UONGOZI-Journal of Management and Development Dynamics

2023, Vol 33, No.1, 39-54

©2023 UONGOZI Journal of Management and Development Dynamics, Mzumbe University, Tanzania

ISSN 2619-8665

Participation of Community Governance Structures in the Governance of Strategic Purchasing under the Fiscal Decentralisation Context in Tanzania

George Romanus Igulu

ORCiD: **https://orcid.org/0000-0001-5065-2208**

Received: 02 May 2024
Revised:16 June 2025
Accepted: 25 June 2025
Published: 30 June 2025

ABSTRACT

Fiscal decentralisation reforms in lower and middle-income countries are believed to accelerate Universal Health Coverage (UHC) development. Implementing UHC requires health financing reform. Strategic purchasing is a vital component of health finance that enhances primary healthcare delivery and improves health system performance. Community participation in strategic purchasing at their facilities through local governance structures holds service providers more accountable for implementing strategic purchasing that places the community at the centre of service delivery, thereby improving responsiveness, equity, and financial protection. This study examined how Tanzanian community governance structures under Direct Health Facility Financing (DHFF) participate in the procurement process within health facilities. A cross-sectional design was employed to collect both qualitative and quantitative data from four regions—Mbeya, Kilimanjaro, Ruvuma, and Songwe—chosen based on their 2018-star ratings. Data were gathered through structured questionnaires from 280 respondents who were members of health facility governing committees. Descriptive and multivariate logistic regression analyses were used for the quantitative data. The study found that members of governance structures participate actively in the strategic purchasing of their health facilities under the DHFF arrangement. Members are highly involved in authorising and reviewing health commodities and services for purchase. However, governance structures are less engaged in evaluating, selecting, debating, and awarding bids. Participation of governance members is associated with age, availability of information reports, and the method of member selection. DHFF enables community members to procure health commodities based on population needs. To ensure that community governance structures effectively address elements that significantly enhance community access to healthcare, additional efforts are necessary.

Keywords: *Strategic Purchasing, Community Participation, Governance Structures, Fiscal Decentralisation, Health Financing*

1.0 INTRODUCTION

Health system financing is considered to be crucial for speeding progress toward Universal Health Coverage (UHC) (Kutzin, 2013). Health financing reform, in particular, is critical to making the UHC a reality (Kapologwe et al., 2019; Sekwat, 2003). In health system, health financing plays three essential functions which are (i) revenue collection, in which funds are collected from people, organisations, governments, and donors; (ii) pooling funds, which is concerned with the accumulation of funds on behalf of the citizens; and (iii) purchasing, which involves transferring pooled resources to healthcare providers to use them to provide health services. That being the case, purchasing is a crucial function in health financing for enhancing the quality of healthcare delivery and improving health system performance (Mathauer et al., 2019). In recent years, there has been a shift from a passive purchasing approach, where health providers receive budget allocations with minimal oversight, to a more active and strategic purchasing approach that involves connecting health providers with health service users (DEHNAVIEH et al., 2016). Thus, to attain desirable health system goals and UHC, strategic purchasing governance is essential as a strategic part of health system financing (Ezenduka et al., 2022). At the primary health care (PHC) level, community involvement—through established governance structures—has been highlighted as playing a significant role in guiding health interventions such as strategic purchasing (Kesale et al., 2022a).

