

**HEALTH SERVICE AGREEMENTS: IDENTIFICATION OF
CONSTRAINTS AND OPPORTUNITIES IN MEDICAL PROVISIONING AT
KCMC IN MOSHI MUNICIPALITY**

**HEALTH SERVICE AGREEMENTS: IDENTIFICATION OF
CONSTRAINTS AND OPPORTUNITIES IN MEDICAL PROVISIONING AT
KCMC IN MOSHI MUNICIPALITY**

BY

MUYANGA .L. GAMA.

Reg.no 130000050/T.11

**A Research Report Submitted to the School of Public Administration and
Management (SoPAM) in Partial Fulfilment of the Requirements for Award of
the Degree of Master of Public Administration (MPA) of Mzumbe University**

2013

DECLARATION AND COPYRIGHT

I, Muyanga .L. Gama, declare that this is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommended for acceptance by the Mzumbe University, a dissertation entitled, **Health Service Agreements: Identification of Constraints and Opportunities in Medical Provisioning at KCMC in Moshi Municipality**, in partial fulfillment of the requirements for award of the degree of Master of Public Administration of Mzumbe University.

Signature

Major Supervisor

Signature

Internal Examiner

Signature

External Examiner

Accepted for the Board of

Signature

DEAN/DIRECTOR FACULTY/DIRECTORATE/SCHOOL/BOARD

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DEDICATION

This work is dedicated to my parents Mr. Leonidas Gama and Mrs. Ester Gama for exposing me to education. Their investment is highly appreciated. It is also dedicated to the late Sr. Tambarose Gama, may the Lord rest your soul in peace.

ABBREVIATIONS

CBOs	-	Community Based Organisations
CG	-	Central Government
CHMT	-	Council Health Management Team
D by D	-	Decentralization by Devolution
DDH	-	Designated District Hospital
FBOs	-	Faith Baised Organisations
HSR	-	Health Sector Reform
HSSP	-	Health Sector Strategic Plan
IT	-	Information Technology
KCMC	-	Kilimanjaro Christian Medical Centre
LGAs	-	Local Government Authorities
LGRP	-	Local Government Reform Program
MDGs	-	Millennium Development Goals
MMAM	-	Mpango wa Maendeleo ya Afya ya Msingi
MoH	-	Ministry of Health
MoHSW	-	Ministry of Health and Social Welfare
MSD	-	Medical Stores Department
NGOs	-	Non-Governmental Organisations
NPM	-	New Public Management
NSGRP	-	National Strategy for Growth and Reduction of Poverty
OPD	-	Out Patient Department
PHCSOP	-	Primary Health Care Service Development Program
PMO-RALG	-	Prime Minister's Office – Regional Administration and Local Government
PPP	-	Public Private Partnership
RMO	-	Regional Medical Officer
RS	-	Regional Secretariat
SPSS	-	Statistical Package for Social Science
TFDA	-	Tanzania Food and Drugs Authority
URT	-	United Republic of Tanzania

ABSTRACT

This study identified the opportunities and constraints in medical provisioning as a result of health service agreements (PPP) in health sector. The study was conducted at KCMC in Moshi Municipality. The objectives of the study were to examine if health service agreements have resulted in the achievement of national health goals through its policies and guidelines in medical provisioning, to identify constraints that lead to unavailability of drugs and to identify opportunities in medical provisioning that are the results of health service agreements.

The sample size of the study involved 84 respondents. The key respondents of this study were MSD zonal manager, director of health services at KCMC, head procurement department, head pharmacy department, ten pharmacists, ten MSD employees, twenty nurses and forty patients. The selection of the respondents was based on both purposive and accidental sampling techniques. In this research, a case study design was used.

With regard to the introduction of PPP, the study findings revealed that the introduction of PPP has improved the health service delivery. Before PPP in 1990, accessibility to drugs was 45% while after PPP the drugs provision improved by 30% to make total accessibility of 75% in 2000s. Not only access to drugs availability, but PPP improved efficacy and effectiveness on service provision, Outpatients attendance also increased, This is because of better services.

The findings also revealed that there are some factors that lead to constraints in PPP, particularly in medical provisioning, for example bureaucracy, budgetary constraints, human resource capacity, mistrust and poor policy implementation.

Conclusively, PPP should be cemented by clear plans and strategies by every actor in the partnership, with a focus to good and harmonized policies. The government should avoid bureaucracy and practice full decentralization of PPP in medical provisioning.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE PROBLEM

1.0 Introduction

This study was aiming at assessing health service agreements that exist between the government and the private sectors (Faith Based Organisations). The agreements is in a form of Public Private Partnership (PPP), therefore the study focused on identifying constraints and opportunities in medical provisioning through this collaboration that exists between the government and faith based organisations in delivering health services. Chapter one presents background information to the research problem, statement of the research problem, general purpose and objectives of the study, research questions, significance of the study, limitations and delimitations of the study, conceptual framework, and finally the chapter ends with the definition of key concepts of the study and organization of the research.

