Journal of Public Health | Vol. 29, No. 2, pp. 147–156 | doi:10.1093/pubmed/fdm016 | Advance Access Publication 25 April 2007

Community views on health sector reform and their participation in health priority setting: case of Lushoto and Muheza districts, Tanzania

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ABSTRACT

Background Community participation (CP) is a key concept under 'primary health care' programmes and 'Health Sector Reform' (HSR) in many countries. However, international literature with current empirical evidence on CP in health priority setting and HSR in Tanzania is scanty.

Objectives To explore and describe community views on HSR and their participation in setting health priorities.

Methods A multistage sampling of wards and villages was done, involving group discussions with members of households, Village Development Committees (VDCs) and Ward Development Committees (WDCs).

Results Respondents at village and ward levels in both districts related HSR with a cost sharing system at public health facilities. Views on the advantages or disadvantages of HSR were mixed, most of the residents pointing out that user charges burden the poor, there is a shortage of drugs at peripheral health facilities, the performance of government health service staff and village health workers does not satisfy community needs, health insurance is promoted more than people actually benefit, VDC and WDC poorly function as compared to local community-participatory priority-setting structures.

Conclusion HSR may not meet the desired health needs unless more efforts are made to enhance the performance of the existing HSR structures and community knowledge and enhance trust and participation in the health sector programmes at all levels.

Keywords community participation, decentralization, health reform, priority setting, Tanzania

Background

The government health policy in Tanzania aims to establish institutional arrangements guided by the government, based on evidence and designed to improve the functioning and performance of the health service delivery system.[1,2] The national Health Sector Reform (HSR) process began in the 1960s, especially after the 1967 Arusha Declaration (Ministry of Health-Tanzania, unpublished results). Decentralization of health planning authorities to regional and district levels in Tanzania began in the 1970s as a crucial element of HSR.[3] The decentralization approach adopted in Tanzania is often cited as an example of democratization of the decision-making process at lower levels.[4] Conyers[5] defined decentralization as a means for harmonizing the interest of both national and local development through both the improved management of rural development . . . and

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the achievement of popular participation combined with national unity.

Despite the importance of community participation (CP) in health, there has, since the 1990s been inadequate case studies and synthesis work showing international experience in this area.[6] The word 'participation', which is sometimes confused with the word 'involvement', might mean letting someone in the system on a voluntary basis through persuasion or education or through coercion.[7, p. 617] Some analysts maintain that participation is supposed to make a difference rather than a process, as sometimes it may seem not so much as influencing the decision, but rather more achieving a platform for the acceptance of a decision already made elsewhere in the system.[8] Similarly, priority setting has been a widely discussed topic both nationally and internationally, yet there is a general lack of empirical evidence on the topic.[9] Evidence on CP in health is imperative to show the way forward, as Tenbensel[10] argues 'the most important clues for best practice could be from an analysis of *existing practice*'.

This paper highlights and compares the views on HSR and CP in a health priority setting in two districts located in Tanga Region, north-eastern Tanzania. The study was designed to explore and describe how the concept of CP in health was perceived from the community perspective in the context of HSR after almost 15 years of the Alma-Ata Declaration when officially the primary health care (PHC) concept was internationally launched.

Methodology

Study areas

Lushoto and Muheza districts are located in Tanga Region, north-eastern Tanzania. Small-scale farming of fruits and vegetables in Lushoto district and of oranges, bananas and maize in Muheza district is the chief economic activity. Muheza is located near the city of Tanga along the coast while Lushoto is located high in the West Usambara Mountains.[11] Malaria is the major public disease in both districts. The national HSR programme is in different phases of implementation in both districts.[11,12]

Study design and populations

This study was a multiple-case embedded exploratory study[13] targeting, among other participants, the adult members of households at village level and members of the PHC committees through Ward Development Committees (WDCs) and Village Development Committees (VDCs) in each district. In this paper, we report in detail the specific two-district case study findings involving focus group discussion (FGD) with village household members and VDC and WDC members, which due to shortage of space in the journal they could not be published altogether, with findings from other informants.[11,12]

Ethical consideration

The study received national ethics clearance through the National Institute for Medical Research. The clearance was presented to district authorities who were asked for their approval of the study in their areas. Ward and village leaders and the targeted study participants were asked for their consent and informed of their right to withdraw from the study any time they wished without penalty. They were also assured of confidentiality of any information seeming necessary to be treated so. All the authorities and study participants were promised that the study report would be presented to government authorities, other clients including the policy and managerial decision-making levels both locally and internationally.

