COMMUNITY PARTICIPATION IN DECENTRALIZED MANAGEMENT OF HEALTH SERVICES IN TANZANIA: A CASE STUDY OF MOSHI RURAL DISTRICT

By

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Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the University of Dodoma, a dissertation entitled: "***Community Participation in Decentralized Management of Health Services in Tanzania: A Case Study of Moshi Rural District"*** in partial fulfillment of the requirements for the degree of Master of Arts in Public administration of the University of Dodoma.

……

Prof. Davis Mwamfupe

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Date ……

DECLARATION

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I, Lyimo Hope J. declare that this dissertation on Community Participation in Decentralized Management of Health Services in Tanzania: A Case Study of Moshi Rural District: is my own original work and that it has not been presented and will not be presented to any other University for similar or any other degree award. Any source of information is dully acknowledged.

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DEDICATION

This dissertation is dedicated to my late mother Mrs Ruwaichi Lyimo; my father James Lyimo my brother Patrick Lyimo and my sister Mary Lyimo. Without their endless love, care, encouragement and support throughout my studies, I could not have grown up to earn this great achievement. May God bless them.

ABSTRACT

This work is about ‘Community Participation in Decentralized Management of Health Services in Tanzania: A Case Study of Moshi Rural District’. The issue of community participation in facility health budget planning has gained profound importance all over the world, particularly in resource-poor situations where governments have often failed to provide adequate public-sector services for their community members. The aim of this dissertation was to provide the experience of implementing community participation and the challenges of promoting it in the context Moshi Rural District.

A sample size of 96 respondents was employed in this study. Semi-structured questionnaires were administered and analysis of policy and legislative documents was also undertaken. Quantitative data were computed to produce frequencies and cross tabulations,. The Statistical Package for Social Science (SPSS) was used for management of data and analysis. In this study the theories pertaining to participatory theory was established to familiarize the reader with paradigms, frameworks and approaches in the field of community participation.

The findings from the study reveal that community participation in the decentralized management of health services in Moshi Rural District requires supportive policies and laws, since there is limited participatory, none-transparent and none-answerable to the community members. The study recommends that, the community members should stand on themselves so as to supervise their health heed as of their own and the government should find appropriate ways of engaging the community members in the planning processes.

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LIST OF ABBREVIATIONS

CCHP	Council Comprehensive Health Plan
CHMT	Council Health Management Team
GoT	Government of Tanzania
O&OD	Obstacle and Opportunity Development
HSSP	Health Sector Strategic Plan
MDGs	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
NSGRP	National Strategy for Growth and Reduction of Poverty
NGO	Non Governmental Organization
PHCDP	Primary Health Care Development Program
SPSS	Statistical Package for Social Scientist
URT	United republic of Tanzania
USD	United States Dollar
UK	United Kingdom
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 General Introduction

This section looks at the historical background of the study, statement of the problem, general objective of the study, specific objectives of the study, research questions, and significance of the study and finally limitations of the study/delimitation of the study. This study aimed at looking into the role of community participation in decentralized management of health services in Moshi Rural District in Tanzania. It further investigated the level of community participation in budgeting process as well as monitoring the implementation of district health budget in Moshi Rural District as a case study. The study has five sections that include: introduction which involves background to the research problem, literature review which involves two theories that guide the study and empirical evidences; section three has the research methodology; the findings and discussion and the last section has the summary, conclusion and recommendation.

1.2 Background Information

For the development of any nation in the world it needs people who are healthy and able to participate in economic activities. These can only be achieved through ensuring proper health system management and community participation in planning for their health. To ensure quality health and wellbeing of the society the government of Tanzania through the Ministry of Health and Social Welfare has implemented many strategic plans some of which are short and long-term in nature. The National Health Policy of 2007 succeeded those of 1990 and 2003. The first Health Sector Strategic Plan (HSSP) was implemented from1999 to 2002. The

HSSPII started in June 2003 and ended in 2009 and a third one ran for a period of five years starting from July 2009 to June 2015.The Primary Health Care Development Programme (PHCDP) that is still under implementation is running for five years from 2007 to 2017. The plan aims at improving service delivery by strengthening the primary health facilities and improving human resource for health in the country (MoH Report, 2003).

Key health policies such as health sector plans, health policy are incorporated in the National Strategy for Growth and Reduction of Poverty (NSGRP). The NSGRP (2005–2010) is organized around three outcome clusters, which are growth and reduction of income poverty, improved quality of life and social wellbeing, and good governance and accountability. According to the NSGRP (2005), good governance and accountability which belongs into cluster III among of other thing it's aimed at develop structure and system of democratic governance which are democratic, participatory, representative accountable and inclusive.

In achieving broad community participation in decision making, the government of Tanzania has been implementing several reforms that aimed to insure good governance and community participation. The Local Government Reform Programme (LGRP) started in 2000 to facilitate decentralization of political, financial, and administrative powers to local governments and change central and local government relations (URT, 1998). The program implements strategies that are geared towards decentralization by devolution to enhance public ownership of development.

Health system governance problems cover a broad spectrum of issues ranging from lack of participation, transparency, and ineffective health care provision, to unfair

health financing and unequal access to health care (WHO, 2006). Not surprisingly, good governance that includes elements such as participation was suggested as the single most important factor in achieving the Millennium Development Goals (UNDP, 2002).

The Ministry of Health and Social Welfare introduced reforms that aimed at introducing decentralization of power to local government authorities for delivery of health services and management of resources in order to bring quality health services closer to the people and respond to their demand and health needs. As an outcome of these reforms, Health Boards, Health Facilities Committees and new allocation formula have been introduced to ensure good governance and community participation in the delivery and management of health care services within their district.

The World Bank's Africa Development Indicators (2010) suggest that in the health sector there are some aspects such as health system governance community participation, stock out of essential medicines and staff absenteeism at the local facility level that have a huge impact on overall health outcomes. Poor community participation can sometime lead into poor implementation of the health programs because people may tend to ignore the program in believe that their concerns were not taken into board (ADB, 2010).

More concretely, the issue of community participation in planning and budgeting remain a key concern in Tanzania. By having underlined procedure for ensuring community participation in planning would add a valuable contribution to the strengthening of the health system in Tanzania. The framework proposed in this conceptual framework acknowledges the need for a comprehensive 'systems

thinking' perspective that takes into consideration the community desire and demand in participation in planning for budget process. It is the interest of this study to examine the role of community participation in decentralized management of health services in Tanzania Moshi Rural District as a case study.

1.2 Statement of the Problem

As per the NSGRP, good governance including community participation in development programs has been a pre-requisite for the achievement of broad based growth and improvement of quality of life and social well-being. The government implements local government reforms, among other reasons, to improve the quality of public services, good governance and participation at district level. Through decentralization by devolving more powers and financial resources to the district authorities, health service providers should make better use of public resources while community members play their civic role of participating in planning and holding service providers to account in case of any misuse or abuse of public office or resources.

Congruent with such efforts, there are, multiple planning, budgeting, and reporting systems such as Planning and Reporting (Plan Rep), Opportunities and Obstacles to Development (O&OD), Council Comprehensive Health Planning Guidelines (CCHPG), and other specific donor funded project planning and reporting guidelines that have been introduced. These are strategies to enhance community participation at grassroots level adopted by the government to improve community participation in their social services provision including health services.

Despite such efforts to bring people close and participate in their health services provision, community engagement is still challenges in most districts. According to

Masuma and Maggie,(2004) citizen representative bodies such as Health Committees and Boards are unknown to ordinary people and are not functioning to the extent planned and wished. This implies that, central ministries are fully in control of priorities and processes for district authorities planning and reporting. Legal and policy prescriptions for roles of community and autonomy of Health Facility Governing bodies and that of the Council in planning, implementation and reporting are reduced to mere rhetoric by simply a telephone call from the central government. Therefore the purpose of this study is to examine community participation in planning and budgeting for the health sector budget in Moshi Rural District.

1.3 Objectives and Research Questions

1.3.1 General Objective of the Study

The general objective of this study was to examine community participation in decentralized management of health services in Tanzania. Moshi Rural District will be taken as a case study.

1.3.2 Specific Objectives

The study specifically wants to achieve the following objectives:-

a. To evaluate the role of community participation in the formulation of district health budget.
b. To examine the extent to which existing policy and laws promote community participation in planning for health.
c. To unravel challenges for enhancing community participation in the planning process of health budget.

1.3.2.1 Research Questions

In order to achieve the above objectives, the study used the following research questions:

Specific Objective A:

a. What is the role of community participation in health budget formulation?
b. To what extent are the existing policy and laws promoting community participation in planning for health services?
c. What could be the challenges for enhancing community participation?

1.4 Significance of the Study

Community participation in decentralized management of health system in Moshi Rural District is one way to ensure trust and sense of ownership of service delivery in the country. Through involvement of community in planning and setting priority for health programs it would help to bring transparency, accountability and also help to solve some diseases which mainly are originated from community due to poor hygiene and lack of public health education.

The rationale of this study was to put open the reality concerning knowledge attitude and practice of Moshi Rural District in involving community in planning for health budget. The study will help to add on the body of knowledge regarding interventions to ensure community participation in planning process for health budget especially during the time for developing Comprehensive Council Health Plans (CCHP).

The findings from the study will be communicated to policy makers and implementers to insure community members are consulted in planning and budgeting for the health budget. The study also provide an opportunity to other students and researchers to undertake similar work using other programs and interventions implemented in Tanzania for the purpose of improving community participation in planning for health budget.

Furthermore, during the course of preparing this dissertation, the researcher benefited from this exercise, through increased knowledge on research work and making executive presentations in his daily professional work, and make sound decisions with regard to improving community participation in decision making.

1.5 Scope and Limitation of the Study

The study was affected by various limitations such as limited knowledge among the community members on research which led some attempt to hide some information and also fear to speak openly. This limitation was solved by providing them with information about main purpose of conducting this research and the key objective of the research. Community members (target groups) were able to participate in the research and also were educated on their rights to participate in community meeting and their role as community members to participate in the management of health programs in their areas.

A financial constraint was another limitation encountered during the study. The money that was estimated could not meet the accomplishment of the journey of data collection; hence the researcher had to use money from his own pocket and other sources to carry out the respective activities. The critical obstacle was the unwillingness of women to discuss issues more openly due to being restricted by

their husbands to participate in the research activities the husband would always jump in the dominate the discussion, leaving the women in isolated situations. The researcher had to take time to educate men in families of the prevailing situation and they could then allow them engage in the research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature review on the subject. The purpose of this review is to look into the theories which are relevant to the study as well as looking into empirical studies relevant to the current study. By doing so this chapter will identify the knowledge gap and this is followed by definition of concepts. Theoretical and empirical reviews are also presented. The chapter also provides the conceptual framework that guided the collection and analysis of data. The chapter ends by the identification of knowledge gaps which in some ways is linked to the objective of the study.

2.2 Definition of Concepts

2.2.1 Participation

Participation in social science refers to different mechanisms for the public to express opinions and ideally exert influence regarding political, economic, management or other social decisions(World Bank 1996) Participatory decision-making can take place along any realm of human social activity, including economic (i.e. participatory economics), political (i.e. participatory democracy or par polity), management (i.e. participatory management), cultural (i.e. polyculturalism) or familial (i.e. feminism). For well-informed participation to occur, it is argued that some version of transparency, e.g. radical transparency, is necessary but not sufficient (Mitchell, 1999; Sharma and Deepak 2001). It has also been argued that those most affected by a decision should have the most say while those that are least affected should have the least say in a topic.

Defining participation means many things to many people. Our review of the different bodies of literature about participation of the various classifications of participatory activities helped to highlight the breadth of activities people are engaged in and identify some of the overlapping meanings and expressions of participation. It allows us to distinguish three broad categories of participation - public, social and individual participation – which are defined below he engagement of individuals with the various

Structures and institutions for democracy, key to public participation is the relationship between individuals and the state. The collective activities that individuals may be involved are at the heart of social participation. The individual choices and actions that people make as part of their daily life and that are statements of the kind of society they want to live in Paul (1987).

2.1.2 Community

Communities are groups of people with a common interest. A public community with open access is available for all to join, while membership of a restricted community is limited to a particular group Rothman (1972) had noted that you can also start a public community with invitation-only access, allowing you to control membership and manage access to the community's resources.

A community provides the means for users to stay in touch, share information, and exchange ideas. Communities provide an excellent way to connect members of a project team, organize a task force researching an emerging technology, or bring together a group of people who share any interest.

Starting a community can help you to build a valuable repository of information and expertise about a specific subject. In addition to sharing files, bookmarks, and other resources, when members need the solution to a specific problem, posting a question to the community forums is a great way to leverage knowledge within the community. Experts within the community can answer the questions and share their insights with other members.

Use the tools provided with the community's application to reach out, make connections, get organized, and start sharing information. As a community owner, you can invite others to join, and manage the content and membership for the community. If owner moderation is enabled, you can also review and manage the content of community blogs, files, and forums Scott (1983).

2.1.3 Decentralization

Decentralization (or decentralization) is the process of redistributing or dispersing functions, powers, people or things away from a central location or authority. While centralization, especially in the governmental sphere, is widely studied and practiced, there is no common definition or understanding of decentralization. The meaning of decentralization may vary in part because of the different ways it is applied. Concepts of decentralization have been applied to group dynamics and management science in private businesses and organizations, political science, law and public administration, economics and technology.

