Community Engagement in Health Services Delivery and Governance: Experience from the Philippines

Derick W. Brinkerhoff

RTI International
701 13th Street NW, Suite 750
Washington DC 20005 USA
dbrinkerhoff@rti.org

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**Introduction**

Linking communities with service providers is a well-recognized means to align service delivery to local needs and preferences. In the education and health sectors, parents’ associations and health committees bring communities into partnership with public providers precisely for the purpose of assuring that services meet user needs. The literature on state-society synergies for co-production of services highlights this outcome, which leads to increased efficiency and effectiveness (see, for example, Evans 1996). From the governance perspective, accountability and responsiveness to citizens emerge when the information provision on needs and preferences is joined with community monitoring and oversight (Brinkerhoff 2000). Such governance-enhancing outcomes, in the ideal, lead service providers to pay attention to performance. Empowered communities can serve as sources of demand and capacity not just for efficient service provision but also for performance that is accountable and responsive.

However, what evidence is there for these theorized benefits for both service delivery and governance? What are the practical implications of engaging communities with service providers? What factors facilitate or constraint the emergence of the benefits of community engagement? This paper explores these questions, and presents the experience of a recent demonstration project in the Philippines, funded by the US Agency for International Development, that sought to engage community members at the facility level in improving health service quality, while also contributing to increased provider responsiveness and accountability. The paper concludes with some lessons from the Philippines experience that are potentially applicable elsewhere for public management reforms aiming to improve service quality and contribute to better governance. The discussion begins with a review of the trajectory of participation in health that has led to the view of community members as governance actors, not simply as service beneficiaries.

**Community participation in health**

Community participation in health has a long history in the developing world and an extensive literature; this rapid overview hits only the highlights. Early notions viewed participation mostly as
community members receiving benefits from investments in improved health services. Subsequently, participation expanded from the community’s passive consumption of benefits to include its more active roles in project implementation, self-help, and service delivery. Communities came to be involved in co-financing, co-managing, and co-producing health services (see Kahssay and Oakley 1999). For example, community-based health insurance programs mobilize community funding, run sensitization campaigns, recruit members, manage contributions, negotiate with providers, and monitor performance. Village-managed pharmacies make available basic drugs to rural residents. Volunteer health auxiliaries provide health education to their communities and mobilize them for disease prevention. These varied instrumental forms of community participation, and their associated organizational mechanisms, remain widespread features of health service delivery in almost all developing and transitioning countries (see Morgan 2001).

Experience in a variety of countries with citizen engagement in service quality demonstrates that it is not appropriate or effective in all aspects of quality. For example, questions of technical standards, cost containment, or health safety are quality issues that require expertise beyond that of the average community member (see Charles and DeMaio 1993). Power and social distance factors between community members and health providers can also limit the extent of citizen involvement in assessing quality. In many societies, health professionals hold high social status, and lay individuals are reticent to challenge or confront them. However, participation can potentially help to address quality issues related to communities’ direct experience with health facilities and providers, including: access to services, effective utilization of services, interpersonal relations and staff behavior, physical infrastructure, and service choice (see Brown et al. Undated).

In health as in other sectors, beginning in the 1990s, views about participation reflected broader changes in the role of government, public sector reforms, and the emerging emphasis on democratic governance. At this time, responsiveness and accountability began to enter the discourse. Market-driven reform metaphors recast communities from collective recipients of health services to individual
consumers/customers – “users and choosers” (Cornwall and Gaventa 2001). Democratic governance expanded the customer idiom to incorporate communities as rights-bearing citizens. Democratization through decentralization brought governments closer to local citizens, and created mechanisms for local expression of needs and exercise of rights, and public decision-making processes to respond to local demand (Brinkerhoff with Azfar 2010). Such changes created space for communities to participate as empowered “makers and shapers” of health decision-making (Cornwall and Gaventa 2001, see also Church et al. 2002). For example, local health councils contribute to assessing health needs and setting priorities, and they help to identify local resources to address them. Associations of people living with HIV/AIDS lobby governments to enact policies against stigmatization and to allocate funding for long-term treatment.

