



Examining the links between accountability, trust and performance in health service delivery in Tanzania

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List of Acronyms

CHF	Community health fund
CHMT	Council health management team
CHSB	Council health service board
DGC	Dispensary governing committee
DMO	District medical officer
DMT	Dispensary management team
FGD	Focus group discussion
HCGC	Health centre governing committee
HFC	Health Facility Committee
HGC	Hospital governing committee
HFGC	Health facility governing committee
HCMT	Health centre management team
HIV-AIDS	Human Immunodeficiency Virus – Acquired Immuno-deficiency Syndrome
HMT	Hospital management team
HP	Health providers
MOHSW	Ministry of Health and Social Welfare
MSD	Medical stores department
NGO	Non-governmental organisation
NHIF	National Health Insurance Fund
OPD	Outpatient department
PHSDP	Primary health service development programme
PMO-RALG	Prime Minister’s Office for Regional Autonomy and Local Government
RCH	Reproductive and child health
STI	Sexually transmitted infection

TOC	Trainers of community
TUKI	Timu ya uwezesaji ya kijiji
VGC	Village government committee
VHC	Village health committee
WDC	Ward development committee
WHC	Ward health committee

Executive summary

In Tanzania, health facility governing committees (HFGCs) were introduced at all levels of the health system as a mechanism for improving accountability between health care providers and communities. Health facility governing committee members have an official responsibility for community participation in the health system, improving quality of care, ensuring exemptions are respected, and mobilising resources from communities, such as in the case of the community health fund (CHF). Health facility governing committees typically consist of eight members and operate at the health facility level.

Despite their longstanding existence, little is known about how facility-level governing committees function or the extent of their impact on health service delivery. One of the challenges faced by these committees is a lack of clarity in terms of their official role and the extent and nature of their interaction with existing local government committees. Therefore, the aim of this study was to examine the pre-conditions for the effective functioning of the committees, both in terms of representing community voice and in improving health worker performance and resource mobilisation in relation to the Community Health Fund, a voluntary health insurance scheme over which the committees have some responsibility. The role of interpersonal and institutional trust among and between health facility governing committee members and other groups/committee in the community were also considered in the effective operation of health facility governing committees.

Methods

This project conducted detailed case study investigations of two selected dispensary governing committees, referred to as health facility governing committees: Kivukoni and Sofi Majiji in Ulanga district. As an initial step, both published and unpublished documents were reviewed to examine the available evidence regarding local accountability structures followed by a **rapid** appraisal of all 19 dispensary governing committees in Ulanga district to measure functionality. The indicators used to measure functionality were based on the degree of consistency of the actual structure and operation of committees compared to the national guidelines. These included the extent of gender representation, the transparency of the selection process for members, the frequency of committee meetings, and the consistency of member attendance at meetings. Following the rapid appraisal, two committees were selected for in-depth case study: a less functional and a well functioning committee, respectively.

Within each site, in-depth interviews were carried out with all health facility governing committee members, health workers, village leaders, village health committee members, prominent members of the local community, and members of the trainers of community (TOC) group, which is a non-governmental accountability structure. Focus group discussions (FGDs) were also carried out with community members from each site. The research team managed to attend the HFGC meeting in each site during the data collection period and some time was also spent observing health worker practices and the health facility context. At the facility level, the team assessed staffing levels, opening and closing hours, and the availability of equipment and key drugs and medical supplies. The condition of the buildings and the availability of posters and information sheets and a number of antenatal consultations

were also observed in each site. Interviews and focus group discussions were recorded, transcribed and then translated from Swahili to English. The translated data were imported into Nvivo 8 and analysed using thematic content analysis.

Results

The rapid appraisal revealed that all of the committees had at least one female member on the committee who was a community representative, and the majority of members (more than 70%) in 16 facilities were from the community, and were voted onto the committee. Also, less than 30% in 16 facilities were appointed (none elected) members. Fifty three percent of facilities (or eight) met monthly in accordance with the guidelines, and 47% (or seven) had at least 75% of the members present at the last three meetings, 40% (or six) had between 50-75% of all the members attending the last three meetings and 13% (or two) had less than 50% of all the members attending the last three meetings.

A composite score ranging from 1 to 3 of committee functionality was constructed based on the above indicators. Only five committees were considered to be well functioning, those with an average score of 2.5 and above. Six facilities had average functionality (a score of between 2.5 and 1.75), and four were less functional (scoring below 1.75). A less functional committee (Kivukoni) and a well functioning committee (Sofi Majiji) were selected for in-depth case study. Sofi Majiji was identified as a good performer based, among other things, on the frequency of meetings held and the highest number of Community Health Fund (CHF) members enrolled by the committee, which were 200 in 2009. In Kivukoni, meetings were less frequent, and CHF members were limited to 61 in 2009. Awareness of the committee roles was also greater among a larger number of stakeholders in Sofi Majiji than Kivukoni.

We set out in the first instance to measure the impact of the committees on health worker performance in terms of health worker availability in facilities, opening and closing hours, and dealing with problematic behaviour of health workers towards patients. The issue of opening and closing hours was addressed by both sites. In Sofi Majiji, there were posted signs to ensure patient awareness of official working hours, and in Kivukoni, arrangements were made to ensure staff presence outside of official working hours to deal with emergencies. Sofi Majiji also took steps to deal with health worker shortages by requesting a midwife from the district. No direct action was taken in relation to provider-patient behaviour, but steps were taken in both sites to deal with concerns regarding relations between the facility and the community more generally.

We also examined the impact of the committees on resource mobilisation in terms of how money was spent by the committees. In Kivukoni, the committee approached the district about drug shortages but no response was received. In Sofi Majiji, the committee approached the district about drug shortages and was encouraged to use CHF money to purchase more drugs. Efforts to mobilise communities to join the CHF were mostly undertaken by health care providers in both sites. In Sofi Majiji, the committee also mobilised labour from the community for construction of the health facility and provider houses. They managed to levy funds from an NGO to support construction activities. In both sites, the committees managed to use user fee funds to finance small expenses at the facility, with Sofi Majiji also managing to

use CHF money to buy drugs. Generally, however, the committees were limited in their availability to decide how to spend user fee and CHF revenue.

In order to understand the reasons for greater impact in Sofji Majiji compared to Kivukoni we analysed relationships within committees and among committee members and other stakeholders in the community to identify potential differences, and specifically, to assess the role, if any, of trust in explaining differences in impact.

Overall, there was no evidence of distrust within the committee *in either site*, although trust might have been enhanced by *meeting away from the health facility*, to avoid potential bias towards provider interests during discussions. However, in Sofi Majij, the committee was more strongly mobilised due to its engagement in the facility construction activities which provided a role and *raison d'être* to the committee, uniting members and allowing them to become known by various actors in the community. Supervising the construction activities also provided the basis for most of the committee's discussions during the meetings, hence giving an agenda to the meetings. Meetings also happened more frequently as there was so much to discuss. Overseeing the construction activities provided a means for the committee to manage funds and develop responsibilities in line with their official terms of reference.

The relationship between the HFGC and the health providers was reported to be good *in both sites*. However, as currently structured, committees in both sites tended to largely reflect the interests of providers rather than communities, with the in-charges acting as a promoter of the interests of the dispensary management team and the health facility. Although the agenda for the meeting was developed jointly by the chairman and the in-charge, the in-charge would generally lead discussions, and meetings took place at the facility, making it more difficult for community concerns with the facility to be raised. The lack of representation of some of the villages on the Sofi Majiji HFGC, resulting from the phased implementation of the Primary Health Service Development Program (PHSDP) policy (often referred as Mpango wa Maendeleo ya Afya ya Msingi (MMAM) in Swahili), was felt to limit the committee's capacity to undertake resource mobilisation activities, although they were still very effective in this way.

The initial introduction of the Health Facility Governing Committee (HFGC) generated a certain amount of bad feeling among the village government in both sites. The HFGC was set up as an apolitical organ, operating independently of the elected village government, and was also seen to duplicate the role and activities of the village health committee, which was a political body formed from members of the village government. Further, village leaders also believed that members of the HFGC were paid allowances from the generated CHF funds, which resulted in further bad feeling, as the village government does not receive allowances. While the HFGC did receive allowances during the initial introductory meeting between the HFGC, the village government (VG) and the ward council, this practice subsequently discontinued.

However, this initial distrust was overridden in Sofi Majiji through the committee's responsibility for supervising the health facility construction activities, especially the management of funds associated

with the facility's construction. In this way, the committee managed to demonstrate their capacity for effective fund management and through their collaboration with the village government, to build trust.

Good relations with the village government were found to be essential to the effective operations of the committees, allowing them to serve as a bridge between the facility and the community. Indeed, only the village government had the authority to mobilise people to attend village meetings. Other groups, such as the HFGC, needed local government approval and support to access community members. Therefore, the HFGC was never able to arrange or hold a meeting with the community purely to discuss issues related to the health facility. The agenda of the HFGC had instead to be fitted into a broader village meeting agenda.

The communities in both sites were generally wary of the HFGC due to a broader distrust of government structures and a distrust of providers which also extended to the HFGC. Although HFGCs are in principle established to act as a linkage between the health system and the community, in practice, our findings suggest that the relationship between the HFGC and the community is less significant in determining impact because of the way the committees are embedded within the government system.

The impact of the Sofi Majiji HFGC was also facilitated by its good relations with the district. Indeed, the committee was well known at district level for its success in mobilising CHF contributions, resulting in interpersonal trust. This familiarity, combined with the personality of the in-charge and his established clinical reputation, made the HFGC more willing to report its problems to the district, and the district, in turn, was more willing to respond and provide assistance.

Recommendations

Strengthening the internal functioning of the committee

Training/Capacity Building

There is an urgent need for more rigorous capacity building of HFGCs on their roles as well as their expected relationships with other committees. In addition, it is necessary to suggest ways of engaging these committees in collaborative action that will build interpersonal and institutional trust. Possibly, members of the village health committee and neighboring NGOS might be included in the training. This would serve to foster stronger links among the different groups as well as a shared understanding of respective roles and responsibilities.

- The training/capacity building of the HFGC has to go hand-in-hand with empowering members to be creative in identifying ways to generate funds from government and non-governmental structures for supporting the needs of the health facility.
- There is also a need to identify effective methods of resource mobilisation among the community, especially in relation to the CHF.

Supervision

Training has to consider regular supervision of HFGCs from the district level, which is vital, especially in overseeing the selection process of committee members, ensuring appropriate fund management, and offering advice in relation to resource mobilisation strategies. Such supervision should also examine the communication strategy adopted by the HFGC with regards to the community, and the extent of interactions with other committees, for example.

Care is needed when introducing allowances to ensure that they do not generate distrust among other key players in the community. Allowances might be tied to specific activities, which could involve a broader range of stakeholders, such as mobilisation of the CHF. The allowances could then be paid to all of those who contribute to resource mobilisation, rather than being tied to the HFGC. This might serve to motivate greater mobilisation activities and to encourage a broader range of stakeholders to get involved.

Building trust with other structures

- There is a need to build trust between the HFGC and the village government, as the village government provides access to the community, and can elicit community 'buy in' to various initiatives, such as contributions to the CHF.
- This could be done by involving the village government in the training activities and encourage joint ventures between the HFGC and the village government. However, such ventures need either to be ongoing (such as construction work) or repeated (such as mobilisation of CHF contributions). One-off activities are not sufficient to build trust. Facility construction work is an important opportunity to build on as it not only allows for the development of relations between the HFGC and the village government, but also provides the HFGC with the means of managing resources, which is both empowering and motivating.
- According to the guidelines, a member of the village government should be a member of the HFGC. The village government should be encouraged to ensure that the chairman of the village health committee is included as a member of the HFGC.
- Creativity is needed in identifying more effective ways of communicating with the community and other structures, to improve community trust and encourage engagement with the committee.
- It is important to ensure that the community understands the concept of risk pooling, especially that their CHF contributions will go into a larger pool to finance the care of the community, and that they will not be reimbursed if they do not use services.

Strengthening 'community voice' within HFGCs

It is important to ensure greater neutrality in the conduct of meetings and the interests discussed, possibly ensuring greater representation of community interests. However, this may negatively affect participation by the in-charge given their other responsibilities at the facility and time constraints. Ideally, the venue should not be too far from the facility. Alternatively, the community members on the committee might meet separately within the community and report back their decisions or suggestions to the committee.

- Greater sensitisation is needed for the community to understand the role of the HFGC in representing their needs to the facility, and encourage them to raise their concerns and issues.
- Ideally such sensitisation might be carried out by an independent community-based organisation (an NGO, religious leader, women's group, etc.)
- The village government and ward development committee need to ensure that those eligible for representation on the committee are those using the facility, and hence, so long as a village uses a dispensary in a neighboring village, they should be eligible for representation on the committee.

1. INTRODUCTION

Despite the acknowledged importance of good health service delivery in achieving health outcomes, especially for poorer groups, delivery systems in lower income countries suffer from multiple weaknesses (Gilson et al., 2007). Health worker performance is often poor (WHO, 2006), patients face financial barriers to access, often incurring costs, even in systems that are officially free (Whitehead et al. 2001; Xu et al. 2003). Often patients are unaware of their rights or feel disempowered to challenge practises that might seem unfair (Freedman, 2007).

The need to emphasise and strengthen health system accountability in order to improve service delivery has been acknowledged (World Bank, 2003). Accountability is essentially about answerability, involving an obligation, supported by sanctions, at least to explain and answer questions (Brinkerhoff, 2001). It is relevant both to relationships within the state and between the state and citizens. In many countries, health facility governing committees have been introduced as a mechanism for improving accountability between health care providers and communities. Their role is typically to oversee quality of care at the facility, and often also to mobilise resources from communities to finance health care services, and ensure transparency in the way funds are used.

In Tanzania, health facility governing committees were first introduced under the Local Government Act of 1982, linked to the Alma Ata Declaration (1978). Health facility governing committee members have an official responsibility towards community participation in the health system, improving quality of care, ensuring exemptions are respected, and mobilising resources from communities, such as in the case of the community health fund (CHF). Health facility governing committees (HFGCs) typically consist of eight members and operate at the health facility level. Although there is little evidence regarding the effectiveness of facility level accountability structures, district-level accountability structures within Tanzania have been found to not be functioning effectively (Kessy, 2008) (Joint Annual Health Sector Review 2005). A study conducted in 2007 in six Tanzanian districts found that only one district council had a properly functioning board (United Republic of Tanzania, 2007).

Despite their longstanding existence, little is known about how facility-level committees function or the extent of their impact on health service delivery. One of the challenges faced by these committees is a lack of clarity in terms of their official role and the extent and nature of their interaction with existing local government committees.

Rationale

The central aim of this study was to generate better understanding of how health facility governing committees operate in Tanzania. This included an exploration of the pre-conditions for the effective functioning of these committees, both in terms of representing the community voice and in improving health worker performance and resource mobilisation in relation to the Community Health Fund, a voluntary health insurance scheme over which the committees have some responsibility. Through this

process, we also considered the role of interpersonal and institutional trust among and between health facility governing committee members and other groups/committees in the community in the effective operation of health facility governing committees. The focus on trust in relation to local level accountability structures was relevant because theory suggests that performance, accountability and trust are inter-linked. Trust enables collective action: it enables people to work together, to tackle joint projects. Trust would therefore seem to be relevant to the functioning of committees where different people are brought together and are required to interact with one another and with other structures in the community. It is hoped that the information generated by this research can be used to increase the effectiveness of health facility governing committees in rural Tanzania.

Definition of Key Concepts

Our intention was to explore the impact of health facility governing committees in terms of the nature of decisions taken, the extent to which they attempt to follow through on decisions made, and finally, the actual changes they manage to bring about in terms of health services. The key areas of impact considered in this study were health worker performance and the use and mobilisation of resources.

With regard to health worker performance, the focus was on the following impacts:

- Health worker presence and availability in facilities (official and actual staffing levels);
- Time keeping by health workers and the opening and closing times of facilities; and,
- Steps taken in relation to problematic health worker behaviour towards patients.

With regard to the use and mobilisation of resources, the focus was on the following impacts:

- The nature of activities/inputs for which resources are requested;
- The management of Community Health Fund (CHF) funds;
- Equipment availability within facilities and the state of infrastructure; and,
- CHF enrolment rates within the facility, as HFGCs are responsible for encouraging community members to join the CHF.

