EFFECTIVENESS OF HEALTH FACILITY GOVERNING COMMITTEES IN TANZANIA

A CASE STUDY OF MUSOMA DISTRICT COUNCIL

EFFECTIVENESS OF HEALTH FACILITY GOVERNING COMMITTEES IN TANZANIA

A CASE STUDY OF MUSOMA DISTRICT COUNCIL

By

Vedastus Pancras

A dissertation Submitted to the School of Public Administration and Management in Partial Fulfillment of the Requirements for Award of the Degree of Master in Public Administration (MPA) of Mzumbe University

2016

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled **"Effectiveness of health facility governing committees in Tanzania: A Case study of Musoma District Council**, in partial/fulfillment of the requirements for award of the degree of Master of Public Administration (MPA) of Mzumbe University.

_____

Major Supervisor (Dr Orest Masue)

_____

Internal Examiner

_____

External Examiner

Accepted for the Board of School of Public Administration and Management

_____

DEAN, SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

DECLARATION

AND

COPYRIGHT

I, **Vedastus Pancras,** declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature ----------

Date ----------

ACKNOWLEDGEMENT

I would like to thank the almighty God for his gift of life and blessings. Writing this dissertation would not have been completed without assistance from various people. Therefore, I extend my sincere gratitude and appreciation to all whom with their help in whatever form, have made my study possible.

My utmost gratitude goes to my supervisor Dr. Orest Masue, for his valuable comments, guidance, support and easy accessibility during the entire course. I appreciate his contribution that led to the preparation of the proposal and finally this dissertation.

This work could not materialize without the co-operation of the management, employees and Health facility governing committee members of Musoma District Council. I am grateful for their cooperation and acceptance during the period of study.

I would also like to extend my thanks to the lectures of the School of Public Administration at the Mzumbe University (MU), for their guidance and support during the coursework. My heart full thanks to my colleagues MPA class 2014-2016 whom we used to study and discuss together, I appreciate their contribution to the success of this work. Lastly, I extend my gratitude to all staff members at Mzumbe University for their kindness and professional guidance to my administrative needs. Obviously, without them, this academic pattern would have never come to a good end. However, I remain solely liable and responsible for errors and omissions contained in this dissertation.

DEDICATION

This dissertation is dedicated to my lovely family (my dear wife Stella, my daughters, Caroline Clara and Caren) who missed my presence at home when conducting this study.

ACRONYMS AND ABBREVIATIONS

CHF	-	Community Health Fund
CHMT	-	Council Health Management Team
CPH	-	Community Participation in Health
D by D	-	Decentralization by Devolution
DHO	-	District Health Officer
DHS	-	District Health Secretary
DMO	-	District Medical Officer
DMT	-	Dispensary Management Team
Dph	-	District Pharmacist
FBO	-	Faith Based Organizations
FP	-	Family Planning
HFC	-	Health Facility Committees
HFGCs	-	Health Facility Governing Committees
HFMT	-	Health Facility Management Teams
HSR	-	Health Sector Reforms
KSAs	-	Knowledge, Skills and Attitudes
LGAs	-	Local Government Authorities
MCH	-	Maternal and Child Health
MDC	-	Musoma District Council
MMAM	-	Mpango wa Maendeleo ya Afya ya Msingi
MoH	-	Ministry of Health
NBS	-	National Bureau of Statistics
NGO	-	Non Governmental Organization
PAHO	-	Pan American Health Organization
PHC	-	Primary Health Care
PHCSDP	-	Primary Health Care Service Development Programme
PMO-RALG	-	Prime Minister's Office Regional Administration and Local Government
PO-RALG	-	President's Office Regional Administration and Local

		Government
REPOA	-	Report on Poverty Alleviation
RHMTs	-	Regional Health Management Teams
RS	-	Region Secretariat
SPSS	-	Statistical Package for Social Science
UNICEF	-	United Nation International Children Fund
URT	-	United Republic of Tanzania
USAID	-	United State Agency for International Development
VGC	-	Village Government Council
WEOs	-	Ward Executive Officers
WHO	-	World Health Organization

ABSTRACT

This study examined the effectiveness of health facility governing committees in Tanzania with a critical focus on Musoma District Council. In specific, the study aimed at examining the extent at which the HFGCs accomplish each of their roles and also exploring the challenges facing HFGCs. Cross-sectional research design and both qualitative and quantitative research design were used in the methodology. A sample size of 70 respondents who comprised Council health management team(CHMT), Ward Executive Officers (WEO), health staff and members health facility governing committees were selected from the population of 429. Both probability and non-probability sampling techniques were used, whereby under probability sampling techniques, a simple random sampling was used while under non probability sampling, the purposive sampling techniques were used. Data were collected using questionnaires, interviews, Focus Group Discussions (FGD) and observation. Data were analyzed descriptively by using SPSS computer software. The findings revealed that the procedures used to select the HFGC members were decentralized to the lower levels with the large inclusion of different social strata in its composition. Most of the committee members moderately participated in their roles. However, the majority of the committee members had low knowledge and they were not competent enough to accomplish their roles particularly in planning and budgeting. Furthermore the research findings revealed several challenges faced HFGCs in accomplishing of their roles such as inadequate knowledge among committee members, especially those with primary education, inadequate financial resources for implementing their activities also the majority of the local communities gave inadequate support to the committees especially on health facility development activities like mobilization of construction materials. Therefore, for these committees to be effective there is a need for multiple effort from high level (Ministry and Council) and health partners to allocate adequate budget for HFGCs activities, to build the capacity of the committee members, sensitize community to mobilize adequate resources and actively participate in health development activities.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE PROBLEM

1.0 Overview

This chapter presents the background information regarding the study, which examined the effectiveness of health facility governing committees in Tanzania. It contains subsections which are the background of the study, the statement of the research problem, objectives of the study, and research questions. Other components include the significance of the study, the scope of the study, justification of the study and the structure of the research.

1.1 Background to the Study

1.1.1 Provision of Health Services before Reforms

The history and characteristics of the health services provision in Tanzania can be traced for some years back. Before independence in 1961, Tanzania was a German colony (1889-1916) and later British Protectorate (1916-1961). In this era the health facilities were very few owned by the colonialist. During the 72 years period, the colonial medical services targeted foreigners working for the colonial governments and neglecting the indigenous. Colonial productivity policy strongly emphasized on the production of cash crops for export rather than domestic crops. The overall organization and delivery of the health services to the natives during that particular time have been determined by the social, economic, and political necessities of the royally colonial rulers rather than the wishes of the Tanzanian by then called Tanganyika. In general, the health care services for the servant were worse. After independence, the government has expanded and strengthens the health services with a vision to advance the health and well-being of all Tanzanians with a focus on those most at risk, particularly the poor to promote the health system to be more responsive to the needs of the people particularly in rural areas (Mboera, 2011; Ngwilizi, 2002). However attention and efforts were invested in strengthening health and social services from the National level to the grassroots level. This revolution

and policy transformation was favorable to the majority of Tanzanians particularly those who live in rural areas because the services provided in the colonial era were favoring the elites and the wealth society who live in urban areas (URT, 2007).

In addition, Tanzania pursued a health policy that aimed at providing equal and free access to health facilities and services to the entire population as a result of the introduction of the Arusha Declaration in 1967. This was a strong and a revolutionary step towards the communism generated from *Mwalimu Nyerere's* basic principle and conviction that improving the health and wellbeing of all Tanzanians as the way forward to sustainable development (Mboera, 2011).

Therefore, health care services were financed by the government and provided in all public health facilities free of charge in order to reach both rural and urban communities including the poor who could not afford the costs of health care. However, very few voluntary agencies were provided with health services at modest fees (URT, 2007; 2008). The government was seen as the only actor responsible to bring health care services, education, water and other social services to the community whereby the citizens seen as the recipients and not as active participants/ actors in the process of services delivery. These social service delivery continues to remain largely financed by the government budget through taxation. This consequently led to excessive workload and financial burden to the government (URT, 2008).

However, in the 1980's due to population increase and more social services demands of the people, the country found itself in an economic slump, exacerbated by Structural Adjustment Policies. As it was the case in many other African countries the Government could not meet many of these demands of an expanding health sector (Wangwe et al., 1998). As the result the country experienced a shortage of drugs, medical supplies, staff and other essential items, including dilapidated structures, resulting in inadequate services. The need to revisit the strategies became apparent (Mboera, 2011).

In the late 1970s, the health systems were challenged by the Alma-Ata declaration, which emphasized that government, should not provide health services free to her

people, but the sustainable health system should consider community involvement as a fundamental and core principle in managing primary health care (Draper et al., 2010; WHO & UNICEF, 1978). Alma-Ata Declaration specifically stipulated that 'people as the principal beneficiaries have the rights and duty to participate individually and collectively in the designing, planning and implementation of their health care' (WHO & UNICEF, 1978, p. 4). The Ottawa Charter also proposed local people involvement in social services through effective community action, particularly in setting priorities, making decisions, planning and budgeting and implementing to ensure that people are willing and engaged in deciding matters that affect their lives, including the health-related matters (Ottawa Charter, 1986). In line with the Alma-Ata Declaration and the Ottawa Charter, other policies, including decentralization of health systems was introduced within the health sector reforms in many countries, including Tanzania, as an important approach that can provide opportunities for community particularly those in rural areas to participate in health services delivery.

1.1.2 Health Sector Reforms

Health Sector Reforms (HSR) started in 1994 with the aim to enhance the access, quality and efficiency of health service delivery. The main objective of the HSR is to strengthen the primary health care services with the focus of improving the District, Regional and specialized referral health services (URT, 2009). The Health Sector Reforms are in the different dimensions, including the following: decentralization of health services; financial reforms such as enhancement of user-charges in government hospitals, introduction of health insurance and community health funds in all levels of health delivery and public/private partnership reforms that facilitate encouragement of private sector to complement the effort of the public health services. They also include organizational reforms such as integration of vertical health programmes such as immunization into the general health services.

1.1.3 National Health Policy

The health policy is an important instrument which emphasizes the need for increasing community involvement in health development. The revised Health Policy of 2007 indicates that health services will focus on those most at risk, poor and will satisfy the needs of the community in order to increase the lifespan of all Tanzanians by creating awareness and responsibility to the individual citizen of his/her health and the health of the whole family (URT, 2009).

1.1.4 MMAM Programme

In 2007 the Ministry of health and social welfare (MoHSW) developed the Primary Health Care Service Development Programme (PHCSDP). This programme is better known by the Kiswahili name of Mpango wa Maendeleo ya Afya ya Msingi 2007-2017 (MMAM). The objective of the MMAM programme was to accelerate the provision of primary health care services for all by 2012, while the remaining five years of the programme focus on the consolidation of achievements (URT, 2007/2008).

The main areas was to strengthen the health systems, rehabilitation, human resource development, the referral system, increase health sector financing and improve the provision of medicines, equipment and supplies. This programme was implemented by the Ministry of Health and Social Welfare in collaboration with other sectors particularly planning and finance, works, water and administration and personnel by the existing decentralized government administrative set-up including the Prime Minister's office- Regional Administration and Local Government (PMO-RALG), Regional Secretariat (RSs), Local Government Authorities (LGAs) and local community through Village and user Committees (URT, 2007).

1.2 Statement of the Problem

In early 1990s, Tanzania adopted various policies and strategies aimed at strengthening community participation for sustainable development. The concepts of health sector reform and decentralization have been emphasized in the public sectors, particularly in many developing countries. Governance through user committees has

become a common phenomenon in the reformed public sector in these countries, with the aim to increase community participation in the development activities. According to URT (2013) every health centre and dispensary is required to have the health facility governing committees. Through the decentralization and health sector reforms, since then and now these committees have either been introduced or strengthened in order to enable ordinary people at the local level to participate, design, implement and monitoring the health development activities at their localities (Crook and Manor, 1998; Masue 2014). These user committees are responsible for coordinating the community preferences for participatory planning, mobilize and manage the community resources from grassroots for better and quality health services provision

A requirement for effective local-level participation through decentralization by devolution (D-by-D) is that there are competent people at the local level who are capable for managing the decentralized functions. The indicators for competences include the members of the user committees to have relevant skills and knowledge on decision making, planning, implementation, supervision and monitoring and evaluation (Naidoo and Kong, 2003). These management capabilities are vital, particularly at the health facility level where actors are responsible for translating decentralization policies into concrete actions through mobilizing resources and preparing health facility development plans and budgets. It is therefore important for these user committees to be effective and capable in order to realize their goals.

Despite the efforts made to form these user committees as tools to enable grassroots participation in health services, there have not been sufficient studies on effectiveness of HFGCs particularly in Tanzania. Therefore, this study intended to examine the effectiveness of the HFGCs in Tanzania.

1.3 Objectives of the Study

The general objective of the study was to examine the effectiveness of health facility governing committees (HFGCs) in accomplishing of their roles. More specifically, the study was meant to:

i. Examine the formation and composition of HFGCs.
ii. Identify the roles of HFGCs
iii. Examine the extent in which the HFGCs accomplish each of the roles
iv. Explore the challenges facing HFGCs in Musoma District.

1.4 Research questions

The study sought to answer the following question:
Are the health facilities governing committees in MDC effective?

More specifically, the study sought to address the following research questions:

i. How a HFGC is formed and what is its composition in terms of inclusion of different social strata?
ii. What are the legal provisions for the establishment, composition, roles and mandate of HFGCs?
iii. What are the general and specific roles of HFGCs?
iv. To what extent do the HFGCs in Musoma District accomplish each of their roles?
v. Do the HFGCs use their mandate fully?
vi. What factors influence the HFGCs' effectiveness in accomplishing their mandated roles?

1.5 Significance of the Study

The study contributes to the existing knowledge about the effectiveness of the HFGCs whereby the knowledge obtained can be used by different institutions and researchers as reference material for academic endeavors. Furthermore the findings of this study may stimulate other studies on effectiveness of HFGCs and might act as pointer for further studies. To the government the study can help the policy maker and the policy implementers to formulate and implement the policy which will be helpful in capacitate the community committees, especially training courses for the HFGCs on their roles and facilitate them with adequate resources (funds) for carrying out their roles/tasks. The study provides an understanding on how HFGCs in

Musoma accomplish their roles, whether they have a significant influence on various decisions related to health service delivery.

1.6 Scope of the Study

The study focused on the effectiveness of the Health facility governing committees' in Tanzania specifically to examine its composition in terms of the stakeholder's involvement, to identify their roles as well as to explore the challenges that faced the HFGCs. The study was conducted in Musoma District Council and narrowed down to five selected health facilities, namely: Murangi health centre, Nyakatende, Suguti, Nyambono and Kurugee dispensaries. The District was selected because it is among the districts with low community participation particularly in health development activities (NBS, 2010)

1.7 Structure/ Organization of the Dissertation

This research consists of five chapters/sections. The first chapter covers the Introduction and Background Information. The second chapter covers the Literature review and the third chapter addresses the research methodology used. The fourth chapter analyzes the presentation and discussion of the research findings and the fifth chapter presents the summary, conclusions, recommendations and policy implications. Lastly the list of bibliography and appendices are indicated.

