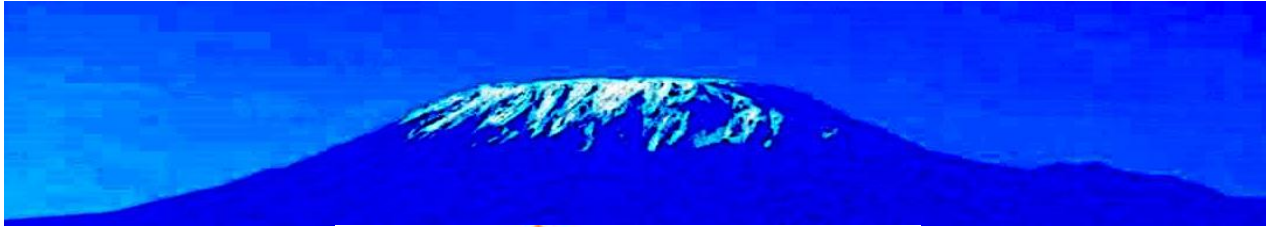


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The Determinants of the Performance of Health Facility Governing Committees (HFGC) in Selected Primary Health Facilities in Tanzania

Anosisye Kesale¹, Christopher Mahonge², and Mikidadi Muhanga³

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Abstract

Lower and Middle-Income Countries (LMICs) implement fiscal decentralization through Direct Health Facility Financing (DHFF) to empower Health Facility Governing Committees (HFGCs). The measure is designed to enable HFGCs to effectively participate in the planning, implementing and controlling health service delivery at primary health facilities. However, it is not empirically known what HFGCs members perceive to be determinants of the performance of these HFGCs under DHFF context. Drawing from community participation and decentralization literature, this study was conducted to assess the determinants of the HFGCs performance under DHFF as perceived by the HFGC members in four selected regions in Tanzania. A cross-sectional research design was employed to collect both qualitative and quantitative data from the four regions. The study has found that availability of finance to the health facility has RII 0.8964 score is ranked 1st important determinant of HFGC performance, followed by clarity of powers and functions with RII 0.8928 score (2nd) and communication between the HFGCs and community has RII 0.8792 score ranked third (3rd). This study concludes that contextual factors significantly influence the performance of HFGCs than HFGC members' characteristics in carrying out their devolved functions. The study recommends working environment for HFGCs to be improved for strengthening HFGCs performance.

Background Information

Good health is a cornerstone of development in all societies (URT, 2003a; URT, 2003b; IMF, 2004; URT, 2007a; WHO, 2010; WHO, 2012a; 2012b; Muhanga and Malungo, 2018; Muhanga *et al.*, 2019; Muhanga, 2020). It is against this background that, proper management of health services delivery has been considered to be a key aspect towards efficient and effective health services delivery. Involvement of the community members, in this case, has been considered worthwhile towards that end. Community participation is recognized to be an important aspect in improving the quality of health services at Primary Health Care (PHC). It remains uncontested that community participation enhances the acquisition of perfect information on community preferences, tastes, and needs. It is through community participation, local problems get local solutions (Jiménez-rubio, 2014; Martínez-Vazquez, 2011; Oates, 2003). Some lower- and middle-income countries (LMICs) adopt decentralization policy (decision making and fiscal decentralization) to facilitate community participation in the management of primary health care through the establishment of community health governing structures (Abimbola *et al.*, 2016; Anosisye, 2017). As a result, Health Facility Governing Committees (HFGCs) comprising community members have been established to manage and monitor health service provision at primary health care facilities (Kessy, 2014). In the early days of decentralization, only decision-making powers were decentralized to the HFGCs in primary health facilities, however, HFGCs and health facilities are inadequately performing their responsibilities (Kesale, 2017; Muhanga and Mapoma, 2019; Roman *et al.*, 2017). Currently, LMICs are decentralizing fiscal powers and