1.1 Historical Background of the problem

The provision of social services to the community is the task of the government concerned. Tanzania has remained strongly committed since independence to financing the provision of basic social services including health, education services, etc. The effort of Tanzania government in health service provision can be traced back since the *free-health-for-all* policy stated in the Arusha declaration (1967). The government was responsible to provide free medical care to all citizens (with an exception of Grade one and two) as cited in Itika and Mwangeni, (2006).

The declaration went hand in hand with the expansion of health service facilities in rural areas. There was a service agreement between the government and the private hospitals, where the private hospitals were required to operate not for profit. The government was responsible to provide subsidies to private hospitals, to ensure that they provide quality health services.

The economic crisis during the 1980's deteriorate the free-for-all health service agreement. The government was unable to provide subsidies to the private hospitals which provide health services with no profit. As supported by Fabricant and Burghardt (1992), "one of the reason of failure of many governments to deliver social services to its citizens was the economic crisis and bureaucracy of those governments.

The problems of health service delivery started immediately after the 1980s economic crisis. The 1980s economic crisis led to shortage in supplies of drugs, deterioration of facilities, low staff morale, and poor quality of care (MoH, 1998). Because of the economic crisis the government moved toward the market based economic reforms, this resulted in the establishment of private hospitals regulation amendment act of 1991 and new health service agreements. The citizens started to contribute for health services provided, there was no free health service for all.

The economic crisis lead to prolonged economic instability in many governments, especially those in the developing countries, this instability have resulted into failure to provide health services effectively. This is due to the fact that revenue collection in these countries is not enough to meet the budgetary demands for effective health service provision. This of course has necessitated them to depend on donor funds and grants to cover the budget gap.

The demand for better services in health, lead to the adoption of new health service agreement (Partnership) in health service provision. The partnership was one among the six strategies that Health Sector Reform Plan of Action of 1996-1999, adopted to improve health service provision. Partnership initiates the new service agreement between the government and the private organization, in health service provision.

1.2 Statement of the problem

Despite the proper service agreements that the government of Tanzania has made and still makes in order to ensure there is quality in social service delivery, but there was still a big problem in delivering quality social services which have negative impact on economic development. PPP was initiated to reduce the burden that the government face in delivering the social services, the burden was due to increased population and

economic crisis, therefore PPP was seen as the relief in social service provision (Itika in Itika *et al* 2007).

The national health policy is aimed at providing direction towards improvement and sustainability of the health status of all the people, by reducing disability, morbidity and mortality, improving nutritional status and rising life expectancy (URT, 2003). One of the policy objectives was to ensure the availability of drugs, reagents and medical supplies and infrastructure (URT, 2003). In achieving its objectives the policy will ensure that there is a clear health service agreement between the government and the private sector, mainly the FBOs. This will be done by promoting and sustaining PPP in the delivery of health services, as one among the strategies to achieve the national health policy.

The provision of essential drugs, reagents, medical supplies and equipment will be based on the national drug and supplies policy guidelines. The overall objective of the national drug policy is to make available to all Tanzanian at all times the essential pharmaceutical products, medical supplies and equipment which are of high quality, proven effectiveness, acceptable standard and safety at a price that the individual and the community can afford, when these are needed for health promotion, prevention and treatment of illness (URT, 1991).

It is the task of the government to ensure that essential pharmaceutical products, medical supplies and equipments will be available in health centers and hospitals to improve health services through its policies and budget. KCMC gets its budget from the government through MSD. The funds are channeled to MSD for drugs procurement and other medical facilities. Apart from the government budget, KCMC also gets its funds from donors and the cost sharing scheme. Cost sharing scheme was initiated because of financial difficulties that exist in health sector for a number of years, leading to increased unavailability of essential drugs and medical supplies (MoH, 1998).

But what exists in reality despite the good policies in health sector is the bias in improvement of health services. It was observed that one of the major problems that interferes the delivery of health service is inadequate availability of drugs in many hospitals (MoH, 1998). This research tried to identify constraints that results to poor

provisioning of medical supplies in respect to the unavailability of drugs, and it identified the opportunities that PPP get in provisioning of medical supplies.

1.3 Objective of the study

1.3.1 General objective

The overall purpose of the study was to identify constraints and opportunities in medical provisioning as a result of health service agreements that exist between the private hospitals and the public sectors.

1.3.2 Specific objectives

- To examine if health service agreements have resulted in the achievement of the national health goals through its policies and guidelines in medical provisioning.
- To identify constraints that lead to unavailability of drugs.
- To identify opportunities in medical provisioning that are the results of health service agreements.

1.4 Research questions

- Do health service agreements result in the achievement of national health goals, through its policies and guidelines in medical provisioning?
- What are the constraints that lead to unavailability of drugs?
- What are the opportunities in medical provisioning that are the results of agreements in health services?

