

## **CHAPTER NINE**

### **SUMMARY, CONCLUSION, AND RECOMMENDATIONS**

#### **9.1. Introduction**

This chapter provides the summary of the study, the main conclusion, and the recommendations based on the study findings. The next subsection summarises the study paying more attention to the key findings.

#### **9.2. Summary**

The increasing importance of community-level accountability in PHC has elevated community-based accountability as the best means towards achieving cost-effective and equitable use of resources for improving service delivery and attaining universal health coverage. For almost two decades, Tanzania has been implementing policy interventions for enhancing both community financing and community-based accountability in health care. Despite these policy interventions and initiatives, accountability remains a critical challenge in community-level health service delivery. The study examined the relationship between empowerment and community-based accountability in rural PHC using Kasulu District Council as a case. The focus was on the influence of empowerment attributes on the capability of community members to demand and enforce accountability, the legal and institutional frameworks that govern the implementation of community-level health financing and accountability arrangement, and the implementation and operations of two main structures for community-level health care financing and accountability, namely the CHF and HFGCs.

Data collection involved a structured household survey questionnaire with 400 respondents obtained through random sampling from eight villages, IDIs with 24 PHC stakeholders at village and district level including facility managers, Village Executive Officers, and village chairpersons. Eight Focus group discussions that involved HFGC members were conducted in eight PHC facilities. Further, eleven village meetings and seven HFGC meetings were observed. Supplementary data on the legal and institutional frameworks and documented records was collected through reviewing documents from different offices at the community, district, and national level. Quantitative data analysis involved processing of survey data using the Statistical Package for Social Sciences (SPSS) version 20. Statistical analysis of the survey data involved the chi-square, multinomial logistic regression, and Principal Component Analysis (PCA). Data from interviews, focus group discussions, and documents was coded using Nvivo version 10 software and analysed using both deductive and inductive thematic analysis. The following paragraphs summarise the findings from the four study objectives.

The first objective was to examine the influence of empowerment attributes on the capability to demand and enforce accountability. The findings revealed that only a small proportion (12.75 percent) of the respondents felt that their level of empowerment was high. Majority of the respondents felt they had a low capability to demand and enforce accountability (73.1 percent) against only 4.6 percent who felt they had a high capability. The perceived levels of empowerment were relatively high in terms of the readiness to contribute for collective health financing, the ability

to demand better services at health facilities, and being aware of the existence and roles of HFGCs and their members. On the other hand, the levels were significantly low for the perceived power to influence and affect decisions, perceived influence, and efficacy to change health care priorities, and the trust in health workers and officials who manage the funds. Similarly, the majority of the respondents felt less capable of understanding information related to finance and health care, and they had limited skills related to financial analysis and priority setting. However, gender, employment status, and level of education were significantly associated with the variation in the capability to demand and enforce accountability ( $p < 0.005$ ).

The attributes, which were significantly associated with the capability to demand and influence accountability, included possession of power to influence choices, trust in health workers and government officials, possession of skills related to financial management and health care, and the capacity to analyse and understand the information related to finance and health care ( $P < 0.005$ ). Principal Component Analysis results revealed that improvement in the level of trust, perceived power and internal efficacy, convenience and utility of information, and skills relating to financial management and participatory health care planning and decision-making could best improve the capability to demand and enforce accountability. However, the inexistence of assured community activation forces at community levels such as formal organised CSOs and NGOs calls for planned interventions that should focus on improving capacities of communities and their key actors in these priority areas.

The second objective was to assess the extent to which the legal and institutional frameworks that govern the CHF and HFGCs promote community participation, ownership, and control over financial and service delivery plans and decisions. The findings have revealed that the existing laws, policy guidelines, and roles largely seek to promote community participation, ownership, and control over financial and service delivery plans and decisions. The law encourages flexibility in procurement to allow PHC facilities obtain medicine and medical supplies from alternative suppliers on a competitive basis. The guidelines further emphasise that the CHF should be community owned, community-led, and the communities through the HFGCs should have control on the key decisions. The guidelines seek to ensure a fair representation of community groups and empower the HFGCs as representative organs of the communities to exercise control over important decisions including financial decisions. However, the actual operations of both the CHF and HFGCs slightly deviate from the requirements of the formal guidelines. For example, some required procedures were neglected during the formulation of HFGCs to accommodate the interests of different community-level stakeholders including grassroots politicians, political parties, health professionals, and preserve the social-cultural norms of the communities. Cases related to partial contributions, contributing when sickness occurs, and extending the right to use a single card beyond one household were common in all the study communities. These forms of non-compliance were associated with unexpected results such as low enrolment and limited willingness of community members to pay CHF contributions.

The third objective was to explain how the process of managing the CHF at community and facility level affects community-based accountability. The study found that communities participate effectively at the stage of mobilisation and collection of funds, which involve a broad range of actors at facility, village, and ward levels. Most facility managers kept community members informed on the contributions by publishing the names of contributors and amounts they had paid on the notice boards. Communities participate in priority setting and budgeting through representation in HFGCs. However, representatives' inadequate technical and financial knowledge and skills made them listeners who approved plans and decisions made by facility managers and their management teams. Available members of HFGCs verified medicines once delivered. In addition, all community members could access medicine invoices on the notice boards and thus, track expenditure on medicine. The village assemblies provided the opportunity for communities and their grassroots authorities to summon and question the facility managers on matters related to the CHF, spending, and service delivery at the facility. However, the findings revealed that community members often hesitated to ask questions in open public gatherings, especially sensitive questions that could result in retribution by health workers and government officials.

