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**Rural Communities' Healthcare Governance Partnerships: a
Lay Participant Perspective**

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Abstract

This paper analyzes the capability and influence of rural community actors in community-based healthcare governance partnerships, namely the Health Facility Governance Committees (HFGCs) using the Lay Participant perspective. Practical evidences are drawn from a mixed methods study conducted in Karagwe and Morogoro districts between May 2013 and March 2015. The analysis shows that all community actors, especially individual community members, community representatives, elected community leaders, informal community groups, and Civil Society Organizations (CSOs) as well as Non-Governmental Organizations (NGOs) have pertinent weaknesses that make them unable to contribute effectively towards enforcing accountability of public officials and health services providers. The main reason is that, the design and social context of rural communities make partnerships for empowerment partnerships for disempowerment. In conclusion, community-based healthcare governance partnerships cannot work best in the current context of Tanzanian rural communities. Therefore, there is a need for rational capacity building interventions aimed at empowering all the defined community actors and transformational redesign of the community healthcare governance systems.

1. INTRODUCTION

The search for excellence in public services management has gone through different paradigms, which at different times emphasized both centralization and decentralization of planning and implementation of public policies and programs. Justification of actions and inactions as well as engagement of different social actors in the public, private, and civil society realms in planning, production, and distribution of public goods and services has historically depended on the need for efficiency and effectiveness in terms of delivery of public goods and services. While countries do not have equal economic endowments, in Low and Middle Income Countries (LMICs), the challenge towards realization of efficiency and effectiveness has been how scanty resources available can be well managed to deliver the best services to their people. Among others, the governance approach seeks to answer this question by calling different actors in the public, private, and civil society realms to wield power and exercise control on planning, making, and implementing public policy. The assumption that informs this thinking is that, empowering different actors to participate in policy making and implementation will necessarily enhance accountability, transparency, and responsiveness; which in the long run is expected spillover into effective management of resources invested in public service delivery.

With the view that participation of actors from the public, private, and civil society realms is vital for improving policy making and services delivery, the concept of partnership governance becomes important. In a simple language, as used by the Manchester City Council, a partnership refers to an agreement between two or more independent bodies to work collectively to achieve an objective, normally excluding the familiar relationships between client and contractor or employer and staff. According to Jessop (1997), partnerships as used in public services management insist on interactions in the delivery of services that goes beyond cooperation between the state and the market and thus includes local level actors (community). Given the nature of local communities' relationship, partnership governance unlike formal institutional governance tend to exhibit a complex mix of formal and informal relationships. However, the sense of partnership remains intact because of the features including shared formal goal, defined significance, preset principles that govern partnerships, and presence of practical guidelines and policies for the operations of partnerships. In the management of healthcare, enticement of the partnership governance models has resulted into community health governance partnerships, especially forums that bring together local level executive government officials, services providers (public and non-public), and communities and their actors with the aim of promoting accountability in prioritizing, planning, and implementing healthcare programs and interventions. The essence of having in place community partnerships is that, through collective power, action, and consciousness, community actors can effectively influence plans, decisions, and actions of providers and public officials. Consequently, accountable healthcare plans and practices at community level would result into improved health outcomes.

Using data collected through a mixed method study in six villages from Karagwe and Morogoro districts, the paper argues that in the context of rural Tanzania, community health partnerships

provide a limited potential for ensuring accountable healthcare. This is especially due to weaknesses pertinent among community actors, which make them unable to hold providers and government officials accountable for their decisions, actions and inactions related to health services delivery. The analysis was guided by the lay participant perspective to health governance, which suggest that an average actor who lacks an abstract set of knowledge related to or needed for a specific function in managing healthcare may not adequately control decisions and actions of health services providers. In addition, the perspective assumes that the knowledgeable collaboration between health professionals and executive government officials at community level place actors on the side of community in a position where they become disempowered. It concludes that given the rural context and power tensions arising from the design of community partnerships, partnerships for empowering community actors becomes actors for disempowerment. The paper is divided into five parts. The first part provides a general introduction. The second part builds a conceptual basis of the argument, especially focusing on Community Health Governance Partnerships (CHGP) and Lay Participation as central concepts, around which the main argument is built. It also synthesizes key issues from the empirical literature relevant to the topic. The third part provides a brief description of the study methods. The fourth part analyzes the key results and provides the key arguments. The fifth and last part provides conclusion and some policy implications.

2. CONCEPT AND ANALYTICAL PERSPECTIVE

2.1. Community Health Governance Partnerships

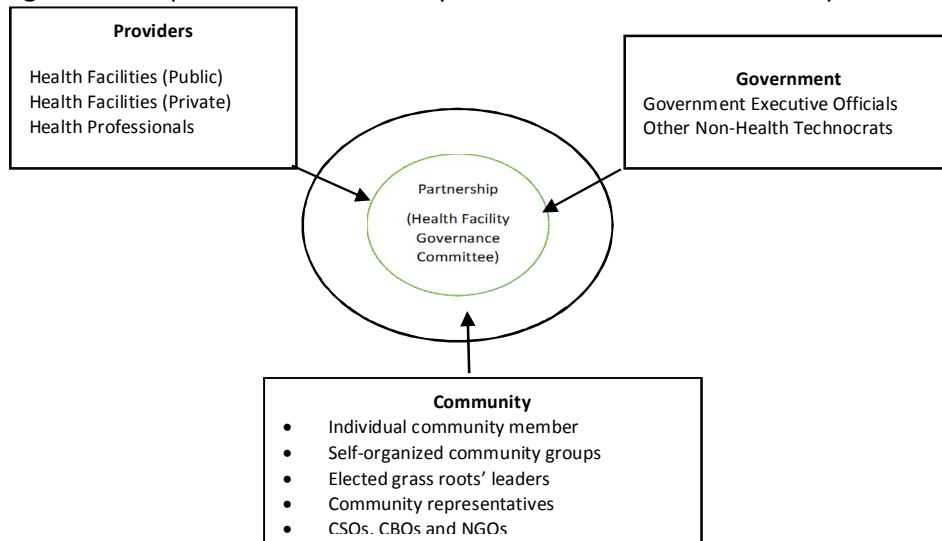
In the context of healthcare management, partnership governance is a relatively new, but popular model. Recently, increased call by the international community that effective healthcare needs participation of communities and private sector in planning, implementation, and management of health interventions and systems (Fidler, 1997; Lewis, 2006), health governance is largely organized along partnerships (Mitchell & Shortell, 2000). It takes the health governance discourse beyond the traditional emphasis on 'community participation' as used by Kessy and Ramsey (2014) and Heritage and Dooris (2009). Instead of insisting that communities should be involved in planning, designing, and implementing healthcare interventions, the community governance partnership model emphasizes that communities and key actors in the societal realms should 'partners' with the government and private sector in planning, designing, and implementing programs and interventions aimed at improving healthcare. Unlike traditional participation, the concept of partnership centrally assumes that participants shall have relatively equal powers (Hillman, 1984) and thus be able to fairly bargain and influence decisions for assuring mutual benefit.