AN OPERATIONALIZATION OF RESEARCH QUESTION, VARIABLE(S), INDICATORS, DATA SOURCE AND TARGET POPULATION

RESEARCH QUESTION	VARIABLES	INDICATORS	DATA SOURCE	TARGET POPULATION
Do health service agreements result in the achievement of national health goals, through its policies and guidelines in medical provisioning?	National health goals. Health service agreements (PPP).	Healthy society, Reduction of infant and maternal mortality, availability of human resources, availability of drugs.	Primary source (interview and questionnaire) Secondary data source (Documentary review)	MSD zonal manager, Director of health services at KCMC, Head department of procurement, Head pharmacy department, pharmacists, Nurses, and Patients.
What are the constraints that lead to unavailability of drugs?	Constraints in medical provisioning.	Budgetary constraints, unfair distribution and corruption.	Primary source (interview and questionnaire)	MSD zonal manager, Director of health services at KCMC, Head department of procurement, Head pharmacy department, pharmacists, Nurses, and Patients.
What are the opportunities in medical provisioning that are the results of agreements in health services?	Opportunities in medical provisioning.	Healthier society, rise of individual and national economic status, reduced mortality rate.	Primary source (interview and questionnaire)	MSD zonal manager, Director of health services at KCMC, Head department of procurement, Head pharmacy department, pharmacists, Nurses, and Patients.

1.5 Significance of the study

To ensure that there is efficient and effective delivery of health services to the citizen as one of the goals of Tanzania development vision 2025, particularly in medical provision, the study have a great importance to both the government and the private sectors, as it assessed the health service agreements in the provision of social services, it examined

efficiency and fair practices in the distribution of drugs in hospitals, it identified if the achievement of national goals through this agreement, it also examined some of the challenges and come out with recommendations. This will enable the government to review its policies and guidelines in order to improve the health service delivery. The findings were the challenges to both the government and the private institutions to strengthen their collaboration. The study was also the initiator for further researches in the same area of the study.

1.6 Delimitation of the study

In identifying the opportunities and constraints the study did not focus on those private hospitals which have no collaboration with the government. Also it did not focus on dispensaries and public hospitals. The study focused specifically to KCMC (Faith based organisation) which collaborate with the government in order to provide quality health services to the people the study was conducted at Longuo ward where KCMC is situated in Moshi municipality. The study identified constraints and opportunities in medical provisioning, the study was guided by three specific objective, to examine if health service agreements have resulted in the achievement of national health goals through its policies and guideline in medical provisioning, to identify constraints that lead to unavailability of drugs and to identify opportunities in medical provisioning that are the results of health service agreements.

1.7 Definition of Terms

1.7.1 Health

Health has been defined by different scholars, and in most approaches it is recognized that it is not merely the absence of disease or infirmity but a generic term seeking to encompass all dimensions of individuals and groups of population's level of well being. The World Health Organisation (WHO, 1946) defined health as a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity. Thus, good health is a synthesis of physical, mental and social well being. Therefore Health services is the health operational activities which includes all services delivery in

aspects of health promotion, prevention and curative services for individual groups and the population at large.

1.7.2 Service agreement in health

The service agreement in health is in the terms that the government provides the strength of its purchasing power, outlines goals for an optimal health system, and empowers FBOs to innovate, build, maintain and or manage delivery of agreed services over the term of the contract. The FBOs receive subsidies from the government to provide quality health services, while the government should ensure that there is an availability of human resource, the essential drugs and equipments.

1.7.3 Public-Private Partnerships (PPPs)

According to Koldine (1986) as cited in Nkya, (2007) PPP involves a ‘reconfiguration of organisational structures and relationships between the sectors so as to provide, produce or deliver a service’ where both partners realizes a benefit. To add, Itika *et al* (2011), defines PPP as a contractual agreement between a public agency (federal, state or local) and a private sector entity for sharing expertise, resources, risks, rewards and responsibilities of each in delivering a service or facility for the use of the general public.

1.7.4 Social services delivery

Social service delivery refers to decision made through collective choice mechanism, the kind of good and social services to be provided by a designed group of people also the quality, quantity and efficiency of goods and services to be provided to people. Social services include, water, health, education, communication, roads etc. (Mhamba and Titus, 2006).

1.7.5 Constraints

Concise Oxford Dictionary (2001) tenth edition defines constraint as a limitation or restriction, stiffness of manner and inhibition. It may also mean as the element factor or a subsystem that works as a bottleneck. It restricts an entity, project, or system (such as a

manufacturing or decision making process) from achieving its potential (or higher level of output) with reference to its goal

In this study constraints are referred to those factors that lead to the unavailability of drugs in hospitals. For example the factor may be the poor settings of policy objectives with regard to the current situations in health sector.

1.7.6 Opportunities

The Concise Oxford Dictionary (2001) defines opportunity as a favorable or advantageous circumstance or combination of circumstance. Or it is a chance for progress or advancement.

This study treats opportunity as the advantageous issues that are the result of PPP in health particularly in medical provision. For example it may happen that the availability of drugs at KCMC reduces the distance and cost of travel to the patients.

