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ORIGINAL RESEARCH

Weaknesses and strengths of the community health systems governing structures in Tanzania: A call for harmonisation

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ABSTRACT

Introduction: Strong community health governance structures (CHGS) are essential for effective community health systems. In Tanzania, several governance structures exist at the village level; however, limited linkages between different structures have resulted in coordination challenges and fragmented efforts. We, therefore, conducted a study to explore stakeholders' perspectives on the strengths and weaknesses of CHGS to inform future harmonisation efforts.

Methods: An exploratory qualitative case study design was conducted in December 2021 in two selected regions of Tanzania. A total of 42 in-depth interviews were carried out with key stakeholders involved in community health governance, including members of Council Health Management Teams (CHMTs), health facility in-charges, chairpersons of Health Facility Governing Committees (HFGCs), Village and Ward Health Committees, district health system coordinators, and local government officials. Data were analysed using thematic analysis.

Results: Key weaknesses identified included a lack of operational boundaries between committees, overlapping membership, inadequate financial support for committee operations, and a poor understanding of operational guidelines. Conversely, the existence of a defined committee structure and specified standards for operation were identified as strengths.

Conclusion: Tanzania's CHGS demonstrate several promising features; however, challenges such as overlapping memberships, unequal financial support, fragmented subcommittees, and inconsistent access to operational guidelines undermine their effectiveness. Addressing these gaps through harmonisation, equitable resource allocation, and targeted capacity-building is important to strengthen CHGS and enhance their responsiveness.

Keywords: Harmonization, structures, weaknesses, opportunities, challenges, Tanzania.

Abstract in Español at the end of the article

INTRODUCTION

Community Health Systems (CHS) are increasingly recognised as essential components of resilient health systems [1]. The growing acknowledgement of CHS stems from their role in enhancing community health by bridging the gap between formal healthcare services and the communities they serve. CHS operates within a continuum of care that includes a network of local actors, such as community health workers (CHWs), volunteers, and healthcare facilities, collaborating to deliver services effectively [1,2]. This approach not only improves access to essential services but also fosters trust between healthcare providers (HCPs) and community members [2-4].

Tanzania has long advocated for greater community participation in planning and budgeting processes, as well as in implementing programs to improve access to quality health services and monitor service provision at the local level [5]. Following her independence in 1961, Tanzania established democratic local government authorities (LGAs) to improve the delivery of public services, including health services [5,6]. These were later formalised by the Local Government (District Authorities) Act of 1982 and Local Government (Urban Authorities) Act of 1982 [7,8]. To effectively carry out their functions, these local governments established various committees to support governance and service delivery (9). Among these was the Village Health Committee (VHC), which was responsible for health promotion, disease prevention, encouraging the use of health services like vaccinations and antenatal clinics and developing village health plans that outline strategies to tackle local health needs and mobilising resources for health initiatives, including constructing and maintaining healthcare facilities [9]. The committee typically comprised a CHW, the village chairman, other elected members, and a facility in charge from the local health facility. The VHCs serve a three-year term, after which elections are held to select new members, and their meetings are conducted quarterly.

In the late 1990s, the government introduced another governance structure, Health Facility Governing Committees (HFGCs), to enhance governance and improve health service delivery at the primary care level [5,10]. These structures were part of Health Sector Reforms to increase community involvement in the administration and management of primary healthcare facilities. These committees were established to strengthen community participation, increase accountability, and ensure that health services effectively meet local needs. Each HFGC is composed of a chairperson, typically chosen from the community, a secretary who is often the health facility manager, and other co-opted community members [5,10]. Their responsibilities include overseeing financial transactions, inspecting health commodities, contributing to planning and budgeting, and ensuring the upkeep of health facilities. Members of the committee are elected every three years and convene quarterly to assess and address facility-related matters [5,11].

