FUNCTIONALITY OF PRIMARY HEALTH FACILITY GOVERNING COMMITTEES IN IMPLEMENTING DIRECT HEALTH FACILITY FINANCING IN TANZANIAN LOCAL GOVERNMENT AUTHORITIES

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EXTENDED ABSTRACT

The Alma Ata Declaration of 1978 identified community participation in health service delivery as a cornerstone component for improving Primary Health Care (PHC). Therefore, it advocated for providing opportunities for health service users/communities to directly participate in the designing, implementation and monitoring of healthcare facility operations. To incorporate communities in the planning, implementation and evaluation of primary health care services, community governance structures known as Health Facility Governing Committees (HFGCs) were established in Lower and Middle-Income Countries (LMICs). These HFGCs are composed of community members devolved with powers and functions of representing the community in the governance of health service delivery in primary health care facilities (PHCF). There have been continued efforts to strengthen community participation through having functional HFGCs to improve health service delivery in PHCF through decentralization. The fiscal decentralization is the reform currently adopted by many LIMCs countries to empower both community governance structures and service providers in improving health service delivery at the PHCF.

Tanzania, like other LIMCs countries, is implementing fiscal decentralization through Direct Health Facility Financing (DHFF) to empower service providers and deepen the community's participation in the planning, implementing and monitoring PHCF to improve health service delivery. However, the status of the HFGCs' functionality in accomplishing their assigned powers and responsibilities under DHFF is not known. This study was conducted to assess the functionality of HFGCs under the DHFF context in selected Tanzania Local Government Authorities. Specifically, the study assessed (i) the functionality level of HFGC in primary public health facilities under DHFF; (ii) the accountability of HFGCs in the public primary health facilities under DHFF and (iii) the perceived factors determining the functionality of HFGCs under DHFF.

A cross-sectional research design was used in which both qualitative and quantitative data were collected simultaneously or at one data collection phase to assess the performance of HFGCs. The sampling of the regions, councils and health facilities is based on the President Office-Regional Administration and Local Government's Star Rating Assessment of the performance of all public primary healthcare facilities in Tanzania, which was accomplished at the beginning of 2018, that is, the same year DHFF started. The sample size for this investigation was determined using a four-stage multistage cluster sampling process. In the first stage, four regions were purposefully chosen based on their performance (two regions high and two low performance). From each region chosen in stage one, two councils were chosen in the second round. One of the two councils chosen had a low and another with

high performance in the area based on the star rating assessment. Four health facilities were purposively selected from each council selected. Two health facilities were chosen because of their low and other two health facilities because of the high performance in the council. The location of the facility and council was also a criterion to accommodate the diversity of the council and health facilities. In stage four, respondents for the structured questionnaire were selected proportionally from each HFGC in which the response was 280 respondents. Respondents for interview and focus group discussion were purposively selected. The participants were chosen for interviews and focus group discussions (FGDs) based on their ability to provide relevant information about the performance of HFGCs under DHFF. Therefore, for a respondent to be included in the interview and FGDs was supposed to be a member of HFGC implementing DHFF. The point of saturation determined the number of interviews and FGDs.

The closed-ended structured questionnaire was used to collect quantitative data from each selected member of the HFGCs. The Open Data Kit (ODK) software was used to develop the data gathering software (database). To collect data, a quantitative approach based on mobile data collecting (MDC) was used. Data were captured via mobile phones and then transferred to a central server. The response rate for HFGCs who filled out the questionnaire was 280 respondents. Qualitative data were collected through interviews and FGDs. In-depth interviews were conducted with HFGC chairpersons to examine the extent they have been accomplishing the HFGC mandates under DHFF settings. On the other hand, FGDs were conducted with other members of HFGCs excluding the HFGC chairpersons. Quantitative data were coded, processed and analysed by using IBM-SPSS v. 25. In assessing the functionality of HFGCs under DHFF context, Descriptive and inferential statistics were used to analyse data. A binary logistic regression model was employed to determine factors associated with HFGC functionality. To assess the accountability of HFGCs under DHFF implementation, the descriptive statistic and binary logistic regression were employed based on the HFGCs accountability index or predictors of accountability. To assess the perceived factors determining the performance of HFGCs, Relative Importance Indices (RII) within Multiple regression were employed.

The findings from this study HFGC functionality under DHFF was found to be good at 78.57 %. Specifically, 87.14 % of HFGCs were found to have good functionality in mobilizing communities to join Community Health Funds, 85 % were good at participating in the procurement process, 81.43 % were good at discussing community health challenges and 80% were good at planning and budgeting. However, there was a difference in functionality among HFGCs, with HFGCs from primary health facilities that indicated a high-performance during star rating assessment in 2018 having relatively good functionality, scoring 79.45 %,

as opposed to HFGCs from primary health facilities that had a low performance, scoring 73.88 %. Regarding accountability, the HFGCs indicated good performance scoring 78 %. HFGCs were found to have a high level of accountability in terms of encouraging the community to join community health funds (91.71%), participating in receiving medicines and medical commodities (88.57%), and timely provision of health services (84.29%). The HFGC's responsibility was shown to be substantially associated with the health planning component (p=0.0048) and the financial management aspect (p=0.0045). Furthermore, the study found that the factors which are more important for the functionality of HFGCs are the availability of finance to the health facility with RII 0.8964 score which ranked the first important determinant of HFGC performance, followed by the clarity of powers and functions with RII 0.8928 score, as second important determinant, and communication between the HFGCs and community with RII 0.8792 score, as a third important determinant.

The reality from the findings of this study on fiscal decentralization through DHFF in selected HFGCs supports the idea that decentralization empowers subnational health actors since the performance of HFGCs in health facilities implementing DHFF was found to be good. This study implies that the setting and how fiscal decentralization is implemented are critical for determining whether or not it empowers actors. Therefore, for HFGCs to be empowered and be able to better perform their duties and responsibilities, the context and the characteristic of HFGC member are key determinants. It is therefore recommended that, the government review educational level for the members of HFGCs, timely transfer funds to the health facilities, conduct comprehensive training to the members of the HFGCs on how to carry out their functions and increase the number of prime vendors.

Keywords: Performance, Health Facility Governing Committees, Direct Health Facility Financing, Fiscal Decentralization.

MUHUTASARI ULIOPANULIWA

Azimio la Alma Ata la mwaka 1978 lilibainisha ushiriki wa jamii katika utoaji wa huduma za afya kama sehemu ya msingi ya kuboresha huduma ya afya ya msingi. hiyo, ilisababisha kutoa fursa kwa watumiaji/jamii za huduma za afya kushiriki moja kwa moja katika kupanga, kutekeleza na kufuatilia shughuli za vituo vya huduma ya afya. Ili kujumuisha jamii katika kupanga, kutekeleza na kutathmini huduma za afya ya msingi, miundo ya utawala wa jamii inayojulikana kama Kamati za wananchi za Usimamizi wa Kituo cha Afya zilianzishwa katika Nchi za Kipato cha Chini na Kati. Kamati hizi zinaundwa na wanajamii waliopewa mamlaka na majukumu ya kuiwakilisha jamii katika usimamizi wa utoaji wa huduma za afya katika vituo vya afya ya msingi. Kumekuwa na jitihada zinazoendelea za kuimarisha ushiriki wa jamii kwa kuwa na Kamati zinazofanya kazi ili kuboresha utoaji wa huduma za afya katika vituo vya afya kupitia ugatuaji. Ugatuaji wa fedha ni mageuzi yanayotekelezwa kwa sasa na nchi nyingi za LIMCs ili kuwezesha miundo ya utawala wa jamii na watoa huduma katika kuboresha utoaji wa huduma za afya katika vituo vya kutolea huduma.

Tanzania, kama nchi nyingine za uchumi wa chini na kati, inatekeleza ugatuaji wa fedha kupitia Utumaji fedha wa moja kwa moja katika Kituo cha Afya ili kuwawezesha watoa huduma na kuongeza ushiriki wa jamii katika kupanga, kutekeleza na kufuatilia ili kuboresha utoaji wa huduma za afya. Hata hivyo, hali ya sasa ya utendaji wa kamati za wananchi za usimamizi wa utoaji huduma katika kutimiza mamlaka na majukumu waliyokabidhiwa chini ya ugatuaji/mageuzi ya fedha kupitia utumaji wa fedha wa moja kwa moja kwenye vituo haijulikani. Utafiti huu ulifanyika ili kutathmini utendaji wa kamati za wananchi chini ya muktadha wa ugatuaji wa fedha katika Mamlaka za Serikali za Mitaa za Tanzania. Hasa, utafiti ulitathmini (i) kiwango cha utendakazi wa kamati katika vituo vya afya vya msingi vya umma chini ya muktadha wa ugatuaji wa fedha; (ii) uwajibikaji wa kamati katika vituo vya afya vya msingi vya umma chini ya muktadha wa ugatuaji wa fedha na (iii) mambo muhimu yanayohitajika ili kuboresha utendakazi wa kamati katika muktadha wa ugatuaji wa fedha.

Muundo wa utafiti wa sehemu mbalimbali ulitumiwa ambapo taarifa ya ubora na kiasi ilikusanywa kwa wakati mmoja au katika awamu moja ya ukusanyaji wa data ili kutathmini utendajikazi wa kamati. Sampuli za mikoa, halmashauri na vituo vya kutolea huduma za afya zimetokana na Tathmini ya Upimaji Nyota ya Wizara ya Tawala za Mikoa na Serikali za Mitaa ya utendaji kazi wa vituo vyote vya kutolea huduma za afya za msingi za umma nchini Tanzania, iliyofanyika mwanzoni mwa mwaka 2018, yaani, mwaka ambao ugatuaji wa fedha katika vituo vya afya ulianza ilianza. ukubwa ya sampuli ya uchunguzi huu ilibainishwa kwa kutumia mchakato wa sampuli wa nguzo wa hatua nne. Katika hatua ya kwanza, mikoa minne ilichaguliwa kwa makusudi kulingana na utendaji wao (mikoa miwili yenye utendaji mzuri na miwili ya utendaji wa chini). Kutoka kwa kila mkoa uliochaguliwa katika hatua ya kwanza, halimashauri mbili zilichaguliwa katika mzunguko wa pili. Moja kati ya halimashauri

mbili zilizochaguliwa ilikuwa na vituo vyenye utendaji wa chini na nyingine yenye yenye vituo vingi vyenye utendaji wa juu kulingana na tathmini ya ukadiriaji wa nyota. Vituo vinne vya afya vilichaguliwa kimakusudi kutoka kwa kila halmashauri iliyochaguliwa. Vituo viwili vya afya vilichaguliwa kwa sababu ya vituo vyake vina utendaji wa chini na vingine viwili kwa sababu ya utendaji wa juu katika halmashauri. Eneo la kituo kilipo (mfano katika mji au pembezoni mwa mji katika halmashauri pia kilikuwa kigezo cha kumudu utofauti wa halmashauri na vituo vya afya. Katika hatua ya nne, wahojiwa wa dodoso iliyoundwa walichaguliwa kwa uwiano kutoka kwa kila kamati ambapo wahojiwa 280 waliweza kufikiwa kati ya 288 waliohitajika. Washiriki wa mahojiano na majadiliano ya vikundi walichaguliwa kimakusudi. Washiriki walichaguliwa kwa mahojiano na mijadala ya vikundi kulingana na uwezo wao wa kutoa taarifa muhimu kuhusu utendaji kazi kamati za usimamizi chini ya mukutadha wa ugatuaji wa fedha katika vituo. Kwa hiyo, ili mhojiwa ajumuishwe kwenye mahojiano na majadiliano alipaswa kuwa mjumbe wa kamati ya usimamizi anayefanya kazi katika muktadha wa ugatuaji wa fedha katika vituo vya kutolea huduma za afya.

Hojaji iliyobuniwa isiyokamilika ilitumika kukusanya taarifa za kiasi kutoka kwa kila mwanachama aliyechaguliwa kutoka kamati ya usimamizi. Programu ya Open Data Kit (ODK) ilitumiwa kutengeneza programu ya kukusanya taarifa. Tarifa iliyokusanywa iliingizwa kwenye ODK. Ili kukusanya taarifa, mbinu ya upimaji kulingana na ukusanyaji wa taarifa kwa njia ya simu ilitumika. Taarifa zilinaswa kupitia simu za rununu na kisha kuhamishiwa kwa seva kuu. taarifa ziliyopatikana zilitumwa kwa mtafiti kwa kutumia jukwaa la ODK. Kiwango cha majibu kwa washiriki waliojaza dodoso ni wahojiwa 280 kati ya 288. taarifa za hojaji zilikusanywa kupitia mahojiano na majadiliano. Mahojiano ya kina yalifanyika na wenyeviti wa kamati za usimamizi ili kuchunguza kiwango ambacho wamekuwa wakitimiza majukumu yao chini ya mipangilio ya ugatuaji wa fedha katika vituo. Kwa upande mwingine, majadiliano yaliendeshwa na wajumbe wengine wa kamati bila kuwajumuisha wenyeviti wa kamati. taarifa ya kiasi ilinakiliwa, kuchakatwa na kuchambuliwa kwa kutumia IBM-SPSS v. 25. Katika kutathmini utendakazi wa kamati za usimamizi chini ya muktadha wa ugatuaji wa madaraka, takwimu za maelezo na kiasi zilitumika kuchanganua taarifa. Muundo wa urejeshaji wa vifaa wa visababishi ulitumika ili kubainisha vipengele vinavyohusishwa na utendakazi wa kamati. Ili kutathmini uwajibikaji wa kamati katika mukutadha wa utekelezaji wa ugatuaji wa fedha, urejeshaji wa takwimu wa maelezo ulitumika kulingana na faharasa ya uwajibikaji ya kamati au vitabiri vya uwajibikaji. Ili kutathmini vipengele vinavyotambuliwa vinavyobainisha utendakazi wa kamati, Fahirisi za Umuhimu Husiani ndani ya Rejea nyingi zilitumika.

Kulingana na matokeo ya utafiti huu utendakazi wa kamati katika mukutadha wa ugatuaji wa fedha ulionekana kuwa mzuri kwa asilimia 78.5. Hasa, kamati zilionekana zinafanya kazi vizuri katika majukumu ya kuhamasisha jamii kujiunga na Mifuko ya Afya ya Jamii kwa

asilimia 87.14, katika kushiriki katika mchakato wa ununuzi kwa asilimia 85, %, kujadili changamoto za afya ya jamii kwa asilimia 81.43 na katika kupanga na kupanga bajeti kwa asilimia 80. Hata hivyo, kulikuwa na tofauti ya utendaji kazi kati ya kamati za usimamizi, huku kamati za usimamizi kutoka vituo vya afya vya msingi ambayo ilionyesha utendaji wa juu wakati wa tathmini ya ukadiriaji wa nyota katika 2018 utendajikazi mzuri kiasi, ukipata asilimia 79.4, tofauti na kamati za usimamizi kutoka vituo vya afya vya msingi ambavyo vilikuwa na utendaji wa chini. Vilivyopata asilimia 3.88 Kuhusu uwajibikaji, kamati zilionyesha utendaji mzuri wa asilimia 78. kamati zilionekana kuwa na uwajibikaji wa hali ya juu katika suala la kuhamasisha jamii kujiunga na mifuko ya afya ya jamii (91.71%), kushiriki katika kupokea dawa na bidhaa za matibabu (88.57%), na utoaji wa huduma za afya kwa wakati (84.29%). Utendaji kazi wa kamati ulilionyeshwa kuwa unahusiana kwa kiasi kikubwa na upangaji afya (p=0.0048) na kipengele cha usimamizi wa fedha (p=0.0045). Kwa hivyo, utafiti uligundua kuwa mambo ambayo ni muhimu zaidi kwa utendakazi wa HFGCs ni upatikanaji wa fedha kwa kituo cha afya chenye alama ya RII 0.8964 ambayo iliorodhesha kigezo cha kwanza muhimu cha utendaji wa HFGC, ikifuatiwa na uwazi wa mamlaka na kazi kwa alama ya 0.8928, kama kibainishi cha pili muhimu, na mawasiliano kati ya kamati na jamii yenye alama ya 0.8792, kama kibainishi cha tatu muhimu.

Kutokana na matokeo ya utafiti huu juu ya ugatuaji wa fedha kupitia utumaji fedha moja kwa moja kwenye vituo katika kamati za usimamizi zilizochaguliwa unaunga mkono wazo kwamba ugatuaji huwawezesha watendaji na wasimamizi wa afya wa mataifa madogo naya kati kwani utendaji wa kamati za usimamizi katika vituo vya afya vinavyotekeleza ugatuaji ulionekana kuwa mzuri. Utafiti huu unamaanisha kuwa mpangilio na jinsi ugatuaji wa fedha unavyotekelezwa ni muhimu katika kubainisha kama unawawezesha wahusika au la. Kwa hivyo, ili kamati za usimamizi ziwezeshwe na ziweze kutekeleza majukumu na wajibu wao vyema, mukutadha na sifa za wanachama wa kamati ni suala muhimu.

DECLARATION

I, **Anosisye Mwandulusya Kesale**, do hereby declare to the Senate of Sokoine University of Agriculture that this thesis is my original work done within the period of registration and that it has neither been submitted nor concurrently being submitted in any other institution.

…….. . ……

Anosisye Mwandulusya Kesale **Date**

(PhD Candidate)

The above declaration is confirmed by supervisors.

…….. . ……

Prof. Christopher P. Mahonge (PhD) **Date**

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Dr. Mikidadi I. Muhanga (PhD) **Date**

LIST OF PUBLISHED PAPERS/MANUSCRIPTS

i. Kesale AM, Mahonge C, Muhanga M (2022) Effects of decentralization on the functionality of health facility governing committees in lower and middle-income countries: a systematic literature review. GLOBAL HEALTH ACTION 2022, VOL. 15, NO. 1https://doi.org/10.1080/16549716.2022.2074662

ii. Kesale AM, Mahonge CP, Muhanga M. The functionality of health facility governing committees and their associated factors in selected primary health facilities implementing direct health facility financing in Tanzania: A mixed-method study. Health Sci Rep. 2022;5: e611.https://doi:10.1002/hsr2.611.

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DEDICATION

This thesis is dedicated to my mother Monica Sanga (Rest in Eternal Peace), who raised me alone and with determination so that I could attain this academic level.

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LIST OF ABBREVIATIONS AND ACRONYMS

CAG	Controller and Auditor General
CHMT	Council Health Management Teams
DHFF	Direct Health Facility Financing
FGD	Focus Group Discussion
HFGCs	Health Facility Governing Committees
HSR	Health Sector Reforms
LGAs	Local Government Authorities
LMICs	Lower- and Middle-Income Countries
MDC	Mobile Data Collection
MSD	Medical Store Department
ODK	Open Data Kit
PHC	Primary Health Care
PHCF	Primary Health Care Facilities
PO-RALG	Presidents' Office- Regional Administration and Local Government
RII	Relative Importance Index
SAPs	Structural Adjustment Program
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Globally, good health is a cornerstone of development in all societies (Kapologwe *et al*., 2019; Yates, 2009). To achieve good health for all, the Alma Ata Declaration of 1978 identified community engagement as a vital component for strengthening primary health care delivery at the grass roots level. The Alma Ata Declaration calls for allowing health service users or communities to participate directly in the design, implementation and monitoring of healthcare facility operations in order to promote healthcare responsiveness, sustainability and efficiency (Oakley, 1989) . As a result, the majority of lower and middle-income countries (LMICs) have undergone a substantial transformation since the 1980s, changing from state-controlled public administration to more devolved political, fiscal and administrative systems. Decentralization involves the transfer of major decision-making powers and responsibilities for health services, such as planning, budgeting, and financial management, from the central government or a large unit of local government to a smaller unit closer to the community (Cobos Muñoz *et al*., 2017; Falisse & Ntakarutimana, 2020). Decentralization entails a variety of approaches including de-concentration, which involves transferring authority and responsibility from the national level to regions or districts within the same ministry (Kessy, 2014); Devolution involves the transfer of authority and responsibilities to lower-level government structures (Kessy, 2014; Liwanag & Wyss, 2019; Tsofa *et al*., 2017); Delegation occurs where semi-autonomous agencies are created to carry out functions that were previously carried out by the Ministry of Health (Kessy, 2014). The desire of LMICs to devolve resources, decision-making powers and authority from the central to elected sub-national units was intended to increase community participation and establish a community-based decision-making process.

Decentralization produced community governance structures in many LMICs such as health facility governing committees (HFGCs) that are made up of elected community members to promote community participation in monitoring the provision of health services at primary healthcare facilities (Kessy, 2014; McCollum *et al*., 2018). Offering HFGCs extensive decision-making authority would be intended to improve health facility performance and guarantee that service delivery is responsive to community needs and preferences. HFGCs are tasked with specific functions in the governance process, such as planning, managing finances, procurement process, addressing community health challenges and managing health workers (Kapologwe *et al*., 2019; Ved *et al*., 2018). Committees are anticipated to improve the performance of healthcare facilities and enhance the delivery of health services in primary healthcare by carrying out their devolved responsibilities.

Health Sector Reform (HSR) was adopted in Africa as part of structural adjustment programs (SAPs), which were a response to the economic crises that the continent experienced in the 1970s and 1980s and caused the collapse of many sectors, including the health sector (Collins *et al*., 1999; Collins & Green, 1994). In the health sector, it was observed that the health system that existed was top-down and therefore inefficient and not responsive to the citizens' needs and preferences (Collins & Green, 1994). The HSR increased community participation at the PHC level by establishing community governance committees to manage health facilities. However, critics such as Lugalla claim that SAPs achieved less because they did not focus on weak institutions in underdeveloped countries tasked with implementing SAPs (Lugalla, 1995b).

In Tanzania, as in many other African nations, HSRs can be traced back to the 1960s, when the government replaced the colonial administration with democratic local governments to enhance service delivery (Frumence *et al*., 2013; Jonsson, 1986; Lugalla, 1995a). The government implemented the villagization strategy of 1972-1975, along with the decentralization of PHC, to ensure citizens' access to health services (Jonsson, 1986). The creation of village health committees made it possible for the community to participate in the planning and coordination of PHC (Jonsson, 1986). The economic crisis of the 1970s and 19802 resulted in the underfunded health sector, whose local governments were replaced by Regional Development Directorate and District Development Directorate until the 1980s when local governments were reintroduced. Tanzania decentralized administrative, political, and fiscal powers and responsibilities from the central government to District Councils to handle health services at the PHC in the 1990s as part of SAP programs.

The Tanzanian government established HFGCs in 1999 as part of HSR to ensure that communities are involved in the planning, delivery and monitoring of health services provided at the PHC (Kapologwe *et al*., 2019; Kessy, 2014b; URT, 2013). These HFGCs have been given specific duties and responsibilities, including overseeing health facility revenue, expenditure, and performance, and taking part in the establishing of facility plans and budgets, raising money for the construction and maintenance of infrastructure, addressing the community's health issues and encouraging participation in the upgraded Health Community Fund. Furthermore, HFGCs have been assigned the responsibility of dealing with controlling outbreaks/pandemics such as cholera, COVID-19in they communities. Since decentralization was completely implemented in Tanzania at the council level rather than the facility level, these HFGCs have been operating with a limited degree of decentralization (Boex, 2015).

Numerous reforms have continued to be adopted to improve decentralization and empower community participation and ownership of health service delivery at the facility or grassroots level. Fiscal decentralization at primary healthcare facilities was adopted in the 2017–2018 fiscal year through the Direct Health Facility Financing (DHFF) approach (Kapologwe *et al*., 2019). This DHFF reform aims to give lower public primary health care facilities greater autonomy and decision-making space by assisting them in managing their finances more effectively through planning, budgeting and monitoring budget implementation on themselves (Kalolo *et al*., 2022). The government implemented fiscal decentralization through DHFF, in which main health facility funds are directly deposited into the health facility accounts (Kapologwe *et al.,* 2019). The DHFF allows for the direct transfer of government, non-state actors (NSAs), and external funds to a health facility to meet the facility's operational needs. According to Kapologwe *et al*, (ibid), the DHFF is defined as

> *a funding modality or mechanism where funds from Government or Non-State Actors are disbursed directly from any funding source or treasury to health facility without going through any other channel in order to improve timely disbursement, efficiency use, accountability, transparency, autonomy, and service delivery while adhering to the financial guidelines, regulations, and laws* (Kapologwe *et al*., 2019).

Prior to the establishment of the DHFF in Tanzania, all funds for health facilities were deposited into council accounts, including those from the central government (Ministry of Finance and Planning), development partners, and funds collected directly from facilities. The Council Health Management Team, which reports directly to the Council Medical Officer, was in charge of these finances. Many PHCs at the time had no bank accounts. Primary health facilities had to go through burdensome bureaucratic processes in order to acquire their funding and support health activities. The funds were occasionally reallocated by the council to support other council projects or weren't timely distributed to the primary health facilities, which resulted in the cash frequently failing to achieve the targeted health facilities (Boex, 2015). As a result, healthcare professionals at primary healthcare facilities and HFGCs were unable to properly direct, manage, and control their finances. There is a call for assessing the functionality of HFGCs under fiscal decentralization through DHFF to ascertain whether the context have impacted their functionality.

1.2 Statement of the Problem

Since the 1990s, service provision governance through user committees has been widely implemented in the decentralized or reformed service provision system in LMICs (Manor, 2004). The fundamental purpose of involving users in the governance of service delivery, such as education, health, and water, has been to empower users/ordinary citizens in the community to hold service providers accountable and promote responsiveness, efficiency,

and quality of service (Gurung *et al*., 2018). Users' committees have been formed or reinstated and strengthened as a result of adopted reforms to represent the voice and interests of users or communities in service provision. Despite the existence of these committees, empirical research from several LMICs has found that their performance in carrying out their devolved responsibilities and powers has been very poor (Falisse *et al*., 2012; Ngulube et al., 2004; Panda *et al*., 2016; Yuan *et al.*, 2017). The nature of decentralization adopted by particular countries has been identified as a primary cause for these committees' poor success (Falisse *et al.*, 2012; Liwanag & Wyss, 2019; Panda *et al.,* 2016; Wu *et al*., 2021). Empirical research from Tanzania, as well as other LMICs, revealed the low functionality of HFGCs in carrying out their responsibilities (Boex *et al.*, 2015; WHO, 2015). Indeed, the CAG report of 2008 on the audit of PHC management stated that HFGCs are less effective in their oversight function of overseeing health facility performance (NAO, 2008). One of the primary impediments to the successful functioning of HFGCs in Tanzania is limited fiscal powers and space (Boex *et al*., 2015; WHO, 2015).

The government of Tanzania launched the DHFF initiative to close the performance gap and improve the functionality of HFGCs in Tanzania to improve service delivery among primary health facilities. The DHFF arrangement directs facility funds from the Ministry of Finance and other development partners into PHF accounts rather than District Council accounts (Kalolo *et al*., 2022; Kapologwe et al., 2019). The DHFF initiative aimed to empower and improve the fiscal autonomy of HFGCs and health facilities in terms of planning, budgeting, financial management, and drug and medical commodity procurement. Since the implementation of the DHFF, health facility funding has been sent in time, and the fiscal autonomy of the HFGCs are expected to be expanded. One of the significant responsibilities of the HFGCs which has not received its importance in Tanzania is responding and containing outbreaks/pandemics such as COVID-19 in they are areas. Many studies have been assessing the response and containment strategies used by bureaucrats or high levels organs giving no attention to community governance structures which are close and part of the communities. The empowered HFGCs are expected to carry out their responsibilities successfully under the DHFF context, hence boosting health service delivery including responding to the outbreaks/pandemic. However, critics have expressed mixed feelings about the empowering of community governance structures such as HFGCs through decentralization such as fiscal decentralization to enable them better to fulfil their devolved functions. For example, Bossert contends that empowering the community by expanding the decision space does not guarantee that the community will use the space as intended (Abimbola *et al*., 2014; Bossert *et al*., 2003; Bossert *et al.*, 2015). This is because, despite being granted decision-making and fiscal powers, community groups such as HFGCs may choose not to use the granted powers and continue to operate as they did before the

introduction of new fiscal and decision-making space for them. Others say that governments implement decentralization without adequate preparation, particularly in changing the mindset of communities about how the new arrangements will benefit them (McCollum *et al*., 2018; Ramiro *et al*., 2001). All of these causes many government interventions to fall short of their stated goals. Since the inception of the DHFF arrangement in Tanzania, the functionality status of HFGCs in the DHFF context is not known. This study was carried out to determine the extent to which HFGCs carry out their devolved functions in the selected Local Government Authorities in Tanzania under the DHFF setting.

1.3 Justification of the Study

The fulfilment of both global and national health goals is dependent on their implementation at the grass-root level, as community engagement is a cornerstone for achieving health objectives in primary health care, according to the Alma-Ata Declaration. The third Sustainable Development Goal (SDG) emphasizes good health and well-being; similarly, the Tanzania National Health Policy of 2003 emphasizes and grants communities' powers to monitor and administer primary health care facilities. So far, no comprehensive study has investigated the functionality of user committees/HFGCs under the DHFF setting including ascertaining how HFGCs have been responding and containing the outbreaks such as COVID-19 in Tanzania, which provides fiscal autonomy for health facilities and HFGCs to govern the use of facility funds. This study's findings are useful to researchers and policymakers because they fill a knowledge gap by examining how fiscal reform through the DHFF has improved and empowered communities to monitor and manage health service delivery while fostering accountability, responsiveness, and equality. This study also contributes to the body of knowledge on grassroots empowerment through fiscal decentralization, which may be beneficial and replicated in other sectors with user committees, such as water committees.

1.4 Objective of the Study

To determine the extent to which Health Facility Governing Committees (HFGCs) accomplish their devolved functions under the DHFF context.

1.4.1 Specific Objectives

i. To assess the functioning level of HFGC in public primary health facilities under DHFF implementation
ii. To assess the accountability of HFGCs in the public primary health facilities under DHFF implementation.
iii. To determine the factors affecting the functionality of HFGCs under DHFF implementation.

1.5 Main Research Questions

i. How do Health Facility Governing Committees exercise their devolved powers and functions under the DHFF context?
ii. What is the level of accountability of Health Facility Governing Committees in public primary facilities in implementing DHFF?
iii. What are the important factors influencing the functionality of HFGCs under the DHFF context?

1.6 Theoretical Framework

This study employed three theories that were used to guide this study, each theory has explained its assumption and the way it was used to guide the study.

1.6.1 Theory of Fiscal Federalism

The theory of fiscal federalism was developed by Wallace Oates in 1972 and later modified by other scholars such as Musgrave in 1984 (Oates, 2003). The Theory of Fiscal Federalism's core assumption is that the Central or Federal government/higher level authorities generate the goods and services that are uniform due to incomplete information. Uniform goods and services, on the other hand, are appropriate and better for national consumption or benefits, such as defence and foreign policies. Uniform goods and services are not appropriate for meeting local needs or communities, such as health, education and water. Uniform provision of products at the local or community level may be problematic since it ignores the heterogeneous nature of local communities in terms of requirements, tastes, and preferences. As a result, citizens' local government institutions are better positioned to provide locally based goods and services such as health care because their proximity to the community allows them to obtain perfect information about community preferences, tastes, and needs, as well as local solutions to locally based problems at a low cost. In this regard, local government institutions such as primary health care facilities achieve more "allocative efficiency," which implies delivering a mix of commodities and services that fit the preferences, tastes and needs of community members (Brian, 2007; Oates, 2003; Smoke, 2000). If local government institutions are required to raise funds and make political and financial decisions regarding the provision of goods and services, they will always be inventive and creative in producing such services at lower cost using local technology that they have either developed themselves or borrowed from neighbouring local governments.

From the perspective of public expenditure, Musgrave (1984) contends that the level of government whose residents are very satisfied with the provision must deliver public goods

and services. If the satisfaction is felt nationwide, the national government should be providing these goods and services, but if only a portion of the advantages is felt nationally, then the local government in question should be providing those products. It should yield not only because of the information advantage but also because local governments can achieve "allocative efficiency" due to their proximity to actual resource costs (Fjeldstad *et al*., 2004; Smoke, 2000). Financial responsibility and a sufficient revenue base should be devolved to the citizens or local government institutions like primary healthcare facilities to properly deliver goods and services at the local level (Oates, 2003).

Decentralization should therefore transfer administrative, political and fiscal powers and responsibilities to citizens and service providers at the community or grass-roots level in order to equip them with the necessary decision-making tools to enhance services that meet the preferences and needs of locals. Currently, LMICs are implementing fiscal decentralization as proposed by the fiscal decentralization to tape its gains such as allocative efficiency and empower local actors such as HFGCs and health providers. Setting in which fiscal decentralization is implemented (local level) and the actors' characteristics play critical roles in realizing fiscal federalism benefits. Therefore, fiscal decentralization follows or is the results of fiscal federalism theory which suggest that fiscal decision-making powers be delegated to the local level.

1.6.2 Empowerment Framework

This study was guided by the Empowerment Framework (Alsop *et al.,* 2005; Alsop and Heinsohn, 2005; Raich, 2005). According to Alsop (ibid), capacity of the individual group to make effective choices or decisions is attributed by two factors which are the agency and opportunity structure (Alsop *et al.*, 2005). The empowerment framework emphasizes that the individual or group should not only be capable of making good decisions but also capable of transforming those choices into desired outcomes. According to the framework, capacity is defined as a group's or an individual's ability to make a purposeful decision that is ultimately beneficial to the beneficiaries.

The two most important drivers of an individual's or group's ability to make effective decisions are the agency and opportunity structure (Raich, 2005). The ability of an actor to make meaningful decisions is described as the agency. In this usage, agency refers to an individual or a group who has been given the authority to make decisions.

The framework goes on to suggest that for the actor, an individual or a group to make good decisions, they must possess certain traits known as "asset endowment" (Conger & Kanungo, 1988). Assets are the actor's attributes that enable him or her to make effective

decisions. The actor's attributes may include information, financial, organizational, material and psychological human assets. These have a crucial role in affecting productivity and shielding actors from shocks. However, even if an actor has all the resources necessary to make smart choices, the circumstances of their work may prevent them from doing so. Opportunity structures refer to the agency's operating environment, whether it is formal or informal. Opportunity structures are the "rules of the game or the institutions which regulate and shape the conduct of the actors and dictate their interactions and the choices they must make. Formal institutions include laws and regulations frameworks that govern one's actions in making decisions. Informal institutions include norms, values and cultural practices (Friis-Hansen & Duveskog, 2012; Haldane *et al.*, 2019). Therefore, rational or effective choices are facilitated or constrained by the circumstance around actors.

Empowerment happens when the agency and the opportunity structure interact. It is emphasized that the environment/opportunity structure plays a significant role in transforming assets base into an effective agency. For tracking empowerment, three measurements are proposed: (1) whether an opportunity to make a decision exists (presence of choice), (2) whether a person or a group uses the opportunity to choose (use of choice), and (3) whether the choice produces the desired outcome (achievement of choice) (Alsop *et al*., 2005; Raich, 2005). In this study, the empowerment framework was used to assess whether changing opportunity structure through granting fiscal powers, resources and responsibilities to the HFGCs through DHFF influences the functionality of the assigned responsibilities. Therefore, the self-reported measurement approach is used to measure the extent to which fiscal decentralization has empowered HFGC members to accomplish the assigned functions. Self-reported measurement of empowerment in health is used to capture HFGC members' perceptions about how empowered they feel in accomplishing their mandates under the DHFF context.

Decentralization influences the degree of empowerment given to primary health care facility actors, which include both elected community representatives (HFGCs) and administrative players (health workers) (Tsofa *et al*., 2017). Decentralization, for example, grants elected community representatives or HFGCs space or a chance to participate in decision-making and keep health providers accountable. Then, HFGCs are expected to use the space or opportunity offered to them to participate in decision-making and hold service providers accountable. Fiscal decentralization does transfer fiscal authority and control from the central government or high-level authorities to the sub-national or citizenry. The devolved fiscal authorities and responsibilities are expected to be employed in raising revenue, deciding expenditures, and managing health facility finances at basic healthcare institutions (Fjeldstad, 2001; Oates, 1999). As a result, fiscal decentralization empowers community

governance institutions such as HFGC by providing them with the ability to make fiscal decisions and the capacity to implement those decisions to achieve the intended aim.

In Tanzania, fiscal decentralization was implemented through Direct Health Facility Financing to empower elected community representatives through HFGCs and health service providers to actively engage in governing and managing health service delivery. The DHFF was created to fill fiscal gaps created by the concentration of fiscal powers at the council level, leaving primary healthcare facilities with only political authority. As a result, HFGCs were unable to oversee facility revenue, expenditure, and finances. The implementation of the DHFF grant program allows HFGCs to make both political and fiscal decisions in their facilities. However, to what extent the empowered HFGCs use the opportunity provided by both fiscal and political decisions in the context of the DHFF is unknown.

1.6.3 Principal Agency Theory

The agency theory describes a connection between two actors in which one actor is labelled as a master or principal and delegates his/her tasks to another actor known as an agent to perform on behalf of the master or principal (Bendickson *et al*., 2016; Kivistö & Zalyevska, 2015; Schneider & Mathios, 2006). When the principal delegates obligations to the agent, the agent must ensure that they are carried out as planned and in the best interests of the principal. The principal is constantly watching the actor ensuring that the desired objective is attained (Eisenhardt, 1989). In the course of overseeing the agency, the principal compensates the agent based on the extent to which the delegated obligations have been met. If the agency is to be adequately compensated, it must adhere to the concept to the greatest extent possible (Mitnick, 2015). In this kind of relationship, agents always report to the principal on the extent to which they have accomplished the delegated responsibilities.

Accountability, which refers to the relationship between the actor and the forum, is reflected in the principal and agent theory (Brinkerhoff, 2004; Danhoundo *et al*., 2018). In this type of accountability, the relationship between the two, the actor is required to justify or report to the forum on his/her conduct, after which the forum will evaluate the actor's work and give judgment. The decision may be to reward or sanction the performer, and the actor may be disadvantaged as a result. As a result, the forum is the principal in accountability, and the agency is the actor (Emanuel & Emanuel, 1996; Lodenstein *et al*., 2017). The community is responsible for overseeing health service provision at the primary health care facility. The community, however, has assigned that role to the HFGCs (Tanzania, 2013). The members of the HFGCs are elected by the communities to oversee the health facility on their behalf. The committees are required to justify or report to the community on what they have done,

and the community then passes judgment based on the HFGCs performance in improving service delivery at the facility. As a result, the community serves as the primary forum, and the HFGCs serve as the agents' actors. If the HFGC performs well, the committees tend to re-elect the members; if the HFGC does not perform well, the members are not re-elected (Boydell *et al.*, 2019; Fox, 2015). Fiscal decentralization via the DHFF arrangement enables the agency or actors to carry out the given obligations to the best of their abilities. In this study, the Principal Agency Theory is used to assess how the HFGC members as an agency feel empowered by the DHFF context in accomplishing their delegated mandate by their principal or communities.

The three theories have been used because they complement each other in the sense that the weakness of one theory in guiding the study is complemented by the stregnth of the other theory. Fiscal federalism provides that local goods and services should be provided by the local communities because they have information advantage on the local preference, tastes and needs and can produce those goods and services on low cost; therefore they have “allocative efficiency”. However, the theory does not provide the conditions that need to be met for the local actors to produce goods and services that fit local users. The empowerment framework in this context extends the fiscal federalism perspectives by providing the characteristics which facilitate the capacity of the local actors to make effective decision in producing local goods and services such as health services. The framework states that for the local actors whether individual or groups such as HFGC members to make effective decisions depends on the interactions between the individual or group characteristics and the context in which the individual or the group operates. Therefore, the context may facilitate or limit the capacity of the individual or a group to make effective decisions despite the individual having perfect information about the local user’s preferences, taste and needs. The empowerment framework does not however provide how the local actors should account themselves to their principals or local communities on the extent they have accomplished their mandates. The Principal Agency Theory complement this by explaining the accountability relationship between the service producers and service user. This study also assessed how the local services producers or HFGC members perceive their accountability level in accomplishing the devolved mandates.

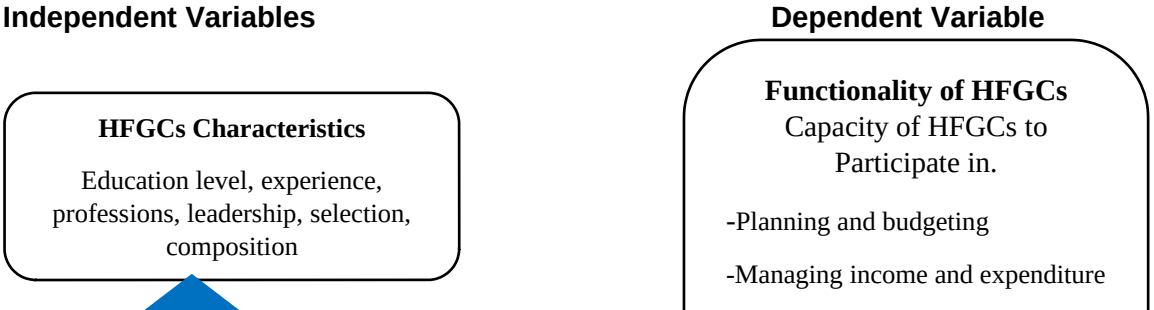
1.6.4 Conceptual Framework

Participation of the community in the governance of primary health care facilities is critical to improving health service delivery and overall health system performance. Considering community participation is accomplished through established community governance institutions known as HFGCs, which comprise community people. These HFGCs are allocated functions. In Tanzania, the HFGCs are assigned specific powers and functions

including participating in Planning and budgeting, managing income and expenditure procurement process. Other functions include participation in managing facility performance, managing facility resources, mobilization of facility finances, managing constructing and renovating facility infrastructures and discussing the challenges confronting the community. For HFGCs to be able to accomplish these functions they need capacity and the proper environment to support them to carry out their functions effectively.

Decentralization promises a pleasant atmosphere in which HFGCs can carry out their delegated tasks. Indeed, fiscal decentralization, as advocated by fiscal federalism, is said to provide a major opportunity for these local-level governance institutions to participate in governing and managing health service delivery that is responsive to their local needs and preferences. Tanzania is implementing fiscal decentralization at primary health care facilities to empower HFGCs and service providers in response to fiscal federalism arguments. This is occurring following the failure of political and administrative decentralization of producing the desired objectives. Fiscal decentralization is said to help other types of decentralization, such as political and administrative components function better.

Figure 1.1 demonstrates the relationship between HFGC attributes and the DHFF environment, as well as the impact on HFGC functionality. Figure 1.1 implies that the functionality of HFGCs is determined by the traits of its members, such as education level, experience, occupation, leadership, selection, and composition. The fiscal decentralization context (DHFF) in which HFGCs operate creates a suitable environment for them to carry out their allotted tasks. The DHFF is expected to empower HFGCs by providing quick access to funds, financial standards, and training for HFGCs on their roles and financial management. Additionally, the DHFF framework aims to clarify HFGC's authority and responsibilities as they do their duties. The DHFF's empowerment will enhance the HFGC's capacity to carry out its duties and raise the quality of health service delivery at their facilities. For the HFGCs to make effective decision, there should be interaction between the HFGCs and DHFF in which at the end of the day after interactions which almost support each other that end hance HFGCs in their localities. The functionality of the HFGC in the areas depend much on the interaction context and HFGC qualities.



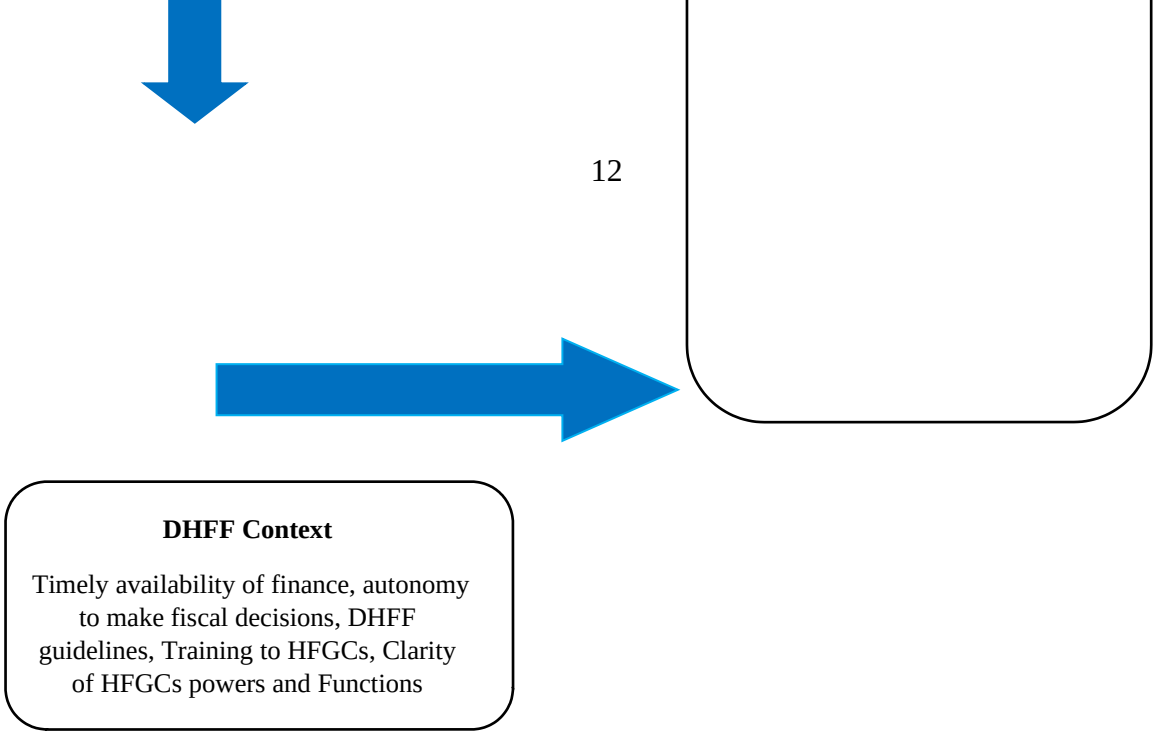


Figure 1.1: Conceptual Framework

1.7 Methodology

1.7.1 Study Area

The study was conducted between February and April 2021 in Kilimanjaro, Mbeya, Ruvuma and Songwe regions in Tanzania Mainland located in East Africa. Kilimanjaro and Mbeya were purposively selected because they are the highest performer and Ruvuma and Songwe regions were purposively selected because they were the least performer according to Star Rating Assessment conducted in 2018 by the President Office-Region Administration and Local Government in all regions before the introduction of DHFF program (Yahaya, 2019).

