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Do community health committees participate in governing health workers in primary healthcare facilities under fiscal decentralization?—An explanatory qualitative study from Tanzania

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Abstract

Background: Decentralization is implemented at the local level to increase community participation in improving service delivery. Majority of developing countries are implementing Fiscal decentralization in primary healthcare through various approaches such as Direct Health Facility Financing, among other things, to empower Community governance structures to govern Primary Health Facility operations to improve the responsiveness of health service delivery and achieve Universal Health Coverage. One of the primary functions of these governance committees is to oversee health workers in their health facilities.

Aims: This aimed at assessing how empowered governance committees govern health workers in their facilities under fiscal decentralization.

Methods: To collect data for this study, an explanatory qualitative design with phenomenology traditions was used. To select the area of study, health facilities, and participants, a purposeful sampling procedure was used. Data were gathered through interviews and Focus Group Discussions to explore committee participation in governing health workers in primary care. Thematic analysis was used to analyze the collected data.

Result: The findings of the study suggest that community governance committees' participation in governing health workers under fiscal decentralization remains limited. Majority of the committees have found to have low limited participation in governing different aspects of health workers. The majority of the committees have discovered that hiring casual workers such as security guards and cleaners is more important than other functions.

Conclusion: The study implies that lower and middle-income countries' willingness to implement fiscal reforms at the local level and empower communities to take the lead in governing health workers still there are very limited specific powers granted

to them to govern health workers. Therefore, capacity building to the governance actors is critical if we are to achieve the benefit of fiscal decentralization.

KEYWORDS

community governing committees, fiscal decentralization, governance, health workers, universal health coverage

1 | INTRODUCTION

Effective governance of the health workforce is critical for achieving health system performance as well as Universal Health Coverage (UHC). However, in primary health care in sub-Saharan countries, health workers continue to be unequally distributed, underpaid, underproductive and unmotivated.[1] Training, deployment, and, most critically, retention issues for health workers continue to be widespread at the primary healthcare facilities in many sub-Saharan countries. countries This has resulted in low quality, inequity, low responsiveness and low utilization of primary healthcare facilities in many Sub-Saharan countries.[2,3] One of the barriers to achieving population health and UHC is the governance of health workers in primary care. As a result, global health communities and developing countries have continued to take steps to address governance issues in primary health care (PHC) to achieve UHC goals.[1,4,5] Health Sector Reforms through Decentralization Policies are among the initiatives undertaken by countries to grant powers and responsibilities for administering and governing health service delivery, including health workers at PHC facilities. Decentralization reforms at PHC facilities allow the community to participate in managing and governing health workers through their representatives in the best way to improve health service delivery. Many developing countries have recently implemented fiscal decentralization to empower service providers and community governance structures in health facilities to better manage and govern health facility operations, including health workers.[6–8] It is expected that management teams and governance bodies will use the granted fiscal and decision-making powers to effectively address health workers' challenges and manage their performance through these government-led initiatives.

Governance of primary healthcare facilities in many developing is vested to communities at the catchment area using the health services delivered by a respective facility.[9] This is motivated by the Alma Ata Declaration of 1978, which emphasizes community participation in the planning, implementation, and monitoring of their own health.[10] Indeed, developing countries have established community governance structures through decentralization to ensure meaningful community participation in the governance of primary healthcare facilities. Given that they are the apex decision makers at the facility level, one of their roles has been to make major decisions about the management of health workers in their facilities.[11,12] These governance structures at the facilities are expected to make decisions such as recruiting new workers based on the required health worker force, motivating workers through various incentives, training, rewarding, and sanctioning health workers based on their performance.[13,14] However, empirical literature has reported poor functionality of these community governance structures in accomplishing their devolve mandates including governing health workers in many countries.[15,16] Limited fiscal powers in executing their devolved political/decision making roles has cited as big challenges, others being lack of awareness on roles and powers and low education to accomplish their assigned mandates.[11,17] As result, many developing countries have been implementing health sector reforms such as fiscal decentralization in different forms to grant fiscal and decision making autonomy and responsibilities to the governors and management actors at the facility levels.[2,3,18,19] The question remains as to how the empowered community's government structures have participated in the management of health workers in the context of fiscal decentralization.