In addition to HFGCs and VHCs, it is common to have other subcommittees at the primary level. For example, Village AIDS Committees were formed to enhance the community's response to HIV/AIDS, and similar committees exist for diseases such as tuberculosis, many established in response to funding and donor needs [9,12]. Moreover, in recent years, the Ministry of Health in Tanzania introduced Primary Health Care Committees to promote primary health care in villages [9]. However, the addition of these health-related committees alongside HFGCs and VHCs has led to disorganisation and overstretched the limited workforce. Often, new committees draw from the same pool of members as the VHCs, which disrupts the VHCs' ability to meet regularly and perform their intended functions. Additionally, different villages may have unique committees based on the specific development partners working in their areas, further complicating management and coordination. These overlapping structures create challenges that necessitate harmonisation. However, a clear understanding of the weaknesses and strengths of the existing CHGS is a crucial step before initiating the harmonisation process. Therefore, this qualitative study was conducted to explore stakeholders' experiences and perspectives on the strengths and weaknesses of the CHGS in Tanzania.

METHODS

Study design

An exploratory qualitative case study design was conducted in December 2021 in two selected regions of Tanzania. The case study approach was deemed appropriate as the phenomenon under study is grounded in complex social processes [13].

Study context

In 2014, Tanzania approved the National Community-Based Health Program (CBHP) Policy Guidelines aiming to promote and improve the health and well-being of the respective community and socioeconomic development of Tanzania. CBHP is implemented from the national to the community level whereby the Ministry of Health (MoH) is responsible for the formulation of policy, guidelines, and strategies, the Ministry of President Office Regional Administration and Local Government (PO-RALG) is responsible for overseeing the administration and implementation of the CBHP at the district and municipal levels [14]. At the regional level, the Regional Authority and Regional Health Management Team (RHMT) plan, budget, oversee, and support the implementation of CBHP at the regional and district levels. Besides, RHMT reports to MoH while the Regional Authority reports to PO-RALG. CBHP is implemented at the district or municipal level, and the council health management team (CHMT) is responsible for planning and coordinating its implementation. CHMT also supervises CBHP and compiles data to be reported to higher-level authorities,

i.e., RHMT. At the District/Municipal level, CBHP is implemented through community-based (Ward Development Committee), Village Health Committee (VHC), and facility-based health committees (Health Center Governing Committee and Dispensary Health Governing Committee (DHGC)). Nevertheless, at all levels, development partners, including international organizations and local organizations, initiate and support implementing projects in line with CBHP (Figure 1).

This study was conducted in two regions of mainland Tanzania: Njombe and Mbeya. These regions have a high prevalence of HIV/AIDS, prompting the government and development partners to implement numerous programs and approaches, including many of the existing CHGS. Therefore, stakeholders from these regions were the most suitable for understanding the strengths and weaknesses of the CHGS in Tanzania.

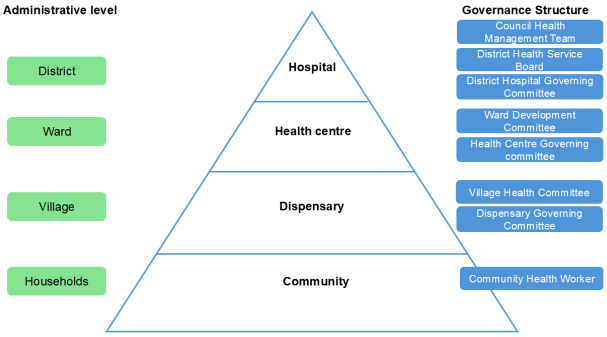

Figure 1. Organisation of Community Governance Structures in Tanzania.

Study population and sampling strategy

In total, 42 informants CHGS stakeholders were recruited for the study. Using purposive sampling method, study participants were recruited based on their titles/positions, roles and responsibilities in the community health governing structures. The participants included members of CHMT, coordinators of the community health systems, health facilities in charge from the visited facilities, chairpersons of the health facility governing committees, chairpersons of the ward health committees, chairpersons of the ward development committees, Chairpersons of Village Health Committees, the village executive officers, ward executive officers and officials responsible for health at the ward level (Table 1).

