How not to decentralise

Accountability and representation in health boards in Tanzania

Suzan Boon SNV Tanzania

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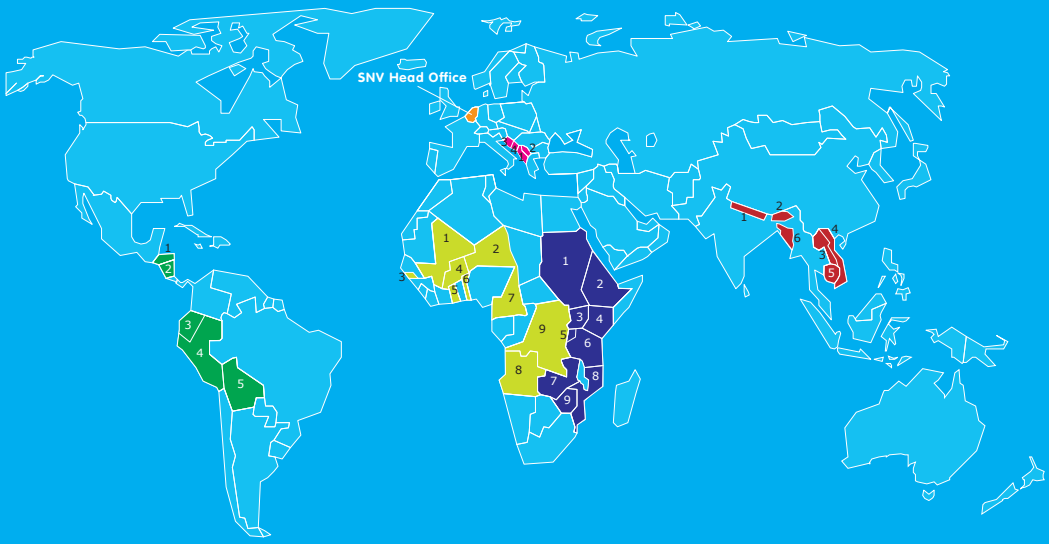

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Abstract

As decentralisation expands in Africa, local management structures are also likely to become more important. The paper investigates issues of representation of and accountability to users of public services in local management structures. The study challenges the assumption that user representation in such structures enables users to voice their interests and makes services better adjusted to their needs. Though the paper concentrates on health, issues raised are likely to be applicable to the delivery of other public services like water and education. The findings reveal that because selection is not democratic, representatives see themselves as primarily accountable to government and not to their communities.

1 Introduction

Since the 1990s Tanzania has engaged in a health sector reform programme with the main objective of improving service delivery. The Ministry of Health introduced the reforms after a review of the health system that revealed inefficiencies, lack of accountability, poor quality of services and under-financing. The improvement of service delivery will be achieved through "deeper partnerships with non-government health providers, decentralisation, community voice and enhanced skills and motivation among health workers" (GoT, 2003:1). The main strategy of the reforms is to devolve administration and management of health services to local authorities by introducing Council Health Services Boards and various Health Facility Committees that work under the local governments.

The boards and committees[1] have a mixed membership with government, voluntary agencies, private for-profit health providers

1 Council Health Service Boards are further referred to as '(health) boards' and Health Facility Committees as 'health (facility) committees' or both as (local management) structures

and community representation.[2] Through these structures genuine transfer of power and authority to the communities is expected to take place (GoT, 2000:v). This involves a greater responsibility of communities in financing public health services. Payment is done through user fees or membership of the Community Health Fund which is a community based financing scheme "whereby households pay contributions to finance part of their basic health care services to complement the government health care financing efforts" (GoT, 2001:5).

All over the world local management structures like the health boards and committees are promoted because of the conviction that inclusion of user and other non-state actors in public service management will lead to increased representation of and accountability to service users. This study questions whether the inclusion of user representation in local management structures indeed enables users to voice their interests and makes services more responsive to their needs.

In citizen voice and state responsiveness initiatives, different levels of citizen engagement can be distinguished: consultation, presence and influence (Goetz, 2001:8). Consultation involves opening arenas for dialogue and information sharing which can be one-off or ongoing. Presence involves institutionalising regular access in decision-making. "Influence brings citizen engagement to the point where groups can translate access and presence into a tangible impact on policy-making and the organisation of service delivery. This can happen when accountability mechanisms incorporate citizen concerns and preferences (…)" (Goetz, 2001:9).