¹ (Corresponding Author- akesale@mzumbe.ac.tz), Department of Policy Planning and Management Sokoine University of Agriculture, College of Social Sciences and Humanities, P.o. Box 3035, Morogoro-Tanzania

² Department of Policy Planning and Management, Sokoine University of Agriculture, College of Social Sciences and Humanities, P.o. Box 3035, Morogoro-Tanzania

³ Department of Development Studies-Sokoine University of Agriculture, College of Social Sciences and Humanities, P.o. Box 3024, Morogoro-Tanzania

authorities to empower HFGCs to accomplish their devolved responsibilities (Panda and Thakur, 2016). LMICs including Tanzania and Kenya are undertaking fiscal decentralization through Direct Health Facility Financing (DHFF) program to grant fiscal autonomy and empower HFGCs in performing their responsibilities. In this program, funds from the national level and other sources are directly deposited into the primary health facilities accounts to allow HFGCs to have powers and autonomy to control, manage and timely allocate them.

In primary health facilities, fiscal decentralization entails shifting fiscal powers and responsibilities from higher-level government or central government to primary health care institutions such HFGCs (Mpaata and Lubogoyi, 2018). Fiscal decentralization is expected to facilitate and enhance the process of resource allocation by bringing fiscal powers and freedom to local decision-makers (HFGCs) to come out with context-based solutions (Bossert, 2016).

Literature provides that political and administrative dimensions of decentralization depend much on the presence of fiscal decentralization through different arrangements to produce the intended outcomes in service delivery. Introduction of Direct Health Facility Financing (DHFF) arrangement was meant to empower health providers and HFGCs to effectively participate and have control in planning, budgeting, procurement, and financial use in primary health facilities. In this context, it is expected that efficiency, equality accountability, and innovation in health service provision can be realized (Cheema and Rondinelli, 2007; Panda and Thakur, 2016). However, what practically determines the performance of HFGCs in accomplishing their devolved responsibilities under the DHFF context is empirically not known. Existing studies on DHFF implementation in Tanzania have just assessed the impact of DHFF on financial management at the health facilities (Kajuni and Mpenzi, 2021), and, the prospects together with challenges of DHFF implementation (Mwakatumbula, 2021). Fiscal decentralization literature has provided principles to adhere during fiscal decentralization including the provision of an adequate enabling environments such as a legal framework that states the powers and responsibilities of HFGC and service providers (Smoke, 2000). Other principles of fiscal decentralization are assignment of appropriate responsibilities to the service providers and HFGCs and an appropriate intergovernmental transfer system (Buchanan and Musgrave, 2018; Oates, 2003; Hart and Welham, 2016; Samadi *et al.*, 2013).

In Tanzania, fiscal decentralization in primary health care facilities is implemented through Direct Health Facility Financing (DHFF) program. Under DHFF, funds from multiple sources such as basket funds and other intergovernmental transfers are directly deposited to the public primary health facility bank accounts. The DHFF implementation started in the fiscal year 2017/18. Before the introduction of DHFF in Tanzania, the facility spending powers were decentralized to the council level. All facility funds were managed and controlled by the Council Health Management Teams (CHMT). Therefore, HFGCs and health facilities had inadequate planning, budgeting, control powers, and access to their financial resources (Boex *et al.*, 2015; Kapologwe *et al.*, 2019). Most of the primary health facilities had no bank accounts. Indeed, even the funds which were collected at the facility level such as user fee charges were deposited into the council accounts (Kuwawenaruwa *et al.*, 2019). Boex (2015) revealed that the disbursement of funds into District Council accounts instead of health facility accounts created a loophole for reallocation and misuse of facility funds by local councils instead of improving the services delivery. Therefore, the Government of Tanzania decided to introduce the DHFF to ensure flexible timely funding at the level of service delivery points so that to ensure increased efficiency in financial use and quality service delivery to the public. According to DHFF implementation protocol, HFGCs mandates are to prepare facilities plans according to the citizens' or community needs and preferences. Also, budgeting based on available resources. Indeed, they are responsible for procuring health equipment, drugs, and other

