Acknowledgements

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Abstract

Although cross-country and cross-jurisdiction variation in the quality of services is a well-established fact, very little is known about whether and how individuals decide to complain about poor quality of services. This study contributes to this research area by identifying the mechanisms that affect individual decisions to complain about the quality of services in Tajikistan. The analysis is based on qualitative and quantitative data and seeks to understand why individuals are often unwilling to complain about poor quality of healthcare services. We show that the decision to complain is correlated with individual social capital and socioeconomic status. These results suggest that the correlates of whistleblowing are similar to other forms of political participation. Thus the design of bottom-up approaches to monitoring healthcare providers in developing countries should take into the account the sociocultural context in which they are implemented.
Introduction

Cross-country and cross-jurisdiction variation in the quality of services is a well-established fact. However, factors affecting individual decision to submit complaints when the quality of services falls below expectations have not yet been analyzed. Expressing dissatisfaction is the first step toward improving the quality of services, but we know very little about the decision-making process that leads to this outcome. This study contributes to this research area by identifying the mechanisms that affect individual decisions to complain about the quality of services in rural areas of Tajikistan.

Tajikistan is a particularly interesting case for developing a theory of whistleblowing for two reasons. First, after the end of the civil war, the country has witnessed the growing political activism from the civil society and this sparked the international community interest in the fruitfulness of bottom-up source of accountability in the country in which mechanisms for electoral accountability have been weak. The presidential elections have been uncompetitive and until 2000, local officials used to be appointed rather than elected. This prompted discourse about the potential of NGOs ability to emerge as accountability mechanism to compensate for the weakness of electoral channels. Second, Tajikistan has lagged behind other countries in the region on many health indictors including, the incidences of diabetes, maternal and infant mortality rates, and growing rates of cardiovascular diseases and frequent outbreaks of child contagious diseases. Rapidly deteriorating infrastructure of primary healthcare facilities (PHC),

especially in the rural areas, and shortages of heat, electricity, and running water have contributed to the deterioration of sanitation standards; whereas low salaries of medical personnel have created shortages of providers in rural areas and have encouraged extraction of illicit payments for services. In 2010, for example, as many as 67 percent of the residents who received medical care encountered at least one of the following types of problems: disrespectful treatment by staff, long wait lines, and/or extraction of bribes. Surprisingly, however, less than two percent of them filed a complaint. Why? What factors have discouraged community members from reporting dissatisfaction with healthcare services to authorized officials?  

This paper addresses this question by showing that individual interaction with the healthcare system is shaped by personal networks that affect both access to providers and availability of information about alternative channels for articulating grievances. Not only do individuals with a higher level of social capital receive better services, but they are also more likely to know to whom they should complain. They also have better access to the officials in the Ministry of Health and head physicians who oversee primary healthcare providers and turn to them when dissatisfied with the quality of healthcare. Individuals with low levels of social capital have access to channels that are external to the healthcare system (such as local elected officials or community organizations) but they do not perceive those channels as effective and as a result do not submit their complaints to these actors.

This conclusion emerged from analysis of both qualitative and quantitative data. The quantitative analysis is based on the Life in Transition survey collected by the World Bank and the European Bank for Reconstruction and Development in 2010. We supplemented this survey with qualitative data from focus groups conducted in rural areas of two Tajik provinces in spring and fall 2013. The qualitative analysis captures the decision-making process that triggers expression of dissatisfaction.

This study speaks to an interdisciplinary community of scholars. From the political science perspective, this study calls belated attention to the phenomenon of whistleblowing, i.e. complaining when the quality of services is poor. The paper shows that whistleblowing is one


5 Ibid.
manifestations of “voice”—the primary form of political participation. Citizens vote to express their support for candidates, contact incumbents regarding their problems, and sign petitions to express their support for public policies. All these types of political participation have been extensively analyzed by political scientists. The voluminous literature, however, has left unexamined whistleblowing as another manifestation of voice. This paper fills this void by providing a systematic analysis of micro-level drivers of whistleblowing and shows that the correlates of whistleblowing are similar to those of other forms of political participation. Thus, theories of voice should encapsulate whistleblowing as a form of political participation and a mechanism of accountability.

