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**PAPER ON:  
Lay Participation, People Policing Money to Improve Health  
Outcomes in Rural Tanzania: Another Institutional Fix?**

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### **Abstract**

**Background:** The past twenty years have seen remarkable shifts in thinking about health governance. Increasingly, community-based financial accountability mechanisms such as Health Governance Committees, Public Report Cards (PRCs), Citizen Score Card (CSCs), Patient Rights Charters, and Public Expenditure Tracking Systems (PETs) are emphasized as alternative to the defunct arm's length financial control mechanisms. It is argued that community actors, especially citizens, organized citizen groups, and elected representatives at grassroots' level enjoy the use of collective action, power, and voice as best tools for holding providers and health bureaucrats accountable for spending and financial decisions in order to improve health outcomes. However, little evidence affirms that the lay community actors are capable enough to hold bureaucrats and providers accountable for financial decisions and spending outcomes. This paper examines the capability of community actors to hold health bureaucrats and providers accountable for financial decisions and spending outcomes.

**Methods:** The study was conducted in two rural districts namely Morogoro and Karagwe. It involved detailed interviews with 50 key informants including health technocrats and bureaucrats at district level, elected leaders at village and ward levels, members of facility health governance committees, representatives of selected civil society organization and a structured questionnaire with 100 villagers randomly sampled from households in two villages in the districts. Supplementary data was collected from documentary sources from health facilities, government reports, and previously published research findings.

**Results:** Study findings show that community-based financial accountability mechanisms are not (in practice) as effective as they are theoretically promoted by donors and international community. There are different limitations that make community-based accountability mechanisms of limited usefulness including constraining power tensions and rent seeking behaviour among members who form participatory accountability forums, inadequate skills and limited information access for most of the community actors, cultural virtues that do not support challenging authorities, and little political will and support from both the central and local government.

**Conclusion:** Community based financial accountability mechanisms and initiatives serve an important role of empowering community actors to participate profitably in making financial decisions and priority setting forums. However, these mechanisms have not been able to serve as means for exit, especially facilitating for influence and control of bureaucrats and providers by community actors. In some of the ways, when participatory forums such as Health Facility Governance Committees are encouraged to adopt formal and artificial procedures, they accidentally serve as forums for silencing community actors rather than empowering them.

## **1. INTRODUCTION**

The past two decades have witnessed strong intellectual thrust in health promotion, financing, and governance. One notable form of paradigm shift has been the rise of community-based perspectives competing out traditional "arms' length" (Shore & Wright, 2000, p. 65) perspective on financial accountability. In healthcare, the term *community* has become an "icon" (Bovens, 2005, p. 189) premodifying all the best health promotion initiatives. Researchers use different concepts including: "social accountability monitoring", "community-based monitoring" (Molina, Pacheco, Gasparini, Cruces, & Rius, 2013, p. 5), "community accountability" (Molyneux, Atela, Angwenyi, & Goodman, 2012, p. 542), "Public accountability" and "social accountability" (Bisht & Sharma, 2011, p. 250). All these concepts amplify the resurgence of *community-based accountability* in governing healthcare. They all insist adoption of the "shortest route to accountability" (Lewis & Pettersson, 2009, p. 9) in healthcare where communities; especially citizens, their organized groups, and elected community leaders can directly exercise influence and control on providers and public officials. In addition, the community-based perspectives strongly emphasize that regardless of whether they have formal training and skills related to healthcare, communities and their constituent actors know what is

best for their people and thus they can effectively hold government and providers accountable for decisions, spending, and health outcomes.

Specifically in Tanzania, financing for promoting health care has significantly increased, community-based financial accountability tools have been crafted and supported by both the government and development partners since the early 1990s, but neither accountable management of financial resources nor improved health outcomes may be celebrated (Kanungo, 2005; Strengthening Health Outcomes through Private Sector Project, 2013). Community-based financial accountability mechanisms including Community Health Governance Committees (CHGC) and Village Health Committees (VHCs) have been created throughout the country (Ifakara Health Institute, 2011). Public Expenditure Tracking Surveys (PETS) have been in use since the 1990s, Citizen Report Cards (CRC), and Community Score Cards (CSC) have been in use to monitor flow of funds allocated for healthcare against quality of health services. Policies and laws have been enacted to empower community actors so that they can effectively play their role. Despite well acknowledged international and domestic support, no significant evidence showing that these community-based financial accountability mechanisms effectively promote financial accountability and improving health outcomes. In Tanzania, estimates show that misuse of money allocated for healthcare is still as high as 61 percent in general and 67 percent in rural areas (Strengthening Health Outcomes through Private Sector Project, 2013; United Republic of Tanzania, 2013). Therefore, community-based perspective on health financial governance leaves questions. The most important question that this paper tries to address is whether a community actor, 'a lay participant' is capable of holding officials and providers accountable. To answer this question, the paper focuses on existing actors, mechanisms, and capability of community actors in different aspects including their power, skills, knowledge, and perceived internal and external efficacy.

This paper utilizes findings of a study on rural communities in Karagwe and Morogoro districts, which have limited access to both information and access to services, thus depending on advantage offered by ties, interconnectedness, and regular interactions as both empowering factors and source of information. The definition of accountability is limited to 'public accountability', which relates to social-vertical accountability, accountability to community; especially citizens, their organized groups, and their elected representatives at community level. The paper is divided into five key parts: the current part, which provides the general introduction; the second part provides a conceptual analysis of the key concepts 'lay participation' and accountability in the context of modern healthcare. The third part describes methods used by the study. The fourth part presents and discusses key study findings. The fifth and last part provides a conclusion and highlights the proposed action.

## **2. LITERATURE REVIEW**

Both what is referred to as 'lay participation' and financial accountability are central issues in modern healthcare. The two concepts relate closely since the first is a dominant perspective and the second is a tool for managing healthcare financing efficiently and effectively. In modern healthcare, it is emphasized that having mechanisms to safeguard investment in healthcare is a *life-saving* strategy while allowing communities themselves to police their money is the cheapest and most effective life-saving strategy (Checkland et al.,

2013; Cornwall, Lucas, & Pasteur, 2000). The first stands for financial accountability while the second stands for community-based financial accountability. Therefore, the conceptual interception in healthcare is concerned with why the two are important and why they should be brought together to achieve effective health governance.

### **2.1. Lay Participation: Definition and Necessity**

In the first place, “lay participation” sounds like an abusive phrase, especially, when it is used as a label for community actors who may include educated and knowledgeable individuals or groups. The concept ‘lay participants’ was first used by Freidson (1970) to refer to people who do not have abstract body of knowledge that can be applied in health care field. In the growing literature on health governance, the term “lay” is often used to refer to “people who are neither healthcare professionals, nor healthcare researchers, but may have some specialized knowledge related to health (Entwistle, Renfrew, Yearley, Forrester, & Lamont, 1998, p. 463). In the early 1990s, lay participation was used as a perspective derogating the traditional assumption that only epidemiologists and biomedical experts know what is best for promoting healthcare. The lay participation perspective is based on an implicit assumption that “empowered health promoters are more effective in their roles as educators and advocates “(Booker, Robinson, Kay, Najera, & Stewart, 1997, p. 453). As connected to community-based approaches, in modern health governance lay participation draws much from *Lay Participation in Health Decision Making* by Charles and DeMaio (1993) where its use is not much different from “community participation”, “public participation” (p. 883), which for them excludes traditional health care decision-makers; whether providers, government officials, or managers at the service delivery level. In summary, even a well-educated individual becomes a lay participant if he/she is not equipped with knowledge and skills applied in healthcare decision-making and governance. The major omission in these definitions is absolutely denying that communities may contain people who are well-equipped with knowledge applied in the healthcare profession.

