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Research Article

Factors Influencing Accountability of Health Facility Governing Committees and its Implications to Health Services Delivery in Njombe District Council, Tanzania

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Abstract

Introduction:

HFGCs are the user committees that represent the preferences of the grassroots in health matters. Health Facility Governing Committees (HFGCs) have been introduced at all levels of the health system as a mechanism for improving accountability between health care providers and communities. Despite the presence of HFGCs, health facilities are not performing well. This study intended to assess factors influencing accountability of HFGCs to the community and to the Council Health Governing Boards.

Methods: A cross sectional study design was employed to 98 respondents who comprised Council Health Management Team, HFGCs and health staff. Simple random sampling, purposive and convenience sampling techniques were employed to collect data. The study used interviews, literature review, Focus Group Discussions, questionnaires and observation. Data collected were analyzed using both quantitative and qualitative methods. The collected data were sorted and cleaned manually to detect errors before making any computations.

Qualitative

A qualitative approach was employed in the study to allow in-depth interviews and discussion with key informants. In-depth interview was done to CHMT and health staff.

For quantitative data, data entry was done by using microsoft office excel 2016 before importing them to the Statistical Package for Social Sciences (SPSS V.20). Thus, already summarized data which were quantitatively oriented were imported into SPSS V.20 for further analysis.

Results: Factors influencing accountability of HFGCs includes: Level of education, training to members, knowledge of committees about their roles and fund.

Conclusion

Accountability of HFGCs is low which is contributed by low level of education, lack of training and inadequate fund. There is a need to review the guideline on election of Health Committees particularly the part of education level, building ability and capacity to the committees and to have adequate budget for HFGCs activities.

Keywords: Health facility governing committees and accountability

Introduction

Health Facility Governing Committees (HFGCs) are the committees that represent the favorites of the grassroots in health issues. HFGCs were first introduced in 1999 within health facilities of all levels of the health system, specifically hospitals, health centers and dispensaries alongside the introduction of the Community Health Fund; but currently, it is termed as improved Community Health Fund (iCHF). Tanzania introduced HFGCs at all levels of health services delivery structure from the hospitals, health centre and to the dispensary level in the early 2000s so as to improve community involvement in health services delivery .The existence of a health facility committee whose members include

community representatives is significant to every health facility so as to ensure community contribution in health planning, strengthen decentralized health systems and improve the delivery of health services.

The goal of establishing Health Facility Governing Committees was to improve community involvement in health services delivery through enhancing accountability, as well as a means to enhance health goals in terms of coverage, access and effective utilization of resources. According to the guideline HFGC, a member should have 21 years or above, should be a Tanzanian but not necessary for those representing NGO's, should have primary education or above but must know to read and write Swahili, should be an active member of iCHF and elected members of the committees, should not be a leaderof any political party or be employee of the respective district council. Health facility governing committee members have an official duty for community participation in the health system: improving quality of care, ensuring exemptions are respected, and mobilizing resources from communities such as in the case of the community health fund.

The HFGCs were established under section 153(1) of the Local Government (District Authorities) Act Cap 287 and 288. Njombe District Council is among the District Councils in Tanzania which have different governing bordies such as HFGCs and CHGB.S The Local Government (Council Authorities) Act 1982 gives statutory powers for the establishment of HFGCs at the health centers and dispensaries as an independent body which has the mandate for establishing organizational structures at the community level to increase public administrative authority in management of health services. The facility governing committees should be approved by the full council after it has been established. The official inauguration of the health center governing committee is done by the Chairperson of ward development committee and witnessed by the Councilor of the respective ward.

Procedures of selecting HFGCs are: WEO shall advertise the vacant posts for representation of the health facility users as per listed criteria i.e. must be a Tanzanian, aged 21 years and above, must be at least standard seven leaver or must know how to read and write and must be iCHF member

According to the guideline for establishment and Operation of Council Health Boards and Health facility committee, community members are expected to play an important role in developing local health plans through the established facility boards and committees. However, such plans are prepared at the council level by the Council Health Management Team (CHMT). In practice, the bottom-up planning has been difficult because communities do not have the opportunity or required capacity. The process of developing the Comprehensive Council Health Plan (CCHP) shows that the HFGCs are consulted in the initial stage of health planning, which involves identification of priorities and needs to be included in the annual plans. The CHSBs and CHMTs are responsible for receiving and reviewing the annual plans and budget projections from the health facilities (hospital, health centers, and dispensaries)8.

