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Assessing Government Actors' Knowledge of Community Participation in Health Governance in Dodoma, Central Tanzania

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Abstract

Community participation (CP) has been recognized as the key principle in health governance. Yet, knowledge of its effective applicability varied. This paper assessed the government health actors' knowledge of CP in health governance. The purpose of the paper was to examine the actors' level of knowledge concerning the perspectives of CP in health governance. Purposive and convenient sampling was applied due to the need to meet specific participants and the many other categories, making reliability certain. A sample of 79 was engaged, comprising community representatives in health committees at district and facility levels, health service providers, political actors, and administrators. Data were collected using semi-structured interviews, focus group discussions, and documentary reviews. The analysis was executed by theme and content analysis that employed semantic differentials and weighted mean. It was found that most community representatives in facility-level health committees had low knowledge of CP in health governance. This was connected to the low level of education that these actors have. The paper found various perspectives on CP, including resource mobilization, use of health services, facilitation of health services, community representation in health services, and broadness of the process of CP. It was concluded that most government health actors had a low level of knowledge regarding CP. This was related to the ineffectiveness of local health governance and recommended developing a CP policy that defines and articulates how CP should be understood and practiced in the context of health services.

Keywords: Actors, Dodoma, Knowledge, Community participation, and Health Governance

1. Introduction

Community Participation (CP) is a very popular concept. According to Work (2002), it was rooted in decentralization since the 1950s and 1960s. During this period, British and French colonial administrators prepared colonies for independence. It is further argued that CP was done by devolving responsibilities for certain programmes to local authorities. With global emphasis on governance

and human-cantered approaches to human development, CP has developed into projects and governance arenas. Today, the adoption of CP in health governance has been the subject of many development interventions (Rifkin, 2014). CP became an official principle in health policies around the 1970s following the World Health Organization (WHO) Alma Ata Declaration of 1978 (Cleary *et al;* 2013). Countries then adopted CP as the national policy strategy to address the health challenges of centralized health governance. CP was considered to address the structural and non-structural challenges within the decentralized health governance (WHO, 2012).

In this work, CP is referred to as the process of enabling communities to gain the understanding and control of the processes in decision-making and practices over health services. This entails understanding and participating in planning, implementation, monitoring, evaluation, and feedback on health services to improve health governance. The local health services are provided within the representation of structures created to enable communities to participate. However, effective CP partly depends on knowledge among actors, among other factors in the health system.

Knowledge is recognized as a key resource for organizational success (Oufkir *et al;* 2017). Despite the difficulty in defining it, known as the criterion problem, knowledge emerges out of a complex interplay of social, cognitive, cultural, institutional, and situational elements (Kamanzi, 2007). Oufkir *et al;* (2017) provide several explanations of knowledge. It is explained that knowledge exists in many forms in the organization. The first one is the tacit knowledge rooted in action, experience, and involvement in a specific context. It is composed of beliefs, know-how, and skills. The second one is explicit knowledge, which is articulated, codified, and communicated in a symbolic form and/or natural language. Both forms interact permanently in the enterprise through many conversion mechanisms. First, knowledge distinction is the organizational level that is shared among distributed actors belonging to the same organization (for instance, knowledge incorporated into routines, models, and regular and predictable behaviour). The second one is the collective knowledge owned by a group of persons that share a mutual identification, actions, and projects (for example, communities). The last one is individual knowledge, personal and intangible knowledge. It encompasses people, abilities, know-how, and know-what.

Pritchard (2010) identifies two types of knowledge: propositional and ability or know-how knowledge. A declarative sentence states propositional knowledge

that something (i.e. a proposition) is the case. It is typically contrasted with the ability to gain knowledge or know-how. Ability knowledge, often called 'know-how', involves knowing how to do something, such as ride a bike or swim. The two types of knowledge are treated differently because, intuitively, at least, one might know how to do something, for instance, swim, without having any relevant propositional knowledge. It is argued that what category of knowledge is permitted, the method for imparting the knowledge, and what to impart are arguably the main challenges (Huda *et al;* (2016). Huda *et al.* (2016) look at knowledge from two perspectives: one that looks at knowledge as the core of society's survival and is thus seen as binding on the entire society. The other perspective is the individually required perspective of knowledge. It is argued that knowledge is a means of advancement and the individual's and society's perfection. According to Landers *et al.* (2002), whatever assumptions we might make about people's knowledge, there is still a large discrepancy between what people do and what people should do. Booth (2011) supports that there is a closed loop between what we know and what we do: the know-do gap. Bennet and Bennet (2008) also argue that knowledge depends on context. Huda *et al.* (2016) look at the ability to knowledge by synthesis that knowledge is worth pursuing if it equips individuals with the capacity for creative and original thought as well as problem-solving skills.

