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Issue Dedication:
This issue of the JRCD is dedicated to Cheryl Williams who passed away suddenly in 2010. She was in the first semester of her PhD program in Nursing at the University of Saskatchewan at the time of her death. Her co-authored paper in this issue is based on her master's thesis research. Pammla Petrucka was Cheryl's advisor. It was Pammla's wish to publish this peer-reviewed article in honour of Cheryl's work and her family.

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Improving Health Services through Community Participation in Health Governance Structures in Tanzania

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Abstract

Decentralization policy in Tanzania has facilitated the formation of local health governance structures to ensure greater participation of communities in the management of health services. Using different methods, such as a review of existing literature, interviews, and focus group discussions with various stakeholders at the central government level as well as in fourteen councils, this paper analyzes and discusses limitations to the proper functioning of local health governance structures. The study reveals that service boards and facility governing-committees are relevant health governance structures in providing checks for the accountability of health managers and providers, forging linkages between the technical-medical professionals and communities, and also in ensuring communities' participation in improving health service provision. Unfortunately, the performance of these structures is weak in most cases, which ultimately compromises community participation and ownership. Capacity strengthening with the aim of improving the understanding of their roles and functions, enhancing their planning and budgeting skills, and their understanding of hierarchies and division of roles and responsibilities among governance structures, are among the major recommendations from this study.

Keywords: health sector reforms, community participation, health governance structures, service boards, facility-governing committees, health services

1.0 Introduction

Decentralization has been advocated by development agencies as an instrument to ensure broader participation of citizens as well as to improve local governance leading to poverty reduction from the bottom up (Jutting et al., 2005). It has been defined as the transfer of authority and responsibility from the central government to local government, quasi-independent organizations or the private sector (Litvack & Seddon, 1999). Yuliani (2004) summarizes the four main types of decentralization that have been described in the literature: (a)*decentralization by deconcentration*, whereby the agents of central government control are relocated and geographically dispersed; (b) *decentralization by devolution*, which entails the transfer of governance responsibility/decision making powers for specified functions to sub-national levels through publicly or privately owned institutions that are largely outside the direct control of the central government; (c) *decentralization by delegation*,whereby the managerial responsibility for specified functions is transferred to other public organizations outside the normal central government

control (provincial or local government or parastatal agencies); and lastly (d) *privatization,* whereby devolution to private ownership is done[1].

Accordingly, the decentralization of health systems has also been a popular topic for many years although there has been little consensus on how to define and analyze decentralization. In a widely disseminated World Health Organization (WHO) publication, decentralization has been defined by Mills et al. (1990) based on the four-fold typology defined above: (a) *deconcentration,*in which authority and responsibility is shifted to regions or district offices of the Ministry of Health; (b) *devolution*, which shifts authority and responsibility to other structures of government such as states or municipalities; (c) *delegation*, which creates semi-autonomous agencies to carry out functions which were once controlled by the Ministry of Health; and (d) *privatization,* which shifts responsibility and control to private owners.

Within the Tanzanian context, decentralization is the transfer of responsibility from the central to the local government. The decentralization policy based on the principle of devolution (D-by-D), was initiated in 1996 after being endorsed by the government in the policy paper on Local Government Reform (United Republic of Tanzania [URT], 1998). The reforms laid out a policy of devolution of functional responsibilities versus the earlier deconcentration approach to governance, which had continued to persist despite the reintroduction of elected local governments.

One pillar of the D-by-D process in Tanzania is the service function that involves a decentralization of public services, such as health and education, to bring service management and hence the provision of services closer to the end user, and to increase the quality and quantity of these services. The principle of subsidiarity involves a decentralization of public service provision linked to devolution of political powers to lower levels as far as possible and feasible. This principle is to let local councils have discretionary powers when it comes to planning, budgeting, administration and organization of services (URT, 1998).

Through the D-by-D process, several institutions that are considered to be important for the improvement of access to health care and quality of service delivery have been created at local government and community levels. A major objective of these governance structures is to ensure a greater participation of communities in planning and budgeting processes, as well as in the implementation of programs to improve access to quality health services, and to monitor service provision at the local level. The structures include the Council Health Services Boards (CHSBs) and Health Facility Governing Committees (HFGCs), both established since the mid-1990s (in this paper these are referred to as boards and facility-governing committees, respectively). In line with this, a cost sharing policy as well as community based health financing mechanisms known as Community Health Funds (CHFs), have been introduced as a means to involve communities in the financing of mobilizing resources for financing health services. The funds generated through cost sharing (i.e., clients pay user fees) are managed by the facility-governing committees with the aim to improve service provision, while the funds generated by the CHFs (with the matching grant from the Ministry of Health and Social Welfare) are managed by

[1]Privatization has become prominent in recent times although some scholars argue that this is not a form of decentralization

both facility-governing committees and the boards, with the same objective of improving service delivery.