In the growing literature, the biggest question has been why lay participation is important despite limited knowledge and skills needed for making informed healthcare decisions. Charles and DeMaio (1993) summarize three reasons why lay participation has become inevitably crucial in healthcare governance. These reasons are: (a) the lost faith in legitimacy and superiority of professional healthcare knowledge as determinant of best healthcare decisions, (b) redefinition of the appropriate role of local communities in healthcare resources allocation decision-making, and (c) increased desire to make healthcare providers more accountable to the communities that they serve (p. 883). For most health governance scholars, these reasons may be directly attributed to the changing philosophy about who possesses the right to make what healthcare decisions are in whose interest; a more democratic and participatory mode of decision making free from dominance of professionals (Booker et al., 1997; Charles & DeMaio, 1993; Charles, Gafni, & Whelan, 1997; Murthy & Klugman, 2004). In this respect, even with open and obviously known weaknesses of community actors, the only option in health governance is to

empower them so that they can effectively participate and hold decision makers and providers accountable.

## **2.2. Financial Accountability: Traditional Versus Modern Perspective**

The concept accountability has been identified as difficult to define as “electricity” (Royal Commission on Financial Management and Accountability, 1979) most due to its complexity and dynamism that make it “chameleon-like” (Mulgan, 2000, p. 555). It is dynamically defined depending on fields, dimensions, and paradigmatic history. However, based on Royal Commission on Financial Management and Accountability (1979) and Fooks and Maslove (2004), six features may augment existence of accountability in a health system. Regardless of whether it is used in its traditional or modern sense, accountability entails: (a) established [connecting] relationship between decision makers and those affected by such decisions, (b) agreed upon defined responsibility for decisions and actions, (c) readiness of those with authority to delegate or confer authority to others, (d) answerability for decisions made and actions taken, (e) accounting for action must include an element of judging performance, and (f) sanctions for correction if expectations are not met (Fooks & Maslove, 2004, pp. 3-4). The fault with these element remains that they cannot provide clarity of what kind of accountability is in place and accountability for what? Indeed, they may also denote other features such as decentralization, rule of law, and transparency, which may coexist with accountability or exist even without accountability. However, these elements should be considered useful for asserting that a health system adheres to accountability principles.

In its traditional sense, financial accountability differed from what it is used to mean in modern healthcare governance. It was informed by the thinking that governments are created to cater for public good and thus are needed to have in place mechanisms for ensuring equity in spending through creating “arms’ length” (Shore & Wright, 2000, p. 65) institutions for ensuring efficiency and effectiveness in public spending. Financial accountability referred to arms’ length institutions and processes for ensuring that officials tasked with managing public funds act within acceptable standards and they are responsible and answerable for decisions and actions related to allocation, disbursement, and spending of resources for delivering public services (Cooksey & Kikula, 2005; Emanuel & Emanuel, 1996). Examples of traditional mechanisms include compliance with accounting standards, timely annual financial reporting, financial administration rules and procedures, external auditing, and oversight role of independent committees and commissions.

Traditional financial accountability processes and institutions share some common characteristics. They were part of rational government initiatives to safeguard taxpayers’ money. They are implemented using government resources, and their implementation is for the purpose of feeding the government with information on disciplined use of money to achieve delivery of public good (Bisht & Sharma, 2011). In addition, traditional mechanisms are characterized by being coercive; backed up by authority (Shore & Wright, 2000), formal, legal, bureaucratic (Bisht & Sharma, 2011) sanctions, and horizontally enforced. It generally meant enforcing compliance within government institutions with a

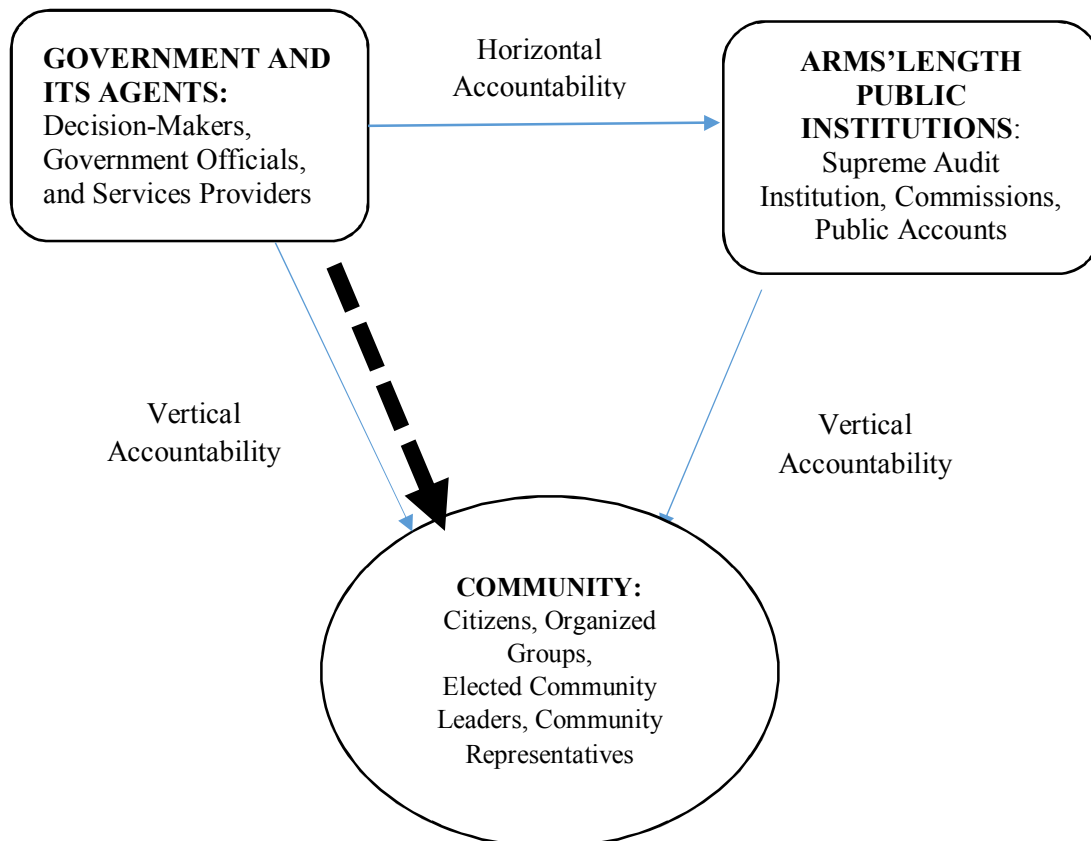
set of known frameworks, which include defined actors and procedures. Therefore, communities do not have direct role in overseeing how money is allocated and used.

In its modern sense, financial accountability has undergone significant modification. Close to “lay participation” (Charles & DeMaio, 1993, p. 881), “lay accountability”, and “lay governance” (Robinson & Ward, 2005, p. 170), it has largely lost its technical focus where it required specialized knowledge and skills related to financial administration. Instead, modern perspectives contend that effective accountability must allow actors including citizens, their organized formal and informal groups and local representatives to use collective power and voices as their best tools for holding officials and providers accountable for decisions, spending, and results (Bisht & Sharma, 2011; Garg & Laskar, 2010). In other words, modern financial accountability undermines the techniques, knowledge, and skills needed for monitoring public finance. They significantly seek to maximize the capability of average citizens to influence decisions and actions related to planning, setting priorities, making decisions, and allocation, and spending of financial resources as a result of collective voices and powers enjoyed by people in their own communities.

### 2.3. Conceptual Framework

To understand modern community-based financial accountability, one needs to understand how the difference between the traditional long route of accountability and the modern-short route to accountability in healthcare governance as shown in figure 1.

Figure 1: Conceptual framework for community-based financial accountability in healthcare.



Source: Based on Review of Literature

In figure 1, the dashed arrow shows the short route of accountability, or community-based accountability, which the modern conception of financial accountability in healthcare relies on. It strongly emphasizes that officials and providers should be directly answerable to communities rather than arms' length institutions or political representatives at central government level (Fooks & Maslove, 2004, p. 6). Preference of the "short route" as used in the literature is justified with the argument that community actors will effectively play financial oversight role since they have advantages such as collective voice, collective power, collective altruism, and the general concern for community health and well-being.