Some themes emerged regarding the effect of the CHF on community-based accountability. Medicine stock-outs stood as a predominant linchpin in the management of the CHF that affected the readiness to contribute and monitor the use of funds. Stock-outs were associated with reversed expectations about the importance of the CHF, and frustration of health workers. There were other important themes, which pertinently explained the connection between the management of the CHF and community-based accountability. The first one was the belief in traditional belief systems and related sanctions such as superstition, witchcraft, and curses trying to sidestep the formal-legal sanction systems with a view that the latter is procedural and causes misunderstanding among the communities. The second theme was the existence of contentions regarding the 'free riders' –those who were to receive free services through social inclusion arrangements such as the waiver and exemption. There were perceptions that these arrangements were unfair and allowed the free riders to empty the health facilities leaving the payers to suffer from the impact of stock outs.

The study identified some critical accountability concerns that affected the legitimacy of the CHF in the communities and thus, affected the readiness to contribute and participate in monitoring both the use of funds and delivery of services at community and facility levels. These were recurrent stock-outs and acute shortages of medicine and medical items in the PHC facilities, the existence of many free service users, and absence of referral services for CHF policyholders. These challenges made the communities unwilling to contribute and participate in financial and service delivery oversight.

The fourth objective was to evaluate the ways in which HFGCs enhance community participation and the enforcement of community-based accountability. The study found that health facility committees had represented community groups including

the women and micro-entrepreneurs who had special representation as SACCOs members. There was also geographical representation for villages in the catchment areas that were being served by the health facilities. The committees held their meetings quarterly and could have additional meetings to discuss any matters that needed their approval.

Besides these strengths, the study identified limitations that made health facility committees ineffective in terms of enhancing participation and enforcement of accountability. The committees were found to have limited autonomy and control over fiscal decisions. The district council enjoyed most of the powers, which allowed it not to honor the facility financial plans and decisions that HFGCs approved. Similarly, rather than carrying out the central oversight function that was related to financial scrutiny and ensuring that health care plans and decisions reflected community health needs and priorities, the commonly identified activities of the committees were verifying received medicine, mobilising contributions, endorsing the already prepared plans and budgets, and identifying facility infrastructures that needed maintenance or repair. To a large extent, these activities facilitated the day-to-day management of health facilities and thus were not rationally meant to allow communities to effectively exercise control over financial and service delivery decisions.

The study further identified that the capacity of health facility committees to carry out their formal functions was relatively restricted due to restricted financial autonomy and limited competencies among their members. HFGCs had limited legitimacy and trust from communities, which was associated with the absence of formal direct linkage with the communities. The committees worked with village authorities in addressing facility problems. However, the cooperation was often *ad hoc*, contingent, uncoordinated, and characterised by dyads which made grassroots officials protect facility managers and health workers against accountability pressures from the communities.

Different factors including knowledge and experience, fame or popularity of the members, which are attached to the political, economic, and social status; and the existence of gender stereotypes that root from community traditions vitiated the capability to influence plans and decisions in the health facility committees. Further, the findings revealed overlaps between HFGCs and other committees at village and ward levels in terms of power, functions, and accountability relations. These overlaps resulted in confusion regarding which committee should be responsible for which matters in the management of primary health care. In the long run, the communities failed to identify the appropriate channel that they should take to address concerns related to accountability for money and service delivery. However, the findings show that communities preferred approaching grassroots officials over health facility committees and their members for their accountability concerns.

### **9.3. Conclusion**

The study has examined the relationship between empowerment and community-based accountability. The findings have revealed that majority of the community

members feel less empowered and have low capabilities to demand and enforce accountability. The capabilities of the community members to demand and enforce accountability are further constrained by the limited efficacy and responsiveness in the management of both the CHF and HFGCs. It is therefore indicated that both the perceptions of powerlessness and disempowering institutional environments at community level have significant influence on the success of community-based accountability.

Similarly, unforeseen gaps that arise during the implementation and limit mutual trust, effective communication, and development of a strong partnership between communities, health workers, and government officials at grassroots and district levels have been noted. Unforeseen challenges such as medicine shortages and stock outs significantly affect the readiness of communities and their representative institutions to exercise control over fiscal and service delivery decisions. Limited support from the district council contribute towards mistrust and suspicion. Subsequently, the legitimacy of community-based accountability arrangements within the CHF and HFGCs is undermined. Also, communities may not participate effectively in policy interventions if they think they have been imposed on them, or they contradict with their social-cultural norms. Without addressing these concerns within the CHF and the operations of HFGCs, these forums, which aim at empowering communities to demand and enforce accountability are likely to disempower communities and thus affect both participating in healthcare financing and playing their oversight role.

