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RESEARCH ARTICLE

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Perceived performance of health facility governing committees in overseeing healthcare services delivery in primary health care facilities in Tanzania

Anosisye M. Kesale[1,2] | **Mwandu Kini Jiyenze**[2,3] | **Leonard Katalambula**[4] | **Ally Y. Kinyaga**[3] | **Nathanael Sirili**[5] | **James S. Ngocho**[6] | **George Ruhago**[5] | **Amani Kikula**[5] | **Ntuli A. Kapologwe**[7] | **James T. Kengia**[7]

[1]Department of Local Government Management, School of Public Administration and Management, Mzumbe University, Morogoro, Tanzania

[2]Centre for Educational Development in Health Arusha (CEDHA), Arusha, Tanzania

[3]Center for Reforms, Innovation, Health Policies and Implementation Research (CeRIHI), Dodoma, Tanzania

[4]Department of Public Health and Community Nursing, School of Nursing and Public Health, University of Dodoma, Dodoma, Tanzania

[5]Muhimbili University of Health and Allied Sciences (MUHAS), Dar es salaam, Tanzania

[6]Department of Epidemiology and Applied Biostatistics, Kilimanjaro Christian Medical University College, Moshi, Tanzania

[7]Department of Health, Social Welfare and Nutrition Services, President's Office Regional Administration and Local Government (PORALG), Dodoma, Tanzania

Correspondence
Anosisye M. Kesale, Department of Local Government Management, School of Public Administration and Management, Mzumbe University, P.O. Box 2, Morogoro, Tanzania.
Email: akesale@mzumbe.ac.tz

Abstract

Health Facility Governing Committees (HFGCs) play a vital role in overseeing health services delivery in the primary health care system. However, despite their existence in Tanzania hiccups remain reported on the quality of health services delivered in primary health care facilities. The latter poses a question on the performance of HFGCs in overseeing the services delivery at the primary health facilities. This study sought to assess the perceived performance of the HFGCs and the associated factors in overseeing the healthcare services delivery at the primary health facilities in Tanzania. A cross-sectional study was conducted in five regions of Tanzania: Mwanza, Dar Es Salaam, Kilimanjaro, Pwani, and Arusha. A self-administered questionnaire containing structured questions was used to gather information from randomly selected 574 HFGC members. Data were analyzed descriptively and the binary logistic regression model was used to determine factors associated with the perceived performance. Half (50.52%) of the HFGCs members perceived themselves to have good performance. Furthermore, only 51.05% of all the participants had received any form of health management and governance

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training whereby about two-thirds had received training for only 1 day. The main factors associated with the perceived low performance of the HFGCs members were age, level of education and duration served in the HFGC. A low level of education was associated with the poor perceived performance of the HFGC (AOR 0.36 [CI: 0.23–0.55]). Similarly with increasing age, the odds of good-perceived performance lowered (AOR 0.26 [CI: 0.13, 0.55]). Serving as a HFGC member for less than 1 year was associated with poor perceived performance (AOR 0.40 [CI: 0.17, 0.95]). From these findings, it is recommended that the criteria for recruitment of HFGC members should be revisited. Furthermore, a qualitative study to explore contextual factors influencing the perforce of HFGCs is recommended.

KEYWORDS
health facility governing committees, performance, Tanzania, training needs

Highlights

- Effective community participation through Health Facility Governing Committees (HFGCs) is critical in improving the delivery of primary health care.
- Half of the HFGCs members perceived themselves to have low performance.
- Age, education level and experience of the HFGCs members are associated with low performance among HFGCs members.
- There is a need for reviewing the educational qualification criteria of HFGCs members to strengthen their management and governance capacities.

1 | INTRODUCTION

A strong Primary Health Care (PHC) system remains a cornerstone for quality health care services and population health in general.[1,2] PHC is rooted in a commitment to social justice, equity, solidarity and participation. Community participation is recognized as an essential element of health system resilience in ensuring the availability and governance of health services.[3] Community participation is important in enhancing health service delivery, quality of health services, and responsiveness at the PHC. Different efforts have been put in place by lower and middle-income countries to adopt community participation to improve health service delivery. In Tanzania, community participation in the provision and management of health services in health facilities is through various defined community governance structures.[4,5] These include the Council Health Service Boards (CHSB), district hospital boards (DHB) and health facility governing committees (HFGCs) for hospitals, health centres and dispensaries.[6–8] These community governance structures in health were designed to ensure accountability and to strengthen the linkage between the health system and the community in service delivery. HFGCs for instance are the governance entity for primary health care

facilities such as health centers and dispensaries. The HFGC is made up of elected community members, health facility in-charges, and other representatives of private health facilities under their control.[8] Members of HFGCs must be at least 21 years old, know how to read and write Kiswahili, and live in the area where the health facility is located. The primary responsibilities of HFGCs include planning and budgeting, mobilizing resources, supervising health facility performance, managing health facility assets, and procuring medical commodities. HFGCs also help to manage infrastructure construction and renovation, as well as collect and solve community health issues.[8]

