool risks and join such schemes (e.g. Zhang *et al.*, 2006). It also adds nuance to Freizer's (2005) observation that AKDN's success in Tajikistan is owed to its deep local embeddedness. In other words, a positive experience with collaborative schemes in communities does not automatically produce positive attitudes towards more formal, externally-introduced community structures and savings or risk-pooling schemes.

In Khuf, negative and confused perceptions around externally-introduced savings and risk-pooling schemes dominated, yet people simultaneously expressed much trust in local *mahallas*. This suggests that the interplay

Table 1 Emerging findings on collective action dimensions in Khuf and Vamd, Rushan

Dimensions of collective action	Khuf	Vamd
VO active membership	Low	High
Collaboration between VO and *mahallas*	Weak	Strong
CBHF membership	Low	High
Collaboration on activities between VO and external actors (SudVO, local authorities, collective farm)	Low	High
Trust in externally-induced community initiatives	Low	High
Perceptions of VO leadership´s strength of representation vis-à-vis external actors	Weak	Strong

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between the two different types of social capital matters more than the existence of generally defined social capital. The differences between the two villages in trust in and collaboration with external actors highlight that encounters between actors at the macro- and micro-level are relevant to social capital's use for collective action for community development. Consequently, local communities, as the Vamd case demonstrates, may be effective in obtaining support to solve problems or cooperate on a wider spatial level with other groups of actors to achieve particular goals. In Vamd, where CBHF and VO enrolment were high, the VO leadership was widely appreciated and numerous examples of collective action involving the VO could be named. In other words, strong bonding capital coincided with stronger bridging and linking capital through the *mahalla* and VO leaders.

In Khuf, the locally anchored *mahalla* retained its function and legitimacy as an institution for collective action, implying strong bonding social capital. At the same time, trust towards organizations, formal institutions of decision-making and their leadership outside the community was low and collaboration with these actors was not established, implying weaker bridging and particularly linking capital. This resonates with evidence from Vietnam that shows that people living in cohesive communities are less likely to purchase health insurance (Jowett, 2003), as informal collective action for saving, mutual credit, and risk-pooling crowds out the institutionalized, externally-introduced scheme. These results also echo Portes and Sensenbrenner (1993) who found that high levels of bonding social capital, expressed through tight-knit solidarity groups, can constrain activity that could allow access to greater financial capital; e.g. partaking in a competing (externally-induced) savings network that threatens the viability of pre-existing solidarity schemes. The importance of bridging and linking capital in collective action speaks to Gilchrist's (2009) observation on the 'well-connected community': community development has been successful where it has sought to strengthen connections between individuals, groups, and outside agencies. Such extra-local ties play an essential role in building coalitions, navigate complex environments, and ultimately coordinate collective action for communities (Gilchrist, 2009: 46–47). Hence, bonding social capital can have both isolating (i.e. distancing) as well as outreaching effects. It can aid the build-up of financial or human capital, or hamper it.

Our results suggests that trust was decisive in people's motivations to sign up to the VO activities. Trust is seen as the core link between social capital and collective action as it helps to overcome the risk of loss if the trustee does not live up to commitments, and seize opportunities to enhance common welfare (Ostrom and Ahn, 2009). Trust in the reciprocity of agents other than close kin, and ultimately an equilibrium of reciprocity in an environment of different interests and asymmetric information, is

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essential to achieve mutually beneficial results, i.e. collective action (Ostrom, 1998). It is possible to distinguish between trust in the competence of others to meet their commitments, and 'goodwill trust', i.e. a more emotional acceptance of the moral commitment of others to do what is perceived just (Purdue, 2001). The Khuf community's confusion around the benefits of different savings schemes may have contributed to their lack of competence trust, while the case of fraud damaged their goodwill trust. The lack of positive experiences with external actors Khuf can be interpreted through contact theory, suggesting positive experiences of contact with others increases 'out group trust', making them more willing to overcome differences and collaborate (Hewstone and Swart, 2011).