Accountability refers to the obligation to justify words and deeds to society in general, and to a specific set of internal and external stakeholders. It embraces the actors, mechanisms and institutions by which civil society organizations are held responsible for its actions. It includes financial accountability and performance accountability more broadly. There are different types of accountability such as financial accountability. political accountability as well as performance accountability. In health care system accountability are normally measured by looking performance or results. Health Facility Governing Committees are responsible to the community and to the Council Health governing Boards (CHGBs) and it have several roles and responsibilities to perform such as to involve in planning and budgeting of health facilities activities, to advice CHGBs on health issues, to approve financial resources for procurement and other expenses of health facilities and to attend meeting (quarterly and ad-hock meeting).

Accountability of HFGCs is measured by accountability measurement which is greater extent in accomplishing their roles, some extent and lesser extent. HFGCs have official duty to the community concerned such as resource mobilization and ensure that there is quality of health services. There are different responsibilities of HFGCs as stipulated in the guideline such as coordinating and managing the community based initiatives and plans within their locality, scrutiny and approve the plans and the budget of the facility, to share the facility health information with the community, mobilize resources including iCHF for financing facility activities, approval iCHF expenditures for procurement and other expenses of the facility, to control funds disbursed for project implementation with highest transparency and accountability to the community8 .

Health facility governing committees are contributory structures in health planning at the community level, as it helps to address community needs and help in resources mobilization (WHO, 1990). The overall goal of establishing HFGCs was to improve community involvement in health services delivery through enhancing accountability, as well as a means to enhance health goals in terms of coverage, access and effective utilization of resources. The main objectives of establishing the HFGCs at the grass root level are: to increase accountability and transparency at the health facilities, to improve delivery of health services delivered, to speed up responses to local community health needs, to improve better information flows, to increase energy and motivation among local stakeholders and to empower the community towards their own health priorities7.

The main tasks to be performed by HFGCs at the grass root level are: To review and approve the health care implementation plans of the respective facility, to plan for the utilization of the fund according to collections and needs, to keep iCHF records, timely produce reports to the district levels, to oversee the general operations and management of the health facility, to advise the community on matters related to the promotion of health services, to represent and articulate community interests on matters pertaining to health in local development forums, to facilitate a feedback process to the community pertaining to the operations and management of the health facility and mobilization of community resources towards the development of health services within their areas5.

Ccommunity members are expected to play an important role in developing local health plans through the established facility boards and committees. However, such plans are prepared at the council level by the Council Health Management Team (CHMT). In practice, the bottom-up planning has been difficult because communities do not have the opportunity or required capacity.

The revised Health Policy of Tanzania (2007) has emphasized the need for increasing local communities' participation in their own local health priorities. It stipulates that health services will be emphasized to the most vulnerable groups, the poor and will fulfill the needs of the community in order to increase the lifespan of all Tanzanians by creating awareness and responsibilities to the individual citizen on his/her health and the health of the whole family (MoHSW, 2007). Various initiatives have been established such as Primary Health Services Development Programme and Direct Health Facility Financing so as to empower the communities and facilities on providing quality health services.

Health care organizations have an obligation to ensure quality health services and this will be attained through having different strategies

including active community involvement in different health issues so as to ensure there is quality health care. Thus HFGCs are very important so as to allow community participation in different matters such as planning and budgeting, mobilizing financial resources and promoting health infrastructure and logistic systems. Universal coverage is the current argument for a successful health system. Health strategic plans have been developed, implemented and evaluated, but they indicate a great distance to universal coverage. A number of relevant issues still need to be addressed to have a well-functioning health system that addresses universal coverage.

