Participatory Planning in Primary Health Facilities in Tanzania

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Abstract

Participatory planning plays a significant role in ensuring the delivery of effective healthcare services, particularly in resource-constrained settings. Understanding the dynamics of participatory planning is crucial for fostering community engagement, building local capacities, and fostering collaboration among stakeholders. Tanzania continues to face challenges in participatory planning, including resource constraints, capacity gaps, information gaps, and a lack of autonomy. By exploring demographic, socio-economic, organizational, institutional, cultural, and social factors, the study aims to shed light on how participatory planning can be optimized to enhance healthcare delivery in primary health facilities. The research adopted a quantitative approach with a descriptive design, ensuring rigor and reliability in data collection and analysis. The sample size of the study was 180 respondents, selected using simple random sampling. In order to guarantee clarity, relevance, and reliability, a researcher-developed questionnaire was verified through expert review and pilot testing. The utilization of the Relative Importance Index (RII) enables the ranking of criteria by their significance, thereby providing valuable insights into the factors influencing participatory planning in Moshi municipality. Key findings underscore the importance of clarity by defining roles in planning with strong agreement on its importance. Education and access to information also significantly impact participation. Results inform policymakers to have clear roles and awareness creation to enhance community involvement effectively. The implications of this research extend beyond academic discourse, offering actionable recommendations for policymakers and health administrators. By emphasizing the importance of role clarity, education, and access to information, the study provides practical guidance for improving participatory planning in primary health facilities.

Keywords: Participatory Planning, Primary Health Facilities, Relative Importance Index, Tanzania

1. Introduction

Development of any nation in the world needs people who are healthy and able to participate in economic activities. These can only be achieved through ensuring proper health system management and proper participation in planning for their health. Participatory planning is a crucial aspect of development projects, allowing diverse stakeholders as community members, healthcare workers and local authorities to actively engage in decision-making processes (Kiologwe et al., 2022).

The roots of participatory planning in Tanzania can be traced back to the early 1990s, a turning point in the country's political and economic trajectory. Faced with internal crises such as economic stagnation and rising public dissatisfaction, along with external pressures from international financial institutions and donors, Tanzania began moving away from the post-independence socialist model of Ujamaa. This period saw major reforms including the introduction of multi-party democracy, economic liberalization and privatization, and the adoption of the Decentralization by Devolution (D-by-D) policy. These reforms aimed to devolve power and decision-making to local communities, fostering their active participation in their own development. These reforms collectively laid the foundation for participatory planning by promoting the local governance, citizen engagement, and the community-led development processes. Participatory planning was seen as a means to achieve these goals, allowing communities to voice their needs, priorities, and aspirations (Kilewo & Frumence, 2015; Kamuzora et al., 2013). Not surprisingly, good governance that includes elements such as participation was suggested as the single most important factor in achieving the Sustainable Development Goals (Akbar et al., 2020).

Participatory planning is a major component of health sector reforms in Tanzania, which were heavily influenced by the country's policy of decentralization started in the late 1990s (Kessy, 2023). The government embraced the Decentralization by Devolution (D-by-D) framework as a means of devolving decision-making authority and resources from central government to local authorities. Umbrella health bodies such as Council Health Management Teams (CHMTs), Council Health Service Boards (CHSBs), and Health Facility Governing Committees (HFGCs) instituted in the health sector are mandated to enhance community involvement in the health planning and budgeting lines of the health system (McCoy et al., 2012; Frumence et al., 2014; Kilewo & Frumence, 2015).

Participatory planning is operationalized at the district level through the Comprehensive Council Health Plan (CCHP). The process of CCHP is meant to be

bottom-up health priorities at the community level are consolidated and inform the district health plans through HFGCs (Kesale et al., 2022b).

In Tanzania, participatory planning has gained momentum as a result of various reforms aimed at decentralization and community empowerment. This approach has been particularly significant in the health sector as it ensures community needs are addressed, improves accountability, resource use, and promotes an inclusive, sustainable healthcare delivery, where it allows communities to provide ideas on planning and management of primary health facilities (Kilewo & Frumence, 2015). To ensure quality health and well-being of the society the government of Tanzania through the Ministry of Health and Social Welfare has implemented many strategic plans some of which are short and long-term in nature. The National Health Policy of 2007 succeeded those of 1990 and 2003. The first Health Sector Strategic Plan (HSSP) was implemented from 1999 to 2002. The Health Sector Strategic Plan II started in June 2003 and ended in 2009 and a third one ran for a period of five years starting from July 2009 to June 2015. The Primary Health Care Development Program (PHCDP) which started from 2007 to 2017 aimed at improving service delivery by strengthening the primary health facilities and improving human resources for health in the country (Ministry of Health, 2021).