Governance (how political, economic and administrative authority is exercised within the health system), is an important dimension of the planning, organization, and performance of health systems (Alliance for Health Policy and Systems and WHO, 2008). Yet, only limited knowledge and understanding is available to inform policy and practice on effectiveness of the governance processes following the health sector reforms in the wider decentralization context. Past studies have focused on specific health interventions or services, with little work on the effectiveness of different regulatory, incentive, oversight, participation or decision making options for wider health systems.

Therefore, this paper assesses community participation in steering health services through established health governance structures (boards and facility-governing committees) and the implications on health services delivery. The major hypothesis is that functioning decentralized health governance structures result in broadened community participation in decision making processes, which in turn brings about improved delivery of services by considering communities' needs and expectations. Essential elements leading to the proper functioning of these governance structures include:

- their understanding of the rationale behind devolution/health sector reform processes and their roles and functions;
- appreciation, recognition, and support of their roles for broadening community participation in health-related decision making processes; and
- social processes, such as interpersonal relationships among the members of various boards and facility-governing committees and with the authorities below and above them.

The interplay among these factors determines the level of the functionality/performance of these governance structures and ultimately the health care outcomes.

2.0 The Theoretical Framework

Decentralization that involves a variety of mechanisms to transfer fiscal, administrative, ownership and/or political authority for health service delivery from the Ministry of Health to alternate institutions, has been promoted as a key means of improving health sector performance (World Bank, 1993). The benefits of such policies have been indicated to include:

- improved "allocative" efficiency by allowing the mix of services and expenditures to be shaped by local needs and user preferences;
- improved technical efficiency through greater resource consciousness at the local level;
- improved quality of services, transparency, accountability, and legitimacy owing to users' oversight and participation in decision making; and
- greater equity through the distribution of resources towards traditionally marginal regions and groups.

In Tanzania, decentralization and promotion of participation of local structures in the management of health services is supported through devolution. One of the objectives is the devolution of responsibilities for service provision from the central level to councils, and to communities in line with the government policy of D-by-D. This devolution is aimed at improving *quality of health services, transparency, accountability, and legitimacy by broadening participation of health services users in decision making.*

Lewis (2006) provides a range of meanings given to the terms "governance" and "accountability" within and beyond the health sector. Firstly, “governance” can refer to the traditions and institutions by which authority is exercised. It encompasses capacities to formulate sound policies, generate intelligence, manage resources, exert influence through enforcing regulations, provide services efficiently, and ensure accountability. Included are the processes that allow citizens to select and hold accountable, monitor and replace government. Secondly, “accountability” is seen as a component of governance that refers to the responsibility and ability of one group to explain their actions to another (Hyder et al., 2007). The WHO (2000) used the concept of “stewardship” to capture these functions, although it has consequently been suggested that “governance” is a more comprehensive, widely recognized, and thus preferable term (Siddiqi et al., 2006). As a result, following this conceptualization, boards and facility-governing committees are seen as governance structures in the sense that they can exercise authority in managing health-related resources through planning and budgeting processes and enforce regulations necessary for the efficient provision of quality services. They can also ensure accountability by allowing citizens participation in decision making about their health and hold health managers and providers accountable.

This paper applies these definitions of "governance and accountability" to analyze the capacity of the two health governance structures (boards and facility-governing committees) with regard to enhancing participation of communities in decision making about their health. It also examines the capacity of these governance structures in exercising authority in managing health resources through planning and budgeting processes, and with regard to promoting accountability in delivery of quality health services. Indicators proposed by Ramiro et al. (2001) to assess community participation have been used for the interpretation and discussion of the findings. They measure community participation with the following indicators: democratic selection of community representatives/members, high involvement of community members in health decision making, full attendance of representatives/members in board/committee meetings, and regular community consultations and information dissemination activities.

3.0 Methods

In this study, a two-pronged approach was used. Firstly, it involved an in-depth review of existing literature on the acts and guidelines for establishing the boards and facility-governing committees, published government reports on health sector reforms, as well as minutes of various meetings conducted by the boards, and facility-governing committees. Secondly, qualitative interviews and focus group discussions with stakeholders at council and community levels were conducted. At the council level, interviews were held with board members and Council Health

Management Teams (CHMTs)[2], which are groups of professionals in charge of the design and implementation of the Comprehensive Council Health Plans (CCHPs). At the community level, interviews were held mainly with facility-governing committee members and councilors.