services. Lastly, they are responsible for making sure funds are being used according to the budgets and not misused by the service providers. Empirical studies conducted on the impact of DHFF in Tanzania have found that DHFF increases the community participation (HFGCs) and ownership in the management of health serviced delivery at the primary health facilities (Kajuni and Mpenzi, 2021; Mwakatumbula, 2021). However, these studies have not highlighted the factors determining the performance of these community health structures in the management of health serviced delivery. This article, therefore, assessed the perception of HFGCs members on the determinants of HFGCs' performance in selected primary health facilities which are implementing DHFF in Tanzania.

Theoretical Framework

According to Empowerment Framework, the capacity of an individual or group to make an effective choices is determined by two factors; agency and opportunity structure (Alsop and Heinsohn, 2005; Raich, 2005). Agency refers to the ability of the individual or group to make a meaningful decision or choices which is influenced by asset endowments such as information, literacy level, and social capital. Opportunity structure comprises the institutions and social-political context within which actors operate whether to make meaningful choices. The combination of agency and opportunity structure is termed as the degree of empowerment (DOE). The degree of empowerment (DOE) is measured by: (i) the presence of opportunity to make choice (ii) whether actors use the opportunity to make purposive choices either indirectly through representation or directly through participation, and, (iii) if they use the opportunities given, whether choices are translated into desired development outcomes. When all the three mentioned dimensions are achieved then development outcomes can be achieved (Alsop and Heinsohn, 2005; Raich, 2005).