We adopted a multi-stage sampling strategy involving five stages, as shown in (Figure 2). In the first stage, two regions (Mbeya and Njombe) were selected out of 27 regions of Tanzania mainland purposively. In the second stage, we stratified the districts within each region into rural and urban districts. From each stratum, we randomly selected two districts in each region, comprising one rural and urban district making total of four district. In the third stage, we listed all wards with health facilities in each selected district and randomly selected one ward to be included in the study. In the fourth stage, from each ward chosen, all villages with health facilities were grouped in one stratum, and those without health facilities were listed to form the second stratum. We randomly selected one village from each stratum to be included in the study. In the fifth stage, we identified the study participants purposively based on their titles/leadership positions, roles and involvement in the existing CHGS at the village, ward and district level.

Table 1. Information about study participants.

Participants' role/involvement in CHGS	Number
Members of CHMT	6
Community health system coordinators	2
Health facility in-charges	8
Chairpersons of HFGCs	6
Chairpersons of Village Health Committees	4
Chairpersons of Ward Health Committees	2
Village Executive Officers	8
Ward Executive Officers	4
Ward Health Officers	2
Total	**42**

Data collection procedure

A semi-structured interview guide was developed and piloted before data collection. The guide included questions and probes to explore stakeholders' experiences and perspectives on the strengths and weaknesses of the existing CHGS in their settings. Initially developed in English, it was later translated into Kiswahili, the native language of both the investigators and study participants.

Six research assistants conducted the IDIs in pairs, with one moderating the interviews and the other taking notes on key information, including nonverbal communication. The research assistants had backgrounds in social sciences, pharmacy, and medicine. Each interview lasted an average of 60 minutes and was audio-recorded. To ensure participants' comfort and privacy, the interviews were conducted in the informants' offices.

Data analysis

The verbatim-transcribed audio-recorded interviews, the notes from the document review, and the field notes were read and reread to be familiar with the content and context before the start of the analysis.

We conducted a qualitative content analysis as explained by Granheim and Lundman [15]. All the audio transcripts from the IDIs were verbatim transcribed before starting the analysis. The lead author guided the authors in revisiting the study objectives and the IDI guides and teased out the main domains targeted by the objectives and data collection guides. Based on the domains developed, a preliminary codebook was developed. The authors then chose a rich transcript and read it manually and individually. After reading individually, the authors came back and jointly discussed issues

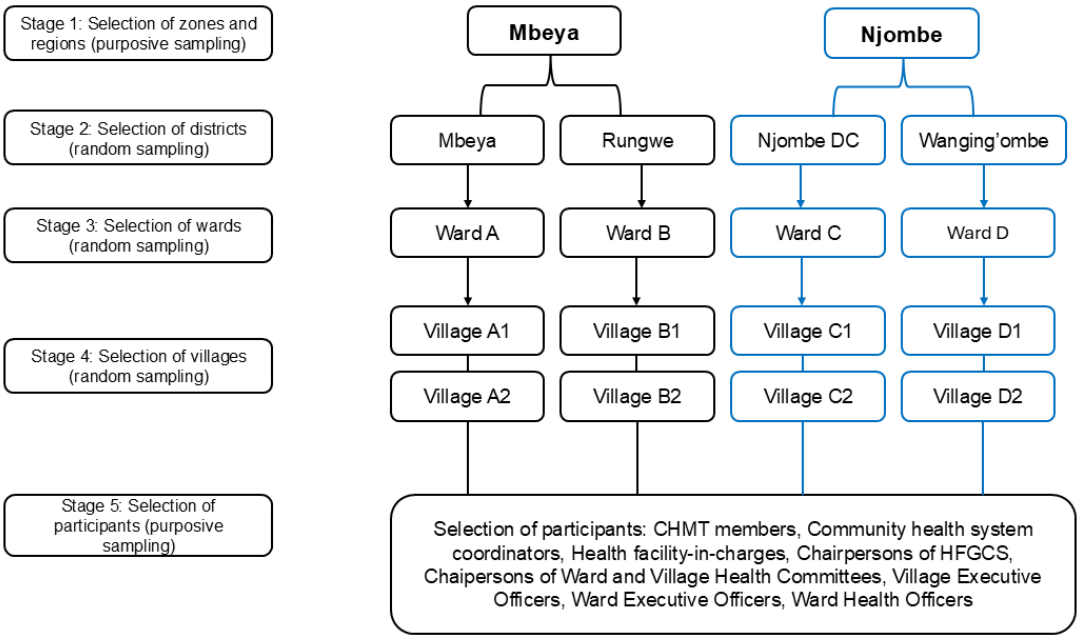

Figure 2. Sampling strategy for selection of participants.