Despite the formation of these governing structures and the availability of guidelines[6,9,10] several studies have reported the ineffectiveness and low efficiency of HFGC in discharging their duties despite health facilities being decentralized with political and administrative powers and functions. The World Health Organization[11] reported the unsatisfactory performance of the HFGC despite good intentions and efforts done by the government in South Africa as it was found that only three out of five facilities had HFGCs and only 35% of them conducted meetings. When exploring the role of HFGCs in ensuring social accountability in primary health care in West and Central Africa, it was observed that HFGCs failed to ensure social accountability among community members.[12] Poor leadership and linkage with other communities, low awareness of their roles and shortage of skills were cited as the main reasons for poor performance.[13] It has been asserted that the availability of training and financial autonomy for the healthcare facilities inspires HFGCs to carry out their delegated obligations under established protocols and practices.[14] However, in some facilities, it was found that meetings are more frequent when there are facility funds are available with discussions mainly focusing on funds utilization rather than the day-to-day functioning of the facility.[15,16] In the absence of fiscal decentralization in the catchment area of health facilities, other kinds of decentralization such as administrative and political have been insufficient.[17,18]

Fiscal decentralization has been advocated as a crucial component in delivering autonomy to decentralized health levels in a decentralized health service delivery. Fiscal decentralization refers to the transfer of fiscal or financial resource duties and powers from the central government to field levels or local government entities in the form of taxes, grants and financial-related decision-making powers.[14,19,20] It is expected that by shifting fiscal authorities to subnational levels such as HFGCs, the delivery of health services will fulfill local demands and respond to community needs on time. As a result, fiscal decentralization improves resource allocation by putting authority in the hands of health decision-makers (HFGCs). It is suggested that if fiscal decentralization is well designed, it can have a major impact on other dimensions of decentralization such as political and administrative decentralization, resulting in efficiency, equity, accountability, and innovation in health service provision.[21,22]

Since the 1990s, the Tanzanian government has been undertaking several reforms to strengthen the PHC health service supply. These reforms include increasing community participation in healthcare delivery oversight at primary healthcare facilities. To promote community participation, a legal framework was designed in 1999 that establishes HFGCs as community representative organs and lays out criteria for selecting members from the communities as well as their functions. As a result, beginning in 1999, every primary health care facility was required to have an HFGC. Since the establishment of HFGCs, promising improvements in health service delivery have been observed such as improved follow-up on the issues of staff recruitment and drug stock out, issues related to mismanagement of patients and rehabilitation and construction of health facilities as among the achievements of HFGC in Tanzania.[23,24] Elsewhere there were good signs of positive community–facility relations.[1,2] Despite the recorded positive impacts, shreds of evidence suggest that there has been the poor performance of HFGC in accomplishing their devolved functions.[25] HFGCs were found not to participate in planning and budgeting, managing financial resources and participating in the procurement process.[6]

To address HFGCs and health facility difficulties, Tanzania's government began implementing fiscal decentralization reform in primary health care facilities in 2017, by transferring fiscal responsibilities and functions from the council level to the facility level.[26] This fiscal decentralization is carried out using the Direct Health Facility Financing (DHFF) approach, in which facility funds from various sources, such as the Ministry of Finance and user fees are deposited in facility accounts rather than council or district accounts.[1] HFGCs are in charge of managing money, participating in planning and budgeting, and overseeing the use of funds in accordance with the health facility plan.[27,28] However, it

is not known how the empowered HFGCs currently performs under the DHFF context in public primary health facilities in Tanzania. Therefore, was conducted to assess the performance of HFGCs in accomplishing their devolved functions in primary health facilities implementing DHFF in Tanzania.

2 | METHODS

2.1 | Study area and design

Tanzania, through its national health policy, recognizes the existence and the role of the health facility governance committees. They are in place to facilitate community participation in the provision and management of health services in the district health system. Through the Ministry of Health (MOH) and other stakeholders, performance improvement assessments and training are continuously done.

Among the stakeholders, Benjamin Mkapa Foundation (BMF) in collaboration with the Centre for Reforms, Innovation, Health Policies and Implementation Research (CeRIHI), PORALG, regions and councils supported the needs assessment training which aimed at strengthening the management and governance capacity of the HFGC members in selected Councils of five regions namely; Arusha, Kilimanjaro, Pwani, Dar es Salaam and Mwanza. Within these supported sites and before the training, a baseline assessment was done. The baseline assessment aimed at establishing a self-rating level of performance and the factors that influence the perceived performance as members of the HFGC.

This was a cross-sectional study design done as part of the needs assessment training program under the BMF needs assessment training program.