From a public policy perspective, the paper calls international organizations’ attention to the importance of the local context when promoting bottom-up accountability approaches. Over the past decade, international donors have increased their support of community based monitoring (CBM) to improve the quality of services because in theory it should reduce community members’ dependence on local elected officials for monitoring service providers. In practice, however, CBM has yielded mixed results depending on the context in which it was implemented. This sparked a debate about the usefulness of CBM as a tool of accountability. The emerging literature has identified the collective action problem and the elite capture as the two most common barriers to effective monitoring by the community members. The former


arises because participation in the community monitoring schemes imposes costs on individuals and they seek to free ride on the efforts of other community members. Low rates of community members’ participation create opportunities for a handful of insiders to emerge as agenda setters and undermine the influence of community members. Therefore, previous research has focused on the mechanism that could mitigate either of these problems.\(^{10}\) This paper brings to the foreground social capital and personal networks as another factor affecting the successful implementation of CBM in developing countries.

This effectiveness of bottom-up monitoring is particularly salient for Tajikistan because it is piloting a new formula for financing primary healthcare and scorecards for monitoring the quality of healthcare at primary healthcare facilities.\(^{11}\) However, low rates of community members’ participation in the provision of feedback for the scorecards can lead to inaccurate measures of providers’ performance. Therefore, understanding the factors that can affect decision of individuals to report problems can affect the success of healthcare reform financing in Tajikistan.

This paper begins by exploring the question of why individuals refuse to report instances of poor quality healthcare delivery in Tajikistan and discusses the relevance of the existing theories of political participation to the Tajikistan context. Part II describes data. Part III summarizes our qualitative results and Part IV is dedicated to the quantitative analysis. We conclude by discussing the agenda for future research on whistleblowing and CBM.

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\(^{10}\) For extensive discussion of mechanism design to address the collective action problem see Elinor Ostrom, Governing the Commons: The Evolution of Institutions for Collective Action (Cambridge, MA: Cambridge University Press, 1990).

Part I: When and Why do People Complain?

The evidence for individual unwillingness to complain emerges from the Life in Transition Survey administered by the World Bank and EBRD in late 2010. The goal of the survey was to capture individual experiences and attitudes ten years after the dissolution of the Soviet Union by focusing on economic, political, and sociological dimensions of life in the former Communist countries. The Tajik sample includes 1007 individuals residing both in rural and urban areas the country’s three provinces and its capital. The questions about the quality of public services focus on individual experiences when seeking healthcare, education, and other public services. Individuals were first asked whether, in the past 12 months, they obtained such services. Those who did where subsequently asked whether they encountered such problems as long lines, doctors absenteeism, or disrespectful treatment. Those who answered affirmatively were asked: “Do you know where to file a complaint if you were dissatisfied with your local public clinic or hospital?” and those who said yes to this were further asked: “Have you ever filed a complaint?”

About 70 percent of the sample interacted with health providers in 2010. As many as 67 percent of them encountered some type of problem with services delivery including disrespectful treatment by staff, long wait lines, and extraction of bribes. About 42 percent of those respondents who encountered problems with the service delivery knew where to place a complaint about the service. However, less than 2 percent of those who both encountered a problem and knew where to file a complaint did so (Figure 1).

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13 The wording for the questions as follows: “During the past 12 months have you or any member of your household received medical treatment in the public facility?” if “Yes,” “Have you encountered a problem with your local public health clinic or hospital during the past 12 months?”; “Did you know where to file a compliant if you were dissatisfied with local clinic of hospital?” If “Yes”, “Have you ever filed a complaint?”
To understand the factors affecting the decision to complain, we focus on existing theories of political participation. Most of the drivers specified in these theories tend to fall into three categories: habits, resources, and social networks. We discuss the relevance of these drivers for the Tajikistan context in greater length below.

Socialization As the Driver of Whistleblowing

Political habits are formed as a result of socialization into political processes during childhood, when children take cues from their parents and neighbors about acceptable forms of political behavior.  

