IMPLEMENTATION EVALUATION OF DIRECT HEALTH FACILITY HEALTH FACILITY FINANCING AT LOWER HEALTH FACILITIES IN TANZANIA

A CASE STUDY OF DODOMA CITY COUNCIL

By
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A Dissertation Submitted Partial Fulfillment of the Requirements for Award of the Digree Masters of Science in Health Monitoring and Evaluation to the School of Public Administration and management in of
Mzumbe University

2019

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a research report entitled: ***implementation of direct health facility health facility financing in lower health facilities in Tanzania, a case study of Dodoma City Council:*** as a partial fulfillment of the requirement for award of the Degree of Masters of Science in Monitoring and Evaluation of Mzumbe University.

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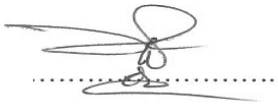
Signature 

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DECLARATION

I, Burra , Joseph Michael,declare that this thesis is my original work and that it has not been presented and will not be presented to any other University for similar or any other degree award.

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AKNOLEDGEMENT

This work is a contribution of several efforts ,individuals and institutions whose contribution has made this work to be the way it look today.

First and foremost I would like to extend my heartfelt appreciations to Mzumbe University, Ikungi District Council, University of San Francisco Califonia and Global Funds for their financial suport during pursuing my Master's Degree, I really appreciate the contribution they made during my studies.

My second appreciation goes to my Research Supervisor Mr Deogratias Faustine Mpenzi for his tireless effort towards completion of this work. Mr Mpenzi I have learnt A lot from you and I will always be gratefull to you. Again thank you very much for contributing into my achievements towards this work and in my programme in general.

I am indepted to Ikungi DC Executive Director Mr Juctice Laurent Kijazi and to my Boss Dr Katalyeba Vitalis for being patient with me during development of this work, for their major support and generally to my fellow CHMTs for being there for me all the time and all the way.

Lastly but not least, to my family, I could have not done this alone you were there to support me all the time, My wife Josephine, my doughter Germana, my sons Michael and Jonathan thank you so much, I am endepted to you, thank you for your patience and support during the whole time of my studies. To you Michael and Jonathan, bear in mind that not very long time ago I was a son, young boy like you, things will not remain the same.

To all of you I will always be gratefull. Thank you so much may Almighty God bless you copiously

DEDICATION

This dissertation is dedicated to my mother the late Mrs Martha Gallet and my father the late Mr Michael Gallet (R.I.P)

LIST OF ABBREVIATIONS

ANC	Antenatal Clinic
ARB	Autonomous Region Of Bougainville
BRN	Big Results Now
CCHP	Comprehensive Council Health Plan
CEMONC	Comprehensive Emergency Obstetric Care
CHF	Community Health Funds
CHW	Community Health care Provoder
DHFF	Direct Health Facility financing
DHA	District Health Accountant
DMO	District Medical Officer
DHFF	Direct Health Facility Financing
DHMT	District Health Management Team
DMOH	District Medical Officer Of Health
HBF	Health Basket Funds
HCP	Health Care Providrs
HCW	Health Care Prviiders
HFGC	Health Facility Governning Committee
IEC	Information Education And Communication
MDG	Millennium Development Goals
MNCH	Maternal, Newborn And Child Health
NGO	Non-Governmental Organization
RBF	Result Based Financing
TDHS	Tanzania Demographic Health Survey
UNICEF	United Nations International Education Children Fund
WHO	World Health Organization

ABSTRACT

Introduction: The Direct Health Facility Financing meant to ensure directly disbursing funds to the lower level health facilities and enabling them together with communities set their own health priorities so as to improve delivery of health services to achieve Universal Health Coverage (UHC). The main focus of the evaluation was implementation of Direct health facility financing in lower facilities in Tanzania, specifically it looked at Disbursement of funds,human resources availability and their capacity in implementation of DHFF, community participation and how social demographic affect the implementation ot DHFF.

Methodology: This process evaluation study was conducted in Dodoma City Council and applied the descriptive cross-sectional design. There were 99 Questionnaires, 12 in-depth interviews, 6 focused group discussions, and documentary review. A total of 22 health managers and 32 HFGC participated in an in-depth interview and Focused Group Discussions. Quantitative Data were imported to STATA 13 to run test statistics such as the logistic regression statistical test and chi-square statistical test that was used to assess the relationship and associaition between the dependent and independent variable respectively. While for qualitative data were transcribed read and re-read for completeness, and then uploaded in Atlas ti 7 to assist the data analysis process. The analysis was assisted by quere tool report.

Results: It was found that DHFF funds were disbursed very late from Central Government to facility account. Human resources for health number and their attitude is negatively affecting implementation of DHFF by 74 Percent and 96 Percent respectively, so there is critical shortage of health care providers and unpleasant attitude with insurficient capacity toward users of services. There is observed improvement in motivation due to autonomies in managing facilities funds by health care providers and improved financial fast-tracking of payments due DHFF programme being free from higher-level bureaucracies. Community participation is very low, only 14 Percent of the general population is aware on participation in the planning. It was found that social demographic factors like education, for example, none educated community 75 Percent attend tradition healing compared to the remaining 25 Percent who first attend facility services when they fall sick. Poverty, distance to the facility and local belief were important factor that is affecting implementation DHFF..

Conclusion: DHFF Funds are disbursed into the facility account untimely so resulting in an occasional shortage of essential commodities. There is critical of human resources shortage for health that affect implementation of DHFF. There is low community involvement in the implementation of DHFF and social demographic factors such as literacy, economy and distance to facilities is negatively

affecting implementation of DHFF. We recommend the government to timely disburse funds,recruit human resources for health in the required number, sensitise community participation by preparing simple to understand manuals and advocate health promotion to enhance care seeking behaviours to the communities.

Keywords: *Direct Health Facility Financing (DHFF), financial management*, Health Facility Autonomy and Community Participation in facility plans.

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CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND INFORMATION

An important issue that came up repeatedly most of the time was how the epidemiological transition has affected health-financing systems and attempts to achieve universal health coverage. Riko Elovainio presented a conceptual framework for addressing this question, based on the World Health Report 2010: Health Systems Financing: The Path to Universal Coverage (World Health Organization, 2010 which outlines the types of health-financing levers available to policymakers in three broad areas: raising funds for health, reducing financial barriers to access through prepayment, and pooling of resources (spreading the financial risks of paying for care across the population) and efficiency (WHO, 2016).

In 2009 low-income countries around the world spent an average of 6. 1 per cent of their Gross Domestic Products (GDPs) on health in 2009, lower-middle-income countries spent 6.2 per cent, and upper-middle-income countries spent 7.0 per cent. The region of sub-Saharan Africa spent 6.1 per cent of its total GDP on health, far less than the 9.5 per cent of GDP that the countries of the developed world spend on health.In terms of U.S. dollars, low-income countries spent $25 per person on health in 2009 versus the more than $4,600 per person spent in high-income countries. In the Africa Region of the World Health Organization (which includes all countries of Africa, not just the low-income countries), per capita, health spending was $83, less than 2 per cent of the average spending in high-income countries (WHO, 2009).

Elovainio commented that economic growth will facilitate additional spending on health in low-income countries. The International Monetary Fund projects show that beginning in 2012, economic growth across the whole of sub-Saharan Africa should average 5 per cent per year, which corresponds to a per capita GDP growth rate of around 3.5 per cent per year (International Monetary Fund, 2011). This suggests that even if health receives the same share of GDP as it does now, health expenditures will grow, but it is likely that health spending will receive an increasing share of GDP and thus grow at an even greater rate (IMF, 2011).

All of the countries of sub-Saharan Africa have ways in which they can raise more funds domestically for health spending if they chose to do so. The pressure to find new funding sources is especially high in countries in which large informal econom ic sectors make it difficult to collect revenues, either in the form of taxes or in the form of health insurance contributions. This situation is often accompanied by tax collection systems that are inefficient and inequitable. Wage-based deductions are generally the easiest to administer and collect, and thus they offer the greatest potential for achieving an equitable system in which people earning more would pay more. However, in those low-income countries in which a relatively low (although usually growing) Percent of the workforce has formal paid employment, other options also need to be pursued. These other options might include "sin taxes," that is, taxes on harmful products such as alcohol, cigarettesetc(Elovaino, 2010)).

For many countries, especially least developed countries in the sub Saharan Africa, development effectiveness may not be an area of priority due to their relatively higher dependence on donor support in the health sector. For these countries, upstream PFM arrangements such as budget formulation and execution, resource allocation, domestic revenue mobilization and financing may be more relevant in terms of Public Financial Management in health sector.Collaboration on downstream PFM implementation arrangements for donor-financed projects will still be relevant for low-income countries (LICs) that continue to receive significant donor support in the health sector (WHO, 2010).

Harmonizing and ultimately aligning development partners' financial management systems will help achieve better outcomes for health interventions in partner countries through bringing aid on budget, enhancing budget execution, reducing transaction costs, increasing fiscal transparency and oversight over the use of aid funds and other government funds. It will also ensure coordinated efforts and support for strengthening countries' capacity (WHO, 2010).

Guided by the World Health Assembly resolution WHA64.9 from May 2011 and based on the recommendations from the World Health Report 2010 “Health systems financing: The path to universal coverage”, WHO is supporting sub Saharan countries in developing of health financing systems that can bring them closer to universal coverage through; Raising funds for health; Reducing financial barriers to access through prepayment and subsequent pooling of funds in preference to direct out-of-pocket payments; and Allocating or using funds in a way that promotes efficiency, effectiveness, equality and equity (WHO, 2011).

1.2 HEALTH CARE FINANCING IN TANZANIA

Health financing is fundamental to the ability of health systems to maintain and improve human welfare. At the extreme, without the necessary funds no health care Providers would be employed, no medicines would be available and no health promotion or diseases prevention would take place. Health care financing is among the key component of a functional health system. Financing involves three aspects, namely revenue collection, risk pooling, and purchasing. In recent years, there has been a growing demand for access to high-quality and affordable care for all, thus the government is committed to responding with a process of developing health financing strategies underway since early 2013. An inter-ministerial steering committee has been developed, composed of key ministries and department to ensure that the proposed reforms meet the needs of the population. Improving the prepayment mechanisms are the main agenda in the development of the strategy, which is assumed to be a potential facilitator in the progress towards Universal Health Coverrage (WHO, 2008).

However, financing is much more than simply generating funds. To understand the nature of the indicators that can be used to monitor and evaluate health system

financing requires explicit assessment of what it is expected to achieve. The goals can be expressed in various ways, but there is general consensus that health financing systems should not only seek to raise sufficient funds for health, but should do so in a way that will not affect individual economies and hence jeopardizing quality of services and facility utilization of lower levels (WHO, 2016).

In Tanzania before the introducuction of direct health facilities health is financed from two sources i.e 1. funds collected within the facility ie community health funds, out of pocket user fee,nhif and other insurances and 2. funds from central government (health basket funds and result based funds). These funds are allocated by ministry of finance through ministry of Presidents office, Regional Administration and local government to the district councils for utilization by lower health facilities (Gibson, 2016).

The workforce that provide services have lost motivation to work, community do not see that they are the owners or the governors of the health facility management, planning process was top down which did not reflect the community actual needs, lack of or and out of stock of essential commodities in the lower health facilities. Low utilization of lower health facilities as a result of poor quality of services provided in those facilities. So donors and central government were dissatisfied with the situation that even the little funds available were not properly used to improve health services in the lower level facilities. In fact, very little of the disbursed funds reached those facilities with very insignificant impact (Kelvin Swere, 2016).

During the year 1993 to 1994 to user fee was introduced in referral and some services in regional hospital; the user fee was further introduced in 1994 to December 1994 to regional hospital; in the year 1995 onwards it was then introduced to the district hospital and in the last phase it introduced to health Centre and dispensary. Exemption and waiver were an integral part of the cost-sharing policy introduced in 1994 (Kida, 2014).

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Therefore, it was decided that financial policies must grapple with questions of how even the little available amount of funds that are allocated to reach lower-level facilities can be available to provide services to the needy who attend services in those lower-level facilities and hence improve services and increase utilization of these frontline facilities (health centres and dispensaries) (Ntuli A. Kapologwe et al, 2019).

Preceding the DHFF programme, districts managed and controlled funds for primary healthcare facilities and, therefore, facilities had no direct access to cash or to direct control of financial resources. Some funding sources that were collected at the health facility, including user fee revenue, National Health Insurance Funds and Community Health Fund premiums, were deposited into the district account. Districts would plan for health activities and budget for these facilities each year. At some points event, those funds planned for lower health facilities were used for other purposes that were not related to services to them. This resulted in delays in the implementation of various health interventions contributing to the poor quality of health services delivery. There was a demoralized health care workforce, the severe shortage of essential health commodities like medicines hospital supplies, medical types of equipment, laboratory supplies and dental supplies. The community did not participate in decision making like in the planning process so they lacked a sense of ownership. This was coupled with poor autonomy at the primary health facility

levels. The result of this poor quality of services so lower-level facilities were not achieving the goal of proving services to all (Universal Health coverage) because of low utilization of these facilities by the communities around. Due to all these the Government of the United Republic of Tanzania in collaboration with donner countries came with the DHFF program (URT, 2017).

1.3 DESCRIPTION OF THE PROGRAM

1.3.1 DHFF PROGRAM

Direct Health facility financing (DHFF) is a direct government funds disbursement to a health facility account to meet the operational requirements of the lower-level health facility. The facility prepares plans and budgets once they are approved, funds are disbursed directly to the facility account. The spending of the funds by facilities will not be subject to pre-approval or pre-audit of transactions, but will rather rely on post control measures, in particular, the budget and expenditure control as part of the liquidation process (Catherine Goodman, 2009) (URT, 2017).

The implementation of the DHFF programme started from 2017/2018 fiscal year in all district councils in Tanzania, under the guidance of the President's Office – Regional Administration and Local Government. The DHFF programme is a government inventiveness that aims to implement financial decentralization in the health sector at the same time as fostering health services improvement and lower-level facilities utilization. The programme was introduced to meet the following goals: improving the structural quality of maternal and child health services by improving the services pertaining to these two groups; increasing accountability and governance in the health system at the primary healthcare level; increasing health system responsiveness for patients who receive healthcare in the respective health facilities; and improving healthcare-seeking behavior and service utilization at the primary health facility level and avoiding bypass at this level. More than 95Percent of the Tanzanian population do not live within 5 km from a primary health facility (dispensary or health centre) Before the DHFF programme, districts managed and controlled funds for primary healthcare facilities and, therefore, facilities had no direct access to cash or to direct control of financial resources. Some funding sources

that were collected at the health facility, including user fee revenue, National Health Insurance Funds and Community Health Fund premiums were deposited into the district account. Districts would plan for health activities and budget for these facilities each year (Ntuli A. Kapologwe et al, 2019).

This resulted in delays in the implementation of various health interventions contributing to the poor quality of health services delivery. This was coupled with poor autonomy at the primary health facility levels and responsible health facility-governing committees. The DHFF programme envisages increasing motivation and autonomy of HFGC as seen in other countries, for example, in Kenya (Antoni Opwara et al, 2009).

The DHFF programme implementation includes the following components: (1) training on DHFF programme, through which 138 regional team members were trained so that they can, in turn, train others at district councils through the cascade approach; (2) supportive supervision and mentorship; (3) employment of assistant accountants; (4) dissemination of facility Financing Accounting and Reporting Systems and DHFF programme implementation guidelines; (5) opening of accounts approved by the Bank of Tanzania; (6) disbursement of funds to approved facility accounts; and (7) provision of tools for DHFF programme implementation and coordination. The Regional Health Management Team and CHMT will provide technical support and mentorship on financial management, implementation of annual plans and budget to the health facilities following the provided guidelines. It is anticipated that the programme will lead to specific changes, including improvement of services delvered and improvement of health sector infrastructure (URT, 2017).

1.3.2 GENERAL OBJECTIVES FOR DHFF

To improve the delivery of health services to achieve Universal Health Coverage (UHC) by strengthening services, decentralizing and managing adequately infrastructure, human resources and funds for running the facilities including procurement of medicines and medical supplies

1.3.3 THE RATIONALE BEHIND THE IMPLEMENTATION OF DHFF PROGRAM

a) Strengthening Decentralization of Health Services Management to the facility level.
b) Improve service delivery and utilization of lower facilities
c) Improving efficiency and effectiveness of the use of funds e.g. Health Basket Fund
d) Responding to the performance initiative of the Health Basket Fund and RBF.