Today, communities (and their civil society counterparts) are central to health market and health governance reforms. Paying attention to increasing accountability and responsiveness has become a stronger common thread in both types of reforms. The most basic level of community participation, which engages members in service co-delivery – often at the invitation of government actors, remains widespread. However, there has been a shift toward higher levels of participation where communities are actively engaged in expressing their preferences as consumers and voters, providing input to health decisions, and exercising their rights as citizens (Murthy and Klugman 2004). This shift recognizes that communities are not simply supply-side partners. They play a role in the demand side of health governance by fulfilling functions that contribute to provider responsiveness and accountability, as well as to service quality. Communities are governance actors whose direct connections to providers can enable them to express needs and preferences through “voice,” as well as to serve as potential sources of accountability pressure on providers (Brinkerhoff and Bossert 2008). In a range of countries, citizens have been engaged in monitoring service delivery performance in one way or another, using tools such as citizen report cards, absenteeism tracking, and membership on facility boards.
While community engagement to increase accountability and responsiveness is intrinsically desirable from a good governance perspective, important questions for policymakers concerned with service delivery and health outcomes are: a) whether communities have the capacity to exercise an accountability role given the information asymmetries and power differentials between communities and health professionals; and b) whether community participation has demonstrable impacts on efficiency, effectiveness, and health outcomes. Research that can credibly document links between governance improvements and service delivery or health outcomes faces methodology and data challenges, although some studies have shown results. For example, Peters (2002) demonstrates that community engagement in oversight of service providers contributed to more effective, equitable, accountable, and affordable reproductive health services in India. Box 1 offers another example, and summarizes the results of a study in Uganda that reveal health and accountability impacts of community participation in monitoring.

Box 1. Evidence for the Impact of Community Participation in Monitoring Health Service Delivery

A randomized experiment with community participation in monitoring of public primary health providers in 50 facilities in Uganda revealed important health and accountability results. Facilitated by local nongovernmental organizations (NGOs), community representatives in treatment villages worked with health providers to develop joint community “contracts” for service improvements and then used citizen report cards, which compared facility performance with national standards and averages, to monitor progress. After a year, treatment and control communities were compared. The study documented a 33 percent reduction in child under-five mortality, as well as a number of other positive impacts on service utilization and health outcomes. Treatment communities were more engaged in holding providers accountable through monitoring, and health worker behaviors changed to be more responsive to serving community health needs.

Source: Björkman and Svensson (2009)

The Philippines context

An East Asian and Pacific nation with an estimated population of around 90 million people (2009), the Philippines is a lower middle-income country with a democratically elected government. Total health expenditure per capita is US$36. Non-communicable diseases are a growing problem, while the country also contends with the communicable diseases common to developing countries, such as malaria,
tuberculosis, dengue fever, and diarrheas. The contraceptive prevalence rate is just over 50 percent (2008) and maternal mortality is around 200 per 100,000 live births. Health statistics indicate that the Philippines not making sufficient progress to meet the 2015 Millennium Development Goal on MCH (figures from www.wpro.who.int/countries/phl/ and healthsystems2020.healthsystemsdatabase.org/).

Public health services in the Philippines have been a local government responsibility since the passage of the Local Government Code in 1991, which launched a significant decentralization. Provinces, cities, and municipalities receive intergovernmental fiscal transfers in the form of block grants (Internal Revenue Allotments, or IRAs) from the national government. Local governments have a large amount of discretion in allocating IRAs: 80 percent of the funds are unconditional, with the remaining 20 percent released subject to a centrally approved local development plan. Of the five devolved national agencies, the Department of Health (DOH) has had the largest amount of its revenue shifted to IRAs (Schwartz et al. 2000). Local taxes plus a number of other dedicated funds also provide resources for health at the local level.

