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Community empowerment and accountability in rural primary health care: the case of Kasulu district in Tanzania

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This study investigated the relationship between empowerment and community-based accountability in rural Primary Health Care. The focus was on empowerment attributes among community members, existing legal and institutional frameworks, the management of the Community Health Fund, and the role of Health Facility Governance Committees in Kasulu district. The study employed a mixed method approach that included both quantitative and qualitative data collection and analysis methods. The study found that the majority had lower levels of empowerment (87.3percent) and limited capability to demand and enforce accountability (73.1 percent). The feeling of having power to influence choices; trust in health workers, government officials, and community leaders; possession of skills related to finance and health care; and the capacity to obtain, analyses, and understand financial and health related information were significantly associated with the capability to enforce accountability. However, gender, education, employment status, and occupation were found to have significant influence on the variation in the capability. Married males in the young-adult age with average rural household income, employed and having higher education were more likely to have the capability to enforce accountability. Principal Component Analysis results revealed that building mutual trust, increasing power and confidence of community members, adequate availability and utility of relevant and simplified information, and improving skills related to financial and health service monitoring could enhance the capability to demand and enforce accountability. The findings also revealed the existence of a gap between the formal guidelines and actual operations of both the Community Health Fund and Health Facility Governance Committees. Community-level participation in the Community Health Fund is limited to mobilization. Contribution and accessing contribution updates through notice boards. Health Facility Governance Committees have limited autonomy to make financial and purchase decisions while the district council exercises more control over allocation and purchase decisions. Delays in decisions result in persistent stock-outs of medicine and medical items, which cause mistrust from communities and thus limit the readiness to contribute and monitor resources and service delivery. Essentially, limited confidence, legitimacy, and trust that Health Facility Governance Committees can address critical concerns of the communities undermine their efficacy as institutions for enhancing community-based accountability. The study concludes that community-based accountability interventions are more likely to be effective if they integrate promotion of agency among communities and improving the opportunity structure. Specifically, both enhancing the capacities of community-level actors to hold service providers and government officials accountable and creating institutional environments that facilitate community actors' control over the key financial and service delivery decisions and actions are imperative. Finally, a participatory approach to designing and implementing health policy interventions is critical for

developing community ownership as a key prerequisite for successful community-based accountability. Among others, the study recommends strengthening capacities of community-level implementers, improving cooperation between the district council and community-level stakeholders, and interventional studies to assess the impact of trust, information, and financial skills on community-based accountability.