CHAPTER TWO

LITERATURE REVIEW

2.0 Overview

This chapter covers the theoretical literature review, including definition and explanation of terms, concepts and theories. The chapter also covers the synthesis of the literature, conceptual framework and research gap. Finally, it shows the empirical studies that relate to the effectiveness of the health facility governing committees,

2.1 Concept and Theories related to the study

This section presents the definition of various terms, concepts and theories that related to the study, including decentralization, user committees, effectiveness, empowerment, local empowerment through user committees, health facility governing committees in Tanzania, decentralization as empowering process and finally it explains the participation theory.

1.1.1 Concept of Decentralization

The term decentralization has been defined by several authors, but in a simple term, it means the shift of authority and power from central to the lower level of government. More precisely, decentralization is defined as the transfer of power, authority and functions from national to local authorities (Crook and Manor 1998; Rondinelli et al., 1989). Decentralization has got various categories, including devolution, deconcentration and delegation (Box 1) which seek to bring, among other things, a sense of participation and ownership of the local lower level priorities and budgets for effective decision making that benefits their own health development (Gilson et al., 1994; Villadsen, 1996). According to Rondinelli (1981), participatory approach in a decentralized health system is very crucial and inevitable because it brings several benefits, including the capacity to gather local resources within the locality and the reduction of unnecessary bureaucratic procedures, leading to more

effective and practical resources forecast as well as providing free room for representation in decision making processes.

1.1.2 Decentralization in Tanzania

In early 1961 to 1990s, Tanzania like many other developing countries adopted different strategies, programmes and policies generally aimed at strengthening participation as well as the eradication of poverty, ignorance and diseases. It was during that period whereby Tanzania adopted various top-down policies, including Socialism-Arusha Declaration (1967), introduction of LGAs (1965) and the decentralization policy (1972), which focused on transfer of key authorities and functions of government from the centre to the lower level organizations so as to enable community to share and discuss in details development issues that affect their daily life. The decentralization policy has been presented in two main categories namely: deconcentration and devolution. During the deconcentration period, rural development was centrally coordinated and managed at the district and regional levels (Max, 1991; Molel, 2011; REPOA, 2008).

Decentralization in Tanzania has been considered as critical idea for both central and local government development (Ngwilizi, 2002). These contribute a lot in improving the central government administrative structures however actual involvement by the rural and urban community in the development process was not much materialized. This type of decentralization was more of deconcentration than the devolution of power through local level democratic organs (Massoi and Norman, 2009). The Local Government system was re-introduced early 1980s, followed by its reform in 1996, where it was accompanied by the Decentralization by Devolution (D-by-D) policy. The policy shifted from the former centralized system to the decentralized local governance system (Max, 1991). For that matter, the local government was very crucial transformation used as a driving force for (D-by-D) policy to reinforce the local government authorities with the major aim of improving service delivery to the public particularly those in rural areas. Therefore, D by D in Tanzania intended at shifting power and authority to autonomous elected local organizations, especially lower level people, which have been given definite tasks and responsibilities to

perform in their local areas, including the social and economic services (Bossert & Beauvais, 2002). This led to the introduction of HFGCs to all health facilities in the country. However, when all these transformations take place, no sufficient studies had been conducted to assess the effectiveness of these HFGCs.

2.1.3 Decentralized governance and user committees

In most cases, some of the social, economic and administrative activities are governed through formal and informal structures of the user committees that represent the entire population of the locality. In Tanzania, structures such as Local Government including District Councils, Ward and Villages are established in order to empower the lower level people to engage in and participate in different development activities. The drive for strengthening council health services has been linked to the national strategy of decentralization by devolution (D by D) as implemented sequentially by the Ministry of Prime Minister's Office-Regional Administrative and Local Government and most recently known, President's office Regional Administrative and Local Government (PO-RALG). A key element in efforts to make stronger council health services has been the effort to establish and strengthen the institutions and organizations particularly Regional health management teams and District health management teams crucial for governance, planning, budgeting, implementation and monitoring of local health services. These can be viewed in relation to the structure of health service delivery system in the most of the developing countries

Lower level health committees (Ward and village) have been well-known and established for a considerable time and deal with all health matters in their respective geographical areas, but they are not involved in the direct management or governance of health facilities. Rather, specialized dispensary and Health Centre committees are accountable for governing all health facilities as stipulated in the guidelines for establishment

There is no formal structural relationship between the ward and village health committees on the one hand and the health facility committees on the other. The

most important way in which local communities are involved in the planning and management of council health services is through their participation in local user committees known as Health Facility Governing Committees (HFGCs). This seems to work relatively well because the primary health facilities (dispensaries and health centers) are close to the community members as every village and Ward is supposed to have dispensaries and health centers respectively. Hence committee members are regular health services users, and their contributions have apparently resulted in visible changes and improvements for their wellbeing (MoHSW, 2007).

Box 1. Basic definitions of types of decentralization

Decentralization is defined as the transfer of authority, power, resources, and responsibility of service delivery from the central government to lower levels in a political-administrative and quasi-independent organizations or the private sector (Agrawal and Ribot, 1999; Crook and Manor, 1998; Kessy, 2014; Litvack and Seddon, 1999; Smith, 1985)

Devolution refers to the legally transfer of power to the elected lower level political bodies like LGAs in which their functions are autonomous and independent of the central. It allows the establishment of local management with a degree of discretion to manage activities without necessarily having constant reference to central government officials (Kessy, 2014; Mniwasa and Shauri, 2011).

Deconcentration refers to a transfer of central government authorities and management workload to lower-level, or to other local authorities who are upwardly accountable to the central government. (Mniwasa and Shauri, 2011; Ribot, 2002: Yuliani, 2004).

Delegation refers to the shift of specific managerial and administrative roles and functions to the organizations that are outside of the central government structure. These organizations can be indirectly monitored by the higher authority responsible (Kessy, 2014,; Mniwasa and Shauri, 2011; Yuliani, 2004)

Privatization means the shift of responsibility, functions and control of service delivery to private owners (Litvack and Seddon, 1999; Smith, 1985; Yuliani, 2004).

2.1.4 Concept of Effectiveness

Effectiveness is the degree to which the agreed tasks are achieved and the extent to which targeted problems are successfully solved. Is the ability to accomplish the assigned roles. It means the achievements of goals and objectives without much regard to the amount of input resources involved. Emphasis of attention is realization of the goal or objectives of the purchase transaction (Mukandala and Peter, 2004).

Organizational effectiveness is seen as the capability of the organization in either relative or absolute terms to develop its environment by using the available scarce and valued resources (Yuchtman and Stanley, 1967)

In this study effectiveness of HFGCs will be measured in terms of the accomplishments of goals through the use of indicators such as the extent to which stakeholders are included, the extent to which members are being empowered, and the access to information. However, most institutions usually are seeking to achieve several different goals at the same time, and the success of one of these goals often may inhibit the accomplishment of another. For instance, high efficiency may well be achieved at the expense of high employee spirits or low environmental pollution. (Reimann, 1975).

2.1.5 Concept of Empowerment

Empowerment can be defined as the expansion of assets and capabilities of poor people in order to enable them to participate in, negotiate with, influence, control, and hold accountable the institutions that affect their lives (Narayan, 2002). Empowerment can be defined in different ways based on the aspect of socio-economic, cultural and political contexts. However, Bailey, (1992) indicates that, how we precisely define empowerment within our projects and programmes will depend upon the specific people and context involved in that particular project.

Generally, empowerment refers to the expansion of freedom of choice and action to shape one's life. It implies control over resources and freedom in decision for better results. It is a transformational process through which individuals and groups are enabled to take greater control of their lives and the environment. Empowerment is

the catalyst that enables individuals to pursue their goals successfully through positive integration at the individual and community levels (Kabeer, 2001). Empowering poor men and women requires the removal of formal and informal institutional barriers that prevent them from taking action to improve their choices.

The key formal institutions barriers include; insufficient laws, rules and regulations while informal institution barriers include; norms of society, social exclusion and corruption among others (Narayan, 2002). Empowerment is a continuous process that happens over time. It has also more intrinsic (inherent not separable) than extrinsic value though its instrumental values cannot be taken for granted. This is to say, some empowerment elements are within a person; one should not wait for others to empower them but empowerment comes from oneself and others only support to strengthen the person's empowerment (Masue, 2010).

2.1.6 Local empowerment through user committees

People from the grassroots are empowered in several ways, such as user committees where they can address their needs. Community user committees are the small group of people obtained through election or appointment that represent the interest and needs of the community in a particular service or product. According to Manor, (2004) and Masue, (2014) there are three ways in which people from the local lower levels can become members of community user-committees as elaborated below:

The first method is being a member through an appointment. In this method the appointing authority might be the local authority or central government depends on the prevailing situation. A good example of this is health committees that might consist of a few number of health staff operating in a particular local area, and a larger number of people selected by local health professionals and/or a bureaucrat from the health institution/organization who works at a higher level. This type of committee seems to lack fully autonomy and power due to the top-down approach to obtaining members. In the actual implementation these committees had less influence to the local committees and hence poor performance

The second method is being a member of the committee automatically by virtual of the position. In this method people can become members by belonging to a particular category. For example, the head of the health facilities by virtual of their position qualify to be the members of the HFGCs. Also the users of a certain service like forest product or who live in areas around a particular forest may be included as members of a joint forest management committee. The weakness of this type of committee is that it seems that the selection process in this category is neutral therefore, tend to exclude the poor and instead serve the interests of wealthy groups. This often leads to ineffective and poor service delivery.

The third method is being a committee member through a democratic process. This method involves some kind of free and fair election among the community users of a particular service to elect their representatives. For instance, in case of the HFGCs the community elects three users of the health services to represent the community of that locality. This method promotes the D by D policy whereby the local level people exercise their democracy through bottom-up approach. However the questions remain about how much autonomy and power do the elected members of these user committees have on the decision making process.

2.1.7 Health Facility governing committees (HFGCs) in Tanzania

Health facility governing committees (HFGCs) are the user committees that represent the preferences of the grassroots in health matters. They were first introduced in 1999, within health facilities of all levels of the health system specifically Hospitals, health centers and dispensaries alongside the introduction of the Community Health Fund (CHF) (URT, 2013). In an effort to improve community involvement in health services delivery, Tanzania recognized HFGCs at all levels of health services delivery structure from the hospitals, health centre to the dispensary level in the early 2000s. These committees at Hospital level are best known as Hospital boards while at the health centre to the dispensary are known as Health Centre/ Dispensary governing committees. The existence of a health facility committee (HFC) whose members include community representatives is an important approach to ensure community contribution in health planning, strengthen

decentralized health systems and get better the delivery of health services (McCoy et al, 2012).

Pursuant to section 153(1) of the local government (District Authorities) Act Cap 287 R.E 2002, which confer powers to the local government to make by laws, the Musoma District Council enacted by law known as ‘‘the Musoma District Council (Council health service board establishment) instrument, 2005’’ that clearly stipulates the establishment, composition and the roles of the HFGCs. Membership of the dispensary and health central committee is eight and nine respectively, which drawn from different stakeholders, vote members, including three from society dispensary users, one delegate from a private not for profit health facility, one from a private for profit health facility and three-non vote appointed members (the health facility in-charge, one representative from a WDC and one representative from a village Government Committee). The HFGC is chaired by a chairperson who is elected from among the vote members of the committee. At least one third of the members are required to be women (URT, 2005Sec 37-38).

Members of a dispensary committee are selected through the following procedures: - Ward Executive Officer (WEO) shall advertise the vacant posts for representation of the health facility users, the qualified candidates will make applications; Then the list of qualified selected applicants shall be submitted to the Ward Management Team for scrutiny before being forwarded to WDC which shall do the final assortment and then being forwarded to the council for approval and inform accordingly the WDC. HFGC is required to meet quarterly but it may convene an extra ordinary meeting when need arise. Tenure of office for HFGCs is three years (URT, 2005 Sec 39-40).

Box 2: Specific responsibilities of the health governing committee

1. Coordinating and managing the community based initiatives and plans within their locality.
2. Scrutiny and approve the plans and the budget of the facility.
3. Mobilize resources, including CHF for financing facility activities.
4. Approval CHF expenditures for procurement and other expenses of the facility
5. To control funds disbursed for project implementation with highest transparency and accountability to the community
6. To discuss the quarterly, bi-annual and annual financial progress report from Health facility management team (HFMT)
7. To ensure availability and functional transport, communication facilities and staff houses.
8. Responsible for advising and suggesting to the Council health service board (CHSB) on health services, employment, distribution, incentives and training needs.
9. Link with Dispensary/Health centre Management Teams and other actors to guarantee the delivery of quality health services to the community.
10. To conduct quarterly HFGCs meetings
11. To share the facility health information with the community

Source: URT (2013).

2.1.8 Decentralization as an empowering process

The impact of decentralization to effectiveness in service delivery has got several benefits to the local communities. According to Rose-Ackerman (2006); Narayan, (2002) they argued that decentralization helps to minimize corruption that tends to crop up with bureaucracy and centralized authority. This is because decentralization strives to ensure increased access to information, which promotes informed decision and awareness of the general public about their rights and obligations. With decentralization therefore, there is potential for increased transparency and accountability at the local levels, a situation that is enemy and

unfavorable for corruption to build up in the service delivery systems. This can be translated as better/improved service delivery.

Furthermore decentralization improves citizen's access to social services and ensures that social services provided to the citizens are responsive to the local contexts. For example, Atkinson and Haran (2004) found that decentralization of the health system in Brazil improved consistency delivery of the health services with more people participation, and access to quality health services were enhanced considerably due the management style of the health (behavior of good management practice) and the extent of engagement with the population (population awareness of community-based activities). In this way, it is possible to suit the local contexts in terms of expertise and experience. However, the amount of power that should be conferred to the local levels to bring about effectiveness in service delivery remains to be the major challenge (Masue, 2010).

Decentralization is very important instrument for development in many countries around the world including the developing countries. Effective decentralization depends on the ability of local government to involve local people and development partners in services delivery. In order to sustain and improve local governance, there are three factors to be taken clearly into account; first is popular involvement second is accountability and the third is accessible information (Kunming, 2013). Nowadays, effectively decentralizing decision making process, resources mobilization and accountability to lower levels of government is ubiquitous trend for central governments in many countries of the world, especially in the Third World.