The decisions to empower local level structures or communities is supported by the empowerment framework.[20,21] According to Alsop,[20] capacity of the individual group to make effective choices or decisions is attributed by two factors which are the agency and opportunity structure. The empowerment framework emphasizes that the individual or group should not only be capable of making good decisions but also capable of transforming those choices into desired outcomes. The ability of an actor to make meaningful decisions is described as the agency. The framework goes on to suggest that for the actor, an individual or a group to make good decisions, they must possess certain traits or attributes known as "asset endowment."[22] The actor's attributes may include information,

Keypoints

- Fiscal decentralization is implemented to empower and facilitate community participation at the Primary healthcare care facilities.
- Participation of the community through community governance structures in governing health facility operations including health workers improve responsiveness of health service delivery.
- Governing committee participation in governing health workers is still very limited.
- This may significantly affect the level of health workers in responding to community preference and needs hence lower the facility responsiveness.

financial, organizational, material and psychological human assets. However, even if an actor has all the resources necessary to make smart choices, the circumstances/context of their work may prevent them from doing so. Opportunity structures refer to the agency's operating environment, whether it is formal or informal. Opportunity structures are the "rules of the game" or the institutions which regulate and shape the conduct of the actors and dictate their interactions and the choices they must make. Therefore, empowerment happens when the agency and the opportunity structure interact. For tracking empowerment, three measurements are proposed: (1) whether an opportunity to make a decision exists (presence of choice), (2) whether a person or a group uses the opportunity to make decisions (use of choice), and (3) whether the choice produces the desired outcome (achievement of choice).[20,21] In this study, the empowerment framework was used to assess whether changing opportunity structure through granting fiscal powers, resources and responsibilities to the Health Facility Governing Committees (HFGCs) through Direct Health Facility Financing (DHFF) influences them to oversee/govern health workers in their health facilities.

Tanzania like other developing countries has been implementing fiscal decentralization through DHFF arrangement since 2018.[23] The DHFF arrangement involves direct depositing of health facility funds from different sources such as Basket funds, Ministry of Finance (Intergovernmental transfer), user fees and funds from different insurance schemes.[24] In this arrangement community governance structures, which in Tanzania are known as HFGCs are assigned fiscal powers and responsibilities of participating in planning and budgeting financial management and procurement which they to use in accomplishing their core functions which one of them is participating in managing and governing facility health workers.[16,25] Therefore, under DHFF context it is expected that HFGCs would have such fiscal power in making significant decisions about the management of health workers at their facilities. Before the DHFF in Tanzania, different assessments empirical evidence suggests that HFGCs had poor functionality, including in managing health workers, because they had limited fiscal powers, among other things.[23] By that time, fiscal authority had been devolved to the council/district level, facilities did not have bank accounts, and all facility funds were deposited into the district account. To manage the funds, the District Health Management Team and District Medical Officer were given fiscal authority.[26] As a result, governance actors at the facility level were simply waiting for the council/district level to decide and send funds to health facilities at their leisure, resulting in funding delays and the implementation of health interventions. Because it was difficult for HFGCs to initiate anything about health workers under this arrangement.

However, there is little information on the extent to which community governance structures or HFGCs participate in managing and governing health workers in many developing countries. The available empirical evidence on fiscal decentralization has focused on the functionality of HFGCs under fiscal decentralization, the accountability of HFGCs under fiscal decentralization, the acceptability of the DHFF approach to service users, and the breadth of HFGC role and functionality.[24,25,27] The purpose of this study was to determine the level of participation of HFGCs in health worker management functions in public PHC facilities that were implementing DHFF.