1.7.2 Research Design

A cross-sectional research design was employed in which both qualitative and quantitative data were collected simultaneously or at one data collection phase. Both qualitative and quantitative data were used to evaluate the functionality of HFGCs in terms of the extent they accomplish their functions including governing COVID-19, accountability and factors influencing the functionality of HFGCs under the DHFF context (Minichberger *et al*., 2016).

1.7.3 Research Approach

This study employed a mixed-methods approach that combined qualitative and quantitative research approaches to better understand the knowledge of the performance of HFGCs in primary public healthcare facilities that implement DHFF in Tanzania (Creswell, 2013; Iwami & Petchey, 2002; Schoonenboom & Johnson, 2017).

1.7.4 Sampling procedures and Sample size

A total of 280 participants were employed in this investigation as the sample size. A four-stage multistage cluster sampling procedure was used to obtain the sample size for this study. Multistage cluster sampling was adopted because the study involved geographically

distinct regions and in-person data gathering was necessary. The sample criteria were developed based on the Presidents' office Regional Administration and Local Government's Star Rating Assessment of all primary healthcare facilities in Tanzania, which was finished at the beginning of 2018. The Tanzanian government established a star grading system to rate the performance of primary healthcare facilities including HFGCs. To identify the low and high-performing primary health facilities and their HFGCs, the examined primary health facilities and their HFGCs were ranked. The Star rating assessment of 2017/18 was taken as a baseline because it is in the same year DHFF was introduced.

Table 1.1: Sampling process and sampling techniques

Stage	Respondent	Sampling procedure	Inclusion criteria
First stage	Four (4) regions selected Kilimanjaro, Mbeya, Ruvuma and Songwe	• Purposive	Performance of the region in star rating assessment, Zonal representation
Second Stage	8 LGAs selected; Two LGAs from each region selected in stage one	• Purposive	Performance of the LGAs in star rating assessment, nature of the LGA (Urban and Rural),
Stage Three	32 health facilities were selected from all (8) councils. 2 health centres and 2 dispensaries from each LGA because they all implement DHFF	• Stratification of health facilities into Health centres and Dispensaries • Purposive selection of health centres and dispensaries	Performance of health facility (A good and poor performing health centre and dispensary), Location of the facility within the LGA (Diversity)
Stage Four	280 HFGC members; members from each selected health facility	• Proportion sampling selection of HFGC members	members of the HFGC

At stage four, the representatives from HFGCs were obtained using the Buddhakulsomsiry and Israel (Buddhakulsomsiri & Parthanadee, 2008) proportion sampling technique, with P equal to 0.5 and a confidence level of 95 %. Therefore, 288 members of the HFGC were

needed, as per the techniques. Then, using Pandev's proportionate sampling technique in which 9 HFGC members were meant to be chosen from each HFGC, the number of HFGC members from each chosen health facility was calculated (Pandey & Verma, 2008). There were 280 respondents (responses) from all health facilities in this study.

The participants in the interviews and FGDs were chosen based on their membership in the HFGC and PHCF which determined their ability to provide relevant information about how the HFGCs operated under DHFF and the breadth of their roles in the HFGCs. Participants who were not HFGC were not included in this study. As a result, HFGC chairpersons were specifically chosen for interviews, and HFGC participants were specifically chosen for FGDs. The 11 questions in the FGDs guide were all related to HFGC governance and HFGC functions. A total of 14 interviews with HFGC chairpersons and 13 FGDs with HFGC members, each with 6 to 9 participants, were conducted. Once the saturation point was reached, a total of 14 interviews and 13 FGDs were conducted. Interviewers and FGD participants reached saturation when they continued to give similar answers, so the interview added no new information.

Table 1.2: Characteristics of the study participants in the Interviews and FGDs

	HFGC members	HFGC chairperson	In Charges (HFGC secretariat)	Total No of Participants
Total Interviewed		14		14
Focus Group Participants	85		13	98
Age ≤ 35	31	4	7	
≥ 36	54	10	6	
Sex Male	38	9	8	55
Female	47	5	5	57
			Total Number of Participants	112

1.7.5 Data Collection Method

1.7.5.1 Quantitative Data Collection

To collect quantitative information from each selected member of HFGCs, a closed-ended structured questionnaire focusing on specific HFGC functions was used. The data collection software (database) was built using Open Data Kit (ODK). The data were then entered into

the ODK. Data were gathered using a quantitative mobile data collection (MDC) strategy. Mobile devices were used to collect data, which were subsequently sent to a centralized server. A three-day training course on mobile data collection techniques was attended by four research assistants. The course was followed by pre-testing of the techniques in Dodoma region which is outside the study region. The researcher received the collected data via the ODK platform. All research assistants used tablets with GPS capabilities because all of the chosen facilities had GPS coordinates as part of quality control. Out of 288 HFGCs, 280 responded to the survey.

1.7.5.2 Qualitative data collection

To capture qualitative information, in-depth interviews with HFGC chairpersons and Focus Group discussions (FGDs) involving all selected HFGC members were conducted. The interview and focus group instructions were taught to research assistants before they started gathering data. The qualitative data collection instruments were evaluated before travelling to the study area. The interview plan comprised 21 inquiries about the operation and administration of HFGC. All 11 of the FGD's queries were on the HFGCs' governance and operations. One of the questions asked during HFGC chairperson interviews was what are the primary functions of HFGCs? Chairpersons were also required to describe how they have been carrying out each of the DHFF's functions. Members of the HFGC who participated in the FGDs were requested to discuss the responsibilities they were carrying out in overseeing healthcare facilities and their involvement in implementing the DHFF into action. Participants in the FGD were also questioned on the difficulties and elements that would aid members in implementing the DHFF successfully.

The open-ended questions were used as they did not allow the respondents to indicate whether they agreed or disagreed to lessen bias in this area. The respondents were interrogated and encouraged to create correct and true information. Gathered information and constantly making decisions based on responses and impressions rather than pre-existing ideas helped to minimize researcher bias. The research questions were straightforward and well-structured, with a broad subject at the beginning and a particular query about HFGC functionality under DHFF at the conclusion.

1.8 Data Analysis

IBM-SPSS statistic v. 25 was used to code, process and analyse quantitative data. All respondents' socio-demographic variables were analysed using descriptive statistics (mean and standard deviation, frequency and percentage) (Pallant, 2020). In objective 1, To determine the level of participation of HFGC members in decision-making about the HFGC's primary tasks in a particular facility, the mean score was measured using the 4-point Likert

Scale. Because the outcome variable was dichotomized (0=poor function, 1=good function), a binary logistic regression model was used to identify factors related to HFGC functionality. The accountability of HFGCs was evaluated in objective 2 using a binary logistic regression analysis to determine whether or not the HFGCs carry out their tasks. To determine whether HFGC is accountable or not, indicators of accountability such as the availability of a price list, suggestion box, meeting minutes, evidence of communication between HFGC and the community, the current state of facility infrastructures, and progressive reports were examined whenever available. Relative Important Indices (RII) in multiple regression were used to examine the contribution of various predictors of HFGC and DHFF on the operation of HFGC in objective 3. The efficiency of HFGC is influenced by which predictors are more significant than other factors, according to RII.

The themes that arose during data collecting were used to examine the data acquired for this study. The audio recordings of the in-depth interviews and focus groups were made. The audio recording was transcribed verbatim. Researchers were able to read and re-read the excerpts as a result of this. The textual extracts were then converted into codes based on the study's focus areas, which were the performance of HFGCs in public primary health facilities under DHFF implementation. As a result, all specific areas in which respondents mentioned the functionality of HFGCs in the specified or assigned functions were coded. The created codes were used to capture significant themes related to functionality aspects triggered by HFGCs in the governance of PHCF and the generated themes were linked to the study's target area. All the functionality topics were examined and enriched from the acquired data to make them more significant and correspond to the study topic, and overlapping themes were merged into one. The themes were then fine-tuned and defined to ensure that the reader understood what they meant in the context of community participation in the governance of PHCF fiscal decentralization context.

Limitation of the study

The study was conducted during the second wave of Covid-19, due to its nature there were tight conditions of conducting interviews and focus group discussion as people were advised to maintain social distancing. Also, some respondents were hesitant with researchers. To address that, researcher and research assistants took all the measures such as distributing masks to the respondents, maintaining social distance and sanitizing.

1.9 Research clearance

This research was carried out in conformity with the principles of the Helsinki Declaration. All procedures were followed in compliance with the applicable norms and legislation. The Sokoine University of Agriculture provided the IRB with the number SUA/ADM/R. 1/8/668.

The permit was then filed to the President's Office Regional Administration and Local Government (PO-RALG) to be granted permission to research local government authorities. PO-RALG issued a permit with the registration number AB.307/323/01 to allow the study to be carried out in the chosen areas. All human participants in this study gave their informed consent by signing consent forms before being included in the study.

1.10 Organization of the Thesis

The thesis is divided into seven chapters that are organized in the form of published manuscripts. The first chapter is an introduction that gives background information on health service decentralization and community participation in primary health care through community governance organizations known as Health Facility Governing Committees (HFGCs). Fiscal decentralization is later presented as a key component of Tanzanian decentralization. The chapter then provides a problem statement, justification for the study, objectives, theories driving the study, and the methodology used.

The second chapter presents the first manuscript developed from the literature review and published in a peer-reviewed journal. This work covers several pieces of literature on the influence of decentralization on the performance of HFGCs in low- and middle-income countries. Taylor and Francis published the manuscript in the journal Global Health Action. The reviewed literature explains how HFGCs function in a decentralized scenario. The primary areas evaluated in the literature review are the countries in which the research was conducted, the members of the HFGCs in a given country, the tasks devolved to the HFGC, the functionality of HFGCs, the factors affecting HFGCs and the health outcomes attained.

The third chapter presents the second manuscript developed from the specific objective one and published in a peer-reviewed journal. The manuscript focuses on the general functionality of HFGCs in Tanzanian primary health care facilities that are implementing DHFF. The manuscript is published by Willey in the journal Health Science Reports. The manuscript describes how the HFGC function in Tanzania under fiscal decentralization through the DHFF setup. The functionality of the HFGCs has been self-reported and measured by HFGC members who have expressed their perception of the extent to which they accomplish each function allocated to the HFGC. Therefore, the manuscript has shown the functionality level of each role assigned to them. In the end, the manuscript provides the factors associated with the functionality of HFGCs under the DHFF context.

Chapter Four covers the third manuscript published by PLOS Global Public Health, which was likewise produced from the first objective, which is on the functionality of HFGCs in the

context of DHFF. The manuscript explicitly evaluates the functionality variation among the DHFF HFGCs selected from primary health facilities with high and low performance as measured by Star Rating The assessment was conducted by President's Office Regional Administration and Local Government (PORALG) in 2018. The manuscript demonstrates how the functionality of various HFGCs is comparable and varied under the DHFF setting.

Chapter Five offers the fourth published manuscript stemming from the study's second objective, which was to assess the accountability of HFGCs under fiscal decentralization in Tanzania. The study was published in PLOS ONE, a peer-reviewed journal, on the quest for accountability of HFGCs implementing DHFF in Tanzania. The manuscript begins by developing an accountability index based on a literature review, which is then used to assess the accountability of the HFGCs. then HFGC accountability is based on the self-evaluation of HFGC members as perceived in several established accountability indexes. The manuscript also highlights the factors associated with the accountability of HFGC members under DHFF.

The sixth chapter contains the published manuscript resulting from the study's third objective. The manuscript focuses on the perceived factors that influence the performance of HFGCs in the DHFF context. The paper was published in Tanzania Journal of Community Development, a peer-reviewed journal housed by Sokoine University of Agriculture. This manuscript evaluates the factors that HFGC participants feel are important for them to exercise their given powers and responsibilities in the context of the DHFF in Tanzania. Members have indicated the factors they perceive most essential in determining their performance in this manuscript. As a result, the paper concludes by presenting those factors as perceived by HFGC members.

Chapter seven contains a peer reviewed article on the governance strategies which were adopted by the HFGCs as response to COVID-19. Since this study was conducted during the COVID-19, and HFGCs are assigned a role of dealing with emergencies in the health facilities, therefore it was very crucial to explore how they have been governing the pandemics in their facilities. Given the uniqueness of the COVID-19, assessing the roles played by community governance structures under fiscal decentralization. Therefore, this article has provided the strategies which were put in place by the HFGCs from the facility that had high and low performance.

Chapter eight contains the general discussion, conclusion, and recommendation. As a result, the chapter highlights the study's precise objectives as well as summary findings for

each objective. The overall discussion of the study was then done based on the findings, followed by the concluding remarks. The study's policy and practical implications, as well as theoretical implications, have been established. The chapter concludes by identifying areas for future research.

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CHAPTER TWO

2.0 EFFECTS OF DECENTRALIZATION ON THE FUNCTIONALITY OF HEALTH FACILITY GOVERNING COMMITTEES IN LOWER AND MIDDLE-INCOME COUNTRIES: A SYSTEMATIC LITERATURE REVIEW

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Abstract

Health facility governing committees (HFGCs) was established by lower and middle-income countries (LMICs) to facilitate community participation at the primary facility level to improve health system performance. However, empirical evidence on their effects under decentralization reform on the functionality of HFGCs is scant and inconclusive. This article reviews the effects of decentralization on the functionality of HFGCs in LMICs. A systematic literature review was conducted using various search engines to obtain a total number of 24 relevant articles from 14 countries published between 2000 and 2020.

Inclusion criteria: studies must be on community health committees, carried under decentralization, HFGCs operating at the individual facility, effects of HFGCs on health

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performance or health outcomes and peer-reviewed empirical studies conducted in LMICs. The study has found variation functionality of HFGCs under a decentralization context. The study has found many HFGCs to have very low functionality while some few HFGCs in other LMICs countries are performing very well. The context and decentralization type, members' awareness of their roles, membership allowance and availability of resource to the facility in which HFGC operate to produce the desired outcomes play a significant role in facilitating/limiting them to effectively carry out the devolved duties and responsibilities. Fiscal decentralization has largely been seen as important in making health committees more autonomous even though does not guarantee the performance of HFGCs.

Keywords: Effects, Health Facility Governing Committees, Functionality, Lower and Middle-Income Countries, Systematic Literature Review

2.1 Introduction

The Alma Ata Declaration of 1978 identified community participation in health service delivery as a critical component of improving Primary Health Care (PHC). It is advocated for providing opportunities for health service users to directly participate in the design, implementation, and assessment of healthcare facility operations, to improve healthcare responsiveness, sustainability, and efficiency (Muhanga and Mapoma, 2019; O'Meara *et al*., 2011). To incorporate communities in the planning, implementation, and evaluation of primary health care services, a variety of mechanisms have been developed by Lower and Middle-Income Countries (LMICs) (Abimbola, 2019). The introduction or adoption of Health Facilities Governing Committees (HFGCs), also known as Community Health Committees, Village or Ward Health Committees, was one of the mechanisms utilized to improve community engagement in primary health care facilities (McCoy *et al*., 2012). These HFGCs despite various terminologies used to name them in different countries are community governance structures made up of community members who are responsible for representing the community in the planning, implementation, and management of health service delivery in primary health care facilities. Since the 1980s, the HFGCs have been working in various Health Sector Reforms (HSR) contexts, depending on the country's distinctive path (Bossert, 1998; Kesale *et al*., 2021). Some countries have combined community participation with decentralization measures, whereas others have not. Following the establishment of these HFGCs, the global health community has been eager to learn whether or not the existing HFGCs have achieved the desired health outcomes.

The decentralized health system is defined as the transfer of major decision-making powers and responsibilities for health services such as planning, budgeting, and financial management from the central government or a large unit of local government to a smaller unit that is closer to the community (Jim,nez and Smith, 2005; Kesale, 2017; Kesale, 2016; Massoi and Norman, 2009). Decentralization refers to a variety of measures, including de-

concentration, in which authority and responsibility are transferred from the national level to regions or districts within the same ministry; Devolution, in which authorities and responsibilities are delegated to lower-level government structures; Delegation, in which semi-autonomous agencies are created to carry out functions that were previously controlled by the Ministry of Health; and Privatization, in which private owners assume responsibility and control (Abimbola, 2019; Kessy, 2014). Decentralization is adopted in the health sector to improve the performance of the health system, which improves the delivery of health services.

In the context of decentralization, it is widely accepted that community participation in primary health care facilities through various structures, such as HFGCs, can be functional enough in accomplishing their devolved functions and yield desired outcomes(Eliza and Oscar, 2018; Kessy, 2014; Roman *et al.,* 2017). The goal of incorporating community involvement into primary health care was to increase citizen participation in the design, execution, and assessment of health service delivery in institutions such that the services generated reflected community preferences and needs. As a result, community members are expected to provide input during the management and governance of health facilities to make decisions that address community health concerns and promote community health, albeit this may not be the case in all health facilities. Indeed, under decentralized reform, HFGCs composed of community representatives elected or chosen by their community are likely to have a significant impact on health service delivery. This is because decentralization provides HFGCs with more options (functions and powers) and creates a conducive environment for them to carry out their duties (Bossert, 1998; Bossert *et al*., 2015). As a result, the HFGCs are given crucial authority and decisions, such as revenue collection and expenditure, planning and administration of the health facility's performance. The notion is that by forming HFGCs made up of community members and decentralized with additional functions and decision-making capabilities to govern health facilities, the community will be better served. HFGCs are better positioned and have more discretion than the central government to make new and more innovative judgments that are locally focused and maximize people's preferences. Alma Ata's dedication to establishing community engagement is congruent with the decentralization concept.

Empirical research, on the other hand, reveals that implementing decentralization in primary health care institutions and devolving authority to lower-level governance structures may not inevitably influence community engagement or HFGCs functionality. As Abimbola (2019) and Bossert (1998) argue, agents devolved with discretionary powers and functions may choose not to exercise or take advantage of their devolved capabilities, continuing to behave and operate as they did before decentralization. As a result, certain agents, such as HFGCs,

may not effectively carry out or be functional in accomplishing their devolved powers and duties to achieve the desired health objectives. As part of community participation in health care delivery, HFGCs would be expected to use devolved authorities to manage and govern primary health facility operations.

Despite the adoption of community participation in health service provision, empirical evidence on the functionality of HFGCs under decentralization as a part of community participation at the primary health care facility is lacking. The present empirical evidence is based on a small number of case studies or countries, which do not reflect the reality of the functionality of HFGCs in improving health outcomes in a decentralized setting. Three studies, for example, looked at the empirical evidence of the impact of decentralization on health outcomes(Cobos Muñoz *et al*., 2017; McCoy *et al*., 2012; Tsofa *et al*., 2017). Many of the research looked at the impacts of decentralization on health outcomes as well as the impact of accountability measures. The flaw in these empirical studies is that they didn't look at the functionality or performance of HFGCs in a decentralized setting. Given the relevance of HFGCs in enhancing health system performance, a systematic review based on broader empirical research from Lower- and Middle-Income Countries is required to assess the effect of decentralization on the functionality of HFGCs.

2.2 Methods

A systematic literature review was conducted on empirical studies based on the protocols established by Cochrane Methods(Higgins et al., 2008) and guided by the criteria articulated by PRISMA for systematic review reporting in the field of health(Beller, 2013; Chandler and Hopewell, 2013). The protocol and PRISMA the following process to be indicated, data search strategy, selection process, quality assessment, Data extraction, Result, Data synthesis

2.2.1 Data Search Strategy

We conducted a literature search from the different databases such as PubMed, MEDLINE, JSTOR, Willey, Emerald Insight and Taylor and Francis to get empirical articles published from 2000 up to 2020. Article published between 2000 to 2020 was selected because many Lower and Middle-Income countries implemented decentralization in the 1990s, therefore by 2000 many countries were implementing it and the impact of decentralization started to be realized. A manual search was also conducted on different web pages to get evaluation reports from different institutions. The selected databases were chosen because they publish public administration contents therefore, they adequately offered the needed articles for this study.

The goal of this study was to see how decentralization affected the functionality and efficacy of Health Facility Governing Committees (HFGCs) in terms of enhancing health system outcomes. Because the amount to which powers are devolved to HFGCs varies by country under decentralization, this study looked at the functions of HFGCs in the context of the powers that have been devolved in the given country. These committees are responsible for guaranteeing the availability of critical medical equipment and pharmaceuticals, planning, budgeting, mobilizing and administering facility money, managing health personnel, and organizing communities to join community health funds, among other things. Since the term Health Facility Governing Committees is used differently in lower and middle-income countries, with some countries referring to them as health facility committees, community health committees, health users' committees, and village or ward committees, this study searched for articles using similar terms all terms amounting to community health committees. Words like "HFGC", "Village health committees" "community health committees" "effectiveness," "functionality," "performance," "impacts," "outcomes," "effects," "outputs" and "decentralization" were paired with terms like "effectiveness of health facility committees" or "performance of health facility governing committees" to find articles.

2.2.2 Selection process

All studies of various designs were eligible for the evaluation process if they met established inclusion and exclusion criteria. The following criteria were used to select eligible articles: the article had to be about health facility governing committees, (ii) it had to be original published articles or peer-reviewed articles, and (iii) it had to be conducted in lower and middle-income countries as defined by the World Bank (Fantom, 2016), (iv) written in English language (v) the study's goal was to determine the effectiveness, functionality, performance, or effects of the governing committee of a health facility on improving health outcomes. (vi) The factor of time (from 2000 to 2020). Papers that satisfied the criteria were chosen and subjected to quality control and data selection.

2.2.3 Quality Assessment

To assess the quality of the selected studies, the researchers used a variety of assessment tools or criteria. The procedure for a systematic review of the literature was used for quantitative investigations (Thomas *et al*., 2004) while for qualitative studies, the Critical Assessment Skills Program (CASP) was adopted https://casp-uk.b-cdn.net/wp-content/. The CASP indicators were utilized to choose which qualitative research should be included in the study, with 14 out of 29 qualitative studies matching the CASP requirements. The 14 studies chosen are those with a quality rating of more than 75% (high quality), of which 6 were chosen, and those with a rating of more than 50% but less than 75% (medium), of which 8 were chosen, and those with a rating of less than 50% (poor quality), of which 15 were not.

These two assessment tools assisted in ensuring that the selected studies were methodologically appropriate for the investigation, that biases were avoided, and that their flaws were addressed. After the quantitative study assessment, the indicators "strong," "moderate," and "weak" were utilized to represent the quality of the selected quantitative study.

2.2.4 Data extraction

We retrieved information about the functionality or performance of HFGCs in carrying out their devolved powers and responsibilities at the facility level in the context of decentralization from each selected paper. The extraction was directed by the inclusion criteria set forth in order to successfully extract relevant information for the aim of this study. As a result, papers published before 2000 and after 2020 were eliminated, leaving just papers published between 2000 and 2020. Then we looked at data from studies that looked at the functionality or performance of HFGCs in primary health care facilities exclusively (health centers, dispensaries, and health posts) that had been decentralized and given certain powers and responsibilities. This allowed information about a certain HFGC's responsibilities or tasks in a given facility to be extracted. We extracted information about the parameters influencing HFGC decentralized functionality or performance, as well as the health outcomes attained as a result of the HFGC functionality or performance, from each research.

2.3 Results

2.3.1 Included Studies

The course of the literature review in this study is depicted in Figure 1. The method began with a total of 602 articles and tittles being retrieved from various search engines, after which 25 articles were identified as duplicates from the 602 identified articles and titles, leaving the study with 575 articles and tittles. Relevant articles and titles about decentralization in health care provision were evaluated for relevance; we ended up with 229 articles and titles following the screening. After reading the abstracts to evaluate if they were relevant to the study topic, 151 papers were eliminated, leaving 78. The reasons for the deletion are listed above. After a careful analysis, 24 articles qualified for extraction since they satisfied the predetermined criteria.

Equation 1 Literature Search Flow Diagram

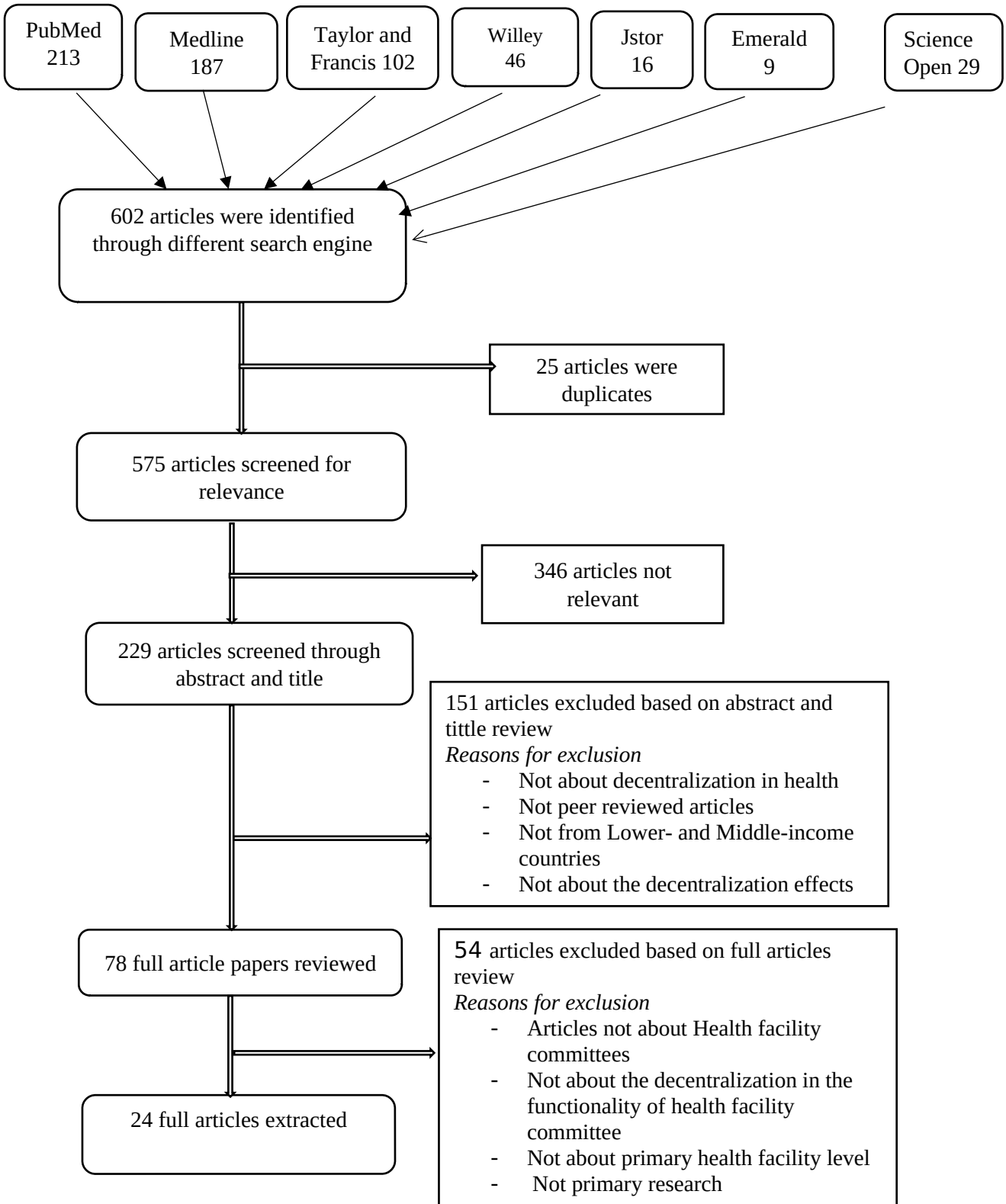

Figure 2.1: Literature Search Flow Diagram

2.4 Data Synthesis

The studies were divided into four categories: the first dealt with the membership of HFGCs in primary health care institutions, the second with the roles devolved to the HFGC as a result of decentralization, and the third with the roles devolved to the HFGC as a result of decentralization. The third category dealt with HFGC functionality in a decentralized environment, the fourth with the factors that influenced HFGC functionality, and the final category dealt with the effects of HFGC functionality on health service delivery. A meta-analysis was not performed in this investigation due to a number of limitations, including the research designs employed and the outcome measurement criteria used in each study. The quality assessment tool was adopted to ascertain the validity of the reviewed empirical studies since the instrument is recommended for covering empirical studies used in international development settings (Waddington *et al*., 2012)

Table 2.1: Summary of the studies on the effectiveness and effects of Health Facility Governing Committees on Health system performance

Author	Africa Region	Members of HFGC	Roles of HFGC	Functionality of HFGC	Factors affecting Functionality of HFGC	Health Outcomes
(Goodman *et al*., 2011)] Catherine Goodman., Antony Opwora., Margaret Kabare and Sassy Molyneux (2011) Health facility committees and facility management - exploring the nature and depth of their roles in Coast Province, Kenya	Kenya	**Committee members included the** o A health worker in charge as secretary o Between 8 and 18 community members. o The chair and the treasurer were chosen from the community members. o Most of the latter were farmers, though some were professionals such as teachers, and a few were community health workers	• oversee operations and management • To advise the community on matters • Articulate community interests • To facilitate a feedback process • To implement community decisions • Mobilize community resources • Raise funds Hire and fire subordinate staff	• Represent community • Oversee facility operations • Make final decision • Participate in outreach activities • Make final decision on the use of funds • An established good relationship with health workers • Participate in employing casual staff • Disciplining health workers	• Support from a higher level in training and resolving disputes • HFC allowance • introduction of fiscal decentralization through DFF • Availability of resources Negative • Lack of clarity of HFGC roles • less education	
Waweru *et al*., 2013 Are Health Facility Management Committees in Kenya are ready to implement financial management tasks: findings from a nationally representative survey	Kenya	- **Committee members included the** o A health worker in charge as secretary o Between 8 and 18 community members. o The chair and the treasurer were chosen from the community members. o Most of the latter were farmers, though some were professionals such as teachers, and a few	• Supervise and control the administration of the funds allocated to the facilities. • Open and operate a bank account at a bank • Prepare work plans based on estimated expenditures. • Keep basic books of accounts and records of accounts of the income, expenditure, assets, and liabilities of the facility • Prepare and submit certified periodic financial	•Determine how funds to be utilized •Raise issues, they have held in the community with facility staff •participate outreach activities •Sensitize the community on health matters •Raise funds •Participate in employing clerical staff • Participating in	• A strong relationship between HFGC and worker • difference between municipal and non-municipal in controlling facility banks accounts • selection and representation of members **Negative** • education level • lack of awareness of their roles	• Mixed

		were community health workers	and performance reports • Keep a permanent record of all its deliberations.	preparing annual facility plan	• allowances	
(Njoroge *et al*., 2019) Karuga RN, Kok M, Mbindyo P, Hilverda F, Otiso L, Kavoo D, *et al.,* (2019) "It's like these CHCs don't exist, are they featured anywhere?": Social network analysis of community health committees in a rural and urban setting in Kenya	Kenya	• local leaders, • health facility staff and lay community members	• Provide leadership, • oversight in the delivery of community health services, • promote social accountability and mobilize resources for community health	• We're not central actors in the exchange of health-related information. • Therefore, CHCs had little control over the flow of health-related information It emerged that CHCs were often left out in the flow of health-related information and decision-making, which led to demotivation	• Lack of information	
(Maluka and Bukagile, 2016)Stephen Oswald Maluka1* and Godfrey Bukagile2 (2016) Community participation in the decentralized district health systems in Tanzania: why do some health committees perform better than others?	Tanzania		• Discuss and pass health center plans and budgets • Identify and solicit financial resources • Oversee the facility management • Ensure delivery of healthcare services • Link community with the health facility • Articulate community interest • Mobilize the community to join community health insurance	• perceived to be useful in sensitizing community members on CHFs, • supervised construction and rehabilitation of the health facilities, • managed health facility bank accounts and Monitoring the provision of health services at the facility, including drugs and medical supplies.	• the financial incentive to the health facility committees • Managerial and leadership practices of the district health managers, including effective supervision and personal initiatives • Inadequate training and • low public awareness	

(Capurchande *et al*., 2015)Capurchande RD,Coene G, Roelens K, Between compliance and resistance: exploring discourses on family planning in Community Health Committees in Mozambique.	Mozambique	• CHCs are composed of voluntary members, termed family planning facilitators, who are selected at the grassroots level.	• Mobilizing and counseling users/clients to use Family planning services	Inconsistence functionality of committees among facilities	• Training • sociocultural background • differences in knowledge as well • geographical • location	Not beneficial
(Kilewo and Frumence, 2015)Emmanuel G. Kilewo and Gasto Frumence (2015) Factors that hinder community participation in developing and implementing comprehensive council health plans in Manyoni District, Tanzania Quality	Tanzania	• Community representatives • Health facility inchage • Private health services providers' representatives • Faith-based health provider's representatives • Village government representatives	• Participating in preparing health facility plan • role of facilitating the health facility Management Teams (HFMs) in planning and managing health initiatives in areas under them jurisdiction	Low participation of HFGCs in health Planning	• Low awareness of HFGC in participation in the planning process • Lack of financial resources allocated to support the implementation of HFGC activities • HFGC members lack management capacity • Lack of awareness of the roles and responsibilities of HFGC leads to poor participation in the development of CCHP Poor communication and information sharing • between CHMT and HFGC	
(Loewenson and Rusike,	Zimbabwe	•	• facilitate people in the area to identify their	• Drug availability	• Support from a higher level in	• Beneficial effects:

2004)Loewenson *et al* (2004) Assessing the impact of Health Centre Committees on health system performance			priority health problems, • plan how to raise their own resources, • use information from the health information system and from communities in planning and evaluating their work • assess the impact of the health interventions in	• Sufficient number of staff • Increased resource placement	training and resolving disputes • HFC allowance • introduction of fiscal decentralization through DFF • Availability of resources Negative • Lack of clarity of HFGC roles • less education	Improved drugs availability, sufficient number of staff and improved allocation of finances
(J. Falisse, 2020)Jean-Benoit Falisse a, L ´eonard Ntakarutimana (2020) When information is not power: Community-elected health facility committees and health facility performance indicators	Burundi	• Members are elected by and from among the Health facility catchment population.	• Mobilization, management and allocation of the resources of the HF to ensure optimal implementation of the activities • check the integrity of the health infrastructure, drugs and equipment planning the development of HFs (quality of and access to services) and community health activities	• Failed to make major decisions to manage health facility	• Training to members • Information's • Social-cultural factors • The context in which HFGC operated	• do not lead to visible improvements in terms of social • Accountability, HF management, and use of and access to HF services.
(Lodenstein *et al*., 2017)Elsbet Lodenstein 2017 Social accountability in primary health care in West and Central Africa: exploring the role of health facility committees	Benin, Guinea and congo	• Composed of health workers and community members	• Monitoring of the budget formulation • execution, the management of user fees, • the establishment of drug inventories and orders. • promote financial transparency of pricing	• They collect information about health challenges • Control and ensure availability of drugs prices • Manage facility finances • Manage	• HFC leadership and synergy with other community structures	•

			policies • Prevent extortion of patients and illegal drug sales. • Disciplinary measures. HFCs are • contribute to conflict resolution between • the community and health providers	performance of health workers • Provide feedback to the community • improved health worker presence, • the display of drug prices and replacement of poorly functioning health • Workers.		
(Mcmahon *et al*., 2017)Shannon A. McMahon 2017 "We and the nurses are now working with one voice": How community leaders and health committee members describe their role in Sierra Leone's Ebola response	Sierra Leone's			• They communicated Ebola-related messages to their peers, • enhanced provider understandings of community fears, • Advocated for community needs within the health system. • Enabling mechanisms that supported community activities included the dual orientation of health committee members as community-members and • health system-affiliate	• Financial or in-kind • Recognition of the government's limited human resource capacity to manage crises, • Recognition of the severity of Ebola, and • NGO supervision, -direction, and support Negative • inadequate supplies and resources, • criticism and distrust from their community, and • Concerns or misunderstandings about the purpose of a task. • Contact tracers, in	• Positively contributed to combating Ebola

					particular, highlighted that they were to receive weekly allowances but that this payment was irregular	
(Lodenstein *et al*., 2019)Elsbet Lodenstein (2019) "We come as friends": approaches to social accountability by health committees in Northern Malawi		• Composed of community representatives and facility staff	• bridging the communication gap between community and health staff, • inspection of facility conditions and drug stock, • formulating recommendations on facility equipment, • complaint management	• Monitored performance of health workers • Mediated Conflicts between health workers and patients • Reporting facility operations to the local authorities	• Committee capacities to judge health worker performance, • lack of clarity of roles and responsibilities • in upward and downward reporting processes	• Positive impacts on the performance of the facility staff
(J. B. Falisse *et al*., 2012)Falisse, J. B., Meessen, J. Ndayishimiye, and M. Bossuyt, "Community participation and voice mechanisms under performance-based financing schemes in Burundi	Burundi			• Conflict with facility staff • Poor relationship with the community • was not able to monitor funds	• Members were not aware of their roles •	•
(Waweru *et al*., 2016) Tracking implementation and (un)intended consequences: A process evaluation of an innovative peripheral health facility financing mechanism in Kenya	Kenya	• Community representatives	•	• Funds reach facilities on time • Funds are well monitored by the committee • Health workers are monitored by the committees	• Deepened decentralization	• Patient satisfaction improved • Proper and timely utilization of funds, Health workers are well monitored

(Ogbuabor and Onwujekwe, 2018)Daniel C. Ogbuabor and Obinna E. Onwujekwe (2018) Implementation of free maternal and child healthcare policies: assessment of the influence of context and institutional the capacity of health facilities in South-east Nigeria, Global Health Action	Nigeria			• HFCs are not involved in identifying eligible users of free care and managing free care refunds •	• health facilities lacked service charters and complaint boxes • HFCs lack the legislative framework for the effective and efficient discharge of their functions	•
(Oguntunde *et al*., 2018)Olugbenga Oguntunde , Isa M. Surajo, Dauda Sulaiman Dauda, Abdulsamad Salihu, Salma Anas-Kolo and Irit Sinai5 (2018) Overcoming barriers to access and utilization of maternal, newborn and child health services in northern Nigeria: an evaluation of facility health committees	Nigeria	• one facility health provider and • 12-15 community residents. • Members represent all ethnic, religious, age, and gender groups who receive services in the facility. • Residents of hard-to-reach locales in the facility catchment area are • also included	• Find solutions to problems that people report about health facilities, as well as with • mobilizing the community to improve utilization of maternal and child health services, • Sensitizing men and women in the community about the importance of obtaining maternal and child health services in the health facility.	• Mobilize community • Facilitate renovation of the facility • Provide linkage with communities and health workers • Ensured availability of medicine and medical equipment		• Facility health committees appear to have a positive influence on the quality of maternal and child health services • in the selected facilities
(Ngulube *et al*., 2004) Governance, participatory mechanisms and structures in Zambia's health system: An assessment of the impact of Health Centre	Zambia	•	• Participate in planning and budgeting • Monitor expenditure • Mobilize communities to participate in health matters	• Engaged in planning and budgeting • Monitored expenditure and revenue collection • Sensitizing community on health		Beneficial effects • Improved quality of service provision, improvement in monitoring of facility funds

Committees (HCCs) on equity in health and health care Centre for Health			• Discussing issues relating to the health of the population			
Mabuchi *et al* (2017) Pathways to high and low performance: factors differentiating primary care facilities under performance-based financing in Nigeria	Nigeria	•	•	• Better equipped facilities • Motivated staff • A good relationship with the community	• Contextual factors (competition and access) • Community engagement and support Performance and staff management	Beneficial effects: • Facilities are better equipped, and good management of health workers
(Gurung *et al.*, 2018)Gagan Gurung1, Sarah Derrett2, Philip C. Hill3 and Robin Gauld Nepal's Health Facility Operation and Management Committees: exploring community participation and influence in the Dang district's primary care clinics	Nepal	• clinic manager, • the village development committee chairperson, • elected members including school teachers, • female community health volunteers, • at least one of each of the following: Dalit (a marginalized caste), Janajati (an ethnic group), and • female representatives (Gurung	• To manage funds, human resources, and health programs, based on the principle of health sector decentralization • Infrastructure Local resources • Management of local staff • Management of permanent staff • Financial management • Health needs assessment	The depth of participation seems low • HFMC members did not consult with the community in a regular or systematic way, • There was no practice of providing feedback to the community.	• no democratic selection processes • HFMCs were influenced and captured by powerful elites.	
(Kamble *et al*., 2018)Kamble RU, Garg BS, Raut AV, Bharambe MS. (2018) Assessment of functioning of village health nutrition and sanitation committees in a District in	India	• Community health workers (called Accredited Social Health Activists (ASHAs)), • village nutrition and child development workers, • Auxiliary Nurse	• Conduct local health planning, and monitor the Anganwadi system and government health services. • Utilize the received facility funds • Preparation of village	• Low performing their duties and responsibilities • But at least Participate in preparing facility plan • Approved fund	• Lack of Committee meetings with full attendance	little success in improving local health, sanitation, or nutrition

Maharashtra. Indian J Community Med		Midwives (ANMs), • Members of the locally elected government (called the gram panchayat), and • Interested citizens.	health plan • Preparation of village health register • organization of meetings and various health-related activities like health • camps, household survey, cleaning	utilization Organized sensitization program		
(Scott *et al*., 2017)Scott K, George AS, Harvey SA, Mondal S, Patel G, Ved R, et al. (2017) Beyond form and functioning: Understanding how contextual factors influence village health committees in northern India	India	• Community health workers (called Accredited Social Health Activists (ASHAs)), • village nutrition and child development workers, • Auxiliary Nurse Midwives (ANMs), • Members of the locally elected government (called the gram panchayat), and • Interested citizens.	• Conduct local health planning, and monitor the Anganwadi system and government health services. • Utilize the received facility funds • Preparation of village health plan • Preparation of village health register • organization of meetings and various health-related activities like health • camps, household survey, cleaning	most • held monthly meetings, • identified a wide range of issues that required improvement, sought to address them largely by appealing to government officials	• Ingrained but negotiated social hierarchies; • Demoralizing resource and capacity deficits in government services undermining VHSNC legitimacy; • Contested VHSNC intersectoral authority despite widespread intersectoral needs and responsibility; • Fragmented and opaque accountability for supporting the VHSNC; • Underpinning power politics; and Parallel systems.	• little success in improving local health, sanitation or nutrition
(Singh and Purohit,	India	• Community health	• Conduct local health	• Failed to	• gaps in	• little success in

2012)Rajpal Singh (2012) Limitations in the functioning of Village Health and Sanitation Committees in a North Western State in India		workers (called Accredited Social Health Activists (ASHAs)), • village nutrition and child development workers, • Auxiliary Nurse Midwives (ANMs), • Members of the locally elected government (called the gram panchayat), and Interested citizens.	planning, and monitor the Anganwadi system and government health services. • Utilize the received facility funds • Preparation of village health plan • Preparation of village health register • organization of meetings and various health related activities like health camps, household survey, cleaning	accomplish their duties such as • Raising awareness • Participating in planning Approving expenditure	composition, formation and • The problems relating to the selection of members, • their training, • supportive supervision, • proper reporting and • responsive feedback mechanism	improving local health, sanitation, or nutrition
(Madon and Krishna, 2017)Shirin Madon and S. Krishna (2017): Challenges of accountability in resource-poor contexts: lessons about invited spaces from Karnataka's village health committees	India	• Community health workers (called Accredited Social Health Activists (ASHAs)), • village nutrition and child development workers, • Auxiliary Nurse Midwives (ANMs), • Members of the locally elected government (called the gram panchayat), and Interested citizens.	• Conduct local health planning, and monitor the Anganwadi system and government health services. • Utilize the received facility funds • Preparation of village health plan • Preparation of village health register • organization of meetings and various health related activities like health camps, household survey, cleaning	• mobilize community enrollment in the facility • Raising health awareness • Deciding on how to use funds Planning and monitoring village health		Moderately improved health service delivery
(Srivastava *et al*., 2016)Aradhana Srivastava1 2016 Are village health sanitation and nutrition committees fulfilling their roles for	India	• Community health workers (called Accredited Social Health Activists (ASHAs)), • village nutrition and child development	• Maintain data on the nutritional status of women and children, • Refer severely malnourished children to rehabilitation centers, • Prepare the nutritional	• Committees perform few of their specified functions for decentralized planning and action-conducting	• irregular meetings, • members' limited understanding of their roles and responsibilities, • restrictions on	•

decentralized health planning and action? Mixed methods study from rural eastern India		workers, • Auxiliary Nurse Midwives (ANMs), • Members of the locally elected government (called the gram panchayat), and interested citizens	components of the village health plan, and • Educate community members on nutritional issues. • Supervise Anganwadi Centres (AWCs), which are village-level nutrition and pre-school education centers, • Monitor the Village Health and Nutrition Day (VHND)	health awareness activities, • Supporting medical treatment for ill or malnourished children and pregnant mothers. Monitored drug availability with community health workers.	planning and fund utilization, and • Weak linkages with the broader health system.	
Author	South America Region	Members of HFGC	Roles of HFGC	Functionality of HFGC	Factors affecting Functionality of HFGC	Health Outcomes
(Iwami and Petchey, 2002)Iwami and Petchey (2007) A CLAS act? Community-based organizations, health service decentralization and primary care development in Peru	Peru			Committees were able to make major decisions such as the utilization of funds and linking community with a facility		the improved user of satisfaction

The Composition of Health Facility Governance Committees under decentralization

Many HFGCs were discovered to be made up of community representatives, reflecting community participation in the management and administration of health service delivery in many decentralized limits. The importance of community participation is mirrored in the composition of HFGCs, with community representatives accounting for the majority of HFGCs in the research examined. The following research, for example, has highlighted community representatives in HFGCs (Capurchande *et al*., 2015; Falisse, 2020; Goodman *et al*., 2011; Kamble *et al*., 2018; Khan *et al*., 2021; Kilewo and Frumence, 2015; Madon and Krishna, 2017; Mcmahon *et al*., 2017; Oguntunde *et al*., 2018; Scott *et al*., 2017; Waweru *et al*., 2013). Health facility In charges or health facility staff have been mentioned also to be a member of the HFGCs who in many committees become HFGC secretaries (Kilewo and Frumence, 2015; Maluka and Bukagile, 2016; Mcmahon *et al*., 2017; Ngulube *et al*., 2004; Oguntunde *et al*., 2018; Scott *et al*., 2017). Village governments or members of the local government in some countries are included in the HFGCs as has been highlighted by the governing guidelines (Gurung et al., 2018; Kilewo and Frumence, 2015; Maluka and Bukagile, 2016; Scott *et al*., 2017; Srivastava *et al.*, 2016). Gender representation has not been left out in the composition of HFGCs in many countries, this is evidenced by the special requirement of gender representation among community representatives in the HFGCs (Gurung et al., 2018; Kilewo and Frumence, 2015; Maluka and Bukagile, 2016; Srivastava et al., 2016; Ved et al., 2018).

