The Accountability of Health Facility Governing Committees and its Associated Factors in Selected Primary Health Facilities Implementing Direct Health Facility Financing in Tanzania

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Abstract

Users Committees such as Health Facility Governing Committees (HFGCs) are one of the popular mechanisms used to represent communities and civil societies in holding service providers into account. This study embarked on assessing the status of accountability of HFGCs under the DHFF context in Tanzania as experienced by the supply side (HFGCs members). A cross-sectional design was employed in collecting both qualitative and quantitative data at one point in time in 32 selected health facilities. A closed-ended questionnaire, in-depth interview and FGDs were employed to collect data. Data were analyzed through descriptive statistics and Multiple logistics regression, and thematic analyses. The study found high accountability of HFGCs by 78%. specifically, HFGCs have high accountability in mobilizing the community to join community health funds 99.71%, receiving medicines and medical commodities 88.57% and timely health services 84.29%. It was reviled that the accountability of the health facility governance committee was significantly associated with the health planning aspect (p=0.0048) and financial management aspect (p=0.0045). This study concluded that the fiscal decentralization context empowers HFGCs to be accountable in accomplishing their responsibilities hence improving health service delivery in developing countries. This study recommends more efforts to be directed in supporting HFGCs addressing challenges of managing health facilities works and mobilization of resources from other stakeholders.

1. Background

Social accountability is getting popular as a strategy for addressing primary health care challenges such as poor utilization and allocation of resources, unresponsive health service delivery and ineffective and inefficient health system [1]–[3]. Social accountability is defined as *"citizens' efforts at ongoing meaningful collective engagement with public institutions for accountability in the provision of public goods"* [4]. In primary health care, this concept is derived from Alma Ata Declaration 1978 and sustained by Astana Declaration 2018 that individual, families and community participation in the management and implementation of health programs are the cornerstones for achieving Universal Health Coverage (UHC) [5]. In many developing countries, social accountability in primary health care facilities is democratically represented by Health Facility Governing Committees (HFGCs). The HFGCs are community governing structures, created to be a community, civil societies and other interest groups representatives for voicing and shaping health service delivery in community interest [6], [7]. In many developing countries these HFGCs are democratically elected by communities therefore HFGCs are directly accountable for their actions to communities [7], [8].

In a broader sense accountability relate to responsibility and responsiveness because it follows the principle of responding or being able to accomplish the given responsibilities [9]. It is all about account giving or one's obligation to justify and explain his/her conduct[8]. There are three components of accountability namely the locus of accountability (who), the domains of accountability (What) and the procedure of accountability (How). The locus of accountability entails who is being held into account or holds others accountable, in primary health care these can be nurses, incharges, patients, communities, or

community governing structures such as HFGCs [6], [10], [11]. The domain of accountability refers to the activity or devolved functions to which the person or institution can legitimately hold responsible therefore required to justify its actions [9], [10], [12]. These domains can be professional competency, community benefits of interest, professional ethics, financial performance and legal compliance. The last component is procedural accountability which entails mechanisms used to evaluate the accountability of a party [13]. These can be through formal or informal evaluation of the compliance of the locus of accountability to the devolved functions or domain or response or justification by the accountable part such as HFGC to the extent they have accomplished their assigned duties [14], [15]. After evaluation, the evaluator can decide to sanction or reward the part held into account.

Principal-Agency Theory can best be used to explain the relationship between the communities and HFGCs in primary health care facilities. the Principal-Agency Theory entails the act in which the principal is striving to maximize the value/output by engaging/delegating its responsibilities to the agents which are followed by the principal regularly monitoring or holding the agents or the agents held him/herself into account based on his/her performance [9], [14], [16], [17]. The Principal/Agent Theory marches with the accountability definition that entails the "*relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgment, and the actor may face consequences"* [9]. In the context of primary health care governance, communities, civil societies and other interest groups are Principal/Forum in which they have delegated their responsibilities to govern primary health care facilities to the HFGCs [13], [18], [19]. On the other hand, HFGCs are agents/actors that are democratically elected by the Principal or forum which is communities or interest groups. Therefore, the HFGCs should formally or informally render accounts consistently to their electorates or appointees which are communities [20].