Objectively, the reforms introduced by the Ministry of Health and Social Welfare aimed at introducing decentralization of power to local government authorities for the delivery of health services and management of resources in order to bring quality health services closer to the people and respond to their demand and health needs (Kesale et al., 2022a). As an outcome of these reforms, Health Boards, Health Facilities Committees, and new allocation formulas have been introduced to ensure good governance and proper participation in the delivery and management of healthcare services within their district (McCoy et al., 2012). Health Boards and Facility Committees create platforms for community members to be directly involved in decision-making, planning, and oversight of local health services, ensuring that services align with local needs (Kesale et al., 2025b; Bossert, 1998). They also hold health workers and administrators accountable for performance and use of resources. Meanwhile, new allocation formulas aim to distribute health funding more equitably, ensuring that resources are allocated based on population needs rather than political or historical biases (Abimbola et al., 2019). Together, these mechanisms help to build a more responsive, fair, and effective health system at the local level. (Kesale et al., 2022a; Kapologwe et al., 2020; Kapologwe et al., 2019).

According to a survey conducted in Tanzania, only 30% of primary health facilities engage in participatory planning processes, indicating a significant gap in the implementation of inclusive decision-making practices (Tanzania Ministry of Health and Social Welfare, 2015). Furthermore, community members' perceptions of their involvement in healthcare planning are low, with only 45% reporting that their opinions and suggestions are considered in the decision-making process (Tanzania Health Information Bulletin, 2019). This data demonstrates the existing problem in the participatory planning of primary health facilities in Tanzania. With such challenges, studies have not given enough attention to factors influencing participatory planning of primary health facilities in Tanzania (Kigume et al., 2018).

Despite its importance, participatory planning in the health sector faces several challenges which covers a broad spectrum of issues ranging from lack of participation, transparency, and ineffective healthcare provision, unfair health financing, and unequal access to health care (Kiologwe et al., 2022; Kilewo & Frumence, 2015)

Participatory planning in primary health facilities in Tanzania is influenced by various factors including leadership and governance, community engagement and ownership, capacity building, communication and information sharing, resource allocation, policy, and legal frameworks (Nabyonga-Orem & Asamani, 2023; Kilewo & Frumence, 2015). While the different literatures acknowledge the existence of factors that influence participatory planning, there is a lack of clarity regarding which factors have the most significant impact. This knowledge gap hinders effective decision-making and implementation of participatory planning initiatives. To bridge this gap, it is important to examine the key factors influencing participatory planning in primary health facilities in Tanzania, and to identify which of these have the greatest impact on effective planning and implementation. This study seeks to address the following research question: What are the key factors influencing participatory planning in primary health facilities in Tanzania, and which of these have the greatest impact on effective planning and implementation?

2. Literature Review

2.1. Definitions

2.1.1. Primary Health Facilities

Universal health coverage employs primary health care that is essential, scientifically grounded, and socially acceptable. Primary health facilities are defined as all immediately accessible, general health care facilities that treat a broad range of possible presenting problems, and which can be accessed by a wide range of patients on demand, and not as the result of a referral for specialist care (World

Health Organisation, 2019). It is the component of the health care system that serves as the entry point to the system for all new needs and problems, continues to provide person-oriented care over a period of time, treats all, but the very rare, unusual conditions, and organizes or integrates care provided in other places. In Tanzania, Primary Health Care Facilities include Dispensaries and Health Centres that provide essential health services close to the community, focusing on disease prevention, maternal and child health, treatment of common conditions, and health promotion (Tanzania Ministry of Health and Social Welfare, 2015).

2.1.2. Participatory Planning

Participatory planning is a way of working together that includes communities, especially those who are often left out, in making decisions about development and planning. It is different from older methods where decisions are made by a few people at the top. It focuses on sharing power, having local people take charge, and learning from each other (Eriksson et al., 2022). Participatory planning can take place in several formats. These include dialogue meetings, opinion surveys, panels, consultations, various forms of diary or report kept by users or citizens, art interventions, open labs, and mental mapping. Participatory Planning emphasizes that having effective laws, systems, and tools in place is crucial to ensure genuine participation, rather than mere lip service (Wilson et al., 2019). Participatory planning helps create a fairer, more just, and sustainable society by seeing citizens as people who contribute, not just as those who receive help (Nyseth et al., 2019).