Other definitions and descriptions of decentralization used in the study include: "Decentralization is usually referred to as the transfer of powers from central government to lower levels in a political-administrative and territorial hierarchy (Crook and Manor 1998; Agrawal and Ribot, 1999). This official power transfer can

take two main forms. Administrative decentralization, also known as deconcentration, refers to a transfer to lower-level central government authorities, or to other local authorities who are upwardly accountable to the central government (Mustafa, 2005). In contrast, political, or democratic, decentralization refers to the transfer of authority to representative and downwardly accountable actors, such as elected local governments" (Larson). "The term decentralization is used to cover a broad range of transfers of the "locus of decision making" from central governments to regional, municipal or local governments" (Sayer et al.). Decentralization reform refers to "transforming the local institutional infrastructure for natural resource management on which local forest management is based" Ribot (1999). "Decentralization is "the means to allow for the participation of people and local governments" Morell (2010). Decentralization is transferring the power from the federal to regional level or delivering management functions to other authorities. In this study therefore, decentralization should mean a complete transfer of decision making power and authority from the central government to local agencies.

2.1.4 Management

Management in business and organizations is an art that coordinates the efforts of people to accomplish goals and objectives using available resources efficiently and effectively. Management comprises planning, organizing, staffing, leading or directing, and controlling an organization to accomplish the goal. Resourcing encompasses the deployment and manipulation of human resources, financial resources, technological resources, and natural resources. Management is also an academic discipline, a social science whose objective is to study social organizations (Cumming et al 1968).

Management is the organizational process that includes strategic planning, setting objectives, managing resources, deploying the human and financial assets needed to achieve objectives, and measuring results. Management also includes recording and storing facts and information for later use or for others within the organization. Management functions are not limited to managers and supervisors. Every member of the organization has some management and reporting functions as part of their job (Aldefer, 1969). In this study management should be perceived as the process of ensuring goals and objectives of the local government are achieve in an efficient and effective manner through organizational resource.

2.2 Theoretical Literature Review

This study applied theories such as Public Participation Theory, and Aronstein's Ladder of Participation Theory.

2.2.1 Public Participation Theory

The roots of community participation can be traced to ancient Greece whereby the community members were consulted during the decision making process. Community participation theory suggests that in discussing the theory of public participation, it is useful to review broad theories of decision-making structures. In exploring the role of technology in public policy decisions in the book "Citizen Participation in Public Decision Making (1987)" DeSario and Langton conclude that public decisions are increasingly being influenced by technology. In the context of decision-making structures there are two approaches that are involved; technocratic approach and the democratic approach.

2.2.2 Arnstein's Ladder of Participation Theory

Perhaps the seminal theoretical work on the subject of community participation was by Arnstein (1969). The particular importance of Arnstein's work stems from the explicit recognition that there are different levels of participation, from manipulation or therapy of community members, through to consultation, and to what we might now view as genuine participation, i.e. the levels of partnership and citizen control (see Figure 2.1). The limitations of Arnstein's framework are obvious. Each of the steps represents a very broad category, within which there are likely to be a wide range of experiences. For example, at the level of 'informing' there could be significant differences in the type and quality of the information being conveyed. Realistically therefore, levels of participation are likely to reflex a more complex continuum than a simple series of steps. The use of a ladder also implies that more control is always better than less control. However, increased control may not always be desired by the community and increased control without the necessary support may result in failure.

Figure 2. 1: A Ladder of Participation

Citizen control
Delegation of power
Partnership
Placation
Consultation
Informing
Therapy
Manipulation

Source: Arnstein (1969)

Since Arnstein, increasingly complex theories of participation have been advanced and new terminology added. In particular, there has been a shift towards understanding participation in terms of the empowerment of individuals and communities. This has stemmed from the growing prominence of the idea of the citizen as consumer, where choice among alternatives is seen as a means of access to power. Under this model, people are expected to be responsible for them and should, therefore, be active in public service decision-making. In this context, Burns et al (1994) modified Arnstein's ladder of participation and proposed a ladder of citizen power (Figure 2.2).

This is more elaborate than Arnstein's ladder, with a further, more qualitative breakdown of some of the different levels. For example, a distinction is drawn between 'cynical' and 'genuine' consultation, and between 'entrusted' and 'independent' citizen control. The phenomenon of 'civic hype', increasingly recognized during the 1990s (see, for example, Harvey, 1989), is incorporated at the bottom rung of the ladder. This essentially treats community participation as a marketing exercise, in which the desired end result is 'sold' to the community.

Figure 2. 2: A Ladder of Citizen Empowerment

Citizen Control
12. Independent Control
11. Entrusted Control
CITIZEN PARTICIPATION
10. Delegated Control
9. Partnership
8. Limited Decentralized
DECISION MAKING
7. Effective advisory board
6. Genuine Consultation
5. High Quality Information
CITIZEN NON PARTICIPATION
4. Customer care
3. Poor information
2. Cynical consultation
1.Civic Hype

Source: Burns et al, (1994)

2.3 A Continuum of Involvement

As a development of this ladder concept of participation Wilcox (1999) identifies five interconnected levels of community participation.

Figure 2. 3: A Ladder of Participation

Information
Consultation
Deciding together
Acting together
Supporting individual & Community initiatives

Source: Wilcox, (1999)

Wilcox's (1999) work has arisen from the UK regeneration context and reflects a philosophical progression in though around participation. That different 'levels' of participation are acceptable in differing context and settings, this progression recognizes that power is not always transferred in apparently participative processes, but that the processes still have value. As opposed to the common interpretation of Arnstien, that brings the thought that it is only acceptable to be striving towards citizen control. Within some contexts this move in philosophy has been further developed to describe levels of involvement as a continuum.

2.2.3 Theory of Good Governance

Governance is the activity of governing or relates to decision that defines expectations, grants power or verify performance. It consists either of separate process or of a specific part of management or leadership process. Sometimes people set up a government to administer this process and systems. The word governance drive from the Greek verb (kubernao) which means to steer and it was used for the first time in a metaphorical sense by Plato. It then passed on to Latin and then on to many other languages. According to the United Nations Development Programme (2006) Governance has been defined as the rule of the political system to solve conflicts between actors and adopt decision (legality). It has been used to describe

"the proper functioning of institutions and their acceptance by the public". And it has been used to invoke the efficacy of government and the achievement of consensus by democratic means (participation). Participatory Governance focuses on deepening democratic engagement through the participation of citizen in the process of government with the state.

The idea is that, citizen should play more direct role in public decision making or at least engage more deeply with political issues. Government officials should also be responsive to this kind of engagement. In practice participatory governance can supplement the role of citizen as voters or as watchdogs through a more direct form of engagement. Tanzania are among the countries which adopt good governance although she is not practicing fully due to the following: Existence of corrupt leader in the government and increase of corruption in the government system, disobedience to the rule of law, abuse of human rights, low number of citizen who participate in national election. So this theory has a long way in Africa before fully applied in community participation.

2.3 Empirical Literature Review

Participation and transparency has become a major issue in public health policy and care in Tanzania, as a necessary means towards involving community in achieving quality and equitable health care services. Participation of community to a large intends improve performance of health care providers, management of public finances, and democracy in the delivery of public health care.

Community participatory in planning enables the community to make decisions, in the process of analyzing, planning, implementation and monitoring and evaluation of

the plans. In the process of planning, the community is facilitated to discuss and consult each other on their development issues.

According to International Association for Public Participation (2007) public participation is based on the belief that those who are affected by a decision have a right to be involved in the decision-making process. Public participation is the process by which an organization consults with interested or affected individuals, organizations, and government entities before making a decision.

Midgley,(1986) defines community participation as, "the theory that the local community should be given an active role in programs and improvements directly affecting it. It is only rational to give control of affairs and decisions to people most affected by them. He further explains that besides, since no government or authority has the means to solve all the public problems adequately, it is necessary to involve people in matters that affect them. Generally community participation means some form of involvement of people, with similar needs and goals, in decisions affecting their lives.

However, delegating powers to people is not an easy task and involves great inquiry into the change in the attitudes of the authorities and professionals, within the community. According to Nabeel Hamdi (1997) defines community participation as a powerful idea which refers to the process by which professionals, families, community groups, government officials, and others get together to work something out, preferably in a formal or informal partnership. He explains that community participation was initially an outcome of the public pressure demanding "environmental justice".

The advocates of community participation believe that it brings many lasting benefits to people instead of only a means of getting things done. Sherry Arnstein (1969) associates citizen participation with citizen power and control as, "the redistribution of power that enables the have-not community members, presently excluded from the political and economic processes, to be deliberately included in the future". Also Christopher Alexander (2007) explains that participation is "inherently good" and that it brings people together in creating and making decisions about their environment. Since people are actively involved in the process, Alexander, (ibid) argues that participation helps promote sense of ownership and control among the people.

To ensure proper management of the government fund and accountability of government officials, we need to ensure community ' participation in programs at the local level which will in turn leads into proper management of public resources. Participation brings transparency and accountability at all levels. Also participation makes the government accountable for what the people want instead of the government deciding on behalf of the people. Various academicians and politicians have emphasized community participation in public administration as a means of collaborating with community members to promote democratic values such as transparency and accountability.

According to Repoa (2010), Tanzania local government authorities were thought to be in a better position than the central government bodies to identify people needs and to encourage broader citizen participation in democratic governance .Involving community in deliberative and collective action will lead into civic engagement and centering public management on the community. Scholar such as Citrin and Muste

(1999) also emphasize that government effort to provide more opportunities for community participation and input in government performance evaluation and policy decision-making is an important strategy for improving trust in government.

Local government continuously faced the challenge of improving the quality of public service especially health programs and also the capacity to implement adequate policies and practices that respond to the challenges of economic and social development. Proper economic and social development demand influences from community whose expectations and trust lies on the local government that is responsiveness and values transparency and accountability.

Community organizations such as Non government organization have also expressed their interest in a more participatory approach to the decision-making processes. Community participation in planning and decision making results in building trust among the government and its people which in turn leads into the improving transparency and accountability at the local level.

Again Rowe (2005) noted that there are three different levels of citizens participation in which citizens can participate in the decision making process. The levels are

a) Citizen communication where information is flowing from the government body to the public;
b) Citizen consultation, where information flows from the public to the government; and
c) Citizen participation, where information is exchanged between the public and the government and some degree of conversion is taking place within the process.

Budget transparency is one of the pre-conditions that lead into increasing community participation and increase public accountability in service delivery to the people. Budget transparency is necessary to the local government and also in service delivery because it will build trust and recognition among the people and its governments. Poterba and von Hagen (1999) have noted that transparent budget process as the one that provides clear information on all aspects of Government fiscal policy. He also explain that budgets that include numerous special accounts and that fail to consolidate all fiscal activity into a single 'bottom line' measure are not transparent. Transparent budget is one that is easily available to the public and to participants in the policymaking process and the one that have consolidated information.

2.1.1 Local Government and Health Sector Reforms

In Tanzania the health service delivery in the country is mainly managed by the Ministry of Health and Social Welfare at the national level and the Prime minister office for Rregions and Local government in mainly responsible for health delivery at the district level. Article 146(1) of the constitution of the United Republic of Tanzania provide transfer authority and resources to people at the lower level of government in order to give them wider opportunities to participate in planning, implementation and evaluation of development projects within their respective areas. The government of Tanzania has introduced Local Government Reform Programme (LGRP) which started in 1996 to speed up, among other things, political, financial, and administrative accountability at district level. The program also sought to improve transparency in local government transactions and bring public services down to the people (URT, 1998).

In line with Local government reform program which are general, the Ministry of Health and Social Welfare introduced health sector reforms which resulted to decentralization of power to local government authorities for delivery and management of services. According to Local government reform program (1998), the overall purpose of the Health Sector Reform in Tanzania is to provide accessible, good quality, and cost effective district health services, organized at a decentralized level. The Local Government Reforms and Health Sector Reform Programs such as Health sector strategic Plan (I, II, III) all of them open up the opportunities for community members to participate in the planning, implementation and monitoring of health delivery and resources resource allocation at district level.

In order to ensure community participation in planning, good governance and community ownership in the public health care systems at the local level the Ministry of Health and Social Welfare has establish Health Boards, Health facilities committees and new formula based fiscal allocation to councils. Due to these reforms the local authorities have been given mandate to engage directly in the decision-making processes.

At district level, comprehensive council health plan have been introduced as a planning document of the district and its formulation procedure must involves community members within the district so that they can identify their priority and included in the plan based on available resources.

2.1.2 Opportunities and Obstacles to Development (O&OD)

To ensure community participation in every stage of planning from grass root to the national level the government has introduced a planning process method which is Opportunities and Obstacles to Development. This was one way to ensure sense of

community ownership and control among the people. Local Government Reform has been an engine to promote such Decentralization by Devolution policies empowering the grassroots and enhancing quality of service delivery for poverty eradication. According to URT (2007) the O&OD is a participatory community planning process to empower the people based on a bottom-up approach with a positive outlook. The Opportunities and Obstacles to Development (O&OD uses a planning model; which enables the community to identify in logical framework: the specific objectives, opportunities, obstacles causes, interventions, and steps for implementation.

The O& OD methodology has been institutionalized in the Local Government Authority structures in Tanzania so that it can be used as a planning model during the planning stage. It has been developed in line with the government's aspirations to devolve powers to the communities as declared in the Constitution of the United Republic of Tanzania, and implemented in the ongoing Local Government Reforms. In so doing, the government envisages to restore the spirit of self-reliance, local resource mobilization, transparency and accountability by ensuring effective community participation in planning, decision making, implementation and, therefore, ownership of their development activities.