that were coming out but not reflected in the preliminary codebook and enriched the codebook. With the enriched codebook, the team was subdivided into two pairs and jointly coded similar transcripts. The pairs came together and discussed the codes they derived from the transcript. There was not much discrepancy between the two pairs, and coding continued individually for the rest of the transcripts among the group of the four authors. After coding all the transcripts, the team discussed the codes, grouped similar codes, and abstracted them into sub-themes and themes.

Ethical considerations

We obtained ethical clearance from the Research and Ethics Committee of the Muhimbili University of Health and Allied Sciences with reference number MUHAS-REC-12-2021-908. Permission to conduct the study was obtained from the Regional and Municipal authorities and heads of the facilities and organisations involved in data collection. We obtained each participant's signed written informed consent before the interview or discussion. The informed consent included information on rights to participate, privacy, confidentiality, who to contact in case of risks or queries, benefits of the study, uses of the audio-recorder and dissemination of the collected information.

RESULTS

Summary of the findings

Following the analysis, five themes with 12 sub-themes emerged. The themes were grouped as strengths and weaknesses (Figure 3).

Weaknesses of the existing CHGS in Tanzania

Lack of operational boundaries between committees

Participants stated that the existing CHGS lacks clear structural and functional boundaries, leading to overlapping activities and memberships between committees. For instance, they noted that both the Medicine Procurement Committee and the Health Centre Governing Committee oversee facility operations to ensure smooth service delivery. Additionally, some sub-committees were established by donors to implement specific vertical programs, often with overlapping memberships. As a result, members are accountable to multiple authorities, which increases their workload and contributes to inefficiencies and inconsistencies.

> *"... a member being in more than one committee sometimes that is possible.... and that overlapping sometimes exists, you may find that a member is both in village, dispensary and health facility governing committees representing another committee. Sometimes, it has once brought a problem to someone in politics. One is also a member of the community committees. As you know, sometimes every village has prominent people.... when she/she is not taken on board, it becomes a challenge, so sometimes you find this prominent leader in every committee..."* (IDI-MOI-district hospital No.4)

Additionally, participants stated instances of misalignment between committee activities and goals. For

