CHALLENGES FACING HEALTH FACILITIES GOVERNING COMMITTEES IN ENSURING PROVISION OF BETTER HEALTH SERVICES IN TANZANIA: A CASE OF SELECTED HEALTH CENTRES AT BUSEGA DISTRICT

Ludia Josephales Mtebe

Master of Business Administration in Leadership and Governance

Institute of Accountancy Arusha

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Ludia Josephales Mtebe

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A Dissertation Submitted in Partial Fulfilment of the Requirements for the Degree of Master of Business Administration in Leadership and Governance

Institute of Accountancy Arusha

December, 2022

DECLARATION

I, Ludia Josephales Mtebe, do hereby declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other higher learning institutions for similar or any other academic award.

………………………

Signature

………………………….

Date

CERTIFICATION

I, the undersigned, certify that I have read the proposal entitled, "**Challenges Facing Health Facilities Governing Committees in Ensuring Provision of Better Health Services in Tanzania: A Case of Selected Health Centre at Busega District",** and hereby recommend for acceptance of the dissertation by the Institute of Accountancy Arusha fulfilment of the requirements for the degree of Master of Business Administration in Leadership and Governance offered by the Institute.

………………………

Kusekwa Mabondo

(Supervisor)

………………………

Date

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Date _______________________________

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ABSTRACT

The present study aimed at assessing the challenges facing the health facilities governing committees towards the provision of better health services with reference to Busega district. . The study was guided by three objectives which were intended to; identify the kinds of communication channels used in sharing information, find out the kinds of motivation provided by the government to the HFGCs and examine the kinds of government support to the HFGCs towards supervision of Health centres' provision of better health services at Busega district. The research problem was based on low performance of HFGCs in ensuring the improvement of better services among health centres in Tanzania. . The study employed descriptive research design since the study was a qualitative approach in nature. A sample size of 71 respondents was extracted from a total population of 332 people. Sampling techniques included convenience and purposive sampling. Data collection methods included interviews, focused group discussions and documentary review. The data were analysed through content and thematic analysis. The findings revealed that there were weak communication channels between HFGCs and other stakeholders. Moreover, the results indicated that there was lack of motivation to the HFGCs, and the government provided financial support as well as support supervision but not satisfactory. The present study recommends that there is a need for the government to review the policies to improve the communication, motivate and support the health facilities governing committees to ensure better provision of health services among health centers at Busega and Tanzania in general.

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LIST OF ACRONYMS AND ABBREVIATIONS

CHF	Community Health Fund
CHMT	Council Health Management Team
D by D	Decentralisation by Devolution
DFF	Direct Facility Financing
DHFF	Direct Health Facility Financing
DHS	District Health Secretary
DMO	District Medical Officer
FGD	Focus Group Discussion
FMN	Facility Management Nurse
GoT	Government of Tanzania
HFC	Health facility committees
HFGCs	Health Facility-Governing Committees
HIMS	Health Information Management System
LGAs	Local Government Authorities
RHMTs	Regional Health Management Teams
SPSS	Statistical Package for Social Science
URT	United Republic of Tanzania
WEOs	Ward Executive Officers
WHO	World Health Organisation

CHAPTER ONE

1.0 BACKGROUND TO THE STUDY

1.1 Introduction

This chapter presents the introduction and the background information regarding the study, which aimed at assessing the functioning of Health Facility-Governing Committees (HFGCs) towards the effective provision of health services at Busega district. It contains subsections which are the background to the problem, the statement of the research problem, objectives of the study, research questions, significance of the study, the scope of the study, justification of the study and the organisation of the research.

1.2 Background to the Problem

To achieve the goal of universal health coverage, progress in healthcare service quality is essential. Community involvement has been emphasised internationally as a method of enhancing responsibility and accomplishing health goals in terms of coverage, accessibility, and efficient utilisation (WHO, 2022). Today's health care system is fragmented, and it needs to transform quickly if it is to provide continuous, integrated patient care (Peek, 2021). The use of new technology, medications, and care models, as well as rising public expectations for quality and safety, are all variables that have an impact on the provision of health services (WHO, 2022). Every nation in the globe must therefore make sure that its citizens have access to high-quality healthcare in order to improve their state of health.

Generally, decentralization in health systems has a long history worldwide. It all started with the Alma-Ata Declaration in 1978, which emphasised the value of primary healthcare, which was often

given in subpar facilities, particularly in poor nations (Jafari, et al., 2019). All nations, individuals working in health and development, and the global community were urged to protect and advance health in the Alma-Ata Declaration. Community involvement has been a major component of global health policies and initiatives worldwide (Lodenstein, et al., 2017). By incorporating the community in the development of global health systems, the globe has been working hard to ensure that the quality of health services is improving on a daily basis ever since.

Also, the Alma-Ata Declaration made it clear that individuals, who are the primary beneficiaries, have the right and obligation in taking part both individually and collectively in the development and delivery of their health care (Kapologwe, et al., 2019). In order to ensure that people are willing and engaged in making decisions that affect their lives, including decisions pertaining to their health, the Ottawa Charter also proposed local people's involvement in social services through effective community action, particularly in setting priorities, making decisions, planning and budgeting, and implementing (Azevedo, 2017). According to the Alma-Ata Declaration and the Ottawa Charter, other policies, such as the decentralisation of health systems, have been implemented as part of health sector reforms in many nations, including Tanzania. This is a crucial strategy because it can give communities, particularly those in rural areas, the chance to participate in the delivery of better health services.

Additionally, the application of the decentralisation system in the health sector is thought to be the cause of community involvement in the provision of health care (Kapologwe, et al., 2019). In order to create healthcare services in the public interest and hold healthcare professionals and legislators responsible, community involvement requires allowing healthcare consumers to voice their concerns (WHO, 2017). To encourage community participation at the facility level, health facilities have created committees, suggestion boxes, customer service desks, and other practises

(Goodman et al., 2011). Decentralization's function in the healthcare industry must therefore include enhancing service quality, increasing service efficiency, and assuring accountability in the health systems. Thus, the decentralisation approach enables the community to be acknowledged as a crucial component in the health sector.

In a similar vein, Africa developed the Bamako Initiative, which put the idea of community involvement in the planning of health services into practise (Obionu, 2017). The Bamako proposal was a formal declaration adopted by African health ministers in 1987 that advocated localising health decision-making and enacting practical national drug policies to enhance the provision of vital pharmaceuticals for Sub-Saharan Africans (Azevedo, 2017). Since then, many low and middle-income countries in Africa have created health facilities governing committees to be well-known organisations for community involvement (Lodenstein, 2017). As a result, health facility governing committees are crucial institutions that were established with the primary goal of enhancing health care in health facilities through community involvement. However, the majority of African nations still have subpar healthcare systems. In general, the history of ensuring better health services in Tanzania can be traced back to colonial era. The British colonial authority in Tanzania emphasised the role of central government officials as it developed its health system, which was focused on treating colonialists or Tanzanians who worked in the cash crop industry (Mboera, 2011). In order to provide public goods and services, including healthcare, Tanzania removed British colonial authority in 1962 and formed democratic local government institutions. The referral system for the health system established after colonialism is organised like a pyramid, with the dispensary level at the bottom, followed by health centres, district hospitals, regional hospitals, zonal hospitals, and, at the top, national hospitals (Kapologwe, 2019).

Administratively, Tanzania has two ministries that are in charge of overseeing the health facilities: the President's office for regional administration and local government, which manages ownership and operations of primary health facilities, and the Ministry of Health, Gender, Elderly, and Children, which writes policies and guidelines (Yahya, 2018). Tanzania has embraced a decentralisation strategy in the health sector through a variety of health sector reforms to enable community engagement in the management of basic health care (Kesale, 2017).

As a result of the decentralisation through the devolution process, a number of institutions that are crucial for enhancing access to health care and the quality of service delivery have been formed at the local government and community levels (Yahya, 2016). In order to enhance community involvement in the health systems and strengthen primary health care, Tanzania is implementing decentralisation in its health systems. Thus, Council Health Management Teams (CHMTs) are supervised by Regional Health Management Teams (RHMTs), who are also responsible for ensuring that supportive supervision of CHMTs is conducted as usual (Renngli, et al., 2018). CHMTs are required at the council level to perform supportive supervision at all of their council's hospitals, health centres, and dispensaries (Renngli, et al., 2018). Additionally, health centres should promote dispensaries in their service region by providing monitoring. Health Facility-Governing Committees (HFGCs), made up of members of the community, are in charge of managing facility operations, while the Council Health Service Board (CHSB) is in charge of managing council operations (Pancras, 2016).

Furthermore, the Community Health Fund (CHF) was implemented in Tanzania in 1999, and primary healthcare facilities began to establish Health Facility-Governing Committees (HFGCs) at the same time (McCoy, 2012). These committees were intended to supervise health clinics and

pharmacies with a primary focus on primary care. These are essential for guaranteeing neighbourhood involvement in health planning, developing decentralised health systems, and enhancing service provision (Kapologwe, et al., 2019). Therefore, the communities and other interest groups must be aware of the HFGCs' actions as they carry out their delegated duties and powers, and the HFGCs must make themselves available for inquiries from the community and interest groups regarding various facets of the provision of healthcare services in healthcare facilities (Kesale, 2022).

In that case, the committees meet four times a year and are composed of three appointed members and five members from the community (IHI, 2011). Local communities are actively involved in the development and control of council health services through their involvement in these neighbourhood users (Kessy, 2017). This means that the health facilities were specifically created to foster a close relationship with the community in order to ensure that the health facilities, in partnership with the community, provide quality health care services.

However, despite the establishment of these committees, Tanzania's basic health facilities continue to provide low-quality healthcare with limited accessibility; like many other nations, it has an unequal regional distribution of service quality (World Bank, 2015). Generally speaking, metropolitan areas offer better quality and provider accessibility than rural ones. The additional challenges to executing the provision of health services in Tanzania's health facilities include infrastructure and medicine availability (World Bank, 2015). Therefore, the government of Tanzania through its ministries must exert significant effort through a variety of ways in guaranteeing that her people can access and receive health care of the required calibre.

Empirically, numerous investigations on HFGCs have been undertaken in order to eradicate the existing problems facing health centres in Tanzania. Yahya (2018) revealed that despite great efforts to improve healthcare quality in Tanzania through HFGCs, the majority of facilities struggle to offer high-quality treatments, as noted in his study of holding a mirror to the quality of care in Tanzania. This is demonstrated by a five-star assessment of 6993 facilities, which found that only 2% of them fulfilled the minimal requirement of three stars or more in terms of quality and that 34% of them were healthcare facilities.

In addition, Pancras (2016) identified unfriendly services brought on by the under-supportive supervision of HFGCs as one of the main obstacles to accessing better health services in health centres, including those in Tanzania. He made this observation in his study on the effectiveness of health facilities governing committees. In a similar vein, Renngli, et al. (2018) identified critical challenges faced health centers including persistent lack of qualified human resources, overworked healthcare providers, multiple district manager roles, weak supply chains, high donor fragmentation, and inefficient allocation of limited financial resources that may have been caused by weak supply chains. Despite health facilities government committees in Tanzania to continue struggling in their role of overseeing the provision of better health services among health centres, the situation is becoming worse..

Despite numerous studies that have been conducted regarding the difficulties HFGCs face in ensuring the provision of health services, most of them restricted to the difficulties that governing bodies of healthcare facilities face in ensuring the delivery of better healthcare. Therefore, from this backgroung, the purpose of the present study was to evaluate the difficulties that the HFGCs face in ensuring the delivery of better health services at the Busega district. By so doing, it will be

necessary to identify the channels of information sharing that are used, as well as the types of government incentives and support that the HFGCs receive. These are the issues that the earlier studies did not take into account. So, there is a research deficit such that after being filled it can help in overcoming the existing probem.