There is evidence that most LMICs are supporting fiscal decentralisation at the PHC to improve financial management and governance in the catchment areas (Boex, n.d.). To make this work, economic power and responsibility are delegated to PHC facility actors, such as the management team and communities, as governance actors. This arrangement enables them to make their own financial decisions, thereby improving the health system's operation and meeting the preferences, tastes, and needs of the community (Chen et al., 2023). At the PHC facilities, communities are involved through established community governance structures, which are responsible for overseeing healthcare facilities, enhancing accountability, utilising resources effectively, and establishing connections between healthcare facilities and the communities. There are variations of names placed on these structures in different countries, such as subcommittees for managing community health initiatives (Goodman et al., 2011; Haricharan et al., 2021), health facility

governance committees (HFGCs) (Kesale et al., 2022b), or community health committees (Goodman et al., 2011). When responsible for procurement, their main role is to ensure that providers comply with the law when exercising their powers—such as purchasing health commodities and services—and that the public interest is protected and prioritised. For the benefit of the community, these governance structures help ensure equitable resource distribution, uphold facility standards, and promote responsive services. All these efforts aim to protect communities from financial barriers when accessing healthcare.

Empirical evidence suggests that strategic purchasing plays a crucial role in promoting equality in distribution effectiveness, efficiency, achieving "value for money," controlling healthcare system expenditures, and improving the provision of high-quality healthcare services (Ezenduka et al., 2022; Gatome-Munyua & and Cashin, 2022). As a result, other literature contends that strategic purchasing plays a significant role in increasing the transparency and accountability of providers toward populations (Waithaka et al., 2022). Thus, strategic purchasing is crucial for enhancing health system performance by ensuring availability of health commodities and services at the health facilities when effectively managed and governed by all stakeholders (Gatome-Munyua & and Cashin, 2022). Critics, on the other hand, argue that strategic purchasing can only realise its potential if citizens or communities are involved in its governance; otherwise, it will never achieve its full potential at the PHC (Hanson et al., 2019). Given the fact that strategic purchasing is directly related to the UHC, involving communities in governance entails increasing people's capacity to control their health by recognising their rights and responsibilities in the process of purchasing for their health delivery (Kachapila et al., 2023). Indeed, empirical findings suggest that communities are likely to have improved purchasing opportunities, implementation, and monitoring of service providers as a result. These results will hold service providers more accountable for implementing strategic purchasing that places the community at the heart of service delivery, enhancing responsiveness, equity, and financial protection for the population. (Matovu et al., 2022)

The Empowerment Framework offers substantial guidance on how citizens or communities can effectively participate in and make informed decisions to improve service delivery to citizens (Alsop et al., 2005; Alsop and Heinsohn, 2005; Raich, 2005; Swai et al, 2022). The framework posits that an individual group's capacity to make effective choices or decisions is attributed to

two factors: agency and opportunity structure (Alsop et al., 2005). Agency describes an actor's ability to make meaningful decisions. This usage defines agency as an individual or a group that holds the authority to make decisions related to procurement aspects. The framework goes on to suggest that for an actor, whether an individual or a group, to make beneficial decisions, they must possess certain traits known as "asset endowment," including information, financial, organisational, material, and psychological human assets. Despite having all the resources to make smart choices, an actor's environment may prevent them from doing so. Opportunity structures refer to the agency's operating environment, whether it is formal or informal. Opportunity structures are the "rules of the game or the institutions that regulate and shape the conduct of the actors and dictate their interactions and the choices they must make.

Empowerment occurs when agency and opportunity structures intersect. The environmental and opportunity structure plays an extremely important part in facilitating the transformation of assets via an efficient agency. To assess empowerment, three metrics are suggested: (1) the existence of decision-making opportunities (presence of choice), (2) taking advantage of these opportunities by an individual or group (use of choice), and (3) the attainment of the intended result from the choice made (achievement of choice) (Alsop & Heinsohn, 2005). This study employed the empowerment paradigm to evaluate the impact of altering the opportunity structure by conferring procurement powers, resources, and duties to the HFGCs through DHFF on their engagement in governance structures in their designated purchasing roles. Self-reported assessments of empowerment in health were utilised to determine HFGC members' opinions of their feelings of empowerment in fulfilling their responsibilities under the DHFF framework (Raich, 2005).