1.8 Organization of the research

This research is organised into five chapters. Chapter one is about introduction which consists of background to the Problem, statement of the Problem, research questions, research objectives, general Objective, specific objectives, significance of the Study, limitation and delimitations of the study and the conceptual framework. Chapter two critically analyses theoretical literature review and literature review from earlier studies. Chapter Three based on research methodology and provides explanations on the study area, research design, research approach and population for the study. The chapter provided explanations on sampling procedure and sampling methods, and data collection methods and data analysis methods. Chapter four was about data analysis and discussion and chapter five was about recommendations. References and appendices were placed at the end of the proposal.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The main objective of this study was to identify constraints and opportunities in medical provisioning at KCMC. Therefore, the literature review centres on the concepts related to Public Private Collaboration as a means of public service delivery where in our case health service delivery was the concern. The purpose was to get in depth ideas on state of knowledge, and thus be able to come up with an appropriate study framework. In this section theoretical literature review and empirical literature review are discussed, and finally the knowledge gap and chapter summary are given.

2.1 Theoretical literature review

The literature review focused on the underlying theory of Public Private Partnership, where New Public Management (NPM) theory was discussed. It is in this subsection where the emergence of PPP in health service provision, policies and guidelines in health service agreements, actors of PPP in health sector, models or forms of service agreements under PPP, advantages and challenges facing the PPP in health provisioning was discussed.

2.1.1 New Public Management Theory

The need to strengthen the delivery of public goods and services for citizens has, in recent decades, assumed great significance both in developed and developing countries (Karim, 2003 as cited in Njunwa, 2007). To improve service delivery to the people through better public administration systems, countries have come to the issue of public sector management reform. The public sector management reform has resulted due to increased external pressure and the challenges of globalization. Public sector management reform was initiated to search for new methods of producing and delivering public services. The search for new methods has brought about new concepts such as New Public Management (NPM).

Miller and Dunn (2006) argue that NPM are set of operating principle, these operating principles were not necessarily generated and abstracted from well defined theory, but as practical solutions to the operational problems confronting governments. Primarily governmental institutions were seen as undemocratic, unresponsive, inefficient and failing in most other measures of what constitutes an effective organization. One of its remedies was to outsource public services as a means to efficiency. In this regard PPP fall within this NPM framework as an alternative service delivery arrangements of many governments.

PPP is an integrated approach to service delivery which is in line with the NPM. The NPM emphasizes the need for new way of solving governmental problems or creating opportunities, not as public activities in themselves, but by way of co-operating between public and private actors in concrete problems or situations presenting opportunities.

The NPM theory reveals how the government failure to provide welfare to the community has catalyzed the need cooperation with other sector to ensure its goal attained. Generally New Public Management seeks to emphasize Efficiency, Effectiveness and an Economical government (3Es).

2.2 An overview on the emergence of PPP

2.2.1 The emergence of PPP in general

According to Itika in Itika *et al* (2011), the reason for the emergence of PPP (service agreement between Public and Private Institutions) was the task of many governments to reconstruct the war torn economies after the Second World War. Governments during the time were still using the traditional administrative bureaucracy, which was lacking efficiency and effectiveness in socio-economic delivery.

Njunwa (2007) also argue that, from the late 1970s and throughout the 1980s as well as the 1990s almost all givers of foreign aid expressed their dissatisfaction over the manner recipient government bureaucracies spent foreign assistance (loan/grants).

The foreign assistance givers accused public bureaucracies for bad governance and misappropriation and embezzlement of public funds, while the targeted group (citizens) suffered. For this reason all givers of aid decided that to eradicate the misuse of foreign aids by the corrupt officials, they could channel these foreign assistance to the private organizations e.g. NGOs, FBOs etc and not through government.

Privatization in different forms became fashionable, the most far reaching being the total withdrawal of government from specific economic sectors such as mining, telecommunication or energy production and distribution (Itika in Itika *et al*, 2011).

Although regulations and policies about privatization were put forward to reduce the role of the government in social and economic development, still many of the expected outcomes of privatization were not realized. Itika in Itika *et al* (2011) argue that, one reason for this has to do with the weakness of the private sector itself to be a significant actor in economy and the governments are often too weak to create the enabling environment for private sectors. This has resulted to the new shift of social delivery, where the governments join hands with private organizations and create an effective partnership between them. This was from 2000 onwards.

PPP has significantly taken its roots from there, for example the collection of parking fees in urban areas is now outsourced to private operators, Garbage collection and disposal in almost all local government authorities is done by private firms (Nkya, 2004).

PPP has also take an effect into sectors of general cleanliness activities in Public offices, schools, universities, hospitals and hotels. The provision of security services has largely been outsourced as the government police forces cannot fully meet the security needs all over the country. It is also seen in education, where currently the government own ten (10) universities and university colleges, and the private-owned universities and university colleges are nine (9) (Statement by the Minister of Science and Technology and Higher Education in “*Uhuru*” Newspaper, January 11, 2006,p.5, as cited in Njunwa,2007).

As for provision of primary and secondary school education, private operators currently account for 30% from 2.5% in 1967 and the provision of medical and health services is also done through PPP with private operators account for 25% (Kavishe, 1990 as cited in Njunwa, 2007).

2.2.2 The emergence of PPP in health sector

The government through its initiatives to ensure better life to its citizen came up with the Arusha declaration immediately after independence, the Arusha declaration was inaugurated in 1967. Arusha Declaration stated that the government would provide free medical care to all citizens (with an exception of Grade One and Two) (Itika and Mwageni, 2006). The free health for all policy was one among other themes of the Arusha declaration.