#### **2.4. Empirical Evidence on Community-Based Financial Accountability**

Empirical research on community-based financial accountability generally focus on three main angles: individual accountability mechanisms, community actors and their capability, and the general efficacy of the community-based monitoring financial accountability. Studies in the first category seek to understand strength and limits of accountability tools such as PETS (De Graaf, 2005; Kanungo, 2005) and HFGCs (Ifakara Health Institute, 2011). Knowledge on CSCs and PRCs remains scant, which compels relying on data from institutional reports and conference papers such as World Bank (2007), and Mishael (2011). Also, there is both intensive and extensive knowledge about the impact of NGOs and CSOs on community health governance, of which the most cited include Ebrahim (2003), Doko and Kulkarni (2013), and Pasha (2006). In addition to these studies, empirical and conceptual literature that focus on community-based accountability in general such as Murthy and Klugman (2004), Garg and Laskar (2010), Pollock and Whitelaw (2005), Mansuri and Rao (2004), Mswia et al. (2003), and Molina et al. (2013) have been useful in examining the extent to which both community-based mechanisms and community actors play role in ensuring financial accountability and improving health outcomes.

While the majority of studies on HGCs identify their importance, they also cite atrocities that limit communities' potential role. Ifakara Health Institute (2011) identifies HFGCs as increasing community access to procedures for setting health care financing priorities, ensuring quality of services, and mobilize community members to contribute to CHF. However, due to nepotism, favoritism, and limited capacity of members to represent community interests, HFGCs fail to ensure financial accountability. Related findings are also reported by Khumalo (2006) and Falisse, Meessen, Ndayishimiye, and Bossuyt (2012) whose studies show that health committees allowed citizens to voice their concerns and insure discipline in spending and delivery of services. For Khumalo (2006), having in place traditionally established participatory structures at community level (as for *indunas*<sup>1</sup>

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<sup>1</sup> In South Africa, where the tribal community authority called 'induna' were adapted to new responsibilities related to promoting accountability and general oversight of local healthcare delivery.

in South Africa) widens the potential for functionality of accountability initiatives. It is however reported that even in South Africa, there were limitations including fear of being victimized by health professionals. For example, the study points out that women rejected use of suggestion boxes fearing retribution from nurses.

In studies by Molina et al. (2013), Lewis (2006), and (Deininger & Mpuga, 2005), accountability mechanisms manifested in what Lewis and Pettersson (2009) have called the “short rout” (p. 6) of accountability, especially directly communities using collective voices and action were significantly attributed to successful control of corrupt behavior among public officials and healthcare providers. Molina et al. (2013) stresses that community members have better incentives to monitor resources compared to bureaucrats since they bring together their collective consciousness aimed at controlling corruption and improving their health. However, all these conclusions may be questioned on one on whether all communities and community actors (who may include the corrupt leaders and members) develop artistic and collective interest for realization of common good. In some of the societies including Tanzania, it has been found that those who are expected to represent people’s interests and hold providers accountable for improved health outcomes tend to develop their own interests, which constrain their role in community-based accountability forums. Therefore, one needs to be careful since the common interest attribute attached to communities may not be a permanent feature of all communities.

Against the position that community voices which are not co-opted provide effective means for health governance and ensuring financial accountability, there are scholars who see absolute lay-control of the health governance as a necessary danger to health administration (Ackerman, 2004; Eng & Young, 1992; Robinson & Ward, 2005). Ackerman (2004) examines the dangerous side of strong “social control”(p. 447) and suggests that “social actors”(p. 459) can work right if they are invited to participate in the core activities of the state. In other words, this presents the view that community-based mechanisms should only be used to strengthen the existing traditional arms’ length accountability mechanisms for health financial governance. Related to this position, but more extremely, there are scholars who discredit community actors. Macmillan and Townsend (2006) believe that the so called community-based mechanisms involve institutional manipulation and cooptation of social actors for legitimizing bureaucratic domination. Van Slyke and Roch (2004) characterize community actors with limited capability due to inadequate knowledge and civic competencies, predominant self-interest overriding community interests, and rent seeking behavior among most of the community actors (Van Slyke & Roch, 2004). In addition, some see encouraging community-based accountability as promoting threatening pressures of “lay actors”(Charles & DeMaio, 1993, p. 884) on stable and professionally designed health initiatives. As observed by Charles and DeMaio (1993), one may not hesitate to say that the literature has little than “a more talk on lay participation in health decision-making than has been actual change” (p. 882) in practice.

Indeed, the potential influence of community actors on financial accountability and health outcomes should not be taken for granted. Some authors who focus on such relationships point out that there are complex, dynamic, and varying relationship across communities

(Cooksey & Kikula, 2005; Macha, Mushi, & Borghi, 2011; Mitchell & Shortell, 2000; Mushi, Melyoki, & Sundet, 2005). A mix of individual, social, systemic, and environmental factors may permit community actors to work effectively in one community, while discourage others or all the actors in another community. A list is long, but they include factors such as participant selection criteria and procedures (Fung, 2006), amount and extent of social capital (Bowles & Gintis, 2002), recognition of roles, and level of commitment to community (Booker et al., 1997). The other identified factors include political space and freedom, incentives and institutional arrangement that promote public voice and political dialogue (Grogan & Gusmano, 2007; Sidney Verba, 1995), culture that allows citizens to challenge authority (Grogan & Gusmano, 2007), and information availability (Lieberman, Posner, & Tsai, 2013) for community actors.

Despite setting an angle for our focus, studies on community actors' capability determinants suffer from two main fallacies: they take public voice for granted (Falisse et al., 2012; Goetz & Jenkins, 2002; O'neil, Foresti, & Hudson, 2007); communities as homogeneous (Falisse et al., 2012); and community actors as always harmonious in terms of interests. On the way, they overlook crucial variables such as endowment with knowledge, skills, power, authority, and other potential resources (Grogan & Gusmano, 2007, p. 86). Equally, studies pay a little attention on state-civil society relationship in a given political system (James, 2005, pp. 14-15), power configuration in community (Bisht & Sharma, 2011) and how it effects actors' capability and influence, and compatibility with social and ideological norms (Centre for Health Policy, 2007; Mercer, 2003). In addition, there is also a gap regarding how the design of participatory mechanisms (Arroyo & Sirker, 2005) including membership (Ditzel, Strach, & Pirozek, 2006), recruitment methods, relationship, and formality levels in developing the so called 'collective voice'(O'neil et al., 2007, p. 6). As Ditzel et al. (2006) suggest, health governance problems may be similar, but need to be approached contextually.

Studies generally point as a useful set of explanations and factors worth to consider. However, the general terrains in the growth of literature and research suggest that there is a drive towards developing what may be called a 'universal explanation' that prescribe a pattern of relationship between community-based accountability and financial accountability as well as health outcomes. The biggest mistake is that, the literature is largely influenced by publications and research that is insensitive of context. Precisely, the debate on the impact of community-based financial accountability has a relatively shaky empirical grounds. More attention should be paid on actors' capability and the mechanisms in place (design and configuration).

### **3. METHODS**

Ontologically, measuring accountability sounds relatively subjective. One may not quantify it, but may we can examine the "capability" of community actors to hold officials and providers accountable in the framework offered by existing accountability mechanisms. Thus, the study was more interprets using proportional statistics to assess how capability related characteristics are distributed in a small sample of the average citizens (users) as part of the community actors' population. A community was considered to be a

geographically located group of interacting *actors* (individuals, groups, collectivities) held together by need, norms, values, relationship and social glues, which are shared through regular communication and interaction. The actors that the study focused on were; average citizens, voluntarily organized groups of citizens, and leaders of the people at community level, and representatives in community-based accountability forums. Given the administrative structure of Tanzania and the nature of the study, a maximum point to locate a community was a village level where autonomous grassroots' decisions are made.

