Implementation of direct health facility financing in Kigoma District Council, Tanzania

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IMPLEMENTATION OF DIRECT HEALTH FACILITY FINANCING IN KIGOMA DISTRICT COUNCIL, TANZANIA

By

Flora Joram

A Dissertation Submitted in (Partial) Fulfillment of the Requirements for the Degree of Master of Science (Project Management, Monitoring, and Evaluation in Health) of

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences, a dissertation entitled: **"Implementation of Direct Health Facility Financing in Kigoma District Council, Tanzania",** in (partial) fulfillment of the requirement for the degree of Master of Science (Project Management, Monitoring, and Evaluation in Health) of Muhimbili University of Health and Allied Sciences

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DECLARATION AND COPYRIGHT

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

Signature: ……. **Date**:……

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DEDICATION

This work is dedicated to my beloved parents Mwl. Joram James and Mwl. Nkumi Nchimbili, who since my academic career, has been praying for me, supporting, encouraging, and guiding me in the right way to reach this far. I also dedicate this work to my beloved husband Dr. Jairos N. Hiliza, our beloved daughters; Ilakoze and Ilambona for their prayers, sacrifices, support, and being deprived of my presence in the period of study.

ABSTRACT

Background: In 2016 Tanzania adopted direct health facility financing (DHFF) aiming at improving efficiency, foster innovations, and improve the quality of health services and its delivery; enhance accountability; increase service utilization and enhance community ownership of health services through improved joint priority setting, planning, monitoring, and resource mobilization. Since the program started, the assessment of implementation on whether actors align with the program guidelines has limitedly been conducted.

Objective: To explore experiences on the implementation of the program at primary health facilities in the Kigoma district council.

Method: This was a process evaluation that adopted a cross-sectional exploratory study using key informant interviews guided by a semi-structured interview guide. Key informants were selected among the DHFF program implementers at Kigoma primary health facilities. Qualitative content analysis was adopted for data analysis.

Results: Most of the respondents reported using the DHFF program guidelines, all facilities had program planning guidelines, HFGCs were actively involved in planning for and use of the funds; and the procurement procedures were followed. Some implementers received training on how to implement the program-related activities while others were not, and implementers received regular supportive supervision from the CHMTs. The persisted barriers included; lack of program ownership, delays in receiving funds, shortage of key implementers, also, low allowances to the committee members, internet network problems, inadequate funding, lack of meals and transport allowances, the complexity of the program rules and regulation, inadequate knowledge on the program implementation, and interferences from community leaders found to negatively affect the program implementation.

Conclusion: Generally, the implementation of the program was as per guidelines as it was experienced by implementers and the strategies used to implement the program. However, there were critical barriers experienced by program implementers which impeded the program implementation that needs to be dealt with by relevant authorities to ensure program

sustainability and acquire targeted outcomes. To mitigate these impediments, the district officials need to ease the procurement process, budget comprehensively into the CHOP, and create awareness about the program among key actors and the community.

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LIST OF ABBREVIATIONS

CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
HFGCM	Health Facility Governing Committee Members
CHOP	Comprehensive Health Facility Operational Plan
D by D	Decentralization by Devolution
DFF	Direct Facility Funding
DHFF	Direct Health Facility Financing
HFMT	Health Facility Management Team
HMIS	Health Management Information System
HRH	Human Resource for Health
IRB	Institution Review Board
KIIs	Key Informant Interviews.
LGA	Local Government Authority
MUHAS	The Muhimbili University of Health and Allied Sciences
PHC	Primary Health Care
PO-RALG	President Office Regional Authority and Local Government
RA	Research Assistant
RBF	Result Based Financing
TBA	Tradition Birth Attendant
UHC	Universal Health Coverage

WHO	World Health Organization
NHIF	National Health Insurance Fund
CHF	Community Health Fund

DEFINITION OF OPERATION TERMS

Direct Health Facility Financing	A government initiative that aims to implement fiscal decentralization in the health sector whilst fostering health services improvement. It involves direct disbursement of government or external funds to a health facility to meet the operational requirements of the health facility.
Implementation	The realization of an application or execution of a plan, idea, model, or design as intended to achieve the targets.
Strategy implementation	It is a term used to describe the activities within a workplace or organization to manage the activities associated with the delivery of a strategic plan.
Heath system	It is the organization of people, institutions, and resources that deliver healthcare services to meet the health needs of target populations
Primary Health care	This refers to essential healthcare that is based on scientifically sound and socially acceptable methods and technology, which make universal health care accessible to all individuals and families in a community.
Experience	It is the knowledge or mastery of an event or subject gained through involvement in or exposure to it.

CHAPTER ONE

1.0. INTRODUCTION

1.1. Background

Ensuring access to health care is a key component of the global agenda for health, as well as a programming priority. Globally, health financing emphasizes equity primary health care (PHC) and support for secondary and occasionally tertiary hospital care, aiming to minimize mortality and morbidity and improve the quality of health services(1).

To achieve PHC service delivery as stipulated in the Alma Ata Declaration, the decentralization of the health system to peripheral health systems was pinpointed as a prerequisite(2).

The World Bank enumerated the advantages of health system decentralization being; improved allocative efficiency by allowing the mix of services and expenditure to be shaped by local user preferences; improved technical efficiency through greater cost-consciousness at the local level; service delivery innovative through experimentation and adoption to local conditions; improved quality of transparency, accountability and legitimacy owing to user and participation in decision making; and greater equity through the distribution of resources towards traditionally marginal regions and groups(3).

In Africa region, the 2008 Ouagadougou Declaration on Primary Health financing, heads of states agreed to create an enabling environment; including incremental funding of health services reaching at least 15% of the overall national budget as it was earlier recommended in the Abuja Declaration 2001(4).

The same resolution quotes from other sources to indicate that if universal coverage of essential health services is to be achieved, health financing must move towards a predominant reliance on public funding for health services as the priority for governments. This will reduce reliance on prepayment to eliminate barriers to access health services, as many countries in the

region are yet to institutionalize robust prepayment systems that eliminate impoverishment of families due to out-of-pocket expenditure at the point of service(4).

Sub-Saharan countries have adopted several financing approaches to meet PHC objectives; the approaches include Result Based Financing (RBF), facility funding by revolving funds, and direct facility financing approaches(5). Most African countries have adopted decentralization by devolution (D by D) through directing health facility financing, to grant autonomy to health care providers in the planning, fund management, procurements, and expenditure reporting (6–9).

Over two-thirds of Tanzanians reside in rural areas and rely on local health facilities (such as Dispensaries and Health Centers) run by their Local Government Authorities (LGAs) to provide them with basic health services. Therefore, efforts to achieve major, sustainable improvements in local health outcomes will have to ensure that resources (including health staff, drugs, and medical supplies, operational expenses, as well as other health-related resources) reach the primary health facilities that form the front-line of public health service delivery in Tanzania(10).

In 1999, the Government of Tanzania established resources decentralization by devolution (D by D). The aim was to pool funds from government collections, donors, and other sources and put in one basket (basket funding) which was distributed proportionately to local government authorities, and granted the decision making power and the implementation of the national health strategies to local government authorities in mainland Tanzania(11).

This Health Financing Model targeted on allocative efficiency, where available resources are allocated by and in proportion to need. A reasonable rule is that areas with poorer health indicators should receive a larger allocation of funds. Therefore, a system in which areas with poorer health indicators get a larger share of funds(12).

In 2016 Tanzania adopted Direct Health Facility Financing (DHFF) program(7). However, still, there have been complaints from the facilities that they still face challenges in accessing the funds(13). The implementation of the program country-wise started from the midpoint of

(February 2018) the 2017/2018 fiscal year in all district councils in Tanzania, under the guidance of the President Office – Regional Administration and Local Government (PO-RALG). The direct health facility financing is a governance and leadership initiative to operationalize Health Sector Strategic Plan IV towards improved quality of services as well as utilization of services at the Council level. It supports the Health Care Financing Strategy and the move towards Universal Health Coverage(14). Direct health facility financing program, is expected to strengthen health services management at the facility level by improving efficiency and effectiveness use of funds. It charters towards sustainability and maintenance of health as an important development pre-requisite, as well as improving service delivery and utilization at lower health facilities (14).

It is further expected to enhance community ownership of health services through improved joint priority setting, planning, and monitoring, and resource mobilization. It is also expected that health service efficiency will improve through addressing the challenges encountered and reported by health facility staff, management, and community.

The DHFF depends on funds disbursed from Health Basket Funds (HBF), NHIF, CHF, and cost-sharing user fees to support health priorities and ensure adequate resource allocation for agreed-upon program areas(15). Funds are allocated to the individual facility within each district based on the workload.

1.2. Problem statement

Implementation of the DHFF program intends to strengthen health services management at the facility level by improving the efficiency and effective use of funds. It charters towards sustainability and maintenance of health as an important development pre-requisite. It aims to improve health service delivery and utilization in the primary health facilities, enhance community ownership of health services through improved joint priority setting, planning, and monitoring. It further focuses on resource mobilization as well as to improve efficiency in delivering health services through addressing the challenges encountered and reported by health facility staff, management, and community(14).

However, existing challenges such as understaffing, inadequately trained staff, delay in funds disbursement, and health facility geographical location are listed as the impediments of the implementation of health-related programs(16). Tanzania is experiencing a shortage of around 50% health workforce with a mean HRH attrition rate of 15.3% and none reporting rate of 26%(17). The situation is worse in rural health facilities; the few available health workers in rural facilities perform multiple duties including patients care, data management, and managerial tasks. Despite these tasks, the majority of health care providers have low financial management and procurement skills(17). The addition of the DHFF program that includes financial management and procurement logistics, add more burden to the already compromised primary health facility system.

Given the above, this study aimed to explore the experiences on the implementation of DHFF as per the program guideline in Primary Health Facilities in Kigoma District Council.

1.3. The conceptual framework for the implementation

The successful implementation of the DHFF program depends on how various facilitators and strategies interact. It further depends on how challenges are handled.

Facilitators of implementation *(Figure 1)* include community participation and functionality, availability of implementation guidelines, and friendly logistics and procurement procedures.

As illustrated in *figure 01,* the strategies on the successful implementation of DHFF include providers, receiving training about the program, and understand how it works. Supportive supervision from the accountants and CHMT is needed to support the financial management of resources by providers and assist in the generation of financial reports.

Both facilitators and strategies encounter challenges of which proper handling and solving leads to successful program implementation.