We also examined the role of trust in the functioning of health facility governing committees and health facilities, and the relationships between committees, community members, health providers and other committees within the community. Trust was defined as:

- *Interpersonal trust*: respectful treatment; personal knowledge of each other.
- *Institutional trust*
 - Integrity: transparent rules (roles, expectations, decision-making procedures, conflict resolution); consistent procedures (meet regularly, consistent attendance over time, regular reporting on discussions and actions taken); fair and impartial decision-making (absence of bias in procedures, consideration of all sides).

- Benevolence: inclusive procedures (allow voice to all community groups, procedures to prevent domination by particular actors)
- Competence: sanctions for rule-breaking; seen to achieve fair results i.e. determination & implementation of collective agreements in mutual interest

Structure of Report

This report begins by presenting background information on the various accountability structures in Tanzania, and then proceeds to outline the study methods and the main findings from the research.

2. BACKGROUND TO ACCOUNTABILITY STRUCTURES IN TANZANIA

Health System Structure

Within central government, the Ministry of Health and Social Welfare (MOHSW) defines policies, develops appropriate guidelines and is responsible for preventive services, drug supply, donor coordination, the overall health budget, human resources planning and quality assurance. Since decentralisation by devolution in 1998, local government structures have come under the responsibility of the Prime Minister's Office for Regional Administration and Local Government (PMO-RALG). The PMO-RALG is responsible for implementing health (and all other) policies and services at district and lower levels and is based in Dodoma. Districts make annual plans and budgets and are responsible for resource allocation and financial management within the district.

The structure of the health system in Tanzania follows the administrative structure of the country and is split into six levels: zones; regions; four to five districts per region; divisions; wards; and villages. The public network of providers includes referral (tertiary) hospitals at the zone level (one per zone), secondary hospitals at the regional level, district hospitals at the district level, and health centres and dispensaries at the ward and village levels. Often there is no health centre at the ward level, only dispensaries. Although located at the village level within Figure 1, dispensaries often serve more than one village and in some cases, there may be only one dispensary per ward. There may be between two and ten villages per ward.

District Level Funding Sources for Health

The main sources of finance available to districts include development assistance partners working in the health sector, whose funding is channelled through a pooled fund (known as the basket) which is disbursed to district councils against their health plans and budgets. Districts also receive government funds in the form of block grants from the PMO-RALG.

Cost-sharing, in the form of user fees, was introduced in the public health sector in 1993, initially for hospital services only, and now covers all public facilities. User fee revenue is collected at facility level, and, for primary level facilities, it is sent back to the district where it is held in accounts and disbursed

against facility plans and budgets. In contrast, hospitals keep revenues in their own accounts and can use them at their own discretion.

The CHF was introduced nationally from 2001, and operates as a voluntary pre-paid health insurance scheme for rural households, who pay between 5000-10,000 TSH per year and, in return, receive free care at primary level public health facilities. Central government provides a matching grant for all membership contributions. CHF and matching grant funds constitute an additional source of funds at the district level. Contributions are collected by the officer in-charge of the facility and regularly deposited into an account along with user fee revenue, with this money being held by the district council.

The National Health Insurance Fund (NHIF), a parastatal organisation responsible to the Ministry of Health, is a compulsory health insurance scheme for public servants, their spouses, and a maximum of four dependents per member. The NHIF was introduced in 2001. District level health facilities are reimbursed on a fee-for-service basis for services provided to NHIF members. Hence, NHIF funds constitute an additional funding source available to facilities and districts across the entire country.

Accountability Structures

In relation to health, at the district level and below, there are a number of institutions with responsibility for planning and budgeting for health services and managing and raising resources to ensure the availability of health services to the population. Hereafter, these institutions are referred to as ‘financial management and planning structures,’ as they are effectively responsible for financial management and accountability related to health service delivery, and they oversee the use of the various sources of funds outlined above. At the district level, the structure is the Council Health Service Board (CHSB), which oversees a range of institutions at the facility level: hospital governing committees (HGCs) at hospital level; health centre governing committees (HCGCs) at health centre level; and dispensary governing committees (DGCs) at dispensary level (United Republic of Tanzania, 2001) (Figure 1). These institutions also have responsibility for mobilising contributions to the CHF, as well as for planning how to use CHF and user fee revenue, and reporting back to communities on financial management.

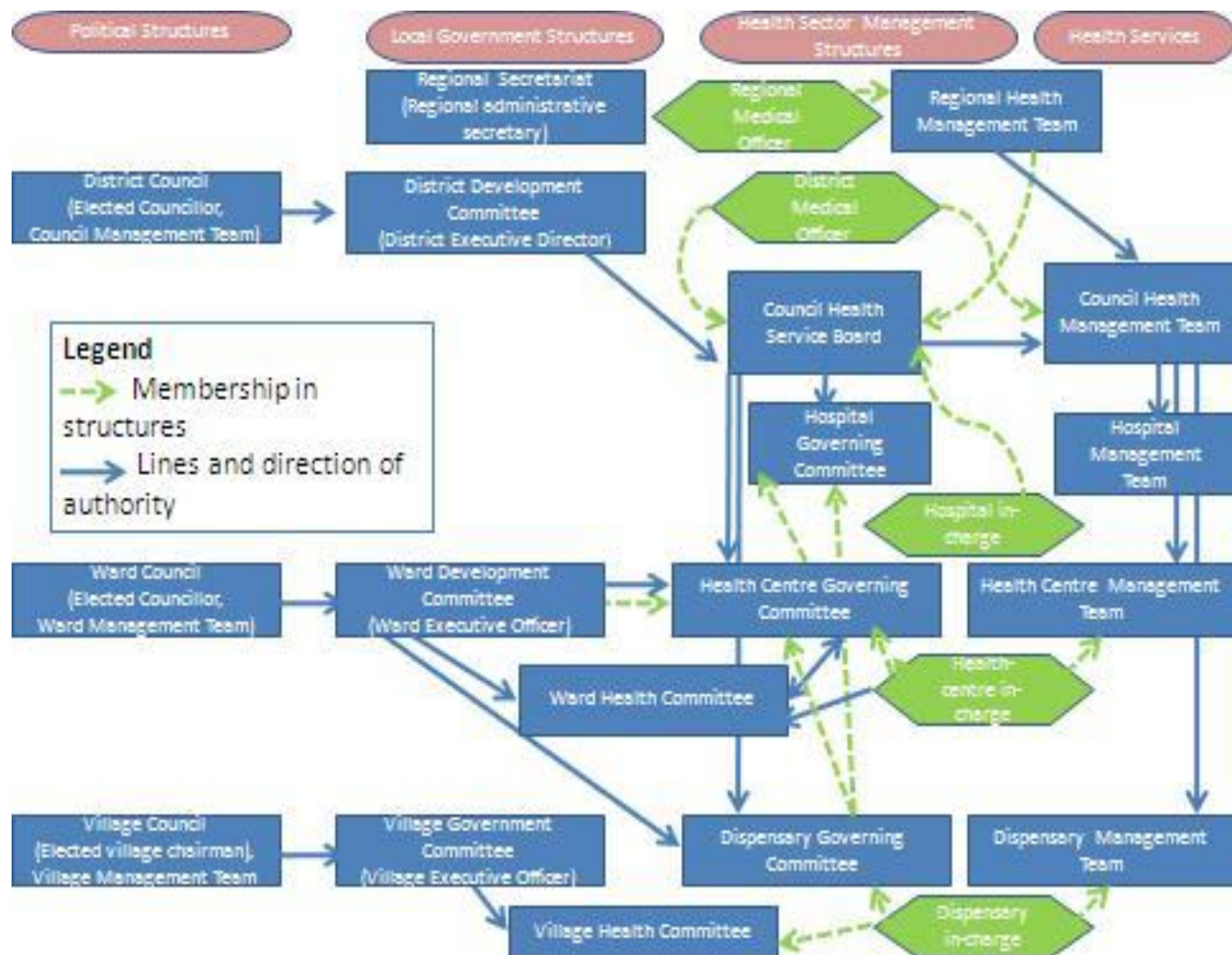
Each of these institutions is constituted by community members, facility in-charges and members of other agencies working in health within the specific geographical area. These institutions are directly responsible to the government structures at each level (e.g. the CHSB is responsible to the district council; the HCGC and DGC are responsible to the ward development committee (WDC)). The community members who are part of these institutions are nominated in each case by the local government structure (district council, for CHSB, ward development committee for HCGC and DGC) and subsequently voted by community members. However, they should not hold political posts, ensuring their political neutrality. Two representatives from the WDC or the village government plus the health facility in-charge should also be members of the HCGCs and DGCs respectively.

There are also a number of additional government structures at ward and village levels responsible for fund mobilisation for health, including mobilising CHF contributions, managing user fee revenues, and

coordinating community plans. These are the ward health committee (WHC) and the village health committee (VHC). These bodies are formed as sub-components of the ward development and village government committees. The ward councillors and village chairman are members of these committees and hence, these are political bodies. The facility in-charge is typically a member of the WHC and VHC and would act as the secretary of the committee. However, there are no clear lines of authority or channels for communication between the HCGCs and WHCs and DGCs and VHCs respectively, despite significant overlap in roles and responsibilities.

There are also a number of institutional bodies charged with overseeing the implementation of activities planned by the CHSB in relation to service delivery within the district. Hereafter, these bodies are referred to as 'implementation structures' and they are responsible for monitoring and supervising health facilities within their district. These institutions include the Council Health Management Team (CHMT) at district level, which in turn oversees hospital management teams (HMTs), health centre management teams (HCMTs) and dispensary management teams (DMTs), which are responsible for the day-to-day running of health facilities. Whilst the CHMT is responsible to the CHSB, there are no clear lines of authority between the HMT and HGC, the HCMT and the HCGC and the DMT and the DGC. However, there are linkages between these structures as in each case there is at least one member of the financial management and planning structure that is also a member of the implementation structure. In all cases, these are medical personnel: the district medical officer (in the case of the CHSB and the CHMT); the hospital in-charge (in the case of the HMT and HGC); the health centre in-charge (in the case of the HCMT and HCGC); and the dispensary in-charge (in the case of the DMT and DGC). At district level, data on CHF enrolment and revenue generated from CHF contributions is compiled and managed by a CHF coordinator who is a member of the Council Health Management Team. The CHF coordinator is typically either a health provider or involved in health administration at the district hospital.

Figure 1 Overview of Local Level Accountability Structures within the Health System in Tanzania



3. METHODS

This project conducted detailed case study investigations of two selected dispensary governing committees, hereafter referred to as health facility governing committees: Kivukoni and Sofi Majiji in Ulunga district. Ulunga is a rural district located within the centre of the country in Morogoro region. Ulunga was selected as it was one of the sites of a health system strengthening project called Empower. The Empower project was also undertaking research on health facility governing committees and the Empower team facilitated our entry to the field and assisted us with undertaking a rapid appraisal of health facility governing committee functionality.

The investigation started with a rapid appraisal of all 19 dispensary governing committees in the district at dispensary level. The indicators used to measure functionality were based on the degree of consistency of the actual structure and operation of committees compared to the national guidelines.

These included the extent of gender representation, the transparency of the selection process for members, the frequency of the committee meetings, and the consistency of member attendance at meetings. For each of the above functionality indicators, a scoring system was developed to rank committees in terms of their level of functionality (Appendix 1). Committees were able to score a maximum of 3 points and a minimum of 0. The information was collected through interviews with the facility in-charge at each location. This information was validated by comparing the information provided against minutes of meetings, where available.

Following the rapid appraisal of all dispensary governing committees, two health facility governing committees were selected as case studies for detailed investigation. One health facility governing committee was selected because it was relatively well-functioning (Sofi Majiji) and the other because it was less well-functioning (Kivukoni). There were two possible choices of poor performers (with the same score) and five possible good performers. The other factor influencing our choice of site was the number of current CHF members, and geographical accessibility, as data were collected during the rainy season. A well functioning committee was expected to have a higher number of CHF members compared to other facilities, given the committee's role in mobilising people to join the CHF. Care was taken to ensure that the poor performing committee selected would have at least a minimal level of functionality. The rapid appraisal was followed by a phase of in-depth case study work. In this in-depth phase of work, one month was spent in each of the selected sites. The data collection methods included document reviews, in-depth interviews and focus groups.

Data Collection

Data collection in Kivukoni took place between 27 March and 20 April 2009. Data collection in Sofi Majiji took place between 31 July and 24 August 2009. Data were collected by two female social scientists.

In-depth Interviews

In-depth interviews were carried out with all health facility governing committee members, health workers, village leaders, village health committee members, prominent members of the local community, and members of the trainers of community (TOC) group, which is a non-government accountability structure. The TOC group is constituted by volunteers from the community, working for the village government, who provide education about HIV/AIDS to their peers. They also register orphans with the village government. The prominent members of the community were identified through discussions with village leaders and community members. Those people mentioned most frequently by different groups as being community leaders were also selected for interviews. The interviews covered, among other things, awareness of the health facility governing committees and their roles, the functioning of the committees (including the role of trust), the strengths and weaknesses of the committees, and their perceived impact on health service delivery and resource generation for the CHF. All the interviews were tape recorded. A total of 20 in-depth interviews were carried out in Kivukoni and 21 in Sofi Majiji, as indicated in Table 1.

Table 1 Overview of in-depth interviews carried out by site

In-depth interviews in Kivukoni	In-depth interviews in Sofi Majiji
7 Health Facility Governing Committee Members ¹	5 Health Facility Governing Committee Members ²
4 Health workers ³	5 Health workers
2 Village leaders (1 from Kivukoni village and 1 from Minepa village) ⁴	3 Village leaders (1 from Sofi Mission, 1 from Majiji village and 1 from Kiswago village)
2 Trainers of Community (TOC) ⁵ (1 from Kivukoni village and 1 from Minepa village)	3 Trainers Of Community (TOC) (1 from Sofi Mission, 1 Majiji and 1 from Kiswago)
3 Village health committee members (2 from Kivukoni village and 1 from Minepa village)	3 Village health committee members (1 from Sofi Mission, 1 Majiji and 1 from Kiswago)
1 Islamic religious leader (Sheik) ⁶ – at ward level	1 Islamic religious leader (Sheik) – at ward level
1 Parish priest- at ward level	1 Parish priest - at ward level

Interviews were also conducted with key stakeholders at the district level, including the district medical officer (DMO), the district CHF coordinator and the district hospital in-charge. These interviews took place during an initial visit to gather background information on the district context and the committees within the district.

Focus Group Discussions

Focus group discussions (FGDs) were also carried out with community members from each site. Two FGDs were conducted in each village served by the health facility, one with men and one with women. Members of the community were selected with the help of the village leader, with the added condition that at least one member from each hamlet in the village participated. Most of the focus group discussions were conducted in venues such as primary schools, ward offices and health facilities. The questions covered issues such as the links between the community and the health facility governing committee, the degree of transparency on fund use at the facility level, and the perceived impact of the committee on health service delivery.

Observations

¹ The interview with one health facility governing committee member was stopped because the respondent seemed to be drunk and it was difficult to understand him. Due to the nature of his business (selling local alcohol) it was not possible to interview him again.

² The health facility in-charge in both sites was interviewed as a provider and committee member, and one nurse attendant was interviewed twice in Sofi Majini, both as health provider and a committee member.

³ Two health providers were not interviewed in both sites because they were new to the facility.

⁴ The Minepa village leader was interviewed both as a village leader as well as a health facility governing committee member.

⁵ Trainers of Community (TOC) are groups of young people who train/educate the community in different health issues, mainly focusing of HIV/AIDS. These groups are under the village government. It was founded by SolidarMed, which is a non government organisation that supported the initial formation of the group.

⁶ Sheik, a senior official in an Islamic religious organization.

The research team attended an HFGC meeting in each site during the data collection period. The team was not able to obtain the minutes of the HFGC meetings that they attended, but managed to obtain minutes for the previous three meetings: two conducted in 2008 and one in January 2009. The minutes indicated how many members participated in the meeting, along with the agenda discussed and the actions taken by the committees on problems identified. The minutes from the January 2009 meeting included revenue and expenditure information.