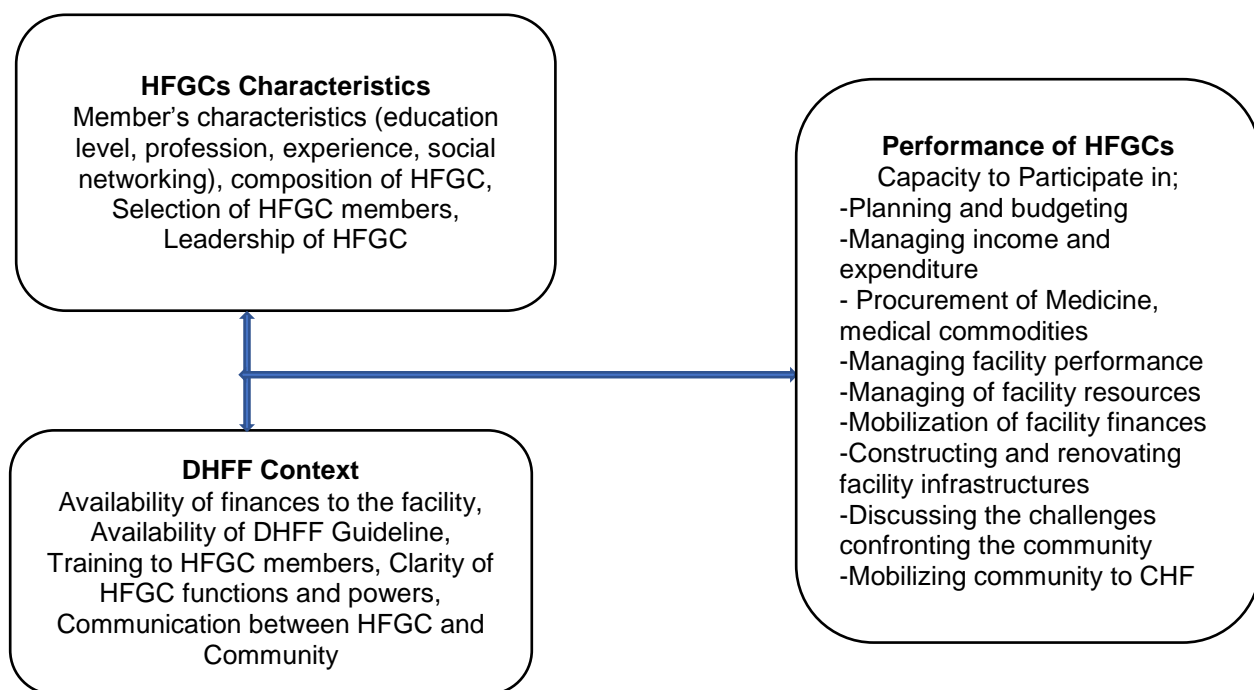


Fig.1: Conceptual Framework

In the context of Health Sector Reforms, HFGC stands as an agency that makes decisions having members with different characteristics including skills, experience, and education level. The DHFF arrangement provides a conducive environment for HFGCs to operate or carry out

their devolved functions. DHFF empowers health facilities and HFGCs by removing barriers that were limiting health facilities to use their space to decide with respect to planning, budgeting, management of funds, procurement of drugs, and other medical supplies. The DHFF arrangement has granted fiscal powers to the communities through their elected HFGCs to play an oversight role over revenue collection, spending of facility funds, planning, and budgeting. It is expected that this empowerment will result in the improvement of HFGC performance.

Before the DHFF implementation, the Star Rating Assessment conducted in 2017/18 to measure health facility performance indicated that a limited number of health facilities had good performance while the majority of health facilities had poor performance in health service delivery (Yahya and Mohamed, 2018). McCoy et al (2012) argue that the performance of health facility is directly related to the performance of HFGCs. Despite government efforts to empower HFGCs and health facilities through DHFF arrangement in the primary health facilities in Tanzania to improve their performance, what determines HFGC performance is not empirically known. It is in this context that, this study assessed the perceptions of the HFGCs members on the determinants of the performance of HFGCs under DHFF context in Tanzania.

Methodology

Study Area

The study was conducted in Songwe, Mbeya, Kilimanjaro, and Ruvuma regions in Tanzania Mainland. The regions were selected based on the Star Rating Assessment conducted in 2017/2018. In 2015, the government of Tanzania introduced a Star Rating Assessment System to measure the performance of primary health facilities and provide feedback for improvement. The Star Rating is based on the average scores of established indicators (0-19% no star or 0 star, 20-39% 1 star, 40-59% 2 stars, 60-79% 3 stars, 80-89% 4 stars and 90-100% 5 stars). The minimum performance standard set by the government was 3 stars for a respective health facility (Yahya and Mohamed, 2018). The last star rating assessment was conducted in 2017/18. In the same year which DHFF started (2018), the government of Tanzania introduced DHFF to improve the performance of HFGCs and primary health facilities in the service provision. Kilimanjaro and Mbeya regions were purposively selected because of the majority of their facilities in the good performing category in the Star Rating Assessment. On the other side, Ruvuma and Songwe regions were purposively selected after having the majority of their facilities under the poor performing category. The selection was meant to reflect variations in terms of determinants of HFGCs performance in primary health facilities with good and poor performance.

Research Design

This study employed a mixed method research design. A cross-sectional research design was applied in which both qualitative and quantitative data were collected at a single point in time. A cross-sectional design was chosen because it allows researchers to assess numerous characteristics of the population at once, to measure the prevailing situation in the community, and as well as it provides information about the current population that someone wants to study. The data were collected from HFGC members to assess their perception of important determinants of the performance of HFGCs under the DHFF context.

Sampling Techniques and sample size

This study employed both probability and non-probability sampling procedures to select the representative's sample from the population. A multistage sampling technique was employed to select the study units. The sampling procedure and inclusion criteria have been indicated in detail in Table 1.