2 | THE METHOD

2.1 | Research area

This study was conducted in the Mbeya region, with the participation of two councils, Mbeya City Council and Chunya District Council. The councils were chosen on purpose based on their performance in the star rating assessment conducted by Tanzania's President's Office - Regional Administration and Local Government (PO-RALG). The star rating assessment used in this study was conducted in early 2018, before the start of the DHFF implementation in primary healthcare facilities. The goal of the star rating assessment was to assess healthcare facility performance and provide feedback to each facility for improvement. Health facilities performance was measured based on the average scores of established indicators (0%–19% no star or 0 stars, 20%–39% 1 star, 40%–59% 2 stars, 60%–79% 3 stars, 80%–89% 4 stars and 90%–100% 5 stars.[28,29] The acceptable or minimum performance set by the government for all facilities was 3 stars.[29] Therefore, Mbeya region was selected because was among the high-performing regions in Tanzania with the majority of health facilities that had a high performance as per star rating assessment. Mbeya City Council was chosen because it was one of the councils with poor performance, and Chunya District Council was chosen because it was the highest-performing council in the Mbeya region. The DHFF arrangement served as the context for this qualitative study, which sought to assess how community governance committees oversee health workers in primary healthcare facilities. The DHFF was a government initiative aimed at facilitating fiscal decentralization in all primary healthcare facilities by empowering health providers and communities to manage and govern their facilities. Under the DHFF framework, governing committees are responsible for participating in all major decisions pertaining to all facility operations such as financial management, procurement, oversight of health workers, construction and renovation, and linking community and facility.

2.2 | Research design

This study used an explanatory qualitative study with phenomenology tradition to gather data from the two councils in Mbeya region between February and April 2021. The study used this design approach because it wanted to discover the experiential and explanatory aspects of governance practices in the DHFF context among health facilities that performed well and those that performed poorly during the star rating assessment in 2018.

2.3 | Sampling and sampling techniques

The study used purposively sampling technique in selecting the Mbeya region because it was among of the region that had high performance during the star rating assessment in 2018. Two councils were selected based on their performance during the star rating assessment in 2018 and location as urban and rural councils were engaged. Mbeya city council was purposively selected because had low performance during star rating and is the urban council. Chunya district council was purposively selected because was the highest performer in Mbeya region in 2018-star rating assessment but also is a rural council. From each council a high performing health facilities and low performing health facility within the council were selected whereby a total of five health facilities were selected in which two of them were high performing health facilities and three were low performing health facilities.

2.4 | Data collection methods and tool

Focus Group Discussions (FGDs) and interviews were used to collect data from each selected health facility's Community Governing committees. Face-to-face focus groups were held with members of governing committees to explore their involvement in governing health workers in primary healthcare facilities. Five FGDs were held at each of the selected health facilities, with six (6) to eight (8) members of the committees participating. The members of the committees were involved because they were tasked with supervising the health workers in their respective health facilities; indeed, the DHFF was established to empower and give autonomy to communities so that they could participate in overseeing health service delivery. The chairs of the community governing committees of the selected health facilities were interviewed. Six interviews were conducted in total, with the number of interviews determined after the saturation point was reached and no new/fresh ideas were coming in.

Before data collection, a team of four research assistants was chosen based on their educational background (social science, preferably health-related program) and at least 2 years of experience with qualitative research. The research assistants were both male and female; shortly after being chosen, they attended 3 days of training to familiarize themselves with the tool and the study topic so that they understood what was expected of them. Following training, all research assistants participate in piloting the data collection tool to ensure that the interview guide is correct, of high quality, and has integrity. In conducting interviews and FGDs, research assistants introduced themselves to the participants as well as the aim of the research and asked the participants if they agree or disagree to participate in the interview or FGDs.

2.5 | Data analysis

A theme analysis technique was used to analyze the data, and NVivo software (QSR-international) version 12 was used to transcribe the materials. The group interactions and context were both considered when transcribing the materials. The investigator triangulation method was used, with the first and last authors, two separate researchers, analyzing the transcribed material and cross-checking the quotes to support the findings. The following procedures were used to analyze the data: The first step was verbatim transcription of the audio recordings, the second step was for the researchers to re-read and become acquainted with the recordings and field notes, the third step was labeling and coding the important details, the fourth step was developing categories, the fifth step was formulating themes, and the sixth and final step was interpreting.

2.6 | Ethical consideration

Ethical approval for the study was obtained/sought by the IRB of the Sokoine University of Agriculture. The IRB with the number SUA/ADM/R. 1/8/668 was sought from the Sokoine University of Agriculture. The permit was then submitted to the President's Office -Regional Administration and Local Government (PO-RALG) to be permitted to research local government authorities. PO-RALG offered a permit with registration number AB.307/323/01 to allow the research to research the selected regions. Informed consent was obtained from all human participants of this study. Those who accepted and signed the informed consent forms before they were involved in the study.