2.2 Theoretical Literature Review

2.2.1 Participatory Theory

The theoretical basis for this study is grounded in participatory theory to investigate the implications or the influence of participatory planning of primary health facilities. Participatory theory, also known as participatory development or participatory planning, is an approach to decision-making and problem-solving that emphasizes the active involvement of all stakeholders (Draper & Rifkin, 2020; Eriksson et al., 2022). This theory assumes that those affected by a decision or program have the right to be involved in the decision-making process (Avril & Neem, 2016). It advocates for inclusivity, empowerment, and the recognition of local knowledge and expertise (Teal et al., 2023).

One of the key principles of participatory theory is that all individuals and communities should have equal opportunities to influence decisions that affect their lives (Thomas & Van De Fliert, 2014). This means that power dynamics need to be acknowledged and addressed, ensuring that the voices of marginalized and disadvantaged groups are heard and respected. This includes groups such as women,

ethnic and religious minorities, indigenous peoples, and people with disabilities (Williams, 2004).

Participatory theory also recognizes the value of local knowledge and expertise. A study by Howard-Grabman et al. (2017) emphasizes the importance of dialogue, collaboration, and sharing of information between decision-makers and those affected by their decisions. It promotes the idea that individuals and communities have unique insights and experiences that can contribute to better decision-making and more effective policies and programs.

For this study, Participatory theory provides a valuable framework to explore the key factors influencing participatory planning of primary health facilities in Moshi, Tanzania. The theory is directly relevant to the current study as far as the theory's constructs provide a framework for analyzing and addressing these most influencing participatory planning factors. By adopting a participatory approach, the study can ensure that key stakeholders, such as community members, health workers, and local authorities, are actively involved in the decision-making process. This involvement can help to identify and address the specific needs and preferences of the local population, thus contributing to improved health outcomes and increased ownership of primary health facilities.

2.3. Empirical Research

Participatory planning emphasizes the active involvement of community members in decision-making processes related to development and spatial planning. This approach promotes inclusivity, transparency, and empowerment by integrating local knowledge and addressing the needs of diverse stakeholders (Akbar et al., 2020). It fosters social learning, builds trust, and enhances the legitimacy of planning outcomes (Hakiman & Sheely, 2023). Moreover, participatory planning can lead to more sustainable and context-sensitive solutions by reflecting the lived experiences of affected populations (Hassan et al., 2011). Despite its benefits, challenges such as power imbalances and resource constraints can limit its effectiveness, necessitating thoughtful facilitation and equitable engagement strategies (Kilewo & Frumence, 2015).

Notwithstanding these difficulties, participatory planning has produced some encouraging results. Essen et al. (2025) and Ndunguru (2008) also found that a small level of community participation was associated with improved service delivery, better drug availability, and greater local ownership. The participation of citizens in health planning led to increased accountability of health workers and ensured services were matched to community needs.

Despite covering the same topic, the effectiveness of participatory planning differs greatly from district to district. Based on the findings of Aguilera et al. (2024) and Frumence et al. (2014), certain districts seem to demonstrate greater effectiveness in implementing the participatory processes because of the active supervision, leadership, and encouragement of the committee members. In contrast, weaker performance is observed in other districts due to the limited financial resources, low institutional support, and absence of adequate incentive mechanisms (Kiologwe et al., 2022). The varying effectiveness of HFGCs suggests that although there is a space for participatory planning framed by decentralization, the context and the leadership on the ground are key for determining the effectiveness of participatory planning.

Another emerging concern is the inclusiveness of the participatory processes. In most cases, women, youth, and other marginalized groups are found to be less represented in the health planning forums, hence inequity in service delivery (Kamuzora et al., 2013). Even though tools like PlanRep have made coordination possible since it is a system used for budgeting and planning, flexibility has not been realized for the integration of inputs from community-based partners and development actors (Kiologwe et al., 2022). Such inadequacies call for capacity building and communication strategy improvement alongside institutional mechanism reforms to make participatory planning meaningful and inclusive.

3. Methodology

The methodology section was organised into study settings, population and sample, eligibility criteria, data analysis methods.

3.1. Study settings

A quantitative approach with cross-sectional study was conducted across 2 hospitals, 3 health centers, and 28 dispensaries between October 2023 and March 2024. Moshi municipality is among the seven districts of the Kilimanjaro region in northern Tanzania, is the capital of the Kilimanjaro region. The municipality has an estimated population of 184,292, where men aged 15–64 years account for 48.4% of the total population (United Republic of Tanzania, 2022). The municipality is among the municipalities with low community participation in Tanzania (Kapuya et al., 2024).