The partnership model is governed by several key principles, which are proposed for building equitable distribution of powers and benefits. First, it is a requirement that participants are prepared for participating in the partnership and develop a shared vision about the essence and ultimate goal of the partnership (Bracht & Tsouros, 1990). This implies joining a partnership should not be a forced decision of a potential partner. Second, participants in a partnership need to develop a clear, rational, and fair decision making processes and procedures that are likely to place one of the participants in a disadvantaged position (Mangold, Denke, Gorombe, Ostroski, & Root, 2014). Third, partnership models need clear, consistent, and consensual communication among actors in the partnership. Fourth and last, building and implementing the partnership model needs that the partnership relationship is built on basis of trust as the central and core value (Wildridge, Childs, Cawthra, & Madge, 2004). In other words, a partnership may not be successful if it is a partnership constituted by partners whose interests cannot be harmonized, they are potentially

unequal in the sense that there are no chances for a party to bargain, or there is distrust between and among partners.

In health governance, community partnership has become common in both developed and developing countries. Health Facility Governance Committees (HFGC), such as Dispensary Governance Committees (DGC), Health Centre Committees (HCC), and Hospital Boards are commonly used to provide chance for government authorities, health services providers, and communities and their integral groups to collaboratively plan, design, and implement healthcare decisions that correctly address priority needs of a particular community. At community level, these forms of partnerships have a tripartite composition of membership, especially including government officials, community, and services providers who include both public and private providers. The key actors in the partnerships are illustrated in figure 1.

Figure 1: Composition of Community Health Governance Partnerships



Source: Shumbusho (2015, p. 4)

As shown in figure 1, HFGCs, which provide a form of Community Partnership Forum (CPF) attract membership from different three sources. The first source is the 'providers' side, which includes both public and private health facilities which are directly engaged in services delivery. It also includes individual health professionals who may be undertaking healthcare functions on behalf of health facilities or on their own behalf. The second source is the 'public officials source', which includes government executive officials at grassroots level such as the Village Executive Officers (VEOs) and Ward Executive Officers (WEOs) as well as other officials entrusted with other functions in support of healthcare. These may include managing finances, procurement, and any other related functions. The third and last source is the 'community', which is made up of different actors. Community actors range from an individual member of a community to community groups, which may be self-organized and informal or formal regulated institutions such as CSOs, CBOs, and NGOs. On the other side, community actors include two types of community representatives. First, politically elected community leaders (such as village, mtaa, and kitongoji chair person in the context of Tanzania) and second, representatives of different sections of the community who are recruited to partnerships according to terms specified by the guidelines and legal procedures that govern operations of those partnership forums.

There are some important differences between actors from the three sources that should be noted. These include differences related to their compulsory skills on the side of professionals and some public officials as well as possibility of exercising authoritative and legitimate power over the rest of the community, which is unique for government executives even at the local level. In addition, there are also difference in terms of both social distance between each actor and the general public on the first hand, and ability to access information in possession of the other actors.

2.2. Lay Participation: Concept and Analytical Essentiality

In the first place, “lay participation” sounds like an abusive phrase, especially when community participation is taken as the only alternative for improving health services delivery. In health systems management, the concept appeared first in the 1970, when Freidson (1970) used it to refer to people who do not have abstract body of knowledge that can be applied in the health care field. In the early 1990s, its usage used from appreciating the fact that healthcare in ‘a special’ and ‘technical’ profession to a derogative one. Lay participation was then used as a perspective derogating the traditional assumption that only epidemiologists and biomedical experts know what is best for promoting healthcare.

As a perspective, lay participation was 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. For them, a lay participant is an average community member or the unspecified public that is called to participate and influence healthcare decisions including deciding what are the overarching health needs of communities. At this juncture, both abstract knowledge and practical skills are considered when judging whether someone is a lay participant or not. However, for them when they use the term community, the assumption that an average community may have people who are well-equipped with knowledge applied in the healthcare profession does not apply.

Today, health governance researchers use the term “lay” to refer to “people who are neither healthcare professionals, nor healthcare researchers, but may have some specific knowledge related to health (Entwistle, Renfrew, Yearley, Forrester, & Lamont, 1998, p. 463). As opposed to the familiar usage where a lay person is likely to be someone who has not gone to school, its use does not differ much from what Carey (1987) suggests, especially that priests believe someone who lacks theological knowledge (not exposed to the heavenly secrets) is a lay person. In this context, a PhD holder is as lay in healthcare as he is in the church if his education has nothing to do with healthcare or a supporting function relevant to healthcare management.

While the literature on health governance is growing fast, debates on whether lay participation is necessary appear to be disappearing. Beyond the popular call for lay participation, there is a growing consensus that lay communities should gain more power to police, influence, and control healthcare planning, budgeting, policy making, and implementation even if their knowledge and skills are limited. 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 determine how health systems should be managed (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 communities so that they can effectively participate and hold decision makers and providers accountable.

3. METHODS

The study was primarily based on qualitative assumptions including the one that effectiveness of participatory community programs' governance forums should be understood by considering a complex and dynamic nature of relationship and power between different actors. In addition, most of the indicators of effective lay participation such as influence, self-confidence, knowledge, and efficacy can be compared at individual level, but their ontological nature constrain both objective measurement and generalizability. Informed by these two main assumptions, the study utilized a mixed methods design benefiting from both qualitative survey design and in-depth case analysis in two rural districts especially Karagwe and Morogoro districts.