1.3 Statement of the Problem

The existing problem is based on the low performance of HFGCs in ensuring the improvement of better services among health centres in Tanzania as it was intended by the local government urban authorities Act of 1982 under the section, and the local government districts authorities Act of 1982, which is evidenced by the poor provision of health services among the health centres.

In Tanzania, HFGCs were first established in 1999 under the Local Government Urban Authorities Act of 1982 and the Local Government District Authorities Act of 1982, linked to the Alma-Ata Declaration (1978) (Pancras, 2016). These HFGCs were assigned specific governance functions to perform, such as participating the planning, budgeting and procurement process, mobilising people to join community health funds and collecting, discussing and addressing community health challenges (Kessy, 2014; Frumence, et al., 2014; Kesale, 2021).

They are also responsible for participating in monitoring the renovation and construction activities of the health facilities and working with different stakeholders and partners to mobilise resources for the health facilities (Goodman, et al., 2011; Renngli, et al., 2018). Therefore, the HFGCs were established as local bodies that will provide supportive supervision to the primary health facilities by engaging the community.

Nonetheless, several studies outside and within Tanzania have exposed unresolved challenges that have been facing these committees. According to Kessy (2014), the HFGCs have not been

successful in mobilising financial resources for improving healthcare delivery, which is found to be weak across districts. Moreover, (Kesale, 2021) discovered that delay in accessing funds for implementing facility plans impairs and lowers the quality of service delivery in Tanzania. Furthermore, (Boex, et al., 2015; Kapologwe, et al., 2019) comment that HFGCs and health facilities had inadequate planning, budgeting, control of powers, and accessi to their financial resources. Therefore, the present study intends to assess theways that can address the challenges that lead to the failure of HFGCs in implementing their roles.

1.4 Objectives of the Study

A research objective is a clear, concise, declarative statement which provides direction in investigating the variables. Objectives summarise what is to be achieved by the study (Moon, 2016). With clearly defined objectives, the researcher can focus on the study and help the researchers to avoid the collection of data which are not strictly necessary for understanding and solving the problem and facilitate the development of the research methodology (Akaranga & Makau, 2016). The following are the objectives of the study;

1.4.1 General Objective

To assess the challenges facing health facilities governing committees in ensuring the provision of better health services in the selected health centres at Busega district.

1.4.2 Specific Objectives

(i) To identify the kinds of communication channels used in sharing information towards the provision of better health services in selected health centres at Busega district.

(ii) To find out the kinds of motivation provided by the government to HFGCs towards the provision of better health services in selected health centres at Busega district.

(iii) To examine the kinds of government support to HFGCs towards supervision of health centres' provision of better health services at Busega district.

1.5 Research Questions

The research question is a specific inquiry to which the research seeks to provide a response to (Akhtar, 2016). A clear, focused and appropriately complex research question guides the research from the background to the study, literature review, methodology and final report (Akhtar, 2016). The following are the research questions of the present study;

i. What are the communication channels used in sharing information towards the provision of better health services in selected health centres at Busega district?
ii. How does the government motivate the HFGCs towards the provision of better health services in selected health centres at Busega district?
iii. How are the HFGCs supported by the government towards the supervision of health centres' provision of better health services at Busega district?

1.6 Scope of the Study

The present study intended to assess the challenges facing HFGCsin ensuring the provision of better health services at Busega district. Specifically, the study intended to identify the kinds of communication channels used in sharing information towards the provision of better health services in selected health centres; to find out the kinds of motivation provided by the government to the HFGCs towards the provision of better health services in selected health centres at Busega district and examine the kinds of government support to the HFGCs towards supervision of Health centres' provision of better health services at Busega district. The study did not cover the roles of the HFGCs.

1.7 Limitations of the Study

The researcher encountered sampling bias which was solved by using appropriate sampling techniques that helped in minimising the biasness. Furthermore, some of the respondents refused to cooperate in providing the right and sufficient information needed for the study; as a challenge, this was solved by assuring them that the information provided for this study will not be disclosed for any other purpose as one of research ethics.

1.8 Significance of the Study

The study provided the researcher with an understanding of the challenges facing the HFGCs, the knowledge of the communication channels used in sharing information, as well as the motivation and support they get from the government towards the provision of better health services. Academically, the knowledge obtained can be used by different institutions, students and researchers as reference material on HFGCs.

Furthermore, the findings may act as a directing point for other studies on HFGCs. To the government, the study can help the policymakers and the policy implementers in formulating and implementing policies which will be helpful in capacitating the committees. Also, the study will help the HFGCs in combating the challenges and strengthen their supportive supervision of the health centres in order to improve the provision of services. In addition, the study will increase community awareness of HFGCs and hence improve participation.

1.9 Organisation of the Dissertation

The present study is organised into five chapters. The first chapter covers the background to the study,statement of the problem, research objectives, research questions, scope of the study, limitations of the study, significance of the study, organization of the study and conclusionn.. The

second chapter presents a review of existing literature, both theoretical and empirical, conceptual framework and research gap. The third chapter covers the methodology to be adopted in conducting the study. The fourth chapter illuminates the findings of the study, while the fifth chapter covers the summary, conclusions and recommendations of the study.

1.10 Conclusion

Therefore, this chapter introduces the study and builds up the urgency of the problem. The chapter elaborates clearly on the problem that the study intends to solve and the importance of the study itself. Therefore, it guides the researcher while conducting the research study.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter covers the theoretical literature review, definitions of operational terms and concepts. The chapter emanates the empirical studies that relate to the effectiveness of theHFGCs. Furthermore, it stipulates the research gap, theoretical framework and the conceptual framework.

2.2 Theoretical Literature Review

2.2.1 Sharing Information in Health Care Setting

The transition from centralised to decentralised care methods is unavoidable in the present healthcare systems around the world. Nowadays, it seems as though many different people are involved in health care, and they all need to share patient information and talk about their management (Peek, 2017;Vermeir, et al., 2015).

According to Bennett, et al. (2015), there are really just two ways for communities to influence their members' health. The first way is through taking part in community-based health programmes like community-based health care, and the second way is by showing support for organisations that manage health issues. These structures include a clinic committee or community health committee that is responsible to the community and oversees the operation of the clinic.

This is the focus of this study, and it represents a more formalised platform for community participation. As a result, interest in and utilisation of information and communication technologies to support health care is rising (WHO, 2017). However, while information technology is widely discussed and heavily invested in, communication systems are given much less attention, and many health services have not yet adopted even more basic services like voice mail or electronic mail

(Bailey, 2021; Vermeir et al., 2015). Our general understanding of the function of communication services in the provision of healthcare still has vast gaps.

In order to effectively communicate health information to the public and policymakers on a regular basis and during humanitarian crises, African nations are working to build resilient communication networks. These networks will encourage long-term relationships and sustainable lines of communication between researchers, clinicians, journalists, policymakers, and medical librarians (Karuga, 2022; Halden, 2019; Obionu, 2017). The transmission of timely and evidence-based health information has therefore depended on strengthening the communication skills of researchers, policymakers, and knowledge intermediaries like journalists, librarians, and journal editors.

Concerns concerning the improvement of health information systems have grown in Tanzania (Yahya, 2018). The Tanzanian government has built a Health Management Information System (HIMS) to provide each level of the health sector with essential information in a timely and accurate manner in order to support informed local decision-making. It calls for an integrated, decentralised, practical, and dependable system (Renngli, 2018; Yahya, 2018). Studies, however, have revealed limitations in Tanzania's conveyance of health information and expertise. The ability to convey this information to the intended community and the health providers' capacity to interchange expertise and information are both inadequate (Kessy, 2014; Pacras, 2016; Kesale, 2021). Additionally, although the community receives the information, the majority of them are unable to apply it effectively because they lack the requisite prior knowledge (Kesale, 2021).

2.2.2. Government Efforts in Capacitating the HFGCs

The Tanzanian government has persisted in implementing a number of reforms to strengthen the healthcare system, including giving HFGCs the authority to complete their assigned duties (Kessy,

2014; pancras, 2016). The Tanzanian government decided to establish direct health facility financing in order to enable flexible and timely funding and utilisation at the level of service delivery locations, leading to increased financial efficiency, accountability, and high-quality public service delivery (Kesale, 2021). The DHFF project is also in line with global health objectives like Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC) (SDGs). However, the appropriate health authority has fallen short in its efforts to empower and train locals, which has also resulted in less-than-ideal community participation. It is frequently necessary to provide long-term assistance and capacity development to community members elected to govern institutions (Kessy, 2014). Therefore, the government of Tanzania needs to support the health facility governing bodies more in order to increase their capabilities.

2.2.3 Relevance of Health Facilities Governing Committees

The health facilities governing committees are considered to be very important and relevant bodies for regulating the supply of health services; these organs are specifically emphasised as being important in connecting technical teams with communities (Mboera, 2011; Mubyazi & Hutton, 2012; Lodeinstein, 2017; Karuga, 2022). Thus, members of the HFGC attend community meetings and serve as a liaison between the community and technical experts. This allows them to clarify concerns and provide assistance to both community and technical members. When it comes to monitoring the activities and decisions of the technical teams, the committees serve as accountability structures (Karuga, 2022; Kesale, 2021; Lodeinstein, 2017). The committees are also thought to be required for establishing tight collaboration with other sectors and partners in order to carry out initiatives that require joint efforts in the council's key areas, such as water and education

(Frumenceet al, 2014). Therefore, the health facilities governing committee is considered to be a link between the community and the health facilities along with other stakeholders.

A study by Bailey et al. (2017) on supportive supervision as a strategy to improve primary healthcare services in Sub-Saharan Africa suggested that, in order to reduce the challenges and improve the provision of health services, Tanzania should implement quality improvement initiatives including supportive supervision which is observed to be poor across health setting including health centres including the health centres in which the health facilities governing committees are responsible for supportive supervision to improve service provision.

Different studies have been carried out and revealed how weak supportive supervision has led to poor provision of health services and how the supervision can be strengthened. However, there is limited knowledge of the challenges facing the HFGCs that make them underperform their supportive supervision functions. Therefore, this study intends to assess the challenges facing the health facilities governing committees in ensuring the provision of better health services, which will help the HFGCs and the policymakers find a way to ensure the identified challenges are reduced and thus strengthen the supportive supervision of the HFGCs in the health centres. The failure to carry out this study will result in ongoing weak support supervision of HFGCs and, consequently, poor provision of health services in health centres.

2.3 Empirical Literature Review

A study by Gurung et al. (2018) on health facility operations and management (HFMC) committees revealed that, in the majority of cases, HFMC members did not regularly or systematically communicated with the community, highlighting a gap between the committee and the larger community. Furthermore, there was no established procedure for giving the community input. This

raised worries about whether community representatives merely spoke about their own issues rather than representing those of the entire community. This result is consistent with other research from Bangladesh, the Philippines, and African nations, which revealed that committees did not take the population's concerns into account (Goodman et al. 2011; Falisse et al. 2012).

2.3.1 Communication Channels Used in Sharing Information towards Provision of Better Health Services in Health Centers

In a study on the governance of the health systems after devolution in Indonesia, McCollum et al. (2018) found that the policy mentions community engagement. In order to do this, multisectoral yearly community consultative forums for planning and development are held, to which residents, local community and religious leaders, and representatives of local organisations are all invited. Although respondents believed that the Kader (who attended the monthly village women's meetings) should be responsible for community engagement rather than the community as a whole, many regions did not implement these meetings as intended, which led to inadequate information sharing. The failure to address obstacles to attendance and active participation of hard-to-reach and marginalised groups, such as lack of funding for transportation for those in remote areas, the dominance of discussion by local elites, the announcement of meetings at short notice in English language newspapers, and a failure to advertise meetings in local languages, was highlighted in a similar study conducted in Kenya by Collum et al. (2018).