The study targeted rural communities as a way of getting preliminary data for a PhD project on *Community-Based Financial Accountability in Rural Healthcare* in May 2014. Morogoro and Karagwe. The two districts reflected typical environments of rural communities in Tanzania, but in different administrative contexts. Karagwe district provided context for remote rural communities which have difficulty of access to both information and health services while Morogoro presented rural communities with relatively improved access to information, but still lack improved health services. The study involved interviews with 50 purposely selected stakeholders including community leaders, members of VHCs, HFGCs, in charges of health facilities, and representatives of organized citizen groups and a structures questionnaire on 100 respondents including 50 from each of the two districts. Two villages with health facilities were randomly selected from each district, and 25 households from each village were selected. Twenty-five respondents including 12/13 and 13/12 males and females aged 18 years were randomly selected at household level. Interviews were conducted after processing and examining data from questionnaire. Supplementary data was collected from documentary sources from health facilities, village governments, HFGCs' meeting minutes. Interviews were recorded, transcribed, and coded for thematic interpretive content analysis while responses from questionnaire were processed for descriptive statistics to examine how different capability indicators were distributed among respondents.

#### **4. RESULTS AND DISCUSSION**

This section presents, analyzes, and discusses study findings. The analysis is organized around the key selected thematic aspects. Data from interviews and structured questionnaire are simultaneously compared along the discussion related to a particular theme or related themes. Direct extracts from interviews and descriptive statistics are used where necessary to support the interpretation of field data and for the purpose of retaining the original voice of respondents. Information from documentary sources was used to verify and relate findings from original sources.

##### **4.1. Existing Processes and Mechanisms at Village Level**

It was emphasized in previous sections that community actors are given a pivotal role in promoting financial accountability. Whether they possess skills and knowledge required for participating in planning and monitoring resources for healthcare, what matters first is their presence, participation, and attempt to influence decisions so that they can be compatible with community needs and interests. As the entrance point, through both questionnaire and interview, the study sought to know whether there are institutional arrangements and processes that support 'lay participation' as conceptualized in previous

sections. Also, questions on how such practices were carried out and whether communities find them applicable in healthcare planning, prioritization, and monitoring resources were included.

#### ***4.1.1. Participatory Forums and Tools***

Learning from interviews and documented evidence, HFGCs existed in all the studied villages. However, in all cases, they also included members from other villages or ward level since dispensaries served more than one village. As part of formal guidelines, HFGCs are responsible for developing facility plans and budgets, planning for availability of drugs and equipment, mobilizing contributions to the Community Health Fund (CHF), reporting employment and training needs of facilities to District Council, ensuring personnel availability at facilities, and liaising with the dispensary management to ensure delivery of quality services (United Republic of Tanzania, 2001). Apart from problems that are their statutory functions, they also seek to reconcile interests of communities and health facilities. For example, at , the committee documented resolutions aimed at resolving a conflict between the users and the dispensary management. However, it can be noted that issues that occupied a good space in the HFGC's meetings were rarely related to promoting financial accountability for communities. In most cases, HFGCs activities are primarily concerned with rescuing improving performance of health facilities. The notable problem was that, given limited time for meetings, discussions on issues directed towards health facilities' performance were repeatedly documented and most ended without conclusions. In the researcher's observation, most of the issues discussed during HFGCs' meetings had little to support community's 'oversight' role.

Despite existence, both the interviews and questionnaire affirmed that HFGCs have little direct linkage with communities and rarely inform communities on their plans, priorities, and the need for monitoring financial resources. Out of 100 respondents who responded to the questionnaire, 11 percent agreed that HFGCs informed them on plans, priorities, and helped them monitor money allocated for healthcare. 18 percent respondents neither agreed nor disagreed, while 71 percent disagreed that HFGCs informed them on matters related to financial planning and monitoring. This shows that HFGCs are not having direct connection with community members. While 26 percent only knew HFGCs and their main role, 3 percent neither agreed nor disagreed that they knew them, while 71 percent did not know them. On the side of key informants, it was noted that the majority know HFGCs and other related mechanisms, but few, especially officials such as VEOs and WEOs know their functions. Moreover, respondents acknowledged that there are other mechanisms than HFGCs used by the government to make people participate in setting health priorities, monitor financial flows, and question officials and healthcare providers at different stages of health administration. These include village meetings, notices released by VEOs, special meetings with elected community leaders such as the Village Chairperson, Member of District Council, private meetings with Hamlet Chairpersons, VEOs at hamlet levels, and VHCs' meetings. However, these occasions are very rare and rarely concentrate on issues of healthcare and financial oversight.

While community-based accountability forums are well known to people in authority, few average citizens are informed of such forums. From questionnaire, it was revealed that majority of community members (88 percent) do not know individuals who represent them in the health financial governance forums such as HFGCs. This is probably due to the fact that their meetings are held at health facilities where average citizens cannot access them easily. Even in and where HGCs were relatively active, members of such committees said that meetings they have not taken appropriate steps to educate other members on the role of HFGCs. At one of the two villages in Morogoro District, one of the respondents who was an elected community leader assured the researcher that there were meetings which allowed community members and health professionals to discuss healthcare related issues. However, at the end, the members were cautioned of taking gossips from those meetings to ‘villagers’ as they were just discussions and not having approved by the district. As a matter, *“members of HFGC explained that during such meetings community representatives just listen to the reports by the VEO and Health professionals”* [Interview with HFGC Member] then they go home. In this way, participation of community representatives in HFGCs may not necessarily benefit communities or equip them with knowledge on what role are HFGCs expected to play.

Apart from health governance committees, it was also noted that there are efforts by the government to nurture participatory budgeting. Indeed, interviewees agree that the government insist participatory budgeting, but participation of average villager *“has not meant seriously process”* [Interview with VEO]. In Morogoro District, it was reported that the WEO, VEO and councilor had visited one of the two village and educated citizens on the importance of participatory budgeting and how it is done. However, practical budgeting was not as participatory as respondents were emancipated during those meetings. It rather involved the ‘experts’ than ‘villagers’. A limited number of key informant respondents had heard of PETS, CSCs, and CRCs, but they could not explain clearly what exactly they meant and how they worked in connection with financial monitoring and oversight. From a researcher’s point of view, participation in health financial governance is more limited to HGCs. Participatory budgeting is becoming familiar, but still communities lack capacity building to make them understand it and participate.

It is well observed that basic processes and structure for community-based participation in health financial governance are in place, but their operations are not guided by formal guidelines mainly due to the fact that few potential community actors know the guidelines. In an interview with a member of HFGC at one of the villages in Morogoro, it was learnt that in most cases, decisions in the HFGC are always made without revisiting existing formal guidelines. Instead, they are guided by personal experiences and intuitions of those who *‘know better’*. As a result, decisions can sometimes be manipulated anytime, made without consent of some participants, or some participants leave decisions to be made even where they do not support them. In one of the two villages in Karagwe, even the composition of HFGCs did not conform to the requirements. VSCs are rarely concerned with empowering citizens to question officials and providers regarding health financial resources allocation. Instead, they are much concerned with informing citizens of what the

government wants them to do. One may point out that in rural areas, institutions designed for the purpose of empowering communities for exerting accountability concentrate on functions, which are too marginal to empower communities (probably since no one monitors how they work).

Five main observations can be made regarding existing mechanisms and structures may be identified. First, very few members of communities (8 percent) are well informed of the role of structures such as HFGCs, their legal functions, and how they are supposed to be formulated. Second, while people have more trust in their locally organized structures, the formal health financial governance structures lack links with the informal structures. Third, the existing structures are established out of the formal government guidelines and their activities including meetings are carried as a requirement by the government rather than empowering communities to participate in planning and monitoring resources allocated for healthcare. Fourth, in areas where health facilities are used by more than one village, both the composition provided by government guidelines and criteria for community representation become hardly applicable. Fifth, promoting community-accountability is one, but not the only role of the existing community governance processes and structures. This role may only become their central role if those structures in specific villages are encouraged and emancipated to do so. In this respect, the claim that HFGCs and VHCs are formal healthcare financial accountability promotion forums in all villages as formally documented is more a promise of their potential than their actual role.