Districts were conveniently selected for a community-mapping study under the author' doctoral research. The two districts are commonly deprived in terms of access to quality healthcare services, but they differ in terms of accessibility of information where access is relatively improved in Morogoro compared to Karagwe. Three villages with primary health facilities were randomly selected from each district, especially Mtamba, Mkuyuni, and Lundi in Morogoro and Rwenkende (currently in Kyerwa District), Kamagambo and Chonyonyo in Karagwe¹. One primary healthcare facility that served each of the six villages was selected. These were: Mtamba Dispensary (101775-5), Mkuyuni Dispensary (101770-6), (which has been promoted into a health centre), and Lundi Dispensary (101760-7) in Morogoro and Rwenkende Medivision Dispensary (106316-3), Kamagambo Dispensary (106274-4), and Chonyonyo Dispensary (108995-2) in Karagwe.

Data collection was done into two phases: first, between December 2012 and May 2013 and second, between December 2014 and March 2015. A structured questionnaire was administered with 390 household level respondents aged above 18 years. 65 participants were randomly selected from each of the six villages. The sample included 32 male and 33 female participants for all villages from Morogoro while 33 male and 32 female participants in all villages from Karagwe. 60 in-depth interviews including 10 from each of the six villages were conducted with purposely selected stakeholders including elected community leaders, members of HFGCs, in charges of health facilities, representatives of organized citizen groups, and VEOs as well as WEOs. Data from questionnaire was coded and processed using SPSS Version 20 while interviews and extracts from documents were coded using the QSR NVivo 10 data management software and both of the datasets examined and analyzed manually in relation to selected qualitative codes.

4. FINDINGS ON PARTNERSHIPS IN KARAGWE AND MOROGORO

This section analyzes and discusses the key findings focusing on the key selected thematic aspects of the topic. It simultaneously compares and discusses data from interviews, documentary sources, and questionnaire in connection with particular themes. Direct extracts from interviews and

¹ During the study design and start of data collection, the new district had been created, but information on health administration was not separate from Karagwe District council. Thus, for analytical consistency, Rwenkende (now in Kyerwa district) was treated as part of the Mother District, Karagwe.

descriptive statistics are used where necessary to support the interpretation of field data and retain original voices of respondents.

4.1. Community versus Bureaucratic Actors

The first task in fulfilling study objectives was identifying the actors and exploring what they do as connected to ‘health governance’ at community level. With that idea, one would be able to examine how different community actors interact and influence both the functioning and accountability in health governance partnerships, which HFGCs are one form. The study identified different actors at community level who may adequately qualify to take the label of being ‘community actors’. These are well-distinguished from what could be identified as ‘bureaucratic actors’. As shown in table 1, actors who are characterized as ‘community’ and those characterized as ‘bureaucratic’ are identified.

Table 1: ‘Community’ versus ‘Bureaucratic’ actors

Community Level Community Actors	Community Level Bureaucratic Actors
<ul style="list-style-type: none"> • Individual citizens at different times • Informal, self-organized community groups such as women’s self-help groups • Formal accredited community groups such as CBOs, CSOs, and FBOs • Individuals appointed as representatives of different community groups in partnerships • Elected local leaders: such as Kitongoji chairperson and Village Chairperson 	<ul style="list-style-type: none"> • Individual healthcare professionals in the public and private health facilities • Village Executive Officers (VEOs) and in some cases Ward Executive Officers (WEOs) • In charges of Health Facilities both in public and private sector facilities

Source: Field data, 2013-2015

Despite difference in formulation, status, and mode of influence, which in turn affect the legitimacy of their role and power, the actors have some characteristics in common. First, their demands are justified by the ‘right’ argument, which implies that even at times their participation and influence is abstracted, the recognition that they stand for community tends to prevail. Second, they have little or no direct connection with both services providers and executive arm of government at central and grassroots level. Their interaction appears to be in form of invitation or it is signified by the need on either sides. Third, modes of communication and interaction between these actors are more contingent, flexible, and informal compared to how they interact and communicate with bureaucratic actors. Fourth, their main concern in addition to fulfilling personal goals relate to seeing things happening and get praise and support from community. This is opposed to the concern of bureaucratic actors whose main concern in addition to fulfilling personal goals relate to seeing things happening perfectly and get praise and support from their top executives whether from the government or the private sectors as well as increasing their importance as suggested by the bureaucratic politics model of public services management.

4.2. The Sense of Community and Collective Identity

Before dealing with individual community members, it was important to identify the level at which social groupings in the studied geographical areas identify themselves as constituting a community. However, this was to be done guided by the defining features of community according Clark (1973) and a “health community” according to Li et al. (2009), especially including elements such as sharing geographical location, continued interaction of individuals, groups, and collectivities held together by need, norms, values, relationship and social glues, which are shared through regular communication and interaction. However, these interactions should be justified on basis of collectively felt and shared problems, needs, or challenges as related to their health. In

these definitions, sharing a basic healthcare unit was the most important point of departure for defining a community. The sense of a community based on these criteria differed from one geographical area to another depending on existence of overarching shared health financial accountability, access to, and quality of services concerns.

In this study, a village was found to be a default marker of common identification. However, sharing a primary healthcare facility by villages made them feel that they were a single community while economic gap among close households within in a village made members identify each other not as a single community. Therefore, a sense of community identity was found intricate due to mismatch between the political administrative structure (village) and sharing a primary healthcare unit (dispensary) to which shared concerns are attached. Example, in Mtamba and Matombo villages, the study found that majority of the people relied on the Mtamba-Matombo dispensary. They also expressed strong concern for performance and efficiency in the dispensary. Due to these shared health needs, they closely identified themselves as one. This is different from Chonyonyo where both interaction and collective identification was found to be limited. Chonyonyo, Ihanda, and Rukole had a shared dispensary, but due to little concern that comes for depending on privately provided services in Omurushhaka and also on Nyakahanga Designated District Hospital, the sense of collective concern for healthcare was found to be very low even within Chonyonyo Village. Thus, based on the study findings, it is proposed that the minimum level for defining a community in rural Tanzanian healthcare context should be a village. However, it should also be noted that the sense of community may dynamically shift due to income inequalities in a population or lack of something to share regarding healthcare problems and expectations. Thus, to be regarded as a healthcare community, a village or group of villages should be brought together by sharing a collectively governed primary healthcare facility, around which shared and collectively-felt needs and concern for services are initiated.