2.1.3 Planning Process in Ward level

Local Government (District) Authorities Act of 1982 as amended by Act No. 6 of 1999 establishes the Ward Development Council. The WDC is comprised of a councilor representing the ward in the District Development Council and chairpersons of all village councils within the ward. The WDC also includes member(s) of the district council, who ordinarily reside in the ward; and invitees

from, for instance NGOs and other civic groups involved in the promotion of development in the ward. However, the invitees have no right to vote in the meetings. The WDC is responsible for developing general development plans for the ward.

The role of the ward development committee in planning is important in the aspect of identifying cross-village/street interventions, which reflects the needs at community level as well as in the view of bridging the Community Plans with the LGA Plan. In the rural setting, after receiving the instruction, with the support of ward officers, the Village Council reviews the Community Plan in the past year.

After the review of the Plan by the community and the village council based on O&OD planning methodology, the Village Assembly is supposed to approve the Three-Year Plan (TYP), which is then directly submitted to the LGA. In the urban setting, the Ward Plan is also supposed to be annually reviewed by representatives of Mtaa (community units based on streets in urban area). After the review, the WDC consolidates the Three-Year Ward Plan and submits to the LGA. In the O&OD planning process, the role of ward is only to provide technical advice on the Community Plans, which are then directly submitted to the LGA after approval by the Village Assembly. Thus, the role of the ward to consolidate cross-village intervention is not defined in the process.

2.1.4 Quality of Health Care

As per the Tanzania Demographic Health Survey, (2004) while there is some improvement in some of the indicators for health, there is deterioration in others. The total fertility rate is up from 5.6 children per woman in 1999 to 5.7 in 2004. Under-five mortality has improved from 146.6 per 1,000 live births in 1999 to 112

in 2004 while maternal mortality is up from 578 per 100,000 live births in 1996 to 454 in 2010.

In its efforts to ensure quality healthcare services and rights of service users, MoHSW developed the Client Service Charter for use with both healthcare service providers and users. It outlines services to be offered to citizens, roles and responsibilities of service providers and users, rights, guiding principles, and complaint mechanisms (URT, 2002).

2.4 Research Gap

From the number of studies reviewed, it has been revealed that community member's participation in planning has increased in recent years. The studies reveal that when community members are involved in the decision making process leads to the sense of ownership within the community. Approach like partnership have shown that increasing community participating in development project leads into sustainability of the project and the community members would be working and benefiting together and also they will have control over their affairs.

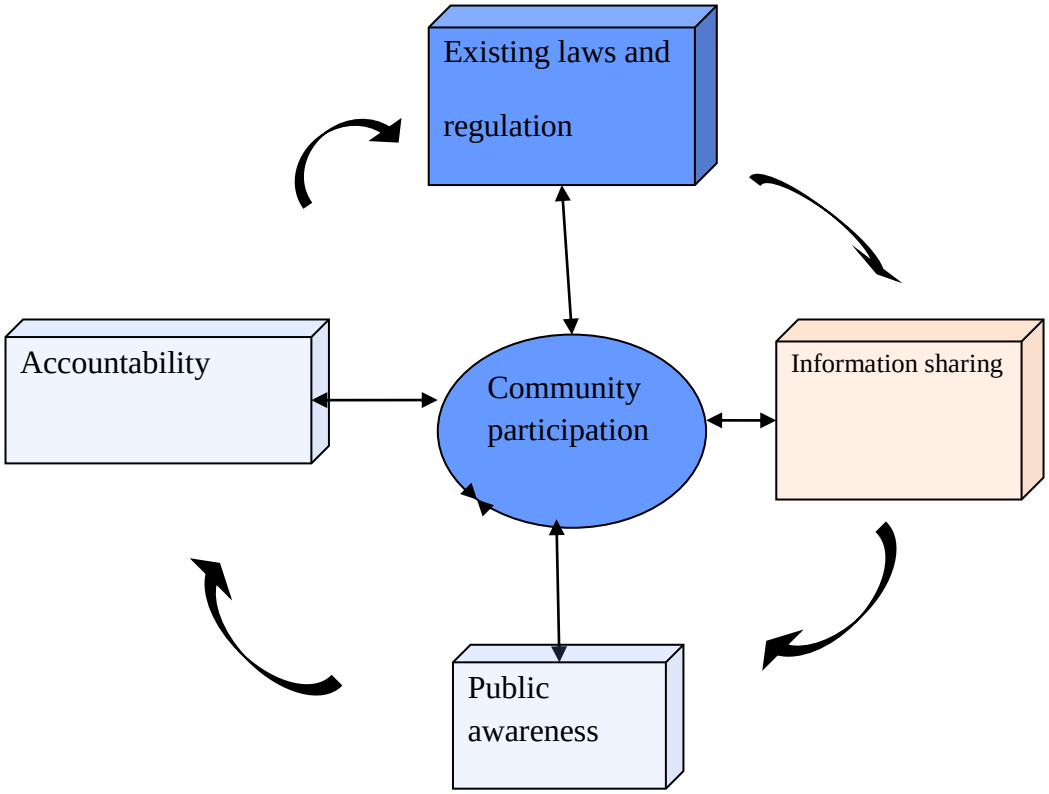
Therefore this study was carried out in view of contributing to the existing knowledge gap by examining the community participation in decentralized management of health system in Moshi Rural District. It aimed at showing necessity of involving the community in decision making and also the need of community members to participate in formulation of district health budget based on their priorities.

2.3 Conceptual Framework

This study will adopt a conceptual framework developed by Bolden (2004) as a means of assessing a service performance or intervention done in improving a situation. This model determines the improvement of an intervention from the perspective of recipient and from service providers' point of view.

According to Kothari (2004) conceptual framework is a presentation of researcher ideas about the cause and effect of phenomenon. It shows the relationship among the variables. Conceptual framework that will be employed in this study has four variables which affect each other and hence leads to ensure community participations in planning for health budgets. These variables which ensure community participation in decision making are such as information sharing, existing laws and policies, and accountability, which all these enable community participations in planning for health budget.

Figure 2.1: Conceptual Framework on Community Participation



Existing laws in the Tanzania pave the way for the community to participate in decision making process in the country. In this context laws and regulation are the one which enable community members to take participation in decision making that in one way or another helps them to resolve some issues in the health sector. In the other hand poor implementation of these policies hinders community participation in the planning for health budget staring from the first stage of planning which is the ward level to the national level.

Community concerns are general issues that worry or disturb the communities; from these they extract their needs, which are more specific. Communities are capable of identifying their own concerns and needs, but if community members are poorly involved in the identification of the problem within their areas may leads to fail for

some problem because some of the health problem are highly caused by community members. If community participation is ensured it will leads into the proper identification of problem and decision making that will enable community to participate in planning for health budget.

In decision making, communities make specific decisions for action, based on the concerns they have identified and the findings of their exploration. This is a planning phase, and community's participation is highly needed to ensure collective action on decision made.

Existing laws and policies are expected to provide a framework for citizen participation in planning, implementation, public health care. They are also supposed to provide a framework for service providers to be answerable to service users, and at the same time empower community members to hold the public health care system accountable. Community participation is expected if all the four conditions apply efficiently and effectively.

CHAPTER THREE

RESEARCH METHODOLOGY

This section presents the philosophical assumptions underpinning this study. The chapter includes research approach and techniques applied from sample and sampling technique, data collection, data analysis and interpretation. The research design cover the reasons for selecting respondents, data sources, data analysis and a brief note on assumptions and weaknesses.

3.1 Description of the Study Area

This study was conducted in Moshi Rural District which is among of the seven districts of the Kilimanjaro Region of Tanzania. Moshi Rural District is bordered to the north by the Rombo District to the west by the Hai District, to the east by the Mwanga District and to the south by Moshi Urban District. According to the 2012 census, the population of the Moshi Rural District was 466,737. The Moshi Rural District is divided into 4 divisions, 31 wards and 150 villages.

3.2 Research Design

Research design is a roadmap for researchers. It is a step by step approach; Donald and Panneerselvam, (2007) defined research design as the blue-print for collection, measurement and analysis of data. It aids the researcher in allocation of his limited resources by posing crucial choices and the blueprint to include experiments, interviews, observations and the analysis of records. This study adopted descriptive research design. Descriptive research attempts to describe, explain and interpret conditions of the present i.e. “what is’. The purpose of a descriptive research is to examine a phenomenon that is occurring at a specific place (s) and time. A descriptive research is concerned with conditions, practices, structures, differences

or relationships that exist, opinions held processes that are going on or trends that are evident. According to Yeasmin at el., (2012) descriptive research design is used to obtain information concerning the current status of the phenomena and to describe "what exists" with respect to variables or conditions in a situation.

Both qualitative and quantitative research methods were employed. This aimed at getting opinions from the target population and to also establish a link between social cultural, political, economic and institutional challenges in relation to community participation in decentralized health system in Moshi Rural District, descriptive research method utilizes elements of both qualitative and quantitative research.

3.3 Study Population

The study population consisted of service users, service providers. The service user respondents were person of the age 18 years and above who are not leaders and they were identified through random sampling. According to the National Statistic Bureau the Population (2013) of Moshi Rural Districts for people between 18 years also to 70 years old is estimated to be 231,911. On the other hand, service provider's respondents were obtained through purposive sampling and comprise of members of Council Health Management Teams, District Health Boards and Committees, Mitaa/Village leaders, Health Workers including Medical Officers, Assistant Medical Officers and Health Secretaries.

3. 4 Sampling Procedure

The study used random sampling for data collection. The technique was used because it ensures equal chance to all respondents to be selected in the research and it also helps to avoid bias during selection of respondents to be interviewed in the

study. In simple random sampling each unit of the population has a known, equal, non-zero probability of being included in the sample. The selection of each unit is independent of the selection of any other unit. The random sampling method was applied in selection of individual respondent from wards within the study area. This method gives equal chances to all the wards to be selected as a member of the sample.

In non-probability sampling, the method employed was purposive sampling. Purposive sampling procedure refers to the selecting those members of population that have definable characteristics (Saunders et al., 2003) for this study subjects was selected because of some characteristic and assumption that they have the most reliable and representative information by virtue of their positions within the district, this methods it was used to select wards with health facilities from the Moshi Rural District.

The study involved a simple random sampling as effective methods to obtain community around those wards that are having public health centers as key respondents in the study area. The study consisted of 5 public health facilities from which respondents were taken. The sample groups include service providers and service users. Based on this community present sound and relevant information on community participations in the planning and budget for health in the study area.

3.5 Sample Size

According to Kothari (2004:56), sample size refers to the number of items to be selected from the population to constitute a sample. The sample size in this study comprise of 96 respondents from Moshi Rural District who are service users, service providers and Mitaa/villages leaders aged 18-70 years. In that case the whole sample

was 96 respondents and service users were preferred due to the fact that they were the most beneficiaries of service provided by the government. The sample drawn from the population which fulfills the requirement of efficiency, representativeness, reliability and flexibility which was validated by using the formula illustrated by Kothari (2004) which provides simplified method of calculating size of the sample as:

$$n = \frac{N}{1 + N(e)^2}$$

Where by

- N= total population 18-70
- e =precision level (error detection)1-10%
- n= sample size to be included in the study
- 1=constant

Therefore; n= 231,911/1+231,911(0.05)

n=96

Table 3. 1: Distribution of Respondents

S/N	Respondents category	Number of respondents
1	Councilors	5
2	Service providers	10
3	Health Board Members	10
4	Ward Executive Officers	5
5	Community Members	60
6	District Medical Officer	1
7	Council Health Management Team	4
8	District Executive Director	1
	Total	**96**

3.5 Data Collection

This study included both primary and secondary data. Primary data was collected through interviews with respondent in the field. The collection of primary data was completed through use of structured questioners. Secondary data was collected through documentary review. This was done trough reviewing several laws, regulation and government policies. These two methods helped researcher to get detailed information about community participation in planning at different level of government system.

3.6.1 Interview

According to (Kothari 2005) interview is a method of collecting data which involves presentation of collecting oral verbal stimuli and reply in-terms of oral verbal responses. Interview guideline was used in closed and open-ended question. Two in-depth interviews were conducted with two key female informants who have knowledge and experiences regarding community participation issues in public health care. They were identified during the administration of household semi-structured questionnaires. This was done in order to obtain qualitative data that will inform about status of community participation in planning.

3.6.2 Questionnaire Survey

Questionnaire can be defined as an instrument consisting of a series of questions about this study. It is a highly structured method of data collection tool. It is a format containing list of questions sequentially ordered to obtain information relevant to the objective of the study (Adama, 2010) closed and open ended questions were used in the constructions of the questionnaires. Questionnaires were administered to districts officials because of their busy work schedule.

3.6.2.1 Secondary Data Collection

The secondary data were collected from administrative materials, letters and minutes of meetings, laws, policies and regulations covering a variety of issues. Most of the information collected from secondary data was related to community participation in planning at local government decision making bodies.

The researcher read a number of policies he was able to access which relate to governance and accountability in relation to health care service delivery. The policy documents were critically analyzed in relation to the research questions. Documents analyzed are the Constitution of the United Republic of Tanzania, Local Government Laws, National Health Policy, and Health Sector Strategic Plan III. Others were the Local Government Reform Programme and Guidelines for the formulation of district health plans

The secondary data were collected trough desk review as background information to understand the status of the interventions planned to tackle the impediments for community participation, and the level of contribution towards improving community participation in decision making.