The Local Government Code designated local health boards (LHBs) to serve as the primary mechanism for community participation in health. The Code stipulated that the community would be represented on the board by a member of a health NGO; the majority of LHB members are local elected and public health officials. Boards fulfill an advisory function on health budgets, planning, and personnel issues (Ramiro et al. 2001).

The national-level DOH retains responsibility for health policy, surveillance and monitoring, standards and service quality, management of donor-funded projects, as well as planning and funding for a set of core health programs (MCH, nutrition, tuberculosis control, safe water and sanitation, etc.). Quality assurance (QA) and continuous quality improvement (CQI) have been elements of the DOH’s program strategy since the late 1990s. The Sentrong Sigla Certification (SSC) has driven QA and CQI through facility licensing and certification. SSC has contributed importantly to health services utilization and health outcomes, and has stimulated local government engagement in raising the quality of health
care in public health facilities. Today, SSC is complemented by the accreditation programs of the national health insurance, PhilHealth, for outpatient care and selected service packages, as well as the latest QA/CQI program, the Service Delivery Excellence in Health (SDExH) initiative.

SDExH was pilot tested in selected municipalities in the provinces of Negros Oriental and Misamis Occidental in 2007–2008, and is now being rolled out to other facilities and provinces with assistance from USAID. The initiative establishes Quality Health Improvement Teams (QHITs) of health professionals in each participating facility. SDExH’s objectives are to: a) enable local health facilities to assess, plan, and implement measures to improve the quality of health care; b) develop QA partnerships between national and subnational health offices and local governments; and c) establish mechanisms through which service users can participate in the provision and utilization of quality health services. The QAPC demonstration project connected to this third objective of SDExH.

The QAPC demonstration

USAID, through the Health Systems 20/20 program, supported a demonstration project from June 2009 to July 2010 that introduced community input to QA/CQI initiatives in cooperation with provincial and municipal governments. The project established joint committees (Quality Assurance Partnership Committees, or QAPCs) in three public health facilities in two provinces with high MCH mortality rates, Compostela Valley and Misamis Occidental: the Compostela Valley Provincial Hospital (CVPH), the City Health Office (CHO) in Oroquieta City, and the Rural Health Unit (RHU) in Lopez Jaena. Health Systems 20/20 gave a grant to a local NGO, the Gerry Roxas Foundation (GRF), to support the local governments, the health facilities, and communities in establishing and operating the QAPCs; and helping them to track progress and outcomes. The demonstration project was undertaken in cooperation with existing health systems strengthening efforts in USAID-supported sites in the Philippines.

As noted above, health programs around the world have experimented with participatory community health committees in various forms, largely oriented toward mobilizing and/or managing local resources for service delivery. There are fewer examples of such structures that address oversight and
accountability (Murthy and Klugman 2004). The QAPC was intended explicitly to serve both QA and health governance functions, taking inspiration from a similar committee piloted in Rwanda (see Brinkerhoff et al. 2009). On the service side, the QAPC offered facilities feedback on client satisfaction. On the governance side, the QAPC aimed to channel community voice to contribute to health service provider responsiveness, oversight, and accountability. Through collaboration and consensus, the QAPC sought to provide review and problem-solving to identify actions to improve facility services.

**QAPC Formation:** In the summer of 2009, GRF launched the process of setting up the committees in the three pilot sites through a series of workshops. These day-long events in each site combined a general orientation to the QAPC concept for local government and community invitees, and solicitation of interest among the invitees to serve on the committee, followed immediately in the afternoon by the first meeting of the newly formed QAPC to address organizational start-up. A second workshop (also one-day long) followed the first, and assembled the QAPC members to undertake action planning. QAPCs then met on an average of monthly throughout the demonstration project period.