Sampling approaches

In Tanzania, a district has at least two divisions, and division has several wards. The latter consists of at least two villages. A multistage sampling technique was adopted to select four wards in each district and four villages, one from each ward. At the ward level, members of the WDC in each village and members of the VDC were purposively identified to participate in FGDs, as was done in two other districts covered under the same study.[12] Fig. 1 shows the names of the divisions, wards and villages covered in each of the two districts.

We attempted to select the villages within each ward from the selected divisions which were not immediate neighbours (i.e. wards not bordering each other). The wards were purposively selected to ensure that two of the four villages were somewhat close to the District Capital/headquarters, and the other two were located several miles away so as to cater for any possible difference in views or experience with HSR and CP in health by the study population living in different localities. The assumption was that the effectiveness of CP in health and HSR might vary between different localities within a district and between districts.

Study questions

The questions were shaped to explore (i) community knowledge of HSR, (ii) communities' actual participation in health priority setting, (iii) how community priorities correspond to those set at higher decision-making levels, (iv) how the VDC and WDC responsible for local community health programmes performed their duties in relation to community desires or expectation.

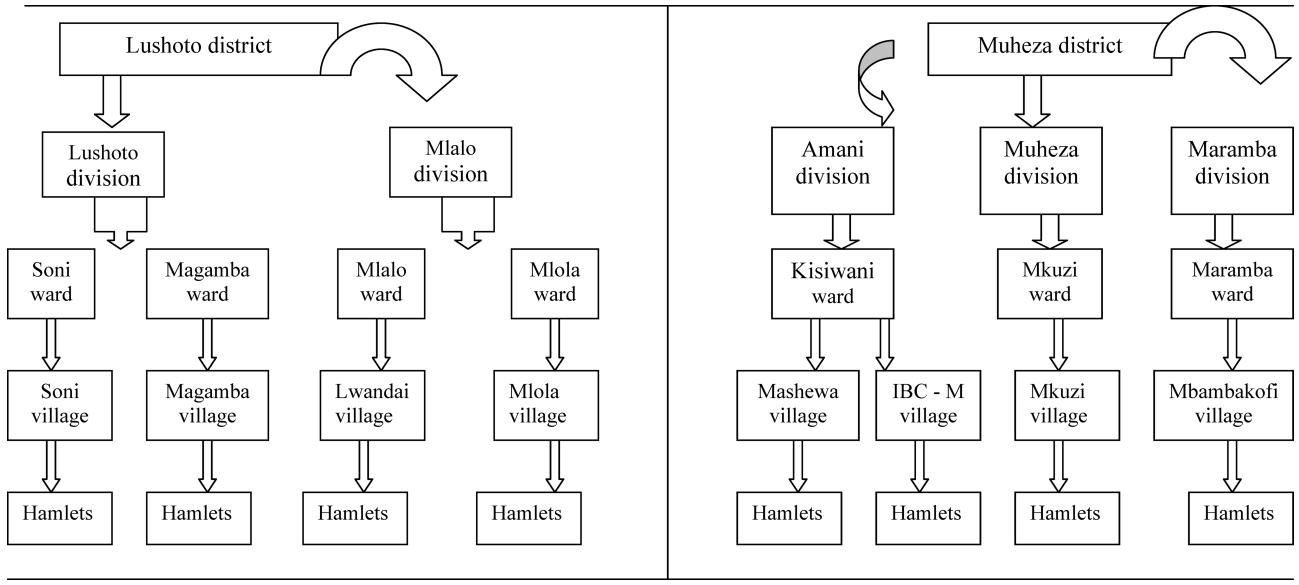

Fig. 1 Study wards and villages selected using a multistage sampling procedure.