As suggested by Bovens [9]three important elements need to be in place between the HFGCs (actor or agent) and Communities (forum or principal). That, in process of accomplishing their devolved functions and powers, HFGCs (agents) are obliged to inform the communities and other interest groups (principal) about their conducts. In the same vein, the communities and other interest groups (principal), should interrogate the HFGCs (agent/forums) and ask questions about several aspects and information relating to health service delivery in their communities or health facilities. Lastly, after hearing the response from the HFGCs, the Communities and civil societies represented by HFGCS may be in a position to pass judgment to the HFGCs. The judgment may be positive if the Communities and civil societies have judged that HFGCs are doing well, but also citizens may impose sanctions if they judge that HFGCs have failed to exercise their duties and authorities. Since citizens (communities and civil societies) elect and appoint members of HFGCs, the sanctions may be re-electing or not re-electing the HFGCs in the next term. Therefore, Justifying, explaining, reporting and sanctioning may all amount to accountability [9].

Even though the contribution of the HFGCs in overseeing the implementation of primary health care plans is appreciated by the global health community, there is limited evidence about HFGC's accountability in enforcing social accountability under fiscal decentralization [3], [9]. The existing empirical shreds of evidence have been focused on exploring the mechanism used by HFGCs to hold health providers into

account [3], [20], [21], the relationship between managerial competence, accountability and hospital board governance [8]. Furthermore, studies have shown the linkage between citizens and elected politicians [14]. Lodenstein et al [2]found that the HFGCs accountability cycle in Sub-Saharan countries is less practiced and institutionalized. Of now, several lower and middle-income countries are decentralizing fiscal powers and responsibilities to HFGCs. However, how HFGCs accomplish their devolved fiscal powers and responsibilities in primary health facilities implementing DHFF is not known. This study assesses the status of the HFGCs accountability and their associated factors in primary health facilities implementing DHFF in Tanzania

2. Methods And Approaches

The Context

As a part of Health Sector Reforms in Tanzania, HFGC was introduced in 1999 in health centers and dispensaries to represent communities and civil societies organizations in the management of health services provision in health facilities. The Council Health Service Board (CHSB) and Health Facility Governing Committees (HFGCs) guideline of 2013[22] have assigned HFGCs specific functions. These functions are participating in mobilizing financial resources, mobilizing citizens to join improved community health funds and preparing health facility plans and budgets. Additionally, managing income and expenditure of the facility, discussing community health challenges and finding their solutions, identifying communities needs and preferences. Furthermore, participating in procurement of medicine and medical commodities and participating in the construction and maintaining of health facilities infrastructures. However, several studies conducted in Tanzania to assess the accountability and performance of HFGCs since its establishment found that HFGCs were not accountable because they were not accomplishing their duties accordingly. Boex and WHO [23], [24]found that HFGCs were not effectively exercising their duties and powers because fiscal power and authorities of primary health facilities were devolved to the council levels through Council Health Management Committees (CHMT)and not HFGCs and health providers. Additionally, facility funds were deposited to the council accounts and were managed by the CHMT. Health providers and HFGCs had no control and direct access over the facility funds. To address this problem to Health Facilities and HFGCs, the government of Tanzania introduced Direct Health Facility Financing (DHFF). The DHFF is an arrangement initiated by the government of Tanzania to empower and grant HFGCs and primary health facilities autonomy to plan, budget and manage facility finance to improve health services delivery [18]. It uses the world Direct Health Facility Financing (DHFF) because the funds from multiple sources are directly sent to the public primary health facility bank account. This form of fiscal decentralization is widely implemented in all public primary health facilities in Tanzania. The DHFF implementation started in the fiscal year 2017/18 in all district councils in Tanzania.

Despite introducing fiscal decentration through DHFF in all public primary health care facilities to empower HFGCs to have fiscal and decision-making powers in the course of overseeing the health facility delivery, the status of HFGCs accountability in primary health facilities implementing DHFF is not known.

Indeed, there is no consensus and parameters established to measure the accountability of HFGCs in the process of managing and implementing health plans and operations to improve the quality of health service provision. This study, therefore, is dedicated to establishing an accountability index for HFGCs and then after use those indices to measure the accountability of HFGCs in improving the quality of health services under DHFF.

Research Design

The study employed a cross-sectional design in which both quantitative and qualitative data were collected simultaneously in selected health facilities from four regions implementing DHFF.