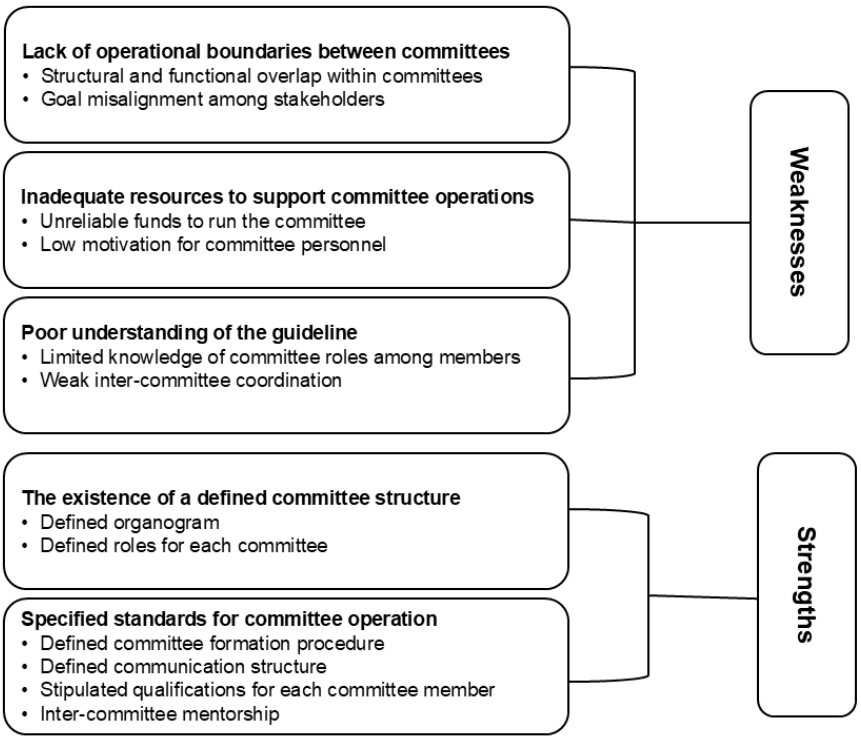

Figure 3. Summary of findings.

example, during disease outbreaks, ward health committees may conduct unplanned community visits, while donor-funded committees operate in the same community with different objectives. Some participants emphasized that when stakeholders lack a shared goal, committee performance becomes fragmented, leading to poor outcomes.

> *"I might have already agreed with the service providers that on a certain date, we will possibly go to a certain place. Unfortunately, on that same date, the implementing partner might have scheduled another task, which is also important for them to accomplish. If they fail to meet our objective or cannot participate with us, and since we rely on them for transportation, the schedule will be disrupted. Therefore, once again, you find it's not due to deliberate reasons but rather operational ones."* (IDI-CHBS-coordinator No.4)

Inadequate funds to support committee activities

Participants described that health committees are often underfunded, which limits members' participation in activities, particularly scheduled meetings and community visits. Several participants emphasized that no funds were allocated to compensate Village Health Committee (VHC) members for conducting community outreach activities.

> *"Honestly, the majority is volunteer work... let's say generally, but when we sit in a meeting, we might even be given ten thousand shillings for each meeting, but the majority is volunteer work, and maybe there are official payments, but... that is not the case"* (IDI-VHC No.3)

Participants also stated that there is low motivation among committee members as they work under challenging conditions with a small allowance or sometimes their given only transport fare. For instance, participants stated that signatories are not compensated for their time when dealing with committee activities, reducing their motivation to attend decision making meetings. Furthermore, participants revealed the lack of regular meetings due to absenteeism lading to postponement of the important meetings.

> *"…Motivation is not there; motivation is not yet (…) there is no motivation. I can't talk about that because the aspect of motivation is not well… people value more their daily earning activities rather than attending a committee meeting"* (IDI-VEO No.6)

Poor understanding of the guidelines among the committee members

Respondent revealed that committee members have limited understanding of what and how to operate their function as complementing system. For instance, study participants stated that in some areas the dispensary governing committee is not coordinated with the village health committee which makes it a challenge to work together on the priority health issues that cut across the community and the facility.

> *"...readiness is there, but maybe they need more understanding and empowerment to be able to comprehend their responsibilities well; many of them have limited understanding on what is done by who…sometimes the same person may be burdened to follow on two or more indicators while members of other committees are not involved"* (IDI-CHPHC No.1)

Additionally, study respondents exposed that some committee members are unaware of their committee structure. Some participants stated that some committee members are not familiar with the modality of how to work together in implementation of the priority interventions in their areas.

Strengths of the existing CHGS in Tanzania

The existence of a defined governing committee structure

Participants stated that guidelines which describe the composition and leadership position of most of the existing CHGS are available. For example, participants said that health facility-based governing committees such as the Dispensary Health Governing Committee and Hospital Governing Committee chairperson must come from the community, and the committee secretary is the head of the respective facility. Also, the Village Executive Officer (VEO), Ward Executive Officer (WEO), and Medical Officer in charge (MOI) are direct members of the respective community-based committees.

> *"The health facility governance committee is working on solving facility issues and is comprised of community representatives and health professionals. Health facilities must have these committees. I mean all levels, starting from dispensaries, health centres, and hospitals. These committees operate and report to the council board; this is the higher-level governance instrument among these committees, and that's how health governance structures operate in the community…"* (IDI-Chairperson hospital board No.3)

Additionally, respondents described that the roles of the committees are defined in the existing guidelines. Respondents for instance said that at the village level, the VHGC had a role in overseeing health services delivery at the dispensary and in the community. While at the ward level, the health centre governing committee is in charge of dispensary committees within that ward.