It is also worth learning that critical barriers to the success of community-based accountability interventions stem from the implementation process rather than the institutional setup and design of the interventions. It may not be easy to close this implementation gap in the situations where communities consider the policy interventions to be centrally packaged and imposed on them. To a large extent, the social acceptability rather than the scientific soundness of the interventions determines the chances for successful implementation of health policy interventions in community settings. Thus, a more participatory approach in the design and adoption stages would make the communities feel that the interventions are 'homegrown' and thus are legitimate, acceptable, and community-owned.

The findings bring to the attention of health systems management and primary health care researchers one point of theoretical importance. This is especially, the necessity of considering the relationship between empowerment and community-level accountability as conditioned by different forces in three interdependent spheres. The first sphere is the design, adoption, and implementation of community empowerment interventions –especially the extent to which the communities are made to understand the relevance of the interventions and their legitimation. This can be well comprehended through the PPM. The second is the relationship that arise as part of interactions between the actors in the implementation of health care interventions such as health professionals, communities, and government authorities. Important aspects in this sphere relate to motivation of different actors, competing interests, and

trust which determine the development and strength of community partnership. These aspects are relevantly explained by the IMCHB and its assumptions.

The last, but relatively stronger compared to the two is the institutional sphere. This sphere, which related to the institutional theory explains the primacy of formal and informal rules and organizational contexts that surround the implementation. It has been learnt from the findings that the efforts to empower the communities and enhance community-level accountability represent the competition between the formal rules such as laws and policies on one hand, and societal norms on the other hand. Taking into account the three theories may provide a holistic and pragmatic framework for understanding and addressing the failures in the implementation of community-level empowerment and accountability policy interventions in rural PHC.

Overall, these findings present an important message that the efforts to enhance the capacities and competencies of community members may not allow communities to effectively demand and enforce accountability if institutional and contextual environments pose limitations that affect development and articulation of collective voices. In addition to capacities and competencies, engaging in collective oversight actions for demanding and enforcing accountability becomes possible if there are transparent and institutionalized arrangements that allow the communities and their key actors to challenge plans and decisions and hold service providers and officials accountable for resources and service delivery. At this point, it is important to conclude that improvement in the capacities of community members may not be successful without creating institutional environments conducive to empower community-level actors to have autonomous control over the key decisions related to finance and service delivery. In other words, effective empowerment interventions need to take into account the improvement in both agency and opportunity structure as mutually interdependent spheres. The existence of friendly and responsive institutions increases the confidence of individuals and organised communities and their institutions to demand and enforce accountability. The institutions encourage communities to demand their rights and exercise power and control over service providers and government authorities.

#### **9.4. Recommendations**

Based on the findings and conclusion, this study makes five recommendations in relation to the research objectives and potential areas identified for further research.

First, the district council in collaboration with the ministries responsible for health and local government as well as civil society actors should conduct extensive awareness creation campaigns and capacity building interventions for improving agency among the rural communities. The interventions should focus on creating awareness on the rights and responsibilities of communities in the management of finance and health service delivery at the community level and developing competencies required to collect, analyse, understand, and use available information for monitoring resources and service delivery at community and facility level. These competencies are vital for empowering the communities and enhancing their capabilities to demand and enforce accountability.

Second, the study recommends that the ministries responsible for health and local government should strengthen the mechanisms for enforcing the legislation and policies that govern the operations of the CHF and HFGCs to increase compliance with the rules and guidelines. This is because noncompliant practices such as partial contributions, abuse of CHF cards, and politicisation of HFGCs were found to affect the credibility of the CHF and HFGCs. Consistent with the laws and guidelines, the implementation should ensure that communities have access to referral services and are free to procure medicine and medical supplies from other suppliers than MSD. This will allow PHC facilities to reduce stock-outs, which have become a centre of sensitive accountability concerns in the CHF. Overall, the planned changes in the legislation to make the CHF a compulsory fund may not yield positive response from communities without addressing these malpractices. The malpractices make the communities lose confidence in the CHF and the HFGCs and therefore, undermine community ownership, participation, and oversight.

Third, the study recommends major transformation within the operation of the CHF to make it a community-led, community owned, and highly acceptable social health insurance scheme. The Ministry for local government should take a leading role in the process. This can be achieved through consultation and participation of the communities in developing plans for improving the CHF; strengthening partnership between communities, health workers, and grassroots authorities; and strengthening communication and cooperation between the district and community-level stakeholders who participate in the management of the CHF. Strong partnership and collaboration between communities, health workers, grassroots authorities and the district council are imperative for increasing trust, legitimacy, and acceptability of the CHF in the communities. Trust and legitimacy are central for increasing the efficacy of achieving both higher enrolments in the CHF, which is a prerequisite for increasing the contribution levels and motivation among communities to take action to ensure accountability for finance and service delivery.

Fourth, the study recommends intentional intervention to strengthen the capacity of HFGCs to carry out their mandatory strategic role. The district council should initiate a continuous capacity building training for equipping HFGC members (especially new members) with financial, planning, and decision-making skills. In addition, more interventions are required in terms of devolving fiscal control powers to HFGCs and the communities in general. This could be achieved through issuing simplified guidelines, which define the powers and responsibilities of different actors in the management of PHC at community and district levels including the HFGCs and grassroots authorities.