Some time was also spent observing health worker practices and the health facility context. At the facility level, the team assessed staffing levels, opening and closing hours, and the availability of equipment, key drugs and medical supplies. The team also observed the condition of the buildings and the availability of posters and information sheets. The number of antenatal consultations was also observed in each site. During the consultations, the focus was on provider behaviour towards patients (language used, the position of the provider in relation to the patient, the number of questions asked, whether or not a patient was examined), and patient behaviour towards the provider (demonstration of physical/mental comfort, based on body language and dialogue). The aim was to assess the degree of trust between providers and community members. Finally, a community village meeting was also attended in each site.

Document Review

At the national level, we reviewed the guidelines for the formation of the various health-related structures at district level and below (United Republic of Tanzania, 2001, 2007; Joint Annual Health Sector Review 2005, Health sector strategic plan III, 2008). Published and unpublished literature on the role of health facility governing committees and other mechanisms for promoting local level accountability within the health system were also reviewed (Kessy, 2008). In the selected facilities, CHF membership cards were reviewed to assess the number of current members and changes in enrolment rates over time.

Data analysis and presentation

Interviews and focus group discussions were recorded, transcribed and then translated from Swahili to English. The translated data were imported into Nvivo 8 and analysed using thematic content analysis. Five interviews were initially coded in parallel by two research scientists. Through this process, a code book was agreed upon and used to code the remaining data. There was the scope for themes, for example, on the general factors influencing the functioning of health facility governing committees, to emerge in an open and grounded way. The validation of findings was achieved by triangulating data across respondent groups and by looking for documentary evidence, where available, to further validate findings. Analyses were undertaken on an on-going basis during the study, as transcripts and other information from the case study sites became available.

Rapid Appraisal

This section presents the results of the rapid appraisal to assess the level of functionality of all public dispensaries in Ulanga district and to assist in the selection of the case study sites. As mentioned above, the aspects of functionality examined during the appraisal were: the composition of the committees; the transparency of the selection process for members; the frequency of the committee meetings; and the consistency of member attendance at meetings.

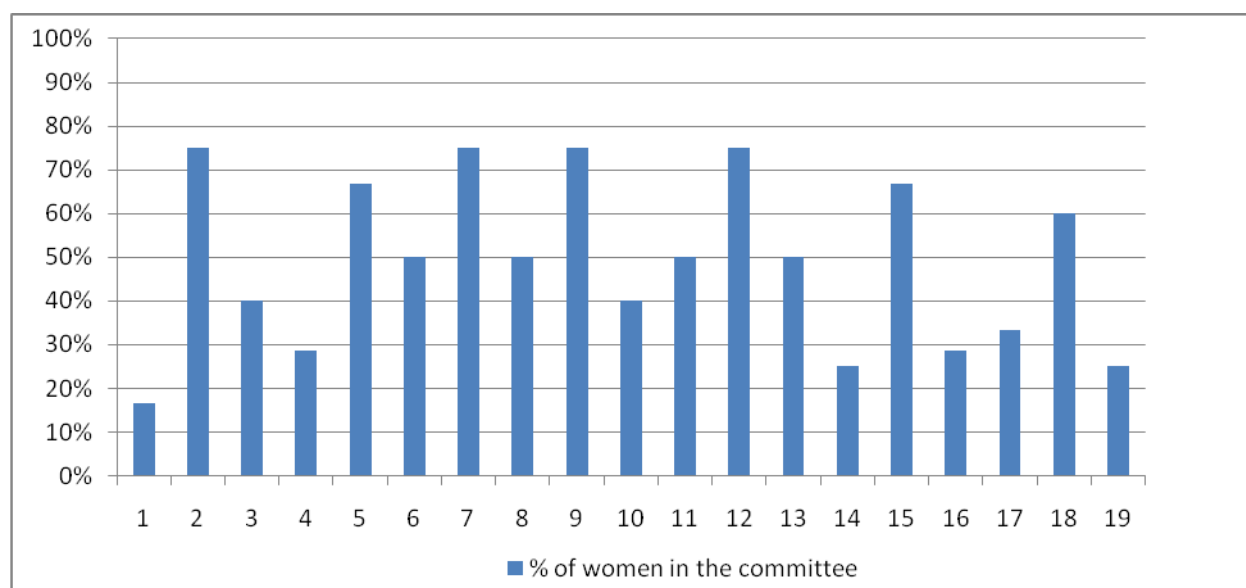
There were 19 dispensaries across the district. All of the dispensary committees were in their second phase of implementation, which started in most cases in 2007, although one began in 2006 and two in 2008. Officially, committees are supposed to have eight members: five elected members of the community and three appointed members from the government and health providers. Out of the five elected members, three are supposed to be representatives from the community without political affiliations, with at least one female member, and two are supposed to be elected representatives from dispensaries in the area (including private for profit and private not for profit facilities). Appointed members include a representative from the WDC, from the village government, and the health facility in-charge.

The rapid appraisal revealed that the majority of the community members in the committees were farmers and in 11 out of 19 (57.8%) dispensaries there were also professionals, including parish priests, pastors, business men and health officers. In 4/19 (21%) of surveyed facilities, the members included a village chairperson or a village executive officer/ward executive officer, or both these types of official; however, it was not clear whether they were elected as community representatives or not.

Composition of committee members

All of the committees had at least one female member on the committee who was a community representative, consistent with the guidelines. However, women acted as chairperson of the committee in only 6 out of the 19 committees. Furthermore, few of the appointed members were women (for example, in only one of the committees was the in-charge a woman). Women and men from the community had an equal right to become chairs of the committee or to hold any formal position within the committee after being selected by the community.

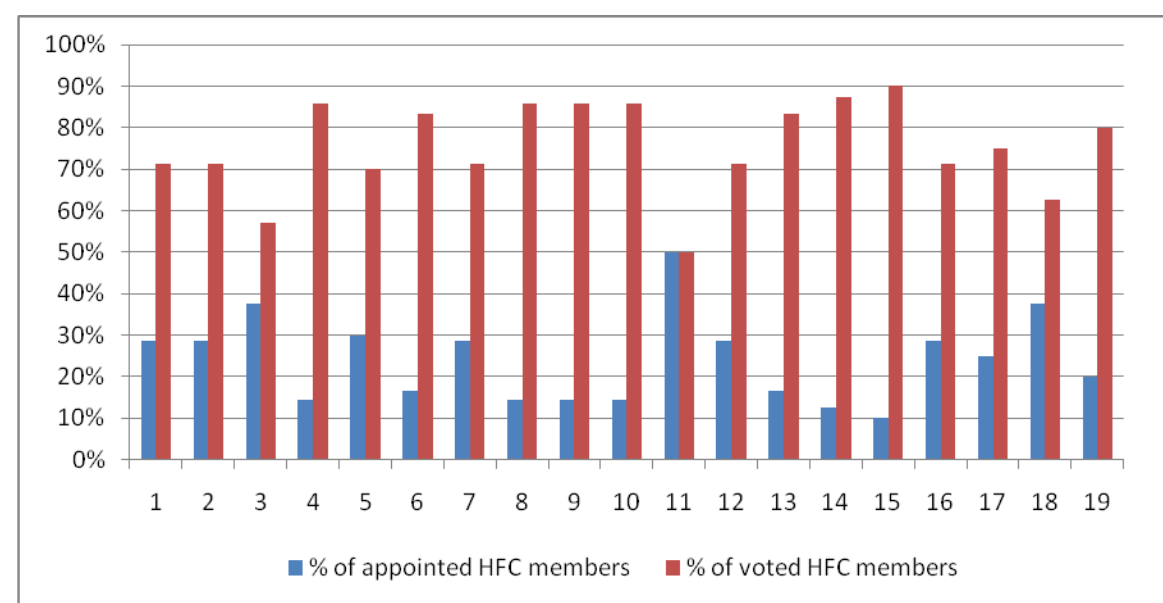
Figure 2 Proportion of female members in HFGC's at public dispensaries in Ulanga



Transparency of selection process for members

According to the guidelines, representatives from the community are supposed to be shortlisted by the ward development committee and voted onto the committee by the community. The other members of the committee (the facility in-charge and members of NGOs) are appointed. This criterion was met by all committees in Ulanga district. Indeed, the majority of members (more than 70%) were from the community, and were voted onto the committee, and less than 30% were appointed members (Figure 3).Figure 3

Figure 3 Proportion of members appointed compared to those voted



Frequency and structure of meetings

According to the guidelines, meetings are supposed to take place four times per year. In practice, out of the 15 facilities that responded to the question, eight (53.3%) met this frequently, with the remainder meeting less often (one – two times). Facilities reported that, in line with the guidelines, the chairperson and the secretary are the ones responsible for calling meetings, with the chairman leading the meetings. The dispensary, and more specifically, the health facility in-charge's office, or dispensary hall, if any, were the places where meetings were generally conducted (Table 2). Although all committees reported that the committee secretary kept minutes of the meetings, they could not be obtained by the team.

Table 2 Structure and location of meetings – frequency of responses

	Chairperson	Secretary	Other Member	Both chair/ Secretary
Who calls the meeting?	10	7	0	2
Who leads the meetings?	18	1	0	0
Who keeps the minutes?	0	15	0	2
	Dispensary	Secretary's home	Chairperson's home	
Where do the meetings take place?	19	0	0	

Consistency of member participation at meetings and underlying causes for inconsistency

Out of the 15 committees that responded to the question of consistency of participation of members, seven (47%) had at least 75% of all the members present at the last three meetings, six (40%) had between 50-75% of all the members in attendance at the last three meetings and two (13%) had less than 50% of all the members attending the last three meetings.

Out of 19 facility in-charges, 16 (84.2%) reported at least one challenge leading to poor attendance and poor adherence to the meeting timetable. Lack of allowances was most frequently reported to be a key challenge. Limited availability of members, organisational challenges and a lack of meeting structure were also frequently mentioned. Three of the nine factors mentioned were only raised by one committee (Table 3).

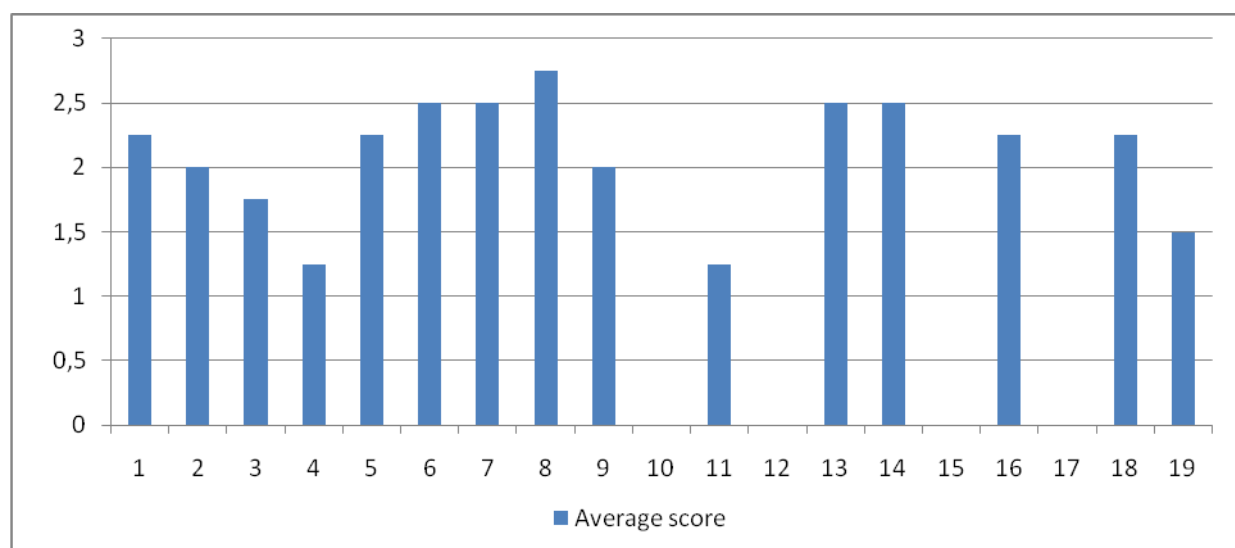
Table 3 Reasons for lack of consistency in the people attending meetings

Challenges	Frequency of Responses
Lack of allowances	8
Poor participation of the members due to daily duties	4
Limited awareness of how to perform roles (poor knowledge of roles)	2
Distance from the village to the health facility, or difficulty accessing meeting place due to rain	2
Lack of agenda for the meeting - difficulty knowing what to discuss during meetings	2
Sickness, transfer or death of members	2
Lack of education of committee members	1
Poor communication channels among committee members to inform about meetings	1
Meeting date coincides with the date of the village meeting	1

Overall functionality scores

A composite score of the five core indicators was compiled to measure the overall functionality level of each facility committee. Only five committees were considered to be well functioning, those with an average score of 2.5 and above (Figure 4). Those considered to have average functioning were with a score of between 2.5 and 1.75, and the less functional committees were those scoring below 1.75. A well functioning and less well functioning committee were selected for in-depth case study based on the scoring system and other criteria mentioned above.

Figure 4 Average functionality score by committee (maximum score = 3)



Out of 19 dispensaries, only one was not able to provide information on the number of CHF members. On average, the number of CHF members was 76 in 2008. Sofi Majiji had the highest number of CHF members (200), and Mahenge had the lowest number (15) of CHF members. Out of 18 dispensary

committees providing information, 10 had requested CHF money from the district and budgeted for the money. Thus far, none had received money from the district.

Case Study Sites

Community History

In 1975, both the Kivukoni and Sofi Majiji villages were formally registered as villages. This was part of the national 'villagisation policy' which influenced the formation of villages across the whole country. Social services were also allocated within these villages such as schools, health facilities, village government offices and the like.

In the early years after the formation of the villages in 1975, wealthy and powerful clans were ruling the community. For instance, in Sofi Majiji, the Majiji clan took the top positions in the government administration. In Kivukoni, there were many powerful clans, so the administrative positions were taken by people from a range of different clans. The name Sofi Majiji was the name attributed to the area ruled by the Majiji clan before the formation of the village. However, in Kivukoni, the area was known as 'limaumau' before registration and this name was a result of one elder who used to call beautiful women 'limaumau' (meaning beautiful woman). However, after registration, the village was named Kivukoni. The reasons for the change were unknown.

Traditional and modern leadership

Previously, the elders in both sites were considered as leaders, advisers, and people with the final say on issues related to the customs and traditions in the community. In cases of drought, famine and conflict, the elders were responsible for finding solutions for the community. There are still traditional rituals that are carried out by the elders in parallel to government initiatives. For instance, in early 2009 in both sites, many people experienced hardship due to hunger, so the elders conducted rituals to bring rain so that people could restore their harvest. At the same time, the government distributed free fertilizer to the community.

There were some claims that traditional rules and regulations were being destroyed by government and were also affected by the arrival of new people through migration, bringing different cultures and traditions.

"Our traditional rules and practices are now destroyed by the social styles emerging as a result of migration and politics and this is why our tradition doesn't go well" (FGD, men group, Kivukoni site)

Previously, only the elders were allowed to go to spiritual places to conduct the rituals and pray. Community members reported that youth no longer respect traditional values and that life has become

more individualistic when compared to the lives led by the earlier generations. In both sites, respondents mentioned that community members used to volunteer for activities free of charge, but that people now shy away from such voluntary work.

In parallel to the traditional leadership, the political system in both sites follows the national standard, as presented in Figure 1 above. There are leaders who are selected by the community, such as the village chairpersons and the 25-person village council.

Community organisations and structures related to health

In addition to the official structures outlined earlier, there were a number of additional health-related groups or associations found in both sites. These include trainers of the community (TOC), Timu ya uwezesaji ya kijiji (TUKI)⁷, and HIV/AIDS committees.

The TOC group works with drummers to communicate their messages to the community through music and dance/theatre. The names and roles of the members are posted at the village government offices. The village government also relies on the TOC group to provide entertainment with their drums whenever they have sensitisation activities or village meetings. The members of the group meet every month, together with the drummers. The TOC has been effective in encouraging the community to avoid risky behaviours that might result in HIV infection and other sexually transmitted infections (STIs).

“We see that there are some changes in this community ...even when you sit with a person and tell him about HIV/AIDS the person can understand what you are saying and you can discuss it and he can ask you questions. But in the beginning it was very difficult and they used to run away when they saw us” (TOC member, Kivukoni site)

The idea for the TOC was originally put forward by SolidarMed. SolidarMed is a Swiss association which aims to promote the development, improvement and long-term security of primary health care. SolidarMed has organised two workshops and provided training on how the TOC can begin income generating activities to finance their sensitisation activities.