The study covered 14 councils (out of 133) in Mainland Tanzania. The councils were selected based on a multiple set of criteria to ensure that boards and facility-governing committees at different phases of implementation of the health sector reform program were included. In addition, the selection of councils ensured that eight health zones in the country were covered. Good performing as well as relatively poor performing councils, with respect to the Community Health Fund (CHF)[3], were included and differentiations between rural and urban councils were taken into account (see Table 1).[4] In each council, the district hospital, one health centre, and one dispensary were sampled. Thus, a total of eight hospitals were covered (six councils did not have a district hospital and they were served by district designated hospitals, which are faith based hospitals partnering with the government in provision of health services). Hence, a total of 14 health centers and 14 dispensaries were sampled.

4.0 Results

4.1 Community Participation in Decentralized Health Governance Structures

This subsection provides some evidence on community participation by using indicators proposed by Ramiro et al. (2001).These indicators include: how the selection process and tenure of the board and facility-governing committee members have enhanced community participation, the attendance of members in meetings, regular community consultations and information dissemination, and the representation of community views in higher organs such as the full council.

The guidelines and legal instruments establishing the boards and facility-governing committees stipulate the procedure and process to be followed in selecting the members, the composition of and the tenure of the boards and facility-governing committees, as well as the qualification of the members (URT, 2001a). Recruitment of members is supposed to be competitive. In all the 14 sampled councils, the board members acknowledged that they were informed of the vacant positions through public announcement, the most notable being newspapers and council notice boards (from the district level to the village level). Despite this impressive process of advertising the vacancies, several irregularities were reported in the recruitment

[2]A CHMT is headed by the District Medical Officer or, in the case of urban councils by the Municipal Medical Officer of Health,who is adviser to the District Executive Director/Municipal Director on health matters. Other staff on the core team include: Health Officer (responsible for preventive services,)Nursing Officer, Laboratory Technician, Pharmacist or Pharmaceutical Assistant, Dental Officer and Health Secretary. There could be other co-opted members and this vary by council (URT, 2007).

[3]Performance of CHF was measured in terms of enrollment into the scheme. Good performing councils had more than 10% of the households in the district enrolled into the scheme, while the poor performing ones had less than a 10% enrollment.

[4]Sampling by zones was not meant for comparison purposes, but to get views from respondents from all eight health zones in the country.

process. These included the selection of board members using discretionary powers of the District Medical Officers (DMOs) in rural councils and the Municipal Medical Officer of Health (MMOH) in urban councils. In some few cases (3 out of 14), the board members only submitted their application letters and were later notified of their selection without being interviewed. The following quote drives the point home:

> We were anxious to join the board, unfortunately the process was delayed for one year….finally our names were announced and we were called for inauguration of the board….none of us was interviewed nor expected to be called after a long silence. It appears that there was sloppiness on the part of the authority and something might have happened that they had to establish the board on ad hoc arrangements (board member, Ulanga District).

Table 1.*The Sampled Councils*

Council	**Region**	**Performance CHF**	**Phase in Health Sector Reforms**	**Zone**
1. Ilala MC	Dar es Salaam	No CHF	I	Eastern
2. Kinondoni MC	Dar es Salaam	No CHF	I	Eastern
3. Temeke MC	Dar es Salaam	No CHF	I	Eastern
4. Hai DC	Kilimanjaro	High performing	I	Northern
5. Ulanga DC	Morogoro	Low performing	I	Eastern
6. Lindi TC	Lindi	Low performing	I	Southern
7. Hanang DC	Manyara	High performing	I	Central
8. Rombo DC	Kilimanjaro	High performing	II	Northern
9. Igunga DC	Tabora	High performing	II	Western
10. Sengerema DC	Mwanza	Low performing	II	Lake
11. Songea MC	Ruvuma	High performing	II	Southern Highlands
12. Kyela DC	Mbeya	Low performing	II	Southern Highlands
13. Mbinga DC	Ruvuma	Low performing	III	Southern Highlands
14. Liwale DC	Lindi	Low performing	III	Southern

Note: DC=District Council; MC=Municipal Council; TC=Town Council; Municipal and Town Councils are urban councils, District Councils are rural councils.