3.7 Data Analysis

Data analysis in a general way involves a number of closely related operations, which are performed on collected data and organized in a manner that they answer the research question (Kothari, 1990). All data collected from the interviews, questionnaires and focus group discussion were analyzed and codes were given to them. Tabulations and frequencies were used to analyze raw data.

Also the researcher arranges the processed data by using MS-Excel computer program and Statistical Packages for Social Sciences (SPSS) software version 16 to enter data and perform analysis. In SPSS data were analyzed by using analysis of variance because of its useful in comparing (testing) two or more groups for statistical significance.

All data in graphical presentation were presented by using pictorial and tabular data organization methods such as histogram, pie charts and bars, percentages and ratios of quantitative data.

3.8 Validity and Reliability

Validity in this study was focus on the appropriateness of the instrument, truthfulness of the results, interpretation and meaning of the scores derived from the instruments. According to Baradyana (2007), validity is concerned with whether the instrument used in the study measure what it intended to measure. It is therefore the extent to which scores on a test enable to make meaningful and appropriate interpretations. Researcher conducted pre-test of the tools that were used for data collection.

Reliability is essentially about the degree of accuracy and comprehensiveness of coverage as well as consistency of with which repeated measures produce the same results across time and observers (Bogdan and Biklen, 1992). The data collected in this study was done in ethical and gender consideration manners, without forcing or influencing the respondents to test the validity and reliability of the instruments. Moreover the triangulation of data, methods and respondent enhanced validity and reliability of data.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents a discussion of the findings of the study. The findings are presented in many ways to allow a logical flow of ideas as governed by study objectives and research questions. Based on the survey results it does provide general view of study about the community participation in decentralized management of health services in Tanzania. The chapter begins by presenting community participation in planning for health budget, the extent to which the existing policy and legislations either promote or hinder community participation in budget planning and the community perception on the public health care system of the Moshi Rural District is answerable to community members. The chapter goes further to present possible benefit resulting from decentralized management of health systems.

4.1 Background Characteristics of Respondents

4.2.1 Respondents Socio–economic Characteristics

The background characteristics of the respondents interviewed in this study include socio-economic variables such as; sex, age, education level, occupation and marital status of the respondents. These socio-economic characteristics have impact on the acquisition of the knowledge on community participation behaviors. The knowledge shape attitudes of the people towards participation in decentralized management of health services. Each variable presented on the same (Table 4.1) but are discussed each differently.

Table 4. 1: Respondents Socio-economic Characteristics

Category	Frequency	Percentage
Sex		
Male	59	61.4
Female	37	38.5
Age(Years)		
15-19	15	15.6
20-24	5	5.2
25-29	18	18.8
30-34	9	9.4
35-39	17	17.7
40-44	17	17.7
45-49	7	7.3
50 and above	8	8.3
Education level		
No formal education	18	18.0
Primary level	49	51.0
Secondary level	16	16.0
College level	14	14.5
Employment status		
Self employed	65	67.7
Public employed	20	20.8
Private employed	11	10.5
Marital status		
Married	43	44.7
Not married	17	17.7
Widow	15	15.6
Divorce	2	2.0
Living with a partner	23	23.9

4.1.2 Sex of Respondents

Sex differences had great impact in community participation in different health issues especially on this study. It is contended (Adesina et al, 1995) that, any new program or policy has different implications to different gender groups depending on

their responsibilities and ownership of natural resources. The majority of the respondents in this study area are men (61%) basing on the sampling devised and the remaining 38.5% are females. This is justified by the purposive sampling method that was used to obtain the households as well as the simple random sampling method that was used to obtain the respondents in each area.

4.1.3 Age of Respondents

Age is another variable which can affect community participation in health management. The interviewed respondents of about 18.8% were aged between 25-29 years, 9.4% were aged but 30-34 years followed by 17.7% were of 35-39 and 40-44 years in the survey there were no respondent with the age below 18 years because of maturity. Therefore, the well matured nature of respondents enabled the study to have reliable information. This is due to the fact that, experience is an advantage when it comes to organization behavior that is possible to have genuine answers from mature respondents.

4.1.4 Education Level of the Respondents

Education is the one of the long-term strategies that may be used to influence attitude and adoption of participation measures, so as to bring changes or new improved working management in health services. The study result shows the majority of the sampled respondents (51%) have primary education. Only 14.5% had attained college level while about 10% had attained secondary education and about 18% of the interviewed community members were found to have no formal education. This could mean that the majority of people in the study area have low education level, and it could have destructive implication to respondent. Of course

the triangulation of respondent from different categories enhanced trustworthy of the results.

4.1.5 Occupations of the Respondents

The respondents` main occupations provide an explanation with regard to the possible mechanisms and ways applied in participation in decentralization of health service management. The occupation in the study include; self employed which accounts about 67.7% of the total respondents, public employed accounts for 20.8% and private employed about 10.5%. However, respondents in self employed are reported being engage in small scale agriculture activities where they only get foods and not doing it for business this lead to the community member to have low income generating activities. Therefore, it could then be difficult for them to actively participate in the economic development especially where contribution is deemed necessary.

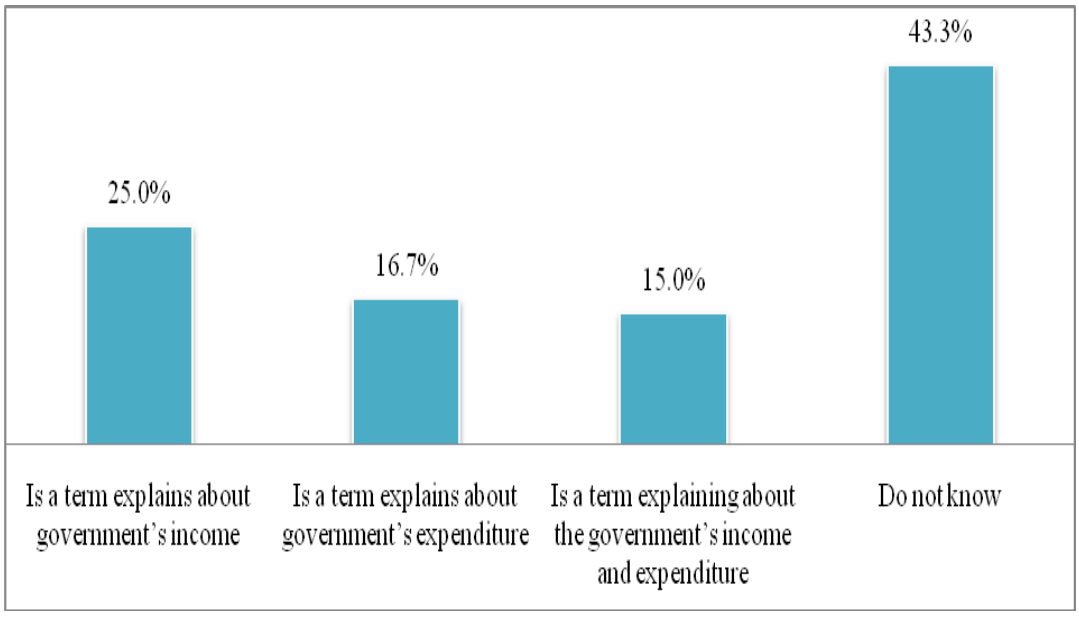
4.1.6 Marital Status of the Respondents

According to URT (2006) the minimum age at marriage in Tanzania is 16-18 years for females and males respectively. From the study, it was found that about 44.7% of respondent were married, 17.7% are single, and 23.9% are just live with their partner illegal and other category like widow and divorce account for 15.6% and 2.0% respectively. To some extent this ratio made it possible for women to participate in the study, as from the cultural practices women are restricted by their husband to associate freely with people by their husband.

4.2 The Role of Community Participating in Health Planning and Budgeting

Planning of health service budget involves the participation of community members so that they can give their priorities. A better identification of community needs and priorities in health services needs to be sourced from the community itself and so be presented during budget planning resulting in increasing availability of services as per community priorities, transparency and accountability, promoted trust among health systems and communities, and perceived improved quality and accessibility of health services. Furthermore, the findings show the importance of external facilitation and support in enabling health professionals and community representatives to arrive at effective working arrangement.

Figure 4. 1: Understanding of the Term 'Budget' by Community members

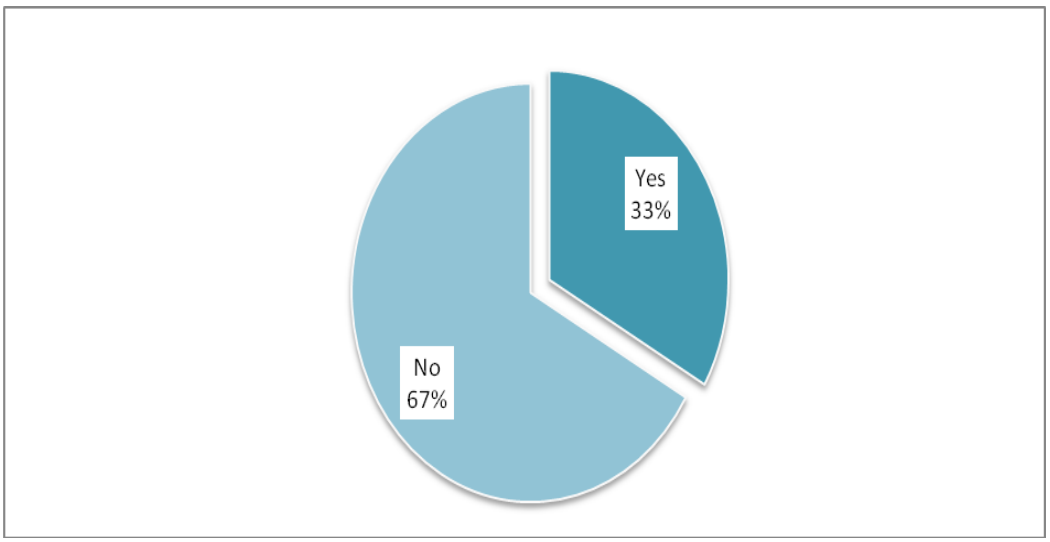


Source: Field Data 2014.

The Figure 4.1 shows the community members understandings of the term budgeting in different meanings, the study results reveals that about 43.3% of the interviewed community members did not understand the meaning of the term, while those who

responded in the dimension of understanding the term were 25% of the respondents, they argued that the term explains about government's income. While 16.7% of the total respondents said that the term explains about government's expenditure and indeed, 15% of respondents said that, the term pointed to the government's income and expenditure. This being the case then, it can be inferred that, the 43% of respondents do not understand exhaustively the meaning of government budget. Therefore it has an implication of difficulties in participating them in the whole process of planning the same in the health services for the community.

Figure 4. 2: Community Participation/Consulted in the Planning and Budgeting.



Source: Field Data 2014

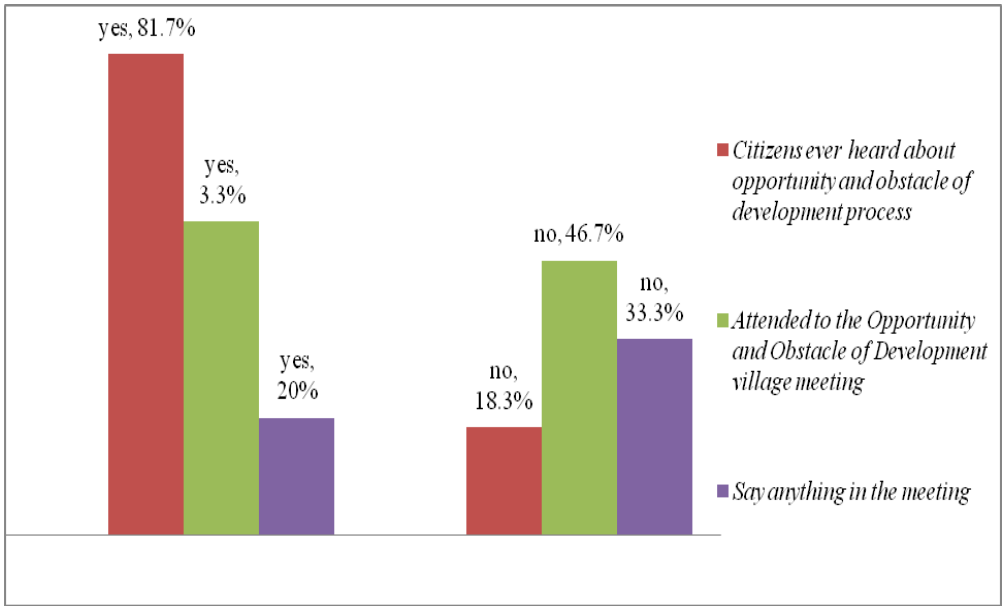
The habit of community to participate in decentralized management of health services on the side of planning, budgeting, implementation and giving feedback in this study is still revealed as a challenge because only 33% of the interviewed community members reported to participate in management decentralization activities. While the majority (67%) of the interviewed community responded that they are no participation in any health management decentralization. This being the

case it can be concluded that the community is rarely participating in the decision to plan, budget implement and even evaluate the decentralized community health budgeting. Therefore, it implies that, their role in facilitating the availability of community health services is more passive than active or proactive.

4.3 Existing Planning Policy and Legislations

As part of the efforts to look into local community participation this study looked into whether people had actually attended and contributed any ideas during O&OD meetings. The responses are shown in Figure 4.3. Three categories emerge from this issue some of the community members had heard about O&OD process but others had note. Some had attended but others had not even those who had attended some did not even contribute anything in the discussion.