The Roles and powers of Health Facility Governing Committees under decentralization

The HFGCs were found to have been devolved with many responsibilities and roles to fulfil in the course of governing and administering primary health facilities, according to the extract's investigations. Some of the responsibilities include managing and overseeing facility operations (Goodman *et al.*, 2011; Maluka and Bukagile, 2016; Njoroge *et al*., 2019), to articulate community interest and address community health matters (Falisse, 2020; Goodman *et al*., 2011; Lodenstein *et al.*, 2019; Maluka and Bukagile, 2016; Oguntunde *et al*., 2018; Scott *et al*., 2017), Participating in planning and budgeting (Goodman e*t al*., 2011; Lameck, 2017; Lodenstein *et al.*, 2017; Maluka and Bukagile, 2016; Ngulube *et al.*, 2004; Scott *et al.*, 2017; Srivastava *et al*., 2016; The *et al.,* 2016). Other common functions of HFGCs are to mobilize facility resources such as funds and other materials (Goodman *et al*., 2011; Lodenstein *et al*., 2019; Maluka and Bukagile, 2016; Ngulube *et al*., 2004; Njoroge *et al*., 2019; Oguntunde *et al*., 2018), managing the performance of health workers including hiring and firing (Goodman *et al*., 2011; Gurung *et al*., 2018; Maluka and Bukagile, 2016) and facilitate feedback to community and health facilities(Goodman *et al*., 2011; Lodenstein *et al*., 2017, 2019; Maluka and Bukagile, 2016; Ngulube *et al*., 2004)**.**

The Functionality of Health Facility Governing Committees in the Decentralized Health System

The extracts reviewed have highlighted the functionality of HFGCs as a means of facilitating community participation in the decentralized context. The results indicate that the functionality of HFGCs in many countries is still very low and below the expectation of pioneers of health reforms even though in other countries HFGCs are functioning well. Some studies which have shown that HFGC functionality under decentralization context is very limited are *(Capurchande et al., 2015; Falisse, 2020; Falisse et al., 2012; Gurung et al., 2018; Kamble et al., 2018; Kilewo and Frumence, 2015; Njoroge et al., 2019; Ogbuabor and Onwujekwe, 2018; Singh and Purohit, 2012; Srivastava et al.*, 2016). On the other hand, other studies have found that HFGCs are functioning very well and accomplishing their duties and responsibilities to a large extent (Goodman *et al*., 2011; Iwami and Petchey, 2002; Lodenstein *et al*., 2017, 2019; Loewenson and Rusike, 2004; Madon and Krishna, 2017; Maluka and Bukagile, 2016; Mcmahon *et al*., 2017; Ngulube *et al*., 2004; Oguntunde *et al.*, 2018; Scott *et al*., 2017; Waweru *et al*., 2013). Indeed the studies have highlighted some of the roles which are performed well by the majority of the HFGC such as engagement in the planning and budgeting process (Goodman *et al.*, 2011; Iwami and Petchey, 2002; Maluka and Bukagile, 2016; Ngulube *et al*., 2004; Waweru *et al*., 2013, 2016). Monitored performance of health workers (Lodenstein *et al*., 2017, 2019; Mcmahon *et al*., 2017; Oguntunde *et al*., 2018), finding solutions to the community health problems (Maluka and Bukagile, 2016; Mcmahon *et al*., 2017; Oguntunde *et al*., 2018; Scott *et al*., 2017). Other HFGCs were doing well in mobilizing and sensitizing communities on health programs (Maluka and Bukagile, 2016). Meanwhile, HFGC has been found to be ineffective in other circumstances, failing to engage in budgeting and planning, linking community and health facilities, convening HFGC meetings, and making other significant decisions that could improve health service delivery (Falisse, 2020; Falisse *et al.*, 2012; Gurung *et al.*, 2018; Kamble *et al*., 2018; Njoroge *et al*., 2019).

Factors Influencing the Functionality of Health Facility Governing Committees under Decentralization

A variety of factors have been linked to the functionality of the HFGCs in developing nations' decentralized health systems. These variables are linked to both positive and bad functionality in various ways. The highlighted factors found to be associated with HFGCs functionality are HFGC membership allowance (Goodman *et al*., 2011; Maluka and Bukagile, 2016; Mcmahon *et al*., 2017; Waweru *et al*., 2013), Awareness on the HFGC roles and powers (Falisse, 2020; Falisse *et al.*, 2012; Goodman *et al*., 2011; Lodenstein *et al.*, 2019; Loewenson and Rusike, 2004)], introduction of fiscal decentralization (Goodman *et al*., 2011; Kilewo and Frumence, 2015; Waweru *et al*., 2013). Other factors are Training to committees

(Capurchande *et al*., 2015; Falisse, 2020; Singh and Purohit, 2012), availability of resources (Goodman *et al*., 2011; Kilewo and Frumence, 2015; Maluka and Bukagile, 2016; Waweru *et al*., 2013), context in which the facility operate (Falisse, 2020; Mcmahon *et al*., 2017; Ogbuabor and Onwujekwe, 2018; Singh and Purohit, 2012; Srivastava *et al.*, 2016). Furthermore, social norms, leadership, HFGC selection and composition, and even the ways of recruiting members were found to be linked to HFGC functionality.

2.5 Discussion

In Lower- and Middle-Income Countries, expanding decentralization in primary health care institutions is proposed as a foundation for improving community engagement in the management and control of health service delivery. Indeed, decentralization is claimed to give community health structures like HFGCs considerable powers and functions, empowering them and increasing the depth of engagement in boosting health service delivery at the facility level. This is in line with the Alma Ata Declaration's aim of community participation in the design, implementation, and administration of their health care. Therefore, it’s expected that decentralization would positively influence the functionality of HFGCs and be able to deliver their mandates. To determine the functionality of HFGCs in the decentralized health system in primary health care, we did a systematic literature review. 24 studies were reviewed from 13 countries in 3 regions. linked matters relating to the functionality of HFGCs were assessed including the roles of HFGCs, the membership of the HFGCs, the functionality of HFGCs, the factors influencing the functionality of HFGC and the effects of HFGCs on health outcomes under decentralization. In a decentralized setting, we discovered functionality inconsistency among HFGCs in lower- and middle-income countries, with the majority of HFGCs having limited functionality even after decentralization.

The study discovered that HFGCs in many nations from various locations, such as Asia, Africa, and South America, had similar compositions, with community representatives and other government staff in all of them. These committees have found that the bulk of their members come from communities with few government officials, such as village or local government representatives, and facility employee representatives, to reflect the community. This means that the HFGC was created to increase community participation in defining health service delivery and to be responsive to community needs and preferences. The survey also discovered that the majority of HFGC roles are similar across countries and locations. In many countries, the role of the HFGC is to connect communities with health facilities, participate in planning and budgeting, approve facility expenditure, mobilize and sensitize communities about various health programs, and manage health worker performance, including hiring and firing some clerical staff. Other responsibilities include directing facility administration, managing health facility finances, discussing and addressing

community health concerns, and managing health facility finances.

Decentralization of powers and functions to HFGCs at the primary health care facility level does not guarantee effective HFGC functioning or increased community participation at the facility level, according to the study's findings. This is because, in many nations, HFGCs have been shown to have a variety of performances in their decentralized roles. After decentralization, it was envisaged that HFGC would be able to carry out its tasks and responsibilities more effectively and have an impact on health service delivery. However, when it comes to reality, the results show that this isn't the case. This is in line with Bossert (1998) belief that giving grassroots organizations more decision-making power does not guarantee that change will occur. Many HFGCs have discovered that various circumstances are preventing them from realizing their full potential. For example, HFGCs fail to fulfil their responsibilities because they are unaware of the scope of their responsibilities and powers, while others are working with insufficient resources, lack of support from higher levels, and small committee composition. Allowance to members of the HFGCs has been found to be critical in encouraging them to carry out their responsibilities, even though members declare that they are working freely for the benefit of the community.

The "allocative efficiency" principle states that because of the information advantage that sub-national institutions or facility level institutions have over the national government, they can improve health outcomes through proper resource allocation. However, the situation in some health facility committees is a little different. These committees have been proven to have fewer effects on the performance of the health system than expected, some of which contradict the allocative efficiency thesis. The performance variances or efficacy of health facility committees in low- and middle-income nations can be explained by a variety of factors. The decentralization environment that different lower and middle-income nations have experienced or implemented is one key influence.

2.6 Conclusion

Decentralization in the health system promised the empowerment of subnational health institutions, which would be particularly effective in carrying out their tasks in enhancing primary health care outcomes. However, reality differs from assumptions, as many studies have shown that decentralization alone cannot improve health service delivery at the primary health care facility level through influencing community engagement and the functionality of community governance structures such as HFGCs. Instead, the setting in which HFGCs function, as well as the adoption context for decentralization, are critical to achieving the benefits of HFGCs and decentralization in general.

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Author Contribution

Anosisye Kesale Conceptualised, wrote the introduction, methodology and searched the literature and did the analysis. Mikidadi Muhanga participated in writing the manuscript, methodology, data analysis, discussion and supervision. Christopher Mahonge engaged in conceptualization, methodology, data collection, data analysis and discussion

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None of the authors have any competing interest

Ethics and Consent

Not Applicable

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Paper Context

Governing committees for health facilities were formed to encourage community participation in the delivery of health services. Decentralization is thought to have a significant impact on the HFGCs' ability to govern service delivery. The findings reveal that HFGCs have promising effects, despite the fact that they are still far from fulfilling their full potential. These committees should be capacitated in their tasks and powers and given full autonomy in order to realize their full potential.

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CHAPTER THREE

3.0 THE FUNCTIONALITY OF HEALTH FACILITY GOVERNING COMMITTEES AND THEIR ASSOCIATED FACTORS IN SELECTED PRIMARY HEALTH FACILITIES IMPLEMENTING DIRECT HEALTH FACILITY FINANCING IN TANZANIA: A MIXED-METHOD STUDY

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Abstract

In Lower and Middle-Income Countries, decentralization has dominated the agenda for reforming the organization of service delivery (LMICs). The fiscal decentralization challenge is a hard one for decentralization. As they strive to make decisions and use health facility funding, primary healthcare facilities encounter the obstacles of fiscal decentralization. LMICs are currently implementing fiscal decentralization reforms to empower health facilities and their Health Facility Governing Committees (HFGCs) to improve service delivery. Given the scarcity of systematic evidence on the impact of fiscal decentralization, this study examined the functionality of HFGCs and their associated factors in primary health care facilities in Tanzania that were implementing fiscal decentralization through Direct Health Facility Financing (DHFF). To collect both qualitative and quantitative data, a cross-sectional approach was used. The research was carried out in 32 primary health care facilities in Tanzania that were implementing the DHFF. A multistage sample approach was utilized to pick 280 respondents, using both probability and nonprobability sampling procedures. A structured questionnaire, in-depth interviews, and focus group discussions were used to gather data. The functionality of HFGCs was determined using descriptive analysis, and associated factors for the functioning of HFGCs were determined using binary logistic regression. Thematic analysis was used to do qualitative research. HFGC functionality under DHFF has been found to be good by 78.57%. Specifically, HFGCs have been found to have good functionality in mobilizing communities to join Community Health Funds 87.14%, participating in the procurement process 85%, discussing community health challenges

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81.43% and planning and budgeting 80%. The functionality of HFGCs has been found to be associated with the planning and budgeting aspects p-value of 0.0011, procurement aspects p-value 0.0331, availability of information reports p-value 0.0007 and Contesting for HFGC position p-value 0.0187. The study found that fiscal decentralization via DHFF increases the functionality of HFGCs significantly. As a result, the report proposes that more effort be placed into making financial resources available to health facilities.

Keywords: Functionality, Health Facility Governing Committees, Fiscal Decentralization, Primary Healthcare Facilities, Lower-Middle Income Countries, Community Participation

3.1 Introduction

In all countries, community participation in primary health care (PHC) is essential for achieving excellent health and people's well-being (Gurung *et al.*, 2018b; WHO-UNICEF, 1978). As a result, community participation in the design, execution, and monitoring of health service delivery at primary health care institutions is essential for achieving excellent health, among other things (PHC) (Kessy, 2014). Decentralization initiatives in Lower and Middle-Income Countries (LMICs) allowed communities to participate in governing and administering primary health care delivery. Community governance structures known as Health Facility Governing Committees (HFGCs) were created to govern decentralization initiatives in Lower and Middle-Income Countries (LMICs) allowing communities to participate in governing and administering primary health care delivery. Community governance institutions called Health Facility Governing Committees were created to represent communities in the governance and management of primary health care facilities (Kesale, 2016; McCoy *et al*., 2012; McNatt *et al*., 2014). The newly formed HFGCs are assigned specific responsibilities and powers in the administration of primary healthcare facilities (Mabuchi *et al*., 2018; Muhanga and Malungo, 2018). Following that, LMICs have continued to pursue reforms such as fiscal decentralization to empower and strengthen community engagement, or the use of HFGCs to improve health service delivery at primary health care institutions(Kapologwe *et al*., 2019). It is considered that the more empowered and autonomous HFGCs are, the more likely they are to carry out their delegated obligations, hence improving the health system's responsiveness to community needs and preferences (Cobos Muñoz *et al*., 2017; McCoy *et al*., 2012). Therefore, HFGC's functionality in this context entails the ability of the HFGCs to accomplish their assigned functions or duties and responsibilities.

In theory, decentralizing governance and control of health service delivery to user committees such as HFGCs improve service delivery and establish a link between health care professionals and communities (Mabuchi *et al*., 2018; Njoroge *et al.*, 2019). However

empirical studies suggest that achieving enhanced users committee's participation in governing and managing health service delivery can be very complex (Ramiro *et al*., 2001). Several issues related to the complexity of having effective and functional user committees or HFGCs in primary health care institutions have been identified in the literature. Country context and nature of decentralization undertaken by each county are some of the cited reasons for ineffective HFGCs in primary health care (Bjorkman and Svensson, 2009; Ramiro *et al*., 2001). For instance, Abimbola *et al.* in Nigeria HFGCs were found to be underperforming in their roles because some members were unaware of their responsibilities and had the insufficient financial capacity and ability to manage facility resources *(Abimbola et al.*, 2016). Ved *et al.* suggest that in India community participation through village health, sanitation and nutrition committees are not functional because they are not aligned with decentralized government (Ved *et al*., 2018). To unlock the HFGCs functionality gaps, the literature suggests the implementation of full decentralization (fiscal, political, and administrative) at primary health care facilities (Meyer *et al*., 2017; Sakyi *et al.*, 2011; Shayo *et al*., 2012). This stems from the fact that fiscal and political decentralization provides an atmosphere in which HFGCs can use their powers and fulfill their mandates. This is reinforced by the empowerment framework, which says that an agency and opportunity structure influences an individual's or group's ability to make effective decisions. The ability of an individual or group, such as HFGC, to make a meaningful decision that is influenced by their age, material ownership, abilities, experience, and educational level is referred to as agency. Opportunity structure refers to the formal or informal setting in which individuals or groups function, such as fiscal decentralization, which is determined by norms, the availability of funding, availability rules, and regulations (Alsop and Heinsohn, 2005; Raich, 2005). Currently, some LMICs are implementing fiscal decentralization through various arrangements in primary health facilities among other things to empower and improve HFGCs' functionality.

In Tanzania, HFGCs were established in 1999 as part of Health Sector Reforms (HSRs) to increase community involvement in the administration and management of primary health care facilities (Kapologwe *et al*., 2019). These HFGCs are made up of members of the community who are either elected or appointed by their peers, civil society, and private health providers. The following functions are delegated from these HFGCs: Participate in the development of facility plans and budgets for the management of facility income, expenditures, and performance. Similarly, to gather funds for construction and maintenance management. Furthermore, discussing and addressing the community's concerns, as well as rallying the community to participate in the improved Health Community Fund (Kapologwe *et al*., 2019; Kapologwe *et al*., 2020). However, prior to 2018, empirical evidence suggests that HFGCs performed poorly in carrying out their duties (Bakalikwira *et*

al., 2017; WHO, 2015). For instance, Maluka *et al and* Kamuzora *et al.*found that implementation of decentralization in the district was offering only a tiny number of local elites, particularly medical professionals, were offered powers and were allowed to participate in decision making, leaving community people and other stakeholders powerless (Kamuzora *et al*., 2013; Maluka *et al.*, 2011). In other research from Tanzania, low funding, lack of fiscal autonomy, late transfer of funds to the facility, and a lack of community participation in planning were identified as impediments to decentralization at primary health care facilities (Boex *et al*., 2015; Frumence *et al.*, 2013; Kilewo and Frumence, 2015; WHO, 2015). To address these issues, Tanzania's government implemented Direct Health Facility Financing (DHFF) to increase fiscal decentralization at primary health care facilities and allow more community/HFGC and service providers to participate in the governance and management of their health facilities at the facility level.

3.1.1 The Introduction of Health Facility Financing in Tanzania

In 2017/18 by introduced the Direct Health Facility Financing arrangement in all public primary health facilities. The DHFF was introduced to improve the performance of the primary health care system (Kapologwe *et al*., 2019). Under the DHFF arrangement, intergovernmental transfers for health and other funds such as Users' fees, funds from insurance schemes and development partners are directly deposited to the health facility bank accounts. The DHFF arrangement empowers service providers' and HFGCs' autonomy to plan, budget and manage facility finances to improve health services delivery (Kapologwe *et al*., 2019).

The main goal of the DHFF implementation in Tanzania was to address HFGC functionality issues such as restricted budgetary autonomy and powers, among other factors. However, there have been few studies undertaken in Tanzania to investigate the functional condition of HFGCs in the setting of DHFF. Studies on DHFF have focused on the prospect and challenges of its implementation as well as the impact of DHFF on financial management (Kajuni and Mpenzi, 2021; Kesale *et al*., 2021; Mwakatumbula, 2021). Given the limitations of previous studies in informing about the status of HFGCs in carrying out their given powers and responsibilities in the context of the DHFF, this study was designed to evaluate the functioning of HFGCs in Tanzanian primary health care facilities implementing the DHFF. The study is essential because the findings may be beneficial in establishing a link between fiscal decentralization empowerment and its impact on HFGCs' functioning. The findings can undoubtedly assist other developing nations in replicating fiscal decentralization in primary health care institutions, whether through DHFF or otherwise.

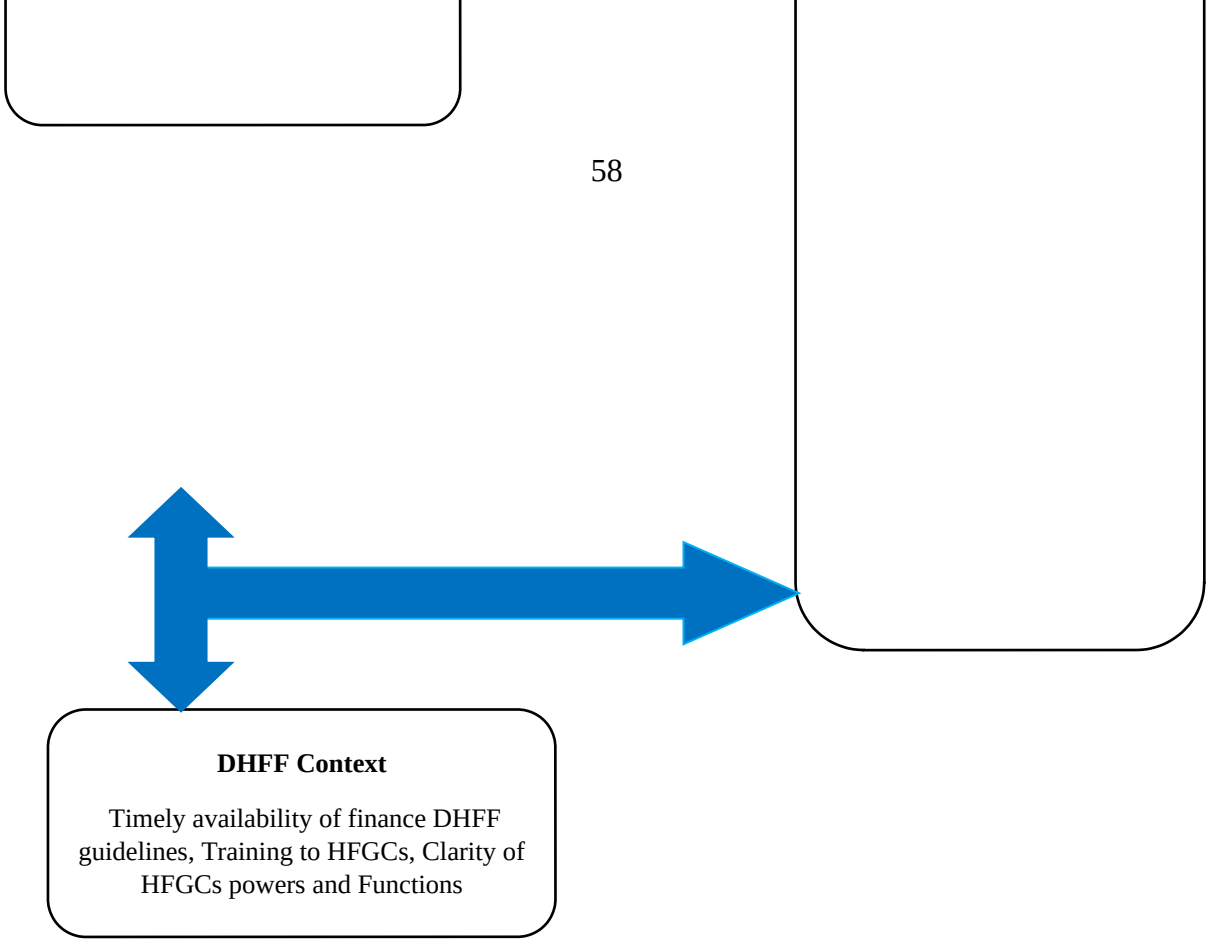

Figure 3.1: Conceptual Framework

Figure 1 depicts the connection between the properties of HFGCs and the DHFF context, as well as its impact on HFGC functionality. Figure 1 implies that the functionality of HFGCs is determined by the qualities of its members, such as their education level, experience, occupation, leadership, selection, and composition. The fiscal decentralization context (DHFF) in which HFGCs operate creates a favourable setting for them to carry out their delegated tasks. The DHFF is expected to empower HFGCs by providing prompt access to funding, standards for using finance, and training for HFGCs on their roles and financial management. In addition, the DHFF framework is intended to explain HFGC's powers and mandates as they carry out their tasks and obligations. As a result of the DHFF empowerment, the HFGC's ability to carry out its responsibilities will be enhanced, and health service delivery at their facilities will improve.

3.2 Methods and Materials

A cross-sectional design was employed in which both qualitative and quantitative data were collected simultaneously. The study was conducted between February and May 2021 in all four regions.

3.2.1 Sample size and sampling procedure

This study used a total sample size of 280 respondents. The sample size for this investigation was determined using a four-stage multistage cluster sampling process. Because the study encompassed geographically separated areas and face-to-face data collection was essential, multistage cluster sampling was used. The sample criteria were based on the Ministry of Reginal Administration and Local Government's Star Rating

Assessment of all primary health facilities in Tanzania, which was completed in early 2018. Tanzania's government implemented a star rating system to assess the performance of primary health care facilities, including the functionality of HFGCs. The assessed primary health facilities and their HFGC were ranked to determine the low and high-performing health facilities and HFGCs (Yahya, Mohamed, 2018). Star rating assessment of 2017/18 has been taken as a baseline because it is in the same year DHFF was introduced (Lodenstein *et al*., 2019; McCoy *et al*., 2012).

Table 3.1: Sampling process and sampling techniques

Stage	Respondent	Sampling procedure	Inclusion criteria
First stage	Four (4) regions selected Kilimanjaro, Mbeya, Ruvuma and Songwe	• Purposive	Performance of the region in star rating assessment, Zonal representation
Second	8 LGAs selected; Two	• Purposive	Performance of the

Stage	LGAs from each region selected in stage one		LGAs in star rating assessment, nature of the LGA (Urban and Rural),
Stage Three	32 health facilities were selected from all (8) councils. 2 health centers and 2 dispensaries from each LGA because they all implement DHFF	• Stratification of health facilities into Health centers and Dispensaries • Purposive selection of health centers and dispensaries	Performance of health facility (A good and poor performing health center and dispensary), Location of the facility within the LGA (Diversity)
Stage Four	280 HFGC members; 9 members from each selected health facility	• Proportion sampling selection of HFGC members	members of the HFGC

At stage four, the representatives from HFGCs were obtained by applying the proportion sampling technique as proposed by Buddhakulsomsiry and Israel (Buddhakulsomsiri and Parthanadee, 2008; Israel, 2012), the formula assumed 95% confidence of level and P at 0.5. therefore, according to the techniques, the size of HFGCs members required was 280. Then the number of HFGC members from each selected health facility was determined by applying the proportional sampling technique as used by Pandev (Pandey et al., 2008) in which 9 HFGC members were supposed to be selected from each HFGC. The total simple size respondents (response) from all health facilities for this study was 280.

3.2.2 Qualitative Participant Recruitment and Selection Criteria

Qualitative recruitment of participants was done purposively. The participants who were involved in the interviews and FGDs were selected based on their ability to provide relevant information about the functioning of the HFGCs under DHFF and the depth of their roles in the HFGCs. Non-HFGC participants were excluded from this study. Therefore, HFGC chairpersons were purposely selected for interviews and members of HFGC were purposively selected for FGDs. The FGDs guide was composed of 11 questions which were all about the governance of HFGC and functions of HFGCs. A total number of 14 interviews were conducted with HFGCs chairpersons and 13 FGDs were conducted with the HFGCs members composed of 6 to 9 participants. The number of 14 interviews and 13 FGDs were obtained after reaching the saturation point. Saturation was reached when interviewers and FGD participants kept providing similar responses therefore no new information was added through the interview.

3.2.3 Data Collection

3.2.3.1 Quantitative Data Collection

A closed-ended structured questionnaire based on specific HFGC functions was used to acquire quantitative data from each selected member of HFGCs. Open Data Kit was used to construct the data gathering software (database) (ODK). After that, all the data was entered into the ODK. A mobile data collecting (MDC) quantitative approach was applied to collect data. Data was collected via mobile phones and then transmitted to a central server. Four research assistants participated in a three-day training session on mobile data collection skills and methodologies, which was followed by pre-testing of the skills in facilities outside of the study area. The ODK platform was used to send the acquired data to the researcher. All selected facilities had GPS coordinates as part of quality control, thus all research assistants used GPS-enabled tablets. A total of 280 out of 288 HFGCs responded to the survey.

3.2.3.2 Qualitative Data collection

In-depth interviews with HFGC chairpersons and Focus Group discussions (FGDs) involving all selected HFGC members were used to collect qualitative data. Before beginning data collecting, research assistants received training on the interview and focus group guides. Before heading to the study region, the qualitative data collection tools were tested. The interview outline included 21 questions about HFGC's functionality and governance. The 11 questions in the FGDs guide were all regarding the governance of HFGCs and their functions. The HFGC chairperson's interviews involved questions like what main functions of HFGCs are, indeed Chairpersons were required to explain how they have been accomplishing each of the functions under DHFF. HFGC members who were involved in the FGDs were required to highlight duties that they have been accomplishing in governing health facilities, their roles in implementing DHFF. The FGD participants also were asked about the challenges and the factors that might help members to implement DHFF effectively.

To reduce bias in this area, we asked open-ended questions that prevented respondents from agreeing or disagreeing. Indeed, we questioned and guided individuals to produce accurate and true information. The researcher bias was reduced by focusing on the collected data and consistently basing decisions on replies and perceptions rather than pre-existing beliefs. The research questions were kept short and well-organized, starting with a general topic and ending with a specific question about HFGC functionality under DHFF.

3.2.4 Quantitative Analysis

The statistical program Statistical Product and Service Solution (SPSS) was used for the analysis (version 25). At a 5% level of significance, all statistical tests were determined. Data were analyzed using descriptive and inferential statistics, and the sample and participant characteristics were described using frequency tables and bar graphs. A binary logistic regression model was employed to determine characteristics associated with HFGC functionality because the outcome variable was dichotomized (0=poor function, 1=good function)(Julie, 2005). The general multiple logistic regression models are given as:

$$\log it[\pi(x)] = \log\left(\frac{\pi(x)}{1-\pi(x)}\right) = \beta_0 + \beta_1 x_1 + \ldots\ldots + \beta_p x_p$$

$$\log it[\pi(x)] = \log\left(\frac{\pi(x)}{1-\pi(x)}\right) = \beta_0 + \beta_1 x_1 + \ldots\ldots + \beta_p x_p$$

Where, $\pi(x)$ is the likelihood of HFGC functionality is ”good function”, x_i's are set of independent variables and β_i's are their respective parameters (Delwiche and Slaughter, 2003). The results of the model are presented in the form of a regression parameter estimate and estimated odds ratios (OR). The estimated OR, determined by taking the exponent of the regression parameter estimates, shows the increase or decrease in the likelihood of having good functionality at a given level of the independent variable as compared to those in the reference category. An estimate of OR > 1 indicates that the likelihood of having good functionality for participants at a given level of the independent variable is greater than that for the reference category. Similarly, an estimate of OR < 1 specifies that the chance of being having good functionality at a given level of the independent variable is less than that for the reference category.

3.2.5 Variables of the study

The dependent variable for this study was the functionality of HFGC. The Functionality of HFGCs in primary health facilities implementing DHFF was statistically analyzed based on the experience of HFGC members in accomplishing their assigned functions as indicated in the four points Likert Scale in which each point was in percentage. Then, the four points Likert scales were dichotomized for further analysis. The first two points namely “Very Low” and “Low” were coded 0 and “High” and “Very High” were coded 1. the score of functionalities was calculated by summing up all dichotomized variables. The possible minimum score was 0 and the possible maximum score was 9. The functionality score was

categorized into two categories those who scored above the median (5) were regarded as good functioning while those who scored 5 or less were regarded as poor functioning. This practice is consistent with the analysis conducted in the study of health system responsiveness conducted in Tanzania (Kapologwe et al., 2020). The independent variables for this study included nine (9) items (functions) which determined the functionality of HFGCs as indicated in table 3.

3.2.6 Qualitative Analysis

A total of 14 in-depth interviews and focus groups were recorded, verbatim transcribed, and anonymised for analysis. The theme framework was employed as the theoretical framework to assess the data of HFGCs after data collection based on topic areas. The material was classified independently by four researcher assistants, and the researcher then analyzed the coded content, subcategories, and categories to determine critical conclusions. As a result, the statement referring to HFGC members' participation in various HFGC functions was studied to determine the functionality of HFGCs and to determine if the empowerment framework's argument was applicable or not.

3.2.7 Reliability

Many aspects of interest in the social sciences and other professions, such as anxiety or job satisfaction, are difficult to quantify. We ask a number of questions and integrate the answers into a single numerical value in such circumstances. When things are utilized to make a scale, however, they must be internally consistent. Cronbach's alpha was used in this study to assess our instrument's internal consistency and reliability. It assesses how well a set of variables or items accurately reflects a single, one-dimensional latent feature of people. Cronbach's alpha values vary from 0 to 1, with values greater than 0.7 indicating adequate internal reliability. The Cronbach’s alpha value for the 9 specific functions of HFGCs is 0.922. This indicates that there is a high level of internal consistency for our scale

The consistency of the study decision trail was used to establish qualitative dependability. The process began with the selection of assistance researchers who were well-versed in the research issue, i.e., they had a background in community health and governance at the very least. The researchers were trained and orientated on qualitative data gathering for three days, as well as the data collecting method (interview and FGD tool). Data collectors did, in fact, take part in pilot research to get a sense of what's going on in the field. The environment for interviews and focus groups was set up ahead of time. To ensure privacy and uniformity, a separate room was set aside for interviews and focus groups that were far enough away from being reached or heard by health care practitioners. All this was done to ensure participants' freedom. apart from obtaining written consent, we sought oral consent

before beginning these interviews and tried to record the oral agreement on tape. we also wanted to lighten up the tone of the interview and make it more relaxed and conversational. Through explanation and self-determination (participants could withdraw from the study at any moment), we adhered to the ethical norms of the research procedure. The same research assistants that collected the data and had expertise with the atmosphere, participants, and reactions to the data collection process analyzed the data verbatim and transcribed the audio recordings. Some of the participants were interviewed after the data was analyzed to see if what was written matched their opinions.

3.2.8 Ethical Approval

This research was carried out in conformity with the principles of the Helsinki Declaration. All procedures were followed in compliance with the applicable norms and legislation. The Sokoine University of Agriculture provided the IRB with the number SUA/ADM/R. 1/8/668. The permit was then filed to the President's Office Regional Administration and Local Government (PO-RALG) to be granted permission to conduct research on local government authorities. PO-RALG issued a permit with the registration number AB.307/323/01 to allow the study to conduct research in the chosen areas. All human participants in this study gave their informed consent by signing consent forms before being included in the study.

3.3 Findings and Discussion

3.3.1 Socio-Demographic Characteristics

Table 1 shows the socio-demographic characteristics of the study's participants. The age of the members of HFGC was measured in years, the sex of the members was classified as male or female, and the educational level of the members was classified as the primary school in this study. A secondary school diploma, a certificate, a diploma, an advanced diploma, and a university degree are all options.

Table 3.2: Socio-Demographic characteristics of HFGC members No=280

Variable	Frequency (f)	Percent (%)

Age		
<30	32	11.43
31-45	100	35.71
46-60	107	38.21
61+	41	14.64
Sex		
Male	139	49.64
Female	141	50.36
Education level		
Primary	150	53.57
Secondary	64	22.86
Certificate	24	8.57
Diploma	30	10.71
Advanced diploma	5	1.79
University degree	7	2.50

Table 3.2 shows the characteristics of the study's participants. The study's participants were divided into four regions: Mbeya, Kilimanjaro, Songwe, and Ruvuma; health facilities were divided into health centers and dispensaries; and member positions were divided into chairperson, secretary, and normal member.

Table 3.3: Number of Participants as per region, type of facility, and Position N=280

Variable	Frequency (f0	Percent (%)
Region		
Kilimanjaro	93	33.21
Mbeya	64	22.86
Songwe	54	19.29
Ruvuma	69	24.64
Type of Health Facility		
Dispensary	161	57.50
Health center	119	42.50
Position		
Chairperson	43	15.36
Secretary or facility in charge	34	12.14
Member of the HFGC	203	72.50

3.3.2 The Functionality of HFGC under Direct Health Facility Financing (DHFF) Context

Table 3.3 shows the members' experiences with the 9 primary functions that have been assigned to HFGCs in Tanzania. Under the DHFF context in Tanzania, HFGC members

were meant to report the amount to which their HFGC had been functioning in each function in their primary health facility.

Table 3.4: HFGC functioning in various areas under decision making under DHFF, n=280

Variable (Specific Function of HFGCs)	Poor Functionality (%)	Good Functionality n (%)	Mean (SD)
Participate in Preparing facility plan and Budget according to community needs	56(4)	224(80)	3.91(0.92)
Managing facility income and expenditure	63(22.49)	217(77.5)	3.88(1.03)
Participate in managing the procurement of health equipment, drugs and services	42(15)	238(85)	4.00(0.88)
Participate in managing facility performance	80(28.57)	200(71.43)	3.73(1.05)
Management of facility resources	63(22.49)	217(77.5)	3.90(0.95)
Mobilization of facility finances from different sources	118(32.13)	162(57.86)	3.49(1.05)
Participate in managing constructing facility infrastructures	70(25)	210(75)	3.79(1.05)
Discussing the challenges confronting the community	52(18.57)	228(81.43)	3.96(0.87)
Mobilizing community to join improved Health Community Fund	36(12.86)	244(87.14)	4.23(0.87)
Overall HFGCs Functioning	**60(21.43)**	**220(78.57)**	**3.86(0.79)**

3.3.3 Factors Associated with the functionality of HFGCs under DHFF Context

As presented in the methodological section binary logistic analysis was used to assess factors associated with the functionality of HFGCs as presented in the methodological section. The result shows that in unadjusted analysis, the functionality of HFGCs was significantly associated with the region (p=0.0456), Age of respondents (p=0.0272), Education level (p=0.0135), Governance (p=0.0086), Health Planning aspects (p<.0001), Financial management aspects (p<.0001), Procurement Aspects (p<.0001), Informational reports (p<.0001), Measures taken by HFGC (p=0.0287), Quality (p<.0001) and Important (p=0.0032). After adjustment of variables, it was reviled that the functionality of HFGCs was significantly associated with Contesting position, Health Planning aspects, and Procurement Aspects and Informational reports (table 4). With respect to Contesting position, the result showed that those HFGCs members who had contesting positions were significantly more likely to have high functionality at their health facilities as compared to those who had no contesting position (AOR=6.413, p=0.0187). With regard to Health Planning aspects, it was noted that those respondents who had good planning were significantly more likely to have good functionality as compared to those who had poor planning aspects (AOR=10.325,

p=0.0011). As compared to those respondents who reported to have poor procurement aspect, those respondents who reported to have good procurement aspect were significantly more likely to have high functionality (AOR=4.986, p=0.0331). With respect to Informational reports, those HFGC members who reported to have good information reports were significantly more likely to have high functionality as compared to their counterparts [(AOR=10.387, p=0.0007]), see table 4].

Table 3.5: Factors associated with the functionality of HFGCs

Variable	Unadjusted logistic regression		Adjusted logistic regression	
	OR [95%CI]	p-value	AOR [95%CI]	p-value
Region				
Kilimanjaro	5.137[1.033, 25.551]	0.0456	1.950[0.303, 12.531]	0.4817
Mbeya	0.136[0.054, 0.343]	<.0001	8.580[0.982, 74.960]	0.0519
Songwe	0.113[0.044, 0.291]	<.0001	6.416[0.854, 48.195]	0.0708
Ruvuma	Reference		Reference	
Age				
<30	Reference		Reference	
31-45	0.966[0.410, 2.277]	0.9368	1.017[0.233, 4.431]	0.9823
46-60	2.105[0.859, 5.163]	0.1038	2.115[0.421, 10.623]	0.3629
61+	4.203[1.176, 15.025]	0.0272	1.536[0.213, 11.061]	0.6699
How selected				
Elected	Reference		Reference	
Appointed	0.639[0.351, 1.165]	0.1441	2.987[0.637, 14.004]	0.1651
Contesting position				
No	Reference		Reference	
Yes	1.775[0.989, 3.187]	0.0546	6.413[0.749, 30.191]	0.0187
Education level				
Primary	Reference		Reference	
Secondary	1.799[0.876, 3.693]	0.1097	1.683[0.506, 5.592]	0.3957
Certificate	1.577[0.554, 4.489]	0.3931	4.080[0.747, 22.276]	0.1045
Diploma or above	3.942[1.327, 11.706]	0.0135	6.145[0.749, 50.430]	0.0909
Governance				
Poor	Reference		Reference	
Good	3.372[1.362, 8.349]	0.0086	0.621[0.100, 3.870]	0.6100
Health Planning aspects				
Not good	Reference		Reference	
Good	30.794[14.812, 64.020]	<.0001	10.325[2.540, 41.972]	0.0011
Financial management aspects				
Poor	Reference		Reference	
Good	17.745[8.959, 35.148]	<.0001	1.056[0.264, 4.223]	0.9386
Procurement Aspects				
Poor	Reference		Reference	
Good	23.364[11.497, 47.481]	<.0001	4.986[1.138, 21.858]	0.0331
Informational reports				
Poor	Reference		Reference	
Good	36.127[14.675, 88.936]	<.0001	10.387[2.671, 40.391]	0.0007
Measures were taken by HFGC				
Poor	Reference		Reference	
Good	3.882[1.152, 13.086]	0.0287	0.463[0.097, 2.203]	0.3335
Quality				
Poor	Reference		Reference	
Good	12.812[5.712, 28.739]	<.0001	1.922[0.592, 6.241]	0.2769
Important				
Poor	Reference		Reference	
Good	4.162[1.612, 10.744]	0.0032	0.964[0.155, 6.000]	0.9683

3.4 The qualitative Data

The autonomy and powers of HFGCs

Participants agreed that the number of HFGCs and their fiscal powers have increased as a result of the DHFF implementation. The DHFF setup, according to the participants, has given HFGC more room to participate in planning and budgeting as well as obtaining financial resources. All these have eased the process of allocating and managing the use of allocated resources. One of the HFGC chairpersons, for example, had the following response:

"Under DHFF arrangement member of HFGCs, we are comfortable with exerting of power in different dimensions…. It is very easy now to do what HFGC is required to do because we have all powers now"

Mobilization of community to join Community Health Insurance

HFGCs have been heavily involved in organizing communities to join CHF under the DHFF structure, according to participants in the depth interviews. Village gatherings, religious organizations, and burial rites were listed as examples of varied techniques used to organize community members to join CHF. In-depth discussions with the HFGCs chairperson confirmed this as well.

"As we are speaking, CHF education is being provided to the community members, we members were divided into different groups and approached the churches found in our ward for sensitizing the community to join CHF. We have been also sensitizing communities through visiting their hamlets"

Participants also discussed the difficulties that many communities face in recruiting community members to join CHF. Despite their commitment to this function, FDG comments indicated that the number of community members joining the upgraded community health fund is not promising in comparison to the efforts made.

"The challenge we encounter now is the number of community members joining the CHF is very low compared to the efforts we have put in sensitizing the community about the importance of being a member of CHF.

