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Spotlight
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Health Facility Committees: Are they working?

Introduction

Health Facility Governing Committees (HFGCs) were first introduced in 1999, within health facilities of all levels of the health system alongside the introduction of the Community Health Fund (CHF). CHF is a voluntary scheme for rural populations, providing primary and, in some cases, secondary care in public facilities.

The committees typically consist of five members from the community and three appointed members (the health facility in-charge, a member of the village government committee and Ward Development Committee). The committees meet four times a year.

The main roles of the committee, according to the Ministry of Health and Social Welfare (2001) are to:

- Develop the plans and budget of the facility.
- Mobilise the community to contribute to the CHF and ensuring the availability of drugs and equipment.
- Responsible for reporting health provider employment and training needs to the district council, and ensuring their availability at the facility.
- Liaise with Dispensary Management Teams (DMT) and other actors to ensure the delivery of quality health services.

Study background

A case study was carried by IHI researchers in Ulanga district in the study areas that were selected to provide case studies of 'well performing committee' (1st study area) and 'less performing committee' (2nd study area) to identify:

- How these committees are perceived by various groups within the community;
- Which activities these committees are actually engaged in;
- What impact they have had to date; and how these committees can be more effective.

41 in-depth interviews with different groups in the community: health providers, HFGC members, village leaders and members of other health related committees, 10 Focus Group Discussions (FGDs) with community members and HFGC meeting observations were carried out.

Health facility governing committees in Ulanga District

All public primary health facilities in Ulanga District have a HFGC. Each committee had at least one female community representative, with community members constituting 70% of the committee membership. Although community members are not supposed to hold political positions, 21% of committees consisted of village chairpersons, village executive officer or ward executive officer as members. 53% of facilities met quarterly in accordance with the guidelines. Participation at meetings was relatively consistent (almost half of the committees had at least 75% of the members present at the last three meetings). Occasionally, health providers were invited to the HFGC meetings.

One of the HFGCs meetings involving health providers

Formation of the committees

The HFGCs in both study areas were first formed in 2003 and governed for three years. In 2007 new members were appointed. The village government leaders were responsible for advertising the positions and selecting candidates. The community members in both study areas comprised a range of professions, including parish priests, pastors and business people.

Knowledge of committee roles

In the second study area, most of respondents from the community thought the main function of the committee was to mobilise contributions to the CHF. The HFGC was often referred to as the 'CHF committee'. Members of the HFGC interviewed in both study areas had some awareness of the committee's responsibility for health care delivery. The committee in the 1st study area oversaw the dispensary construction activities that were taking place between 2007 and 2009 and this increased awareness of their roles. Indeed, this committee was also associated with supervising the construction activities, purchasing drugs and financial management. In neither site did respondents see the committee as a channel for community members to present their views and complaints about health services.

Main activities and impact of the committees

In both study areas, the committees had been effective in tackling issues relating to health worker performance, community-provider relations and revenue generation:

1) Activities to promote health worker performance

- Ensuring the availability of health providers at the health facility outside of working hours to attend emergencies (2nd study area).
- Addressing human resource shortages by requesting a midwife to be sent to the facility from the district (1st study area). *"At this dispensary, we have a midwife because we asked the district; these are the efforts of the HFGC"* (Health provider, 1st study area).

2) Activities to promote facility and community relations

- Raising awareness of opening and closing hours by posting signs (1st study area).
- Dealing with conflicts between the community and providers (both study area).

"There is a plot conflict between the facility and a villager in 2nd study area. We have tried within our committee to discuss the issue; we are now planning to conduct a meeting with the village government to discuss the issue again" (HFGC member, 2nd study area).

3) Activities to mobilise resources for the health facility

- Using CHF money to purchase drugs (1st study area).
- Mobilising labour from the community and funds from NGOs for construction of the dispensary and staff houses (1st study area).
- Using user fee revenue to cover petty expenses at the facility (both study areas).
- Health care providers rather than the HFGC were mostly responsible for the mobilization of community members to join the CHF (both study areas).

Key messages for effective committee action

Engaging in Public Health Initiatives within the Community

Engagement in community level public health activities helped build relations with the village government and other community groups, raised community awareness of the committee and motivated committee members.