Figure 4. 3: Community Responds on Opportunity and Obstacle Development



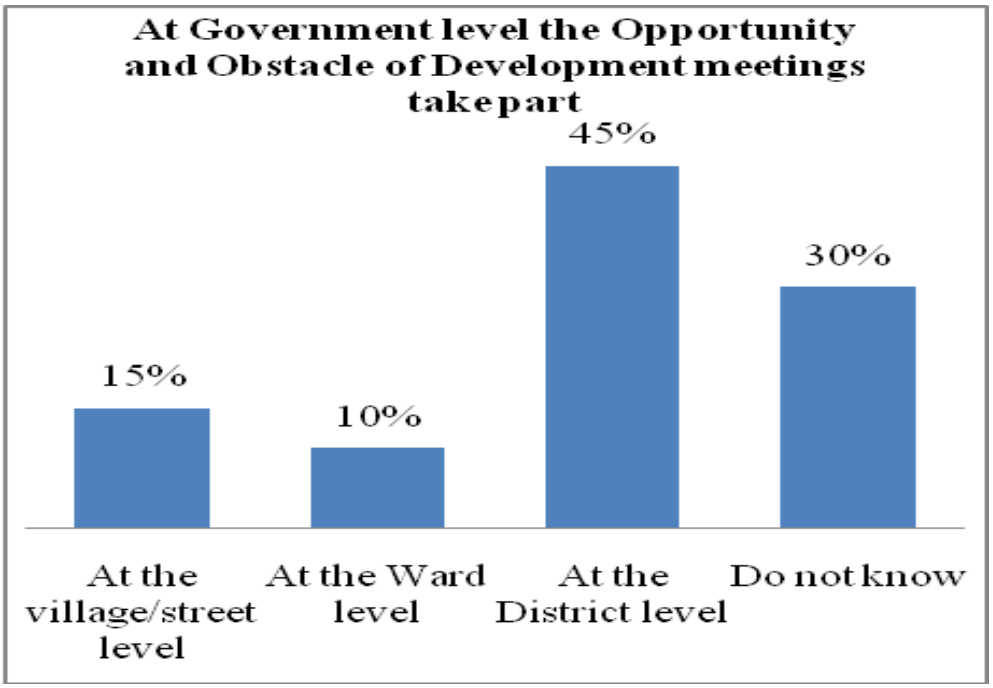
Source; Field Data 2014

Figure 4.3 above shows that, the majority of that is respondents (81.7%) of the community members have heard about opportunity and obstacle of development

process. Another (46.7%) of the overall respondents said that, they have attended the village meeting on opportunity and obstacle of development and indeed (33.3%) who attended the meeting but never contributed any ideas during the discussions in the meeting. Therefore it can be concluded that the majority of people attend the village meeting for the discussion on opportunity and obstacles for development but never contribute in the respective meetings. This impliedly could be due to having the majority of the community members having low education, of which affect them in the process of contributing to the meeting in issues that affect health service. Furthermore, the other reasons could be that, the matters in the meeting are discourses of a technique nature, and this was reported by the Director of Municipal Council of Moshi District during an interview held on 13th April 2013 when he argued:

> *" the community members attend village meeting for sensitization on the obstacles and opportunity for development, unfortunately they are very passive during such meeting, and they never contribute any ideas during the session. This might be due to ignorance in terms of lack of understanding or the issues discussed are of technical nature as such they cannot jump in to contribute in the discussion"*

Figure 4. 4: Community Knowledge on Opportunity and Obstacle of Development meetings



Source ; Field Data 2014

Also community members were asked about the knowledge on opportunity and obstacles of development. Responses on this issue showed some variations in knowledge of O&OD meetings. The findings in Figure 4.5 above shows that, only 45% of the respondents reported that most of the health management meetings are conducted at the district level therefore this affected negatively most of the community members to participate in the respective meetings. On the other hand, a minority of respondents (15%) said that the respective meetings are held at the village/street level. And indeed, about 30% of the overall respondents said that, they did not know where the meetings take place.

On the other side, the Figure 4.5 above shows that, while discussing how frequent are community meeting on opportunity and obstacle of development of health management process guideline, or the frequency which should the meetings be

conducted, the responses were: of about 35% of the Community do know while 25% reported that meetings are conducted annually, 21.7% once every three years and the least 18.3% meetings are conducted monthly. Therefore, it can be concluded that the community members do not even know the frequency of conducting the meetings of which implies that even the participation is too low in the respective meetings.

4.4 Community Perception on the Public Health Care's Systems

In this aspect the study intended to measure the awareness of the community member of the entity responsible for organizing/planning the O&OD meeting at the level of village/street. The Table 4.2 above shows that, 31.7% respondents said it is the Village Executive Officer, 30% of all respondents said it is the Ward and District and 26.7% respondents said it is to the Ward development committee while 11.7% don't know the entity responsible.

Table 4. 2: Responsible People for Planning Opportunities for Development Meeting at the Level of village/street

Responsible Person	Frequency	Percentage
Village Executive Officer	19	31.7
Ward development committee	16	26.7
Ward and district facilitators	18	30
Do not know	7	11.7

Source*:* Field Data 2014.

Therefore it can be concluded that the entity responsible to organize community meeting for the obstacles and opportunities for development is not properly known to the respective community members. Therefore this implies that it is even difficult for the community member to participate in the health development issues.

Table 4. 3: The Means used to Disseminate the O&OD Meeting Information to the Community

Measures	Frequency	Percentage
Through blowing the trumpets on streets	20	33.3
Through letters from street/village leaders	19	31.7
Publishing on public notice boards	13	21.7
Do not know	8	13.3

Source: **Field Data 2014**

Table 4.3 shows the means used to disseminate the O&OD information for the meetings to the community members whereby, 33.3% of the respondents said it is through blowing the trumpets on streets, 31.7% of the total respondents said it is through letters from street/village leaders, while 13.3% respondents said that they don't know. This being the case it can be concluded that, blowing trumpets and writing letter are the major means used to inform community for the O&OD meetings. This again implies a very outdated style of communicating with the community. There is no utilization of modern technology in community mobilization for example Facebook, internet etc.

Table 4. 4: Kind of Documents which offers Evidence about the Problems/ priorities Raised by the Community in O&OD meeting

The documents	Frequency	Percentage
Village/street community meeting minutes	17	28.3
Opportunity and Obstacle of Development meeting minutes	21	35
Do not know	22	36.7

Source: **Field Data 2014**

This aspect investigated the kind of document from the Villages which prove that the priorities raised by the community in the meetings under O&OD are documented

properly. The results shows that 36.6% of the respondents said that they don't know, while 35% and 28.3% of respondent said it is the Opportunity and Obstacle of Development meeting minutes and village/street community meeting minutes irrespectively. Therefore from this information it can be concluded that the 63.4% of respondents do not know the document to audit the priorities if any raised by the community during the O&OD meeting. It then implies that, the community participation in terms of monitoring the priorities under the O&OD is very poor because they don't know even the documents to cross check if their priorities are taken into hold.

Table 4. 5: Responsible People for Approving the Village/street O&OD Plans

Person Responsible	**Frequency**	**Percentage**
Ward Executive Officer	14	23.3
Village/street assembly	16	26.7
Ward and district facilitators	15	25
Do not know	15	25

Source: **Field Data 2014**

The data from the table 4.5 shows that, about 26.7% of the total respondents said the village/street assembly is responsible, followed by 23.3% respondents who said the ward executive officer, while about 25% respondents said that they don't know the one responsible. Therefore the community is indifferent in terms of the responsible person to approve the O&OD plan, and this makes difficulty to understand the validity and reliability of the plans.

Table 4. 6: Responsible People to Review and Consolidate the Village/streets Plans

Responsible	Frequency	Percentage
Village Council	17	28.3
Ward Development Committees	20	33.3
District and Ward facilitators	11	18.3
Do not know	12	20

Source: **Field Data 2014.**

The last part of the table 4.6 is about the person responsible to review and consolidate the Village/streets plans identified in O&OD meeting into ward level plans and then forward the plans to the local government authorities. The findings show that 33.3% respondents said the ward development committee is responsible. This is followed by 28.3% of the total respondents who said the village council; while 20% falls under don't know categories. Therefore, still we experience a substantial number of the community to be ignorant of who should review and consolidate the village or street plan in the O&OD. This is not health for community participation in their development endeavors especially health service provision

4.2 Community Participation in Planning for Health Facility Budget

Community participation in the planning is the one of determinant to asses' service delivery at the public health facilities. Community members can participate in planning session either by participating in the community meetings, through consultation, giving out their voices in planning, by writing letter and through their chosen representatives. Community participation can lead to better identification of community needs and priorities, increased knowledge of the community representatives about budget planning in increasing transparency and accountability,

promoted trust among health systems and communities, and perceived improved quality and accessibility of health services. Furthermore, this area discusses the importance of external facilitation and support in enabling health professionals and community representatives to arrive at effective working arrangement.

Table 4. 7: Citizens Awareness on the Laws and the Place to Access Budget Documents.

Responsible	**Frequency**	**Percentage**
Religious institutions	9	15
Are aware	18	30
Are not aware	30	50
doesn't know	3	5
Total	**60**	**100**

Source: **Field Data 2014**

Table 4.7 shows that the majority of respondents that is, 50% are not aware of the law and places to access the budget documents. While other respondents were in different, some said, from public facilities that are 30%, from religious institutions 15% and indeed 5% again said they don't know. Therefore, it is still problematic when it comes to community participation because they are not informed of the law guiding budget documentation.

Share Other Information with the Public apart from Budget Information

Furthermore, the interviewed Local Government Officials and health service providers mentioned different means which they use to share information with the public. About 82% and 84% of the interviewed Local government officials and Health service providers , respectively, said that they use community meetings as a means for information sharing with the public, and about 65% and 60% of the

interviewed Local government officials and Health service providers , respectively, mentioned that they publicize the information on notice boards or walls.

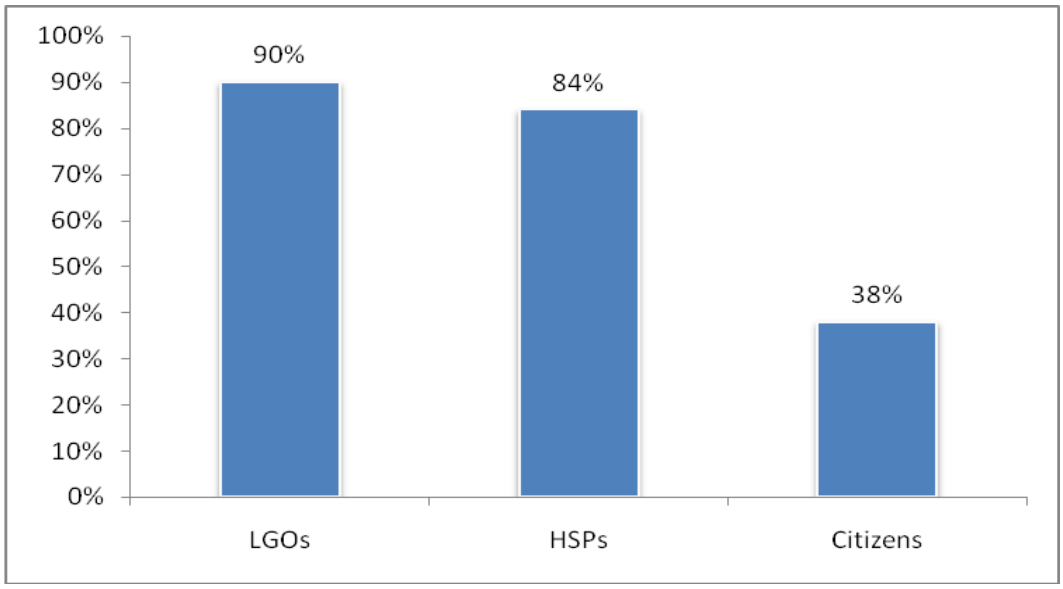
However, about 15% and 11% of Local Government officials and health service providers, respectively, were providing information to the public upon request, and only 2% of the Local Government Officials and none of the health service providers use news papers as a means of sharing informing with the public The reader should note that the sum of all frequencies exceeds 100 because multiple answers were possible. This indicates that the dissemination of information to the public by both the Local government officials and Health service providers is mainly done through community meetings and notice boards and very few use newspapers and provide information upon request.

Awareness of Laws about Access to Information

The study results show that few community members interviewed (38%) are aware of the existence of laws that ensure the provision of budget documents to the public. The majority does not know about such provisions. This does not mean that respondents who indicate awareness of the laws and regulations on access to information also know and understand their specific content. Rather, they may just have heard about the existence of such laws without ever reading them closely.

In contrast to community members the majority of the interviewed Local government officials (90%) and Health service providers (84%) confirmed that they are aware of the existence of laws which obligate them to share budget documents with the public (compare Figure 4.5 below).

Figure 4. 5: Awareness of any Laws Ensuring the Provision of Budget Documents to the Public



Source; Field Data 2014

Availability of Budget Documents

Beside the basic awareness of the existence of laws that regulate access to budget information, the study also inquired whether citizens, Local government officials and Health service providers understand their content, namely which particular budget documents are required to be published (Such provisions are made in the Local Government Finances Act (1982) and amended (2000) or the Local Authorities Financial Memorandum (2010).