3.2. Study Population and Sample

The study population comprised a total of 336 respondents, including 288 Health Facility Governing Committee (HFGC) members drawn from various levels of primary health facilities. Specifically, HFGC members were selected from 8 health

centres and 28 dispensaries, with 8 members from each facility, making a total of 288 HFGC respondents. Additionally, 48 Council Health Management Team (CHMT) members were selected from 4 hospitals, with 12 members from each hospital. The breakdown is presented in Table 01 below:

Table 01: Study Population by Facility Type and Respondent Category

Facility Type	Number of Facilities	HFGC Members per Facility	Total HFGC Members	CHMT Members per Facility	Total CHMT Members	Total Respondents
Dispensaries	28	8	224	0	0	224
Health Centres	8	8	64	0	0	64
Hospitals	4	0	0	12	48	48
Total	40	—	288	—	48	336

Source: Moshi Municipal Council (2021)

The sample size for the study was calculated using the Kothari (2004) formula, which is shown below:

$$n = \frac{Z^2 pqN}{e^2(N-1) + Z^2 pq}$$

Whereas n: *the sample size for a finite population*
N: *size of population, which is the number of academic employees (4,863)*
P: *population reliability (or frequency estimated for a sample of size n), where p is 0.5, and p + q= 1*
e: The *margin of error considered is 5% for this study*
Z α/2: *normal reduced variable at 0.05 level of significance Z: is 1.96*

$$n \frac{(1.96)^2 0.05 \times 0.05 \times 336}{(9.04)^2 (336-1) + (1.96)^2 \times 0.05 \times 0.05}$$

n = 180

A sample of 180 respondents was selected from the total study population of 336 respondents. The sample was proportionally distributed across the different facility types based on their population sizes. Specifically, 120 respondents were selected from Health Facility Governing Committees (HFGCs) at dispensaries and health centers, and 60 respondents were selected from the Council Health Management Teams (CHMTs) at hospitals. The proportional allocation ensured representation from all facility types to reflect the composition of the study population accurately. The detailed sample distribution is presented in Table 02 below.

Table 02: Sample Distribution by Facility Type and Respondent Category

Facility Type	Total Population	Proportion (%)	Sample Size (n=180)	Respondent Category
Dispensaries	224	66.7%	80	HFGC Members
Health Centers	64	19.0%	40	HFGC Members
Hospitals	48	14.3%	60	CHMT Members
Total	336	100%	180	

Source: Survey Data

3.3. Eligibility Criteria and Selection of Health Care Facilities

Thirty-three health facilities were purposively selected in the Moshi municipality. Two of the facilities were hospitals, three were health centers, and twenty-eight were dispensaries. The challenges for low community participation within the facilities were an inclusion criterion. The HFGC members and CHMT members were eligible for enrolment. The list of HFGC and CHMT was provided by the respective facility. stratified sampling was employed to select sample of health facilities to be involved in this study whereby the health facilities were divided into dispensaries, health centers and hospitals. Simple random sampling was used to select study respondents. The study employed questionnaire as data collection method. The questionnaire with attitude scale was used with 5-Point-Likert-Scale response format (1= strongly disagree (SD), 2= disagree (D), 3= neutral (N), 4= agree (A), 5= strongly agree (SA). These metrics were chosen because they, more explicitly, participatory planning than other metrics.

3.4. Data Analysis Methods

The study employed Relative Importance Index (RII) to determine the relative importance of different factors identified in the data. The indicators in this study were ranked using the Relative Importance Index (RII). RII was used as one of the most dependable methods for ranking variables in structured questionnaires using Likert scales (Abinaya Ishwarya & Rajkumar, 2021). RII is suitable for allowing easy comparison of factors based on frequency and perceived importance. Calculating the Relative Importance Index (RII) is important in this study since the value of the index specifies the ranked degree of importance. The RII formula was introduced into Microsoft Excel 2016 to determine the index for sets of objects, as seen in Equation 1.

$$\frac{\sum w}{AN} -= \frac{5n5+4n4+3n3+2n2+1n1}{5N} \quad \text{(Equation 1)}$$

Where w is the respondent's weighting of each factor, which can range from 1 to 5, for instance, n1 represents the number of respondents for Not Important, n2 represents the number of respondents for Less Important, n3 represents the number

of respondents for Moderately Important, n4 represents the number of respondents for Important, and n5 represents the number of respondents for Very Important. Thus, the highest weight (in this case, 5) is A, and the total number of people labeled as N. The Relative Importance Index ranges from 0 to 1. According to Tholibon et al. (2021) and Johnson and Lebreton (2004) five significant levels are generated from RI values: high (H) (0.8 RI 1), high-medium (H-M) (0.6 RI 0.8), medium (M) (0.4 RI 0.6), medium-low (M-L) (0.2 RI 0.4), and low (L) (0 RI 0.2).