Tanzania, like other nations, has been pursuing fiscal decentralisation via Direct Health Facility Financing (DHFF) to empower communities with planning, budgeting, procurement, and financial management powers and responsibilities (Kapologwe et al., 2019). Increasing community autonomy and ownership of primary healthcare facilities, as well as their governance, has been one of the specific aims of fiscal decentralisation. To accomplish this, community governance structures at the facility level are given the procurement powers and functions necessary to participate in planning processes and purchase medicines, medical supplies, and other goods and services (Kapologwe et al., 2023; Kesale et al., 2022b; Kesale &

Swai, 2023). The goal is to guarantee that service providers are more accountable to the community and that service provision is in the community's best interest. However, it is currently unclear how community governance structures are involved in the purchasing process within the DHFF context.

Most of the research on fiscal decentralisation through DHFF has looked at how well health facility governing committees work under DHFF (Kesale et al., 2022b) how well direct health facilities help with maternal health services ((Tukay et al., 2021)) and how well DHFF programs are received in Tanzania (Kalolo et al., 2022). There is limited empirical evidence on the extent to which members of the community governance structures participate in the procurement process of the health facilities under the DHFF context. The primary objective of this study was to evaluate the level of community participation in governing strategic purchasing in public primary health facilities that implement DHFF in Tanzania.

2.0 METHODS

2.1 Study Design

The researcher used a cross-sectional design to gather quantitative data on the engagement of community governance committees in strategic purchasing at health institutions across four selected regions: Mbeya, Kilimanjaro, Songwe, and Ruvuma. This design was relevant because it allowed data collection in a single phase from community governance structures operating under the DHFF arrangement.

2.2 Study Area

The study was conducted in four regions namely Kilimanjaro, Mbeya, Songwe, and Ruvuma. These regions were categorised into high- and low-performance zones based on a star rating evaluation conducted in January 2018, aligning with the official start of Tanzania's DHFF programme. The President's Office of Regional Administration and Local Government evaluated and ranked each primary healthcare facility in Tanzania (Yahya & Mohamed, 2018). The facilities received a star rating from zero (0) to five (5) based on their performance. A primary care institution was classified as a high performer if it attained three (3) or more stars; conversely, it was deemed a low performer if it obtained less than three (3) stars. The majority of healthcare facilities in Mbeya and Kilimanjaro exhibited good performance, but most facilities in

Ruvuma and Songwe showed low performance. This study was conducted at health facilities categorised as high- and low-performing based on the 2018 Star Rating assessment to evaluate the efficacy of empowered Health Facility Governing Councils (HFGCs) in executing their procurement responsibilities. This initiative stems from literature demonstrating a strong correlation between HFGC performance and the success of health facilities. Consequently, when HFGC performance is strong, the health facility's performance is usually elevated, and vice versa (McCoy et al., 2012).

2.3 Sample size and sampling procedures

A multistage sampling technique was employed to select regions, councils, health facilities, and members of the HFGCs. The first phase involved identifying the regions with the highest healthcare facility performance in the 2018-star rating assessment, specifically those performing well (Mbeya and Kilimanjaro) and those performing poorly (Ruvuma and Songwe). The second phase involved selecting two councils from each region: Chunya, Siha, Madaba District Council, and Tunduma Town Council, which showed many well-performing health facilities, alongside Mbozi District Council, Mbeya City Council, Songea, and Moshi Municipal, which had the lowest-performing facilities. The third phase involved selecting four primary healthcare facilities from each of the councils chosen in the second round. When selecting a facility, initial factors to consider included the type (health centre or dispensary) and the quality of medical services provided. Each council then designated two dispensaries: one demonstrating relatively high performance and the other low performance. I selected two health facilities: one with exemplary performance and the other with subpar performance. This resulted in 16 high-performing and 16 low-performing healthcare facilities, totaling 32 primary health institutions. In the fourth stage, I selected HFGC members as respondents. The final phase involved proportional sampling, with a minimum of nine members chosen from each HFGC, resulting in a total of 280 responses.