Fifth and last, the study points out some potential areas for further studies. First, a nationwide study to examine the influence of variation in rurality on the implementation of empowerment and community-based accountability interventions is required. Building on the findings of this study, a comparative study may be appropriate for drawing generalisable conclusions. Second, the study recommends for pre-and post-intervention studies that should seek to evaluate the influence of the

priority empowerment attributes on increasing the capability to demand and enforce accountability. The priority focus of the interventions should be on (1) trust and faith in representative organs and grassroots institutions, (2) perceived powerfulness and self-efficacy (3) convenience and utility of information, and (4) perceptions and knowledge of healthcare rights and entitlement. The study recommends that such studies should use a participatory quasi-experimental design, which entails researchers' control over the intervention process.

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## APPENDIXES

### Appendix 1: Household Survey Questionnaire for Community Members

#### INTRODUCTION

**Dear respondent,**

The University of Dar es Salaam through its students and staff conducts research aimed at addressing critical problems that affect development of community members. I, Respicius Shumbusho Damian am a PhD student doing research on *Community-based Financial Accountability in Healthcare, especially among rural communities*. As one the participants selected for the study, I would request you to provide your contribution through answering some few questions, which are expected to take approximately 45 to 60 minutes. I assure you that the information you will provide is purely for academic use and not otherwise. I also assure you that your identity will not be disclosed to any other person as a source of the information you will provide. Participation in this study is voluntary and free. Feel free to drop or refuse to answer any of the question you are not comfortable with.

#### PART A. SAMPLE IDENTIFICATION AND BASIC DEMOGRAPHICS

1. Ward
  - 1) Bugaga
  - 2) Rungwe Mpya
  - 3) Nyakitonto
  - 4) Titye
  
2. Village Name
  - 1) Bugaga
  - 2) Nkundutsi
  - 3) Rungwe
  - 4) Kaguruka
  - 5) Nyakitonto
  - 6) Mugombe
  - 7) Titye
  - 8) Lalambe
  
3. Gender
  - 1) Male
  - 2) Female
  
4. Marital Status
  - 1) Married (currently)
  - 2) Not married (ever)
  - 3) Divorced
  - 4) Widowed
  
5. Age of the respondent (years)
  - 1) 18-35 (young)
  - 2) 36-50 (young adult)
  - 3) 51-59 (mature adult)
  - 4) 60-70 (old age)
  - 5) 71 or above (elderly)

6. Level of formal curricular education
  - 1) Less than primary education
  - 2) Primary education
  - 3) Secondary education
  - 4) University degree
  - 5) Other higher education (non-degree)
7. Employment status
  - 1) Currently Employed
  - 2) Currently not employed
  - 3) Retired
8. Occupation/main income earning activity
  - 1) Farm activities (crop/animals)
  - 2) Employed in formal sectors
  - 3) Self-employed entrepreneur (MSME)
  - 4) Housewife/man depending on partner
  - 5) Student
  - 6) Others (specify) \_\_\_\_\_
9. Special health need group
  - 1) Disabled (any disability)
  - 2) Pregnant woman
  - 3) Elderly above 60
  - 4) Others (specify) \_\_\_\_\_
  - 5) No special health needs
10. Estimated household income category when compared to the average rural household income (30,940-46,410TZS)
  - 1) Very low (below 15,470TZS)
  - 2) Low (15,470 up to less than 30,940)
  - 3) Equals to the average income (30,940 to 46,410)
  - 4) High compared to the average income (above 46,410 to 61,880TZS)
  - 5) Very high compared to the average income (above 61,880)
11. Type of household considering leadership and family structure
  - 1) Complete family household (with father, mother, children)
  - 2) Father and children household
  - 3) Mother and children household
  - 4) Non family household[e.g. ghetto]
  - 5) Others (specify) \_\_\_\_\_
12. Estimated distance from the nearest primary healthcare unit
  - 1) Less than a kilometer (less than 12 minutes)
  - 2) Between 1 and 2.9 kilometer (between 12 and 35:59 minutes)
  - 3) Between 3 and 4.9 kilometer(between 36 and 59:59 minutes)
  - 4) Between 5 and 6.9 kilometer(between 60 and 83:59 minutes)
  - 5) 7 Kilometers or above (more than 84 minutes)

**PART B: COMMUNITY ACTIVATION ACTIVITIES (TO DEMAND FINANCIAL ACCOUNTABILITY)**

13. Have you ever attended any form of campaigns aimed at mobilising community members (citizens) to demand for accountability of officials and providers of health services in your area?
  - 1) Yes [if yes go to Q14]
  - 2) No [if no skip Q14]
14. If yes in Q13, who conducted the campaign? Encircle all that apply