Further, in some councils (5 out of 14), especially those in the first and second phase of implementation of health sector reforms, it was found that the replacement of the board after the expiry of the tenure had not been done in a timely manner, which has led to a stalling of board activities until a new board was put in place. In some cases (3 out of 14) this took six months to one year. This is attributed to the fact that the recruitment process for the replacement of the board members starts right after the expiry of the tenure of the incumbent board. Some boards (5 out of 14) had fewer members than what the guidelines stipulate; some members had died and others relocated to other areas without being replaced. This is particularly the case with community representative members. They are selected from the community and are not council employees at any level. Without a community representative on the board, the essence of community participation is impaired. This was noted in both rural and urban councils alike:

> In our District, the first board worked from 2002 to 2005 (four years tenure as stipulated in the guidelines), but the successor board was inaugurated in December 2007. Since its inception, the board had only met once(board member, Hai District).

In the majority of cases (11 out of 1414), the board relies on the DMO, who is the secretary, for the decision to convene meetings. This is in contrast with the regulation, which states clearly that the chairperson, who is to be a community representative, is responsible for convening scheduled as well as special or extraordinary meetings of the board. The common practice is that the board waits for the DMO to call for the meeting. The same is also experienced at the facility level, where the medical officer in-charge is also considered responsible for convening meetings contrary to the guidelines. This is one of the reasons for the limited number of meetings as well as for the inactivity and limited understanding of the roles and responsibilities by some board and facility-governing committee members. Respondents noted the following:

> Our board has met only once since its inception. The council board is unknown to most of the hospital employees (although it is supposed to also monitor delivery of the services at the hospital) because there was no formal introduction given after inauguration(member, Ulanga District).

> ….we wait for the District Medical Officer to call us. If he doesn't call us we cannot convene!(board member, Sengerema District).

The selection of the members for the primary health facility-governing committees was noted to be more transparent compared to the boards. In most of the cases (23 out of 28), these members were selected through village general meetings after the submission of their application.

By constitution, the board is supposed to have four representatives from the community. However, community representation may not be ensured, because only those who can read, write, and have the ability to follow up on council matters, would send their application. It is possible that certain location or group of people may not be represented. This was found to be the situation in two urban councils whereby at least two of the three members representing communities were found to be from the same ward, while other wards had no representatives. In most of the boards and facility-governing committees, the gender balance of the members was

met, and members from the private-for-profit and private not-for-profit sectors were represented.

4.2 Relevance and Legitimacy of Community Governance Structures

Table 2 below shows the functions of the boards and facility-governing committees as per the legal instrument. The boards and facility-governing committees seem to be aware of some of their responsibilities, although in many cases they have not executed their roles fully because of various reasons presented below. In reviewing the boards' and facility-governing committees' functioning and relevance, the study revealed that in all 14 councils, there are critical issues affecting the performance of these institutions. As a result, while the boards and facility-governing committees have been considered useful in eight out of 14 councils, and hence are important institutions, their relevance has been questioned in other councils where these bodies are not functioning properly. The major reason leading to questions about their relevance is their limited educational capacity to deliver on responsibilities formally placed upon them through the guidelines. Other factors are managerial and/or operational. They include limited incentives to participate effectively at the community level in particular, limited financial means to carry out executive functions apart from meetings, the lack of annual action plans, as well asthe lack of platforms for meetings and for sharing experiences. A high discretion of DMOs, which leads to limited decision making power of these entities, is another impediment. Capacity challenges are also attributable to the uncompetitive selection process being practiced in some areas, as discussed above. The following are voices from the respondents:

> Health board members are unable to comprehend the health planning, budgeting, and delivery systems. The major reason is their education level, which is too low for the job. Being able to read and digest the information presented in the Comprehensive Council Health Plans is not a simple task; the task needs a person with at least tertiary education to work effectively(board member, Liwale District).

> We have no powers to spend anything without prior agreement by the Municipal Medical Officer…..it is regrettable that we have to send our intentions to purchase by writing a "dokezo"(a note) and wait up to one month, even more……this is unnecessary bureaucracy that impairs timely delivery of health service(board member, Ulanga District).

> We are excluded from handling of money possibly because we are less "educated" on financial matters….the technical people normally assume that we are mere informers(board member, Sengerema District).