Participation in Planning and budgeting process

In the implementation of the DHFF, it was discovered that HFGC engagement in planning and budgeting is high. Participants believed that under the DHFF, they no longer had to wait for council-level planning to be completed. They revealed that they have been actively participating in the planning process through HFGC meetings, with certain members also participating through the planning committee. Participants in the focus groups described

their involvement in many functions, including financial roles. The following was said by one of the FGD partcipants.

"We are currently able to control and monitor funds used in our facilities because we participate in deciding the use of facility funds… as HFGC chairperson, I make sure whatever we endorse to be used should also appear in the health facility plan and should be budgeted too"

Procurement of Medicine and Medical commodities

Participants expressed their satisfaction with their ability to participate in the procurement of medicines and other services and items under the DHFF. They defined their involvement in the process as identifying drugs that needed to be purchased and approving the usage of monies to purchase medicines and other goods. They further stated that they had engaged in obtaining procured products and services. Focus Group Discussions (FGDs) on the procurement process revealed the same thing.

……when the health facility in charge wants to buy anything she informs us as committees, therefore we revisit our health plan and budget to see if such an item was planned to be procured….

Another one added

……. The problem comes when we receive medical commodities sometimes we get stuck on the standard and quality of the materials that are to be received because we don't know how to go through them……

Financial Management

Participants felt that they had actively participated in the management of health institution finances under the DHFF. They highlighted the HFGC meeting as a decision-making place where they have been discussing and making financial management decisions. They did, however, mention certain areas where they are struggling, such as raising funds from sources other than the government, health insurance, and out-of-pocket/user costs.

……. In our facility, we haven't identified or solicited any other sources of finance than user fees, improved community health funds and National Health Insurance Funds… we didn't know if we were responsible for going out of what we have…

Communication between HFGCs, Health Workers and Community

Participants expressed favorable feelings about their relationships with health workers and communities in in-depth interviews and focus groups. They agreed that they spoke with health workers and communities on a regular basis to identify the community's concerns. They've been collaborating with health workers to address issues in a variety of ways,

including developing health plans and submitting them to village governments. This is what one of the respondents had to say:

"We communicate with communities through several ways such as attending village assembly, meeting with individuals who have experienced some challenges in accessing health services… then we work closely with health works to address those challenges"

3.5 Discussion

The goal of this study was to evaluate the functionality of HFGCs and associated characteristics in Tanzanian primary health care facilities that were implementing DHFF. In general, the study revealed that HFGCs in Tanzanian primary health care facilities applying DHFF functioned well. The study also discovered that contesting the position, participation in health planning and budgeting, participation in procurement process/aspects, and discussion of various informational reports tabled in HFGC meetings are all significantly associated with the functionality of HFGCs in primary health facilities implementing DHFF.

Participants revealed that prior to the adoption of the DHFF in primary health institutions, they only had the political power to make decisions, but no monetary capacity to enforce such decisions. Because fiscal responsibilities remained in the hands of the councils, primary health facility plans, budgets, and procurement processes were all under their authority. HFGCs lacked the authority and autonomy to sway financial decisions based on community needs. However, after the implementation of the DHFF arrangment, health facilities and HFGCs have better control over their operations. Because the DHFF no longer conducts planning and budgeting at the council level, the HFGCs have been given space to participate in the planning and budgeting process. Currently, the HFGCs are in charge of approving all expenditures for facility medicine and other goods and services. Indeed, health facility management is obligated to report to the HFGC on quarterly financial, operational, and facility plan implementation status. As a result, the HFGCs have the opportunity to gather all pertinent information on facility operations and discuss it in order to improve healthcare delivery. These findings corroborate the empowerment framework's assertion that the capacity of a group to make successful decisions is linked to the informal and formal setting in which the group/HFGC operates (Alsop and Heinsohn, 2005; Raich, 2005).

Furthermore, as found in other studies or literature (Lodenstein *et al*., 2017; Waweru *et al*., 2013; WHO-Unicef, 1978) in lower and middle-income nations, community participation through community governing structures is a cornerstone for enhancing health service delivery at primary health care institutions. If political and administrative decentralization is not implemented simultaneously with budgetary decentralization, they are unlikely to be

effective in influencing community participation in governance and managing health service delivery in catchment regions (Fjeldstad *et al*., 2004; Smoke, 2003; The World Bank, 2015). The outcomes of this study back up the link between the effectiveness of community health institutions like HFGCs and fiscal decentralization via DHFF arrangements. According to this study, HFGCs are given fiscal powers and autonomy to govern primary health care facilities as a result of fiscal decentralization under the DHFF arrangement.

The HFGCs are functioning under the DHFF because they have been provided the opportunity to engage in planning and budgeting, procurement of medicines, medical commodities, and services, as well as through various operational reports delivered to HFGC meetings by health facility management. The HFGCs may engage with communities and debate and address community health concerns through HFGC meetings, thanks to the framework provided by the DHFF setup. Other community health issues are incorporated into health facility plans and budgets in order to be addressed. Participants agreed that HFGCs receive all quarterly operating reports as required by DHFF guidelines under the DHFF arrangement, which helps HFGCs be more informed about their health facilities. All of these were not done or executed properly prior to the adoption of the DHFF.

Similarly, the findings of this study are consistent with empirical evidence from studies conducted in other countries that have implemented fiscal decentralization through DHFF, such as Kenya, which revealed that after implementing this type of fiscal decentralization, HFGC performance improved (Goodman *et al*., 2011; McCollum *et al*., 2018; Tsofa *et al*., 2017; Waweru *et al*., 2013). Other countries, on the other hand, implemented fiscal decentralization in primary health care facilities, but HFGC functionality remained weak. In Burundi's primary health care facilities, for example, fiscal decentralization was introduced, but the HFGCs' functionality did not improve (Falisse *et al*., 2012). This means that depending on how fiscal decentralization is implemented, the results may vary, as in Kenya and Tanzania, where the DHFF arrangement was used, and Burundi, where payment for results was used.

Furthermore, HFGCs have been discovered to have a wide range of performance in many functions devolved to them. The HFGCs have been found to have reasonably good functionality in organizing the community to join community health funds, discussing and addressing community health concerns and engaging in the procurement process, planning, and budgeting, as shown in Table 3. The DHFF's environment, in which HFGCs and facility employees are mandated to collect community health concerns and address them through facility plans and budgets, may have contributed to this (Mwakatumbula, 2021). Other studies conducted prior to the implementation of the DHFF in Tanzania indicated minimal

participation of HFGCs in discussing and addressing community health concerns, low participation of HFGCs in the planning process, and low attendance at HFGC meetings(Frumence *et al*., 2014; Maluka and Bukagile, 2016; Shayo *et al.,* 2012).

The study may have underlined the relevance of fiscal decentralization in empowering sub-national health organizations, particularly community governance structures like HFGCs. As the empowerment framework suggests, changing the context in which actors operate, such as through the use of the DHFF structure, improves the functionality of HFGCs, hence strengthening community engagement in the management and control of health service delivery. This is influenced by the fact that the factors found to be linked to HFGCs are also DHFF requirements. To maintain transparency and seamless operation of HFGCs, DHFF mandated HFGCs to engage in planning and budgeting, procurement processes, and health facility management to deliver quarterly reports to HFGCs Meetings. These findings contradict those of other studies, which found gender, educational levels, and other factors to be important (Gurung *et al*., 2018a; Iwami and Petchey, 2002; Kesale *et al*., 2021; McCoy *et al*., 2012; Roman *et al*., 2017).

3.6 Conclusion

The functionality status of HFGCs within the fiscal empowered environment is provided in this study, which adds to the body of knowledge and policy debate on the implementation of fiscal decentralization through DHFF. The study discovered that HFGCs in primary health care facilities employing DHFF have a high level of functionality. Other studies conducted prior to the DHFF implementation revealed that HFGCs were underutilized and that community participation in controlling and maintaining health facilities was limited. This research has helped to find factors related to HFGC functionality under fiscal decentralization that have not been identified in earlier research. In contrast to earlier studies conducted in Tanzania that used just qualitative or quantitative methods, using a mixed-method approach allowed researchers to obtain quantitative and qualitative findings that helped to explain the extent to which HFGCs fulfill their given duties. Future research should be performed to determine the extent to which HFGCs fulfill oversight tasks in health institutions while also conducting managerial functions.

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Competing interests

No competing interest

Ethical Approval Statement

The Sokoine University of Agriculture provided the IRB with the number SUA/ADM/R. 1/8/668. The permit was then filed to the President's Office Regional Administration and Local Government (PO-RALG) to be granted permission to conduct research on local government authorities. PO-RALG issued a permit with the registration number AB.307/323/01 to allow the study to conduct research in the chosen areas. All human participants in this study gave their informed consent by signing consent forms before being included in the study

Transparency Statement

The authors certify that this manuscript is an honest, accurate, and transparent account of the study being described; that no significant components of the study have been omitted; and that any differences from the study as intended (and, if applicable, registered) have been explained.

Availability of Data and Materials

All data generated or analysed during this study are included in this published article and supplementary file.

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CHAPTER FOUR

4.0 THE FUNCTIONALITY VARIATION AMONG HEALTH FACILITY GOVERNING COMMITTEES UNDER DIRECT HEALTH FACILITY FINANCING IN TANZANIA

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Abstract

Decentralization reforms through Direct Health Facilities Financing (DHFF) have empowered Health Facility Governing Committees (HFGCs) to participate in different governance aspects to improve service delivery at the facility level. However, there is little research on how empowered HFGCs perform in the context of the DHFF. The purpose of this study was to evaluate the functionality of HFGCs under DHFF in Tanzanian primary health care facilities that had a variation in performance in 2018. To collect both qualitative and quantitative data, the study used a cross-section design. The study had a sample size of 280 respondents, who were chosen using a multistage cluster sampling technique from 32 primary health care facilities that were practicing DHFF. Data was collected via a closed-ended structured questionnaire, in-depth interviews with chairpersons of HFGCs, and Focus Group Discussions. To examine the functionality of HFGCs, researchers used descriptive and theme analysis. In the 2018-star rating assessment, the study discovered that HFGCs functioned well in both high and low-performing health facilities. When HFGCs from high-performing health facilities were compared to HFGCs from low-performing health facilities, it was discovered that HFGCs from the high-performing health facilities had comparatively high functionality. The functionality of HFGCs in Tanzania has thus been impacted by the DHFF context.

Key Words: Health facility Governing Committees (HFGCs); Direct Health Facility Financing (DHFF); Decentralization; Functionality**;** Lower- and Middle-Income Countries (LMICs)

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4.1 Introduction

Improving health service delivery is a precondition for achieving Universal Health Coverage in Lower- and Middle-Income Countries (LMICs) (Cobos Muñoz *et al*., 2017; Masefield *et al*., 2020). The LMICs have embarked on health sector reforms through Decentralization by Devolution to enhance the improvement of health service delivery in the primary health care (Kessy, 2014; Renggli *et al.*, 2019). Decentralization by Devolution (D by D) entails "the transfer of governance responsibility/decision-making powers for specified functions to sub-national levels through publicly or privately owned institutions that are largely outside the direct control of the central government"(Kapologwe *et al*., 2019). The D-by-D has created community governance structures such as Health Facility Governing Committees (HFGCs) to allow communities to participate in the governance of the primary health care facilities (Kesale, 2017; Kilewo and Frumence, 2015). The HFGCs are responsible for planning, implementing and controlling service delivery at the primary health facilities to bring about health systems responsiveness, increased efficiency and effectiveness and increase accountability to health service providers*(*Molyneux *et al*., 2012; Mwakatumbula, 2021). Therefore, functional HFGCs promise meaningful community participation in the health service delivery at primary health care. In the context of this study, the functionality of HFGC is defined as the ability of HFGCs to accomplish their devolved functions in their health facilities.

Community participation in the planning, implementation and monitoring of health service delivery at the primary health facility the widely recognized for influencing the efficiency, accountability and responsiveness of service providers. The established HFGCs as governance organs in the primary health care facilities representing the community are appreciated for their contribution to shaping health service delivery(Lodenstein *et al.*, 2017). This is because HFGCs provide opportunities for individuals to participate in making decisions affecting their health and they are answerable for their performance (Lodenstein *et al*., 2019; Nathan *et al*., 2006). HFGCs are charged with specific functions to accomplish in the governance process such as participating in planning (Kamuzora *et al*., 2013; Masefield *et al*., 2020; Tsofa *et al.*, 2017), managing finances (Kuwawenaruwa *et al.*, 2019) procurement process (Tsofa *et al*., 2017), addressing communities health challenges (Kamuzora *et al*., 2013; Maluka and Bukagile, 2016)and managing health workers (Eboreime *et al.*, 2017). Through accomplishing their devolved functions, HFGCs are expected to rise health facility performance and improve health service delivery in primary health care (Waweru *et al.,* 2016), (Kesale, 2016; McCoy *et al.*, 2012). However empirical evidence suggests that HFGCs performance in developing countries is low and below expectation (Ogbuabor and Onwujekwe, 2018). Some cited reasons for the limited performance of HFGCs are limited decentralization to HFGCs, members not being able to

know their responsibilities, shortage of funds in their facilities, compositions of HFGCs and educational level (Boex *et al*., 2015; Waweru *et al*., 2016). To address HFGCs functionality challenges developing countries have embarked on fiscal decentralization to empower HFGCs and health facilities to accomplish their responsibilities (Waweru *et al.,* 2013).

In Tanzania, HFGCs were established in 1999 as part of decentralization reforms to increase community involvement in the administration and management of primary health care facilities (Kesale *et al*., 2021; Kessy, 2014). According to the HFGCs establishment and operationalization guidelines of 2013, HFGC are composed of eight (8) members in the dispensaries and nine (9) in health centers (Tanzania, 2013). The members of the committees are community representatives, health facility in charge, local government representatives, private health services representatives and faith-based representatives. Community representatives are elected by the community while other representatives either are elected by their groups or by virtual of their positions(Tanzania, 2013). The following functions are delegated from these HFGCs: Participate in the development of facility plans and budgets for the management of facility income, expenditures, and performance. Similarly, to gather funds for construction and maintenance management. Furthermore, discussing and addressing the community's concerns, as well as rallying the community to participate in the improved Health Community Fund.

Tanzania like other LMICs introduced HFGCs in 1999 and embarked on fiscal decentralization through Direct Health Facility Financing (DHFF) approach since 2017/18[26]. The DHFF approach involves direct depositing of facility finance from different sources such as finance from the Ministry of Finances (MoF) to the health facility accounts. DHFF also empowers HFGCs with planning and budgeting, financial management, procurement and other governance powers and autonomy to the HFGCs (Kapologwe *et al*., 2019; Mwakatumbula, 2021)Before the introduction of DHFF, health facilities and HFGCs had no fiscal powers and autonomy over the health facility resources because the council's levels were ultimately controllers of facility finances and were also planning and budgeting for health facilities (Kesale *et al*., 2021; Tukay *et al.*, 2021)These practices led to delay in disbursement of finances to the facility which caused the late implementation of health intervention as well as minimized the functionality of HFGCs. However, there is limited information on how the empowered HFGCs perform to accomplish their assigned powers and functions in primary health facilities after the introduction of the DHFF arrangement in Tanzania. The few studies which have been conducted on DHFF have just concentrated on assessing the influence of DHFF on health services delivery in general *(*Kajuni and Mpenzi, 2021; Kapologwe *et al*., 2019, 2020; Kesale *et al.*, 2021; Mwakatumbula, 2021; Tukay *et al*.,

2021). This study embarked on assessing the functionality of HFGCs in primary health facilities implementing DHFF in Tanzania.

4.2 Methods

4.2.1 Study Area

The research was carried out in four geographical regions, each of which has different geographical councils that were categorized based on their performance (high performance and low-performance regions) in the star rating assessment conducted in January 2018, the same year that the DHFF was launched in Tanzania. The President's Office Regional Administration and Local Government undertook a star rating evaluation to evaluate the performance of Tanzania's basic health care institutions. The star rating assigned stars to facilities based on their performance, with stars 0, 1,2,3,4,5 being assigned to the facilities. Primary health care facilities that received three stars or more were considered excellent performers, while those that received less than three stars were considered bad performers. As a result, Mbeya and Kilimanjaro were chosen because the majority of their health facilities performed well, while Ruvuma and Songwe were chosen because the majority of their health facilities performed poorly. The HFGCs at both high- and low-performing health institutions were studied to see if the DHFF setup had an impact on their ability to carry out their devolved functions. This is because the literature suggests that health facility performance is strongly associated with HFGC performance. Therefore, when health facility performance is high, HFGC performance tends to be high as well, and vice versa (Kesale *et al*., 2021; McCoy *et al*., 2012).

4.2.2 Research Design

In this study, a cross-sectional design was used. Between February and April 2021, quantitative and qualitative data were collected from a large number of subjects or respondents at a single point in time to analyze the functionality variation among HFGCs in chosen health institutions.

4.2.3 Sample Size and Sampling Procedure

Select regions, councils, primary health facilities, and members of HFGCs were sampled using a multistage cluster sampling technique. The first stage began with the identification of regions with a predominance of high-performing health facilities (Mbeya and Kilimanjaro) and low-performing health facilities (Ruvuma and Songwe). The second stage was to choose a council from the selected region that had a high-performance rate for the majority of health facilities (Chunya, Siha, Madaba District Council, and Tunduma Town Council) and a council with a low performance rate (Mbozi district council, Mbeya city council, Songea, and Moshi Municipal). Stage three entailed selecting four primary health care facilities from each of the councils chosen in the previous stage. The health facility selection was divided into two categories: the type of facility (health center or dispensary) and the facility's performance. Stage four involved selecting respondents who are members of HFGCs, with proportional sampling used to choose at least 9 members from each HFGC, resulting in a total of 280 respondents.

Table 4.1: Sampling process and sampling techniques

Stage	Respondent	Sampling procedure	Inclusion criteria
First stage	Four (4) regions selected Kilimanjaro, Mbeya, Ruvuma and Songwe	• Purposive	Performance of the region, Zonal representation
Second Stage	8 LGAs selected; Two LGAs from each region were selected in stage one	• Purposive	Performance of the LGAs in star rating assessment, nature of the LGA (Urban and Rural)
Stage Three	32 health facilities were selected from all (8) councils. 2 health centers and 2 dispensaries from each LGA because they all implement DHFF	• Stratification of health facilities into Health centers and Dispensaries • Purposive selection of health centers and dispensaries	Performance of health facility (A good and poor performing health center and dispensary), Location of the facility within the LGA (Diversity)
Stage Four	280 HFGC members; 9 members from each selected health facility	• Simple random selection of HFGC members	members of the HFGC

5.2.4 Data Collection Methods

To collect quantitative data from each HFGC member, a closed-ended structured questionnaire focused on specific HFGC functions was used. The data gathering software (database) was built using Open Data Kit (ODK). All of the data was then entered into the ODK. To collect data, a quantitative approach called mobile data collection (MDC) was used. Mobile phones were used to collect data, which was subsequently sent to a central server.

Four research assistants went through a three-day training program on mobile data collection skills and techniques, which was followed by skill pre-testing in facilities outside of the study area. The gathered data was sent to the researcher using the ODK platform. As part of quality control, all of the facilities were given GPS coordinates, therefore all of the research assistants used GPS-enabled tablets. The poll received 280 responses out of a total of 288 HFGCs.

4.2.5 Qualitative Data collection

In-depth interviews and Focus Group Discussions were both used to acquire qualitative data (FGDs). A total of 14 in-depth interviews with HFGC Chairpersons from various health facilities were undertaken to learn about the HFGC members' experiences performing their devolved functions under the DHFF. A total of 14 Focus Group Discussions (FGDs) with 6 to 9 participants were also held, involving all members of the HFGCs. After achieving saturation, the number of interviews and focus groups was reduced. Interviews and FDGs were held in specially designed rooms where participants were free to speak freely without being interrupted.

4.2.6 Quantitative Analysis

Analysis was done using Statistical Product and Service Solution (SPSS) statistical software (version 25) and Statistical Analysis System (SAS version 9.4). Descriptive and inferential statistics were used to analyze data, and Frequency tables were used to describe the sample and the characteristics of the participants. The dependent variable for this study was the functionality of HFGC. The Functionality of HFGCs in improving health service delivery under the DHFF context was statistically analyzed based on the experience of HFGC members in accomplishing their assigned functions as indicated in the four points Likert Scale in which each point was in percentage. Then, the four points Likert scales were dichotomized for further analysis. The first two points namely “Very Low” and “Low” were coded 0 and “High” and “Very High” were coded 1. the score of functionalities was calculated by summing up all dichotomized variables. The possible minimum score was 0 and the possible maximum score was 9. The functionality score was categorized into two categories those who scored above the median (5) were regarded as good functioning while those who scored 5 or less were regarded as bad functioning. This practice is consistent with the analysis conducted in the study of health system responsiveness conducted in Tanzania [30]. The independent variables for this study included nine (9) items (functions) that determined the functionality of HFGCs as shown in Tables 2 and 3.

4.2.7 Qualitative Data analysis

Qualitative data was analysed through the adoption of five steps analysis process. The process was designed to accommodate patterns and themes to be captured emerged during

data collection. The collected data were recorded through audio therefore analysis process started with transcriptions of the audio into notes from in-depth interviews and FGDs. Then the data were coded based on keywords relating to the functionality of HFGCs to capture the variations and commonalities among categories of primary health facilities. Then thematic areas relating to the objective of the study and which also related to the guiding framework of the study were identified to help to explain the data and their relationship.

4.3 Variables of the Study

The functionality of HFGC was the study's dependent variable. The functionality of HFGCs in primary health care facilities implementing DHFF was statistically analyzed based on the experience of HFGC members in carrying out their assigned responsibilities, as expressed on a four-point Likert Scale with percentages for each point. The four-point Likert scales were then dichotomized for additional investigation. The first two points, "Very Low" and "Low," were given a 0 rating, while "High" and "Very High" were given a 1. The functionality score was derived by adding all dichotomized factors together. The lowest possible score was 0 and the highest possible score was 9. The functionality score was divided into two categories: good functioning and poor functioning. Those who scored over the median (5) were considered good functioning, and those who scored 5 or below were considered poor functioning. This practice is in line with the findings of a Tanzanian study on the responsiveness of the health system. As shown in table 3, the independent variables for this study included nine (9) components (functions) that determined the functionality of HFGCs. These functions are assigned to the HFGCs by the Tanzania HFGC establishment and operationalization guideline of 2013(Tanzania, 2013).

4.4 Ethical Approval and Consent to Participate

The Sokoine University of Agriculture provided the IRB with the number SUA/ADM/R. 1/8/668. The permit was then filed to the President's Office of Regional Administration and Local Government (PO-RALG) of Tanzania to be granted permission to conduct research on local government authorities. PO-RALG issued a permit with the registration number AB.307/323/01 to allow the study to be conducted in the chosen areas. All human participants in this study provided written informed consent by signing consent forms before being included in the investigation.

4.5 Results

4.5.1 Social Demographic Characteristics

The social demographic characteristics of this study involved locations, types of health facilities, positions of members of HFGCs, age in terms of the number of years of members

of HFGCs, sex of members of HFGC and education level of members of HFGCs. More details have been indicated in table 1.

Table 4.2: Demographic characteristics of HFGC members

Variable	Frequency	Percent
Region		
Kilimanjaro	93	33.21
Mbeya	64	22.86
Songwe	54	19.29
Ruvuma	69	24.64
Type of Health Facility		
Dispensary	161	57.50
Health center	119	42.50
Position		
Chairperson	43	15.36
Secretary or facility in charge	34	12.14
Member of the HFGC	203	72.50
Age		
<30	32	11.43
31-45	100	35.71
46-60	107	38.21
61+	41	14.64
Sex		
Male	139	49.64
Female	141	50.36
Education level		
Primary	150	53.57
Secondary	64	22.86
Certificate	24	8.57
Diploma	30	10.71
Advanced Diploma	5	1.79
University degree	7	2.50

4.5.2 The Functionality of HFGCs under DHFF Context

Table 2 indicates the functionality of HFGCs in primary health facilities that had high performance in 2018 when DHFF started to be implemented in all public primary health facilities in Tanzania. the functionality of HFGCs in Table 2 is indicated through the functionality of HFGCs in their devolved functions in primary health facilities.

Table 4.3: HFGCs Functioning under DHFF in Primary Health Facilities that had High Performance as per 2018 Star Rating Assessment n=146

Independent Variable	Dependent Very low n (%)	Variables Low n (%)	High n (%)	Very high n (%)	Mean (SD)
Participate in Preparing facility plan and Budget according to community needs	7 (5.22)	18(13.43)	82(61.19)	27(20.15)	3.78(1.08)
Managing facility income and expenditure	7(5.22)	28(20.90)	66(49.25)	33(24.63)	3.67(1.21)
Participate in managing the procurement of health equipment, drugs and services	6(4.48)	14(10.45)	78(58.21)	36(26.87)	3.93(1.05)
Participate in managing facility performance	10(7.46)	35(26.12)	67(50.00)	22(16.42	3.42(1.25)
Management of facility resources	5(3.73)	29(21.64	71(52.99)	29(21.64)	3.67(1.15)
Mobilization of facility finances from different sources	10(7.46)	45(33.58)	60(44.78)	19(14.18)	3.25(1.27)
Participate in managing and constructing facility infrastructures	7(5.22)	29(21.64)	75(55.97)	23(17.16)	3.58(1.16)
Discussing the challenges confronting the community	5(3.73)	26(19.40)	73(54.48)	30(22.39)	3.72(1.13)
Mobilizing the community to join the improved Health Community Fund	4(2.99)	15(11.19)	56(41.79)	59(44.03)	4.13(1.07)

Table 3 indicates the functionality of HFGCs in various aspects devolved to them in primary health facilities that had low performance in 2018. The functionality of HFGCs was evaluated through the Likert Scale level. Each function was measured by using the mean score.

Table 4. 4: HFGCs Functioning under DHFF in Primary Health Facilities that had Low Performance as per 2018 Star Rating Assessment n=134

Independent Variable	Dependent Very low n (%)	Variables Low n (%)	High n (%)	Very high n (%)	Mean (SD)
Participate in Preparing facility plan and Budget according to community needs	2(1.37)	29(19.89)	77(52.74)	38(26.03)	3.82(1.07)
Managing facility income and expenditure	6(4.11)	22(15.07)	76(52.05)	42(28.77)	3.86(1.12)
Participate in managing the procurement of health equipment, drugs and services	5(3.42)	17(11.64)	91(62.33)	33(22.60)	3.89(1.00)
Participate in managing facility	8(5.48)	27(18.49)	78(53.42)	33(22.60)	3.69(1.17)

performance					
Management of facility resources	4(2.74)	25(17.12)	77(52.74)	40(27.40)	3.85(1.09)
Mobilization of facility finances from different sources	8(5.48)	55(37.67)	63(43.15)	20(13.70)	3.22(1.24)
Participate in managing constructing facility infrastructures	5(3.42)	29(19.86)	86(58.90)	26(17.81)	3.68(1.09)
Discussing the challenges confronting the community	3(20.5)	18(12.33)	89(60.96)	36(24.66)	3.94(0.96)
Mobilizing the community to join the improved Health Community Fund	1(0.68)	16(10.96)	69(47.26)	60(41.10)	4.17(0.94)

The results in figure 1 indicate that HFGCs from both primary health facilities that had high and low performance in 2018 have good functionality. HFGCs from primary health facilities that had high performance has recorded 79% of good functionality while the counterpart has recorded 73% of good functionality Under DHFF implementation.

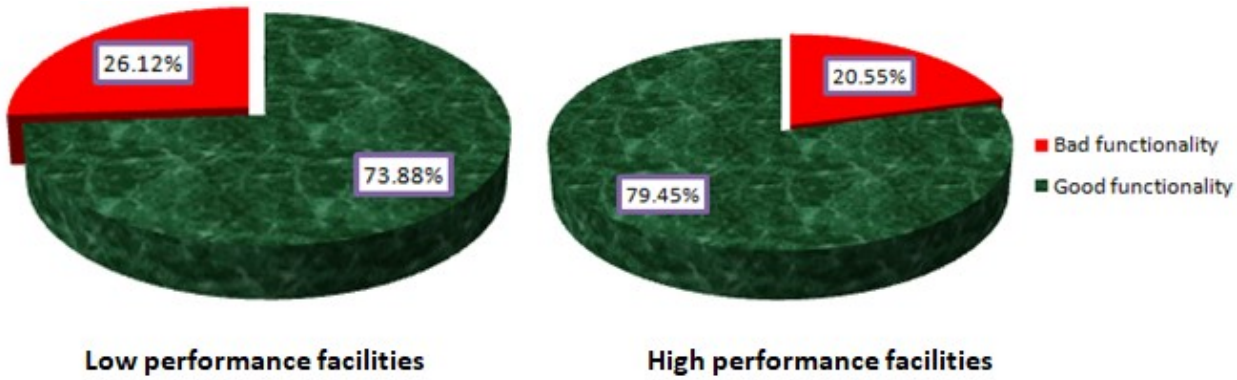

Figure 4.1: Functioning level of HFGCs in Primary Health Facilities under DHFF implementation

Figure 2 indicates the current performance of HFGCs from both health facilities that had high and low performance. Quantitatively, the results show that HFGCs from both health facilities which had high and low performance are relatively functioning good in participating in mobilizing the community to join improved community health funds (CHF), participating in the procurement of health commodities, medicines and other services, participating in the planning and budgeting as well as discussing community challenges

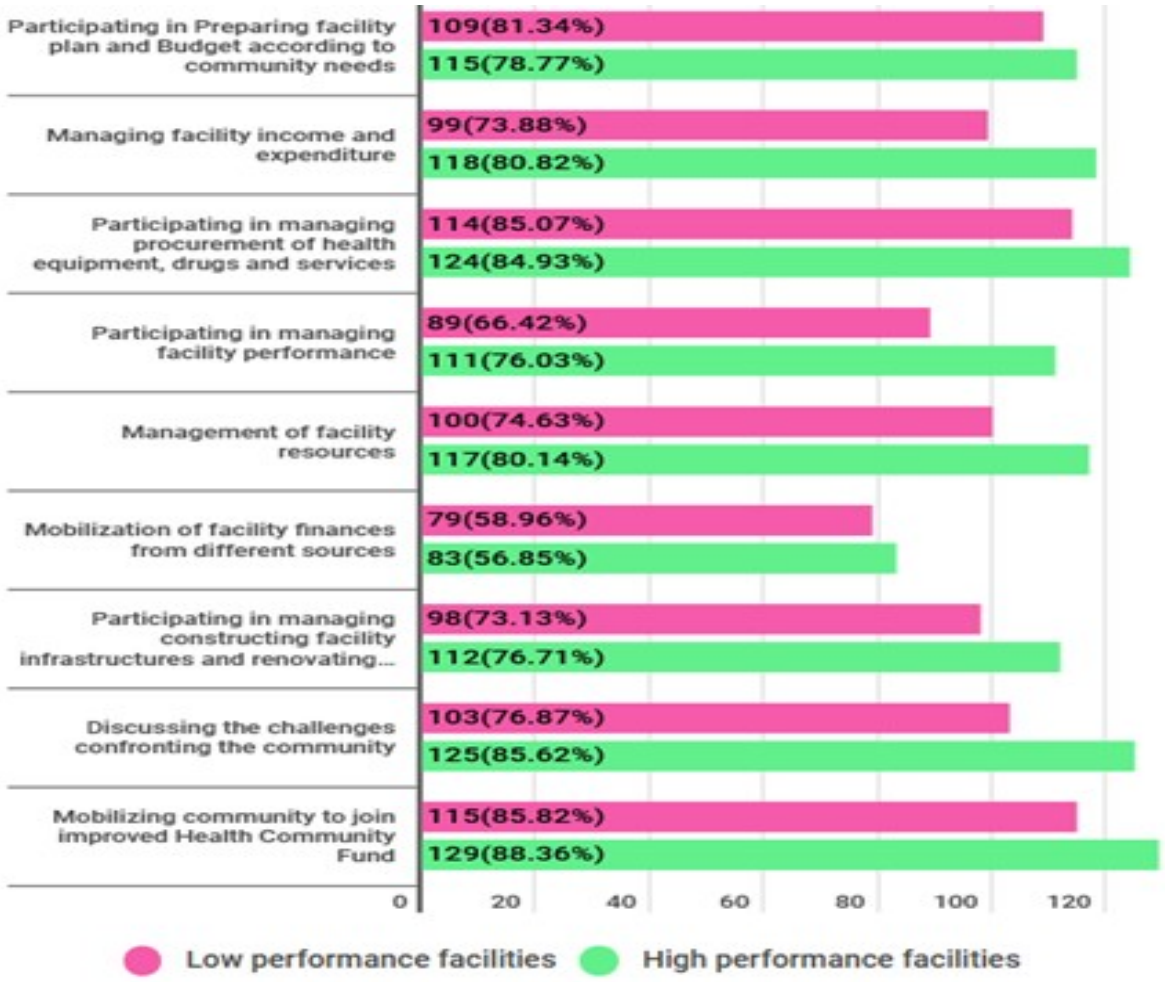

Figure 4.2: Prevalence of functionality HFGCs in their devolved Functions

4.6 Perspectives of HFGC members on the functionality of HFGCs under DHFF Implementation

Management of Facility Resources

The participants in a primary health facility that had high performance in the start rating assessment conducted in 2018 reacted that they have been participating in the management of facility resources in the health facility as one of their assigned functions.

> *"We make sure to take care of all our resources not to get damaged or been stolen, but this is for few observable resources and not all the resources because for me I don't know how many resources the facility has"*

Collecting and Addressing Community Health Challenges

The major aim of establishing of HFGCs was to ensure the community forms part in addressing community health challenges because HFGCs members are from the community so they have adequate knowledge of the community health challenges. Participants from both interviews and FGDs agreed that they have been linking community and health facilities even though they have not been able to address all the challenges.

"To sincerely we still have problems here which are very difficult to be solved by our levels such as availability of medicines, medical commodities and health workers"

Mobilizing Community to join Community Health Fund (CHF)

Participants highlighted that they have hardly been participating in mobilizing community members to join CHF for the purpose of mobilizing facility funds and also helping community members to be able to get health services. Different mechanisms of mobilizing the community have been mentioned by the participants.

"Yes, we are still doing that and mobilize them to join the CHF, using ten cell leaders based on where they live and through that, we get many people. even when there is an open meeting on the street, we also influence them"

Financial Management

Facility intervention to the large extent requires finance to smoothly be implemented. HFGCs are assigned the role of overseeing the utilization and management of facility funds. HFGCs members perceive that DHFF has granted them powers to exercise such a role. Participants explained the extent they have been participating in managing such funds.

"Ok, we understand the system, when the money arrives, we are informed by the accountant or the secretary of the committee, so we are responsible to know how much money we have received and call a meeting with the committee ready to facilitate the plans as scheduled".

Participate in Planning and Budgeting

Participants also explained how they have been engaging in the preparation of health facility plans and budgets in their areas.

"We are part of the planning team and indeed we get the opportunity to place our ideas and community challenges when the facility plan and budget are tabled to our HFGCs for approval"

4.7 Perspectives of HFGCs members on their functionality from primary health facilities that had low performance in 2018

Participating in Preparing Comprehensive health facility Plan and Budget

Members of HFGCs perceive that they participate in the planning process and have been able to channel community issues in the plan and budgeting. They also recognized that they have been overseeing the implementation of the plan. some other members thought that last year they have not participated in the preparation of the plan

"About the comprehensive plan, first we prepare the plan, we sit here as a team because we were given the paper for plan generation and were directed that we

must include specialists, teachers and the committee together with the facility workers and we fill the tables accordingly, and this is the first step"

Mobilizing communities to join Community Health Fund

The reaction of the HFGCs on their functioning on issues relating to the mobilization of the community to join community health funds was very positive. Through both interviews and FGDs members perceive that they have done enough but shortage of medicine in many health facilities.

"We go and visit the societies try to educate people on a certain thing, for example, people were not used to visiting our health facility for different services so the committee tends to educate them and influence them to use our facility, also to join the CHF"

Management of Health facility finances

Health services delivery requires finances; therefore, mobilization and management of facility funds is vert imperative for improving primary health care delivery. the participant responded with their experience in the mobilization and management of funds.

"We have had powers and freedom in managing facility finances now since we know what health facility has and that money cannot be used without our authorization. So, we feel responsible for mobilizing funds and we have been doing so through approaching different stakeholders"

Another responded

"As the council construction agent present the budget which was a high amount and the society did not have so we reached an agreement that we will join force with the council and the money collected will be used for that".

Participation in the procurement of medicines, medical commodities and other materials

In this theme, participants responded that since the beginning of the implementation of DHFF they have been part of the procurement process of their health facility. They outlined their roles such as approving the demands of items to be procured, aligning procurement with facility plan and budget and being part of the team, which confirms the items which are being delivered to the health facility. Also highlighted some challenges.

"Maybe the problem is interference from the council level because sometimes we were told that the council has already identified someone who is going to renovate and build our buildings so it became difficult for us to supervisor the council tenderer"

Addressing community health challenges

Participants revealed that since they are members elected by the communities, therefore, they have been collecting community health challenges through different mechanisms and through HFGC meetings they discuss address those challenges

> *"For example, now we know that medicines on the facility are the result of the presence of money, in order to have more medicine you must have money, so you come to find out on the absence of the medicine in the facility even the iCHF card won't be of much help"*

4.8 Discussion

The study looked at how well HFGCs functioned in a DHFF environment in primary health care facilities that had a range of performance in 2018. The goal was to see if there was any variation or similarity in HFGC functionality under DHFF among a group of HFGCs from primary health care facilities with varying performance. According to the findings of this study, the functionality of HFGCs from both low and high-performing primary health facilities in 2018 is generally good, as HFGCs from primary health facilities with varying performance have recorded good functionality above 70% under DHFF, as shown in figure 1. In a 2018-star rating assessment, the average HFGC functionality across the country was less than 60%. Indeed, qualitative data from interviews and focus groups have revealed that HFGCs are more involved in their devolved functions as a result of DHFF implementation. The findings of this study are similar to those of earlier studies conducted in Tanzania to analyze the impact of DHFF in primary health care institutions, which revealed that DHFF led to enhanced community ownership, more autonomy, and improved financial management (Kajuni and Mpenzi, 2021; Mwakatumbula, 2021).

However, there is a difference in functionality among HFGCs, with HFGCs from primary health facilities that had a high-performance during star rating assessment in 2018 having relatively good functionality, scoring 79.45 percent (see figure 1), compared to HFGCs from primary health facilities that had a low performance, scoring 73.88 percent (see figure 1). The functionality of HFGCs has improved under the DHFF setup, according to qualitative findings, because HFGCs have been able to fully participate in many areas that represent their functions. That means that in the context of DHFF implementation, HFGCs have felt empowered to apply their powers and hold health service providers accountable. HFGC's performance in supervising and monitoring health service providers increased as a result of fiscal decentralization in primary health care through a different arrangements, such as Direct Facility Financing (DFF) in Kenya (Eliza and Oscar, 2018; Goodman *et al*., 2011; Mccollum *et al*., 2018). Fiscal decentralization, according to the literature, increases the functionality of service providers and provides autonomy to different sub-national entities,

such as HFGCs, when done properly in different situations(Anosisye, 2017; Asfaw *et al.*, 2004; The World Bank, 2015).

It was discovered that HFGCs from both high and low-performing primary health institutions have good functioning in similar duties such as rallying the community to join CHF, engaging in the planning and budgeting process, facility procurement, and discussing community concerns (see figure 2). This means that the implementation of the DHFF in primary health care institutions has broadened the scope and offered possibilities for HFGCs to carry out their allocated responsibilities as outlined in the empowerment framework (The World Bank, 2015). The precise areas in which HFGCs have been found to have strong functionality are the most strategic tasks that determine facility performance, so good functionality of HFGCs in those areas can help primary health facilities improve to some extent. According to McCoy et al, the functionality of primary health care facilities' HFGCs determines the performance of health facilities whether they operate well or poorly (McCoy *et al*., 2012).

HFGCs from high-performing primary health facilities, on the other hand, were found to be relatively effective in some specific duties, such as encouraging communities to join CHFs, discussing community concerns, managing facility resources, and monitoring facility income and expenditure. While HFGCs from primary health care facilities that performed poorly in 2018 were discovered to have reasonably strong functionality in mobilizing funds from other sources and participating in planning and budgeting. The findings imply that HFGCs from high-performing health facilities work well in a variety of specific roles, which explains why their overall performance is superior to that of their counterparts. This confirms the argument provided by McCoy *et al* and Kessy that the performance of health facilities tends to be reflected in the performance of HFGCs (Kessy, 2014; McCoy *et al*., 2012).

Finally, it was discovered that implementing DHFF in primary health care facilities increased the functionality of HFGCs in many delegated functions. Even while there is no direct statistical evidence of a direct association between HFGCs and DHFF, the evidence from the 2018 Star rating assessment supports our position. The average performance of HFGCs according to the star rating assessment conducted prior to the implementation of DHFF was below 60%, but this study found that the performance of HFGCs in selected primary health facilities implementing HFGCs is above 70% in both low and high performing primary health facilities. Participants believe that DHFF has given them a conducive environment in which to do their tasks.

4.9 Conclusion

The study discovered that HFGCs functioned well in both high and low-performing health institutions in the 2018-star rating assessment, the same year the DHFF began. In comparison, HFGCs from high-performing health facilities were discovered to have relatively high performance. According to the findings, HFGCs from both high and low performing health facilities have good functionality in similar activities but have comparatively poor functionality in a few devolved functions such as mobilizing resources from other sources and managing facility performance. These findings suggest that increasing the functionality of community governance systems in primary health care institutions in developing countries will necessitate extensive budgetary decentralization. Fiscal decentralization through a different arrangement, such as the DHFF, allows other types of decentralization, such as political decentralization, to be meaningful, as this study found that HFGCs increased their functionality in various aspects, such as addressing community health challenges. When community governance structures (HFGCs) are financially empowered, they are better able to oversee health care provider accountability and improve PHC health service provision.

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Contributors

AK conceptualized the study, conducted fieldwork, analyzed data and drafted the final draft. CM engaged in conceptualization, developing the methodology and finalization of the article. MM engaged in the conceptualization, fieldwork, and review of the final draft. All authors approved the final draft.

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CHAPTER FIVE

5.0 THE QUEST FOR ACCOUNTABILITY OF HEALTH FACILITY GOVERNING COMMITTEES IMPLEMENTING DIRECT HEALTH FACILITY FINANCING IN TANZANIA: A SUPPLY-SIDE EXPERIENCE

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Abstract

User committees, such as Health Facility Governing Committees, are popular platforms for representing communities and civil society in holding service providers accountable. Fiscal decentralization via various arrangements such as Direct Health Facility Financing is thought to strengthen Health Facility Governing Committees in improving accountability in carrying out the devolved tasks and mandates. The purpose of this study was to analyze the status of accountability of Health Facility Governing Committees in Tanzania under the Direct Health Facility Financing setting as perceived by the supply side. In 32 different health institutions, a cross-sectional design was used to collect both qualitative and quantitative data at one point in time. Data was collected through a closed-ended questionnaire, an in-depth interview, and a Focus Group Discussion. Descriptive statistics, multiple logistic regression, and theme analysis were used to analyze the data. According to the findings, Health Facility Governing Committees' accountability is 78%. Committees have a high level of accountability in terms of encouraging the community to join community health funds (91.71%), receiving medicines and medical commodities (88.57%), and providing timely health services (84.29%). The health facility governance committee's responsibility was shown to be substantially connected with the health planning component (p=0.0048) and the financial management aspect (p=0.0045). This study found that the fiscal decentralization setting permits Committees to be accountable for carrying out their obligations, resulting in improved health service delivery in developing nations.

Keywords: Accountability, Health Facility Governing Committees, Direct Health Facility Financing

5.1 Introduction

Accountability in the health system is necessary for people to receive accessible, relevant, and responsive health care. Accountability in health care refers to the obligation of health care practitioners or the community to respond to public inquiries regarding their decisions and activities, which are the basis of their mandate, authority, and legitimacy (Belle and Mayhew, 2016; Fetene *et al*., 2020). As a result, accountability encourages accountability between different levels of the health system, resulting in improved health service delivery. Social accountability is highly recommended as an approach for influencing the responsibility of policymakers and health service providers through community participation to improve accountability in public health programs (Joshi, 2017). Social accountability

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through community participation in holding service provider into account help to address primary health care challenges such as poor utilization and allocation of resources, unresponsive health service delivery and ineffective and inefficient health system (Boydell *et al.*, 2019; Lodenstein *et al*., 2017, 2019). In primary health care facilities, social accountability or community participation is represented by community governance structures known as Health Facility Governing Committees (HFGCs). These HFGCs are created to represent communities, civil societies and other interest groups for voicing up and shaping health service delivery in community interest (Tsofa *et al*., 2017; Waweru *et al.*, 2013). The HFGCs have two key functions in primary health care: first, they must hold into account health service providers for health facilities to function properly. Second, through community outreach and co-management of health facilities, HFGCs act as an extension of service providers.