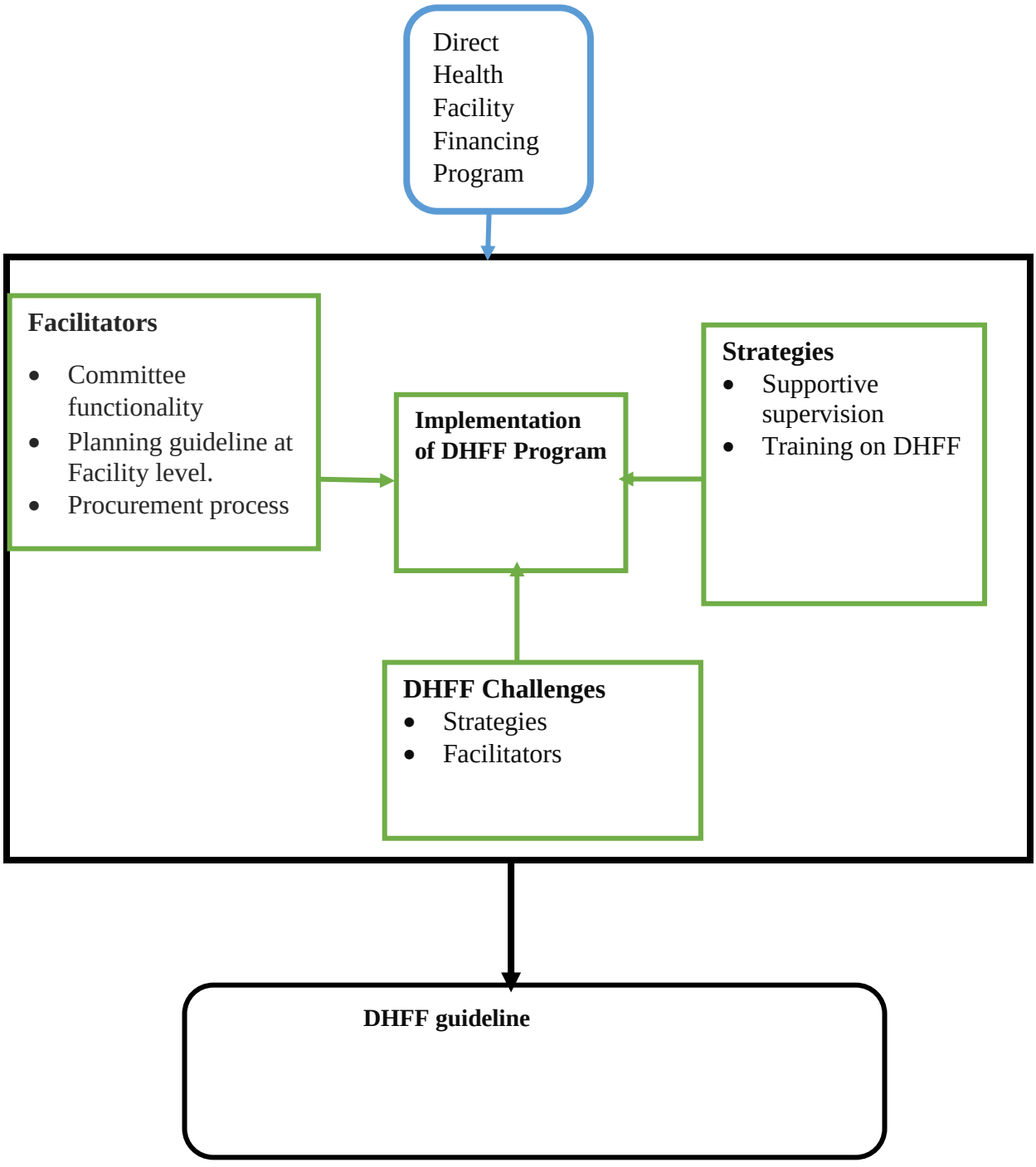


Figure 1: Conceptual framework of DHFF Implementation Program

1.4. The rationale of the Study

The study adds knowledge on the implementation of the DHFF program as it has explored experiences and challenges encountered during the implementation process.

1.5. Main Research question

What are the experiences of the DHFF program implementation among primary Health Facilities in Kigoma District council?

1.6. Specific Research Questions

1. How the strategies used to implement the DHFF program were in line with the guideline?
2. What facilitated adherence to DHFF program guideline during implementation?
3. What were the barriers encountered during DHFF program implementation?

1.7. Objectives

1.7.1. Broad objective

To explore the experiences on the implementation of the DHFF program at primary health facilities in Kigoma district council.

1.8.2. Specific objectives

1. To analyze the experience on the strategies used to implement the DHFF program in line with the DHFF guideline in Kigoma district council.
2. To explore experiences on facilitators for adherence to DHFF guideline during DHFF program implementation in Kigoma District Council.
3. To explore experiences on barriers encountered during DHFF program implementation in Kigoma District Council.

CHAPTER TWO

2.0. LITERATURE REVIEW

2.1. Experiences on implementation of Direct Health Facility Financing Program

The Alma Ata Declaration on primary health care states that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care". Community participation has re-emerged as an integral part of the decentralization of the health sector and essential for achieving high coverage and equitable distribution of health services(18).

Depending on the context, several studies have found varying experiences in health facility funding programs. The operations of Health Facility Committees (HFCs) reported having had improved since the introduction of DFF in Kenya. However, only a few people in the broader community had the information to participate actively in decision making. Particularly, limited financial information was observed in most health facilities(19).

Likewise in a comparative study done in Ghana, Zambia, Uganda, and the Philippines found a significant variation of the experiences in community involvement in the implementation of Health Facility Funding Programs(2).

Studies done by *Cornwall et al* have shown limited experiences from the key actors of the direct health facility financing program(18,20). A study by *Opwora et al* illustrated five stages of community participation; they found community participation ranking at the lowest stage of participation, indicating community being the recipient of health services only(19).

On the contrary, a study done by *Goodman et al* found increased community participation in health care services after the introduction of health facility funding programs(20). It further found health facility committee members (community representatives) were not able to read and write, and some were too old that could not actively involve themselves in implementing in the program(20). A study done by *Gasto et al* in Kongwa District Tanzania found an increased facility in-charges autonomy over financial management.

It further documented delays in fund disbursement and insufficient budget(21), which was also documented in the study done in Kenya(22). Some facilities experienced delays in receiving funds which affected the effectiveness of the implementation of the direct health facility financing program, and difficult financial reporting requirements, both affect the ability of facilities to deliver services effectively(23).

2.2. Direct Health Facility Financing Implementation barriers

The Government of Tanzania and its development partners identified that the existing health funding structure was not sustainable due to its donor and out of pocket dependence(12). Various studies done in the African context have enlisted inconsistent prioritization of health, weak budget implementation, and lack of transparency and accountability in the use and allocation of public resources as a barrier for DHFF implementation(15).

A study by *Opwora et al* documented poor facility manager autonomy at the primary health facility levels and lack of accountability of health facility governing committees; it further noted lack of training on HFGC members and persistence confusion over DHFF operation, reflecting limited HFC training and lack of DFF documentation at the facility level. It also found, workers, having problems with the accounting system, particularly filling and balancing of the DFF cashbook. Many said they could not understand the entries forcing them to frequently seek assistance from the district health accountant and, thereby, interrupting service provision at their facilities. In some facilities, DFF funds were not spent initially, even after several disbursements(19).

Findings from an evaluation of the health sector services fund (HSSF) in Kenya reported challenges to effective implementation of HSSF like delay in receiving funds, complexity documentation, inadequate HSSF training, low community awareness, lack of clarity in roles and responsibilities, and inadequate level of funds were found to be the barriers for DHFF(21,23).

Also, the study done by *Gasto et al* revealed several challenges that hinder the effective functioning of decentralization. These include inadequate funding, untimely disbursement of funds from the central government, insufficient and unqualified personnel, lack of community participation in planning, and political interference(21).On the contrary, a study done in Kenya reported common perception among health workers that direct facility funding motivated health workers to work better. Workers found it easier to perform their jobs because of the help provided by supportive staff(24).

2.3. Strategies towards Direct Health Facility financing implementation

Healthcare financing should be equitable, fairness in financial contribution, and protection against financial risk based on the notion that every household should pay a fair share. Health policymakers have long been concerned with protecting people from the possibility that ill health will lead to catastrophic financial payments and subsequent impoverishment(25).

World Health Organization Africa Region (WHO AFRO) reported on the progress that has been made in terms of universal adoption of the decentralization concept by countries, relocating decision-making power to district and community levels with enhanced community participation through community-based committees and availability of **various** types of community-owned resource persons, such as community health workers, traditional birth attendants (TBAs) or traditional practitioners, community drug distributors and others. Most countries in Africa have made significant efforts to work with health-related sectors to amplify socio-economic gains. Primary health care has assumed a central position in the multispectral approach and is driving it through the health management committees established at the operational level(4).

Tanzania government is dedicated to bringing fair, equitable, and quality health services to all Tanzanians in line with Universal Health Coverage (UHC). The district health services constitute the backbone of the health care in the country and deliver essential health care at a dispensary, health center, and district hospital level(14).

To achieve better health; adequate infrastructure, human resources, and funds for running the facilities including procurement of medicines are mandatory to increase the health status of the population.

A study done in Kenya reported to have training before DFF program implementation, training on how the fund was to be operated was conducted for the in-charges and HFC members. HFC members were also trained in their roles concerning DFF and health facility management. The executive committee members were taken through the accounting procedures and the process for making monthly returns using a special cash book dedicated to the DFF funds(19).

The training of HFCs in both districts was highly valued by members; however, problems emerged which pointed to shallow coverage of key elements of DFF operations such as the rules of the scheme, financial management, and filling in the cash book. All facilities surveyed had active HFCs(19). Likewise, the study done by *Gasto et al* showed several benefits of decentralization, including increased autonomy in local resource mobilization and utilization, and enhanced bottom-up planning approach, increased health workers' accountability, and reduction of bureaucratic procedures in decision making(21).

The DHFF program guideline in Tanzania illustrates substantial experience in planning health services at the council level and over the years, the planning capability has improved. The implementation of the DHFF program should be as much as possible aligned with the routine planning processes and take place within the normal CCHP planning timetable. The major shift is that health facilities will develop annual plans that will be compiled in the CCHP, will now have increased funding and plans will, therefore, be implementable(14).

The successful implementation of the DHFF program depends on providers getting training about the program and understanding how it works, including the implementation of a new financial reporting system. Similarly, assistant accountants are required to support the financial management of resources by providers and assist in how to prepare financial reports(26).

CHAPTER THREE

3.0. METHODOLOGY

3.1. Study design

This was a process evaluation that adopted a cross-sectional exploratory study design using a qualitative approach to collect and analyze data concerning the study objectives. This design was used to assess a set of predetermined DHFF program areas of focus on its implementation process. However, the choice of using qualitative instead of quantitative research was influenced by the nature of this study which needed an in-depth understanding of the program and aimed at exploring facilitators, strategies, and barriers for the implementation of the DHFF program.

3.2. Study Period

Data collection was conducted from the first week of August 2019 to the third week of August 2019.

3.3. Study Area

The study was conducted in Kigoma District Council which is located on the shores of Lake Tanganyika in the North West corner of Kigoma region which is located at longitudes 29.5 and 31.5 east, and Latitudes 3.5 and 6.5 South of the Equator. The region has 45,066 square kilometers with a population of 215,458 and a female to male ratio of 1:1 as per the 2012 population census(27). Kigoma District Council is among the eight Councils in Kigoma region as shown in the map. (Figure 02)