2.4 Data Collection Method

To gather information for this study, a structured, closed-ended questionnaire was used, which asked about the main duties that HFGCs have regarding facility procurement. The respondents were asked to evaluate the options and indicate their level of involvement in the facility procurement process. The data was collected by trained and experienced data collectors.

2.5 Quantitative Analysis

A descriptive analysis was conducted to assess the level of participation of community governance structures in the strategic purchasing of their facilities under the DHFF arrangement. To achieve this, the outcome variables were dichotomised. We used IBM SPSS (version) to determine the factors associated with community members' participation in the strategic purchasing of their health facilities. Thus, the dependent variable of the study was the involvement of governance structures in the procurement process. A statistical analysis of the HFGCs' engagement in the strategic procurement process at primary health facilities under the DHFF architecture was conducted, reflecting their perceptions of the assigned purchasing duties, as indicated on a four-point Likert scale, with each point corresponding to a percentage. Subsequently, I established two groups (dichotomisation) utilising the four-point Likert scales for additional analysis. I documented the initial two values as 0 for "very low" and "low", and 1 for "high" and "very high". The participation score was derived by summing all dichotomised components. The potential scores varied from 0 to 7, with 7 representing the maximum. The participation score was divided into two categories: low involvement and high participation. Individuals who achieved scores beyond the median (4) were categorised as high participants, whilst those who scored 4 or less were designated as low participants. This methodology aligns with the results of a Tanzanian study regarding the responsiveness of the health system and the efficacy of Tanzanian Health Facility Governing Committees (HFGCs). The study's independent variables, as illustrated in Tables 2 and 3, comprised seven components that influenced the participation of governance structures under DHFF. These components delineated the responsibilities allocated to each governance framework.

3.0 RESULTS

3.1 Socio-Demographic Characteristics

The socio-demographic details of the study's participants are shown in Table 1. The HFGC members' ages were measured in years, their sexes were classified as male or female, and their educational backgrounds were categorised as primary school, secondary school, a certificate, a degree, an advanced degree, or a university degree.

Table 1: Socio-Demographic Characteristics of HFGC Members

Variable	Frequency	Percent
Age		
<30	32	11.43
31-45	100	35.71
46-60	107	38.21
61+	41	14.64
Sex		
Male	139	49.64
Female	141	50.36
Education level		
Primary	150	53.57
Secondary	64	22.86
Certificate	24	8.57
Diploma	30	10.71
Advanced diploma	5	1.79
University degree	7	2.50
Total	280	100

The characteristics of the study's participants are listed in Table 2. The participants came from the regions of Mbeya, Kilimanjaro, Songwe, and Ruvuma. Their positions were divided into three categories: chairperson, secretary, and conventional member.

Table 2: Number of Participants as per Position, Facility and Region

Variable	Frequency	Percent
Region		
Kilimanjaro	93	33.21
Mbeya	64	22.86
Songwe	54	19.29
Ruvuma	69	24.64
Type of Health Facility		
Dispensary	161	57.50
Health center	119	42.50
Position		
Chairperson	43	15.36
Secretary or facility in charge	34	12.14
Member of the HFGC	203	72.50
Total	280	100

3.2 Participation of governing structures in the governance of strategic Purchasing

Table 3 illustrates the community governance committees' participation in various aspects of strategic purchasing under the DHFF arrangement at the selected health facilities. at the end, the overall participation has been provided.