Charters towards sustainability and maintenance of health as an important development pre-requisite (URT, 2017)

To achieve the above rationale the DHFF has set some indicator that was used at Health centres and dispensary levels to make sure they were used to as two types of formula for funds disbursement which are going to be briefly explained below. First Base allocation formula second Performance allocation formula and third Base allocation Formula

BASE ALLOCATION FARMULAR

The base allocation to LGAs is divided across all 184 LGAs. This is done basing on a formula based on four allocation factors:

i. Population (60 Percent)
ii. Poverty count (10 Percent)
iii. Land capped (20Percent)
iv. Under-five mortality (10Percent) (URT, 2017).

b. Performance Allocation Formula

Sets of indicators at each level use the performance allocation formula for the Health Basket Fund. The World Bank Programme is disbursing funds to the Health Basket according to the HBF Performance Scorecard and these were assessed at the facility level where implementors will struggle to improve achievement for each indicator ie reaching agreed set target. If the targets are reached by 100Percent the total amount stipulated is disbursed. The disbursement of funds to the LGAs will depend on the

performance. For the allocation, to each LGA the individual LGA performance score is used together with the assigned share according to the resource's allocation formula described above. The performance score is calculated basing on 12 indicators assigned for each LGA where each indicator carries the weight of its different weight. If the performance score is high the individual LGA will get a higher share of the total allocation to the LGAs *(URT, 2017)*.

DLI 4 – "LGAs have improved annual MNCH service delivery and quality as measured by the LGA Balance Score Card"

TABLE 1.1; DHFF INDICATORS

SN	Indicators	Score	National Baseline	Target Values				
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Maternal, Neonatal and Child Health Service Delivery Outputs (6 Criteria, Subtotal Score: 50)								
1.	Percent of pregnant women attending four or more antenatal care visits (ANC4)	10	42.1Percent	45Percent	49Percent	53Percent	57Percent	60Percent
2.	Percent of ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for malaria	7	42.5Percent	45Percent	49Percent	53Percent	57Percent	60Percent
3.	Percent of ANC attendees receiving adequate quantity of iron and folic acid tablets until next ANC visit	5	50.2Percent	53Percent	56Percent	59Percent	62Percent	65Percent
4.	Percent of institutional deliveries	13	44.7Percent	48Percent	51Percent	54Percent	57Percent	60Percent
5.	Percent of women of reproductive age using modern family planning methods	10	37.3Percent	38Percent	39Percent	40Percent	41Percent	42Percent
6.	Children 12-59 months receiving at least one dose of Vitamin A supplementation during the past year	5	51.0Percent	53Percent	55Percent	57Percent	61Percent	65Percent
Improving Conditions for Quality of Care (6 Criteria, Subtotal Score: 50)								
7.	Percent of PHC facilities with “3 stars” rating or higher	15	7.0Percent	10Percent	15Percent	25Percent	35Percent	50Percent
8.	Percent of	10	91.0Perce	93Perce	95Perce	97Perce	99Percent	100Perce

	dispensaries with skilled HRH		nt	nt	nt	nt		nt
9.	Percent of PHC facilities with continuous availability of 10 tracer medicines in the past year	10	30.6Percent	35Percent	40Percent	45Percent	50Percent	55Percent
10	Percent of LGAs with functional Council Health Service Boards	5	86.3Percent	88Percent	91Percent	94Percent	97Percent	100Percent
11	Percent of completeness of quarterly DHIS 2 entry by LGA (by Day 30 after the end of each quarter)	5	89.5Percent	91Percent	92Percent	93Percent	94Percent	95Percent
12	Percent of LGAs with unqualified opinion in the external audit report	5	80.0Percent	85Percent	90Percent	95Percent	100Percent	100Percent
	TOTAL	100						

Sources: PO RALG 2018

1.3.4 ALLOCATION TO HEALTH FACILITY LEVEL

The following ceilings were used for allocating the council envelope to the various cost centres. The ceilings have been formulated based on ceiling range per cost centre provided in the CCHP guideline.

TABLE 1.2: COST CENTRES ALLOCATION

Allocations to Cost centre	
Office of DMO	15Percent
Council Hospital	25Percent
Voluntary Agency Hospital	10Percent
Health Centre and Dispensary	45Percent
Community initiatives	5Percent

Source : PO RALG 2018

1.3.5 ALLOCATION TO INDIVIDUAL HEALTH CENTRE AND DISPENSARY

Each Health Centre and Dispensary was allocated a base allocation of 33Percent. The base allocation is based on the Percent earmarked to medicine by the CCHP guideline. It has been set to make sure that each facility is managed according to procure necessary for availability of medicine and supplies i.e provided with 33.3Percent for medicines.

The amount beyond 33Percent is allocated using three adjusters:

i. Utilization rate (50 Percent)
ii. Distance (20Percent)
iii. Service population (30Percent) (URT, 2017).

The data used for the number of health facilities will come from the MoHCDGEC Health Facility Registry (HFR) and PORALG verified Facility Bank Accounts 2017/18 statistics.

1.3.6 DISBURSEMENT LINKED INDICATORS FOR LGAS (DLI 4)

i. Percent of a pregnant woman attending four or more ANCs
ii. Percent of ANC attendees receiving at least 2 doses of intermittent preventive treatment for malaria
iii. Percent of ANC attendees receiving adequate quantity of iron and folic acid tablets until next ANC visit
iv. Percent of institutional deliveries

v. Percent of women of reproductive age using modern FP methods
vi. Children 12-59 months receiving at least one dose of Vitamin A supplementation
vii. Percent of PHC facilities with '3 stars' or higher
viii. Percent of Dispensaries with skilled HRH
ix. Percent of PHC facilities with continuous availability of 10 tracer medicines in the past year
x. Percent of LGAs with functional Council Health Service Board
xi. Percent of completeness of quarterly DHIS 2 entry by LGA-
xii. Percent of LGAs with unqualified opinion in the external audit report

Below is a set of these indicators, their weight and accepted performance targets

1.3.7 EXPECTED PROGRAM EFFECTS

Universal access to primary health to all and utilization of lower-level health facilities in general benefit few beyond what was supposed to be happening. now this evaluation on DHFF implementation in lower facilities stud will have the following efforts

i. This study is going to influence POLICY adjustments on direct health funds disbursement and implementation of DHFF as result contributing to tangibles like to essential commodity availability, availability of funds for the daily running of the facility and staff motivation.
ii. The study will help top managers to raise their concern on the role of Health Care Providers in number, community through HFGCs, health promotion activities aiming at raising community care seeking behaviours and mid-level managers involvement (CHMTs) in implementation of DHFF, as a result, improving utilization of lower-level health facilities in general
iii. Shade light on the role of community participation and how best can they participate in implementation DHFF as a result of improving the quality and utilization of services in lower health facilities

iv. The study will ascertain the significant role of social demographic factors like literacy, poverty, distance from the facility, education/literacy level, decision making in terms of gender in affecting the implementation of DHFF concerning services delivery improvement and lower health facility utilizations.

In general, the findings obtained in the study can be used by different stakeholders such basket funds donors, health care providers and the community to bring effect to policies, reallocate resources and make other important decision to improve implementation of DHFF and finally achieving universal health for all.

1.3.8 DIRECT HEALTH FACILITY FINANCING LOG MODEL

A logical model is a visual and systematic way to illustrate p rogram theories by showing the relationship between components of a program and its expected effects . Simplified model of an intervention that indicates how and why you believe your programme will work – what the relationship is among the resources you have to deliver the programme, the activities you will do and the outcomes or changes/effects that you hope to achieve *(URT, 2017)*

TABLE 1.3: DIRECT HEALTH FACILITY FINANCING LOG MODEL

INPUTS	PROCESSSES	OUTPUT	OUTCOME	IMPACT
• Facility Plans adhered to guideline • Functional Health Governing Committee • Quality HMIS data • Verified list of facilities with bank accounts • Qualified Assistant accountants and 1 Qualified Staff • Effective Communication channels Health facilities Performance Contract	• Train and mentor HFGC & facility staff on proper implementio n • HFGC conduct regular meetings • Conduct Facility Data Quality Assessment and Use • Timely Approve of funds per current financial guideline • Timely approve of pharmacetica ls and supplies procurement • Maximize revenue collection and create other sources • Advocate for more decentralized SWAp activities • Share analysed information	• Number/types of topics HFGC trained & mentored • Number meeting Conducted & issues agreed • Number of Data Audit sessions conducted • Number of financial Audit Queries produced • Number of Procurement/fu ncial Audit Queries • Amount of revenue collected Number of Joint Ward/Village activities conducted • Number of information shared and feedback • Number of patients complains	• Improve transparency and accountability • Enhance community partnerships	• Better perform ance gain more value for money

	and provide timely feedback to all potential stakeholders • Signing and implementing contract	• Number of performance scores achieved by each		

Source: PO RALG

1.3.9 STAKEHOLDERS ANALYSIS

A stakeholder is any person group or organization that can place a claim on the organization's attention, resources, or output, or is affected by that output" (Bryson, 2003). "People or small groups with the power to respond to, negotiate with, and change the strategic future of the organization"((Ackermann, 2011).

Now from the above definitions I can define Stakeholders as partner who in one or the other can affect the whole process of implementation of DHFF.

Here bellow is a brief analysis on how they take part in the implementation of DHFF and their role.

TABLE 1.4: STAKEHOLDERS ANALYSIS

SN	STAKEHOLDER	INFORMATION NEEDED	LEVEL OF INVOLVEMENT	Role they play
	MOF and treasury	Disbursement report	Ministry	High
	NATIONAL DHFF COORDINATION	1.provision of guidelines 2.training implementers Supervision to districts and regions on DHFF	MINISTRY	High involvement
1	City Council HEALTH Management Team	1.Progress Report DHFF implementation 2.funds disbursement 3. Human resources deployment report 4. DHFF training reports	DISTRICT LEVEL	High
2	Health Facility Governing committee	1.Planning and budgeting report 2. committee meeting minutes and reports 3. Funds management reports 4.responces to questionnaire and other data collection tools	Facility level	High
3	Community	1. Responses to questionnaire and other data collection tools	Villages levels	High
4	Health Care Providers	1. Responses to questionnaire and other data collection tools	Facility levels bbggx	High

1.4 PROBLEMS DHFF INTENDS TO ADDRESS

Public funding is not reaching frontline health facilities i.e health centres and dispensaries in the a required amount and time. Instead, most facilities rely on the collection of user fees to fund their operations. Funds move very slowly through the government system due to bureaucratic management from Treasury to the district level, and council management teams appear to give priority to spending on costs of health administration, rather than the operation of facilities and FGC. Second, when funds are released, there are major delays before they can be used. In many districts, it takes 4 months into the financial year before approval is granted for operational expenditures, due to the long process individual expenditure items take very long time. This process adds little value to the quality of services provided and facility capacity for the purchasing and effectively handicaps facility activities for a substantial part of the year limiting the achievement of DHFF goals of achieving universal health for all (URT, 2017).

Third, there is reduced ownership of facility activity at the local community level, as all financial decisions are controlled more centrally at the district levels by CHMTs. Increasing the local ownership and connecting planning at the community level with the available resources is expected to bring benefits, enabling local facility staff to be responsive and accountable for their actions. Last, the unreliability of operational support has fostered a wide variety of user fee regimes. These have low levels of accountability, and at times impede access for priority services such as maternity care.The Direct Health Facility Financing is a Governance and Leadership initiative operationalizing Health Sector Strategic Plan IV towards improved quality of services as well as utilization of services at the Council level on one hand and donors need to see community involvement and facility accountability and, management to their health on the other hand. Furthermore, DHFF supports the Health Care Financing Strategy and the move towards Universal Health Coverage (URT, 2017).
The main goal of establishment of DHFF is to realize the structural decentralization to lower health facilities that can increase better performance and gain more value for money so as to achieve Universal Health Coverage (URT, 2017).

There are huge efforts which have been invested in sensitization, advocacies, training and supervision, purchase of different types of equipment used in operationalizing and realization of DHFF but up to now little is known on the progress made after DHFF took course.

This was a process evaluation focused on the implementations of the DHFF . The study centred at assessing funds disbursement,staff and community capacity in planning process and budgeting. Furthermore it looked at effect of social demogrphic factor on DHFF implementation. Since there has not been many studies on DHFF therefore, the result of this study provides light to decision-makers, policymakers, implementing partners, and all other stakeholders to adopt corrective measures to rectify the situation for better implementation of Direct Health Facility Financing.

1.5 EVALUATION QUESTIONS

1.5.1 GENERAL EVALUATION QUESTION

What affects the process of implementation Direct Health Facility Finncing in health centres and dispensaries in Tanzania?

1.5.2 SPECIFIC EVALUATION QUESTIONS

i. How are funds being disbursed (duration and procedure) in DHFF implementation in loer health facilities.
ii. How staff availability in number in lower facilities affect the implementation of DHFF in lower health facilities.
iii. In what ways is the implementation of DHFF influencing community participation in managing lower health facilities.
iv. What social demographic factors are influencing the implementation of DHFFin lower healt facilities.

1.6. OBJECTIVES OF THE STUDY

1.6.1 GENERAL OBJECTIVE

An overall objective of this process evaluation study was to assess how the process of implementation of direct health facility financing is being performed at the level of health centres and dispensaries in Tanzania. The study will assess the consistence of implementation of direct facility financing in regard to DHFF guidelines.

1.6.2 SPECIFIC OBJECTIVES

i. To explore how funds are being disbursed (timeliness nad procedures) in DHFF implementation in health centres and dispensaries in Tanzania
ii. To assess how staff availability in number in lower facilities affect the implementation of DHFF in health centres and dispensaries in Tanzania
iii. To examine how community participation in implementation of DHFF in health centres and dispensaries in Tanzania
iv. To examine the effect of a social demographic factor is influencing the implementation of DHFF in health centres and dispensaries in Tanzania.

1.7 SIGNIFICANCE OF THE EVALUATION STUDY

In many rural areas, universal access to primary health and utilization of lower-level health facilities in general lags behind what was supposed to be happening. Now this study has contributed to the revealing of the following; This study assessed how direct health funds disbursement is implemented as result contributing to tangibles like to essential commodity availability which gives an area of study on the reasons why utilization of lower facilitie is low as, funds for the daily running of the facilities and how these direct funds contribute to the utilization of these lower-level facilities

The study assessed the capacity of Health Care Providers in number and skills in the implementation of DHFF, as a result improving DHFF implementation in general and also how staff motivations is related to autonomy in managing facilities under this DHFF which can be used by scholars to learn on factors that motivate employee behaviours at work

The study has assessed how community participation in implementation DHFF as a result of improving the quality and utilization of services in health centres and dispensaries. How the DHFF programme is improving facility ownership by the community as well as their involvement in managing their services to enhance responsibility and accountabilities to foster the utilization of those lower-level facilities

The study is therefore important as it has shed light into some gap if adjusted to done in some other ways could improve implementation of DHFF for example increase amount of supervision,mentoring,training and periodic enaluation of the program can improve DHFF implementation (Opwara et al, 2009).

The study has shed light to in sense that the findings obtained in the study can be used by different stakeholders to assess policies, reallocate resources and make other important decision to improve implementation of DHFF to achieve the intended goal of improving quality of services and utilization of lower-level health facilities and finally achieving universal health for all. Also the studyis requirement of fulfilling my master degree study on mornitoring and evaluation.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODCUTION

This chapter aims to give a highlight to the readers of this research on what other scholars have experienced in similar projects in other areas of the world, share the experiences to improve implementation of DHFF in Tanzania. This literature review is also expected to come up with some in shortfalls funds disbursements,availability in human resources for health in DHFF implementing facilities and the motivation of who workingthere currently and to see what is missing in terms of community participation and client satisfaction that could account to responsility and accountability in services delivery that were also seen in other evaluation studies elsewhere that if addressed can help DHFF implementation in Tanzania. In a nutshell this chapter analyses literature related to the implementation of direct health facility financing from different scholars around the world. Their experiences, findings and challenges met which they addressed and what was not adequately addressed in their evaluation reports (Shona McCombes, 2019).