3 | RESULTS

3.1 | Background information of the FGDs and interviews

This study involved 43 participants who were members of the community governing committees in the selected health facilities. The FGDs involved 37 members of governing committees with the exception of the chairperson of the committees which males were 16 females were 2. Interviews involved six respondents of which four were males and two were females

3.2 | Experience and perspective of the committee members on their participation in overseeing health workers in primary health facilities

In this section the experience and perspectives of the members of health committees on what and how they have been governing health workers in health facilities under the DHFF context is presented. Direct quotes are used in presenting the results to support the established themes.

3.3 | Overseeing performance health workers

According to the participants, they have been overseeing the performance of the health workers based on the experiences of

community members who visit the health facilities. They claimed that whenever they heard of any problems with health workers, they had to report them to the facility in charge, and that sometimes specific health workers were summoned to the committee meeting to explain why community members were dissatisfied with him or her. However, some other members from peripheral and low-performing health facilities responded that it has been difficult for them to keep track of health workers due to an insufficient number in their health facilities, and they are afraid of losing them. Even in some of the high performing facilities committees' members responded that they are not aware if DHFF also empowered them in participating in managing health workers.

> *You know, as a committee, seminars are more important for us to be aware of what we are supposed to do in things like how to manage the performance of health workers, which is why sometimes a person can be a committee member and not understand his/her work very well, which is a problem.* FGD—Highly efficient rural facility

> *"We as a committee normally supervise them well, and if they face any challenges, we discuss and try to solve them*" A female Chairperson of a high-performing urban facility.

> *Normally, we receive feedback from the community about each health worker, and we then inform the health facility in charge of how the community members rate his or her performance*. FGD—A rural facility that had low performance.

> *Regarding health workers for sure we don't think if it's our role because we don't have enough skills to supervise them since they professionals*. FGD—Low performing urban facility.

3.4 | Hiring and firing health workers

One of the functions of community governance committees in health facilities is to ensure that the required number of employees is present. Respondents gave varying answers about how they manage the recruitment of health workers in their facilities. Participants agreed that they had participated in the recruitment of health workers, but only for casual workers. Both respondents from high and low-performing health facilities stated that they employ cleaners and security guards in their facilities but do not recruit professional workers because professional workers are only deployed to health facilities by the government. Some committee chairs added that they have approached District Medical Officers and other government officers, as well as the council level, to request special consideration during the deployment of health workers.

> *"Yes, we do that, but only for the purpose of hiring security guards, which we do with the assistance of the village chairperson; however, the facility does not have enough funds to pay them, so the village pays their salary."* Committee Male Chairperson—Underperforming rural facility.

> *We do participate in hiring and firing staff, but only for cleaners and security guards; the committee's role after that is to ensure that we set aside the budget and pay their salary*. FGD - a high-performance urban facility.

> *"For us here, we hire security guards and cleaners, but because our facility lacks adequate health workers, we decided to recruit volunteers to whom we pay a small stipend, and they have really helped to rescue the situation in our facility."* A female Chairperson of the Committee—A high-performing rural facility.

> *I'm not sure, but we usually pay cleaners and possibly employ security guards*. FGD—A rural facility that performs poorly.

3.5 | Motivating health workers

Participants' experiences and perspectives on motivating healthcare workers varied. While participating, some urban areas expressed their belief that they have been motivating employees by providing various incentives such as ensuring that there is sugar and bread for health workers who are on night call/shift. They also stated that certificates have been awarded to those who perform well and receive positive feedback from community members. However, the majority of respondents from both urban and rural areas stated that it has been difficult to provide incentives to health workers due to a lack of funds to facilities due to low facility revenue.

> *"We have a small budget for those who volunteer in order to motivate them to work more efficiently."* A male Committee Chairperson—A High-Performing Urban Facility.

> *Yes, it's a good thing, and we all want to motivate our health workers and health facility administrators, but the problem is where to get that incentive when we can't even afford to buy essential health commodities*. FGD—A High Performing Urban Health Facility.

> *"All we've managed to do in our facility is make sure there's sugar and bread for the health workers who come in for the night shift, but otherwise the facility has a severe lack of funds."* FGD—High Performing Rural Health Facility.