The Government of Tanzania has made great efforts to reform the healthcare system by developing comprehensive policies and guidelines, but there are still challenges in terms of accountability, community voice, information reporting, and feedback. Despite the presence of HFGCs in health facilities there is a lot of challenges facing those facilities such as; low enrolment of households in iCHF, inadequate medicines and medical equipment, and inadequate human resources for health. For example in 2015, Tanzania set a goal of achieving 30% of CHF enrolment among household but only 16.4% was achieved an According to the staffing level of MoHSW as revised in 2014 to 2019, the minimum staffing level of dispensary is 15 health care workers and for health center is 39, but in Njombe District council have not succeeded to meet such requirements because most of dispensaries have less than ten health care workers for example in Kanikelele dispensary there is 5 health staff, Mfriga dispensary 4, Ibumila dispensary 6, and Mtwango health center there is 21.Furthermore according to World Health Organization there is scarcity of health workers whereby for every 1000 people, there are 0.3 doctors and 4.4 nurses and midwives while WHO (2018) Doctor to patient ratio is 1:1000 and nurses for morning shift is 1:4,evening shift 1:5 and for night shift is 1:8.

Methods

Study area

The study conducted at Njombe District Council (NDC); which is one of the six councils constituting Njombe region. Njombe District council have 35 Health Facilities and all Facilities have HFGCs and CHGBs. The council has 3134 square kilometers that is equivalent to 3,133,400 hectares. The council has 2 divisions which are Lupembe division and Makambako division. The NDC has 11 wards, 44 villages, 219 sub-villages with 20,526 households.

Study design, population and sampling

The study employed a cross sectional study design whereby both primary and secondary)were collected so as to document ideas, opinions, and information. Probability and non-probability sampling procedure was used. In probability sampling, simple random sampling was used to interview health staff and in non-probability sampling, purposive sampling were used for health facilities committee's members and CHMT.

Sample size was 98 which obtained at the level of precision of 7% to repesent the entire study population which was 190; comprising 8 CHMT members, 64 HFGCs members of 8 dispensaries, 18 HFGCs members of 2 health centers, and 100 health staff. The study subjects who were eligible to participate in this study were members of HFGC, CHMT members and health staff from ten health facilities from Njombe District council who agreed to participate in this study.

Data Collection and Measurements

The study drew its data from two main sources: primary sources and secondary sources. The study was based on both qualitative and quantitative approach. The primary sources were original sources of information that used interviews, focus group discussion which were collected from 94 respondents. Questionnaire and focus group discussion were used to collect data from HFGCs from Mtwango Health Center and Siloam Dispensary. Health while interview was used to collect data from both HFGCs and health staff. Secondary sources included published and unpublished reports and records such as; files of HFGC members, reports, guidelines, directives, policies, regulations, books, journals and minutes of HFGC meetings. Questions were prepared in English language and in Kiswahili language.

The study used both structured and unstructured interview schedules for data collection from 98 respondents. In order to make study results consistent an, the same and uniform research instruments (questionnaire, interview guides and focus group discussion) were administered to all respondents. Also pilot testing of the two instruments (questionnaire, interview) was done in Morogoro region specifically at St. Thomas Health Centre at Kilakala and Mlali Dispensary in order to find out if they were well understood.

Data analysis Methods

Data collected were analyzed using both quantitative and qualitative methods. The collected data were sorted and cleaned manually to detect errors before making any computations.

Qualitative

A qualitative approach was employed in the study to allow in-depth interviews and discussion with key informants. In-depth interview was done to CHMT and health staff. A researcher also obtained data from respondents through face to face communication. The study used both structured and unstructured interview schedules for data collection in order to get the experiences and feelings about accountability mechanism of HFGC to the community and to the CHGBs. Also getting understanding about the factors facilitating or impinging roles HFGCs to accomplish their roles.

For the structured interviews, the researcher created an interview guide prior to the face to face interview to ensure the interviews are focused and efficient to enable comparison and summarization. It's a suitable method because in some places other tools like questionnaire may not be suitable because respondents in some places do not have writing and reading skills and this makes them difficult to explain their views, but instead I used face to face interview so as to know the factors influencing accountability of health facility governing committees (HFGCs) and its implications to health services delivery in Njombe District Council Tanzania.