2.2 | Sample size and sampling

From the five regions, the support by BMAf provided training to 1339 members of HFGCs. We used the latter number to compute a sample size to be included in this study. Using Yamane formula 1967, at a 95% confidence interval and margin of error of 5% and a non-response rate of 15% (due to the self-administered nature of the questionnaire) and a design effect of 1.5 we obtained a sample size of 574.

Multistage sampling was used to recruit participants for this study. In the first stage, five regions were purposefully selected. These were all regions that were supported by the Benjamin Mkapa Foundation on…. These regions were Kilimanjaro, Arusha, Pwani, Dar es Salaam and Mwanza.

The second stage involved the selection of councils to be included in the study. From Dar es Salaam all three old councils (Kinondoni, Ilala, and Temeke) were included due to their large population size and health facilities network. From the other four regions, we randomly selected two councils to be included in the study (Table 1).

In the third stage, we adopted a random sampling strategy to obtain the participants from the HFGCs from dispensaries and Health centres. We included only members of HFGC who are community members who are ordinal citizens, health facility in-charges who are secretaries of the HFGC, representatives of private health facilities in the HFGCs, representatives of NGOs in the HFGC; representatives of the health facility workers (e.g. health professionals representing) of HFGC were excluded in this study.

2.3 | Data collection, processing, and analysis

Data were collected using a structured questionnaire that was designed in the Open Data Kit mobile survey app (ODK). The questionnaire was developed by health management and governance specialists who are familiar with the Tanzanian environment. It was designed by authors who are health system experts and members of the PO-RALG, who are the coordinators and implementer supervisors of primary health care in Tanzania, and then translated into Swahili to ensure that the meaning of the questions was retained. The accuracy of the translation was verified by the

TABLE 1 Social and demographic characteristics of respondents (N = 574)

Variable	All *n* (%)	Kilimanjaro *n* (%)	Mwanza *n* (%)	Dar es Salaam *n* (%)	Arusha *n* (%)	Pwani *n* (%)
Sex						
Male	313 (54.53)	68 (21.73)	51 (16.29)	61 (19.49)	65 (20.77)	68 (21.73)
Female	261 (45.47)	69 (26.44)	37 (14.18)	61 (23.37)	48 (18.39)	46 (17.62)
Highest level of education						
Primary education	229 (39.90)	33 (14.41)	65 (28.38)	30 (13.10)	50 (21.83)	51 (22.27)
Secondary school	119 (20.73)	29 (24.37)	18 (15.13)	33 (27.73)	24 (20.17)	15 (12.61)
Above secondary	226 (39.37)	75 (33.19)	5 (2.21)	59 (26.11)	39 (17.26)	48 (21.24)
Type of health facility						
Dispensary	487 (84.84)	122 (25.05)	75 (15.40)	99 (20.33)	89 (18.28)	102 (20.94)
Health center	77 (13.41)	15 (19.48)	13 (16.88)	16 (20.78)	22 (28.57)	11 (14.29)
District hospital	7 (1.22)	0 (0.00)	0 (0.00)	7 (100.00)	0 (0.00)	0 (0.00)
Other	3 (0.52)	0 (0.00)	0 (0.00)	0 (0.00)	2 (66.67)	1 (33.33)
Age group						
Mean ± SD	46.06 ± 12.62					
≤30	70 (12.20)	19 (27.14)	6 (8.57)	10 (14.29)	12 (17.14)	23 (32.86)
31–40	152 (26.48)	22 (14.47)	31 (20.39)	24 (15.79)	35 (23.03)	40 (26.32)
41–50	142 (24.74)	26 (18.31)	22 (15.49)	35 (24.65)	34 (23.94)	25 (17.61)
51–60	134 (23.34)	44 (32.84)	20 (14.93)	31 (23.13)	20 (14.93)	19 (14.18)
61+	76 (13.24)	26 (34.21)	9 (11.84)	22 (28.95)	12 (15.79)	7 (9.21)
Years of being a member of the health facility committee						
Mean ± SD	3.168 ± 2.860					
≤1	194 (33.80)	27 (13.92)	47 (24.23)	38 (19.59)	55 (28.35)	27 (13.92)
2	115 (20.03)	18 (15.65)	17 (14.78)	49 (42.61)	13 (11.30)	18 (15.65)
3–5	188 (32.75)	68 (36.17)	17 (9.04)	24 (12.77)	32 (17.02)	47 (25.00)
>5	77 (13.41)	24 (31.17)	7 (9.09)	11 (14.29)	13 (16.88)	22 (28.57)
Frequency of membership of HCCC						
Once	316 (55.05)	58 (18.35)	62 (19.62)	84 (26.58)	64 (20.25)	48 (15.19)
Twice	195 (33.97)	61 (31.28)	21 (10.77)	25 (12.82)	38 (19.49)	50 (25.64)
More than twice	63 (10.98)	18 (28.57)	5 (7.94)	13 (20.63)	11 (17.46)	16 (25.40)

authors who took part in the training, as well as one member of the Council Health Management Team from each region, to maintain consistency and retain the original meaning based on the function of the HFGC as per guideline. The questionnaire was pilot-tested on 20 members of HFGC before data collection.