In South Africa, a study by Padarath and Friedman (2018) revealed the absence of institutional procedures for clinic committees to interact with their audiences. Instead, most committees interact with the communities they represent through informal communication and general community meetings. Additionally, there was no proof that district health councils, hospital boards, or clinic

committees had structures in place that permitted lateral communication among the governing institutions or that they had consistent, coordinated communication practises.

The study, carried out in central and western Africa by Lodenstein et al. (2017), showed that there was a lack of a systemic and widely accepted feedback procedure, leaving more room for concerns and issues to be overlooked. Even when Health facilities committees (HFCs) actively collected complaints, there was a chance that the complaints would be lost due to inadequate documentation. In addition, the study explained that while there is a positive relationship between HFCs and health providers in terms of accountability, it is not functioning, is inconsistent, and, despite being effective in some instances of subpar performance, is not always coherent, authoritative, and inclusive.

According to a study by Abimbola, Drabarek, and Molemodile (2015) on community health committees in Nigeria, there was a conflict between the HFGCs' strong desire for independence and their belief that this desire was a result of past encounters with the unresponsiveness of the government, low expectations for the government, or an unclear understanding of what to expect from the government. The committees' relationships with governments were influenced by the degree to which committee members thought they had the right to demand things from governments. Additionally, a common belief among primary health care managers in local and state governments was that committees were set up to aid in the achievement of government objectives rather than to guarantee that communities' needs were satisfied.

In their study on community health committees in Sub-Saharan Africa, Karuga et al. (2022) found that health committees held healthcare providers accountable by keeping an eye on absenteeism, the calibre of services, and spending in healthcare facilities. However, because selection processes were frequently opaque and non-participatory, health committees lacked legitimacy. Health professionals believed that committee members lacked the necessary education and training to

participate in planning; thus, they excluded them from budgeting and planning processes. Women's participation was constrained by the male predominance of the majority of health committees.

According to a TARSC (2015) study on enhancing the capabilities of health centre committees as advocates for health in Zimbabwe, HCCs have used mobile phones to monitor and report on the availability of medicines at health centres and have raised concerns about staff shortages, low staff morale, late medicine deliveries, and unaffordable fee charges for services.

The majority of members of neighbourhood health committees in the Chisamba district of Zambia are not actively engaged in the preparation and full execution of community health action plans due to poor information transmission, according to a study by Choomba (2019) on the subject. It was noted that efficient and improved information dissemination from the health institutions to the committees is necessary if community involvement and participation are to improve.

More than three-quarters of HFGC members were frequently informed about happenings at the health facility, while just a small percentage were not frequently informed, according to a study by Pancras (2016) done in Tanzania. The results also revealed that the majority of HFGCs members gave feedback to the community on the decisions they made, with only a small number of members claiming they did not. The FGD did reveal that committee members learn a lot about health facilities through committee sessions, though. Information is shared inside and between committee members as well as with other health stakeholders, claims the aforementioned declaration. The study did not, however, describe the means of communication used to spread the information.

The study on the drivers of HFGC performance in Tanzania revealed that communication between HFGC members and communities was identified as the third most important aspect of HFGC performance. The results of the interviews showed that the success of HFGCs depends on

communication between communities and them. This is due to the fact that communication enables HFGCs to monitor service delivery and spot problems that need to be fixed (Kesale, Mahonge&Muhanga, 2021).

2.3.2 Kinds of Motivation Provided by the Government to the HFGCs towards the Provision of Better Health Services in Health Centers

The shared role in governance is essential, according to EQUINET's (2014) study on health centre committees as a vehicle for social engagement in health systems in east and southern Africa. The combined position provides the health centre committees with the knowledge, authority, and incentive to return to the communities and foster communication and consultation on plans. Engage with local authorities, form beneficial alliances, and promote communication with other players in order to mobilise social action and input as well as to ensure that various issues are resolved.

In their study on effective and meaningful participation or limited participation in South Africa, Harichan, Stuttaford, and London (2021) outlined a number of issues that had an impact on various challenges, such as a lack of funding for transportation reimbursement, operating costs, and activities required for committees to operate effectively. Due to their socioeconomic disadvantage, members of health committees cannot and should not be asked to cover the costs of participation.

In their research in Zimbabwe, TARSC (2015) found that health professionals did not always understand or value the role of HCCs, particularly when authorities did not effectively communicate these roles or when there were no legal instruments defining these roles. This indicates that healthcare professionals have a poor opinion of HCC.

Moreover, Waweru, et al. (2013) studied about Kenya's health facilities management committees (HFMC) and found that HFMC members were highly motivated and satisfied with their jobs. Users'

limited awareness of HFMCs, a lack of training and clarity in HFMC roles, and some signs of tense interactions with in-charges were challenges. Maluka and Bukagile (2015) found that the health committees' influence on policy, planning, and budgeting were limited in their study on community participation in the decentralised health systems in Tanzania. These challenges were likely common to many similar settings and were, therefore, important considerations for any health facility-based initiatives involving HFMCs. Inadequate training and limited public awareness also had an impact on the committees' success.

Iramba and Iringa districts in Tanzania both had a framework in place for motivating their committees, according to Joseph and Maluka's (2017) study on Leadership and management strategies in the context of decentralisation influence on the performance of CHF. According to the data, HFGCs in Iringa received a Tsh. 5000 allowance following each of their quarterly meetings. The fact that the HFGCs were not always paid their stipend right away and occasionally had to wait until the next meeting had a significant negative impact on the committee members' morale. In contrast, payments went smoothly in the Iramba district.

2.3.3 Kinds of Government Support to the HFGCs towards Supervision of Health Centres' Provision of Better Health Services.

Beyond form and functioning: Understanding how contextual factors affect village health committees in northern India was studied by Scott et al. (2017). The lack of resources and capacity in government services made it difficult for committee members and actors in the health system to establish relationships, which increased public mistrust of government institutions.

A study on the use of health committees to encourage community involvement as a social determinant of the right to health in South Africa and Uganda was undertaken by Mulumba, London, and Ngwena (2018). The study found that the conceptualization of the health system needs

mainstream health committees. Their work should be viewed as comprehensive, encompassing not only initiatives to enhance healthcare quality and equity but also initiatives focused on socioeconomic determinants of health. Their initiatives highlighted the necessity for central governments to protect health committees' autonomy as vehicles of participatory democratic governance by integrating them into their health systems.

According to a study by Opwora et al. (2010), the government of Kenya introduced the direct facility financing scheme (DFF), a novel financing method, to provide extra cash at the facility level. The findings showed that DFF improved community accountability by including more HFC training, more FMN (facility management nurse) support, and giving HFCs some resource control.

In their study on HFGCs in Sub-Saharan Africa, TARSC et al. (2014) found that different eastern and southern African countries use different techniques to increase capacity. While some communities employ interactive training techniques, others assemble two or three HFGC representatives from various HFGCs in a district to conduct district-level training. The training has been characterised as sporadic, with a lack of resources and trainers, restrictions on how and what to train in a select few countries, difficulties scaling up training to a large number of HCCs, and a tendency for external sponsors to choose the training's theme (TARSC et al., 2014). In other words, the training given to HFGCs in Africa does not ensure that the committees will improve. Poor performance is a direct result of the members' poor training.

Kessy (2014) observed that the pervasive health systems concerns, over which HFGCs have no direct influence and for which they have no answers, also limit HFGCs' capacity to carry out their tasks and obligations. These include running out of drugs, having insufficient human resources, having weak communication infrastructure, having a burdensome bureaucracy, etc.

In his study on the effectiveness of health facility-governing committees in Tanzania, Pancras (2016) noticed a problem where the HFGCs did not have enough money to carry out their activities. The results showed that even though the health department had a number of funding sources, only a small number of them were permitted to carry out the HFGC's activities.

2.4 Research Gap

A number of studies on the governing committees of health facilities have been done. However, there are limited studies on the challenges facing the health facilities governing committees in performing their functions. Specifically, studies have identified that there has been weak communication between the HFGCs and other stakeholders (Pancras, 2016; Mabuchi, 2018, Lodenstein, 2017). However, these studies did not identify and elaborate concisely on the communication channels suitable for sharing information among the stakeholders in ensuring better health services provision. Moreover, studies have elaborated on how the HFGCs help the government to achieve its goals (Abimbola, Drabarek & Molemodile2015), but they have rarely explained how the government motivates and supports the committees. Therefore, the purpose of this study is to assess the challenges facing the HFGCs in ensuring the provision of better health services by specifically identifying suitable communication channels to be selected and used by HFGCs, as well as exploring the support and motivation provided by the government to HFCGs in ensuring the provision of better health services in Tanzania.

2.5 Theoretical Framework

2.5.1 Bossert Decision-Space Approach

In Tanzania's decentralised health systems, the Bossert decision space concept is used to explain the range of options for various health-related functions and plans that have been passed from the

centre to local authorities (Pancras, 2016). Bossert proposes the concept of decision space, which he defines as the range of effective choices that central authorities allow local governments to use (Frumence et al., 2016)). It can cover a wide range of functions and operations carried out by local governments, giving them more freedom and discretion to make their own judgements. The choice or discretion of local entities to make judgements about their plans can be classified as narrow, moderate, or wide.

Bossert argues that the decision space approach has several advantages. It puts the focus squarely on the extent to which authority over public choices is shifted from central to local authorities (Pancras, 2016). Therefore, we should expect a given decentralisation reform to permit more local choice over budgets and financing in some areas and hiring and firing in others. As explained above, Tanzania is implementing a devolution form of decentralisation and therefore has the power and authority to make its own choices or discretions over health decisions and plans using a decision space analytical framework.

This theory will be used in the study to assess the support and motivation provided by the government, which is the central authority to the HFGCs, which have been formed after decentralisation and have been granted the discretion on providing supportive supervision to the HFGCs in ensuring the provision of better health services.

2.5.2 Participation Theory

Participation theory explains the degree to which community members participate in decisions about their own development advantages, which vary depending on citizen involvement and commitment. In this theory, Arnstein devised a ladder or hierarchy of citizen participation that connects three major steps: the first is known as non-participation. At this level, decision-makers play a significant

role in assisting citizens in implementing the policy at hand in order to achieve their goals, but citizens do not have the opportunity to provide feedback to decision-makers and planners about the progressing interventions.

Token participation is the second step on the citizen involvement ladder, where members of the community may have the opportunity to share their thoughts with decision-makers by expressing their opinions on a policy, program, or initiative that benefits them (Frumence et al. 2014). On the other hand, at this point, authority is not transferred, implying that community members may lack the necessary communication routes to ensure that their ideas are heard.

Citizen power is the final step in the citizens' participation ladder. Citizens have their own powers at this level, allowing them to participate in policy formation, implementation, monitoring, and evaluation of initiatives (Frumence et al., 2014). Citizens' participation like this gives people a lot of opportunities to participate in and impact policies and decisions that directly affect their lives.

Generally, this theory will be used to identify the communication channels used in sharing information among stakeholders to ensure the provision of better health services.

2.6 Conceptual Framework

The figure below shows a Conceptual Framework of this study, whereby the underlying assumption in this study is that the functioning of HFGCs is a dependent variable that depends on government support and motivation provided to the HFGCs which are considered to be the independent variables of the study. Moreover, government support and motivation depend on the communication channels available for sharing information between the government and other stakeholders, and also, government support and motivation can determine the challenges that may affect HFGCs. Furthermore, the communication channels can either facilitate or reduce the challenges that may face the HFGCs.