These levels of citizen engagement provide other opportunities for citizens to express their preferences than through elections exclusively. In conventional democratic systems elected representatives influence and hold the public service deliverers accountable. They themselves are influenced by and accountable to the community. This is the so-called 'long route of accountability' (The World Bank, 2003:6). Consultation, presence and influence assume a direct link between the public service providers and users which is referred to as the 'short route of accountability' (The World Bank, 2003:9).

2 See Annex 1 for an overview of membership in the board and various committees

In Tanzania, the conventional long route has apparently not led to the desired level of health service delivery. The health boards and committees are structures that create the link between users and providers, i.e. the short route of accountability. The presence of representatives from the community and other non-government health providers is expected to lead to 'increased voice' and 'community ownership', hence reaching the level of influence. The study aims at finding out whether users at the moment indeed have a voice and increase responsiveness of health service delivery through the health boards and committees.

2 Methodology

2.1 Objectives and research questions

The objective of the study as outlined above will be answered by analysing representation and accountability in the health boards and committees. For representation, the study uses Ramiro (2001:62) as reference and focuses on the following indicators: democratic selection of representatives and presence of regular consultations. The analysis of accountability follows Brinkerhoff's (2001:2-4) definition components of accountability:

- Answerability: This is the obligation to answer questions regarding decisions and actions and, going a step further, also giving explanations and justifications.
- Enforcement/sanctions: These can be legal sanctions for illegal or inappropriate actions and behaviour but also incentives like the use of market mechanisms for performance accountability.
- Locus of accountability: The accountable and overseeing actors can be located within or outside the state structures. Outside involves citizens, civil society and private sector that seek to articulate demands and comment on public institutions. The effectiveness of these actors is influenced by the connection to some degree to the structures that can hold the government to account and the capacities to articulate those demands and comments and be taken seriously by government officials.

Based on Ramiro's and Brinkerhoff's classifications, the study uses the following sub-questions:

- *Members' selection:* How are members selected? Are democratic elections or government selection the dominant feature?
- *Perception of members of their role:* How do members perceive their role as member of the board or committee? Do they focus on their constituencies[3] or government?
- *Answerability:* To whom and on what are the boards and committees accountable? Are there regular consultation meetings with constituencies?
- *Enforcement and sanctions mechanisms:* What enforcement and sanction mechanisms are in place? Does the power lie with the constituencies or the government? What is the importance of market mechanisms in accountability?
- *Locus of accountability and effectiveness:* Are the boards and committees located within or outside the state structure? How effective can the non-state actors be in their position as members? What decision-making powers do the boards and committees have within the state structure?

The below table gives an overview of the indicators used and the link to the short and long routes of accountability as described in the introduction.

Table 1: Overview of indicators

	Short route	**Long route**
Members' selection	Democratic elections by constituencies	Selection by government
Perception on role	Constituency-focused	Government-focused
Answerability	Regular consultations with constituency	Directed to government
Enforcement / sanctions	Elections – market mechanisms	Dissolving power with government
Locus of accountability	Outside state – capacities of members	Inside state – decision-making power

The study is based on two districts as case studies. Both districts are located in the Kilimanjaro region in north of Tanzania. In one district the board and committees were formed in the year 2002. In the other district the board and committees are still in the establishment phase.

3 'Constituencies' refers to the represented communities, voluntary agencies and private for-profit health providers.

2.2 Data collection

The study used the following data collection methods:

- *Desk study* - Collecting background information, legal frameworks and literature review.
- *Focus group interviews*[4] *with health facility committees* – Staff of the district council's health department selected the committees with the only condition that they should be operating in areas with predominantly settled farmers.[5] The purpose of the interviews was to bring out information on the formation process, representation and accountability.[6] After a few open questions on the establishment and membership of the committee, the participants built a Venn diagram showing direct and indirect relationships between their committee and other actors (groups, organisations, institutions and other committees) and the content of the relationships i.e. what goes from the committee to the other actors and vice versa. The diagrams are used to establish the committees positioning in its environment and answerability patterns. The exercise stimulated participation from all members present (on average 6 per interview) and limited interventions from the interviewers.
- *Individual interviews* – In the face-to-face interviews members of the health boards gave their views and perceptions on motives for establishment, members' selection, consultations, their roles and accountability by answering open questions. In addition to board members, a representative from the Ministry of Health was interviewed with a focus on the background and motives and the establishment process of the structures.