One area in which the boards and facility-governing committees have not been successful, is the mobilization of financial resources for improving health care delivery, with the exception of few urban councils. None of the sampled health boards have been able to raise funds for their facilities. However, facility-governing committees in three sampled urban health facilities have been able to raise cash for supporting health delivery. Other facility-governing committees (especially the ones in rural areas) have mostly mobilized labor for construction and rehabilitation of the facilities. Furthermore, sensitization of communities to contribute to the CHF was

found to be weak across councils. This poor performance in mobilizing resources has been attributed to three main reasons:

- The low capacity of some members to mobilize funds:

  In many cases, and in particular in the rural areas, the capacity of the facility-governing committees to mobilize funds is impeded by their powerlessness (as discussed below), lack of support by the district authorities, inadequate training and sensitization on resource mobilization, and a low education level.[5] In some districts there were obvious sources of funds, but the facility committee members could not tap them, i.e., charging a certain amount of funds from each bag of crop sold through the primary cooperative societies.[6]What is imperative from the findings is that being a committee or board member does not automatically translate into capabilities to mobilize funds. Skills on resource mobilization have to be imparted in line with forging linkages with tax authorities and other funding sources, including the private sector.
- Notwithstanding the low capacity of members to mobilize funds, resource mobilization is seen as rather an individual issue, not a board issue; that is, for the boards and facility-governing committees that have been able to mobilize any resource (labor and financial),this was facilitated by certain influential individuals with particular capacity and comparative advantage.[7]In rural councils the most members can usually do is to mobilize labor for construction and rehabilitation activities at the facility.
- Low awareness on the legitimacy endowed on these organs as far as mobilization of the resources is concerned.

Rural-urban disparities on capacity to deliver were observed. Councils in Dar es Salaam municipalities do not seem to suffer from the same capacity problem as councils in rural areas, in part due to the fact that members in boards in Dar es Salaam municipalities seem to command a higher level of understanding of the issues. This could be attributed to the fact that these organs in Dar es Salaam have had an opportunity to attract members who are relatively more educated. But a fundamental problem that cuts across all councils, is inadequate training provided to the board and committee members after selection. This is a major reason for incomplete understanding among members of their responsibilities in many of the rural and urban councils alike. It also limits the understanding of the nature of relationship they ought to forge with other structures at council level.

Sensitization of communities to contribute to the CHF is one of the core mandates of boards and facility-governing committees. The extent to which boards and facility-governing committees are involved in promoting CHF membership and sensitizing communities varies across councils but is generally limited. While funding constraints are clearly a limitation to conducting sensitization campaigns, it also does not appear that boards and facility-governing committees adequately

[5]The requirement for the education background for the board members is a 'Form IV' education, while it is Standard VII or knowing how to read and write Kiswahili for the HFGC

[6]This example was mentioned in three districts with cash crops but it has to be taken with caution since the boards and facility-governing committees are not eligible for collecting taxes.

[7]Comparative advantage could be in terms of having done similar activities before, knowing potential contributors to charity issues, having own company which supports charity work etc.

understand and appreciate the usefulness of the CHF especially in terms of potential source of funding for the improvement of healthcare delivery.

Table 2.*Functions of the Boards and Facility-Governing Committees*

The Council Health Services Boards
According to the 2001 guidelines for establishment of Council Health Service Boards (CHSB), the CHSB shall ensure delivery of appropriate and affordable health care services and mobilize and allocate resources using criteria that ensure equity, cost-effectiveness and efficiency. Further, the CHSB shall submit health plans and CCHP budget to the council for approval, analyze and approve CHMT progress reports, support CHMT in managing and administering health resources, promote community involvement through sensitization for own health care initiatives, promote sustainable health infrastructure and reliable logistics and supply system, and liaise with other health facility committees and partners with similar interest in health provision. CHSB is supposed to meet quarterly.
Hospital Governing Committees
The Hospital Governing Committee (HGC) is responsible for receiving, discussing and approving annual hospital plans and progress reports and, monitor and follow up the availability of funds from different sources, including those from cost-sharing. The Committee also ensures that the hospital health services meet the required standards and satisfy the needs of the target population, and liaise with other health committees, partners in health provision and promotion, and ensure regular feedback to the community on health development and hospital matters relevant to the respective community. Governing Committees are charged to raise, supervise, monitor and control hospital resources and to administer and monitor the discipline of hospital personnel and their adherence to ethical codes of conduct. HGC is supposed to meet quarterly.
Health Centre and Dispensary Governing Committees
These committees are responsible for receiving, discussing and approving plans, budget and progress reports at their levels and ensure that the health services meet the required standards and satisfy the needs of the target population, identify and solicit financial resources for running the facilities and liaising with the CHSB and other committees and partners in health provision and promotion. These committees are also charged with the responsibility of promoting health infrastructure, supplies and logistic system, advice the council on human resources development in terms of recruitment, training, deployment and motivation, and to facilitate the management teams in planning and managing community based health initiatives within its catchment area in the context of the Ward Development Plans. Both HCGC and DGC are supposed to meet quarterly.