- 1) Community radio
  - 2) CSOs and NGOs at community level
  - 3) Informally Organised Citizen Groups
  - 4) Local government personnel/officials
  - 5) Elected community leaders
  - 6) CSOs and NGOs from other parts of the country
15. Have you ever heard of or attended any community forum that was aimed at making average citizens participate in health priority setting, budgeting, and monitoring how money allocated for healthcare is used?
- 1) Yes heard and attended
  - 2) Yes heard, but not attended
  - 3) No, neither heard nor attended[if the answer is 2, or 3 skip Q16]
16. If you attended any of the participatory forums in Q15, how frequent were such forums organised and conducted in your community?
- 1) Very often
  - 2) Often
  - 3) Neither often nor rare
  - 4) Rare
  - 5) Very rare
17. To what extent would you agree that CSOs and informal community networks are encouraged to participate in priority setting and monitoring use of money allocated for healthcare
- 1) Strongly agree
  - 2) Agree
  - 3) Neither agree nor disagree
  - 4) Disagree
  - 5) Strongly disagree
18. To what extent would you agree that Informally Organised Community Groups/networks are encouraged to participate in priority setting and monitoring use of money allocated for healthcare
- 1) Strongly agree
  - 2) Agree
  - 3) Neither agree nor disagree
  - 4) Disagree
  - 5) Strongly disagree
19. To what extent would you agree that CSOs play an active role in supplying information needed by community members to enforce accountability in the delivery of health services?
- 1) Strongly agree
  - 2) Agree
  - 3) Neither agree nor disagree
  - 4) Disagree
  - 5) Strongly disagree
20. How frequent are reports on allocations and spending of money for healthcare put public in your community/village?
- 1) Very often
  - 2) Often
  - 3) Neither often nor rare

- 4) Rare
  - 5) Very rare
21. If financial reports are put public in your community, what methods were used to present such reports to the public/community members
- 1) Printed reports mounted on noticeboards at health facilities
  - 2) Printed reports read and explained during meetings
  - 3) Printed report copies distributed to individual citizens
  - 4) VEOs explaining orally (without written records)
  - 5) Others (specify what is done)\_\_\_\_\_

**PART C: COMMUNITY MEMBERS’ EMPOWERMENT ATTRIBUTES’ RATING**

B1 (a) The following criteria will help us understand your capability as a community member enforce financial accountability in relation to healthcare. For each of the criteria, rate yourself between 1 and 5 rating points where the rating points may be interpreted as: 1=very low, 2=low, 3=neither low nor high, 4=high, 5=very high

	Attributes of empowerment	Self-rating options				
		1	2	3	4	5
22	I have sufficient information on the sources of money used to finance healthcare for community members					
23	I feel ready to contribute money required for financing healthcare for my community members					
24	I feel that I have sufficient access to information that may allow me question on allocation and spending money for community healthcare					
25	I feel that it is my right to access information on how money allocated for healthcare should be spent/was spent					
26	I feel that I have power to influence decisions and actions related to prioritising and spending on health					
27	I can read and understand financial reports that show the money allocation and expenditure					
28	I have skills related to budgeting, planning, or financial performance analysis					
29	I am informed of the existence of Dispensary Governance Committee (HFGC)					
30	I know the representatives who represent our community in Health Facility Governance Committees [HFGCs ]					
31	I feel that representatives in the HFGCs represent my interests/priorities regarding healthcare					
32	I feel that elected community leaders are strong enough to influence officials and providers to act according to community members’ healthcare needs					
33	I know the role and responsibility of HFGCs					
34	I feel that I can go to the VEO’s office and demand information					
35	I feel that I can demand better/quality health services at the health facility					
36	I feel that it is my responsibility to make sure that money allocated for healthcare is not misused					
37	Do you feel that community leaders have sufficient					

	motivation police allocation, spending, and tracking financial flow?					
38	I feel that public officials responsible for administration of finance available for healthcare serve community interests					
39	I am sure that the government allocates money for healthcare					
40	I am confident that the money allocated for healthcare is well managed and spent					

#### **PART D. OVERALL RATING**

B2 (b)

41. To what extent would you agree that your own interests are considered during planning how resources available for healthcare should be allocated/used?

- 1) Strongly Agree
- 2) Agree
- 3) Neither agree nor disagree
- 4) Disagree
- 5) Strongly disagree

42. To what extent would you agree that government officials who are responsible for passing plans on healthcare financing consider the needs/priorities of the local community members?

- 1) Strongly Agree
- 2) Agree
- 3) Neither agree nor disagree
- 4) Disagree
- 5) Strongly disagree

43. How would you rate your capability to influence decisions on how money available for community healthcare should be allocated/used?

- 1) Very low
- 2) Low
- 3) Average
- 4) High
- 5) Very high

44. How would you rate the general performance of HFGCs in terms of providing opportunity for communities to participate in priority setting and monitoring spending on healthcare?

- 1) Very low
- 2) Low
- 3) Average
- 4) High
- 5) Very high

#### **E. OTHER QUESTIONS**

45. Does your household have members who use Tiba kwa Kadi (TIKA) (contribute to the CHF and use the card to receive health services)?