Data collection methods

We undertook FGDs with members of the VDC and WDC and some members of households at village level. The latter participants involved adult individuals found at home on the day of study in the village. According to national decentralization policy arrangements, VDC and WDC include members democratically elected by the local residents to represent them in either or several of the following key subcommittees at village and ward levels, respectively: Finance and Planning, Defence, Security and Social Welfare, Water, Health and Works. At village level, the village chairperson (VC) and the village executive officer (VEO) become members of the VDC by virtue of their positions as is the case of the ward executive officer (WEO) and the ward councillor (WC) who become members of the WDC. Village household members were mobilized for FGDs after appointment with the ward and village government leaders. The latter were asked in advance to mobilize adult members of the household irrespective of their sex and other demographic background as long as they could freely express themselves in FGDs. Male and female participants mixed in the same FGD as the local leaders cleared doubts that none would feel hesitant to express themselves. Each FGD had 6–12 participants as recommended.[13,14]

Data processing and analysis

All FGDs were tape recorded to complement the handwritten notes taken during the discussion sessions and were moderated and notes taken interchangeably by skilled researchers led by social scientists. The rest of the research scientists acted as observers and took some notes. The research team met daily for a debriefing; social scientists transcribed the field notes assisted by the project leader. Although the study themes were the same, each locality and study population group was treated as a separate case, and ultimately, a comprehensive transcription of all the FGDs was done later in triangulation, looking at content and emerging patterns of the themes as recommended for multiple-case embedded studies.[15] No software was used in the analysis. The data were analysed manually by a group of research scientists going through the notes and transcriptions made by the social scientists using the taped records, after which two scientists (one being the principal investigator) worked more on the report. The analysis focussed on the specific themes under study against the data collected in the field and the transcriptions made thereafter.

Results

Community knowledge and views on HSR

Knowledge on HSR

The term HSR was not new to all the study participants at village and ward levels, the majority reporting that they had frequently been hearing of it on Radio Tanzania and in public meetings. However, there were mixed views about the meaning of the term HSR, most of the participants identifying user fees in public health facilities, health insurance (HI), existence of private medical practice, supply of essential

materials such as drugs, water and electricity at health facilities and key health service staff. The extent to which these aspects were viewed and experienced varied slightly between some study settings within and between the two study districts.

User fee system

In Lushoto district, a few participants viewed user fee introduction at health centre and dispensary levels to have improved the quality of health services. Conversely, the majority reported user fees as a burden to rural residents who have low ability to pay. Almost all the residents in Muheza district noted low quality of health services after user fee introduction, but a few within some groups observed that the quality of care at government health facilities had been low even in the earlier periods. Those who appreciated the improved quality of health services identified the availability of drugs, use of revenue collected from user fees for renovating health facility buildings and installing water and electricity services that were previously unavailable before user fee introduction. Soni village residents (Lushoto) complained that the same type of drugs had been prescribed each time they paid shillings 500 at the government dispensary. Residents in the other three villages (Lushoto) added that the antenatal clients were disappointed when they were required to pay shillings 100 each visit they made to the clinic (claimed as being a contribution to the salary paid to the health facility watchmen). It was added that poor residents opted for self-medication using traditional herbs or over-consulting traditional health practitioners; as some participants said,

People are not against the idea of paying, but for sure there are those who cannot afford the 500 shillings charged for laboratory services at the Mlalo Health Centre. Nowadays people who attend there [government health centre] are the seriously ill ones, otherwise it is not cheap to go there for minor illnesses [Mlola WDC members—Lushoto].

Three participants in Mashewa village, Muheza district had the following opinions:

From my understanding of HSR, I feel something missing. We lack closer health services for malaria, onchocerciasis and other diseases.

During colonial times, we were paying some money and obtaining sufficient services unlike nowadays, [when] we pay at government facilities but still face inconveniences such as the presence of a few doctors to serve the too many and increasing patients.

For the past ten years, there are some changes now. Health services, e.g. for maternal and child health at least have been brought closer to people, although there are several weaknesses related to cost sharing and some other aspects of services.

The experience of services brought closer to rural residents was shared in Mkuzi village (Muheza), while in Mbambakofi village people lamented that in the past, there was a school health programme whereby children were getting drugs, but nowadays children are told to go with shillings 200 and whoever does not show that amount receives no drugs. Additional reports from either all or the majority of the FGD village level participants in both districts concerning user charges are as outlined in Box 1.

Box 1 Views on cost sharing system in the public health sector as reported by FGD participants in selected villages in Lushoto and Muheza Districts, north-eastern Tanzania

Negative Experience (Shortcomings identified so far)

◆Reports from Mlalo village household FGD participants and those in Soni village that the clients directed by the government staff to buy drugs at private retail outlets (after the ones in the drug kit have run out) pay more than 500 shillings. Meanwhile, some participants in Soni village said that SP (sulfadoxine-pyrimethamine popular as '*Fansidar*') for malaria was sufficiently available at the government dispensary, but many people feared taking it because of its side effects (*unmentioned*), slowness in lowering body temperature and lacking antipyretic effect.