HIV/AIDS committee

The HIV/AIDS committee is formed by appointed village council members and all the hamlet chairpersons in the village. The research team found that there were not less than 10 members in the committee. There was evidence that the HIV/AIDS committee was working hand-in-hand with the TOC group, especially on sensitisation activities.

⁷ In English, this means ‘Empowering team of the village’.

TUKI

The TUKI committee is entirely formed by people from the community. The members are selected by the community after sending an application letter for TUKI committee membership to the village government. The aim of the committee is to inform people about income generating activities and to warn against corruption. They meet every month and their roles and activities are posted on the wall at the village government offices.

Ward Health Committee

The ward health committee (WHC) includes most of the members of the ward development committee, is chaired by the ward councillor, and the secretary of the committee is the health facility in-charge. The committee appeared to be largely inactive in the two study sites. There was also confusion from the community about the difference between the WHC, the Village Health Committee (discussed below) and the HFGC, which are also indicative of a lack of community sensitisation to particular structures.

Village Health Committee

The village health committee is one of several committees that together comprise the social welfare committee of the village. It was reported in both sites that, initially, the health facility in-charges were the secretaries of the village health committees (VHC). However, later, the in-charges were relieved of their roles and village health workers were appointed by the village government as the secretaries of the committees. There was no evidence on the reasons for these changes in either site. Village health workers are also responsible for assisting health providers during the vaccination clinic.

In theory, this committee is supposed to collaborate with the health facility governing committee to mobilise community contributions to the CHF. In practice, the main reported activities were carried out by the VHC and included sensitising the community about hygiene, encouraging the use of the dispensary, and undertaking vaccination campaigns.

Health Structures

The traditional healing systems were the same in both sites. Previously, before the emergence of the formal health sector, people used materials such as roots and tree leaves for healing. In some cases, it was the custom for the caretaker and the patient to go far away from home until the patient gets well. The traditional approach of healing was reported to be cheaper than the formal health system. Without cash, it is impossible to access health care at a health facility. This was felt to be a particular problem for pregnant women, in particular, ensuring the availability of money to be used during delivery.

“Nowadays labour is very difficult, but in the past there were no problems” (FGD, Men group, Kivukoni site)

Kivukoni (less performing committee)

Kivukoni dispensary serves two villages: Kivukoni and Minepa. In 2008, the dispensary served a population of 11,102. The population served included a variety of ethnic groups, including the Wasukuma and the Wapogoro people. The health facility has five health workers: a clinical officer who is the facility in-charge; a clinical officer who is the assistant facility in-charge; the in-charge of the Reproductive and Child Health (RCH) centre (a Nurse Midwife); and two nurse attendants (for dispensing, dressing, and providing injections). One of the nurse attendants stands in for the RCH in-charge in her absence. Dispensing, dressing and providing injections are also carried out by clinical officers and the RCH in-charge in the absence of the two nurse attendants.

The facility has two buildings (the outpatient department (OPD) and the RCH centre):

- The OPD has six rooms: two rooms for clinical officers, one dispensing room, two stores (one for medicines and another for facility equipment), and a dressing and injection room.
- The RCH centre has three rooms: a consultation room, a labour room with two partitions, and a ward which is also used for consultations and checkups.

Sofi Majiji (well performing committee)

The Sofi Majiji dispensary serves three villages: Sofi mission, Majiji and Kiswago. In 2009, the dispensary served a population of 11,412. The population served included a variety of ethnic groups, including the Wasukuma and the Wapogoro people.

The health facility has five health workers: a clinical officer who is the facility in-charge, the RCH in-charge (Nurse Midwife), two nurse attendants (for dispensing, dressing, and providing injections) and a health officer. As in Kivukoni, in the absence of the RCH in-charge, one of the nurse attendants has to take care of the clients. Dispensing, dressing and providing injections were also carried out by clinical officers and the RCH in-charge in the absence of the two nurse attendants.

The facility has one building. One part of the building is the outpatient department (OPD) and the other part the RCH centre:

- The OPD has four rooms: one for clinical officers, a dispensing room, and a dressing and injection room. The dressing room is used as a store, and so the injection room is also used for dressing. The health facility building is new and was opened in 2008.
- The RCH department has two rooms: a consultation room and a labour room. These two rooms are also used for consultation and checkups.

4. OVERVIEW OF THE HEALTH FACILITY GOVERNING COMMITTEES

Village Representation

The health facility governing committees (HFGCs) in both sites (Kivukoni⁸ and Sofi Majiji⁹) were formed in 2003 to supervise the CHF, which was introduced in the district in the same year, as a result of an order from the local government authority (the district council). The HFGC was comprised of health workers, community members, and NGO members. The community and NGO members are appointed for a three year period (referred to as a phase), after which they are re-selected. The first phase was from 2003 to 2006 and the second was from 2007 to the present.

At Kivukoni dispensary, the committee currently has representatives from Kivukoni and Minepa villages. However, previously it had representatives from all three villages: Kivukoni, Minepa and Mavimba. In the second phase that began in 2007, Mavimba village ceased to be represented by the committee as its members were seeking health care at Milola dispensary, which for most people was closer than Kivukoni dispensary. Thus, the people in Mavimba are now represented by the Milola HFGC. In Kivukoni, discussions were underway as to whether to construct a new dispensary in Minepa or to upgrade the Kivukoni dispensary to a health centre. This is in line with the national program of having a dispensary in each village as discussed below.

Similarly, in Sofi Majiji there were changes in the representation of the committee over time. Community members were initially selected from all three villages of Sofi Majiji ward: Majiji; Kiswago; and Sofi Mission. In the second phase (2007 to date), however, community members of the committee were selected only from Majiji village, where the initial and current dispensary is located. A new dispensary was constructed in Majiji village by the Majiji people and officially opened on 12 July 2008 as part of the primary health service development programme (PHSDP)¹⁰, which seeks to construct a dispensary in every village by 2012. To facilitate this initiative, the local government, through the district, is supposed to support 85% of the construction cost, with the community providing the remaining contributions in the form of manual labour. In Majiji village, for instance, the community members participated by providing sand, making bricks, and carrying water. The village government leader in Majiji decided that the members of the HFGC should come from the village that constructed the dispensary. However, at the time of the field work, only Majiji village had completed the construction of its dispensary, which continued to serve the entire ward. Kiswago village had already started the construction of its public dispensary, which was in the final stages of completion but not yet open. Sofi mission hadn't yet started the construction of its dispensary, but had drawn up plans. Villagers there were using the mission dispensary which mainly serves students at the missionary secondary school. The facility is closed when students are on holiday.

⁸ Kivukoni dispensary is the focal point of the study and considered to be the first case study site.

⁹ Sofi Majiji dispensary is the focal point of the study and considered to be the second case study site.

¹⁰ The overall objective of the program is to accelerate the provision of primary health care services for all by 2012. The main focus is on strengthening health systems, rehabilitation, human resource development, the referral system, increasing health sector financing and improving the provision of medicines, equipments and supplies.

“The first health committee decided that each village should have one representative but in this new committee all members come from this village (Majiji) because each village should have a dispensary and this new dispensary was built by the Majiji villagers. The other two villages (Kiswago and Sofi mission) didn’t take part in the construction of the dispensary” (HFGC member, Sofi Majiji site)

The following section describes the current and previous members of the HFGCs in both sites. Information on the previous members is incomplete.

Overview of HFGC Members

The current Kivukoni HFGC is made up of six members of the community and two¹¹ health providers (Table 4). There are currently five members of the Sofi Majiji HFGC: three community members and two health care providers. There were previously an additional two community members on the committee at Sofi Majiji; however, one resigned and became a member of TUKI, and the other moved to Dar es Salaam and had not participated in the HFGC meetings for quite some time before moving (Table 5). Although the community members are re-selected every three years, a number of them continued to be members during the second phase of the committee (three in Kivukoni and two in Sofi Majiji).

Over 60% of the members were male. They were between 30 and 64 years of age. Most of the members were farmers, although some also had other roles such as religious positions. The members all had a primary level education or higher.

¹¹ There are two clinical officers at the facility, working as a secretary for the HFGC. One is permanent and the other is assisting /acting as secretary. In most cases, they are working interchangeably.

Table 4 Overview of Kivukoni HFGC members

No.	Gender	Age	Education Level	Occupation	Status	Village	Mber 1	Mber 2
1	M	64	Secondary	Farmer, retired vet, catholic parish chairperson	Chair	K	Y	Y
2	M		Primary	Farmer	Member	K	Y	Y
3	F		Primary	Farmer	Member	K	N	Y
4	M	43	Primary	Farmer, village chairperson, sheikh	Member	M	Y	Y
5	F		Primary	Farmer	Member	M	N	Y
6	M		Primary	Petty business	Member	K	N	Y
7	M	45	Primary	HF in-charge, farmer	Secretary	K	Y	Y
8	F	47	Primary	Asst. clinical officer, farmer	Asst secretary	K	N	Y

NOTE TO TABLE: F (female), M (Male); Mber 1: Member during first phase 2003-2007; Mber 2: member during second phase (2007 to date); K: Kivukoni village; M: Minepa village; Y: yes; N: no.

Table 5 Overview of Sofi Majiji HFGC members

No.	Gender	Age	Education Level	Occupation	Status	Village	Mber 1	Mber 2
1	F	49	Secondary	Farmer/Roman catholic teacher/Member of TUKI	Chair	M	Y	Y
2	M	48	Primary	Farmer	Member	M	N	Y
3	M	30	Primary	Business/Farmer	Member	M	N	Y
4	M	48	Secondary	HF in-charge /Pastor at church/ Farmer	Secretary	M	Y	Y
5	F	50	Primary	Nurse attendant / Farmer	Member/ Signatory	M	N	Y
6	M				Member/Re signed	M	N	Y
7	F				Member/ Moved	M	N	Y

NOTE TO TABLE: F (female), M (Male); Mber 1: Member during first phase 2003-2007; Mber 2: member during second phase (2007 to date); M: Majiji; S: Sofi Mission; K: Kiswago; Y: yes; N: no.

In Kivukoni, there were two clinical officers covering for each other. The health facility in-charge started working in Kivukoni in 2005, while his colleague, who was also a clinical officer and assistant health

facility in-charge, started in 2007. In both sites, the health facility in-charges were also members of the ward development committees.

In Sofi Majiji, there were two health providers who are officially members of the HFGC and both usually attend the meetings. It was felt necessary to have two health providers to have an extra signatory¹² because of the construction activities which were taking place at the dispensary. The in-charge had been working at the facility since 2004 and was well known for his medical attention to children and pregnant women. He was also a pastor of the Pentecostal church in Majiji. In 1988, he completed the Rural Medical Assistant¹³ course, and was posted in Mahenge hospital, in Ulanga. Later, he started working at the mission health facility until 2002, when he moved to Ilagua dispensary and then to Sofi Majiji in 2004. The nurse attendant started working in Sofi Majiji in 2000. She stands in for the in-charge when he is unavailable.

Usually the committee chairperson is appointed by common agreement among the committee members. The chairperson should be a community member. In both sites, the chairpersons had remained the same since their initial appointment in 2003, possibly because of their experience and reputation within the community. Both were religious leaders, and in Sofi Majiji, the chairperson was also a member of TUKI.

Signatories were appointed within the committee to authorise expenditures or the use of funds for construction by the committee in Sofi Majiji. There were two groups of signatories. The first group consisted of the chairperson and secretary. The second group included another member of the community (who is a representative of the community), another health provider (the nurse attendant), and the village chairman. The inclusion of a community member as signatory ensures the transparency of financial transactions to the community. The committee has the power to plan and budget on behalf of the dispensary management team, which has the role of identifying the needs of the facility. There was not a second group of signatories in Kivukoni, possibly because they do not have construction activities.

Selection process for the community members of the HFGC

There was some inconsistency of accounts regarding the process of selecting community members to join the HFGC. In both sites, the facility in-charge joined the committee some time after its formation, meaning that there was little historical record confirming the order of events. However, respondents consistently indicated that the instruction to form the HFGC came from the district medical officer (DMO) in both sites (Figure 5).

¹² Signatories are supposed to authorise the use of construction funds and are also responsible for depositing CHF money at the district level.

¹³ In Tanzania, rural dispensaries are staffed by a rural medical aid (R.M.A) with one or two helpers. In some cases, a nurse/midwife is also provided. The RMA attends a three year training course in anatomy, physiology and hygiene, with good grounding in diagnostic methods and the treatment of common diseases.

“The information came from DMO that we were supposed to appoint a dispensary committee” (HFGC member, Health Provider, Sofi Majiji)

In Kivukoni, the DMO initially informed the ward development committee about the formation of the committee. In Sofi Majiji, the DMO informed the health facility directly. The health facility in-charge then informed the ward development committee (WDC) about the need to have the HFGC and recruit community members. This may be due to the closer connection between the DMO and the facility in-charge in Sofi. The in-charge in Sofi Majiji had a good relationship with district managers, such as the CHF coordinator, due to the large number of people enrolled in the CHF, and his good reputation. This may be the reason why he was informed directly about the need to form the HFGC.

Subsequently, the WDC informed the village government¹⁴ who announced the availability of positions on the HFGC to the community through posters. The posters were shown at the ward office and other places, like on big trees around the community. Those interested were to send a letter to the WDC. However, in practice, some community members sent their application directly to the village government, who transferred the applications on to the WDC.

The WDC then reviewed the applications and made an initial assessment of candidates. They transferred the names of those selected back to the village government. Then the village leaders would call a general meeting with the community to obtain their views in relation to the names that had been selected. It is only at this final stage that the community preference is officially considered in the selection process.

“Nearly 10 people were selected by the WDC. Others didn’t get many votes during the community meeting; they were omitted and this is why we remained with only six candidates” (HFGC member, Kivukoni site)

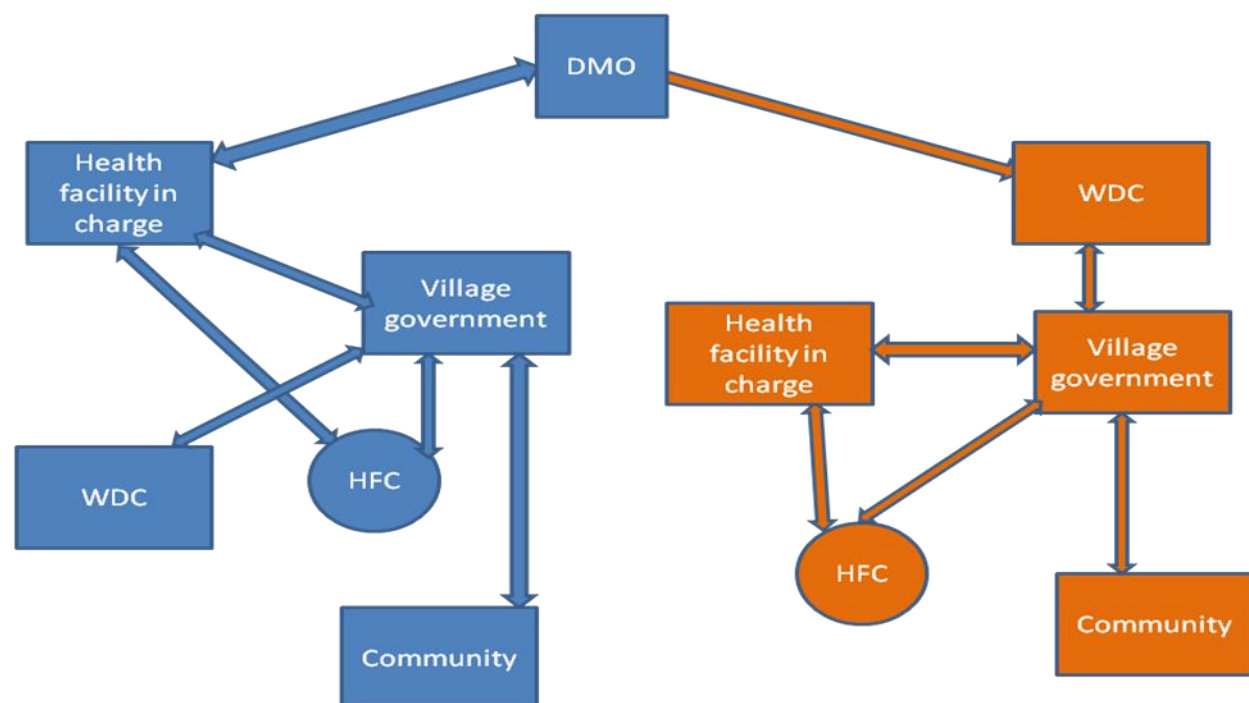
However, community participation at these meetings in both sites was reportedly low, limiting community involvement in the selection process. Furthermore, candidates were required to know how to read and write, which further limited those eligible for selection. There was no indication of any disagreements from the community regarding the people selected in either of the phases or sites. Following the community meeting, the selected member names were communicated to the WDC and then to the district through the DMO.