- 1) Yes
- 2) No

#### **Appendix 2: Standard Interview Guide (individual interviews)**

1. Let us start by talking about the coverage and capacity of the dispensary/health centres to deliver primary health services to its catchment

- population. Can you explain how many villages, hamlets, and households depend on the PHC facility, which is in this village?
2. What are the sources of funds for running the dispensary/health centres in this village?
  3. How would you explain the success and role of the CHF in terms of increasing access to health services by low-income households in this community?
  4. How does the community participate in the management of the CHF including making important decisions on how the money should be used and ensuring that the funds are well managed?
  5. Apart from community members, who are the important stakeholders who play role in the management of the CHF and what are their roles?
  6. Let us now talk about the dispensary/health centres committee: How is it created? What are its roles?
  7. How would you assess the ability of the members of dispensary committees to carry out their functions and representing community needs?
  8. Can you explain how your office works with other community level institutions to improve delivery of primary health services and ensure that the money available for primary health services delivery is efficiently and effectively utilised for better health outcomes?
  9. Let us now talk about reporting and sharing information related to money and health services delivery in this community. How are the information related to money and health services transmitted from health facilities to other organs at community and district levels?
  10. How does the dispensary committee relate with other village government organs in terms of carrying out activities related to primary health services and community health?
  11. The government policies require public health facilities including dispensaries and health centres to provide free services to some groups in communities. These groups include the children below five years, pregnant women, the elderly, and the poorest household. In your view, what have been the positive and negative effects of these policies on primary health services delivery in this community?
  12. Let us now learn the main problems that your village faces in the process of delivering improved health services to its catchment population.
  13. What do you think may be done to increase participation of communities in the management of primary health services delivery in this community?

**TANK YOU FOR YOUR VALUED TIME**

### Appendix 3: Focus Group Discussion (FGD) Guide

#### DEMOGRAPHIC DETAILS

Cadre of Participants \_\_\_\_\_

Location/Venue \_\_\_\_\_

Date \_\_\_\_\_ Starting Time: \_\_\_\_\_ Ending

Time: \_\_\_\_\_

Audio File No \_\_\_\_\_ Transcript Number \_\_\_\_\_ Group Size \_\_\_\_\_

Recorder \_\_\_\_\_

Moderator:    R.S. DAMIAN   

Transcriber's Name: \_\_\_\_\_

#### DISCUSSION GUIDE

***A Note to transcriber:** Please, use the initial "I" before the words of the interviewer and "P" before the words of all other participants.*

#### Moderator Opens up the Discussion:

- Welcomes up attendees, introduction of the research team members such as the recorder.
- **Introduction of the Topic:** The moderator introduces the essence and aim of the study and explains why it is important for attendees to participate. For example, you have been asked to participate, as your experience and view are important. I realise you are busy and I appreciate your time.
- **Consenting:** The moderator explains the benefit that the community will get due to participating in the study. Furthermore, emphasis should be made that there is no payment for participation in the discussion. Instead, at the end of the discussion, the team will refund each participant the travel cost not exceeding 10,000 (Ten Thousands) shillings. In addition, the moderator should assure participants that the information they will provide as part of the discussion will be kept anonymous and only for the intended purpose. In case participants feel that they do not want to continue with the discussion may decide to stop or deny from responding to any specific question. The moderator asks participants to allow the team to record the discussion, as they will need to sit down and extract themes. To **proceed, the participants must give a verbal consent.**

**Ground Rules:** The moderator asks the participants to identify some basic rules that will guide the discussion. These rules may include selecting the chairperson to moderate the discussion and the timekeeper. In addition, they should propose ground rules, which the moderator may restate to include the following standard focus group discussion rules

- One person speaks at a time
- There is no right or wrong answers. All the contributions matter. Therefore, we let all participants to say what they have in mind.
- Respect for the views of others. Do not interfere. You may raise hand and ask the chairperson if you have a point of interruption or addition.
- Consensus is not necessary. So, do not hastate to give your view when it is against others' view.
- What happens at the beach? Leave it for the beach. We should not talk about what we have discussed here out of here!
- The moderator allows participants if there are any questions before the beginning of an actual discussion.

#### Warm Up

First, I would like to let everyone introduce himself or herself. Can you tell us your names and your position?

#### Opening Question

1. Let us use the first few minutes to share our experience about the role of the Dispensary Governance Committee/Health centres Governance Committee. What exactly do you do as members of the committee?

### **Guiding Questions**

2. Let us discuss what we understand about the dispensary committee. How it is formulated? How it works? In addition, what are its key roles in relation with obtaining and supervising money at the dispensary?
3. Let us now talk about the funds for running the dispensary. Where does the facility committee get money to finance different activities and expenses required for running the dispensary?
4. How far would you consider CHF as having been successful in this village in terms of getting many households participating in the fund?
5. How does the dispensary committee participate in the management of funds obtained for financing activities of the dispensary/health centre? At what stage do you get information about the money?
6. Apart from the funds, what other reports, and information do you get from dispensary/health committee meetings?
7. I would also like to get your views on whether there are enough funds to finance different expenses of the dispensary including medicine and medical items.
8. How would you talk about the quality of services at the dispensary?
9. As committee members, how do you help community members to make sure that their needs are considered during planning and priority setting?
10. How does the dispensary committee work with the village government on matters related to the management of the dispensary/primary healthcare?

### **Closing Question**

11. Of all these issues, we have discussed in this Focus Group Discussion, what key issues would you think need to be addressed to make participation of community in primary healthcare management successful in this community?

**Conclusion:** The moderator ends up by offering participants opportunity to ask any question they feel would like to ask. Thereafter, the moderator and team should appreciate participation by respondents and emphasise at least two things: anonymity and confidentiality on one hand and not letting people who did not participate know what individual participants in the discussion said. End up by allowing the chairperson to close the session.