2.1.9 Participation Theory

Participation theory explains the different levels of citizen participation in development activities from weak to strong structures of citizens' power to make decisions. Basically the theory emphasized that the degree to which community members are participate in decide their own development benefits may vary based on the level of citizen involvement and commitment. Community participation in health development activities is most advocated for providing a means for potential

beneficiaries of health services to get involved in all stages including the design, implementation and evaluation of approved projects, with the aim to improve the responsiveness, sustainability and efficiency of health services. Oakley (1989) argues that citizen participation should be seen as a fundamental right of the entire population and that it is a principal factor in the success of development programs, as it allows individuals to choose what they like or don't like.

According to Arnstein (1969), the participation of community can be established based on the roles of beneficiaries or actors. Arnstein came up with a ladder or hierarchy of citizen participation connecting three major steps: the first step is known as ''non-participation'', in this step the control and power of decision-making process is centralized to the point that decision-makers and planners instruct the citizens about which policies, programmes or interventions that will work better for them. In this level the decision makers are the one who plays the big role to help the people to design and formulate an even to implement the said policy in order to achieve their goals, but the citizens do not have an opportunity to give the decision makers and planners any feedback about such interventions/programmes progress.

The second step in the ladder of citizen participation is known as ''token participation''. At this level the citizens have partial autonomy and power in decision making. For instance, during discussion with decision-makers and planners, community members may have an opportunity to exchange ideas by receive information and give their views on a certain policy, programme or project that they thought will work better for them. On the other hand, authority is not redistributed at this stage, indicating that community members may lack the potential communication channels to ensure that their ideas can be heard.

Arnstein indicated the third and uppermost stage in the ladder of citizens' participation as ''citizen power''. In this level the citizens ''own powers'' thus the citizens take part in the process of policy formulation initially from designing, implementing, monitoring and finally evaluation of the projects which ultimately increase the sense of ownership and empowers the lower level local people to

exercise their obligation and responsibilities. This kind of citizens' involvement provides a wide chance for people to participate in and shape the policies and decisions that have straight positive implications on their lives (Arnstein 1969; Frumence et al., 2014)

2.2 Literature Review from Earlier Studies

This section reviews the previous academic writings, studies and researchers who conducted their studies on the similar topic relating the user committees. The review is intended to address the objectives of this study

2.2.1 Formation and Composition of HFGCs

In striving to strengthen and sustain the governance dimensions of health service delivery at the lower level, through decentralization process, the government established HFGCs from hospital to primary health care facilities (Kessy, 2008). The committees are vested with different tasks, but the ultimate goal is the enhancement of the health services delivery. Through decentralization by-devolution, the whole process of electing committee members is vested to the respective local communities in collaboration with the village governments (Frumence et al., 2014; Masue, 2010; 2014; Sohani 2005). The studies by Kessy (2008); Macha et al (2011) reveals that the committee members are appointed for a three years period (referred to as a one phase), after which they are re-selected. Members of the HFGCs were democratically nominated through the process of community mobilization in general village meetings. The village government leaders were responsible for advertising the vacant positions and short listing the candidates before submitted to the general village meeting for final decision. The HFGCs typically consist of eight members comprised a variety of professions, including health staff, parish priests, pastors and private health practitioners. The committees operate at the health facility level; however, some committees both in urban and rural had fewer members than what the guideline stipulates, Kessy (2008); in particular members have died and others transferred to other areas without being replaced in time. The study insisted that without the presence of community representative in the committee, the real meaning of community involvement is missed.

The study by Ifakara Health Institute (2011) indicated few female representatives as each committee had at least one female community representative, although the community members constituting 70% of the committee membership. The study further indicated that 21% of committees consisted of village chairpersons, village executive officer or ward executive officer as members which are contrary to the guideline for HFGCs establishment that restrict community members to hold government and political positions except for the facility in charges.

Furthermore members from private for earnings and private not-for earnings were fine represented in the composition of the committees as stipulated in the guidelines. However special requirements were made to encourage and facilitate women's involvement in the committee in order to avoid dominated by local elites. The officer in charge of the facility served as secretary to the committee (Frumence et al., 2014; La Forgia 1985; Sohani 2005; Zakus 1998).

2.2.2 Legal provisions for establishment and Composition of HFGCs

The studies by Loewenson et al. (2014); Macha et al. (2011) found that most of the national policies and laws had elements of commitments to community participation in health issues, particularly in Kenya, South Africa, Zimbabwe and Mozambique; all these constitutions institute rights to health services and to community involvement in health issues. In Tanzania, HFGCs were first established under the Local Government Urban Authorities Act of 1982 and the Local Government District Authorities Act 1982, collectively linked to the Alma Ata Declaration (1978).

2.2.3 The Roles of the HFGCs

Many studies on HFGCs explain clearly and give a compromise on the roles and functions as significant factors for influencing their effectiveness (La Forgia 1985; Sohani 2005; World Bank 2008; Zakus 1998). This clarity includes well narrated roles, scope, mandate and authority of the HFGCs to avoid confusion and interference among different implementing authorities, particularly during planning, implementation and monitoring of the projects. However clear coordination and accountability arrangements on the roles between committee members, community,

facility staff and other partners are very important during implementation. Sohani (2005) indicated how dispensary health committees were faced by conflicts between staff and community representatives in their day to day functions, especially over the use and control of dispensary funds, because of unclear understanding of the FGC assigned roles. Moreover Kessy (2008) argued that HFGC members have an important responsibility to strengthen the spirit and morale of community involvement in the health system, improving quality of health care, ensuring exemptions are adhered and mobilizing resources, such as funds in the case of the community health fund (CHF) and from partner contributions. Although there is little evidence concerning the effectiveness of facility level accountability structures, Regional and District level accountability structures within Tanzania have been found to be fairly functioning effectively

The study conducted in Zambia by Bossert and Beauvais (2002) found that the central role of the facility committee includes mobilizing resources both money and non monetary from the residents, who are active committees that participate in fundraising to finance both health care provision and development services and as participants in decisions on how to raise community fees. Frumence et al. (2014) supported the argument by indicating that one benefits of having HFGCs is to assist the HFMTs in identifying and mobilizing funds from their jurisdiction for operating the daily activities of the facilities they govern. The HFGCs focus to encourage the community members to join the CHF, and the generated funds can be used to purchase drugs and hospital supplies for facilitating smooth health services delivery at the people. These committees were also assigned other roles including resource mobilization, planning and budgeting, approval of funds, supervising the construction activities, purchasing of materials and drugs, and give feedbacks to the community (Kessy, 2008; Macha et al, 2011; Masue, 2010). The culture of the committee members' involvement in community level activities increases the mutual relations with the village leaders, villagers and also raised community awareness on health related issues.

2.2.4 The extent and capabilities of the HFGCs to accomplish their roles

Different researchers and scholar works described the capabilities and resources of HFGC members as significant factors for their good performance (Oakley 1989; Sohani 2005; WHO 1991). These include level of participation, knowledge and management skills, as well as attributes such as confidence and competencies among the committee members. Study by Kessy; (2014); Masue (2010) indicated that the committees (health and school committees) had both low level of knowledge and low competencies in accomplishment of their roles. Moreover Bjorkman and Svensson (2009) highlighted the importance of data and comparative information sharing about the quality of health care for enabling community members to hold staff and officials accountable which are lacking among the committee members. Most of the literature indicates the good participation of committee on the assigned roles although these members are expected to participate on an unpaid basis, which might lower their level of performance (La Forgia 1985; Ngulube et al., 2004; WHO, 1991). Moreover Serneels and Lievens (2008) in their study of the determinants of health worker performance in Rwanda, found that Community Health Committees were only effective in improving the quality of care through monitoring performance indicators if they had got fully powers to reward well-performing health workers and discipline poor performers, but in reality, that capabilities and planning for such monitoring and evaluation were absent. A study conducted by Frumence et al. (2014) found that not all village members are involved in health planning, but their requirements are represented and discussed in the HFGCs by few elected members, but it is not clear how these few elected members collect community views about their needs. Similarly, Bjorkman and Svensson (2009) noted that there is little information sharing within and among committee members that leads to a failure to have common agreement on what is reasonable to expect or demand from service providers. This information asymmetry inhibited both community and committee members from effectively monitoring health facility activities.

2.2.5 Do the HFGCs use their mandate fully?

According to Sepheri and Pettigrew (1996), most of the roles and responsibilities of the HFGCs committee, particularly budgeting and planning and community mobilization are sometimes done by both politicians and bureaucrats due to inadequate knowledge and resource capability among the committee members. Another important dimension to measure mandate of the committee is its relationship to the catchment population of its health facility and the ability which is low among the committee members. However, in order to improve the representation and legitimacy of HFGC members more committee empowerment is needed. Methods used to choose representatives and the degrees to which they present the needs and priorities of the entire community are critical factors in determining the perceived legitimacy of the representatives in front of the entire population served (Mubyazi and Hutton, 2003). Studies conducted by Kasaje et al. (1987); Loewenson et al (2004) found that poorly performing health facilities appear to be related with poorly empowered HFGCs.

Moreover, these studies emphasized that HFGCs and facility management teams operate synergistically with each other mainly on; staff performance, skills and perceptions on CPH and staff relationship with the community can influence the functioning of HFGCs. Loewenson et al, (2004) also found accomplishment of the HFGCs roles depends on the active participation from both community and health facility management teams. Thus the HFGCs are likely to use their mandate when there is more effective community participation when health staff was responsive, cooperative and willing and able to perform their work. Generally in the health sector HFGCs have been formed at different community social strata in order to promote community involvement, especially at Health centers and Dispensaries but their competencies are low (Rifkin et al., 1988).

2.2.6 Challenges facing HFGCs

The study by Kessy (2008) indicates that despite the committee is responsible for sensitizing the community for resource mobilization this role was not realized as the

study point out the low attentiveness on the legitimacy invested on the HFGC's as far as resources collection is concerned. Furthermore the capacities of members have been related with their educational knowledge, practice in performing the same activities (experience), and to the orientation provided after the nomination. These indicated that the ability to execute the assigned functions was limited because of the limited training provided at the beginning. This was mainly a big challenge with newly elected facility committees; except for induction speeches and stipulation of copies of their roles and responsibilities, no formal training has been provided.

Furthermore, many studies indicate the committees had inadequate funds for implementing the planned activities because the majority of the local communities in the rural areas were unable to contribute to the development activities except in the situations where their labour could be useful. On the other side the government budgets and supplements are very limited to these committees (Frumence et al., 2014; Macha et al, 2011; Masue, 2010; Word Bank 2008).

2.3 Synthesis from the literature reviews

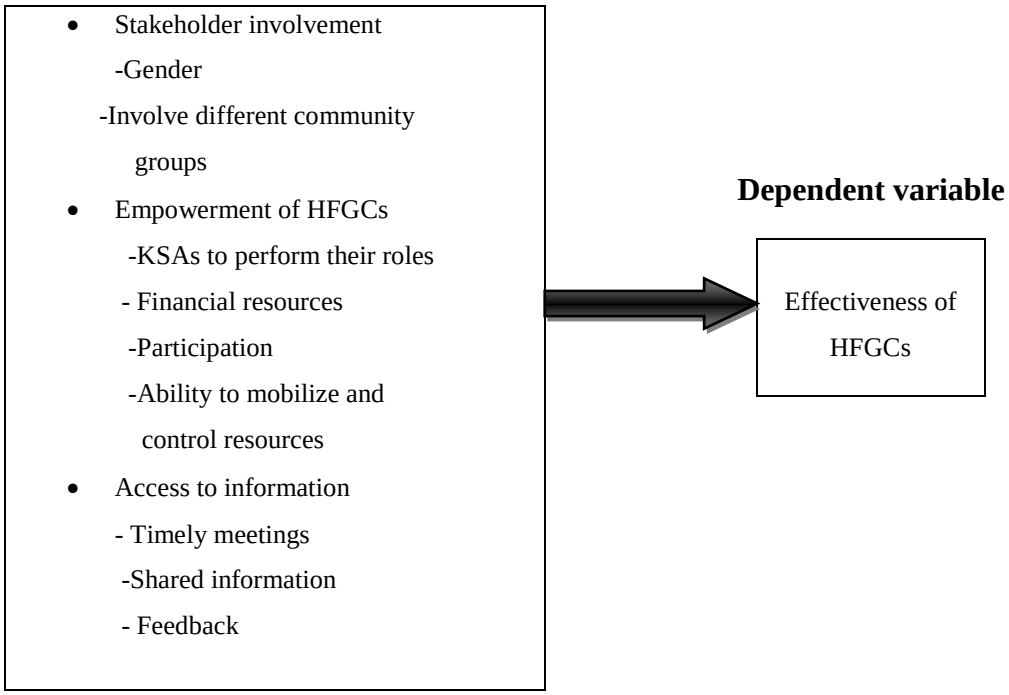
From both theoretical and empirical literature reviews, the experience shows that certain elements are almost always present in achieving effectiveness of the organization goals. In this view; some key elements like , ability to make decision, ability to mobilize and control resources, access to information, inclusion/participation, task control, formal leadership, training, reward for group performance and accountability are identified as important elements of organization effectiveness (Frumence et al., 2014; Green, 1992; Rifkin, 1986).

As indicated above, various studies conducted described the capability and resources of HFGC members as significant factors for their good performance (Sohani, 2005). Information sharing about the quality of health care is very important to enable service users to raise their voices to make staff and officials more accountable. Other factors identified as being important for achieving the effectiveness are successful leadership, adequate resources - materials and funds for promoting the activities of the health centre and Dispensaries (Ngulube et al., 2004; Rifkin et al., 1988; WHO 1991).

2.4 Conceptual Framework

Figure 2.1 shows Conceptual Framework of this study. The underlying assumption in this study is that effectiveness of HFGCs is influenced by stakeholder's involvement, empowerment of HFGCs and access to information.

Figure 2.1: Conceptual framework



Source: Constructed from the reviewed literature, 2016.

2.4.1 Dependent Variable

The dependent variable of the study was the Effectiveness of the health facility governing committees in accomplishment of their roles; Effectiveness means the capacity to accomplishment the roles. This was examined by the extent to which the health facility governing committees are capable to accomplish the assigned roles.

2.4.2 Independent Variables

The independent variables of the study were as follows; the involvement of different stakeholders; the extent to which the health facility governing committees are

empowered and the extent to which the health facility governing committees are accessible to the information flow within and between the committee members and from the community. Each variable was measured as follows:-

2.4.2.1 Stakeholder involvement in HFGCs

Involvement of stakeholders explains how HFGCs are composed in terms of inclusion of various community groups like the user of the health services in the facility, representatives from NGOs, representatives from FBOs, representatives from private health sector, and gender especially female representatives. National health policies and guidelines encourage comprehensive planning processes, but the in practice actual involvement of stakeholders in the planning and priority-setting process is still inadequate (Mubyazi et al., 2007).