Table 3: Participation of HFGCs members in Procurement aspect

Statement	Very Low N(%)	Low N(%)	Moderate N(%)	High N(%)	Very high N (%)	Mean (SD)
Identify and project on the goods and services to be procured basing	19(6.79)	28(10.00)	33(11.79)	147(52.50)	53(18.93)	3.67(1.10)
Our HFGC do approve goods and services demanded to be procured	11(3.93)	19(6.79)	20(7.14)	150(53.57)	80(28.57)	3.96(0.99)
Our HFGC participate in assessing and selecting bidders for supplying goods	37(13.21)	28(10.00)	30(10.71)	150(53.57)	35(12.50)	3.42(1.22)
Tenders and procurement are tabled before the HFGC for discussion and awards	29(10.36)	19(6.79)	41(14.64)	151(53.93)	40(14.29)	3.55(1.14)
Our HFGC participate in inspecting and receiving goods and services procured	12(4.29)	15(5.36)	27(9.64)	133(47.50)	93(33.21)	4.00(1.02)
Our HFGC ensure facility assess ledger is updated as goods and services	19(6.79)	25(8.93)	41(14.64)	152(54.29)	43(15.36)	3.63(1.06)
Our HFGC is engaged in receiving audit reports from auditors	29(10.36)	17(6.07)	30(10.71)	141(50.36)	63(22.50)	3.69(1.19)
Overall Procurement	9(3.21)	35(12.50)	36(12.86)	168(60.00)	32(11.43)	3.64(0.95)

Table 4: Participation of HFGC members in Procurement aspects (Dichotomised from Likert Scale)

Strategic Planning aspects	Low Participation N (%)	High Participation N (%)	Mean (SD)
Identify and projecting the goods and services to be procured basing	80(28.58)	200(71.43)	3.67(1.10)
Our HFGC do approve goods and services demanded to be procured	50(17.86)	230(82.14)	3.96(0.99)
Our HFGC participate in assessing and selecting bidders for supplying goods	95(33.92)	185(66.07)	3.42(1.22)
Tenders and procurement are tabled before the HFGC for discussion and awards	89(31.79)	191(68.22)	3.55(1.14)
Our HFGC participate in inspecting and receiving goods and services procured	54(19.29)	226(80.71)	4.00(1.02)
Our HFGC ensure facility assess ledger is updated as goods and services	85(30.36)	195(69.65)	3.63(1.06)
Our HFGC is engaged in receiving audit reports from auditors	76(27.14)	204(72.86)	3.69(1.19)
Overall Procurement	80(28.57)	200(71.43)	3.64(0.95)

3.3 Factors Associated with Participation in Governing Strategic Purchasing

According to the study, the involvement of committees in supervising strategic purchasing is directly linked to age, the availability of informational reports, and the process used for selecting members. The level of participation in strategic purchasing governance increases with the age of committee members (0.0007). Furthermore, it has been found that giving committee members access to information increases their likelihood of participating in the governance of strategic purchasing (0.0001). Indeed, members elected by the community are more likely than those appointed by government officials to actively participate in strategic purchasing governance (0.0237). Table 4 shows the factors associated with the participation of governing structures in overseeing strategic purchasing.

Table 5: Factors associated with strategic purchasing (adjusted)

Variable	Poor n (%)	Good n (%)	Chisq	p-value
Type of Health Facility			0.2864	0.5925
Dispensary	44(27.33)	117(72.67)		
Health center	36(30.25)	83(69.75)		
Position			0.5058	0.7765
Chairperson	13(30.23)	30(69.77)		
Secretary or charge	8(23.53)	26(76.47)		
Member of the HFGC	59(29.06)	144(70.94)		
Age			17.0583	0.0007
<30	14(43.75)	18(56.25)		
31-45	38(38.00)	62(62.00)		
46-60	24(22.43)	83(77.57)		
61+	4(9.76)	37(90.24)		
The way they were selected to be a member of the committee			5.1156	0.0237
Elected	51(24.88)	154(75.12)		
Appointed	29(38.67)	46(61.33)		
Sex			0.1157	0.7337
Male	41(29.50)	98(70.50)		
Female	39(27.66)	102(72.34)		
Education level			5.8259	0.1204
Primary	49(32.67)	101(67.33)		
Secondary	17(26.56)	47(73.44)		
Certificate	8(33.33)	16(66.67)		
Diploma or above	6(14.29)	36(85.71)		
Informational reports			16.1441	<.0001
Poor	66(25.48)	193(74.52)		
Good	14(66.67)	7(33.33)		
Facility performance			0.2450	0.6206
Poor	37(30.08)	86(69.92)		
Good	43(27.39)	114(72.61)		