Table1: Sampling process and sampling techniques

Stage	Respondent	Sampling procedure	Inclusion criteria
First Stage	Four (4) regions selected Kilimanjaro, Mbeya, Ruvuma and Songwe	<ul style="list-style-type: none"> • purposive 	Two (2) good-performing regions and Two (2) poor-performing regions
Second Stage	8 LGAs selected; Two LGAs from each region selected in stage one	<ul style="list-style-type: none"> • purposive 	One (1) good performing LGA and One (1) poor-performing LGA from each region
Third Stage	32 health facilities were selected from all (8) councils, 2 health centers and 2 dispensaries from each LGA because they all implement DHFF	<ul style="list-style-type: none"> • Multi-stage sampling Health centers and Dispensaries • Purposive selection of health centers and dispensaries 	A good and poor performing health center be selected from each LGA a good performing dispensary and a poor- performing dispensary members of the HFGC
Fourth Stage	288 HFGC members (9 members from each selected health facility)	<ul style="list-style-type: none"> • Simple random selection of committee members • Purposive selection of HFGC Chairperson for interviews 	

Sample Size

A sample size of HFGC members

$$n = \frac{N}{1 + N * (e)^2}$$

n = sample size for HFGCs members

N = population size of HFGCs members from 32 selected facilities

e= desired level of precision (in this case is 0.05)

Having acquired the above sample, the proportional sampling technique (Pandey and Verma, 2008) was employed to determine the number of representative samples for each health facility.

$n! = n \times N/n!$

From this calculation, 9 HFGC members were selected from each health facility making a total number of 288 sample size for this study. However the response rate for this study was only 97.2%.

Data Collection method

A closed-ended structured questionnaire was employed to assess the perception of HFGCs members on the determinants of HFGCs performance in selected primary health facilities. Qualitative data were collected through interviews and focus group discussions. Interview guide had a total of 26 questions which covered a maximum of 40 minutes. A total number of 14 in-depth interviews were conducted with HFGC Chairpersons to assess their perception of the factors they think determine HFGCs' performance. Also, 13 focus group discussions were conducted with participants who were members of HFGCs.

Data Analysis

The relative important indices (RII) model was employed to determine the perception of HFGCs members on important determinants contributing to the performance of HFGCs under DHFF.

The Relative Important Index (RII) is used to determine the relative importance of the quality of each determinant as perceived by the participants (Holt, 2012). The Relative Important Index is only used with questionnaires which are in five-point Likert Scale form (Aziz *et al.*, 2016; Azman *et al.*, 2019). RII ranges from zero to one (0-1). Therefore, in this study, HFGCs members were required to provide their responses on each determinant through five Likert scale points. The HFGCs members were provided with twelve determinants to rank their importance in influencing their performance under DHFF context. These determinants were the education level of HFGC members, experience of the HFGC members, a profession of the members, and selection of the members of the HFGC. Other determinants were the composition of the members of HFGC, leadership of HFGC, a social network of members HFGCs, availability of guidelines on HFGC, and training to HFGC members. Further, clarity of HFGC functions and powers, timely availability of finance, and communication were also among the determinants. IBM-SPSS version 25 was employed in calculating the frequency of the scores assigned by each HFGCs member on each determinant. Then, to determine the ranking of important factors contributing to the functioning of the HFGCs, the RII was statically computed using the RII equation (Muhwezi *et al.*, 2014) as follows :

$$\text{Relative Important Index (RII)} = \text{RII} = \frac{\sum W}{(A \times N)}$$

Where;

W = Weightage given to each factor by the respondents

A= Value of higher Weight = 5

N = Total Number of Respondents 280

Qualitative Analysis

The content analysis was employed to analyse the data collected through interviews and FGDs. Audio recorded data were all selected for transcriptions, followed by the transcription which was done manually. The coding of relevant parts of the study was done with the guidance of a research question which was about the factors influencing the performance of HFGCs. Narrations, opinions, and statements describing the participants' feelings on the issues influencing the performance of HFGCs were captured and summarized. The guiding theory of empowerment framework for this study was used to benchmark the response of the participants ,if they felt they were empowered, and, if the empowerment enhanced their use of available avenue to exercise the powers and authority to improve service delivery.