◆Charges drive poor pregnant women to consult traditional birth attendants or decide to deliver at home in an attempt to avoid being told to buy gloves as part of cost sharing on child delivery services while (according to them) the government policy requires pregnant women to access all the basic services free of charge.

◆Participants in all the FGD in Lushoto acknowledged children under five years of age being exempted from user charges.

◆Other participants stated that children were seriously dying due to shortage of essential services at government dispensaries and health centres including shortage of health service staff.

◆The tendency of patients being required to contribute to the cost of fuel for the ambulance in case of need for referral to the next higher health facility (in both districts).

◆Lack of essential laboratory services at lower health facility levels that prompted self-referrals by patients or official referrals by health staff to next higher facilities or to mission health facilities was also reported to be a common practice in both districts, contributing to additional cost burden to the patients and their families (both districts).

Compulsory and Voluntary Health Insurance Schemes

The National Health Insurance Fund (NHIF) scheme was mentioned in all the FGD at village and ward levels in both

districts. There was a common complaint in that HI advocated by the government has not benefited rural residents. A few village household FGD participants and VDC and WDC members in each district further argued that HI has not been as beneficial as expected since civil servants such as teachers whose salaries are deducted to contribute to the NHIF have been complaining about the excessive bureaucracy experienced when following up claims of their insurance entitlements.

In both districts, the community health fund (CHF) scheme was mentioned as another social HI whereby household members are mobilized in groups to pay an agreed amount of money per annum to cover some medical service costs in advance of illness so that one can access the services at times of illness. There was some dissatisfaction expressed by the community members and their local development committee leaders/representatives that the CHF and the NHIF schemes were initiated without adequate community sensitization for people to understand and agree on the objectives and practicality; as one participant in IBC Msasa village—Muheza remarked, CHF will be helpful to this village . . . , but villagers should have enough say when it comes to expenditure of the funds mobilized.

Health Basket Funding System [HBFS]

The Health Basket Funding System (HBFS), recently introduced a sector-wide approach to financing district health service priorities based on the government, DANIDA and several other donors' support through a common basket,[11,16,17] is poorly recognized by household members in rural village settings in both districts. In Muheza district, participants in one WDC argued that although the government introduced the HBFS with good intentions, the system seems to favour urban residents more than rural ones:

Urban areas get [the] lion's share of the budget for rehabilitation of health facilities and drug supply because of [a] deliberate attempt by the district officers who would like to be seen doing something by high ranking government leaders when they visit them unlike remote areas where such leaders rarely reach.

In Mkuzi ward, WDC participants in the FGD stated that they had heard about the HBFS, but did not know what it really meant and had never been involved in setting local budgets for health under such a system.

Health service personnel

Compared to urban areas, participants in all the study localities mentioned that the shortage of staff at government health facilities undermined the quality of services delivered. At Mlola WDC in Lushoto people reported that in the past there had been village health workers who were trained to distribute drugs in the village, but that they no longer saw such people and drugs. A similar point was made by the Magamba village FGD participants who reported that in the past there had been a system for every village to appoint a person (mostly from among the youths) to attend short-term courses on various community health issues. These youths would come back to serve the villages that provided the scholarship, but such a system no longer existed and instead the activities had been left to people who, in most cases had no prior training to deal with community priority health problems.

CP in health priority setting

Recognition of formal local priority-setting structures and processes

In both study districts, the majority of the FGD participants at village and ward levels identified the VDC and WDC as the local priority-setting structures in which the community can be represented and the participatory community approach as one of the processes for priority setting.[18] They felt that in the national health sector local government reform arrangements, needs assessment should follow hierarchy, starting at grass-root (hamlet) level to village level to ward level through to district level, regional level and finally to national level (Fig. 2).