This paper operationalized knowledge as substantive, theoretical, and practical understanding or know-how of a subject of CP. It is operationalized in terms of the government health actors' ability to answer correctly the question of CP by referring to specific components, including planning, implementation, monitoring, evaluation, and feedback. According to Boon (2007), there is a conviction that including users and other non-state actors in governance improves CP, leading to improved health governance. Yet, governance is still the main challenge in managing health services, of which knowledge of CP requires understanding. In developed countries like England, CP has been improving over historical times in the policy arena (Gorsky, 2008). There is a relative influence of the community in decision-making processes. Unlike in many developed countries, adopting CP indicates less responsibility for including community actors in developing countries.

Despite investment in planning, CP in Africa is limited, with barriers to managing and using health services (Kaseje, 2006). Tanzania had developed a policy and legal framework for CP to create a mechanism for community members to participate and influence the local health system. There were limited studies to examine the knowledge of CP among actors within the local health system acting

to influence CP. These stemmed from knowledge of factors influencing CP within the local health system. As a matter of concern about CP, knowledge of government health actors as a pre-requisite for practical CP was missing in the body of research. Mboera *et al.* (2007) conclude that there are gaps in knowledge among health actors in Tanzania. Therefore, this study intended to examine the government health actors' knowledge of community participation in health governance in the study area. This paper contributes to the arguments of the debate based on issues of capacity informed by knowledge of CP by government health actors on one hand and community awareness on participation as the principal actor in health governance on the other.

2. Methodology

The study was conducted in Dodoma Municipal and Kongwa District Council. Dodoma Region is one of the six regions in Tanzania with the poor performance of the participatory health governance structures, namely Council Health Service Boards (CHSBs) and Health Facility Governing Committees (HFGCs). These regions include Dodoma, Singida, Tabora, Tanga, Mbeya, and Songwe (URT, 2017b). Yet, being more disadvantaged than other poorly performing regions, Dodoma featured the least in human development (URT, 2015). The study employed the cross-sectional descriptive design. The design was important for the examination of the knowledge of CP among government health actors. The design was also selected because of the need to complement the study's qualitative data. The mixed approach was imperative in the search for breadth and depth of the knowledge of CP among government health actors. The sample constituted the government health actors from the study area's 14 selected public health facilities. The sample size involved 79 government health actors, including health service providers, council health service boards and health facility governing committees, administrators, and political actors. There were 14 key informants involved. Each health facility had 1(health provider) among 5 participants per health facility.

The semi-structured interviews were employed by Mselle *et al.* (2013). The semi-structured interviews were held with the health service providers (15), political actors (15), administrators (13), CHSBs (8), and HFGCs (28) members using the researcher's interview guide. The reason for using it was the need to capture opinions and details because of its flexibility. The participants expressed their opinions on the real world regarding knowledge of CP in health governance, including using and implementing health services and programmes, planning, monitoring, and evaluation levels. The knowledge test by the semantic differential method, as used by Masanja *et al.* (2015), enabled the collection of data from

members of CHSBs and HFGCs, administrators, political actors, and health providers on the conception of CP in health governance processes.

The documentary review method was done by a desk review of the available literature related to CP knowledge in health governance. In the study, the primary documents included the minutes of public meetings conducted by the Village and Street governments with community members and the minutes of meetings by the HFGCs and CHSBs. The study employed various methods for processing and analysis. The major themes informed the variable of knowledge of CP in health governance. The analysis methods involved theme and content analysis for qualitative data. The semantic differentials scale was used to analyse government health actors' knowledge of CP. The differentials in meanings were converted to numerical expressions. The data were presented by explanation building and tables.

3. Results and Discussion

This section presents and discusses five demographic components of health actors relevant to the study, as presented in Table 1. These involved sex, age, marital status, occupation and education levels. The results indicated the following.

3.1 Education

Table 1 presents results on the education level of government health actors, including members of CHSBs, HFGCs, political actors, administrators, and health providers on the one hand and community members on the other.

Table 1: Education Levels of Government Health Actors in Percentage

Education	PhD	Master	Bachelor	A	D	C	S	STD	AD	Nn
GHAs (N=79)	0.3	4.7	9.2	5.8	17	18	6	39	0	0

Note: GHAs stands for government health actors, PhD for Doctor of Philosophy, A for the advanced diploma, D for the diploma, C for Certificate, S for secondary, STD for standard seven, AD for adult, and Nn for none.