In the study by Antony Opwara and others in 2010 in their report on DFF implementations in Kenya coastal province came up with some challenges in some important area of DFF goals namely funds disbursements and expenditures, health care motivation, health care availability (Antoni Opwora et al, 2009).

2.2 THEORETICAL LITERATURE REVIEW

2.2.1 FUNDS DISBURSEMENT AND EXPENDITURE

The pattern of expenditure for DHFF in Kenya was similar in all facilities concerning facility income (user fees, sale of ITNs, income-generating activities). For these none-DFF sources, wages and domestic travel allowances accounted for 15 Percent and 17 Percent of the expenditure, respectively; 14 Percent was spent on construction and maintenance, while non-drug supplies and food took 10 Percent which seem inadequate hence not properly addressing essential commodities availability. The main difference to DHFF funding was that facilities were allowed to spend this income on drugs and sitting allowances for Health Facility Committee members,

which accounted for 13 Percent and 11 Percent, respectively. Many Health Facility Committee members felt that the restriction on purchasing drugs using DFF grants was not warranted. They argued that the system of supplying drugs through Kenya Medical Supplies Agency (KEMSA) (similar to MSD in Tanzania) had failed to ensure adequate supplies. Drug shortages were reported to be prevalent; an observation supported by data from the facility survey which showed that, on the day of the survey, all facilities had a stockout of at least one essential drug or medical supply. One district manager said he would personally allow expenditure of DFF on drugs as a stopgap measure if there were severe shortages. So DFF in Kenya falls short of addressing the problem of availability of essential commodities to ensure efficient and effective health care deliveries to the needy (Antoni Opwora et al, 2009).

2.2.2 HEALTH CARE PROVIDER MOTIVATION

Opwara still explain that it was a common perception among health care Providers and DHMT members that DFF had motivated health care providers to work better. Firstly, it was said to be easier for health care providers to plan their work since they worked with a predetermined budget. This was in contrast to the pre-DFF period when the flow of funds was erratic and planning for services very difficult. Secondly, health care Providers found it easier to perform their jobs because of the help provided by the support staff. This made it easier for Health Care Providers to improve their carrier by practicing the their professional skill (Gagan Gurun, et al, 2018)

2.2.3 AVAILABILITY OF HEALTH CARE WORKERS, AND CAPACITY IN FINANCIAL ACCOUNTING

Before DFF implementation, facilities were always understaffed in kenya, and health care providers were obliged to engage in other activities, such as registering clients, collecting funds and dispensing drugs, in addition to providing consultation and administering treatment. DFF funding ensured that health care Providers could concentrate on performing their core duties of providing healthcare and this increased their ability to meet DMHT targets, therefore impacting positively on

motivation. The most common targets set were improvements in the proportion of fully immunized children, facility-based deliveries, and increased antenatal attendance. The improved staffing meant that even though DFF was said to have increased the administrative and clerical workload on health care Providers, few complained that although there is a requirement that there must at least be one skilled health care worker for DFF to operate still the staff allocated were insufficient to attend all clients as there were increased client attendances at the facility hence we are overburdened (Catherine Goodman, 2009).

2.2.4 COMMUNITY PARTICIPATION AND CLIENT SATISSFACTION

It was also important that DFF covered facility utilities such as water and electricity, and supplies such as food rations, stationary, needles and syringes, cotton wool, spirit, torch batteries and kerosene, as reductions in stockouts were reported to have greatly improved or reduced morale of the care provider to provide health care services harmoniously hence leading to cliends dissatisfaction. So, from the DFF study in costal Kenya, it was found that DFF in Kenya failed to address client satisfaction both internal and external clients (customers and Health Care Providers) (Gagan Gurun, et al, 2018).

Moreover, health care providers felt that having control of DFF funds had increased their capacity to make timely decisions and resolve problems in collaboration with Health Facility Committee members through participatory planning and involvement in the implementation of the facility budget by Health Facility Committee. The community in Kenya felt that the facility is their property for their health betterment, it increased their confidence compared to pre DFF period(Catherine Goodman, 2009).

Previously, when supplies(for example needles and syringes), were needed, health care providers had to go through the DHMT and the complex district accounting system. This used to cost them valuable time and, in the case of Tana River, a week could be spent at the District headquarters trying to get the district accountant to release funds but now it just a matter of an hour to call for Health Facility Committee to decide and act. In coastal Kenya one of the demotivators that were seen was

despite the reduced time spent in the bureaucratic release of the fund still more needed to be done to make sure staff spend the insignificant amount of time to allow them to have more time to serve their clients and reduce the time for commodities stockouts. The most important link to the improved motivation of health care providers, according to most report was the provision of allowances for carrying out outreach activities, accompanying referred patients, and travelling to the district headquarters for re-supply, submitting HMIS reports or even visiting the bank to withdraw cash from facility accounts (Antoni Opwora et al, 2009).

There was the fact DFF in Kenya it has assisted the facilities as it has motivated staff, for example when they come to the district to bring the returns or when they refer patients, normally there before the grant, they were not paid any money. They had to liaise with the relatives who are yet poor. So it was not motivating at all, but with the grant, they have some allowances, they have the provision; if they refer patient their allowance is there. They are paid, they feel very nice. They are more motivated to work. Before the introduction of DHFF, there was no motivation because before [DHFF], the staff were being forced to go out on outreaches with no transport and no lunches. After DHFF there is no problem and if you tell someone to go for outreach, they are happy to go and their work is the same, now there is no such problem almost everybody is motivated. There is greater motivation because whatever they do, they have support. they have a source there have finances but still, there is a bureaucratic procedure by authorizing officer that financial account so DFF in Kenya did properly address Public Financial management (PFM) gap that was observed during its implementation (Gagan Gurun, et al, 2018)

2.3 EMPIRICAL PART

This chapter analyses literature related to factors that affects implementation of DHFF in lower health facilities from different scholars around the world.

Health financing system

Being financed, insured and protected from health risks and health uncertainties is a very important aspect in human welfare and development. The declaration Alma-Ata and reinforcement by the Abuja declaration made a turning point in financing health

by explicitly putting forward the 'Health for all' commitment for all Nations, which obliged all nations to review their health financing mechanisms(WHO, 2001).

Health financing is therefore essential as it portrays the ability of health systems to improve the health status and welfare of its population. Any health plan without financial resource will not be implementable. All material and human resources require funds to implement(WHO, 2015).

The most used types of health financing include general revenue also known as earmarked taxes, social insurance collections, private insurance premiums, community based health financing and direct out of pocket payments. The aim of health financing is to ensure equity and equality in the provision of health care services to improve social welfare of the population in need (Christopher JL Murray, 2000).

In many African countries, primary care facilities are insufficiently resourced, and user fee reduction or purging policies have been poorly planned, without alternative sources of facility income. IN Kenya for example The Health Sector Services Fund (HSSF) is an innovative scheme established by the Kenyan Government in 2010 to disburse funds directly to health facility bank accounts. Health Facility Management Committees (HFMC),which include local residents and the facility in-charge, are responsible for planning, budgeting and implementation of HSSF activities. (Catherine Goodman, 2009).

In Papua New Guinea Direct Facility financing is a project that strengthen the rural health system in selected districts by increasing the coverage and quality of primary health care (PHC) in partnership with both state and nonstate service providers through supporting the Government of Papua New Guinea in implementing the National Health Plan (NHP) as it relates to rural health. It built on the Asian Development Bank's (ADB) experience in strengthening health service delivery in rural areas of PNG.1 The project covers two districts in each of the following eight provinces: Eastern Highlands, East Sepik, Enga, Milne Bay, Western Highlands, West New Britain, Morobe, and the Autonomous Region of Bougainville. The approximate total number of beneficiaries in the 16 districts will be 1.2 million. The

provincial assortment was made by the Government. The project is seen as the first stage of the government's Rural Health Service Transformation Project with the clear intention of rolling the project out to additional districts and provinces as government and external funds become available (GPNG, 2014).

2.4. EVALUATION GAP

From te studies conducted in Kenya it is observed that there were some gaps which were not well addressed. These are HFGCs capacity to participate in planning process and address facility targets. HGFC need to be conversant in participating in the whole process of planning and planning is all about knowing the gaps in services and the target that need to be met.

The place social demographic factors have in the implementation of DHFF. So this study is going to avaluate the effect social demographic factors have on DHFF especially the culture of the community understudy of attending traditional healings. The deterring effect of economy (user fee) in using facility, distance to the facility and in general health promotion issues that appeared to affect the implementation of DHFF in Tanzania.

This study also addreses the effect disbursement in terms of timing and procedures have in the whole implementation of DHFF. At te end of this evaluation study we will comeup with solusition to these gaps. Now this this evaluation study is expected to address these gaps.

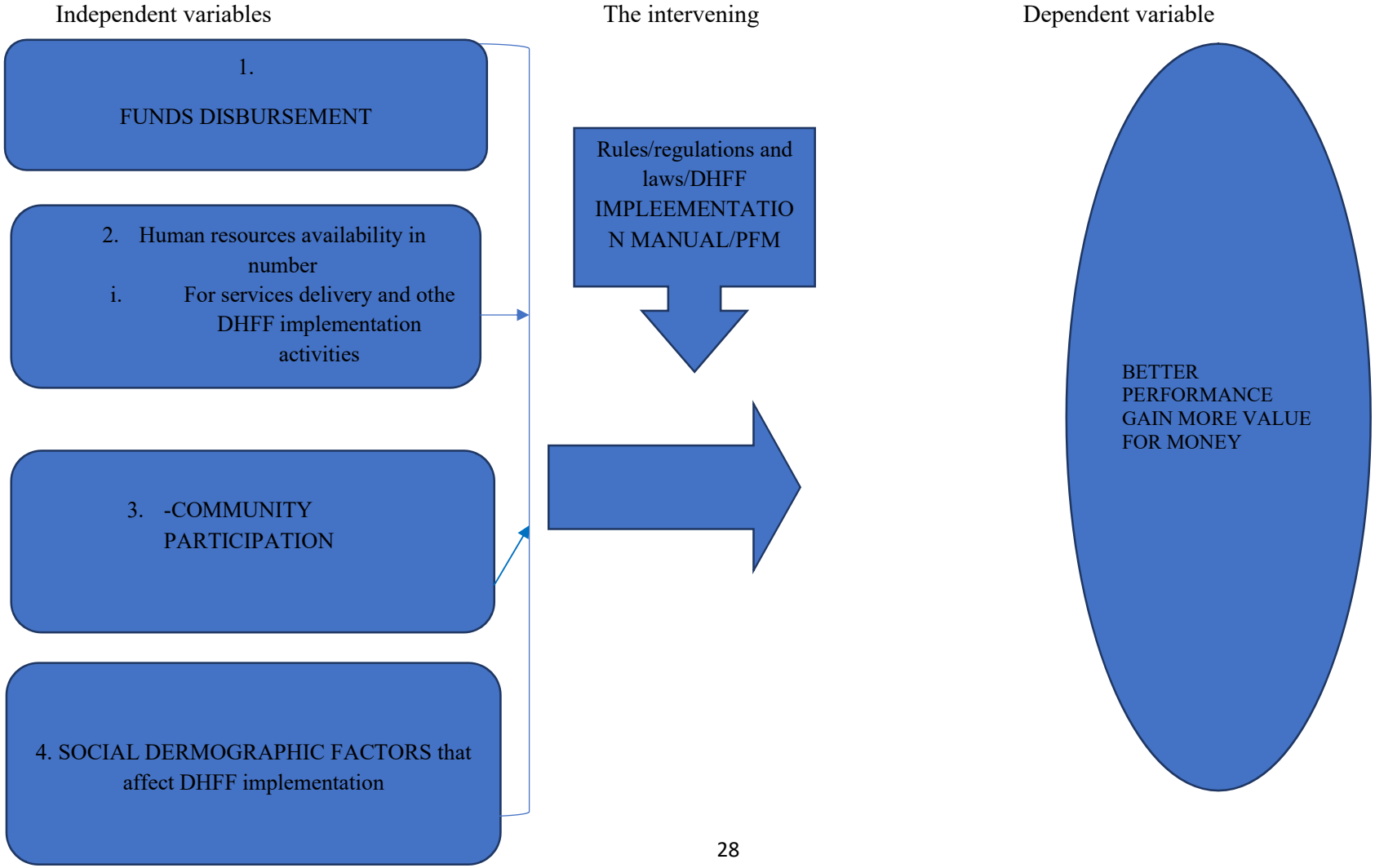
2.5 CONCEPTUAL FRAME WORK

The figure below illustrates factor that affects facility utilization which may act as positive or negative forces to the community in Dodoma city council and in one way or the other act as barrier or facilitator toward implementation of DHFF to foster services improving and facility utilization in other areas as a result of implementation of Direct health facility financing. These factor including household decision to seek services, literacy, distance to facility, and participation in the facility decision making, and accessibility to services and availability of funds and availability of other necessary commodities for services delivery, availability of health care

providers their insufficiency in number and professional skills and also other unknown social demographic factors that in one way or the other affect implementation of DHFF

The first column shows that some of the determinants of improvement of services in the implementation of DHFF in relation to factors like demographic and social-cultural conditions toward better performance gain more value for money. As an outcomes in terms of improving qualities of health services, increasing availability of the workforce. Improving labour force motivation and funds disbursement that reduce out of stock of essential commodities such medicines, laboratory supplies and hospital supplies that are necessary factor for health care infrastructure improvement. The independent variables which if funds are not available, essential commodities are not in place at every time of need, Health Care Providers are not available as per staffing level, even the available ones are not motivated, and the community is not involved in decision making (through Health facility Governing Committees) on their facility plans and budgets and daily management including implementation of decisions and given proper feedback then they will negatively affect expected better results. Now in the study we will assess if programme implementers (health facility in-charges, City Health Management Team and Health Facility Governing Committees, community, the community and health service providers) to capture their knowledge of DHFF, if they have stick to the implementation as documented in the programme document and other factors influencing abiding by the plan of implementation, for example, training, policy and guidelines, and supportive supervision employment of assistant accounts, frequent auditing of the funds, provision of quarterly and annual report and mentorship

FIGURE 2.1:CONCEPTUAL FRAMEWORK



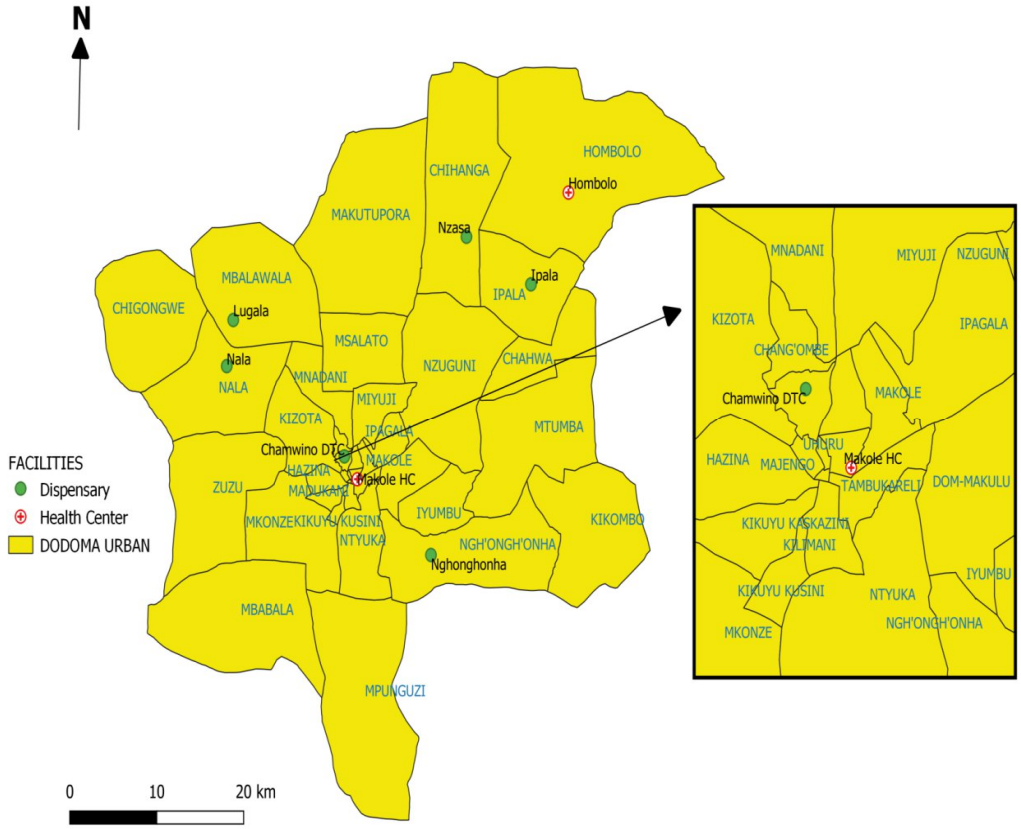
CHAPTER THREE: EVALUATION DESIDN

3.1 STUDY AREA

This evaluation was conducted in Dodoma City Council, which is among the 8 districts of Dodoma Region and comprises of 35 facilities (4 Health centres and 31 Dispensaries). The study assessed the implementation of DHFF in relation to better performance, gain more value for money. The relevancy of the study is based on the fact that the area is one of the districts implementing DHFF representing many facilities of a similar type in Tanzania with shortages of health care providers. This is one of the councils which has received training, supervision for the process of implementation of DHFF. The study will involve all the facilities of the district. The city council was also purposively selected as a typical mixed urban and rural district that has a moderate level of socio-economic development and is fairly accessible in terms of transport and communication networks.