Sample Size and Sampling Techniques

This study used both probability and non-probability sampling procedures to select the representative sample from the population [25]. A multistage sampling technique was employed to select the study units. The selection was based on Star Rating Assessment which was conducted in early 2018 the same year DHFF implementation started. The main focus of the star rating assessment was to measure the performance of health facilities and provide feedback for improvement. Health facilities performance ware measured based on the average scores of established indicators (0-19% no star or 0 stars, 20-39% 1 star, 40-59% 2 stars, 60-79% 3 stars, 80-89% 4 stars and 90-100% 5 stars) [26]. The acceptable or minimum performance set by the government to all facilities was 3 stars (Yahya and Mohamed, 2018). Within the star rating assessment report, one of the areas assessed was social accountability (Service Area 8) in which the functionality of HFGCs was assessed and HFGCs with low and high functionality were indicated. The selection started by purposive selecting Four regions, two high performing regions (Mbeya and Kilimanjaro) which the majority of their HFGCs have been rated 3 stars and above and other two low performing regions (Ruvuma and Songwe) which the majority of their HFGCs were rated below 3. Stage two involved the selection of a council with low HFGC performance and a council with high HFGCs performance from each selected region. In this state, eight councils were purposively selected. The third stage involved the selection of 4 health facilities from each selected council selected in the second stage. In each council, health facilities were stratified based on the type of health facilities (Dispensary and health centre). Then two health centers (a high and low performing HFGC) and two dispensaries (a high and a low HFGC performing HFGC) were selected based on the star rating assessment. In the event where there is one health center in the council then a dispensary of the required characteristics was selected. A total number of 16 high-performing health facilities and 16 low-performing health facilities according to the star rating assessment of 2018 were selected making a total of 32 health facilities for the study. From 32 selected health facilities, their HFGCs were selected as the unit of inquiring of this study. The fourth stage involved the selection of respondents from each HFGC committee selected in stage three.

Data Collection

To determine the accountability status of HFGCs under DHFF both quantitative data and qualitative data collection methods were employed. A closed-ended structured questionnaire based on the designed

accountability index which corresponds to assigned functions of HFGCs were used to collect data from members of HFGCs. The data collection software (database) was created by using Open Data Kit software (ODK). Then all data collected were entered in the ODK. A mobile data collection (MDC) quantitative approach was employed to collect data. After data was collected through mobile phones then were sent to the central server. Four research assistants attended three days of training on mobile data collection skills and techniques which was followed by pre-testing of the imparted skills in selected facilities that were out of the study area. The data collected were sent to the researcher through the ODK platform. As a part of quality control, all selected facilities had GPS coordinates therefore all research assistants used tablets that had GPS sensors. The response rate for HFGCs who filled the questionnaire was 280 respondents out of 288. A total number of 32 In-depth interviews with the HFGC chairpersons were conducted to assess HFGC accountability. The interview guide having an accountability index was used to interrogate the HFGC chairpersons. Focus Group Discussion (FGDs) was also employed to collect qualitative data too in which a total number of 32 focus group discussions composed 6 to 9 HFGC members. Interviews and FGDs were conducted in health facilities selected for this study.

Data Analysis

The accountability of HFGCs was measured through descriptive statistics and Multiple Logistic regression analysis to assess whether HFGCs act to accomplish their functions or not. Predictors of accountability such as availability of price list, suggestion box, minutes of the meeting, evidence on communication between HFGC and community were assessed to determine the accountability of HFGCs. Qualitative data analysis of interviews and FDGs was conducted through thematic analysis. The analysis of the data recorded through audio started by defining or selecting parts of the recorded audio which were related to the accountability index of HFGCs. Then transcription of the selected parts of the audio-recorded interview and FDGs was done. After transcription, the statement of text showing the feelings and experience of the HFGCs in accomplishing their duties on the implementation of DHFF, the response of the participants was analyzed through the guidance of Principal agency theory. Therefore, the statement relating to the experience of HFGC members' participation in different functions of HFGC was analyzed to determine the accountability.

Ethical Approval and Informed Consent

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

3. Results

The demographical profile consisted of 280 respondents who were members of the HFGCs from four regions. the Respondents were categorized into type of health facility, their position in the HFGC, age in terms of years, sex and their educational level. for more details see Table 1.