¹⁴ During the first phase of implementation, in Sofi Majiji, all three villages had the role of announcing the vacancies to members of their respective communities. During the second phase, only the Majiji village government made the announcement. In Kivukoni, announcements were not made in Mavimba village in the second phase and members were selected only in Kivukoni and Minepa and Mavimba was represented in the Milola HFGC.

Figure 5 illustrates the different actors involved in the selection process of the members of the HFGC and the lines of communication between actors. There is a two-way flow of information between actors in all cases but some actors do not communicate directly with one another.

Overall, the health facility in-charge in Sofi Majiji (less so in Kivukoni) acted as gatekeeper to the DMO in terms of communication during the selection of HFGC members. The health facility in-charge and the village government are the two key actors involved in the process, given the extent of their relationship with other actors.

Figure 5 Overview of actors involved in the community member selection process



Note to figure: blue is Sofi Majiji and orange is Kivukoni and the arrows represent the interaction between different actors.

HFGC Meetings

In both sites, meetings were supposed to be conducted quarterly. The HFGC committee in Kivukoni had only met three times in 2008. Not all members attended the meetings, with only three members attending regularly. In Sofi Majiji, they had conducted meetings more frequently than the guidelines suggest because of the construction activities that were taking place. For instance, in 2008 they conducted five meetings and all the members regularly participated in the meetings. In both sites, meetings were cancelled unless more than half of the providers and community members were present. The secretary was reported to be responsible for coordinating the meetings. In Kivukoni, the secretary did not consistently fulfil this role, resulting in less frequent meetings.

*“Our doctor (Secretary) is slack to call for meetings, which hinders our performance”
(HFGC member, Kivukoni site)*

Meetings usually took place at the health provider’s office in Sofi Majiji or outside the veranda of the facility in Kivukoni. In some instances, members of the Dispensary Management Team (DMT) and/or village government were invited to join the meetings in both sites. In Sofi Majiji, minutes of a meeting in 2008 revealed that the village chairman and village executive officer of Majiji village were present at the meeting which involved the selection of an accountant and storekeeper to oversee the construction activities.

Delays to meetings and interruptions were reported frequently in both sites. During our observations, the meeting in Kivukoni was supposed to start at 9.00am but actually started at 12.17pm. In Sofi Majiji, the meeting was supposed to start at 8.00 am but instead started at 11.00am. The reasons for the delays in both sites included providers continuing with their service delivery tasks, and delays in the arrival of community members who had not been informed about the meeting and had to be contacted while others waited.

Overall, the meetings were participatory. All members were encouraged to contribute their ideas during the discussion. Generally men spoke up more in both sites and there was more interaction observed in Sofi Majiji. Every individual contribution was treated equally and with respect. The secretary would first introduce the agenda and then members would contribute ideas one after another.

Training of the HFGC

Soon after the selection of committee members, in both sites, the HFGCs received a short training session of one hour conducted by the health facility in-charge. The main aim of the training was to provide an understanding of the roles and responsibilities of the HFGC according to the guidelines. The guidelines were read to the HFGC members during the training session. The guidelines remained at the health facility in-charges’ offices. However, in Sofi Majiji, the WDC and village government also had a copy of the guidelines. A more detailed two week training course was conducted by the Empower project in April 2009 in Malinyi¹⁵.

Roles of the HFGC

This section provides an overview of the roles of the HFGCs, as perceived by different stakeholder groups in the two sites. Overall, the HFGCs were able to identify the greatest number of roles as compared to other groups. The second group most able to assign roles to the committee were the

¹⁵ This training improved committee members’ understanding of their roles and responsibilities, explained that they can budget for activities from CHF revenue, and that the committee has to apply to the district to receive these funds. They were also informed about the official frequency of meetings. The members also had the opportunity to learn about writing cheques and keeping financial records.

health providers (HP). Knowledge among other groups on the roles of the HFGCs was more limited (Table 6). More roles were reported by community members, village leaders and other committee members in Sofi Majiji than in Kivukoni, indicating a higher visibility of the committee in Sofi Majiji. This is also reflective of the higher level of functionality and activity of the Sofi Majiji HFGC, described in the next section.

The main categories of roles mentioned were related to health service delivery, accountability and information sharing and resource mobilisation. In Kivukoni, community members, village leaders and other committee members generally thought the only function of the committee was to mobilise contributions to the CHF, with some awareness of the committee's responsibility for health care delivery among the village leaders. Some people even regarded the HFGC to be what they refer to as the 'CHF committee'. In practice, however, health providers were more generally responsible for mobilising people to join the CHF.

"That is what I know: they are supposed to mobilise people, to educate them so that they are aware of the scheme and how it works. If you know nothing about the scheme, even I can't join, so they have to teach people, that is their duty" (Health Worker, Kivukoni site)

In Sofi Majiji, the HFGC was associated with a broader range of roles, including supervising the construction activities, purchasing drugs, and financial management. The dispensary construction activities that were taking place between 2007 and 2009 in Sofi Majiji might also be one of the factors that raised awareness about the HFGC in this site. Members of the HFGC were often present at the construction site of the new dispensary and once this was completed, they remained present to supervise other construction activities, such as that of toilets and pit latrines.

"When we were elected, one of the roles was to oversee the construction of this building (dispensary building)" (HFGC member, Sofi Majiji)

"I found them there continuing with the supervision of the construction activities of the dispensary, the whole committee was there: the chairman and all other representatives were there from morning, they prepared food there and eat there" (Village leader, Sofi Majiji site)

However, there was still some confusion regarding who were members of the committee.

Facilitator: ... who did you find at the facility during the construction of the toilet?

Respondent 4: I found Liko and Ephramia Mbasa who is the chairman of the health facility governing committee

Facilitator: Mbasa is the chairman, what is the position of Liko in that committee?

Respondent 4: I don't know his position but he is a member of the committee

Respondent 5: I do not think Liko is a member of the committee, Liko is a technician. He was responsible for buying construction equipment, like cement etc.

*Respondent 5: There is also Magasa. Unfortunately, I don't know other members.....
(FGD, Men group, Sofi Majiji site)*

Table 6 Overview of the perceived roles of the HFGC in both sites

Perceived role of the HFGC	HFGC	HP	Community members	Village leaders & Influential people	NGOs & other committee members
Health service quality					
Supervision of construction activities at the health facility.	√	√	√	√	√
Responsible for purchasing drugs.			√		
Identify health facility problems and find solutions or report them to the government.	√	√	√		
Ensure providers treat patients with respect.	√ X				
Ensure services are given to the community and drug availability.	√ X	√ X		X	
Ensure health provider availability in the facility.	X	X			
Accountability – Information Sharing					
Encourage the community to seek health services at the health facility and respect working hours.	√	√			
Educate the community on issues concerning HIV and AIDS and family planning.	√				
Make sure that health facility and community are on good terms. Conflict resolution between health providers and community.	√ X	X			
Administer the drugs when brought to the health facility.	√			√	
Resource use and mobilisation					
Mobilise people to provide their labour to support building/repair of the health facility.	√ X	X			
Mobilise people to join the CHF.	√ X	√ X	√ X	√ X	√ X
Collect money.	√			√	
Manage money obtained from the district for construction of the dispensary and house of the provider.	√ X	√ X			√
Educate people about hygiene and inspect environmental cleanliness.	√				

NOTE TO TABLE (X) represents respondents from Kivukoni and (√) Sofi Majiji.

The accountability and information sharing roles of the HFGCs were reported mainly by committee members and health care providers.

“The role of this committee (HFGC) is to ensure how much has been contributed and also to make sure that the amount collected has been deposited in the bank” (IDI, Religious leader, Sofi Majiji site)

These groups also mentioned that the committee should act as a communication bridge between the community and health providers.

“We members of the committee are (HFGC) like a bridge between members of the community and health workers at the dispensary. And one of our main activities is to bring good communication to members of the community” (IDI, HFGC, Kivukoni site)

In contrast, in both sites, the committee was not seen by the community as a vessel through which they can present their views and complaints concerning health service issues. The main reason was the limited knowledge that the community had on the existence of the HFGC. Also, a minority mentioned the lack of trust of the community towards the government structures. In this case, the trust issue has implications for the relationship between the community and committee.

The HFGC committee members and health providers were able to describe a broad range of roles related to improving quality of care within the facility, especially in Sofi Majiji. The committee members from the community, the secretary and village chairperson often open new drugs kits arriving at the health facility and check that the drugs that were ordered are there. Some of the community members in Sofi Majiji mentioned that the HFGC is also responsible for buying drugs. However, this only happened once and was not usual practice¹⁶. The committee members also mentioned the committees’ responsibility for monitoring the behaviour of health providers in providing treatment and ensuring the availability of drugs.

The following section examines the actual impact of the HFGC in each of the sites.

5. IMPACT OF THE COMMITTEES

This section examines the impact of the committees in both study sites in relation to health provider performance and resource mobilisation. In relation to health worker performance, we set out to examine possible impact on health worker availability in facilities, opening and closing hours, and dealing with problematic behaviour of health workers towards patients. The issue of opening and closing hours was addressed by both sites, as discussed subsequently, and Sofi took steps to deal with health worker shortages. No direct action was taken in relation to provider-patient behaviour, but steps

¹⁶ Purchasing drugs is generally the responsibility of the district through the Medical Stores Department.

were taken in both sites to deal with concerns regarding relations between the facility and the community more generally.

With regard to resource mobilisation, we set out to examine the impact of committees on the use of resources, and how money was spent, especially regarding investment in equipment. We found that in both sites, committees managed to use funds to finance small expenses at the facility, with Sofi Majiji also managing to use CHF money to buy drugs. Generally, however, the committees were limited in their availability to decide on how to spend user fee and CHF revenue. In Sofi Majiji, the construction work provided the opportunity for resource management on a large scale as discussed below.

Kivukoni

Health Worker Performance

The lack of availability of health providers at the health facility outside of working hours was an issue dealt with by the committees in both sites. The problem was initially pointed out by the health providers as a result of receiving many patients after working hours and was communicated to the committee members through the in-charge. To deal with the problem, the health providers in Kivukoni decided to prepare a schedule of providers, to ensure that someone remained at the facility after working hours to attend to emergency cases. The issue was discussed at the committee meeting and the official working hours were written down and posted in front of the OPD building.

“People do not understand, they still bring patients after working hours, and in most cases after coming from their farms, they don’t care if we need to rest” (Health Provider, Kivukoni site)

The committee also got involved in dealing with tensions resulting from a personal relationship between a nurse and a member of the community’s husband. The committee and the DMO received a letter of complaint from a community member. The committee called a meeting with the nurse, and later, with the woman from the community who had written the letter, and reached consensus that the issue was so personal that they could not intervene. However, they warned the nurse that she should not let the relationship interfere with her work at the health facility.

“There is one nurse. We got complaints about her. The letter came from the district medical officer as a result of the complaint raised by a woman at the community and we discussed it. A woman from the community was the one who wrote the letter saying that if the nurse was not transferred to another place she would kill her. Her husband has moved away and he is now living with the nurse” (HFGC member, Kivukoni site)

Resource mobilisation

The health providers made the committee aware of a conflict over a plot of land. The health facility and community members both claimed to own the plot which was near to the health facility. This issue was

discussed in the committee meeting and it was agreed that village government intervention was required. It was reported that several times, the committee reported the problem to the village government with no concrete solution. However, during their meeting in April 2009, they agreed to write an invitation letter to the village government to participate in their next meeting so that they could discuss the issue and find a solution. However, at the time that the field work was conducted, this had not yet happened.

Drug shortages at the facility were also discussed by the committee, especially during the planting season, when people from many different areas come to reside in Kivukoni for their farming activities. The issue was brought to the committee by the in-charge as it had been discussed by the dispensary management team. The committee alerted the district to the problem. The district reported that the problem was caused by delays from the Medical Stores Department (MSD).

“We have noted it (drug shortage problem) in our minutes and submitted them to the district (DMO) but at the district level they said that they get the drugs they are given. They said that they face the same predicament and they have forwarded their complaints but things are still the same” (Health Provider, Kivukoni site)

Officially, the committee is responsible for mobilising community members to join the CHF. However, there was very little evidence which showed the committee’s involvement in mobilising people to join the CHF. It was reported that most of the mobilisation and sensitisation activities are done by providers at the health facility during health education and outreach services. The health facility governing committee members also mentioned undertaking one to one discussions with community members about the CHF when they have time. There was no mention of the committee having organised any community meetings as part of their mobilisation activities. However, the ward councillor had reported discussing the CHF during a ward meeting.

Improving CHF mobilisation strategies was one of the items on the agenda of the meeting observed during the current research. As discussed later, the committee in Kivukoni faces a number of challenges which hinder mobilisation activities.

“In practice, mobilisation activities are poor because even the village leaders themselves are not well sensitised” (HFGC member and health provider, Kivukoni site)

Resource use

The HFGC applied to use the funds from user fees to construct benches for the patients to sit on when waiting at the facility and to buy other equipments for cleaning the facility.

Sofi Majiji

Health worker Performance

Officially, health providers have to work from 8.00am to 3.30pm, Monday to Friday, in all public primary health facilities. In addition, they have to attend to all emergency cases during non-working hours. In contrast, the majority of community members felt that the providers should be available for the whole day, every day of the week. The community therefore complained to the village government leader and the HFGC about the lack of provider availability. In Sofi Majiji, the health workers live at a distance of between 1 to 2 kilometres from the facility, making it difficult for them to attend to patients outside of working hours. The committee helped to inform the community about the providers' working hours during a general community meeting and during clinics and health education activities. The HFGC also requested a sign from the district CHMT which stated the official working hours of the dispensary. This sign is now on display at the facility. Community members reported a greater awareness of facility working hours and that more people come early to the facility.

"For sure there is a contribution because if you consider the community was not caring about time thus, we (HFGC) wrote a letter to the district that we need a board/poster which shows working hours, this are why you see it there. Therefore, the committee was educating the community about working hours" (HFGC member, Sofi Majiji site)

However, the providers continue to complain about their workload because people still come after-hours. The lack of health provider housing close to the facility accentuated concerns over workload in Sofi Majiji. In contrast, in Kivukoni, the health providers lived close to the facility.

There was no midwife at the dispensary. The health providers reported this to the committee and the committee agreed to ask the District Medical Officer for a midwife. One midwife was brought to the facility, however, there were a number of complaints from fellow workers and from the committee that she was often absent. The committee reportedly took time to discuss the issue with her once but nothing changed. It was an ongoing point of concern as it impacted on the work load of other providers. The HFGC and the dispensary management team decided to report the case to the district and request a new midwife.

The HFGC involvement in the facility construction activities has led to a better working environment for health providers. This has improved their performance, as they have additional work space available. However, the initial impetus for construction came from the village government.

"Now the working environment is better than at the former building where we had one room for all the OPD services. We were sometimes asking patients to sleep outside the dispensary. Although we still don't have a ward dispensary, in the new dispensary there are now enough rooms at the OPD and RCH" (Health provider, Sofi Majiji site)

Resource mobilisation

The HFGC has managed to some extent to mobilise people to join the CHF. However, the health providers had the greatest impact on enrolment rates. Health providers developed their own initiative to attract people to join. They felt that the annual 5,000 Tsh premium per household was discouraging people, so instead, they advertised the monthly equivalent premium of 416 Tsh. This proved very effective in encouraging people to join, although the premium is still paid once per year.

“When you divide 5000 shillings by 12 months you will find that each month a family is only contributing 416 shillings for health services. When people understand this they start contributing to this fund. This is how we got many members into this fund” (Health Provider, Sofi Majiji site)

The HFGC mobilised people to contribute their labour during the construction of the dispensary, the house of the nurse, the toilet and the pit latrine. The permission to mobilise people to engage in construction activities was obtained from the village government. The construction of the pit latrine was carried out by prisoners from Majiji village.