Source: Compiled by the authors using the LITS II

take place. Specifically, cultural norms and social networks affect the rates of utilization of healthcare system among immigrants.\textsuperscript{15}

Tajikistan, like many other former Soviet Republics, is an interesting case for tracing the relationship between socialization and the choice of grievance resolution strategies because of sweeping reforms that affected the structure of the healthcare system. In the late 1990s the government changed the process of financing services and the distribution of power among various stakeholders, and also devolved some of the authority for primary healthcare provision from the national to local governments. These reforms required the local population to learn new strategies for interacting with the new system. The speed with which older generations have been re-socialized into the post-Soviet healthcare could have contributed to cross-generational differences in preferences for the choice of grievance resolution venues. For example, older individuals could still continue turning to those grievance-resolution channels that used to be effective under the Soviet system, whereas younger ones may have more trust in the institutions that emerged or may have become empowered after the independence.

In Tajikistan the actors who can assist community members with resolving issues with the provision of primary health care include both insiders and outsiders (Figure 2). Health care services are split into three tiers: health houses, health centers, and hospitals. Health houses and health centers are the primary point of service for residents of rural areas. Policlinics provide primary care in urban areas. Policlinics and health houses provide immunization, basic first aid, basic prenatal care and medical referrals. Health centers provide more specialized services and offer diagnostics, basic treatment, and surgeries. Patients with more complicated health issues are referred by primary healthcare facilities to hospitals, which are usually located in larger cities.

As a part of the Soviet legacy, both health houses and health centers are still subordinated to hospitals. Head physicians at those hospitals play a major managerial role in health centers and health houses, make hiring decisions, and allocate medical supplies to those facilities. Thus, head physicians constitute the first set of insiders who can influence the quality of health care service. Head physicians report to the Ministry of Health officials and officials at the health


**Figure 2: Structure of Flow of Funds and Accountability for Healthcare Providers in Tajikistan**

Outsiders include local officials and community organizations that do not have formal powers to oversee providers, but can still influence providers’ behavior via allocation of resources. Primary healthcare facilities are funded by hospitals and local councils (jamoats). Hospitals in turn receive funds from the district administration (hukamats). Jamoat and hukamat officials can influence providers’ behavior as well as the quality of healthcare by supplementing resources provided by hospitals. For example, local governments can pay for gasoline for ambulance services, provide sanitation and electricity infrastructure, and make other capital investments to improve working conditions of the primary care providers. Traditional community organizations called makhala can also affect the quality of healthcare service by mobilizing community resources to build or renovate primary care facilities. Makhala trace their roots back to pre-Soviet times when they used to served as the primary community governance institution; they had to curtail many of their activities during the Soviet rule, but became active again after the independence and received a quasi-official status in the Tajik constitution.

If socialization serves as the driver of whistleblowing, one should observe cross-generational differences in preferences for using either of the channels. Older residents who are used to relying on head physicians as the mechanism for ensuring providers’ accountability may prefer doing so even after the emergence of new channels of accountability. Those who do not have any memories about the Soviet system may be indifferent to either of the two channels.

Social Capital as the Driver of Whistleblowing

The second hypothesis focuses on social capital as a potential driver of whistleblowing. In the literature on political behavior social networks serve multiple purposes: they affect individual exposure to peer pressure, serve as conduits of information about the saliency of the specific event, and change the perception of public goods and group identities. Social networks can affect the decision to blow whistle via social sanctions and access to actors who oversee primary care providers. Since complaining can trigger retaliation by providers, individuals are more likely to turn to those actors whom they trust to maintain their confidentiality and thus

might start addressing the problem by discussing the issue with people in their personal networks. Individual choice of a grievance-resolution channel then will be influenced by the presence of personal ties between the individual and institutional actors. At the same time, the decision whether to complain or not can be influenced by attitudes toward complaining. Depending on social norms, peer pressure could work either way: to encourage or to discourage whistleblowing.

Tajikistan provides an interesting case to study the importance of social networks because on the one hand it is a kin-based society in which the relations between and within the clans are influenced by the structure of personal networks but on the other hand, the civil war during the mid-1990s caused massive exodus of the population from the affected areas and this subsequently disrupted existing personal networks.