Furthermore, it was revealed that when the needs assessment follows a bottom-up approach, an idea may originate from any one person at the hamlet level to a 10-cell or hamlet leader and then follow the chain to higher level village leaders (Fig. 1): hamlet member to hamlet leader to VEO/village government chairperson. The VEO in consultation with the VC may convene a village meeting to discuss and agree on the issue(s) at hand. Then the idea may be passed over to the VDC, but anything needing a higher level decision is passed on to the WDC, to the Full District Council (FDC) through the Ward Councillor (WC). The WC is a community leader democratically elected to represent the ward at various FDC meetings and is a representative of all the villages in the ward. The post of the VEO and WEO are determined by appointment at higher levels while the WC is politically elected through a democratic voting system by the villagers in a given sub-constituency. Both the VEO and WEO work under the office of the district council executive officer (DED). The VEO and WEO are the secretaries at the local community development meetings at village and ward levels, respectively, with the responsibility for executing the decisions passed at various meetings at their level of administration falling on them. The WEO coordinates and oversees the functioning of the VEO to

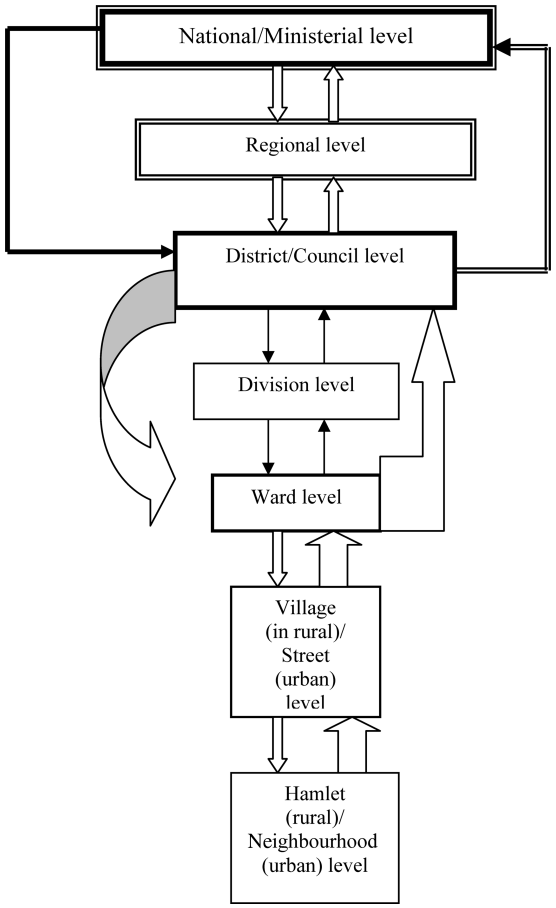

Fig. 2 Hierarchical priority setting decision-making levels under decentralization arrangements in Tanzania.

ensure that the activities planned are implemented in line with the existing by-laws and regulations guiding the implementation of such activities including those addressing health. The FDC is the highest authority, deciding on district development priorities, and their work includes scrutinizing district plans and approving them for budget allocations before the plans are sent to the regional administration secretariat for scrutiny. The plans are then submitted to the central government/ministerial level. The FDC is constituted by WCs in the district council area, the DED, district medical officer (DMO), district health secretary and invited departmental officers from key sectors such as education, agriculture, engineering/works, water and social welfare. The DED acts as the secretary of the FDC meetings, and is responsible for executing the FDC resolutions. The FDC is led by the Council chairperson who is democratically elected among the ward councillors and can be fired should he or she doesn't fulfil responsibilities as expected.

Participants in Muheza district reported that needs assessment or priority setting sometimes starts at the national level and moves downward to district level. Sometimes, a level is bypassed. For instance, WDC agenda normally bypass a division level (Fig. 2), going directly to the DMOs office or the FDC, as has been reported in both districts and confirmed by the DMO, the divisional executive officers and some other district level local and central government officers during personal communication with the research team. This bypass behaviour was not supported by the divisional officers who complained that when they are confronted with any emerging critical local health problem they find that as a result of being bypassed they sometimes have to deal with local communities they are not adequately familiar with. As also shown in Fig. 2, the Regional Health Secretariat just scrutinizes the plans developed at district/town/municipal council level before they are submitted to the ministerial level for approval. The role of the regional office is to check if the district/council plans adhere to the government planning guidelines, although the decision-making power on health priorities is in the hands of the district council, and once the council plan is approved, the funds and other budget components approved at the central government level are sent directly to the council office at district level (Fig. 2).

Perceived CP versus actual participation

In two WDC (one in Muheza and one in Lushoto), FGD participants reported that district authorities gave orders for the community to follow in order to accomplish certain activities planned at district level. "We sometimes face a big challenge by finding ourselves implementing things whose origin is not known to us," they said.