Lastly, the visibility and effectiveness of VO leadership as shown in Vamd, contrasting with less visible and active VO leadership in Khuf, underlines Krishna's (2002) point on the centrality of mediating agents in instrumentalising social capital for collective action. As donor-induced community-based structures, VOs typically exhibit characteristics of Western associational models, in terms of democratic legal-rational decision-making processes. Over time, however, a more patrimonial leadership usually permeates these initiatives (Olivier de Sardan, 2011). Regardless of their development impact, these associational structures often engender new types of social mediators. The Vamd VO leader can thus be seen as one of these *local brokers of development* (Bierschenk *et al.* 2002) or network brokers (Morgan-Trimmer, 2013). In the context of community development in aid-settings, such brokers mediate between different organizational cultures and institutions. The VO leader in Vamd, as opposed to the VO leadership in Khuf appears to master the developmentalist jargon and concepts needed to collaborate with the MSDSP, and run his own NGO, while remaining locally embedded, essential for keeping his authority towards villagers. He has carved out manoeuvring space for himself and is able to show results and give meaning to each organization. Interpreted though the lens of social capital, this community leader has accumulated social capital with both the external partners and the community. In the interaction with external groups of actors social capital with the community functions like a resource and vice-versa (Purdue, 2001). The question of representation and legitimacy of these brokers however remains pertinent to raise, particularly when, in their broker position, they are accountable to different stakeholders and their (self)-(s)election is not necessarily based on democratic principles, as Molyneux *et al.* (2012) have found. Working with people who hold locally powerful positions could exclude the voices of those marginalized in the process of representation. Furthermore, frames and narratives of power, development and responsibility resonate differently between actors (between community members but also between

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communities and external actors). The distrust towards the state, and disappointment with the neglect of its welfare-provision task, rooted in a Soviet-influenced perspective of the state, featured in both villages, as observed elsewhere in Gorno-Badakhshan (Remtilla, 2012). This arguably created a place for AKDN's services butrelating to this new actor also meant 'buying into' a new development narrative. The self-sufficiency principle underlying many externally-induced community-based initiatives stems from a discourse of local responsibility and self-reliance. As Scott *et al.* (2017) found this can have adverse effects on collective agency at this local level, sowing discord between village members who identify with the self-responsibility paradigm and non-cooperative peers. The same study also observed resistance to the community-based initiative, motivated by a rejection of the local responsibility frame and a belief that the improvement of (access to) public goods and services is principally a government responsibility. This shows that the local responsibility discourse can be an instrument of power, and underlines the need for an explicit consideration of power in the study of social capital phenomena.

This study has several limitations. First of all, the findings rely on a relatively limited body of qualitative data collected over a short period of time. Future studies could rely more on participant observation and longer-term immersion to gain deeper insights into the community's collective-action challenges and power dynamics. Secondly, we cannot rule out respondent bias. AKDN facilitated access to some of the FGD study settings, although AKDN representatives were excluded from the interviews and FGDs. In addition to the authoritarian political context and communities' reliance on AKDN's charity this may still have inhibited respondents from fully expressing their opinions. Lastly, most participants spoke their second language (Tajik) in the FGDs, which may have limited their ability to express themselves.

Conclusions

This study has explored the dynamics of social organization and collective action between local and externally-induced structures with a focus on CBHFs in two villages in Gorno-Badakhshan, Tajikistan. The observed patterns in social organization and perceptions are inevitably incomplete and time-bound. However, the tentative findings serve multiple purposes. First of all, it adds to the literature on civil society in Central Asia by deepening the understanding of social organization and layered attitudes towards community-based aid in Gorno-Badakhshan. Second, the findings highlight the nuances in and limitations of social capital theory in understanding

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collective-action dilemmas. Lastly, a few lessons for NGOs engaged in similar community-based interventions can be drawn. The research points to the importance of bridging and linking social capital for communities to capitalize on external assistance for collective action, and for external development actors to tap into strong bonding capital existing at community-level. This warrants strong efforts to seek close collaboration with existing local institutions for collective action that hold widespread legitimacy, instead of setting up new structures. Second, the findings suggest goodwill and competence trust-building is essential for community members to overcome their risk of loss in furthering collective action through the engagement with external actors. The confusion around different savings schemes and lack of perceived benefit for Khuf citizens suggest that many different, potentially short-running schemes must be avoided in favour of longer-term investment in thorough take-up of single interventions. The Vamd case study implies that networks brokers are key in instrumentalising the community's social capital as a resource towards the external parties and vice-versa. At the inception phase, development projects with isolated communities would therefore need to seek out effective and legitimate local brokers while paying attention to the voice of underrepresented groups of people who could be marginalized by the dominant local leadership. The building of leadership capacities of such local representatives based on principles of inclusion might therefore be necessary. Lastly, the findings encourage reflection on the limitations of externally-induced community-based initiatives in pooling community resources, and the self-responsibility paradigm that underpins it. This carries implications for the responsibility of policymakers and donors to strengthen (access to) basic services for all.

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