To test whether the respondents can differentiate between documents that are part of statutory provisions, namely the signed audit reports, audited statement financial position and the audited statement financial performance, the questionnaire also included budget documents that are not part of such provisions such as the receipts of funds from the government and the annual implementation reports. The

distribution of answers in Figure 4.8 shows that the respondents were not able to differentiate among the mentioned budget documents according to the existing laws.

Table 4. 8: Documents Supposed to be made Public According to the Existing Laws or Regulation

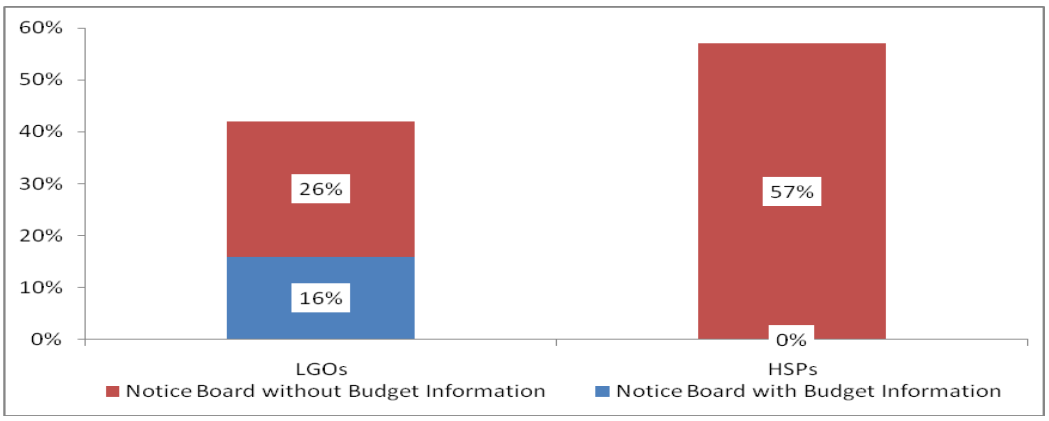
Responsible	Frequency	Percentage
Local Government Offices	15	25
Public health facilities had notice boards for posting public information	33	55
Local Government Offices found with budget information	3	5
Had no such information posted	9	15
Total	**60**	**100**

Source; ***Field Data 2014***

Availability of Notice Boards

About 25% of the local government offices and 55% of public health facilities had notice boards for posting public information. However, from among all local government offices, only 5% were found with budget information and 15% had no such information posted. From among the existing notice boards at public health facilities, none had posted budget information.

Figure 4. 6: Notice Board Availability



Source: **Field Data 2014**

The results indicate that very few local government institutions and none of the public health facilities are posting the budget information on their notice boards. This implies that every community members who are interested in financial documents cannot access them without making efforts by requesting them from the responsible institution.

Community participation is the most important sections in health service delivery concerns, from figure 4.8 majority 70% of the community member are unaware of the laws ensuring provision of budget document and only remained 30% are aware of the laws. The figure 4.8 also presents the place of accessing budget documents; citizens most access budget information in public meetings (30%), access from public officials (25%), access from public facilities/offices (21.7%), access from religious institutions (15%) and don't know (8.3%).

4.4 Accessibility of Health Facility Budget Documents

Table 4. 9: Budget Document Accessibility

Responsible	**Frequency**	**Percentage**
Community members respond to access development plans	27	45
Access signed audit report on the account	15	25
Access information on receipts of funds from the government	12	20
Access information about implementation reports	6	10
Total	**60**	**100**

Source: **Field Data 2014**

The result shows the kind of budget documents accessible to the community members, majority 45% of the citizens respond to access development plans, 25%

access signed audit report on the account, 20% access information on receipts of funds from the government, 10% access information about implementation reports.

Existence of Health Boards

Community members seems being aware to some extend the existence of facility health boards, where majority 61.5% of the community members heard of health centre committee, 55.5% heard of dispensary committee, the two committee exists and has been known to majority of the community members because are working direct with the local community stated by health board members.

Table 4. 10: Community members Awareness on Existence of Health Board and Facility Committees

Responsible	**Frequency**	**Percentage**
Heard of health committee	21	35
Heard of dispensary committee	15	25
Heard of ward health committee	12	20
Know any member of health board or committee	9	15
Heard about council health board	3	5
Total	**60**	**100**

Source: **Field Data 2014**

Also the findings shows that citizen's awareness on the existence council health board and ward health committee are highly unknown whereby about 20% and 5% gave a positive response that is they have heard about their existence. The surveyed community was asked if they know any member of health board or committee, about 15% respondents know them, this is because of the relationship to the role and the work they have in relation to the community.

The roles of facility health governing committee as stated by the community members are to make sure availability of the quality health services in the facility (75%), health worker are working to satisfy service user (67%), stands as the health facility supervisors (60%). While the service providers say the health board and committee exist and working highly to make sure the service is available to the community.

4.5 Community Perception on the Complaints on the Public Health Care's System of the Moshi Rural District.

Table 4. 11: Community Members Awareness on Existence of Complaints and Aware of Health Service user's Rights.

Responsible	Frequency	Percentage
Health care services delivered	24	40
Are aware	6	10
Are not aware	9	15
doesn't know	21	35
Total	**60**	**100**

Source: **Field Data 2014**

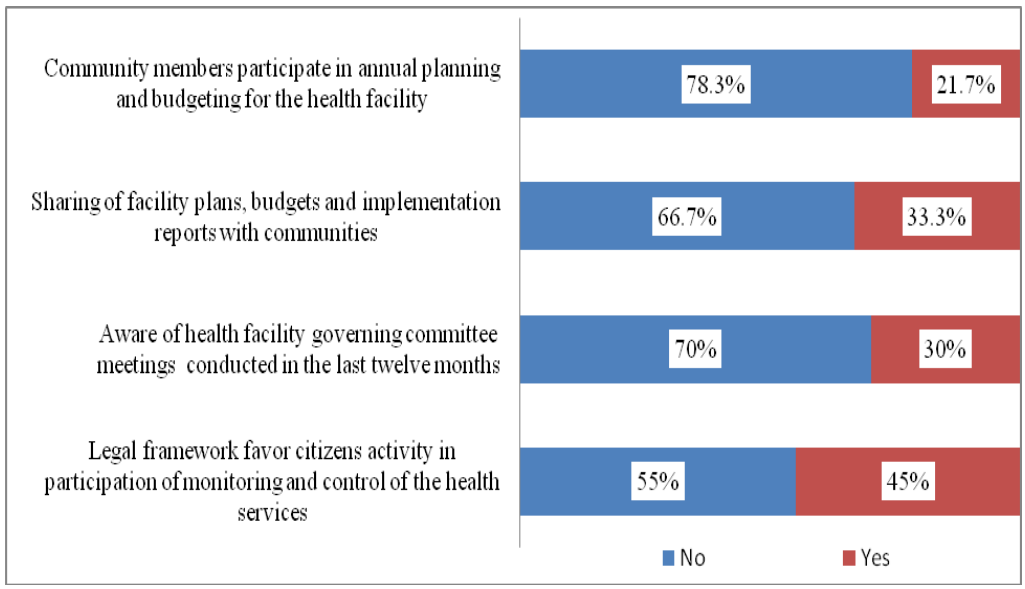
To assess the availability of complaints at community level, in this sense health service users were asked whether there were any kind of complaints in their respective health facility. The analysis of the data with respect to rural settings revealed that the respondents in the facilities located in rural districts expressed more availability of complaints as compared to urban facilities. Table 4.10 above shows that majority 40% report the existence of complaints regarding health care services delivered, and only 10% says there is no existence of complaints. Few citizens (10% only) are aware of the performance of oversight bodies at health care facilities

satisfactory and 15% are not aware while the majority 35% of the citizens doesn't know these oversight bodies around.

4.6 The Challenges of Community Participation in Health Service Decentralized System

In this objective the intention was to find out some of the challenges encountered in the service delivery at local level. This would then help to create resolution measure for the respective challenges. In this objective the community members participation was investigated as perceive to be a challenge. The question of corruption in the service delivery system was also investigated.

Figure 4. 7: Community Responses on Participation in Budget Planning and Legal Framework Favors



Source: **Field Data 2014**

In the pursuit of more effective and efficient government service delivery, number of local government bodies and representatives of civil society are taking active approaches through the implementation. The findings in figure 9 shows majority 78.3% of the community members don't participate in annual planning and

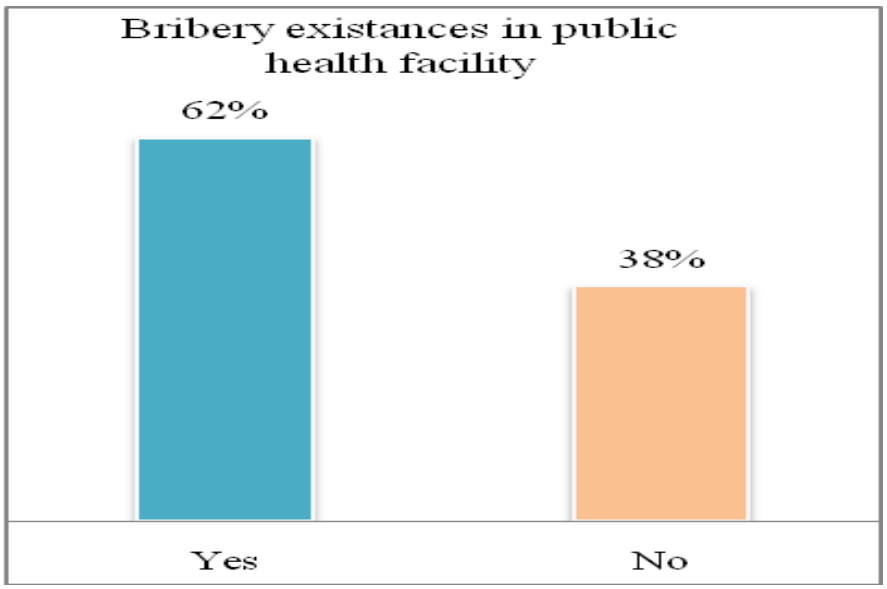
budgeting for the health facility in their locality and only 21.7% of community members participate. 70% of the community members are not even aware of the meeting take place in a space of one year ago going further the health workers says community members seems to have no morale in attending the facility governing committees during planning session as only 30% of the community members are aware of this meeting conducted. 66.7% of the community members respond that there is no sharing of facility plans, budgets and implementation report with community. Therefore there is lack of community participation in the meetings that are held on health related issues.

Community Participation

Given the lack of access to information, the low awareness of health governing boards and committees, citizen representation through committees does not automatically translate into community participation. As required by law, direct participation should also be encouraged. However, a clear (67%) of respondents have not directly participated in planning for health care services in Moshi Rural District. The essence of participation is aptly captured by Julius Nyerere (1973) by asserting that;

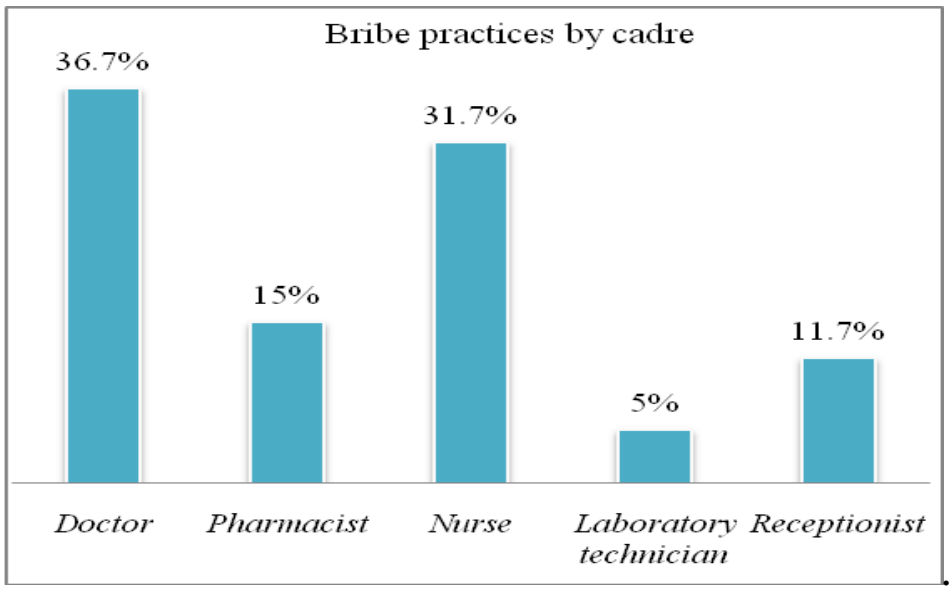
> "sovereignty of the people is the most important because the good of the people is the only legitimate purpose of all national activities, and only the people themselves can say what is to their good (p.35). People must be allowed to make their own decisions, and therefore their own mistakes. We can advice and warn, but if we try to run them we are destroying them (p.8)."