2.4.2.2 Access to information

Information is a very important guidance to better decision making. Well informed community are well prepared to take advantage of opportunities including the available services, exercise their rights, discuss effectively and hold government and non government service providers accountable. Sharing and releasing of information about the performance of institutions, future plans, financial progress reports and many other issues of interest enhances transparency in the government, public service, and the private sector organizations. Information flow should be easily available by every citizen. Unrestricted two-way information flow that allow information sharing from government to citizens and from citizens to government is vital to the responsive and answerable governance. The basic assumption here was that access to information promote stakeholder's knowledge, competences and initiatives by making them more effective in their performance. The more the information they have, the higher is their self-confidence and initiative to make decisions and the higher is their performance (Masue, 2010).

2.4.2.3 Community Participation in resource mobilization

The main objective of community participation on the user committee was to have local answerability for the planned activities and for agreed decisions. Moreover it shows that the boards and Community Committee also have a role in to ensure availability of adequate supplementary local resources for the health sector.

As defined by the Rifkin (1978), people participation in health refers to the process in which every person and the entire families would come to view health not only as a right but as a responsibility. The strategy would discourage passive acceptance of government sponsored programs substituting active participation (or cooperation) at every stage.

The community must first be participated in the evaluation of the situation, the identification of the problem and the setting of the priorities. Then with the help of the policy planner, the community plan for their primary health care activities and subsequently they cooperate fully when these activities are carried out. Such cooperation includes the acceptance by individuals of a high degree of accountability for their own health care, for instance, by contributing CHF for their heath, by adopting a healthy life style, by applying principles of good nutrition, sanitation and hygiene or by making use of immunization services. Moreover, communities can provide un-skilled/casual labours such as physical manual works and other available resources to improve health services delivery (Rifkin, 1978).

The WHO (1981), emphasized on the issue of citizen involvement in health activities through its publication relating to indicators for progress toward Health for all by the year 2000 states that people involvement (the term, it prefers to community participation because it implies active rather than passive involvement in health activities) can be examined by the extent of people involved in and the degree of decentralization in decision-making as well as the establishment of effective communication channels for presenting people's requirements and needs.

2.5 Concluding Remarks for the Chapter

The literature review in this study provides the clear policies and structures for the formation and composition of the HFGCs. Many organizations, including Musoma District Council have enacted an instrument/by-law that clearly stipulates the composition and procedures for selecting the committee members which emphasizes the bottom-up participatory approach. Moreover the literature managed to stipulate the roles of the HFGCs including to mobilize and manage funds for the facility activities, planning and budgeting, approval of funds, supervise construction activities also to conduct procumbent of medicine and materials for the facility, though mostly the committee members participate in an unpaid basis. However, most of the literatures, including Frumence et al. (2014); Kessy, (2008); La Forgia (1985); Macha et al. (2011); Sohani, (2005); Word Bank (2008) indicated some of the common responsibilities of the committees including, coordinating the community preferences for participatory planning, mobilize and manage the community resources but little have been indicated about the capabilities in terms of knowledge and resources available for the committees which are the indicators for the good performance and effectiveness of the committees.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Overview

This chapter presents the methodological aspects used in this study. These methods include research approach and design, area of the study, the population of the study, sampling procedure and sample size, data collection methods, validity and reliability of Research Instruments, research ethics consideration, and data analysis which employed in this study.

3.1 Research approach and design

A research design is a plan for collecting, organizing and analyzing data with the objective of combining the relevance of the research with the economy in procedure (Kothari, 1985). In this study a cross sectional case study design was adopted whereby data (both primary and secondary) were collected at a single point in time (within three months). This provided a snapshot of ideas, opinions, and information and so on (Bryman, 2001; Creswell, 2009). It was most preferred because of its broad scope and can incorporate many variables of interest to the researcher.

3.2 Area of the Study

The study was conducted in Musoma District, Mara region, Tanzania. Musoma District Council is one among the nine Local Government Authorities of Mara region, It lies between 1°30’ and 2°00’ latitudes south of the equator and between 32°15’ and 30°15’ Longitudes East of Greenwich. It is boarded by Tarime district to the North, Serengeti to the East, Bunda to South and Lake Victoria to the West (Appendix IV). It was selected because according to the National Bureau of Statistics (NBS) 2010 indicates Mara Region being among the last top ten Regions with low community participation, especially HFGCs in health services specifically in Musoma District Council particularly, with regard to enrollment of CHF members whereby it stood at 38% in 2014.

3.3 Population of the study

The population of this study was 429 members; comprising of 8 CHMT members, 192 HFGCs members of 24 Dispensaries (each with 8HFGC members), 9 HFGCs members of one health centre, 21 WEOs and 199 health facility staff. According to the guideline from Ministry of Health and Social Welfare (2013), the HFGCs consist of eight members for Dispensary level and nine members for Health centre level of which five members are from the community and three appointed members (the health facility in-charge, a member of the village government committee and Ward Development Committee) (URT 2013). Musoma district council has one division, namely Nyanja with 21 Wards and 68 villages. The district has got 1 government health centre and 24 government dispensaries with a total number of 199 staff. The District has a population of 216,409 people, of which males are 106,163 and female are 110,246, as per 2012 census.

3.4 Sampling procedure and Sample Size

The sample size consisted of 70 (16%) respondents among 429 members of the total population. The selection criterion of sample size was based on getting the sample which was representative, adequate, independent and homogenous of the population as appropriate. At CHMT level, four members namely; District Medical Officer (DMO), District Health Secretary (DHS), District Health Officer (DHO) and District Pharmacist (Dph) were selected purposively due to their position in relation to the subject as they were considered to have the required information and document that would guide implementation of the HFGCs activities in the District. Also one health centre with the 9 members of the HFGC was selected purposively because in the district there is only one health centre and it was very crucial to be included in the sample. In attaining the result of this study I used simple random sampling in which all 24 dispensaries available were written on a separate slip of paper, and then mix those slips of paper thoroughly in a box and then draw at random as a lottery the four slips. The slips drawn were represented the selected sample of the four dispensaries from which their respective committee members were the sample size. Also one WEO and five health staff from each selected 5 health facilities were chosen

purposively because they work closely with the committees. Moreover accidental sampling was used to collect data from 5 staff in every selected health facilities that were available during the day of data collection. However, during data collection process the researcher managed to meet majority of the expected respondents, except for the Dispensary committees where 24 out of 32 committee members were available (actual composition).

Table 3.1: Summary of the population of the selected sample

Type of respondent	Population	Sample size		Technique for selecting the sample
		Planned	Actual	
Council Health Management Team	8	4	4	Judgmental/Purposive sampling
1 Health centre with 9 HFGC members	9	9	9	,,
Health staff	199	20	20	Simple random sampling
WEOs	21	5	5	,,
24 Dispensaries with 8 HFGC members	192	32	24	,,
Total	**429**	**70**	**62 (89%)**	

Source: Researcher own adaptation, 2016

3.5 Data collection methods

Data were collected from both primary and secondary sources. Primary data were collected through questionnaires, interviews, focus –group discussion (FGD) and observations.

3.5.1 Primary Data collection methods

3.5.1.1 Questionnaires

A questionnaire is a set of questions designed to produce the data necessary for addressing research objectives. It lists all the questions a researcher wishes to address to each respondent and it provides a space or some choices for respondent to choose. The questionnaires used in the study included open-ended and closed-ended questions (Appendix I attached). Open ended questions were used in order to get the experiences and feelings from HFGCs members about the HFGCs roles.

Closed-ended questions were structured to gather information that could not be obtained using open-ended questions (questions which needs no more explanation like personal information). Generally questionnaire is relatively low cost in terms of material, money, time and privacy assurance.

3.5.1.2 Interview

The study used both structured and non-structured interview schedules for the data collection in order to get the experiences and feelings about the composition and roles/functions of the HFGCs, as well as the challenges in accomplishment of their roles. For the structured interviews, the researcher created an interview guide prior the face to face interview to ensure the interviews are focused and efficient to enable comparison and summarization (Appendix II attached).

3.5.1.3 Focus Group Discussion (FGD)

This method was used in soliciting information from HFGC members from the two selected health facilities. FGDs of 6 and 9 HFGC members at Nyakatende Dispensary and Murangi HC respectively were asked various questions ranging from their knowledge about HFGCs formation, composition, roles and its associated challenges (Appendix III attached). In this study, FGDs offered an excellent way to get people talk, and allowed for cross-checking during data analysis especially on the committee roles. Group members were able to correct and interact with one another in case somebody did not remember or else did not provide correct answers in a way that did satisfy the group. However, in all two groups, women were few (5 out of 15), and could not express their views as openly as men.

3.5.1.4 Observation

The researcher used observation method in data collection in order to complement what was not obtained from the interview and questionnaires. HFGC roles were observed, which included how HFGC members participate and conduct meetings, how members discussed on the health facility's issues like the approval of the funds for procurements guided by observation checklist as it can be seen in appendix IV.

3.5.2 Secondary data collection methods

The researcher used documentary review methods in order to access accurate and reliable data. Documents reviewed comprise of personal profiles of HFGC members, reports, guidelines, directives, policies, regulations, books, journals and minutes of HFGC meetings.

3.6 Validity and Reliability of Research Instruments

Validity and reliability are two concepts that are important for defining and measuring the quality and consistence of research instruments (Golafshani, 2003).

3.6.1 Validity

Validity refers to the quality that an instrument used in research is accurate, correct, true, and meaningful and right (Guba and Lincoln 1998). Validation of data collection instruments mainly aims at developing indicators that provide evidence that the information generated through selected instruments in the research is reliable and believable. For validity purposes, the researcher used triangulation of the data and persons (multiple/different sources of data) to ensure that data on a particular issue were obtained from different people such as HFGC members, CHMTs and health facilities' staff. Thus, for the purpose of quality and to minimize biasness, the study data collection instruments were refined through the comments from the research supervisor, and the researcher himself in the field. The aim was to make the instruments focus on the purpose of the study.

3.6.2 Reliability

The extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability. In other words it means that if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable (Golafshani, 2003). In order to make this study results consistent and reliable, the same and uniform research instruments (questionnaire, interview guides and focus group discussion) were administered to all

respondents. Furthermore, reliability was attained through pilot testing of the two instruments (questionnaire, interview) in order to find out if they are well understood**.** Pilot testing of the reliability and validity of data gathering instruments were conducted in Musoma. The responses derived from the pilot study enabled the researcher to redesign some of the research questions for ambiguity clarification and made necessary adjustments.

3.7 Data analysis Methods

The raw data from the respondents were sorted and arranged in an orderly manner so as to facilitate systematic retrieval later. Qualitative methods were used to analyze the data after the elementary analysis in the field. Content analysis was used to analyze the data collected through focus group discussions, individual interviews and documents to get an interpretation of their meaning. Sorted data were typed in a computer using predictive analytical software (PASW) formally known as statistical package for social science (SPSS) program in accordance with these categories. This was done by coding the obtained data and categorizing them into themes for the purpose of producing meaningful units of analysis that appeared in terms of words, phrases and sentences in the computer. Quantitative data were derived from documents and questionnaires which were first summarized in tabular form showing numbers in terms of frequencies, sums, percentages and rank orders (Table 4.1 to 4.8). In the second stage the summarized data from tables were then be analyzed and interpreted.

3.8 Research Ethics Consideration

This study adhered to the principles of ethics in social sciences research and professional codes of conduct to safeguard the rights of the participants and enhance trustworthiness of the findings. This study was conducted after insuring the following; obtaining permission to access the organization that the research intends to be conducted, ensuring voluntary participation, informed consent, confidentiality and anonymity were strictly observed. With regard to obtaining permission to access the areas of study (MDC), the researcher sought an introduction

letter from the Mzumbe University, which was very helpful in granting me a permission letter for data collection. During the field work, the researcher asked the participants to participate in the study voluntarily, and gave them a clear explanation of purpose for carrying out the study. This was important in establishing confidence to the respondents on how the information they provided would be used. Also privacy and anonymity of individual respondents were highly taken care of as no individual names were taken to ensure that they were free to give their opinions and feelings.

3.9 Concluding remarks for the Chapter

This chapter mainly presents the methods and instruments used in data collection, analysis and presentation. Different data collection instruments including questionnaires, interview, FGD and observation were used. Triangulation of data and person were very important to minimize biasness in order to have consistence of data hence making them more reliable. The lessons learnt during the study is that although the proposal is a systematic tool for research guideline, flexibility during the field work is very important and inevitable as during the field work the actual sample size contacted was 68 out of 70 planned. Data was collected for two months from December to January 2016 which was very short compared to the importance and tedious work of collecting data as it was interrupted by daily normal and ad-hock activities of the interviewees hence increase the time for follow-ups to the field. For reliability and good responses, strategies for administering the questionnaires need some changes, particularly instead of distributing questionnaires for respondents and collect them later, it's better for the researcher to have a short session with the respondents.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE RESEARCH FINDINGS

4.0 Overview

This chapter provides major results and discussions arising from the data analysis on the examination of the effectiveness of the HFGCs Committees at Musoma District Council. The findings are discussed under five main sections; the first section focuses on respondents' opinions on the how HFGG is formed and its composition in terms of inclusion of different social strata; the second section examine on the legal provisions for the establishment, composition, roles and mandate of the HFGCs; the third section identifies the roles of the HFGCs; the fourth section examine the extent in which the HFGC accomplish each of their roles; and the fifth section presents the challenges facing the HFGCs in Musoma District.

4.1 General characteristics of respondents

This study involved five categories of respondents; these include Dispensary governing committee members (39%), Health centre governing committee members (15%), CHMT (7%), WEOs (8%) and Health facility staff (32%). Results from table 4.1 indicate that, majority of respondents (60%) were males while (40%) were females. The researcher was interested to know how the sampled respondents were distributed in terms of sex and confirm if both sexes participated to provide their views in this study. The result also revealed that 39% of respondents aged between 41 to 50 years, while 18% of them aged between 51to 60 years. These findings indicate that majority of respondents in this study were aged group of 41to 50 years, matured for decision making. Furthermore the findings indicate that majority 39 (63%) respondents had at least college certificate, mostly representing the civil servants while nearly one third 19 (31%) respondents had primary education, indicating low level of education the majority of the committee members had.