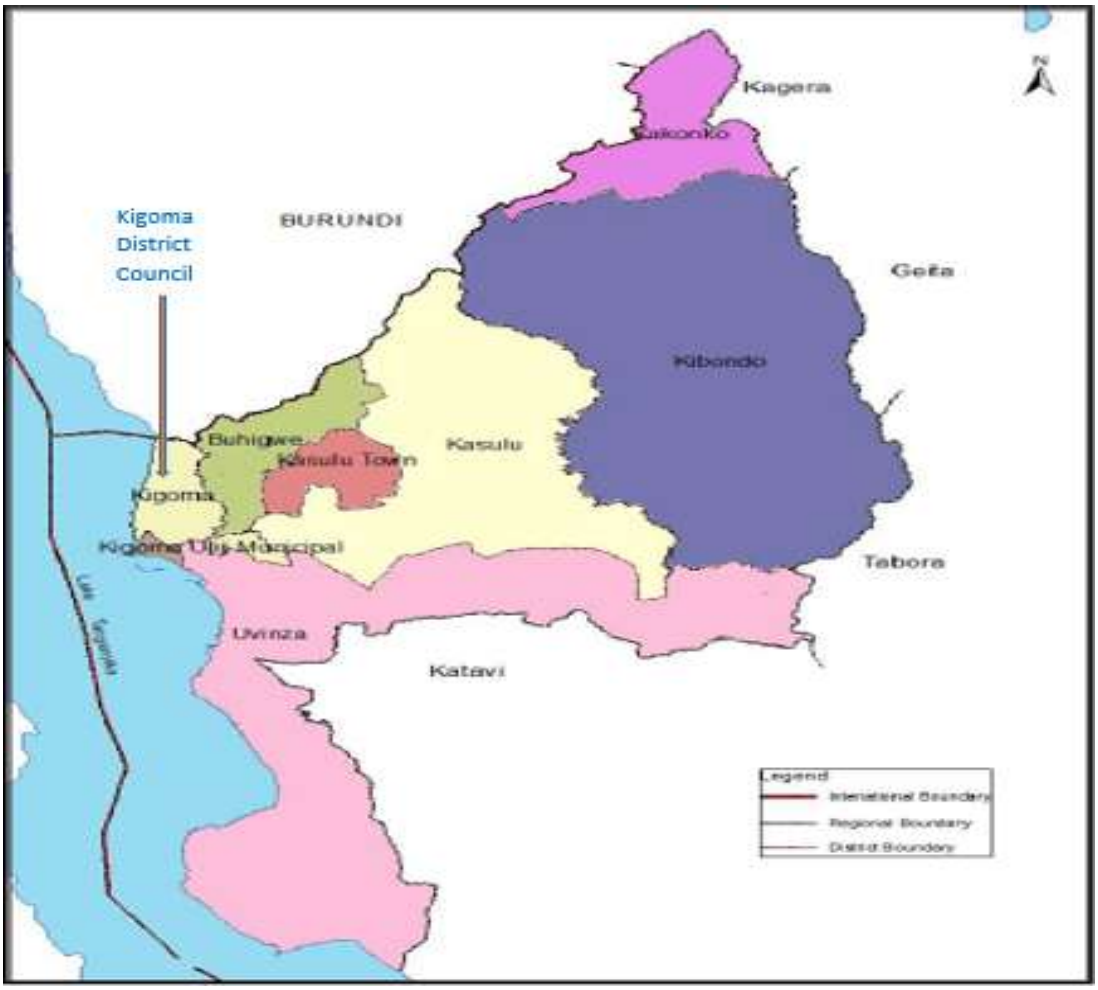


Figure 2: Kigoma map showing Councils. (27)

Kigoma district council was chosen from the other districts due to its geographical differences among the health facilities. Some facilities are allocated in peripheral areas along Lake Tanganyika where transport is a big challenge. Health workers in Kigoma district council experience different geographical challenges in reaching services at the district level where they can access support on how to implement the DHFF program. Also, the area experiences the shortage of HRH since most of the workers who get employment in that area do not report to their working stations due to its geographic locations and shortage of social services such as transport, clean water, education, internet networking, and better health services.

According to Tanzania HMIS, Kigoma district council has a total of 46 health facilities of which 34 (74%) are publicly owned; two health centres and 32 dispensaries, which implement a direct health facility funding program.

3.4. Study participants

Participants were health facility in-charges, health facility nurse in-charges (matrons/patrons), and health facility governing committee chairpersons and members. These were directly involved in the implementation of the DHFF program at health centers and dispensaries.

3.5. Sampling procedures and sample size

A purposeful sampling technique was used to get information-rich participants (28). The implementers from seven (7) primary health facilities at Kigoma district were interviewed until the saturation point was reached at the21st participant. Seven health facilities were chosen from other health facilities depending on their geographical location. These health facilities were assigned letters A, B, C, D, E, F, G, and from each health facility three participants were interviewed; Health facility in-charge, Matron/patron, and HFGC chairman/ member. Among seven health facilities visited three health facilities A, C, and G are located along Lake Tanganyika where transport is a big challenge. The other four health facilities B, D, E, and Fare located near district offices. This was based on the assumption that those health facilities near district offices may get quick support from district offices as compared to those facilities allocated along Lake Tanganyika.

Health facility in-charges ranged from 27 to 48 years of age. All the in-charges had diploma education. Nurses (matrons/patrons) ranged from 23 to54 years of age; five of them were registered nurses (RN) and two (2) were enrolled nurses (EN). Health facility governing committee chairpersons had the age ranging from 35 to 64, six of them had primary education and only one had diploma education.

Table 1: Study participants' operational cadres aggregated by age and sex

Participants operational cadre aggregated by age

		Matron/ Patrons (n)	Health Facility In-charge (n)	HFGC Chairpersons (n)	HFGC Members (n)	Total
Sex	Male	2	4	5	2	13
	Female	3	2	0	3	8
	Total	5	6	5	5	21

Participants operational cadre aggregated by age

Age	21 - 30	1	0	0	0	1
	31 - 40	3	4	2	1	10
	41 - 50	1	3	2	3	9
	50 >	0	0	1	0	1
	Total	**5**	**7**	**5**	**4**	**21**

Table 2: Distribution of Study Participants by Health Facility

Health facility	Participants (n=21)
Health Center A	3
Health Center B	3
Dispensary C	3
Dispensary D	3
Dispensary E	3
Dispensary F	3
Dispensary G	3

Distribution of Study Participants by Implementing titles

Implementing Title	Participants (n=21)
Health facility in-charges	7
Health facility patrons/matrons	7
Health facility governing committee chairperson	3
Health facility governing committee members	4

3.6. Data collection methods and tools

Both key informant interview guide and checklist were used to collect data. The interview guide questions were piloted at Ujiji health center and Buhanda dispensary in Kigoma municipal, each guide was piloted to respective targeted participants, thus; a guide for health facility in-charges was pre-tested to in-charges, interview guide for patron/matron was pre-tested to patron/matron and interview guide for HFGC chairperson was pre-tested to HFGC chairperson.

A key informant interview guide was used and administered individually to acquire an in-depth understanding of DHFF program implementation experiences from each study participant.

As for this study, the semi-structured interview guide was used, the interviewer was free to probe and explore different aspects of the study. The guide was developed to include all health facility in-charges, health facility matrons/patrons, and community representative members from HFGCs that were directly involved in the implementation of DHFF. The semi-structured interview guide was developed in the English language and then translated to the Swahili language to minimize language barriers during the data collection process.

A checklist was used to probe the availability of required relevant documents such as DHFF guidelines, CHOP, and reports related to the implementation of the DHFF program. These documents were reviewed to supplement the information gathered from interviews that were related to the study objectives.

Two trained Research Assistants (RAs) were recruited to assist in data collection, together with the Principal Investigator (PI). The role of RAs was to take spoken notes, and audio-recording of the interview while the PI was to administer the interview and fill in the checklist.

In-depth interviews were conducted at primary health facilities with participants who were directly involved in the implementation of the program, to get an in-depth understanding of the experiences encountered during the implementation process. During interviewing, notes were taken using notebooks. All interviews were audio-recorded using a tape recorder.

3.7. Data Collection Procedures

The researchers pre-tested the interview guide questions and checklist to health care workers at Ujiji health center and Buhanda dispensary to check practicability and align their responses with the study objectives. Pre-testing results were used to modify both interview guides and checklist to mitigate the challenges encountered during pre-testing before proceeding on the actual study process.

Two research assistants who were holders of degree in nursing and community sciences respectively were recruited and trained. The training included; understanding the objectives of the study, research questions that need to be answered, familiarizing them with interview guides and checklist, taking spoken notes, audio-recording, study area as well as the importance of confidentiality in research.

Upon arrival at Kigoma district authority, an introduction letter was handled to District Executive Director (DED), study objectives, and methodology was explained. Researchers were introduced to Kigoma District Medical Officer (DMO) who subsequently wrote the introduction letter to health facilities at which the data was collected.

An appointment to study participants was sought through phone calls, which included clarification of the visit purpose and time to spend with a participant. Upon arrival at the health facility, an introduction letter from DMO was handled to the health facility in-charge, who then informed eligible study participants. A consent form was given to each study participant, after understanding the study objectives and his/her right in the interview process, permission to continue with the interview was granted. Permission to respond to about a 50-minute interview was also sought from the participants. After obtaining written consent from participants, in a confidential and quiet room/place identified by participants, an interview was conducted. After an interview participant was thanked. This procedure was done for every eligible participant to the point of saturation. The point at which there was no new information obtained from participants or which was expected to be added and bring change to findings of the study.

A checklist was used to substantiate the interview findings and to capture the relevant documents such as the availability of DHFF guidelines and implementation reports at a health facility.

3.8. Data management

All interviews were audio-recorded and spoken notes were taken. Recorded scripts were checked after every interview for consistency and improvement. Every evening, a daily debriefing session was carried out between the principal researcher and research assistants to ensure that the study protocol was adhered to. Audio-recorded and spoken notes were transcribed verbatim. All transcripts were translated into the English language from Kiswahili and typed into computer files using Microsoft word 2007. Computer files were given serial alphabetical letters based on the interview date and participant position. Monitoring of data was at a high level of confidentiality, only those who were directly involved in the study (the researcher and assistant researchers) had access to the collected data. The tape recorders with audio-recorded data and supplementary collected data were kept in a safe box accessed by the principal investigator alone.

3.9. Analysis Plan

Analysis began during data collection so that interesting topics for further exploration to be incorporated into on-going fieldwork(29). After completion of each interview session, the PI carefully and repeatedly read through the audio-recordings and transcripts to identify whether there was any information skipped during interviewing in the field. Then, all the interviews were transcribed and translated into the English language qualitatively.

The content analysis approach was used in which the unit of analysis was chosen to be a whole interview to be kept in mind as a context for a meaningful unit during the analysis process. The texts were read and re-read several times to familiarize them with the interview materials. Codes were identified in the texts and then wrote at the margins. These were abstracted to form codes. These codes were collected and transferred to a coding sheet.

Through code comparison for similarities and dissimilarities, the codes were grouped into categories. The categories were further abstracted to form the main categories basing on the objectives of this study. Field notes and review of documents such as facility guidelines and DHFF implementation reports were used to clarify the emerging categories.

3.10. Trustworthiness

In a qualitative study, trustworthiness is attained when the findings of such a study are worth believing(30). To ensure trustworthiness, four criteria were considered, namely; credibility, dependability, transferability, and conformability(31). The credibility of the findings of this study was enhanced through the triangulation of informants where health facility in-charges, Nurses, and the health facility committee chairpersons with experiences and rich information on program implementation were interviewed. Triangulation of data collection methods was used to enhance the credibility and dependability of the study. Data were collected using interview guides, and document reviews were carried to increase the trustworthiness of the study findings. To ensure that the findings reflected informants' perspectives rather than the researchers' understanding of the question under study, categories were inductively generated and presented with the support of subcategories and quotes. The transferability of the findings of this study is enhanced through the description of the study data collection process, and analysis. Triangulation of methods was employed for data obtained from in-depth interviews and document reviews during the analysis process to strengthen the validity of the findings and making them trustworthy.

3.11. Ethical Considerations

Ethical clearance was obtained from Muhimbili University of Health and Allied Sciences (MUHAS) Research and Ethics Review Committee (REC) Reference number DA.287/298/01A. After obtaining ethical approval, an introduction letter from the Director of Postgraduate Studies was granted. Further permission and approval were obtained from Kigoma Regional Administrative Secretary (RAS) and then Kigoma District Executive Director (DED). Introduction letter to Kigoma District Medical Officer (DMO) was written

from DED who then introduced researchers to primary health facilities at which the data was collected. At each government authority, study objectives, methodology, and benefits were explained.

Written informed consent was sought from each study participant. Study objectives, methodology, and benefits were explained to each study participant. Only study participants who consented were interviewed and were free to withdraw from the study at any point in time. To assure confidentiality, the interviews were conducted in a comfortable place identified by participants themselves. Participants were assigned letters instead of names and only the researchers had access to the participants' information.

3.12. Dissemination plan

The findings of this study will be submitted and presented to the examination panel of the School of Public Health and Social Sciences in Partial/Fulfillment of the Academic Requirements for the Award of the Master of Science in Project Management Monitoring and Evaluation in Health.

The findings from the study will also be discussed with Kigoma district authority specifically the Kigoma district health management team and then the health facilities that participated in the study.

3.13. Study limitation and mitigation

The limitation of the study was on obtaining the data from the respondents due to the nature and sensitivity of the study. Some participants were not open to giving the information. However, to mitigate the limitations the researcher used face to face guided interviews and targeted individuals rather than groups of participants with a recording of the discussion. The PI assured the respondent on the confidentiality of the information recorded.