Figure 4. 8: Health Worker Ethics in Accountability



Source: **Field Data 2014**

Figure 4. 9: Bribe Practices by Cadre



Source: **Field Data 2014**

A community health worker is a frontline public worker who is a trusted member of and/or has a usually close understanding of the community she/he serves. This trusting relationship enables the CHW to serve as a link/intermediary between

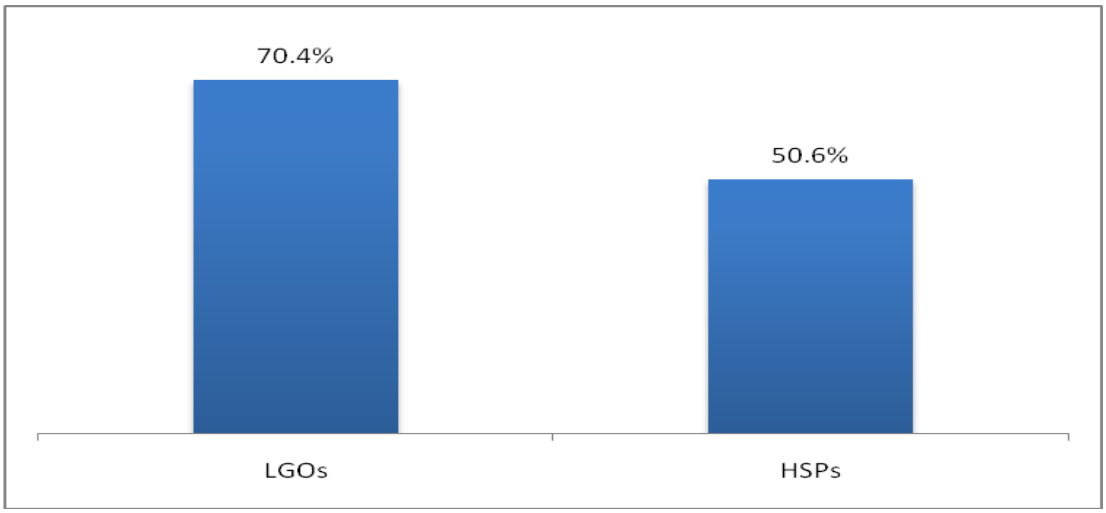
health/social services and the community to facility access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. But the figure 10 above shows the existence of bribery in public health facilities, as majority 62% community members agreed and only 38% community members disagree. On the bribe practice by cadres, doctor leads by 36.7%, followed by nurses (31.7%) while laboratory technicians (5%) are only involved lowery. Therefore bribery is a major challenge in the management of health facilities at local level

Complaints about Services

About 70.4% of the interviewed Local government officials of health service providers indicate that community members use the information to complain about the services which are offered by the government institutions like village or Mtaa and Ward offices or health services from dispensaries, health centers or hospitals, and they demand for improvements. This is contrary to 50% respondents who are against the view (compare figure 4-14 below). Therefore it can be concluded that, the community members complain about the services provided at local level. This is vivid as one of the heath officers at Moshi Rural District health center had the following to say during an interview:

> "*Basically there are lot of complain that are given by the community as far as the health services provision is concerned in the district. They complain of lack of involvement, poor health service and indeed weak customer care from the receptionists*"

Figure 4. 10: Community members Complain on the Services Offered by Government



Source: **Field Data 2014**

RULES AND REGULATION THAT ENSURE COMMUNITY PARTICIPATION

THE CONSTITUTION OF THE UNITED REPUBLIC OF TANZANIA 1977 (As revised in 2005)

The constitution of the United Republic of Tanzania 1977(as revised in 2005) Article 18.b provides for the right for every citizen to seek, receive, and disseminate information regardless of state boundaries. Article 21.2 which states (2) Every citizen has the right and the freedom to participate fully in the process leading to the decision on matters affecting him, his well-being or the nation its further emphasizes that every citizen has the right to participate in planning and take part in event which are important event for community. These rights are important foundations upon which access to information and participation of community members should be implemented. In view of this study, community members should use these Constitutional rights to participate and demand for information have access to them

and take part in decision making regarding health plans, budgets, expenditures and progress reports.

LOCAL GOVERNMENT (DISTRICT AUTHORITIES) ACT, 1982

(REVISED EDITION 2000)

Article 111.2 of the Act, among other things, gives a local government authority to take all such measures as in its opinion are necessary, desirable, conducive, or expedient for the furtherance and enhancement of the health, education, and the social, cultural and recreational life of the people. As per this article, enhancement of people's health is one of the roles and responsibilities of local government authorities.

Article 111A (1) states the objectives of the local government authorities, among others, to promote and ensure democratic participation in, and control of decision-making by the people concerned. Also to establish and maintain reliable sources of revenue and other resources in order to enable Local Government Authorities perform their functions effectively and to enhance financial accountability of local government authorities, their members and employees.

Article 67.1 declares that every meeting of the district council is open to the public and the press. Article 69 further declares that minutes of the proceedings of a district council shall be open to inspection by members at all reasonable times, and by any member of the public at such time and under such arrangements as may be sanctioned by the Chairman, and any person may obtain an extract from the minutes upon payment of such fee as may be specified by the district council. In the opinion of the researcher, these two articles give every citizen the right to access any

information relating to annual health plans, budgets, and implementation progress reports since they are discussed by the district council.

THE LOCAL GOVERNMENT FINANCES ACT, 1982 (REVISED EDITION 2000)

Article 43 gives every local government authoritative the mandate to pass a detailed annual budget of the estimates of the amounts respectively expected to be received and expected to be disbursed by the authority during the financial year and whenever circumstances so require, an authority may pass a supplementary budget in any financial year.

Article 44 states that the Regional Commissioner may authorize in writing any person to have access to the record including books of accounts of a local government authority and submit a report to the Regional Commissioner in connection with the records.

THE NATIONAL HEALTH POLICY 2007

The National Health Policy of 2007 is clear about citizen participation in the governance of health services at all levels and that every dispensary must have a participatory annual health plan which all community members must participate in its implementation. It puts responsibility on community members to protect and care for resources at public health facilities. It also demands for both village and ward health committees to involve all community members in decision making regarding improvement and management of health services. The policy gives responsibility to the district council to ensure quality of health services through information dissemination, planning, coordination, implementation, monitoring and evaluation of

health services in collaboration with communities and other stakeholders at all levels of the district

THE DISTRICT COUNCIL (COUNCIL HEALTH SERVICE BOARD ESTABLISHMENT) INSTRUMENT ACT, 2001

This is a legal instrument to guide the establishment and functions of district health boards and health governing committees in Tanzania. It provides a general framework out of which every council is expected to enact its own bylaw for the establishment and functioning of health board and health facility governing committees. The instruments providers for detailed roles and responsibilities of both health boards and health facility governing committees. The only shortcoming of this Act is that it directs accountability of members and committees upward to the council and none to the communities they represent.

LOCAL AUTHORITY FINANCIAL MEMORANDUM

The local government financial memorandum of 2010 is a document which guides the accounting techniques and procedures. This document states under section 31(1) publication of the accounts and audit report shall be made within six months of the receipt of the report of the auditor and after submission to the council. The council shall undertake to publish at its own office and in the local newspaper within its area the following; A) the audited statement financial position and B) the audited statement financial performance. Researcher believe that this financial memorandum give the districts authority responsibility to publish the information and also gives the community members power to demand for information from the district authority

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

In summary we may argue that community participation in facility budget planning within developing countries, is characterized by weak health policy and laws, poor education, seriousness from the public issues and low public awareness, and this requires effective mobilization of both communities and health systems and adequate continued procedural guidance in written form and by conducive managerial functions.

Simply establishing institutional arrangements of participatory planning, priority setting, and governance in the absence of strong capacity building and support will not result in greater responsiveness to community needs and priorities. In addition, this study confirms that community participation is an important element in improving health service. Community representatives have real-life experience as users of the healthcare system and other public services and can offer insight into the values and beliefs of the public at large.

Role of Rules and Regulations

Despite the presence of good laws and regulations, the majority of community members seems to be not aware of the existence of laws and regulations such as the Local Authority Financial Memorandum (2010) and the Local Government Finance Act (1982) that direct the local government authorities to publicize budget documents like the audit reports, audited statements of financial position and performance at their offices for public consumption. This is due to limited accessibility of existing laws and regulations by the public or by difficulties to

interpret them as many laws are formulated in English. This makes it difficult for community members to understand them, as the majority has only achieved the primary education level.

Participation in the Budget Planning Process

The new establishment method O&OD process is a bottom-up planning model which seems to be not clearly understood by the wider public as the majority of the interviewed community members were not aware of the process. Those who were aware and attended the process were hardly given a chance to express their views. This may result in improper planning of development activities that affect the community. As most of the plans come from the top and need to be implemented at the bottom government level, the plans are not owned by the community. Hence, the sustainability of the implemented projects is at risk.

Budget Implementation and Oversight Process

Community participation in the village or street assembly is stronger as the majority of community members is aware of such institutions and understands the importance of taking part in such meetings. However, the local leaders seem to have difficulties disseminating the meeting information to the community with regard to date, time and places for conducting the meetings. This result in a lower attendance of the meeting which, in return, causes the meeting may not address important issues concerning the improvement of social services

5.2 Conclusion

This study aimed to show the experience of promoting community participation in planning of health budget through accountable priority setting for trust in Tanzania health systems. The findings show that the process of involving representatives of

special groups in the preparation of the facility health budgets planning take a long time. This is because initially, the CHMT members did not see the importance of engaging the public in health budget planning. This manifested itself in their perception that the community representatives do not understand the health related problems in the district and that they had little knowledge of health problems. This is not surprising because in Tanzania and elsewhere, it has been accepted that health is something medical professionals are responsible for, they are providers, and communities are service users. However, after inputs on facility health budget planning, as a result of the involvement of community representatives, the CHMT members came to learn that communities are important in the facility budget planning.

The findings also show the community members response on opportunity and obstacle for development by attending and contributing to the development meeting, enabling health professionals and community representatives to arrive at effective working arrangement. It is evident from the study that despite the existence of guidelines for community participation, it took a long time for the CHMT members to appreciate the value of community participation in the budget planning process. The researchers' role in promoting community participation in the study setting cannot be underestimated.

Apart from pushing for the community participation, researchers find out that NGOs intervene in training representatives of the community groups on facility budget planning. Similar experiences have been reported elsewhere. For example, Paxman and colleagues documented how training and support provided by NGO to 620 village health committees in India helped to improve reproductive and child

healthcare coverage and outcomes. In addition, Bjorkman & Svensson (1986) reported an intervention in Uganda that included structured and facilitated interactions among health facility committees, communities and health facility staff to develop an effective monitoring and a health information system.

Another reason for the need of community participation is to speak to the power relations and community capacity issues. Evidence shows that power is centralized despite the existence of impressive structures for community participation. In addition, there is a lack of information about policies, laws, people's rights, and even what is happening in the country. Consequently, health facility committees, boards, and the public, seem unable to influence quality of the decentralized healthcare facility budget planning processes. In these contexts, external support is required in improving community awareness of their roles and responsibilities in the district development process and broadening their understanding of the laws, regulations, and guidelines that govern district health systems.

Respondents reported on existing policy and legislations in promoting or hindering community participation in planning that improve the priority setting and service delivery.While the majority of the respondents attributed these changes to the involvement of the community representatives, some factors other than community representatives might have contributed to these improvements.

For example, recently the national policy environment, political leaders, and other stakeholders in the country have been pushing for an improvement in health services for the marginalized groups of society including women, disabled, elderly, and people living with HIV/AIDS. Notwithstanding the favorable national policy environment, the findings suggest that it was not until community representatives

were involved in the priority setting that the outcomes being reported here were realized. The community representatives were able to raise these problems during the health budget planning meetings.

There is some evidence indicating that community participation is an important element in strengthening the health system and improving health service delivery as far as budget is concerned. A Canadian study provided insights into the nature, extent and impact of citizen participation on policy and service outputs in community health centers across the country. The findings from the study show that the community members who were participants in decision-making processes of the organizations, felt that their participation 'led to improved programs and services, and that the range of programs and services met the needs of the community'.

Furthermore, community health centers were seen as 'organizations that increased community capacity through helping communities and individuals to raise awareness about health and social issues, identify community strengths and weaknesses, build shared community values, increase community and individual confidence to participate, and increase levels of trust within the community'. Similarly, recent reviews in low- and middle-income countries concluded that community participation could be effective in terms of improving the quality and coverage of healthcare, as well as impacting on health outcomes.

However, while recognizing the importance of working with community representatives, it is also imperative to note challenges embedded in the community participatory structures. Despite good roles played by community representatives in the facility budget planning process, it should not be taken for granted that community representatives do a good job of representing their communities.

The study has not been able to verify processes through which community representatives were selected. In addition, further research is needed to explore the extent to which community representatives represent community views and how feedback from the budget planning are shared with the wider communities.

However, it is also imperative to enhance the individual capacity of service providers, administrators and elected officials to be receptive to other stakeholders, and to carry out consultative and inclusive planning processes. Effective implementation of decentralization requires strengthening both 'supply' and 'demand' sides. Flores and colleagues working in Guatemala have reported considerable success in transforming the attitudes of healthcare workers and officials through addressing community capacity to act as empowered community members. The approach indicated is not a top-down change in policy or creation of more official structures, but a bottom-up addressing of how communities engage with health services on their own terms.

Furthermore, it is imperative to note that the process of promoting community participation in the facility health budget planning is not smooth. The traditional cultural contexts within which the health systemic implemented created challenges to both researchers and decision makers, which consequently slowed down the implementation. For example, the process of involving representatives of special groups in the preparation of the facility health budget planning took a long time.

This is because of the embedded tradition of health professionals' unwillingness to involve the communities in priority settings. In addition, the CHMT members felt that they had no authority to allow participation of other stakeholders in the district health priority setting. Frequent meetings between the researchers and district health

decision makers seemed to have increased the level of trust and receptivity to the adoption and implementation.

In addition to formal collaborations, informal networks in the form of friendly relationships among researchers and decision makers were also imperative. Furthermore, the presence of a project focal person dedicated to the implementation of the intervention became evident in this study.