Resources as the Drivers of Whistleblowing

Resources can serve as another driver of the decision to complain. Numerous studies have documented a strong correlation between political participation and individual socio-economic status. Higher income level frequently translates into greater political knowledge, perception of political efficacy, and time availability. Given that per capita income rates in Tajikistan are the lowest in the region, resource constraints could be a primary factor affecting the decision to complain about the quality of healthcare services.

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Part II: Methods and Data

We examine the relevance of these channels to whistleblowing using a mixed-method approach. The qualitative analysis focuses on how people describe their reasons for lodging or withholding a complaint. The goal of the qualitative analysis is to identify any additional factors that influence individual behavior but have not been captured by the existing theories of political behavior. The lack of variation in the dependent variable in the quantitative data is the second reason for collecting the qualitative data. As we had noted in the introduction, the number of respondents who complained is extremely small and this makes it impossible to estimate a regression model with “decision to report” as an outcome of interest.

The qualitative sample is based on 12 focus groups (FG) conducted in the two most populous provinces: Khatlon and Soghd. Each FG included 8-10 individuals. To increase the external validity, we included both Tajik and Uzbek speaking individuals, males and females, young and old, and residents of relatively large as well as small villages. To increase participation, the discussions were conducted separately with young females, older females, and older males.

To make the discussion less abstract, we asked respondents in half of the groups to talk about their experience with the quality of child and maternal health care (MHC) and asked the other half about healthcare related to cardiovascular diseases and diabetes (CVDD). These services were chosen because they are the primary focus of ongoing healthcare finance reform and because their high prevalence ensured that people would likely have sought either of these services or would have known someone who sought these services.

We used a combination of situational vignettes and open-ended questions to elicit general information about how community members interact with providers and more specific information about how they handle dissatisfaction. Since the participants could not be guaranteed anonymity, they were asked to talk about “people like you,” but many of them volunteered anecdotes from their own or family members’ experiences. Rather than starting with specific hypotheses, we tried to focus on as many aspects of the quality of healthcare as possible, and subsequently coded FG transcripts with three goals in mind: (1) to develop a list of factors that could prevent community members from expressing dissatisfaction with healthcare services, (2)
to capture participants’ preferences for the types of channels for grievance articulation, and (3) to uncover any cultural or social constraints on whistleblowing. The transcripts were translated from Tajik and Uzbek into Russian and in order to reduce the problem with inter-coder reliability all Russian language transcripts were coded by a single coder, a native Russian language speaker. We believe that the analysis has reached saturation because by the time the last transcript has been coded there were no new themes. However, the number of excerpts per each theme was very low— in most cases below three -- which makes it impossible to differentiate between the mainstream themes and outliers. Therefore, we assigned equal weights to each category regardless of the number of excerpts it contained and included all themes in our write-up.

Our qualitative analysis partially informed our quantitative analysis by providing the insights about the relationship between the social capital and whistleblowing and formulating some of the hypotheses, which we tested using the second wave of LITS data. The survey was administered in 2010 by EBRD and the World Bank to a representative sample of the population of Tajikistan residing in both rural and urban areas. The goal of the quantitative analysis is to test for external validity of some of qualitative results and the relevance of the existing theories of political participation to whistleblowing. Details on our estimation strategy and measures are provided in Part IV.

Part III: Results from the Qualitative Analysis

To understand barriers to whistleblowing, FG participants were asked to discuss problems they face when seeking medical care at PHC facilities and then to name an official or an organization that they could turn to for help with solving these problems. Problems mentioned by the participants included the long distances they had to travel to get to the facility, poor customer service, shortage of medical personnel, extortion of illicit payments, and the high cost and low affordability of services. The prevailing sentiment, especially among the Uzbek speaking older men, was that complaining was ineffective: “Complaining about the lack of services in your village is not going to make any difference… Even if people want to complain,
they know that it will not change anything (FG 2)” The entire focus group agreed with this statement.