3.5. Ethical Approval

Mzumbe University granted ethical permission for the study, guaranteeing compliance with norms and ethics for research. Furthermore, Moshi Municipality provided an ethical clearance letter, allowing the study to be carried out within its borders. These approvals attest to the rigorous adherence to institutional procedures and all relevant ethical concerns during the whole study process.

4. Analysis and Discussions

4.1 Demographic Characteristics of Respondents

From the descriptive data analysis provided, the majority of participants are male (59.4%) compared to females (40.6%). Again, the majority of participants have a degree level of education (52.2%), followed by diploma (26.1%). The age distribution of participants is fairly even, with the highest percentage falling within the 37+ age group (28.9%). Overall, these demographic characteristics suggest that the study has a good mix of gender, education, age, and organizational tenure, which is likely to provide a comprehensive view of the factors influencing participatory planning in primary health facilities.

Table 03: Demographic Characteristics of Respondents

Category		**Frequency (%)**	**Mean**	**Std. deviation**
	Male	107 (59.4%)		
Gender	Female	73 (40.6%)	1.41	0.492
	Certificate	8 (4.4%)		
	Diploma	47 (26.1%)		
Level of education	Adv. Diploma	19 (10.6%)	3.31	1.068
	Degree	94 (52.2%)		
	Masters	12 (6.7%)		
	21 – 25	50 (27.8%)		
Age	26 – 30	47 (26.1%)	2.47	1.179
	31 – 36	31 (17.2%)		
	37 +	52 (29.9%)		

Source: Survey Data

4.2. Relative Importance Index Analysis

Using the Microsoft Excel tool, the respondents' feedback was analyzed. Relative Importance Index analysis was created based on the information provided in the questionnaires. In order to rank the criteria according to their relative importance, relative index analysis was chosen. The Relative Importance Index (RII) calculation is significant to this study because its result indicates the ranked degree of relevance. It is particularly beneficial for surveys that employ a Likert scale. The comparison of RII with Five significant levels are derived from RI values, according to Johnson and Lebreton (2004) and Akadiri (2011): high (H) (0.8 RI 1), high-medium (H-M) (0.6 RI 0.8), medium (M) (0.4 RI 0.6), medium-low (M-L) (0.2 RI 0.4), and low (L) (0 RI 0.2).

All participatory planning factors (demographic characteristics and the level of participation, organizational structures/institutional management and socio-cultural factors to participation) were evaluated using Cronbach's Alpha Reliability Coefficients. All variables have internal consistency values of at least 0.7, according to Table 04. This demonstrates that the data have strong internal consistency reliability and that every variable was suited for analysis and none of the variables were discarded. The internal consistency reliability is determined by Cronbach's alpha, which uses the following criteria: Excellent (>0.9), Good (0.70.9), Acceptable (0.60.7), Acceptable (0.60.7), Poor (0.50.6), and Unacceptable (0.5).

Table 04: Cronbach Alpha Reliability Table

Variables	No of items	Cronbach's Alpha
Demographic factors	10	0.605
Organizational/Institutional arrangement	10	0.814
Socio-cultural factors	10	0.833

Source: Survey Data

4.3. Demographic Characteristics and Level of Participation

The Relative Importance Index (RII) analysis of demographic characteristics and participation levels reveals that education is the most influential factor in participatory planning, with the highest RII of 0.844 and a mean score of 4.2. This suggests strong consensus among participants on the importance of education for effective engagement. Sex ranks second (RII 0.837, mean 4.1), also indicating high perceived importance. Other factors like DC_LP8, DC_LP9, and DC_LP10 follow closely with slightly lower RIIs but are still considered highly relevant. Lower-ranked factors such as DC_LP3 to DC_LP7 show medium importance, with RIIs between 0.708 and 0.634. While these are seen as less critical, they still contribute meaningfully to participatory planning.