Free health for all policy went hand in hand with the strategy for expansion of health facilities especially in rural areas where the government were responsible for free health service delivery to its citizens. During this time the private for profit health services were prohibited. The strategy for expansion of health facilities was impressive.

Benson (2001) as cited in Itika and Mwageni (2006) adds that health facility during that time was located within 10 kilometres of 90 percent of the population. Itika and Mwageni (2006) also adds that, the private sector for profit was particularly hit hard by the enactment of Private Hospitals Regulations Act of 1977, which disqualified health services for profit in the country.

Faith Based Organisations operate the health services not for profit, this is because they were receiving a sum of money from the government to help them operate the services. Underfunding led to shortages in supply of drugs, deterioration of facilities, low staff morale, and poor quality of care (MoH, 1998 as cited in Itika and Mwageni, 2006).

Underfunding of health sector during the time was due to world war and economic crisis. Nkya (2007) argue that, the emergence of PPP can be traced back from the ideological shift from the state driven development and the impact of the world wars and

economic crisis of the 1980s. Itika (2011) also argue that the need for governments to reconstruct the ‘war torn economies’ was also the main drive for the emergency of PPP.

Due to economic crisis the government moved towards the market based economic reform. The market based economic reforms resulted into the establishment of Private Hospitals regulation amendment act of 1991 (Itika and Mwageni, 2006). The government still shows no delay in formulating initiatives to improve health status for the citizens, where in 1994 and 1996 the Health sector reform (HSR) proposal was developed and a health sector reform strategy was approved by the government. The health sector reform plan of Action for the year 1996 to 1999 was also endorsed, the action plan included six strategies; decentralization, improvement of central health systems, health management, financing, human resource, and partnership (Itika and Mwageni, 2006).

The government introduces the National Public Private Partnership policy in 2009. This is because partnership with the private sector is always necessary to increase accessibility and quality of health services. Government and private service providers offer opportunity for a regulated collaboration, where by joining hands with all which can provide services to improve the health of the people is beneficial for the development of the country (URT, 2009). The private sector consists of all non state actors, which are Faith Based Organisations, Non Government Organisations, Community Based Organisations and all other private health providers.

Through the PPP policy the government introduces the Health Sector Strategic Plan (HSSP) III of 2009 to 2015 in which the focus will be on the partnership for delivering the Millennium Development Goals. This strategic plan aim at contributing to Tanzania’s effort to reduce child and maternal mortality and to control important infectious diseases (URT, 2009).

2.3 Policies and legislative framework for health service agreements (PPP) and health service provision in Tanzania

2.3.1 National Health Policy 2007

Ongoing socio-economic changes, new government directives, emerging and re-emerging of diseases and changes in science and technology necessitated to update the National Health Policy of 1990 (URT, 2007). The revised health policy of 2007 has been approved by the Ministry of Health and Social Welfare (MoHSW) and it is in use. The policy outlines achievements and challenges facing the health sector. The resource constraints (especially human resource) and insufficient availability of medicines and supplies constitute the major problems in health service provision.

In order to deliver quality health services to the community, the government put its vision and mission in National Health Policy. The vision of the government through this policy is to have a healthy society, with improved social wellbeing that will contribute effectively to personal and national development. The mission is to provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable. The health service will focus on those most at risk, and will satisfy the needs of the citizens in order to increase the life span of all Tanzanians (URT, 2007).

2.3.2 Tanzania Vision 2025

The vision 2025 is said to be the update of the Arusha declaration in 1967 (first vision document of the country after independence), the document provide philosophy and direction for long-term development.

The nation wants to achieve by 2025 a high quality of livelihood for its citizens, peace, stability and unity, good governance, a well educated and learning society, and a competitive economy capable of producing sustainable growth and shared benefits (URT, 1998).

The document identifies health as one of the priority sectors contributing to a higher quality livelihood for all Tanzanians. This is expected to be attained through strategies, which will ensure realization of the following health service goals;

- i. Access to quality primary health care for all.
- ii. Access to quality reproductive health service for all individuals of appropriate ages.
- iii. Reduction in infant and maternal mortality rates by three quarters of current levels in 1998.
- iv. Universal access to clean and safe water.
- v. Life expectancy comparable to the level attained by typical middle income countries.
- vi. Food self sufficiency and food security.
- vii. Gender equality and empowerment of women in all health parameters.

2.3.3 Local Government Reform and Decentralisation by Devolution (D by D)

Since 1994 Tanzania has embarked on a Local Government Reforms Programme (LGRP). The aim of the reform is to establish decentralisation by devolution (D by D). This implies that Local Government Authorities (LGAs) take full responsibility for planning, budgeting and management of government services, including health, education and water supply.

The D by D has put the LGAs in charge of delivering social services and has given the Prime Ministers' Office – Regional Administration and Local Government (PMO-RALG), the task to monitor or supervise and co-ordinate their activities, in line with the policies and guidelines of the sectoral ministries.