Dodoma City is one of the districts among 8 of Dodoma region. It borders with Mpwapwa district in the south, Chamwino in the East, Bahi in the West.
Administratively, the district has 41 wards, and according to the 2012 Tanzania National Census, the population of Dodoma City has 523,008. The health care system in Dodoma City is largely based on both public and private health facilities, including 4 health centres and 31dispensaries. But in the study, only 35 facilities were considered because they are publc facilities implementing DHFF.

FIGURE 3.1: MAP REPRESENTING VISITED HEALTH FACILITIES AND OTHER PUBLIC FACILITIES DODOMA CITY COUNCIL



3.2 EVALUATION PERIOD

This process evaluation was conducted from October 2018 -January 2019 (development of proposal). Data collection, collation, and processing was done from February 2018 to July 2019, which involved data analysis and report writing

3.3 EVALUATION APPROACH

This evaluation employed process evaluation because DHFF program is at the second year of the implementation. This approach allowed the evaluation of The National Direct Health Facility Financing Guide, with Health Sector Strategic Plan IV guidance to the transformation of the health sector and an opportunity for long

term planning. Process evaluation was used because the program is at the second year of its implementation so will allowed assessment of implementors consistence to the Implementation plan. the evaluation used several questions to determine whether the DHFF programme was implemented according to the design and to identify areas of deviation. The main focus was to see/observe and decide whether the health service providers demonstrated high or low consistence of implementation to the DHFF such presence of Health facilities governing committees, fuds being disbursed timely, availability of at teast one professional health care proviber. If there is available working HMIS system and data quality assessment are conducted , if there are employed assistant account and if supervisios and mentoring activities are conducted as planed.

3.4 EVALUATION DESIGN AND TECHNIQUE

The descriptive cross-sectional study design was employed in this evaluation since this study involved a group of the population that share similar characteristics at a specific point in time but who differed in key factors that are evaluated. It included detailed description and analysis of a single group, persons, process and or system or any other entity at one particular time during the evaluation of DHFF. The study aimed to determine how well the program is implemented to achieve its objective in details and also ascertain the dynamic factors that made the program succeed or fail. This design enabled us to get the results of our interest in our sample. Data were collected at a single time from a sample drawn from a population under study. The DHFF implementation is at the second year of implementation so it fits the reason for the choice of the study design. The study used content analysis technique.

3.5 FOCUS OF EVALUATION AND DIMENSIONS

The process evaluation was the main focus of study as DHFF programme implementation in public health centres and dispensaries is at the in second year of implementation, programme implementers (health facility in-charges, City Health Management Team and Health Facility Governing Committees, community, the community and health service providers) to capture their knowledge of DHFF, if they have stick to the implementation plan as documented in the programme

document and other factors influencing abiding by the plan of implementation, for example, training, policy and guidelines, and supportive supervision employment of assistant accounts, frequent auditing of the funds, provision of quarterly and annual report and mentorship to the facility workers.

3.6 VARIABLES/INDICATORS

In this evaluation study, there were two types of variables namely independent and dependent variables. There was only one dependent variable ie better performance gain more value for money in implementation DHFF in relation to the second group of independent variables like such as social-cultural conditions, literacy level, distance from the facility, poverty,gender, or age that affected better performance gain more value for money which collectively known as socio-demographic, second independent variable is funded disbursement which will allow easy purchase of essential commodities, provision of daily running costs. The third being Health Care Providers are available and finally, the community is involved in decision making on their facility planning, budgets and daily management including implementation of decisions at the facility.

TABLE 3.1: DHFF VARIABLE/INDICATORS

VARIABLE	INDEPENDENT VARIABLE			DEPENDENT
1.	Cultural	Good	Categorical	Better performance gain more value for money
2.	Distance to the facility	Long/short	Categorical	
3.	Enonomy affect facility utilization	Yes/no	Categorical	
4.	Literacy	Yes/no	Categorical	
5.	Gender	Male/female	Categorical	
6.	Funds disbursed to the facility	Yes/no	Categorical	
7.	Knowledge on funds disbursement by the community	Yes/no	Categorical	
8.	Essential commodity availability	Yes/no	Categorical	
9.	Health Care Providers availability	Available /not available	Categorical	
10.	Health Care Prviiders motivated	Yes/no	Categorical	
11.	Health providers attitude affect services	Yes / no		
12.	HFGC available and functional	Yes/no	Categorical	
13.	HFGC participte in planning and budgeting	Yes/no	Categorical	
14.	Community utilize facility	Yes/no	Categorical	
15.	Community aware of planning process			
16.	Facility workers know their plan/budget	Yes/no	Categorical	

3.7 POPULATIONS AND SAMPLING

3.7.1 TARGET POPULATION

The target populations of this evaluation were all district-level managers (CHMT), health centres and dispensaries Officers in charge, facilities Governing committees (from the community) those who are responsible for planning, receiving and utilization of funds to provide services, those council management team who allocate and supervise human resources for health and services receiver of Dodoma City the community. From the targeted population of the study information about how the implementation of DHFF was being effected as per DHFF implementation guidelines, to learn if the stakeholders (community) involvement were as intended.

3.7.2 SOURCE POPULATION

The source populations of this evaluation was all dispensaries and health centres workers living in Tanzania from implementation of DHFF

3.7.3 STUDY POPULATION

The study populations of this evaluation was all dispensaries and health centre workers, HGFCs, CHMT (DHFF focal person) and the communities (health facility governing communities and user of health centres and dispensaries services patients and clients conveniently found at the facilities), in DHFF implemntting facilites in Tanzania facilities Governing committees those who are responsible for planning, receiving and utilization of funds to provide services (HFGCs and facility workers).

3.7.4 STUDY UNITS AND SAMPLING UNIT

In this evaluation study, my sampling units were Health Facilities governing committees ii. Health care providers iii. Council Health Management teams iv. Users of health centres and dispensary services

3.7.5 SAMPLE SIZE

The sample that was involved in the study is the population saved by facilities under DHFF implementation. The sample size for a population-based survey was determined by using the Yamane formula in which three factors were critical: (i) n which is the estimated sample size that is present in the population, (ii) N population size equal to 282,302 and (iii) e which is the acceptable margin of error equal to 10Percent. For a survey design based on a simple random sample, the sample size required is calculated according to the following formula:

Yamane formula

$$n = N/1 + N * (e)^2$$

Where:

n= required sample size = 99 respondents

e=ma2rgin of error at 10Percent (standard value of 0.1)

The study targeted the implementation of DHFF an experience of the mentioned district. The sample size of my study was 99 respondents. The respondent were conveniently selected in their facilities as shown in the table below.

TABLE 3.2: SHOWING FACILITIES AND DISTRIBUTION OF RESPONDENTS

	NAME OF THE FACILITY	POPULATION(N)	RESPONDENTS(n)		HEALTH CARE PROVIDERS
			ME	KE	
1.	HOMBOLO RHC	11,822	5	5	17
2.	KIKOMBO RHC	13,552	0	0	7
3.	MKONZE RHC	7,879	0	0	23
4.	MAKOLE UHC	21,401	9	10	102
5.	HOMBOLO MAKULU	7,854	0	0	5
6.	MKOYO DISP	7,024	0	0	3
7.	CHIHANGA DISP	2,886	0	0	3
8.	GAWAYE	5,215	0	0	1
9.	NTYUKA	4,186	0	0	3
10.	ZUZU	8,087	0	0	5
11.	NZASA	7,778	3	4	2
12.	MICHESE	4,804	0	0	3
13.	MAHOMANYIKA	4,794	0	0	3
14.	KITELELA	3,194	0	0	2
15.	MBALAWALA	4,585	0	0	3
16.	LUGALA	6,901	3	3	2
17.	CHIGOMGWE	5,602	0	0	3
18.	NALA	5,580	2	3	6
19.	MBABALA A	6,301	0	0	3
20.	MBABALA B	4,816	0	0	2
21.	MPUNGUZI DISP	10,279	0	0	2
22.	MATUMBULU	6,714	0	0	3
23.	NG'ONG'ONHA	12,389	5	6	4
24.	MAPINDUZI	6,148	0	0	3
25.	CHOLOLO	4,967	0	0	3
26.	CHAHWA	3,609	0	0	2
27.	MAHOMAKULU	3.309	0	0	2
28.	IHUMWA	11,029	0	0	4
29.	MTUMBA	5.169	0	0	5
30.	MKULABI	5,054	0	0	3
31.	VIKONJE	4,063	0	0	4
32.	IPALA	6287	7	8	3
33.	KIKUYU DISP	17.110	0	0	17
34.	MAKOLE	36,202	0	0	13
35.	CHAMWINO	31,275	13	14	17
		282,302	46	53	283

Note : Numbers in the table above represents respondents that were conveniently selected in the facility

3.7.6 DATA COLLECTION TECHNIQUE

Since this evaluation study has employed both qualitative and quantitative methods the techniques were discussed separately.

3.7.6.1 QUANTITATIVE SAMPLE

For quantitative, probability sampling strategies that were used (simple random, and stratification). The procedure was tha regions were Stratified where Dodoma region was selected purposefully. Districts in Dodoma where stratitfied to pursefully select Dodoma city, again facilities were further stratified into health centres and dispensaries where 2 health centres and 6 dispensaries were randomly selected and communities individuals in the health facilities and community members were conveniently selected. The general population was obtained from the district profile which was later calculated using Yamane formula to get respondents who were distributed according to their population distribution in the facilities catchment areas and conveniently selected where they were met at the facilities. The importance of stratification was to ensure the presence of key subgroups within the sample to ensure representativeness. Simple random sampling was used to assign individual participants to study with equal chances among them, as this gave an equal chance for every eligible respondent to participate in the study.

3.7.6.2 QUALITATIVE SAMPLE

The sampling procedure for the qualitative sample was purposive, participants were found at the facilities at time of study due to the nature of their responsibilities in facility management. They were sported for in-depth interview and focused group discussion which was used in assessing community participation during the process, patients who were found at the facility and typical case sampling in particular in which subjects were selected based on the fact that they are implementers of DHFF. Respondents were selected among those conveniently found at the facility during the study for community members. On the side of Health care providers facility in charges and providers those who work with Facility Financial Accounting and Reporting Systems a DHFF financial management and reporting system, for CHMT respondents were City Medical Officer of health, DHFF focal person because of their

vast experience in working DHFF, facility guardians and City Health Secretary because they are the ones who mentors HFGCs. All these were selected using a typical case sampling due to the fact they are vastly informed on DHFF and its implementation management because of their roles and responsibilities in council. The sample were selected among those who have agreed to participate in a qualitative sample where the sample size depended on the saturation point in this case reasearcher had 44 respondents.

3.7.7 INCLUSION AND EXCLUSION CRITERIA

All health care providers who work in DHFF financed facilities, community members of Dodoma City in those areas that implement DHFF was included in this study and CHMT, all health facility governing committee who implement DHFF were involved in this study.

3.8. DATA COLLECTION

The process evaluation used mixed methods, both quantitative and qualitative methods to collect data to complement each other and provide stronger evidence for conclusion. The methods were used sequentially to measure overlapping but also different features of the evaluation with enriched data that elaborate understanding of this process evaluation.

Different data collection methods are as explained below

3.8.1 QUESTIONNAIRES

In this study questionnaires were used to get responses from respondents, to assess their involvement in health facilities management to get evidence of decentralization and their knowledge of health funds disbursement, expenditure arrangement and change in services delivery in their facilities. They were asked if they know that there are funds brought by their government to their facility account? Did that bring any change to availability to staff motivation?. Were they informed on those funds arrival? Did it improve availability of essential commodities like medicines?, how many human resources are available and if they are enough for services delivery? What are workers attitude towards clients and how they behave if it affect DHFF implementation. It also assessed the effect of social demographic factor and how it

affects DHFF implementation for better performance to gain more value for money. There were 99 respondents visited for responses. The tools were made in light of the conceptual framework In conducting a process evaluation, the tool was used to measuring the implementation processes.

3.8.2 IN-DEPTH INTERVIEW

In-depth interview guide was used to collect information from CHMTs, health care providers, community (in this case conveniently found respondents that were in the facilities receiving services) and health facilities governing the committee. The aim of administering in-depth interview guide knowing what is their perception and opinion on the cause of the changes they see. Are funds disbursed timely and into the facility accounts?. Are human resources available in required amount, what is the participation of community in managing their facility, what are the social demographic factor that affect implementation of DHFF and how did these changes come about. And their opinion on what are the factors that may have contributed to what we see today in their facilities. Specifically, to facilities workers and CHMT if they think that what is practised in DHFF goes in line with DHFF guiding document and what is their opinion on what best can be done to improve implementation of DHFF that can improve the quality of service and facility utilization by the community to gain value for money. There were 12 interviews conducted.

3.8.3 DOCUMENTARY REVIEW

The documentary review was used to collect data that involved going through documents, and analysis of the document that contained reports and information of the DHFF activities conducted to operationalize the program plans. There was a review of document of the DHFF training reports, receipt of funds, facility plans and budgets, budget implementation report documents, funds bank reconciliation reports, financial audit reports and HFGCs meeting records to see how functional are HFGCs and Mentorship reports the aim is to see if the implementation manual and instruction has been observed and implemented as per the DHFF guide document. To see how the community was engaged in the whole process.

3.8.4 FOCUSED GROUP DISCUSSION

The focused group discussion was used to collect information from,managers, HFGCs and Health Care Providers. The aim is to know what is their perception and opinions of the implementation of DHFF implemntation and opinion on what best can be done to improve the implementation. There were 6 focused group discussions conducted to reach saturation.

3.8.5 DATA COLLECTION FIELDWORK

All data collectors were given one-day orientation on how to collect data, pre-tested and each data collector was assigned a specific facility to avoid the chances of involving the same participant more than once. Data were collected in all sampled facilities i.e. 2 health centres and 6 dispensaries to obtain the number of respondents, and patients that were conveniently found in those selected facilities. There were 4 data collectors who were trained for the task.

3.9 DATA MANAGEMENT AND ANALYSIS

3.9.1 DATA ENTRY

3.9.1.1 QUALITATIVE DATA ENTRY

After being collected from the field using Interview tool (audio records) and focused group discussion tools data collected were transcribed read and re-read for completeness, and then uploaded in Atlas ti 7 to assist the data analysis process. We used conent analysis technique and by preparing predetermined theme out of which codes were prepared. Deductive codding was used where families were created out of objectives and code created out of themes. Through the query tool, a report was produced for analysis. The analysis was assisted by quere tool report.

3.9.1.2 QUANTITATIVE DATA

After being collected from the field using questionnaires data were entered into MS excel ready for the data cleaning process

3.9.2 DATA CLEANING

Data were entered into MS excel, cleaned and verified for completeness and accuracy to minimize errors. Every questionnaire was reviewed for correctness and

completeness before and after it was exported into Stata for quantitative data analysis that was assisted by stata 13

3.9.3 DATA ANALYSIS

The data cleaned were labelled and coded. Data were imported to STATA 13 to run test statistics such as the logistic regression statistical test and chi-square statistical test that was used to assess the relationship and associaition between the dependent and independent variable respectively.