4.0 DISCUSSION

The purpose of this study was to assess the participation of community governance structures in strategic purchasing at primary health care. Overall, the study found that governance structures actively participate in all aspects of strategic purchasing within primary healthcare facilities. The study showed that community governance structures have high participation in approving the goods and services to be purchased, as well as receiving and inspecting the goods and services delivered to health facilities after procurement. The findings indicate that community governance structures at primary healthcare facilities exhibit low participation rates in assessing and selecting bidders, as well as in discussing and awarding tenders to bidders. According to the empowerment framework, an individual's or group's capacity to make effective decisions depends on the context in which they operate. The findings reveal that, in the DHFF context, community governance structures effectively participate in making governance decisions regarding strategic purchasing at their facilities. This supports the ideas of the empowerment framework, which argues that individuals or groups should be given opportunities to exercise their delegated powers and mandates. The study found that under DHFF, governance structures actively participate in purchasing tasks at their health facilities, such as helping to approve the goods and services to be procured, checking the received goods and services, and discussing auditors' reports about their facilities.

These findings are contrary to the findings of other studies, which found that even after fiscal decentralisation empowered governance structures to participate in major strategic purchasing decisions, citizens were still less likely to participate (Cavalieri & Ferrante, 2016; Raich, 2005). In Kenya, for instance, it was found that health providers continued to make major decisions about strategic purchasing and were not accountable to the citizens or governance structures. Participation of governance structures in approving goods and services is critical in providing value for money spent on health facilities because it ensures that citizens do participate in determining whether what is purchased by the facility is truly what is demanded by service users. This result implies that decentralisation alone does not guarantee effective community participation in the governance of health facilities; instead, creating an enabling environment by empowering governance actors is critical. Kapologwe et al. (2019) concluded that participation in inspecting procured goods and services increases the accountability of service providers to communities through their empowered representatives, such as governance structures. This study

revealed that the approach is applied under the DHFF in Tanzania, as findings suggest that it has managed to provide a conducive environment for members of this structure to exercise their powers. Comparatively, the study has found that among purchasing functions, governance structures in Tanzania have somewhat low participation in assessing and selecting bidders (66%), discussing and awarding tenders to bidders (68%), and identifying and projecting goods and services to be procured. Despite governance structures achieving high performance in all purchasing functions, the above functions, in which governance structures have comparatively moderate or low performance, are critical for determining value for money and the responsiveness of health services to populations. Some empirical evidence suggests that participation in identifying goods and services, for example, plays a significant role in determining the responsiveness of health services to the population (Kapologwe et al., 2020). Purchases are expected to ensure that populations receive high-quality services and achieve UHC; therefore, the participation of governance structures in deciding what the community needs is very critical. The findings also suggest that age, the method by which members of governance structures are selected, and the availability of information reports to members regarding health facility finance and purchasing information are associated with the participation of governance structures in strategic purchasing governance. The health facility's access to information reports concerning health facility finance and procurement allows members of governance structures to make arguments that are consistent with the findings of empirical research (Kachapila et al., 2023; Waithaka et al., 2022). Additionally, it has been found that members' participation in governance structures is associated with their age; the older a member is, the more likely they are to participate in the governance of strategic purchasing in healthcare facilities.