Table 4.1: General characteristics of respondents (n=62)

Variable	(%)	n
Categories of respondents		
DFGC		24(39)
H/CFGC		9(15)
CHMTs		4(6)
WEOs		5(8)
H/F Staff		20(32)
Gender		
Male		37(60)
Female		25(40)
Age groups		
21 to 30 years		12(19)
31 to 40 years		15(24)
41 to 50 years		24(39)
51 to 60 years		11(18)
Level of education		
Primary education		19(31)
Secondary education		4(6)
College certificate		34(55)
Degree education		5(8)
Marital status		
Married		42(68)
Single		17(27)
Widowed		2(3)
Divorced		1(2)
Position in Government		
Member of VGC		6(10)
Member of WDC		5(8)
Civil servant		35(56)
No any position in government		16(26)

Source: Field data 2016, n=Number of respondents, %= percentage

The descriptive statistics in Table 4.1 indicate that two third (68%) of respondents were married, 17(27%) were single while widow and divorced account to a portion of 3% and 2% respectively. Table 4.1 further indicates that 26% of total respondents had no any position in the government while (10%) and (8%) were members of VGC and WDC respectively. The researcher was interested to know how the sampled respondents were distributed in terms of gender, age groups, level of education and

marital status in order to confirm if both social strata participated to provide their views in this study.

4.2 Formation and Composition of HFGC

Result from the findings show that out of 41 required HFGC members from 5 selected health facilities (four Dispensaries and one Health centre with 8 and 9 HFGC members respectively) only 33(81%) members were available in which 22(67%) were men and 11(33%) were women. Results from table 4.2 indicate all committee members are aged between 21 and 60 years whereby the majority 23(70%) were aged between 31 to 50 years. Also more than half (58%) members had primary education and (42%) had at least secondary education indicating that majority of the committee members had primary education. These three variables (gender, age and education) correspond with the requirements that at least one third of the members to be women attain the age of 21, not older than sixty five years and can read and write in Swahili or English.

Table 4.2: General characteristics of the HFGCs (n=33)

Variable	n (%)
Gender	
Male	22(67)
Female	11(33)
Age groups	
21 to 30 years	4(12)
31 to 40 years	11(33)
41 to 50 years	12(36)
51 to 60 years	6(18)
Education level	
Primary education	19(58)
Secondary education	4(12)
College certificate	9(27)
Degree education	1(3)
Position represent	
Representative from VGC	7(21)
Representative from WDC	6(18)
Head of health facility	5(15)
Representative from health facility users	13(39)
Representative from FBOs	1(3)
Representative from private H/sector	1(3)

Source: Field data 2016, n=Number of respondents, %= percentage

Result from table 4.2 revealed that 7(21%) members were representative from VGCs, 6 (18%) members represent the WDCs, and 5 (15%) members were head of the facilities. Moreover the findings show that 12(39%) were members from community health users, whereby FBOs and private health sectors, each were represented by 1(3%) member

The findings from the interviews administered to HFGCs, CHMTs and WEOs discovered that, the procedures used to select the HFGC members in all five selected health facilities were adhered to as per the established requirements since they originated from the lower level people themselves as clarified by one of the WEO;

> *After every three years I used to advertise the vacant posts for representation of health facility users for our Dispensary. Each village is supposed to participate to select one representative. Since our Ward has got five villages, then those five names (one from each village) were forwarded to the WDC for scrutiny to final selection of three members. Moreover the WDC select four representatives to join the three members as follows; one from WDC, one from VGC, one from private health provider and one from FBO. My office forwarded the final selection attached with the meeting minutes to the council director for approval and the council will inform us accordingly after the approval. Finally the WDC launch the approved HFGC on the planned date to take in charge*

From the explanation above, it shows that the District level did not influence the election process of committee members. The whole process is decentralized to the lower level (WDC). As it was noted from the focus group discussions, the election of HFGC was organized and conducted by the WDCs. The District level is responsible for issuing the directive letters to the WEOs to remind some key issues like the end date of HFGC office tenure, date of election, qualification of members as per the guideline and not interfered the election process. In his study, Masue (2010) examined empowerment and effectiveness of school committees and found that the election process for school committees was left to the schools and the village government.

Effectiveness of HFGC depends largely on its composition in terms of inclusion of different social strata and gender, which are one of the independent variables that I indicated in my conceptual framework (Figure 2.1).

The findings from the study indicate that all selected Dispensary committees have got 6 members out of required 8 members. This was contrary to the requirement as per Sect 153 of the Local Government (District Authority) Act Cap 287 R.E 2002, which stipulates that the DFGC is supposed to have 8 members. Most of the missed members are the representatives from private health providers for profit and from private health providers not for profit, this differs from the study by Kessy (2008) which found that in most of the boards and committees, the gender balance of the committee members was met and members from private for profit and private not-for profit were represented. Moreover, during the interview, one WEO commented as follows:

> *In our area, especially in rural areas there are no private health facilities that provide health care to the citizens; however, some individuals, mostly the health staff owned small pharmacies but the HFCG guideline restricted them to become committee members. For that matter, we couldn't appoint them to be the representatives in our health committee.*

This quotation indicates first; the WEOs are well knowledgeable about the composition and qualification required for HFGCs members. Second; most HFGCs in Musoma District Council had inadequate representatives from both private health providers and NGO/FBOs, a situation that needs improvement. Generally user committees, in particular the HFGCs were indicated to be more significant in solving the given community problems at their localized environment when there is perfect community participation. Given a clear mandate and responsibilities, these committees can also link and coordinate easily with other organizations, institutions and structures at that level such as religious, school, Village and Ward Health Committees for solving health related problems at the community (Kessy, 2008; Masue, 2010).

4.3 Legal provisions for establishment and Composition of HFGCs

Results from table 4.3 indicate the majority of respondents (97%) are not aware on the Act that establishes the HFGCs although 21(64%) of the respondents saved as the members of the committee for three years. However, very few respondents 2 (3%) were able to mention the Act without going far into the specific sections. All 62 respondents were aware that the committees are legally required to save for the period of three years and they can apply for two terms.

Table 4.3: Level of understanding on Legal provision for the establishment of the HFGCs (n=62)

Variables	n (%)
Knowledge on Act that Establish HFGCs	
Yes	2(3)
No	60(97)
Time saved as a Member HFGC	
Less than one year	11(33)
Two years	1(3)
Three years	21(64)

Source: Field data 2016, n=Number of respondents, %= percentage

However, during the interviews the CHMTs and WEOs admitted that there is an Act that establishes these committees, though they were not able to mention it. This was also explained by one of the CHMT members as follows

> *These committees have been established under the law, although I do not know exactly that law. In case of tenure of office, I know that the manual for HFGCs from Ministry of health and social welfare of 2013 indicates that, the committees serve for a period of three years.*

From the quote above it indicates that all levels of the respondents had inadequate knowledge about the Act that establishes the HFGC. This situation tends to lower the actual legitimacy of HFGCs and therefore minimizes the effectiveness in the accomplishment of their roles.

4.4 Specific roles of the HFGCs

The concern for the study was to identify the actual specific roles performed by the HFGCs. Each individual committee member was asked to rate his/her status of participation and level of knowledge based on the scales; ‘‘low’’ if their participation and knowledge was 0% to 50%, ‘‘moderate’’ if their participation and knowledge was 51% to 75%, and high if their participation and knowledge was 76% to 100%, for each of the given eleven roles.

Table 4.4 Status of HFGC participation against level of knowledge in their roles (n=33)

Variable	Status of participation			Level of knowledge		
	1(%)	2(%)	3(%)	1(%)	2(%)	3(%)
Planning and Budgeting	1(3)	8(24)	24(73)	18(55)	13(39)	2(6)
Discuss health facility reports	7(21)	21(64)	5(15)	19(58)	11(33)	3(9)
Mobilize financial resources	6(18)	22(67)	5(15)	17(52)	13(39)	3(9)
Liaise with HSB and other partners	8(24)	22(67)	3(9)	23(70)	9(27)	1(3)
Promote health infrastructure	6(18)	18(55)	9(27)	21(64)	10(33)	2(6)
Advice on HR recruitment and training	6(18)	21(64)	6(18)	22(67)	8(24)	3(9)
Plan community based health initiatives	9(27)	17(52)	7(21)	18(55)	14(42)	1(3)
Approval CHF expenditures	1(3)	8(24)	24(73)	27(82)	3(9)	3(9)
Control resources	2(6)	15(45)	16(49)	25(76)	4(12)	4(12)
Committee meetings	1(3)	9(27)	23(70)	17(52)	12(36)	4(12)
Give feedbacks to the community	2(6)	23(70)	8(24)	27(82)	4(12)	2(6)
Total -Average	4(13)	17(51)	12(36)	21(64)	9(27)	3(9)

Level of knowledge key 1 = Low , 2= Moderate, 3= High, n= Number of respondents,

% = percentage.

Source: Field data 2016.

Generally, the result from the study reveals that the committee members performed all 11 assigned roles, though their level of participation and knowledge differs.

Findings from table 4.4 indicate that an average of 12(36%) committee members highly participated in their assigned roles, particularly in planning and budgeting, approval CHF expenditures for running the facility activities and also attended normal and ad-hock committee meetings. Findings, further indicate that the majority of the committee members (51%) moderately participated in their assigned roles including mobilize financial resources, especially CHF for implementing facility activities, participate in promoting health facility infrastructure, including construction of facility wards and staff houses, also they participated to promote community based initiatives, and also give feedbacks to the community.

However, on the side of their knowledge, the findings indicate majority (21) which translates to 64% of respondents had low (0%-50%) knowledge on the roles. This situation indicates that the committee members suffer from inadequate knowledge that need to be addressed for improving its effectiveness. The study by Masue (2010) found that the school committee members had low understanding of their responsibilities which was not affected by education levels.

Furthermore the procedures for priority setting observed was the decentralized health system that indicates some elements of Arnstein's hierarchy of community participation because the presence of HFGCs in every facility level enables and empower the entire community to participate in the designing, preparation, implementing and monitoring of the health projects under their jurisdiction (Arnstein, 1969). Community involvement has become a catalyst for enabling local people to raise their voices and addressing community health needs. HFGCs have been viewed as a central link by making sure that the needs of rural poor people are incorporated in comprehensive health facility plans before handling over to District level for compilation and approval. Moreover the big challenge is that, there were no formal communication channels agreed on how the facility committee members gathered community information about their health priorities (Frumence et al., 2014).

4.5 The extent in which the HFGCs accomplish each of the roles

Competences in role accomplishment are very important to determine the effectiveness of the HFGCs. An interview followed by the FGD was conducted to the two HFGC (9 members from Murangi health centre and 6 members from Nyakatende dispensary) in order to allow for an in-depth discussion and cross check the awareness of the committee members with regard to competences in their roles. This was done by asking the HFGC members to mention the roles that they performed and assess their level of understanding and competences they had by letting them to explain how they performed the roles. The scales are based on the ‘‘Low’’ (below 50%) and ‘‘High’’ (above 50%). Findings indicated that members were able to mention seven roles which were largely similar to those roles given in the MOHSW for HFGCs guideline (2013) as shown in table 4.5.

Table 4.5 Roles understanding and competences of the HFGC (n= 15)

Roles performed	Level of understanding		Competences	
	Low	High	Low	High
Planning and Budgeting	13	2	14	1
Mobilize resources	9	6	10	5
Approval CHF Expenditures	11	4	11	4
Control facility resources	12	3	13	2
Conduct meetings	8	7	11	4
Monitor facility construction activities	10	5	9	6
Monitor procurements activities	11	4	12	3
Total- Average	11	4	11	4
Percentage	70	30	76	26

Source: Field data 2016, n= number of respondents.

Findings from table 4.5 reveal that 30% of the committee members were highly understanding of their roles while the majority 70% indicated a low understanding of their responsibilities. Furthermore, an average of 76% of the respondents indicates that they had low competences for accomplishing their roles. This indicates that the low education level among the committee members might be the contributing factors for the low understanding of their responsibilities. Similar findings were obtained by

Masue (2010) on his study to examine the empowerment and effectiveness of School Committees in Tanzania, whereby it was observed that the implementation capabilities of the members of the two school committees were considerably low by an average of 61%. Study by Kessy (2014) on the technical review of Council health service boards and health service governing committees in Tanzania revealed that the ability of the committee members could be associated with their educational level, familiarity in undertaking the same tasks, and the orientation they received after the appointment

Moreover, the study examines whether the committee members were trained on their roles or not. The findings from table 4.6 indicate almost half 18 (54.5%) committee members trained on their roles while 15(45.5%) were not trained due to the reason that they were newly appointed to replace the vacant posts including the health facilities in-charges.

Table 4.6 Training regarding HFGCs roles (n=33)

Variable	n (%)
HFGCs trained on roles	
Yes	18(55)
No	15(46)

Source: Field data 2016**,** n= number of respondents, %= percentage

The findings from interview show that the CHMTs played a role to make sure that the committee members were conversant in accomplishment of their roles, though not adequate as explained by one of the CHMT members;

> *We capacitate the committees in several ways. For example, after they have been elected to office, all committee members were trained on their roles and duties, though it took only one day because of financial constraints. Also, we distributed one HFGC guideline manual (2013) issued by the ministry of health and social welfare for each committee in 2014.*

From this experience, it was learned that the one session of training given was not much practical helpfully to the committees, but rather the day to day practices of the committees made them conversant on their roles. Also, the distribution of the ministerial HFGC guidelines (2013) one per each committee was not adequate for all

committee members for references. However, some members declare that they never come across it before. The study by Kessy, (2008) indicated that the capacity of the HFGCs to carry out their roles was limited because of the limited orientations received at the beginning.

A similar observation was also made by Macha et al. (2011) in their study on examining the links between accountability, trust and performance in health services in Tanzania which indicated that, after the selection of committee members, short training gathering of not more than hours were facilitated by the health facility in-charges. The specific goal of the orientation was to give the general knowledge about the roles of the HFGC as stipulated to the guidelines. The guidelines were generally read to the committee members during the orientation meeting without detail interpretation and remained at the health facility in-charges' offices. Therefore more effort should be taken from the District level to capacitate the committees in order to enhance its effectiveness.

4.6 Do the HFGCs use their mandate fully?

The study was tailored to elicit how committees perform some of their roles including preparation of facility plans and budgets, conduct meetings, make decisions, and also records keeping including previous meeting minutes and procurement receipts were noted fairly conducted. However, it was noted that the committees did not have sufficient power and autonomy in various facility decisions specifically concerning the use of facility funds as no expenditure without the written approval from the DMO and the District Executive Director approval as enplaning by one of the committee members.

> *We have no powers to spend or purchase anything without prior agreement and approval by the DMO's Office before drawing the money bank. After reaching the consensus through the meeting we have to send our intentions/ needs by writing a request letter, attached with the minutes of the meeting and wait for approval that might take some few days. …this is unnecessary bureaucracy that impairs timely decision of the HFGCs*

From the above findings, it is indicative that the HFGC members did not use their mandate fully hence they lack adequate power and authority in decision making. The

studies by Kessy (2014); Loewenson et al. (2014) revealed that the implementation of the HFGC activities were faced several administrative bureaucratic processes in the Council including delayed approval of the facility requests.