#### ***4.1.2. Formal and Informal Community Organizations***

In all the studied villages there were organized citizen groups, which may not legally be called NGOs or CSOs, but were identified as facilitating for collective voice for average citizens. Unlike NGOs that have limited inclusion, these locally organized groups seem to facilitate quick free information flow. Most of these groups were organized by women. Examples of these were ‘*Tusaidiane*’, ‘*Mtaji wa Maskini*’ and ‘*Tulamke*’ in Morogoro and ‘*Tweyambe*’, and ‘*Abatasigana*’ and ‘*Makadada*’ in Karagwe. These groups were identified as important for helping members to share information on government plans on healthcare financing and how officials and providers manage money allocated for healthcare. Formal organizations, which were identified as connected with healthcare related matters were not at that time working in study areas. While some had their established offices in the nearest towns, some had established some facilities in the nearest villages as it was for *Mavuno* in one of the villages in Karagwe. The main challenge to informally organized groups was the limited acceptance by officials and authorities due to their legal status.

Despite absence of formal registered CSOs and NGOs in rural areas, locally organized citizen groups in form of self-help associations play a role that is sometimes played by NGOs and CSOs in urban areas. Information shared through these informal groups is much trusted and taken seriously by community members. Thus, they are very active in information sharing. However, in some of the interviews it was noted that informal community groups sometimes provide information which is not reliable. For instance, one of the HFGC members who were interviewed explained a scenario where *Makadada* group members had circulated information that VEOs had used money allocated for

constructing a dispensary for building their own houses and buying motor circle. Indeed, when follow-up was made, it was confirmed that no money had been allocated for constructing a dispensary in that financial year. Informal organized groups in rural areas bridge the gap left by absence of NGOs and they complement the role of rarely trusted formal platforms designed by the government. However simple, remote, and informal they are, in some ways, these community forums provide free information sharing environments and development of a collective agenda at community level.

#### 4.1.3. Mechanisms-Actors' Role Assessment

The question whether specific community actors were active in a given community setting is hard to answer directly given overlaps in combinations of actors and mechanisms. Overall, 31 percent of respondents who participated in the questionnaire agreed that community actors play an active role, 18 percent neither agreed nor disagreed, while 51 percent disagreed. With view that how active will each of the specific actors influence healthcare decisions and monitoring financial flows depend on the mechanism in question, there was a need to consider a combination of individual mechanisms and individual actors as shown in Table 1.

Table 1: Mechanisms, actors, and how active they are in promoting financial accountability

Existing Mechanism	Existing Actors	Key Role	How Active they are?
Village Standing Committees (VSCs)	-elected community representatives, elected community leaders, influential individuals	Approve key decisions and plans including those of HFGCs, Making Final Deliberations on matters difficult to reach consensus	Autonomous, active, but lack specific focus on 'priority setting' and 'financial monitoring' agenda
Health Facility Governing Committees (HFGCs)	-community representatives, elected community leaders, public officials, health facility managers and professionals, owners/representatives of private health facilities.	Resources mobilization, legitimizing priorities, and justification of decision and action taken with the aim of promoting quality of services and proper use of resources	Includes many stakeholders, limited autonomy, subject to VSCs, committed to financial prioritizing and monitoring, but limited power and influence
Other Informal-Community-based Forums	Citizens organized groups mainly in form of self-help organizations, informal citizen musters	Information sharing and promotion of free dialogue out of formal government processes.	Active, retains freedom and confidence to share among individuals, allows for quick

			information flow, but not reliable
Participatory Budgeting	Community representatives at village level, community leaders, local officials	Makes community priorities known to decision makers and planners at district and higher levels	Provides opportunity for including critical needs e.g. gender, disabled, in plans. Also communicates upwards people's priorities, but actors' interests limited by cascaded planning guidelines
PETS, CSC, and CRC	Used by NGOs, but no Actors Concerned with these tools in studied areas	Document evidence on how resources are well managed and perception of people on quality of health services	Not actively known in the studied areas

Source: Field data, May 2014

From table 1, each combination of actors and mechanisms show both strength and weakness in terms of making the two active. This might reflect that designing mechanisms necessarily needs designers to think about specific actors who should be included and how different combinations of actors affect the oversight potential by those actors. Issues related to design including processes, authority, and power relations are covered in details in the next section.

**4.2. Design: Authority and Power Relations in Participatory Forums**

Three factors are important in determining efficacy of community-based participatory financial accountability initiatives. These are: how participatory forums such as HFGs and VSCs are designed, how internal processes affect influence by individual community actors, and the relationship arising from a mix of participants in these forums. Related to these aspects, the designs of participatory forums was reviewed.

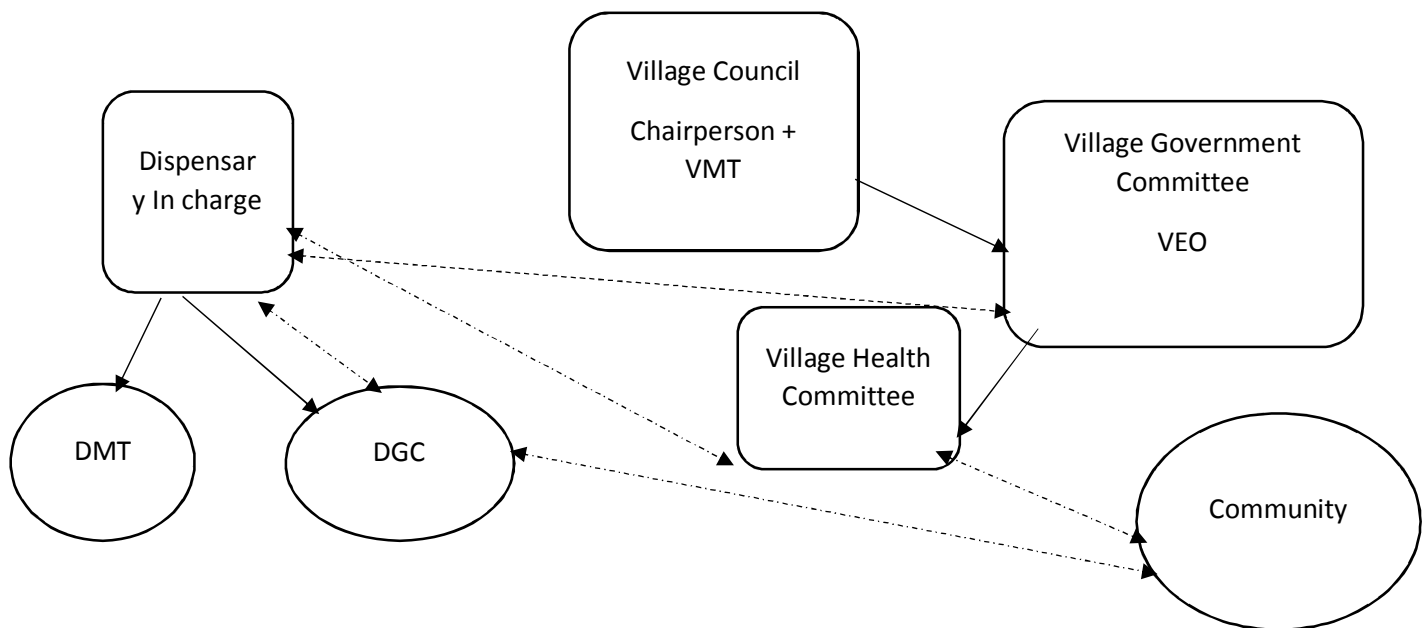
**4.2.1. Design of Forums and Role of Authority**

Starting with HFGCs, the numbers of members and criteria for inclusion is well spelt out in the '*Guidelines for the Establishment and Operations of Council Health Service Boards and Health Facility Governance Committees*'. HFGCs have legal mandate to review and approve financial plans by the village government and facilities, set funding priorities and budgets, identify sources for funding, and assuring that financial resources are effectively used to accomplish plans. The membership is supposed to include three non-vote members; especially the in charge of the dispensary who serves as a secretary, two representatives of Village Government Council; three elected representatives of community, and one representative from not for profit and for profit private health facilities in the village or

villages served by a single dispensary. Overall, in all studied villages, the majority of the participants (at least 60 percent) were elected from community. However, when it comes to negotiations within HFGCs, interviewees had view that elected representatives were not as influential as health professionals, VEOs, WEOs, and somehow Village Chairpersons. Therefore, power of numbers did not work. Guidelines insist that there should be at least one representative of women, which was fulfilled in all studied communities.