During the scheduled training sessions at the regions, questionnaires were administered to randomly selected participants with a consideration of a similar proportionate representation of the interviewed members from the respective regions (clusters).

2.4 | Dependent variable

Our dependent variable was the perceived performance of HFGCs. To get the outcome variable, thirteen Likert scale questions were asked, each of them had five responses 1 = strongly disagree, 2 = disagree, 3 = not sure, 4 = agree

and 5 = strongly agree. The thirteen Likert scale questions were derived from the Perceived Performance of Facility Governing Committees in Overseeing Service Delivery in Primary Health Care Facilities in Tanzania.

The mean score of thirteen elements was calculated, the computed composite variable had a possible minimum score of 1 and the possible maximum score of 5 then the score was dichotomized, those respondents who scored 3 or less were regarded to have poor perceived performance and those who scored 4 or 5 were regarded to have good performance.

2.5 | Reliability

Cronbach's alpha of thirteen questions was computed to examine the internal consistency or reliability of our tool. The Cronbach's alpha values range from 0 to 1, and the values above 0.7 represent an acceptable level of internal reliability[29] In this study the Cronbach's alpha value was 0.915 indicating that there is a high level of internal consistency for the scale.

2.6 | Independent variables

The independent variables of this study included the status of receiving the initial training for the Committee, terms of membership and years of being a member of the health facility Committee. Others included the sex of the respondent and education level.

2.7 | Data analysis

To describe the baseline characteristics of the respondents, basic descriptive statistics such as frequency and percentage were generated. Cross tabulation was also used to determine the percentage of performance for committee members based on their demographic features. Because the outcome variable had two responses (0 = poor performance, 1 = good performance), a binary logistic regression model was employed to identify factors associated with health facility governance committee members' perceived performance. The results of the model were presented in the form of regression parameter estimates and estimated odds ratios (ORs). The estimated OR, determined by taking the exponent of the regression parameter estimates, shows the increase or decrease in the likelihood of the outcome at a given level of the independent variable as compared to those in the reference category. SAS version 9.4 was used for data analysis and the significance of all statistical tests was determined at a 5% level of significance.

3 | RESULT

3.1 | Social and demographic characteristics

Among 574 health facility governance committee members, more than half (55%) were male, their age ranged from 18 to 79 years with a mean of 46.06 ± 12.62. The majority of respondents (85%) were from dispensaries followed by those from health centers (13.41%); only seven respondents came from the district hospital. Just over half of respondents, (55.05%) were members of HFGC at one term followed by (33.97%) who had two terms as members of HFGC. About (34%) of respondents had not more than 1 year of experience as a member of the HFGC (Table 1).

3.2 | Previous attendance to and need for health management and governance training

Almost half 293 (51%) of health facility governance committee members had received previous health management and governance training, among them 196 (67%) received a 1-day training (Table 2). About 293 (55%) of members

TABLE 2 Attendance to previous training received (N = 574)

Variable	Frequency	Percentage
Receiving the initial training for Committee		
No	281	48.95
Yes	293	51.05
Days did the training last[a]		
One day	196	66.89
More than 1 day	97	33.11
The training we received has enabled me to carryout the work of the Committee[a]		
Strongly disagree	12	4.10
Disagree	52	17.75
Not sure	63	21.50
Agree	134	45.73
Strongly agree	32	10.92
As a member of the committee, I am competent enough to carry out the responsibility		
Strongly disagree	33	5.75
Disagree	169	29.44
Not sure	132	23.00
Agree	165	28.75
Strongly agree	75	13.07
As a member of the committee, I have sufficient skills to perform the duties		
Strongly disagree	27	4.70
Disagree	181	31.53
Not sure	149	25.96
Agree	148	25.78
Strongly agree	69	12.02
Do you think at the moment there is a need for training to enable committee member		
No	11	1.92
Yes	563	98.08

[a]293 had received previous training.

said that the previous training enabled them to carry out the work of the committee. Concerning needs for training, the majority of the 563 (98%) reported that they needed health management and governance training to enable them to perform their duties and responsibilities.