The study found that most government health actors had standard seven levels of education followed by certificate holders. On the other hand, most of the community members had a standard seven-level education. These results are consistent with those by Gibbs and Campbell (2012), the study on CP in primary health care in South Africa who found that formal health and social development policies allocate public sector employees an increasing role in facilitating CP in the delivery of health services, yet they have low capacity on CP. This can be associated with a low level of education that underscores CP's low level of

knowledge. This implies the compromised ability of these actors to negotiate within the health system. Education level can influence the level of knowledge and awareness among health government actors. This is because of the increased capacity for rational thinking and acting.

3.2 Level of Knowledge of Government Health Actors on CP

This section examines the knowledge level of the government health actors on CP in health governance, as presented in Table 2. Generally, the study revealed that most government health actors had a low level of knowledge of CP based on the indicators of resource mobilization, health service use, facilitating health programmes, community representation in health, and broadness of the CP concept.

Table 2: Level of Knowledge of CP by Government Health Actors

Government Health Actors	RM	HSU	FP	CRH	BP Mean		KL
CHSBs (n=8)	1	1.9	0.5	3.8	0.6	2	Low
HFGCs (n=28)	1.5	2	0.7	1.6	0.1	1	VL
Administrators (n=13)	1.8	2.3	3.5	2.8	0.8	2	Low
Providers (n=15)	3.4	2.4	2.9	4.3	0.8	3	Moderate
Politicians (n=15)	2	1.4	3	2.3	0.4	2	Low
Mean	2	2	2	3	1		
KL	Low	Low	Low	Moderate	VL		

Note: Scores 1 indicates very low and 5 indicates a very high level of knowledge; RM stands for resource mobilisation, HSU for health service use, FP for facilitating health programs, CRH for community representation in Health, BP as a broad process, HP for health plans, M for meetings, VL for very low & KL for knowledge level.

3.2.1 Resource Mobilisation in Health

Table 2 presents results on the knowledge of government health actors based on resource mobilization. It was found that the government health actors possess a low level of knowledge of CP about the dimension of resource mobilization. It was found that only the majority of health service providers had a higher knowledge of the resource mobilization element of CP. Box 1 also presents results based on a resource mobilization perspective.

Box 1: Resource Mobilisation Understanding of CP

Community members participate in health projects such as building health facilities through the cost-sharing government policy. The community contributes resources and labour for the erection of the walls, and the government makes the completion of the remaining housing infrastructure of health facilities. Government health actors such as health service providers facilitate CHF services, building health facility infrastructures and healthcare access through user fees and community contributions.

The results in Box 1 relate to the contribution approach by Taylor *et al;* (2008) that considers participation primarily as voluntary contributions to a project in terms of time, resources, or community-based knowledge. Professional developers, usually external to the community, lead participation and decide how the contributions will be used. According to Bamford (1997), in a given context, the reasons for community participation must be specified, the form of anticipated participation defined, and specific strategies identified. This underscores the knowledge of health service providers' ability to lead CP in health governance.

> "*Community participation in the hospital services is through the Street Chairperson, hamlet leaders and other outside persons whom they are invited in some matters of the health facility"* (Health Service Provider, DMC, 2017).

Chitambo *et al.* (2002) have a different view on CP that healthcare professionals can assist the community in obtaining commitment (and funds) from local, regional and national healthcare agencies to address their care priorities. This explanation equals the view of community participation as the means in its low level according to Arnstein's Ladder of Participation, 1969 because it takes the interest of one actor to accumulate resources for the planned health activities from community members. This implies that CP is done as a response to contribute to the planned health programmes that require information given to the community members.

3.2.2 Use of Health Services

Table 2 presents results on the use of health services. The study found that most health service providers, as opposed to other government health actors, knew the use of health services as one of the elements of CP. Box 2 presents results on understanding CP in the form of health services.

Box 2: Use of Health Services Perspective of CP

CP was reported as a pillar of use of healthcare services, including treatment services, immunization campaigns, and health programmes by mother/child and elders through the outreach, inpatient, and outpatient departments.

The results in Box 2 indicate that most health service providers had the conceptualization of CP with the inclusion of the health service utilization dimension. This relates to CP as the means put forward by Mikkelsen (2005). In this regard, one health service provider stated that:

> *"CP means enabling people to get access to services at the health facility. CP is done via meetings, hamlet leaders, planning on constructing health facilities, and clinic attendance. The community members participate in environmental sanitation activities at households, community or public places, and proposed dispensary area"* (Interview: Health Service Provider KDC, 2017).