3.10 ETHICAL ISSUES

Ethical clearance was obtained from Mzumbe University and Dodoma City Director. Informed consent was obtained respondents during field visits and importance of their participation was carefully explained for respondent full participation. The responses obtained remained anonymous and the respondents were ensured that every participant's response was kept confidential and maintained throughout the data collection period. Tool for data collection did not include the names of the respondents to collect the data from potential identifiers

CHAPTER FOUR: STUDY FINDINGS AND DATA ANALYSIS

4.1 INTROCTION

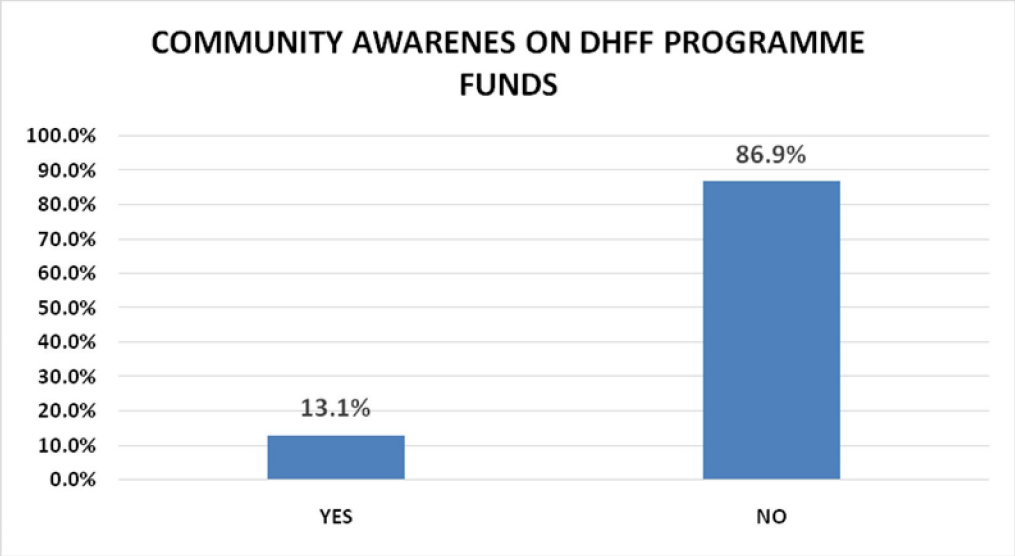
This chapter represents the study findings and data analysis in the process evaluation of the implementation of DHFF in Dodoma city Council. The total of 22 health managers was involved in the study and participated in an in-depth interview and focused group discussions. There were 14 of CHMTs while 8 health facilities charges. There were 99 community members involved in this survey among whom 28 HFGC members from different facilities involved in interviews and 32 were involved in focused group discussions while 12 respondents participated in In-depth Interview. Different CCHP reports quarterly implementations from 8 different facilities, CHMT members and PO RALG and 2 annual reports for 2017/2018 and 2018/2019 files on DHFF implementation were reviewed.

4.2 FUNDS DISBURSEMENT TO HEALTH FACILITIES ACOUNTS

During the assessment of this objective, five-question was asked as follows

The 99 Respondents of the questionnaire were asked to assess if they know anything about DHFF programme. The responses were as YES or NO. among respondents 13.1 Percent said that YES they know while 86.9 Percent did not know anything about DHFF programme

FIGURE 4.1: COMMUNITY AWARENES ON DHFF PROGRAMME DEPOSITING FUNDS TO FACILITY ACCOUNT.



During interviews and focused group discussion, it was found that most of the community had little awareness of the program. One of the respondents said that;

> "*I do not know a direct health facility financing programme, I just recently heard about funds for more than 300 health centres renovations announced by the President of our country …. But each… the one you are talking about I do not know*"(FGD)

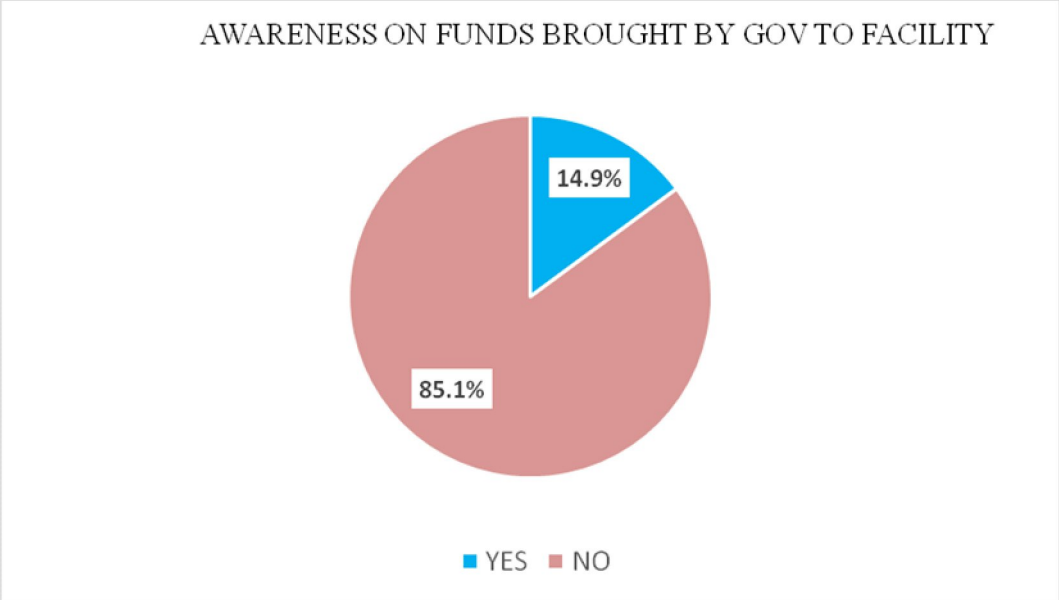
It was also found that most of the staff at facilities had a good level of awareness on DHFF programme as it was seen during a focussed group discussion with members of the facility staff in one of the visited facility one of them said that;

> " *I know this programme is the programme where government brings fund through facility account for use by the facility for the purchase of things like medicines daily running of the facility, payments of staff when delivering services like outreach for vaccination and activities which were not there before"*(FGD).

When the respondents were asked through questionnaires if they know anything about funds brought by the government to the facility.

The responses were as YES or NO. Among respondents, 14.9 Percent said that they know while 85.1 Percent did not know anything about funds brought to the facility by the government into their facility account.

FIGURE 4.2 AWARENESS ON FUNDS BROUGHT BY GOV TO FACILITY



During the interviews and focused group discussion, it was found most of the community members had no awareness except few who had little awareness on the program especially on the details of the programme. One of the respondents said that;

"*I just know that funds are brought to our facility but I do not know the detail, I just heard people talking on those funds ….")*(IDI20 19).

Most of the HFGC had partial knowledge of the receipt of funds in the facility account as demonstrated by one participant, who said that:

> " *I know there are funds brought here because when they get the funds we are normally called for a meeting to discuss what to spend. They just mention the list of items for espenditure, we approve the list including the purchase of medicines. You know when we are attending these meetings discussing funds some of the matters discussed are so strange to us and we are told that these*

are technical issues so we just agree and we are paid for our attendances ."(IDI 2019).

Another group of respondents (health care providers) during a focussed group discussion with a member of the facility staff in one of visited facility responded with good knowledge on the receipt of funds. One FGD participant said that:

" I know the fund that is brought by the government to our facility account, we even participate in meetings that plan for expenditure, budgeting and even implementing some activities for those funds"(FGD 2019)

When asked if funds being brought to facility account help facility worker to improve the services and make it easy for performing their responsibilities. One partipant said that:

" *.the funds have assisted us because we are now paid when we go for services like mobile outreaches when travelling for submission of the monthly and quarterly or even annual reports we are paid the cost of travelling to the district headquarter. Previously we had to visit our relatives there to assist sheltering us when we go for such report as we do not have money to cover the cost, furthermore, we are now paid for services like going to outreach services which were not there before the arrival of this programme. This has improved the situation here at our workplace"* (FGD 2019).

Facility staff were also asked if funds being brought to facility account is enough for the motivation of facility worker to improve the services and make it easy for performing their responsibilities. One participant said;

"*The funds are not enough because we are given instruction on how to allocate funds among planning priorities, sometimes you plan for what you perceived as important for the facility but when you submit the budget it is returned with instruction to remove this, remove that because what you have put in your budget is not allowed. This surprises me, the budget is ours but people up there tell us what to do but it does not reflect our problems. So I can say that these funds are a relief to us but is not covering motivation sufficiently. For example because of a severe shortage of staff we work for many extra hours which when planed in the budget we are told that the guidelines for planning do not allow extra duty payments or on-call payments*"(FGD 2019).

When asked if funds being brought to facility account help facility to improve the availability of essential commodities for services deliveries like medicines, medical equipment, hospital and dental supplies which in turn improves services and enhance the utilization of the facility by communities around. One of the response was as follows

> *" the funds have improved the availability of essential commodities like medicines, previously clients would come and they are told to go buy medicine in a nearby medical store but now after the arrival of the funds the situation is better. But still there is a problem for example funds were supposed to arrive on July for the first financial quarter but we get those funds in maybe October or November, you can see since July up to the time funds arrive there are no medicines and the community knows that, so when funds arrive they still have the notion that there is no medicine so in terms of utilization this trend of funds disbursement does not really enhance utilization as perceived, this is a challenge."* (FGD 2019).

Another respondent who is a health care participant said that;

> "*things are better these days we buy the medicines according to our needs so the shortage of essential commodities has been reduced to a greater extent. The only problem we have is that with MSD who are the only primary sources of medicines many Items are not available so some times we have money but medicine we need are out of stock in MSD, and we can not purchase from other suppliers if they do not give us out of stock document of which in fact they don't give or they provide it very late after several communications. I think we need to have other supplies of medicines to completely reduce this shortage of medicines"* (FGD 2019).

When asked what do they think there is any other challenge that affects utilization of facilities to atain value for money that is related to disbursement of funds, One of the respondents had this opinion that;

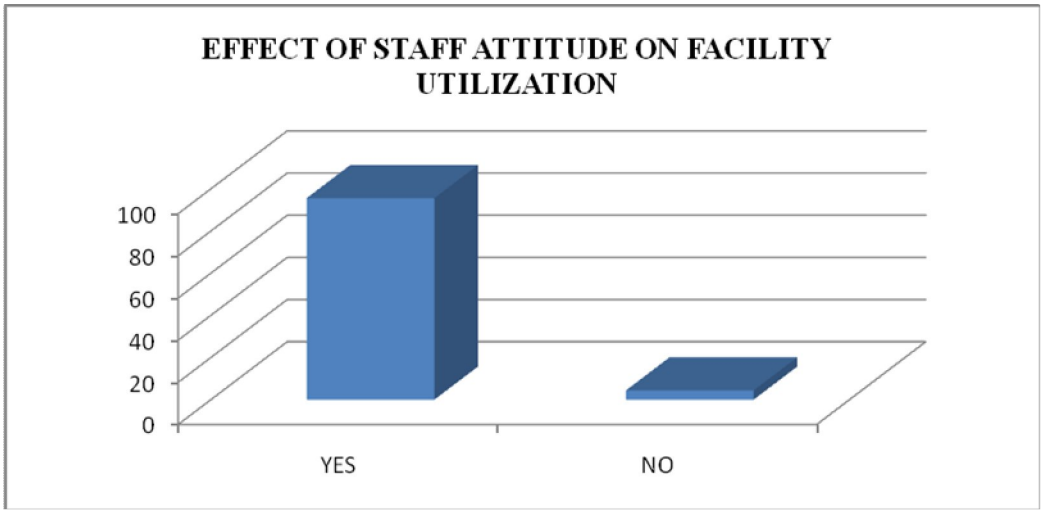
> "*when we attend dispensary services you find that the only investigation available for patients is malaria investigation, we need investigation more than that because we go to other facilities sometimes just because we need more advanced investigation and services. If we get the said funds why do the investigations remain the same? We should be able to access good investigations at our dispensaries*" (FGD 2019)

In the documentary review, it shows that there were bank reconciliation report at visited facilities were receipt of funds document as an evidence of delay in funds disbursement

4.3 CAPACITY OF HEALTH STAFF, FHGCS AND COMMUNITY IN TERMS OF PLANNING, BUDGETING

During the assessment of this objective two questions were asked as follows questionnaire was administered that, does an attitude of providers affect your decision to attend facility services responses. The response were Yes or NO. It was found that 95.6 Percent were not attracted to attend facility services due to providers attitude while 4.4 Percent were not affected by facility providers to attend services. 3 (p=0.1) (Chi-square test was used)

FIGURE 4.3: EFFECT OF STAFF ATTITUDE ON FACILITY UTILIZATION



Most of the interviewee complained that going to attend facility services very much depends on how the customer was received and served last time they went for services. If they are mishandled they will opt next time they fall sick not to come again. One of interviewee said;

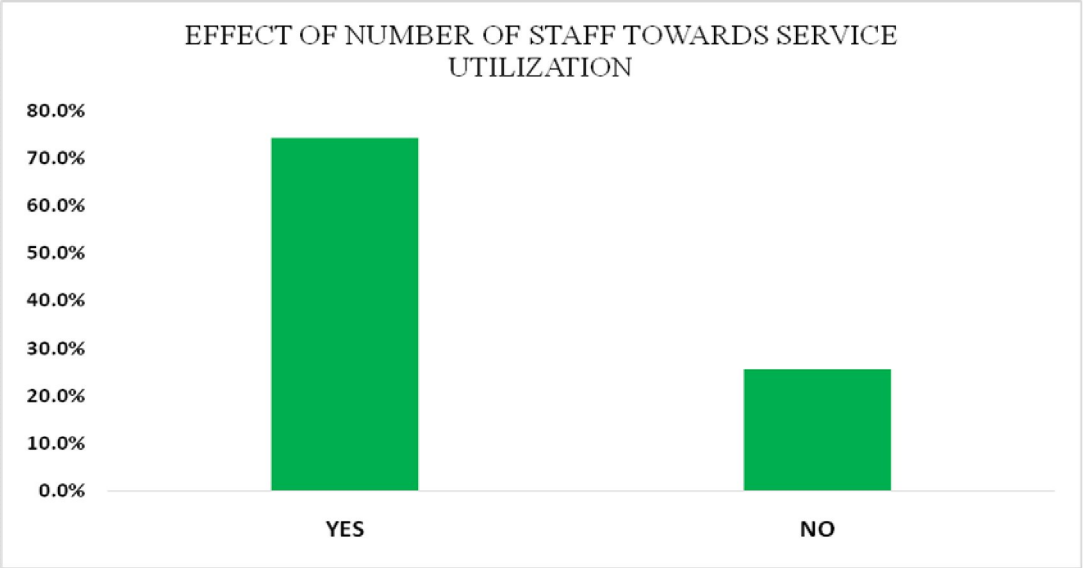
> "*I would rather pay a lot of money in another facility than coming to a facility where you are not treated fairly with bad language and long queue, you see early in the morning when you arrive you find many had arrived before you and yet you meet provider with bad language how would you come again? I better pay expensively than coming again in such facility"*(IDI 2019)

Another respondent said that;

> "*I think something is wrong in our facility, there must be a big problem here. We are supported to attend delivering mothers about 158 per month but only 6 delivered here las month."* (IDI 2019)

The question was asked if they know the current number of staff and if the number of care providers has impacted the utilization of the facility services to gai value for money. The responses were YES or NO. the result was that 74.2 Percent of the respondent said that the number of staff at the facility affect the utilization of health facility while 25.8 Percent said the number of facility worker don't affect utilization.

FIGURE 4.4: EFFECT OF NUMBER OF STAFF TOWARDS SERVICE UTILIZATION



To know the opinion on the effect of the number of staff on the utilization of the facility most of the 12 interviews respondent said that the number of staff has a major effect on utilizing their facilities. One of them sais

> *" when you come to the facility for services you find along the queue and see there are only two staff attending patients. You can not complain, there are many patients, they are overburdened obviously. Next time you look for a private facility to save waiting time that is lost at the public facility. If you do not look for a private facility you will spend the whole of the day just to wait for a doctor or a nurse at the facility."*(FGD 2019).