Health policy and implementation are organised according to the three administrative levels of government. At the centre is MoHSW, responsible for development of policy and the regulatory, monitoring and evaluation of policy implementation and sectoral impact, as well as overall management of the reform process.

The devolution has necessitated a close working relationship with PMO – RALG, which bears responsibility for service delivery. At the regional level, a Regional Medical Officer (RMO) form part of the Region Secretariat (RS), whose role is to provide supervisory and the technical support to councils, and to perform a regulatory function, by adhering to national policies and guidelines. The RMO is responsible for the regional hospitals.

According to Tidemand *et al* (2008), councils have administrative, executive as well as legislative powers and elected councilors sanction all council plans, budgets and regulations. Councils are responsible for the planning, management and delivery of health services at district level.

Council Health Management Team (CHMT) receives both a block grant from Central Government (CG) and a district basket grant, funded through sectoral budget support. These are allocated to preventive and curative budget subvotes at the district level, and to dispensaries and health centres in the periphery (Tidemand *et al*, 2008).

2.3.4 Health Sector Reform

Health Sector Reforms (HSR) started in 1994 and aims at improvement of access, quality and efficiency health service delivery. Primary health care was adopted as the most cost effective strategy to improve health of the people. The major focus of HSR is to strengthen the District health services, as well as strengthening and reorientation of secondary and tertiary service delivery in hospitals in support of primary health care (URT, 2007). The programme also aims at strengthening of support services at the central level, in the MoHSW, it agencies and training institutions.

The health sector reforms are in the following dimensions; Decentralisation of health services, financial reforms, such as enhancement of user charges in government hospitals, introduction of health insurance and community health funds and public private partnership reforms such as encouragement of private sector to complement public health services. They also include organisational reforms such as integration of vertical health programmes into the general health services, and propagation of demand oriented researches in the health sector.

2.3.5 Health Sector Strategic Plan II

The Health Sector Strategic Plan II 2003 – 2008 (HSSP II) articulated as a process of health sector reform aimed at addressing the recognizable deficiencies in the sector and achieving specific goals and targets in health as set out in the Millennium Development Goals (MDGs) and the National Strategy for Growth and Reduction of Poverty (NSGRP). The main focus of the HSSP is provision of quality health service. This strategic plan document has been coherent with national policies and the priorities that are identified by the nation.

In ensuring Health service delivery and the quality assurance of health care to the population, the HSSP II integrates strategies. The strategies include; strengthening District health services, hospital reforms, role of the central ministry and central support systems for health, human resource for health, health sector financing, public private partnership, sector co-ordination and HIV/AIDS programming (URT, 2003). HSSP III to a large extent follows the structure of the HSSP II document, which has proved its value in the past years.

2.3.6 Health Sector Strategic Plan III

The focus of the third Health Sector Strategic Plan 2009 – 2015 (HSSP III), will be on Partnership for delivering Millennium Development Goals. In the coming years, the health sector will embark on two major programmes, the Primary Health Service Development Programme and the Human Resource for Health Strategic Plan. These programmes will improve accessibility and quality of health services and contribute to achieving the MDGs (URT, 2009). The programmes are important in improving the health of the population, thus the focus of the HSSP III is on partnership.

In the area of health, other ministries, departments and agencies are also supposed to support the MoHSW in improving the health of its people, i.e. through education, agriculture or water supply. The health sector has to work in partnership with all government institutions that are responsible for services that have impact on health.

Partnership with the private sector is also necessary to increase accessibility and quality of health services. The private sector consists of all non state actors, i.e. FBOs, NGOs, CBOs and all other private health providers. The service agreements between government and private service providers offer opportunities for a regulated collaboration. Joining hands with all who can provide services to improve the health of the people, is beneficial for the development of the country. Development partners provide the health sector with the needed financial, technical and moral support.

Other important partners, who are also beneficiaries of the health services, are the communities and families, that have to take ownership of their own health, such as, healthy life styles, early treatment and adequate care at home, that can save many lives. All efforts in the health sector should be focused on mobilizing them to collaborate for better health, starting from the level of the household.

2.3.7 Primary Health Care Service Development Programme (PHCSDP)

This programme was developed in 2007 by MoHSW to cover a period of ten years from 2007 to 2017. The programme is better known in Swahili as Mpango wa Maendeleo ya Afya ya Msingi (MMAM). The objective of the MMAM is to accelerate the provision of primary health care services for all by 2012, while the remaining five years of the programme will focus on consolidation of achievements.

The main areas to be strengthened by the programme, was strengthening the health systems, rehabilitation, human resource development, the referral system, increase health sector financing and improve the provision of medicines, equipment and supplies.

The first element of the programme in the provision of health services is to increase workforce in health by increasing the through put in the existing training institutions by 100 percent, upgrading 4 schools for enrolled nurses, production of health tutors and upgrading the skills of existing staff by provision of information technology (IT) skills and acquiring new medical technology (URT, 2007).

The rehabilitation of existing health facilities and construction of new ones, as to have a dispensary in each village and a health centre in each ward is planned as well as improving the outreach services. These include 8,107 primary health facilities, 62 district hospitals, and 128 training institutions by the year 2012 (URT, 2007). The referral system will be strengthened by improving information communication system and transport.