Quantitative

For quantitative data, data entry was done by using microsoft office excel 2016 before importing them to the Statistical Package for Social Sciences (SPSS V.20). Thus, already summarized data which were quantitatively oriented were imported into SPSS V.20 for further analysis. In order to ensure that data were correct and valid, there was a data cleaning before the entry process. This was done by sorting each questionnaire and examining if numbers had been written correctly in the format relevant to information to be coded.

FGD was used to HFGCs members,this method was used to get information from HFGC members ranging from their knowledge, level of participation in committees activities and discovering factors facilitating/ impinging them to accomplish their roles. For qualitative data which was collected by an interview and FGD was analyzed by content analysis.

Analyzed data were presented in tables as frequency and figures as frequency and percentages. The findings from the data analysis were presented by using tables and figure.

Ethics Consideration

The study protocol was approved by Mzumbe University IRB number MU/DPDS/INT/38/Vol.IV/160. Then, a permit to conduct the study in Njombe Region with reference number Ref.Na.AB.301/326/O1H/22 was obtained from the Njombe Regional Administrative Secretary (RAS). Then, a permit to conduct the study in Njombe District Council with reference number Ref.Na. NDC/E.10/82/9.was obtained from the Njombe District Executive Director. In addition, the District Medical Officer (DMO) provided an introduction letter to all Health Facility in charges .Informed consent was obtained from all participants prior to data collection. All methods used in this study were carried out in accordance with relevant guidelines and regulations of Mzumbe University. Finally, a high level of confidentiality was maintained for all information obtained from the respondents of this study, and it was used only for the intended purpose.

Results

General Characteristics of Respondents

The findings show that majority of respondents were aged between of 30 to 39 years, which is equal to 40 (42.1%) of all 98 respondents, 22 (21.1%) respondents were aged between 40 to 49 and 18 (18.9%) respondents were aged between 20-29while only 17(17.9%) respondents were aged above 50. The findings show that higher percentages of respondents were married 58(61.1%) while 30(31.6%) of the total respondents were single. On the other hand, the results show that 5(5.2%) of respondents were widowed and only 2(2.1%) of respondents were Religious Sisters.

Categories of respondents	Frequency	Percent
HFGCs from dispensary	23	33.7%
HFGCs from health center	18	10.1%
Health staff	53	50.6%
Council health management team	4	4.2%
Total	98	100%
Age of respondents	Frequency	Percentages
21 – 29	18	18.9
30 -39	40	42.1
40- 49	22	21.1
50 and above	18	17.9
Total	98	100.0
Sex of respondents	Frequency	Percent
Male	44	45.3
Female	54	54.7
Total	98	100.0
Education level	Frequency	Percent
Primary	31	31.5
Secondary	5	5.3
Certificate/ Diploma	57	57.9
Bachelor Degree	5	5.3
Total	98	100.0
Status of the respondent	Frequency	Percent
Married	60	61.1
Single	31	31.6
Widowed	5	5.2
Nun	2	2.1
Total	98	100.0

Table 1: General Characteristics of Respondents (N=98)

Source: Research Data (2021)

Factors Impinging Accomplishing the Roles of Committee Members

Among the factors impinging Health Facility Governing Committees (HFGCs) to be accountable to the community as a members are: inadequate finance which was reported by 15 (36.6%) respondents, lack of training which was pointed out by 14(34.1%) respondents, inadequate knowledge among the members which was reported by 10(24.4%) respondents and distance from to health facility which was reported by 2(4.9%) respondents. During an interview with Medical Doctor from Lupembe health center, she was quoted saying:

> *Lack of fund is a big problem because we depend from basket fund and not all time money come on time and sometimes the facility might have another challenges with need to be solved quickly that paying health facility governing committees, there for I have to solve the other problems first like buying medicine and later on pay the committees (In charge of Lupembe health center).*