There are design and relational problems in the health financial governance structures at village level that result from lack of role clarity, overlaps, and limited connectivity between structures as shown in figure 2.

Figure 2: Overview of Village Health Financial Governance System



Source: Field Data, June 2014

While the dashed arrows show membership, the full-line arrows show direction of authority in the structures. As it may be note, the design of the village financial governance system does not subject the core structures to community power. This means that HGCs (and their processes) are not formally accountable to communities. According to guidelines, the health facility in charge is a default HFGC secretary. The Village chairperson is a chairperson of HFGC and is responsible for convening meetings, but still the meetings are (sometimes convened) and always hosted at health facilities. This places community representative in environments, which may limit their power and freedom. While VHCs have access to village government resources and enjoy powers that the Village Government Committee and VEOs exercise, HFGCs do not have access to both. HFGCs are mandatorily required to have members from VHCs, but VHCs do not need representation of HFGCs (except for the health facility in charge who a default member of VHC. These relations limit both the functionality of HGCs and chances for effective community representation.

Contrary to the guidelines, in two of the four villages, interviewees pointed out that some HFGCs members were not obtained depending on these criteria. While HFGCs were required to meet quarterly, in two of the villages they had not met for the last 7 and 4 months respectively. In Morogoro, one of the respondents who were interviewed had view that favoritism and nepotism highly affected recruitment where those who constituted HFGCs were either relatives or close friends of VEOs, facility in charges, and Village Chairpersons. Furthermore, it was pointed out by some community representatives in Morogoro that recruitment of members to HFGCs was also determined by membership to political parties. As a result of these atrocities, most of average citizens felt that HFGCs would not always stand for community interests.

Power structure result into decisions that are not consensual in participatory partnership. From interviews, it was identified that power distribution resulting from health governance partnerships was determined by knowledge, authority, and skills of those partners. Both in budgeting and scheduled meetings, interviewees had view that free, informed, and consensual decisions was rare. In most cases, VEOs and dispensary in charges come to meetings informed of the agenda, while community representatives and community leaders find the agenda on the table and thus fail to follow discussions properly. To make the point more clear, one respondent who was a member of HFGC had the following to say:

*We usually participate in the committee as our responsibility, but there are others who participate because they know what they are doing. We are just invited, sometimes with very short notice. The proper date of the meeting is not known. When we get there we become listeners to what they have on papers. Sometimes even the agenda of meeting is not known to most of us. I have doubt whether my fellows [community representatives] know what is being discussed or they all get out of the meeting with nothing like I do [HFGC Member,]*

Interviews and site visits during HFGCs meetings revealed that unequal power relations that occur in participatory decision-making and setting priority forums lead into loss of confidence among community representatives. While officials and health professionals said they were always confident with what they defend during meetings, 59 percent of the community representatives think what they contribute may not necessarily be the best options. This difference is probably due to information access, knowledge of guidelines, and certainty of what is the exact agenda of forums. As a result of unequal power distributions and relations, the so called 'partnerships' become tools for silencing communities rather than empowering them. As one respondents expressed, some participants in community health governance partnerships are not easily challenged:

*We work through a form of partnership between community, government, and providers. They call us and tell us all to give views on different issues, but at the end they never decide in favour of us [community representatives]. We can take time to discuss, but at the end we are not able to challenge what the VEO, doctors [meaning health in charge] or any other officer says it is right. We meet and talk,*

*but at the end we don't have chance to disagree with what they want [HFGC Member]*

What can be learnt here is that despite existence of participatory forums, officials and health facility in charges hold a convenient advantage of influencing decisions. Even on matters that need experiences of community members and representatives, there are preconceived notions that decisions related to 'money' and 'health' should be made by officials (VEOs) and health professionals.

#### **4.2.2. Power, Influence, and Power Relations**

Power and influence has significant influence in 'partnership' form of decision making that involve actors with unequal powers. From interviews and questionnaire, it was evident that the partnership environments did not empower community actors to demand accountability. From a questionnaire, 70 percent respondents believed that participating in HFGCs does not empower individual community representatives, only 25 percent believed that such environments empower community representatives, and 5 percent were undecided. Among other reasons, respondents thought that HFGCs members would always avoid challenging VEOs and health professionals. For them, a group of members of HFGCs may not visit the facility or VEO's office and authoritatively demand financial report, especially with a fear of losing membership and showing loyalty. According to interviewees in two of the villages, if a representative successfully does this, it may be because of personal influence or relationship with a facility in charge or VEO rather than his/her membership to HFGC. Therefore, being part of participatory forums such as HFGC does not necessarily empower community representatives to demand accountability.

It was also noted by the study that power and influence in community-based financial accountability forums was more attached to position and authorities held by individuals in the government and other community institutions. Respondents were asked to agree or disagree whether each of the 9 identified participants in participatory financial accountability forums and partnership were powerful and influential. Public health facility in charges were identified as the most powerful and influential (66 percent), followed by owners and managers of private health facilities (including pharmacies) and Village Chairpersons both of which had 34 percent of the choices. Amazingly, VEOs who were credited by HFGCs as very influential were ranked fourth powerful (32 percent), followed by locally organized community groups (23percent), community representatives (6 percent), CSOs (2 percent), average individual citizen (2 percent), and finally Hamlet Chairpersons (1 percent). The ranking demonstrate that providers, professionals, officials, and leaders who are not very closer to the people have more power compared to those actors who are closer to the community.

In case of the relationship arising from the membership composition of participatory community-based financial accountability forums, there were crucial lessons to learn from members of dispensary governance committees in all the studied villages. In most cases, interviewees who were community representatives expressed a sense of being cautious while they discuss issues in forums such as HFGCs. The study demonstrated that relationship

arising from coexistence of community-representatives, health professionals, and local government officials in committees significantly hampered voices of community representatives. For example, there were incidents where community representatives were sure that decisions to be taken did not favour their communities, but kept quiet due to fear that they would be victimized when they fall sick. Explaining this, a community representative at one of the villages said;

*We are asked to give our views during committee meetings, but as you know, you have to be careful. When they stand for issues and you try to stand against them [health professionals], you must also think what will happen when you go to the dispensary for treatment and find yourself in the hand of someone you pretended to stand against. To make my life safe, I always keep my lips closed [HFGC Member].*

Such expressions apart from showing little trust, they also express fear, passivity, and apathetic participation of community representatives in health financial accountability forums. While some members believed they would face reattribution, others thought that officials such as VEOs and elected leaders such as chairpersons were more entitled to speak on behalf of community members compared to an average community member. One may not be sure whether such relationship would also be interpreted in the opposite way to mean more confidence, more trust, and more respect to officials and health professionals by community representatives. However, result of these patterns of relationship in health financial governance are more negative. Such relationship elevate a sense of inferiority complex and thus force community representatives and leaders opt to remain silent even where they see that officials and health professionals fail to consider community priorities or where there are doubts regarding financial allocation. In the long run, they limit both altruism and determination of community actors to influence and stand for community needs and interests.

#### **4.3. Actors' Capability: Knowledge, Skills, Competencies, and Efficacy**

The central task in solving the puzzle whether 'lay participation' can significantly promote financial accountability in healthcare is assessing their capability to identify the best priorities, influence financial allocation, and hold officials and providers accountable for results.