The other area for interest was to know how committee members shared information which was the independent variable of the study. During the study, meetings were identified as one among the key methods of information exchange within the committee members and between the committee and community members as well as CHMTs.

Table 4.7: Number of meetings attended per year (n=33)

Variable	n (%)
Number of meetings attended	
Less than 3	2(6)
Three	4(12)
Four	7(21)
More than four	20(61)

Source: Field data 2016, n= number of respondents, %=percentage.

During the study it was found that the respondents were aware that the committee is supposed to meet at least four times a year. Findings from table 4.7 indicated the good trend of the meeting attendances whereby more than 61% of the respondents attended more than four meetings per year. However, through the previous meeting minutes I managed to observe a number of meetings conducted last financial year ended June 2015 for each of the selected health facility as follows; Murangi health centre was conducted 7 meetings, Nyakatende, Nyambono, Suguti and Kurugee each were conducted 6 meetings. This was concurrent to the requirement that establishes the committee which requires it to meet quarterly but can convene extra ordinary meeting when needs arise (URT, 2005). The committees had no specific office within the facility area or elsewhere. Meetings usually took place either at the health facility's office, outside the veranda of the facility or under the trees within the facility. In some instances, members of the Dispensary Management Team (DMT) and/or village government were invited to join the committee meetings. In Murangi

Health centre, the minutes of a meeting in 2014 revealed that the village chairman, village executive officer of Murangi village and seven health staff of Murangi health centre were present at the meeting which discussed the arrangements for hiring house to accommodate newly recruited Nurses.
Moreover result from table 4.7 indicate more than half (60%) members were attended more than four meetings while 2(6%) attended less than three meetings.

Moreover it was noted that the health facility in charge is the secretary to the committee who is responsible to call for committee meetings. The methods used to call members for meeting is through the use of mobile phones and physical visit within the nearby members. Furthermore, it was observed that the committees were budgeted for only four meetings (one per quarter). The main reason that was given for non-adherence to the number of meetings planned was that, the facilities usually use collected CHF for construction, rehabilitation, procurement of medicines and other hospital supplies to supplement the government funds and therefore no expenditure is allowed without the approval from the committee. Study by Macha et al, (2011) revealed that, HFGCs had convened more meetings than what the guidelines suggest because of the development activities that were taking place in the facility particularly construction of staff houses and facility Wards. For instance, in 2008 they conducted five meetings and all the members actively attendedd in the meetings. The findings revealed no proper time table schedule for the meetings was available neither in the health facility files/notice boards nor to the committee members rather what was actually done is that the Health facility in charge convenes a meeting as the needs arise. However it was observed that no specific amount of fund paid to the committee members during meetings as it was explain by the committee secretary that committee members paid an allowance that not exceed Tsh 10,000 for normal meetings though not regularly depends on the availability of funds.

Moreover, it was observed that the head of the facility (committee secretary) guides most the discussions, potentially restraining the image of community ideas. Furthermore the health facility in-charge as a secretary to the committee is the one

who determines whether the meeting convened or not as indicated by one of the committee members:

> *…All meetings are convened by the committee secretary and conducted at the facility, many discussions are largely related to the facility activities, and little is discussed about the community.*

It was observed that the power of the chairperson is somehow overridden by the committee secretary who is also the head of the facility due to his professional and technically know how (Macha et al., 2011).

During the study I observed how the committees use their mandate to discuss different facility issues and the procedures used for approval of funds for procurement and other payments, although the process of procurement take 3 to 5 days. First the committee secretary prepares the list of items to be procured and request 3 quotations from 3 different suppliers who were primarily identified by the council. Then, during meeting the committee members pass through each quotation (led by the secretary) and finally approval the lowest bidder. After that, two signatories (secretary and one member usual a chairperson) sent the meeting minutes to the DMO's office for approval and permission to draw the amount approved bank ready for expenditure since the cheque payment system is not yet in place. The secretary conducts all procurements and other payments as approved and finally submitted to the committee for verification and quantification. The Secretary is the custodian of all receipts and payment documents for further auditing purposes.

Information is an important input in making decisions for effectiveness of HFGCs. Information sharing was one of the independent variable of this study which was assessed. The study examined how information was shared within and between members and how feedbacks were given. The assumption behind is that the well-informed committee member/community can participate effectively and make good and well informed decisions. Under the decentralized health system the HFGCs are the important institutions that link the local community to the health facility and other health stakeholders (Frumence et al., 2014).

Table 4.8 Committees and Community access to information (n=33)

Variable	n(%)
Committee informed	
Not often	8(24)
Often	22(67)
Very often	3(9)
Feedback to community.	
Yes	27(82)
No	6(18)

Source: Field data 2016, n= number of respondents, %=percentage

The study revealed that all 33(100%) respondents had an access to information about different things happening in the health facility. However, more than three quarters (25) which translates to 76% of the respondents at least were often informed while few 8 (24%) were not often informed about different things happening in the health facility, Moreover, findings indicate majority 27(82%) respondents gave feedbacks to the community about the decisions they made while few 6 (18) respondents indicate they did not give feedbacks.

However, during FGD session, it was identified that the committee members get a lot of health facility information through committee meetings. This information is then shared with the community and other stakeholders as indicated by one of the committee members;

> *Obviously, I get a lot of information that relates to this dispensary through our committee meetings. For example, in the meeting conducted on February 2016 we were introduced new recruited Nurse. Also, we discussed a lot the dispensary budget, and then we approved CHF worth Tsh420, 000 for implementing different activities in our facility including procurement of medicine.*

From the above quote it was noted there is information sharing within and between the committee members and other health stakeholders. Also, it was noted one among the roles of HFGCs is to represent the needs of the respective communities in decision making processes within the area of jurisdiction, especially during planning and budgeting session (Frumence et al, 2014).

However, details from FGD show that committee does not often give formal direct information and feedbacks to the community, but rather, these information and feedbacks are first given to the Village and Ward leaders then the community receive it formally during normal WDC and Village meetings. The reason indicated were; first, no funds allocated to the committee to perform the task, and secondly; the community tends to ignore the meetings that convened by the HFGCs, and hence no strong community support to HFGCs.

4.7Challenges to the HFGCs

During the study, three major challenges were noted which affected HFGCs effectiveness in the accomplishment of their roles. These include, inadequate financial resources for implementing HFGC activities, inadequate knowledge among HFGC members on roles and responsibilities and inadequate support from community to HFGC members

4.7.1 Inadequate financial resources

During the interview and FGC with the CHMTs and committee members it was noted that HFGCs have inadequate financial resources for implementing their activities. The findings indicate that though Health department has several sources of funds for implementing its activities only few sources are allowed to implement HFGCs activities, These sources include donor funds (Basket fund), Central government funds (OC) and Council own sources including CHF.

However the big challenge was the low ceiling of the funds released compared to the actual needs of the health department which resulted to the funds allocated not match with the actual facility needs. This was elaborated by one CHMT member as follows.

> *The committees have many good activities to perform that could improve health services delivery, but the big challenge is inadequate funds that make them to implement some of activities partially and others not implemented at all. For example, the amount of funds (CHF) allocated to implement committee meetings for the financial year 2015/2016 was not exceeding 5 million for all 24 Dispensaries. This amount is very small to facilitate at least 4 meetings per each facility. Moreover, other committee activities such as planning and budgeting is limited to one day session and each member is paid an*

allowance not exceeding Tsh 10,000. In some cases disbursement of Central government funds delayed and therefore these contribute a lot for the committee failure in performing their assigned roles.

Although among the roles performed by the committee is planning and budgeting, to identify, mobilize and solicit resources, especially to sensitize the community to contribute CHF, the findings revealed that almost half (51%) of the committee members their participation on these roles were moderate (Table 4.4). The reason given was due to inadequate payments because during mobilization, the committee members travel far from their home to visit community members and no payments made to refund for their fares and lunch. Study by Ifakara Health Institute (2011), indicated that committee members can be reluctant to grant up their time to attend committee meetings if not paid hence community sensitization for resources contribution are poor due to limited allowances and motivations to the committee members.

4.7.2 Inadequate knowledge among HFGC

The study findings show that the large number 29(58%) of the committee members were standard seven levers and lacked the necessary skills and knowledge for accomplishing their roles successfully (Table 4.2 & 4.4). Results from table 4.5 indicated that 70% of the HFGC members had low understanding of their roles assigned. Furthermore the findings revealed that majority of committee members (76%) had low capabilities for accomplishing their roles, particularly planning and budgeting, mobilize and control facility resources especially CHF, monitoring facility construction activities and procurement process. Study by Kessy (2008) indicated the inadequate knowledge, particularly; the information on the CHF enrollment and the total of fund that has been raised was limited among the committee members.

4.7.3 Inadequate support from community

During the FGDs it was noted that, the majority of the local communities gave inadequate support to the committee, especially when it comes the issue of health facility development activities like mobilization of construction materials (water

stones and bricks). The Majority of the community members are not ready to volunteer when needed to contribute their physical manpower. However, although the health policy (2007) insisted the need for community to participate and contribute for their health services delivery especially CHF, still the enrollment is not 100% as explained by one of the committee members

> *The Community offers very little cooperation to committee, especially in community volunteer activities like mobilization of stones, and bricks for staff house construction. Also, some people still have the wrong idea that the government is doing everything for their health and therefore they are not supposed to pay CHF. These bring a very big challenge to us in the operation of the facility because the government funds are not sufficient to fund all facility activities.*

The explanation above gives an evidence that inadequate community support is a limiting factor to the effectiveness of the HFGCs in accomplishing their roles.

CHAPTER FIVE

SUMMARY, CONCLUSION AND POLICY IMPLICATIONS

5.0 Overview

This chapter provides the summary, conclusion policy implications, limitations of the study and areas for further research as drawn from the findings.

5.1 The Summary of the study

This study intended to examine the effectiveness of the HFGCs in accomplishing of their roles. In this study a case study research design was adopted. Under this design, a cross-sectional approach was used whereby data (both primary and secondary) were collected at a single point in time (within two months December to January 2016). This is a qualitative study which largely concerned with an in depth and insight for theoretical explanation of a phenomenon rather than statistical explanation. A quantitative design was used to test some theories and models through the research questions, in which the effectiveness of the HFGCs was examined.

The study was specifically conducted in Musoma District in Mara region, Tanzania. The sample size consisted of 70 respondents, comprising of CHMT members, HFGCs members, WEOs and the health facility staff whereby the actual sample size contacted during the field work was 62 (89%) respondents. Data were collected from both primary and secondary sources by using questionnaires, interviews, focus group discussion (FGD) and observations.

The findings revealed that the procedures used to select the HFGC members in all five selected health facilities were decentralized to the lower (Ward and Village) level since the committee members originated from the lower level community. Moreover, to a large extent, the HFGC composition in terms of personal characteristics and inclusion of different social strata adhered to the legal requirement for establishment of HFGCs as per Sect 153 of the Local Government (District Authority) Act Cap 287 R.E (2002).

Result from the findings show that the HFGC members available from the five selected health facilities were relatively less than the number required, whereby women representation were less than men in all selected facilities.

Findings indicate that committee members participated and performed roles which were largely similar to the roles given in the MOHSW for HFGCs guideline (2013). Majority of respondents participated in different HFGC roles including planning and budgeting though more than half of them had low knowledge which to a large extent is associated with their level of education. It was noted that the committee members were given inadequate training on their roles, particularly the newly appointed members.

Moreover, during the study, meetings were identified as one among the key methods of information exchange within and between the committee and community members as well as other health stakeholders. It was noted that HFGCs have inadequate financial resources for implementing their activities also majority of the local communities gave inadequate support to the committee, especially when comes the issue of health facility development activities like mobilization of construction materials.

5.2 Conclusion

From the literature review and findings of this study it emerges out that the procedures for the formation and composition of the HFGCs were decentralized to the lower level (Wards and Villages) since the committee members originated from the lower level community. The study findings indicated that the number of women's representation was low in all four selected facilities compared to the men. Evidence from the study indicates that committee members, mostly participated in planning and budgeting, mobilized and managed financial resources, promoting health facility infrastructure, approval of funds and procurement of medicine and materials. Nevertheless, the majority of them had low knowledge, especially in planning and budgeting. However the other factors for achieving HFGCs effectiveness were not well achieved as the study findings indicate that the committee members received inadequate training on their roles, inadequate funds for implementing its activities

and inadequate support from community especially on health development activities like mobilization of construction materials. Therefore, for these committees to be more effective in accomplish their roles, multiple effort from high level (Ministry and Council) and other health partners might be needed in order to build the capacity of committee members and allocate adequate financial resources to fund HFGC activities

5.3 Theoretical Implications

The findings from this study indicate that the committees had less number of members, especially women and private/ NGO's compared to the requirements. This implies that the theory of participation does not match with the actual implementation. The committees seem to work in the lower levels of the participation theory. Other factors have to be considered in order to attain the maximum (third) level of citizen participation. There is a need to review the traditional rules, practices and social responsibilities of the men and women in the community that might influence gender representation in the committees.

The study findings indicate that the committees had provided inadequate training (not more than one session), inadequate financial resources and also inadequate support from the community. This is an indication that, the committee members lacked the power and the ability to accomplish their roles. From a theoretical aspect, empowerment has been explained as the development of possessions and capabilities of deprived people to involve in negotiate with, influence, manage, and hold answerable for their wellbeing (Narayan, 2002). Generally the findings show that there is a gap between the theory and practices of empowerment at the local level.

5.4 Policy Implications

The study finding provides two policy implications: First, it indicates that the D by D policy is weak in terms of resource allocation and capacity building to the local lower levels. There is a need to strengthen the resource capability through adequate and timely allocation of funds to support activities of the HFGCs particularly training of the committee members on their roles. If this is done the capacity of the HFGCs

will be strengthened hence increase its effectiveness. Second, it indicates that the D by D policy aimed at transferring power and authority from the central government to the local lower levels to enable the grassroots to participate in decision making, but the HFGCs had no fully mandate in decision making particularly during fund authorization that needs approval from council level. The committee members faced unnecessary bureaucracy from Council level, hence limiting the power and authority of the committees.