Also, this was confirmed by the researcher in an interview with health staff as health staff members from different health facilities said that the main reasons for failure to accomplish their roles and to conduct the meetings was lack of budget to finance the meetings, especially ad-hoc

meetings. The facilities have several needs and the budgets are not enough. So, when it was realized that a high amount of payment for the committees, it became very difficult to pay them because of budget limitations. These factors contribute to poor information sharing among committee members on all issues pertaining to health facilities including those related to developing and implementing health facility plans. Another respondent said during an interview that: "*Some members were interested to be members of HFGC with the intention of receiving allowances and other payments; therefore, the absence of such allowances has discouraged them to participate in HFGC activities".* During an interview with human resource for health one nurse said;

> *Factors that hindered accountability on the among HFGC members includes lack of awareness because most of them are standard seven, poor communication and information sharing between members and HFGC, unstipulated roles and responsibilities of Health Facility Governing Committees, lack of management capacity among Health Fsacility Governing Committes members, and lack of financial resources for implementing HFGC activities (Health staff from Matembwe dispensary.)*

The results of an interview with health staff from both ten health facilities revealed the following factors that hinder HFGCs to accomplish their roles: inadequate fund, lack of knowledge being too busy with their daily activities, poor communications between HFGCS and community and distance from their residence to health facilities. During an interview with health in charge, one of the health staff in charge said: '. *Once I tell the members that the coming meeting will not have an allowance he is sure that the attendance of members will be poor, only few of them will attend including chairperson of the committees...'.* The respondent said that this will happen even if he will state the reasons for not paying the member at that meeting. From documentary review (through reviewing some documents), it was confirmed attendance of meetings especially for emergency meeting was not satisfactory compared with the formal one (Figure 1).

During Focus Group discussion (FGD), most of the committee members admitted that they had not been trained on their roles and responsibilities. One of committee members from Ibumila dispensary was quoted saying:

> *I was selected in this committees since many years (10 years) and every time when they select other members I have been reselected too but since then I got one training at Njombe District Council concerned with CHF which is nowadays iCHF but other things concerned with planning and resource mobilization I do for experience because I don't get any training (HFGC Ibumila dispensary}.*

Another committee member during FGD at Lupembe health center said; '*It's true that our health facility has a bank account, but the budget is small so it becomes difficult for the committees to implement some good planned activities like renovating our health facility'*. The researcher confirmed during FGD that the committees have many good plans but when it comes to the implementation, it is poorly done due to inadequate budget of the facilities.

Knowledge of HFGCs Regarding Roles and Responsibilities

The results from questionnaire revealed that most committee members have moderate knowledge concerned with their roles and responsibilities. For example, 12(53.7) of respondents had moderate knowledge concerned with planning and budgeting, 25(615) of respondents have moderate knowledge concerned with discussing health facility reports and 27(65.9) of respondents admitted that they have moderate knowledge concerned with approval of iCHF expenditures for procurement and other expenses of the facility (Table 2).

From interview with HFGCs, one of the committee members from Iwafi dispensary said: *'... I think this will be good for us as health facility governing committee's member to be trained concerned with our roles and responsibilities in this health facility, to be train how we can control financial resources and to know what we are supposed to do and not…'* Moreover, the research findings revealed that many committee members are aware that they are supposed to attend formal meetings and emergency meetings as it has been revealed that 21(51.2%) of respondents know that it's among their duties.

		Level of knowledge					
S/No	HFGC assigned roles	1= Low		2=Moderate		3=High	
		Number of respondent	Percentages(%)	Number of respondent	Percentages (%)	Number of respondent	Percentages (%)
i.	Planning and budgeting	2	4.9	22	53.7	17	17
ii.	Discuss Health facility reports	3	7.3	25	61.0	13	31.7
iii.	Mobilize financial resources	6	14.6	23	56.1	12	29.3
iv.	Give feedback to community	2	4.9	22	53.7	17	41.5
v.	Promote health infrastructure and logistic system	4	9.8	25	61.0	12	29.3

vi.	Advice and recommend on human resource recruitment, training, selection and deployment	4	9.8	25	61.0	12	29.3
vii.	Planning and managing the community based health initiatives within its area	2	4.9	26	63.4	13	31.7
viii.	Approval iCHF expenditures for procurement and other expenses of the facility	2	4.9	27	65.9	12	29.3
ix.	Control financial and other resources of the Health facility	3	7.3	26	63.4	12	29.3
x.	Attend normal and ad-hoc committee meetings	1	2.4	21	51.2	19	46.3
xi.	Coordinate with Council health service board and partners in health provision and promotion	4	9.8	27	65.9	10	24.4