CHAPTER FOUR

4.0. RESULTS

4.1. Introduction

The study aimed to explore the experiences on the implementation of DHFF as per DHFF guidelines in primary health facilities of Kigoma district council.

During the analysis, three main categories emerged. The existence of formal training and supportive supervision towards the implementation of the DHFF program emerged with two subcategories including; usefulness of formal training on DHFF program implementation and supportive supervision from CHMTs.

The second category was adherence to DHFF program implementation guidelines which had three subcategories including; availability of planning guidelines at the health facility, functionality of heath facility governing committees, and adherence to DHFF program guidelines on procurement processes.

Lastly, the third category was on the existence of DHFF program implementation barriers which hindered the smooth implementation process of the DHFF program. This had ten sub-categories which include; lack of sense of ownership of the program, delays in disbursement of funds, inadequate health workers at the health facility, low awareness of the DHFF procedures for health facility governing committee members, insufficient of fund disbursed, lack of meals and transport allowances to DHFF implementers, internet network problems, the complexity of the program rules and regulations, low knowledge on program implementation among DHFF program implementers and interferences from community leaders.

Table 3: Summary of the findings Showing Category and Sub-Category

CATEGORY	SUBCATEGORIES.
Existence of formal training and supportive supervision towards the implementation of the DHFF program. Adherence to DHFF guidelines facilitates the program implementation process	• The usefulness of Formal Training on DHFF Implementation. • Supportive Supervision from CHMTs is crucial on DHFF implementation • Availability of Planning Guidelines at the health facility. • The functionality of Heath facility Governing Committees. • Procurement process.
Existence of barriers that hinder smooth implementation of DHFF Program	• Lack of Sense of Ownership of the Program. • Delays of Fund Disbursement. • Inadequate Health Workers. • Low allowances for Health Governing Committee Members. • Insufficient of Fund disbursement • Lack of Meals and Transport Allowances. • The complexity of the Program Rules, Regulations, and Operational System. • Low knowledge of program implementation. • Elected community leaders interferences.

4.2. Existence of formal training and supportive supervision towards the implementation of the DHFF program

This part presents the first main category that emerged during analysis. The implementers' experiences were explored on training and supportive supervision of CHMT to respective health facilities. The participants were asked whether they received training and how the training helped them in implementing the DHFF program. They were also asked whether they receive supportive supervision from CHMT and how such supervision enabled smooth implementation of the program. This category has two subcategories as explained below;

4.2.1. The usefulness of Formal Training on Direct Health Facility Financing Program Implementation

The effectiveness and Usefulness of the DHFF program rely on formal training to the program implementers. As it is stipulated in the DHFF guidelines, key DHFF program stakeholders are supposed to be trained to ensure smooth and sustainability implementation of the program.

In the Kigoma district council, formal training was not provided to all program implementers. There was the variability of formal training among study participants, some received informal training during supportive supervision and on the job mentorship.

The study participants were asked whether they receive formal training regarding DHFF program implementation and how such training help them in the implementation of the program.

The study participants reported formal training on the implementation of DHFF to be useful. Experiences from the study participants show that few facilities in-charges who received formal training regards it to be useful in the planning, procurement, and reporting of financial expenditure. Directions received from training helped them to follow the guidelines when performing activities related to the program. One participant from the dispensary said;

> *"Of course, I received the training, the training helped me on program implementation because if you receive training first you get directions on the guidelines to follow, for example, if I want to procure anything I have to conduct price competition and if I want to plan I have to call the committee meetings to set our priorities"* ***(Health Facility In charge for Facility A).***

Several other participants responded similarly, that formal training on the DHFF program enabled smooth program implementation without jeopardizing other duties at the health facility, as one participant said.

> *"To say the truth without training, I could not be able to do anything with this program, the training helped much as you can see I have no background in financial management, but now because of training I can handle and manage the funds we get following the directions".* ***(Health facility in-charge for facility C).***

The procurement process to health facility in-charges was adhered to because of formal program training. One participant responded,

> *"……I had no basic knowledge on the procurement process, because of the DHFF training now I can follow all procurement processes without difficulties"****(Health facility in-charge for facility C).***

Participants who have not formally trained on the DHFF program reported difficulties in the implementation of the program. They reported receiving on-site mentorship during supportive supervision, and on the job mentorship and coaching at health facilities from those who received formal program training. Lack of formal training, affected the effectiveness and quality of the program toward strengthening the program, as it was said by one of the participants;

> *"Aaaaa no I did not receive any formal training before the DHFF Program, but we receive on-site mentorship when they (CHMT) come for supervision, and even when we send documents to DMO for signing they correct us where we have done wrongly, in*

this way we learn!" We also get support from those who receive training as we ask them if we face any difficulty ***(Matron Health Facility D).***

It was further reported that the DHFF program guideline has some financial technical terms which need expert clarifications, which was missed to the informally trained participants. One patron responded;

"……..some other financial and procurement terms like Local Purchasing Order form are difficult to understand and even difficult to populate, if the in-charge is on leave I take his responsibility, I face difficulties in handling the DHFF program activities" ***(Patron for health facility A)***

4.2.2. Supportive supervision on implementing Direct Health Facility Financing Program

Supportive supervision refers to a friendly and supportive way of creating something to occur in the right way as required whereby the supervisor and supervisee assume the same role to demonstrate and study from each other. The DHFF program requires and gives the CHMT a supervisory role which includes, supervising health workers at health facilities, share the updates on how to implement program-related activities as well as approving work plans and funds to be used at the primary health facility.

In Kigoma District Council, supportive supervision was both ways, the CHMT could visit the health facilities, and health facilities workers could visit the CHMT offices for similar purposes.

Participants were asked whether scheduled and non-scheduled supportive supervision regarding the program was practiced. It was further enquired whether the supportive supervision was helpful and enabled smooth implementation of the program.

Participants reported supportive supervision being a pivotal pillar in supporting the DHFF program implementation at primary health facilities.

They further reported CHMT to have an overall supervisory role, including the approval of work plans which were a pre-requisite for funds to be disbursed.

The health facility workers acknowledge to be supervised regularly, it was reported that the DHFF program accountant and the DHFF district coordinator have a scheduled and non-scheduled visit to health facilities to support the implementation of the program, and even the health facility in-charges were regularly visiting the district office to get directions on how to implement DHFF related activities. This was supported by one of the respondent responses as follows:

> *"At the DMO office, they have a schedule to visit our facility for supportive supervision normally it is every quarter, but the accountant and DHFF coordinator they come to our facility regularly especially after the DHFF funds have been deposited into our facility account* ***(Health facility in-charge for health facility D).***

Participants reported visiting the CHMT office, especially when planning for procurement, and other DHFF fund expenditure. The CHMT approve the document and provide directives, as one health facility in-charge responded;

> *…… I occasionally go to the DMO office and receive directions from the DHFF coordinator or accountant. They show me how to perform activities concerning the program they show us many things for example how to plan, keep documents concerning the usage of money at the facility, and so on****" (Health facility in-charge for facility G).***

The participants also reported the importance of being supervised by CHMT, as they receive the updates on how to implement DHFF related activities and following the DHFF guidelines; One of the respondents revealed this by saying*;*

> *"There is a huge advantage of getting the supervision because when they supervise they give us the update too"……and, therefore they help us much as you can find that we have forgotten something at the facility as there are so many things to attend to, so when they come they remind us many things****" (Health Facility In charge for Facility D).***

Other health care providers reported that, during supportive supervision, they are mentored on how to prepare DHFF program implementation reports, especially, financial reports and on the consumables and supplies. They perceived the supportive supervision to support implementation activities of the program as one participant responded as follows;

> *"To prepare program report is difficult, but they (CHMT) come to our facility for supportive supervision, they mentor and coach us on how to prepare the DHFF program implementation report"* ***(Matron for facility E)***

This was further supported by facility patrons that when they send implementation report to the DMO office, a DHFF program coordinator support and coach them (health facility workers) on how to improve implementation reporting and reports. One participant responded;

> "*we get the supportive supervision, when we go to the DMO office with any documents for approval, there is the person who is responsible with this program so before going anywhere this person pass through our reports and provide advice on how to correct it"* ***(Patron from facility G).***

Similarly, another participant responded that*;*

> *"……. the CHMT comes to support us and see how we perform activities even those related to DHFF program at the facility level every quarter. This to some extent helps us in implementing the program properly"****(Patron for Facility B).***

On the contrary, the HFGC chairperson reported not to be aware of the supportive supervision. They reported noticing district staffs come to the facility regularly. As one responded;

> ***"****Frankly speaking, I have not been supervised by the CHMT, but I only see government staffs from the district come here regularly* ***(HFGC member for facility A).***

4.3. Adherence to DHFF guidelines facilitates the program implementation process

This part addresses the second main category that emerged during analysis. Facilitators that were explored include program planning guidelines, the functionality of the health facility governing committee, and the procurement process.

The participants were asked whether they had planning guidelines, and how they use guidelines when planning. They were also asked whether the health governing committee is functional and its involvement in matters concerning DHFF implementation activities.

They were asked also how the program guidelines are used when conducting the procurement process. It has three subcategories that were explored and analyzed.

4.3.1. Availability of ProgramPlanning Guidelines

The presence of DHFF planning guidelines was reported to be helpful in the preparation of Comprehensive Health Facility Operation Plans (CHOP). It was further reported that health facilities' priorities were identified based on the directive from the Ministry of Health priorities stated in the DHFF guidelines. As a participant from the health center stated;

> *"……. during annual planning, DHFF guidelines are used as a vision for CHOP and if the plan does not reflect DHFF guideline directives are returned for correction. In the DHFF guideline, there is a room for adding priorities basing on health facility context"* **(*Health facility in-charge for facility G).***

The study revealed the involvement of HFGC members in the preparation of health facility plans as directed in the DHFF guidelines. This was reported across all study participants, as one of them from the dispensary was quoted as;

> *"During the planning period, we call the committee here at the facility to discuss the planning process then we use the 13 Ministry of Health priorities and if we have other priorities we have apart from those we also say it and this is done as it is directed in the program guidelines"****(Matron for Facility D).***

A similar experience was expressed by another participant from the health center who revealed to use the guidelines when preparing DHFF yearly implementation plan which has to be approved by the PO-RALG. This supported the positive implementation of the DHFF program as stated in the guidelines. This was stated by one of the participants from a dispensary;

"Of course yes, we use a guide to prepare a plan, of which after being approved by PO-RALG through DMO they return it to us, therefore when we want to implement the program every quarter I use the approved plan and guideline from PO-RALG, for example; for the April-June quarter you have to implement certain activities depending on the initial plan, therefore, I use the guide and plan approved by PO-RALG……" ***(Health facility in-charge for facility E).***

4.3.2. Functionality of the Health Facility Governing Committee

All interviewees in this study reported having functional HFGC with active members from a varied range of geographical places surrounding the health facility where most of the members were peasants and few had a limited background in health issues. All HFGCs had a written constitution and minutes for the meetings. Meetings were held regularly as scheduled and members received a sitting allowance whenever they had a meeting. The existence of allowances was perceived to increase membership participation in the meetings.

It was reported that when funds are deposited into the facility account, a health facility in-charge calls all committee members to plan for procurement as they were also involved from the initial stage of the planning. This was reported by the participant from the health center as follows:

"We have the facility committee; the committee is the one that is responsible to decide on the priorities of the facility and the things that need priorities so that to improve service at the facility" ***(Health facility in-charge for facility F).***

The experiences from the study participants revealed that the HFGC members have the task of identifying additional health facility priorities from the initial stage during the preparation of the plan and implementation.