“Fetching water, carrying sand, carrying bricks, we do all the tasks ourselves. The government has helped with iron sheets, cement and nails” (HFGC member, Sofi Majiji)

Fifteen percent of the construction of the dispensary and the house of the nurse was funded by the community and the rest by the government as part of the PHSDP strategy. However, the construction of the toilet and pit latrine was carried out entirely using community resources.

It was decided to construct a new dispensary because there was not enough space around the old one and the building was in disrepair. The issue was discussed by many people from the community on different occasions, including during a general meeting involving the village leader, who decided to construct the new dispensary. Because of the HFGC's perceived role of linking the community to the development of the dispensary, the construction mission was handed over to the HFGC by the village government leaders. The dispensary was officially opened at the end of 2008. Initially, before the construction of the new dispensary, permission was obtained from the CHSB by the health facility in-charge. In order to withdraw money from the bank to support the construction work, the HFGC needed permission from the village government, especially the village chairman as one of the signatories.

The rationale for building a house for the providers was to ensure that they were close to the facility. Soon after the construction of the dispensary, the committee raised the issue of constructing health provider houses near the facility with the village government. The village government and the HFGC asked for financial support from the district and started constructing houses for the providers. The HFGC also asked for support from SolidarMed who agreed to fully fund the construction of a house for the health facility in-charge.

The committee has also managed to organise a meeting with SolidarMed, which resulted in the promise of 30 million Tsh to build the in-charge's house. They have also requested funds from SolidarMed to construct a resting room for women after delivery. A large number of pregnant women deliver at the dispensary because the Lugala hospital is too far (more than 10km). However, they only have one bed at the dispensary and if there is more than one attending woman, they must sleep on the floor. The HFGC is waiting for feedback on their application. The committee also encouraged people to plant trees around the dispensary to provide a place to rest for patients while they are waiting for services or relatives.

Resource use

Using user fee revenue, the committee once took a decision to buy small items for the dispensary, such as a bucket to store drinking water for patients, especially children, and soap. This was initiated by the health providers who identified the needs and problems at the health facility and presented them to the committee through the in-charge.

The HFGC also obtained authorisation from the CHMT to use CHF money to purchase drugs that were in short supply. This was prompted by a three month wait for drugs which did not arrive. Patients were complaining and some even accused the providers of selling the drugs. The providers informed the committee and, as some CHMT members were visiting the facility for supervision, the committee informed the CHMT, and they suggested using CHF money to buy drugs and then to pay the money back. Normally, the HFGC would not be able to use the CHF revenue directly (before submitting the funds to the district). They are supposed to budget for it and later claim the money from the district. However, in this instance, they used the money they had collected through the CHF and then later applied for 200,000 Tsh from the district to refund this money. The health facility had not yet received the requested funds at the time of data collection and had been waiting for five months.

“For instance, drugs were brought in December last year and they lasted for three months. We reached a time when these drugs were finished and we didn't receive further drugs until May and the situation was not good. The doctor informed us (HFGC members) that they didn't have drugs and people suffered. We were lucky because a group of health managers from the district who came for supervision told us to authorise an amount of money from the CHF funds to go and buy drugs for people to use. It's true; we have authorized 200,000 shillings to buy drugs, which we used until June before receiving a new kit of drugs” (HFGC member, Sofi Majiji site).

Resource management

The HFGC in Sofi Majiji was also responsible for managing the resources at the facility for the construction activities. It was reported that the committee entered into conflict with a construction contractor about payment. The contractor requested payment of funds prior to completing the construction work. The case was reported to the WDC and the committee, which was asked to justify its position. The committee presented to the WDC the terms of reference that was initially given to the contractor, which showed that the contractor would only be paid the full amount after finishing the construction work. The case was also reported to the village government. It was finally agreed to follow the terms of reference and the support the committee's position.

The next section explains the issues which influence the functionality and the degree of impact of the HFGC in each of the sites.

6. ISSUES AFFECTING THE FUNCTIONALITY AND IMPACT OF THE HFGC

This section will start by presenting a brief summary of the key issues and experiences of each of the sites which facilitated or constrained committee functionality and impact. We then examine key relationships and the role of trust in explaining functionality and impact. Finally, a number of policy recommendations are made for improving HFGC functionality elsewhere in the country.

Contextual Factors Affecting Functionality and Impact in Kivukoni

The health facility governing committee's activities were limited by the lack of a clearly identified role for the committee and the absence of a stimulus for meetings (such as supervising construction activities). Generally, the Kivukoni HFGC didn't act on most of the decisions taken, their CHF coverage was limited and they met less frequently. Until the Empower training in Kivukoni, the HFGC had no idea they could use CHF revenue to make budgets for health facility expenditures or even their own allowances. Due to their limited activity, the committee failed to build up a strong rapport with the village government, which limited their access to the community for mobilisation activities.

Further, they appeared to have weaker links to the district authorities, creating difficulties for them to access and mobilise funds for use within the health facility, although they did manage to use user fee revenue on one occasion. Partly, this may be due to the in-charge who was not very well connected.

There was also more limited knowledge about the HFGC within the community among different groups, and lack of understanding of the HFGC role. A lack of transport was reported to limit HFGC mobilisation activities relating to the CHF in the community. This resulted in community distrust of the HFGC, and may have affected their willingness to enroll in the CHF.

In Kivukoni, there was a general sense of alienation from government at the ward and village levels. The committee felt they were expected to pass on ready made decisions from the district and there was little sense of ownership of the ideas or information they were supposed to share. Some committee members indicated that they disowned issues they perceived as being imposed from the top down, such as CHF mobilisation.

“We haven’t released any information to people because we do not participate in government meetings, we are not involved in government decisions, and there is not any member of this committee who has done so” (HFGC member, Kivukoni site)

A related concern was the lack of meeting allowances, which had a significant effect on committee functionality in Kivukoni. During the first phase of the HFGCs, members of the committees were receiving sitting allowances from the district during their meetings. This practice ceased later, with no clear reason from the district. A lack of allowances affected motivation for meeting, especially in Kivukoni.¹⁷

“When you go to do something which doesn’t have any profit you feel as if you are just wasting your time” (HFGC member, Kivukoni site)

Allowances are seen to be a catalyst and motivator for people to work hard, especially for health providers who, in some cases were torn between their need to attend the committee meeting and attend patients.

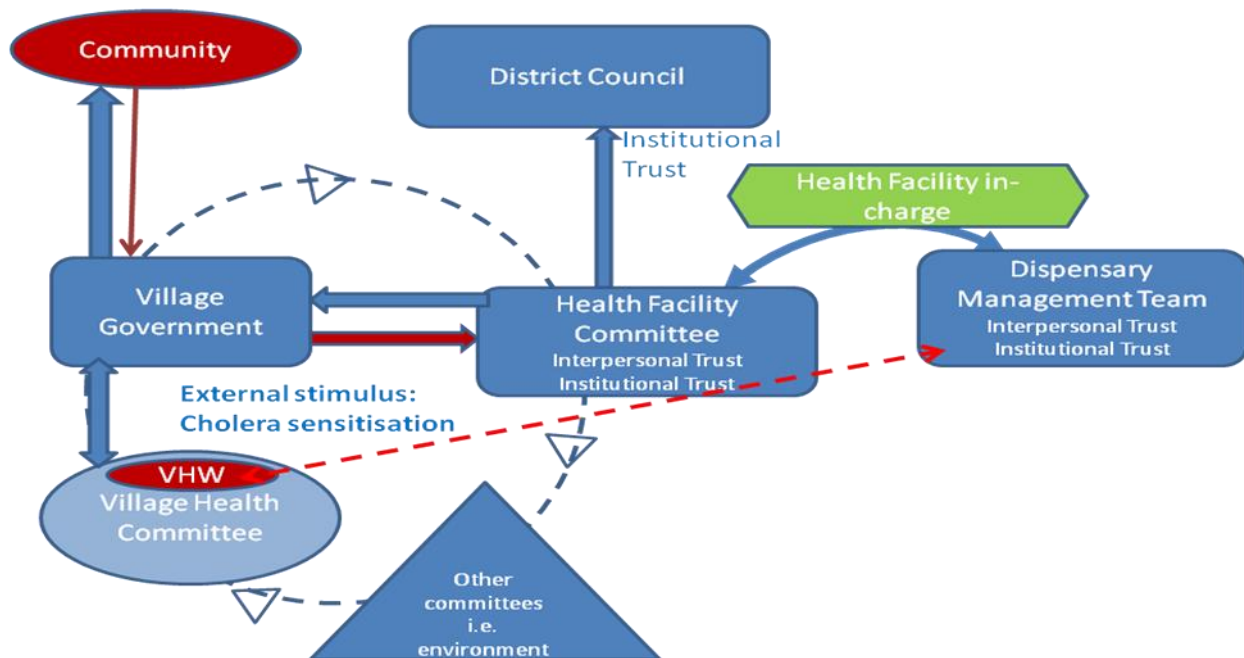
Despite evidence showing little impact of the committee on improving health worker performance and resource mobilisation, interestingly, the services provided in Kivukoni dispensary appeared to be of a good standard, especially in relation to pregnancy-related care, due to the new RCH building. Kivukoni was also awarded a high quality of care ranking in an assessment of all facilities and providers in Ulanga district carried out by the ACCESS project under the Quality Improvement and recognition initiative¹⁸ at IHI. However, it did not appear that the HFGC was instrumental in achieving high quality.

¹⁷ However, the Empower training informed members that they can plan for their allowances from the CHF fund. Currently, each health facility implementing the CHF is eligible to use 70% of the collection for the development and improvement of the services at the facility level and the remaining 30% is for management at the district level. So the members of the committee can now budget for their sitting allowances from the amount they have collected.

¹⁸ Quality Improvement and Recognition Initiatives (QIRI) use a performance improvement approach to improve the quality of services available at health facilities. A performance gap at a health care facility can often be attributed to six factors: Job Expectation, Performance Feedback, Staff Motivation, Professional Skills and Knowledge, Client Satisfaction and Facility Physical Environment and Tools.

Overview of key relationships and trust in relation to impact in Kivukoni

Figure 6 Overview of key relationships and trust



Note to figure: two way relations indicated by two way arrows. One way relations indicated by one way arrows. Blue arrows indicate actions or information flows; red arrows indicate distrust or tension.

Relationships within the Health Facility Governing Committee

There was evidence of interpersonal trust among members of the health facility governing committee based on their familiarity with one another. The chairman and the secretary (health facility in-charge) were responsible for setting the agenda and reminding other members of the dates of the meeting and the meeting place, which was normally in the health facility. Everyone was given an equal opportunity to speak during the meetings and was treated with respect fostering institutional trust. Although the meetings were not held as frequently as indicated in the guidelines (four times a year) the committee did manage to meet three times during the year of study.

However, meetings were substantially delayed, in some cases, due to provider's engagement in other activities, which indicates a lack of provider respect towards other committee members, who were expected to wait. Further, having the health facility in-charge lead the meetings, and holding meetings at the facility may have biased the agenda in favour of providers and contributed to an unequal balance of power between members of the facility and members of the community on the committee. Some members reported that the in-charge was slow to call meetings which affected the frequency of meetings, demonstrating the overall authority of the in-charge in the running of the meetings. However, it was generally reported that the relationship between the in-charge and the chairman was good and that they set the agenda jointly.

There were no clear, pre-established rules for decision making within the committee. Members did not describe consistent criteria for reaching decisions. Most members emphasized the importance of reaching consensus when making decisions. Some members mentioned voting, but in practice this did not happen. The pre-established culture of consensus seemed to guide discussions. The team could not establish clear reasons as to why voting did not take place.

“When we are about to make a decision, we agree among ourselves (HFGC members) we do not quarrel or fight. Although according to the guidelines, we are required to vote, this has never happened in this facility” (IDI, HFGC member, Kivukoni site).

There was limited evidence of disagreement among committee members possibly due to the provider bias of the committees. There were also no clear guidelines for conflict resolution or rule breaking, should they arise.

Overall, there was no evidence of distrust within the committee, and the foundations for trust were present, although trust might have been enhanced by having a more neutral meeting place, to avoid potential bias towards provider interests during discussions.

Relationship between the Health Facility Governing Committee and the Dispensary Management Team

The relationship between the HFGC and the health providers was reported to be good. The in-charge was a member both of the DMT and the HFGC, which ensured close rapport between providers and the HFGC and interpersonal trust between these two groups. The DMT members met monthly to discuss health service provision at the facility and any issues arising were reported to the HFGC through the health facility in-charge. The health facility in-charge played a very important communication role of information sharing between the two groups, generating institutional trust. The issues raised and addressed by the committee were almost always instigated by providers. For example, in response to concerns raised by the DMT, the HFGC decided to use user fee revenue to buy equipment and construct benches for the facility.

Furthermore, the decision to ensure that health workers were constantly available at the facility by means of staff rotation was a result of discussions among members of the DMT which were then acted on by the HFGC, and implemented by providers. Finally, despite the absence of clear guidelines with respect to handling health worker behavioural issues, the committee managed to address the problem caused by the relationship between a nurse and a community member's husband by sitting with the nurse and warning her to be careful.

Relationship between the Health Facility Committee and the Community

Although the HFGC was supposed to act as a bridge between the facility and the community, in practice this role was thwarted, due to the difficulty of communicating directly with the community, a general community distrust of government structures which extended to the HFGC, and a community distrust of providers which also extended to the HFGC.

The HFGC's lack of direct access to the community limited community awareness of the HFGC. Only the village government had the authority to mobilise people to attend village meetings. Other groups, such as the HFGC, needed local government approval and support to access community members. Therefore, the HFGC was never able to arrange or hold a meeting with the community purely to discuss issues related to the health facility. The agenda of the HFGC had instead to be fitted into a broader village meeting agenda. There was no evidence of regular participation of HFGC members in village government meetings. The absence of a structured linkage between HFGCs and the community was also identified as a constraint to HFGC functionality in the report by Kessy (2008).

"During the village meeting we are supposed to get permission from the government leader and that doesn't occur in every meeting, it happens when we ask" (HFGC member, Kivukoni site)

However, use of village meetings as a channel for communication was also not perfect due to a certain degree of distrust between the community and government, meaning that the turnout of community members at the meetings was generally quite poor. Indeed, community members were reluctant to attend village meetings as numerous decisions had been taken by village leaders without the consent of the people, such as selling community land to the Sukuma. The village leaders also did not report the revenue generated from the sale. Indeed, the community generally felt alienated from government and powerless to influence government structures.

Difficulty communicating with the community contributed to a lack of transparency in relation to HFGC activities. Hence, the community did not know how much money was collected through the CHF, for example, or how the CHF money was used, which limited institutional trust; this also made the community less willing to enrol in the CHF:

"Every day at the facility there are no drugs, you have to go and buy them. This (CHF) is a dirty game" (FGD, Women, Kivukoni site)

In Kivukoni, the committee was seen as trying to elicit community resources through CHF collections rather than to make improvements to health services, which further generated distrust.

"This committee has not made any decisions to improve services. I told you that their main activity is to mobilise people. I remember last year ... they failed to sensitise people ensure the general cleanliness of the facility but they continued to mobilise people to contribute

to the CHF" (Community member, Kivukoni)

In Kivukoni, the community felt limited in their ability to engage with the committee because of a lack of awareness of the committee, of their rights in relation to health care, and a general disempowerment relative to government.

"We fail to speak or contribute to this committee because we have little knowledge about our rights. After all, do you think there is much we can do to change the decisions which have already been made by the government?" (Community member, Kivukoni site)

In Kivukoni, as in Sofi Majiji, the community had a greater awareness of the activities of the TOC in relation to HIV prevention than of the HFGC. This might have been due to the novel ways the TOC communicated with the community, including drama. The TOC was also formed by the village government, which may have further facilitated their access to the community. It was also reported that the TOC does not mobilise people to contribute money, it educate people on how to prevent HIV infections, which was seen to be more relevant to the needs of the community.