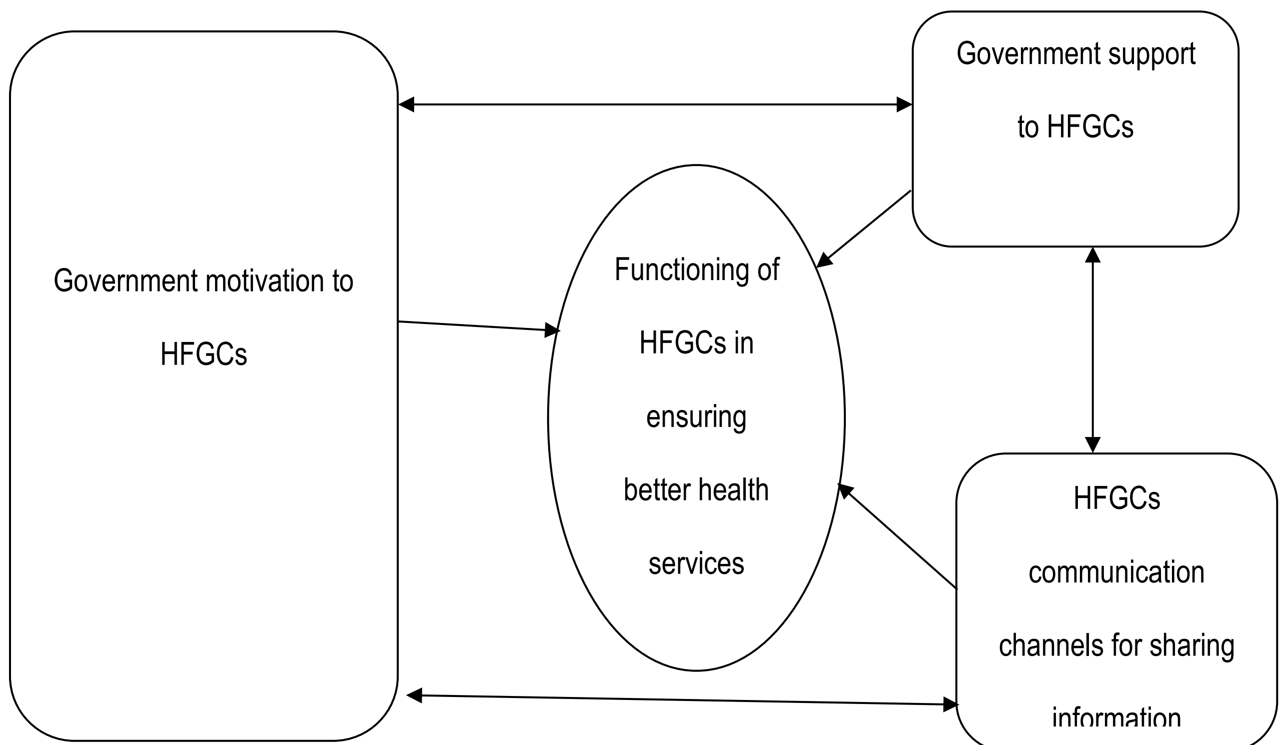

Figure 2.1 Conceptual Framework

Source: Researcher's Synthesis of Ideas from Reviewed Literature (2022)

2.7 Conclusion

Therefore, this chapter has provided different ideas and findings extracted from different authors. The ideas have traced the whole concept of health facilities governing committees. However, the gap was identified from the literature, and now it is upon the researcher to bridge the gap.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter emanates the methodological aspects used in this study. These methods include research design, the research approach, the area of the study, the study population, sampling procedure and sample size, data collection and techniques, data management and analysis and research ethics considerations employed in this study.

3.2 Study Area

This study was conducted in the Busega district in the Simiyu region in the selected health centres. Busega district is selected as the study area purposively because different studies have revealed that there is an ineffective provision of health services in Busega district due to different reasons. For instance, Mabeyo (2013) revealed different challenges hindering the effective provision of health services at Ngasamo village in the Busega district, including a chronic shortage of equipment, an irregular supply of drugs, low motivation and supervision of health workers, and poor transportation and communication. Moreover, Konje, et al. (2022), in their study on the provision of inadequate information on postnatal care and services during antenatal visits in Busega, revealed the limited practice in the provision of postnatal care education by health care workers. The education that should be provided to pregnant women during antenatal care is not provided due to inadequate staffing levels, poor infrastructure at health facilities and inadequate knowledge on the part of healthcare providers.

Due to that fact, this study area provided reliable results to the researcher on the functioning of health facilities in strengthening primary health care services. Busega district represented other districts in Tanzania which are faced with low-quality primary health care services. Busega district has a total number of 4 health centres.

3.3 Research Design

A research design is the arrangement of conditions for the collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy and procedure (Kahtar, 2016). The present study employed descriptive research approach taking Busega district as a case study.. A case study design is a research design that is used to generate an in-depth, multifaceted understanding of a complex issue in its real-life concept (Carolan, Forbat & Smith, 2016). According to Yin (2014), case studies can be used to describe, explain or explore events or phenomena in the everyday contexts in which they occur.

This study design allows the collection of both primary and secondary data at the same time, resulting in a snapshot of ideas, views, and data (Miles, 2015). Because the case study design was less expensive, it allowed the researcher to work with the limited resources available. In addition, the case study design helped the researcher to complete the research in a short amount of time. It also permits the researcher to apply one or more data collection methods based on the situation and the research topic's nature (Miles, 2015). Therefore, this research design was suitable for providing reliable results for the study.

3.3.1 Research Approach

A qualitative research approach was used in this study. In contrast, qualitative research is an inquiry process of understanding a social or human problem based on building a complex, holistic picture

formed with words, reporting detailed views of informants, and conducted in a natural setting (Creswell, 2012). The subjective assessment of people's attitudes, opinions, and behaviour is the focus of a qualitative research approach. The qualitative approach enabled the researcher to gain much data as possible from a relatively small sample size. Moreover, the qualitative approach allowed flexibility since opinions can change and evolve over the course of conversation and hence the researcher can capture this. However, some quantitative aspects were used during the computation of frequencies in determining the magnitude of the phenomena under investigation.

3.3.2 Target Population

The target population is the specific conceptually bounded group of potential participants to whom the researcher may have access that represents the nature of the population of interest (Casteel and Bridier, 2021). The target population must avoid having participants who do not represent the study's needs, which will misrepresent the population of interest (Kumar, 2018).

The total population in the study was 332 people. The target populations of the study included 4 health centres whereby the study included a population of 36 members of HFGCs because they can provide information on how the HFGCs work and communicate with the stakeholders to ensure better provision of health services. Moreover, the study population also included 8 council health management team (CHMT) members for the purpose of obtaining information on how the government support and motivates the HFGCs. Furthermore, 8 health staff from the selected health facilities provided information on communication channels, and 280 community members were also a part of the population.

3.3.3 Sampling Techniques and Sample Size

3.3.3.1 Sampling Techniques

The sampling technique is a method used to select individual members or a subset of other populations to make statistical inferences from them and estimate the characteristics of the whole population (Taherdoost, 2016). This study used non-probability sampling techniques to select the study respondents, including purposive sampling and accidental sampling techniques.

Convenience sampling involves selecting the participants selected based on their availability and willingness to take part (Stratton, 2021). This method was used to select community members because their participation depends on their availability and whether or not they are ready to take part in the study. Therefore, only the respondents who were easy to reach were taken as a sample. Convenience sampling was used to select the community members.

Purposive sampling is an intentional selection of informants based on their ability to elucidate a specific theme, concept or phenomenon (Etikan, 2016). Purposive sampling allows the researcher to gather qualitative responses, which leads to better insights and more precise research results (Taherdoost, 2016). This method was used to select the CHMT members, which are the District Medical Officer (DMO) and the District Health Secretary (DHS). These two CHMT members were selected specifically because of their position in relation to the HFGCs, as they are considered to have the necessary information and documents to guide the implementation and supervision of the HFGCs' activities in the District. Moreover, the HFGCs members were selected purposively since they are the key players and thus can provide information about how they work, the challenges they encounter, the communication channels and the support and motivation they receive from the government and the health facility workers who work closely to the committees were also selected purposefully.

3.3.3.2 Sample Size

Sample size refers to the number of participants in a study (Casteel and Bridier, 2021). The sample size in this study was 71 respondents acquired through different sampling techniques, and the sample size was determined by the saturation point from respondents. Data saturation is a point in the research process where enough data has been collected to draw necessary conclusions, and any further data collection will not produce value-added insights (Hennink et al., 2017). The saturation point is an important indicator that a sample is adequate for the phenomenon studied and that data collected have captured the diversity, depth and nuances of the issues studied and thereby demonstrates content validity (Morse, 2014). The respondents were as follows; at the level of CHMT, 2 members were selected purposively, namely District Medical Officer and District Health Secretary. Moreover, 8 health care providers and 36 HFGCs members were selected purposively, and 25 Community members to represent the community were selected through convenience sampling technique.

3.3.4 Data Collection Methods

Data collection is a systematic approach to accurately collect information from various sources to provide insights and answers, such as testing hypotheses and evaluating an outcome (Mishra & Alok, 2017). Data collection methods are broken into two categories, namely secondary and primary data collection methods. In this study, primary data collection methods were used for the purpose of obtaining information from the participants of the study. The information to be collected through primary data collection was crucial since it helped the researcher to draw conclusions about the study. The primary data collection method that was used included the interview method and focused group discussion. Also, Secondary data collection methods such as documentary review were used. The researcher reviewed relevant documents in order to access accurate and reliable data.

3.3.4.1 Interview

An interview is a conversation where questions are asked to elicit information (Howell, 2013). Interviews include the possibility of collecting detailed information and giving the researcher direct control over the flow of the process and a chance to clarify certain issues during the process if needed. This study included both structured and non-structured interviews. For the structured interviews, the researcher created an interview guide to ensure that the interviews were focused and contrasted different answers given to the same question, and the non-structured interviews did not have a guide to allow more expression from the respondents (Mishra & Alok, 2017).

Structured interviews were used to collect data from the CHMT members and health facility staff and to collect information on examining the government support and government motivation to the HFGCs as well as the communication channels used in sharing information towards the provision of better services in the Busega district. Non-structured interviews were used to collect data on the communication channels used in sharing information towards the provision of better services in the Busega district from the community members.

3.3.4.3 Focused Group Discussion

A focus group discussion involves gathering people from similar backgrounds or experiences together to discuss a specific topic of interest, and it generally involves a group of 8 to 12 people (Moon, 2016). In this study, FGDs offered an excellent way to get people free to talk, whereby, a total of 3 groups were composed of a maximum of 8 members.Group members were able to correct and interact with one another in case somebody did not remember or else did not provide correct answers in a way that did satisfy the group (Howell, 2013). The researcher used this method to collect information from the HFGCs members on the government support and government

motivation towards HFGCs as well as communication channels for sharing information towards the provision of better services.

3.3.4.4 Documentary Review

This is a form of qualitative research that uses a systematic procedure to analyse documentary evidence and answer specific research questions (Howell, 2013). Documents that were reviewed included the HFGCs guidelines, policies guiding the functioning of HFGCs, articles from the internet as well as the minutes of HFGC meetings. The information obtained from these documents was used by the researcher to identify the communication channels as well as the government support and motivation in ensuring the provision of better health services in the Busega district. The documentary review was performed by reading such sources and analysing the intended information so as to attain relevant theoretical and empirical information for the present study from other scholarly works.

3.4 Pilot Study

A pilot study is a small feasibility study designed to test various aspects of a method planned for a larger, more rigorous or confirmatory investigation (Polit & Beck, 2017). Therefore, the trial investigation was conducted involving 15 respondents. The trial study enabled the researcher to test the instruments prior to administering the research in the actual study area. The trial study group had different characteristics from the intended group to be studied, and it was undertaken 3 days prior to the major fieldwork. The pilot study enabled the researcher to correct any errors that could exist, especially in data collection tools, prior to the start of major fieldwork.