Respondents had different views on their own capability and capability of different actors to act in community-based accountability forums. Related to general personal capabilities, majority of the respondents who were involved in the questionnaire (67 percent) respondents disagreed that they do not have capability to influence decisions in participatory community-based forums, 16 percent were neutral, and 17 percent agreed that they were capable of influencing decisions. In terms of capability to impose sanctions if officials and providers acted contrary to their expectations, 6 percent of the respondents were confident that they may effectively impose sanctions upon officials and providers, the majority (91 respondents) felt that they don't have sufficient capability, while 3 percent were neutral. Related to skills required to participate effectively in priority setting and

financial monitoring, 25 percent agreed that they had adequate skills, 60 percent disagreed that they do not possess adequate skills, while 15 percent were neutral.

In terms of the general knowledge needed to understand and participate in setting priorities, planning, and monitoring finances, 45 percent respondents agreed that they had such knowledge, 13 percent were neutral, and 42 percent disagreed that they did not have adequate knowledge. Another relevant aspect was power to influence decisions and actions of other acts, which the majority (44 percent) were confident that they have power, 14 percent were neutral, and a nearly equal proportion (42 percent) disagreed that they had no such power. In relation to external efficacy, which relates to the perceived responsiveness of officials and providers to views and proposals of community members, 31 percent of the respondents agreed that officials and providers were readily responsive, 2 percent were neutral, while a big proportion (67 percent) thought officials and providers are not readily responsive. The overall assessment of their own perceptions shows that most of the respondents see that they have limited capability to participate in priority setting and monitoring finance, mainly due to little responsiveness of officials and providers.

From both interviews and questionnaire, it was noted that there is much limited access to information on healthcare financing. Overall, 78 percent respondents disagree that information on financial resources allocated for health and their use is not made available for them. VEOs were identified as the most reliable source of such information, but as many as 92 percent said they had never visited the VEO's office with a purpose of enquiring how efficiently and effectively the money allocated for healthcare is managed. The majority 26 percent respondents rely on information supplied by informally organized community groups, 20 percent rely VEO's office, 11 percent rely on noticeboards in different public premises, and 9 percent rely on family members and friends. 5 percent of the respondents rely on health facilities while 5 percent on community radios (namely Radio Karagwe and Radio Abood) in Karagwe and Morogoro respectively. 4 percent of the respondents use other sources including the internet, and websites. 2 percent rely on television, 1 percent relies on NGOs and CSOs that work in those areas while no one relies on newspapers. It is worth learning that many people rely on informal sources though not recognized under formal guidelines. Despite the fact that people have little confidence in the VEO's office, they largely depend on it as a reliable source of information (probably to get reliable information). Another important point to note is that, while community representatives are not directly accountable to communities, they are of potential use as source of information compared to NGOs, health facilities, radios, and televisions. In addition, as demonstrated through interviews with members of HFCCs, users believe that VEOs and health facilities are not compulsorily required to publish financial reports. In Karagwe, it was reported that even in situations where there are complaints regarding funds mismanagement, VEOs and health facilities don't usually release information to clear people's doubt.

Lack of adequate knowledge and skills needed to adequately participate in healthcare priority setting and financial monitoring was identified as a critical problem that make

community-based financial accountability ineffective. Of the 100 who filled in the questionnaire, 60 percent felt that they do not have adequate skills, 25 percent only felt that they had such skills, while 15 percent were not sure whether they had such skills. 79 percent were clear that they did not understand financial reports whenever they read them. Therefore, they did not take trouble to read them at all as they believed they could not ‘get anything’ (meaning understanding). In the interviews, it was noted that most of the actors in community-based monitoring structures had little or no basic skills required to understand the process of prioritization. Leaving aside specialized financial planning and healthcare intervention related skills, most of them including village chairpersons, hamlet chairpersons, and community representatives in HFGCs and VSCs had low education that could not allow them become active participants in planning and financial monitoring. According to one of the interviewees at , whenever HFGC included skilled or relatively educated representative, such a representative was more supportive to officials and health professionals than community representatives. Equally, it was clear that lack of skills and knowledge resulted into inferiority complexity and sometimes stereotyping. Even some of the interviewees were clear that they were not free to argue with people who know on something they do not know. In the researcher’s view, such a partnership between the skilled and educated participants on one hand and less educated and skilled participants on the other hand could not be a fair partnership.

There were other social and cultural environments that were found to affect the potential role of specific community actors. For instance, despite gender mainstreaming attempts, there were evidence that women had little influence on decisions in both Karagwe and Morogoro. Equally, in both districts, influence of an individual actor on decisions did not depend on how best was the alternative proposed by such individual, but individual’s social status including wealth, traditional authority, position in religious institutions, or type of employment. Commonly, in both Karagwe and Morogoro, it was studied that there is a widely shared perception that an average person should not have the right to challenge authorities. This affects both fair participation in decision making and the potential of individuals to challenge officials or health professionals. As a result, it was demonstrated that an average person or community representative would opt keeping quiet even if there was something wrong with a decision or doubts of funds’ mismanagement. It is thus important that social and cultural barriers be considered when thinking about community actors’ capability. The barriers are systematically summarized in table 2.

#### 4.4. Summary of Key Constraints

From the study, the barriers that constrain community-based financial accountability in rural healthcare can be categorized in three groups. They include factors related to community actors, the existing accountability mechanisms, and other contextual factors not directly connected to actors and accountability mechanisms.

Category	Actor/Mechanism/ Context Description	Constraining barriers
	Individual Citizens	<ul style="list-style-type: none"> <li>Most of the individuals lack access to necessary information.</li> </ul>

<b>Community Actors</b>		<ul style="list-style-type: none"> <li>Community members as individuals fear victimization.</li> <li>Low internal and external efficacy (perceived influence and responsiveness of government, officials and professionals)</li> </ul>
	Community Representatives	<ul style="list-style-type: none"> <li>Community representatives keep silent due to fear of retribution</li> <li>Distance from meeting laces discourage members from participation</li> <li>No funds to pay fare, which sometimes was as high as 4000 Tshs for some members.</li> <li>There are no means or environments that motivate community representatives to participate in committees</li> <li>Low internal efficacy: feeling that whether they participate or not they may not alter anything.</li> <li>Some community representatives are not legitimate to some community groups (most due to favoritism and party affiliation)</li> </ul>
	Elected Grassroots' Leaders	<ul style="list-style-type: none"> <li>Elected grassroots leaders are cajoled by officials and health professionals as good for nothing</li> <li>Elected grassroots leaders are powerless due to limited income, knowledge, key skills, and information</li> </ul>
	Informal Organized Groups	<ul style="list-style-type: none"> <li>Legitimate to community, but most lack legitimacy to officials and formal authorities</li> <li>They sometimes share wrong or exaggerated information, which when called out to justify no one comes out. This is generally labeled "<i>umbea</i>" (a Swahili street word for gossips) which sometimes result into conflicts.</li> </ul>
	NGOs and CSOs	<ul style="list-style-type: none"> <li>NGOs and CSOs in rural areas enjoy little legitimacy compared to informal community organizations.</li> <li>No commitment to rural healthcare governance. Even NGOs, which are known did not have permanent presence in the villages we studied.</li> <li>Not accountable to communities, but rather accountable to donors who finance their programs.</li> </ul>
<b>Accountability Mechanisms and tools</b>	HFGCs	<ul style="list-style-type: none"> <li>Inadequate government support in terms of resources, capacity building, and monitoring.</li> <li>Lack of finance to make their operations predictable, sustainable, and motivate members to participate.</li> <li>Unequal power distribution where some actors, especially officials and health professionals have more powers to dictate decisions, plans, and they are rarely questioned during meetings.</li> <li>Their structure and operations make them relatively disconnected from other governance forums such as VSCs and VHCs</li> <li>HFGCs and their members are not clearly and directly accountable to community</li> </ul>
	VSCs, VHCs,	<ul style="list-style-type: none"> <li>Autonomous, but are more for the government at community level than people</li> <li>They are not friendly sitting with healthcare specific committees created for community participation and financial monitoring such as HFGCs.</li> </ul>