The same information was revealed by another participant as follows;

"……..so, what we do, we prepare the plan with the committee basing on the priorities set by the ministry of health and additional priories identified by HFGC, we normally

*use 3 to 5 days……"(**Health facility in-charge for facility E).***

Experiences from the HFGC's members revealed that there was positive involvement in matters concerning DHFF implementation; for example, they are signatories in approving DHFF facility plans and procurement plans. This was revealed by the HFGC chairperson at the health center as follows;

> "*The letter from the DMO comes to the facility in charge for the aim of calling a meeting aimed to prepare a procurement plan, they cannot implement anything without involving us because I have a place to sign, and truly I can say that everything done at the facility concerning DHFF implementation am aware of it" (**HFGC Chairperson for facility A).***

The same findings were also supported by one of the respondents from the health facility governing committee at dispensary who reported that;

> "*…… all the funds deposited in our health facility account has been used to procure facilities supplies as planned and nothing can be done without the committee involvement". **(HFGC chairperson for facility E).***

4.3.3. Adherence to the Program Procurement Processes

The DHFF guidelines require the HFGC involvement in procurement processes, starting from planning, bidding, and reception of the delivered supplies. It also mandates the committee with the review of the supplies expenditure report. This sustains the program and increases community accountability to the DHFF program. Responses from participants illustrate the involvement of HFGCs in procurement processes. They sit and discuss what to procure, where to procure, and come out with the common agreement. After this process, they conduct bidder competitions to find a price at the market and they (HFGCs) select one bidder from three bidders who seems to have affordable price compared with others and ordering is done using Local Purchasing Order (L.P. O) as one of the key informants from health center said;

> *"……. if we want to buy stationeries OR anything, the committee sits after the funds have been deposited in our facility bank account and decide. for example, ten thousand is for the supplies for cleanliness, or one hundred thousand is for buying gas as it is in the facility plan, after agreement from committee members we go to the market to conduct bidding, we used the guide of 3 bidders, based on the market prices, then we choose the one who has a low price compared to others" (**Health facility in-charge for facility C).***

Most participants reported procurement approval to take a long time, and sometimes cause some supplies to become out of stocks, as after the committee has approved, the meeting minutes were sent to DMO for approval, then to District Executive Director who also approve the procurement. After all, this District Procurement Officer verifies the procurement list and finally to the chosen supplier. This was reflected by the participant from the health center as;

> "*We have a bit long process we normally sit with the committee, after sitting with the facility workers and knows what we need at the facility, the committee approves what we want to procure then we write minutes and send it to the DMOs office, after DMO we also go to the procurement office where we get technical advice about what is supposed to be procured using DHFF money after that we go to the DED who also approve the procurement plan after that we go to the supplier and give him/her the list of the things we want to procure, this process can take even a month causing stock out of supplies in our facility"**(Health Facility In charge for Facility F).***

4.4. Existence of barriers that hinder the smooth implementation of DHFF Program

This part explores the third main category of barriers encountered during DHFF implementation. The participants were asked about the barriers encountered during the implementation of the DHFF program. These barriers were reported to affect negatively the desired outcome of the program. Analysis has generated ten subcategories namely; lack of sense of ownership of the program, delays of funds disbursement**,** inadequate health workers,

Low awareness of the DHFF procedures for health facility governing committee members, internet network problems, insufficiency of funds disbursed, lack of meal and transport allowances, the complexity of the program rules and regulations, inadequate knowledge on program implementation and Interferences the community leaders.

4.4.1. Lack of Sense of Ownership of the Program

The study revealed the implementers at the health centers and dispensaries to have less mandate on the program implementation, although funds were deposited into their health facility accounts, they did not have the mandate to use the funds to solve the facility needs without the approval from the DMO, even if they planned for it. The experience from Health facility implementers shows that (CHMT) can deny the implementation of certain activities in the CHOP if that activity is not in their interest. This was well expressed by one of the Program implementers at the health facility as follows;

> ***"****Challenges are so many first, funds are deposited into our accounts (facility accounts) but in a real sense, they (CHMTs) are still the owner of the funds. They are the ones who approve how to use the funds. It reaches a stage when we see that the facility needs a certain thing we want to buy it, but they say no you cannot buy it even if it is in the plan, this is a challenge"* ***(Health facility in-charge for facility B).***

Across the district, DHFF implementers at Dispensaries and health centers reported to have no mandate on utilizing the DHFF fund rather the CHMTs have a mandate even to cancel what the facility real need, and they (Health facility implementers) had no mandate to utilize fund without CHMTs approval.

> "*We are not free to use the money at the facility though funds are deposited in our facility account. We can plan to buy gas for our facility usage but when we go to the district for approval, they (CHMTs)cancel what we need at the facility and bad enough we cannot do anything without their approval"****(Health facility In charge for the facility D)***

4.4.2. Delays of Funds Disbursement

Participants reported the delay of fund disbursement to be one of the challenges facing DHFF implementation. Activities in the CHOP were supposed to be implemented in each quarter, but they reported a trend of not receiving funds to support implementation at a required time which affects activities implementation at the health facility as they were forced to implement more than one quarterly planned activities in one quarter which affected implementation efficiency and effectiveness. One of the participants at the dispensary put this more clearly when she said;

> "*There is also a delay of funds, deposition into our health facility bank account for example; we plan to implement certain activities in October – December you find nothing has been deposited into the account for the whole quarter. It can be deposited even after two quarters. If we implement the past quarter at the same time, there is a need to implement the current quarter too"* ***(Matron for facility G).***

It was noted that; most of the time, funds deposited into facility bank accounts cover two previous quarters and the current quarter. In this instance necessitate implementers at the facility level to utilize funds meant for three quarters in one quarter. This cause crowding of activities with understaffing rendering inefficiency and ineffectiveness of the performance at the health facility, as it was stated by one of the participants at the health center that;

> *" …… it can happen that all the funds deposited at the same time, for example, funds that cover three quarters deposited into the facility bank account at once. Therefore, we have to implement the activities of both three quarters. This affects much our normal work performance at the facility as we have to spare extra time to finish those activities. And we have much time to be out of stock for essential supplies"* ***(Health facility in-charge for facility E).***

4.4.3. Inadequate Health Workers

Many respondents revealed a shortage of health workers at the facilities to impede the successful implementation of the DHFF program. At the district office, two temporary employed accountants were dedicated to counter check activities from all 32 health facilities

in the district. Even a week can elapse while waiting to be served. In these cases, it was reported to interfere with daily clinical services when one staff is making follow up on the approval of program-related activities. One of the respondents from the dispensary said the following;

> *"Most of the time there is an interference of the timetable. Because you can find that in the facility there are only two workers, then the other one can take leave while it is the time to collect the plans at the district office. Therefore you have to find a person from the neighbor facility to take charge at your facility instead of you so that you bring the document at the district office. This affects the normal clinical routine at the facility, real affect work performance at the facility*" ***(Matron for Health Facility D).***

It was found that health facilities staff uses their extra time to complete the program related activities so that they spare time for the patients at the facility. This was reported by the health facility in-charge as follows;

> " *speaking the truth this program affects my responsibility at the facility. I also use night time to compensate for the time so that I at least get time for the patients at the facility"* ***(Health facility in charge of facility B).***

Understaffing was even seen at the District office. All 32 health facilities had no accountant. The two accountants available at the district level serve32 health facilities to support the implementation of DHFF related activities in the whole district. Study participants reported harshness from the accountants when they (DHFF implementers) seeks assistance from them. It was pinpointed that, their harshness was caused by their shortage in number, and the district not able to pay monthly allowances to the accountants on time, as they were working with the district temporarily. This was reported by one of the respondents from the health center as follows;

> *"....in our facility, there is no accountant. Therefore, we depend on two accountants at the district office and they sometimes become angry with work, as there are only two accountants for the whole district.*

*You can have a document that has already signed by the DED when it comes a time to go to the accountant, you find that she has many files that she is supposed to work with, and there are more than 30 health facilities that they work with. Remember even those two we have they are not employed by the government, they are the party time workers and they get paid depending on the availability of money at the district office., You can go there and find that they are not paid even for the three months that makes them harsh when serving us****" (Health facility in-charge for facility F).***

4.4.4. Awareness of Health Facility Governing Committee to the Program Procedures

It was noted that HFGC members were not aware of allowances directives reflected in the program guidelines. They were de-motivated as they claimed to receive very low allowances. They reported to sit and discuss the implementation of DHFF planned activities and approve an expenditure of many funds but receive ten thousand per sitting. Members of the committee demanded more allowances rather than the amount which was directed in the guideline where each member has to receive ten thousand as a sitting allowance for every meeting concerning DHFF matters. One respondent from community representative said;

"*…...we approve an expenditure of a lot of funds, but we only receive ten thousand in return, this is de-motivating us" **(HFGC Member for facility F).***

They demanded enough proportion of funds that they have to distribute among themselves as they heard the health facility receive a certain amount of money; this was because most of the committee members had low knowledge and were unaware of DHFF funds expenditure and the importance of such fund at the Health facility. This was expressed by one of the participants as;

*"The challenges I have here at my working place, whenever funds are deposited into facility account. The committee members demand much money in a proportion of the deposited amount. They always ask why do they sit for a meeting and paid only 10 thousand while we have heard the account has received six million? Why don't we take some amount of money and distribute among ourselves, hahahaaaa when you educate them you face the challenge****" (Health Facility In charge of facility A).***

4.4.5. Effect of the Internet on Implementation of the Program

Participants especially those who work in health facilities along Lake Tanganyika reported a problem in accessing the internet. They were forced to travel to town (Kigoma Municipal) to access the internet.

The experience shows that the internet network problem was a challenge that hindered the smooth implementation of the DHFF program as expressed by one of the respondents as follows;

> *"……. if you want to login into FASI system you need a network; for example, if you want to procure anything you login into the system to prepare a checklist to pay the bidder, I use the internet and here in the village there is an internet networking problem so to login in the system you find it difficult requiring a cost to travel to the town where I access the internet to prepare the checklist instead of doing it at the facility while continuing to attend the patients"* ***(Health facility in-charge for facility G).***

Similar experience on Internet connectivity problems was reported by health workers who worked at the health facility located along Lake Tanganyika. They were not even able to communicate with DHFF implementers at the district level even through their mobile phones to receive updates regarding program implementation. They were also not able to login to the DHFF system if they were at the facility, this led them to have a regular trip to the town where they can access the internet and support from the CHMT. This was considered as a setback to the performance at the health facility. One respondent from the dispensary was quoted as follows;

> "*There is the problem of a network at our facility, I cannot communicate if am here at my office, I cannot even make a call and if I want to call anyone there is a place where we find network we have to climb a small mountain to access network, therefore if am here I cannot log in into the program system as it needs network also*" ***(Health facility in-charge for facility F).***

Internet networks were not big challenges among the implementers at the health centers and dispensaries allocated near district offices. They reported having access on the internet when they needed it in fulfilling DHFF related matters. This was reported by one respondent as follows;

> "*Program activities requiring the use of the internet are done here at the facility, internet networking is available here especially during the night, I can make a call at districts when I am here at the facility"* ***(Health facility in-charge for facility A).***

4.4.6. Insufficiency of Funds Disbursement

Respondents reported their health centres and dispensaries to receive an inadequate amount of funds which was less than they planned in the CHOP. And hence priorities were not covered as planned. This was ascertained during the document review at which the CHOP plan was compared to a facility account bank statement. Other respondents from health facilities reported to have large coverage in service provision to clients compared to the amount of fund they received, as it was said by a respondent from a dispensary;

> *"……..small amount of funds is deposited into the account. The fund is not enough considering the needs of the facility for example here at my facility there is a high population of people who seeks service here"* ***(Health facility in-charge for facility D).***

A similar experience was reported among implementers from health facility governing committee representatives from the community, who reported to have difficulties when planning for the procurement of health facility supplies.