At another occasion in 4 focused group discussions one participant said that;

> *"we most of the time receive complains from villagers that they are waiting for a long time to receive services at their facility where they have paid their CHF premium and also we receive complains that patients wait for a long time for staff who say that they are going home to prepare food since it has not been possible to get something to eat the whole day, we pray the government could see this" (FGD 2019).*

Another respondent said that

> *"You can come early in the morning but on arrival, you are told the staff are not there, one had gone to the district headquarter to submit report while the other is running an outreach clinic at the nearby village for vaccination, this brings discouragement to come back another time for services." (FGD 2019).*

The researcher also had several interviews and focused group discussion with staff in several health facilities. It was found that staff are also aware of the effect of their number in the delivery of services. One of the participant said;

> *"you come for work, you find pregnant mother waiting for delivery while you are alone at the same time patients are waiting at OPD to be served. So they have to wait for several hours before receiving services while I am attending delivering mother. This discourages them to come again so they normally opt to get services in facilities far from this one to avoid long waiting time, We also get tired so after working hours you can be called to attend emergency patient, because of a heavy day at work earlier that day you sometimes take a long time to respond, people do not like this they are discouraged and this is a big challenge for us." (IDI 2019).*

When asked if there are other challenges in spending the funds brought by the government, most of health facility in-charges complained of the shift of focus from patients to soft that is used for managing funds, they responded that;

> *"this funds when you are informed that there are funds get started for allocation and spending, you are required to use soft were for transactions, this consumes a lot of our time we are not good at using these soft were, sometimes we spend up to three days to address soft were problem at the district office,it consumes a lot of our time, instead of working" (IDI 2019)*

In one of the focused group discussion with CHMTs, they said that most of the facility in charge are not doing professional tasks as most of the time they are busy with funds hence adding up to an already alarming shortage of health care providers. One participant said that;

> *"you come to work here at the office and you find that most of the facility charges are always at the accountant office. When you ask them they say FFARS is not working they are waiting for the accountant to solve the problems. Now, do you think they are working? The funds are creating a new problem of staff shortage here."(FGD 2019)*

From the field experience to know how DHFF has affected the motivation of Care Providers the researcher conducted interviews and focused group discussion respondents perception against DHFF.

It was an ordinary practice among health care Providers CHMT members that DHFF had motivated health care providers to work better. Firstly, it was observed to be easier for health care providers to plan their work since they worked with a prearranged budget. This was in contrast to the pre-DHFF period when the flow of funds was unpredictable and planning for services very easier said than done. DHFF funding ensures that health care providers to concentrate on performing their core duties of providing healthcare and this increased their ability to meet facility targets, impacting positively on their motivation. The most common targets set were improvements of disbursement and performance indicators like the proportion of fully immunized children, facility-based deliveries, and increased antenatal attendance. Without improved staffing it meant that even though DHFF is said to

have eased things but it has increased the administrative and clerical workload on health care Providers, as I actually found during my evaluation. The participant also complained during focused group discussion that:

> *"The government brought me here as trained personnel alone but now if you check the workload, I could not do it alone. There is seing of patients here, there is checking of the children there, doing tests for others yet there is preparing payment vouchers so one person alone would not work" (FGD 2019)*

It was also important that DHFF covered utilities such as water and electricity, and supplies such as stationary, MEDICINES, medical equipment and supplies and Liquid Gas Petrolium, as reductions in stockouts were reported to have greatly improved morale, this was said by one FGD participant:

> *"If you are provided with whatever you need and you give it to your client, then you feel you have done whatever you are supposed to do. For example, if you require stationery and you get it there and then when you feel satisfied … so there is fair satisfaction in the running of this facility with the coming of this fund." (FGD 2019)*

Moreover, health care providers are now comfortable having control of DHFF funds had increased their capacity to make timely decisions and resolve problems in collaboration with HFGCs members. Previously, when supplies(for example commodities were needed, health care providers had to go through the CHMT and the complex district accounting system. This used to cost them valuable time and, in the case of dispensaries and health centres, a week could be spent at the District headquarters trying to get the district accountant to release funds. This was said by one participant that:

> *"…the mere fact that now you have some funds to manage… you know that gives you some motivation somehow. Then eeh . . . the fact that at least to some extent we are in control of some of the activities and damage control measures: because when something runs out you can easily say now you are going to purchase it without consulting the DMO or the DHS." (FGD 2019.)*

The most important thing to the improved motivation of health care providers, according to most interviewees, was the provision of allowances for carrying out outreach activities, accompanying referred patients, and travelling to the district headquarters for submitting HMIS reports or even visiting the bank to withdraw cash from facility accounts, one of the participant during IDI said that;

> *"It has assisted the facilities. it has motivated our staff, like normally when they come to the district to bring the returns or . . . when they refer patients, normally there before the grant, they were not paid any money. They had to interact with their relatives, So it was not motivating at all, but with the grant, they have some allowances, they have the provision; if they refer patient their allowance is there." (IDI 2019)*

Another community respond said that;*"They are paid, they feel very nice. They are more motivated to work" (IDI 2019)*

One Council manager had this to share;

> *"There was no motivation because before DHFF staff was being forced to go out on outreaches with no transport and no lunches. Nowadays there is no problem and if you tell someone to go for outreach, they are happy to go and their work is the same ... now there is no such problem almost everybody is motivated." (FGD 2019)*

One of the health care participant had this opinion to share; *"There is greater motivation because whatever you do, you have support. You have a source…you have finances…" (IDI 2019)*

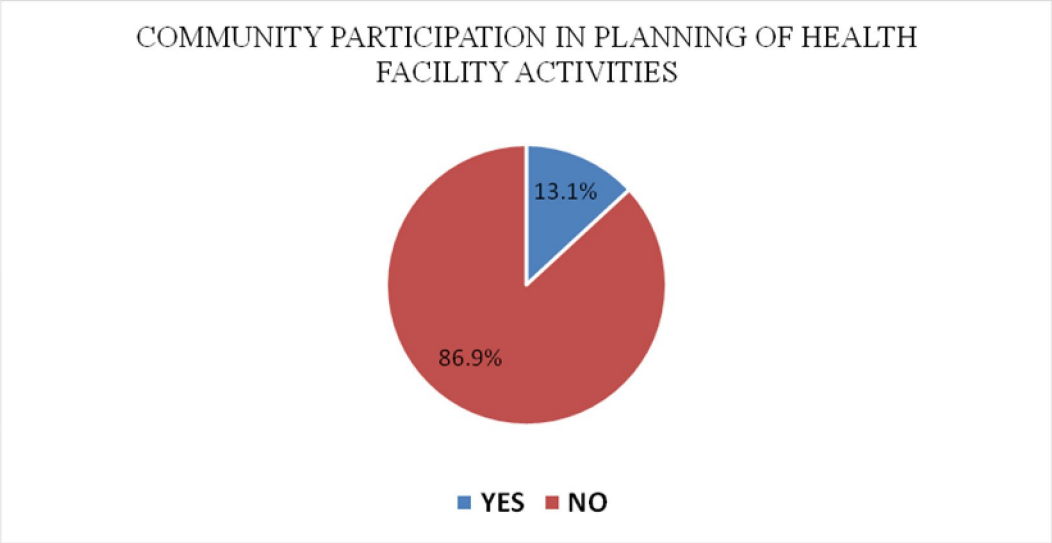
4.4 THE DHFF IMPLEMENTATION EFFECT ON COMMUNITY PARTICIPATION

During assessment of this objective five question were asked to 99 respondents of questionaires as follows

1 Respondents were asked if they participate in planning of activities in their facility annual plan

It was found that there were YES or NO. among whom 13.1 Percent said that they attended planning while 86.9 Percent did not attend planning.

FIGURE 4.5: COMMUNITY PARTICIPATION IN PLANNING OF HEALTH FACILITY ACTIVITIES



Here the general practice the planning process of dispensaries and health centres was that health Facility governing were supposed to participate by being invited to attend planning meetings where agendas were prepared by the facility in-charges in collaboration with chairpersons. After the planning meetings community are supposed to be involved through public noticed board and meetings.

The community was also required to know their representatives to the planning meetings. during interviews and focused group discussion, most of the community appeared not to know anything about participation in the facility plan and budgeting. When asked one of them said;

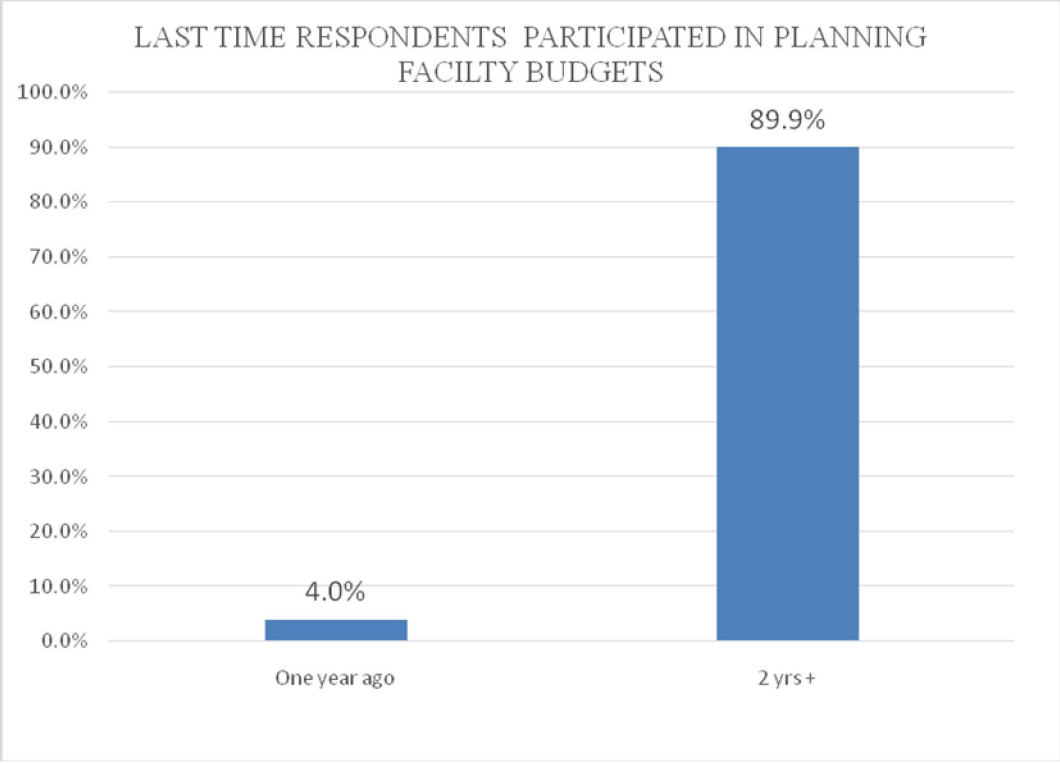
*" my friend I have never heard about this kind of thing so I have never participated in facility plans"(*IDI 2019)

Most of the members of Health facilities Governing Committees did not know about planning for the facility activities every year. Bu few of them appeared to have participated in the planning meetings. One of the participant said;

> "*as a member of HFGC, we are normally called to participate in the planning meeting. When in such meeting our secretary just read some items for us some of these they say are technical and difficult to understand so we approve the budget*" (FGD 2019)

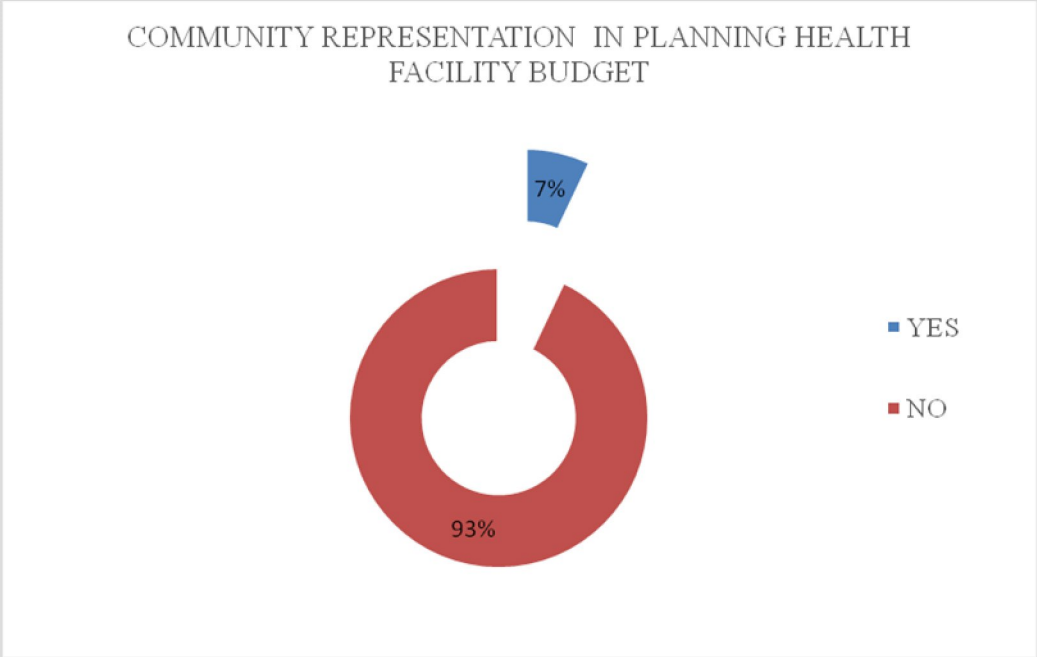
Respondents were asked when was the last time they participated participate in the planning of activities in their dispensary annual plan. There were three response 1. Always participate 2. Last year 3. Never participated. The responses were found that only 4 Percent said that they participated last year, no one said they always participate while 89.9 Percent said that they never participated.

FIGURE 4.6: LAST TIME COMMUNITY PARTICIPATED IN PLANNING FACILTY BUDGETS



Respondents were asked if they were represented in the planning of activities in their facility annual plan. Responses were YES or NO. 7.1Percent respondents said that they were represented while 92.9 Percent said NO they are not.

FIGURE 4.7: COMMUNITY REPRESENTATION IN PLANNING HEALTH FACILITY BUDGET

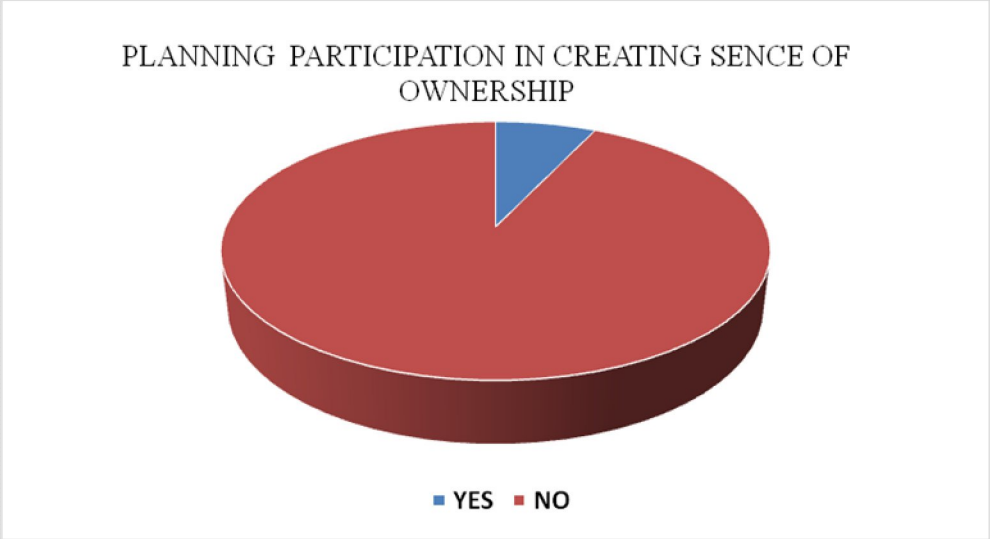


We wanted to know if the community is aware of the presence of the Health Facility Governing Committee who represent the rest in managing facility affairs on behalf of others. It was found that most of the community members did not know about HFGCs.