**=THE END=**

**Appendix 4: Meeting observation schedule/checklist)**

(a) Type of Meeting: \_\_\_\_\_ Village/Facility: \_\_\_\_\_

(b) Date of a Meeting: \_\_\_\_\_ Time Started \_\_\_\_\_ Time ended \_\_\_\_\_

(c) Number of attendees: Male \_\_\_ Female \_\_\_ Total \_\_\_ Absentees \_\_\_ (actual/estimate)

Tick for each of the following:

	<b>Observation clues/questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
1	Is the meeting organised and conducted in a formal way?			
2	Did the meeting start at expected time?			
3	Was there a list of written agenda to be discussed?			
4	Did the participants have agenda before the meeting day?			
5	Did the meeting have a chairperson and secretary?			
6	Was the chairperson playing her/his actual role?			
7	Was the secretary playing her/his actual role			
8	There was no undue influence and forcing opinions?			
9	Were all members encouraged to discuss/ contribute on the agenda?			
10	Were the views of each of the participants respected?			
11	Were questions asked addressed and answers provided?			
12	Were there signs of gender equality?			
13	Did the secretary note down contributions of all members?			
14	Were all the discussions open, inclusive, and transparent?			
15	Were participants showing motivation to follow the agenda?			
16	Were the representatives of communities given chance to present priorities of their people			
17	Were there complaints, which were reported for discussion?			

To be filled for every meeting attended. Detailed notice should be provided at the end of the day on which the meeting was observed.

Review Section	Detailed Description/Comments/or write NIL
Who called the meeting?	
How was the attendance?	
Comment on participation (fairness, influence, power)	
Comment on Participants' Information and knowledge of the matter on the agenda?	
How does the meeting reach consensus? How is the agenda concluded?	
Were there any complaints?	

Main Strength of the meeting:

Main weakness:

Overall impression/lesson from the meeting:

**Appendix 5: A list showing (bold and underlined) wards, villages, and respondents sampled for the survey study.**

s/n	Ward Name	Villages	# of respondents
1	Asante Nyerere	1. Asante Nyerere	0
		2. Sogeeni Kwiliba	0
		3. Kibirizi	0
		4. Lugoma	0
		5. Nyamusanze	0
		6. Shunga	0
2	Herushingo	1. Herushingo	0
		2. Kigadye	0
		3. Nyarugusu	0
3	Kagerankanda	1. Kagera	0
		2. Mvinza	0
4	Kitagata	1. Kitagata	0
		2. Nyaugwa	0
5	<b><u>Rungwe Mpva</u></b>	1. <b><u>Kaguruka</u></b>	<b><u>50</u></b>
		2. Nyakafyeke	<b><u>0</u></b>
		3. <b><u>Rungwe Mpva</u></b>	<b><u>50</u></b>
6	Kurugongo	1. Chekenya	0
		2. Kabulanzwili	0
		3. Kurugongo	0
		4. Migunga	0
		5. Nyenge	0
7	Rusesa	1. Kakirungu	0
		2. Making	0
		3. Rusesa	0
		4. Zeze	0
8	Makere	1. Kalimungoma	0
		2. Kasasa	0
		3. Makere	0
9	Nyamnyusi	1. Kitema	0
		2. Mukiheta	0
		3. Nyamunyusi	0
10	<b><u>Bugaga</u></b>	1. <b><u>Bugaga</u></b>	<b><u>50</u></b>
		2. <b><u>Nkundutsi</u></b>	<b><u>50</u></b>
11	Shunguliba	3. Kazage	0
		4. Malalo	0
		5. Shunguliba	0
12	Buhoro	1. Buhoro	0
		2. Kibirizi	0
		3. Lugoma	0
		4. Nyamusanze	0
		5. Shunga	0
13	Muzye	1. Mutala	0
		2. Muzye	0
14	Nyachenda	1. Mwali	0
		2. Nyachenda	0
15	<b><u>Nyakitonto</u></b>	1. <b><u>Mugombe</u></b>	<b><u>50</u></b>
		2. <b><u>Murubaga</u></b>	<b><u>0</u></b>

		3. <b>Nyakitonto</b>	<b>50</b>
		4. Katonga	0
		5. Mkesha	0
<b>16</b>	Kwaga	1. Kabagwe	0
		2. Kwaga	0
		3. Ngage	0
<b>17</b>	Nyamidaho	1. Kumkambati	0
		2. Kuntundu	0
		3. Mvugwe	0
		4. Nyamidaho	0
<b>19</b>	Kigembe	1. Kasangezi	0
		2. Kigembe	0
<b>18</b>	Kitanga	1. Kitanga	0
		2. Kiyungwe	0
<b>20</b>	<b><u>Titve</u></b>	1. <b>Lalambe</b>	<b>50</b>
		2. <b>Titve</b>	<b>50</b>
<b>21</b>	Kalela	1. Kalela	0
		2. Kunde	0
		3. Nyakayaga	0