According to Burns *et al.* (1994), participation is contested around defining it. This gives differentiated understanding among communities and individuals. Also, Mosquera *et al. (*2001) and Loewenson *et al. (*2014) argue about differences in understanding how to build and apply the concept of participation. This is because the concept holds multidimensional views in development interventions. One conception of the term is the one that is based on CP as the means. The other conception views the concept as an end in itself. The two are variably applicable by development practitioners, with different merits between community members and facilitators of development. The health governance model (World Bank 2004) puts three categories of actors in health governance: government, political, and community. There is a closed loop between what we know and what we do: the know-do gap (Booth, 2011). Referring to the context of knowledge about CP, another health service provider in DMC said that:

> *"CP concept means community member's involvement in various health activities after being enabled. Activities done to involve the community include mother and children care and special groups on pro-poor policy. The mobile clinic is not done because of the centrality of the health facility to the central business district. Community participation is high because of high utility. For instance, we serve about 300-350 clients daily"* (Interview: Health Service Provider DMC, 2017).

Phipps *et al.* (2017) provide five practices of successful knowledge, including understanding partners' political, social, and economic context, building trust among partners, developing the capacity for knowledge, enabling knowledge to be co-constructed, and building a culture of knowledge for all participants.

3.2.3 Facilitation of Health Programmes

Table 2 presents results on knowledge of facilitating health programmes. The study found that the level of knowledge by government health actors on the dimension of facilitating health programmes of CP is low. The results indicate that only most administrators knew how to facilitate the planned government health plans. The FGD revealed that in the planning of health facility infrastructure, it was noted that government leaders always consult with communities to have shared responsibilities on resources between the government and the community members. Box 3 also presents qualitative results on the CP perspective of resource mobilization understanding.

Box 3: Resource Mobilisation Understanding of CP

> Community members participate in health projects such as building health facilities through the cost-sharing government policy. The community contributes resources and labour for the erection of the walls, and the government makes the completion of the remaining housing infrastructure of health facilities. Government health actors such as providers facilitate CHF services, building health facility infrastructures and healthcare access through user fees and community contributions.

This means that the government health actors, such as health administrators, are central decision-makers who consult with the community for knowledge delivery about planned services and programmes. These results concur with the instrumental approach of CP. Taylor *et al.* (2008) postulated that health and well-being are defined as a result rather than a process, with CP as an intervention supporting other public health or primary health care interventions, health planning, or service development. Professionals usually lead CP, and the important components of interventions or programmes are predetermined according to local and national priorities. In responding to his understanding of CP, another political leader said:

> *"CP in Health means the Village Executive Officers (VEOs) involve the hamlet leaders; the hamlets go to Council leaders. The activities done on CP include environmental cleanness, CHF sensitization, family planning, and clinic attendance"* (Interview: Village Leader, KDC, 2017).

These explanations relate to the efforts put by government health actors on issues related to environmental sanitation as an invited space (Mdendemi, 2014) for community members to contribute physically. Therefore, most local government administrators believed that CP was the means to facilitate added resources from the community in delivering primary healthcare services.

3.2.4 Community Representation in Health Services

Table 2 presents results on knowledge of community representation in health services. The study revealed a low level of knowledge of community representation in health services by government health actors. Among them, most health service providers and members of CHSBs are relatively more knowledgeable than political actors and members of HFGCs and administrators. This is because of their health-oriented professional and higher educational background than other government health actors. These findings concur with Neuwelt (2012), who found that community representatives view CP as a process of trust-building and information-sharing between communities and health professionals. It is argued that these relationships make people feel comfortable seeking care, and professionals mold services to people's needs. But all these depend on the level of knowledge of CP by health actors.

> *"When required, we normally write letters to the Village Executive Officers (VEOs)/Street Executive Officers (SEOs) to select members. These collect information on the challenges of the community. They conduct meetings in the community".*
> (Interview: Health Service Provider, DMC, 2017).

This understanding relates to the health service approach by Rifkin (1985), which states that communities contribute to health care by giving human resources, materials, and/or money. Health professionals interact with the community through community health workers, who act as brokers between community members and health services under the supervision of health professionals. In this approach, health professionals largely control decisions about healthcare delivery and oversee the CHWs representing the community.