3.5 Data Analysis

Data analysis is the most crucial part of any research. Data analysis is defined as a process of cleaning, transforming and modelling data to discover useful information (Stratton, 2021). The purpose of data analysis is to extract useful information and taking a decision based on the data analysis. Thematic analysis and content analysis were used to analyse the data collected through interviews, focused group discussions and documents on getting an interpretation of their meaning. The thematic analysis involves reading through a data set and identifying patterns in meaning across the data to derive themes. Moreover, Content analysis The researcher analysed the data by carefully reading and re-reading the collected qualitative data and later noting the information relevant to the study and later considering the information that has been repeatedly provided by the respondents.

3.6 Validity and Reliability

Validity is the extent to which a measure adequately represents the underlying construct that it is supposed to measure (Mohajan, 2017). Reliability can be defined as a degree to which the measure of a construct is consistent or dependable, under different conditions, on different occasions, supposedly with alternative instruments which measure the construct or skill (Heale & Twycross, 2015).

To ensure the validity and reliability of data, the researcher ensured the quality of instruments used in the study to be accurate, correct and meaningful and also minimised biases by refining them through the comments from the research supervisor to the researcher in the field to ensure that the instruments focused on the purpose of the study. Moreover, in order to ensure the reliability and validity of the study, the same and uniform research instruments were administered to all respondents. Also, a pilot study was carried out in order to find out if they could be well understood

by the respondents. However, if the reliability and validity of data could be poor, the study will produce false results due to unreliable information obtained from the respondents and, as a result, cause the researcher to draw incorrect conclusions about the study.

3.7 Ethical Consideration

Ethical considerations are a set of principles that guide research designs and practices (Moon, 2016). Ethics enhance the purpose of research, which includes the dissemination of knowledge, reporting or telling the truth and finally, the need to counteract errors (Akaranga & Makau, 2016). This study adhered to the principles of ethics in social sciences research and professional codes of conduct to safeguard the rights of the participants and enhance the trustworthiness of the findings. This study was conducted after ensuring voluntary participation; informed consent and confidentiality were strictly observed. During the fieldwork, Oral informed consent was obtained from all the key informants who participated in the study, and they were informed of their right to withdraw from the study at any time. All the interviews were recorded in the notebooks with the permission of each respondent, and the results of the interviews were kept, as no individual names were taken to ensure that they were free to give their opinions and feelings.

3.8 Conclusion

This chapter concentrated on the elements and content of the research methodology. It began with the introduction, which provided an overview of the chapter. The research design and approach are the chapter's primary highlighted elements, and they were the benchmark by which all research was measured, along with a justification for their selection. This chapter justifies all the methods that the researcher used to ensure that the study succeeds. These methods guided the researcher in the field on how to select samples from the population, how to collect the information from them and

analyse the collected information to draw conclusions from the result by ensuring all the procedures preserved the ethics in the study. This helped the researcher obtain validity and reliability of results. The chapter also addressed the problems with research ethics. By keeping the identities and personal information of the participants a secret, confidentiality was maintained. The rights of the participants and the researcher's obligation have also been stressed in the chapter as crucial sections with legal repercussions if not followed. The research process is summarised as the chapter comes to a close.

CHAPTER FOUR

4.0 PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

The findings are presented in this chapter using a qualitative data analysis technique, which comprised a number of procedures, including gathering the raw data, extracting pertinent material, identifying recurring themes, recurring grouping themes, and producing a narrative. The study objectives served as the basis for the major themes in this approach. To highlight specific findings, narratives have been presented in their entirety for each study objective.

4.2 Presentation of the Findings

4.2.1 Communication Channels Used in Sharing Information towards the Provision of Better Health Services in Health Centres.

The theme was obtained from the first research objective, which aimed at finding out the communication channels that were used by the HFGCs in sharing information with other health stakeholders to ensure the provision of better health services in their health centres. From the analysed data, three sub-themes were initiated, including 1. Information sharing among health facilities governing committees, 2. Mechanisms of communication between health facilities governing committees and communities, and 3. Communication between the governance structures (HFGCs and CHMT). These sub-themes were developed in order to capture a clear picture of the communication channels used in sharing information towards the provision of better health services. Below is the explanation of the stated sub-themes.

4.2.1.1 Information Sharing among HFGCs Members

The results from focused group discussions reported that many health facilities governing committees have been using single communication channels, particularly meetings, which are supposed to be done quarterly (4 meetings in every financial year). On the other hand, few health facilities governing committees use multiple channels of communication in sharing information among the health facilities governing committees. These methods include meetings, phone calls and normal phone messages.

This was revealed through 18 statements (81.8%) from the HFGC members, which featured the use of meetings as the only communication channels used by the health facilities governing committees in sharing information. Moreover, 4 statements (18.1%) from the HFGCs members explained the use of multiple communication channels other than meetings, including phone calls and normal text messages. However, the meeting was still mentioned as the most used communication channel among the others.

Furthermore, the HFGCs members revealed that the meeting was not sufficient to be used in sharing information among the HFGCs members. Other methods should also be used to ensure efficiency in communication. Though some HFGCs have been trying to share different information through other channels too, still these communication channels are inefficient since some HFGCs are hard to reach, especially those living in rural areas. This is caused by some reasons, including network problems and other members' lack of devices, such as phones, that they can use for communication through other methods, such as phone calls and text messages. One of the HFGC members was quoted saying:

> *Meeting is the most used communication channel to share information among ourselves, though it is not sufficient, we need to use multiple communication*

> *channels in order to have stable communication. These other channels are weak in rural areas due to different reasons, the strongest being network problems in rural areas, which sometimes cause a delay in information shared. Another reason is some of the HFGC members do not have phones hence making it hard for them to communicate or receive information through the other channels other than meetings.*

Moreover, another HFGC member revealed that:

> *Though the HFGCs leaders have been trying to use these other communication channels such as normal phone text messages, they do not make a follow-up if the information shared has reached the intended people (HFGCs members) and get feedback.*

The data analysed through the focused group discussions also revealed that despite the fact that meeting is the most used communication channel, the HFGCs are not undertaking the meetings as required in the HFGCs guideline, which requires the HFGCs to sit four times in every financial year and also the attendance of members in the meetings is still poor. A number of reasons were identified from the FGDs of the HFGCs members, including weak supportive supervision from CHMT featured in 11 (26.19%) statements, ineffective sharing of information expressed in 12 (28.57) statements, low motivation from the government expressed in 14 (33.33%) statements and unclear roles explained in 5 (11.9%) statements. Meeting attendance of the HFGCs has been illustrated in the tables below.

HEALTH CENTRE	NUMBER OF HFGCs MEETINGS IN FINANCIAL YEAR 2021/2022
Health Centre 1	3
Health Centre 2	2
Health Centre 3	2
Health Centre 4	2

Table 4.1 Meetings of HFGCs in Financial Year 2021/2022

Source: Field Data (2022)

	Health centre 1	Health centre 2	Health centre 3	Health centre 4
Quarter 1	8 members	4 members	_	6 members
Quarter 2	8 members	_	_	5 members
Quarter 3	6 members	_	_	4 members
Quarter 4	8 members	_	_	6 members

Table 4.2 Meeting Attendance of Members in HFGCs Meetings

Source: Field Data (2022)

4.2 Mechanism of Communication between Health Facilities Governing Committees and the Community

The data collected indicated that health facilities governing committees mostly use general meetings to communicate with their communities. Moreover, other mentioned channels include informal communication channels, suggestion boxes at the health centres and specific community meetings of health. However, interviews with selected community members revealed that the attendance of the community members in the meetings is not effective, which hinders effective communication between HFGCs and the communities.

The researcher identified that the reasons for many of the community members not to participate in the meetings that are considered to be the most used communication channel between them and the HFGCs include a lack of awareness of the HFGCs as well as negative attitude towards the committee members, as one of the community members was quoted saying that,

> *I am not aware of the committee you are talking about. I only visit the facility for treatment and am not interested in making a follow-up on the administration of the facility, although I am always not satisfied by the services provided there.*

Another community member also claimed that,

> *I do not believe the committee can help us to improve the services at our health facility. Even the chairperson of our committee is an alcoholic. I do not think that these committee members are perfect for improving the health services hear.*

The figure below illustrates the communication channels used to share information between HFGCs and the community.

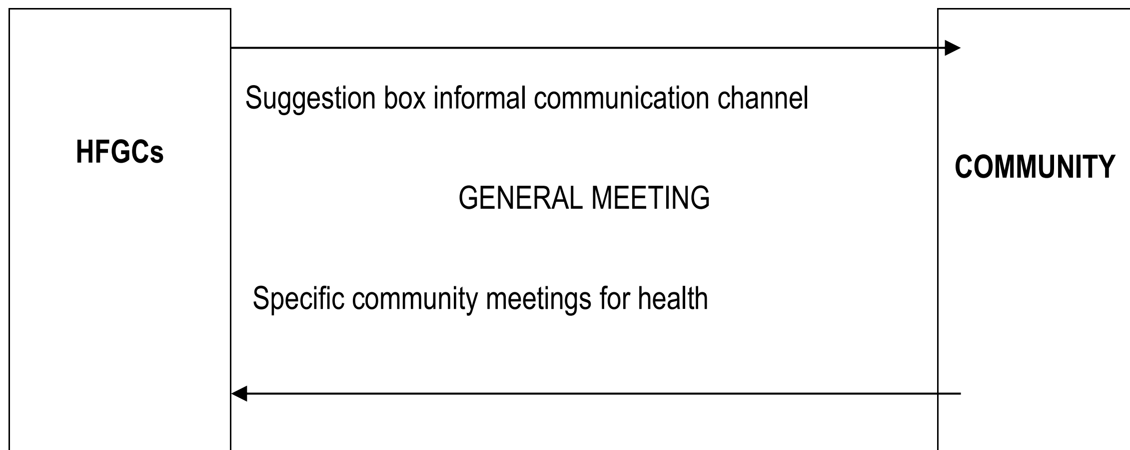

Figure 4.1 Mechanisms of Communication

Source: Field Data (2022)

4.2.1 Communication between the Governance Structures (HFGCs and CHMT)

Data collected through focused group discussion and interviews revealed that communication between governance structures themselves are weak, ad hoc (when necessary or needed) and inconsistent. While provision for such communication might exist on paper, it is not known in practice. None of the respondents, for example, were able to provide information on how they communicated with other governance structures. There is no evidence to suggest that health facilities governing committees and council health management teams have coherent and co-coordinated mechanisms to communicate with each other. Nor are there any mechanisms to facilitate lateral communication between the governance structures.

This was revealed through 27 statements (87.2%) from the HFGCs members in FGDs, which expressed that there is a weak communication between these governing structures and 4 statements (12.9%) from the HFGCs that perceived the communication as normal, not weak. This means that the communication between the governing structures is still weak.