> "*We face challenges whenever we want to procure sufficient supplies for our dispensary because the fund is not enough to cover all the facility needs"****(*****HFGC's member for Facility E*****).***

4.4.7. Lack of Meal and Transport Allowances

In this study, meal and transport allowances to both HFGC members and health facility staff was pinpointed to be a big challenge facing DHFF implementation; as DHFF funds reported not to cover this aspect.

Study participants from health centers and dispensaries revealed that health facility in-charges use their earnings to pay the committee members for transport and meal allowances. It was further found that they do this to meet DHFF requirements which direct that, in every step of the procurement process HFGC members should be represented. In this instance they have to travel to the town where they can access different bidders and conduct price competition as directed by the program guidelines, one participant stated;

> *"….people (HFGC members) we normally go with to do procurement quotation you find that they don't have even money for transport and meals. They are normal villagers, you tell them it's a direction from the government that we have to go to the town to do price competition. He said; he does not have money for transport. That forces me to pay my own money for their transport so that to show that I have followed the guideline in implementation"* ***(Health facility in-charge for facility D).***

Similarly, the HFGC chairperson reported demanding transport support from the facility in-charges especially when they are required to sign a fund withdrawal form to withdraw funds from the facility bank account in town (Kigoma Municipal) as a community representative and most of them were peasants who always claimed not to afford transport. One of the participants said;

> *"….it happens after following the whole process, to authorize fund to withdraw from Bank account, As HFGC representative I need to sign fund withdraw form at the bank, and I am required travel to Kigoma municipal where the bank is.In this case, I have to ask support from the in-charge"* ***(HFGC chairperson for facility D).***

Health facility in-charges working at health facilities located along Lake Tanganyika reported the same which showed widespread concern. It indicated persistent of the problem across Kigoma district, as one of the participants was quoted as;

> *"……..I am forced to support an HFGC member to travel with me for fund withdraw procedures at the bank in town" (****Health facility in-charge for facility E).***

The same findings were also reported by the study participants from the facility located nearly to the district office. They reported experiencing difficulties in accessing money to cover transport and meals. They claimed to have very low economic status as they can not afford money to cover all the trips they travel from their facilities to the town where they can do the procurement of supplies for their health facilities. This was supported by the response from one participant as follows;

> "*The problem I can say here is concerning money for Transport and meals. The health facility in-charge does not pay us to cover those expenses in all the trips we made to town when we want to conduct bidders' price competition, she sometimes gives us her own money and if she does not have it we borrow money from our friends".* ***(HFGCS' Chairperson for facility F).***

4.4.8. Complexity of the program rules, regulations, and operational system

Participants also reported program rules and regulations hinders the smooth implementation of the program. As it restricts modification of rules referring to community context, geographical areas, and topographic nature of the area. For example, you cannot implement any activity which is not within the guideline even if it is of importance to the health facility. One of the participants from the health center replied;

> "…… *when funds are deposited in the account you are already forced that you have to implement certain activities as they are in the CHOP, for example, if they say that you have to pay 10 thousand to each committee members it remains the same you cannot change it"* ***(HFGC for facility C).***

Nevertheless, participants reported the program not to allow correction in the program computer system when you have uploaded any information in the system, it is once for all. This was reported to bring more challenges to DHFF implementers as they experienced difficulties when working with the DHFF computer system. As another respondent at the health center explained;

"…there is no place that allows correction in DHFF computer system if you upload anything accidentally you cannot correct errors, also there is a challenge of information duplication in the system" ***(Health facility in-charge for facility D).***

4.4.9. Inadequate Knowledge of program Implementation

Knowledge regarding the DHFF program was noted to be lacking among implementers. Most had not trained about the program, reporting, regulations on DHFF program funds, planning, and coordination both at the health facility and at the District level.

This caused some of the implementers at the district level to provide wrong directions to implementers at the Health facility level. This was explained by one of the respondents as follows;

"……. even those who supervise us have no direct technical knowledge concerning the program. If you go with the document today, they can show you how to do it and if you go back tomorrow to the same person he/she changes the rules. This reflects their little knowledge on rules and regulations of the program implementation……" ***(Health facility in-charge for facility B).***

Respondents preferred that program respective activities to be performed by the respective department. Procurements to channeled through the procurement department at the district office, financial management to be done by accountants and not them (implementers at health facilities) as they do not have a background in managing government funds, procurement, and their related activities. This caused hardships when performing DHFF activities especially those related on how to manage funds and procurement, one participant from the health center categorically said;

"I think one of the challenges happens, as a result, most of the health facility in-charge perform tasks that were not employed for. And they were not taught to be accountants or procurement officers at the health facility. Other activities have to be reduced especially those concerned with the accountants because the facility in charge was not taught to perform such kind of activity and has little knowledge in handling funds" ***(Patron at facility F).***

4.4.10. Community leaders Interferences

Elected community leaders were reported to believe that, their role was to supervise and deserve being given incentives from DHFF program funds. It was found that they ask health facility in-charges to give them incentives from DHFF program funds. This caused hardship in Program implementation among the Health facility in-charges, as one participant stated;

> *"……. the politicians come here thinking that we have a lot of money. They come thinking that they will get money from the facility. This is also the challenge we have. They even interfere with our plans here at the facility……."* ***(Health facility in-charge for facility A).***

CHAPTER FIVE

5.0. DISCUSSION

5.1. Introduction

This chapter covers the discussion of the key findings generated from qualitative analysis. Discussion focuses on implementer's experiences to program training and supportive supervision, adherence to DHFF program guidelines during implementation, and barriers that affected smooth program implementation.

5.2. Training and Supportive Supervision

The study has found most of the program implementers are being not formally trained about the DHFF program. However, the importance of formal training regarding the program implementation was valued by program implementers who were trained formally and informal. Similarly, a study done in Kenya reported training to be valued by implementers of the DFF program as it was helpful in DFF operations such as the rules of the scheme, financial management, and filling in the cash book(19). Other similar studies were done in Kenya by Tsofa B. et al, Opwora A. et al, and Waweru E. et al documented the pivotal importance of training in the sustainable implementation of direct facility-based financing programs(6,24,32). This means regular capacity building in terms of skills, knowledge development, and programmatic guidelines is an important category for successful DHFF program implementation and sustainability.

The health facility staff implementing DHFF program activities acknowledged by receiving scheduled and non-scheduled supportive supervision regarding program implementation. The supportive supervision modality was both the CHMT visiting the health facility or health facility staff going to the CHMT office. A similar finding was documented in a study done in Kenya where CHMT was supporting the DFF initiative at the facility, the team had an overall supervisory role, including the approval of work plans which were a pre-requisite for funds to be transferred(19).

In this case, coordinated supportive supervision from district managers has a positive influence on program implementation by impacting updated implementation guidelines.

5.3. Adherence to Program guidelines

The study has revealed that all health facilities had DHFF planning guidelines that enable the health facility team to prepare CHOP. Health facility governing committee members were actively involved in the planning and implementation process of the DHFF program as stated in the guidelines. Similarly, *Opwora et al* in Kenya found all health facilities to have planning guidelines for DFF implementation, and HFGC members were involved in DFF implementation activities(19).

Furthermore, the study reported all health facilities to have a well-functioning HFGC with active members. The committees were actively involved in all matters concerning the implementation of the DHFF program at the health facility. This was contrary to the study done by *Goodman et al* who found health facility committee members (community representatives) not able to read and write, and some were too old that could not actively involve themselves in implementing DFF in the program(20). Moreover, our study findings coincide with findings in the study done by *Opwora et al* who found all facilities surveyed to have properly formed health facility management committees with many playing an important role in facility planning and decision making(19). A similar finding was also reported in a study done in Kenya that reported the facility committee to have improved with the introduction of DFF. These studies reported that DFF increases Committee participation and developed their (committee) sense of facility ownership(32,33).

It was further found that DHFF program implementers adhere to the procurement process as stated in the guidelines, in which HFGC members were involved in the whole process of procurement, including vending processes and approval of procurement expenditures. *Opwora et al* also found similarly, active involvement of HFGC members on matters related to DFF implementation activities including planning as well as procurement for health facility supplies(24).

Commendably, adherence to program procurement procedures and other financial regulations by involving all key program actors sustain the program to impact the community with anticipated program outcomes and impacts.

5.4. Barriers to Program implementation

In this study, barriers for implementation of the DHFF program were reported to be; lack of program ownership, delay, and insufficient of funds disbursed, understaffing of implementers at the health facility and district level, low awareness of the program procedures among health facility governing committee members, internet and networking challenges, program not covering meals and transport allowances, rigid program rules and regulations, low knowledge on DHFF implementation and inappropriate program perception from some of the elected community leaders.

The study has found limited autonomy over the approval and expenditure of the DHFF program funds among the implementers at primary health facilities. To operationalize the CHOP at health facilities, CHMT had to approve, the procurement of supplies or construction. A similar observation was documented by *Opwora et al* that, facility manager was having poor autonomy at the primary health facility levels on DFF fund management and lack of accountability of health facility governing committees (20).

Funds disbursement into the health facility account was not done timely as stipulated in the program guidelines. Two to three-quarters of a year were found to pass without funds being deposited into the health facility account. This can be explained by partly DHFF funds being donor depended or competing government priorities. Various studies done in the African context have enlisted among others, the barrier being inconsistent prioritization of health, donor-dependent, and weak budget implementation. Also, the lack of transparency and accountability in the use and allocation of public resources was documented as a barrier for DHFF implementation(12)(15). Besides, the study done by *Gasto et al* found untimely disbursement of funds from the central government to lower authorities due to similar reasons(21).

It was further found that the DHFF program has added more duties and responsibilities to understaffed health facilities. This necessitated the few available staff to stretch themselves to cover all responsibilities including program activities. This makes services being provided to be inadequate and substandard. *Gasto et al* revealed insufficient and unqualified personnel, impeding successful program implementation(21).

In this study, most of the participants were found to be de-motivated. This was attributed to little allowances, the geographical location of the health facilities, and lack of or missed information about the program. This finding is contrary to the findings from a study done in Kenya, which found a common perception among health workers that direct facility funding programs motivated health workers to work better and efficiently. Workers found it easier to perform their jobs because of the help provided by supportive staff(24). This can be partly due to differences in study participants and study area.

In this study, the geographical and topographical nature of the area was a serious impediment to internet networking as the program requires the internet for proper implementation. This was found in the facility along Lake Tanganyika shore at which internet networking was a challenge. Implementers could not log in to the program computer-based system, and even to make phone calls was a challenge.

Insufficient program funding came out in this study to negatively affect the program. Thus after prioritization and budgeting in the CHOP, fund disbursed was not as it was in the CHOP. This implies that health facilities lacked funds for planned activities. This finding coincides with other similar studies done in the African context which have enlisted inconsistent prioritization of health plans, donor-dependent budget, and weak budget implementation to be the impediment factor for proper program implementation (15).

It was found that health facility in-charges and members of HFGC collaborate to secure vendors and even to withdraw funds from the facility account, they use their earnings to travel to a place where they receive such services (mostly in town). They do it in low morale as there were no meals and transport allowances for such activities.

Program implementers in this study were considering the DHFF program to be complex, tight regulations, and even unfriendly program internet based operational systems. This was partly due to the geographical location of the facility not covered by internet networking.

The program computer system was found to be a challenge by being un-editable and even guidelines dictate complex procedures especially for the procurement of health facility consumables and minor construction. These findings are similar findings from an evaluation of the Health Sector Services Fund in Kenya which was reported to be complexity in implementation(21,23).

Importantly, we found that DHFF implementers and the community lack complete and adequate knowledge and information respectively on the scope and implementation of the DHFF program. It was perceived that this program was for the benefit of the health facility staff, the community was just supporting them. These findings echo an evaluation study done in Kenya which documented, low community awareness, lack of clarity in roles and responsibilities to be the barriers for DHFF(21,23). Likewise, in our study, these barriers were found to negatively affect program implementation activities. This means that the DHFF program can be affected by these barriers if not properly addressed.