**Appendix 6: List of PHC facilities in Kasulu District Council August 2015**

S/N	Facility Number	Facility Name	Facility Type	Ward	Village	Status	Ownership
1	100195-7	Asante Nyerere	Dispensary	Asante Nyerere	Asante Nyerere	Operating	Public - LGA
2	100434-0	Bugaga	Dispensary	Bugaga	Bugaga	Operating	Public - LGA
3	106547-3	Nkundutsi	Dispensary	Bugaga	Nkundutsi	Operating	Public - LGA
4	100482-9	Buhoro	Dispensary	Buhoro	Buhoro	Operating	Public - LGA
5	105516-9	Mtabila	Dispensary	Buhoro	Buhoro	Closed	Public - LGA
6	105745-4	Muyovozi	Health centres	Buhoro	Shunga	Operating	Public - LGA
7	101359-8	Heru-Ushingo	Dispensary	Herushingo	Herushingo	Operating	Public - LGA
8	102689-7	Kigadye	Dispensary	Herushingo	Kigadye	Operating	Public - LGA
9	110229-2	Nyarugusu	Dispensary	Herushingo	Nyarugusu	Operating	Public - LGA
10	102163-3	Kagerankanda	Dispensary	Kagerankanda	Kagerankanda	Operating	Public - LGA
11	105766-0	Muvinza	Dispensary	Kagerankanda	Muvinza	Operating	Private-FBO
12	102403-3	Kasangezi	Dispensary	Kigembe	Kasangezi	Operating	Public - LGA
13	102701-0	Kigembe	Dispensary	Kigembe	Kigembe	Operating	Public - LGA
14	105755-3	Muzdalif-Kasangezi	Dispensary	Kigembe	Kasangezi	Closed	Public - LGA
15	103142-6	Kitagata	Dispensary	Kitagata	Makere	Operating	Public - LGA
16	104100-3	Makere	Dispensary	Kitagata	Makere	Operating	Public - LGA
17	103159-0	Kitanga	Dispensary	Kitanga	Kitanga	Operating	Public - LGA
18	102232-6	Kalela	Dispensary	Kwaga	Kalela	Operating	Public - LGA
19	103355-4	Kwaga	Dispensary	Kwaga	Kwaga	Operating	Public - LGA
20	105724-9	Mutala	Dispensary	Muzye	Mutala	Operating	Public - LGA
21	105763-7	Muzye	Dispensary	Muzye	Muzye	Operating	Public - LGA
22	105840-3	MWALI	Dispensary	Nyachenda	Mwali	Operating	Public - LGA
23	106644-8	Nyachenda	Dispensary	Nyachenda	Nyachenda	Operating	Public - LGA
24	108754-3	Kimwanya	Health centres	Nyachenda	Nyachenda	Operating	Public - LGA
25	105636-5	Mugombe	Dispensary	Nyakitonto	Mugombe	Operating	Public - LGA
26	106680-2	Nyakitonto	Health centres	Nyakitonto	Nyakitonto	Operating	Public - LGA
27	108748-5	Mvugwe	Dispensary	Nyamidaho	Mvugwe	Operating	Public - LGA
28	106721-4	Nyamidaho	Dispensary	Nyamidaho	Nyamidaho	Operating	Public - LGA
29	103169-9	Kitema	Dispensary	Nyamnyusi	Nyamnyusi	Operating	Public - LGA
30	108758-4	Nyamnyusi	Dispensary	Nyamnyusi	Nyamnyusi	Operating	Public - LGA
31	102178-1	Kaguruka	Dispensary	Rungwe Mpya	Kaguruka	Operating	Public - LGA
32	107164-6	Rungwe Mpya	Dispensary	Rungwe Mpya	Rungwe Mpya	Operating	Public - LGA
33	108414-4	Zeze	Dispensary	Rusesa	Zeze	Operating	Private-NGO
34	110237-5	Malalo	Dispensary	Shunguliba	Malalo	operating	Public - LGA
35	107449-1	Shunguliba	Dispensary	Shunguliba	Shunguliba	Operating	Public - LGA
36	103454-5	Lalambe	Dispensary	Titye	Lalambe	Operating	Public - LGA
37	107837-7	Titye	Dispensary	Titye	Titye	Operating	Public - LGA
38	106809-7	Nyarugusu Camp	Health Centre	Kitagata	Makere	Operating	Private-FBO
39	106841-0	Nyenge	Health Centre	Kurugongo	Nyenge	Operating	Public - LGA
40	107170-3	Rusesa	Health centres	Rusesa	Rusesa	Operating	Public - LGA
41	107447-5	Shunga	Health centres	Buhoro	Shunga	Operating	Public - LGA

**Source:** Kasulu District Council, Health Department

**Appendix 6: A sample financial statement template for health facilities**

Health Facility Financial Statement				
Health Facility Name and Number				
For period from			to	
Account Name	Start Balance	In Total	Out Total	End Balance
Cash				
Bank				
Imprest				
<b>Total</b>				
<b>Income accounts</b>				<b>Total for period</b>
User Fees				
CHF Claims				
NHIF Claims				
Other				
<b>Total Income</b>				
<b>Expense Accounts</b>				<b>Total for period</b>
Watchman				
Water, Electricity, etc.				
Allowances				
Transport				
Bank Charges				
Medicines and supplies				
Equipment and Maintenance				
Other				
<b>Total Expenses</b>				
<b>Income less Expenses</b>				
<b>Surplus or (-Deficit)</b>				
Prepared by:			Date	
Authorized by:			Date	

**Source:** Financial Management Guidelines for Health Facilities, Page 15