Other focus groups provided a more nuanced account that points to the relative ineffectiveness of external channels vis-à-vis the internal ones. Table 1 in the appendix provides examples of participants’ responses about the effectiveness of each institutional actor. Most participants perceive external channels as ineffective especially when it comes to addressing customer service or illicit payment issues. Only one participant pointed out that as a disabled person he was entitled to free medical care and he also had access to a lawyer from an NGO, who could represent him if he was treated disrespectfully by providers. Another person mentioned a successful lobbying of the head of the *khukamat* to open a PHC facility in the village. But by and large, participants perceived external channels to be ineffective.

A somewhat different picture emerged with regard to the internal channels. The head doctor was perceived as most influential in addressing problems related to customer service, which is not surprising given that this individual oversees providers at PHC facilities. Although local residents perceived the head doctor as a very powerful figure, they complained to him only in exceptionally extreme situations, such as when a provider’s incompetence had led to a death or a disability.

The desire to maintain good relationships with providers at PHC facilities is one barrier that kept people from complaining. People recognized that a direct confrontation could damage one’s personal ties with a provider. The social capital represented by these personal ties frequently serves as insurance of a sort because doctors who belong to a patient’s personal network can provide services for free if the patient cannot afford to pay for them: “Seeking healthcare we frequently encounter financial issues…I, for example, before going to the public clinic double-check the schedule to see whether the doctor who I know has office hours because I do not have money to pay another doctor. My doctor can see me and my child for free” (FG 16). This social capital allows low-income households to address their financial constraints, and can be depleted by expressing dissatisfaction with the services provided.

Poor access to information about the cost of services is another critical barrier to complaints, especially when providers seek to overcharge community members. A young woman described an incident in which she objected when a nurse wanted to charge her money for vaccination that she was supposed to provide for free. Knowing this, she was able to act on it.
Like her, some participants were familiar with the laws that protected patient rights. Others, on the other hand, complained: “You go to see a doctor and do not know how much the visit will cost you” (FG 13). For these people, lack of information on what things were supposed to cost made it difficult to complain.

A third factor that influences whether a complaint is made is the gatekeeping function played by the head of the household, who controls the household budget and is the decision-maker regarding access to health care for each household member. Household members view the head of household as having responsibility for lodging a complaint on their behalf, rather than taking on this responsibility themselves. Whether a complaint is made is thus a function of whether the head of household views it as being in the best interests of the household overall and/or is willing to take the necessary steps.

Thus the most relevant factors affecting whether individuals express their dissatisfaction with the quality of medical services are (1) their perceptions of the effectiveness of those to whom they might complain; (2) their understanding of their rights; and (3) the inclination of the head of household to complain or not. Patients refrain from complaining when they are afraid of depleting social capital that exists between providers and community members and subsequently would not be available for use in the future.

Qualitative data also point to variation in access to providers’ personal networks. Some FG participants noted that they could call providers outside the regular office hours to receive a consultation or even request a visit. Others noted that the nurse usually calls them and notifies them about doctors’ office hours. Still others provided examples of people who were unable to receive treatment because they tried to obtain it from a provider who they had not met personally.

The most important insight from our qualitative analysis is that personal networks serve as a gateway to healthcare for many community members. Although the importance of personal networks has been recognized in the public health literature, the importance of social capital for reporting quality of healthcare has yet to be examined yet. As our analysis has demonstrated, for countries like Tajikistan, social capital is an important determinant of healthcare access. Community members are less likely to complain about poor quality of services for fear of depleting social capital and subsequently being denied access to health care and because they perceive external channels as an ineffective vehicle for dealing with providers. Community
members who have access to internal channels use them on rare occasions because social capital enables them to get good quality care.

Part IV: Quantitative Analysis

The goal of the quantitative analysis is to test for the association between social-capital and knowing where to express dissatisfaction with services. This analysis is based on LITS survey data. We focus on awareness of channels for expressing dissatisfaction rather than the use of these channels because, as we have noted earlier, less than 2 percent of respondents who experienced problems with healthcare reported them. Therefore, rather than focusing on complaining, we examined a related outcome without which a complaint cannot be placed: whether a respondent knew where to complain. The respondents were asked: “Do you know where to file a complaint if you were dissatisfied with your local public clinic or hospital?” This question was posed to all respondents who used healthcare within the past 12 months of the survey regardless of how they were treated by providers.  