There was also a certain amount of community distrust of providers which might have also affected their perceptions of the HFGC. Informal charges were reported in Kivukoni. Indeed, village health workers were charging community members for vaccinations, which were supposed to be provided for free. The VHWs had an incentive to charge community members as they did not receive any official remuneration from the government. Indeed, initially VHWs were acting as volunteers. Later, districts were supposed to pay them. Then, the village government was asked by the district to pay the volunteers. The village government said that they did not have the means to pay the VHWs, so the VHWs started to charge clients for vaccinations. However, they did not report how much revenue was obtained to the health facility. Although providers at the facility did not support this practice, this affected the community's attitude towards health workers more generally, and caused tension between health workers and the VHWs.

The existence of many local structures in the community dealing with social issues, including health, caused confusion in relation to the HFGC. For instance, the community often confused the HFGC with the Village Health Committee or the Ward Health Committee. Community members also expressed uncertainty regarding the *"need for a HFGC while there is a VHC that can take care of that"*.

Despite a limited community awareness of the HFGC role, the community generally had a good level of awareness regarding the political processes within their area. The 25 members of the village council board are selected by the community during the election of the councillor and other political representatives of the ward and village government. It seems that during these elections, the majority of community members were aware of what is going on and who the candidates are for the various posts. Thus, after the elections they are aware of who won and they know that these people will represent them on various committees.

Relationship between the Health Facility Governing Committee and other Committees

There was no evidence of ongoing relationships between the HFGC and other committees in the area. However, there was a single occasion in which the HFGC worked with the environmental committee and the VHC to encourage people to take precautions during a cholera outbreak. The district medical officer informed the health facility and the VHC about the outbreak and the need to take preventive action. The VHC has the official role of promoting hygiene and sanitation within the community. However, they elicited support from the facility in-charge and other members of the HFGC along with members of the environmental committee in this instance. There was no other evidence of HFGC engagement with other committees. Generally, the belief that the HFGC received allowances also negatively affected their relationship with other committees, which did not get allowances.

Relationship between the Health Facility Governing Committee and Village Government

The initial introduction of the HFGC generated a certain amount of bad feeling among the village government. The HFGC was set up as an apolitical organ, operating independently of the elected village government, and was also seen to duplicate the role and activities of the village health committee, which was a political body formed from members of the village government.

Village leaders also believed that members of the HFGC were paid allowances from the CHF funds generated which resulted in further bad feelings, as the village government does not receive allowances. While the HFGC did receive allowances during the initial introductory meeting between the HFGC, the VG and the ward council, this practice subsequently discontinued.

“In the first meetings, we got allowances at the WDC and some of the village leaders didn’t get any and that information was all over the villages and many people perceive that we are still getting allowances” (HFGC member and health provider, Kivukoni)

Indicative of this bad feeling, the facility in-charge, who should officially be a member of the VHC, was removed from the VHC and replaced by village health workers (VHWs) without clear justification. This appeared to be a reaction of the VHC against the HFGC as a whole, rather than directed at the in-charge himself.

The village government distrust of the HFGC made it difficult for the HFGC to access the community as mentioned above, limiting their capacity to mobilise CHF contributions. Indeed, there was very limited participation of the HFGC in the village government meetings.

“If the village leader doesn’t understand the CHF, why should I join” (FGD, women , Kivukoni site)

However, the HFGC demonstrated a certain degree of institutional trust towards the village government

by calling upon them to help resolve conflict. For example, they approached the village government to intervene regarding conflict between the community and the facility over land ownership. However, due to their distrust of the HFGC, the village government failed to respond to the HFGC request and did not intervene in relation to the plot dispute, undermining the impact of the committee.

There was a single instance where the HFGC and the village government were found to cooperate and work together, which was during the cholera sensitisation campaign, however, this did not appear to build trust or facilitate the establishment of ongoing relations between the two structures.

Although officially accountable to the ward development committee within the ward council, the HFGC in Kivukoni had very little interaction with the ward council, although the reasons for this were not clear.

Relationship between the Health Facility Governing Committee and the District Council

The HFGC regularly shared their meeting minutes and informed the district about problems of drug shortages, demonstrating their integrity or willingness to follow procedures and being transparent. This highlights the existence of a certain degree of institutional trust in the district council. However, there was no evidence of the district responding to HFGC requests or of their offering any financial support to the HFGC, possibly due to a lack of a close relationship between the HFGC and the district managers (i.e. interpersonal trust). Ongoing drug shortages limited the HFGC's ability to increase CHF enrolment in the ward. Limited cash support from the district affected the performance of the Kivukoni HFGC, in terms of their ability to implement measures to improve facility functioning and incentivise member participation in meetings. According to the guidelines, HFGCs are supposed to be responsible for financial management and fund allocation at facility level. However, as primary health facilities do not have facility accounts, funds remain at district level and are not always readily accessible. This dis-empowers the committee as they are constrained in their ability to fulfil their role as fund managers. A review of committees carried out by Kessy (2008) also found that they generally had limited control of resources, despite their official mandate.

Contextual Factors Affecting Functionality and Impact in Sofi Majiji

Probably the main underlying cause of the greater functionality of the HFGC in Sofi Majiji was their responsibility for supervising the health facility construction activities, especially the management of funds associated with the facility's construction. This served multiple purposes, including: providing a role and *raison d'être* to the committee; uniting them and allowing them to become known by various actors in the community. As this was an ongoing activity, it also served to generate ongoing trust and engagement between actors.

Supervising the construction activities also provided the basis for most of their discussions during the meetings, hence giving an agenda to the meetings. Meetings also happened more frequently as there

was so much to discuss. Overseeing the construction activities provided a means for the committee to manage funds and develop responsibilities in line with their official terms of reference.

The engagement of the committee in the construction activities also strengthened their relationship with the village government, essential to accessing the community. Evidence suggests that previously, the village government was resistant to the HFGC, seeing the committee as a competitor to the village government's VHC. However, the involvement of the HFGC in the construction activities enhanced their legitimacy in the eyes of the village government. The HFGC reported all expenditures to the village government during the village meetings and would report to the village chairman before going to withdraw money for the construction work. During the period of facility construction, the HFGC proved their capacity for financial management which served to build the trust of the village government and the WDC. However, there was no evidence to show that information on expenditure relating to the construction work was actually shared with the community.

Gaining the support of the village government is critical to the success of the HFGC, especially in relation to mobilising CHF contributions from the community, because it is only the village government that has the authority to call people to a village meeting.

The HFGC's successful management of the construction activities also strengthened their relationship with the district and with NGOs in the area. This resulted in their being able to leverage further funds both from the government and, through the TOC, from SolidarMed, for the construction of houses for the health facility in-charge and another health provider.

However, there were number constraints limiting the functioning of the HFGC in Sofi Majiji. As in Kivukoni, a lack of transport was reported to limit CHF mobilisation activities. To overcome this problem, in Sofi Majiji, mobilisation activities were mostly carried out by health providers at the health facility and, more specifically, during health education in the morning and during the clinic.

"It affects us because when we are going to mobilise about CHF contributions, from this place to Mipapa it is 12 kms. This means that we have to ride a bicycle or go on foot. When you hire a bicycle you have to pay yourself" (HFGC member, Sofi Majiji site)

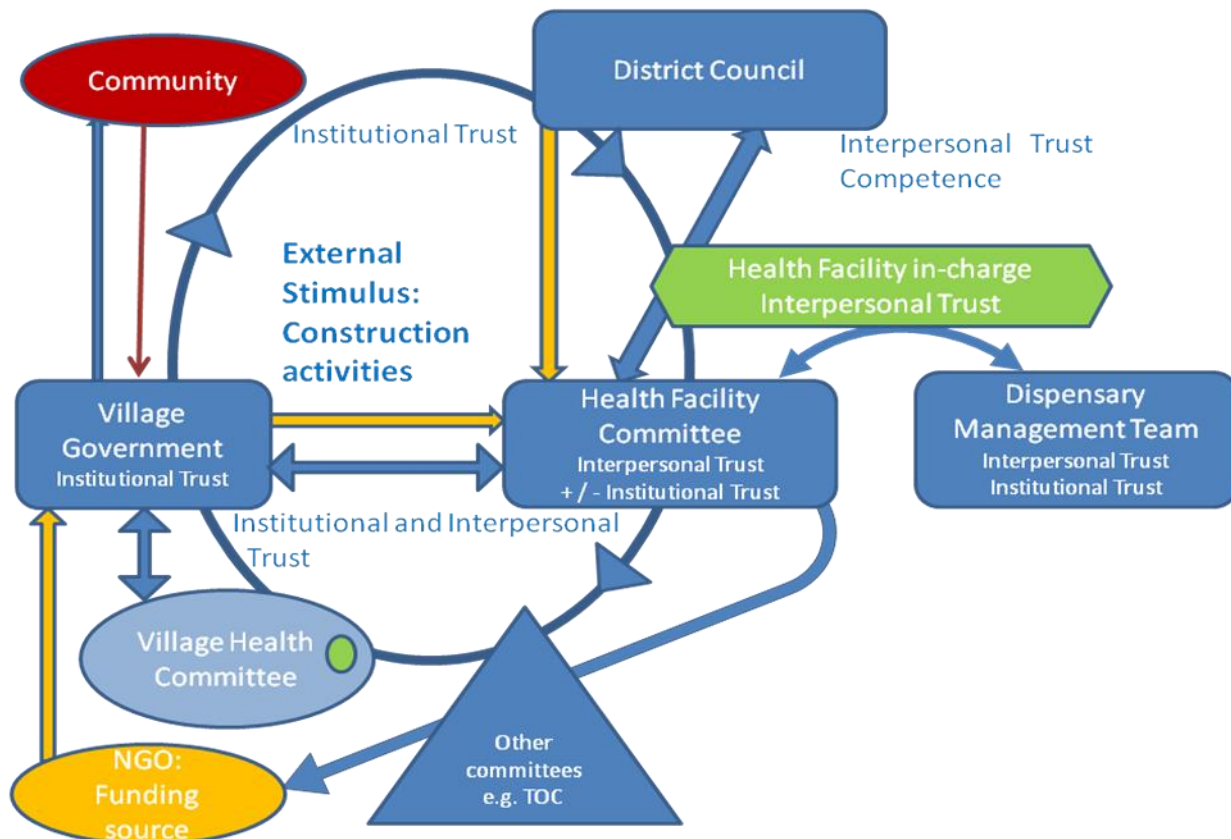
A related concern was the lack of meeting allowances. However, this did not impede the conduct of regular meetings in Sofi Majiji.

Overall, the Sofi Majiji HFGC was well known at district level for their success in mobilising CHF contributions, resulting in interpersonal trust. This familiarity, combined with the personality of the in-charge and his established clinical reputation, made the HFGC more willing to report their problems to the district, and the district, in turn, was more willing to respond and provide assistance. The in-charge was a well respected clinician, undertaking deliveries and treating children. He was also a pastor, further increasing his status in the community. A recent study of facility governing committees across Tanzania also found that those committees that have been successful in raising resources (either labour

or capital) were facilitated by certain influential individuals who were well connected with district authorities (Kessy, 2008).

Overview of key relationships and trust in relation to impact in Sofi Majiji

Figure 7 Overview of Key Relationships and trust in Sofi Majiji



Note to figure: two way relations indicated by two way arrows. One way relations indicated by one way arrows. Blue arrows indicate actions or information flows; red arrows indicate distrust or tension. Yellow arrows indicate flows of funds. Green colour indicates the presence of the health facility in-charge.

Relationships within the Health Facility Governing Committee

The relationship among members of the HFGC was generally reported to be good with respectful treatment being accorded to all members. Everyone was given an equal opportunity to speak during the meetings. There was a single reported instance of distrust within the HFGC. One member resigned accusing the leaders of the committee of corruption in the use of funds for facility construction. However, the case was later dealt with by the village government, and no evidence was found in support of the accusation. There was no other evidence of disagreement among committee members.

It was reported that the relationship between the in-charge and the chairman was good and that they set the agenda jointly.

Meetings took place more regularly than indicated in the guidelines and consistency of participation was relatively good. However, similar to Kivukoni, the meetings were sometimes delayed due, in some cases, to provider's engagement in other activities.

Knowledge of committee roles by committee members was generally good. However, there were still some differences between official roles and actual practice. For example, the chairman (community representative) was supposed to lead discussions in the committee. However, in practice, the secretary (facility in-charge) would lead discussions and direct the agenda, indicative of a health provider bias which contributed to an unequal balance of power between members of the facility and members of the community on the committee.

Members did not describe consistent criteria for arriving at decisions. Most emphasised the importance of reaching consensus. Voting was also used by committee members when selecting an accountant and store keeper to oversee the construction activities.

Benevolence was found to be lacking due to the current lack of representation of other villages on the committee. The lack of representation of community members from all three villages was reported to affect the work of the HFGC in mobilising people to join the CHF. The lack of representation of the other two villages on the HFGC created an understandable distrust of the HFGC among the people in the other two villages, as very little information was provided explaining the rationale for this. Further, as the other two villages continued to use the facility in Majiji village, it was felt to be unfair that they should not be represented on the HFGC. However, the problem is a temporary one, until facilities have been built in the other two villages. Despite this, the HFGC was still able to achieve a high rate of CHF enrolment across the ward.

In addition to a lack of representation of other villages on the committee, there was also a lack of representation of certain ethnic groups. For instance, the Wasukuma, which make up a significant proportion of the population in Sofi Majiji, did not have any representation on either committee. They were generally regarded as outsiders/migrants/fugitives, and their concerns and views were not represented¹⁹.

¹⁹ The Wasukuma people are not indigenous to the area. They migrated from their original land in the Northern part of the country to look for grazing land for their cattle, as they are pastoralists. They settled in Ulanga district which they found to be a conducive environment for grazing. The government provided them with a permit to settle in these areas, without the prior consent of the indigenous population.

Relationship between the Health Facility Governing Committee and the Dispensary Management Team

Similar to Kivukoni, the relationship between HFGC and the DMT members was good. This was facilitated by the fact that health providers were members of the HFGC and the DMT. The strength of the relationship between the DMT and the HFGC allowed for a number of actions to be taken by the HFGC on behalf of the DMT and also for the DMT to provide support to the needs of the HFGC. For example, in response to concerns raised by the DMT regarding staff shortages, the HFGC requested a midwife from the district. They further requested a sign for the facility indicating working hours in response to provider concerns that community members were not aware of facility opening hours. Through the in-charge, the DMT also assisted the HFGC. For example, the in-charge was instrumental in involving providers in CHF mobilisation. He had the initiative to introduce a novel way of marketing the CHF to community members, involving a monthly rather than a yearly fee, which made the premium seem more affordable. In this way, Sofi Majiji succeeded in achieving the highest rate of CHF enrolment in the district.

Relationship between the Health Facility Governing Committee and the Community

Community awareness of the HFGC was higher in Sofi Majiji compared to Kivukoni due to the construction activities which were highly visible in the community.

However, as in Kivukoni, a lack of direct access to the community affected the ability of the HFGC to engage with the community. Hence, the community did not know about the amount of money collected through the CHF, for example, or how the money was used, although information on expenditure and revenue in relation to the construction work were frequently reported to the village government. Community members also mentioned a lack of transparency regarding the use of funds generated from community fines imposed on those who did not participate in the construction activities, which contributed to community distrust of the village government. Community members felt that they were generally ignored in the decision making processes and only involved when they were needed for labour or to make other contributions, such as to the CHF.

However, this did not undermine the performance of the HFGC in Sofi Majiji in relation to resource mobilisation, indicating the extent of hierarchical relations within society, meaning that community members largely follow instructions (and requests to contribute resources), even if there is distrust.

There was also a certain amount of community distrust of providers which could have affected the community's perceptions of the HFGC in Sofi Majiji. Community members reported that village health workers were selling clinic cards for registering children to women. However, in Sofi Majiji, this appeared to be counteracted by interpersonal trust in the facility in-charge and the construction activities, which reflected positively on the HFGC.

As in Kivukoni, the community had a greater awareness of the activities of the TOC in relation to HIV prevention than of the HFGC.

Relationship between the Health Facility Governing Committee and other Committees

Members of the HFGC in Sofi Majiji showed competence in managing the construction funds from the district, which created trust among other committees. Through the TOC, the HFGC managed to obtain funds from SoliderMed for the construction of the house of the health facility in-charge. However, there was no other evidence of collaboration between the HFGC and other committees.