The importance of individual, family, and community participation in the management and implementation of health initiatives has been extensively underlined in both the Alma Ata Declaration of 1978 and the Astana Declaration of 2018. Social accountability through various mechanisms such as HFGCs promises to increase health service providers' and the health system's overall accountability. As a result, functional HFGCs are critical in primary health care for improving community health service delivery and addressing the health problems of all individuals. Strengthening community health care through empowering HFGCs means tackling individual and community health concerns by giving them autonomy and the authority to regulate and govern their own health. Universal Health Coverage (UHC) is primarily achieved by ensuring that everyone, including patients and the poor, has access to care, that the care is of sufficient quality, and that no financial obstacles prevent anyone from getting health services. As a result, responsible primary health care is intended to promote population health through well-managed and accountable primary health care facilities that improve population access to health services and quality care while lowering financial obstacles.

Accountability is related to responsibility and responsiveness in a broader sense since it is based on the notion of responding to or being able to complete the given tasks (Bovens, 2007). It is all about account giving or one’s obligation to justify and explain his/her conduct (Bakalikwira *et al*., 2017). There are three components of accountability namely the locus of accountability (who), the domains of accountability (what) and the procedure of accountability (how). In primary health care, the locus of accountability refers to who is held accountable or who holds others accountable; in primary health care, this can include nurses, incharges, patients, communities, or community governance bodies like HFGCs

(Brinkerhoff, 2004; Emanuel and Emanuel, 2018; Kessy, 2014). The domain of accountability refers to the activity or delegated functions for which a person or entity can be held liable and hence must defend its conduct (Bovens, 2007; Emanuel and Emanuel, 2018; Meyer *et al.*, 2017). The final component is procedural accountability, which refers to the methods that are used to assess a party's accountability (Waweru *et al*., 2013). These can include formal or informal assessments of the locus of accountability's compliance with the delegated functions, as well as justifications from the accountable part, such as HFGC, to the extent that they have completed their assigned duties (Blair, 2018; Kesale, 2017). After evaluation, the evaluator can decide to sanction or reward the part held into account.

The interaction between communities and HFGCs in primary health care institutions is best explained using Principal-Agency Theory. The Principal-Agency Theory describes the act of a principle attempting to maximize value/output by engaging/delegating tasks to agents, with the principal regularly monitoring or holding the agents or the agents themselves to account based on their performance (Blair, 2018; Bovens, 2007; Buchanan, 1976; Gailmard, 2012). The Principal/Agent Theory marches with the accountability definition that entails the “relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgment, and the actor may face consequences” (Bovens, 2007). Communities, civil societies, and other interest groups are the primary/forum in which they have assigned their responsibilities to control primary health care facilities through the HFGCs (Kapologwe *et al*., 2019; Kesale, 2016; Waweru *et al*., 2013). HFGCs, on the other hand, are agents/actors who are democratically elected by the principal or forum, which is a community or interest groups. As a result, the HFGCs should provide consistent accounting to their electorates, which are communities, whether formally or informally (Roman *et al*., 2017).

As suggested by Bovens (2007) Three critical aspects must exist between HFGCs (actors or agents) and communities (forum or principal). In the course of carrying out their delegated functions and powers, HFGCs (agents) are required to inform communities and other interest groups (principals) about their actions. Similarly, communities and other interest groups (principals) could question the HFGCs (agents/forums) about many aspects and information relevant to health service delivery in their communities or health institutions. Finally, after hearing the HFGCs' responses, the communities and civil societies represented by HFGCS may be able to cast judgment on the HFGCs. The verdict may be favorable if communities and civil societies believe that HFGCs are performing well, but citizens may impose sanctions if they believe that HFGCs have failed to carry out their duties and authorities. Because citizens (community and civil societies) elect and appoint members of HFGCs, the consequences may include re-electing or not re-electing the HFGCs in the

following term. As a result, justifying, explaining, reporting, and disciplining may all be considered accountability (Bovens, 2007).

Despite the fact that the global health community recognizes the HFGCs' importance in overseeing the execution of primary health care plans, there is limited evidence about HFGC accountability in achieving social accountability under fiscal decentralization (Bovens, 2007; Lodenstein *et al.,* 2019). The available empirical evidence has been devoted to investigating the method utilized by HFGCs to hold healthcare providers accountable (Lodenstein e*t al*., 2019; Roman *et al.*, 2017; Tsofa *et al*., 2017), the link between management competency, accountability, and hospital board governance (Bakalikwira *et al*., 2017). Furthermore, studies have shown the linkage between citizens and elected politicians (Blair, 2018). Lodenstein *et al* (2017) discovered that the HFGC accountability cycle is less practiced and institutionalized in Sub-Saharan African countries. Several low- and middle-income countries are now delegating budgetary authority and responsibility to HFGCs.

5.2 The Direct Health Facility Financing Context In Tanzania

HFGC was established at health centers and dispensaries in Tanzania as part of the Health Sector Reforms in 1999 to represent communities in the management of health services offered in health facilities. The 2013 guidelines of the Council Health Service Board (CHSB) and Health Facility Governing Committees (HFGCs) (Tanzania, 2013) have assigned HFGCs specific functions. Participating in the mobilization of financial resources, motivating residents to join enhanced community health funds, and preparing health facility plans and budgets are examples of these functions. In addition, managing the facility's income and expenditure, discussing community health concerns and developing solutions, and assessing community needs and preferences. Participating in the acquisition of medicine and medical commodities, as well as the development and maintenance of health facility infrastructure. Several studies were undertaken in Tanzania to analyze the accountability and performance of HFGCs since their establishment, however, revealed that HFGCs were not accountable because they were not carrying out their duties properly. Boex and WHO (Boex *et al*., 2015; WHO, 2015) It was discovered that HFGCs were not properly carrying out their duties and powers because budgetary control and authority over primary health care facilities had been delegated to council levels via Council Health Management Team (CHMT) rather than HFGCs and health providers. Furthermore, facility monies were placed into council accounts and administered by the CHMT. Health providers and HFGCs have no authority over or direct access to facility money. Tanzania's government introduced DHFF to address this issue for Health Facilities and HFGCs. DHFF is a Tanzanian government initiative that empowers and grants autonomy to HFGCs and basic health care facilities to plan, budget, and manage facility financing in order to improve health service delivery

(Kapologwe *et al*., 2019). It utilizes the term DHFF since payments from various sources are transferred directly to the public primary health facility bank account. This type of fiscal decentralization is commonly used in Tanzania's public primary health care facilities. The DHFF implementation began in all Tanzanian district councils during the fiscal year 2017/18.

Despite the implementation of fiscal decentration through DHFF in all public primary health care facilities to empower HFGCs with fiscal and decision-making capabilities while overseeing health facility delivery, the status of HFGC accountability in primary health facilities implementing DHFF is unknown. Indeed, there is no agreement or guidelines in place to assess the accountability of HFGCs in the process of managing and implementing health plans and operations in order to improve the quality of health service supply. This study examines the level of HFGC accountability and the factors that influence it in Tanzanian primary health care facilities that are implementing DHFF.

5.3 Methods

5.3.1 Research Design

The study used a cross-sectional design, in which both quantitative and qualitative data were collected at the same time in selected health facilities throughout four regions that have implemented Direct Health Facility Financing.

5.3.2 Sample Size and Sampling Techniques

This study used both probability and non-probability sampling procedures to select the representative sample from the population (Gravetter, 2012). The research units were chosen using a multistage sampling process. The selection was based on a Star Rating Assessment, which was carried out in early 2018, the same year that the DHFF implementation began. The President's Office of Regional Administration and Local Government completed the star rating assessment in all primary health care facilities in Tanzania. The primary goal of the star rating assessment was to examine the performance of health care facilities and provide feedback for future improvements. One of the topics analyzed in the star rating evaluation report was social accountability (Service Area 8), in which the functionality of HFGCs was evaluated and HFGCs with low and high functionality were identified (Mohamed, 2018). The domains utilized to evaluate the functionality of HFGCs were the number of meetings held by the HFGC per year, issues covered at HFGC meetings, HFGC engagement in the planning and budgeting process, and communication between the community and the HFGC. Other factors were concerns discussed and resolved at HFGC meetings, HFGC orientation and training, and HFGC engagement in the procurement process. The sampling procedure is summarized in Table 1.

Quantitative Sample size

Table 5. 1: Sampling process and sampling techniques

Stage	Respondent	Sampling procedure	Inclusion criteria
First stage	Four (4) regions selected Kilimanjaro, Mbeya, Ruvuma and Songwe	• Purposive	Performance of the region, Zonal representation
Second Stage	8 LGAs selected; Two LGAs from each region were selected in stage one	• Purposive	Performance of the LGAs in star rating assessment, nature of the LGA (Urban and Rural)
Third Stage	32 health facilities were selected from all (8) councils. 2 health centers and 2 dispensaries from each LGA because they all implement DHFF	• Stratification of health facilities into Health centers and Dispensaries • Purposive selection of health centers and dispensaries	Performance of health facility (A good and poor performing health center and dispensary), Location of the facility within the LGA (Diversity)
Fourth stage	280 HFGC members; 9 members from each selected health facility	• Simple random selection of HFGC members	members of the HFGC

At stage four, the HFGC representatives were obtained using the proportion sampling technique suggested by (Buddhakulsomsiri and Parthanadee, 2008; Israel, 2012), The formula assumes a 95% confidence level and a P of 0.5. As a result of the strategies, the number of HFGCs members required was 288. The number of HFGC members from each selected health facility was then estimated using the proportional sampling technique developed by (Pandey et al., 2008) where 9 HFGC members were meant to be chosen from each HFGC For this study, the total number of simple size respondents (response) from all health facilities was 280.

5.3.3 Qualitative Recruitment of participants

Purposive qualitative recruitment was carried out. The participants were chosen for interviews and focus groups based on their capacity to provide meaningful information about the accountability under HFGCs under Direct Health Facility Financing. Chairpersons of HFGCs were purposely chosen for interviews because they expected to be well-versed in the functionality and responsibility of HFGCs. In the case of FGDs, all members of HFGCs were involved because they were all expected to assist in carrying out HFGC's duties and

obligations. The point of saturation determined the amount of 14 interviews and 16 focus groups. Saturation occurred when interviewers and FGD participants continued to provide similar responses, resulting in no new information being supplied throughout the interview. Because qualitative participants were a subset of quantitative participants, their profiles are comparable to those of the quantitative participants. The HFGC chairperson and members were involved in the quantitative collection.

5.4 Data Collection Methods and Techniques

5.4.1 Quantitative Data collection

A systematic closed-ended questionnaire was used. Face-to-face interviews with participants were utilized to obtain data from selected HFGC members. The Open Data Kit software was used to develop the data gathering software (database) (ODK). The acquired data was then entered into the ODK. To collect data, a quantitative approach based on mobile data collecting (MDC) was used. After data was captured via mobile phones, it was transferred to a central server. Four research assistants who were interviewing respondents received three days of training on mobile data collection skills and methodologies, followed by pre-testing of the imparted skills at selected facilities outside the study region. The acquired data were provided to the researcher using the ODK platform. All selected facilities had GPS coordinates as part of quality control, so all research assistants used tablets with GPS sensors. The response rate for HFGCs who completed the questionnaire was 280 out of 288.

5.4.2 Qualitative Data Collection

In-depth interviews with HFGC chairpersons were undertaken to examine the group's responsibility. The interview guide, which included an accountability index, was used to question the HFGC chairpersons. To acquire qualitative data, a Focus Group Discussion (FGD) involving HFGC members was also used. In the health facilities chosen for this study, interviews and focus groups were held.

5.4.3 Data Collection Tools

Based on the delegated tasks of HFGCs as allocated by the HFGC establishing guidelines and DHFF protocol in Tanzania, quantitative data collection techniques were created into an accountability index. This study did, in fact, use the accountability indicators used by the star rating assessment to assess the functionality of HFGCs. As a result, the broader issues that informed the questionnaire development were financial management, planning, and budgeting, community linkages and complaints, and community mobilization to join enhanced community health insurance. Others were involved in procurement, performance management, and service quality assurance.

We generated qualitative data collecting guides based on the HFGC functions allocated to HFGCs in Tanzania by the HFGC guideline of 2013 and DHFF protocol, which correlate to the indicators used to assess the functionality of HFGCs during the 2018 Star Rating Assessment.

5.5 Data Analysis

To determine if HFGCs act to fulfill their tasks, descriptive statistics were used to assess their responsibility. The accountability of HFGCs was assessed using predictors of accountability such as the availability of a price list, a suggestion box, meeting minutes, and evidence of communication between the HFGC and the community. Interviews and FDGs were transcribed verbatim for qualitative data analysis. In-depth interviews took an average of 25 minutes, while focus groups took an average of 32 minutes. The analysis of the audio data began with defining or selecting elements of the recorded audio that were connected to the HFGCs' accountability index. Multiple Logistic Regression was employed to assess the factors associated with the accountability of HFGCs. The selected parts of the audio-recorded interview and FDGs were then transcribed.

The transcription of the audio was completed by the Research Assistant who was in charge of gathering it. The response of the participants was evaluated deductively using the direction of Principal agency theory after transcription of the text statement demonstrating the feelings and experience of the HFGCs in carrying out their duties on the implementation of DHFF. As a result, the statement referring to the experience of HFGC members' participation in various HFGC functions was reviewed to assess accountability.

5.6 Data Cleaning

The data cleaning was done especially for open-ended questions like transportation used to reach the health facility, which allowed research assistance to write, some of them wrote "by car" and others wrote "Car" because they have the same meaning we renamed car to by car because they have the same meaning. The random missing did not detect because the data was collected using a mobile device via the ODK platform, there were data quality checks on a daily basis for any observation, and we communicated with research support for explanation and direction.

5.7 Ethical Approval and Informed Consent

Sokoine University of Agriculture provided ethical approval or an IRB for the project. The Sokoine University of Agriculture provided the IRB with the number SUA/ADM/R. 1/8/668. The permit was then filed to the President's Office of Regional Administration and Local

Government (PO-RALG) to be granted permission to conduct research on local government authorities. PO-RALG granted the researcher a permit with the registration number AB.307/323/01 to conduct research in the chosen areas. All human participants in this study gave their informed permission. Those who agreed to participate in the study and signed informed consent papers before doing so.

The study, however, was subject to various biases, such as the giving of monetary incentives to the participants. Face masks, sanitizers, and transportation allowances were among the incentives provided. Because the data was collected during the second wave of COVID-19 in Tanzania from February to April 2021, face masks and sanitizers were provided. As a result, adherence to the COVID-19 protocol was prioritized, despite the fact that this may be perceived as having an impact on participants. Participants who lived a long distance away from the health center where the data was collected were given transportation.

5.8 Results

The demographic profile included 280 respondents from four regions who were members of the HFGCs. Respondents were classified according to the type of health facility, their position in the HFGC, their age in terms of years, sex, and educational level, as indicated in table 2 below.

Table 5.2: Demographic characteristics of HFGs members N=280

Variable	Frequency	Percent
Region		
Kilimanjaro	93	33.21
Mbeya	64	22.86
Songwe	54	19.29
Ruvuma	69	24.64
Type of Health Facility		
Dispensary	161	57.50
Health center	119	42.50
Position		
Chairperson	43	15.36
Secretary or facility in charge	34	12.14
Member of the HFGC	203	72.50

Age		
<30	32	11.43
31-45	100	35.71
46-60	107	38.21
61+	41	14.64
Sex		
Male	139	49.64
Female	141	50.36
Education level		
Primary	150	53.57
Secondary	64	22.86
Certificate	24	8.57
Diploma	30	10.71
Advanced Diploma	5	1.79
University degree	7	2.50

5.9 HFGCs Accountability Index

The developed accountability index of the HFGC in developing nations is shown in Table 5.3. This accountability index was produced based on a review of the literature, the Tanzania HFGC guideline, and the DHFF protocol, which illustrate the functions that HFGCs are required to execute in the course of governing and managing health facilities.

Table 5. 3: HFGCs Accountability Index

HFGC Accountability Index
Linkages with stakeholders to identify health challenges
Established collaboration with other development partners
Convened HFGCs official meetings as per schedule
Presented and discussed facility plan implementation reports in HFGC meetings
Evidence on the matching of facility resources with patients or community needs
Timely care to facility patients when they attend a health facility
presented to the Ward Development Committee/ Village Council
Authorized funds by HFGC as per budget
Facility expenditure did as per financial guidelines
Discussed quarterly facility financial reports in HFGCs quarterly meetings
Participation of HFGC in the facility procurement process
Participation of HFGC in the planning and budgeting process
Participation of HFGC in receiving medicines and other goods
HFGC participation in staff motivation, recruitment and training
HFGC ensures income and expenditure are known to the community quarterly
HFGC ensures the suggestion box is available in a location where it can be seen by the patients
HFGC ensures the price list for services provided is displayed to the extent that can be seen by the patients
HFGC participates in mobilizing the community to join improved community health funds
HFGC ensure the Mobile number and names for complaints are displayed in a location where they can easily be seen by users
HFGC ensures the client service charter of the facility is displayed in a location where it can easily be seen and read by the health service users

5.10 Accountability of HFGCs

To assess the accountability of HFGCs in Tanzania, prepared accountability indexes were distributed to respondents in order to determine the extent to which their HFGCs have met all of the aspects of accountability. Respondents were asked to rate the extent to which the HFGC achieves that data in each item. The information is presented in Table 5.4 below.

Table 5. 4: Perceived Accountability of HFGCs in the public primary health facilities Implementing DHFF in Tanzania N=280

Statement on the extent HFGC accomplishes their Responsibilities	High Acc N (%)	Low Acc N (%)
HFGC communicates with other stakeholders to identify health challenges and needs	150(53.57)	130(46.43)
HFGC has established collaboration with other development partners to work together in providing services to the community	201(71.79)	79(28.21)
HFGC convene meeting with Facility Health workers to discuss different issues of our facility	222(79.29)	58(20.71)
HFGC ensures Health facility progressive reports are presented in the HFGCs meetings	227(81.07)	53(18.93)
HFGC ensures that health facility resources match patient's or Community needs	214(76.43)	66(23.57)
Patients receive timely care when they attend our health facility	236(84.29)	44(15.71)
Facility progressive reports are presented to the Ward Development Committee/ Village Council	224(80.00)	56(20.00)
HFGC authorizes the use of funds as budgeted	230(82.14)	50(17.86)
HFGC ensures facility funds are used as per financial guidelines	229(81.79)	51(18.21)
HFGC ensures financial reports are provided quarterly and comply with the reporting systems	227(81.07)	53(18.93)
HFGC endorses and participates in the procurement process of all goods and services of the health facility	225(80.36)	55(19.64)
HFGC participates in the planning and budgeting process	229(81.79)	51(18.21)
HFGC participates in receiving medicines and goods procured by our facility	248(88.57)	32(11.43)
HFGC d make a recommendation on staff motivation, recruitment and training to the Council Health Service Board	122(43.57)	158(56.43)
HFGC ensures income and expenditure are known to the community quarterly	188(67.14)	92(32.86)
The suggestion box is available in a location where it can be seen by the patients	203(72.50)	77(27.50)
The price list for services provided is displayed to the extent that can be seen by the patients	192(68.57)	88(31.43)
HFGC participates in mobilizing the community to join improved community health funds	254(90.71)	26(9.29)
he Mobile number and names for complaints are displayed in the location where they can easily be seen by users	214(76.43)	66(23.57)
The client service charter of the facility is displayed on the location where it can easily be seen and read by the health service users	176(62.86)	104(37.14)
Overall accountability	**220(78.57)**	**60(21.43)**

Table 5.4 shows the results of HFGC members' perceptions of the HFGC's accountability at public primary health institutions implementing DHFF in selected Councils in Tanzania. In general, the results show that HFGC members view HFGCs to have high accountability for 78.57 percent of the time and low accountability for 21.43 percent of the time. Specifically, it is perceived that HFGCs are more or have higher accountability in mobilizing communities to join Improved Community Health Funds, receiving medicine, medical commodities, and goods, ensuring patients receive timely care in their facilities and authorizing funds per the budget. Meanwhile, HFGCs have been found to have low accountability on topics such as

employee motivation, recruiting, and training, engaging with stakeholders to identify health challenges, and ensuring the client services charter is applied successfully in health facilities.

5.11 Experience of HFGCs on their accountability in primary health facilities implementing DHFF

Participants responded to several themes during FGDs and in-depth interviews, but the themes that emerged as common among respondents were mobilizing communities to join Improved community health funds, participating in Receiving medicine and medical commodities, financial management (authorizing expenditure and income), and collecting and discussing community health challenges.

Financial Management

Participants' responses on how they have been fulfilling their obligations of managing financial resources varied in this theme area.

> *"We constantly review financial condition because without finances, you can't manage the facility, therefore finance was number one, how to boost revenue, and how to spend it."* (FGD 15-High performing Facility, Chunya District Council)

Another participant responded

> *"I believe the agenda that is unavoidable in the meeting when we meet is about how much we have collected (revenue collection and future plans)."* HFGC Chairperson- High performing facility, Mbeya City Council)
>
> *"In financial management, we make sure that all funds are deposited into the facility bank account, and if there is a need for funds, such as paying the cleaners, we convene a committee meeting and agree on the transaction."* (FGD 1-Low performing facility, Madaba District Council).

Mobilizing Community to join Community Health Fund

Participants reacted to the way they have carried out their responsibilities in ensuring community people join enhanced community health funds in the individual primary health facilities through focus groups and in-depth interviews.

> *"We organize the community by speaking with patients when they visit the facility, and we also speak with the village chairperson to assist us during village meetings so that we can continue mobilizing the community"* (HFGC Chairperson- High Performing facility, Songea Municipal Council)

Procuring and Receiving Medicine and Medical commodities

One of the main responsibilities of HFGC committees is to guarantee that they are involved in identifying the medicines and medical supplies that health facilities require. They also endorse medications and medical commodities to be procured by the facility, and they are a part of the team that receives medicines and medical commodities procured according to orders. In terms of how well they perform this function, respondents had the following reactions.

> *"We always question the health facility in charge about the availability of medicines and medical supplies, and then we negotiate a new structure of receiving them either through prime suppliers or the Medical Commodities Department,"* (FGD 11- low-performing Facility-District Council of Chunya).

Another participant added

> *"We are part of the medical reception team, so we evaluate medicines and medical supplies to verify whether they match what we requested; if they don't, we don't receive them."* HFGC Chairperson – High performing facility, Moshi Municipal Council)

Reporting, Collecting and Discussing with Community About Health Facility Operations and Challenges

Participants testified about how they have communicated the progress and plans of their health facilities to the community. They also talked about how they have dealt with community health issues and how they have managed their health care facilities. Participants also agreed that the fundamental function of HFGCs at primary health care facilities is to identify, discuss, and resolve community health concerns. Above all, they acknowledged the importance of the HFGCs members' existence to the powers of the communities. They testified that they were voted to serve on HFGCs because the community believes they are capable of managing the health facilities. Participants responded in the following ways during focus groups and in-depth interviews:

> *"We have communicated to the community what we are doing and the status of the health center operations through meetings with communities and another gathering."* (HFGC Chairperson- Moshi Municipal Council)
>
> *“As members, we collect and debate community health challenges... When a member of the community lodges a complaint, we collaborate with health experts to determine the best method to address it."* (FGD 3- Tunduma Town Council- High-Performance Facility).

Another participant said

"Some of us here have been in this HFGC for three terms because the community trusts us and has voted for us in every election because they believe we are doing a great job of reforming health service delivery at this institution." (FGD 2- Mbozi District Council-Low performing facility).

Factors associated with the accountability of the health facility governance committee

As indicated in the methodology section, binary logistic regression was used to examine parameters related to accountability.

The results are shown in Table 5 below. The accountability of the health facility governance committee was found to be substantially related to the health planning element (p=0.0048) and the financial management component (p=0.0045). In terms of health planning, the results revealed that health facility governance committees with effective planning were considerably more likely to have high accountability than their counterparts (AOR=5.46, p=0.0048). Members of the committee who had good financial management were more likely to have high accountability than those who had bad financial management [(AOR=5.33, p=0.0045).

Table 5. 5: Binary logistic analysis for factors associated with the accountability of HFGCs

Variable	High Accountability	Low Accountability	Unadjusted		Adjusted	
	N (%)	N (%)	OR[95%CI]	p-value	OR[95%CI]	p-value
Type of Health Facility						
Dispensary	124(77.02)	37(22.98)				
Health center	96(80.67)	23(19.33)	1.25[0.69, 2.24]	0.4619		
Position						
Chairperson	35(81.40)	8(18.60)	ref			
Secretary	30(88.24)	4(11.76)	1.71[0.47, 6.26]	0.4148		
Member of the HFGC	155(76.35)	48(23.65)	0.74[0.32, 1.69]	0.4752		
Age						
<30	21(65.63)	11(34.38)	ref		ref	
31-45	72(72.00)	28(28.00)	1.35[0.58, 3.15]	0.4923	1.69[0.46, 6.24]	0.9151
46-60	93(86.92)	14(13.08)	3.48[1.37, 8.74]	0.0080	3.13[0.72, 13.59]	0.8366
61+	34(82.93)	7(17.07)	2.54[0.85, 7.59]	0.0939	0.49[0.09, 2.59]	0.6903
Sex						
Male	108(77.70)	31(22.30)	ref			
Female	112(79.43)	29(20.57)	1.11[0.63, 1.96]	0.7236		
Education level						
Primary	115(76.67)	35(23.33)	ref		Ref	
Secondary	51(79.69)	13(20.31)	1.19[0.58, 2.45]	0.6279	1.06[0.35, 3.22]	0.9151
Certificate	17(70.83)	7(29.17)	0.74[0.28, 1.93]	0.5363	0.86[0.19, 3.75]	0.8366
Diploma or above	37(88.10)	5(11.90)	2.25[0.82, 6.17]	0.1143	1.36[0.29, 6.19]	0.6903
Governance						
Poor	25(35.21)	46(64.79)	ref		ref	
Good	195(93.30)	14(6.70)	3.06[1.22, 7.65]	0.0169	1.05[0.26, 4.19]	0.9461
Participation in Health Planning and Budgeting						
Not good	35(41.67)	49(58.33)	ref		ref	
Good	185(94.39)	11(5.61)	25.6[12.4, 53.12]	<.0001	5.46[1.68, 17.77]	0.0048
Participation Financial management						
Poor	33(41.25)	47(58.75)	ref		ref	
Good	187(93.50)	13(6.50)	23.55[11.2, 49.7]	<.0001	5.33[1.68, 16.89]	0.0045
Partcipation Procurement process						
Poor	56(53.33)	49(46.67)	ref		ref	
Good	164(93.71)	11(6.29)	20.49[10.0, 41.9]	<.0001	2.84[0.85, 9.46]	0.0893
Informational reports						
Poor	114(66.67)	57(33.33)	ref		ref	
Good	106(97.25)	3(2.75)	13.05[6.34, 26.8]	<.0001	1.42[0.43, 4.66]	0.5662
Participation in Human resources management						
Poor	186(76.54)	57(23.46)	ref		ref	
Good	34(91.89)	3(8.11)	3.47[1.03, 11.72]	0.0450	1.63[0.59, 4.53]	0.0866
Important management aspects						
Poor	57(57.89)	8(42.11)	ref		ref	
Good	209(80.08)	52(19.92)	2.92[1.12, 7.63]	0.0285	0.78[0.19, 3.29]	0.7392
Level of Health Facility performance						
Low performance	102(76.12)	32(23.88)	ref			
Good performance	118(80.82)	28(19.18)	1.32[0.75, 2.34]	0.3389		

5.12 Discussion

The purpose of this study was to assess the perceived accountability of HFGCs in primary health care institutions adopting DHFF in Tanzanian municipalities. According to the data, HFGCs members believe that HFGCs have high accountability (78 percent) in DHFF Tanzania's primary health institutions. These findings are significant and unique because the majority of previous research has focused on assessing social accountability in basic health care (Boydell et al., 2019; Lodenstein *et al*., 2019; Masefield *et al*., 2020). This study was highly precise in examining the accountability of HFGCs under fiscal decentralization in Tanzania, and particularly in underdeveloped nations. The high accountability of HFGCs in the DHFF setting is confirmed by findings in Kenya following the introduction of direct facility financing (DFF) HFGCs, where the ability to fulfill their responsibilities was judged to be satisfactory (Tsofa *et al*., 2017). In Tanzania, a similar finding was discovered in a study undertaken by Mwakatumbula to analyze the impact of DHFF in primary health facilities, as it was discovered that community autonomy and participation in the management of HFGCs were high in the DHFF setting (Mwakatumbula, 2021). The engagement of HFGCs in the planning process of the comprehensive health facility plan and participation in the health facility procurement process has been proven to be significantly associated with HFGC accountability. A similar result was observed in Kenya during the implementation of DFF, where HFGCs participated actively in the planning and budgeting processes (Opwora *et al*., 2010).

HFGCs, in particular, has been proven to have a high responsibility in areas such as motivating people to join community health funds, financial management, procurement and obtaining medicines and medical commodities. This is the kind of authority that has been devolved to the HFGCs. In certain other developing nations, like Burundi, it was discovered that, despite fiscal autonomy, HFGCs were unable to mobilize facility resources (Falisse *et al*., 2012).

In other nations, however, fiscal decentralization enabled HFGCs to increase their functioning and responsibilities because they were made responsible for all aspects of service provision, including requesting funds to fund facility operations (Jiménez-rubio, 2014; Panda and Thakur, 2016a; Samadi *et al*., 2013).

The participation of HFGCs in resource management at primary health facilities implementing DHFF has been found to be highly associated with their accountability, according to both qualitative and quantitative studies. Respondents mentioned the powers and autonomy afforded by the DHFF system as the reason for their significant engagement (Martinez-Vazquez, 2011; The World Bank, 2015). For example, HFGC members have

shown through qualitative data that they have been dealing with ensuring financial procedures conform with financial regulations and expenditures based on the budget and facility plan. This finding is consistent with other studies that have been conducted to determine whether the DHFF improved performance in Tanzanian primary health care facilities. It was discovered that community ownership and autonomy have increased to the point where community health structures such as HFGCs are monitoring health service provision (Kajuni and Mpenzi, 2021). Fiscal decentralization through DFF was found to have strengthened the accountability of HFGCs in financial management in the coastal area of Kenya, even though in some other facilities, HFGCs were unable to account for the devolved fiscal powers due to a lack of awareness of their tasks (Goodman *et al*., 2011; Opwora *et al*., 2010).

The inclusion of HFGCs in the procurement process has also been considered to contribute to HFGC accountability. It has been shown that, under DHFF, HFGCs do participate in the entire process of acquiring products such as pharmaceuticals, medical equipment, building materials, and other services necessary by the facilities as outlined in the health facility plan and budget. Indeed, it has been shown that HFGCs are entirely liable for supporting all finances for procurement purposes, as well as ensuring that they see and get what has been acquired. This has boosted transparency in healthcare management. According to a study conducted in India, procurement/logistics is a significant input in the performance of the health system; consequently, when important units such as HFGCs are accountable for the given tasks within the procurement process, successful health care delivery is ensured (Panda and Thakur, 2016b). However, due to their poor educational level and understanding of health issues, some other members thought that health personnel continue to dominate the procurement process even in their presence. This was also documented in Nepal, where health staff and powerful elites manipulated HFGCs' participation in the management of health facility operations (Gurung *et al*., 2018).

Despite HFGC members' perceptions of high accountability in many accountability indexes, members also view HFGC to have low accountability in managing health professionals and interacting with other stakeholders. The fact that health worker management is still centralized at the council and national levels contribute to HFGCs' lack of accountability in managing health employees. In the health industry, recruitment, training, and wage payment are not governed by health institutions but rather by the council and the national level. HFGCs are only concerned with complaints involving a specific health worker. However, this should not be used as an excuse by HFGCs because the 2003 health facility guideline states that HFGCs are responsible for supervising facility staff (Maluka, 2011).

Furthermore, HFGC's accountability in communicating with other stakeholders other than the community is minimal. It was anticipated that HFGCs would bring together additional stakeholders such as the private sector, civil societies, and other non-governmental or faith-based organizations to contribute to the establishment of primary health care facilities in their respective areas. However, many HFGCs appear to have focused solely on communication with community members, neglecting other critical issues such as mobilizing stakeholders to deliver health services (Coy and Dixon, 2004; Liwanag and Wyss, 2019; Masefield *et al*., 2020).

The findings have validated the Principal-Agent Theory's relevance and the responsibility of HFGCs. This is due to the fact that participants in the interviews and focus groups explained that they have been working hard to meet the expectations of their communities (Principal). They also stated that they have used various channels to provide input to the community on what they have been doing at their facilities and how various difficulties have been solved. This is in relation to the principal-agent theory, which states that the agent must account for the principal. The findings revealed that the ability of HFGC members to be elected for another term is contingent on how the HFGC and its members have been carrying out their responsibilities. This is supported by the responses of participants, who agreed in interviews that they served in the HFGC for three terms because community people voted for them based on their performance. As the principal-agent theory explains, this means that communities have been passing judgment (rewarding or penalizing HFGC and their members) after analyzing their functionality in serving communal interests.

In general, this study is very relevant in three aspects the decentralization of health services and the responsibility of community health systems. First, the study was able to determine the accountability status of HFGCs in primary health care under DHFF, which earlier studies had not done thoroughly. Second, the study revealed elements linked with the accountability of HFGC under DHFF in developing countries that previous studies had not considered. Third, while this study may not have covered all features that can be duplicated in all countries, it has developed an accountability index that may be used to measure the accountability of HFGCs under fiscal decentralization.

5.13 Conclusion

This research provides critical input to policymakers and development partners working to increase the accountability of community health systems in primary health care in developing countries. Fiscal decentralization through DHFF creates a more conducive climate for HFGCs to carry out their delegated obligations, resulting in accountable community health systems. External and internal support are still required to provide a more

comfortable/hospitable working environment for health facilities, such as clarifying the duties of HFGCs in managing facility health workers through legal frameworks. There is a need to strengthen HFGCs' competence to carry out their specific functions, as well as to educate them on the breadth of their powers and autonomy in administering primary health care facilities.

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CHAPTER SIX

6.0 THE DETERMINANTS OF THE PERFORMANCE OF HEALTH FACILITY GOVERNING COMMITTEES (HFGC) IN SELECTED PRIMARY HEALTH FACILITIES IN TANZANIA

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Abstract

Lower- and Middle-Income Countries (LMICs) are implementing fiscal decentralization through Direct Health Facility Financing (DHFF) to empower Health Facility Governing Committees (HFGCs) to effectively participate in the planning, implementing and controlling health service delivery at primary health facilities. However, it is not empirically known what HFGCs members perceive to be determinants of the performance of these HFGCs under DHFF context. Drawing from community participation and decentralization literature, this study was conducted to assess the determinants of the HFGCs performance under DHFF as perceived by the HFGC members in four selected regions in Tanzania. A cross-sectional research design was employed to collect both qualitative and quantitative data from the four regions. A multistage sampling technique was employed to select the study units. Data were collected from 280 respondents through structured questionnaires, interviews, and focus group discussions. The Relative Importance Index (RII) was used to analyze quantitative data. RII ranked determinants of HFGCs' performance under the DHFF context as perceived by the respondents. Qualitative data were analyzed by using content analysis. The study has found that the availability of finance to the health facility has RII 0.8964 score is ranked 1st important determinant of HFGC performance, followed by the clarity of powers and functions with an RII 0.8928 score (2nd) and communication between the HFGCs and community has RII 0.8792 score ranked third (3rd). RII has ranked education of HFGC members as a least (12th) important determinant of HFGCs having an RII score of 0.7285,

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profession of the HFGCs has been ranked 11th with RII 0.7821 score and selection of members ranked 10th important determinant of HFGCs performance under DHFF with RII0.8007 score. This study concludes that contextual factors significantly influence the performance of HFGCs than HFGC members' characteristics in carrying out their devolved functions. The study recommends that the government put more effort into creating a good working environment such as enhancing the availability of finances, providing guidelines for HFGCs, and enhancing communication between the communities and HFGC members.

Keywords: Health Facility Governing Committees, Direct Health Facility Financing, Determinants, Health Facilities Performance, Perceptions

6.1 Introduction

Good health is a cornerstone of development in all societies (URT, 2003a; URT, 2003b; IMF, 2004; URT, 2007a; WHO, 2010; WHO, 2012a; 2012b; Muhanga and Malungo, 2018; Muhanga *et al.,* 2019; Muhanga, 2020). It is against this background that, proper management of health services delivery has been considered to be a key aspect of efficient and effective health services delivery. The involvement of the community members, in this case, has been considered worthwhile towards that end. Community participation is recognized to be an important aspect in improving the quality of health services in primary health care (PHC). It remains uncontested that community participation enhances the acquisition of perfect information on community preferences, tastes, and needs. It is through community participation, local problems get local solutions (Jiménez-rubio, 2014; Martinez-Vazquez, 2011; Oates, 2003). Lower- and middle-income countries (LMICs) are adopting decentralization policy (decision making and fiscal decentralization) to facilitate community participation in the management of primary health care through the establishment of community health governing structures (Abimbola *et al*., 2016; Anosisye, 2017). As a result, Health Facility Governing Committees (HFGCs) comprising community members have been established to manage and monitor health service provision at the primary health care facilities (Kessy, 2014). In the early days of decentralization, only decision-making powers were decentralized to the HFGCs in primary health facilities, however, HFGCs and health facilities are inadequately performing their responsibilities (Kesale, 2017; Muhanga and Mapoma, 2019; Roman *et al*., 2017). Currently, LMICs are decentralizing fiscal powers and authorities to empower HFGCs to accomplish their devolved responsibilities (Panda and Thakur, 2016). LMICs including Tanzania and Kenya are undertaking fiscal decentralization through Direct Health Facility Financing (DHFF) program to grant fiscal autonomy and empower HFGCs in performing their responsibilities. In this program, funds from the national level and other sources are directly deposited into the primary health facilities' accounts to allow HFGCs to have powers and autonomy to control, manage and timely allocate them.

In primary health facilities, fiscal decentralization entails shifting fiscal powers and responsibilities from higher-level government or central government to primary health care institutions such HFGCs (Mpaata and Lubogoyi, 2018). Fiscal decentralization is expected to facilitate and enhance the process of resource allocation by bringing fiscal powers and freedom to local decision-makers (HFGCs) to come out with context-based solutions (Bossert, 2016).

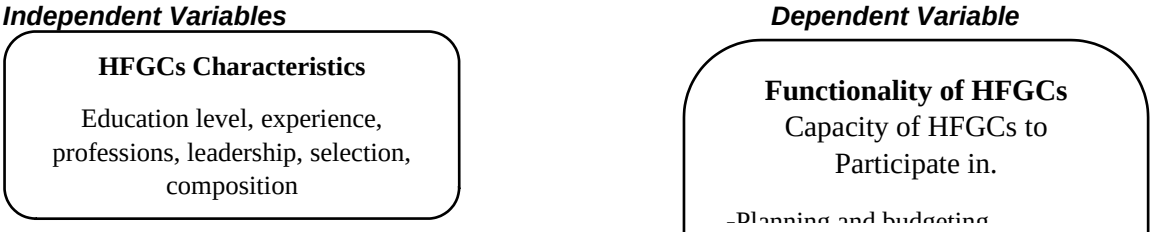
Literature provides that political and administrative dimensions of decentralization depend much on the presence of fiscal decentralization through different arrangements to produce the intended outcomes in service delivery. The introduction of the Direct Health Facility Financing (DHFF) arrangement was meant to empower health providers and HFGCs to effectively participate and have control in planning, budgeting, procurement, and financial use in primary health facilities. In this context, it is expected that efficiency, equality accountability, and innovation in health service provision can be realized (Cheema and Rondinelli, 2007; Panda and Thakur, 2016). However, what practically determines the performance of HFGCs in accomplishing their devolved responsibilities under the DHFF context is empirically not known. Existing studies on DHFF implementation in Tanzania have just assessed the impact of DHFF on financial management at the health facilities (Kajuni and Mpenzi, 2021), and, the prospects together with challenges of DHFF implementation (Mwakatumbula, 2021). Fiscal decentralization literature has provided principles to adhere to during fiscal decentralization including the provision of an adequate enabling environment such as a legal framework that states the powers and responsibilities of HFGC and service providers (Smoke, 2000). Other principles of fiscal decentralization are the assignment of appropriate responsibilities to the service providers and HFGCs and an appropriate intergovernmental transfer system (Buchanan and Musgrave, 2018; Oates, 2003; Hart and Welham, 2016; Samadi *et al.,* 2013).

In Tanzania, fiscal decentralization in primary health care facilities is implemented through Direct Health Facility Financing (DHFF) program. Under DHFF, funds from multiple sources such as basket funds and other intergovernmental transfers are directly deposited to the public primary health facility bank accounts. The DHFF implementation started in the fiscal year 2017/18. Before the introduction of DHFF in Tanzania, the facility spending powers were decentralized to the council level. All facility funds were managed and controlled by the Council Health Management Teams (CHMT). Therefore, HFGCs and health facilities had inadequate planning, budgeting, control powers, and access to their financial resources (Boex et al., 2015; Kapologwe et al., 2019). Most of the primary health facilities had no bank accounts, indeed, even the funds which were collected at the facility level such as user fee charges were deposited into the council accounts (Kuwawenaruwa *et al.,* 2019). Boex

(2015) revealed that the disbursement of funds into District Council accounts instead of health facility accounts created a loophole for reallocation and misuse of facility funds by local councils instead of improving service delivery. Therefore, the Government of Tanzania decided to introduce the DHFF to ensure flexible timely funding at the level of service delivery points so that to ensure increased efficiency in financial use and quality service delivery to the public. According to DHFF implementation protocol, HFGCs mandates are to prepare facilities plans according to the citizens' or community needs and preferences. Also, budgeting is based on available resources. Indeed, they are responsible for procuring health equipment, drugs, and other services. Lastly, they are responsible for making sure funds are being used according to the budgets and not misused by the service providers. Empirical studies conducted on the impact of DHFF in Tanzania have found that DHFF has to increase community participation (HFGCs) and ownership in the management of health serviced delivery at the primary health facilities (Kajuni and Mpenzi, 2021; Mwakatumbula, 2021). However, these studies have not highlighted the factors determining the performance of these community health structures in the management of health service delivery. This article, therefore, assessed the perception of HFGCs members on the determinants of HFGCs' performance in selected primary health facilities that are implementing DHFF in Tanzania.

Theoretical Framework

According to Empowerment Framework, the capacity of an individual or group to make an effective choice is determined by two factors; agency and opportunity structure (Alsop and Heinsohn, 2005; Raich, 2005). Agency refers to the ability of the individual or group to make meaningful decision or choices which is influenced by asset endowments such as information, literacy level, and social capital. Opportunity structure comprises the institutions and social-political context within which actors operate to make meaningful choices. The combination of agency and opportunity structure is termed the degree of empowerment (DOE). The degree of empowerment (DOE) is measured by: (i) the presence of opportunity to make choice (ii) whether actors use the opportunity to make purposive choices either indirectly through representation or directly through participation, and, (iii) if they use the opportunities given, whether choices are translated into desired development outcomes. When all three mentioned dimensions are achieved then development outcomes can be achieved (Alsop and Heinsohn, 2005; Raich, 2005).