The debate has been persistently about what CP means and achievements or failures (Mubyazi and Hutton, 2012). The CCHP of 2001 is the principal planning tool designed to make communities participate in health governance in all processes. One of the interviews with the council-level health service provider indicated that the CCHP forms the core tool for planning all levels of health facilities. It was said that the plan usually contains medical and biomedical

facilities, human resources for health, strengthening of maternal and child health services, and communicable and non-communicable diseases. The documentary review of one CCHP of DMC (2013) indicated CP as a community involvement;

> *"a process of identifying community needs should precede meaningful planning. For such needs to be relevant to the community the programme serves, they should be identified at the grassroots level with the intended users' full participation. This participatory bottom-up approach to planning was used during the preparation process of this CCHP. The method used to involve the community is through Village Health Committees (VHCs), community resource persons, and Community Health Workers in rural areas. The community must contribute labour and financial resources in case there are construction and preventive services" (DMC, 2013).*

This is a placation level of knowledge on participation that uses committees and other structures established for CP as means for the implementation of health services planned by government health actors that require some levels of consultations with structures on behalf of the community as per Arntein's (1969) Ladder of Participation. This understanding of CP in health programmes does not relate to Gryboski *et al.* (2006) results of CP possessions that concern knowledge of the community, planning, communication and collaboration skills, facilitation and mentoring skills that government health actors such as health service providers, CHSB and HFGC, political actors and administrators are supposed to be acquainted with.

3.2.5 Broadness of the Process of Community Participation

As presented in Table 2, the study found a low level of knowledge of the holistic perspective of CP among government health actors. Among them, most health service providers had a higher level of knowledge of the broad process of CP than other actors. According to most health service providers, CP takes on board community members' ownership of primary health care services, resources, and feedback on health services based on community inputs into health services and programmes. Box 5 also presents results based on CP viewed from a broad process perspective.

Box 4: CP as a Broad Process

CP involves community ownership of health services, resource mobilization, and the shaping of the health system on values, culture, and feedback from the community.

The results in Box 4 do not relate to the developmental approach by Taylor *et al.* (2008), who conceptualize health and social care development as an interactive, evolutionary process embedded in a community of place or interest. In partnership with professionals, the community has a role in decision-making and in achieving the outcomes they consider important. Despite CP structures in health governance, this perspective of CP was less known among most government health actors. This is contrary to Neuwelt's (2012) results that most respondents described CP as a complex process of relationship-building over time and quite distinct from consumer feedback processes in general practice.

Gryboski *et al.* (2006) argue that one of the elements of CP involves health workers' possessions. The health workers possess health knowledge, community knowledge, planning, communication, collaboration, facilitation, and mentoring skills. The interview with a health service provider at a regional level articulated the conception of CP in Health as:

> *"CP is a bit broad concept; it involves ownership of health activities, primary health care services, and community control of disease load. It also involves resource mobilization, shaping the health system to address peoples' satisfaction and feedback for the quality of health services. There are cultural differences, taboos, lifestyles, and behaviour"* (Interview: Health Service Provider, DMC, 2017).

This conception of CP relates to that which conceptualizes CP as a process, as informed by Kessy (2014). This understanding of CP links the planning processes, implementation of health activities and services, evaluation, monitoring, and feedback communication. It also accommodates the role of health government actors, including community members, political, administrative, health service providers, and members of CHSBs and HFGCs in the local health system as per the health governance model by the World Bank (2004) that depends much on participation among actors. These results also concur with Gryboski *et al.* (2006) findings that most stakeholders describe CP as a complex process of relationship-building over time and quite distinct from consumer feedback processes in general practice.

4. Conclusion and Recommendations

4.1 Conclusion

This paper has presented and discussed the results based on the government health actors' knowledge of CP. The results indicated that the level of knowledge of CP by the government health actors in the study area was low. This was informed by the government health actors' low understanding of CP. CP is mainly

understood to be the means for implementing government-oriented health programmes and services. These include the perspectives of resource mobilization, health services use, facilitation of planned health programmes and services, and representation of HFGCs and CHSBs members in health services.

It was revealed power differentials among health governance actors, with district and council level holding greater power than lower level health actors, including community members and lower level CP structures. The spaces of CP were mainly closed with a mix of visible, hidden, and invisible powers, contributing to ineffective practices. As a result, the nature of CP at the grassroots level receives low or placation practices in the planning, implementation monitoring, evaluation, and feedback of health services. These processes are not community-oriented but depend on the central and local council actors.

4.2 Recommendations

The paper recommended developing a CP policy to articulate how CP in health governance is understood and practised. The community representatives in health facility committees' recruitment policy requires a change of policy to involve at least four levels of education, a move from knowing how to read and write alone.

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6. Conflict of interest statement

The author declares no conflict of interest in this work.

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