This unnecessary bureaucracy leads to the questioning of the D by D initiatives at the facility level; which suggests that powers have not been completely devolved to that level. This further implies that the policy diverge from the actual implementation. This situation indicates that it is not very easy for local lower levels to attain purely D by D, but rather partial transfer of authority and power from the central government to the lower local levels (deconcentration and delegation). The presence of policy alone is not enough, other practices such as checks and balances, control management systems and monitoring systems are very important for achieving the committee's effectiveness

Moreover the study findings indicate that the committees conducted adequate meetings; whereby the facility in-charge (secretary) led most of the discussions, potentially limiting the representation of community issues. This situation diverges from the existing policy that requires the chairperson who is elected from among the vote members of the committee to lead the committee meetings (URT, 2005; Sec 37-38). During the implementation the policy needs to be flexible to allow any member of the committee to lead the discussion depends on the subject matter on the discussion.

5.5 Limitation of the study and suggestions for further research

The study was conducted in Musoma district, Mara region. A cross sectional case study design was adopted, whereby data were collected at a single point in time (within three months). The study largely used a qualitative research approach, whereby only 62 respondents were involved. For these reasons, the generalization

possibility is low and that the findings may not reflect the characteristics of the entire HFGCs in Tanzania.

Therefore, from the findings of this study, a survey study may be carried out that will use a larger sample size and a wider geographical coverage in order to for generalizable findings.

5.6 Contribution of the study to the existing knowledge

Despite the limitations, the study has contributed to the existing literature in the certain ways. The findings of this study indicated that in some instances, the HFGCs invited some guests, particularly the Dispensary/Health centre staff and village government members to join the committee meetings for discussing different facility matters particularly hiring of the staff houses which increases the degree of participation and empowerments to the committee. Moreover the study revealed that the committee members used mobile phones for information sharing within and between the committee members, particularly in calling for meetings which is the fast way of information sharing.

REFERENCES

Agrawal, A., & Ribot J. (1999). ‘‘*Accountability in Decentralization’’*: A Framework with South Asian and West African Environmental Cases. The Journal of Developing Areas 33: 473-502.

Arnstein, S. R. (1969). A ladder of citizen participation. Journal of the American Institute of Planners, 35: 216-224.

Atkinson, S., & Haran, D. (2004*). ‘‘Does decentralization improve health system performance?’’* Evidence from Ceara in North Brazil. Bulletin of the World Health Organization, .82: 822-827

Bailey, D. (1992). *‘‘Using participatory research in community consortia development and evaluation: Lessons from the beginning of a story’’*. The American Sociologist 23(4): 71-82.

Bjorkman, M., & Svensson, J. (2009). *‘‘Power to the people; Evidence from a randomized field experiment on community based monitoring in Uganda’’*. The quarterly journal of Economics, 124: 735-769.

Bossert, T. J., & Beauvais, J. C. (2002). *‘‘Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines’’*: A comparative analysis of decision space. Health Policy and Planning, 17(1): 14–31. doi:10.1093/heapol/17.1.14

Bryman, A. (2001). *Social Research Methods,* London: Oxford University press

Creswell, J. W. (2009). *Research design: qualitative, quantitative, and mixed methods approaches.* Los Angeles.

Crook, R. & Manor, J. (1998). *Democracy and Decentralization in South Asia and West Africa.* Cambridge University Press, Cambridge.

Denzin & Y. S. Lincoln (eds.). *The landscape of qualitative research. Theories and issues.* London: Sage: 195–220.

Draper, A. K., Hewitt, G., and Rifkin, S. (2010). *''Chasing the dragon: Developing indicators forthe assessment of community participation in health programmes''*. Social Science and Medicine 71: 1102–1109.

Educational Publishers and Distributors Ltd

Frumence, G., Nyamhanga, T., Mwangu, M., & Hurtig A (2014). Participation in health planning in a decentralized health system, Experiences from facility governing committees in the Kongwa District of Tanzania, School of Public Health and Social Sciences, Muhimbili University of Health and allied Sciences, Dar es Salaam, Tanzania.

Gilson, L., Kilima, P., and Tanner, M. (1994). *''Local government decentralization and the health sector in Tanzania''*. Public Administration and Development, 14: 451–477.

Golafshani, N. (2003). "*Understanding Reliability and Validity in Qualitative Research*", The Qualitative Report, 8(4): 597-607.

Green, A. (1992). An introduction to health planning in developing countries. 1st Edition. *Oxford University Press*.

Guba, E.G., & Lincoln, Y. 1998. Competing paradigms in qualitative research. In N. K.

Ifakara Health Institute, (2011). Health Facility Governing Committees. Are they

Kabeer, N. (2001). Resources, agency and achievement: Reflections on the measurement of women's empowerment. Discussing women's empowerment - theory and practice. Stockholm.

Kasaje, D., Sempebwa, E., and Spencer, H. (1987). *''Community leadership and participation in the Serardid, Kenya Rural Health Development Program''*. Annals of Tropical Medicine and Parasitology, 81: 46-55.

Kessy, F. (2008). "*Technical review of Council Health Service Boards and Heath Facility Governing Commitees in Tanzania*". Ifakara Health Insitute. Dar-es-Salaam

Kessy, F. L. (2014). “Improving health services through community participation in health governance structures in Tanzania”. *Journal of Rural and Community Development*, 9(2): 14-31.

Kothari, C. (1985). *Research Methodology- Methods and Techniques*, New age international (P) limited, New Delhi, India

Kunming, P. (2013). ‘‘*Decentralization of local governance, School of Public Administration,* Yunnan University of Finance and Economics, China.

La Forgia, G. (1985). *‘‘Fifteen years of community organization for health in Panama; An assessment of current progress and problems’’*. Social science research Medicine, 20: 55-65.

Litvack, J., & Seddon, J. (1999). *Decentralization briefing notes*. World Bank Institute Working Papers. Washington, DC: World Bank.

Loewenson, R., Machingura, F., and Kaim, B. (2014). Health Centre Committees as a vehicle for social participation in health system in East and Southern Africa, EQUINET discussion paper 101, Harare, Zimbabwe.

Loewenson, R., Risika, I., and Zulu. M. (2004). Assessing the impact of Health Centre Committees on health system performance and health resource allocation, Harare, Zimbabwe.

Macha, J., Mushi, H., and Borghi, J. (2011). ‘Examining the links between accountability, trust and performance in health service delivery in Tanzania’ Ifakara health institute: Dar-es Salaam.

Manor, J. (2004b). ‘‘*Democratization with Inclusion: Political Reforms and People’s Empowerment at the Grassroots’’*. Journal of Human Development, .5(1): 5-29.

Massoi, L., & Norman, A. S. (2009). ‘‘*Decentralization by devolution in Tanzania: Reflections on community involvement in the planning process in kizota*

ward in Dodoma''. Public Administration and Policy Research, .1(7): 133–140.

Masue, O. S. (2010). *Empowerment and Effectiveness of School Committees in Tanzania.* (MPhil Thesis), University of Bergen, Bergen

Masue, O. S. (2014). Empowerment of School Committees and Parents in Tanzania: Delineating existence of Opportunity, Its use and Impact on School Decisions (Phd Thesis). University of Bergen.

Max, J. (1991). The development of Local Government in Tanzania, Dar es Salaam:

Mboera, L. (2011). ''Fifty years of Health services in Tanzania. What Next?" *Tanzania Journal of Health Research,* 13 (5): 66-75.

McCoy, D. C., Hall, J. A., & Ridge, M. (2012). ''*A systematic review of the literature for evidence on health facility committees in low- and middle-income countries''.* Health Policy and Planning, 27: 449–466

Mmari, D. (2005). Decentralisation for service delivery in Tanzania delivered at the conference on Building Capacity for the Education Sector in Africa Oslo, Norway

Mniwasa, E., & Shauri, V. (2001) Review of the decentralization process and its impact on environment and natural resources management in Tanzania. Dar-Es- Salaam.

MoHSW, (2007). *Health Sector Reforms and District Health System*, Dar-Es Salaam, Ministry of Health and Social Welfare.

Molel, A. H. (2011).Participation for local development: The reality of decentralization in Tanzania. Leiden: African Studies Centre. African Studies Collection.

Mubyazi, G., and Hutton, G. (2003). Understanding mechanism for community participation in health planning, resource allocation and service delivery; Harare, Zimbabwe.

Mubyazi, G., Mushi, A., Kamugisha, M., Massaga, J., Mdira, Y., Segeja, M., and Kato, N. (2007). ‘‘Community views on Health Sector Reform and their Participation in Health Priority Setting. Case of Lushoto and Muheza Districts, Tanzania Journal of Public Health 10: 1-10.

Mukandala, R., and Peter, C. (2004). Local Government, Effectiveness and Human Rights in Tanzania: The Case of Bukoba Rural and Mtwara-Mikindani Districts. Geneva.

Mushi, D. (2014). ‘‘Impact of cost sharing on utilization of primary health care services”. *Journal of Providers versus household persectives*. Malawi Medical University, Dar es Salaam Tanzania, 23 (3): 83-89.

Naidoo, J., and Kong, P. (2003). *"Improving Education Management Systems in the Context of Decentralization in Africa-Background Paper For ADEA Study":* The Challenge of Learning–Improving the Quality of Basic Education in Sub-Saharan Africa. Paris: ADEA. National Language Policies.

Narayan, D. (2002). *Empowerment and poverty reduction*, The World Bank.

Narayan, D. (2002). Empowerment and poverty reduction, Washington DC, The World Bank

NBS, (2011). Tanzania Demographic and Health Survey 2010, Dar es Salaam Tanzania

Ngulube, T., Mdhluli, L., Gondwe, K., and Njobvu, C. (2004). Governance participatory mechanism and structure in Zambin’s health system. An assessment of the impact of Health centre committees on quality on health and health care, Harare, Zimbabwe.

Ngwilizi, H. (2002). The Local Government Reform Programme in Tanzania – Country Experience. A paper delivered by Minister of State, President’s Office, Regional Administration and Local Government, Dodoma.

Oakley, P.(1989) Community involvement in Health Development. An examination of the critical issues. Geneva, World Health Organization.

Ottawa Charter, (1986). *The 1st international conference on health promotion and the Ottawa charter for health promotion,* Ottawa, Canada.

Reimann, B. (1975). *Organizational Effectiveness and Managements' Public values*: University of Pennsylvania.

REPOA. (2008).The oversight processes of local councils in Tanzania. Dar es Salaam: REPOA Publications.

Ribot, J. (2002). *Democratic Decentralization of Natural Resources: Institutionalizing Popular Participation.* World Resources Institute, Washington, DC.

Rifkin, S. (1978). Community Participation in MCH/FP Programmes: An Analysis Based on Case Study Material. WHO and UNICE. Geneva

Rifkin, S. B. (1986). Lessons from community participation in health program. *Health Policy and Planning*, 1(96):240-249

Rifkin, S., Muller, F., and Bichmann, W. (1988). *Primary Health Care on measuring participation,* Great Britain.

Rondinelli, D. A. (1981). *''Government decentralization in comparative perspective: Theory and practice in developing countries''*. International Review of Administrative Sciences, 47(2): 133–145.

Rondinelli, D., McCullough, J. S. and Johnson, R.W. (1989). *'Analyzing Decentralization Policies in Developing Countries*: a Political Economy Framework,' Development and Change 20 (1):57–87.

Rose-Ackerman, S. (2006). International Hand book on the Economics of corruption. Edward Elger Publishing Ltd, UK.

Sepheri, A., and Pattigrew, J. (1996). ‘‘*Primary Health care, community participation and community financing*’’; experiences of two middle hill villages in Nepal. Health policy and planning 11: 93-100

Serneels, P., and Lievens, T. (2008). Institution for Health care delivery. A formal exploration of what matters to health workers. Evidence from Rwanda.

Smith, B.C. (1985). *Decentralization.* The Territorial Dimension of the State, London

Sohani, S. (2005). Health care access of the very poor in Kenya, Workshop paper II, Meeting the health related needs of the very poor. Aga Khan Health service, Kenya.

URT, (2007). *Primary Health Services Development Programme- MMAM 2007–2017*, Ministry of Health and Social Welfare, Dar-es Salaam, Tanzania

URT, (2008). *Health Sector Strategic Plan III July 2009 – June 2015* “Partnership for Delivering the MDGs”.

URT. (1998). Local government reform programme: Policy paper on local government reform. Dar es Salaam: Prime Ministers’ Office–Regional Administration and Local Government.

URT. (2005). Subsidiary Supplement No.13. The Musoma District Council (Council Health Board Establishment) Instrument to the Gazette of the United Republic of Tanzania, Dar Es Salaam; Government Printer

URT. (2013). A guideline for establishing and implementing council health service boards, health centres and dispensaries health committees in Tanzania. Ministry of Health, Dar es Salaam

Villadsen, S. (1996). Decentralization of governance in Democratic decentralization in Uganda. A new approach to local governance, p. 60–78.Kampala: Fountain.

Wangwe, S., Semboja, H., and Tibandabage, T. (1998). *Transitional Economic and Policy Options in Tanzania.* Tanzania Political Economic Series, Dar es Salaam: Mkuki na Nyota Publishers.

WHO, (1981). *Development of Indicators for Monitoring Progress towards Health for all by the year 2000*. Geneva

WHO. (1991). Community involvement in Health Development. Challenging Health services. WHO technical report series 809 Geneva, World Health Organization.

Working? Daries Salaam

World Bank. (2008). Improving primary Health care delivery: Evidence from four states. Washngton DC

Yuchtman, E., and Stanley E. (1967). ‘‘*A System Resource Approach to Organizational Effectiveness,*” *American Sociological Review,* 32: 891-903,

Yuliani, E. (2004). *Decentralization*, Deconcentration *and Devolution.* What do they mean? Interlaken, Switzerland.

Zakus, J. (1998). ‘‘*Resource development and community participation in primary health care’’.* Social Science and Medicine, 46: 475-494.

.

APPENDICES

General Information

Topic: Effectiveness of Health Facility Governing Committees in Tanzania: A Case Study of Musoma District Council.

Introduction

Dear Respondent,

My name is Vedastus Pancras. I am conducting a research on the Effectiveness of Health Facility Governing Committees in Tanzania: A Case Study of Musoma District Council. The purpose of this questionnaire is to collect data that will enable the researcher to undertake this study in partial fulfillment of requirement for the award of Master of Public Administration at Mzumbe University

In the following questionnaire, I would like to know your opinions about the topic through your participation by answering the questions which follow.

Your responses will be anonymous and the data collected will be collectively analyzed as a whole and treated as confidential for academic purposes only. Please kindly review the response options carefully before you mark the statement/phrase that answers the question best.

My mobile phone numbers are; +255 756 464 832 or; +255 625 907 509.

Your participation in this study will be greatly appreciated.