"When we got a new health facility in charge, he proposed to our committee that we offer certificates for health workers who have outstanding performance, so we committee, after receiving feedback from the community and consulting with the facility in charge, have been offering certificates to those who are doing well on an annual basis." A male Committee Chairperson - Rural facility with poor performance.

3.6 | Facilitating training to health workers

The governing committee's role includes ensuring that health workers receive training to improve health service delivery. Respondents felt that the DHFF made it easy to allocate funds for training because they have the freedom to use facility funds based on facility needs. Respondents from urban areas believed that facility revenue was critical for their committees to facilitate training because training requires funds for health workers to attend. Respondents from lower performing ng health facilities believed that, despite having the authority to allocate funds to facilitate training, the low revenue collected by their facilities limited their ability to facilitate training.

"Yes, we have employees who attend trainings, and we pay for that as the facility as well, though we rarely do." A female Chairperson of the Committee for a high-performing rural facility.

Everyone is aware that the committee controls everything and has the authority to set aside funds for training under the DHFF, but when we weigh the priorities within our facility, we have always chosen other priorities over training. FGD—High Performing Urban Facility.

"We have that mandate to train our health workers, but we don't have the funds to do so, so we rely on partners and government funds to do so; otherwise, our health workers do not attend those trainings." A male Chairperson of the Committee on Low-Performing Urban Facilities.

3.7 | Building good relationship between health workers and community

One of the primary functions of community governing committees in healthcare facilities is to connect the facility to the community. Respondents gave varying responses to how they have been involved in connecting health workers with the community to ensure good harmony and trust between them. Respondents from high-performing urban areas revealed that they have done very little in connecting health workers and the community because people in urban areas are reluctant to provide feedback about services they receive in health facilities, making it difficult to identify staff who have problems and who are doing well. However, some committee chairpersons in urban areas stated that they have been using suggestion box feedback to identify and address health workers' problems with service delivery. Respondents in rural areas, on the other hand, stated that they have been inviting health workers to community meetings so that community members can provide feedback and health workers can clarify issues raised and apologize when necessary.

"Yes, we meet with health workers to discuss various facility issues, including feedback from community members about each health worker So, we used that channel to resolve any issues that arose between them or with the patients." A male Chairperson of a High-Performing Committee in an Urban Health Facility.

In a city center like this, it is difficult for members of the community to come to them and provide feedback about health workers; however, these people do not attend meetings that include both health workers and community members. FGD—Poorly Performed Urban Health Facility.

Our ward and village governments have been extremely helpful in persuading citizens to attend meetings where health issues are discussed, and community members and health workers can express their concerns. FGD-High-Performing Health Facility.

4 | DISCUSSION

The purpose of this study was to assess whether community governing committees of primary health facilities in Tanzania participate in governing/supervising health workers under the DHFF arrangement. The reason for conducting this study was that Tanzania, like other middle-income countries, has begun a fiscal decentralization reform known as DHFF, which empowers community governing with powers, responsibilities, and autonomy to make decisions about health facilities, including health workers. This study found that, despite having both decisional and fiscal powers, these governing committees' participation in overseeing/governing health workers is very limited. The majority of committees from various health facilities were discovered to be making very limited decisions regarding health workers due to financial constraints, a lack of awareness about their main roles and powers regarding how to oversee health workers, and a lack of awareness about their main roles and powers regarding how to oversee health workers.

Particularly, when compared to other aspects of governing health workers, the majority community governing committees have been found to have convincingly participated in hiring and firing casual workers such as security guards and cleaners. The majority of committees were found to have low participation in managing health

worker performance, motivating health workers, facilitating the training of their health workers, and building good harmony between health workers and community members. As each committee adopted a different approach to governing health workers, the findings suggest that health facilities have various strategies in carrying out such roles and using powers. This implies that the specific committees and context in which the facility is located determine local innovation and creativity in governing health workers.