Source: Research Data (2021)

Table 2: Knowledge of HFGCs Regarding Roles and Responsibilities (N=41)

Lack of training of Health Facility Governing Committees Regarding their Roles and Responsibilities

Lack of training is among the factors impinging accountability of HFGCs to the community and to CHGBs. The findings from questionnaire given to HFGCs show that 27 (65.9%) of all respondents who were the members of HFGCs are not offered any training which seems to be a big problem for them to perform their roles and only 14(34.1%) of respondents are offered training. The researcher observed that during FGD with HFGCs, most of those who said they are trained were members with working experience of more than three years.

Are HFGCs members trained?	Frequency	Percent
Yes	14	34.1
No	27	65.9
Total	41	100.0

Table 3: Training to HFGCs members

During FGD with health facility governing committees at Siloam dispensary, the researcher noted that majority of members were not trained on their roles and when the researcher asked some of them to mention their roles where somehow difficult, one member from Siloam dispensary quoted during FGD said:

Nobody received any kind of training associated with our roles and responsibilities as health facility committee members, and as we know most of the committee members are not health personnel forename four are farmers, two are business and one is teacher therefore it becomes difficult for them to understand what we are supposed to do without getting any training concerned with our responsibilities (HFGC member from Siloam dispensary).

The quotation above was confirmed by the researcher because those who said they were trained were those who worked as HFGCs for more than three years and they were trained after one year or two years but not immediately after being selected. The findings from interview show that most of HFGCs are not trained on their roles as the members of committees; therefore, many committee members are not conversant in accomplishment of their roles as explained by one of HFGCs members from Mfriga dispensary;'...After being selected we start attending meeting and working as committees members without getting any training1 and when it happens a seminar concerned our roles one or two committee member attend it and then give feedback during the meeting...' (HFGC from Mfriga dispensary. The explanation above shows that among the factors facilitating accountability of HFGCs is training of members concerned with their roles and responsibilities.

Discussion

The findings of this research study revealed different hindering factors which faced HFGCs to accomplish their roles: inadequate finance, lack of training, inadequate knowledge among members and distance from and to the health facility. This finding is similar to the other studies17 whereby lack of capacity building was seen as a problem for performance of roles and responsibilities of workers. During FGD with HFGCs members, the researcher noted that HFGCs have inadequate financial resources for implementing their activities. Many health facility in-charges said that fund to pay the committees members for quarterly meeting are from busket fund. The big challenge was the low ceiling of the funds given to the facility compared to the actual needs of the health department which resulted to the funds allocated not matching with the actual facility needs.

This research findings is similar to the study conducted in Zimbabwe on assessment of the impact of Health Centre Committees on health system performance and health resource allocation which exposed several factors impinging HFGCs to be accountable to the community such as inadequate financial resourced and lack of training among members. Also the government budgets and supplements are very inadequate to these committees as it becomes difficult for them to accomplish their roles and responsibilities.

Most of respondents from HFGCs groups except the Secretary of the committee, were not aware of their roles and responsibilities. The CHGB respondents confirmed that not all members of HFGC were trained or oriented towards their duties and responsibilities. The researcher confirmed this from Njombe District Health Secretary because confirmed said that "*it's difficult to offer training every year to the members but they normally trained and oriented members of HFGCs after three years*". Therefore, if they are new members selected in between, it becomes difficult to train those members until the next time of training for all members.

The research findings show that knowledge of HFGCs regarding roles and responsibilities is moderate is some roles and few of roles are high. But level of knowledge in approval of iCHF expenditures for procurement and other expenses of the facility are higher when you compare with other roles, it was found that the HFGC's members were partially aware of their roles because they have never got trained. Moreover, it was observed that some roles were forgotten because they were not the priority of the respective facilities. In other side, the level of knowledge in controlling financial and other resources of the health facility the committees had low knowledge as shown in their results chapter and this is caused by different factors such as in adequate training among health facility governing committee members and low level of knowledge as shown in the results; he majority of members had primary education.