Table 05: Demographic Characteristics and Level of Participation

Variable	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Weighted total	RII	Rank	Importance level	Item Mean
DC_LP1	90	63	11	9	7	760	0.844	1	H	4.2
DC_LP2	67	91	12	8	2	753	0.837	2	H	4.1
DC_LP8	77	69	17	14	3	743	0.826	3	H	4.1
DC_LP9	72	70	20	15	3	733	0.814	4	H	4.0
DC_LP10	42	92	24	20	2	692	0.769	5	H – M	3.8
DC_LP4	33	70	43	29	5	637	0.708	6	H – M	3.5
DC_LP3	46	47	41	40	6	627	0.697	7	H – M	3.4
DC_LP5	24	61	69	20	6	617	0.686	8	H – M	3.4
DC_LP6	18	55	73	20	14	583	0.648	9	H – M	3.2
DC_LP7	22	47	61	40	10	571	0.634	10	H – M	3.1

Source: Survey Data

DC_LP1=Education, DC_LP2=Sex, DC_LP3=Age, DC_LP4,= Marital Status, DC_LP5=Health and disability, DC_LP6=Occupation, DC_LP7= Social economic status, DC_LP8= Religion, DC_LP9= Employment status, DC_LP10= Location

4.4. Organizational Structures (OS) and Participatory Planning

Table 06 shows the relevance level of organizational structure and institutional arrangements on community involvement in participatory planning (OS). OS10**,** OS2**,** OS7**,** OS6**,** and OS5 have slightly lower RIIs, ranging from 0.790 to 0.767, and are ranked from sixth to tenth. These items are categorized as high to medium importance, with item means ranging from 3.9 to 3.8, indicating a mix of "Agree" and "Strongly Agree" responses, with some "Undecided" or lower.

Overall, the findings suggest that OS4 clear role clarification (see Table 06) within organizational structures is paramount for fostering community involvement in participatory planning. The high importance levels and item mean across the board indicate a general agreement among respondents on the significance of these factors. This information is vital for health facility administrators and policymakers, as it highlights the need to focus on strengthening organizational and institutional frameworks to enhance community participation in the planning processes of primary health facilities. The rankings and RIIs provide a clear hierarchy of priorities that can guide efforts to improve participatory planning outcomes.

Table 06:Organizational Structures and Participatory Planning

Variable	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Weighted total	RII	Rank	Importance level	Item Mean
OS4	77	65	31	3	4	748	0.831	1	H	4.1
OS9	63	80	20	14	3	726	0.807	2	H	4.0
OS8	65	75	26	8	6	725	0.806	3	H	4.0
OS3	64	74	27	12	3	724	0.804	4	H	4.0
OS1	59	78	30	10	3	720	0.800	5	H	4.0
OS10	48	95	23	8	6	711	0.790	6	H – M	3.9
OS2	55	81	22	20	2	707	0.786	7	H – M	3.9
OS7	53	80	29	10	8	700	0.778	8	H – M	3.8
OS6	48	82	33	15	2	699	0.777	9	H – M	3.8
OS5	47	74	46	8	5	690	0.767	10	H – M	3.8

Source: Survey Data

OS1=Bureaucracy, OS2=Rules and regulations, OS3= Supportive leadership, OS4= Role clarification, OS5=Organizational culture, OS6=Decision making process, OS7=Communication channels, OS8=Resources allocation, OS9=Transparent, OS10=Hierarchy

4.5. Cultural and Social Factors and Community Participation in Planning (CBS)

Table 07 shows the relevance level of cultural and social factors on participatory planning. CBS10 (Access to information) with RII of 0.740 was ranked the first, indicating that, it is the most significant cultural factor in community participation. The item mean of 3.7 suggests that respondents generally agree that this factor is the most significant compared to others. CSB5 has an RII of 0.693 and ranks second. The item mean of 3.4 indicates that respondents agree it is the second factor in influencing participatory planning in the health sector.

Table 07: Cultural and Social Factors and Participatory Planning

Variable	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree "1"	Total respondents (N)	Weighted total	RII	Rank	Importance level	Item Mean
CBS10	70	44	25	24	17	180	666	0.740	1	H – M	3.7
CSB5	43	66	19	36	16	180	624	0.693	2	H – M	3.4
CBS9	29	50	57	31	13	180	591	0.657	3	H – M	3.2
CSB4	29	52	50	27	22	180	579	0.643	4	H – M	3.2

CSB2	21	61	45	35	18	180	572	0.636	5	H – M	3.1
CSB1	26	65	24	36	29	180	563	0.626	6	H – M	3.1
CBS8	22	54	41	50	13	180	562	0.624	7	H – M	3.1
CBS7	25	41	50	58	6	180	561	0.623	8	H – M	3.1
CSB6	26	37	46	52	19	180	539	0.599	9	M	2.9
CSB3	14	47	62	35	22	180	537	0.593	10	M	2.9

Source: Survey Data

CBS1= Traditional practices, CBS2=Power dynamics, CBS3=Traditional norms, CBS4=Social capital, CBS5=Social Movement and advocacy, CBS6=Access to resources, CBS7=Language and communication, CBS8 Historical context, CBS10=Access to information