2.4 Actors of PPP in health sector

In health service delivery, there are three key actors namely the public, private actors and the civil society, civil society is included as it provides checks and balance between the health service agreement. This is according to Agere, (2000) who argues that, there are three key actors that appear to be appropriate in forging PPP in delivering services to the people. These are;

The state: In this perception, the function of the state is to establish and maintain stable, effective and fair legal-regulatory framework for PPP activity. For example, the government through MoHSW ensures stability and equality in health service by enacting appropriate policies and guidelines for health service provision, mediating interest of the public and private and providing effective and efficient public services. In addition the government ensures that the environment in which the private sector operates is conducive to deliver quality health services.

Private sector: The role of this sector in partnership is to create employment, provide quality health services that cannot be provided by the government, for instance the FBOs are the main providers of social services, and they are well equipped to provide quality health services to the community.

Civil society: This is a key actor in PPP as it connects individuals with the public realm and the state through various interest groups and organization. For example, the CBOs, NGOs allows participation of citizens in economic and social activities that have the potential of influencing the government in poverty reduction policy, these actors also provide checks and balances on government power and monitor social abuse in the whole process of social service management through PPP framework.

2.5 Models or Forms of service agreements under PPP

Different models of service agreements that governments have to choose will depend on the objectives of the government. Choosing the model of delivery that best addresses those objectives will be the task of the government concerned. Governments must also consider which particular arrangements in service agreements allows for the optimum transfer of responsibility and risks to the private sector to meet the said objectives.

Service agreements have been classified differently by many scholars; Rodar and Mulder (1992) argue that, the type of partnership depends on the extent to which the private sector is involved. Agreements can therefore cover consultative functions from the private sector (less involvement) or “devolution” of functions and service delivery responsibilities to the private sector (more involvement). In between the two is advisory, operational and collaborative partnership.

Some of the other classifications of service agreements have been based on the amount of power and expertise sharing between the partners. Kernaghan (1993) uses this criterion to differentiate between collaborative, operational and contributory partnerships.

The most cited, and considerably the most straightforward, classification of PPPs situates different partnership variants on a continuum that reflects the extent to which risk is being transferred from the public to the private partner.

Bennet *et al.* (1999) and Brinkerhoff (2002) as cited in Itika *et al* (2011) argue that, PPP is best seen as a continuum of collaborative arrangements for public and private sector organizations, based on the principle of appropriate allocation of resources rewards and risks. However this continuum provides a range of models from which to choose when considering ways and means for the delivery of a specific public service. These models are summarized below.

Simple cooperation: this includes a situation in which the government (central or local) invites ideas from the business community to improve by laws for regulating certain service delivery activity. In this model the regulations guide the private organ to play

advisory roles (e.g. a municipal to seek an advice to a CBO on how to operate health laboratory).

Joint venture: the government forms a joint venture with a private party where they take joint responsibility for the overall delivery package. In joint venture the legal framework provides the capacity of both public and private organs to balance their roles in managing social services (e.g. a hospital to be operated by a council and a FBO).

Direct services contract: the government contracts out public service to the private provider at an agreed level within defined specifications, payments and for a fixed period. The private organ operates under the regulations that allow it only to manage specific programs in a specified period (e.g. a government agency contracts tax collection to any NGO).

Lease: the government leases infrastructure and facilities to a private firm for a fixed period of time, but the government remains the owner and accountable for such public service delivery. Thus the legal framework allows competitive bidding; the winner has a right to operate using public infrastructures and facilities but bears commercial risks that result from beneficiaries (e.g. non-payment of fee and charges).

Concession: transferring full responsibility for service delivery in a specified area and time to a concessionaire. This includes all construction, maintenance, collection and management; in addition the regulations give power to a private organ also in capital investment (e.g. establishment of an industry like Tanzania Breweries).

Itika in Itika *et al* (2011) argue that, there could be more typologies, depending on the strength of both the private and public sector and opportunities available for public service improvement. But what remains outside these partnership models is either full government investment and public service delivery or full privatization where the government will remain with creating an enabling environment for the private sector to invest in and operate under the normal market conditions.

2.6 Advantages of PPP in health service provisioning

The provision of health service delivery will depend much on the institutional arrangements that govern the partnership that exist between the public and the private. Clear assessment of rights, responsibilities and obligations and a climate of mutual trust and fairness in partnership, will motivate partners, reduce constraints, and enhances growth and sustainability hence a strong partnership will be established. A meaningful partnership for both private and public sector have the following general benefits on improving social services management.

Government centres for health service delivery were few, scattered and far away from villages. Villagers travel a long distance to these health centres. Service agreements that exist between the government and the private sector through PPP was the problem solver for the distance that were existing between the health centres and the villagers. More private health centres were opened in villages, therefore scattering of health centres were reduced and the distance also. Villagers need to travel short distances to reach the health centres.

The study of Itika and Mwageni (2006), came with the results that, the average reduced distance to the health centre from the villages were 165 kilometres.