Source: URT (2001a)

None of the analyzed boards and facility-governing committees have played a meaningful role in setting criteria for exempting the poorest members of the community (from contributing to CHF and/or paying for health services). All interviewed respondents reiterated what is stipulated in the CHF Act. The CHF Act stipulates thatpowers to exempt community members from paying CHF is vested in the hands of Ward Health Committees and Village Councils (URT, 2001b). Thus,

these organs are not directly involved in determining the criteria for exemption of vulnerable groups, which means there is a conflict of interest between the boards and the facility-governing committees and the other health governance structure (see the power relations section below). Respondents echoed unanimously that,since facility-governing committees are charged with the responsibility of ensuring adequate and equitable provision of health services, it is therefore imperative for them to participate in setting criteria for exemption; this is particularly the case for the primary health care facilities.

4.3 Mapping the Power Relation

The assessment of power relations within the councils with regard to how boards and their facility-governing committees interact with other council structures, shows that there are critical issues that require attention. The guidelines for the CHSB and HFGC fall short of explaining the specific roles and competencies of the various bodies in the councils in order to contribute to the achievement of the goal of improving health care services. Different bodies that ought to interact include the Regional Health Management Teams (RHMTs), Council Health Management Teams (CHMTs), structures of other sectors (in particular education), water and sanitation, ward and village health committees, and political organs in particular councilors through full council meetings.[8] For example, the HFGC and CHSB do not have a built-in mechanism for collaboration. As such, the concerns of common interest are not synchronized and solved together, which is quite problematic for the yearly defined Comprehensive Council Health Plans (CCHPs). Sharing of experience and taping of synergies and capabilities are not facilitated. Even well-functioning boards, such as those in the Dar es Salaam region, have not been able to contribute to building the capacities of their respective facility-governing committees. These bodies tend to work in parallel with each other with very little or no learning from each other, even though they are supposed to be working for the same cause.

Although the line of authority between the board and the Social Services Committee (one of the standing committees at he council level) is clear, in the majority of the cases the Social Services Committees do not really demand the results from the boards, or even care to see whether the boards have annual plans of action and meet as scheduled. This lack of monitoring gives the DMO a leeway on whether to present issues discussed in the board to the Social Services Committee or not. Further, the structural link between the Ward Health Committees and the facility-governing committees is weak since it is unidirectional, meaning that the Ward and Village Health Committees are represented in the HFGCs, but not vice versa.

Some DMOs do not see the need of the boards. DMOs and CHMTs are mostly accountable to the local government authorities represented by the District Executive Directors (DEDs)/Municipal Directors. Thus, some DMOs are questioning the relevance of oversight bodies such as the CHSB, in considering the weaknesses they harbor. The major weakness emanates from the fact that a “non-technical body”, which is the CHSB, is made to oversee and approve the activities of a “technical body”, the CHMT.

[8] At the local council level, the representatives make decisions through the Full Council which is the highest legal organ for making decisions that are to be implemented by the bureaucrats. The Full Council meets at least every quarter of the year. The Full Council is supported by a number of Council committees which membership is from the list of Councilors (REPOA, 2008).

4.4 Improvement of Health Services Provision

Despite the discussed limitations, some achievements have been recorded by the boards and facility-governing committees. These organs have made progress, in particular on reprimanding irresponsible health workers; following up on issues with staff recruitment, medicine stock outs, mismanagement of patients, rehabilitation and construction, etc. Table 3 below provides a selection of achievements (with the name of the board and facility-governing committee in parenthesis).

Table 3.*Achievements of the Health Boards and Facility-Governing Committees*

- Lobbied for an increase in equipment and human resources, which has resulted in a reduced waiting time at the facility (Igunga District Council (DC) CHSB, Buyuni Health Centre(HC) in Ilala Municipal Council (MC), Magomeni HC in Kinondoni MC).
- Solved immediate problems related to the mismanagement of patients at the health facilities (Mwananyamala Hospital in Kinondoni MC).
- Mobilized labor for construction and rehabilitation of health facilities (this was evident in almost all rural FGCs).
- Facilitated fund raising for procuring equipment and improving infrastructure at the health facilities (MjiMwema dispensary in Temeke MC, Tandale dispensary in Kinondoni MC, Hai District Hospital in Hai DC, Kyela District Hospital in Kyela DC).
- Facilitated the reinstatement of health services after the closure of the facility by the Council authority due to floods (Kigamboni Health Centre in Temeke MC).
- Reinforced the implementation of the exemption policy by making sure that pregnant women and children under five are exempted (almost all FGCs rural and urban alike).
- Sustained community sensitization and mobilization for the CHF contribution (Liwumbu dispensary in SongeaMC).
- Limited community/patient complaints by forging a strong link between the community and authorities (Tandale Dispensary in Kinondoni MC, Kyela Hospital in Kyela DC, Ipinda Health Centre in Kyela DC).
- Boosted morale and enhanced workers responsiveness to the community and the public at large (Igunga District Hospital in Igunga DC, Mwananyamala Hospital in Kinondoni MC, Kigamboni Health Centre in Temeke MC, Kirokomu dispensary in Rombo DC, Songea CHSB in Songea MC).
- Supervised the collection of out-of-pocket payments at the facility level (Mwananyamala Hospital in Kinondoni MC, Magomeni Health Centre in Kinondoni MC)
- Supervised construction and rehabilitation activities at the facilities (all CHSB and FGCs, rural and urban alike).