Table 1
Demographic characteristics of HFGs members

Variable	Frequency	Percent
Type of Health Facility		
Dispensary	116	57.43
Health center	86	42.57
Position		
Chairperson of HFGCs	28	13.86
Secretary of HFGCs	25	12.38
Member of the HFGC	149	73.76
Age		
<30	25	12.38
31-45	75	37.13
46-60	74	36.63
61+	28	13.86
Sex		
Male	101	50.00
Female	101	50.00
Education level		
Primary	107	52.97
Secondary	46	22.77
Certificate	23	8.91
Diploma	18	11.39
Advanced diploma	3	1.49
University degree	5	2.48

Table 2
Perceived Accountability of HFGCs in the public primary health facilities Implementing DHFF in Tanzania

Statement on the extent HFGC accomplish their Responsibilities	High Acc N (%)	Low Acc N (%)
Our HFGC communicate with other stakeholders to identify their health challenges and needs	150(53.57)	130(46.43)
Our HFGC has established collaboration with other development partners to work together in providing services to the community	201(71.79)	79(28.21)
Our HFGC convene meeting with Facility Health workers to discuss different issues of our facility	222(79.29)	58(20.71)
Our HFGC ensure Health facility progressive reports are presented in the HFGCs meetings	227(81.07)	53(18.93)
Our HFGC ensure that health facility resources match patients or Community needs	214(76.43)	66(23.57)
Our patients receive timely care when they attend our health facility	236(84.29)	44(15.71)
Our facility progressive reports are presented to the Ward Development Committee/ Village Council	224(80.00)	56(20.00)
Our HFGC authorize the use of funds as budgeted	230(82.14)	50(17.86)
Our HFGC ensures facility funds are used as per financial guidelines	229(81.79)	51(18.21)
Our HFGC ensure financial reports are provided quarterly and comply with the reporting systems	227(81.07)	53(18.93)
Our HFGC endorse and participate in the procurement process of all goods and services of the health facility	225(80.36)	55(19.64)
Our HFGC participate in the planning and budgeting process	229(81.79)	51(18.21)
Our HFGC participate in receiving medicines and goods procured by our facility	248(88.57)	32(11.43)
Our HFGC do take make a recommendation on staff motivation, recruitment and training to the Council Health Service Board	122(43.57)	158(56.43)
Our HFGC ensure income and expenditure are known to the community quarterly	188(67.14)	92(32.86)
In our health facility, the suggestion box is available in a location where it can be seen by the patients	203(72.50)	77(27.50)
In our health facility, the price list for services provided is displayed to the extent that can be seen by the patients	192(68.57)	88(31.43)
Our HFGC participate in mobilizing the community to join improved community health funds	254(90.71)	26(9.29)

Statement on the extent HFGC accomplish their Responsibilities	High Acc N (%)	Low Acc N (%)
In our health facility, the Mobile number and names for complaints are displayed to the location where they can easily be seen by users	214(76.43)	66(23.57)
The client service charter of our facility is displayed on the location where it can easily be seen and read by the health service users	176(62.86)	104(37.14)
Overall accountability	**220(78.57)**	**60(21.43)**

Table 2 indicates the result of the perception of HFGCs members on the HFGCs accountability in the public primary health facilities implementing DHFF in selected Councils in Tanzania. generally, the result indicates that the members of HFGC perceive that HFGCs have high accountability for 78.57% and 21.43 low accountability. Specifically, it is perceived that HFGCs are more or have high accountability in mobilizing communities to join Improved Community Health Funds, Receiving medicine, medical commodities and goods, ensuring patients receive timely care in their facilities and authorizing funds as per budget. Meanwhile, HFGCs have been found to have low accountability on staff motivation, recruitment and training issues, communicating with stakeholders to identify health challenges and ensuring client services charter is effectively used in the health facilities.

Factors associated with the accountability of health facility governance committee

Table 3
Binary logistic analysis for factors associated with the accountability of HFGCs

Variable	High	Low	Unadjusted		Adjusted	
	N (%)	N (%)	OR[95%CI]	p-value	OR[95%CI]	p-value
Type of Health Facility						
Dispensary	124(77.02)	37(22.98)				
Health center	96(80.67)	23(19.33)	1.25[0.69, 2.24]	0.4619		
Position						
Chairperson	35(81.40)	8(18.60)	ref			
Secretary	30(88.24)	4(11.76)	1.71[0.47, 6.26]	0.4148		
Member of the HFGC	155(76.35)	48(23.65)	0.74[0.32, 1.69]	0.4752		
Age						
<30	21(65.63)	11(34.38)	ref		ref	
31-45	72(72.00)	28(28.00)	1.35[0.58, 3.15]	0.4923	1.69[0.46, 6.24]	0.9151
46-60	93(86.92)	14(13.08)	3.48[1.37, 8.74]	0.0080	3.13[0.72, 13.59]	0.8366
61+	34(82.93)	7(17.07)	2.54[0.85, 7.59]	0.0939	0.49[0.09, 2.59]	0.6903
Sex						
Male	108(77.70)	31(22.30)	ref			
Female	112(79.43)	29(20.57)	1.11[0.63, 1.96]	0.7236		
Education level						
Primary	115(76.67)	35(23.33)	ref		Ref	
Secondary	51(79.69)	13(20.31)	1.19[0.58, 2.45]	0.6279	1.06[0.35, 3.22]	0.9151
Certificate	17(70.83)	7(29.17)	0.74[0.28, 1.93]	0.5363	0.86[0.19, 3.75]	0.8366
Diploma or above	37(88.10)	5(11.90)	2.25[0.82, 6.17]	0.1143	1.36[0.29, 6.19]	0.6903