- In the second study area, the HFGC was involved in a cholera sensitisation campaign alongside the village government. However, this was short lived and no further health-related community mobilization was undertaken.
- The HFGC involvement in dispensary construction in the 1st study area led to regular, structured meetings, provided experience of managing funds, and built trust with the village government and the district council.

Relationships and trust

The HFGC ideally needs to work closely with the village government. However, in both study area, the initial introduction of the HFGC was badly received by the village government due to its political independence, and perceived conflict with statutory village government structures and responsibilities. However, the HFGC engagement in dispensary construction in the 1st study area served to override this tension, and build positive relations and trust. The district council was also more responsive to problems raised by the committee in the 1st study area, due to the high level of CHF enrollment and the reputation of the dispensary in-charge.

Strong leadership

Having a well known personality helped the committee build community trust and can also facilitate dialogue with government structures. In the 1st study area the in-charge was well known as a pastor and also received IMCI training that increased his ability to treat child health complications.

Dispensary under construction in Kiswago village as part of the PHSDP

General constraints against effective action of HFGC

Despite their achievements, the HFGCs in both study areas are faced with a number of constraints:

Absence of meeting and transport allowances

Committee members can be unwilling to give up their time in the absence of allowances to attend committee meetings and/or activities. *"Mobilization activities are poor due to limited motivations, no support"* (HFGC member, 1st study area).

Risk of 'provider bias'

The meetings take place at the facility and the facility in-charge leads the discussions, potentially limiting representation of community issues. There is a potential for the health facility in-charge as a secretary to determine whether or not the meeting happen.

"...All the meetings are conducted at the facility, little is discussed about the community" (HFGC member, 2nd study area).

Limited access to the community

Only the village government has the authority to call village meetings, and communicate directly with the community. The HFGC had to fit their agenda into broader village meetings. *"We HFGC have to fit our agenda within the broader village agenda otherwise there is no communication"* (member, 1st study area).

Nothing new to discuss

Some committees were held back by not having a varied agenda to discuss.

"We always discuss about CHF mobilization, we ask the district to provide money for transport without any feedback, it also discourages members to attend meetings" (HFGC member, 2nd study area).

Discussion

HFGC functionality and impact was positively affected by external impetus forcing the HFGC to engage with other stakeholders and manage resources. Trust and relationship with other actors and leadership among the village government and other local actors is clearly critical to the success of the committee. District support is also critical to the HFGC's ability to achieve impact, as the district is required to provide the means of addressing other structural concerns at the facility level and their link to the village government structures. The HFGC has its own roles, which in order to perform properly there is a need to consider other external factors and their impact, including specific and general health systems changes, for instance the National Health Insurance Fund taking over the management and administration of the Community Health Fund. Moreover, most of the key findings in this study have also been reported in another review study by Kessy (2008).

Recommendations

Training/Capacity Building

The HFGCs require more training on their roles and expected relationships with other committees, including suggestions of how to engage in collaborative action. Members of the village health committee and NGOs might be included in the training to provide a shared understanding of respective roles and responsibilities. The training should also encourage creativity in generating funds for the health facility.

Supervision

District supervision of the HFGC is vital to encourage resource mobilization initiatives, ensure that funds are being managed appropriately, and to review the HFGC communication strategy with the community and other committees.

Provision of support to undertake operational activities

Care is needed when introducing material and non-material support to ensure that they do not generate distrust among others in the community. These support materials should ideally be tied to specific activities, which could involve a broader range of stakeholders, such as mobilizing people to join the CHF. This might also encourage greater HFGC collaboration with other groups.

Improving relations and building trust

Local stakeholder's gatherings should be encouraged to build trust and facilitate community access. Facility construction activities provide such an opportunity and also enable resource management, which is both empowering and motivating for the HFGC. The chairman of the village health committee should be included as a member of the HFGC.

Strengthening 'community voice'

It is important to ensure greater neutrality in the conduct of meetings to facilitate representation of community interests. Community sensitization is needed so that the community understands that the HFGC is responsible for representing them to the facility. Committee members should ideally be drawn from all villages using the facility, and not just the village that built the facility.

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References

Kessy, F. (2008). *Technical Review of Council Health Service Boards and Health Facility Governing Committees in Tanzania*. Report prepared for the Ministry of Health and Social Welfare, Dar es Salaam, Tanzania.