3.3 | The perceived performance of the members of the health facility governance committees

Overall, 49.5% of HFGC members perceived themselves to have poor (low) performance on their duties and responsibilities (Table 3). Specifically, majority of HFGC members were in agreement with the statements that the committee can hold meetings at least four times a year (89%), committee members can fully identify health needs and problems from the community level (76%), committee members can approve the full use of funds for service delivery (75%), committee members can effectively oversee the procurement of medicine and other medical supplies for health care

TABLE 3 Perceived performance of the health facility governance committees' members (*N* = 574)

Statement: Committees members can:	Poor performance *n* (%)	Good performance *n* (%)
Fully identify health needs and problems from the community level	138 (24.04)	436 (75.96)
Actively participate in the preparation of the annual participatory action plan of the service delivery center	262 (45.64)	312 (54.36)
Thoroughly analyze the implementation reports of the facility's annual work plan	316 (55.05)	258 (44.95)
Actively participate in analyzing the revenue and expenditure statement of the service delivery	239 (41.64)	335 (58.36)
Effectively oversee the procurement of medicine and other medical supplies for health care	243 (42.33)	331 (57.67)
Approve the full use of funds for service delivery	143 (24.91)	431 (75.09)
Evaluate/determine the quality of services provided at the health care facility	243 (42.33)	331 (57.67)
Evaluate and advise on the progress of the fight against diseases facing the community especially AIDS, Tuberculosis and Malaria	326 (56.79)	248 (43.21)
Have enough understanding to be able to engage the community in various measures to combat epidemics such as COVID 19	318 (55.40)	256 (44.60)
Evaluate the quality of service provided at the community level by community-level staff or other health workers	283 (49.30)	291 (50.70)
Evaluate the performance of health orders at the services center level	247 (43.03)	327 (56.97)
Evaluate the performance of community health workers	301 (52.44)	273 (47.56)
Hold meetings at least four times a year	62 (10.80)	512 (89.20)
Overall performance	284 (49.48)	290 (50.52)

58%, they can actively participate in analyzing the revenue and expenditure statement of the service delivery (58%), evaluate/determine the quality of services provided at the health care facility 58%, can evaluate the performance of health orders at the services center level (57%), can actively participate in the preparation of the annual participatory action plan of the service delivery center 54% and a bit over half of them (51%) agreed in the statement that committee can evaluate the quality of service provided at the community level by community-level staff or other health workers.

3.4 | Factors associated with the perceived performance of health facility government committees

Age, level of education and years of a member being in the committees showed significant statistical association (Table 4). Members with higher levels of education as compared with those with primary level education had lower odds of having a well-perceived performance of the HFGC (AOR 0.36 [CI: 0.23–0.55]). Similarly with increasing age, the odds of having a good perception of performance lowered (AOR 0.26 [CI: 0.13, 0.55]), for those aged 60+ relative to the ≤30 age group. While those with 1 year or less of being a member of the committee had lower odds of having a well-perceived performance than those with more than 5 years in the HFGC (AOR 0.40 [CI: 0.17, 0.95].

4 | DISCUSSION

This study aimed at assessing the perceived performance of the HFGCs and the associated factors in overseeing the healthcare services delivery at the primary health facilities in Tanzania. The findings of the study indicate that

TABLE 4 Binary logistic analysis for factors associated with perceived performance for health facility government committees

	Poor	Good	Unadjusted		Adjusted	
Variable	*N* (%)	*N* (%)	**OR [95% CI]**	*p*-value	**AOR [95% CI]**	*p*-value
Sex						
Male	149 (47.60)	164 (52.40)	Ref			
Female	135 (51.72)	126 (48.28)	0.85 [0.61, 1.18]	0.3259		
Highest level of education						
Primary	91 (39.74)	138 (60.26)	Ref		Ref	
Secondary	67 (56.30)	52 (43.70)	0.51 [0.33, 0.80]	0.0034	0.47 [0.29, 0.75]	0.0018
Above secondary	126 (55.75)	100 (44.25)	0.52 [0.36, 0.76]	0.0007	0.36 [0.23, 0.55]	<0.0001
Age group						
≤30	32 (45.71)	38 (54.29)	Ref		Ref	
31–40	64 (42.11)	88 (57.89)	1.16 [0.66, 2.05]	0.6141	0.83 [0.46, 1.51]	0.5456
41–50	77 (54.23)	65 (45.77)	0.71 [0.40, 1.26]	0.2444	0.39 [0.21, 0.73]	0.0032
51–60	63 (47.01)	71 (52.99)	0.95 [0.53, 1.69]	0.8597	0.47 [0.24, 0.89]	0.0227
61+	48 (63.16)	28 (36.84)	0.49 [0.25, 0.95]	0.0354	0.26 [0.13, 0.55]	0.0004
Years of being a member of the health facility committee						
≤1	100 (51.55)	94 (48.45)	0.63 [0.37, 1.08]	0.0947	0.40 [0.17, 0.95]	0.0383
2	68 (59.13)	47 (40.87)	0.47 [0.26, 0.84]	0.0109	0.32 [0.14, 0.73]	0.0069
3–5	85 (45.21)	103 (54.79)	0.82 [0.48, 1.39]	0.4609	0.63 [0.31, 1.29]	0.2046
>5	31 (40.26)	46 (59.74)	Ref		Ref	
Frequency of membership of HCCC						
Once	167 (52.85)	149 (47.15)	Ref		Ref	
Twice	88 (45.13)	107 (54.87)	1.36 [0.95, 1.95]	0.0904	1.18 [0.72, 1.95]	0.5152
More than twice	29 (46.03)	34 (53.97)	1.31 [0.76, 2.26]	0.3237	1.04 [0.43, 2.37]	0.9935
Receiving the initial training for committee						
No	143 (50.89)	138 (49.11)	Ref			
Yes	141 (48.12)	152 (51.88)	1.12 [0.81, 1.55]	0.5076		