Variable	High	Low	Unadjusted		Adjusted	
Governance						
Poor	25(35.21)	46(64.79)	ref		ref	
Good	195(93.30)	14(6.70)	3.06[1.22, 7.65]	0.0169	1.05[0.26, 4.19]	0.9461
Participation in Health Planning and Budgeting						
Not good	35(41.67)	49(58.33)	ref		ref	
Good	185(94.39)	11(5.61)	25.6[12.4, 53.12]	<.0001	5.46[1.68, 17.77]	**0.0048**
Participation Financial management						
Poor	33(41.25)	47(58.75)	ref		ref	
Good	187(93.50)	13(6.50)	23.55[11.2, 49.7]	<.0001	5.33[1.68, 16.89]	**0.0045**
Partcipation Procurement process						
Poor	56(53.33)	49(46.67)	ref		ref	
Good	164(93.71)	11(6.29)	20.49[10.0, 41.9]	<.0001	2.84[0.85, 9.46]	0.0893
Informational reports						
Poor	114(66.67)	57(33.33)	ref		ref	
Good	106(97.25)	3(2.75)	13.05[6.34, 26.8]	<.0001	1.42[0.43, 4.66]	0.5662
Participation Human resources management						
Poor	186(76.54)	57(23.46)	ref		ref	
Good	34(91.89)	3(8.11)	3.47[1.03, 11.72]	0.0450	1.63[0.59, 4.53]	0.0866
Important management aspects						
Poor	57(57.89)	8(42.11)	ref		ref	
Good	209(80.08)	52(19.92)	2.92[1.12, 7.63]	0.0285	0.78[0.19, 3.29]	0.7392
Level of Health Facility performance						

Variable	High	Low	Unadjusted		Adjusted
Low performance	102(76.12)	32(23.88)	ref		
Good performance	118(80.82)	28(19.18)	1.32[0.75, 2.34]	0.3389	

As stated above in the methodological section binary logistic regression was used to assess factors associated with accountability results are presented in Table 3. It was reviled that the accountability of the health facility governance committee was significantly associated with the health planning aspect (p=0.0048) and financial management aspect (p=0.0045). Concerning the health planning aspect, the result showed health facility governance committees who had good planning were significantly more likely to have high accountability as compared to their counterpart (AOR=5.46, p=0.0048). As compared to those committee members who had poor financial management those members who had good financial management were more likely to have high accountability [(AOR=5.33, p=0.0045), Table 3.

4. Discussion

This study embarked on assessing the perceived accountability of HFGCs in primary health facilities implementing DHFF among selected councils in Tanzania. The findings have revealed that the HFGCs members perceive that the HFGCs have high accountability in the primary health facilities under DHFF Tanzania. is it was found that the general accountability of HFGCs is high represented by 78%. This result is in line with the results that were found in Kenya after the introduction of fiscal decentralization through direct facility financing (DFF) HFGCs where the ability to accomplish their responsibilities was found to be good [21]. In Tanzania, a similar result has been found in the study conducted by Mwakatumbula in Tanzania to assess the impact of DHFF in primary health facilities as it has been found that community autonomy and participation in the management of HFGCs is high under the DHFF context [27].

The accountability of HFGCs has been found to be significantly associated with participation in the planning process of the comprehensive health facility plan and their participation in the procurement process of the health facility. The participation of HFGCs in the planning has a big advantage as the promise for community representation in the planning process. It is through the planning process where community challenges can be accommodated and an action plan for addressing them be made and budgeted. Indeed participation of HFGCs in the planning process helps HFGCs introduce interventions for addressing community challenges. A similar result was found in Kenya during the introduction of DFF as it was observed high participation of HFGCs in the planning and budgeting process [28]

Specifically, HFGCs have been found to have high accountability in the issues such as participation of the HFGCs in mobilizing communities to join community health funds, financial management, procurement and receiving medicines and medical commodities. This is the kind of empowerment which have been devolved to the HFGCs. In some other developing countries such as Burundi, it was found that despite fiscal decentralization still, HFGCs were not able to use their powers to mobilize facility resources [29]. However, in other countries, fiscal decentralization facilitated HFGCs to expand the functionality and

responsibilities because they were made responsible for all matters relating to services provision including soliciting finances to fund facility operations [30]–[32].