Table 2 gives an overview of the number of health facility committees interviewed and the number of individual interviews held per represented group per district.

4 Mr G. Prinsen, a PhD candidate from Massey University, New Zealand, designed the study methodology for the focus group interviews and conducted the interviews jointly with the author of this paper.

5 This was done to exclude the influence of the differences in social dynamics between pastoralists and farmers when it comes to shaping formation, representation and accountability processes.

6 The group interviews included more elements but these were not analysed in this study. See Annex 2 for the format.

Table 2: No of interviews held

	District 1	District 2	Total
Health facility committees	5	4	9
Health board – government representatives	4	2	6
Health board – voluntary agency representatives	1	-	1
Health board – private for-profit provider representatives	1	1	2
Health board – community representatives	1	-	1

3 Findings

The first section (3.1) gives background information on the establishment of the health boards and committees and how it is envisaged that they will contribute to improved service delivery from the Ministry's point of view. The presentation of findings in the two districts follows the sub-questions as outlined in the section on methodology: selection of members (3.2), members' perception on their role (3.3), answerability (3.4), enforcement and sanctions (3.5) and locus of accountability (3.6).

3.1 Background information on establishment[7]

The Health Sector Review (1993) recommended the establishment of structures that give communities more power over, a voice in and ownership of health facilities. The Ministry considered which structures were in place that could represent users and give them more power. A logical suggestion would be through the elected representatives in the council but that structure was not seen to be appropriate because of the political influence. They were looking for a more technical structure, which became the District Health Service Boards and various Health Facility Committees.

With the amendment of the 1982 Local Government Act towards the end of 1990s, a clause was included allowing councils to have service boards and committees. In 2000, the Ministry of Health developed a guideline that stipulates the composition, criteria for members' selection, nomination procedures and all aspects related to the

7 Source: Interview with representative from the Ministry of Health

functioning such as the roles, functions, duration of membership, reporting mechanisms, relationships with other actors and sanctions. As a guideline does not have any legal binding, the Ministry also developed a model for the instrument that councils can adapt according to their environment. In introducing the boards and committees to the councils, the Ministry first orients and trains the councillors. The full council has a final say in whether or not to establish these structures, although the Manifesto of the ruling party CCM says that by December 2004 all councils should have health service boards.[8] The Ministry cannot force the councils by issuing directives, but provides facilitation and guidelines. Once the council has decided to establish the structures and start the Community Health Fund, members' selection and legal procedures can start. Following these, the Ministry provides a training to inform the members on their roles and responsibilities.

In the explanation during the interview, the Ministry makes a direct link between the boards and committees and the introduction of the Community Health Fund. Here, it is important mentioning that until the 1990s, when cost sharing was introduced in a few pilot areas, public health services were free of charge all over the country. The contributions are collected at the health facilities and managed by the health board. The board decides on the disbursement of the funds based on plans that the committees prepare. An extra incentive for health facilities to promote the health fund is the top-up from the central government on the collected fees. The reasoning, as the representative from the Ministry explained, is that: "Paying for services will increase the consciousness among the users that they own the facilities and can maintain resources. It creates ownership and a feeling of responsibility among the users. Otherwise users will still consider health services to be merely a government property and responsibility. Now there is involvement and participation. If boards and committees do not meet legal actions can be taken. This is an incentive for users to become a member of the scheme and to get to see the results of their contributions in improved service delivery."

8 In April 2005 about half of the councils inaugurated the boards and committee, while all have resolved to establish them.

However, the guidelines and the instrument by which the structures are established only mention the Community Health Fund as one of the sources of funds for the boards and the committees (GoT, 2000; GoT, 2002). Again another picture is given in The Community Health Fund Act (GoT, 2001). The same health boards monitor, mobilise and administer the funds but there is no mention of health facility committees in this act (GoT, 2001:8). Both the instrument and the act stipulate that the ward health committees[9] are responsible for mobilising communities, supervising contributions, initiating and coordinating community health plans and organising meetings of members of the fund.