Participants were asked among those who said they participated if their participation made them feel that they own the facility and it belongs to them. The responses were YES or NO. 12.1Percent said YES while 87.9 percent said NO

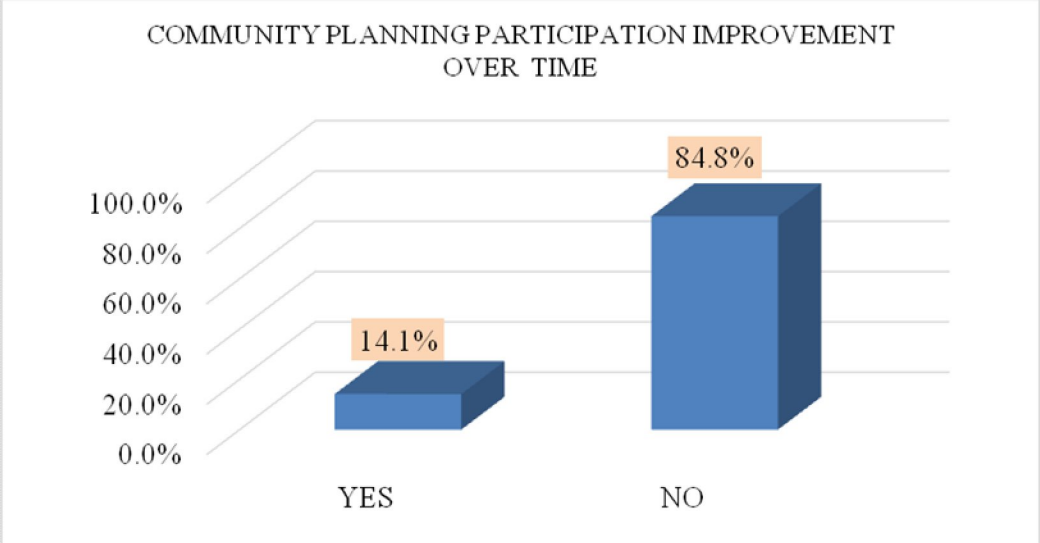
When asked about being represented in planning one of them said; " *No, I have never Attended the planning meeting or not represented by anyone in the facility planning meeting*"(IDI 2019)

FIGURE 4.8: PLANNING PARTICIPATION IN CREATING SENCE OF OWNERSHIP



Participant were asked if their participation in the planning of activities in their dispensary annual plan was seen improving over time. The responses were YES or NO. 14.1Percent said YES while 84.9 said NO.

FIGURE 4.9: COMMUNITY PLANNING PARTICIPATION IMPROVEMENT OVER TIME



In our focused group discussions and interviews, we also wanted to know if community participation is improving over time. It was found that very few community members did know about the participation and also those few agreed that their participation is improving compared to previous days in HFGCs.

When asked about being represented in planning one of them said;

> " *yes it is true the participation is improving. in those days, for example, three years ago there was no Committee for Facility so this is new development we must say. From no committee to the presence of committee is an improvement although most of the people do not know and public addressing on this is not satisfactory*"(IDI 2019)

In the documentary review, it was seen that no guardians attended HFGCs meetings or visited the facility for purposes of seeing DHFF progress and clarification to HFGCs responsibilities. Facilities had minutes for HFGCs quarterly meetings that shows their activeness. and' There were no hard copies for facility plans available at the facilities at the time of visits which implies planning is not conducted as per guidelines laid down by the ministry of health. There are no mentorship reports from higher-level i.e district, regions or others level. No feedback reports found at the facility that reflect supervisions conducted by higher level i.e district, regions or others level

4.5 EFFECT OF SOCIAL DEMOGRAPHIC FACTOR ON DHFF IMPLEMENTATION

During the assessment, it was found that people with primary and lower education have a high likely hood of attending traditional healers services four times more compared to those secondary education and above. The question was asked, that where do you first attend when you fall sick. Respondents were asked to see their responses, there were three types of respondents 1. Those who did not attended school at all, 2. Those with primary education and 3. Those who attended secondary education and above responces. The response were 1,health facility and 2, the second response was traditional healers. It was found that proportion of those who responded that they will attend tradition healers was four times more compared to those who said that they will attend health facility.

During focused group discussion, most of the respondents had shown that many patients will attend traditional healers first before attending facility services. Most of them said that it is their culture they trust traditional healers more than they have trust for health care providers. This kind of response is closely associated with the level of education. Most of those who said they attend traditional healer sare those who have lower or not educated at all. In one of the focused group discussion one participant members said;

> *" you know I live very close to one well-known traditional healer and normally I see more than three women in a day who attend his services. In my place when you find a child with Degedege (convulsions) it is believed that traditional healers will provide healing as they say this is a disease of bad spirit or bewitching*" (FGD 2019)

Another member of FGD conducted contributed by saying that;

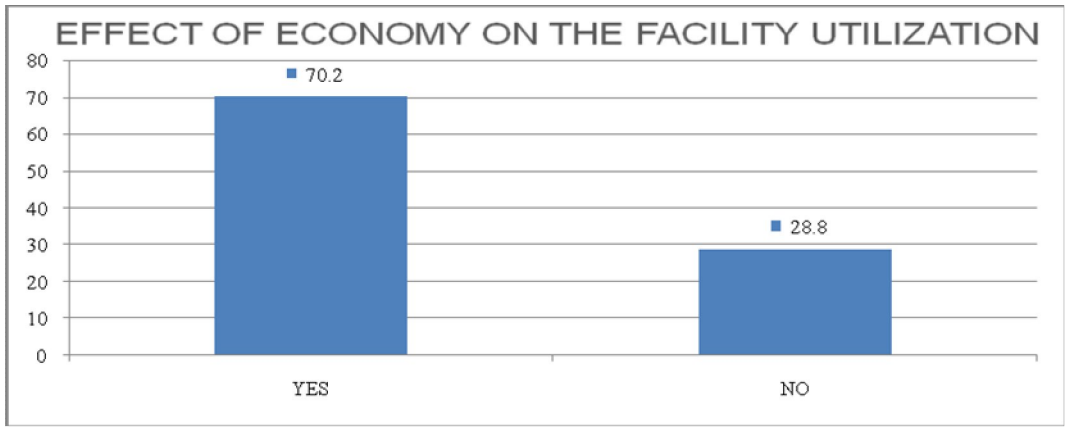
> *" poverty is also the main reason for people to attend traditional medicines together with other reasons like bad providers language and culture. These people (traditional healers) are very cheap you just need 500, shillings to get services while at the facility you must be a contributing member of CHF or you pay 6,000 cash to be attended and sometimes you meet a long queue or arrogant health care provider"(* 2019)

4.5.1 EFFECT OF ECONOMY(SOCIAL DEMOGRAPHIC) ON DHFF IMPLEMENTATION

IN AN effort to learn the effort of the economy on the DHFF implementatio, the question was asked to respondents that if having money at the time when they fall sick will affect their decision to attend facility services. The responses were YES or NO. it was found that 70.2 Percent of all respondents said that financial situation will affect their decision to attend health facility services compared to 29.8 Percent their financial situation at the time of falling sick will not affect their decision to attend facility services. Logistic regretion statistic test was run P-value was 0.001 which implies the statistical significance of the test result.

Graph showing the effect of effect of economy on DHFF implementation

FIGURE 4.10 EFFECT OF ECONOMY ON DHFF IMPLEMENTATION



During interviews one of the mothers who brought her child for vaccination said that it true that some of us are living very far from the facility. participant said that;

> *"You need to hire bodaboda to come to the facility you pay for it, sometimes you find your child is sick and it is in the night time the charges will be more for boda boda. It may happen the mother is alone at home and the father has gone for drinking at the local bar. You will have no option you postpone going to the facility although you see that you have a patient. Having no money is very bad."* (IDI 2019)

Another participant in FGD said that;

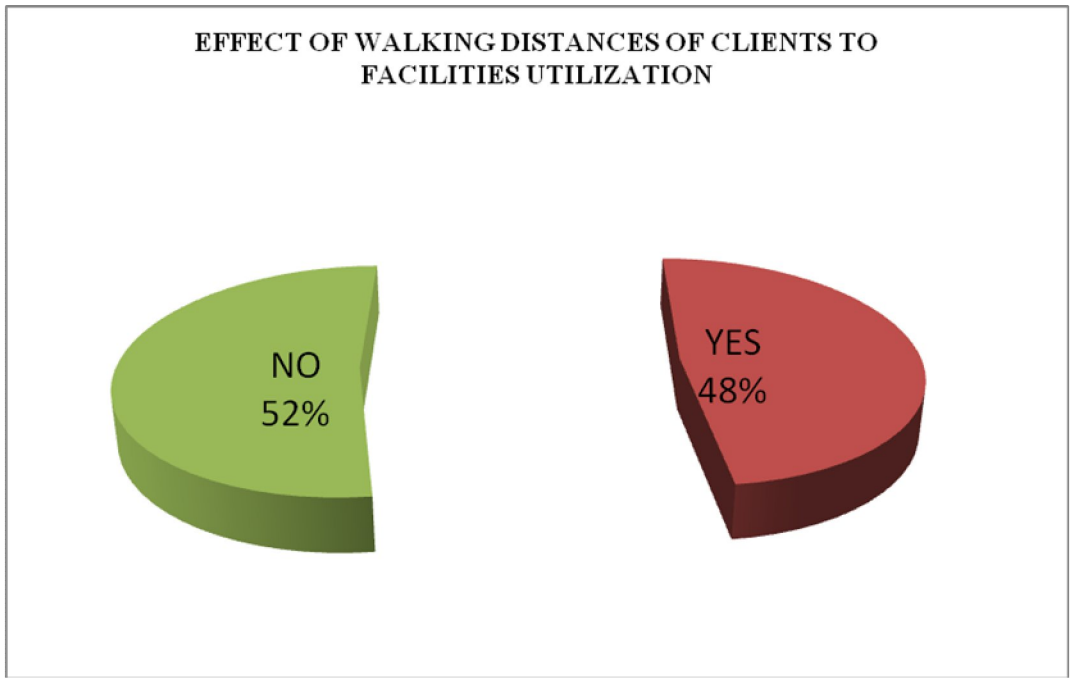
> "*most of the men do not stay at home, they leave behind women to take care of their children when they go for drinking local pombe, they use all their money in drinking. So when a child or anyone falls sick in the family arrangement for selling something or borrowings have to be made. This may take time so causing delay to attend facility services or even decide to just buy cheap pain killers medicine at the nearby shop"* (FGD 2019)

4.5.2 EFFECT OF DISTANCE ON DHFF IMPLEMENTATION

The question was asked to respondents that if the distance to the nearby health facility will affect their decision to attend facility services. The responses were YES or NO. it was found that 48Percent of respondents said that distance to health facility will affect their decision to attend facility services. Compared to 52Percent who said

that distance does not affect their decision to attend health facility, Logistic regretion statistic test was run (P= 0.58).

FIGURE 4.11: EFFECT OF DISTANCE ON FACILITY UTILIZATION



The question of distance to the facility has presented different facet as there were mixes opinions for those respondents interviewed. Some said distance is not a problem since nowadays their good roads so when you have a patient it is easy to attend services.

One of the respondents said that;

> *" my self do not consider distance to the facility a problem, there is a good road, many boda-bodas you just need the money and there you are, go the facility get services, easy like that what matters is money"* (IDI 2019)

There was a respondent a mother with her child when interviewed she had a different opinion on the distance to the facility and its effect on the utilization of lower-level facilities. She said;

> *"I leave more than 15 kilometres when my child or anyone become sick going for facility services becomes a task. Walking all that distance is tiresome. You sometimes decide to go there but you find a long queue or medicines are not there and you are told go and buy somewhere else. This may discourage not to go to the facility next time. Distance matter very much it causes a lot of thinking before going to a distance facility*" (IDI 2019)

The question of distance to the facility has presented different facet as there were mixes opinions for those respondents interviewed. Some said distance is not a problem since nowadays their good roads so when you have a patient it is easy to attend services. One of the participant said that;

> *" my self do not consider distance to the facility a problem, there is a good road, many boda-bodas you just need the money and there you are, go the facility get services, easy like that what matters is money"* (IDI 2019)

CHAPTER FIVE : DISCUSSION OF THE FINDINGS

5.1 INTRODUCTION

Overall findings, DHFF is being not implemented well and although is perceived to have some positive effects on the level of Implementation. Health Facility Governing Committees, comprising of a fair mix of community representatives, were present in all facilities visited; they meet regularly; and, had undergone a sort of partial training in facility management and basic functioning facility but not in DHFF management. The CHMT provides partial support and supervision of health facilities in their quarterly supervision which is not enough, especially through the Accounts assistants, DHFF focal person and District Treasure/accountants.

5.2 DISBURSEMENT OF FUNDS TO FACILITY ACCOUNT

All facilities had opened bank accounts and were accessing funds and utilizing them, generally according to pre-planned budgets DHFF was perceived to have had a highly positive effect on Utilization of facilities to attain value for many ie it was thought to have increased utilization of facilities, especially through the mother and child health outreach programmes, but Disbursement of funds is not timely and not in agreement with laid down procedures like we see in Papua New Guinea were there were agreement that doners had to deposit funds into facility accounts directly bypassing government beaurocratic procedure with pre signed agreements. The trend for disbursement was improving every year where on the fourth year, at same time improving access to health services, which also created the improved availability of supplies and infrastructure hence more clients. In Tanzania this is not the case since there is delay in disbursement. It was also clear that facilities in charges were not adhering to the transparency of funds management. The facilities financial information was just limited to bank account totals with no information on how facility funds had been, received, spent and what remained to the general public. Difficulty in managing funds and network problem was also another sources of added workload, to the already alarming shortage of health care and travelling cost to the District headquarters

5.3 CAPACITY OF HEALTH STAFF, FHGCs AND COMMUNITY IN TERMS OF PLANNING, BUDGETING

Health worker motivation was improved through the provision of allowances. The operations of HFGCs were reported to have slightly improved. Introduction of DHFF resulted in a heavy workload for staff, there were complaints as the increased workload was added on by managerial responsibilities as a result of DHFF. The implementation of DHFF has resulted into availability of medicines, equipments and other hospital supplies that are essesntial for mother and child services so increasing the workload of services delvery due increased attendences by clients.

This is similar to what was seen in Kenya after the introduction of DFF in coastal province. Complex and centralised accounting processes, putting a high burden on facility in-charges, with completion of required reports taking up to 20% of their time . Most of facilities In-charges concerned about being accused of mis-use, with some feeling they were not spending funds and that it was safer not to spend hence creating shortage of essential equipment for services. (Catherine Goodman, 2009).
The similar case was seen in Papua New Guinea like other developing countries it is regarded as an HRH crisis country with an inadequate number of nurses, doctors or midwives per 1000 population (0.58 in DOH, 2010).

The spine of the service is provided by community health workers (7,868) and nurses (3,279). These cadres mainly work in rural areas and are mainly women. In addition midwives (nurses with additional 1 year education) and Health conservatory Officers (health workers positioned with a skill level . even though the official data evidently show a critical staff shortage, so far it is unclear where (in which facilities) staff scarcity exists and where health care workers are underutilized. A workload study implemented in 2001-2002 demonstrated that staff could work more competently if they were to be redistributed and that staff in a number of health facilities was underproductive (GPNG, 2010). This might be the case with DHFF in Tanzania where it might be though that DHFF has added to the workload but in fact the reality is otherwise opposite. In the district of study there was one facility with human resources for health about 103 while the requirement is maximum of 52 while the other facility with the same level having only 7 human resources for health.

In Nepal another country which is implementing Facility financing there were shortage of health care providers resulting from the increased attendance of clients as a result of availability of essential commodities and improved services where HFGC were forced to hired additional workforce to address the problem. The analysis of HFGC meeting minutes shown a range of issues discussed in the HFMC meetings: infrastructure and resource mobilisation, human resources (the hiring of local staff, staff motivation, salary and benefits, fulfilment of sanctions, regularity, and behaviour of service providers), service planning and development (provision of additional services such as laboratory services, conducting outreach clinics in remote areas and access to medicines), and health awareness raising (Gagan Gurun, et al, 2018).