In Soni ward (Lsuhoto), though the village residents were thankful that in the near future they were going to have a health centre in their area, the place where it was being constructed was not the one the community liked it to be built. Delay or lack of feedback from district level authorities for the claims presented from grass roots level was reported to disappoint local populations and their leaders. Sometimes the leaders were being blamed, accused by the local residents for not presenting their concerns to the district level. Apparently, CP was wrongly interpreted in terms of community sensitization or being ordered to participate in sanitation and environmental conservation issues (as reported by the residents in Magamba and Mlola villages (Lushoto District).

Community views of the functioning of the VDC and WDC

Commenting on the functioning of VDC and WDC, residents in Mkuzi village reported that the local health facility committees had been inactive for a long time. It was argued

that such committee should spare at least a day to discuss urgent health problems with the residents, but that has not been the case in practice. Similarly, village-level FGD participants in one ward in Muheza district reported the failure of the WEO to visit their village for a long time, which tempted the villagers to send their problems directly to the district authorities and resulted in getting blamed by the WDC/WEOs office. The Soni WDC members in Lushoto had the following view of CP in setting the health priority agenda and in implementing various health activities:

. . .but for this to work better, people from the district level authority and research experts like you from other government authorities should forerun the process rather than using local leaders like us because local people has a tendency of listening to non-indigenous people who come as visiting experts.

Discussion

Main findings of this study

Community views on HSR and their trust in their local leaders' representation

The results presented above show generally similar experiences and views on HSR and CP in theory and practice in both districts and between the residents closer to the district and those capital in rural areas far away. Our *a priori* expectation that place of residence would reflect some variation in respondents' experiences and views of the HSR and CP approaches was not greatly supported by the results. The study has mainly revealed the low trust that people have in their leaders when they note or feel that their expressed priority needs are ignored by the higher district level authorities. Communities in both study districts expressed their reservations about the effectiveness and outcome of HSR. Whether or not communities are the best judges of their own health and whatever the appropriateness of the existing health programmes, it is fair to consider that their perception on HSR can be attributed to their psychological or ideological feelings, which means that it is crucial that this be assessed systematically and critically so that measures can be taken to make hostile communities cooperate toward making HSR programmes a success.

Claims against local health care prepayment and user fee schemes failing to be accompanied with improved services reflect the low trust the community has in the ability and, probably, in the honesty of the service providers and local PHC committee leaders in managing the revenue collected rather than claimants hating the cost-sharing system as some FGD in Mlola (Lushoto) and Mashewa (Muheza) lamented. Local leaders on their part seem to be disappointed by higher authorities initiating HSR programmes without consulting them or sensitizing the local population who finally blamed or lose confidence in their local leaders and the local PHC committees. The vast literature reveals that CP in development programmes can reduce inequities and inequalities in health by building local capacities and empowerment and is viewed as a crucial element of good governance in decentralized settings.[19,20]

Experience and views on health care payment mechanisms

Generally, community dissatisfaction with their involvement in local health care prepayment schemes and payment that seem less advantageous to them reflect the possibility that they regularly (if at all they do) receive feedback or an explanation of why shortages are experienced. Local leaders themselves get disappointed by people losing trust in them for things such leaders believed were beyond their ability to control e.g. the higher authorities initiating HSR programmes such as a cost-sharing system prior to adequate consultation and sensitization of the local populations, at least though their leaders. The testimony by the communities and some of their leaders that sometimes they were let to implement activities in adherence to orders from above was verified by district level officers who were sceptical of the ability of local community leaders to represent their people at various priority-setting meetings.[12] The latter two consecutive findings support what Oakley[6], Madan[7] and Brownlea[8] had reported on potential weakness in CP approaches: it is not clear who owns the reforms and who is responsible to keep the community informed of and trusting in the system.

The claim that user fees have failed to bring notable improvement in the quality of care at government health facilities and the consequent diverting of pregnant women and poor population groups to traditional health practitioners or retail private agencies cannot be underrated, as similar evidence has been reported from Korogwe district which shares borders with Muheza and Lushoto,[21] besides evidence from other countries.[4,16] Also the observation by some FGD participants in both study districts concerning the financing mechanism such as user fees, HBFS, NHIF and CHF schemes were less popular to community members simply because they were established prior to enhanced community sensitization is valid and is supported by the literature from studies showing similar experience from other countries.[22–25]