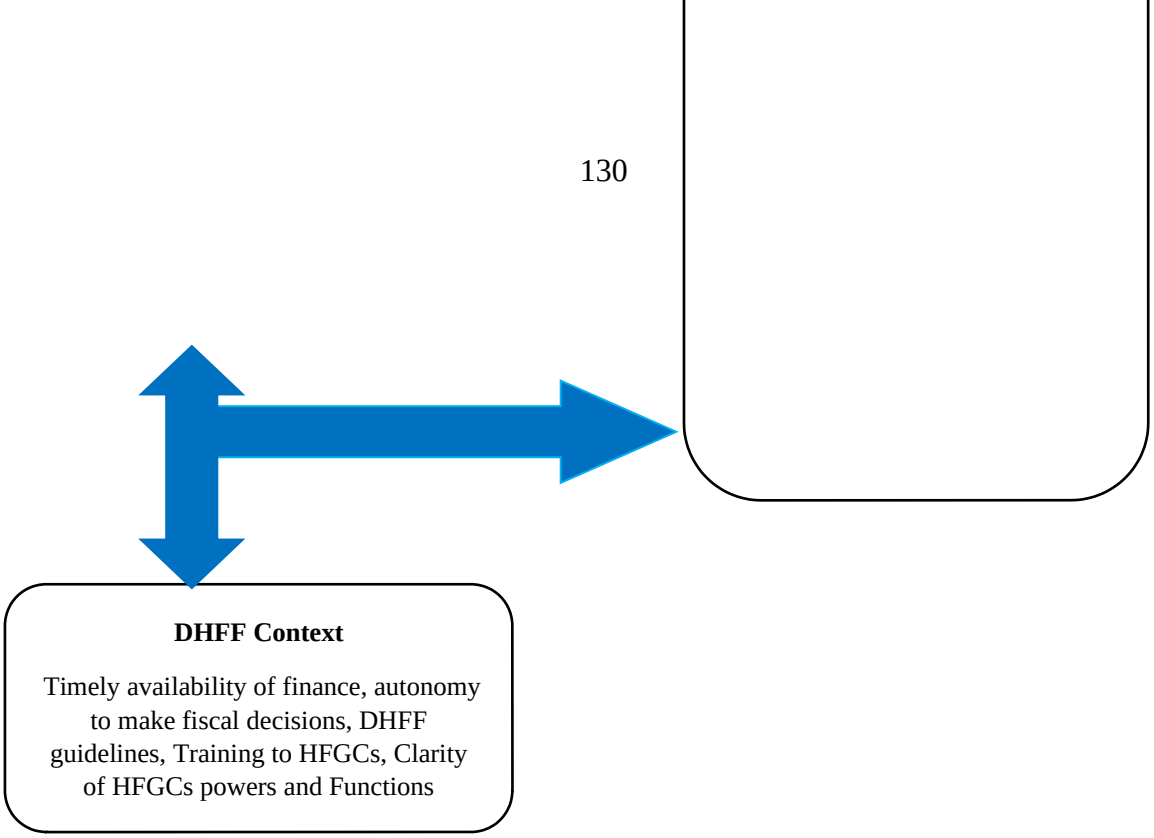


Figure 6.1: Conceptual Framework

In the context of Health Sector Reforms, HFGC stands as an agency that makes decisions having members with different characteristics including skills, experience, and education level. The DHFF arrangement provides a conducive environment for HFGCs to operate or carry out their devolved functions. DHFF empowers health facilities and HFGCs by removing barriers that were limiting health facilities to use their space to decide with respect to planning, budgeting, management of funds, procurement of drugs, and other medical supplies. The DHFF arrangement has granted fiscal powers to the communities through their elected HFGCs to play an oversight role over revenue collection, spending of facility funds, planning, and budgeting. It is expected that this empowerment will result in the improvement of HFGC performance.

Before the DHFF implementation, the Star Rating Assessment conducted in 2017/18 to measure health facility performance indicated that a limited number of health facilities had good performance while the majority of health facilities had poor performance in health service delivery (Yahya and Mohamed, 2018). McCoy et al (2012) argue that the performance of health facilities is directly related to the performance of HFGCs. Despite government efforts to empower HFGCs and health facilities through DHFF arrangement in the primary health facilities in Tanzania to improve their performance, what determines HFGC performance is not empirically known. It is in this context that, this study assessed the perceptions of the HFGCs members on the determinants of the performance of HFGCs under DHFF context in Tanzania.

6.2 Methodology

6.2.1 Study Area

The study was conducted in Songwe, Mbeya, Kilimanjaro, and Ruvuma regions in Tanzania Mainland. The regions were selected based on the Star Rating Assessment conducted in 2017/2018. In 2015, the government of Tanzania introduced a Star Rating Assessment System to measure the performance of primary health facilities and provide feedback for improvement. The Star Rating is based on the average scores of established indicators (0-19% no star or 0 star, 20-39% 1 star, 40-59% 2 stars, 60-79% 3 stars, 80-89% 4 stars and 90-100% 5 stars). The minimum performance standard set by the government was 3 stars for a respective health facility (Yahya and Mohamed, 2018). The last star rating assessment was conducted in 2017/18. In the same year which DHFF started (2018), the government of Tanzania introduced DHFF to improve the performance of HFGCs and primary health facilities in the service provision. Kilimanjaro and Mbeya regions were purposively selected because the majority of their facilities are in the good performing category in the Star Rating Assessment. On the other side, Ruvuma and Songwe regions were purposively selected after having the majority of their facilities under the poor-performing category. The selection was meant to reflect variations in terms of determinants of HFGCs performance in primary health facilities with good and poor performance.

6.2.2 Research Design

This study employed a mixed-method research design. A cross-sectional research design was applied in which both qualitative and quantitative data were collected at a single point in time. A cross-sectional design was chosen because it allows researchers to assess numerous characteristics of the population at once, measure the prevailing situation in the community, and as well as it provides information about the current population that someone wants to study. The data were collected from HFGC members to assess their perception of important determinants of the performance of HFGCs under the DHFF context.

6.2.3 Sampling Techniques and sample size

This study employed both probability and non-probability sampling procedures to select the representative sample from the population. A multistage sampling technique was employed to select the study units. The sampling procedure and inclusion criteria have been indicated in detail in Table 1.

Table 6. 1: Sampling process and sampling techniques

Stage	Respondent	Sampling procedure	Inclusion criteria
First Stage	Four (4) regions selected Kilimanjaro, Mbeya, Ruvuma	• Purposive	Two (2) good-performing regions and Two (2)

	and Songwe		poor-performing regions
Second Stage	8 LGAs selected; Two LGAs from each region were selected in stage one	• Purposive	One (1) good-performing LGA and One (1) poor-performing LGA from each region
Third Stage	32 health facilities were selected from all (8) councils, 2 health centers and 2 dispensaries from each LGA because they all implement DHFF	• Multi-stage sampling Health centers and Dispensaries • Purposive selection of health centers and dispensaries	A good and poor-performing health center be selected from each LGA a good performing dispensary and a poor-performing dispensary
Fourth Stage	280 HFGC members (9 members from each selected health facility)	• Simple random selection of committee members • Purposive selection of HFGC Chairperson for interviews	members of the HFGC

6.3 Sample Size

6.3.1 Data Collection Method

A closed-ended structured questionnaire was employed to assess the perception of HFGCs members on the determinants of HFGCs performance in selected primary health facilities. Qualitative data were collected through interviews and focus group discussions. The interview guide had a total of 26 questions which covered a maximum of 40 minutes. A total number of 14 in-depth interviews were conducted with HFGC Chairpersons to assess their perception of the factors they think determine HFGCs' performance. Also, 13 focus group discussions were conducted with participants who were members of HFGCs.

6.3.2 Data Analysis

The relative important indices (RII) model was employed to determine the perception of HFGCs members on important determinants contributing to the performance of HFGCs under DHFF. The Relative Important Index (RII) is used to determine the relative importance of the quality of each determinant as perceived by the participants (Holt, 2012). The Relative Important Index is only used with questionnaires that are in five-point Likert Scale form (Aziz *et al*., 2016; Azman *et al*., 2019). RII ranges from zero to one (0-1). Therefore, in this study, HFGCs members were required to provide their responses on each determinant through five Likert scale points. The HFGCs members were provided with twelve determinants to rank their importance in influencing their performance in the DHFF context. These determinants were the education level of HFGC members, the experience of the HFGC members, the

profession of the members, and the selection of the members of the HFGC. Other determinants were the composition of the members of HFGC, the leadership of HFGC, the social network of members HFGCs, availability of guidelines on HFGC, and training for HFGC members. Further, clarity of HFGC functions and powers, timely availability of finance, and communication were also among the determinants. IBM-SPSS version 25 was employed in calculating the frequency of the scores assigned by each HFGCs member on each determinant. Then, to determine the ranking of important factors contributing to the functioning of the HFGCs, the RII was statically computed using the RII equation (Hatkar, n.d.; Muhwezi et al., 2014) as follows

Relative Important Index (RII) = RII = $\Sigma W/ (A \times N)$

Where;

W = Weightage given to each factor by the respondents

A= Value of higher Weight = 5

N = Total Number of Respondents 280

6.3.3 Qualitative Analysis

Content analysis was employed to analyze the data collected through interviews and FGDs. Audio recorded data were all selected for transcriptions, followed by the transcription which was done manually. The coding of relevant parts of the study was done with the guidance of a research question which was about the factors influencing the performance of HFGCs. Narrations, opinions, and statements describing the participants' feelings on the issues influencing the performance of HFGCs were captured and summarized. The guiding theory of empowerment framework for this study was used to benchmark the response of the participants if they felt they were empowered, and, if the empowerment enhanced their use of available avenues to exercise the powers and authority to improve service delivery.

64 Results and Discussion

6.4.1 Socio-Demographic Characteristics of HFGC members

This part presents the socio-demographic characteristics of the respondents of this study. The social demographic characteristics of this study were the locations in which the study was conducted, the type of health facility, the position of the members, and the age, sex, and education level of the respondents. Table 2 provides the details in frequency and percentage.

Table 6.2: Socio-Demographic Characteristics of HFGC members (n= 280)

Variable	Frequency	Percent
Region		
Kilimanjaro	93	33.21

Mbeya	64	22.86
Songwe	54	19.29
Ruvuma	69	24.64
Type of Health Facility		
Dispensary	161	57.50
Health center	119	42.50
Position		
Chairperson	43	15.36
Secretary or facility in charge	34	12.14
Member of the HFGC	203	72.50
Age		
<30	32	11.43
31-45	100	35.71
46-60	107	38.21
61+	41	14.64
Sex		
Male	139	49.64
Female	141	50.36
Education level		
Primary	150	53.57
Secondary	64	22.86
Certificate	24	8.57
Diploma	30	10.71
Advanced diploma	5	1.79
University degree	7	2.50

From Table 3, the results indicate that timely availability of finance was ranked 1st important determinant of HFGC performance with RII 0.8964 score, therefore perceived to be most the important determinant for the performance of HFGCs under DHFF. Members of HFGC ranked Clarity of the HFGC functions and powers as the second (2nd) important determinant with an RII score of 0.8928 which was also followed by the communication between the HFGC and community as a third important determinant among the provided determinants with an RII score of 0.8792. However, the education level of the HFGC members was ranked the least important determinant for the performance of the HFGC under DHFF with an RII 0.7285 score. Indeed, the profession RII score of 0.7821 and selection of the members with an RII 0.8007 score have been also ranked low important determinants.

Table 6.3: Perceived determinants for the Performance of HFGCs Under DHFF (n=280)

The factor for the functioning of HFGC	Very Important (5)	Important (4)	Moderate (3)	Slight Important (2)	Unimportant (1)	Total	Total Number (N)	A*N	RII	Ranks
Education level of HFGC members	435	576	66	30	13	1120	280	1400	0.7285	12
Experience of the HFGC members	470	600	48	28	6	1152	280	1400	0.8228	7
The profession of the member	395	604	48	28	20	1095	280	1400	0.7821	11
Selection	345	684	66	16	10	1121	280	1400	0.8007	10
Composition	385	608	111	10	9	1123	280	1400	0.8021	9
Leadership of HFGC	405	664	60	16	5	1150	280	1400	0.8214	8
The social network of members	480	596	69	22	1	1168	280	1400	0.8342	6
Availability of Guidelines	475	688	15	14	1	1193	280	1400	0.8521	4
Training for HFGC members	450	700	30	8	1	1189	280	1400	0.8492	5
Clarity of HFGC functions and Powers	615	556	66	12	1	1250	280	1400	0.8928	2
Timely Availability of finance	765	460	21	8	1	1255	280	1400	0.8964	1
Communication between HFGC and Community	650	540	36	4	1	1231	280	1400	0.8792	3

The study through RII, interviews and focus group discussion has identified perceived determinants that are important in determining the performance of HFGCs under DHFF. Generally, the HFGC members have identified timely availability of finance to the health facility as the most important factor ranked number one in determining the performance of the HFGC. This is supported by the result of an interview conducted with the HFGC chairperson who insisted on the need of having finances in place to accomplish service provisions such as buying medicines and building materials. One HFGC chairperson from an in-depth interview responded that

> *"Most of the activities need finances to be accomplished, therefore, the availability of finances to the facility will help to address the complaint of the patients" (HFGC* Chairperson-Mbeya City Council, 14.02.2021)

This might be caused by the fact that health facility operations depend on finances to be implemented (Kilewo and Frumence, 2015; Tsofa *et al.*, 2017). Delay in accessing funds for implementing facility plans impairs and lowers the quality-of-service delivery.

The clarity of HFGC functions and powers is perceived to be the second important determinant. This is through knowing the expectation and specific deliverables required to be attained by the HFGCs help to reduce the uncertainty of what should be done or not done by the HFGCs the FGDs support the RII results, as participants claimed despite various reforms being implemented in health sector still HFGCs roles are not clear. The findings suggest a need for training and guidelines to be given to HFGC members to clarify their roles and powers to avoid ambiguity and help them to function well.

Past research reveals that the clarity of HFGC functions and powers clarifies power boundaries and functions to help the HFGC focus on important issues (Goodman *et al.,* 2010; McNatt *et al.*, 2014; Waweru *et al*., 2013). Communication between the HFGC members and communities has been ranked the third most important determinant for the performance of HFGC. For the HFGC to perform well, it has to be close to the facility health workers and community, know their problems and find local solutions to address those challenges and improve health service delivery. The results from the interview show that communication between communities and HFGCs is important for the performance of HFGCs under DHFF. This is because communication helps HFGCs to know the status of service delivery and challenges which need to be addressed. A respondent of an in-depth interview argued that: -

> *"Through continuous communication with communities, we tend to know challenges experienced by patients. Hence in HFGC, we discuss those challenges before making important decisions" (*HFGC Chairperson-Siha DC- 02.03.2021)

These findings are in line with a study by Mabuchi et al., (2018) who argues that a good relationship between HFGC and communities is significant for the performance of health facilities. Other important determinants found are the availability of guidelines which ranked fourth and training for HFGC members ranked fifth.

However, the study has identified determinants that are perceived to be least important by the members of the HFGC under DHFF. The least important determinant is the education level of the members, the profession, and the selection of the members. This study is contrary to the findings of studies showing that education, profession, and selection and experience are important (Goodman *et al.,* 2010; Shayo *et al*., 2012; Waweru *et al.,* 2013). This is because this study has found that contextual factors such as availability of finance, communication between the HFGCs and communities, and clarity of HFGCs functions are perceived as the most important factors. However qualitative findings from interviews and focus group discussions indicate that education and training have been reported to be important for HFGCs to accomplish their functions under DHFF. Members have commented on the need for education and training for HFGC members on how to perform their devolved functions. For instance, one HFGC chairperson argued that: -

> *"Education and frequently training are required because we want effective participation in all HFGC functions, but our members do not know what they are required to do to ensure active participation" (*HFGC Chairperson-Tunduma TC, 18.03.2021).

The findings of this study support the selected theory of this study by showing that the contextual determinants in which HFGCs operate stimulate the performance of HFGCs. These determinants are such as availability of finance ranked 1st, Clarity of powers and functions of HFGCs under DHFF ranked 2nd and communication between the HFGCs, health workers and communities ranked 3rd. The determinants are perceived to be more important in determining the performance of HFGCs under DHFF implementation. Therefore, the findings to some extent are in line with the empowerment framework which state that opportunity structures/context in which agency (HFGCs) operate capacitate the agency/HFGCs to make effective choices. A study in Kenya revealed that Direct Facility Financing (DFF) required the participation of HFGCs in the governance of the primary health facility (Goodman et al., 2010; Waweru et al., 2013). In Tanzania, studies have shown that the introduction of DHFF in primary health facilities has resulted in increased community

ownership and empowerment in primary health care facilities (Kajuni and Mpenzi, 2021; Mwakatumbula, 2021). On the other hand, agency/ actor characteristics such as education, experience, and profession are perceived by the members to be less important in determining the performance of HFGCs in primary health facilities implementing DHFF in Tanzania.

6.5 Conclusion

There are renewed drive-in decentralization practices, of now, LMICs are deepening decentralization through granting both decision-making powers and fiscal decision-making to the community health governing structures. This study was conducted to ascertain the determinants of the performance of HFGC under Direct Health Facility Financing in selected four regions of Local Government Authorities in Tanzania. The findings have revealed the perceived determinants important for the functioning of HFGCs under Direct Health Facility Financing including the availability of finances to the facility, communication between the facility, health workers, and community, and clarity of HFGC roles and powers. The study has also identified less important perceived determinants for the function of HFGCs. They include the education of the members, profession, and experience.

Therefore, this study recommends that, if stakeholders want to improve the performance of health service delivery in primary health care facilities through the empowerment of HFGCs, they have to ensure that finances are timely available to the facility and provided guidelines to ascertain the roles and the manners which HFGCs have to accomplish their devolved powers and authority and build good linkage between the communities, health workers and HFGCs. The identified areas require special attention for the sustainability of the functioning of the HFGC under Direct Health Facility Financing.

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CHAPTER SEVEN

7.0 LEVERAGING GOVERNANCE STRATEGIES ADOPTED BY HEALTH FACILITY GOVERNING COMMITTEES IN RESPONSE TO COVID-19 OUTBREAK AT THE LOCAL LEVEL IN TANZANIA: A QUALITATIVE STUDY

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Abstract

The governance of epidemics is very critical for curbing and responding to several infectious epidemics. This study aims to obtain the experience of the Health Facility Governing Committees (HFGCs) members on the governance strategies they adopted to govern the COVID 19 epidemic in their primary health facilities in Tanzania. An exploratory qualitative design was employed to study the governance strategies adopted by HFGCs during the COVID19. In this study, fourteen (14) chairpersons of HFGCs and ninety-one (91) members of HFGCs with experience in governing primary health facilities during a COVID 19 pandemic were involved. Four (4) governance response measures found to be widely used by HFGCs were involved in the study. These included coordinating responders, disseminating health information, explaining health hazards, and carrying out health interventions. However, despite differences in implementation strategies, just two (2) governance response measures, including coordinating responders and implementing, were found to be commonly adopted by the majority of HFGCs. The HFGCs slowly adopted governance strategies in the times of COVID 19 due to the nature of governance pathways adopted in Tanzania, unpreparedness, and unawareness of the HFGCs on their powers and roles during epidemics. Despite being empowered by the Direct Health Facility Financing, still, COVID 19 challenged many HFGCs. Higher level governance actors' perspectives and actions on epidemics impacted the practices of local-level governance actors including

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HFGCs, though observed to be autonomous and supposed to make decisions based on their circumstances. Indeed, for the HFGCs' promise to be realized, their empowerment should go beyond fiscal and political decentralization. Other components of empowering governance actors, such as capacity building and their education level should be considered to fully achieve their potential.

Keywords: COVID-19, Clinical governance, Organization of health services, Health Facility Governing Committees

7.1 Introduction

Governance is appreciated to be the foundation for improving health service delivery at the primary health care (PHC) [1]. It refers to the process in which decisions are made and implemented to protect and promote population well-being [2,3]. Governance is crucial for the achievement of Universal Health Coverage (UHC) and the sixth Sustainable Development Goal (SDG). As a result, the government's initiatives to strengthen governance at all levels promise improved health outcomes and population well-being [4]. Governance gains can be realized through having effective, accountable, and inclusive governance structures or actors [5]. Lower and middle-income countries (LMICs) have implemented innumerable strategies to improve healthcare governance at the primary health care. Decentralization, in various forms, is a frequent policy among LMICs, including fiscal, administrative, and political decentralization used to strengthen governance at the primary health care facilities [6]. Decentralization policy provides for the transfer of administrative, fiscal, and decision-making rights and responsibilities for health service delivery oversight to a subnational governing authority [7,8]. Consistent to Alma Ata Declaration 1978 on the need for community participation in the governance and management of own health, decentralization has resulted into the establishment/introduction of community governance structures known as Health Facility Governing Committees (HFGCs). These HFGCs are supposed to oversee and govern health service delivery at primary health care facilities [9]. These HFGCs are made up of local users/community members who are charged of planning and budgeting, ensuring availability of medicines and health commodities, procurement and linking community to health facilities. Other responsibilities for the HFGCs, include, overseeing the performance of health workers, improving local choices and affecting the quality, responsiveness and coverage of healthcare services [10]. Effective governance of basic health care is critical for responding to complex health shocks like COVID-19 outbreak. However, this can only be realized if there are empowered and well-performing HFGCs that are aware of their governance (oversight and representation) duties.

In the context of a health system, governance signifies the way powers and control are exercised and shared among health stakeholders over health facilities for the greatest

interest of the community [11,12]. That is, having strong and effective governance mechanisms at all levels which ensure protection and promotion of population health also community interest. On the other hand, pandemic/epidemic governance refers to the decisions made and actions taken by the governance actors to mitigate and react to the outbreak [13]. Therefore, epidemic governance is crucial for containing and reacting to a variety of infectious epidemics [13]. The epidemic puts all levels of governance, including primary health care, to the test, necessitating the adoption of new governance measures by governance institutions [14]. According to the literature [14-17], epidemics are characterized by a lack of clarity in defining problems, inconsistency in implementing solutions, and clashing goals and cultures, necessitating the creation of effective and innovative governance structures to handle these issues. As a result of their nature, traditional governance solutions can no longer be effective in resolving epidemic challenges. Empirical studies [18-19] in primary health care suggest that in catastrophic situations, like COVID-19, governing actors must employ innovative and flexible tactics including developing networks, forming partnerships with stakeholders, mobilizing resources, and re-establishing new strategies. These are likely to protect health facilities, their employees, and the general public [1,13,14,20]. Therefore, in that context, successful epidemic governance and protection of the people can be attained [1,21].

In LMICs, governance of primary health care facilities is decentralized to HFGCs [22]. In times of epidemic, health service users are devolved with authorities and responsibilities to oversee and strengthen service utilization, responsiveness, and provider accountability through this people-centered governance method [10,23]. Epidemics, such as COVID-19, , tends to sabotage and disrupt pre-determined healthcare plans and budgets due to its unique characteristics [18,24]. For COVID-19 related problems to be contained, HFGCs must make different and timely decisions to improve facility operations and preserve community health. Due to the fact that the issues faced in connection to COVID-19 governance are not solely technological, COVID-19 governance should employ a mix of socio-political and cultural tactics, with HFGCs' ingenuity and creativity playing a crucial role [18,20,25]. The health outcomes of a community are determined by HFGCs' effective governance of primary health care institutions. This is since HFGCs are in charge of all significant decisions surrounding health facility operations and serve as a link between communities and facilities [24,26,27].

In Tanzania decentralized health care system, HFGCs were introduced in 1999 following the health sector reforms [28]. The HFGCs are composed of elected community members and health facilities in charge [29]. These HFGCs are assigned specific governance functions to

perform such as participating in the planning, budgeting and procurement process. Also, mobilizing people to join community health funds and collecting, discussing and addressing community health challenges. Furthermore, HFGCs are responsible for participating in monitoring the renovation and construction activities of the facility also working with different stakeholders and partners to mobilize resources for the health facilities [30]. In terms of education, the HFGCs guideline requires a member of the HFGCs just to manage reading and writing in Kiswahili. The government of Tanzania has continued to embark on different reforms to strengthen the health system including empowering HFGCs to accomplish their devolved functions. The current reform pursued by the government of Tanzania is the introduction of Direct Health Facility Financing (DHFF). The Government of Tanzania (GoT) decided to introduce Direct Health Facility Financing (DHFF) to ensure flexible and timely funding and usage at the level of service delivery points to ensure increased efficiency in financial use, accountability and quality service delivery to the public [31,32]. This decentralization is the extension of former fiscal decentralization that decentralized fiscal powers from the central government to the council level. The DHFF initiative further aligns with global health initiatives such as the Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs) [33].

The World Health Organization (WHO) published procedures for dealing with outbreaks such as COVID 19 [34]. The framework outlines the critical four (4) response tips that must be considered by management or governance actors to safeguard people from epidemics and other calamities. Indeed, the framework provides direction for health stakeholders in responding quickly to an outbreak. The established response measures are:-: (1) coordinating responders (e.g., joint plan of action describing intervention needed, identification of stakeholders, roles and functions of stakeholders, stakeholders/emergence meeting centers, tools to ensure communication between stakeholders (2) health Information including., surveillance of the diseases; definition of the disease, testing centers or laboratories, case and death statistics and map, risks groups and intervention of the disease such as target group, resources needed, success indicators (3) communicating risks (monitor disinformation and misinformation and transform scientific information into lay language and format, communication plan and channels); and, (4) health interventions (e.g., intervention put in place to control the outbreaks such as the supply of PPE, sanitizers, implementers of interventions, assessing the impact) [34]. These guidelines establish a standard or framework on how health stakeholders, from the national level to primary health actors such as facility managers and governance actors, should respond to epidemics or outbreaks. In this context, it is believed that all choices taken by HFGCs in response to epidemics should be based on WHO guidelines. As a result, it is inferred that during COVID 19, HFGCs are making decisions following the WHO guidelines for handling epidemics.

Although the guidelines are about managing epidemics, it is believed that epidemiological governance, such as COVID 19, should be led by professional conduct, even though governance actors would be innovative in making decisions.

7.2 COVID-19'S experience in Tanzania

The COVID-19 in Tanzania can be traced around March 2021, with the confirmation of the first case. Following this, Tanzania's government banned all public gatherings, by closing academic institutions, banning political party rallies, and sporting events [35]. As part of the government's extra COVID-19 limitations, all overseas passengers were obliged to spend 14 days quarantine in particular hotels. The authorities suspended international flights on April 11th, 2021. Personal protective equipment (PPE) was made available to all levels of health care facilities by the government [5]. Then, there was effective patient screening and isolation, quarantine of confirmed cases, and community mobilization to practice hand washing, sanitizing, and social distance. On May 8, 202, Tanzania's then-president began proposing that traditional medicine, steam inhalation and ingesting indigenous herbs, be used to treat and prevent COVID-19 together with modern professional Covid-19 procedures [36]. The president and his administration encouraged everyone to pray in all houses of worship. In the same vein, the president recommended mass prayers for three days to seeking mercy from God on Covid-19. Tanzania released statistics on Covid-19 cases and deaths early on (shortly after the first incidence), with full data set to be released on May 8, 2020. Tanzania has since halted the distribution of the Covid-19 surveillance report. The president claimed that the number of Covid-19 cases was declining significantly and called for three more days of national prayers. Tanzania thereafter declared herself Covid-19 free. As a result, Tanzanians were told to carry on with their daily activities [35,36]. Even when other countries began to provide the vaccine, Tanzania's President refused to allow vaccinations. Following President Magufuli's model in Covid-19 governance, other levels such as ministries, regional and district levels began to follow suit. Several times, the government publicly questioned global health guidelines on testing and vaccines [35,36].

After the death of President Magufuli on March 17, 2021, the next president, Hon. Samia Suluhu Hassan, acknowledged the existence of Covid-19 in her inaugural address to the country and established an expert task committee to advise the government on the Covid-19 [35]. Following that, all Covid-19 protocols were required to be followed by all citizens, including all levels of government; consequently, testing resumed, and the Covid-19 surveillance report resumed distribution, showing the number of cases and deaths. Covid-19 standards were prepared and executed by the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC) to aid health care providers and other stakeholders in dealing with epidemics. The vaccine was accepted by the government, and President Samia Suluhu Hassan was among the first people in Tanzania to be vaccinated,

demonstrating that the Covid-19 vaccine is safe and reliable. Tanzania is presently following all Covid-19 procedures, and citizens are being vaccinated.

Several studies have been conducted to assess the response of Covid-19 management in Tanzania [35,36]. The research undertaken has highlighted how Tanzania addressed Covid-19 at the national level and its effects from two presidential perspectives (President John Pombe Magufuli and Samia Suluhu Hassan). Indeed, Ruth et al. and Yamanis and Mollel [5,35] research successfully identified Covid-19 containment measures that were adopted by Tanzania's street-level bureaucracy and national government. However, studies have focused on bureaucracy levels while paying less attention to community governance structures such as HFGCs, which represent and link directly with communities and health facilities, more important are the final decision-makers at primary health care facilities. Therefore, is unknown how and what governance measures the empowered HFGCs in primary health care adopted to manage the COVID 19 epidemic in Tanzania. The goal of this study was to assess the governance measures implemented by HFGCs in Tanzania's primary health care facilities.

7.3 Method and Approach

This study was conducted between February and April 2021, a qualitative method was used to investigate epidemic governance at primary health care facilities in Kilimanjaro and Songwe regions in Tanzania. According to the Star Rating Assessment conducted by the President's Office-Regional Administration and Local Government of Tanzania in all primary health facilities in 2018, the Kilimanjaro region was chosen among the regions with high health facilities and HFGCs performance [37]. Songwe was chosen to represent regions with low health facilities and HFGCs performance.

7.4 Study Design

The governance strategies used by HFGCs during the COVID-19 epidemic were investigated using an exploratory qualitative design. The chosen design was judged appropriate since engaging the community through the HFGCs is a social process that is not a linear one. Since the COVID-19 epidemic is a new disease with unknown roles for HFGCs, a flexible design was required to establish the groundwork for future research by providing new insight of HFGCs governed the outbreak within WHO epidemic governance framework.

7.5 Participants and Recruitment

The study areas, councils, and respondents were chosen using a purposive sampling technique. Regions and councils were chosen based on their performance in the 2018-star rating assessment of all primary health care institutions in Tanzania. Songwe was chosen representing regions with low-performing health facilities and HFGCs., Kilimanjaro was

chosen due to having good performing facilities and HFGCs. Then, from each region, two councils were chosen., Moshi Municipal was chosen in Kilimanjaro as a council with the lowest performing health facilities and HFGCs, as well as the urban local authority. Siha district council was chosen being the best performing council in the country according to the 2018-star rating evaluation, but it is also a rural local authority. In Songwe, Tunduma Town Council was chosen for being on its good performance in the region. Mbozi district council represented the region's worst performer, but it is also a rural council, and Mbozi is the Songwe region's headquarters. Two high-performing primary healthcare facilities and two low-performing primary healthcare facilities were chosen from each council. The health facilities were divided into two categories prior to the selection: health centers and dispensaries. As a result, a high-performing health center and dispensary were chosen from each council. A low-performing health center and dispensary were also chosen on purpose. Respondents were chosen from each of the health facilities. The respondents' ability to offer meaningful information about the governance of health facilities during COVID-19 was one of the screening factors. As a result, all members of HFGCs were chosen for FGDs, and only the Chairpersons of the HFGCs of the primary health institutions that were chosen to implement DHFF qualified for interviews. A total of 14 in-depth interviews and 13 focus group discussions were conducted till the saturation threshold was reached. Saturation occurred when the participant began to respond in the same manner and no new information was provided. Each FGD consisted of 6 to 8 participants who are members of the HFGCs.

Table 7.1: Characteristics of the study participants

	HFGC members	**HFGC chairperson**	**In Charges (HFGC secretariat)**	**Total No of Participants**
Total Interviewed		14		14

Focus Group Participants		85		13	98
Age	≤ 35	31	4	7	
	≥ 36	54	10	6	
Sex Male		38	9	8	55
Female		47	5	5	57
Total Number of Participants					112

7.6 Patients and Public Involvement

No patients were involved in this study.

7.7 Data Collection methods

Data were collected between February and April of 2021 when the world was experiencing the COVID -19 HIT, Tanzania inclusive. To gather data from the respondents, the study used in-depth interviews and Focus Group Discussions. FGDs were used to collect data from all HFGC members, while in-depth interviews were conducted to collect data from the HFGC chairpersons. The interview and focus groups were created with the goal of better understanding the governance measures used by the HFGCs during the COVID-19 epidemics. The respondents were asked what were the measures/strategies taken by their HFGC as the health facility governance body to respond to the Covid-19, and how did they implement those strategies. Then, based on this major area of focus, sub-topics of what to discuss were determined to have a better understanding of how HFGC members dealt with the epidemic. Respondents were allowed to share their experiences with some probing questions to learn more about how they dealt with the COVID-19 outbreak.

Table 7.2: Interview schedule

No	**Activity**	**Sub activity**
1	Preamble	1. Interviewer introduction

		2. Asking for consent from the participants and filling the consent form 3. Permission to record
2	Section A	1. What are the powers and responsibilities of your Health Facility Governing Committees? 2. What are the responsibilities of Health Facility Governance Committees in combating pandemics/epidemics
	Section B	1. As Health Facility Governing Committees what have you been doing/measures taken to contain Covid-19 2. How have you been accomplishing those measures? 3. What are the challenges your Health Facility Governing Committee is experiencing in the course of accomplishing its task?
	Section C	1. Do you think Direct Health Facility Financing has provided with any environment to better accomplish your responsibilities in containing Covid-19?

7.8 Data Analysis

The themes that arose during data collection were used to examine the data acquired for this study. The audio recordings of the in-depth interviews and focus groups were made. The audio recording was verbatim transcribed. Researchers were able to read and re-read the excerpts as a result of this. The textual extracts were then converted into codes based on the study's focus areas, which were the governance measures used by HFGCs in the event of a COVID-19 epidemic. As a result, all specific areas in which respondents mentioned COVID-19 governance were coded. The created codes were used to capture significant themes related to governance techniques triggered by HFGCs during the COVID-19 epidemic, and the generated themes were linked to the study's target area. All of the governance topics were examined and enriched from the acquired data to make them more significant and correspond with the study topic, and overlapping themes were merged into one. The themes were then fine-tuned and defined to ensure that the reader understood what they meant in the context of the COVID-19 epidemic.

7.9 Ethical Approval

The IRB with the number SUA/ADM/R. 1/8/668 was sought from the Sokoine University of Agriculture. The permit was then submitted to the President's Office Regional Administration and Local Government (PO-RALG) to seek permit to research in the respective local government authorities. PO-RALG offered a permit with registration number AB.307/323/01 to allow the research to be conducted in the selected regions. Written Informed consent was obtained from all human participants of this study by completing the consent forms before they were involved in the study.

7.10 Results

The collected data were organized into four governance response themes as suggested by WHO (38) which are responsible for coordinating responders, communicating risks, health information, and health interventions As a result, any subthemes that formed from the collection were guided to its main themes. In each theme, respondents were asked what they did or are doing in response to the Covid-19 in their jurisdiction.

7.11 Coordinating responders

Epidemics like Covid-19 necessitate collaborative measures to contain and protect populations from all underlying threats. As a result, responsible local or governance structures, such as HFGCs, are needed to coordinate all parties to ensure that they work together to contain the epidemics. Regarding Covid-19, coordination of responders at the community or grassroots levels necessarily requires the identification of all stakeholders who will contribute to effective control and management of Covid-19 by HFGCs as governance actors responsible for governing service delivery at the facility levels. In doing so, the HFGCs should coordinate responders or stakeholders to develop a plan of action that outlines interventions aimed at controlling Covid-19, as well as specify the duties of each stakeholder.

The majority of respondents acknowledged that they organized responders in communities or villages by identifying them. Religious leaders, village government officials, business people, people with influence in the village, and NGOs or community-based organizations working in the village or given communities were among the stakeholders identified. Although the majority of respondents agreed that they identified certain interventions to be conducted by each stakeholder, many of them highlighted delivering education on social distancing and hand washing.

> *"When we first heard about the disease, our HFGCs identified several key persons such as the church pastor, village chairperson and a man with a big shop in the village who could assist us in combating it, so we went to see them and talked to them.... we decided to meet with all stakeholders."* Respondent-Mbozi District Council

Other respondents stated that the health facility in-charge assisted the HFGCs in understanding how to cope with the outbreak and that they discussed crucial stakeholders to be consulted with the chairperson. After that, they had HFGCs meeting to discuss what was going to happen at the stakeholder meeting. The majority of respondents claimed that

healthcare personnel advised the HFGC on crucial matters and decisions that the committees needed to make.

> *"As soon as we learned about the epidemic, we urged our HFGC chairperson to convene a meeting with facility personnel and HFGC... They then educated us on the epidemic and instructed us on what we should do during that meeting. We came up with new ideas that our HFGC was to implement such as sensitizing the community about covid-19 on washing hands and each household to have a washing hands facility at their doors"* Respondent-Siha District Council

Respondents believed that specific responsibilities to be assigned to stakeholders were not formally distributed, but that each stakeholder volunteered to do something that was within his or her capacity. However, those who are influential and have people such as religious leaders accepted sensitizing people on measures to respond to Covid-19 such as distancing and hand washing, which they also practiced in their worship houses. Other stakeholders, on the other hand, refused to do anything about Covid-19.

> *"Of course, we specified activities for the stakeholders to carry out, but the main focus was on sensitizing communities to change their lifestyles, such as distance and hand washing....." We gave that duty to religious leaders because they are closer to the people"* Respondent-Moshi Municipal council

Other HFGCs in rural areas responded that reacting to Covid-19 was left to health workers and CHWs as it was a professional responsibility. They believed that governance matters such as approving the facility budget should be left to HFGC. As a result, it was left to the responsible health facility to determine who would assist in responding to the Covid-19. Others, believed that Covid-19 had been declared non-existent and that they had never seen it in their village.

> *"I believe it is not within our mandates to meet with stakeholders, one respondent said during the focus groups. "Perhaps health workers can do that... We never got involved with that part here"* Respondent-Siha District Council

Another respondent said: -

> *"We didn't identify any stakeholder or arrange a meeting because we were told that the Covid-19 was just like any other disease and that only people who lived in the town were affected,"* Respondent- Mbozi District Council.

7.12 Health Information

Monitoring information is critical in the setting of epidemics because it determines the impact of interventions implemented by health practitioners and governance actors. Throughout the crisis, practitioners and governance actors are crucial for directing decision-makers such as HFGCs. Surveillance and intervention information are critical for functional HFGCs during

Covid-19. In this context, surveillance information entails providing a clear definition of the disease, HFGCs and service providers preparing to provide information to testing centers or laboratories, providing several cases, death statistics, and a map in a given community, sensitizing about the risk group, and elaborating on what has already worked to build community confidence.

Respondents gave varying responses on the roles they played concerning health information. While others stated that they were involved in providing health information to the community, specifically on awareness creation on Covid-19's symptoms and informing community members on test sites for the Covid-19, others stated that they were never involved in doing so. Since the task was left to health workers when someone visited a health facility. Some claimed that, they lacked testing laboratories and instead assessed symptoms and referred patients to the council or a regional hospital. Some respondents stated that, despite providing information testing facility, the number of persons who attended was relatively low.

> *"We've been educating people about the Covid-19 and trying to differentiate it from other diseases... But we've been doing it with CHWs or health-care workers but the turn up is very low."* Respondent- Tunduma Town Council

Other said

> *"We didn't have any testing arrangements at our facility, and you know, Covid-19 doesn't exist in our community because we're poor... We've been told that the disease is only prevalent in urban areas".* Respondent- Siha District Council

In terms of the number of cases and deaths, HFGC members stated that they have been updating communities about the cases and deaths through a variety of channels, including religious leaders, village leaders, and social media. The majority of respondents from rural settings, on the other hand, claimed that their HFGCs never disseminated information concerning cases and deaths because they either didn't have any confirmed instances and deaths or were afraid of upsetting community members. Others believed that it was not their responsibility.

> *"No one would dare to give statistics on cases and deaths since you need to double-check your data... Have you heard anything like that from the national level? So, how do we go about releasing it?"* Respondent-Moshi Municipal Council.

7.13 Communicating Risks

Like other epidemics, the number of cases and deaths tend to rise during the Covid-19 pandemic. During epidemics, significant increases in cases and deaths frequently result in the rapid spread of disinformation and misinformation, including rumors, gossip, and incorrect information. This makes epidemics like Covid-19 more complex, causing fear and confusion among populations. As a result, all responders, including HFGC, must have

strategies in place to cope with an infodemic. Dealing with epidemics necessitate actors converting scientific material such as Covid-19 into lay language and format, establishing a stronger communication plan that provides relevant and trustworthy messages to the community, and having health monitoring measures to mitigate them.

The vast majority of respondents admitted to having no strategy for communicating risks to community members. During the Covid-19, respondents admitted that there was a surge of information from social media and other sources. According to one of the interviewees,

> *"To be honest, our HFGC did nothing in terms of sharing Covid-19 information to the communities because we were short on information, and we assumed the in charge would come to better educate us and the people about this disease.* Respondent-Mbozi District Council

Some of them admitted that even HFGCs members, were confused about what was actually true about Covid-19, because even higher government figures appeared to hold opposing viewpoints on the issue, leaving HFGC members and communities in a dilemma.

> *"It's certainly frustrating; we don't know whom to trust because everyone is saying different things about the same topics, and even our highest government officials are inconsistent on this. have you visited social media and seen what they are saying?"* Respondent-Tunduma Town Council

Few respondents from urban areas claimed that they had some strategies in place, such as using facility health care workers to deliver testing education and clarifying the message regarding the Covid-19 because of widespread misinformation on social media. majority of rural respondents believed that even health workers did not have clear information regarding Covid-19 in the early days, which surprised HFGCs because they rely on professional guidance.

> *"For us, we decided that our tasks should include organizing meetings and visiting public places with health facility workers and CHW, as well as providing a space for this profession to explain what Covid-19 is all about because they are the ones who understand the disease best."* Respondent-Moshi Municipal Council

Another response was

> *"Even our health workers were unclear about the covid-19, particularly its symptoms... They were terrified, just like us, because they had not been taught or trained about the Covid-19" Respondent*-Mbozi District Council.

7.14 Health Interventions

Covid-19, like other epidemics, demands intervention strategies to limit transmission, severe morbidity and mortality, and the impact on health-care system performance. As the governing body of the health facility, HFGCs were obliged to have established or taken a decision on interventions to address all of the issues identified. The Covid-19 was supposed to come out with interventions such as community engagement and promotion, case management and IPC. These had to include case isolation, early supportive treatment, and protecting health workers as the overseers of health service delivery and the organ that ensures whatever is done at the facility has their blessings. Other methods include testing, contact finding, contact tracing and safe and dignified burials.

When HFGCs members were asked what type of health interventions were adopted in their communities or health facilities, their responses were diverse. Some respondents in rural areas, for example, stated that they conducted village meetings to give Covid-19 sensitization, where villagers were informed about how the disease is transmitted, measures to be taken by each village member, and where to go if one suspected contact with Covid-19.

> *"We ensured that several HFGC members attended every village meeting, as well as the health facility in charge, to educate people about Covid-19....sometimes we used even our local languages to help people understand properly"* Respondent-Mbozi District Council

While other responded: -

> *"We devised a strategy to reach out to the community and raise knowledge about COVID-19... our members were then dispersed throughout the hamlet every Sunday to raise awareness through churches"* Respondent-Siha District Council

Respondents in urban regions stated that it was difficult to organize meetings due to the nature of urban life, thus it was essential to ensure that every household, and public institution, such as schools and offices, have washing hands gear and sanitizer. Other representatives stated that they lacked a community engagement and promotion strategy because the president announced that there would be no Covid-19 in Tanzania.

> *"President Magufuli said that there was no Covid-19 in Tanzania, so how could someone go to a community and start telling people that it is Covid-19?" "We all relaxed and continue about our normal lives"* Respondent-Moshi Municipal Council

Regarding case isolation and early treatment, the majority of respondents stated that it was not implemented in their facilities since it was handled by higher-level facilities such as district and regional hospitals. Interestingly, some respondents in Kilimanjaro stated that they advised people to use traditional herbs and ginger and that it was working and helping them, even though this cannot be scientifically confirmed.

> *"We're utilizing traditional herbs here to protect ourselves from Covid-19, and it's working well... The leaves were similar to those found in Madagascar... "Perhaps they boost our immunity"* Respondent-Tunduma Town Council

Regarding health worker protection, the majority of respondents stated that their governing bodies granted funding to purchase PPE, water tanks, masks, and sanitizer for their health facilities. They also required anyone who visited their health facilities to wear masks and wash or sanitize their hands before approaching any facility employee or office. They stated that all was doable due to the financial resources stored in their facilities.

> *"In our HFGC, we took a budgetary decision to reallocate certain funds that were to be utilized for vaccination promotion to acquire some items that would aid to protect the facility employees, such as masks and water tanks"* Respondent- Moshi District Council
>
> *"Because COVID-19 was not included in our facility plan, our HFGC has yet to make a funding decision. We're also hesitant to plan anything monetary because we haven't received funds from the government or other sources, such as health insurance"* Respondent- Mbozi District Council
>
> *"We wrote letters and sent to stakeholders we thought may help us... The response was great, and as a result, we were able to obtain some quite valuable materials*" Respondent-Tunduma Town Council

However, several respondents from rural facilities stated that they were unable to obtain PPE due to a lack of funding, but they were able to purchase masks, sanitizers, and water tanks for the health facilities.

Respondents from urban HFGCs stated that it was difficult for them to perform contact tracing due to the nature of urban life, but those in rural areas stated that they were able to pursue contact tracing, particularly for those coming from urban areas. Showing stigma to persons arriving from urban regions, as well as the reception of Covid-19 in rural areas.

> *"Whoever comes from the city, we have to follow up on her/his condition, and we have been warning people to be cautious with them because Covid-19 comes from cities"* Respondent-Siha District Council

Respondents had mixed feelings about safe and dignified burials. The majority said they did not participate directly in burial activities. These individuals citing fear of being exposed to disease as one of the reasons. Others said they did not participate because it was handled by health professionals at the district or regional level. Those involved in funeral events stated that they educate people about not participating fully in burial ceremonies, maintaining social distance, and wearing masks if they participate.

"Because we don't know the causes of many of the deaths that are happening at the time, we are asking community members not to participate, particularly when the death occurred far away from here and involves people from urban areas... Only a few relatives should attend" Respondent- Siha District Council.