5.0 Discussion

The boards and facility-governing committees are important health governance structures for three main reasons. Firstly, they can provide checks for the accountability of Council Health Management Teams as well as Facility Management Teams. Secondly, they are useful in forging linkages between the technical teams and communities, and also in ensuring that the communities' views are represented. Thirdly, they are crucial in sensitizing and mobilizing communities to participate in financing and improving the delivery of health services. Unfortunately, they are weak in most areas, which compromises their contributions for improving health care services. The capacity of these health governance structures to deliver on their roles and responsibilities is impeded by various challenges pertaining to the recruitment process and their technical knowledge on critical issues in planning and budgeting and service delivery process. Other impediments include power relations within the council and the far reaching health system related challenges.

Assessment based on the indicators of community participation as defined by Ramiro et al. (2001), showed weaknesses in various aspects: especially in the recruiting process, the attendance of members in meetings, regular community consultations and information dissemination (horizontal accountability), and the representation of community views in higher organs such as the full council (vertical accountability). There was negligence in selecting board members, including the discretion on who should be a member of these structures, and in selecting members in ad hoc manner. In some areas, community representation was not ensured. At least two of the three members representing communities were found to be from the same ward, whereas other wards were not represented. This means that the selection process lacked democratic accountability. As Ramiro et al. (2001) noted, a lack of democratic accountability is problematic for community participation, because it can lead to paternalism and political patronage.

Since there was no higher organ that demanded for the deliberations of the board meetings, the vertical accountability was often left at the DMOs' discretion. Vertical accountability of the boards depends on the DMO, since he/she attends the full council meetings as the secretary of the board. This means that the level of understanding of the DMOs and their willingness to provide leadership and collaboration in working with the boards, are critical determinants of how effective the boards can be. Thus, DMOs and in-charge of health facilities, i.e., the health system managers are seen as pillars in making the boards and facility-governing committees do their job. In councils where the DMO is not cooperative, these organs cannot perform as expected.

As noted above, the selection of the members for the primary health facility governing committees was noted to be more transparent, when compared to that of the CHSB members. In most of the cases, these members were selected through general meetings of the village, after the submission of their application. In other studies, the HFGCs have been noted to be more representative of communities and to also function better, compared to the CHSB (URT, 2007).This is partly because of their responsiveness to the localized problems at that level, as well as their closer involvement with the community, but also because the members are socially controlled by community norms and ties. Given a clear mandate, these committees can also link easily with other structures at that level (Village and

Ward Health Committees) to solve health related problems in the community (horizontal accountability).

A study by Massoi and Norman (2009) argues for the need to institute community involvement in the planning process as this would lead to an increased ownership of processes, accountability, sustainability, effectiveness and efficiency of the development process. However, the findings from this study show that this will not happen automatically unless the community members are capacitated to comprehend issues pertaining to planning and budgeting process the findings which are also supported by Hashagen (2002). Capacity challenges, which are partly attributable to the uncompetitive selection process that is being practiced in some areas and a low level of education achievement in rural areas, were major impediments for effective participation. Thus, although the promotion of good governance sees community participation as a key component within the decentralization policy frameworks (Blas, 2004; Baez & Barron, 2006), strengthening the capacities of the boards and facility-governing committees to understand planning and financial matters and to make decisions outside the control of health professionals and local government authorities, is imperative.

The ability of boards and facility-governing committees to deliver on their roles and responsibilities was also affected by the prevalent health system issues, which these governance structures have no immediate control over and do not have a solution for. These issues include medicine stock-outs, inadequate human resources for health, overcrowded health facilities, poor communication infrastructure (bad road network), lack of transportation for patients, cumbersome bureaucracy of the government system, etc. (Mamdani & Bangser, 2004; URT, 2008). Although improvements have been reported in various studies conducted in Tanzania (Masanja et al., 2008; URT, 2011), these systemic factors still hamper the boards' and facility-governing committees' performance.