4.2.2 Motivation Provided by the Government to the HFGCs towards the Provision of Better Health Services

The findings analysed stressed on various factors of motivation practices to the health facilities governing committees. These factors included financial incentives, Training of HFGCs members, Recognition and communication.

a) Financial Incentives

The analysis of data revealed that the government does not sufficiently provide allowances to the HFGC members. As a result, the health facilities governing committee members become de-motivated in performing their functions. The main reason for not providing sufficient allowances to the HFGCs is that there is no specific budget for the allowances, as one of the CHMT members explained:

> *We have been receiving complaints from the health facilities governing committees that, sometimes, they encounter financial challenges that cause them not to attend meetings, and also working without incentives discourages them. However, the budget that is planned does not include the allowances to the HFGCs; therefore, it becomes difficult to provide them with the allowances. But as the government, we are working hard to find solutions to this challenge.*

Moreover, results from FGD with the HFGCs members revealed that the lack of allowances de-motivates them. As a result, the performance of the health facilities governing committees becomes unsatisfactory. From the data, 23 (88.5%) statements explained that the HFGCs members were de-motivated by the lack of allowances, and 3 (11.5%) insisted that the lack of allowances does not de-motivate them and their performance as HFGCs members are not affected by it. For instance, one of the HFGCs members expressed that;

> *We have seen different meetings conducted in public organisations, the members are provided with allowances, but on our side, we are not receiving any allowances.*

Attending meetings and performing other roles is working, and if we are not motivated financially, then our performance at work will continue to be low.

b) Training of Health Facilities Members

The researcher investigated to identify if there was any training conducted to capacitate the HFGCs members in performing their roles. The results revealed that there was less training conducted in the financial year of 2021/2022. The government officials admitted that really there was less training provided to the HFGCs members. This was exemplified by the following quotation from a CHMT respondent through a structured interview,

Developing a council comprehensive health plan is a technical activity requiring people who are knowledgeable and skilled in planning health-related activities, but many of the HFGCs members have not been well exposed to such type of training.

Moreover, the HFGCs members, through FGDs, insisted that there are fewer training programmes conducted by the government. As a result, they lack enough knowledge and skills in their roles, which has caused their performance in such roles to be observed as poor. Some of the roles mentioned by them include planning, budgeting, approval of funds and monitoring procurement activities, and all these are health-related activities.

The HFGCs members admitted that this de-motivates them since they are not given a chance to develop their capacities in the roles they are undertaking. They have low knowledge concerning these roles, especially in this cadre, but still, there is no training provided to them. They just use what they call experience, which has affected their performance and the performance of the health facilities at large. This was revealed through 22 (91.7) statements which elaborated that the HFGCs members are de-motivated by lack of training, whereas 2 statements (8.3%) insisted that lack of training does not de-motivate them although training really is needed. For instance, an HFGC member stipulated that;

Most of us are not health professionals, and even though our education levels are not that high, we do not have management skills. Despite that fact, training is not yet provided as needed to the HFGCs. This indeed de-motivates us because; we are performing roles which we do not have the capacity to perform. As a result, our performance is rated low from time to time, and even the performance of the health facilities in providing services is not satisfactory. HFGCs are very special organs; if their members are effectively capacitated on their roles, these committees can perform effectively and result in the provision of better services in the health facilities. The government should indeed work this out.

c) Recognition in Decision Making

This was another factor of motivation identified from data analysis. The findings of the study revealed that there is low recognition of HFGCs, especially in decision-making, which has been leading to less motivation. Most of the HFGCs members stipulated that there is a negative attitude existing in a society that these HFGC members are not health professionals; therefore, they cannot make effective decisions concerning health-related issues. As a result, in a lot of situations that require decision-making concerning these health-related issues, the HFGCs have not been consulted due to the negative attitude that has been residing concerning their ability to make decisions.

The researcher identified this from the data collected that 19(90.5%) statements stipulated that the HFGCs members have not been motivated due to low recognition in decision-making. On the other hand, 2(9.5%) statements expressed that the HFGCs members were not de-motivated by the low recognition of HFGCs members in decision-making.

However, the results also revealed that the government is now working hard to eliminate the negative attitude that exists that the HFGCs members cannot make decisions concerning health-related issues, which discourages the HFGCs members from performing their functions as required. The purpose of doing this is to motivate them to perform their roles and improve their performance as well as the performance f the health facilities, as elaborated by one of the CHMT members.

In addition, through the conversation with the health facility staff, the researcher realised that the health facility staffs have a negative attitude towards the HFGCs. Most of them considered the HFGCs members as people who have less knowledge concerning health matters, and hence, they cannot make effective decisions on different health issues in the health centres. Therefore, the health workers considered the committee members as non-professional and believed that they could not have a good contribution to health matters claimed by one of the health workers:

> *Many members of the committee do not know anything about health matters, and I do not believe in the notion that they can help us in planning on health matters. I think such issues should only be handled by us.*

Moreover, one of the HFGCs members stipulated that:

> *The health workers do not consider us to be an important organ in the facility. We do not understand why, but I don't think we can move on without cooperation from them.*

Also, from the structured interviews, one of the CHMT members explained that,

> *Some of the health workers are still obsessed with the old thinking that community members do not know their health needs and priorities because they are not skilled and knowledgeable about health issues.*

d) Communication

The findings revealed that communication is one of the motivational factors considered by the HFGCs. HFGCs members expressed their views that the communication between them and other health stakeholders is weak. There have been delays in sharing information as required; sometimes, the HFCs have been missing important information due to weak communication. Most of the HFGCs members insisted that the weak communication existing in the system de-motivates them since they need to receive timely information for them to perform their roles effectively. From the data collected, 21(87.5%) statements explained that weak communication de-motivates HFGCs members, while 3(12.5%) statements expressed that weak communication does not affect the motivation of HFGCs.

Moreover, the findings revealed that the government is aware of the challenge of communication and that it really de-motivates the HFGCs since unclear channels of communication prevent them from getting some important information on time. However, the government is finding a way to solve the challenges of weak communication, to ensure that the HFGCs are motivated and their performance is increased as stipulated by one of the CHMT members.

Therefore, Data collected from the health facilities governing committees' members revealed that there is less motivation provided by the government. The HFGCs members become discontented with the lack of monetary incentives, specifically allowances, lack of training on their roles, lack of recognition in decision making and poor communication. This has been illustrated in the figure below:

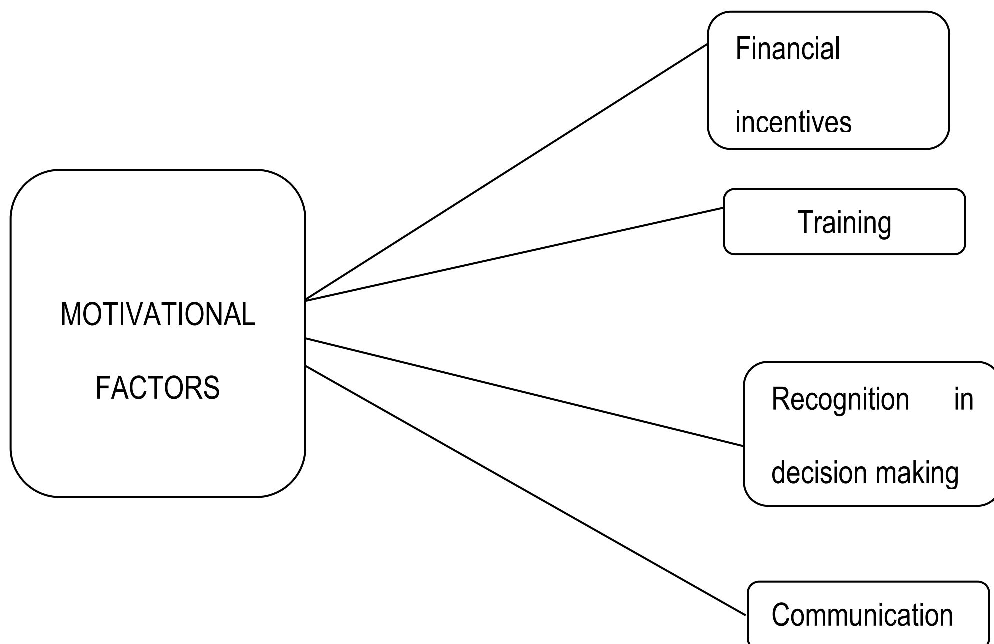

Figure 4.2: Motivational Factors

Source: Field Data (2022)

4.2.3 Government Support to the HFGCs on Supervision of Health Centres' Provision of Better Health Services in Busega District

The researcher carried out interviews to collect information about the government support provided to the HFGCs, and the study finding revealed that government support is very crucial to ensure their performance, although the government support was not strong enough to ensure the effective functioning of the HFGCs as One of the CHMT members claimed that:

> *The effectiveness of the HFGCs indeed requires support from the government. We always provide advice to the HFGCs on how they should perform their roles, also ensuring that the planned activities that are approved are well implemented, although most of the time, we face financial constraints. We sometimes perform supervision, but it is weak, caused by a poor transport system and insufficient human resources to carry on the supervision. The HFGCs are very important to ensure social participation in the health sector.*

Moreover, interviews were conducted with the CHMT members to assess the supportive supervision of the committees by the CHMT revealed that the supportive supervision from the CHMT was weak, which was caused by poor coordination of supervision activities and inadequate human resources. One of the CHMT members stipulated that:

> *Supportive supervision from the CHMT is very crucial to ensure the effectiveness of the HFGCs, but in the real situation, the supportive supervision is weak. The CHMT claims that poor coordination of supervision activities is one of the strong reasons but also, the human resource to undertake the supervision is insufficient. We really need supportive supervision to ensure the committee's effectiveness.*

Furthermore, information obtained from the health facility staff through interviews revealed that the government has been providing financial support to different projects initiated by the HFGCs though the support is not sufficient. The results indicated that sometimes the financial support had been delayed causing a delay in the completion of the initiated projects as planned. One of the health facility staff stipulated that:

> *"The financial support we obtain from the government to implement the approved projects is not sufficient at all, and we most of the time face delays in the*

> *disbursement of funds from the government. Financially, we mostly depend on the cash developed in our health facilities which is always insufficient. This is a huge challenge; something should be done.*

Furthermore, the researcher, through FGDs with the HFGCs members, on the kind of support the HFGCs get from the government and to what extent. All provided answers with a similar context that the government provides financial support as well as support supervision but at a low level that does not satisfy the functioning of the HFGCs; one of them was quoted explaining that:

> *Normally, the government provides financial support to the HFGCs, although not sufficient to finance the activities initiated by the HFGCs. Also, the government, through CHMT, sometimes provide supportive supervision although very merely conducted*.

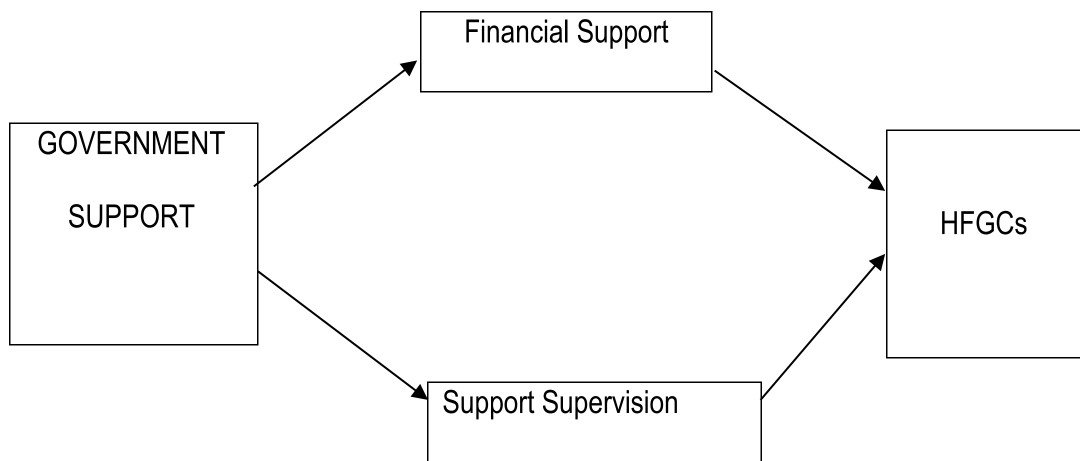

Figure 4.3: Government Support to the HFGCs

Source: **Field Data (2020)**

4.3 Discussion of Research Findings

This section discusses the research findings that have been presented in the previous chapter consistent with the research objectives. The chapter includes the following themes; Communication channels used in sharing information towards the provision of better health services in the health centres. The motivation provided by the government to the HFGCs towards the provision of better

health services and government support provided to the HFGCs towards supervision of Health centres' provision of better health services in Busega district.