7.15 Discussion

Governance of epidemics such as COVID-19 is critical for limiting its effects on communities and health system performance in primary health care. HFGCs are the governance institutions overseeing community health service delivery. All important decisions on health service delivery are made by HFGCs, including how to respond to epidemics like Covid-19 in basic healthcare settings. The goal of this study was to explore the governance response strategies/mechanisms used by Tanzanian HFGCs to respond to the Covid-19 at the local level. HFGCs have had a mixed experience with the governance mechanisms implemented during the COVID-19. Some HFGCs were very active in using their devolved governance abilities and mandates to make decisions to respond to COVID-19, while others did not make the necessary governance decisions. However, in the context of DHFF, this study highlighted the common governance mechanisms used by HFGCs in selected primary health facilities in Tanzania. HFGCs used governance strategies such as coordinating responders (identifying stakeholders, developing an action plan, and assigning responsibilities to each stakeholder). Furthermore , providing health information (directing them to testing laboratories), providing information on Covid-19 cases, deaths and risk areas in their communities); communicating risks (using health facility staff and CHW to provide accurate information about Covid-19, as well as text messages to provide accurate information).; this also included implementing the interventions (organized sensitization meetings, procured PPE, made the financial decision, contact tracing, implemented safe and dignified burial).

Participants reported that HFGCs were slow on responding to COVID-19 due unpreparedness for the outbreaks and hence did not know which approaches would be helpful in combating it. Lack of resources was also revealed to be a serious barrier to HFGC's choice to adopt several HFGCs initiatives, such as the buying of PPE. This study supports the claims made in the literature that the healthcare system's lack of preparedness during the rise of COVID-19 would hurt the epidemic's combat [39–41]. Despite the difficulties, HFGCs played a significant role in guaranteeing the availability of basic healthcare supplies such as PPE, masks, and sanitizers. Governance approaches helped to fill the budget gap in primary health facilities by mobilizing stakeholders and resources to obtain medical commodities and medicines that were required. This also corresponds to

McMullin and Raggo [21] who stated the importance of collective efforts among health stakeholders in dealing with the COVID 19.

The Covid-19 experience in Tanzania, specifically from May 2020 to March 2021 during President Magufuli's presidency, has seen to contribute to the variety of governance responses to epidemics. During this time, the government did not follow the worldwide Covid-19 standard protocol and instead selected its approach, with the president frequently opposing protocols, causing other senior government officials to follow suit. This confused community/local government actors, who were hesitant to follow professional protocol in responding to the Covid-19. Furthermore, even when the governance actors opted to launch Covid-19 initiatives to comply with Covid-19, they were split or rejected by community members who utilized the president's pronouncements on Covid-19 to justify their rejections. To a large extent, the governance systems adopted at the national level have determined government at the local level in Tanzania.

There is little or no difference in the roles given to HFGCs in Tanzania based on the tactics used in combating Covid-19 [42]. Many initiatives remained within their scope of authority and functions, although they were to be implemented in circumstances that were uncommon for HFGCs. According to the guideline [42] In Tanzania, HFGCs are in charge of planning, procurement, budgeting, health promotion, connecting community and health facilities, supervising the building and renovation of facility infrastructures, and overseeing facility assets. This raises some concerns when respondents state that they did nothing or are unaware that dealing with epidemics is part of their duty. The educational level of the HFGCs members may have contributed to the majority of them being unaware and failing to make decisions within their mandates. Members of the HFGCs are only required to know to read and write, according to the HFGC guidelines. Given the powers entrusted to HFGCs, we believe that their members require education beyond reading and writing to carry out their responsibilities effectively.

According to the findings, HFGCs in urban councils were more active in dealing with Covid-19 than HFGCs in rural councils. The majority of respondents from urban HFGCs agreed that they made some decisions to respond to the Covid-19, but the majority of respondents from rural HFGCs claimed that they made no or few decisions to respond to the Covid-19. The decision made by urban HFGCs were to organize stakeholders, mobilize resources from stakeholders, provide health information such as testing laboratories and isolation centers, execute interventions such as suspect isolation, and safeguard health workers by purchasing PPE. While rural HFGCs made decisions regarding village meetings, contact tracing, purchasing masks, sanitizers, and water tanks, and deploying health workers and

CHW to deliver Covid-19 education. The disparity in the techniques used by these HFGCs could be attributed to the nature of the Covid-19 epidemics, which were more prevalent in urban places than in rural ones in Tanzania. As a result, the demand to respond was much greater in urban centers than in rural areas. However, no significant difference was detected in the governance of Covid-19 in Tanzania between HFGCs with good and low performance in the star rating assessment conducted in 2018. In dealing with Covid-19, both high and low HFGC have made almost similar judgments. The location of the HFGCs played a significant role in determining the governance measures taken by a certain HFGC.

Direct Health Facility Financing (DHFF) has been found to have aided HFGCs in making decisions relating to planning, procurement, and financial allocation to some operations in the context of regulating the Covid-19 pandemic in Tanzania. Prior to DHFF, HFGCS, and health facilities were unable to make those decisions without district-level permission, or they could formulate plans but could fail to spend financial resources to accomplish them. This is due to funds being held in council accounts rather than facility accounts. During the pandemic, however, the majority of HFGCs in both urban and rural areas were found to be ignorant of their powers and responsibilities during times of epidemics. This implies that, even though the DHFF permits HFGCs to freely make decisions about planning, procurement, budgeting, and financial management, members are unaware of how to execute such powers. This means that the government's goals of increasing community control in primary health care delivery may not be met. As a result, empowerment entails more than just fiscal decentralization, and more efforts are required to improve individual ability among members of the HFGCs.

HFGCs have been found to partially comply with the WHO framework for managing epidemics. The framework emphasizes Coordinating Responders, Health Information, Communicating Risks, and Health Intervention as critical tips for managing or responding to epidemics such as Covid-19. However, the majority of HFGCs in the study were found to focus on two recommendations, coordinating responders and delivering interventions, but little on health information and communicating risks. Failure to implement health information and communicate risks jeopardizes the effectiveness of HFGCs in implementing health intervention because the two components shape intervention implementation for the actors. Indeed, the responses of HFGCs to the four managing epidemics tips are shaped by the health service providers/staff of the specific HFGCs because they are the ones that advise the HFGCs on critical technical issues such as Covid-19. Because HFGC members are not health professionals, where the health facility in-charge/staff has a good relationship with HFGC, the function tends to be good, and where the relationship is not strong, the HFGC is very limited.

7.16 Conclusion

Effective epidemics governance is critical for limiting its effects at the community level. empowered governance institutions such as HFGCs have the promise for the achievement of effective epidemics governance. While there is evidence of some governance activities being pursued by HFGCs as governance actors in responding to Covid-19 in primary health care, higher-level governance actors may influence their practices to be effective or in effective. Indeed, for the potential of the HFGCs to be realized, the empowerment of HFGCs should not be centered on one component such as fiscal decentralization. Other aspects which involve empowerment of governance actors such as building the capacity of HFGCs members and re-thinking on the education level of the governance actors such as HFGCs need to be settled to fully realize their potential. In times of COVID-19, the functionality of HFGCs in low and middle-income nations appears promising, but more work is needed to unlock their potential and adequately respond to the epidemics.

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Ethical Declaration

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CHAPTER EIGTH

8.0 GENERAL DISCUSSION, CONCLUSION AND RECOMMENDATION

8.1 Introduction

This chapter provides an overview of the research by reviewing its objectives, and main findings and demonstrating how well they addressed the study's main topic. It examines the relevance and consequences of the findings, in terms of theory, policy and practice, based on their proven connection to theoretical knowledge that is now known and empirical data from prior investigations. The study's shortcomings are acknowledged in the concluding paragraphs, where the chapter also offers some suggestions for future research directions.

8.2 Summary of the Major Findings

This dissertation is based on the study on the assessment of the performance of health facility governing committees in public primary health facilities implementing Direct Health Facilities Financing among Local Government Authorities. To achieve its objective the study had the following objective: to assess the functionality of HFGCs in public primary health facilities implementing DHFF; to assess the perceived accountability of the HFGCs in public primary health facilities implementing DHFF in Tanzania and to determine the important factors influencing the functionality of HFGCs in public primary health facilities implementing DHFF in Tanzania. The study was guided by the empowerment framework/theory which entails that the capacity of an individual or a group to make an effective choice is influenced by the agency and opportunity structure. Agency entails the ability of an individual or a group to make a meaningful decision. Opportunity structure refers to the formal or informal context in which an individual or a group operates. Context enhances individual or group capacity to transform the agency into meaningful choices. In the context of this study, HFGCs are an agency and the DHFF is the opportunity structure or formal environment in which the HFGCs/agency operates. Therefore, DHFF creates a conducive environment for HFGCs to make effective choices/accomplish their devolved environment.

The study has found good functionality of HFGCs under DHFF. In particular, the study suggests that HFGCs have high functionality in mobilizing communities to join Community Health Funds, participating in the procurement process, discussing community health challenges and planning and budgeting. Indeed, the study has found that HFGCs implementing DHFF have high accountability specifically, in terms of mobilizing the community to join community health funds, receiving medicines and medical commodities, and providing timely health services.

8.2.1 The Functionality of HFGCs under DHFF Context

It has come to light that HFGCs successfully carry out their responsibilities in the context of the DHFF. This means that DHFF offers a favourable environment for health facility actors like HFGCs to carry out their devolved functions. This suggests that increasing fiscal decentralization at primary healthcare facilities is crucial if community governance structures are to carry out their responsibilities by taking part in the planning implementation and oversight of community health service delivery. Building strong HFGCs at primary healthcare facilities is the potential of achieving the Alma Ata meeting (Bossert, 1998) of participating communities in health service delivery. Indeed, the findings suggest that in the DHFF context, communities are adequately represented in setting health services to be provided in the community's best interests because their local health challenges are easily seen by their

representatives, voiced in formal HFGCs meetings, and addressed by the health service providers (Waweru *et al*., 2013).

The findings of this research demonstrate that, unlike in the early stages of decentralization in LMICs countries, where only political and administrative components were decentralized, decentralization reforms in these countries should not be limited to one or two aspects (Dick-Sagoe, 2020). However, for decentralization to be significant and improve the delivery of healthcare services at the primary level of care, it must address all three dimensions of decentralization: political, administrative and fiscal. As was observed in Kenya when it was put into place in the early 2010s, fiscal decentralization through the DHFF has indeed been found to be effective in raising community involvement in managing the planning and execution of health service delivery (Goodman *et al*., 2011; Opwora *et al*., 2010). The results of this study also call on other nations that have begun fiscal decentralization in primary healthcare facilities and other areas to adopt the DHFF approach because it has been successful in Kenya and Tanzania in influencing community involvement at primary healthcare facilities.

The HFGCs have exhibited improved functioning in terms of encouraging individuals to join community health funds, discussing challenges facing community health, participating in the procurement process, and actively participating in planning and budgeting. The DHFF focused on several functional areas, including strengthening community engagement in planning and budgeting, financial management, and the procurement process, which the HFGCs have deemed to have good functioning (Kapologwe *et al*., 2019). Good functionality in these functional areas suggests that the DHFF has, in large part, succeeded in its goal and has also enhanced community ownership in the operation of healthcare facilities. This is because they address community concerns, include them in facility planning and budgeting as a means of resolving them, oversee the procurement of what they have planned, and keep their promise to the community. Since representatives from the community are involved in recognizing community challenges, determining priorities, and putting them into action, this cycle of community participation under DHFF is crucial for improving health system responsiveness at primary healthcare facilities. All of them were not feasible before the DHFF was implemented in Tanzania because the community lacked fiscal authority and responsibility, which prevented many of them from being put into action (Boex et al 2015; Frumence *et al*., 2013)

8.2.2 The governance strategies adopted by the HFGCs in responding to Covid-19

Regarding the governance strategies that were adopted by the HFGCs in responding to the Covid-19 as one of their responsibilities the study has revealed that despite WHO

recommending the four tips to be adhered by management and governance actors which are coordinating responders, disseminating health information, explaining health hazards, and carrying out health interventions. Only two of them were found to be commonly used (2) as governance response measures, including coordinating responders and implementing, were found to be commonly adopted by the majority of HFGCs. The HFGCs slowly adopted governance strategies in the times of COVID 19 due to the nature of governance pathways adopted in Tanzania, unpreparedness, and unawareness of the HFGCs on their powers and roles during epidemics. Despite being empowered by the Direct Health Facility Financing, still, COVID 19 challenged many HFGCs. Higher level governance actors' perspectives and actions on epidemics impacted the practices of local-level governance actors including HFGCs, though observed to be autonomous and supposed to make decisions based on their circumstances. Indeed, for the HFGCs' promise to be realized, their empowerment should go beyond fiscal and political decentralization. Other components of empowering governance actors, such as capacity building and their education level should be considered to fully achieve their potential.

8.2.3 Accountability of the HFGCs under the DHFF Context

The study's conclusions imply that the HFGCs' accountability under the DHFF implementation in public primary health facilities is generally satisfactory. This means that HFGCs effectively carry out the DHFF's devolved functions and mandates. Fiscal decentralization as suggested by Arends (Arends, 2017) is very significant for providing adequate environment for community governance structures to perform their responsibilities on behalf of the communities. The HFGCs' high accountability means that in the context of the DHFF, the committees can compel service providers to abide by the rules governing the administration of health facilities, such as financial regulations and clinical standards. As a result, the accountability of HFGCs is a sign that the performance of the health system, which is the major objective of the global health communities and country goals, may be improved.

This study's results are consistent with the results of prior empirical research which reveals that fiscal decentralization affects other types of decentralization, such as political decentralization, which gives decision-making authority to stakeholders in the health sector (Cuenca, 2015; Fjeldstad, 2001; Kazungu & Mabula, 2013). The DHFF implementation has revealed that HFGCs have significant accountability for non-fiscal tasks as well, such as decision-making or connecting facilities with communities. This occurred because HFGCs feel confident making decisions when they know they can implement them with the aid of resources or financial backing. Since DHFF funds are promptly transferred into the main health facility accounts, these government structures are free to use the funds right away to

support their decisions. Similar fiscal decentralization was carried out in other parts of Kenya, where these communities' governance systems were found more accountable than they were before the Direct Facility Financing (DHFF) (Goodman *et al*., 2011; O'Meara *et al*., 2011; Waweru *et al.*, 2013).

The study's findings show that strengthened accountability of HFGCs through DHFF will result in effective engagement in managing their health, resulting in quality, inclusive and responsive health service delivery to the community. The provision of high-quality, inclusive, and responsive healthcare services at the community level means a high likelihood of achieving Universal Health Coverage (UHC). Having accountable and competent HFGCs at primary health care facilities guarantees that everyone, especially patients and vulnerable persons, have access to quality and inexpensive health care with low financial constraints (Olu et al., 2019). Therefore, well governed primary health care facilities are very fundamental for achieving the Alma Ata Declaration of 1978 and Sustainable Development Goal number 3 of ensuring healthy lives and well-being for all.

8.2.4 Factors Determining the functionality of the HFGCs under DHFF

The findings of this study reveal that the availability of funds to the health facility, clarity of powers and functions, and communication between communities, HFGCs, and service providers are essential elements in determining the functionality of HFGCs under DHFF implementation. That is, for HFGCs to properly carry out their tasks and obligations, funds are required to fund health interactivities planned; otherwise, HFGCs may engage in planning but fail to implement it due to a lack of funds. Knowing what HFGCs are expected to perform and delineating their powers allows HFGCs to concentrate on governance concerns. This tends to bring unity to the health facility and avoids power struggles between health providers and committee members. It has been revealed that communication is essential in fostering community involvement since it empowers the governing body to comprehend the health needs of the communities and the demands of the service providers, facilitating simple decision-making.

In this respect, fiscal decentralization has provided HFGCs with the essential conditions for them to carry out their powers and mandates, which has enhanced their performance. Indeed, engagement in planning and budgeting, procurement and community mobilization to participate in better community health funds have all been linked to the functioning of HFGCs under the DHFF. The findings of this study confirm Boex's contention that fiscal decentralization at the community level increases community participation significantly (Boex, 2015). Indeed the study challenges the argument of Bossert and Mitchell (2011) that even under decentralization communities may continue to behave the way they used to

behave before decentralization. This study proposes that if fiscal decentralization is successfully implemented, it can considerably impact the community and community governance structures to participate in various aspects and aid to improve service delivery at primary health care facilities. Limited fiscal decentralization may misrepresent the entire idea of decentralization since the central government and other high-level local authorities have been hesitant to give it completely to the lower levels (Gurung et al., 2018; Rotulo *et al*., 2021)

8.3 General Conclusion

From the findings of this study, it can be concluded that, how the decentralization is implemented at the grassroot level such as in the primary health care facilities determine its effectiveness and help to attain the main objectives. There is a need preparing the actors targeted by the decentralization in terms of their mindset, benefits and roles that they expected to carry out and supporting them on how to carry those roles or using the granted powers and space. Indeed, instead of waiting directions to flow from the national level to support decentralized unit at the grassroot level, high level local authorities can play roles much better in supporting the lower-level local authorities. Furthermore, how national leaders and governance behave during the outbreaks such as Covid-19 tended to be adopted also by the lower-level local institution which call for national level organs show professionalism in dealing with outbreaks and calls for local or grassroot level institutions to govern basing on their context while adhering to professionalism.

8.4 Policy and Practice Implication and Recommendation of the study

On the one hand, this study shows how the performance of HFGCs at the local level is impacted by the fiscal decentralization established by DHFF arrangements. On the other hand, the study identifies how the agency level (HFGC members' education level, skills, selection, and professional) and influence from the higher authorities make them vulnerable in the exercise of their devolved powers and mandates at the primary healthcare facilities.

This was evident from both quantitative and qualitative findings in which HFGC members stated that even though DHFF gave them the chance to make decisions at their facility, they still did not make some of the decisions, such as innovating sources of finances for the facility, because they were unaware of whether they had the authority and permitted to do so. Members did respond that they lacked sufficient knowledge to determine whether the standards and quality of medical goods and commodities delivered to the facilities were accurate despite being granted authority and mandates to participate in the procurement process. Through qualitative research, HFGC members highlighted that, as for building activities, the council level occasionally chose service providers to build facility infrastructures, which they believe is a threat to their authority and autonomy. Regarding

medications and medical supplies, it was discovered that there was a scarcity of medication in several facilities and that the issue was brought about by the failure of suppliers to supply prescribed medication on schedule. Due to this, residents of the community have been hesitant to sign up for improved Community Health Funds. The policy implications of these findings are three-fold;

Firstly, at the national level, education criteria for selecting members of the HFGC should be changed to assist members in carrying out their delegated responsibilities and mandates. Currently, HFGC members are just required to know how to read and write Swahili, but the range of their activities necessitates HFGC members with a suitable education background to efficiently perform HFGCs functions. These can be accomplished by establishing, for example, a minimum level of education from four ordinal levels for HFGC members.

Secondly, at the national level, facility financing, such as intergovernmental transfers, should be completed in time to assist in the operations of health facilities such as the procurement of health medicines and medical commodities.

Thirdly, comprehensive training for HFGC members on how to exercise and fulfil their powers and mandates should be provided to HFGC members as soon as they are selected. This will aid in the clarification of the HFGCs' powers and mandates.

Fourthly, because the Medical Store Department (MSD) has monopolized medicine and medical commodities supply but is not effectively and timely supplying medicine and medical commodities, which causes many challenges to health facilities and HFGCs, it is recommended that the government ease procedures and allow the use of more than prime vendors in supplying medicines and medical commodities to reduce bureaucracy. This is because members of HFGCs in many health facilities highlighted a shortage of drugs as a challenge.

8.5 Theoretical Implications of the findings

In examining the performance of HFGCs in public primary health facilities implementing DHFF in Tanzania, this study was guided by the Empowerment Framework and the Principal Agency Theory. Whereas the Empowerment Framework informed the assessment of the functioning of HFGCs in the DHFF context and the parameters determining the functionality of HFGCs in primary health facilities implementing DHFF in Tanzania. The evaluation of the accountability of the HFGCs under the DHFF context was guided by the Principal Agency Theory.

According to Alsop and Heinsohn's Empowerment Framework, the capacity of an individual or a group to make successful decisions or choices is determined by the agency and opportunity structure. Significant trends in the dependent variable, which is HFGC functionality, have been found. The results show that HFGCs perform well in general under DHFF conditions. Therefore, the study has confirmed the used theories that when opportunity structures/fiscal decentralization is improved then the capacity of the agency/HFGCs to make an effective choice is enhanced. This is because, in this study, DHFF arrangements have been found to improve the functionality of HFGCs by providing a conducive environment for members of HFGCs to carry out their allocated fiscal and decision-making tasks. However, members of the HFGCs have not been able to fully utilize the allocated decision-making space (fiscal and decision-making powers) to maximize their potential. This is because of limits posed by agency traits such as a lack of skills and expertise to fulfil certain duties, as well as opportunity structures or DHFF contexts such as a shortage of medicines and medical commodities. For example, some HFGCs indicated that they had difficulty determining whether or not the specifications of medicine and medical commodities received were in the same order due to a lack of medical standard knowledge. Others said that they have been mobilizing the community to join the enhanced community health fund, but the response from the community has been minimal because whenever they visit health facilities, they are told to go to a nearby drugstore and purchase medicines. These results are consistent with the theoretical assumption and empirical evidence that HFGC agency characteristics and composition have a substantial impact on how they participate in decision-making at primary healthcare facilities (Kalolo *et al*., 2022; Kilewo and Frumence, 2015).

According to the principal agency theory, the principal will always seek to optimize production by giving the agency its tasks while routinely holding the agency—or the agents themselves—responsible for their performance. The accountability definition of the Principal/Agent Theory refers to the "connection between an actor and a forum, in which the actor has an obligation of explaining and justifying his or her conduct." The goal of the study was to evaluate how Tanzania's DHFF setting affected how accountable the HFGCs were seen to be. The results of this study showed that HFGCs in primary healthcare facilities in Tanzania using DHFF were highly accountable.

As a result, the finding confirms the empowerment framework and Principal Agency Theory that when the agency interacts with the opportunity structure, the agency's capacity to make effective decisions increases. This study, however, expands the empowerment framework and fiscal federalism by establishing that increasing opportunity structure/context is not enough for the agency to make effective choices. The agency's quality in terms of

education, abilities, and knowledge is important. According to the findings of this study, despite HFGCs having high functioning and accountability, they were unable to complete all the requirements because they lacked the necessary skills and competencies. As a result, despite the substantial influence of opportunity structure on agency, agency qualities are still significant. Despite the substantial influence of opportunity structure on agency, agency traits are still essential for local actors to make decisions and offer services that are responsive to local users.

This evaluation study will generate evidence on both the process and impact of the DHFF programme implementation and help to inform policy improvement. The study is expected to inform policy on the implementation of DHFF within decentralized health system government machinery, with particular regard to health system strengthening through quality healthcare delivery. Health system responsiveness assessment, accountability and governance of the Health Facility Government Committee should bring autonomy to lower levels and improve patient experiences. A major strength of the proposed study is the use of a mixed methods approach to obtain a more in-depth understanding of factors that may influence the implementation of the DHFF programme. This evaluation has the potential to generate robust data for evidence-based policy decisions in a low-income setting. The HFGC members claimed that the community members who elected them as their representatives provide them with an incentive to carry out the powers and duties that have been given to them. They also highlighted that they have been updating them on the work that the HFGCs have been doing on various platforms, such as village meetings. Some participants claimed that when services at the facility were badly provided, the community became quite angry with the HFGC. These comments reflect the principal agency theory's Citation viewpoints, which hold that the principal (Community) either monitors the agency's performance (HFGC) or holds the agency accountable for that performance to their principal (communities). This study has led to the following theoretical conclusion.

Firstly, investigating the empowerment of government programs aimed at improving health system performance at the grassroots level provides an excellent theoretical framework for empowerment research. This current study seeks to demonstrate how empowerment is implemented at the grassroots level and the influence it has.

Second, studying health sector reforms through decentralization at primary health care facilities rather than tertiary or referral level is highly important since primary health care facilities are closest to the community and interact with the typical community regularly. As a result, the study adds to the body of knowledge on how communities might be empowered to manage their health at the primary health care level.

8.6 Area for further research

The following are the areas for future research

i. There is a need of assessing the functionality of HFGCs under the DHFF context from the demand side experience (beneficiaries). This is because this study has just assessed the functionality of the HFGCs as perceived by the supplied side only, this might have caused just to hear the opinion from one side but neglected how service beneficiaries perceive the functionality of the HFGCs.

ii. Assessing how HFGCs fulfil their oversight functions in primary health facilities while also performing managerial functions. This is since even though HFGCs are governance bodies also, they are involved in the daily operations of health facilities

iii. Assessing how the minimum education for HFGC members at the primary healthcare facilities is adequate to perform their assigned powers and mandates.

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APPENDICES

Appendix 1: Performance of HFGCs evaluation, Indicators, Data collection method and data analysis

Specific Objective	**Indicator**	**Type of variable**	**Measurement level**	**Data Analysis**
Objective 1 The functionality of HFGC in delivering health services under DHFF	• Ensuring facility avail the documents of financial statements, Reports • Engaging in the annual plan and budgeting • Endorsement of transactions by all responsible people, • Overseeing the use of funds as per plan and budget allocated, • Communicate with the community to know		Ordinal	Likert Scale Descriptive statistics (Mean score and standard deviation) Thematic analysis

	challenges and preference • Monitor the HR performance, training and motivation • Mobilize facility resources • Mobilize community to join CHF • Overseeing development and renovation of infrastructure • Use of funds as per financial memorandums, • Ensuring the Meeting's agenda corresponds to HFGC functions • Discussing of challenges confronting the facility and action points documented • Ensuring submission of facility progressive reports to the CSHB, Village government and Ward Development Committee			
Objective 2 Level of accountability of the HFGCs in the primary health level	Transparency and Community involvement • Effective communication and collaboration with community • Posting reports in health facility billboards, • Matching resources to patient's need, • Timely care, • Progress reports are submitted village assembly • Minutes of quarterly meetings are available. • Suggestion box available • The price list for service displayed • Quarterly income and expenditure displayed • Working hours for outpatient	Dummy Var Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/	Nominal	Index score Binaly Logistic Regression/Ordinal Logistic Regression Thematic Analysis

	displayed • Mobile number and names for complaints displayed • Meeting between community, health workers and HFGCs held and report are available • Displayed client service charter Financial and performance report review and approval • Use of funds endorsed by the HFGC • Funds are used as per financial memorandums, Supportive supervision • Were you given guidelines for DHFF • Are guideline specific and clear to you • Did you get training on DHFF, • Do you receive feedback after supportive supervision • Mentorship,	Yes/No Yes/No		
Objective 3 Factors affecting the effectiveness of (HFGCs	Educational level • Not att, std 7, form 4, form 6, diploma, university level **Gender** • Female or Male **Profession** • Accountant, teacher, Nurse, business, farmer **Leadership** • Influence over HFGC members and staff, running meetings, setting agendas which reflects HFGCs roles, approving expenditure **Selection** • Selected by community	Dummy Dummy interval Dummy Dummy Dummy Dummy interval Dummy	Nominal, interval	Multiple Regression (Relative Important Indices (RII)) Thematic analysis

	members, • appointed by the government **Composition** **Supportive supervision** • facilitated (Training, feedback, mentorship) • Not facilitated **Elite influence** Clarity of HFGC powers and functions on DHFF • Clear powers and functions • Not clear/stipulated **Age** • Young generation • Older generation **Skills** • Planning and budgeting skills, procurement skills, accounting and bookkeeping skills, report writing skills, negotiating skills and leadership skills	Dummy		

Appendix 2: Star Rating Assessment for the 26 regions

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Table: Star Rating Results in Twenty Six Regions

SRA Region Num	Region Name	Num of Facilities Star Rated	Num of Facilities Rated 0-Star	Num of Facilities Rated 1-Star	Num of Facilities Rated 2-Star	Num of Facilities Rated 3-Star	Num of Facilities Rated 4-Star	Num of Facilities Rated 5-Star	ntage of Faciliti es Rated	Num of Facilities Rated 1-Star or above	Percentage of Facilities Rated 1-Star or Above	Num of Facilities Rated 3-Star or above	Percentage of Facilities Rated 3-Star or Above	RBF?	BRN?
	Arusha	346	10	90	169	74	3		3%	336	97%	77	22%		
	Dar es Salaam	492	26	178	145	117	26		5%	466	95%	143	29%		Yes
	Dodoma	377	14	112	184	64	3		4%	363	96%	67	18%		
	Geita	154	4	24	68	56	2		3%	154	100%	58	38%	Yes	Yes
	Iringa	249	12	110	94	33			5%	237	95%	33	13%		
	Kagera	298	8	37	158	90	5		3%	290	97%	95	32%	Yes	Yes
	Katavi	81	7	34	29	11			9%	74	91%	11	14%		Yes
	Kigoma	269	16	145	98	10	0		6%	253	94%	10	4%	Yes	Yes
	Kilimanjaro	372	10	79	134	126	23		3%	362	97%	149	40%		
	Lindi	244	22	78	121	22	1		9%	222	91%	23	9%		
	Manyara	199	17	84	73	25			9%	182	91%	25	13%		
	Mara	286	27	135	98	26			9%	259	91%	26	9%		Yes
	Mbeya	303	8	66	118	103	8		3%	295	97%	111	37%		
	Morogoro	401	46	161	147	43	4		11%	355	89%	47	12%		
	Mtwara	234	7	93	110	23	1		3%	227	97%	24	10%		
	Mwanza	355	7	51	178	117	2		2%	348	98%	119	34%	Yes	Yes
	Njombe	268	22	131	100	12	3		8%	246	92%	15	6%		
	Pwani	333	17	80	175	59	2		5%	333	100%	61	18%	Yes	Yes
	Rukwa	213	31	84	81	15	2		15%	182	85%	17	8%		
	Ruvuma	300	58	158	69	15			19%	242	81%	15	5%		
	Shinyanga	211	3	30	125	51	2		1%	208	99%	53	25%	Yes	Yes
	Simiyu	207	8	37	130	32			4%	199	96%	32	15%	Yes	Yes
	Singida	218	4	52	109	49	4		2%	214	98%	53	24%		Yes
	Songwe	178	31	96	46	5			17%	147	83%	5	3%		
	Tabora	316	4	92	149	71			1%	312	99%	71	22%	Yes	Yes
	Tanga	385	37	159	159	27	3		10%	348	90%	30	8%		
Total	National (26 Re	7289	456	2396	3067	1276	94		6%	6854	94%	1370	19%		

NOTE: Regions which did not receive any intervention were subject for inclusion for this study. Those regions which received intervention such as RBF, BRN and HDP were not eligible for selection

Appendix 3: Regions and Local Government Authorities selected for the study

Regions Performing well	**Local Government Authorities**	**Number of Facilities Star Rated**	**Number of Facilities Rated 3-Star or Above**	**Percentage of Facilities Rated 3-Star or Above**
Kilimanjaro	Hai DC	61	38	62%
	Moshi DC	81	48	59%
	Moshi Mc	**42**	**18**	**43%**
	Mwanga Dc	53	8	15%
	Rombo Dc	45	15	33%
	Same DC	69	4	6%
	Siha DC	**21**	**18**	**86%**
Mbeya	Busokelo	22	14	64%
	Chunya	**22**	**20**	**91%**
	Kyela	35	16	36%
	Mbalali	53	32	60%
	Mbeya CC	**45**	**15**	**33%**
	Mbeya DC	68	1	1%
	Rungwe Dc	48	13	27%
Regions Performing poorly				
Songwe	Ileje DC	33	1	3%
	Mbozi DC	**80**	**1**	**1%**
	Momba Dc	**34**	**2**	**6%**
	Songwe DC	22	0	0%
	Tunduma TC	9	1	1%
Ruvuma	**Madaba Dc**	**15**	**2**	**13%**
	Mbinga DC	52	5	10%
	Mbinga DC	23	0	0%
	Namtumbo DC	46	0	0%
	Nyasa DC	35	3	9%
	Songea DC	32	1	3%
	Songea MC	**34**	**0**	**0%**
	Tunduru DC	63	4	6%

Appendix 4: (A1); Questionnaire for Health Facility Governance Committee (HFGC)

Respondents; All HFGC Members

Objective 1; To determine the functionality/Governance of HFGCS under the DHFF program implementation.

Serial No. **[__|__|__|__]**

Name of the region: _____

Jina la Mkoa

Name of the District Council: _____

Jina la wilaya

Name of the Health Facility: _____

Jina la kituo/Zahanati

Type of Health Facility: **01**= Dispensary/Zahanati **[ ]** **02=** Health center/Kituo cha Afya **[ ]**

1. Chairperson/Mwenyekiti
2. Secretary or Facility In Charge/ Katibu wa kamati
3. Member of the HFGC/ Mjumbe wa kawaida

Distance from your resident to the health facility in KM……..

Umbali kutoka unapoishi hadi kilipo kituo cha kutolea hudama

Transport used to reach your Health Facility……

Aina ya Usafiri unaotumia kufika katika kituo cha kutolea huduma

The cost incurred to reach your Health facility in T. Shs……

Gharama unayotumia kufika katika kituo cha kutolea

Please put the appropriate number of a response in the given box.

Tafadhari andika number ya jibu unalofikiri ni sahihi katika sehemu uliyopewa

SN	Questions/Swali	Responses/Jibu		
		SECTION A: DEMOGRAPHIC INFORMATION		
1	(a)Sex/Jinsi	1. Male/Mwanaume 2. Female/Mwanamke	1 2	[ ]
	(b)Age in Years/Miaka yako			
2	Number of Years spent schooling Miaka uliyotumia kukaa shule			
3	Your highest education level? Elimu ya juu uliyonayo?	1. Primary/Shule ya Msingi 2. Secondary/ elimu ya sekondari 3. Certificate/ astashahada	1 2 3 4	[ ]

		4. Diploma/Stashada 5. Advanced diploma/ stashada ya juu 6. University degree/shahada ya Kwanza 7. Masters/shahada ya Uzamili 8. PhD/ Shahada ya Uzamivu	5 6 7 8	
4	How were you selected to be a member of the committee? Je ni njia gani ilitumika kukupatia ujumbe wa kamati?	**1.** Elected/ **Nilichaguliwa na wanajamii** 2. Appointed/**niliteuliwa na ngazi za juu**	1 2	[ ]
5	Was there an announcement for the post of committee membership? ***Je kulikuwa na tangazo la kuwataka mgombee nafasi ya ujumbe wa kamati ya usimamizi?***	1 Yes /Ndio 2 No/ Hapana	1 2	[ ]
6	Where was the announcement for the post made available/how was it communicated to the community? ***Je tangazo hilo liliwekwa wap au lilikufikia kwa njia ipi?***	1. Facility noticeboard Mbao ya matangazo ya kituo 2. Village government noticeboard Mbao ya matangazo ya Kijiji/mitaa 3. It was announced during the village assembly Ilitangazwa kwenye mkutano mkuu wa Kijiji/mtaa	1 2 3	[ ]
7	Did you contest for a position? ***Je Uligombea nafasi hiyo?***	1. Yes/Ndio 2. No/Hapana	1 2	[ ]
8	How long have you been working as HFGC member? ***Je umekuwa mjumbe wa kamati ya usimamizi wa kituo cha kutolea huduma kwa vipindi vingapi?***	1. One term 2. Two terms 3. More than two terms	1 2 0	[ ]
9	Do you think 3 years are enough for the HFGCs to govern and deliver expected outcomes?	1. Yes/Ndio 2. No/ Hapana	1 2	

	Je unafikiri muhula wa miaka mitatu (3) unatosha kuweza kusimamia na kuleta matokea bora ya usimamizi wa kituo cha kutolea huduma?			[ ]
10	If the period of three years HFGC membership period is to change what are your suggestions ***Je Kama Muda wa miaka mitatu ya Ujumbe wa kamati ya usimamizi inatakiwa ibadilishwe, ungependekeze miaka ya kuwa mjumbe wa kamati iwe mingapi?***	1. 2 Years Miaka 2 2. 4 years Miaka 4 3. 5 year Miaka 5 4. 6 and above Miaka 6 na kuendelea	1 2 3 4	[ ]

11). For each of the following HFGC functions, please indicate the degree to which you make use of the existing opportunity to participate in decision making under DHFF

Kwa kila kazi za kamati ya usimamizi wa kituo cha kutolea huduma zifuatazo onyesha ni kwa kiwango gani unatumia nafasi/fursa uliyopewa kushiriki kufanya maamuzi?

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Function		1	2	3	4	5
1	Partcipate in Preparing facility plan and Budget according to community needs Kushiriki kuandaa mpango na Bajeti ya kituo cha kutolea huduma					
2	Managing facility income and expenditure Kusimamia mapato na matumizi					
3	Participate in managing procurement of health equipment, drugs and services Kushirki katika kusimamia manunuzi ya vifaa tiba, dawa na huduma					
4	Participate in managing facility performance Kusimamia utendaji wa watumishi katika kituo cha kutolea huduma					
5	Management of facility resources Kusimamia Mali za kituo cha kutolea huduma					
6	Mobilization of facility finances from different sources Kushiriki kutafuta fedha na rasilimali za kutuo cha kutolea huduma kutoka vyanzo mbalimbali					
7	Participate in managing constructing facility infrastructures and renovating the existing Kushirki kusimamia ujenzi na ukarabati wa miundombinu ya kituo cha					

	kutolea huduma					
8	Discussing the challenges confronting the community Kushiriki kuleta na kujadili changamoto za afya zinazoikumba jamii					
9	Mobilizing community to join improved Health Community Fund Kushiriki Kuhamasisha Jamii kujiunga na mfuko wa afya ya jamii ulioboreshwa					

12). To what extent does the HFGC participation in the governance of health facility influenced/resulted to change in the following aspects

Je ni kwa kiasi gani ushiriki wa kamati yako ya usimamizi wa kituo cha kutolea huduma za afya katika kusimamia utoaji wa huduma umeleta madiliko katika maeneo yafuatayo?

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Function		**1**	**2**	**3**	**4**	**5**
1	Partcipate in Preparing facility plan and Budget according to community needs Kushiriki kuandaa mpango na Bajeti ya kituo cha kutolea huduma					
2	Managing facility income and expenditure Kusimamia mapato na matumizi					
3	Participate in managing procurement of health equipment, drugs and services Kushirki katika kusimamia manunuzi ya vifaa tiba, dawa na huduma					
4	Participate in managing facility performance Kusimamia utendaji wa watumishi katika kituo cha kutolea huduma					
5	Management of facility resources Kusimamia Mali za kituo cha kutolea huduma					
6	Mobilization of facility finances from different sources Kushiriki kutafuta fedha na rasilimali za kutuo cha kutolea huduma kutoka vyanzo mbalimbali					
7	Participate in managing constructing facility infrastructures and renovating the existing Kushirki kusimamia ujenzi na ukarabati wa miundombinu ya kituo cha kutolea huduma					
8	Discussing the challenges confronting the community Kushiriki kuleta na kujadili changamoto za afya zinazoikumba jamii					
9	Mobilizing community to join improved Health Community Fund Kushiriki Kuhamasisha Jamii kujiunga na mfuko wa afya ya jamii ulioboreshwa					

13). Please indicate who normally makes the decisions regarding each of the following aspects of governance

Tafadhari onyesha ni nani hasa anafanya maamuzi katika masuala yafuatayo

Key: 0= I don't know/Sijui; 1= Members of HFGC jointly make a decision/Wajumbe wa Kamati ya usimamizi wa kituo: 2= health facility in-charge together with facility management team make a decision/Mganga mfawidhi Pamoja na timu ya uendeshaji wa kituo cha kutolea huduma; 3= Chairperson of HFGC and secretary of the committee make a decision/ Mwenyekiti wa Kamati ya Usimamizi wa kituo cha kutolea Pamoja na mganga mfawidhi; 4= the facility in charge in collaboration with other health workers make a decision/Mganga mfawidhi Pamoja na watumishi wengine wa kituo cha kutolea huduma; 5= Village/mtaa social committee in consultation with the facility in charge make a decision/ Kamati ya Huduma za jamii ya Kijiji au mtaaa Pamoja na mganga mfawidhi;

Functions of HFGC		**1**	**2**	**3**	**4**	**5**
1	Prepare facility plans and budget according to community needs Kuandaa mpango na bajeti ya kituo cha kutolea huduma					
2	Managing and Molibilizing facility funds Kusimamia fedha za kituo cha kutolea huduma (mapato na matumizi)					
3	Procuring health equipment, drugs and services Ununuzi wa dawa na vifaa tiba					
4	Promote health workers affairs and Control health workers' discipline Usimamizi wa masuala ya watumishi					
5	Management of facility resources Kusimamia rasilimali za kituo					
6	Constructing facility infrastructures and renovating the existing Kujenga na kukarabati miundombinu ya kituo					
7	Discussing the challenges confronting the community Kutafuta suluhisho la changamoto za afya zinazoikumba jamii					
8	Mobilizing people to join Improved Community Health Fund Kuhamasisha wanajamii kujiunga na bima ya afya iliyoboreshwa					

14). Please indicate the level of your HFGC functioning in the following Planning function under DHFF

Tafadhari onyesha ni kwa kiwango gani kamati yenu ya usimamizi wa kituo cha kutolea huduma inashiriki katika shughuri za uandaaji na uetekelezaji wa mpango kabambe wa kituo cha kutolea huduma

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Health Planing aspects		1	2	3	4	5
1	To asses the current situation of the health facility Kuchambua hali ya sasa kwa kuangalia: uwezo, upungufu,fursa na changamoto za taasisi/jamii na mazingira yake					
2	Participate in preparing facility priorities basing on the challenges Kuandaa vipaumbele kwa kuchangua maeneo, matatizo ya msingi na kuandaa malengo na shabaha					
3	To analyse and select strategies and intervation to be implemented to established objectives Kuchambua na kuchagua mikakati/afua za kuondoa matatizo au kuwezesha kufikia malengo na shabaha					
4	To prepare the comprehencive plan and budget Kuandaa mpango kazi na bajeti					
5	To implement and monitor the plan Kutekeleza na kufuatilia mpango					
6	To make evaluation of the plan Kufanya tathmini ya mpango: kuangalia kama malengo na shabaha zimefikiwa ama la					

15). Please indicate the level of your HFGC functioning in the following financial management function under DHFF

Tafadhari onyesha ni kwa kiwango gani kamati yenu ya usimamizi wa kituo cha kutolea huduma inatekeleza majukumu yafuatayo katika kazi ya kusimamia resilimali fedha

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Financial management aspects		**1**	**2**	**3**	**4**	**5**
1	HFGC discuss and approves quarterly income and expenditure reports Kamati yetu ya usimamizi inapokea, inajadili na kupitisha mapato na matumizi ya kituo kwa kila robo mwaka					
2	The HFGC has innovated a new source of income for the facility Kamati ya usimamizi wa kituo yetu imebainisha chanzo/vyanzo vipya vya mapato ya kituo chetu					
3	The HFGC ensure finances are managed basing on financial regulation and Kumsimamia rasilimali fedha za kituo cha kutolea huduma za afya kulingana na miongozo					
4	Our HFGC ensure our health facility is audited as per financial guideline Kuhakikisha kuwa kituo kimefanyiwa ukaguzi kwa mujibu wa sheria					

5	Our HFGC approves exependiture basing on approved budget and collections of the facility Kuidhinisha matumizi kulingana bajeti sahihi kwa kuzingatia makusanyo ya kituo					
6	Exemption report is provided Kamati yetu inapokea report ya misamaha ya fedha kwa wagonjwa wote waliotibiwa kwenye kituo chetu					
7	Report on facility debtors and creditors is provided Kamati yetu inapokea taarifa ya madeni na madai ya kituo chetu cha kutolea huduma					
8	Annual and Quarterly reports of the facility Assets and its statuS					

16). Please indicate the level of your HFGC functioning in the following procurement aspects under DHFF

Tafadhari onyesha ni kwa kiwango gani kamati inatekeleza mambo yafuatayo kama kazi yake ya kusimamia manunuzi ya kituo cha kutolea huduma

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Procurement Aspects		1	2	3	4	5
1	Identify and project on the goods and services to be procured basing on the facility data Kuchagua na kufanya makadirio ya bidhaa (mfano dawa) na huduma za kununiliwa kwa kuzingatia takwimu zilizopo kwenye kituo chetu					
2	Our HFGC do approve goods and services demanded to be procured Kamati yetu ya usimamizi inapitisha mahitaji ya bidhaa inayohitajika kununuliwa					
3	Our HFGC participate in assessing and selecting bidders for supplying goods and services Kamati huchambua maombi na kuchagua mtoa huduma katika kituo kwa kutumia sifa au vigezo mbalimbali					
4	Tenders and procurement are tabled before the HFGC for discussion and awards for those who qualify Kamati yetu inahakikisha tenda na manunuzi yote yameletwa kwenye kamati na kujadiliwa kama ya manunuzi kufanyika au mzabuni kupewa tenda					
5	Our HFGC participate in inspecting and receiving goods and services procured Kamati yetu ya usimamizi wa kituo inashiriki katika kukagua na kupokea bidha (mfano dawa) kama zilvyoagizwa na kuingizwa katika reja					
6	Our HFGC ensure facility assesst ledger is upadated as goods and services are procured Kila mwaka ni muhimu kituo kuhuisha taarifa za mali na samani za kituo na kuweka kumbukumbu sahihi kwenye vitabu vya kumbu kumbu					
7	Our HFGC is engaged in receiving audit reports from auditors Kamati inashirikishwa wakati wa kupokea taarifa ya ukaguzi wa dawa na fedha kituoni kutoka kwa wakaguzi					

17). Please indicate the extent to which the following information/reports are reported or presented in your HFGC by the facility health management team.