The level of social capital is the primary explanatory variable in our analysis. Ideally we would like to measure social capital related to healthcare, i.e. respondents’ access to providers’ personal networks. However, these data are not available. Instead, we used a question about access to people who can help with getting things done. Respondents were asked whether they knew anyone [including relatives, friends, classmates, a local boss, or others] whom they could ask for help (i) to get a good job in the government sector, (ii) to get a good job in the private sector, (iii) to settle a dispute with a neighbor, (iv) to get into university, or (v) to obtain official papers such as passports. We counted the number of categories (i-v) for which respondents gave affirmative answers and created the variable SocialCapital with a range from 0 to 4. Another proxy for social networks is the duration of residence in the location in which the survey took place. Individuals who still reside in the locality in which they were born should have more elaborate networks because they have access to their parents’ social capital and stronger ties to local officials and local healthcare providers, since the latter tend to be recruited from the local

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21 There is still a possibility of selection into the use health care. This issue will be addressed in the next draft
population. We created a dummy variable *BorninCommunity* that indicates whether an individual was born in the community in which the interview took place.

To test socialization hypothesis, we used respondents’ age. The cohort born after the collapse of the Soviet Union serves as the references category. We tested for possible cross-cohort differences for individuals who have vivid memories of the Soviet health care system because they were at least 25 years old when the Soviet Union collapsed, and the transition cohorts, i.e. the individuals who grew up during the civil war.

To test for the effects of socioeconomic factors we created a dummy variable to capture respondent’s level of education and the household wealth index. The *Wealth* index was constructed from the questions about a household’s access to tap water, fixed phone line and other utilities, ownership of the dwelling, a car, a second residence, or a computer.

The vector of covariates includes respondent’s gender, the language spoken at home, and the size of the household. The language variable was included because in some provinces there is a substantially large concentration of the Uzbek speaking population who may not have the same level of access to local institutions because of language barriers. To account for unobserved community-level effect we used the conditional logit specification. Table 1 reports odd ratios from the conditional logit model.

The Social Capital Hypothesis

The association between the *SocialCapital* index and respondent’s awareness of existing channels for whistleblowing is positive and statistically significant. The odds ratio of knowing whom to complain to increases by 43 percent as the value of the social capital index increased by one unit. This result is consistent with the qualitative analysis and suggests that one of the mechanisms by which social capital can affect the decision to complain is awareness of grievance resolution channels. Unfortunately, the data are not detailed enough to identify whether those channels are at the Ministry of Health or at the local level. The second measure for social capital, whether an individual still resides in the community in which he or she was born was not statistically significant, but still positive.
Table 1: Correlates of Respondents’ Awareness of Whistleblowing Channels

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Odds Ratios</th>
<th>St. errors</th>
<th>p-values</th>
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</thead>
<tbody>
<tr>
<td>Social Capital hypothesis</td>
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<td></td>
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<tr>
<td>Social Capital Index</td>
<td>1.43</td>
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<td>0</td>
</tr>
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<td>Born in the Community</td>
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<td>0.15</td>
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<tr>
<td>Socialization Hypothesis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 1</td>
<td></td>
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</tr>
<tr>
<td>25-34 (transition period cohort)</td>
<td>1.16</td>
<td>0.36</td>
<td>0.64</td>
</tr>
<tr>
<td>35-44 (transition period cohort)</td>
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<td>0.47</td>
<td>0.17</td>
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<tr>
<td>45-54 (Soviet cohort)</td>
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<td>0.45</td>
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<tr>
<td>55-64 (Soviet cohort)</td>
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<td>65+</td>
<td>0.83</td>
<td>0.39</td>
<td>0.69</td>
</tr>
<tr>
<td>Resource Constraint Hypothesis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Secondary Education</td>
<td>2.28</td>
<td>0.55</td>
<td>0</td>
</tr>
<tr>
<td>HH Wealth index</td>
<td>1.31</td>
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<td>0.02</td>
</tr>
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<td>Covariates</td>
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<tr>
<td>Speaks Tajik</td>
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<td>Number of household members</td>
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<tr>
<td>Male</td>
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<td>LR-test statistic</td>
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<tr>
<td>p-value</td>
<td>0.00</td>
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<td></td>
</tr>
</tbody>
</table>

Y = 1 if respondent said that he knows where to complain and 0 otherwise; the specification accounts for unobserved community-level effect. The sample includes respondents who used healthcare within 12 months. 1 Omitted category is age between 18 and 24 (post-soviet cohort).