50.52% of the HFGCs members perceived to have good performance and 49.48% perceived to have poor performance. The perception of the HFGCs on their devolved functions implies that almost half of the members have adequate capacities to perform their duties and responsibilities. The findings show that HFGC members believe they have been performing well in conducting statutory meetings by 89.20%, identifying community needs and challenges by 75.96%, and authorizing facility expenditure by 75.9. HFGCs, on the other hand, were found to have poor performance in evaluating and advising on the progress of the community's fight against diseases such as AIDS, Tuberculosis, and Malaria by 43.21%, engaging the community in various measures to combat epidemics such as COVID 19 44.60%, and thoroughly analyzing the implementation reports of the facility's annual work plan 44.95%.

The findings suggest that the performance of the HFGCs is in the middle, with some positive signs, but we cannot be confident of this result given the gap between good and poor performance. This implies that HFGC performance under fiscal decentralization is neither good nor terrible. Other countries that implemented fiscal decentralization through DHFF arrangements, such as Kenya, discovered that HFGC performed well in a DHFF setting.[30] However, other African countries, such as Burundi, continued to have low HFGC performance even after implementing fiscal decentralization[31] According to Bossert, implementing decentralization does not ensure greater performance and

functionality of health services or community participation.[32,33] In the sense that people and institutions may choose not to use the decision space given by decentralization and instead reinstate their old ways of doing things. As a result, the findings of this study suggest that HFGCs in Tanzania may not have used the decision space provided by the DHFF as anticipated, though other variables may be impeding the use of DHFF platforms.

The findings also suggest that improving HFGCs performance capacity-building programs such as are inevitable. This is because the result suggests that 37% of the respondent agree that they have enough skills to perform their assigned duties. Respondents perceive training important for the members of the committee to increase their participation in overseeing service delivery by 98%. This might be caused by the nature of the community members who are elected to be HFGC members as they are just required to know to read and write swahil language, therefore they might lack the necessary skills to perform their mandates. Training on the way to accomplish their assigned mandate is necessary to close the educational and experience gap for the members. Under the DHFF arrangement prior to implementation, HFGCs in some areas were trained on how the DHFF arrangement will be implemented and what are the roles of the HFGC and health service providers. Continuous training HFGCs would appropriately give confidence and make community participation meaningful.

The performance of HFGCs is associated with the age of the members of HFGCs, the experience of the members in the HFGCs and the education level of the members of the HFGCs. The education level of the members of HFGCs for instance has influenced the variation of the HFGCs performance among the committees. Similar results have been reported elsewhere where educational levels were seen to have limited the ability of the HFGCs to participate in various functions related to decision making such as planning and budgeting.[7,26,34] According to the Tanzania HFGC guideline, members of the HFGC are just required to know how to read and write Swahili. However, when comparing the devolved functions of the HFGCs to the minimal education level, education criteria must be reviewed. Fiscal decentralization and HFGC guidelines demand HFGC to participate in planning, budgeting, financial management, and procurement, all of which are challenging jobs for someone who only knows how to read and write. As a result, HFGCs have shown poor performance in analyzing the implementation progress report that was presented to them.

Fiscal decentralization through the DHFF approach was intended to empower HFGCs and health service providers by allowing them to participate in the planning and budgeting process, financial management, and procurement process, allowing them to take control of health facility operations. However, the findings suggest that members of HFGCs have diverse viewpoints on the extent to which they have performed these obligations under the DHFF. particular, the results suggest that HFGC had an average performance in terms of engaging in the planning process, analyzing revenue and spending reports, and efficiently overseeing the procurement of medicine and medical commodities. Even though the result was not negative, it was predicted that HFGCs would perform these functions very effectively in comparison to the prior-DHFF environment. As previously noted, their educational level and experience may have hindered their ability to perform these responsibilities appropriately.

This study has strengths and limitations. Compared with the previous studies, this study used a large sample of 574 HFGC members; this sample was drawn from 11 councils in 5 regions of Tanzania Mainland. While interpreting this study caution should be taken to some inherent limitations in the design which include; the use of self-rating techniques to assess the performance of HFGC members, the quantitative nature of the study and thus limiting the exploration of socio-cultural factors. The use of the Mixed Method approach could have provided more comprehensive results than this single approach. Despite some limitations of self-reporting techniques, they are efficient and useful techniques to generate data in adults. The findings of this study reflect a true picture of HFGC performance as the sample size was representative of the general population.