CHAPTER SIX

6.0. CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

This study has generated some insight into the experience of the main facilitators, strategies, and barriers for DHFF program implementation. The results have demonstrated formal training to the program implementers at primary health facility and district to be important for program sustainability and achievement though few implementers at primary health facilities were formally trained. Also, both scheduled and non-scheduled supportive supervision and mentorship were found to impact implementers with updated knowledge, skills, and information regarding the program.

The study has elucidated that, funding for the program is not adhering to the program guidelines. There were delays and insufficient funds disbursement. However, the health facilities staff and HFGC members were ready and cooperative to work and sustain the program.

A good number of barriers were found to negatively affect the DHFF program. To sustain the program and acquire the targeted outcomes and finally impact on community health, these barriers need to be addressed appropriately.

6.2. Recommendations

Based on the study findings, the following are recommended;

1. A collaborative effort from the ministry of health, PO-RALG, and Kigoma regional authority are needed to ensure comprehensive training, supportive supervision, and on-job mentorship to CHMT, HFGCs, and health workers. The training needs to focus on the implementation of the DHFF program. This has to be done repeatedly to update the implementers with new skills and knowledge regarding the program.
2. The government particularly the ministry of finance and PO-RALG should also ensure timely disbursement of sufficient funds as it appears in the CHOP so that health facilities do not experience stock out of some essential supplies and delays of minor construction at the health facility.
3. The district human resource department has to employ accountants in the health facilities, at least each health center who can even serve nearby dispensaries as they are highly needed in the implementation of the program.
4. Health facility in-charges and HFGC should plan for meal and travel allowances to motivate and ease the program implementation processes as the guidelines allow additional priorities.
5. The council health management team (CHMT) should collaborate with the respective health facilities to create community awareness through village assembly or general meetings to own the DHFF program.
6. DED has to address the barriers found in this study for a sustainable program.

6.3. Recommendation for future research

The study was conducted in a small geographical area in rural settings; a future similar study can be expanded to the other settings.

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APPENDICES

Appendix I: General Interview Guides for Health centers and Dispensaries: English and Swahili versions

In-depth Interview Guide for Health facility incharges –English version

Socio-demographic characteristics of participants

(Researcher should first complete this part)

A. Age:_____
B. Sex: _____
C. Station:_____
D. Education:_____

Part I: General knowledge of Direct Health Facility Financing Program

1. Can you tell me what do you understand by Direct Health Financing program?
2. What is DHFF for primary health facilities?
3. How you plan and budget for DHFF implementation?
4. How do you procure supplies?
5. How do you manage to implement DHFF related activities without compromising other facility-related tasks?

Part II: Strategies towards DHFF implementation

1. Did you receive any training on how to implement the DHFF program? If no what do you think were the reasons for not being trained, how do you manage to implement the program without any training attended? AND if yes how does that training helpful on the implementation of the DHFF program?
2. What working tools do you have at your facility? How those tools facilitate the implementation of the DHFF Program?

3. Can you tell me how do you get supportive supervision from the district council level? How does the supervision you get help with the implementation of the DHFF program?

Part III. Direct Health Facility Financing Implementation Hindrances

1. What do you think are the challenges facing the implementation of the DHFF program at your facility? And what do you think are the reasons for such challenges?

SUGGESTIONS

6. What do you think are the ways to solve such challenges you **have** mentioned above**?**

Appendix II: In-depth Interview Guide (Waganga Wafawidhi wa Vituo) – Swahili Version

Taarifa muhimu za washiriki

(Mtafiti ajaze taarifa hizi kwanza)

A. Kituo: _____

B. Cheo: _____

C. Umri: _____

D. Jinsia: _____

E. Elimu: _____

Mwongozo wa mahojiano

Sehemuya I: Welewa wa mhojiwa juu ya Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afya.

1. Unaelewa nini juu ya Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afya?
2. Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya Kutolea Huduma za afya upo kwa malengo yapi?
3. Jinsi gani unafanya mpango kazi wa **bajeti** ya Mpango wa kupeleka fedha moja kwa moja kwenye vituo vya kutolea huduma za afya?
4. Naomba kuelewa ni jinsi gani unavyofanya manunuzi ya vifaa vya kutolea huduma hapa kituoni?
5. Unaweza vipi kufanya shughuli zinazohusiana na Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afyabila kuingilia ratiba zingine za kawaida za hapa Kituoni**?**

Sehemu ya II: Mikakati iliyofanya ili kuwezesha watoa huduma kutekeleza Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afya.

1. Umewahi kupata mafunzo yoyote kuhusu utekelezaji wa Mpango wa kupeleka fedha moja kwa moja kwenye vituo vya kutolea Huduma za Afya?Kama hapana Unafikiri ni sababu zipi zilizosababisha kukosa mafunzo hayo?Na unawezaje kutekeleza shughuli hizo bila kupata mafunzo yoyote? Kama ndiyo,Ni kwa jinsi gani mafunzo hayo yamekusadia katika shughuli za kutekeleza Mradi(Mpango)?
2. Je Mna zana zipi za kazi hapa kituoni mnazozitumia kutekeleza mradi? Ni kwa jinsi gani zana hizo zinavyosaidia kutekeleza shughuli za Mradi(Mpango)?
3. Unaweza kuniambia jinsi unavyopata usimamizi wa msaada wa jinsi ya kutekeleza mradi kutoka ofisi ya afya wilayani? Ni kwa jinsi gani usimamizi huo unakusaidia kutekeleza shughuli za mradi?

Sehemu ya III. Changamoto katika utekelezaji wa Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afya

Unafikiri ni changamoto zipi zinazokumba shughuli za utekelezaji Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afya katika kituo hiki? Na unafikiri ni nini sababu ya changamoto hizo?

Sehemu ya V: Mapendekezo

Je, una maoni gani juu ya nini kifanyike ili kutatua changamoto ulizotaja hapo juu?? (*dodosa kila pendekezo atakalotoa*)

Huu ndio mwisho, mimi sina maswali zaidi. Labda wewe kama una jambo la kuuliza au unataka tujadiliane unaweza kuuliza sasa. Yale yenye jibu la hapa hapa nitakuelezea na yale ambayo majibu yake siyo ya hapahapa nitayafuatilia na kutafuta namna ya kukujulisha kukujulisha.

Asante Sana

Appendix III: In-depth Interview Guide for HFGC Representative: English version

Socio-demographic characteristics of participants

(Researcher should first complete this part)

E. Age: _____
F. Sex: _____
G. Station:_____
H. Education:_____

Part I: General knowledge on DHFF program

1. Can you tell me what do you understand by Direct Health Financing program?
2. What is the target of DHFF to primary health facilities?
3. What is the importance of the DHFF program?

PART 2: Influences on implementation of DHFF Program

1. When and how do you participate in the implementation of the DHFF program as a community representative? Planning, Budget allocation, procurement process?
2. How can you influence other DHFF implementers to implement the program as required?

   Implementation Challenges
3. What do you think are the challenges that can hinder you not to participate fully in the implementation of the DHFF program and what are the reasons for such challenges?

   Suggestions
4. Basing on the challenges you **have** mentioned above what do you think are the solution to overcome those challenges?

Finally, I have no other questions, but you are welcome if you have anything else on this topic that you would like to discuss further. For the question that I can answer here, I will do so. But for a question that I may not be able to answer promptly, I will find out the appropriate information and send the response.

Thank you so much for your knowledge contribution.

Appendix IV: In-depth Interview Guide Mwakilishi kamati ya kituo cha afya- Swahili Version

Taarifa muhimu za washiriki

(Mtafiti ajaze taarifa hizi kwanza)

F. Kituo: _____

G. Cheo: _____

H. Umri: _____

I. Jinsia: _____

J. Elimu: _____

Mwongozo wa mahojiano

Sehemuya I: Welewa wa mhojiwa juu ya Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afya.

1. Unaelewa nini juu ya Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afya**?**
2. Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya Kutolea Huduma za afya upo kwa malengo yapi?
3. Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya Kutolea Huduma za afya una umuhimu gani katika kuendeleza huduma za afya hapa kituoni?

Sehemu ya 11**: Kuwezesha ufanikishwaji wa utekelezaji wa Mpango wa kupeleka Fedha moja kwa moja kwenye vituo vya kutolea Huduma za Afya.**

1. Ni lini na ni kwa jinsi gani unavyohusika katika utekelezaji wa Mpango wa kupeleka Fedha moja kwa moja katika vituo vya kutolea Huduma za afya? (*Hoji kuhusu wakati wa Kupanga,,Ugawaji wa bajeti ,Mchakato wa manunuz*i)
2. Unawawezesha vipi watu wengine katika kutekeleza Mpango huu kamainavyoelekezwa katika mwongozo?

Sehemu ya III. Changamoto katika utekelezaji wa Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afya

Unafikiri ni changamoto zipi zinazokumba shughuli za utekelezaji Mpango wa kupeleka fedha moja kwa moja kwenye Vituo vya kutolea Huduma za Afya katika kituo hiki? Na unafikiri ni nini sababu ya changamoto hizo?

Sehemu ya 1V: Mapendekezo

Je, una maoni gani juu ya nini kifanyike ili kutatua changamoto ulizotaja hapo juu?? (*dodosa kila pendekezo atakalotoa*)

Huu ndio mwisho, mimi sina maswali zaidi. Labda wewe kama una jambo la kuuliza au unataka tujadiliane unaweza kuuliza sasa. Yale yenye jibu la hapa hapa nitakuelezea na yale ambayo majibu yake siyo ya hapahapa nitayafuatilia na kutafuta namna ya kukujulisha kukujulisha.

Appendix V: Checklist for health facilities

Checklist for health centers and dispensaries

Name of facili**y……..**

ITEM	**YES**	**NO**	**REMARKS**
Presence of health facility accountants			
Presence of DHFF facility guideline			
Presence of CHOP facility plan.			
Presence of DHFF focal person at the facility			
Schedule for facility governing committee meetings			
Availability of facility governing committee meetings minutes?			
Availability of bank statements for facility account after every deposit of DHFF program funds			
Available quarterly supportive supervision reports at the health facility			

Appendix VI: Informed Consent (English and Swahili versions)

Informed Consent-English version

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

SCHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES

DEPARTMENT OF DEVELOPMENT STUDIES

CONSENT TO PARTICIPATE IN THE STUDY ON ASSESSMENT OF IMPLEMENTATION OF DIRECT HEALTH FACILITY FINANCING TOWARDS STRENGTHENING PRIMARY HEALTH SYSTEM IN KIGOMA DISTRICT COUNCIL, TANZANIA, 2019

Consent to participate in this study

Hello! My name is **Flora Joram** a Postgraduate Resident in the School of Public Health and Social Sciences of Muhimbili University of Health and Allied Sciences; I am conducting this evaluation project intending to assess how DHFF is implemented among Primary Health Facilities in Kigoma District Council.

Purpose of the study

The purpose of this study is to be able to ascertain the implementation of DHFF in Kigoma District Council. We hope the study results will tell the program designers on how DHFF Program is implemented, will add knowledge on implementation of Direct Health Facility Funding, and explore experiences encountered during the implementation process that will help to meet the desired DHFF Program outcomes.

Participation Procedure

To find answers to some of these questions, we invite you to take part in this study. This is because we feel that your experience as an individual can contribute much information to this study. If you accept, you will be asked some questions. If you do not wish to answer any of the questions, you may say so and we will move to other questions. You may also refuse to answer any question if you feel the question(s) are personal or if talking about them makes you uncomfortable. We request to tape-record the interviews for the sake of keeping the information that you provide correctly. However, you may choose not to be tape-recorded. Your decision will be highly respected.

Risks

No harm is expected to happen to you because of accepting to participate in this study. Sometimes the questions asked might make you feel uncomfortable as a result of personal information disclosure. You may refuse to answer any particular question and may stop the interview at any time.

Benefits

There will be no direct benefit to you, but your participation is likely to help the entire Primary Health System in Kigoma District Council to understand how DHFF Program is being implemented and to understand the Experience encountered during the implementation process.