Socialization Hypothesis

Empirical support is weakest for the socialization hypothesis, which postulates that there should be systematic age differences in the awareness of grievance resolution channels. Although the U-shaped relationship between age and awareness about grievance resolution is consistent with the socialization hypothesis, the differences across age categories are not statistically significant.

The Resource-Constraint Hypothesis

As expected, socioeconomic characteristics are positively associated with respondent awareness of grievance resolution channels. The odds ratio is almost three times higher for
individuals with some post-secondary education than for those without it. For males, odds ratios are 61 percent higher than for females. The odds are also higher for individuals from more affluent households. This positive association between our outcome variable and education, gender, and wealth is consistent with studies of other types of political participation that also find a strong and persistent influence of socio-economic factors on political behavior.

Conclusion

The phenomenon of whistleblowing has been neglected within the literature on political behavior because it has been considered as a form of insider behavior rather than mass political participation. This paper has taken a first step toward showing whistleblowing is a form of mass political behavior and is affected by the same drivers as other types of political participation. The qualitative analysis also suggests that the primary barriers to complaining include low perceived efficacy of local elected and appointed officials and community organizations and community members’ dependence on social capital as the means for gaining access to healthcare. The quantitative analysis revealed that individuals with more elaborate social networks are more likely to know to whom they can complain.

Both of these factors can become barriers to soliciting community members’ input for scorecards that constitute an integral component of the healthcare reform in Tajikistan. The fear of losing access to healthcare may discourage community members from sharing honest feedback about the services they received. Rolling out scorecards, therefore, will require socialization of community members into new ways of providing feedback about the quality of services and adoption of measures that reduce community members’ dependence on social capital to gain access to healthcare.

Furthermore, when introducing CBM, international development agencies should pay closer attention to community members’ socialization into healthcare systems and their social networks. This is especially important for countries undergoing sweeping healthcare system reforms because those community members who were socialized into the old system may find themselves isolated from the newly established institutions. Internal vs. external channels of
resolving patients’ grievances are directly linked to the notions of horizontal and vertical accountability. The former stems from reputational costs that providers face when the community members publicly express their dissatisfaction with their services. These reputational costs are triggered by the introduction of scorecards, crowd maps, and/or community surveys that report back to the community about the quality of services. They generate common knowledge among individuals that other members of the community are also dissatisfied with the quality of services and this may subsequently encourage further citizen reporting. Vertical accountability stems from the distribution of authority within healthcare institutions. Access to internal channels of grievance articulation depends on individual personal networks. Most CBM seem to underestimate the importance of internal channels because they are neither transparent nor equally distributed across all community members. Such channels can still be appropriate in certain context and for certain populations and can be integrated into the CBM.
Appendix 1:

Table 1: Perceived Efficacy of External and Internal Mechanisms for Grievance Articulation