> *"...At the dispensary level, regarding the dispensary's hierarchy, I believe the committee holds the highest authority in managing the facility. Consequently, all financial matters must be approved by this committee, as well as any resolutions for different challenges that arise. For instance, if the clinic lacks a toilet or a servant's house, it is the responsibility of this committee to address these issues and present them to the village leadership…"* (IDI-MOI district hospital No.1)

Presence of specified standards for committee operation

Respondents stated that the guidelines describe the procedures for recruiting or nominating committee members well. Participants said village health committee members are nominated and voted on by the community members during the official village members meeting, while ward and council health committee members usually apply and are interviewed.

> *"…the vacancy was announced by the council followed by receiving applications, the CHMT analyses applications and select the qualified applicants who will then elect the chairman of the Council health service board …"* (IDI-Retired chairperson CHSB No.1)

Participants also described that qualifications of someone to be elected/nominated as a member of CHGS are stipulated in the existing guidelines. For example, participants described that for a community member to be nominated as member of the committee must have at least a primary education level, know how to read and write, and be above 18. While VEO and head of the respective area health facility are the members of technical professional positions by default. Participants insisted that for nominated positions, gender is considered, and women are given priority.

> *"...In selecting committee members, the guideline says a person who can read and write; be confident in communicating a health-related message, and able to deliver interventions to the community… in terms of age, we usually do not consider much! But we select a middle-aged man who is not too old, even those in their fifties or even sixty years at least. But even the one with more than sixty years can be nominated and given a chance to be a member of the committee…"* (IDI-WEO No.2)

Participants likewise explicated that there is a communication structure between committees where matters discussed at lower levels are sent to the higher level for further action. They added that the same hierarchical flow was used to execute the directives from higher-level to lower-level committees.

> *"… there is communication between one committee and another in these committees… it can be indirect that what has been discussed in the lower-level committee will be discussed at the high-level committee depending on the rank. So the plans can be discussed by the Dispensary and then sent to health centres up to the district hospital committees; hence, it will be discussed by the boards…"* (IDI-DRHCO No.2)

Participants further emphasised that newly elected members are mentored by experienced members, and members from higher-level mentoring the lower-level committees. Participants insisted that mentorship helps in resolving conflicting issues, being on board and facilitating harmony between committees. Participants further described that CHSB coordinator is responsible for capacity building of facility-based and community-based health committees at all levels.

> *"… We serve the community. Sometimes, you may find that we have been elected from the community to save that community… sometimes you do not have that capacity at the lower level. …So, sometimes, we get mentorship and education from higher committees. We get training from health facility committees and health professionals……"* (IDI-VEO No.3)

DISCUSSION

In this study, we aimed to analyze the strengths and weaknesses of the existing Community Health Governing Structures in Tanzania. We identified key weaknesses, including a lack of operational boundaries between committees, overlapping membership, inadequate financial support for committee operations, and poor understanding of operational guidelines. Conversely, the existence of a defined committee structure and specified standards for operation were identified as strengths.

Similar findings have been reported in studies from Kenya and Uganda, where overlapping roles, inadequate funding, and poor dissemination of guidelines were major impediments to effective community health governance [16–18]. However, unlike some settings where committee structures are absent [19], the Tanzanian context shows positive evidence of formalized structures aligning with regional trends towards institutionalizing community health governance [16]. Our findings align with Tanzania's National Guidelines for community-based health services which emphasizes strengthening governance structures, clarifying roles, and ensuring resource allocation at community levels [9,14]. Similarly, they are consistent with Tanzania's Health Sector Strategic Plan V (HSSP V 2021–2026), which prioritizes governance efficiency, community participation, and financial sustainability [20]. These findings highlight the need for clearer demarcation of committee roles, standardized membership criteria, and harmonized operational guidelines to reduce fragmentation and improve functionality across all community health structures.