Membership in all three of the QAPCS had a majority of facility staff, with 3–5 community members. Committee size varied; one committee had 24 members, the other two had 16–17. The three committees had some differences in how they were constituted and in their leadership. In Oroquieta City, the mayor appointed the leaders of the QAPC and chose medical professionals for both the chair and co-chair positions. Community representation was mediated through NGOs; there was no direct community membership. In the other two, the committees themselves elected their leaders. In Compostela Valley, community members filled all leadership positions. In Lopez Jaena, the QAPC chair was a local businessman and president of a community organization focused on agricultural development, and the vice-chair was a community member.

These differences in committee composition highlighted the importance of membership selection criteria to ensure that communities are sufficiently represented. In the QAPCs where the community representatives were individual community members and service users (mothers in many cases), the
committees had a direct connection to other MCH service users and to their home communities. In the case of Oroquieta City, the NGO representatives brought breadth of representation at the expense of depth. Comparative experience showed that the two committees where the community members were in the lead were more active, and better able to present community concerns and feedback to the facilities to which they were attached. In the Oroquieta City QAPC, the voice and views of the community were relatively muted.

**QAPC Action Planning and Activities:** An initial identification and prioritization of issues that the QAPC could work on set the stage for action planning. QAPC members at the first committee meeting enumerated a list of health service quality issues and problems in their communities, based on their perceptions. The health professional members of the committee provided technical input regarding the accuracy of those views. Group discussion refined the list to produce a shared vision and prioritization. Table 1 indicates the issues initially identified by the three QAPCs.

<table>
<thead>
<tr>
<th>QAPC</th>
<th>Issues</th>
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<tbody>
<tr>
<td>Oroquieta City CHO</td>
<td>• Inadequate budget for supplies and medicines</td>
</tr>
<tr>
<td></td>
<td>• Uninformed clients/customers</td>
</tr>
<tr>
<td>Lopez Jaena RHU</td>
<td>• Lack of emergency facilities for high risk patients</td>
</tr>
<tr>
<td></td>
<td>• Negative attitudes of some health service providers</td>
</tr>
<tr>
<td>Compostela Valley PH</td>
<td>• Insufficient funds for procurement of medicines and supplies</td>
</tr>
<tr>
<td></td>
<td>• Negative attitudes of service providers towards clients and work</td>
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The issues in Table 1 formed the basis for their action plans. However, these were not the only targets for committee activities. Throughout the demonstration period, the QAPCs took on a number of other activities as members engaged in dialogue among themselves, between committee members and communities, and between members and local officials. The GRF’s field-based provincial coordinators worked with the committees, providing coaching and training, support for conducting monthly meetings,
and assistance with materials development for advocacy and reporting. Table 2, based on GRF reporting and on mid-project and end-of-project field visits, summarizes the activities of the three committees categorized according to their links to responsiveness, accountability, or service delivery outcomes.