4.3.1 Communication Channels Used in Sharing Information towards Provision of better Health Services in the Health Centres

Effective communication is essential for the performance of any institution, as stipulated by Kesale, Mahonge and Muhanga (2021) in their study that the findings show that communication between HFGC members and communities was ranked as the third most significant factor of HFGC performance in their study on determinants of HFGC performance in Tanzania.

Data obtained from the respondents indicated that most of the health facilities governing committees are using a single communication channel to communicate with other health stakeholders, which was mentioned to be meetings. However, very few HFGCs use multiple channels of communication, as mentioned to be phone calls and normal test messages. The use of a single communication channel by most of the HFGCs can be interpreted as a challenge that hinders effective communication since the meetings are not enough to share each and every piece of information to and from the HFGCs as well as the stakeholders.

These results are similar to the findings of a study conducted by Padarath and Friedman in South Africa (2018) which indicated the lack of organised mechanisms for clinic committees to engage with their audiences, with most committees communicating with the communities they represent through general community meetings and informal communication.

Moreover, the study revealed that despite the fact that meetings are the most used communication channel, still, meeting attendance is not pleasing, leading to inactive communications through

meetings. This is to say that the communication among the HFGCs members themselves is weak in the Busega district.

4.3.1.1 Communication between Health Facilities Governing Committees and the Community

There is weak communication between the HFGCs and the community, as identified from the results. HFGCs have been communicating with the community through general community meetings as the most used channel of communication, along with other channels such as suggestion boxes and informal communication. However, the participation of the community members in the general meetings is poor. This reveals that there is an ineffective sharing of information between the HFGCs and the community, which has been caused by a number of factors that are to be worked upon in order to solve the communication challenges. In contrast, Pancras (2016) in Tanzania revealed that more than three-quarters of HFGC members were frequently informed, while only a few were not frequently told about various events at the health institution. Furthermore, the findings showed that the majority of HFGCs members provided input to the community on the decisions they made, while only a few members stated that they did not provide feedback.

However, these findings are similar to the study that was conducted in Kenya by Collum, et al. (2018), which highlighted barriers to effective citizen participation and sharing of information. The barriers include failure to address barriers to attendance and active participation of hard-to-reach and marginalised groups, lack of funding for transport for those in remote areas and the dominance of discussion by local elites. Others are the announcement of meetings at short notice in English-language newspapers and a failure to address local patriarchal norms that limit women's and youth's active participation in the presence of men or elders.

4.3.1.2 Communication between the Governance Structures (HFGCs and CHMT)

CHMT has a responsibility of supportive supervision to HFGCs; however, this study pointed out that there is poor sharing of information or weak communication between these governance structures, which causes poor performance of the HFGCs and, as a result, poor provision of health services. Despite the fact that the council health management team has the responsibility of supportive supervision to the health facilities governing committees, communication between them is not effective. Supportive supervision is one of the factors that facilitates the performance of HFGCs and the overall performance of health facilities.

Therefore, where it happens supportive supervision is not sufficient, the HFGCs' performance becomes poor, which causes the performance of the health facilities to be poor too. This was also observed in the study conducted by Padarath and Friedman in South Africa (2018) that there was no evidence that clinic committees, hospital boards, or district health councils had cohesive and coordinated communication procedures. Also, there is no evidence that there were any systems in place to allow lateral communication across the governing institutions.

4.3.2 Motivation Provided by the Government to the HFGCs

The study identified different factors motivating the HFGCs, including financial incentives, Training, recognition in decision making and communication. The researcher assessed each of the factors and recognised that the HFGCs are not satisfied and hence, less motivated. Through data analysis, the results revealed that there is low motivation provided by the government that lowers the performance of the HFGCs; as a result, poor provision of health services and dispensaries.

A financial incentive is a very important motivational factor; however, the study identified that the HFGCs members complained about the lack of allowances provided to them, which de-motivates them that leads to lower commitment and poor performance. Similar to the study of Joseph and

Maluka (2017) in the Iringa district Tanzania. that the HFGCs did not get the allowance immediately after the meeting. Sometimes the payment was delayed until the other meeting, which largely affected the morale of the committee members. Therefore, the government should find a way to ensure that the HFGCs members are provided with financial incentives such as allowances.

Also, the HFGCs members mentioned training to be a motivating factor; however, the results indicated that there is a lack of training provided to them on their roles. As a result, the HFGCs members have low capacities in carrying on different roles. This is to say that the HFGCs need more training to ensure that they are motivated by improving their capacities in different roles provided to them. These results are contrary to the study conducted by TARSC, et al. (2014) in their study on HFGCs in Sub-Saharan Africa, who discovered that some communities use interactive training methods while others gather together two or three HFGC representatives from a number of HFGCs in a district to train at the district level.

However, it is similar to this study as it reveals that the training has been described as irregular, with a shortage of resources and trainers, rules on how and what to train in only a few countries, challenges scaling up training to a large number of HCCs, and the topic of the training often chosen by external sponsors (TARSC, et al., 2014).

Moreover, health facilities governing committee members are de-motivated by less recognition in the decision-making of health-related issues, which has been observed through negative attitudes from health staff concerning the ability of HFGCs to make such decisions. This is to say that the HFGCs are given few chances when it comes to making important decisions on different health matters. As a result, HFGCs get de-motivated and hence have low performance. This is in line with the study of Maluka and Bukagile (2015) in their study on community participation in the decentralised health systems in Tanzania revealed that the health committees' influence on policy,

planning and budgeting was limited. Moreover, inadequate training and low public awareness affected the performance of the committees. Therefore, the government should work hard to ensure that the HFGCs are given a chance to participate in providing different ideas during decision-making since it motivates them to effectively perform their functions and hence better provision of health services.

Furthermore, communication as one of the identified motivation factors is weak across the health systems. This, as a result, hinders the effective sharing of information among different structures, including HFGCs, CHMT, health facilities (health centres and dispensaries) and the community. Weak sharing of information has led to poor performance of HFGCs as well as poor provision of health services (Kesale, Mahonge&Muhanga, 2021). Therefore, the government, through different communication channels, should ensure that there is effective communication or sharing of information among HFGCs and other health stakeholders.

This is to say that the performance of the HFGCs is facilitated by different motivational factors, as identified above. However, there has been less motivation provided by the government hence, hinders their performance and leading to the ineffective provision of health services in the health facilities. This is contrary to the study conducted by Waweru et al. (2013) on health facilities management committees (HFMC) in Kenya, which revealed that HFMC members expressed high levels of motivation and job satisfaction.

4.3.3 Government Support Provided to the HFGCs

The research findings identify the support provided by the government to be financial support and supportive supervision. However, through the assessment of the identified support indicators, there was less support provided by the government. The delay of funds was one of the strong constraints that hindered the completion of different projects initiated by the HFGCs. Also, weak supportive

supervision by the CHMT was identified due to a number of factors, such as inadequate human resources and poor coordination of supervision activities.

This means that government support is indeed essential to ensure that the health facilities governing committees perform their functions as required for better provision of health services in the health facilities. Therefore, more effort is required by the government to increase the support provided to the health facilities governing committees for better provision of health services in health centres and dispensaries. Hence government support provided to the HFGCs should be strengthened to improve their performance.

These results line up with the study of Kessy (2014), which concluded that the ability of HFGCs to deliver on their roles and responsibilities was also affected by the prevalent health systems issues which HFGCs have no immediate control over and do not have solutions for them; hence they needed more support from the government. Moreover, Pancras (2016) identified inadequate financial resources as a challenge whereby the HFGCs had insufficient funds for implementing their activities. Though the health department had several sources of funds, only a few sources were allowed to implement the HFGCs activities.

4.4 Chapter Summary

This chapter aimed to present and discuss the study findings in relation to the research objectives as the main themes of the study. These objectives included identifying the kinds of communication channels used in sharing information, the kinds of government motivation provided to HFGCs and the kinds of government support provided to the HFGCs.

The results identified meetings as the most used communication channel used by the HFGCs to communicate with themselves and other health stakeholders; however, the meetings are also

ineffective. Other communication channels, such as normal phone messages, suggestion boxes and phone calls, are rarely used to share information. Therefore, the HFGCs face challenges in sharing information due to weak communication, which causes low performance of HFGCs and, as a result, poor provision of health services.

Moreover, the study findings revealed that there is low government motivation provided to the HFGCs by considering different factors, including financial incentives, training, recognition in decision making and communication. Hence, less motivation has led to low performance of health facilities governing committees.

Furthermore, the findings revealed that the government support provided to the HFGCs is weak. The researcher identified supportive supervision and financial support as the support provided by the government, although at a low rate. This hinders the performance of HFGCs and hence, poor provision of health services.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter explains, in summary, the research study process and results, conclusions as well as recommendations. This study aimed to evaluate the challenges faced by health facilities governing committees in Tanzania, particularly the health centres. This study included four health centres in the Busega district. The problem that triggered the undertaking of this research is the poor performance of the health facilities governing committee, which has led to poor provision of health services in health centres in Tanzania. Therefore, this study intends to solve this problem.

Moreover, different studies have been conducted by different scholars on the functioning of health facilities governing committees; however, the problem of poor performance of the health facilities governing committees is still existing. Therefore, there was a need to conduct research on health facilities governing committees to identify the challenges that are facing the health facilities governing committees towards the better provision of health services in health centres and dispensaries. Specifically, identifying the kinds of motivation provided by the government to the health facilities governing committees, communication channels for sharing information and the kinds of support provided by the government to the health facilities governing committees.

Therefore, this study is significant in improving the performance goal of health facilities governing committees by identifying the challenges facing them and hence, helping the government and other decision-makers find a way to solve the challenges and improve the provision of services in the health facilities.

5.2 Summary of the Study and Conclusions

5.2.1 Summary of the Study Process

This study employed a case study design that allowed the collection of both primary and secondary data at the same time, resulting in a snapshot of ideas, views, and data. Because the case study design was less expensive, it allowed the researcher to work with the limited resources available. In addition, the case study design helped the researcher to complete the research in a short amount of time. The study was conducted in 4 health centres in the Busega district.

Moreover, the qualitative approach used enabled the researcher to gain much data as possible from a relatively small sample size and allowed flexibility since opinions can change and evolve over the course of conversation and hence the researcher can capture this. However, some quantitative aspects were used. The total population in the study was 332 people, including health facilities governing committees' members, CHMT members, health staff and community members.

Furthermore, This study used non-probability sampling techniques to select the study respondents, including purposive sampling and accidental sampling techniques. The sample size was 46 respondents. In this study, primary data collection methods were used for the purpose of obtaining information from the participants of the study. The primary data collection method that was used included the interview method and focused group discussion. Also, Secondary data collection methods such as documentary review were used. The researcher reviewed relevant documents in order to access accurate and reliable data. Thematic analysis and content analysis were used to analyse the data collected.

5.2.2 Conclusions

This study was set forth with the aim of evaluating the challenges that are facing the health facilities governing committees. The study conducted included four health centres in the Busega district. The study included three specific objectives; 1. To identify the kinds of communication channels used in sharing information towards the provision of better health services in selected health centres in the Busega district, 2. To find out the kinds of motivation provided by the government to the HFGCs towards the provision of better health services in selected health centres in the Busega district, 3. To examine the kinds of government support to the HFGCs towards supervision of Health centres' provision of better health services in the Busega district. The study used these objectives to determine what challenges were facing the health facilities governing committees that caused their underperformance, which was observed through the poor provision of health services in the health facilities.

5.2.2.1 Conclusion on the kinds of communication channels used in sharing information towards the provision of better health services in selected health centres in the Busega district.