What is already known on this topic

The term CP is complex and difficult to interpret due to the diverse definitions used in the different cultures in which it is applied. Studies on decentralization indicate that to achieve enhanced CP in decision-making is a complex task.[26] Neutralists in the debate have always been asking whether participation should be seen as a means, an empowerment approach or as an end in itself[18,27] while international experience shows a general lack of common definition contributing to poor translation of the concept of CP in practice.[8,28–33] In addition to what has been cited in the background section of this paper, the debate has always been on the extent to which community members can participate in making rational health decisions, including whether or not: the service users are able to make informed judgements on complex technical issues, (a) they are willing to spare time at participatory appraisal meetings and (b) mechanisms in place are appropriate to channel societies' preferences;[27,34] (c) participation should be seen as a means, empowerment approach or as an end in itself.[18,27]

What this study adds

This study augments other studies that CP is by far a less interpreted and implemented concept in many countries, Tanzania being of no exclusion. That is, CP remains advocated in theory (rhetoric) rather than being implemented and felt to be implemented properly (reality). In this paper, we see it is important to understand that the observed or stated low CP and low appreciation of HSR in the Tanzanian situation may be attributed to the residents' lack of interest rather than sensitization (or information) as experience from other countries implementing HSR e.g. Columbia show.[27] We believe that, 'given a chance communities still may not utilize it fully or effectively and may still need decisions to be done on their behalf by other people, but *whom they trust* whether the latter are professionals or non-professionals'. The statement quoted in the last paragraph preceding the discussion section in this paper verifies the latter possibility. However, proponents of CP emphasize that people ought to make their own but informed decisions as a democratic way of expressing their needs; meanwhile, critics at the World Bank contend that user inputs alone cannot drive decision-makers in allocating resources efficiently and optimally especially in the complex medical field.[27] The results and the subsequent discussion in this paper support findings and conclusions by other authors that CP in theory is not synonymous with CP in practice, and neither should it be taken for granted that it can be translated and realized into practice in all contexts and in the same way. Therefore, there is a need for systematic evaluation given the observed dilemma among the general public and even the local community leaders, as is likely to be the case with professional/technical people responsible for community development affairs.

Limitations of this study

Despite precautions taken by the research team, this study is not without its limitations. The purposively selected study areas and populations may not accurately represent the overall district populations. Also, the way the study questions were designed and applied in the field might have influenced the responses and concerns raised by the study populations in some ways e.g. the respondents being more or less to critical or supportive of the existing health system, local elites/leaders, or answering in the way they guessed would be advantageous to them from the report or actions that would be made by the investigators. The mixture of women and men in the same FGD possibly influenced the responses or non-responses on certain study questions.

Conclusion

Mosquera *et al.*[27] assert that people's participation depends significantly on the political and economic system in which it takes place. Politically and administratively, the Tanzanian government places emphasis on good governance in all sectors,[17] and CP through decentralization arrangements is one of the emphases. Keeping this in mind, one of the key points about CP is that for people to participate effectively in any development activity e.g. CHF scheme, they need to be adequately sensitized to ensure their informed and desired participation. It makes no sense to let them participate in any activity without them being told why they have to be and/or are being brought on board. It is imperative to build public trust in the health system as in other development programmes or activities such as those associated with or related to HSR if the programme objectives are to be achieved. Also, CP sensitization should be a continuous process rather than a one-off process. It should also be a means and not an end in itself; lessons should be learned from practical approaches so that appropriate measures to improve the situation can be taken. More training of professionals and technical people on what it means and how to go about CP is crucial. What is important to know is that even if the community may be seen as uninformed in some aspects, it is the target beneficiary, often the greatest implementer and the final user of the intervention or programme.

Acknowledgements

This study was funded by UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) (Contract number ID 00461). Thanks to Dr. E.B. (TDR Programme Manager), Dr. Johannes Sommerfeld (Manger SEB, TDR) and Prof. Norman Hearst (University of California, USA) for their technical guidance, and Prof. Bo Eriksson from Sweden for his technical guidance on manuscript development. Mrs. VB Rwabutaza and Nyangoma-J Mubyazi (data collection and partly technical report writing), Dorica B. Mubyazi (Secretarial duties), the study respondents, central and local government authorities (ethics clearance), NIMR Director General Dr. AY Kitua for approving the study for publication. Neither TDR nor the Journal of Public Health are responsible for the views presented in this paper.

Conflict of interest

The authors report no conflict of interest in relation to this work.

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