4.3. Capability of Individual Community Members

In political theory, individuals are the basic units of political systems analysis. Aggregate characteristics such as preferences, attitudes, perceptions, activism, efficacy, and collective competencies are primarily organized at individual level (Almond, 1956) and thus collective action is primarily a product of individual actors' actions (Easton, 1953). From this view, exercise of influence and control in community partnerships root from empowerment to yield and exercise those virtues at the level of an individual community member, especially those individuals who have entitlement to civil rights and freedoms and perceive themselves as capable of exercising such rights and freedoms. However, across communities and groups, regardless of presence or absence of community empowerment initiatives, individuals are not endowed with equal capabilities and potentials to influence and control decisions that affect them and their communities.

Related to community empowerment for influencing and controlling decisions related to allocation and use of funds available for financing community healthcare, the study used 13 indicators, which may be epistemologically categorized into two groups. The first group includes indicators which have a relative ascertainable character. These indicators allow respondents to judge or think of 'presence' or 'absence' of an attribute within themselves or make assessment based on their own knowledge, experience or recall. The second group included non-ascertainable indicators, especially indicators that lack a categorical character. By virtue, responses in this category have subjective and multilevel-rating interpretations, which may not be objectively agreed upon between the respondents and researcher.

Among others, indicators in the first category included: (i) attending training on budgeting and prioritizing; (ii) being aware of the right to access official financial information; (iii) being aware of existence of HFGCs; (iv) knowing representatives in HFGCs; (iv); and (vi) and being aware of the main role of HFGCs. For all these indicators, the interviewer and respondent could at least have a consensual ground of either ‘assertion’ (Yes) or ‘denial’ (No) of the attributes related to such indicators by the respondent. For such a reason, respondents were asked to choose between ‘Yes’ and ‘No’ responses. Table 2 provides a synthesis of responses on the five questions in this category.

Table 2: Relative ascertainable indicators of community members’ empowerment

Indicator	Yes		No		Total	
	Frq* ²	%	Frq*	%	Frq*	%
Ever attended a training on Budgeting or Priority setting	37	9.5	353	90.5	390	100
Are aware of the right to access official financial information	277	71.1	113	28.9	390	100
Are aware of the existence of HFGCs	161	41.3	229	58.7	390	100
Know their representatives in HFGCs	44	11.2	346	88.7	390	100
Are aware of the main role of HFGCs	45	11.5	345	88.5	390	100
Average Totals (N=390)	113	28.9	277	71.0	390	100

Source: Field data, 2013-2015

From table 2, it is observed that the majority (90.5 percent) have never attended ant training on budgeting and priority setting, which are the key financial and services quality control functions of HFGCs. However, a big majority (71.1 percent) are aware that they have the right to access official information on healthcare financial matters, which includes budgets, allocations by the government, and expenditure on different health related projects and programs. While HFGCs are forums for representing community priorities and exercising control over government officials and health services providers, a sizable majority (58.7) appear not to be informed of their existence.

While it is ideally stated that community representatives in HFGCs represent overarching needs, interests, and priorities of different community groups in community healthcare making decisions, only 11.3 percent knew their representatives and only 11.5 percent are aware of the main role of HFGCs. As related to awareness of existence of HFGCs, it is logical that one becomes represented if such a person knows where s/he is being represented and who represents her/him. In the situation that communities are not aware of HFGCs and who represent them in such committees, ideals of representation and participation become ironical. One may not substantively argue that HFGCs as community partnership forums play their adequate role of representing communities. This is because even if in their day-to-day operations focus keenly on overarching health needs of communities, the point that HFGCs and their role are unpopular to average community members subject them to questionability in terms of their legitimacy, inclusiveness, and practical links with communities.

Also, the study examined eight non-ascertainable indicators in connection with community empowerment to influence community partnership actions and decisions. These were levels of: (i) trust in VEOs; (ii) skills related to budgeting and priority setting; (iii) ability to read and understand financial information; (iv) skills required for analyzing financial reports); (v) understanding functions of HFGCs; (vi) feeling of power to influence decisions; (vii) readiness to

² In table 1 ‘Frq*’ Stands for the word ‘frequency’

challenge authority; and (viii) trust that HFGCs represent community interests. For each of the indicators, respondents were asked to rate themselves at appropriate levels along the five points' rating scale ranging from 'very low' to 'very high'. Table 3 overleaf summarizes the ratings for all the five indicators of which each was standing as an independent question.

Table 3: Non-ascertainable indicators of community members' empowerment

Indicator	Very High		High		Average		Low		Very Low		Total	
	Frq* ₃	%	Frq*	%	Frq*	%	Frq*	%	Frq*	%	Frq*	%
Level of trust in village Executive officers	7	1.8	15	3.8	58	14.8	144	36.9	166	42.5	390	100
Level of skills related to budgeting and priority setting	0	0.0	24	6.1	62	15.9	144	36.9	160	41.0	390	100
Ability to read and understand financial information	12	3.0	30	7.7	56	14.3	128	32.8	164	42.0	390	100
Skills required for analyzing financial reports	11	2.8	32	8.2	88	22.5	120	30.7	139	35.6	390	100
Level of understanding the functions of HFGCs	12	3.0	30	7.7	79	20.2	113	28.9	156	40.0	390	100
Feeling that one has power to influence decisions	16	4.1	25	6.4	67	17.2	108	27.6	174	44.6	390	100
Readiness to challenge authority	18	4.6	23	5.9	61	15.6	117	30.0	171	43.8	390	100
Trust that HFGCs represent community interests	26	6.6	28	7.2	53	13.6	120	30.7	163	41.7	390	100
Average Totals (N=390)	13	3.27	26	6.63	66	16.7	124	31.8	162	41.4	390	100

Source: Field data, 2013-2015

As presented in table 3, the majority of community members have low trust in VEOs. Almost 80 percent including 42.5 percent who said their level of trust was very low and 36.9 percent who said their level of trust was low may not be in support of HFGCs as institutions that work close with VEOs and must accomplish their objective if VEOs are accountable to community members. Noting that VEOs are custodian of information and are responsible for day today administration of social services at village level, limited trust by community members may not provide adequate opportunity to average community members to demand information, which forms basis for collective voicing. Even if VEOs become ready to make information available, there is another limitation that the capability of community members to read, understand, and analyze such information is limited. This is because the majority (about 75 percent) reported that their level of ability to read and understand technical financial information such as cash flows and budgets was generally low or very low. Related to this, only 11 percent certainly agreed that they have adequate skills required to analyze and communicate information published in financial reports. This applies even for financial allocation reports, which the researcher found that were usually placed on notice boards at district offices in both of the districts. However, given the limited visits of district offices by average members, very few out of these 11 percent are capable of accessing information from district offices. Even under situations where some community members can access allocation information from district offices, such information appeared to be of little use as it is general, focuses on allocations rather than how money is spent, and it has little to help in terms of how the money allocated for specific priority expenditures is spent at village or project level.