<table>
<thead>
<tr>
<th>Outcome Category</th>
<th>Compostela Valley PH</th>
<th>Oroquieta City CHO</th>
<th>Lopez Jaena RHU</th>
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<tr>
<td><strong>Responsiveness</strong></td>
<td>Conducted two surveys of customer satisfaction with CVPH services (10/2009, 6/2010)</td>
<td>Suggested improvements in patient referral system, and got commitment from mayors in Oroquieta City and surrounding municipalities to adopt the new referral system</td>
<td>Translated SDExH client feedback form into local language</td>
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<td></td>
<td>Installed two suggestion/complaint boxes with questionnaire in local language</td>
<td>Suggested training program for ambulance drivers in emergency care procedures</td>
<td>Conducted advocacy campaign for emergency shelter for high-risk patients, renovation of RHU toilet, facility access for persons with disabilities, purchase of a generator</td>
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<td></td>
<td>Facilitated training for CVPH personnel on interpersonal communication</td>
<td>Installed suggestion/complaint box at CHO</td>
<td>Installed suggestion/complaint box at RHU</td>
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<td></td>
<td>Lobbied for increased outpatient medical staff, reduced congestion in OB ward, reduced hospital fees, increased availability of medicines</td>
<td>Provided information on community issues to LHB and QHIT</td>
<td>Installed directional signs to guide patients and customers</td>
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<tr>
<td></td>
<td>Provided information on community issues to LHB and QHIT</td>
<td>Lobbied local officials to support community health outreach program</td>
<td>Lobbied for more user-friendly intake forms</td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
<td>Worked with CVPH director to ensure follow-up to community issues</td>
<td>No identifiable activities</td>
<td>Presented community concerns to mayor and local council regarding medicine shortages</td>
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<td></td>
<td>Met with CV governor to present community concerns</td>
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<tr>
<td><strong>Service Delivery</strong></td>
<td>Facilitated IEC** sessions on MCH for pregnant women and nursing mothers, and on patients’ rights and responsibilities</td>
<td>Delivered health orientation to barangay community organizations for MTB</td>
<td>Facilitated IEC sessions at barangay assemblies and purok*** meetings</td>
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<td></td>
<td>Disseminated information on CVPH policies and services</td>
<td>Selected community organizations to support improved MCH service quality and outreach</td>
<td>Worked with traditional birth attendants to increase referrals of pregnant women for facility-assisted births</td>
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<tr>
<td></td>
<td>Mobilized communities for immunizations</td>
<td>Facilitated IEC for Mother Leaders</td>
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*Barangay=village or ward, **IEC=information, education and communication, ***Purok=zone, subdivision of a barangay*
Assessing Results: Table 2 shows that the chief results of the QAPCs relate to increasing the responsiveness and client-focus of service delivery, and to expanding outreach from the facility to MCH service users, largely through facilitation of IEC. Anecdotal evidence suggested that these activities contributed to increased MCH service utilization. The community members of the QAPCs strengthened the linkage between facilities and service users by sensitizing communities regarding MCH issues, and mobilizing community members to utilize available services. The QAPC community representatives served as a communications channel for public health facilities to extend information to communities in the facilities’ catchment areas and increase outreach. For example, in Compostela Valley, QAPC members helped to mobilize mothers for breastfeeding IEC events organized by the hospital. The QAPCs also engaged in collecting feedback on client satisfaction with services, and transmitting this information to facility health providers. Feedback data collection was formalized in CVPH where the QAPC conducted two customer satisfaction surveys touching on the admissions process, cleanliness, food, provider behavior, and billing procedures. In the other two QAPCs, such feedback took place informally at the monthly meetings.

The major governance outcome at the facility level was increased responsiveness to community needs and preferences. A related secondary, but relatively limited outcome was some increase in accountability to service users at the facilities. For example, facility managers took community-raised issues into account in investigating and resolving complaints regarding providers. Beyond governance at the facility level, the QAPC pilot demonstrated the importance of decentralized local government to the effective functioning and sustainability of the committees. Local elected officials as well as the decentralized units of the health system facilitated the establishment and operation of the QAPCs.

Success Factors: A number of facilitating factors contributed to the accomplishments of the QAPCs. Facility staff, already aware of, and engaged in, ongoing QA programs, saw the QAPCs as a natural extension of CQI. By the end of the demonstration project in the summer of 2010, it was apparent that in two of the three QAPC sites – Compostela Valley and Lopez Jaena – there was strong local government
support for the committees to be institutionalized. In Oroquieta City, local officials expressed some support for continuing the QAPC, but the degree of actual commitment was unclear. The following factors emerged as significant:

- **Integration with ongoing DOH QA/CQI programs.** The connection of the QAPC pilot with the DOH’s SDexH initiative was critical. SDexH provides an accepted framework that connects clinical standards and accreditation to a definition of quality that incorporates client perceptions and community input. Even prior to the completion of the demonstration project, that link was already established in the CVPH, where the hospital director attached the QAPC to the wellness center, which is one of the components of SDexH.