Tafadhari onyesha ni kwa kiwango gani taarifa zifuatazo zinaletwa mbele ya vikao vya kamati ya usimamizi wa kituo cha kutolea huduma za afya na kujadiliwa
1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Informational reports		1	2	3	4	5
1	Quarterly reports on income and expenditure Taarifa ya mapato ya kila robo mwaka					
2	Quarterly reports on the number of patients exempted from paying and services they have received Taarifa ya wagonjwa waliotibiwa kwa kuwa na msamaha wa malipo Pamoja na gharama halisi za huduma walizopata					
3						
4	Annual and quarterly reports on the number of patients who have left the facility without paying for their services and the total amount of finances which were supposed to be payed Taarifa ya kila robo mwaka ya wagonjwa waliotibiwa na wameondoka bila kulipa wakati walikuwa wanatakiwa kupia gharama					
5	Quarterly reports on the progress of implementation of the facility plan Taarifa yar obo mwaka ya utekelezaji wa mpango wa kituo					
6						
7	Quarterly reports on the opinion of service users on the quality of services provided by the facility Taarifa ya kila robo mwaka ya maoni ya watumiaji wa huduma za kituo chenu					
8	Quarterly reports on the debts from the admitted patients Taarifa ya kila robo mwaka ya madeni ya kituo chenu cha afya na wadaiwa wenu					

18). Please indicate the level of your HFGC functioning in the following Human resource management aspects under DHFF

Tafadhari onyesha ni kwa kaisi gani kamati yenu inashiriki kufanya maamuzi katika maeneo yafuatayo katika usimamiaji wa utendaji kazi wa watumishi wa kito cha kito cha kutolea huduma

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Human resources management aspects		1	2	3	4	5
1	Our HFGC discuss and recommend to the Council health services board the promotion of facility employee Kamati yasumamizi wa kituo inajadili na kutoa mapendekezo ya watumishi kupandishwa madaraja/vyeo kwa bodi ya huduma za afya ya wilaya					
2	Our HFGC discuss and recommend to the Council health services board on giving training opportunities to a facility employee Kamati yasumamizi wa kituo inajadili na kutoa mapendekezo ya watumishi kupalekwa kwenye mafunzo kwa bodi ya huduma za afya ya wilaya					
3	Our HFGC discuss and recommend to the Council health services board on motivation/incentives to be awarded to a facility employee Kamati ya usimamizi wa kituo inajadili na kutoa mapendekezo ya watumishi kupandishwa madaraja/vyeo kwa bodi ya huduma za afya ya wilaya					
4	Our HFGC receive performance reports of facility employees then recommend to the Council health services board appropriate measures Kamati yasumamizi wa kituo inajadili na kutoa mapendekezo ya watumishi kupandishwa madaraja/vyeo kwa bodi ya huduma za afya ya wilaya					
5	Our HFGC hire and fire casual worker (security guards and cleaners) Kamati yetu inashiriki katika mchakato wa kuajiri wafanyakazi wasaidizi kama mlinzi na wafagizi					
6	Our HFGC do discuss and recommend to the Council health services board the number and type of employees required to be recruited Kama yetu inatoa mapendekezo kwa bodi ya halimashauri juu ya wafanyakazi wanaohitajika katika kituo chetu					

19). How many official meetings the HFGC is required to sit per year?

Ni vikao vingap rasmi kamati ya usimamizi wa kituo cha kutolea huduma inahitaji kukaa kwa mwaka?

1) One/kimoja 2) Two/viwili 3) Three/vitatu 4) Four/Vinne 5) Five/Vitano
6) Six and above/Sita na zaidi **[ ]**

20). Does your HFGC conduct all the official meetings per year as required by the law?

Je kamati yenu inakaa/inafanya vikao vyote rasmi vinavyohitajika kukaliwa kwa mwaka?

1) Yes/Ndio 2). No/Hapana **[ ]**

21). If No, indicate to what extent the following factors do cause meetings not to be conducted as required

Kama hapana onyesha ni kwa kiasi gani sababu zifuatazo zinachangia vikao kutofanyika

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Factors		1	2	3	4	5
1	There is no agenda to sit for Kunakuwa hakuna agenda za kusababisha kukaa kikao					
2	There are no funds to cover/Pay HFGC members Kunakuwa hakuna fedha za kulipia posho ya kikao kwa wajumbe wa kamati					
3	The Secretary of HFGC/Facility In-charge has not called a meeting Mganga mfawidhi hatuiti/haitishi kikao cha kamati					
4	We have not been invited Hatujawahi alikwa kwenye kikao					
5	I don't know Sijui kwanini hakuna vikao					

22). Do you normally attend all the official meetings as required by the law?

Je huwa unahudhuria vikao vyote rasmi vya kamati ya usimamizi wa kituo cha kutolea huduma za afya?

1) Yes/Ndio 2). No/Hapana **[ ]**

23). If Yes, to what extent the following factors influence you to attend those meetings?

Kama Ndio, ni kwa kaisi gani sababu zifuatazo zinakusukuma kuhudhuria vikao hivyo

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Sababu		1	2	3	4	5
1	To get financial incentives Kupata fedha za posho kwa ajili ya kujikimu					
2	I must attend as a member of the committee Kama mwanakamati na wajibu wangu kuhudhuria vikao					
3	To participate in discussing and deciding different matter about our health facilities Nahudhuria kushiriki kujadili na kuamua mambo mbalimbali ya kituo chetu cha kutolea huduma za afya					
4	The law demands me to attend Sheria na miongozo inanihitaji kushiriki vikao hivyo					

24). If no, please indicate to what extent the following issues influenced you to be non-attendance to all the meetings?

Kama jibu ni hapana, tafadhari onyesha ni kwa kiasi gani sababu zifuatazo zilisababisha wewe kutohuduria vikao

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Sababu za kutokuhudhuria		1	2	3	4	5
1	I have other things to do Ninakuwa na mambo mengine ya kufanya					
2	I was not informed on time Sikupata taarifa juu ya kikao					
3	Even if I attend, I have nothing to contribute Hata nikihudhuria sina chochote cha kuchangia kwenye kikao					
4	Even if I attend I don't get a chance to contribute Hata nikuhudhuria sipati nafasi ya kuchangia mawazo yangu					
5	I didn't have the money to cover my transport cost					

	Nakuwa sina fedha za kugharamia nauli ya kuniwezesha kufika kwenye kikao					

25). During the HFGC meeting, does the HFGC always pass through the last minute of HFGCs to know if HFGC decisions were implemented or to know the progress

Wakati wa kikao cha kamati, Je huwa mnapitia muhtasari wa kikao kilichopita na kuangalia kama maazimio ya kikao kilichopita yametekelezwa/kufanyiwa kazi?

1) Yes/Ndio 2). No/Hapana **[ ]**

26). In the case the management team has not implemented the decision of the HFGC does the HFGC take some measures to the facility management team?

Ikitokea kamati ya uendeshaji wa kituo (mganga mfawidhi na wataalamu wake) hawaja tekeleza maamuzi au maazimio ya kamati je kuna hatua zozote mnazozichukua?

1) Yes/Ndio 2). No/Hapana **[ ]**

27). Which of the following measures does the HFGC take when its decisions have not been implemented by the facility management team

Ni maamuzi yapi kamati yenu ilichukua kwa kamati ya uendeshaji wa kituo pale ilipokuwa imeshindwa kutekeleza maamuzi au maazimio ya kamati yenu?

1= Very low/Kwa Kiasi kidogo sana: 2= Low/Kwa Kiasi Kidogo: 3= Moderate/ Wastani; 4= High/Kwa kiasi kikubwa; 5= Very high/Kwa Kiasi kikubwa sana

Measures		1	2	3	4	5
1	Disciplinary action was taken against the management team Hatua za kinidhamu zilikuchukuliwa kwa wote walioshindwa kutekeleza					
2	The health facility in charge was summoned to explain before the committee for not implementing the decision Mganga mfawidhi alitakiwa kujieleza mbele ya kamati kwanini wameshindwa kutekeleza maamuzi ya kamati					
3	The HFGC reported to the higher authority Kamati yetu ilipeleka suala hilo ngazi za juu					
4	The facility management team is directed to implement that unimplemented decision Kamati iliamuru mganga mfawadhi na kamati yake watekeleza maamuzi hayo					
5	No measures were taken Hakuna maamuzi yoyote yaliyochukuliwa na kamati yetu					

28) Please indicate the extent the following statement reflect the collaboration between your HFGC other institutions

Tafadhari onyesha ni kwa kiasi gani kamati yenu inashirikiana na taasisi zingine za katika kutekelza majukumu yake

1=strongly Disagree/; Si kubaliana sana 2= Disagree/Sikubaliani; 3= Agree/Nakubaliana; 4= Strongly agree/Sikubaliani Sana

Statement		**1**	**2**	**3**	**4**
1	Our HFGC normally seek advice from the Council Health Management Team (CHMT) to better decide and accomplish some of the technical matters in our facility Kamati yetu ya uendeshaji inaomba ushauri kwa kamati ya uendeshaji wa huduma za afya ya wilaya kuhusu kuamua mambo ya kitaalamu kwenye kituo chetu				
2	The CHMT timely respond or advice our HFGC when we asked or seek for advice Kamati ya uendeshaji wa huduma za afya ya wilaya inatupa ushauri kwa wakati pale tunapokuwa tumeiomba				
3	As HFGC member we feel the advice provided so helpful to the functioning of HFGC Kama kamati ya usimamizi wa kituo tunaona ushauri unaotolewa kwetu ni mzuri na unatusaidia kukamilisha majukumu yetu				
4	Our HFGC receive professional advice from our Health Facility Management Team on technical matters before we decide on them Kamati yetu ya usimamizi inapokea ushauri wa kitaalmu kutoka kwa kamati ya uendeshaji wa kituo chetu pale tunapotaka kufanya maamuzi				
5	As HFGC members we feel HFGC powers and authority eroded by receiving advice from the facility management team Kama kamati tunajisikia nguvu na mamlaka zetu kupungua tunapopokea ushauri toka kwa kamati yetu ya uendeshaji wa kituo chetu				
5	Our HFGC have a working relationship with other government institutions such as the Ward Development Committee and the village council Kamati yetu ya usimamizi wa kituo inafanya kazi Pamoj na kamati ya maendeleo ya kata				
6	Our HFGC have a working relationship with other government institutions such as the the village council Kamati yetu ya usimamizi wa kituo inafanya kazi Pamoja na kamati halimashauri ya Kijiji Pamoja na vyombo vyake vingine				

Objective 2: To assess the accountability of HFGCs in the public primary health facilities under DHFF implementation

Lengo la Pili: kuangalia uwajibikaji wa kamati za usimamizi wa vituo vya kutolea huduma za afya ngazi za msingi

Respondent; HFGC members

Wahusika; Wajumbe wa kamati ya usimamizi

From the following statement, please indicate the scale to which your HFGC accomplish the following tasks

Kutika kila sentensi eleza ni kwa kiasi gani kamati yenu ya usimamizi wa kituo cha kuolea huduma

1= Very Often/Mara nyingi sana 2= Often/Mara Nyingi 3=Less Often/Mara Chache 4= Never/Haijawahi Tokea

Sentesi		1	2	3	4
1	Our HFGC communicate with the community and other stakeholders to identify their health challenges and needs Kamati yetu kwa kushirikiana na jamii Pamoja na wadau wengine tunaibua mahitaji ya jamii Pamoja na changamoto za afya zinzoikumba jamii				
2	Our HFGC has established collaboration with other development partners to work together in providing services to the community Kamati yetu ya usimamizi imeanzisha mahusiano na wadau wengine ili kufanya kazi Pamoja ya kutoa huduma za afya				
3	Our HFGC convene meeting with Facility Health workers to discuss different issues of our facility Kamati yetu ya usimamizi wa kituo inakaa vikao na wafanya kazi wa kituo ili kujadili changamoto zinazokikumba kituo chetu cha kutolea huduma za afya				
4	Our HFGC ensure Health facility progressive reports are presented in the HFGCs meetings Kamati yetu inahakikisha utekelezaji wa mambo mbali mbali unawasilishwa katika vikao vya kamati yetu				
5	Our HFGC ensure that health facility resources match patients or Community needs Kamati yetu imehakikisha kuwa rasilimali za kituo zanaendana na mahitaji ya wagonjwa na mahitaji ya jamii				
6	Our patients receive timely care when they attend our health facility wagonjwa wanaofika katika kituo chetu wanapata huduma kwa wakati				
7	Our facility progressive reports are presented to the Ward Development Committee/ Village Council Kamati yetu inahakikisha kituo chetu cha kutolea huduma kinawasilisha meendeleo ya shughuri mbalimbali zinazofanyika kituoni kwetu katika baraza la maendeleo ya kata na halimashauri ya kijiji				
8	Our HFGC authorize the use of funds as budgeted Kamati inajadili na kupitisha matumizi ya pesa kama ilivyopitishwa kwenye bajeti za kituo chetu				
9	Our HFGC ensures facility funds are used as per financial memorandums Kamati yetu inahahakisha kituo chetu kinatumia fedha kulingana na miongozo				
10	Our HFGC ensure financial reports are provided quarterly and comply with the reporting systems Kamati yetu inahakikisha ripoti matumizi na mapato ya kituo inatolewa kila robo ya mwaka				
11	Our HFGC endorse and participate in the procurement process of all goods and services of the health facility Kamati yetu inashiriki katika mchakato wa manunuzi wa vit una huduma mbalimbali				

12	Our HFGC participate in the planning and budgeting process of our facility Kamati yetu inashiriki katika kuandaa mpango kabambe na bajeti ya kituo chetu				
13	Our HFGC participate in receiving goods procured by our facility Kamati yetu inashiriki katika mapokezi ya bidhaa zilizonunuliwa na kituo chetu cha kutolea huduma				
14	Our HFGC do take make recommendation on staff motivation, recruitment and training to the Council Health Service Board Kamati yetu ya usimamizi wa kituo inafanya mapendekezo mbalimbali juu ya wafanyakazi kwa bodi ya huduma za afya ya halimashauri				
15	Our HFGC ensure income and expenditure are known to the community quarterly Kamati yetu inahakikisha mapato na matumizi ya kituo yanabandikwa kwenye mbao za matangazo na kujulikana kwa wanajamii				
16	In our health facility, the suggestion box is available in a location where it can be seen by the patients Kamati yetu imehakikisha sanduku la maoni lipo mahali panapoonekana kwenye kituo chetu				
17	In our health facility, the price list for services provided is displayed to the extent that can be seen by the patients Kamati yetu imehakisha bei za huduma mbali mbali zinazotolewa kwenye kituo chetu zimebandikwa				
18	Our HFGC patcipate in mobilizing community to join improved community health funds Kamati yetu imeshiriki kuhamasisha wanajamii kujiunga mfuko wa afya jamii ulioboreshwa				
19	In our health facility, the Mobile number and names for complaints displayed to the location where it can easily bee seen by the facility users Kamati yetu imehakikisha namba za sim una majina ya mtu wa kupokea malalamiko imebandikiwa kwenye kituo chetu				
20	The client service charter of our facility is displayed on the location where it can easily be seen and read by the health service users Sehemu ya mkataba wa huduma kwa mteja inayoonyesha mwajibu na haki za mgonjwa imebandikwa kwenye kituo chetu				

Oversight

22). Have the members of your HFGC ever received training on the implementation of DHFF?

Je wajumbe wa kamti yenu wamewahi patiwa mafunzo juu utekelezaji wa mfumo wa upelekaji wa fedha wa moja kwa moja kwenye kituo na namna ya kusimamia kituo cha kutolea huduma za afya

1. Yes/Ndio 2. No/Hapana **[ ]**

23). Do you think you need more training to be competent in carrying out your duties and responsibilities under DHFF?

Je unafikiri mnahitaji mafunzo zaidi ili muwe na uwezo katika kutekeleza majukumu yenu ya usimamizi wa kituo cha kutolea huduma za afya

1. Yes/Ndio 2. No/Hapana **[ ]**

24). Do you always receive Mentorship on DHFF from CHMT?

Je mnapokea ushauri wa utekelezaji wa majukumu yenu katika mfumo utumaji fedha wa moja kwa moja kutoka kwa kamati ya uendeshaji wa huduma za afya ya halimashauri?

1. Yes/Ndio 2. No/Hapana **[ ]**

25). Have you ever received DHFF guidelines and or any other guideline which shows how the facility should be managed?

Je mmewahi kupatiwa miongozo yoyote inayosimamia upelekaji wa fedha wa moja kwa moja kwenye kituo cha kutolea huduma za afya?

1. Yes/Ndio 2. No/Hapana **[ ]**

26). If Yes, have you ever read to know the duties and responsibilities of the HFGC?

Kama mliwahi ipokea, je umewahi kusoma ili kujua majukumu ya kamati ya usimamizi wa kituo?

1. Yes/Ndio 2. No/Hapana [ ]

27). Does the HFGC ensure financial reports are submitted to the Council Health Service Board as required by DHFF guidelines?

1. Very Often. 2. Often. 3. Less often. 4. Never **[ ]**

Objective 4: To determine the factors affecting the functionality/effectiveness of Health Facility Governing Committees in achieving health outcomes under DHFF

Respondents; HFGC members

1). Please indicate the degree to which the following aspects is important in influencing the effectiveness/functionality of the HFGC in decision making at your facility

Tafadhari onyesha ni kwa kiasi gani mambo yafuatayo ni muhimu katika kusaidia ufanyaji kazi wa kamati yenu ya usimamizi wa kituo cha kutolea huduma

1= Unimportant/Sio Muhimu; 2= Slight Important/Muhimu kidogo; 3=Modarate Important/ Kwa wastani nu Muhimu 4=Important/ Muhimu 5= Very Important/Muhimu Sana

Important aspects		1	2	3	4	5
1	Education level/Kiwango cha elimu					
2	Experience of the members/ Uzoefu wa wajumbe wa kamati					
3	Profession of members/taaluma za wajumbe wa kamati					
4	Selection of the HFGC members uteuzi/uchaguzi wa wajumbe wa kamati					
5	Composition of the HFGC/ Muundo wa kamati					
6	The leadership of the HFGC/ Uongozi wa kamati					
7	The social network of the HFGC members/ mahusiano ya wajumbe wa kamati na wananchi pamoja taasisi zingine					
8	Availability DHFF guideline/uwepo wa miongozo juu ya upelekaji wa fedha wa moja kwa moja kwenye vituo					
9	Clarity of HFGC functions and powers in DHFF/ Uwazi wa kazi na mamlaka ya kamati za usimamizi kwenye afua					
10	Training to HFGC members on DHFF implementation Mafunzo kwa wajumbe wa kamati juu ya utekeleza wa afua ya upelekaji wa fedha moja kwa moja kwenye vituo					
11	Timely availability of finance/ upatikanaji wa fedha kwa wakati kwenye vituo vya kutolea huduma					
12	Communication between HFGC and community Mawasiliano baina ya jamii na kamati ya usimamizi wa kituo					

2). Please indicate the degree to which the following educational level is important for a member of HFGC to effectively participate in accomplishing HFGC duties and responsibilities

Tafadhari onyesha ni kwa kaisi gani viwango vya elimu vifuatavyo ni muhimu kwa wajumbe wa kamati katika kushiriki ipasavyo katika kutekeleza majukumu ya kamati ya usimamizi wa kituo

1= Unimportant/Sio Muhimu; 2= Slight Important/Muhimu kidogo; 3=Modarate Important/ Kwa wastani nu Muhimu 4=Important/ Muhimu 5= Very Important/Muhimu Sana

	Educational level/Kiwango cha elimu	1	2	3	4	5
1	Standard seven/elimu ya darasa la saba					
2	Form four/ kidato cha nne					
3	Form six/ kidato cha sita					
4	Certificate level/astashahada					
5	Diploma level/stashahada					
6	University degree/shahada ya kwanza					
7	Master degree/shahada ya uzamili					
8	Ph.D. level/shahada ya uzamivu					

3). Do you think if you had a higher education level than you have now you could be more effective in carrying out committee roles and responsibilities?

Je unafikri ungekuwa na kiwango kikubwa cha elimu kuliko ulichonacho sasa ungeweza kutimiza majukumu yako kuliko unavyotimiza hivi sasa?

1) Yes/Ndio 2). No/Hapana **[ ]**

4). Do you think having mixed composed HFGC help a committee to be effective?

1) Yes 2). No **[ ]**

5). Does your HFGCcomposed with mixed members of the committee?

Je kamati yenu ya usimamizi inaundwa na watu wenye elimu, uzoefu, jinsia, taaluma tofauti?

1) Yes/Ndio 2). No/Hapana **[ ]**

6). Please indicate the degree to which the following aspects of experience are important to HFGC members to accomplish their duties and responsibilities in the DHFF context

Tafadhari onyesha ni kwa kiwango gani uzoefu wa mwanakamati katika masuala yafuatayo ni muhimu katika kumsaidia kutekeleza majukumu yake kama mwana kamati ya usimamizi wa kituo cha kutolea huduma

1= Unimportant/Sio Muhimu; 2= Slight Important/Muhimu Kidogo ; 3=Modarate/ Wastani: 4=Important/Muhimu 5= Very Important/Muhimu Sana

	experience on/Uzoefu kwenye	1	2	3	4	5
1	Health issues/Masuala ya fedha					
2	Working in other sectoral committees/kuwa mwanakamati kwenye kamati zingine					
3	Political issues/Uzoefu kwenye masuala ya siasa					
4	Social-cultural issues of the particular locality/Uzoefu kwenye masuala ya kijamii yanayohusu jamii husika					
5	Community challenges/ Uzoefu kwenye changamoto za jamii husika					
6	Uzoefu katik kuongoza kamati					
7						

7). Please indicate the degree to which the following modality of selecting members of the HFGC enhance the commitment of the members on the HFGC

Tafadhari onyesha ni kwa kiwango gani njia zifuatazo zinzotumika kuchagua wanakamati zinachangia kuleta ufanisi na uwajibikaji wa mwanakamati

1= Strongly disagree/Sikubaliani kabisa; 2= Disagree/Sikubaliani; 3=Neutral/Upande wowote 4=Agree/Nakubaliana 5=Strongly agree/Nakubaliana kabisa

	Selection modality/namna ya kumpata mwanakamati	1	2	3	4	5
1	Election by the members of the community Kuchaguliwa na wanajamii					
2	Appointed by the village government Kuteuliwa na serikali ya kijiji					
3	Appointed by the Ward Development committee Kuteuliwa na kamati ya maendeleo ya kata					
4	Appointed by the District Medical Officer Kuteuliwa na mganga mfawidhi wa wilaya					

8). Please indicate the degree to which the following occupational/profession of HFGC members are important on the effective functionality of the HFGC in the DHFF context

Tafadhari onyesha ni kwa kiwango gani taaluma zifuatazo za wajumbe wa kamati ya usimamizi wa kituo cha kutolea huduma ni muhimu katika kusaidia kamati kutekelez majukumu yake

1= Unimportant/Sio Muhimu; 2= Slight Important/Muhimu Kidogo; 3=Modarate/ Wastani: 4=Important/Muhimu 5= Very Important/Muhimu Sana

	Occupational/Taaluma	1	2	3	4	5
1	Farmer/Mkulima					
2	Business/Mfanya biashara					
3	Medical Doctor/Udaktari					
4	Nurse/Uuguzi					
5	Economist/Uchumi					
6	Accountant/Uhasibu					
7	Teacher/Ualimu					
8	Engineer/					

9). As a member of the HFGC, did you vote to elect your committee chairperson?

Je kama mwanakamti ulipiga kura kumchagua mwenyekiti wa kamati yenu ya usimamizi wa kituo cha kutolea huduma za afya

1) Yes/Ndio 2). No/Hapana **[ ]**

10). IF Yes; please indicate the extent to the following aspects influenced you to vote for your HFGC chairperson

Kama jibu la hapo juu ni Ndio, ni kwa kiwango gani mambo yafuatayo yalikusukuma wewe kumpigia kura mtu uliyempigia kura ya kuwa mwenyekiti?

1= Strongly disagree/Sikubaliani kabisa; 2= Disagree/Sikubaliani; 3=Neutral/Upande wowote 4=Agree/Nakubaliana 5=Strongly agree/Nakubaliana kabisa

	Factors influenced to vote for a leader/Sababu zilizonisukuma kumpigia kura mwenyekiti	1	2	3	4	5
1	Education level /Kiwango chake cha elimu					
2	Profession has attained/Taaluma yake					
3	Experience/Uzoefu wake					
4	Age/Umri wake					
5	Gender/Jinsia yake					
6	Political affiliation/Chama chake cha siasa					
7	Social network/Mahusiano yake na wanajimii					
8	Wealth/economic status/hali yake ya kiuchumi					

11). If No. How was he/she selected to be a chairperson of your HFGC

Kama jibu ni Hapana, Je mwenyekiti wenu wa kamati ya usimamizi wa kituo cha kutolea huduma za afya alipatikana kwa njia ipi?

1) Appointed by the village government/Aliteuliwa na serikali ya kijiji
2) Appointed by the Ward Development Committee/aliteuliwa na kamati ya maendeleo ya kata [ ]

3) Appointed by our health facility in-charge/aliteuliwa na mganga mfawidhi wetu wa kituo cha kutolea huduma za afya
4) Appointed by the District Medical officer (DMO)/Aliteuliwa na mganga mfawidhi wa halimashauri ya Wilaya

12). Do you think your leader represents/links the HFGC, health workers and community effectively?

Je unadhani mwenyekiti wa kamati yenu ya usimamizi wa kituo chenu cha kutolea huduma za afya ana waunganisha vizuri nyinyi kama kamati Pamoja na wafanyakazi wa kituo na wananchi?

1= Strongly disagree/Sikubaliani kabisa; 2= Disagree/Sikubaliani; 3=Neutral/Upande wowote 4=Agree/Nakubaliana 5=Strongly agree/Nakubaliana kabisa

[ ]

13). Do you think your leader represents your HFGC as you expected?

Je unafikiri Mwenyekiti wa kamati yenu anaiwakilisha kamati yenu kama mlivyotegemea?

1= Strongly disagree/Sikubaliani kabisa; 2= Disagree/Sikubaliani; 3=Neutral/Upande wowote 4=Agree/Nakubaliana 5=Strongly agree/Nakubaliana kabisa **[ ]**

14). Please indicate the degree to which the following leadership qualities are important for HFGC leader to effectively lead the committee and perform his/her responsibilities in the DHFF context

Tafadhari onyesha ni kwa kiwango gani sifa zifuatazo za uongozi ni muhimu kwa kiongozi wa kamati ili kumuwezesha kuiongoza kamati kutekeleza majukumu yake katika kipindi cha kutuma pesa moja kwa moja vituoni

1= Strongly disagree/Sikubaliani kabisa; 2= Disagree/Sikubaliani; 3=Neutral/Upande wowote 4=Agree/Nakubaliana 5=Strongly agree/Nakubaliana kabisa

	Leadership qualities	1	2	3	4	5
1	Participatory					
2	Transparent					
3	Shared vision					
4	Empower people					
5	Lead change					
6	Clear Communication					
7	Good example					
8	Competent					
9	Integrity					
10	Provide feedback					

15). In your HFGC, is there any member who always is allowed to speak out in the meetings?

Katika kamati yenu ya usimamizi, Je kuna wajumbe ambao wakati wa kikao wao ndio anaongea wakati wa kikao

1) Yes/Ndio 2). No/Hapana **[ ]**

16). If yes, how many are they?

Kama Jibu ni Ndio je wapo wangap?

1) One/Mmoja 2) Two/Wawili 3) Three/Watatu 4) Four or more/Wanne au zaidi **[ ]**

17). Does the HFGC always agree and implement what they speak out?

Je wajumbe wengine wa kamati huwa wanakubaliana kutekeleza mawazo ya mtu au watu hao wanaongea kila wakati wa kikao

1) Yes/Ndio 2). No/Hapana **[ ]**

18) If yes, please indicate to what extent the following factors were important in influencing you to agree with he/she/them

Kama Jibu hapo Juu ni Ndio, tafadhari onyesha ni kwa kiwango gani sababu zifuatazo zinawsukumu nyinyi kama wanakamati kukubaliana nao

1= Strongly disagree/ Sikubaliani kabisa; 2= Disagree/ Sikubaliani; 3=Neutral/Upande wowote 4=Agree/ Nakubaliana 5=Strongly agree/ Nakubaliana kabisa

		1	2	3	4	5
1	Because they are experienced than me Kwa sababu wana uzoefu kuliko mimi					
2	Because whole HFGC agree with them Kwasababu kamati nzima inakubaliana nao					
3	Because they are expert in health Kwasababu ni wataalamu wa afya					
4	Because they know how to speak and convince us Kwababu wanajua kuongea na kutushawishi sis					
5	Because they are educated than me kwasababu waw ana kiwango kikubwa cha elimu kuliko mimi					
6	Because they are rich kwasabau yeye ni Tajiri kuliko mimi					
7	Because of his/her gender Kwasababu ya jinsia yake					
8	Because of his/her age Kwasababu ya umri wake					

18). Do you think is healthier for HFGC to have one or two people who always dominate the discussion?

Je unafikiri ni afya/vizuri kwa kamati mtu mmoja au wawili kuwa ndo waongeaji wakuu katika kikao cha kamati yenu ya usimamizi?

1) Yes/Ndio 2). No/Hapana **[ ]**

19). Does your HFGC involve communities in identifying health problems and priorities

Je kamati yenu ya usimamizi inawashirikisha wanajamii katika kuibua matatizo na changamoto za afya kwenye eneo lenu?

1) Yes/Ndio 2). No/Hapana **[ ]**

20). If Yes, indicate the degree to which the following mechanisms are used to involve the citizen in identifying health challenges and priorities in their communities

Kama Jibu ni Ndio, onyesha ni kwa kiwango gani njia zifuatazo zinatumika kuwashirikisha wanajamii katika kuibua changamoto na matatizo ya afya

1= Strongly disagree/ Sikubaliani kabisa; 2= Disagree/ Sikubaliani; 3=Neutral/Upande wowote 4=Agree/ Nakubaliana 5=Strongly agree/ Nakubaliana kabisa

	Njia inayotumika	1	2	3	4	5
1	HFGC attending village meetings to know health problems Wanakamati kuhudhuria vikao mbalimbali vya Kijiji kujua changamoto za afya					
2	Health workers attending village and WDC Watumishi wa afya (Mganga mfawidhi wa kituo) kuhuduria vikao vya Kijiji na kamati ya maendeleo ya kata					
3	Through each HFGC collecting views and opinions from the communities Kila mwanakamati kukusanya maoni na chngamoto za afya kwenye eneo analotoka					
4	Through using village government leaders Kwa kutumia na kuwasikiliza viongozi wa serikali za vijiji na kata					
5	Through special meetings with communities Kwa kuwa na vikao rasmi na wanajaamii kuhusu afya					
6	Through using Community Health Workers (CHW) Kwa kuwatumia watoa huduma wa afya ngazi ya jamii (WAJA)					

21). From your experience, where do citizens always send/forward problems/complaints relating to the health facility

Kulingana na uzoefu wako, je ni wapi haswa wananchi/wanajamii huwa wanapeleka matatizo/malalamiko yao yanayohusu suala afya?

1= Strongly disagree/ Sikubaliani kabisa; 2= Disagree/ Sikubaliani; 3=Neutral/Upande wowote 4=Agree/ Nakubaliana 5=Strongly agree/ Nakubaliana kabisa

	Eneo ambalo wananchi wanapeleka matatizo yao ya afya	1	2	3	4	5
1	HFGC leaders/ kwa viongozi wa kamati ya usimamizi wa kituo cha kutolea huduma ya afya					
2	HFGC members/ kwa viongozi wa kamati ya usimamizi wa kituo cha kutolea huduma ya afya					
3	Village government leaders/ Kwa viongozi wa serikali ya kijiji					
4	Health Facility management team/ kwa kamati ya uendeshaji wa kituo cha kutolea huduma ya afya					
5	Health Facility suggestion box/ wanaweka kwenye sanduku la maoni					
6	To the Facility In-charge/ kwa mganga mfawidhi					

22. Does your facility have a MoFP approved by the Ministry of Finance and Planinning?
Kituo chenu kina akaunti iliyothibitishwa ns Wizara ya Fedha na Mipango?

1. Yes/Ndio 2. No/Hapana

23. Do you have HFGC working guide?
Una muongozo wa wa namna ya kufanya kazi kwenye kamati ya usimamizi?

1. Yes/Ndio 2. No/Hapana

24. Do you have an accountant in this facility?
Mna muhasibu kwenye kituo chenu?

1. Yes/Ndio 2. No/Hapana

25. Have you ever heard about DHFF?
Umawahi kusikia kuhusu DHFF?

1. Yes/Ndio 2. No/Hapana

26. (FoI) Were you oriented on DHFF?
Umewahi kupata mafunzo ya DHFF?

1. Yes/Ndio 2. No/Hapana

27. (FoI) Do you have guidelines and operational manuals for DHFF and FFARS?
Una muongozo wa namna ya kutekelza mpango wa DHFF na FFARS?

1. Yes/Ndio 2. No/Hapana 3. I don't Know/Sijui

28. Have you receive any supportive supervision on the implementation of DHFF in the previous quarter?
Mmewahi kufanyiwa usimamizi shirikishi tangu kuanza kwa utekelezaji wa DHFF

1. Yes/Ndio 2. No/Hapana

29. Have you received any feedback on the previous supportive supervision of DHFF?
Je? Mmewahi kupata mrejesho wa usimamizi shirikishi uliopita baada ya kuanza utekelezaji wa DHFF?

1. Yes/Ndio 2. No Hapana

Appendix 5: (A1); questionnaire for Chairperson of Health Facility Governance Committee (HFGC)

Respondent; HFGC chairperson

Appendix 3: Interview guide for Chairman of HFGCs

Direct Health Facility Financing (DHFF) program implementation in Tanzania: Process evaluation Interview Guide

Objectives

- Document contextual factors that might affect intervention impact

Icebreaker

1. How long have you been working as a chair of HFGC?
   Umekuwa mwenyekiti kwa kamati kwa muda gani/Vipindi vingapi?
2. What are your roles as a Chair to the HFGCs? What roles do you provide?
   Nini majukumu yako kama mwenyekiti wa kamati ya usimamizi? Ni kazi zipi unazifanya?
3. Do you have the necessary skills to carry out the roles described above (question 2)?
   Je ujuzi unaoweza kukusadia kutekeleza majukumu yako kama mwenyekiti wa kamati ya usimamizi wa kituo?
   Unaweza kutuambia ni majukumu yapi ambayo unadhani una ujuzi wake wa kuyatekeleza?
4. What do you think a health committee should be doing (in addition to the roles described

in 2)?

Unaweza kutuambia hasa majukumu ya kamati za usimamizi wa kituo cha afya

5. The guidelines for health committees' work says that health committees should carry out the following tasks (listed as A, B, C, D):
   Kulingana na mwongozo kamati za usimamizi zina majukumu yafuatayo
   A) "Financial managment"
      Usimamizi wa fedha
      i) How do you understand this task? Please describe in your own words:
         Je unaelewa nini kuhusu jukumu hili? Sema kwa maneno yako
      ii) Do you have the necessary skills to carry out this task? a) Yes b) No
         (Yes) What tasks do you carry out?
         Je unafikiri una ujuzi unaotakiwa kukuwezesha kutekeleza jukumu hili?

   B) "Facility Resources Managment"

Usimamizi wa Vifaa

i) How do you understand this task?
Je unaelewa nin kuhusu jukumu hili?

ii) Do you have neccessary skills to carry out this task?
Je unafikiri una ujuzi unaotakiwa kukuwezesha kutekeleza jukumu hili

C) "Take steps to ensure that the needs, concerns and complaints of patients and the community are properly addressed by the management of the facility"
Kuchukua hatua na kushugurikia malalamiko ya wagonjwa na jamii na kuhakikisha yanashugurikiwa na jamii

i) How do you understand this task? Please describe in your own words:
Je unaelewa nini kuhusu jukumu hili?

ii) Do you have the necessary skills to carry out this task? a)Yes b)No c)N/A Je unafikiri una ujuzi unaotakiwa kukuwezesha kutekeleza jukumu hili

D) "To approve facility comprehancive plan"
Kupokea, kujadili na kupokea mpango wa kituo cha kutolea huduma za afya

i) How do you understand this task? Please describe in your own words:
Je unaelewa nini kuhusu jukumu hili?

ii) Do you have the necessary skills to carry out this task? a)Yes b)No c)N/A Je unafikiri una ujuzi unaotakiwa kukuwezesha kutekeleza jukumu hili

E) "Kusimamia utendaji kazi katika maeneo ya motisha, ajira na mafunzo"

i) How do you understand this task? Please describe in your own words.
unaelewa nini kuhusu jukumu hili?

ii) Do you have the necessary skills to carry out this task a)Yes b)No c)N/A Je unafikiri una ujuzi unaotakiwa kukuwezesha kutekeleza jukumu hili?

F) "To mobilize community to join improved community health fund (CHF)
Kuihamasisha jamii kujiunga na mfuko waafya wa jamii ulioboreshwa

i) How do you understand this task? Please describe in your own words.
unaelewa nini kuhusu jukumu hili?

ii) Do you have the necessary skills to carry out this task a)Yes b)No c)N/A
Je unafikiri una ujuzi unaotakiwa kukuwezesha kutekeleza jukumu hili?

6. Please list the training that you have attended as part of a health committee
Umewahi kuhudhuria mafunzo yoyote kama sehemu ya kamati? Taja?

7. Which training course/s was/were the most useful you have received whilst a Health Committee member that you feel you are currently using in your role as a committee member?
   Je katika ya hayo mafunzo uliyohudhuria unadhani ni yapi yalikusaidia sana katika kutekeleza majukumu yako hivi sasa?
8. What previous experiences have provided you with skills useful to be a health committee member and chairperson?
   Ni uzoefu upi ulioupata kabla ya kuwa mwenyekiti wa kamati ambao ulikupa ujuzi unaokusaidia hivi sasa kama mjumbe na mwenyekiti wa kamati?
9. When you joined the health committee, did you receive any orientation or induction? Please explain.
   Ulipochaguliwa kuwa mjumbe na mwenyekiti wa kamati uliwahipewa mafunzo yoyote juu ya kutekeleza majukumu yako?
10. What training do you think an orientation and induction program for new health committee members should include?
    Unafikiri ni mafunzo yapi ungependekeza yatolewa kwa wajumbe wapya wa kamti ili kuwawezesha kutekeleza majukumu yao?
11. What are your roles are a chair of HFGCs
    (If he doesn't mention anything on financial resources) then probe ……What are the roles for financial resources management for you as a chair of HFGC?
    Ni zipi kazi zako kama mwenyekiti wa kamati zinazohusiana na usimamizi wa fedha
12. Are there any challenges you are facing in the course of financial management practices?
    Kuna changamoto zozote unazozipata katika suala zima la usimamizi wa fedha?
13. What is your relationship with health facility staff?
    Ni upi uhusiano wako wewe kama mwenyekiti na watumishi wa kituo?
14. What is your relationship with CHMT members?
    Unahusiana vipi na kamati utekelezaji wa huduma za afya ya halimashauri?
15. What is your relationship with the community about facility management?
    Unahusiana vipi na jamii juu ya usimamizi wa kituo chenu?
16. Has your role as chair of HFGC affected any of your routine activities?
    Je kuwa mwenyekiti wa kamti ya usimamizi wa kituo kumeathiri shuguri zako binafsi za kila siku?

17. Do you have a Village or Ward Health Committee?
    Je mna kamati ya afya ya Kijiji au kata?
18. If yes, how do you work with them?

NI kwa namna gani gani mnafanya nayo kazi?

19. Je mnashirikiana na serikali ya Kijiji ama kamati ya maendeleo ya kata katika kuboresha huduma za afya za kituo chenu?
20. Ni kwa namna gani mnashrikiana na serikali ya Kijiji au kata katika kutekeleza majukumu yenu?
21. Je mnashirkiana na wadau wengine wa maendeleo katika kuboresha huduma za afya kwenye maeneo yenu (Taja wadau hao na namna mnavyoshirikiana nao)
22. Do you get remunerated with any incentives? If yes, What type? Je mnapata motisha/malipo yoyote mnavyotekeleza majukumu yenu?
23. What are the roles played by the HFGCs as a response to the COVID-19? Je ni kazi gani kamati yenu inazifanya ili kukabiliana na mlipuko wa UVIKO?

Appendix 6: Focus Group Discussion Guide

1. As members of HFGC what do you think are the main roles of HFGC?
   Kama wajumbe wa kamati mnafikiri ni zipi kazi za kamati ya usimamizi wa hudma za afya?

2. What actualy do you do?
   Katika kazi hizi nyinyi wanakamati ni ni hasa mmekuwa mkikifanya katika kila kazi?

3. During the HFGC what are the standing agendas of the meeting?
   Katika vikao vya kamati, je ajenda gani huwa lazima ziwepo katika kila kikao?

4. What do you understand about DHFF?
   Je mnaelewa nin kuhusu DHFF?

5. Have you ever received any orientation about DHFF?
   Mmewahi kupewa mafunzo yoyote kuhusu DHFF

6. What are your roles in DHFF?
   Katika DHFF mnafikiri ni yapi majukumu yenu kama wanakamati?

7. Do you think you have effectively been accomplishing those roles?
   Mnafikiri mmekuwa mkiyatekeleza hayo majukumu ipasavyo?

8. What athe necessary factor for accomplishing those roles?
   Je ni vitu gani muhimu vinahitajika kwenu ili muweze kutekeleza majukumu yenu ipasavyo katika DHFF
   What are the roles played by the HFGCs as a response to the COVID-19? Je ni kazi gani kamati yenu inazifanya ili kukabiliana na mlipuko wa UVIKO?

Appendix 7:Observational checklist for accountability of the HFGC

Objective No. 2. Process evaluation. To assess the level of accountability of HFGCs in PPHC

	SOCIAL ACCOUNTABILITY Uwajibikaji	**Transparency in operations and information sharing**: Uwazi Presence of the following displayed at the notice board; 1) the Price list for services displayed (Inc. free services; Bei za Huduma zimebandikwa 2) Quarterly Income and Expenditures reports displayed; mapato na matumizi yamebandikwa 3) Health Facility Governing Committee meetings conducted and minutes available; vikao vya kamati vinafanyika kila robo mwaka 4) Working hours displayed for outpatient services; muda wa kufanya kazi umebandikwa 5) Mobile/phone number and names for complaints displayed **Namba ya sim una jina kwa ajili ya kutolea malalamiko vimebandikwa**			
		Available minutes of the Health Facility Governing Committee (HFGC) for the quarter; Minutes should contain: Muhutasari wa vikao upon a una mambo yafuatayo 1) Date and time indicated/Tarehe na muda wa kikao 2)Agenda available/Agenda zinahusiana na majukumu ya kamati 3)Meeting minutes available for the assessed quarter, muhutasari wa kila robo 4) Attendance list and signatures available, mahudgurio 5) Evidence of use of funds discussed during the meeting Ushahidi kuhusu matumizi ya fedha upo? 6) Evidence of discussion of challenges confronting the facility and action points documented/ Ushahidi wa namna changamoto za jamii zinavyoshughurikiwa			

	HEALTH FACILITY GOVERNING COMMITTEE FUNCTIONALITY Utendaji kazi wa kamati ya usimamizi	**Availability of Facility Progress Report: uwepo wa taarifa zifuatazo** Verify previous Quarter Facility Progress Report, including: **1)** Technical Report (Including work Plan Implementation), utekelezaji wa mpango wa kituo **2)** Financial Report/repoti za mapato na matumizi za kila robo 3) Ushiriki wa kamati kwenye kuanda mpango wa kituo			
		Medicine and Equipment consignment receipt Mapokezi ya dawa (Ushiriki wa kamati) Witnessed its receipt 1 Did not witness its receipt 2 Verify the presence of signature in the Visitors books			
		1) Availability of attendance register of members of HFGC ***If the list is updated = 1*** ***If not updated = 0***			
		2) Number of times you convened meetings last year			
		3)Existence of gender representation in the HFGC team. ***If women are less than 3 = 0 point;*** ***4 points for equal or greater than 3 = 1 point***			
		4) Availability of operational guideline HFGC members			