This finding aligns with those of Smith et al., who found that as members age, their decision-making ability improves due to the experience and skills they have gained (Smith et al., 2023). Similarly, the appointment status of members in governance structures has a direct influence on their participation. Compared to their counterparts who joined governance structures through appointments, it has been found that members of governance structures elected by their communities participate more actively in governing strategic purchasing. Members elected by communities feel a greater responsibility to ensure that purchases meet community needs and

demands, thereby upholding their election. Kesale et al. also found that members of governance structures chosen by citizens were more likely to be responsible for ensuring that governance structures monitor the performance of healthcare facilities than those appointed by government officials (Kesale et al., 2022b).

In general, the DHFF context in Tanzania has been shown to empower local governance structures to participate in strategic purchasing at the primary healthcare level. The substantial involvement of governance structures in strategic purchasing suggests that the health facility's purchasing practices consider demand and need, ensuring population responsiveness. To ensure the effectiveness of health system financing and thus achieve UHC, purchasing must respond to the needs, tastes, and preferences of the population. To enable community governance structures to fulfil their local mandates, fiscal decentralisation and health financing reforms are essential.

5. CONCLUSION

This study evaluated the involvement of community governance structures in the strategic purchasing function—a key element of health system financing and essential for advancing towards Universal Health Coverage (UHC). The findings highlight the importance of community engagement and empowerment as vital enablers for effectively integrating communities into the governance of strategic purchasing processes and achieving UHC. Research has shown that empowerment can help community members make informed purchasing decisions at health facilities that reflect the needs of their population. The study highlights that, although some progress has been made in involving community structures in facility-level decision-making, systemic gaps and capacity limitations still hinder their full and equitable participation. There is an urgent need for capacity development to ensure that community governance structures can participate fairly in aspects that significantly impact the community's access to health services. This study recommends the establishment of clear policy frameworks and institutional support prioritising community voice and agency. The goal is to create an environment of trust, transparency, and collaboration among community structures, health providers, and purchasing agencies.

REFERENCE

Alsop, R., & Heinsohn, N. (2005). Measuring empowerment in practice: Structuring analysis and framing indicators (Vol. 3510). World Bank Publications.

Boex, J., Fuller, L., & Malik, A. (2015). Decentralised local health services in Tanzania. Urban Inst, 1.

Cavalieri, M., & Ferrante, L. (2016). Does fiscal decentralisation improve health outcomes? Evidence from infant mortality in Italy. Social Science & Medicine, 164, 74-88.

Chen, C., Zheng, M., & Zhu, J. (2023). How does fiscal decentralization Affect Health outcomes? Evidence from China. Risk Management and Healthcare Policy, 1893-1903.

Dehnavieh, R., Sirizi, M. J., Mehrolhassani, M. H., & Kalantari, A. (2016). Strategic purchasing of healthcare services in developing countries: a new approach is required. *Iranian journal of public health*, *45*(9), 1241.

Ezenduka, C., Obikeze, E., Uzochukwu, B., & Onwujekwe, O. (2022). Examining healthcare purchasing arrangements for strategic purchasing in Nigeria: a case study of the Imo state healthcare system. *Health Research Policy and Systems*, *20*(1), 41.

Gatome-Munyua, A., & Cashin, C. (2022). Introduction to the Special Issue on Making Progress on Strategic Health Purchasing in Africa. Health Systems & Reform, 8(2), 2129026.

Goodman, C., Opwora, A., Kabare, M., & Molyneux, S. (2011). Health facility committees and facility management-exploring the nature and depth of their roles in Coast Province, Kenya. *BMC health services research*, *11*, 1-12.

Hanson, K., Barasa, E., Honda, A., Panichkriangkrai, W., & Patcharanarumol, W. (2019). Strategic purchasing: the neglected health financing function for pursuing universal health coverage in low-and middle-income countries: comment on" What’s needed to develop strategic purchasing in healthcare? Policy lessons from a realist review". International Journal of Health Policy and Management, 8(8), 501.

Haricharan, H. J., Stuttaford, M., & London, L. (2021). The role of community participation in primary health care: practices of South African health committees. Primary health care research & development, 22, e31.