Appendix I: QUESTIONNAIRE FOR THE HFGC MEMBERS

PART A: PERSONAL IDENTIFICATION

1. Gender of the Respondent.

   (1)Male (2) Female ( )

2. In which Age category do you belong?

   (1) 21 to 30 years (2) 31 to 40 years (3) 41 to 50 years (4) 51 to 65 (5) over 65

   years (6) under 21 years ( )

3. What is your highest level of education?

   (1) No formal education (2) Primary education (3)Secondary education (4)College certificate education (5)Degree education ( )

4. What is your marital status?

   (1) Married (2) Single (3) Widowed (4) Divorced ( )

PART B: FORMATION AND COMPOSITION OF THE HFGC.

5. What is your position in the government (1)Member of VC (2)Member of WDC (3) Civil servant (4)No any position in the government ( )

6. How did you become a member of the HFGC? (1)Appointed by the WDC (2) (3) Voted by the WDC (4) By the virtual of my position (5) By volunteer (6) Voted by the village council meeting (7) Others
7. What position that you represent in this HFGC? (1)Representative for VC (2)Representative for WDC (3)Head of health facility (4)Representative for health facility users (5)Representative for NGOs (6)Representative for FBOs (7)Representative for private health sector (8)Others ( )
8. How many HFGC members are required in your committee as per statutory requirements? (1) Five (2)Six (3)Seven (4)Eight (5) Nine (6)Ten ( )

9. What are the actual numbers of members available in your HFGC? (1) Five (2)Six (3)Seven (4)Eight (5) Nine (6)Ten ( )
10. How many female members are in your HFGC? (1) Less than three (2)Three (3)More than three (4)No anyone ( )

PART C: LEGAL PROVISION FOR THE ESTABLISHMENT OF THE HFGCs

11. Do you know the Act that establishes the HFGCs in Tanzania? (1) Yes (2) No( )
    If YES please mention it…….

12. What is the tenure of office for HFGCs (1) One year (2)Two years (3)Three years (4)More than three years ( )

13. How long have you been a member of this committee? (1)Less than a year (2) One year (3) Two years (4) Three years (5) More than three years. ( )

PART C: ROLES AND MANDATE OF THE HFGCs

14. What is your level of understanding of the roles/responsibilities of the health facility committee? (1)Low (0-50%) (2) Moderate (51%-75%) (3) High (75%-100%) Please list down all roles which you are conversant with……

15. Did you receive any training regarding your roles/responsibilities from District level? (1) Yes (2) No ( )

16. Refer the table below. What is your lever of participation and understanding on each of the role?
    1= Low 2 =Moderate 3= High

		Level of participation			Level of knowledge		
S/No	**HFGC assigned roles**	**1**	**2**	**3**	**1**	**2**	**3**
i	Planning and budgeting						
ii	Discuss Health facility reports						
iii	Mobilize financial resources						
iv	Liaise with Council health service board and partners in health provision and promotion						
v	Promote health infrastructure and logistic system						
vi	Advice and recommend on human resource recruitment, training, selection and deployment						
vii	Planning and managing the community based health initiatives within its area						
viii	Approval CHF expenditures for procurement and other expenses of the facility						
ix	Control financial and other resources of the Health facility						
x	Attend normal and ad-hock committee meetings						
xi	Give feedback to community						

PART D: DO THE HFGCs USE THEIR MANDATE FULLY?

17. How many times HFGC is supposed to meet per year? (1) once (2) twice (3) three times (4) not less than four times (5) I don't know ( )
18. As a member of the HFGCs, can you tell how often you managed to attend committee meetings for the financial year ended June 2015? (1) Once (2) twice (3) three times (4) four times (5) more than four times (6) Not attend at all ( )
19. How often HFGC does has an access to information about different things happening in your health facility? (1) Very Often (2) Often (3)Slightly often (4) Not often ( )
20. Do you give feedbacks to the community about the decisions you made/what is happening in your health facility? (1) Yes (2) No ( )

Appendix II: INTERVIEW QUESTIONS

(a) COUNCIL HEALTH MANAGEMENT TEAMS (CHMTs)

1. For how long have you been working at the capacity of CHMT?

2. For how long have you worked in this District Council?

3. Do you know the Act that establishes HFGCs in Tanzania? If yes please mention it.

5. What procedures should be followed when forming HFGCs?

6. How many statutory members are required for the HFGCs (H/C and Disp)? Please mention them

7. What are the roles of HFGCs? Mention the strong five you know.

8. Is there any training conducted by District level to HFGCs on their roles?

9. How does your office interact with the HFGCs in implementing health decision?

10. For the financial year 2014/2015 was there any budgets for implementing HFGCs activities at facility level? How much was it

11. What are the HFGCs activities at facility level that were budged for the financial year 2014/2015

12. How do you build the capacity of HFGC members in the District Council?

13. From your experience, what are the common problems faced by HFGCs in the course of accomplishing their roles? Mention the major four problems they faced.

(b) Ward Executive Officers

1. For how long have you worked in this District Council?

2. Do you know the Act that establishes HFGCs in Tanzania? If yes please mention it.

3. What procedures should be followed when forming HFGCs?

4. How many statutory members are required for the HFGCs (H/C and Disp)? Please mention them

5. What are the roles of HFGCs? Mention the strong five you know.

6. How does your office interact with the HFGCs in implementing health decision?

7. How do you build the capacity of HFGC members in the District Council?

8. From your experience, what are the common problems faced by HFGCs in the course of accomplishing their roles? Mention the major four problems they faced?

(c) HFGCs

1. What is your level of understanding of the roles/responsibilities of the school committee?

2. Can you mention specific roles of the HFGC which you are conversant with? Please explain what part do you play in those roles?

3. As a member of the HFGC, how often you managed to attend committee meetings this year?

2. How does the HFGC share information with the community and other health partners?

3. What are the main problems of the HFGCs?

(d) HEALTH FACILITY STAFF

1. For how long have you worked in this Dispensary/Health centre?

2. Does your Dispensary/Health centre have a HFGC?

3. How many statutory members are required for your HFGC?

4. How many members are available in your HFGC?

5. What criteria are used to select members of HFGC?

6. What are the roles performed by HFGC in your facility?

7. Do you meet/interact with the HFGC?

8. Do you think members of HFGC are well trained and capacitated to accomplish their roles?

9. Where does HFGC get fund for running their roles/ activities?

10. What challenges do you face when working with HFGC?

Appendix III: FOCUS GROUP DISCUSSION FOR HFGCs

1. How do you become a member of HFGC?

2. Who are the statutory members of the committee?

3. Do you know the roles of HFGC? –Please mention them.

4. What is your level of understanding of the roles of the HFGCS?

6. What are the main problems you face as HFGC members?

Appendix IV: OBSERVATION CHECKLIST FOR HFGCs

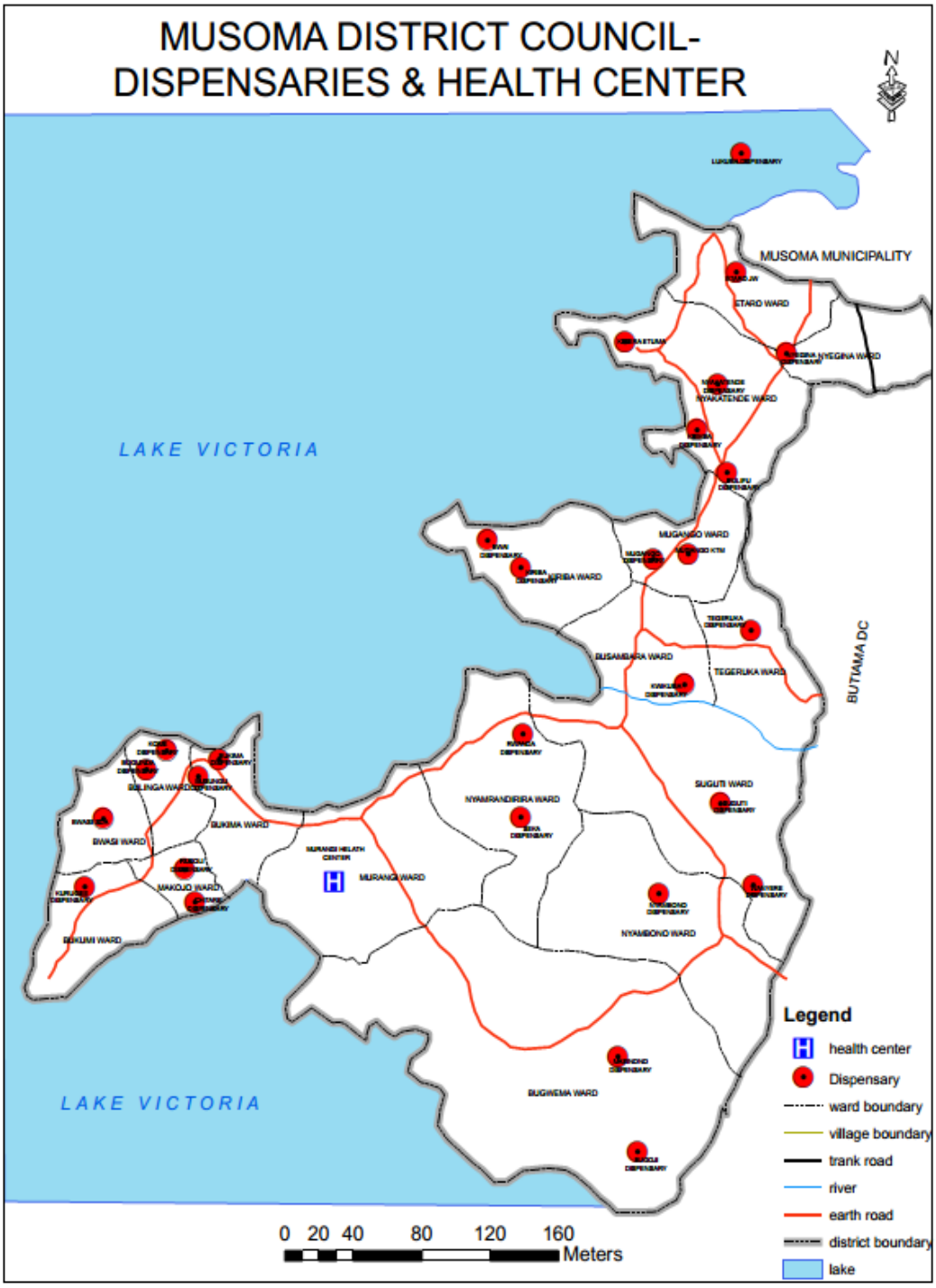
1. Who lead most of the discussions during the committee meeting?

2. How is the fund for procurement approved?

3. How is the procurement conducted?

…….x…….

Appendix V: Map of Musoma District council showing the Health facilities



Source: MDC Cartographic Section, (2015)

Appendix VI: Duration and Schedule of Activities

No	Activity	Duration											
		Year 2015						Year 2016					
		Jul	Aug	Sept	Oct	Nov	Dec	Jan	Febr	Mar	Apr	May	Jun
1	Preparation of Research Proposal, Questionnaire and Submission of Research Proposal												
2	Pilot study and Questionnaire testing												
3	Field work and Data collection												
4	Data Processing and Analysis												
5	Dissertation writing and Submission												

Source: Study plan, May 2015

Appendix VII: Clearance Letters

MZUMBE UNIVERSITY
(CHUO KIKUU MZUMBE)
SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

E-mail: mu@mzumbe.ac.tz
Tel: +255 (0) 23 2604380/1/3/4
Fax: +255 (0) 23 2604382
Cell: +255 (0) 744 694029

P.O.BOX 2
MZUMBE
MOROGORO, TANZANIA

Ref. No. MU/SOPAM/DHR & PSM/VOL.I/ 23rd December, 2015

District Executive Director,
Musoma District Council,
MUSOMA.

RE: DATA COLLECTION PERMISSION FOR MR. VEDASTUS PANCRAS

The above named is a student of this University in the School of Public Administration and Management pursuing Master of Public Administration (MPA) **Mr. Pancras** finished Semester II of her studies which ended in July, 2015 successfully.

As a partial fulfillment of the requirements for the award of Master's degree, every graduate student is required to undertake dissertation on a topic relevant to his/ her area of specialization. The candidate has opted to conduct a study on the topic entitled:

Effectiveness of Health Facility Governing Committees in Tanzania. A Case Study of Musoma District Council

The research is expected to take only six months and thereafter) **Mr. Pancras** will be required to Project evaluation report to the School of Public Administration and Management as per University regulations.

We kindly request your office to allow this student to access various data available in your office in **Musoma District Council** and also interview different people as per his study proposal for accomplishing his study.

Thank you in advance.

Yours Sincerely,

Orest Masue (PhD)
Head of Department of Public Services & Human Resource Management
SOPAM

MUSOMA DISTRICT COUNCIL

Telephone No: 2622163
2620521
2620768

In reply quote.

District Executive Director's office,
P.O.Box. 344,
MUSOMA.

Ref. No. E. 1/14/PART VII/422

28/12/2015

Vice Chancellor,
Mzumbe University
P.O.Box 1
MOROGORO

RE. DATA COLLECTION PERMISSION FOR MR. VEDASTUS PANCRAS

Your letter with reference No. MU/SOPAM/DHR&PSM/Vol II dated 23rd December, 2015 regarding the above subject has been considered.

This is to inform you that, the above mentioned student has been granted a permission to conduct a research titled "(**Effectiveness of the health facility governing committees in Tanzania**"). A case study of Musoma District Council.

Wishing you all the best

M.S. Bitakwate,
For. District Executive Director
Musoma

MUSOMA

Copy to: - Head Department of Health,
P.O.BOX 344,
MUSOMA – Accept & Assist

Vedastus Pancras Kiwango,
Mzumbe University,
P. O. Box 1,
MOROGORO.

Appendix VIII: Budget for the Study

Budget Items	Details	Cost (Tsh)
Research proposal preparation	Stationary (pens, reams, pencils, drafting papers, note books, flash disks and CDs) and internet costs	200,000
	Questionnaire preparation	150,000
	Sub Total	**350,000**
Pilot study	Transport to and from study area (1 person xTsh 10,000x 30 days	300,000
	Subsistence allowance for researcher Tsh 80,000x 30 days	2,400,000
	Sub Total	**2,700,000**
Data processing and report writing	Data entry, cleaning and editing	180,000
	Fare to and from submission of 1st draft report	150,000
	Subsistence allowance during report submission Tsh 100,000x 7 days x 1person	700,000
	-Correction of dissertation	100,000
	Fare to and from submission of final draft report	150,000
	Subsistence allowance during final report submission Tsh 100,000x 7 days x 1person	700,000
	Printing and photocopy	300,000
	Hard cover binding 5 copies @ 50,000/=	250,000
	Sub Total	**2,480,000**
	Grand Total	**5,530,000**

Source: Study plan, May 2015