The study's results are consistent with the tenets of participative theory, which prioritizes empowerment, inclusivity, and the active participation of all parties in the decision-making process. According to the theory, in order for participation to be successful, one must have the ability and opportunity to participate in addition to the right to do so. According to this study, meaningful involvement in primary health facility planning is hampered by ambiguous roles, a lack of education, and poor information availability. These obstacles show a disconnect between the principles of participation in theory and the actual situation. The study backs up the assertion made by participatory theory that sincere engagement results in more responsive and efficient planning by filling these gaps through role definition, education, and enhanced information access. Therefore, the results support the notion that for participatory planning to be successful, informational and structural enablers supporting inclusive and equitable stakeholder involvement must be in place.

The findings on demographic and socio-economic factors that impact participatory planning of primary health facilities highlight the significance of education (DC_LP1) in participatory planning, as evidenced by the high RII and item mean scores. This supports the findings of earlier research (Gholipour et al., 2023; Kilewo & Frumence, 2015) that found low community member participation in the development and implementation of various health projects as a result of a lack of education and awareness regarding community participation. According to this study, inadequate understanding of the topic of health plan participation was partly caused by community members' low educational attainment. Due to their poor educational attainment, the majority of committee members find it challenging to fully engage in the planning of health-related activities and assess concerns. According to other research (Nyama & Mukwada, 2023; Eriksson et al., 2022), key factors in health systems with high levels of education had greater confidence and were more likely to participate in decision-making related to health-related

activities and interventions. The gradual decrease in RII and item mean values for other factors suggests a hierarchy of importance among the factors influencing participatory planning. This finding is consistent with the study by Howard-Grabman et al. (2017) who found education as one of the critical factors in influencing community participation in maternal and newborn health program planning.

The findings on organizational and institutional factors that affect the participatory planning of primary health facilities reveal the impact of organizational structures and institutional arrangements on community involvement in participatory planning, resonate with existing literature on the subject. The Relative Importance Index (RII) values and item mean suggest a consensus among participants on the importance of clear role clarification within organizational structures for effective community participation. This finding is supported by previous studies that have emphasized the role of community participation in development planning and project management. For instance, the World Bank has recognized the need to address social aspects of development, highlighting the importance of community participation in planning and governance (Gilmore et al., 2023). Similarly, research has shown that participatory planning in community organizations can lead to better outcomes when there is genuine participation and a clear understanding of roles (Draper & Rifkin, 2020).

The findings align with previous research, for instance, Hakiman and Sheely (2023) that underscores the importance of clear role definition in participatory planning processes. Studies have shown that role clarification can enhance stakeholder engagement and improve the effectiveness of participatory planning interventions (Sethamo et al., 2022). Moreover, issues such as transparency, supportive leadership, and lack of resources have been identified as factors to successful community engagement, which aligns with the findings that emphasize the need for clear organizational structures (Draper & Rifkin, 2020). Effective stakeholder communication has also been recognized as a critical factor in participatory development planning, affecting the quality of planning and programs at the grassroots level (Morales-Garzón et al., 2023).

In the context of health systems, institutionalizing community engagement has been argued to be critical for quality improvement initiatives and improving health outcomes for communities. This involves integrating efforts to engage communities into existing health systems, which is in line with the study's suggestion to strengthen organizational and institutional frameworks. The high Relative Importance Index (RII) and item mean scores for role clarification (DC_LP1) reflect Participatory Theory's stance on the necessity of clear role definition within

participatory processes. The theory posits that when individuals understand their roles and the significance of their contributions, they are more likely to engage meaningfully in the planning process (Thomas & Van De Fliert, 2014). This is crucial for fostering ownership and ensuring that development initiatives are responsive to the needs of the community. The descending order of importance as indicated by the RII values suggests that while all factors are significant, some are more critical than others for participatory planning. This is consistent with the theory's recognition that participation is not a one-size-fits-all approach and that different factors may hold varying degrees of relevance in different contexts (Claridge, 2004).