<table>
<thead>
<tr>
<th>Efficacy of External Channel</th>
<th>Efficacy of Internal Channel</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inadequate Infrastructure/no PHC facility/Shortage of Providers</strong></td>
<td><strong>Medical Personnel shortages:</strong></td>
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<td><em>Local Assemblies</em> (jamoats):*</td>
<td>The Ministry of Health can address the problem of qualified personnel shortage by setting quotas for each rayon [i.e. administrative unit] and sending medical school graduates to those rayons (FG 5)</td>
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<td><em>Jamoats</em> are responsible for controlling their territories, but they do not have any support and cannot change the situation (FG2)</td>
<td>Head doctor and the Ministry of Health can address the problem of personnel shortage (FG 16)</td>
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<td>The head of the jamoat can open a PHC facility if he finds a rich entrepreneur willing to pay for it.... Jamoat cannot resolve its own problems, how can we expect it to address the problems with ambulance services (FG 5)</td>
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<td>Traditional Organizations (makhalas):</td>
<td><em>Long queues:</em></td>
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<td>Not a single member of the makhala committee has been able to solve problems that people have (FG2)</td>
<td>The head doctor can solve this problem by increasing the staff and the number of doctors so that people do not have to wait in queue and see another doctor. People can also complain to khukamat (FG 13)</td>
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<td>Rayon administration (khukamat)</td>
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<td>Once the head of the rayon khukamat referred a young doctor to the position that opened at the rayon clinic. The young man arrived there and the hiring committee whispered something to each other, and told the young doctor to go back to Dushanbe and bring additional paperwork. When he came back with the extra paperwork, the position had already been filled (FG 5).</td>
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<td>Every Saturday, the head of the khukamat has office hours. I kept coming and nagging him about opening a PHC facility in our village. The security guard was very aggressive and started disliking me, but one day the head of the khukamat issued the order to find a building and to create the facility (FG 2)</td>
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**Rude or incompetent treatment by providers**

For example in Russia or other countries if a doctor makes a mistake during surgery he can be held responsible. In this country, doctors are not held responsible even when their patients die during surgery. People do not complain because it is pointless (FG2)

Even if you come to complain, you will be told to go back to where you came from and complain there (FG2)

Over the past 20 years, the number of invalids Provider sees his acquaintances before other patients waiting in line: “First of all, you should tell the doctor himself that he should not see people out of order and see whether he listens or not. If no, then you can complain to the head doctor, who should tell the provider to see patients in order (FG 10)

*Doctor is rude:* The rayon head doctor can address this problem… If somebody complains that the doctor is rude to patients, then the head doctor can reprimand this doctor or even fire the
increased and thanks to the presidential decree 625, invalids became eligible for free medical care. The problem, however, is that doctors are rude to invalids because they do not pay them any money. I encountered this issue myself. Invalids have access to a lawyer to whom we can turn to have our patient rights defended. And if we do so, then the doctor will be fired (FG2)

Services are not provided when needed: ..I started having contractions and I came to the delivery room in the hospital. The baby was not positioned properly but all the doctors were in a meeting and the nurse was absent. There were only interns around, and you could already see the baby’s feet. If they called a doctor and told him that it was not a regular delivery, I would not have lost my baby… I complained to the head doctor. I asked him whether the meeting was more important than my baby’s life (FG female older than 40, Khatlon)

Doctor is incompetent: “My baby was 6 months old and came down with a fever. We tried to lower it but could not and took him to a doctor. He sent us to the rayon hospital. It was Sunday…and the doctor there was very young and inexperienced. He prescribed a drip of glucose. The nurse tried to but could not find a vein. They did not pay attention to the fact that the baby had fever and you cannot install a drip in this situation. When I saw what was happening, I started yelling at the doctor to do something to help my baby. The nurses came and reprimanded me for being rude to the doctor. I spent three days in the hospital and was completely ignored. Not a single time did the head doctor approach me and ask about my baby. “ (FG 13)

Extortion of illicit payments by providers

The deputies could enact a law [prohibiting illicit payments] but when they seek to get elected they promise a lot, but forget about their responsibilities to the people right after the election (FG 10) For example, you come to see a doctor, and he refuses to see you or is rude to you because you either did not give him any money or did not give enough. Even if you complain to the head doctor, he is not going to do anything even if he promises. Only if the doctor himself realizes that what he did was wrong can the situation change (FG 10) The head doctor can resolve this problem by creating a cashier who would handle all transactions and issue receipts (FG 10)
Providers can address this problem by giving discounts to low income families (FG5).
The Ministry of Health can set a price ceiling for prescription drugs and also randomly audit pharmacies so that they do not overcharge for drugs (FG 11).
The Ministry of Health can create benefits for low income families (FG 13).
The nurse can give injections and measure blood pressure for free and one should be able to obtain medicine at the pharmacy for free (FG 13).
Seeking healthcare we frequently encounter financial issues….I, for example, before going to policlinic double-check the schedule to see whether the doctor whom I know has office hours because I do not have money to pay another doctor. My doctor can see me and my child for free (FG 16).