Determining the required beginning of competence was certainly being the basis for the process of selection, succession, planning, performance of evaluation and human resource development. Furthermore, individual performance can be optimal if the individual has a competence that is reliable in their field. The dependability of human resource competence can be formed, in which the formation is strongly influenced by the organizational capability in managing human resources into several specifications of individual competence, among others: competence of goal achievement, competence of problem solving, competence of interaction to others and competence of teamwork spirit.

Different researchers and scholar works clarify that experience of members are very necessary (Oakley 1989; Sohani 2005; WHO 1991). These are level of participation, knowledge of members and training on their roles. Another thing that might help the committees to perform well their roles is monitoring; that's guidance and supervision.

Limitations of the Study

It was difficult to undertake research without limitations, there were various obstacles in which hindered the efficiency and effectiveness of the study such as time for data collection was not enough, time constraints impact the chances of contacting more respondents and using convenient sampling is another limitation because others members had no chance to participate in the study. The study was conducted in Njombe District Council and was limited only for ten health facilities; therefore, it's good to do the same research in other Districts and other Health Facilities. It can be done to Regional Hospitals, referral Hospitals and National hospitals so as to examine factors influencing accountability of HFGCs to council health governing bodies and to the community intended.

Conclusion

HFGCs are potentially instrumental structure to contribute in the development of facility strategies and the improvement of health services. Although the Government of Tanzania has made great efforts to reform the healthcare system by developing comprehensive policies and guidelines, there are still challenges in terms of accountability, specifically HFGCs. The following recommendations are proposed by the researcher for the improvement of accountability of HFGCs and to have positive effects to health service delivery: -During election of committee members, education background like considering form four level, form six level and those with different courses so as to have members who will have high impacts to the committees and Health facilities. Following the results, the qualifications of HFGCs members like education background should be reviewed and during selection, the consideration should be made to members with higher level of education.

HFGCs to be trained immediately after the selection, short training sessions of one hour should be conducted frequently by the health facility in-charge to provide an understanding of the roles and responsibilities of the HFGCs according to the guideline, the District Council has to allocate appropriate budget for HFGCs activities so as to improve health services to the projected community and every health facility must have all guidelines concerned with Health HFGCs, chairperson should be given a copy and all members should have official documents showing their roles as health committee members.

Abbreviations

HFGCs: Health Facility Governing Committees; CHGBs: Council Health Governing Boards;CHM : iCHF: improved Health FundCouncil Health Management Team;DMO:District Medical Officer;RAS:Reginal Administrative Secretary, FGD:Focused Group Discussion; SPSS: Statistical Package for Social Sciences

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Competing interest

The authors declare that they have no competing interests.

Authors' Contributions

This manuscript is based on s study conducted in partial fulfillment of a masters degree of Health Systems Management (MHSM) of Mzumbe University Morogoro-Tanzania United State.TM designed the study and collected, cleaned and analyzed data. HM critically reviewed the study, contributed significantly to the development of the study and drafted the manuscript. All authors have read, revised and approved the final manuscript.

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Availability of data and materials

All data used for this study are available upon a reasonable request from the first author.

Declarations

Ethics approval and consent to participate

The study protocol was approved by Mzumbe University IRB number MU/DPDS/INT/38/Vol.IV/160. Then, a permit to conduct the study in Njombe Region with reference number Ref.Na.AB.301/326/O1H/22 was obtained from the Njombe Regional Administrative Secretary (RAS). Then, a permit to conduct the study in Njombe District Council with reference number Ref. Na. NDC/E.10/82/9.was obtained from the Njombe District Executive Director. In addition, the District Medical Officer (DMO) provided an introduction letter to all Health Facility in charges. Informed consent was obtained from all participants prior to data collection. All methods used in this study were carried out in accordance with relevant guidelines and regulations of Mzumbe University. Finally, a high level of confidentiality was maintained for all information obtained from the respondents of this study, and it was used only for the intended purpose.

Consent for publication

Not applicable

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