- **Community members in QAPC leadership positions.** Where community representatives led the QAPCs, the committees focused on issues that the communities felt were important. Further, fulfilling these roles served a capacity-building function, community representatives gained skills and confidence in interacting with public officials and in exercising leadership. Sometimes, community members hesitated to consider themselves as appropriate for leadership roles. In one case, for example, the community representatives initially asked the facility director to chair the QAPC. He insisted that a community member should be the chair, and provided encouragement and advice to the housewife who hesitantly at first agreed to lead the committee.

- **Positive attitudes and behaviors of the health facility members of the QAPCs.** Facility staff, with a few minor exceptions, showed a welcoming attitude and receptivity to community representatives, which enabled the partnership dimension of the QAPC to be realized. The demonstration project showed the significance of health facility leadership, signaling their willingness to hear the voice of the community through the QAPC. Such openness also contributed to the motivation of community representatives to serve on the committee.

- **Commitment of community members to participate in the committees.** As a voluntary activity for the community representatives, the QAPC’s ability to fulfill its voice function was dependent
upon representatives’ ongoing engagement and commitment, and upon the support and coaching they received from the GRF field coordinators. Many participatory endeavors start off encouragingly, only to falter over the longer term when interest and enthusiasm wane.

- **Achievement of desired results.** No one wants to participate simply to meet and talk and not see any tangible outputs. The ability of the QAPCs to demonstrate achievement of the outcomes summarized in Table 2 contributed to the commitment of community members to remain engaged, and demonstrated the value of the committees to facility staff and local government officials.

- **Commitment to, and ownership of, the concept by local government officials.** In all three cases, local chief executives issued Executive Orders giving official recognition to the QAPCs, and were strongly supportive of the committees. In two of the three QAPCs, they incorporated financial support to cover expenses for community members to participate in the QAPCs into local budgets.

- **Decentralization.** The devolution of responsibility for health to local governments gave elected officials at the provincial and municipal levels both an incentive to be concerned about community views on health services and the discretion to allocate resources to address service delivery issues. Whether local officials exercise that discretion effectively is an issue. A variety of observers note that local spending decisions and capacity deficits mean that resource allocations do not necessarily match priority health needs (e.g., Schwartz et al. 2000, Langran 2011). Decentralization established an accountability chain of linkages from citizens to local elected officials to providers, which reinforced the direct accountability connection between providers and service users that the QAPCs embodied. The LHBs that the Local Government Code put in place paved the way for the QAPCs in that local officials were already familiar with, and accepting of, organizational structures intended to provide participatory input and oversight.
Lessons for service delivery and governance

The QAPC demonstration project affirms what other experience has revealed regarding service delivery outcomes and citizen participation. The participation of community representatives in the QAPCs extended MCH service outreach and increased the responsiveness of facilities to the quality issues that the committees raised. The QAPCs facilitated feedback to health providers on community needs and concerns, and – as the name of the committees indicates – included community members as partners alongside health providers in the facilities to which the QAPCs were attached.

Further, the demonstration project revealed a number of facilitating factors associated with the QAPCs’ ability to enhance service delivery. These include integration with existing quality and performance improvement programs, commitment and resources from local elected officials and facility staff, community member enthusiasm for serving as QAPC representatives, explicit incorporation of capacity building for community members, the facilitation role of the local NGO, and the positive enabling environment established by the Philippines decentralization (despite the implementation flaws and capacity gaps).

The lessons from the QAPCs for service delivery offer confirmation, first, of the benefits of engaging communities in co-producing health services, in keeping with a long stream of analysis of participation. Second, the QAPC experience corroborates the need to pay attention to the contextual conditions that either support or impede the ability of community participation to contribute positively to service delivery and, ultimately, to health outcomes. Particularly when facilitating conditions are weak or absent, the reputed benefits of participation may not materialize (see Morgan 2001). For example, experience has shown that health professionals are not universally open to input from non-specialists and service users on issues of quality, especially when feedback may be critical.