As our study revealed, it is not uncommon for an individual to serve on multiple committees. On one hand, overlapping membership can facilitate continuity and information sharing among committees. On the other hand, when unmanaged, it leads to overwhelming workloads, absenteeism, and conflicts of interest. This duality mirrors findings from studies in Ethiopia and Malawi, where multitasking committee members faced performance degradation due to divided responsibilities (8,9). In contrast, research from Ghana showed that where overlapping was carefully coordinated, it enhanced system resilience [21]. Tanzania's Community Health Roadmap recommend distinct but complementary committee functions to avoid task duplication [9]. Similarly, the National Health Policy draft (2017) mandates effective coordination and delineation of community health roles to avoid governance inefficiencies [22]. Our findings underscore the need to harmonize the community health systems governing structures to address overlapping membership issues.

Financial support plays a crucial role in sustaining the operations of community committees. Despite this, our findings revealed that while Health Facility Governing Committees (HFGCs) receive some dwindling financial support through health budgets, Village Health Committees (VHCs) often lack dedicated financial support. This imbalance discourages participation and creates systemic inequities. Similar patterns have been reported in Mozambique and Rwanda, where inadequately funded structures showed lower participation and operational sustainability [23,24]. Conversely, dedicated community health budgets in South Africa significantly boosted committee engagement [2]. The Tanzanian HSSP V mandates sustainable financing mechanisms for community structures but acknowledges persistent gaps [20]. The HSSP V also identifies equitable financing as a priority [20]. From the findings of our study, the introduction of harmonized financing strategies across community health system governing structures is vital for enhancing the sustainability and accountability of these structures.

The existence of several health subcommittees, such as village HIV/AIDS committees, was pointed out to potentially fragment efforts and hinder coordination. This is similar to what was observed in Zambia and Nigeria, where uncoordinated vertical subcommittees led to duplication and conflicting priorities at the village level [25,26]. However, some countries, such as Rwanda, have successfully integrated thematic committees under a common governance umbrella [27]. The Tanzanian Community Health Guidelines and the National Health Policy advocate for integrated governance structures to avoid parallel operations [14,22]. We feel that with harmonised governance structures, the efficiency of the community health structures can be enhanced, and the existing fragmentation minimised.

The inconsistent availability and awareness of operational guidelines for certain committees as pointed out in our study, is similar to findings from Sierra Leone and Liberia, where committee operations were hampered by lack of clear or updated operational manuals [28,29]. On the contrary, Cambodia has managed to systematically update and disseminate operational guidelines to the community governing structures [30]. Tanzania's Com-

munity Health Roadmap and Health Sector Strategic Plan V clearly states the importance of accessible, up-to-date operational guidelines at all governance levels [9,20]. However, while it is undisputable that HFGCs generally benefit from structured mandates and capacity building, the VHCs often operate with outdated or poorly disseminated guidelines in Tanzania. Authors feel that it is high time for updating and disseminate operational guidelines as a necessary step toward harmonized and functional CHGS governance.

Despite these gaps, our study pointed out some strength that could be scaled to improve CHGS functioning. Clear committee structures, defined reporting lines, gender parity in nominations, democratic elections, and mentorship models were evident in many communities. This resonates with findings from Senegal and India, where strong governance frameworks and mentorship systems improved community participation and accountability [31]. However, in settings where elections were manipulated or mentorship absent, committee effectiveness declined [32]. In Tanzania, the Community Based Health Guideline and Map emphasizes gender equity, participatory governance, and capacity building [9,14]. Furthermore, the National Health Policy insist on inclusive participation in governance structures [22]. We feel that these identified strengths can serve as a steppingstone towards harmonisation of the community health systems governing structures, through effective participation, coordination and integration.