Results and Discussion

This part presents the socio-demographic characteristics of the respondents of this study. The social demographic characteristics of this study were locations in which the study was conducted, the type of health facility, position of the members, the age, sex, and education level of the respondents. Table 2 provides the details in frequency and percentage.

Table 2: Socio-Demographic Characteristics of HFGC members (n= 280)

Variable	Frequency	Percents
Region		
Kilimanjaro	93	33.21
Mbeya	64	22.86
Songwe	54	19.29
Ruvuma	69	24.64
Type of Health Facility		
Dispensary	161	57.50
Health centre	119	42.50
Position		
Chairperson	43	15.36
Secretary or facility in charge	34	12.14
Member of the HFGC	203	72.50
Age		
<30	32	11.43
31-45	100	35.71
46-60	107	38.21
61+	41	14.64
Sex		
Male	139	49.64
Female	141	50.36
Education level		
Primary	150	53.57
Secondary	64	22.86
Certificate	24	8.57
Diploma	30	10.71
Advanced diploma	5	1.79
University degree	7	2.50

From Table 3, the results indicate that timely availability of finance was ranked 1st important determinant of HFGC performance with RII 0.8964 score, therefore perceived to be most the important determinant for the performance of HFGCs under DHFF. Members of HFGC ranked Clarity of the HFGC functions and powers as the second (2nd) important determinant with RII score of 0.8928 which was also followed by the communication between the HFGC and community as a third important determinant among the provided determinants with RII score of 0.8792. However, the education level of the HFGC members was ranked the least important determinant for the performance of the HFGC under DHFF with RII 0.7285 score. Indeed, the profession RII score of 0.7821 and selection of the members with RII 0.8007 score have been also ranked low important determinants.

Table 3: Perceived determinants for the Performance of HFGCs Under DHFF (n=280)

The factor for the functioning of HFGC	Very Important (5)	Important (4)	Moderate (3)	Slight Important (2)	Unimportant (1)	Total	Total Number (N)	A*N	RII	Ranks
Education level of HFGC members	435	576	66	30	13	1120	280	1400	0.7285	12
Experience of the HFGC members	470	600	48	28	6	1152	280	1400	0.8228	7
Profession of the member	395	604	48	28	20	1095	280	1400	0.7821	11
Selection	345	684	66	16	10	1121	280	1400	0.8007	10
Composition	385	608	111	10	9	1123	280	1400	0.8021	9
Leadership of HFGC	405	664	60	16	5	1150	280	1400	0.8214	8
Social network of members	480	596	69	22	1	1168	280	1400	0.8342	6
Availability of Guidelines	475	688	15	14	1	1193	280	1400	0.8521	4
Training to HFGC members	450	700	30	8	1	1189	280	1400	0.8492	5
Clarity of HFGC functions and Powers	615	556	66	12	1	1250	280	1400	0.8928	2
Timely Availability of finance	765	460	21	8	1	1255	280	1400	0.8964	1
Communication between HFGC and Community	650	540	36	4	1	1231	280	1400	0.8792	3

The study through RII, interviews and focus group discussion has identified perceived determinants that are important in determining the performance of HFGCs under DHFF. Generally, the HFGC members have identified timely availability of finance to the health facility as a most important factor ranked number one determining the performance of the HFGC. This is supported by the result of an interview conducted with the HFGC chairperson who insisted on the need of having finances in place to accomplish service provisions such as buying medicines and building materials. As one HFGC chairperson from in-depth interview responded that

“Most of the activities need finances to be accomplished; therefore, the availability of finances to the facility will help to address the complaint of the patients.” (HFGC Chairperson-Mbeya City Council, 14.02.2021)

This might be caused by the fact that health facility operations depend on finances to be implemented (Kilewo and Frumence, 2015; Tsofa *et al.*, 2017). Delay in accessing funds for implementing facility plans impairs and lowers the quality of service delivery. The clarity of HFGC functions and powers is perceived to be the second important determinant. This is through knowing the expectation and specific deliverables required to be attained by the HFGCs help to reduce uncertainty of what should be done or not done by the HFGC. The FGDs support the RII results, as participants claimed despite various reforms being implemented in health sector still HFGCs roles are not clear. The findings suggest a need for training and guidelines to be given to HFGC members to clarify their roles and powers to avoid ambiguity and help them to function well.