The governance innovation that the demonstration project sought to test was the inclusion of an accountability dimension to the service co-delivery model inherent in the QAPCs. As Table 2 shows, here the results are relatively sparse, though some of the activities classed under responsiveness could be
thought of as having implications for accountability, for example, the suggestion/complaint boxes installed at the three facilities. One observation made by informants in the Oroquieta City case was that the lack of any identifiable accountability activity there could in part be attributed to the appointment by the mayor of the facility director as the QAPC chair, and her subsequent dominance of the committee’s activities.

Several governance-related lessons emerge from the QAPC experience. The first is that engaging community members simultaneously as partners in service co-delivery and as accountability actors engenders some degree of role conflict. The two functions do not necessarily fit together easily. Given social distance, information asymmetries, capacity and confidence gaps, plus reticence to question authority, community representatives will tend to assume the partner role more readily than that of accountability proponent. Further, whatever accountability actions they are willing or able to take happen only to the extent that facility staff are open to allowing them to do so. So, a second governance lesson is that QAPCs, as an “invited” as opposed to “demanded” space – where community members are offered the opportunity to participate in arenas defined by public officials – structurally limits their ability to fulfill a substantive accountability function by defining the terms of their engagement (see Cornwall and Coelho 2007). In most developing countries, “demanded” space is limited, particularly for the poor and marginalized; that is, options to enable citizens to express their preferences and to hold officials to account that are not subject to those officials’ forbearance – such as legislatures, courts, or mandated public hearings – tend to be unavailable or difficult to access.

It is tempting, therefore, to draw a third lesson that the QAPCs proved relatively ineffectual as a governance improvement tool because they lacked any sort of “teeth” to compel accountability. While a strong current in the discourse on accountability focuses on tighter monitoring, stronger penalties and punishments, and public exposure of poor and inefficient practices as remedies to weak performance, there is another narrative. The work on deliberative democracy sees accountability, and the improved performance and exercise of rights that are its aim, as emerging from processes of joint deliberation and
problem-solving rather than confrontational oversight and imposition of sanctions (see Fung and Wright 2003).

From this perspective, the QAPCs appear to hold more promise for governance improvement. In line with Fung (2003, cited in Cornwall and Coelho 2007), QAPCs gave committee members access to information (on community health concerns and needs) and to expertise (through the health professional QAPC members), enabled discussion and deliberation to establish shared positions (on quality and service utilization issues), and contributed to sufficient accountability on the part of the health facilities such that changes were put in place in response to the committees’ actions. The alternate third lesson is that the QAPCs offer an accountability mechanism that enables what Ackerman (2004) calls “co-governance,” which brings non-state actors (in this case community members) into the workings of public sector entities (here, public health facilities) to collectively address performance issues. Over time, learning on both sides, community members and facility staff, improves the quality of governance as well as of services. While such results are difficult to connect to health outcomes, they may nonetheless prove important in the longer term to changing the relationships between service providers and communities in ways that ultimately increase service uptake and behavioral change, while reinforcing incentives for provider responsiveness.

A fourth and final lesson is that health governance enhancement mechanisms operate within health systems and broader governance contexts. The QAPCs’ context was shaped, as noted above, by positive conditions related to the DOH’s pre-existing QA/CQI initiatives, complementary donor-funded support programs, personal commitment on the part of local officials to enable the committees to operate, and the positive incentives stemming from the discretionary decision space decentralization has created. In terms of seeking to identify what works and thinking about transferring success from one setting to another, governance reformers tend to focus on what Joshi and Houtzager (2012) call “accountability widgets,” by which they mean narrowly concentrating on a set of tools and mechanisms while downplaying or ignoring the contextual factors that support the widget and its associated processes, and
that enable it to yield positive accountability results. The QAPC project reinforces the perspective that success with tools and targeted service delivery improvement depends upon incorporating attention to their links to the wider health system and the country’s governance landscape.

References