³ In table 3, 'Frq*' stands for the word 'Frequency'

In connection with participation and influencing the activities of HFGCs, average community members may have impact on HFGCs if they understand the functions and operations of HFGCs, they have faith in HFGCs, and they feel that they have power to influence and challenge decisions by those in authority. As in table 3, the study found that the level of understanding of the functions performed by HFGCs by majority (68.9 percent) was low. This includes 40.0 percent (very low) and 28.9 percent (low). Only 10.5 percent feel that their level of power to influence decisions was high on one hand and the same percent feeling that their readiness to challenge authorities for wrong actions and decisions was high. In addition, the level of trust that HFGCs may efficaciously stand for and represent interests of communities was low where a sizeable proportion, 41.1 and 30.7 percent said their level of trust was very low and low respectively. The overall average for all the eight indicators show the 73.2 percent of the community members had low level of attributes that are potential for them to influence and control decisions and actions of HFGCs and key participants in the HFGCs, 16.7 percent had average level, and only 10.1 percent had high level of such attributes.

Despite the well-felt need for empowered communities to make community health governance partnerships work effectively, the prerequisite potential of an average community member remains inexplicable. An average community member is indeed supposed to initiate forces upon which collective voicing and action, which in turn lead into community influence and control on one hand and officials and providers' responsiveness and accountability on the other hand. In addition, the role of community representatives, organized community groups including informal and formal associations, and elected community leaders in community partnerships such as HFGCs is hardly spontaneous. Instead, they are likely to exert pressures on government officials and providers (bureaucratic actors) so that they diligently manage resources and deliver better services if such pressures are generated by individuals from communities and directed towards such representative forums.

However, in the researcher's observation, the capability of most of the community members to influence proper functioning of HFGCs is limited. Based on findings, there are some notable constraints that affect influence of average community members. First, the level of education is low for the majority of the members, which to some extent make them unconcerned with formal governance principles and make them unable to deal with formal-structured processes such as budgeting and prioritizing as well as information analysis. Second, both budgeting and priority setting on one hand, and financial information analysis appear to be too technical for an average member of a rural community. While adaptation of individuals to these processes need formal capacity building interventions, capacity building for these rural communities has been a missing activator. Third, there are no sufficient community activation forces in these rural communities compared to urban communities; quick information flow such as those offered by ICT and social media for the urban community; and interactions are very limited in the sense that both forums and time for sitting down in groups and exchange ideas is minute compared to urban communities. In all the six communities, the time for exchanging ideas and sharing was largely on Sundays. These include wide-spread activities of CSOs and individual activists. Fourth, while it is true that few who possess some basic knowledge and skills are expected to contribute towards empowering the rest, it was observed that 'fear of authority' stands as a dominant syndrome in all the six communities studied. There is a preconceived notion that it is not right to criticize someone 'in position' to the extent that he or she becomes 'shamed in front of community members'. In this sense, the interpretation of 'authority' is wider than it is in a formal literature. For a rural community member, 'authority' includes government officials, elected leaders, traditional and spiritual leaders, civil servants such as nurses and teachers, and even economically

powerful individuals in the community. As a result, one has to 'shut-up his or her mouth' if someone they think he or she has attributes of being an authority is associated with mismanagement of public resources.

From the researcher's point of view, low levels of competencies among average community members significantly affect the performance of HFGCs. Associated with low competencies is a pattern of traditionally well-conserved culture that focuses on keeping harmony, respect to authority, seniority, communitarian protectionism⁴, and peaceful coexistence that surpass democratic civic competencies that permit freedoms of expression, liberty and individuals' rights in rural communities. This happens because both community actors who directly access operations of these strategic community partnerships and bureaucratic actors may not be keen enough to place interests of communities at the top of their own interests if nobody demands them to do so.

4.4. Other Actors: Collective, Authoritative, and Institutional

As it was identified early, beyond the individual community members' level, the other actors who appear to contribute towards fulfilling the role of HFGCs as community partnership included community representatives who are directly appointed to represent different societal groups, elected community leaders, and organized informal as well as formal community associations. The next few subsections will be focusing on these actors one after another.

4.4.1. Community Representatives

Representatives in HFGCs are prescribed by formal guidelines that govern formulation. The guidelines require that at least percent of HFGCs should directly come from communities and 60 percent should be found through election. This condition was fulfilled in all the six studied HFGCs. However, there were some notable factors that render community representatives have insignificant or little influence in HFGCs. These factors can be generally divided into two categories, especially personal and relational-structural factors.

In terms of personal factors, the study found that the majority of the representatives like the average community members had no competencies required to understand and contribute on strategic issues on agenda during HFGCs meetings. Out of the 22 direct community representatives who participated in the study, 17 had primary school education and only 6 of the representatives said that they had been exposed to training or seminars on budgeting, planning, or financial management. Reasons associated with inclusion of representatives with low competencies were provided, which mainly related to

- Lack of qualified representatives who have interest and readiness to participate in HFGCs activities without clearly known benefits
- Favoritism where representatives are head-picked by officials depending on relationship including family relationship, friendship and other related relationship
- Representative positions in HFGCs strategically used to build a CV for entering in politics where those with such interests seek such opportunities by all means.
- Representatives are sometimes picked not due to competencies, but their social status and influence depending on wealth and spiritual power.

⁴ In the studied communities, keeping community members in good relationship and avoiding isolation from community is taken to be a very important virtue. Someone is ready to risk his or her rights if favour of keeping good relationship between the one who denies the right and rest of the community.

Owing to the reasons above, the representatives who are identified to represent communities in HFGCs are perceived as having little legitimacy to the general public, they are not popular, and they are more loyal to VEOs and facility in charges compared to average community members.