Confidentiality and anonymity

The information that will be collected from this research will be kept confidential. No information other than this consent form will have your identification on it.

Right to refuse or withdraw

Participating in this study is voluntary. You do not have to take part in this research if you do not wish to do so, and refusing to participate will not affect you in any way i.e. nobody will be informed that you have refused to participate in this study.

Duration

The interview will take approximately one hour to one hour and twenty minutes

In case of any Injury

We do not anticipate that any harm will occur to you as the result of participation in this study.

Who to contact

If you have any questions or concerns about this study or your participation in this study you can contact the Study Coordinator or the Principal Investigator, Flora Joram, Muhimbili University of Health and Allied Sciences (MUHAS), P.O. Box 65001, Dar es Salaam (Tel. no. +255755195966) or by email: joramf2012@gmail.com

If you ever have questions about your rights as a participant, you may call Dr. Bruno Sunguya Director of Research and Publications, Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam. (Tel no +255685217272) and Dr. Nathanael Sirili a study supervisor (Tel. no. +255713730179)

Certificate of Consent

I have read the foregoing information, or it has been read to me. I have been allowed to ask questions about. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without any effects.

I ……. On this day……. of…….2019 have read and understood the information about the study and I voluntarily agree to participate.

I agree to have the session tape-recorded YES NO (circle relevant alternative)

Signature of the Participant…….

Name of the Interviewer…….

Signature of the Interviewer…….

Apendix VII: Ridhaa ya kushiriki – Swahili Version

CHUO KIKUU CHA AFYA NA SAYANSI SHIRIKISHI MUHIMBILI

SHULE YA AFYA YA UMMA NA SAYANSI ZA JAMII

IDARA YA ELIMU YA MASOMO YA MAENDELEO

DODOSO LA UTAFITI WA JINSI YA UENDESHWAJI WA PROGRAMU YA KUPELEKA PESA ZA UENDESHAJI WA HUDUMA ZA AFYA MOJA KWA MOJA KATIKA VITUO VYA MWANZO VYA KUTOLEA HUDUMA KATIKA HALMASHAURI YA WILAYA YA KIGOMA VIJIJINI, TANZANIA, 2019.

Ridhaa ya Kushiriki katika utafiti huu

Habari! Jina langu naitwa **Flora Joram** ni mwanachuo wa shahada ya uzamili katika Chuo **Kikuu cha Afya na Sayansi Muhimbili**. **Na**fanya Shirikishi utafiti wenye lengo la kuangalia jinsi programu ya Kupeleka Pesa za Uendeshaji wa Huduma za Afya moja kwa moja katika vituo vya mwanzo vya kutolea huduma za Afya katika wilaya ya Kigoma vijini inavyoendeshwa.

Malengo ya Utafiti

Lengo kuu la utafiti huu ni kutambua uendeshwaji wa programu ya kupeleka pesa moja kwa moja kwenye vituo vya mwanzo vya afya katika kuimarisha utoaji wa huduma katika vituo hivyo. Ni matumaini yetu kuwa matokeo ya utafiti huu utawezesha kutoa elimu kwa watoa huduma na waandaaji wa programu kuhusu uendeshwaji wa shughuli za programu na pia kuweza kupata tarifa zitakazowezesha urekebishwaji wa jinsi ya kuendesha programu hiyo ili kuweza kufika malengo yaliyowekwa katika programu hiyo.

Njia ya kushiriki

Ili kuweza kupata majibu ya baadhi ya maswali, tunakuomba ushiriki katika utafiti huu. Tumekuchagua wewe kwa kuona kuwa ufahamu wako unaweza kuwa wa ufanisi mkubwa kwa utafiti huu. Kama utakubali kushiriki, utaulizwa maswali. Iwapo kutakuwa na swali usilotaka kujibu basi unaweza kueleza hivyo na tutaendelea na maswali mengineyo. Unaweza pia kukataa kujibu swali unaloona kuwa linaingilia uhuru wako, kukuvunjia heshima au unaloona linakufanya usijisikie vema. Tutaomba kunasa mazungumzo yetu katika kinasa sauti. Hii itasaidia kutunza kwa usahihi mazungumzo yetu. Hata hivyo, unaweza kuchagua kufanya mazungumzo bila ya mazungumzo kunaswa. Uamuzi wako wowote tunaupokea bila kinyongo na tunauheshimu.

Madhara

Hakuna madhara yoyote yanayotegemewa kukupata kwasababu ya wewe kushiriki katika utafiti huu.Wakati mwingine baadhi ya maswali yatayoulizwa yanaweza kukufanya usijiskie vizuri. Unaweza kukataa kujibu swali lolote na unaweza kusimamisha usaili wakati wowote

Faida

Hakutakuwa na faida ya moja kwa moja kutokana na kushiriki kwako katika utafiti huu. , Hata hivyo ushiriki wako utaisaidia kupata uelewa wa jinsi prorogram ya upelekaji wa pesa moja kwa moja katika vituo vya mwanzo vya kutolea huduma unavyoendeshwa na pia kutoa elimu ya jinsi ya kurekebisha namna programu inavyoendeshwa ili kufikia malengo yaliyowekwa na waandaaji wa program hiyo.

Haki ya kutoshiriki/kujitoa

Ushiriki wako katika utafiti huu ni wa hiari. Hushurutishwi kwa namna yoyote kushiriki kama utaona huhitaji kushiriki na uamuzi wako wa kutoshiriki hautakuathiri kwa namna yoyote ile. Hakuna yeyote atajulishwa kuwa umekataa kushiriki katika utafiti huu.

Muda:

Mahojiano yatachukua muda wa kama saa moja hadi saa moja na dakika ishirini.

Endapo Utadhurika

Hatutegemei madhara yoyote kutokea kwa kushiriki kwako katika utafiti huu.

Watu wa kuwasiliana nao

Kama una maswaIi katika utafiti huu unaweza kuwasiliana na mratibu mkuu wa utafiti huu**,** Flora Joram , Chuo Kikuu Afya na Sayansi Shirikishi Muhimbili, S.L. P 65001, Dar es Salaam (Simu. no. +255755195966) au kwa email: joramf2012@gmail.com

Kama utakua na maswali yoyote kuhusu haki zako kama mshiriki unaweza kupiga simu kwa

Dr Bruno Sunguya,ambaye ni Mwenyekiti wa kamati ya chuo ya utafiti na machapisho, S.L.P 65001, Dar es Salaam. (Simu namba:+255685217272) na Dr.Nathanael Sirili na Dr ambaye ni msimamizi wa utafiti huu (Simu nambari. +255713730179)

Ridhaa ya kushiriki

Mimi……. Leo hii tarehe……..ya mwezi…….. 2019 nimesoma na kuelewa kuhusu utafiti huu na nimeamua kushiriki kwa hiari yangu mwenyewe.

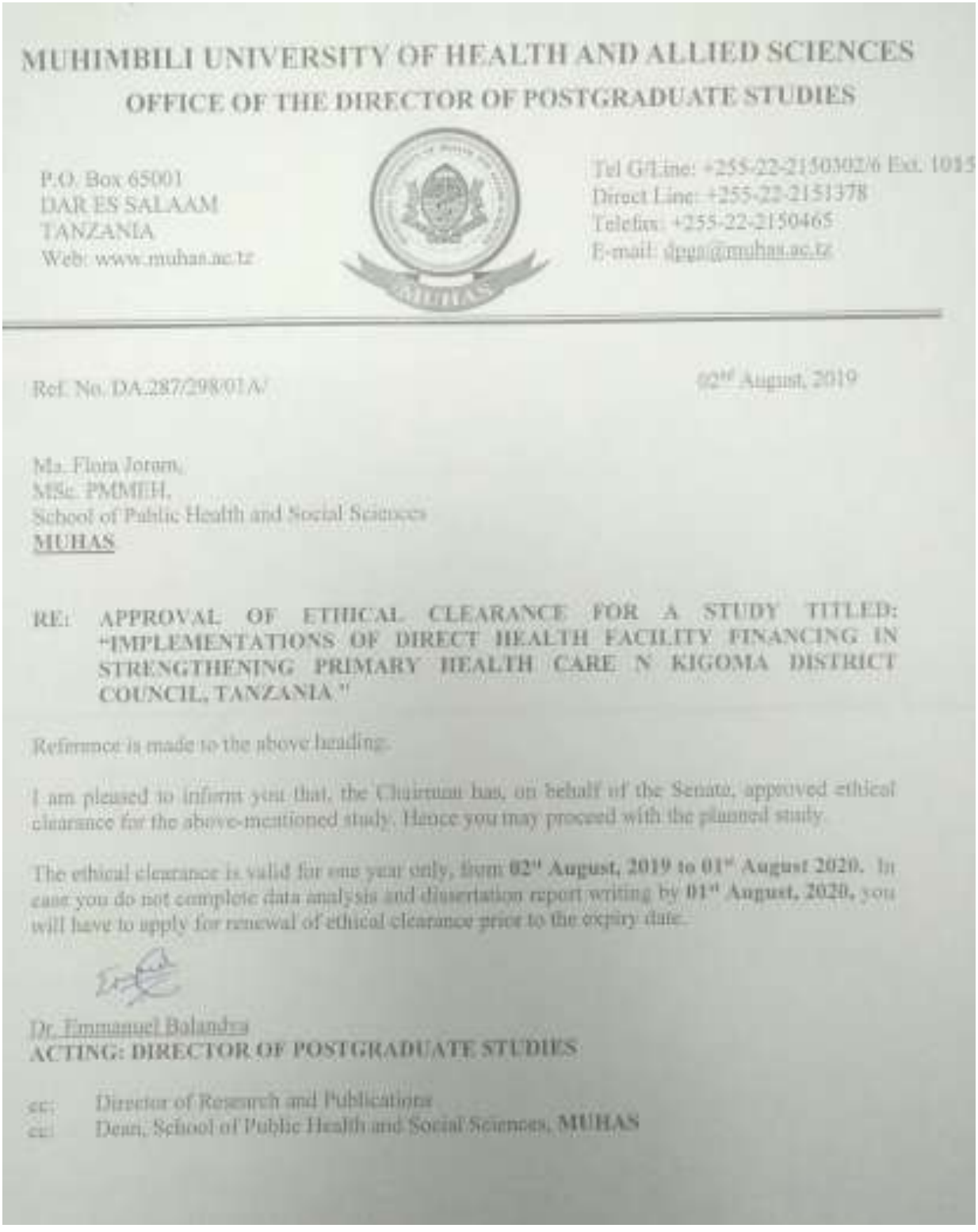
Nakubali pia mazungumzo yetu kunaswa katika kinasa sauti Ndiyo hapana (zungushia inayohusika)

Sahihi ya mshiriki…….

Jina la Mtafiti……..

Sahihi ya Mtafiti…….

Appendix VIII: Approval of ethical clearance



MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR OF POSTGRADUATE STUDIES

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Ref. No. DA.287/298/01A/

02nd August, 2019

Ms. Flora Joram,
MSc. PMMEH,
School of Public Health and Social Sciences
MUHAS

RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED: "IMPLEMENTATIONS OF DIRECT HEALTH FACILITY FINANCING IN STRENGTHENING PRIMARY HEALTH CARE N KIGOMA DISTRICT COUNCIL, TANZANIA"

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has, on behalf of the Senate, approved ethical clearance for the above-mentioned study. Hence you may proceed with the planned study.

The ethical clearance is valid for one year only, from **02nd August, 2019 to 01st August 2020.** In case you do not complete data analysis and dissertation report writing by **01st August, 2020,** you will have to apply for renewal of ethical clearance prior to the expiry date.

Dr. Emmanuel Balandya
ACTING: DIRECTOR OF POSTGRADUATE STUDIES

cc: Director of Research and Publications
cc: Dean, School of Public Health and Social Sciences, **MUHAS**