Methodologically, this study relied primarily on the review of health implementation documents and interviews with the community representatives and key informant interviews with district health managers who daily involved in the implementation activities in the district. However, to minimize this risk, a researcher who was not directly involved in the implementation process. In addition, the study did not manage to validate statements provided by the respondents with hard data from the communities and health workers who were not directly involved in the implementation.

Equally important, the study did not collect hard data on the changes on community participation and the utilization and spending patterns in the facility health budget planning. Further research is needed to gain more insights from the perspectives of the service users. However, the study sheds light on how community participation can be promoted in the context of resource-poor settings, weak organizations, and fragile democratic institutions. Therefore, this study could help healthcare analysts, decision makers, and others improve their understanding of the role of communities in the governance of district health systems and form the foundation for many of the ongoing efforts to promote community participation in planning and priority-setting processes.

5.2 Recommendation

The study recommends that, the community members must stand as themselves so as to supervise their health cares as of their own. The government must find the appropriate ways in engaging the community members in any of the planning processes. However, lack of funds to support the work of the selected community representatives, limited time for deliberations, short notice for the meetings, and lack of feedback on the approved priorities constrained the performance of the community representatives should be considered.

Public institutions should ensure the easy accessibility of the existing laws, guidelines and regulations by the public, and they should also make available information that is supposed to be public as per the Local Government Financial Memorandum of 2010 and the Local Government Financial Act of 1982 amended in June 2000. The responsible authorities should provide community members with information without requiring them to go through a lengthy bureaucratic process.

Most statutory provisions are published in English which is not understood by majority of community members who are service users .Therefore, local authorities should make sure that all statutory provisions are available in Kiswahili and English so that majority of people can read and digest and be able to take part in the planning process.

LGAs need to ensure that all of their offices including the district, ward, village/mtaa and health facilities (dispensaries, health centers and hospitals) comply with the existing laws and regulations and publicize the budget documents for public consumption and also ensure their usefulness by considering the following aspects:

- Apply a consistent format for reporting revenue and expenditure information across all phases of the budget process;
- Disseminate the information in time;
- Ensure comprehensiveness with regard to the budget, audit reports, statements of financial performance and financial position;
- Facilitate free access of information on public places, notice boards, newspapers, public meetings (Village/Mtaa assembly) and, if possible, online.
- Regularly monitor the adherence to statutory provisions and apply consequences to those officials who do not comply with their responsibilities.

Otherwise the citizen and civil and social right holders have to develop a culture and exercise their constitutional rights for demanding budget information from local authorities so that they can follow up whether the available resources, which are committed to the improvement of public social services, are actually enhancing their welfare.

Also, they need to be active participants in the planning of activities that are to be conducted in their areas. Only if they are part and parcel of such meetings, they will ensure that the activities will address their needs.

Moreover, community members need to understand that the improvement of public services depends on their effort to remind their local leaders of their responsibilities. They need to demand clarifications if activities are not implemented according to plan.

Lastly, both the local and central government institutions and community members have to understand the importance of active involvement and information sharing to promote the development of Tanzania.

5.3; Area for Further studies

This study could not cover all the essential and controversial area for community participation thus calls for other studies to supplement the gaps in:

- Community participation in educational provision within Tanzania as decentralization entails also the education services provision
- Community participation in the area of good governance as this is vital for economic development at local and international levels
- Community participation and cultural enhancement within Tanzania, this is also an area of interest and scholars have not investigated.

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APPENDICES

Annex 1: QUESTIONNAIRE FORM TO ASSESS CITIZENS' PARTICIPATION IN PLANNING FOR BUDGET IN MOSHI RURAL DISTRICTS

Date of interview: _____Start time: _____End time: _____

SECTION A: Introduction

1. Name of the interviewee……
2. Name of the interviewee…….
3. District Name: ……
4. Ward Name: ……
5. Village/Street Name: ……
6. Age of the interviewee: Tick whichever is appropriate.
    a. 15 - 19
    b. 20 - 24
    c. 25 -29
    d. 30 - 34
    e. 35 - 39
    f. 40 - 44
    g. 45 - 49
    h. 50 and above
7. Education level: Tick whichever is appropriate.
    a. No formal education
    b. Primary level

c. Secondary level

d. College level

e. Others

specify……

Section B: Citizens participation in the planning for health budget

1. What do you understand by the term 'budget'? Tick whichever applies

   a. It explains about government's income

   b. It explains about government's expenditure

   c. It is a statement explaining about the government's income and expenditure

   d. I do not know

   e. Other (please explain)

……

2. (a) Do community members in this ward participate in the annual planning and budgeting for the health facility?

   f. (1) Yes (2) No

   (b) If yes, under what circumstances?.....

3. If no, please give reasons why

……..

4. Have you ever heard of the Opportunity and Obstacle of Development-process?
    a. Yes
    b. No (If no, proceed to question 26)

5. The Opportunity and Obstacle of Development- process is important for identifying community members' needs. At what government level do the Opportunity and Obstacle of Development meetings take part?
    a) At the village/street level
    b) At the Ward level
    c) At the District level
    d) I don't know
    e) Other specify

6. According to the Opportunity and Obstacle of Development- process guideline, how often should the meetings be conducted?
    a) Monthly
    b) Annually
    c) Once every three years
    d) Once every five years
    e) I don't know
    f) Other specify

    ……

7. Have you ever attended to the Opportunity and Obstacle of Development meeting at your village?
    a. Yes
    b. No

8. If yes to the above question, did you say anything in this meeting?
    a. Yes
    b. No

9. If yes, what did you say?

    ……

10. What else happened during that meeting?

    ……

11. Who is responsible for organizing/planning for an Opportunity and Obstacle of Development meeting at village/street level (at your area)?
    a) Village Executive Officer
    b) Ward development committee
    c) Ward and district facilitators
    d) I don't know
    e) Other specify

12. What means should be used to disseminate the Opportunity and Obstacle of Development meeting information to the community?
    a) Through blowing the trumpets on streets
    b) Through letters from street/village leaders
    c) Publishing on public notice boards

d) I don’t know

e) Other specify

……

13. Which document(s) give evidence about the problems/priorities which are raised by the community in the Opportunity and Obstacle of Development meeting?

    a) Village/street community meeting minutes

    b) Opportunity and Obstacle of Development meeting minutes

    c) I don’t know

    d) Other specify

    ……

14. Who is responsible for approving the village/street Opportunity and Obstacle of Development plans?

    a) Ward Executive Officer

    b) Village/street assembly

    c) Ward and district facilitators

    d) I don’t know

    e) Other specify

    ……

15. Who is responsible to review and consolidate the village/streets plans identified in Opportunity and Obstacle of Development meeting into ward plans and forward plans to the local government authorities?

    a) Village council

    b) Ward development committees

c) District and ward facilitators

d) I don't know

e) Other specify

……

16. Apart from the Opportunity and Obstacle of Development process, how else can you express yourself and have an impact on government priorities?

……

17. Where can you, as a citizen, access government budget documents?

a. From public facilities/offices

b. In public meetings

c. From public officials

d. From religious institutions

e. I do not know

f. Other (please explain)

……

18. Do you know if there are laws ensuring the provision of budget documents to the public?

a. Yes

b. No (If no, please proceed to question number 6)

19. According to the local government laws and regulations, which kind of budget documents of local government/health facility of your area (village/street) should be accessible from the list below?

s/n	Budget document	Response Tick whichever is appropriate in the boxes
a	Implementation report	☐ Yes ☐ No ☐ I do not know
b.	Signed audit report on the account	☐ Yes ☐ No ☐ I do not know
c.	Receipts of funds from the government	☐ Yes ☐ No ☐ I do not know
d.	Audited consolidated balance sheet	☐ Yes ☐ No ☐ I do not know
e.	Statement of income and expenditure	☐ Yes ☐ No ☐ I do not know
f.	Development plan	☐ Yes ☐ No ☐ I do not know

18. Is the legal framework favorable enough for active participation of community members in monitoring and control of the health care services?

1) Yes (2) No (3) I don't know

Why……

18. Awareness of existence of Health Board and Facility Committees

a) Do you know any member of health board or committee? (1) Yes

(2) No

b) Have you heard about council health board? (1) Yes (2) No

c) Have you heard of Health centre Committee? (1) Yes (2) No

d) Have you heard of Ward Health Committee? (1) Yes (2) No

e) Have you heard of Dispensary Committee? (1) Yes (2) No

19 What are roles of the governing committee of the health facility?

a)

b)

c)

d)

e)

20. Are you aware of any meetings of the governing committee of your health facility in the last twelve months?

(1) Yes (2) No

21. If yes, please explain

……

22. Do members of the health facility governing committee share facility plans, budgets and implementation reports with communities which they represent?

(1) Yes(2) No

23. If yes, under what circumstances? 22 If no, please give reasons why

……

25. (a) Do community members in this ward participate in the annual planning and budgeting for the health facility?

(1) Yes(2) No

26. (b) If yes, under what circumstances?

.....

27. If no, please give reasons why

……

28. Are there any complaints regarding health care services from community members/patients in this area?

(1) Yes (2) No

29. If yes, what kind of complaints?

a)

b)

c)

d)

e)

30. Is the performance of oversight bodies at health care facilities satisfactory?

1) Yes (2) No (3) I don't know

Why?.....

Annex 2: QUESTIONS GUIDE TO ASSESS CITIZENS' PARTICIPATION IN PLANNING FOR BUDGET IN MOSHI RURAL DISTRICTS (SERVICE PROVIDERS)

Date of interview: _____Start time: _____End time: _____

SECTION A: Introduction

1. Name of the interviewer…….
2. Name of the interviewee…….
3. Ward Name: ……
4. Village/Street Name: ……
5. Age of the interviewee: Tick whichever is appropriate.
    i. 15 - 19
    j. 20 - 24
    k. 25 -29
    l. 30 - 34
    m. 35 - 39
    n. 40 - 44
    o. 45 - 49
    p. 50 and above
6. Education level: Tick whichever is appropriate.
    a. No formal education
    b. Primary level
    c. Secondary level
    d. College level

e. Others

specify……

SECTION B: PARTICIPATION IN BUDGETING PROCESS

1. As a leader/ healthcare officers, do you think it's important to involve fellow community members in planning activities in your area?

Yes No I don't know

2. For community members to fully participate in the development of their area they need to be properly informed. Do you ensure that your community members are aware about all information concerning the budget?

Yes No

3. If yes, which among the following information do you relay to the community members? Please tick correctly any of the options below

- ☐ Implementation report
- ☐ Signed audit report on the account
- ☐ Receipts of funds from the government
- ☐ Audited consolidated balance sheet
- ☐ Statement of income and expenditure
- ☐ Development plan)
- ☐ Yearly budget

Others (please specify)…….

4. Is there any law or regulations that require Ward officers/ health care officers to relay information concerning the budget to community members?

Yes No I don't know

5. If yes, which among the following information's mentioned below are you required to relay to the community members?

No	Information	Answer(Please tick appropriate box)
1	Implementation report	Yes ☐ No ☐ I don't know ☐
2	Signed audited report on accounts	Yes ☐ No ☐ I don't know ☐
3	Receipt of funds from government	Yes ☐ No ☐ I don't know ☐
4	Audited consolidated balance sheet	Yes ☐ No ☐ I don't know ☐
5	Statement of Income and Expenditure	Yes ☐ No ☐ I don't know ☐

6. Is there any other important information you think community members need to have access to besides budget information?

Yes No I don't know

7. If yes above, what other information do you think community members are entitled to get from your office?

i. …….

ii. …….

iii. ……..

iv. ……..

v. ……..

8. What do you think should be done to improve the cooperation of the community in planning and implementing health budgets in your district?

- [ ] There should be a comprehendible and consistent format of relaying budget information
- [ ] Budget information should be made available at the right time without delays
- [ ] I don't know
- [ ] Others (Please specify)…… ……

9. What methods do you use to relay information to community members? Please tick appropriate box.

- Placing information on billboards or walls
- Newspapers
- Community meetings
- Information is relayed to community members when they officially request through mail
- I don't know
- Other methods (Please specify) ……..

10. Do community members understand these methods of communication?

Yes No I don't know

11. In which language you use to disseminate information to the community members? Please tick appropriate box

- Kiswahili
- English

Native/Indigenous language

Others (Please specify)…… …….

12. As a warden officer/ health care officer who of the following reasons makes you involve community members in the development plan? Please tick appropriate box

Local government laws requires us to do so

Citizens love to be part of development plan

It helps to bring about development

Others (Please specify)…… ……

13. Do community members in this area use the budget information to improve health care services?

Yes

No

I don't know

14. If you answered no above, why do you think community members don't use information given to them?

They don't work on information at hand

They don't understand the information at hand

They are not motivated to use this information

It's not their job to work on the information given to them

Others (Please specify)…… ……

15. Do community members complain about health care services provided in this area?

Yes

No

I don’t know

16. If yes, are their complaints reasonable?

Yes

No

I don’t know

17. What happens when community members complain about health care services?

……

18. How many times are meetings held to discuss the improvement of health care services in the community?

Once a week (weekly)

Once in after three month

Once in after six months

Once in a year (yearly)

Others (Please specify) ……

19. What happens when warden officers/ health care officers don't relay the relevant information as stated by the law to the community?

Citizens follow up on them

Citizens write official letters requesting for budget information

Citizens report them to higher administration

I don't know

Others (Please specify) ……

Thank you for your participation