5 | CONCLUSION

This study has underscored that the majority of the HFGC members have seen to have average performance if not poor. The evidence indicates that about half of the HFGC members perceived themselves to have poor (low) performance on their duties and responsibilities. Based on the evidence generated in this study, we recommend that

recruitment criteria in terms of the education of HFGC members should be revised to be relevant for them to perform their devolved functions. We recommend that given the real situation in both rural and urban areas secondary school education would be appropriate for them. Indeed, training for the HFGC members is recommended to be conducted annually to gauge their performance. Further, a large-scale study that adopts mixed methods is recommended to generate more insights into factors that affect the performance of HFGC in Tanzania.

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CONFLICT OF INTEREST

The authors declared no Conflict of Interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ETHICAL APPROVAL

Ethical approval for this study has been granted by the University of Dodoma (UDOM) ethical clearance committee and endorsed by the National Institute of Medical Research (NIMR)- (Ref. No. NIMR/HQ/R.8a/Vol. IX/2740). A consent form was issued to and completed by participants prior to the administration of the questionnaire.

ORCID

Anosisye M. Kesale https://orcid.org/0000-0002-3658-2386
Mwandu Kini Jiyenze https://orcid.org/0000-0003-3921-9715
George Ruhago https://orcid.org/0000-0001-7469-7822
Ntuli A. Kapologwe https://orcid.org/0000-0003-0900-2937

REFERENCES

1. Kuwawenaruwa A, Remme M, Mtei G, Makawia S, Maluka S, Kapologwe N, Borghi S. Bank accounts for public primary health care facilities: reflections on implementation from three districts in Tanzania. *Int J Health Plann Manag*. 2019;34(1):e860-e874. https://doi.org/10.1002/hpm.2702
2. Maluka S, Chitama D, Dungumaro E, Masawe C, Rao K, Shroff Z. Contracting-out primary health care services in Tanzania towards UHC: how policy processes and context influence policy design and implementation. *Int J Equity Health*. 2018;17(1):1-13. https://doi.org/10.1186/s12939-018-0835-8
3. Barker KM, Ling EJ, Fallah M, et al. Community Engagement for health system resilience: Evidence from Liberia's Ebola Epidemic. *Health Policy Plan*. 2020:1-8. https://doi.org/10.1093/heapol/czz174
4. Frumence G, Nyamhanga T, Mwangu M, Hurtig A. Participation in health planning in a decentralised health system: experiences from facility governing committees in the Kongwa district of Tanzania. *Global Publ Health*. 2014;9(10):1125-1138. https://doi.org/10.1080/17441692.2014.953563
5. Kessy FL. Improving health services through empowered community health governance structures in Tanzania. *Journal of Rural and Community Development*. 2014;9(2):14-31.
6. Kapologwe NA, Kalolo A, Kibusi SM, et al. Understanding the implementation of Direct Health Facility Financing and its effect on health system performance in Tanzania: a non-controlled before and after mixed method study protocol. *Health Res Pol Syst*. 2019;17(1):1-13. https://doi.org/10.1186/s12961-018-0400-3
7. Kesale AM, Mahonge CP, Muhanga M. The functionality of health facility governing committees and their associated factors in selected primary health facilities implementing direct health facility financing in Tanzania: a mixed-method study. *Health Sci Rep*. 2022;5(3):e611. https://doi.org/10.1002/hsr2.611
8. Tanzania J, ya M wa. MWONGOZO WA UUNDAJI NA UENDESHAJI WA BODI ZA HUDUMA ZA AFYA ZA HALMASHAURI NA KAMATI ZA USIMAMIZI ZA HOSPITALI, VITUO VYA AFYA NA ZAHANATI NCHINI TANZANIA Aprili; 2013.
9. Falisse JB, Meessen B, Ndayishimiye J, Bossuyt M. Community participation and voice mechanisms under performance-based financing schemes in Burundi. *Trop Med Int Health*. 2012;17(5):674-682. https://doi.org/10.1111/j.1365-3156.2012.02973.x