The link between community voice in management and ownership of health services and payment for services is not clear. Particularly the different set of roles and responsibilities for health boards in the guidelines and instrument as compared to The Community Health Fund Act together with non-appearance of health facility committees in this Act create confusion.

3.2 Selection of members

According to the guideline, 4 out of 10 district health board members are member by virtue of their position in the government. In a dispensary committee, there are 3 such members out of 8.[10] In the two districts that were studied, the selection process of the non-government members differed for the representatives from the community, non-profit voluntary agencies and private for profit health care facility. In all focus group interviews, there was confusion around the selection process and it took quite some time to get a common understanding among both members themselves and interviewers on how the members were selected.

Community representatives – In one district, the council announced the vacancies for membership and interested individuals could apply. For some committees, potential members were proposed and elected in public meetings. The ward development committees scrutinised the applications before forwarding them for final selection to the health

9 For its composition see Annex 1
10 See Annex 1

department of the district council. The scrutinising was said to be on age, being able to write and read, being an inhabitant of the area and user of the health facility in question.

In the other district, where the structures have been formed recently, a different approach was used. Village governments identified candidates and proposed these to the council for approval. The selected members received a letter of appointment without being aware that committees were being formed. One of the government board's members had a different version of the process, namely that the council did advertise and announce the voluntary positions on public notice boards and through radio. The selection was done by the council. For the board, the council made sure that representatives from different divisions and from outside the district headquarters were included.

Voluntary agency representatives - In 2 out of 9 committees over the two districts there is voluntary agency representation: one church organisation running a health facility and an NGO active in the whole district. For the other committees, except one where an NGO had refused, the committees explained that there are simply no such organisations active in the same area as the health facility. In both districts, the council selected the representatives from voluntary agencies. The board member in one district had initially applied for community representative position but was granted the non-for-profit position because of that person's position in an NGO running a hospital in the area. In the other district the council did the selection on the basis of competencies.

Private for-profit representatives – In 4 out of 9 committees, the private for-profit providers are represented. All 4 are located in the same district. This can partly be explained by the fact that in one district pharmacies are not considered in this category while in the other district they are. In one district the board representative from the private for-profit health care facility was elected in a meeting with all private facilities in the district. The council's health department had called the meeting. Peculiar is that the church organisations were considered to be private facilities while the voluntary agency representative is also from a church hospital.

In the other district a number of private providers applied for a position and the council selected one among those. There is an association of private health providers in that district. The applicant who became the representative informed the other providers but did not consult them at the time of the application. Being the secretary of the association, he felt it to be his duty to apply for membership on behalf of his colleagues.

In summary, it was found that at committee level only few community representatives were elected in public meetings. At board level, only one representative from for-profit providers was elected by those people the member is to represent. For other members at both committee and board level, the district council did the selection with or without application letter. A second remark concerns the low number of representatives in the committees from voluntary agencies (only 2 out of 9 committees) in both districts and the absence of private for-profit providers' representation in one district. A general concern is the confusion around the selection process among the members themselves.

3.3 Members' perceptions on their role

In both districts, the respondents from committees and boards pointed out that the position does not require medical expertise. In addition to the basic criteria like age and literacy, the ability to talk to the community, to get a message across and convince people were seen to be determining factors. This was illustrated with the example of "convincing the public on the importance of the Community Health Fund". All board members interviewed individually see their main role in making sure that the community receives quality health service by advising the council on issues like staffing and supplies.

Three out of 4 interviewed board members did not mention in first instance the role of representing their constituency but see themselves more as an information channel from government to the public. The role of facilitating the relationship with voluntary agencies and private providers was not mentioned. When asked whether there is competition between the private and government health facilities, a private dispensary owner and board member representative of for-profit health facilities answered: "When I go there I forget about my

own. I am not near to other private facilities because they are not part of the health fund scheme and people are not allowed to go there. (…) I feel as if I am working for the government."

Only 1 non-government board members out of the 4 interviewed members was very clear on what is expected from him in his role as board member. The most important role is bringing in the know-how in order to improve the services to the people. In addition to that, the representative would like to improve the collaboration between the government and private providers. The position in the board provides access to policy-making and gives the opportunity to make government also responsive to private providers and appreciate their services.