Both qualitative and quantitative findings have found high accountability in the participation of HFGCs in resource management in primary health facilities implementing DHFF. Respondents have cited the reason for high participation as caused by the powers and autonomy which have been provided by the DHFF arrangement [33], [34]. Through questionnaires, interviews and FGDs for instance, HFGC members have revealed that they have been dealing with making sure financial practices comply with financial regulations, expenditure base on the budget and facility plan. This result is in line with other studies conducted in assessing whether DHFF improved performance in primary health facilities in Tanzania, it was found that community ownership and autonomy have increased to the extent that community health structures such as HFGCs are monitoring health serviced provision [35]. In the coast region in Kenya fiscal decentralization through DFF was found also to have increased the accountability of HFGCs in financial management even though in some other facilities still HFGCs were not able to account for the devolved fiscal powers due to a lack of understanding of their roles [36], [37].

The accountability of HFGCs also has been seen to be contributed by the participation of HFGCs in the procurement process. It has been revealed that under DHFF, HFGCs do participate in the whole process of procuring goods such as medicines, medical equipment, building materials, and other services required by the facilities as shown in the health facility plan and budget. Indeed it has been found that HFGCs are fully responsible for endorsing all finances for procurement purposes and also they accountable for making sure they see and receive what has been procured. This has increased transparency in the management of health facilities. As it was found in the study conducted in India that procurement/logistics stands as important input in the health system performance therefore when important units such as HFGCs are accountable for the assigned roles within the procurement process guarantees effective health service delivery [38]. However, due to low educational level and understanding, some other members felt that health workers are still dominating the procurement process even in their presence because of the education level and wider understanding of health matters. This also was reported in Nepal where HFGCs' participation in the management of health facility operations was characterized by manipulation by health workers and powerful elites [39].

Despite high accountability perceived by HFGC members in many accountability indexes, also members have perceived HFGC have low accountability in managing health workers and communicating with other stakeholders. Low accountability of HFGCs in managing health workers is contributed by the fact that the management of health workers is still centralized to the councils and national levels. Recruitment, training and salary payment in the health sector are not controlled by the health facilities rather than council and national level. HFGCs are just dealing with controlling complaint issues relating to a specific health worker. However, that should not be an excuse for HFGCs because the health facility guideline of 2003 has mentioned that HFGC is responsible for managing facility workers. The study conducted in Tanzania some years back also did find that HFGC had fewer powers to control health workers[40].

Additionally, HFGCs accountability in communication with other stakeholders apart from the community is low. It was expected that HFGCs would link other stakeholders such as the private sector, civil societies and other Non-Governmental or Faith-based societies to contribute to the development of primary health facilities in their particular areas. However many HFGCs seem to have maintained the communication with communities members only. Through FGDs, HFGC members agreed that they have not done enough to mobilize other stakeholders to fund primary health facilities. This is in line with studies conducted in other developing countries as it was revealed community participation in primary health care has failed to cover a wider range of stakeholders to the extent that some groups are left behind [41]–[43].

5. Conclusion

This study offers important feedback to the policymakers and development partners seeking to improve the accountability of community health structures in primary health care in developing countries. Fiscal decentralization through DHFF provides a better environment for HFGCs to accomplish their devolved responsibilities which results in accountable community health structures. External and internal support is still needed to build a more comfortable/conducive working environment for health facilities such as defining the roles of HFGCs in managing facility health workers through legal frameworks. Building the capacity of HFGCs in carrying out their specific functions and sensitizing them on the depth of their powers and autonomy in managing primary health care facilities. All these will help to elevate the accountability of HFGCs in areas where they have been found to have low accountability.

Declarations

Availability of Data and Materials

All data generated or analysed during this study are included in this published article

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Contribution

AK and MM were responsible for the conception of this study, research design, data collection, data analysis and writing the final draft. CM was responsible for the overall leadership of the team (setting the direction and planning) and the review of every part of the manuscript. All authors were responsible for the recruitment of research assistants and review of the final draft for submission.

Ethical Declaration and Informed Consent

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

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