10. Mwandulusya A, Id K, Mahonge C, Muhanga M. The quest for accountability of Health Facility Governing committees implementing direct Health Facility Financing in Tanzania: a supply-side experience. 2022:1–16. https://doi.org/10.1371/journal.pone.0267708
11. WHO. A network for improving quality of care for maternal, newborn and child health: Monitoring framework. March 2016;14-16.
12. Lodenstein E, Mafuta E, Kpatchavi AC, et al. Social accountability in primary health care in West and Central Africa: exploring the role of health facility committees. *BMC Health Serv Res*. 2017;17:1-15. https://doi.org/10.1186/s12913-017-2344-7
13. Molyneux S, Atela M, Angwenyi V, Goodman C. Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. *Health Pol Plann*. 2012;27(7):541-554. https://doi.org/10.1093/heapol/czr083
14. James C, Beazley I, Penn C, et al. Decentralisation in the health sector and responsibilities across levels of government Impact on spending decisions and the budget. In: *7th Meeting of the OECD Joint Network of Senior Budget and Health Officials*. OECD; 2019.
15. Kesale AM, Mahonge C, Muhanga M. The quest for accountability of Health Facility Governing committees implementing direct Health Facility Financing in Tanzania: a supply-side experience. *PLOS ONE*. 2022;17(4):e0267708. https://doi.org/10.1371/journal.pone.0267708
16. Sitienei J, Manderson L, Nangami M. Community participation in the collaborative governance of primary health care facilities, Uasin Gishu County, Kenya. *PLOS ONE*. 2021;16(3):e0248914. https://doi.org/10.1371/journal.pone.0248914
17. Frumence G, Nyamhanga T, Mwangu M, Hurtig AK. Challenges to the implementation of health sector decentralization in Tanzania: experiences from kongwa district council. *Glob Health Action*. 2013;6(1):20983. https://doi.org/10.3402/gha.v6i0.20983
18. Renggli S, Mayumana I, Mboya D, et al. Towards improved health service quality in Tanzania: contribution of a supportive supervision approach to increased quality of primary healthcare. *BMC Health Serv Res*. 2019;19(1):1-23. https://doi.org/10.1186/s12913-019-4648-2
19. Samadi AH, Keshtkaran A, Kavosi Z, Vahedi S. The effect of fiscal decentralization on under-five mortality in Iran: a panel data analysis. *Int J Health Pol Manag*. 2013;1(4):301-306. https://doi.org/10.15171/ijhpm.2013.60
20. Saunders M, Lewis P, Thornhill A. *Research Methods for Business Students*, 4th ed. Financial Times Prentice Hall; 2007.
21. Hart T, Welham B. Fiscal decentralisation A public financial management introductory guide. November; 2016.
22. Panda B, Thakur HP. Decentralization and health system performance—a focused review of dimensions, difficulties, and derivatives in India. *BMC Health Serv Res*. 2016;16(Suppl 6):1-14. https://doi.org/10.1186/s12913-016-1784-9
23. Mwakasangula E, Igulu GR, Kamugisha D, Kesale A, Fundi S. The influence of leadership on good governance: the case of Selected villages in Rungwe and Babati district councils in Tanzania. *SSRN Electron J*. 2015:1-66. https://doi.org/10.2139/ssrn.2562328
24. Waweru E, Opwora A, Toda M, et al. Are Health Facility Management Committees in Kenya ready to implement financial management tasks Findings from a nationally representative survey. *BMC Health Serv Res*. 2013;13(1):1. https://doi.org/10.1186/1472-6963-13-404
25. Boex J. (n.d.) Decentralized Local Health Services in Tanzania. Vol 34.
26. Kesale A, Mahonge CMM. The determinants of the performance of Health Facility Governing committees (HFGC) in selected primary health facilities in Tanzania. *Tanzania J Commun Dev J Commun Dev Prof*. 2021;1(2).
27. Mwakatumbula H. *The Implementation of Direct Health Facility Financing (DHFF): Prospects and Challenges*. Repoa Brief; 2021. *PB 16*.May.
28. Tukay SM, Pasape L, Tani K, Manzi F. Evaluation of the direct Health Facility Financing Program in Improving maternal Health Services in Pangani district, Tanzania. *Int J Wom Health*. 2021;13(December):1227-1242. https://doi.org/10.2147/ijwh.s333900
29. Nunnally JC, Bernstein IH. Psychometric theory. *PsycCRITIQUES*. 1979;24:275-280. https://doi.org/10.1037/018882
30. Goodman C, Opwora A, Kabare M, Molyneux S. Health facility committees and facility management—exploring the nature and depth of their roles in Coast Province, Kenya. *BMC Health Serv Res*. 2011;11(1):229. https://doi.org/10.1186/1472-6963-11-229
31. Falisse J-B, Ntakarutimana L. When information is not power: community-elected health facility committees and health facility performance indicators. *Soc Sci Med*. 2020;265:113331. https://doi.org/10.1016/j.socscimed.2020.113331
32. Bossert TJ, Beauvais JC. Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space. *Health Pol Plann*. 2002;17(1):14-31. https://doi.org/10.1093/heapol/17.1.14

33. Bossert TJ, Mitchell AD. Health sector decentralization and local decision-making: decision space, institutional capacities and accountability in Pakistan. *Soc Sci Med*. 2011;72(1):39-48. https://doi.org/10.1016/j.socscimed.2010.10.019
34. Somi G, Matee I, Wengaa D, Darcy N, Perera S. Analysis of data Dissemination and Use Practices in the Health Sector in Tanzania: results of desk review and interviews with key stakeholders. *J Health Inform Afr*. 2017;4(1):79-89.

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