Surprisingly, this study found no difference in terms of overseeing health workers between community governing committees from health facilities that performed well and those that performed poorly during the star rating assessment in 2018. The findings imply that the facility's high or low performance is related to the performance of the facility's community governing committee because all committees have demonstrated limited functionality in overseeing health workers. Furthermore, there was little variation in the oversight of health workers between the committees that govern urban and rural health facilities. Both urban and rural governing committees were discovered to have similar functioning and problems in this study. This implies that empowering communities' committees that govern health facilities should not be limited to decisions and fiscal decisions but should go beyond that. The findings of this study, for example, indicate that, despite decisional and fiscal powers, adequate availability of finance to the facility and the capacity of community members to execute devolved functions is critical to making empowerment a reality.[30]

Under normal circumstances community committees were expected to have a balanced performance in executing health workers around all aspects such as deployment, motivating, retaining and monitoring the discipline of health workers in their facilities.[2] However, their participation has limited to hiring just casual workers and doing way with other professional health workers. This might be caused by the limited powers granted to them when it comes the magnitude of powers and responsibilities. in many developing countries such as Tanzania, employment labor laws do not recognize these committees, therefore they can not do what they not entitled to. This show weakness and inadequate preparation of the developing countries in pursuit of decentralization. This show that decentralization was not linked to other reforms which empowers decentralized institutions.

Empirical studies indicate that empowering communities to participate in governing health facilities is critical for improving health service delivery at PHC facilities, which implies that managing health workers is part of the committees.[14,31,32] However, the study's findings suggest that committee participation should be well articulated to be effective and meaningful. According to the empowerment framework, empowerment should take into account not only one aspect of the context in which actors of governance operate, but also the actors' capacity in terms of skills, experience, and professions to carry out their devolved mandates. This study supports the empowerment framework argument that the context in which committees operate, as well as the capacity of governance agents such as committee members, are critical for facilitating committees in overseeing health workers at PHC facilities.

In terms of overseeing health workers under fiscal decentralization, the governance strategies used by facilities led by male and female leaders differ slightly from one another. Similar governance strategies are used by the majority of the facility, and both have a set of authority and autonomy limits. When it comes to the issues of recruitment function, both facilities led by females and males appeared to be hiring only security guards and cleaners. In accordance with the findings, despite having sufficient financial authority, health facilities run by men and women both provide very few incentives to health workers. This is because of the financial difficulties these facilities encounter.

The study, however, is limited to qualitative study only to qualitative study which is very difficult to make a general conclusion on the participation of the governance committees in governing health workers. a mixed method study may provide general perspectives on whether fiscal decentralization has empowered governance committees in accomplishing their assigned mandates at the primary healthcare facilities in developing countries such as Tanzania.

The findings suggest that governing committees at primary healthcare facilities may wish to make certain decisions, such as training or motivating health workers, but the financial capacity of the facility may limit their ability to do so, and they may end up doing nothing. This may appear to imply that committees are not functioning or performing their specific roles, but the reality is that they are hampered by contextual factors such as finances. Indeed, the findings imply that, despite giving communities fiscal and decision-making powers, those powers cannot be used effectively because other factors must be addressed in order for the DHFF reform to be meaningful and work as intended. This result is similar to the findings in Burundi after fiscal decentralization, where community committees continued to function as they had before fiscal decentralization because some aspects were overlooked.[12,17,33]

5 | CONCLUSION

The study's findings imply that lower and middle-income countries' willingness to implement fiscal reforms at the local level and empower communities to take the lead in governing health workers is still limited by the context and nature of actors assigned such tasks. The committees have very limited power regarding aspects such as hiring and firing health workers, disciplining health workers as well as retaining them because these functions are being done by the higher authorities and not health facilities governing committees. Despite some positive outcomes from such reforms in some areas, such as financial management, some other specific aspects, such as governing health workers, are extremely complex and require reform designers to critically consider how they will be effectively implemented by community governance actors. Otherwise, reforms implemented may be meaningless to local actors.

AUTHOR CONTRIBUTIONS

Anosisye Mwandulusya Kesale: Conceptualization; data curation; formal analysis; funding acquisition; investigation; methodology; project administration; resources; software; supervision; validation; visualization; writing—original draft; writing—review & editing. Author has read and approved the final version of the manuscript.

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CONFLICT OF INTEREST STATEMENT

The author declares no conflict of interest.

DATA AVAILABILITY STATEMENT

All data are available. The corresponding author had full access to all of the data in this study and takes complete responsibility for the integrity of the data and the accuracy of the data analysis.

TRANSPARENCY STATEMENT

The lead author Anosisye Mwandulusya Kesale affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

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