Related to relational-structural factors, the study identified that the majority of the representatives had inferiority complex that was also accompanied with fear and mistrust. It was learnt that representatives see facility in charges and VEOs or WEOs as knowledgeable people who cannot be challenged by people like them. At Mtamba, one of the representative explained that the VEO is the one who knows the laws and thus what he tells them is the most correct (even where it is not). At Lundi, the representative quoted the VEO who had said that the law does not permit him to provide financial information that had not been approved by the District Executive Director. Indeed, the approval did not happen until it came to be discovered that information was masked since the WEO, VEOs of Lundi and Tegetero villages as well as the Chairperson of Tegetero had caused the loss of 800,000 Tshs. It was also clearly identified through interviews that in most cases matters discussed during committees' meetings are too technical. As it was noted by different interviewees at Mtamba, Kamagambo, Rwenkende, and Lundi, they *"sit down and listen to what the officers say, simply because they [officers] know what they are doing... and thus can't dictate decisions"*. In general, the capacity of representatives to deal with technical information was as difficult as it was for them to deal with superior HFGCs' members, especially the bureaucratic actors (health professionals, VEOs, WEOs, and facility in charges).

Related to fear and trust, the study found that during HFGCs meetings, representatives would opt to keep silent even where they know the decision ahead was not in favour of communities. In some cases, community representatives expressed the view that as they are part of the communities, they may not openly show that they are against what the *'waheshimiwa'* (meaning the respected) find to be appropriate decisions as they may not know the bad angle they may encounter them in the future. In this sense, the *'respected ones'* were health professionals and VEOs. In the researcher's view, such expressions, which were indeed common for all communities (except Rwenkende and Chonyonyo in Karagwe) may be interpreted as fear of retribution or victimization when a representative goes against the view of a these bureaucratic actors.

4.4.2. Elected Leaders

Elected leaders possess acceptability and legitimacy of communities they lead as their frontline facilitators of community development. In all the studied communities, elected leaders, mainly the villages and neighborhood chairpersons commonly participated in community governance partnerships. In terms of HFGCs, village chairpersons served as chairpersons of HFGC meetings who were also responsible for convening committee meetings. Learning from interviews with health facility in charges, it was clear that village chairpersons were recognized as capable of tarnishing the image of either the VEO's office or the health facility as most of the community members listen them and respect them. According to the interviewees from Mkuyuni and Mtamba, one has to be careful with them, which includes making sure they are informed of what is happening and they are in support of decisions taken.

On the other side, based on interviews with members who were in the elected grassroots leaders' category, it was identified that despite efforts to co-opt them, village chairpersons had no sufficient trust in VEOs and facility in charges as they thought they do not listen them. Interviewees at Lundi and Kamagambo expressed the feeling that officials and health professionals come to meetings having agreed among themselves on what they should tell others.

In the researcher's observation, the feeling of powerlessness and lack of self confidence among elected leaders arise from limited income, knowledge, key skills, and information. Like community representatives, it was noted that elected leaders have limited influence in processes through which HFGCs arrive at key decisions.

4.4.3. Formal Accredited Community Groups

Formal organizations, which were identified as connected with healthcare related matters were not at that time working in study areas in both of the districts. While some had their established offices in the nearest towns, some had established some facilities in the nearest villages as it was for Mavuno Improvement for Community Service and Education (MAVUNO) in Chonyonyo village. However, according to interviewees, Mavuno was mainly concerned with education, water, and sustainable agriculture rather than healthcare. In addition, like most of the NGOs that had been experienced in Karagwe, Mavuno had only tried to enter the healthcare industry as a service provider rather than being a watchdog. Also popularly mentioned was the Family Alliance for Development and Cooperation (FADECO) in Karagwe, which was mainly concerned with information flow facilitation allowing rural communities to report malpractices by health facilities in delivering services through their phones. According to the interviewee from Chonyonyo, FADECO through its radio promotes knowledge on community healthcare (mostly on obstetric fistula). For most of the interviews, it was agreed that information sharing to some extent helped communities to understand that healthcare was their right. In Morogoro, the study identified existence of Morogoro Rural Non-Governmental Organization (MRNGO) and Matombo New Vision Development Organization (MNVDO) in Mtamba-Matombo villages. According to the MRNGO leadership, 'health in general' and HIV/AIDS were among their operational areas. However, other interviewees had view that MRNGO had never demonstrated its role in empowering communities on community healthcare.

Despite the fact respondents agree that NGOs and CSOs are important for facilitating awareness creation, in both of the districts were criticized for struggling to be focusing on services provision rather than community empowerment. Equally, NGOs and CSOs in the study communities were accused of being segregative and focusing their efforts in semi-urban areas such as Kayanga and Omurushhaka and Karagwe and not focusing on overarching community needs such as healthcare. In addition, NGOs many respondents who were interviewed in both Morogoro and Karagwe had view that NGOs are private projects of individuals and the target sectors which will give them profit such as education and agriculture.

4.4.4. Informal Organized Community Groups

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 were found to facilitate quick free information flow. Most of these groups were organized by women. Examples of these were 'Tusaidiane' (Mtamba), 'Mtaji wa Maskini' and 'Tulamke' (Mkuyuni), 'Tweyambe, (Rwenkende), and 'Abatasigana' and 'Makadada' (Chonyonyo). 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. In Kamagambo village (and other villages in Kiruruma ward-Karagwe) women were moved following lack adequate health services at their dispensary and little trust that the village government may efficiently mobilize resources and fairly allocate them for healthcare. Consequently, they organized themselves under the name '*Wamama*' where they started a collective women fund called '*kapu la mama*' (meaning mother's

basket) through which they contribute and raise funds for building a laboratory. Their leaders were clear that they usually tracked their own funds and also discussed how funds collected by the village government are used with the aim of making such funds secure until they get 20 million Tanzanian shillings. In one way or another, this initiative shows how effective informal-community networks can play an effective role related to both mobilization and oversight of funds for healthcare.

As opposed to formal-registered CSOs and NGOs, informal self-help networks were found to provide more room for information sharing and promotion of free dialogue out of formal government framework. Equally, the study found that they are active and have strong links with average members of communities. They also retain freedom and confidence to share among individual, and allow for quick information flow. However, given lack of 'formal channels' informal organized community groups were identified with several weaknesses, which for one of the interviewees from Chonyonyo make them poisonous. Informal organized community groups were identified with transforming unverifiable information into topical issues at community level, which sometimes results into conflicts and sometimes enmity. For instance, a popular story was captured on a VEO who had bought a motorcycle and built a house within a time when the construction of a dispensary was in progress at Chonyonyo. A group of women called "*Ma-Kadada*" initiated and spread information that the VEO had stolen money for dispensary construction. The rumors went around and some people reported to the elected community leaders at village and ward levels. A conflict grew big leading into termination of the VEO. Unfortunately, it was later found that no money was stolen. Instead, the VEO had sold his cattle and also obtained a loan from a bank. From this point of reference, informal organized community groups are also referred to as "*vyama vya umbea*" (meaning gossips' associations). Given their informal and unofficial nature, informal organized community groups seems to enjoy legitimacy to communities, but most lack legitimacy to officials and formal authorities at community level. Overall, 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. The main challenge to informally organized groups, which significantly limits their influence is little acceptance by officials and authorities due to their legal status.