A clear division of roles and responsibilities and their respect, both within the boards and facility-governing committees, as well as between them and the other local governance structures, is imperative in allowing the boards and facility-governing committees to fulfill their mandate. Douglas (1986) insists that formal and informal institutions are formed by the actions of various actors. Thus, although individuals think differently, these thoughts are squeezed into a common shape. In any governance system there should be patterns of answerability and sanctions in terms of which actors are in a position to demand information and impose sanctions, and which actors are charged with supplying information and are subject to sanctions (power relations) (Brinkerhoff, 2004). Although power relations are clearly stipulated in papers, disparities between the sanctions that exist 'on paper' and capacity to enforce them pose serious accountability problems. The governance structures seem powerless in most cases and the discretion of the DMOs is very high. The DMOs can supply information when he/she wants and pass it to the organs that he/she chooses.

A study by Massoi and Norman (2009) shows minimal and ineffective contribution bythe D-by-D in the planning process at the grassroots level. This failure is attributed to the inability of the council to involve the community in the planning process, which would include their respective priorities, notwithstanding the fact that citizen participation in community governance structures and organizations (e.g., village and ward leadership, council meetings, school and water committees) appears to have increased between 2003-2006 (Tidemand & Msami, 2010). Thus, even if

community participation is promoted under the D-by-D, if DMOs are not responsive to community issues, the envisioned advantage of community involvement in making decisions about their own health will not be realized.

As Ramiro et al. (2001) noted in their study, there is a general perception of community and board members that health is primarily a medical matter. In this study, this perception was present among DMOs and the health facility in-charges, who questioned the legitimacy of common men/individuals with a low educational level to control medical professionals. Mubyazi and Hutton (2012) also noted that in most of the health projects/programs, professionals dominate the decision making processes by downgrading the non-professionals or non-technical people's knowledge and skills. Thus, community representatives in the HFGC and CHSBare often excluded from partnership models/cooperation. Thus, interactive working, which entails providing support for the community to have equivalent access to information, expertise, and training is lacking (Hashagen, 2002). This paper argues that all partners need to develop an understanding of each other, and all need to develop knowledge and skills needed to manage health systems. There should be an investment in supporting communities to gain access to the information and knowledge, and to help develop the skills they themselves identify as needed for effective engagement in health governance structures.

6.0 Conclusions and Recommendations

The boards and facility-governing committees are seen as important governance structures necessary for checking the accountability of management teams (Council Health Management Teams and Facility Management Teams). Further, these structures are important in forging the linkage between the technical teams and communities and also in representing communities' views. They are also important in sensitizing and mobilizing communities to partake in improving delivery of health services. However, as Mubyazi and Hutton (2012) noted, it is important to identify and counteract the forces working against community participation in governance structures, which may include analysis of the extent to which bureaucratic, systemic, and social-cultural legal factors have promoted or inhibited the achievement of involvement of community members in making decision about their own development.

In this paper, several sociopolitical and systemic weaknesses which impede the performance of the health governance structures and which need immediate attention were noted. It is therefore imperative that measures are taken to improve the functioning of the CHSBs and HFGCs through empowering them to deliver on their roles and responsibilities. This would entail a commitment to work in the following areas:

- Ensure that the community representatives in the boards and facility-governing committees receive strong recognition and support from the communities. This can only be achieved by a transparent and well managed selection process as well as by raising the profile of these organs by advocating for their importance as a vehicle for community participation in making decisions for their own health matters.
- Ensure the board and facility-governing committee members receive capacity strengthening with tailored modules on their roles and functions, leadership, management and governance, and planning and budgeting and clarity regarding the competencies of the different structures.

- Strengthen the efficiency and accountability of community representatives by creating annual plans and by regularly sharing information ontheir progress with the communities.
- The boards and facility-governing committees should become a channel of information to the community about people's rights and obligations within the health sector reform. Thus, they could contribute to changing the attitude of the health professionals, helping them consider the users of health services as their clients and actors in the struggle to improve the community health status.
- The necessity of maintaining special governing committees for each health facility has to be reassessed, knowing that at the village and ward level committees are already in place, are functioning and are linked to the local government authority.
- A budget line should be institutionalized for undertaking capacity building activities and for facilitating meetings and activities of the CHSB and HFGCs.

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