The expectations from the committee members in the district where the boards and committees are operational at the time of application appear to be different from the reality. During the group interviews of all 5 committees, there was mention of the absence of allowances for meetings as one of the main problems of the committee. Though the announcements did not indicate whether it was a voluntary or paid position, none of these members had expected a voluntary job.
A research into the effectiveness of the Community Health Fund in another district in Tanzania revealed that committees are not active due to the absence of allowances for the members (Musau, 2004:15).

The findings on the perceptions do not provide hard evidence, but adding them up the study does conclude that members are more government than constituency-focused. The majority of the members consider themselves as serving the government and had expected allowances when performing their duties. The confusion around the selection process and the selection by government as mentioned in the previous section can explain this thinking. Also worth mentioning here is the long gap between the selection and the start of the committees. In one case it even took two years and three months. It was due to the postponement of the seminar offered by the Ministry during which the official appointment was to be done and members were to be educated on their roles and responsibilities. This shows that there is a strong influence of and dependence on the central government.

3.4 Answerability

Answerability is looked at in terms of 'to whom' and 'on what'. The findings presented in this section are derived from the Venn diagram exercises during the group interviews with the committees.[11] The diagrams, showing the relationships and the contents of the relationships with other actors as perceived by the committee members, give good insights in the answerability patterns.

The table below gives a complete overview of the findings. Taking the first row as an example, it shows that 80% of the committees indicated to have a direct link with the district council. The committees send plans, reports, minutes and all kinds of requests to the district council. Vice versa, the council gives the committees policies and directives, medical supplies, funds and training to staff.

Table 3: Overview of findings Venn diagrams

Actor	Direct link	Content of relationship	
		To	From
District council	80%	• Various plans, reports, minutes • Requests for supplies, funds and other requirements	• Policies and directives • Medical supplies • Funds • Training to staff
Village government	100%	• Information on health situation • Information from higher levels • Various plans, reports, minutes • Requests to inform villagers on e.g. health contributions and campaigns	• Assistance in convening meetings • Voluntary labour • Security • Exemptions health contributions • Enforcement regulations • Information from villagers • Ideas on improving health services
Communities / Users	40%	• Health services • Information e.g. on arrival new drugs and fees collection • Sensitisation on health fund and community ownership of health facility	• Voluntary labour • Security • Requests for services e.g. laboratory • Representative to committee
Voluntary agencies	60%	• Information e.g. homed-base care patients • Requests to join in health campaigns	• Health education / seminar • Information on services provided to patients in area • Patients
Private for-profit providers	40%	• Referral patients • Information e.g. on policy changes	• Promise for supplies • Representative to committee

11 As mentioned in the methodology, only in one district it was possible to do the full exercise (5 committees)

As additional information, it is important mentioning that in one committee, communities or users were not mentioned at all as actor. Two committees did identify users as important actor but with the village government providing the link between the users and the committee. In the district where the committees had been establishment shortly before the interviews and in most cases had not yet met, the committees gave their expectations of which other actors will be important (see table 4) for the committees.

Table 4: Overview of findings stakeholder importance

Actor	Very Important	Important	Not mentioned
Government	100%	-	-
Communities	50%	25%	25%
Voluntary agencies	50%	25%	25%
Private for-profit	-	-	100%

The findings of the Venn diagrams show an interesting picture of answerability patterns between the committees and other actors in the environment. None of the Venn diagrams show the presence of regular consultations with constituencies. Linking this with the earlier conclusion that most constituencies were not involved in the selection process; it is doubtful whether they even know their representatives. The proper representation is in the current situation more dependant on the individuals' receptiveness and awareness of community concerns than a direct input from other users to the one representing them.

Answerability is clearly directed towards the government. Whereas, the committees are to provide the link between providers and users, in two committees the village government provides the link between the committees and communities. Health board members see the board being answerable to the district council. Answerability to the represented groups did not emerge from the interviews.

3.5 Enforcement and sanctions

Legally the district council can dissolve the board and committees in the case of mal-functioning. Since the government selects the majority of the members, constituencies cannot influence decisions through elections.

The use of market mechanisms can be an important incentive for performance accountability. It came up during two informal chats with health facility staff that since the introduction of payment for health services, the number of patients has dropped drastically. The health staff gave two reasons: sick people either stay at home if they do not have sufficient resources for treatment or they go to the private health facilities because the services are better there than in government facilities.