Past research reveals that clarity of HFGC functions and powers clarifies power boundaries and functions to help the HFGC focus on important issues (Goodman *et al.*, 2010; McNatt *et al.*, 2014; Waweru *et al.*, 2013). Communication between the HFGC members and communities has been ranked third important determinant for the performance of HFGC. For the HFGC to perform well, it has to be close to the facility health workers and community, know their problems and find local solutions to address those challenges and improve health service delivery. The results from the interview show that communication between communities and HFGCs is important for the performance of HFGCs under DHFF. This is because communication helps HFGCs to know the status of service delivery and challenges which need to be addressed. A respondent of an in-depth interview argued that: -

“Through continuous communication with communities, we tend to know challenges experienced by patients. Hence in HFGC, we discuss those challenges before making important decisions” (HFGC Chairperson-Siha DC- 02.03.2021)

These findings are in line with a study by Mabuchi *et al.*, (2018) who argues that a good relationship between HFGC and communities is significant for the performance of health facility. Other important determinants found are the availability of guidelines which ranked fourth and training to HFGC members ranked fifth.

However, the study has identified determinants that are perceived to be least important by the members of the HFGC under DHFF. The least important determinant is the education level of the members, profession, and selection of the members. This study is contrary to the findings of studies showing that education, profession, and selection and experience are important (Goodman *et al.*, 2010; Shayo *et al.*, 2012; Waweru *et al.*, 2013). This is because this study has found that contextual factors such as availability of finance, communication between the HFGCs and communities, and clarity of HFGCs functions are perceived as the most important factors. However qualitative findings from interviews and focus group discussion indicate that education and training have been reported to be important for HFGCs to accomplish their functions under DHFF. Members have commented on the need for education and training to HFGC members on how to perform their devolved functions. For instance, one HFGC chairperson argued that: -

“Education and frequently training are required because we want effective participation in all HFGC functions but our members do not know what they are required to do to ensure active participation” (HFGC Chairperson-Tunduma TC, 18.03.2021)

The findings of this study support the selected theory of this study by showing that the contextual determinants in which HFGCs operate stimulate the performance of HFGCs. The determinants are such as availability of finance ranked 1st, Clarity of powers and functions of HFGCs under DHFF ranked 2nd and communication between the HFGCs, health workers and communities ranked 3rd. The determinants are perceived to be more important in determining the performance of HFGCs under DHFF implementation. Therefore the findings to some extent are in line with the empowerment framework which state that opportunity structures/context in which agency (HFGCs) operate capacitate the agency/HFGCs to make effective choices. A study in Kenya revealed that Direct Facility Financing (DFF) required the participation of HFGCs in the governance of the primary health facility (Goodman et al., 2010; Waweru et al., 2013). In Tanzania studies have shown that the introduction of DHFF in primary health facilities have resulted into increased community ownership and empowerment to the primary health care facilities (Kajuni & Mpenzi, 2021; Mwakatumbula, 2021). On the other hand, agency/ actor characteristics such as education, experience, profession are perceived by the members to be less important in determining the performance of HFGCs in primary health facilities implementing DHFF in Tanzania.

Conclusion

There is renewed drive in decentralization practices, of now, LMICs are deepening decentralization through granting both decision-making powers and fiscal decision making to the community health governing structures. This study was conducted to ascertain the determinants of the performance of HFGC under Direct Health Facility Financing in selected four regions of Local Government Authorities in Tanzania. The findings have revealed the perceived determinants important for the functioning of HFGCs under Direct Health Facility Financing include the availability of finances to the facility, communication between the facility, health workers, and community, and clarity of HFGC roles and powers. The study has also identified less important perceived determinants for the function of HFGCs. They include the education of the members, profession, and experience.