Kachapila, M., Kigozi, J., & Oppong, R. (2023). Exploring the roles of players in strategic purchasing for healthcare in Africa—A scoping review. *Health Policy and Planning*, *38*(1), 97–108.

Kalolo, A., Kapologwe, N. A., Samky, H., & Kibusi, S. M. (2022). Acceptability of the Direct Health Facility Financing (DHFF) initiative in Tanzania: A mixed methods process evaluation of the moderating factors. *The International Journal of Health Planning and Management*, *37*(3), 1381–1401.

Kapologwe, N. A., Kalolo, A., Kengia, J., Swai, I. L., Kesale, A. M., Kacholi, G., ... & Anasel, M. G. (2023). Community health systems management and governance. In Leadership and Governance in Primary Healthcare (pp. 91-106). CRC Press.

Kapologwe, N. A., Kalolo, A., Kibusi, S. M., Chaula, Z., Nswilla, A., Teuscher, T., ... & Borghi, J. (2019). Understanding the implementation of Direct Health Facility Financing and its effect on health system performance in Tanzania: a non-controlled before and after mixed method study protocol. Health research policy and systems, 17, 1-13.

Kapologwe, N. A., Kibusi, S. M., Borghi, J., Gwajima, D. O., & Kalolo, A. (2020). Assessing health system responsiveness in primary health care facilities in Tanzania. BMC health services research, 20, 1-10.

Kesale, A. M., Mahonge, C., & Muhanga, M. (2022a). The quest for accountability of health facility governing committees implementing direct health facility financing in Tanzania: A supply-side experience. *Plos One*, *17*(4), e0267708.

Kesale, A. M., Mahonge, C. P., & Muhanga, M. (2022). The functionality of health facility governing committees and their associated factors in selected primary health facilities implementing direct health facility financing in Tanzania: a mixed-method study. *Health science reports*, *5*(3), e611.

Kesale, A. M., & Swai, I. L. (2023). Management and Governance of Health Facilities. In Leadership and Governance in Primary Healthcare (pp. 13-26). CRC Press.

Kutzin, J. (2013). Health financing for universal coverage and health system performance: concepts and implications for policy. *Bulletin of the World Health Organization*, *91*, 602-611.

Mathauer, I., & Dkhimi, F. (2019). Analytical guide to assess a mixed provider payment system. Health financing guidance, World Health Organization 5.

Matovu, F., Gatome-Munyua, A., & Sebaggala, R. (2022). Has strategic purchasing led to improvements in health systems? A narrative review of literature on strategic purchasing. Health Systems & Reform, 8(2), 2151698.

Raich, U. (2005). *Fiscal Determinants of Empowerment*. World Bank Publications.

Sekwat, A. (2003). Health financing reform in sub-Saharan Africa: Major constraints, goals, and strategies. *Journal of Health Care Finance*, *29*(3), 67–78.

Smith, K., Strough, J., Parker, A. M., & de Bruin, W. B. (2023). Age Differences in Social Decision-Making Preferences and Perceived Ability. *Psychology and Aging*, *38*(3), 167–173.

Swai, I. L., Igulu, G., Uhahula, F. C., Kaamo, K. J., Enos, E. J., Mkazeni, N., ... & Anasel, M. G. (2022). The Institutional Frameworks Guiding the Decision making in the Tanzanian Local Government Authorities: Are they gender sensitive?. UONGOZI Journal of Management and Development Dynamics, 32(2), 81-94.

Tukay, S. M., Pasape, L., Tani, K., & Manzi, F. (2021). Evaluation of the direct health facility financing program in improving maternal health services in Pangani District, Tanzania. *International Journal of Women's Health*, 1227-1242.

Waithaka, D., Cashin, C., & Barasa, E. (2022). Is performance-based financing a pathway to strategic purchasing in sub-Saharan Africa? A synthesis of the evidence. Health Systems & Reform, 8(2), e2068231.