Also in Dar es Salaam, there was an actual fall in attendance at first. With the help of donor funding, boards and committees have helped improving health care and now the population is using the public facilities again in good numbers (Rwiza, 2002). The research on the Community Health Fund in another district points out that patients are more willing to pay for services of private facilities because services are of higher quality. Suggestions for improvement include community mobilisation on benefits of joining health fund and revising membership and user fees (Musau, 2004:13).

As long as the boards and committees cannot ensure proper representation of users and users are not sufficiently sensitised, they will not have the feeling that they have a say in the management of services. As a result, their inputs and the membership in the health fund or payment of user fees are likely to remain low.

3.6 Locus of accountability

Health boards and committees are located inside the state structure because the district councils establish them by legal instrument according to the Local Government Act. However, there are also elements of 'outside' accountability through the inclusion of representatives from communities, voluntary agencies and for-profit health providers. As mentioned earlier, the effectiveness of these actors is influenced by the connection to the structures that can hold the government to account and the capacities to articulate demands and comments and be taken seriously by government officials (Brinkerhoff, 2001:4).

The connectivity to the accountability agents within the state is evident in the structure. However, the effectiveness of the

connectivity should be questioned. Here, the decision-making powers of the boards and committees play a role. As concluded in section 3.1, there is confusion around roles and responsibilities concerning the Community Health Fund. According to board members and the representative from the Ministry,[12] boards manage and administer the Community Health Fund. The health facility committees submit their plans for inclusion in the comprehensive district plan. The board has to report to the council on the disbursements of funds. However, the council cannot decide on the usage of health fund revenues without this decision being approved by the board. The same respondents also explained that fees collected at facility level will eventually be returned to the same facility. Again, this was not found in government regulations and continues to create uncertainties around roles and responsibilities.

Other than the Community Health Fund, the boards do not seem have a crucial role in decision-making on health matters in the district. One illustration is that a board meeting was postponed for three months without major implications. Another example is the remark by a voluntary agency representative that NGOs in the district meet once a year and share their plans for the preparation of the council's comprehensive plan but not as part of health board consultations.

Whether the non-government members have the capacities to articulate demands and are taken seriously by officials cannot be answered in this study. The way in which members were selected, their perception of their role and answerability patterns suggest that the ability to play that role is limited.

4 Conclusions and recommendations

From the findings as presented above, a number of conclusions can be drawn on how representation and accountability are organised in the health boards and committees in Tanzania. And, whether the government's intended strategy to give users a voice in and increase

12 Source: individual interviews

responsiveness of health service delivery has the desired effect. The government dominates the selection process of members to the boards and committees. The perception of members on their role is mainly government-focused. It came out clearly that the represented communities, voluntary agencies and private health providers do not have a forum for consultation and raising issues. Voluntary agency and for-profit health providers' representation is low. Members in the boards and committees function rather as individuals than as representatives of particular group having an interest in the matter at stake.

Accountability is directed towards the government and downward accountability through regular consultations with constituencies does not take place. Members do not have the obligation to go back to the community or other private health providers. Moreover, with the absence of elections the represented stakeholders do not have a legal right to recall their representatives. The council can use enforcement and dissolve the structures.

From the users' point of view, market mechanisms can provide the incentive for providers to be accountable and responsive to the users. In the districts studied, these mechanisms have already started working. Users prefer to get services from private facilities if they have to pay anyway. However, the current representation and accountability structures do not provide sufficient incentives to reverse this trend.

Coming back to the 'short and long routes of accountability', theoretically the boards and committees are placed in between the short route and the long routes. These boards and committees could strengthen the voice of users and the responsiveness of providers and make politicians and policy-makers more accountable to service users and hold providers accountable for the services they provide. In the current situation neither of the two is working effectively. The reinforcement of the formal long route is lagging behind because of the boards' and committees' weak decision-making powers and the ability of members in facilitating the short routes.

On the ability of the members to play their role effectively, the study cannot make firm statements but poses a number of questions:

Would the government select those individuals who are known to challenge the government? In addition to that, how do government officials perceive the members and how vulnerable are they when expressing their views without a clear constituency? And how do non-state members perceive members from the government? Government officials have a status that can influence internal dynamics and equality within the boards and committees. On the basis of the findings and conclusions, the study gives the following recommendations for health boards and health facility committees to become local management structures that give users a voice in and increase responsiveness of health service delivery.