		<ul style="list-style-type: none"> <li>Some of their functions, powers, and membership tend to contradict and sometimes obstruct those of HFGCs.</li> </ul>
	Participatory planning/ budgeting	<ul style="list-style-type: none"> <li>Dominated by few with planning expertise (tend to include what they want)</li> <li>Limited choice ( guidelines and limits from central government)</li> <li>No training to key actors on how to do it/ e.g. planning matrix</li> <li>There is a problem of attendance during priority setting meetings</li> <li>Too little external efficacy (think officials and health professionals will not take their proposals serious)</li> </ul>
	PETS, CSC, CRCs	<ul style="list-style-type: none"> <li>No information that they had been used</li> <li>Too technical to be used by rural community actors or average citizens</li> </ul>
<b>Context</b>	Economic	<ul style="list-style-type: none"> <li>Low income which limits autonomy and freedom of representatives and elected community leaders</li> <li>General poverty: makes participation difficult, creates class differences which tend to determine voice and influence in participatory forums</li> <li>Time-cost analysis: while collective gain is important, many of the community members and representatives consider what they are likely to gain or lose when they become altruistic “fighters” for the rights which are not for themselves or their families.</li> </ul>
	Political	<ul style="list-style-type: none"> <li>There is a seemingly limited activism in most of the studied areas compared to rural areas.</li> <li>There is observable apathetic attitude towards participation in priority setting and financial monitoring. Some would not even like to listen to information related to these processes</li> <li>In all the studied areas there appear to be a kind of power personalization where differences in decision making forums stretch to relationship on street.</li> <li>Politicization: including associating difference in health financial governance forums with party affiliation and using these forums to achieve political goals.</li> <li>Rent seeking behavior: officials, elected leaders, and health facility owners and managers using financial accountability forums to further their own interests and win legitimacy and public support rather than listening proposals of participants.</li> </ul>
	Social-Cultural	<ul style="list-style-type: none"> <li>There is a significantly dominant culture of submissiveness to authorities where people believe that officials, professionals, and elected leaders (e.g. Village Chairperson) have absolute right to decide for them</li> <li>Gender bias and patriarchal system.</li> <li>Conflicting powers between traditional and modern legal ways of resolving cases. Even cases of financial leakage are treated humbly, discussed by elders, and they may decide to call an officer and tell him/her instead of putting it to the public. They may also decide to deal such an issues supernaturally “<i>wazee kushughulika</i>” (meaning being dealt</li> </ul>

		with by elders, mainly through spiritual punishments such as 'emitego' in Karagwe).
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Source: Summary from Interview transcripts

#### 4.5. To be or not to be: Something that Lay Participation Can Do

However limited they are, in modern healthcare financial governance, existence of mechanisms for enhancing accountability role of is a non-disputed requirement. Community-based financial accountability forums such as HFGCs and Participatory Budgeting provide window for inclusiveness of an average citizen. This is done through inclusion of community representatives and elected grassroots representatives in participatory health decision making, priority setting, and financial monitoring forums. From findings, the significance of community-based financial accountability in healthcare as a form of lay participation can be summarized in the following points:

- It formalizes the processes and procedures that allow community members to access to information sharing information. In both districts, it was evident that many community representatives could not speak or question on issues during meetings, but when they got out of meetings were able to share their doubts with friends and relatives.
- At least, the process of implementing community-based financial accountability programs at community level creates confidence in the general public that the government is committed to ensure that health plans and decisions reflect needs of communities. This creates hope of responsiveness in healthcare delivery.
- Legal accreditation, policy recognition, and existence of community-based financial accountability monitoring mechanisms and institutions has virtually made public officials, health professionals and healthcare providers somehow abide by the basic principles of governance including transparency, consultation, and the duty to give reason.

Despite the significance, it should also be noted that community-based financial accountability in the context of rural Tanzanian communities have some limitations, which make them less likely to deliver the results they are designed to serve.

- Participatory community-based financial accountability forums has a problem of unequal distribution of power. As a result, the powerful actors mainly local government officials, health professionals, and sometimes private health facilities' representatives tend to dictate decisions so that they can favour them, and sometimes protecting and furthering their private interests and goals.
- There is limited environments of equal participation, free debate on issues, and deliberation during priority setting and decision making forums. The trust of community representatives in health professionals and government officials is too little to allow community-representatives express community priorities, defend community interests, and question on doubted use of money. Decisions and priorities in community-based participatory forums are largely shaped by government policies, officials, and health professionals.
- Design and creation of community-based accountability forums such as HFGCs did not consider how they are supposed to be sustained. The government created HFGCs and

participatory planning models and introduced them, but there is no special arrangements for sustainable financing, capacity-building, and even monitoring to make them sustain their operations. For example, in all the studied areas, HFGCs members often failed to attend meetings due to distance, lack of money to pay for transport, and an intentional consideration that they would neither contribute anything to decisions nor change anything in their favour or for benefit of communities. Generally, good attendees to HFGCs meetings were as good as they attended other meetings including political parties meetings.

- Community-based financial accountability frameworks contradict with preexisted governance structures, both formal and traditional arrangements at community level. For example, while the people of had their traditional system that used elders to plan and set priorities, the new system did not even consider seeking elders' inputs prior to participating in HFGCs. Equally, it seems that there was no rational harmonization of the functions performed by village health committees HFGCs. The same case is also with the relationship between different components of the village health financial governance system as shown in figure 3. Their functions and communication seems to contradict.

## **5. CONCLUSION AND RECOMMENDATIONS**

### ***5.1. Conclusion***

As it is for elections in competitive authoritarian regimes, democrats believe that it is better to have undemocratic elections rather than having none of the two: elections and democracy. The same appears to be the case in the process of promoting community-based financial accountability mechanisms. Probably, this is not the belief of global health governance institutions such as WHO and World Bank, but all those who claim to be health promotion volunteers in low income countries including Tanzania. It is convincing that even if communities are not capable of holding officials and providers accountable, what is needed is to nurture institutions for encouraging them to work effectively and building capacity of community actors to monitor investment in health financing. However, a point of caution in this decent intellectual laxity is that community-based health financial governance institutions may not be effective if they are not adequately supported by both local and central government. Equally, government support to health governance institutions needs to be achieved through creating environment where communities are well represented, are free to determine what they want, and are sufficiently empowered to monitor flow of resources allocated for healthcare at different levels. If this is not a case, efforts to create and strengthen community-based financial accountability in healthcare would continuously qualify being an 'institutional fix'.

### ***5.2. Recommendations***

Based on the findings and discussion in the preceding paragraphs, the study finds it adequate to make the following recommendations.

- There is a need for an intensive capacity building program for equipping community actors with adequate skills needed for effectively participating in setting health

priorities, reading and understanding financial reports as a prerequisite requirement for monitoring financial spending for improving health outcomes.

- The study also recommends for restructuring of community-based financial and health governance institutions to make them more linked with community, accountable to community, and clarifying relationship between related institutions of which relationship is not clearly stated in the existing legal and policy frameworks.
- The ministry responsible for healthcare should create a special fund for HFGCs with the aim of making their operations sustainable. The same can also be done at village level where the smallest possible percent of user charges should directly be used for financing necessary costs needed to make HFGCs carry on their activities as required. This includes fares and seating allowances for members. Even if it is a cost, it may not be as big as the one that the government incurs through financial leakages.
- There is a need for decentralizing the process of setting health financing priorities up to the hamlet level. Equally, all financial reports should be provided to hamlet chairpersons who can share them directly with community members.
- There is a need for a long-term strategy for community empowerment and building positive relationship between communities on one hand and health facilities, health professionals, and government officials on the other hand. Creating environments of trust and cooperation are vital for building an effective community-based financial accountability system.

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