Therefore, this study recommends that, if stakeholders want to improve the performance of health service delivery in primary health care facilities through the empowerment of HFGCs, they have to ensure that finances are timely available to the facility, provided guidelines to ascertain the roles and the manners which HFGCs have to accomplish their devolved powers and authority and build good linkage between the communities, health workers and HFGCs. The identified areas require special attention for the sustainability of the functioning of the HFGC under Direct Health Facility Financing.

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POLICY BRIEF

The Determinants of the Performance of Health Facility Governing Committees (HFGC) in Selected Primary Health Facilities in Tanzania

Lower- and Middle-Income Countries (LMICs) have introduced fiscal decentralization through various arrangements to empower Health Facility Governing Committees (HFGCs) and service providers to effectively manage health service delivery at the primary health care facilities. Together with this, the HFGCs have been anticipated to improve their performance in managing and controlling health service delivery. Focusing on Tanzania, this study was conducted to assess the determinants of HFGC's performance under the Direct Health Facility Financing Context (DHFF).

In Tanzania, fiscal decentralization in primary health care facilities is implemented through Direct Health Facility Financing (DHFF) program. Under DHFF, funds from multiple sources such as basket funds and other intergovernmental transfers are directly deposited to the public primary health facility bank accounts. The Government of Tanzania decided to introduce the DHFF to ensure flexible timely funding at the level of service delivery points to ensure increased efficiency in financial use and quality service delivery to the public. According to DHFF implementation protocol, HFGCs mandates are to prepare facilities plans according to the community needs and preferences, to budget based on the available resources, participate in the procurement process and ensure funds are being used according to the budgets.

This policy brief summarizes the determinants of HFGCs' performance in the implementation of DHFF in Tanzania from a recent study conducted in four selected regions in Tanzania. Through a cross-sectional research design, the study assessed the perceived determinants of the HFGCs performance under the DHFF context. The relative important indices (RII) model was employed to determine the perception of HFGCs members on important determinants contributing to the performance of HFGCs under DHFF. Based on the findings of the study, availability of finance to the health facility, clarity of powers and functions of HFGCs and communication between the HFGCs and community ranked as the most important determinants of HFGC performance under DHFF context.

Lesson Learned

The following are lessons learned from the study.

1. **Availability of finance to the health facilities:** Finances to the health facilities provide room for HFGCs to be able to make decisions over facility operations such as buying medicines, medical commodities, building materials, payment of allowances to service providers and facilitating HFGC meetings. Any delays in accessing facility finances for implementing facility plans impairs and lower the quality of service delivery.
2. **Clarity of HFGC functions and powers** inform the boundaries of the HFGCs mandate and remove uncertainties of their powers.
3. **Communication between the HFGC members, service providers and communities** provides good and sustainable linkage between health facilities stakeholders. This is because communication facilitates the identification of community health and service providers' challenges find local solutions to address those challenges and improving health service delivery.

Policy and practice recommendations

1. The intergovernmental transfer should be timely made to health facilities to facilitate service provision and help HFGCs to govern facility operations.
2. The policymakers should stipulate the specific functions and powers of each stakeholder including HFGCs in the process of governing health services provided to avoid duplication of responsibilities and powers.
3. Capacity building program should be provided to HFGCs members on their roles and powers and the manners they should be performing each specific function and power.
4. Both policymakers and health stakeholders should strengthen and establish facilitative communication infrastructures between HFGCs, service providers and communities to jointly address health challenges and implement health interventions.

Conclusion

In the process of improving community participation in governing health service delivery, contextual factors in which HFGCs operate are perceived to have a significant contribution in facilitating the functionality of HFGC in accomplishing the devolved powers and responsibilities. This calls for urgent attention to both policymakers and practitioners to reconsider and build on these factors if we are to strengthen HFGCs' performance in improving health service delivery at the primary health facilities.