4.5. Design and Structure of the HFGCs' Partnership

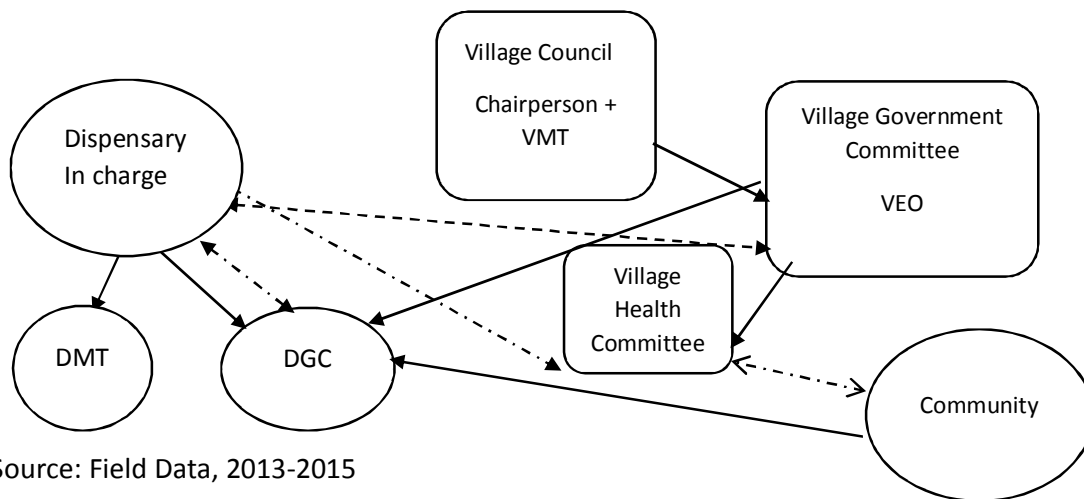
The guidelines for HFGCs formulation and operation specify how frequent HFGCs should meet, their composition, and function. Under the '*Guidelines for the Establishment and Operations of Council Health Service Boards and Health Facility Governance Committees*, HFGCs have legal mandate to review and approve 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. Committees are mandatorily needed to meet at least once within three months and have tenure not exceeding 3 years. Representatives are expected to be obtained through a competitive process (probably to get those with the highest potential) and represent key needy groups in the communities, especially women. Committees are mandatorily needed to meet at least once within three months and have tenure not exceeding 3 years. It is a requirement that both Health Centre Committees (HCCs) and Dispensary Governance Committees (DGCs) have eight members. These should include two (for health centre) or three (for a dispensary) non-vote members one of whom should be the in charge of the primary health facility (who by default a secretary) and a representative of the Ward Development Committee (WDC) (or and Village Government Committee (VGC) for a DGC). Guidelines also allow for six (for health centre) or five (for dispensary) vote-members. For a Health Centre Committee (HCC), the remaining six elect members should include at three elected community members, a

representative of the Health Centre Management Committee (HCMC) and representatives from the private not for profit and private for profit health facilities. For a DGC, the remaining five vote-members must include three elected representatives from community, and representatives of the private not for profit and private for profit health facilities.

The study found that that the guidelines were followed for the non-vote. On the side of vote-members, the composition varied from one HFGC to another, but representation of women was assured. Procedures for obtaining representatives were not clear where in five of the six HFGCs all representatives said they were just ‘invited’ and called to become members of committees. In addition, the majority did not know what group they represented (including women representative).

Structurally, the study found that HFGC had functions that relate to those of the Village Government Committee, which enjoy formal autonomy. However, there are no formal defined relationship between the two. VGCs have a formal mandate to receive and discuss issues and complaints that arise from facilities’ governance, but this is not formally provided under the operations of HFGCs. In addition, HFGCs have no formal linkages and representation in the village government, which is autonomous. Yet the relationship with village standing committees responsible for health seem to be unclear thus placing HGCs at disadvantage. Figure 2 overleaf illustrates the relationship between the village government and the HFGCs in terms of personnel, lines of authority, and representation.

Figure 2: Structural relationship between Village Government Committee and HFGCs



Source: Field Data, 2013-2015

The full arrows show membership while dotted arrows show direction of authority. Learning from figure 2, there are two different, but parallel structures for health governance. One is the traditional village administration structure, which in terms of membership includes the facility in charge. While Village Health committees (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 is a default member of VHC. In terms of representation, VGCs have sufficient representation in HFGCs and the later operate in the framework of the former, but HFGCs have no such representation. Thus, the acclaimed influence of HFGCs on the village health governance system (which includes the mandate to review and approve plans by village government) seems to be constrained and non-

practicable. This makes existence of HFGCs questionable despite its credit, which is providing more focus of health priorities as opposed to VHCs. In relation with the entire community, committees are not having mechanisms in place of integrating voices from different social groups and

In terms of the relationship between HFGCs and communities, communities are ideally part, but in this case separated from the HFGCs. The relationship makes communities 'hanging' as there are no formal mechanisms for integrating community voices as well as making HFGCs accountable to communities. As a result, even HFGCs that were identified as somehow active such as those of Mkuyuni and Mtamba-Matombo, their operations end up not providing means for feedback to communities. While it is clearly that at least 60 percent of the members should be elected (meaning representation), the mechanisms for assured channeling of communities' concerns into HFGCs are not provided by the existing design. In addition, there is no formal requirement and procedure for ensuring that representatives are answerable to communities. Most of the representatives informed the researcher that complaints presented to HFGCs are from personal experiences or communicated to them by friends, relatives, and family members or contingently heard in places like local brew bars popularly known as '*kirabuni*'. These relations limit both the functionality of HGCs and chances for effective community representation.