5.4 COMMUNITY PARTICIPATION IN THE IMPLEMENTATION OF DHFF

Only a minority of people in the broader community had the information to participate actively in decision making and hold HFGCs accountable. Although there were no major cases of misunderstandings, the admission by HFGC members and in-charges that the community knew very little about DHFF raises obvious concerns about transparency. Using the experiences of Nepal where study on participation of community was conducted it was found that Community participation has been recognised as one of the key components for the successful implementation of primary health care (PHC) strategies following the 1978 Declaration of Alma-Ata (World Health Organization, 1978; Draper et al., 2010)

The participation of the community in Nepal look similar to Tanzanian experience which was seen to be low with very small portion of general population are knowing the representation to the facility committees (Gagan Gurun, et al, 2018).

In Kenya situation was similar to Tanania and Nepal as there were challenge of low community awareness, with only 6% of exit interviewees being able to correctly describe HSSF (Catherine Goodman, 2009).

5.5 THE EFFECT OF SOCIAL DEMOGRAPHIC EFFECT ON DHFF IMPLEMENTATION

It is possible that the low education level of the community and lack of interest in health facility matters led to challenges in communicating relevant information and even resulted in low utilization of facility services as most of the community members prefer to attend traditional healers than facility medical services. Economic hardship also appeared to be an obstacle in attending or utilizing facilities this in addition to distances to the facilities is really a problem to lower levels facilities utilization. The economy has close relation to social protection initiative like ICHF and other insurances. These initiatives have implication of out of poket cost for those non members so leading to deterring effect to users of facilities. This reduces the utilization of facilities and even becoming barrier to health care access.

When we talk of care seeking we indirectly mean the closeness of DHFF programme to health Promotion interventions. So to address this implementation of DHFF must go inline with activities of health promotion so that ICHF be advocated,care seeking behaviour be advocated as well.

CHAPTER SIX : SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter aims to cover summary and conclusion of the study, policy implication, recommendations, limitations of the study, and suggest areas that will need further research in terms of the data which have been collected, analysed and discussed.

6.2 SUMMARY

It was found that were funds disbursed for the in October April, and June for the FIRST,second and third quarter respectively this late disbursements. Human resources for health attitude and their number is negatively affecting implementation of DHFF by 96 Percent and 74 Percent respectively, There is critical shortage of health care providers with the unpleasant attitude to users of services. There is seen improvement on motivation due to autonomies in managing of facilities account by health care providers of lower facilities and improved financial fast-tracking of payments due DHFF programme free from higher-level bureaucracies, community participation is unsatisfactory compared to what was expected from the original DHFF plan only 14 Percent of the general population are aware on participation in the planning process while only 13 Percent of the general population knew that there are funds brought to their facilities to improve services, HFGCs were not fully aware of their role in DHFF. It was found that there are social demographic factor like education, for example, none educated community 75 Percent attend tradition healing compared to the remaining 25 Percent who first attend facility services when they fall sick, poverty affecting facility attendance by more than 70 percent, distance to the facility and local belief were important factor that is negatively affecting implementation of DHFF to Forster lower-level facilities utilization

6.3 CONCLUSION

Major conclusion is that funds are disbursed into the facility account untimely so resulting in an occasional shortage of essential commodities. There is critical of human resources for health that affect implementation of DHFF to atain value fror

money. There is remarkable motivation of health care providers those few who currently available at dispensary and healt centre levels. There is low community involvement in the implementation of DHFF and socil demographic factors such as literacy,econmy and distance to facilities is negatively affecting implementation of DHFF to atain value for money.

6.4 RECOMMENDATION

i. Central and local government to disburse funds at the beginning of the first financial quarter of the respective financial year as required. There is need to ensure that it is timely, appropriate and transparent in a sense that community be informed through different media like public notice boards, public meetings and morning session in health educations session at the facilities to raise community awareness.

ii. Central and local Government and other partners through PORALG to prepare a simple and clear manual for HFGCs members to be established for successful implementation of DHFF at the lower levels facilities. This could reduce confusion about DHFF operations, thereby increasing trust, transparency and community participation. We suggest that the manual should cover HGFC roles; procedures for elections; operations of DHFF, including accounting for funds (Facility Financial Accounting and Reporting System); rules on how funds can be used; and information that should be provided for community members. It is better be known that having manual is one thing but disseminating the guides/manual is something else. Also, there be comprehensive training of HGFC members and Health Care providers focusing on key elements of DHFF operations instead of the current situation where it is in charges who have DHFF personal knowledge. This to be provided before the first quarter for every financial year of funds disbursement and repeated periodically to refresh the skills of past trainees and introduce new Health Care providers and HFGC members to DHFF.

iii. Government through PO RALG should recruit more technical staff on financial management issues and Health care providers as well. Health services providers are faced with added responsibilities that are not part of their core duties.
iv. Government (Central and local) to invest in Awareness creation of DHFF operationalization that should be imparted to a community member for them to take responsibility for their roles through different medias.
v. In line with implementation of DHFF there to be community awareness creation programs and activities on Care seeking behavous and ICHF in lower level facilities and health promotion in general to address the effects of social demographic factor on implementation of DHFF
vi. Government through PO RALG to form a Good monitoring and evaluation mechanism on DHFF which is essential to its success, particularly at the facility level. An M and E framework with indicators progress assessment tool should be designed to asses the progress and work upon gaps from regional to facility level.

6.5 POLICY IMPLICATION

This process evaluation study shows that DHFF implementation can be improved successfully at health facilities of lower levels and can achieve the intended results. These DHFF innovative interventions have proved to be a successful strategy for ensuring that funds reach the needy through health systems with minimal bureaucratic interferences. Moreover, HGFCs at the health centre and dispensary levels have proved that these funds can be managed fairly well in low resource settings; by people with relatively low literacy levels; and, that the effect is perceived to be highly positive. Community participation in managing funds that could be increased as facilities have shown a high level of absorptive capacity and have useful ideas of how funds could be utilized to make available all essential health commodities.

The criteria for funds allocation could be shared, fairly explained and understood by HFGC so that they will be in a position to push up the facility performance for the sake of improving accountability and responsibilities for better implementation of DHFF. There is, however, need to increase the scope to strengthen several areas of DHFF implementation and operations. Now we recommend policies are to be reviewed to accommodate mandatory participation of HFGC in directly managing funds the result could be more fruitfull and tangible with emediate effect. The first thing being preparation simple and understandable quide on job description and responsibilities of HFGCs in implementinh DHFF. Even the current financial guides to the facilities have not been fully utilized so mentoring and close supervision by a hired accountant at health facilities level have to be improved in terms of frequency and intensity so that it will yield better results.

6.6 AREAS FOR FURTHER STUDIES

Another research on FFARS (Facility Financing and Accounting Reporting System) should be conducted to determine the implementation process of its use towards enhancing financial management of Health Sector Basket Funds disbursed to the facility.

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APPENDIX

Process Evaluation of implementation of Direct health facility Financing Programming as a Strategy to Foster facility utilization and services improvement among lower level helath facilities

The study will use qualitative method of semi structured interview by conducting interview with direct conversation between interviewer and interviewee to capture information on implementation of Direct health facility Financing Programming as a Strategy to Foster facility utilization and services improvement among lower level helath facilities. The study will cover the list of questions that will address the objective of our study to cover some parts that in one way or another will not be addressed in quantitative methodology. The researchers have considered key features in designing the kinds of questions that was asked to respondents where sequence of questions follow the logical order of the topic.

The researchers are keen with the choice of calm setting that will allow respondents to be confident in giving out information, the purpose of the interview was explained to keep the informants aware of the topic and give them a chance to clarify any doubt about the interview, the interviewer will adhere to the issues of confidentiality to assure the respondent's their safety as well as time for the interview was determined so that the researchers do not interfere with respondents timetable. During the interview process, the researcher will use microphone to record the conversation while noting down other important information.

IDI; Researcher (s): Thank you for giving me this opportunity to speak to you today. I hope you was interested with the topic. We by names are/my name is…….. a Master student in Health Monitoring and Evaluation from Mzumbe University. As I explained before when we were scheduling timetable, today we will talk on implementation of Direct health facility Financing Programme as a Strategy to Foster facility utilization and services improvement among lower level health facilities are valuable information for the success of this study.

We/I would like to assure you that this information you provide is confidential between us and the study team. Also, this information was used solem for the purpose of this study and not otherwise. In our conversation we was recording conversation so as to remember what exactly the information you are going to provide, soon after interview we will have time to listen a bit on what we have been talking as part of your response so that you may have a chance to add any additional information which you think is valuable but you forgot during the session. Also, for any question that we was asking and you feel not comfortable, or it annoying, you wish not to answer let us know and we will skip it.

I hope we are all comfortable and we can start our interview; can't we?

1. How long have you been in this village/facility? What is your occupation?
2. Do you know anything about Direct Health Facility Financing? Probe; where did you exactly hear about it?
3. Do you know the facility budget? Probe: where exactly did you here?
4. How do you participate in facility annual plans?
5. When was the last time to have participated?
6. What is you feeling toward ownership of the facility in regard to you involvement in facility plans?
7. How often do you do you attend meetings on facility services or management matters?
8. "Well…..that is an interesting story; I think your facility leadership(s) is/are not selfish of giving it to you. I wish I could be you……. Anyway how many health care providers are there in you facility? Probe: how happy and motivated they are when you go for services at the facility? Probe is this motivation you see increasing or deterioration?
9. What are the reasons for the state of motivation you observed? Probe: Do you like then to continuous being in the facility?
10. I heard some rumors that some people do participate directly in deciding what was the facilities next years' plan. What about you, what do you know about this?

11. I also heard that government is directly depositing funds to your facility account, what about you do u know that, tell me about that? Probe do you think this contribute to facility services improvements?
12. What is your perception? Can we talk a bit on community involvement in terms of proper facility management?
13. “Well said about that, can you share with me how do you normally participate? Probe; how do you or other community members participate?
14. What are the barriers for attending health facility services? Do your providers(s) encourage you to utilize facility services?
15. What is your opinion based on the barriers to improve health facility services utilization?

I would like to thank you for giving your time and talk to us. This is end of our conversation. Do you have any question?

FGD; Process Evaluation of implementation of Direct health facility Financing Programme as a Strategy to Foster facility utilization and services improvement among lower level health facilities

Definition: FGD – Is the type of an in-depth interview accomplished in a group, whose meetings present characteristics defined with respect to the proposal, size, composition and interview procedures (Morgan, 1988)

Members in the focus group are usually unfamiliar to each other; the size of the group may vary from 5 persons to 10 or more. Selection of these members will depend largely on their tendency to share certain characteristics relevant to the study questions. The supportive environment is created; the moderator will ask focused questions to encourage discussion and free expression of different opinions and point of views. The FGD meetings may be conducted several times in which a moderator who is skilled, may discover the trends in opinions and perceptions revealed through a careful, and systematic analysis by the moderator. (Kruiger, 2002)

The moderator of the FGD will elicit responses by asking broad questions, with the aim to collect sufficient discussion in a given time. FGD is mostly used when there is a need to understand the issue deeply, than it could in other ways of qualitative research. The lead questions (Focus questions) must be properly worded, short and clear; they should not be biased, not sensitive to personal issues which may raise feelings of embarrassment. Time limits must be planned before, anything from 30 minutes to 90 minutes. Selection of participants must not be biased, that is it should consider important aspects such as age, gender and experience/literacy of participants. Informed consent must be obtained prior to the start of FGD both written and verbally in lining the ethics of conducting research.

The venue and time to start the FGD must be clear and usually public place with a convenient setting for all kinds of participants. The moderator must be neutral, encourage shy participants to speak and able to deal with dominant speakers among the members, spontaneously extracting information from participants by avoiding dichotomous questions, that can be answered by 'yes' or 'no'. Notes must be made as well as audio/video recording of all participants. The information obtained from FGD is specific to a given perspective and cannot be generalizable to the population. (www.changethinker.com)

BODY OF MY FOCUSED GROUP DISCUSSION

In my qualitative research, we will use among other tools Focused Group Discussion (FGD) in collecting information from research participants. Of the four objectives, there is a qualitative component in the implementation of Direct health facility Financing Programme as a Strategy to Foster facility utilization and services improvement among lower level health facilities; therefore, our focused group discussion will have the following as our lead (Focus) questions.

(A WORD OF WELCOME AND INTRODUCTION)

Moderator: Good morning/afternoon/evening everybody…….and welcome all participants to our today's focus group discussion about the implementation of Direct health facility Financing Programming as a Strategy to Foster facility utilization and

services improvement among lower level health facilities, I am ……. And along with me are……to work together with me in conducting this focus group discussion.

(OVERVIEW OF THE TOPIC)

Moderator: Today we will discuss about the issue of implementation of Direct health facility Financing Programming as a Strategy to Foster facility utilization and services improvement among lower level health facilities. We know that these government health facilities are the major source or the main point that we normally get medical services to the community in lower levels, thus the ministry of health in Tanzania have since independence encouraged, supported and conducted several programs in sensitizing and advocating of on going improvement of health services which will enhance at the same time increased facility utilization levels in Tanzania. This has been advocated through different programs such as universal health coverage, MMAM and other programmes. Currently there is this Direct Health Facility Financing which being implemented at the lower level health facilities i.e dispensaries and health centres which will now be our main topic of interest.

(GROUND RULES)

Moderator : In our discussion there are no right or wrong answers, we encourage free speaking and differences in opinions and ideas, everyone must listen respectfully when another participant gives his/her views, you do not need to agree each other and we was taking notes of your ideas and recording your discussions, we will ask you to turn off/vibration mode your cell phones and be attentive throughout the discussion for effective participation, you are allowed to talk to each other freely and my role as a moderator and my colleagues is to guide the discussion and chair the meeting. Please introduce yourself and the village you are coming from before you speak for the first time, and we encourage each of us to take part in this discussion. Are we together?

(ACTUALLY QUESTIONS)

1. Well, can anyone tell me how much he/she knows about DHFF? (AIM : To extract whether there is sufficient knowledge about DHFF among participants and thereby the level of understanding the importance of DHFF implementation)
2. Please share with me on how community participate in Health facility management/planning (community/facility workers)? What do you have to say about the importance of direct Health Facility Financing and the implementation? (AIM: To establish whether all actors who were supposed to participate in implementation+ of DHFF are doing as per program design)
3. There are many different perceptions by people on the issues that affect health utilizations? What is your opinion on this? (AIM: To see if there are any local beliefs, individual preferences/opinion or any scientific understanding by participants on the use of facility services)
4. There is an issue of how easy/difficult the availability of medicines and equipments in our facility affect the performance and demotivates health care providers; can you please share your opinion about this? (AIM : To deduce funds availability is guaranteed in by DHFF has effect on staff motivation in health care delivery and if not why, and which steps to take to improve the implementation of DHFF)
5. Community has their representative in managing facility affairs by officially being appointed by community members and actively participate in decision making through planning. Budgeting and implementation of those budgets, what is the practices here can we share you experiences? (AIM: To understand whether the participant consistently participate in facility activities, or otherwise in order to advice appropriate and make proper recommendations thereafter in a report)

6. How many health care providers are there in your facility? are they enough in number to make available all necessary services to you and other clients and patient in a way that convinces you to come for services next time, what is your opinion for this? (AIM : To extract if there is a fact that affect utilization of facility due to lower number of health care providers, in the overall issue of implementation of DHFF in lower facilities)
7. Tell me positive experiences the people/community has in the issue of utilizing facility services. (AIM: To understand good things of the that promotes utilization of health facility services that can also improve DHFF program which attract users, so as to keep it)
8. In this Direct Health Facility funds disbursement and use promotion program by the ministry of health and Presidents Office, what changes would the community prefer to be incorporated in the program to make it even better? (AIM: To probe the possible barriers in DHFF program implementation, which can be avoided to improve the efficiency of the program)
9. Do community tend to avoid to attend Health facility services they normally use and go to other facility, if that is the case, what makes them change? (AIM: To extract if the types of services, the price or the customer care can impact the general implementation of Direct health facility Financing Programme as a Strategy to Foster facility utilization and services improvement among lower level health facilities)
10. What other factor that affect general implementation of Direct health facility Financing Programme as a Strategy to Foster facility utilization and services improvement among lower level health facilities that you think we have not discussed, tell me in your opinion how it acts as barrier? (AIM: To extract if there are other social demographic factors that can impact the general implementation of Direct health facility Financing Programme as a Strategy to Foster facility utilization and services improvement among lower level health facilities)