Relationship between the Health Facility Governing Committee and the Village Government

The committee had a good relationship with the Majiji village government harnessed by the committee's effective collaboration with the village government in construction activities, and management of associated funds, outlined above. This served to override any initial suspicion of the HFGC as a potential competitor to the VHC. Although the collaboration between the HFGC and the village government regarding the construction activities was initiated by the district, it served to foster ongoing trust and collaboration between the HFGC and the village government. The chair or the in-charge sometimes participated in village government meetings to report on expenditures relating to the construction activities. The village government played an important role in upholding integrity, by intervening to address an allegation of corruption within the HFGC. However, there was no indication of a relationship between the Sofi Majiji HFGC and the village government in the other two villages served by the dispensary. Indeed, these village governments had little knowledge of the HFGC role and activities.

There was further evidence of engagement between the village government, the ward council and the HFGC in Sofi Majiji when a complaint was made by a contractor working on the construction of the dispensary regarding his payment. The contractor wished to be paid before completing the agreed work, disregarding the terms of the contract, and took his concern to the ward council. The committee presented the contract to the ward council and the ward then supported the committee in withholding payment until the end of the work. This happened despite the fact that the local ruling party (represented by the ward council) is from the opposition party (the TLP) and the HFGC is seen as being linked to the main governing party at the national level.

Relationship between the Health Facility Governing Committee and the District Council

The relationship between the HFGC and the district council was reported to be satisfactory. Good relations between these two groups was influenced by a variety of factors, including interpersonal trust in the in-charge who was well regarded by the district.

"I should say that my relationship with the District Executive Director and the District Medical Officer is good because when we have problems and speak with them they

understand us. This is why, even when we talked with them about the lack of houses for health providers, they gave money to construct houses for health providers. Even when we were constructing this new dispensary the relationship between us was good” (HFGC member, Sofi Majiji site)

Relations were also supported by the fact the HFGC had achieved a high rate of CHF enrolment within the ward.

The HFGC shared the minutes of their meetings with the district regularly, indicative of institutional trust in the district. Further, they approached the district to address a number of concerns initially raised by the DMT including: drug shortages; working hours of providers; and need for a midwife. In all three instances, the district responded and offered support to the HFGC by allowing them to use CHF revenue to purchase drugs, by providing a sign indicating facility working hours, and by sending a midwife to the facility. The district was also approached to address the issue of the midwife’s subsequent absenteeism, although a response had not yet been received at the time of the field work. The HFGC also requested and obtained additional funds from the district for further construction work for latrines and toilets and funds for constructing houses for providers.

Synthesis

HFGC functionality and impact was positively affected by external stimuli, forcing the HFGC to engage with other stakeholders and manage resources. In Sofi Majiji, the construction work, which was an ongoing activity, served as such a stimulus, motivating the committee to meet, providing an agenda for the meeting, and giving the HFGC the opportunity to manage funds and build interpersonal and institutional trust with the village government, the district and other committees, such as the TOC. HFGC relations with other stakeholders were also supported in Sofi Majiji by the personality and reputation of the in-charge, who was well respected and elicited high levels of interpersonal trust among the community at large.

In Kivukoni, the cholera sensitisation campaign, although short lived, was also effective in uniting the HFGC with other committees and the village government, despite previous tensions. However, the brevity of collaboration was such that supportive relations did not continue beyond the campaign. The absence of ongoing activities requiring collaboration among stakeholders in Kivukoni compromised their ability to override initial tensions and distrust and achieve greater impact.

The Sofi Majiji HFGC’s capacity to secure trust among the village government and the district council was clearly critical to their success. Indeed, village governments are required to resolve potential conflict with the community and ensure the committee has legitimacy in the eyes of the community. Village government support of the HFGC in Sofi Majiji was also found to increase community trust in the HFGC and its willingness to contribute to the CHF. Furthermore, the village government acts as an important bridge between the HFGC and the community in terms of information sharing at village meetings. In Sofi Majiji, the construction work enabled trust building between the village government and the HFGC and village government cooperation and support, overriding their initial scepticism towards the HFGC. In contrast, in Kivukoni, the initial village government distrust of the HFGC remained and the HFGC was not

able to engage with the village government or elicit their support, which undermined their ability to achieve impact.

Similarly, in Sofi Majiji, the relationship between the facility in-charge and the district council was good. Interpersonal trust was stimulated by the personality of the in-charge and his reputation. The district also developed institutional trust in the HFGC as a result of the successful engagement in construction activities and the high level of CHF enrolment. District support was also found to be critical to the HFGC's ability to achieve impact, as the district is required to authorise the use of financial resources, such as the CHF revenue, to intervene in the case of health worker shortages, and provide the means to address other structural concerns at the facility level.

The regularity of HFGC meetings allows for interpersonal trust building among committee members and enables decision making and action, as found in Sofi Majiji; however this is not in itself sufficient for committee impact. As currently structured, committees in both sites tended to largely reflect the interests of providers rather than communities, with the in-charges acting as a promoter of the interests of the dispensary management team and the health facility. Although the agenda for the meeting was developed jointly by the chairman and the in-charge, the in-charge would generally lead discussions, and meetings took place at the facility, making it more difficult for community concerns with the facility to be raised. The lack of representation of some of the villages on the Sofi Majiji HFGC, resulting from the phased implementation of the Primary Health Service Development Program (PHSDP) policy (often referred as Mpango wa Maendeleo ya Afya ya Msingi (MMAM) in Swahili), was felt to limit their capacity to undertake resource mobilisation activities, although they were still very effective.

Although, in principle, HFGCs are established to act as a linkage between the health system and the community, in practice, our findings suggest that the relationship between the HFGC and the community is less significant in determining impact because of the way the committees are embedded within the government system. The committees are not autonomous to interact and work with the community; they need to go through the village government and ask for a permit to do so, thus limiting their impact to the community. This fact makes the relationship between the HFGCs and the village government very important in the functioning of the committee. Unlike in Kivukoni, the relationship between the committee and the village government in Sofi Majiji was good, which also influenced its interaction to the community in line with the construction activities that was taking place at the dispensary.

Returning to our initial assessment of the functionality of all committees across the district, we found that five were performing poorly, and like Kivukoni, met infrequently without consistency in those attending meetings. Having agendas for the meeting influenced the HFGC in Sofi Majiji to conduct frequent meetings, unlike in Kivukoni. In, the rapid appraisal, the lack of agenda for the meeting was stated to affect the work of the committee. Seven committees were meeting at least as frequently as suggested by the guidelines, with consistency in members participating in the meetings, in line with Sofi Majiji. However, three of these committees scored low in the composition of members, indicating that there may have been some provider bias, with an insufficient number of representations by community members.

Overall, there is inconsistent use of the existing guidelines in forming and guiding the operations of the committee. For instance, the committee is supposed to have representatives from nongovernmental organisations from the respective community; however, the findings showed that their representation is low on most of the committees, excluding their voice and contribution. One of the roles of HFGC is to mobilise resources, and also use the resources to improve the services at their own locality; the process of using resources is affected by the bureaucracy at the district level. It was reported that 11 facility committees have applied for CHF funds without any response from the district and the situation might discourage the members, particularly due to the nature of their work (Voluntary work).

External stimuli, trust, relationships with other actors, and leadership (through the facility in-charge) were found to be critical for the functioning of HFGC in Kivukoni and Sofi Majiji to achieve positive impact. The HFGC has its own roles ranging from those related to the community, health systems and local government; however, in order to perform its role properly, the need to consider other external factors is also critical. Therefore, the following issues should be considered as possible mechanisms for improving functionality among committees across the district, as well as elsewhere in the country.

7. RECOMMENDATIONS

Strengthening internal functioning of committees

Interpersonal and institutional trust among members of the HFGC is an important factor enabling committee impact. Such trust is constructed by clearly defined roles and having tangible activities to carry out. Hence, there is an urgent need for more rigorous capacity building of HFGCs on their roles as well as their expected relationships with other committees. Our study indicates that the training/capacity building of the HFGC has to go hand-in-hand with empowering members to be creative in identifying ways to generate funds from government and non-governmental structures for supporting the needs of the health facility, and to identify effective methods of resource mobilisation among the community, especially in relation to the CHF.

The Empower project has recently developed new training guidelines and tools which were successfully piloted in four districts in 2009. This new training protocol, in addition to explaining the role of the committee, also covers methods of resource mobilisation as well as resource management techniques. This is a very positive step forward and there is an urgent need to scale up this training package to allow for greater functionality and impact of committees nationally. We would further suggest that emphasis is also given to illustrating the need for relationships with other committees and providing suggestions for ways of engaging these committees in collaborative action. Possibly, members of the village health committee and neighbouring NGOS might be included in the training. This would serve to foster stronger links among the different groups as well as a shared understanding of respective roles and responsibilities.

Our study highlights that the training on mobilisation of resources and use should not focus exclusively on the CHF, but should also consider the possibility of mobilising funds from districts as well as NGOs in the area. The Empower training guidelines also encourage group work during the training, allowing committee members to work together to develop a plan for resource mobilisation and expenditure requirements. The importance of trust building could be built into this component of the training, as well as making committees aware of the various avenues for accessing funds.

In addition to training, regular supervision of HFGCs from the district level is vital, especially in overseeing the selection process of committee members, and offering advice in relation to resource mobilisation strategies and ensuring appropriate fund management. New guidelines have been developed by the MOHSW, and the CHMT will now be responsible for providing regular supervision of the HFGC which should serve to improve committee functionality. However, such supervision should examine not only the extent of revenue generated and how funds have been used, but also the communication strategy adopted by the HFGC with regards to the community, and the extent of interactions with other committees, for example.

Committee members were generally keen to be paid allowances for attending meetings, and felt this would serve to motivate greater and more regular participation. The national guidelines suggest that CHF revenue be used by committee members to finance allowances. However, our study suggests that care is needed when introducing such allowances to ensure that they do not generate distrust or bad feeling among other key players in the community. It might be preferable to tie the payment of allowances to specific activities, which could involve a broader range of stakeholders, such as mobilisation of the CHF. The allowances could then be paid to all of those who contribute to resource mobilisation, rather than being tied to the HFGC. This might serve to motivate greater mobilisation activities and to encourage a broader range of stakeholders to get involved.

Building trust with other structures

Our study revealed that the relationship between the HFGC and the DMT was generally good. However, to ensure the effectiveness of HFGCs, it is important that they be linked to other structures in the community, particularly the village government and NGOs working in the area.

Links to the village government are important, as the village government provides access to the community, and can elicit community buy in to various initiatives, such as contributions to the CHF (despite a certain amount of community distrust of government structures, community members were generally willing to follow village government instructions). To this end, it is essential to build trust between the HFGC and the village government to counter any initial suspicion. One way of doing this is to involve the village government in the training activities, as indicated above. Joint ventures between the HFGC and the village government might also be encouraged. However, such ventures need either to be ongoing (such as construction work) or repeated (such as mobilisation of CHF contributions). One-off activities are not sufficient to build trust, as we saw in Kivukoni. In this respect, facility construction work can act as an important external stimulus, and a catalyst for trust building and network

development. As this will be an ongoing initiative nationwide, it is an opportunity to build on, as it not only allows for the development of relations between the HFGC and the village government, but also provides the HFGC with the means of managing resources, which is both empowering and motivating.

To facilitate relations between the HFGC and the village government, it will also be important to clarify respective roles during the training. It might also be helpful to provide overall responsibility for the HFGC to the village government. According to the guidelines, a member of the village government should be a member of the HFGC. The village government should be encouraged to ensure that the chairman of the village health committee is included as a member of the HFGC.

Creativity is needed in identifying more effective ways of communicating with the community and other structures, to improve community trust and encourage engagement with the committee. For example, it is important to ensure that community members understand the concept of risk pooling, especially that the CHF contributions will go into a larger pool to finance the care of the community, and that they will not be reimbursed if they do not use services.

Strengthening ‘community voice’ within HFGCs

The current conduct of meetings at the health facility tends to bias the meetings in favour of providers. Ideally, a more neutral meeting venue should be encouraged and identified. National discussions are currently indicating that the District Executive Director should be required to provide a meeting space for the CHSB. It seems that the village government may become responsible for offering a meeting space for health facility governing committees. This would be a helpful initiative, and ideally, a politically neutral meeting venue should be identified, such as schools, for example. This would serve to ensure greater neutrality in the conduct of meetings and the interests discussed, possibly ensuring greater representation of community interests. However, it may negatively affect participation by the in-charge given their other responsibilities at the facility and time constraints. Ideally, then, the venue should not be too far from the facility. Alternatively, the community members on the committee might meet separately within the community and report back their decisions or suggestions to the committee.

Greater sensitisation is needed for community members to understand the role of the HFGC in representing their needs to the facility, and to encourage them to raise their concerns and issues. Ideally, such sensitisation might be carried out by an independent community based organisation (an NGO, religious leader, women’s group, etc.)

While the PHCDP is laudable in seeking to increase access to primary care facilities in rural areas, it has resulted in some villages being temporarily without a dispensary and without representation on the corresponding dispensary committees. Care should be taken to ensure that those eligible for representation on the committee are those using the facility, and hence, as long as a village uses a dispensary in a neighboring village, they should be eligible for representation on the committee. This issue would need to be raised with a variety of stakeholders, including the village government, the district council and the HFGC.

Generally, although this would not affect HFGC functionality, our study indicated that it would be helpful to engage community members in the initiation of new policies so that they feel involved and that their opinion counts. This would help stop them feeling 'used' by the system, and give them a greater understanding of why their input is required and how it will benefit them (to the CHF or for construction work, for example).

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9. APPENDIX

Appendix 1: Assessment of Health Facility Governing Committee Functionality – To assist in selection of case study sites

(Interview the facility in-charge and the committee chair. Seek access to minutes for further validation. At least 20 HFGCs should be selected at random and assessed using the following criteria)

1. Who are the current members of the committee and when did they become members?

Draw up a list of names and for each person, get information on position in the community/job, gender, position in the committee, length of time as committee member, note whether any one simply does not attend any more.

2. How these committee members were identified (election or selection, by whom, through what process)?

Probe: Was it the same process for all current committee members? If not, what other ways were also used? (for whom and why?)

3. On what dates did the committee meet over the last three months? Is that the usual experience of how often the committee meets?

Probe: If not, why has it met so often in these months/what challenges have been faced in organising the meetings in these months?)

4. Did all the committee members attend the last 3 meetings/over the last 3 months?

Get answers by going through members' list initially developed and asking for each person if they were present at each of the meetings identified. If there were loads of meetings then just pick the last 3 meetings to ask about each member's attendance.

Probe: What influences whether and when members attend?

Note: If the respondent cannot remember these issues then go on to Question 5.

5. Usually, do all the members attend every meeting? Roughly how many members are there at most meetings?

Probe: Do some members always attend? Do some members never attend? What influences whether and when members attend?

If possible, look at the minutes of the last 3 meetings/meetings held over the last 3 months and use them a) to validate answers on above issues and b) to identify any specific issues/experiences of interest for follow up.

ASSESSING FUNCTIONALITY

For each of the above functionality indicators, we have created a scoring process to rank health facility governing committees in terms of their level of functionality. The aim is to select committees of high and middle/low functionality, but not one of no functionality. The average score across each criterion will be calculated. Hence, committees will be able to score a maximum of 3 points, and a minimum of 0. In order to be considered as a possible site for the case study, we would need the committee to score a minimum of 1 point. Committees below 1 point would be classified as not functional and excluded from the selection process.

Criteria	Performance standard HIGH (3 points)	MIDDLE (2 points)	LOW (1 point)	NO Functionality (0 points)
Q1 Composition of members	Full compliance with composition requirements /expectations	Slight deviations (e.g. too many men) affecting only 1 or 2 of the positions	Major deviations from the composition requirements	Unclear who the members are
Q2 Selection of committee members	Transparent process of selection for all members	Transparent process of selection for at least 50% of members	Transparent process of selection for less than 50% of members	Unclear how the members were selected
Q3 Meeting frequency	Higher than expected frequency (with expected based on policy guidance OR on a 'conventional practice for setting' derived from document review)	Same as expected frequency	Lower than expected frequency	Have not met at all in the past 6 months
Q4 / Q5 Consistency of members' attendance over time	At least 75% members attended the last 3 meetings OR Most members always attend meetings	Between 50-75% members attended the last 3 meetings OR Some members always attend meetings	Less than 50% members attended the last 3 meetings OR Little consistency in attendance of members	If scored 0 in Q3, then score 0 here.