Results from the respondents reported that many health facilities governing committees have been using single communication channels, particularly meetings, which are supposed to be done four times in each quarter for every financial year. On the other side, a few health facilities governing committees are using multiple channels of communication in sharing information among the health facilities governing committees; these methods include meetings, phone calls and normal phone messages. Furthermore, the HFGCs members revealed that the meeting is not sufficient to be used in sharing information among the HFGCs members; other methods should also be used to ensure

efficiency in communication. Despite the fact that meeting is the most used communication channel; the HFGCs are not undertaking the meetings as required

Moreover, There is weak communication between the HFGCs and the community, as identified from the results. HFGCs have been communicating with the community through general community meetings; however, the participation of the community members in the general meetings is poor. This reveals that there is an ineffective sharing of information between the HFGCs and the community, which has been caused by different factors. Also, this study pointed out that there is poor sharing of information or weak communication between these governance structures, which causes poor performance of the HFGCs and, as a result, poor provision of health services. Weak communication between CHMT and HFGCs reveals that there is weak supportive supervision by the CHMT to the HFGCs. Therefore, when supportive supervision is not sufficient, the HFGCs' performance becomes poor, which causes the performance of the health facilities to be poor too. Therefore, the results revealed that communication channels are used to share information between the health facilities governing committees and other health stakeholders. Hence, the government should strengthen communication channels and ensure the use of multiple communication channels.

a) 5.2.2.2 Conclusion on the kinds of motivation provided by the government to the HFGCs towards the provision of better health services in selected health centres in the Busega district.

The results of the study determined the kinds of motivation provided by the government through the assessment of different factors, including financial incentives, Training of HFGCs members, Recognition and communication. On assessing the training provided, the results revealed that there was less training conducted in the financial year of 2021/2022. On the other hand, the analysis of

data revealed that the government does not provide sufficient allowances to HFGC members. As a result, the health facilities governing committee members become de-motivated in performing their functions. Also, the findings of the study revealed that there is low recognition of HFGCs, especially in decision-making, which has been leading to less motivation in many situations that require decision-making concerning these health-related issues. The HFGCs have not been consulted due to the negative attitude that exists concerning their ability to make decisions. Moreover, the results revealed that there is weak communication existing in the system that de-motivates the health facilities governing committees since they need to receive timely information for them to perform their roles effectively. Therefore, through these results, it can be concluded that the HFGCs members are less motivated by the government, which leads to their underperformance; hence, the government should ensure that the health facilities are governing committees.

b) 5.2.2.3 Conclusion on the kinds of government support to the HFGCs towards supervision of Health centres' provision of better health services in the Busega district.

The results revealed that the government provides financial support as well as support supervision. This is because the support at a low level that does not satisfy the functioning of the health facilities governing committees. The supportive supervision from the CHMT was weak, which was caused by poor coordination of supervision activities and inadequate human resources. The support provided by the government is not satisfactory. Therefore, more effort is needed to ensure that the government supports the health facilities governing committees to effectively ensure the performance of health facilities governing committees is improving for the provision of better services.

5.3 Recommendations

5.3.1 Policy Implications

Health facilities governing committees are among the results of decentralisation in the health sector. These are important to ensure the community's contribution to health planning, strengthening the decentralised health systems and improving the delivery of services (McCoyetal, 2012). The policy can be improved by observing the following issues:

a) The policy should emphasise strengthening and the use of multiple communication channels used in sharing information between the health facilities governing committees and other health sector stakeholders. This is because effective communication channels improve the timely sharing of information that may result in the effective implementation of different decisions made pertaining to health matters in health facilities.

b) There is a need for the government to review the policies on how they can motivate the health facilities governing committees in different ways, such as by providing allowances, including communication allowances and meeting allowances. Moreover, the government should consider providing training to these members of health facilities governing committees for the purpose of improving their capacities.

c) Collaboration between the government structures (CHMT and HFGCs) as well as health facilities governing committees and other health stakeholders such as the community and the health facilities (health staff) should be strengthened. This collaboration will ensure teamwork among the stakeholders, as a result, effective implementation of health sector plans and strategies.

d) The policy should emphasise public awareness creation concerning the health facilities governing committees. This is because the health facilities governing committees represent

the community through decentralisation. Therefore, this will strengthen the communication and relationship between the health facilities governing committees and the communities. Moreover, it will enhance the accountability and responsiveness of the members.

e) The policy should clearly state the monitoring and evaluation strategies for policy practice implementation achievement for better provision of health services in the health facilities, particularly primary health facilities where these structures (HFGCs) operate.

f) Immediate measures should be taken to solve the identified challenges that are hindering the performance of the health facilities governing committees and the poor provision of health services in primary health facilities.

g) Policymakers should develop other related policies to ensure the strengthening and improve the functioning of health facilities governing committees. This will help to reduce the challenges hindering the performance of the health facilities governing committees and strengthen the decentralisation system in the health sector in Tanzania as it was intended.

h) Emphasis on positive attitudes and beliefs towards the health facilities governing committees. This will eliminate the negative attitude existing in a society that the health facilities governing committees' members do not have the capacity to make important health-related decisions. Thus, collaboration among the health stakeholders will be strengthened, which will lead to improved performance of the health facilities governing committees and better provision of health services.

5.3.2 Recommendations for Further Research

a) This study aimed to assess the challenges facing the health facilities governing committees in performing their functions in Tanzania, specifically in the Busega district. The researcher suggests that further studies (research) be done on the strategies to

overcome the challenges facing the health facilities governing committees which have been revealed in this study and other studies.

b) The current study was done in a small area; therefore, there is a need for research on The challenges facing the health facilities governing committees towards the provision of health services in Tanzania that would cover a wider geographical area. Therefore, from the findings of this study, a survey study may be carried out that will use a larger sample size and wider geographical coverage in order to for generalised findings.

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APPENDICES

General Information

Topic: Assessing the challenges facing the Health Facility Governing Committees in ensuring the provision of better health services in Tanzania: A Case of health centres in Busega District.

Introduction

Dear Respondent,

My name is Ludia Mtebe. I am a master student of the Institute of Accountancy Arusha. I am pursueing a degree of Master of Business Administration in Leadership and Governance (MBA-LG). I am conducting research on the challenges facing the Health Facility Governing Committees in Tanzania: A Case Study of Busega District Council. The purpose is to enable the researcher to fulfil the requirements as required by the Institute of Accountancy of Arusha.

In the following questions, I would like to know your opinions about the topic through your participation by answering the questions which follow. Your responses will be anonymous, and the data collected will be collectively analyzed as a whole and treated as confidential for academic purposes only.

My mobile phone numbers are; +255 754603281.

Your participation in this study will be greatly appreciated.

APPENDIX I: Interview Guide

PART A: HEALTH FACILITIES STAFF

1. For how long have you worked in this Health facility?
1. Does your health facility have an HFGC?
2. How many members are available in your HFGC
3. Do you interact with the HFGC?
4. Do you think it is important to have the HFGC in your health facility?
5. Are there any challenges facing the HFGC?
6. What are the channels of communication used to share information between your facility and the stakeholders?
7. Are there any communication problems experienced between the facility and the stakeholders?
8. Is the government supporting the HFGCs? Give reasons for your answer.
9. What is your advice on what should be done to improve service provision in your facility through the supervision of HFGC?

PART B; COUNCIL HEALTH MANAGEMENT TEAM MEMBERS

1. For how long have you been working at the capacity of CHMT?

2. For how long have you worked in this District Council?

3. What are the roles of HFGCs? Mention the strong five you know.

4. Is there any training conducted by the District level to HFGCs on their roles?

5. How does your office interact with the HFGCs in implementing health decisions?

6. How do you build the capacity of HFGC members in the District Council?

7. From your experience, what are the common problems faced by HFGCs in the course of accomplishing their roles? Mention the four major problems they faced.

8. How is information shared among the government, health facilities and the HFGCs?

9. How does the government support the HFGCs to ensure better provision of health services in the health centres?

10. In what way is the government motivating the HFGCs towards the improvement of better services in health centres?

11. In your opinion, what do you think should be done to improve the performance of HFGCs?

APPENDIX II: Focused Group Discussion for HFGC Members

Background Information

(a) Name (optional) ……………………………………………........................... (b) Gender (male/female) ……………………………….............................. (c) Age ……………………………………………………….......................... (d) Level of education …………………………………...................................

(ii) Questions for Focus Group Discussion

1. How long have you been a member of this committee?
2. As a member of the HFGCs, can you tell me how often you managed to attend committee meetings for the financial year that ended in June 2015?
3. How is information shared among the HFGC government, health facility and other stakeholders?
4. How does the government support the HFGCs to ensure better provision of health services in the health centres?
5. In what way is the government motivating the HFGCs towards the improvement of better services in health centres?
6. In your opinion, what do you think should be done to improve the performance of HFGCs?
7. Are there any communication problems experienced between the facility and the stakeholders?
8. From your experience, what are the common problems faced by HFGCs in the course of accomplishing their roles? Mention the major problems they faced.
9. In your opinion, what do you think should be done to improve the performance of HFGCs?

APPENDIX III: Work Plan and Budget

Work Plan

No.	ACTIVITY	DURATION 2022							
		April	May	June	July	Aug	Sept	Oct	Nov
1.	Preparation of Research Proposal, Questionnaire and Submission of Research Proposal								
2.	Pilot study and Questionnaire Testing								
3.	Fieldwork and Data Collection								
4.	Data Processing and Analysis								
5.	Dissertation writing and Submission								

Source: Study Plan, September 2020

Budget for the Study

Budget	Items Details	Cost (Tsh)
Research proposal preparation	Stationary (pens, reams, pencils, drafting papers, notebooks, flash disks and CDs) and internet costs	80,000/=
	Questionnaire and interview guide preparation	50,000/=
	Sub Total	130,000/=
Pilot study	Transport to and from the study area	25,000/=
data collection		100,000/=
Data processing and report writing	Data entry, cleaning and editing	60,000/=
	Correction of report	30,000/=
	Printing and photocopy	100,000/=
	Hardcover binding	50,000/=
	Sub Total	240,000/=
	Grand total	495,000/=

Source: Study Plan, September 2022

Institute of Accountancy Arusha

P.O. Box 2798, Njiro Hill, Arusha, Tanzania
Telephone: +255 27 2970232 Mobile: +255 763 462109 Telex: 50009 IAA TZ
Fax: +255 27 2970234 Email: iaa@iaa.ac.tz Website: www.iaa.ac.tz

Ref. No.: MBA-LG/0024/2021 **27nd JUNE 2021**

DIRECTOR,
BUJEGA DISTRICT COUNCIL,
P.O.BOX 157,
BUJEGA - SIMIYU

Dear ~~Sir~~/Madam,

RE : REQUEST FOR DATA COLLECTION

The purpose of this letter is to introduce to you **Ms. LUDIA JOSEPHALES MTEBE** who is our student pursuing Masters of Business Administration in Leadership and Governance (MBA-LG/0024/2021). Currently, the aforementioned student is conducting a study on **"CHALLENGES FACING HEALTH FACILITIES GOVERNING COMMITTEES IN ENSURING PROVISION OF BETTER HEALTH SERVICES IN TANZANIA)"**. We would like to highlight here that this study is part of the requirement for the award of the above mentioned programme of study.

We therefore request you to extend to the above-mentioned student of our Institute any help that may facilitate her to achieve study objectives. We further request permission for her to see and talk to the staff of your Institution in connection with her study. The period for this request is granted from June to the end of August 2022.

Thank you for your continuing support.

Yours Sincerely,
INSTITUTE OF ACCOUNTANCY ARUSHA

Mishael E. Abduel
FOR: RECTOR

All Communications to be addressed to the Rector