The findings related to cultural and factors barriers influencing community participation in planning are critical to understanding the nuances of community engagement. The Relative Importance Index (RII) and item mean scores provide a quantitative measure of the perceived barriers, with CSB10 (Access to information) emerging as the most significant factor to community participation. Recent literature highlights mixed outcomes regarding participatory planning in Tanzania's health sector. While earlier studies (Frumence et al., 2014; Kilewo & Frumence, 2015) emphasized the potential of Health Facility Governing Committees (HFGCs) to enhance accountability and local ownership, newer evidence challenges this optimism. Kesale et al. (2025) found that many HFGCs operate with very low functionality due to limited resources, unclear roles, and inadequate incentives. Similarly, Kapuya et al. (2024) reported that over 85% of community members were unaware of HFGCs' existence, and only 14.5% viewed them as accountable. Cultural and informational barriers particularly lack of access to information were identified as major constraints to community engagement. These findings suggest that structural decentralization alone is insufficient. Effective participation requires context-sensitive approaches, capacity building, and stronger communication strategies. Without addressing these systemic and contextual limitations, HFGCs risk remaining symbolic rather than functional mechanisms of participatory health governance.

The ranking of factors as indicated by the RII values in the present study suggests a hierarchy of concerns among the community members. This hierarchy reflects the varying degrees of consensus on what constitutes a barrier to participation. For example, CSB10, with the highest RII, is seen as a significant barrier by most respondents, while CSB3, with the lowest RII, indicates a level of indecision among the community members. The item means further illustrate the degree of agreement or disagreement among respondents regarding each barrier. Higher item means suggest stronger agreement that a particular factor is a barrier, while lower item means indicate less consensus or more uncertainty.

In relation to previous studies, these findings underscore the importance of addressing both cultural and social barriers to enhance community participation in planning. It is essential for planners and policymakers to recognize and actively work to mitigate these barriers through inclusive and transparent planning processes, community education, and empowerment initiatives. This can be achieved by strengthening civic education, increasing public awareness campaigns about the roles and responsibilities of Health Facility Governing Committees (HFGCs), ensuring community involvement in member selection, and institutionalizing regular feedback mechanisms between communities and health governance structures. Previously, such efforts were often overlooked due to assumptions that decentralization alone would automatically foster participation. In reality, limited resources, weak institutional frameworks, and lack of sustained political will prevent the implementation of community-centered strategies. As a result, participatory structures were introduced without the necessary support systems to ensure their functionality and legitimacy at the local level. Participatory theory suggests that for development initiatives to be successful, they must be inclusive and sensitive to local contexts, with decision-making processes that involve all stakeholders (Claridge, 2004). The theory emphasizes the importance of overcoming barriers to participation to ensure that community members can contribute effectively to planning and development processes (Thomas & Van De Fliert, 2014).

4.6. Theoretical Implications

The findings reinforce the core principles of participatory theory, particularly the importance of role clarity, education, and access to information in fostering meaningful community involvement. Participatory theory asserts that all the stakeholders should actively engage in decision-making processes that affect them. However, this study highlights that without clearly defined roles, adequate education, and access to relevant information, participation becomes superficial or symbolic. These results suggest that participatory theory must place greater emphasis on structural enablers such as knowledge sharing and role delineation as prerequisites for genuine inclusion and empowerment in health planning. The study delves into theoretical frameworks and empirical evidence, emphasizing the relevance of participatory theory in guiding the analysis.

4.7. Practical Implications

The study reveals that effective participatory planning in primary health facilities depends on practical factors such as clarity of roles, education, and access to information. When stakeholders, including community members and health staff, clearly understand their roles in the planning process, they are more likely to participate actively and meaningfully. Role confusion can lead to disengagement or

the concentration of decision-making power among a few individuals. Additionally, education and awareness are essential for empowering community members to contribute effectively, as many lack knowledge of their rights or the planning procedures. Access to timely and transparent information also plays a crucial role in enabling participation. Without it, communities are left out of key decisions that impact healthcare delivery. Improving communication channels and providing opportunities for capacity-building can enhance community engagement. These practical measures are vital for creating inclusive and responsive health planning processes that reflect community needs and strengthen service delivery in primary health facilities.

5. Conclusion and Recommendations

The study highlights that education, role clarification, and access to information are vital for effective participatory planning in primary health facilities. High RII values and consistent item means indicate strong agreement among respondents on the importance of these factors. However, variations suggest some factors require more targeted interventions. To enhance participatory planning, local authorities should prioritize clear stakeholder roles through guidelines and training. Additionally, raising community awareness can help overcome cultural and social barriers, fostering broader engagement. The findings emphasize the need for a multifaceted, context-specific approach to ensure meaningful and successful participatory planning.

6. Limitations of the Study

The findings of the study conducted in Moshi, Tanzania, may not directly apply to other regions or countries due to unique contextual factors influencing participatory planning. This limitation restricts the generalizability of the results beyond the specific area studied. Furthermore, the study's findings are susceptible to potential sampling bias as the data collection is confined to a specific geographic location and population. This limitation may result in the sample not fully capturing the diversity of perspectives and experiences within the broader community.

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