The first recommendation is the use of democratic elections for members' selection. The representatives will have clear constituencies and can be influenced and held accountable by their constituencies. The study acknowledges that accountability to users in the health sector is not straightforward because services are rather technical, individual and for most users not a daily requirement (Cornwall, 2002; The World Bank, 2003). Therefore, for community representatives it is suggested to give only those users who are a member of the Community Health Fund, whether paying or exempted, the right to vote. An important precondition is the proper education and active campaigning to involve people and make them aware of the purpose of the boards and committees and their role in them. In addition, communities need to be enhanced in their capabilities to exercise their rights and responsibilities.

A second recommendation is the need for clarifying roles and responsibilities, increased autonomy in decision-making and financial independence of the boards and committees. Currently, the strong government position in accountability structures undermines the added value of the local management structures in creating a direct link between users and providers. Increased autonomy and independence will reduce this influence and can stimulate active involvement of members and the use of market mechanisms to improve health service delivery.

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Annex 1: membership in board and committees[13]

District Council Health Management Team
District Medical Officer, District Health Secretary, District Nursing Officer, District Health Officer, District Pharmacist, District Medical Laboratory Technologist, District Dental Surgeon

Council Health Service Board
4 community members, 1 non-profit voluntary and 1 private for profit appointed by Council, Chairperson Council Social Services Committee, District Medical Planning Officer, District Medical Officer, representative Regional Health Management Team

Hospital Management Committee
3 elected community members, 2 members appointed by Council Health Management Team from Health Centre Committees and Dispensary Committees, 1 voluntary agency and 1 private for profit health facilities approved by council, 1 member Council Health Service Board, Medical Officer in-charge, 1 representative District Medical Officer's office

Health Centre Committee
3 elected community members, 1 member appointed by NGOs, Medical Officer in-charge, 1 member appointed by private not-for-profit, 2 members from Dispensary Committees elected annually, 1 member from Ward Development Committee elected annually

Ward Health Committee
Councillor, Ward Executive Officer, 1 Head Teacher appointed by Ward Development Committee, 2 members of community, clinical officer or assistant clinical officer in-charge, 1 member appointed by Ward Development Committee proposed by villages, 1 representative from Community Based Organisation appointed by Ward Development Committee

13 Source: United Republic of Tanzania, 2002

Dispensary Committee

3 members from community, 1 representative from NGO not-for-profit health provides, 1 representative from private for profit health providers, 1 representative from Ward Development Committee appointed annually, 1 representative from Village Government Council, In-charge of dispensary

Annex 2: format focus group interviews[14]

School / Healthpost Committee (SC/HC) - Focus Group Interview	Date/Place

C Joint Management Bodies: SMC/HUMC

Issue:	**Internal Dynamics**	
	Plenary Question	**Output**
1	**A few fact-finding questions, to open conversation:**	
i.	How often did you meet last year?	(i): Meetings last 12 months:
ii.	When was this SC/HC first started, how were elections done?	(ii): When started:
iii.	Do you have constitution, minutes, leaflets, workplans? What do you do with minutes or workplans? (How do you use 'm?)	(iii): Docs:

Issue:	**System & Network**	
	Plenary Group Dynamic	**Output**
2	**With which other groups, organisations or committees does the SC/HC relate, work - directly or irdirectly? (E.g. Village Assembly, DEO/DMO, etc.) Technique: Venn Diagram**	
1st.	**Listing:** List on flip chart the 'persons, groups, organisations, etc' with which the Committee relates.	
2nd.	**Weighing:** Three differently sized round cartons on stock. Take off the flip chart one-by-one and put on round card indicating: 'The bigger round card, the more important to the SC/DC.'	
3rd.	**Positioning:** A card with 'our committee' in the centre of the table. The round card are now placed around the centre. It touches the centre if there is a direct contact. It touches another round card or nothing if there is no direct contact.	
4th.	**Relations:** Then, cut-out paper arrows are placed to-from 'our committee' and the surrounding round cards that touch it. On yellow post-its it is noted what goes from one to the other – and vice versa; the content of the relationships (eg: ideas, money, labour, authorisation, etc.)	

14 Mr G. Prinsen, PhD Candidate from Massey University, New Zealand, designed the methodology and the format of the focus group interviews.

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