4.6. Power Relationship and Diversity of Interest

As noted early, HFGCs are partnerships of different actors, but broadly subdivided into different sub categories depending on powers and influence of different actors over others. The first category generally includes all community actors participating in the HFGCs, especially community representatives and elected community leaders. The second category is that of bureaucratic actors who were defined early as including WEOs, VEOs, health professionals, and in charges as well as representatives of health facilities. The study primarily noted that relations arising from the partnership are power relations where each of the two parties to the partnership struggling to protect its interest. During HFGCs meetings, it is observed that debates between VEOs and village chairpersons usually ended up without consensus. However, at the end, the VEO always ended up winning while chairpersons loosing. On the other hand, if such differences happen between the VEO or WEO and facility in charge, justification must come from the in charge of the health facility. Equally, the justification for any matter upon consensus is lacking, experiences from FGD meetings shown that each of the parties appeal to different lines of reasoning. In most cases, chairpersons tended to appeal to public interests. On the other hand, VEOs and WEOs tend to justify their positions on basis of government regulations, which the clearly know that most of the village chair persons are not aware of. In some incidents, VEOs and health facility managers were identified making reference to wrong justification points. A good example was a claim that showing financial reports to HFGCs members before they are submitted to the district council and approved by the District Executive Director was not accepted (which VEOs themselves admitted that it was not correct but was used to 'postpone' the matter). Unequal power relations suggest that bureaucratic actors are capable to control the agenda and direct meeting into discussing what they think must be discussed and thus reach decisions that favour their interests.

It was also noted by the study that power and influence in HFGCs was more attached to position and authorities held by individuals in the government and other community institutions. Public health facility in charges are identified as the most powerful and influential. This is basically due to the fact that apart from being technically competent, they are also influential because HFGC meetings in all cases with exception of Chonyonyo were conducted at health facilities. Apart from hosting meetings, they also acted under the umbrella of their profession as 'doctors'. In some cases such as Mtamba, it was reported that upon their pleasure, facility in charges were able to

be hospitable to her guests by buying them soft drinks and give them 1500 Tshs for each member as fare. In addition, interviews demonstrated that an average representative in the committee could also be more influential compared to elected community leaders and VEOs depending on his economic position in the village. In all the six studied committees, interviews 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 Mkuyuni 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, Mkuyuni].

Apart from showing little trust, they also express fear, passivity, and apathetic participation of community representatives in HFGC, which suggest that HFGCs lack some characteristics of 'partnerships' and thus qualify to be called partnerships of the unequal. 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 those who were average representatives of communities. However, for some interviewees such as one representative who was interviewed at Rwenkende, the interpretation was different. For her, it meant more confidence, trust, and respect to officials and health professionals by community representatives (which they deserved and was not bad for participation) rather than inferiority complex. In the researcher's view, power relationship that emerge within HFGCs make community representatives and community leaders silent observers even where they see that officials and health professionals act against community priorities and interests. In the way, the capability of community actors to influence decisions and actions aimed at ensuring financial accountability and improve quality of services becomes limited.

5. CONCLUSION AND IMPLICATION

The main aim of the paper was to examine the capability and influence of community actors in health Community Governance Partnerships of which Health Facility Governance Committees (HFGCs) are the most popular both in developed and developing countries. The role of these partnerships is considered to be pivotal in strengthening health systems delivery at community level. In the up-and-coming literature on healthcare, community partnership is perceived as a prescriptive solution for problems arising from corruption, resource paucity, equitable engagement of the market in health services delivery, and the currently expanding role of a democratic state that renders it unequipped to meet public needs without relying on the market and civil society. Theoretically, HFGCs as health governance partnerships are perceived as being forums of communities, for communities, and by communities. In this view, the efforts of global health governance stakeholders have largely taken a form of support for creating and strengthening of HFGCs in all 'communities'. However, a salient lesson from the literature has been that the idea of a 'community' is itself controversial and subject to social, economic, and political dynamics in a given society rather than formal designs of administrative structures.

The study findings support recent findings on community health governance interventions in Tanzania and other countries with related social and economic contexts. Pertinently, community awareness, limited resources and abstractness of enforcement guidelines (Kessy & Ramsey, 2014; Kilewo & Frumence, 2015; Maluka et al., 2011) appear to be among the most consensual, but common constraints that may need solutions rather than further exploration. Closely looking into what accounts for differences between communities, especially rural versus urban calls for going beyond simplistic factors and focusing on issues of design, competencies and how they are dynamical shaped by the social, economic, and cultural context of individual communities.

This study also observes that establishment of HFGCs in Tanzania has been a matter of policy action to be officially adopted and pursued in relation to procedures and frameworks that are designed based on evidences from relatively improved health systems such as those of Brazil, Mexico, Canada, and India. It is easy to note that the adoption did not sufficiently consider the principle that a partnership should have members with equal powers and voices. Community-side actors were simply integrated into the partnership and became participants under already designed and introduced systems. However, the fact remains that formal guidelines do not provide clear mechanisms that may allow rural communities whose competency levels are very low to influence decisions of in HFGCs. Difference in terms of competencies and lack of clear rules make decision-making in HFGCs a game that involves actors with unequal powers. In this respect, HFGCs, which are perceived as partnerships for empowerment become partnerships for disempowerment.

Finally, community-based healthcare governance partnerships, Health facility Governance Committees in particular cannot work best in the current context of Tanzanian rural communities. Efforts to achieve effective functioning of HFGCs should rationally aim to create environments that consider the existing differences between community and bureaucratic actors in terms of power and competencies. Equally, within the process of creating effective community partnerships for health governance, there is a need to reconsider harmonizing the functions performed by the village government and HFGCs and redefining the relationship between the two. With the current relationship, authoritative representatives of communities fail to play their expected role due to dominance of bureaucratic actors and lack of formal mechanisms that subject HFGCs to direct scrutiny by citizens. Lack of positively spirited, altruistic, and socially conscious vibrant Civil Society Organizations among rural communities makes community activation and development of organized collective consciousness (which in turn strengthen) voicing and demanding accountability unrealistic. In the process of promoting functionality of community health governance partnership, the need for building and strengthening capacity of community actors including average community members, representatives, elected community leaders, and organized informal and formal associations is imperative. These capacity building interventions should focus on transformative change in culture aimed at developing virtues of active participation and providing skills required for budgeting, priority setting, and well as analyzing and using financial information for promoting transparency and accountability.

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