Methodological considerations

The fact that this study was conducted in only one zone in Tanzania limits its contextual applicability to many parts. However, the detailed description of the context offsets this limitation. The participants of this study, primarily those interacting with the CHSGs, may have introduced social desirability, and they may have responded in favour of the interviewers. However, the triangulation of the study setting, researchers and data collection methods adds to the strengths of these findings. To ensure the findings are trustworthy, we adopted different techniques, including triangulation of the study setting, researchers, study participants, and data collection techniques. Furthermore, a thick description of the study methodology and context was provided. All these were in line with the recommendations by Guba and Lincoln [33] who set the criteria to assess trustworthiness, reliability, conformability, transferability and dependability.

Conclusion

Tanzania's community health governance structures display several promising features, including democratic representation, specific roles in certain committees, and mentorship opportunities. However, they face considerable challenges, such as overlapping memberships, unequal financial support, fragmented subcommittees, and inconsistent access to operational guidelines. These challenges compromise efficiency, participation, and accountability. To tackle these issues, a focused policy shift towards harmonisation, fair fund distribution, and capacity building is essential. Strengthening these foundations will not only improve committee performance but also enhance the overall responsiveness and resilience of the community health system, particularly in underserved areas.

DECLARATIONS

Publication Consent

Not applicable.

Competing interests

The authors declare no competing interests.

Funding

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Author contributions

NS, GF, TH, MC and GK were responsible for the conceptualization. GF, NS, TH, MC and GK for data organization and cleaning. NS, GF and GK for the methodology. NS, GF, GK, MK, TR, and NN were responsible for the analysis. NS, GF, GK, MK, TR, and NN were responsible for writing the original draft. NS, GF, GK, MK, TR, NN, EN, and EK were responsible for reviewing and editing the manuscript. GF, NS, TH, MC, and GK were responsible for funding the acquisition. GF was responsible for project administration. GF and NS were responsible for supervision. GF and NS were responsible for validation. GF, NS, and GK were responsible for the visualization.

Data availability

The data of this study are available from the corresponding author upon reasonable request.

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Debilidades y fortalezas de las estructuras de gobierno de los sistemas sanitarios comunitarios en Tanzania: Un llamado a la armonización

RESUMEN

Introducción: Unas sólidas estructuras de gobernanza en salud comunitaria (EGSC) son esenciales para que los sistemas de salud comunitarios sean eficaces. En Tanzania existen varias estructuras de gobernanza a nivel de comunidad; sin embargo, los limitados vínculos entre ellas han generado problemas de coordinación y esfuerzos fragmentados. Por ello, realizamos un estudio para explorar las perspectivas de los actores involucrados sobre las fortalezas y debilidades de las EGSC, con el objetivo de orientar futuros esfuerzos de armonización.
Métodos: En diciembre de 2021 se llevó a cabo un estudio de caso cualitativo exploratorio en dos regiones seleccionadas de Tanzania. Se realizaron un total de 42 entrevistas en profundidad a actores clave involucrados en la gobernanza de salud comunitaria, incluyendo miembros de los equipos de gestión sanitaria de los consejos (CHMT en inglés), responsables de los centros de salud, presidentes de los comités de gobernanza de los centros sanitarios (HFGC en inglés), comités de salud de las comunidades y distritos, coordinadores de los sistemas de salud distritales y funcionarios del gobierno local. Los datos se analizaron mediante análisis temático.
Resultados: Entre los principales puntos débiles detectados se hallaron la falta de límites operativos claros entre los comités, el solapamiento de sus miembros, un apoyo financiero insuficiente para el funcionamiento de los comités y una comprensión limitada de las directrices operativas. Por el contrario, se identificaron como fortalezas la existencia de una estructura de comités definida y normas de funcionamiento específicas.
Conclusiones: Las EGSC de Tanzania presentan varias características prometedoras; sin embargo, problemas como el solapamiento de sus miembros, el apoyo financiero desigual, la fragmentación de los subcomités y el acceso desigual a las directrices operativas socavan su eficacia. Es fundamental abordar estas deficiencias mediante la armonización, la asignación equitativa de recursos y el desarrollo de capacidades específicas para fortalecer las EGSC y mejorar su capacidad de respuesta.

Palabras clave: Armonización, estructuras, debilidades, oportunidades, desafíos, Tanzania.

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