Under PPP it was observed that, there is a reduction of cost in health service delivery. The reduced distance toward the health centres is beneficial to the ordinary poor people. Shorter distance is meant to poor people, even those who could not afford to pay for car transport could hire bicycle or walk and spend the money for other necessities including laboratory tests and drugs (Itika and Mwageni, 2006).

It was found that villagers prefer services from private health centres as compared to the public health centres. There is a time wasting in public health centres, during the health service delivery. The reduction of time in health service delivery has serious implications on not only the patient but also economic activities (Itika and Mwageni, 2006). This is because patients got more time to work and improve individual economy and national at large.

PPP has also reduce the number of service seekers in one centre, as the introduction of it in health service delivery, provide the opportunity for other private sectors to open more health centres in villages, which then reduce the time wasting in waiting for the services in one centre. More health centre gives a room to villagers to select the centre of their choice to obtain health services.

The reason why patients go to private service provider is reliability in health service provision. This was supported by the study conducted by Itika and Mwageni (2006) to test the reliability of service delivered under PPP. They ask a question to the villagers, if there was an incidence whereby the patients came for Maternal Child Health services, but failed to get them. The data they obtain showed that 95.2 per cent of the patients never miss service under PPP.

Service reliability could also encourage health service seeker to attend the same health service provider. It is very disappointing to go to the service provider and after spending good hours one is told come tomorrow or the service is not available.

2.7 Challenges facing PPP in health service provisioning

Leadership in government is sometimes weak and rigid, government leadership is too bureaucratic, sometimes decisions need to be made from the top management, this always lead to delaying of projects to be initiated through PPP. Weak organisation structure may also be the causative of poor environment for PPP in health, one of the factors may be corruption that still exists in many of African governments. Itika in Itika *et al* (2011) asserts that, governments are often too weak to be able to create the necessary enabling environment for the private sector, while safeguarding public interests on the other hand many of private sectors are too weak to be significant actors in the economy, at the same time.

PPP has brought significant benefit to Tanzanian government and its people, although it is still a new tool of public management. The experience of PPP in health shows that the partnership between public and private organizations is mostly accompanied by the unavailability of financial, technical support and human resources. Availability of

nurses, clinical officer, doctors etc. is a big problem to developing countries, this can be because of two main reasons, first is the difficulty of the science subjects that make most of students not to prefer for science subjects, and two may be scarcity of the training institution, that making the entrance competition to be high, hence few students can be selected and few can graduate because of difficulty studies and hence few human resources.

The local government reform program and its decentralization by devolution policy, have given a room for the local government to operate health services to the local level, this was supported by the Health Sector Strategic Plan III where partnership is the main theme. But this has remained the vision with limited impact at the local level where PPP are initiated and managed.

The Ministry of Health and Social Welfare has passed the responsibility for implementation of PPP to the local authorities while most resources for making substantial PPPs tick remain under the control of the former. Therefore more decentralization of resources is important (Itika and Mwageni, 2006).

According to Itika and Mwageni (2006), in order to have strong PPPs with some kind of uniformity and consistency which will also allow a room for flexibility that is required in classical PPP model, it is important to have one responsible unit for managing PPPs for all ministries and sectors in the country. These PPP units will be responsible for identifying suitable areas for partnership, conduct feasibility studies, and facilitate establishments, developing general regulatory framework, monitoring and provision of technical support services. The national unit will work closely with municipal and district level PPP units, such units will co-ordinate PPP initiative under support from the national level unit.

2.8 Empirical literature review

Itika *et al* (2011) conducted a study to examine success and constraints for strengthening PPP in health sector. The study provides details on the areas for strengthening PPPs in Tanzania in terms of how they are initiated and challenges overcome.

To them, Public-Private Partnerships (PPPs) in the health services delivery are part of the implementation of health care programmes under the MoHSW and NGOs which covers reproductive and child health, HIV/AIDS, Malaria, basket funding support systems and management information system. The study found that Local authorities and regional hospitals were the implementers of PPP programs as directed by program designers and financiers at the national level.

The study has documented 23 three types of partnerships, some of which are as simple as informal sharing of experiences between the private and public service providers. The more significant types of partnerships are described more in details here under.

Training: Joint training is one of the fundamental areas of partnerships between the public and private sector. Indeed all doctors and nurses working in private hospitals have benefited from training programs organized by the MoHSW. This is highly commended achievement.

Resource sharing: The interesting feature in partnerships is the way deficiencies were complemented through joint resource sharing among the partners. For example, in some cases when there was shortage of malaria drugs from the municipality, mothers were given the drugs by a faith based dispensary at the rate of Tshs. 100 per dose as compared to Tshs. 500 in other private service providers. They were also given Ferrous Sulphate for fifty shillings per dose. In some local authorities, outreach services were offered in a village located about 8 kilometres from public hospital three times per month through combine efforts. As a complimentary, the municipality provided vaccines, co-nurses and out of pocket allowance of Tshs. 5000 per trip per staff. Sharing resources so largely involved situations where the private service providers agreed to allocate a room for local government staff to provide mother and child services.

Joint Treatment: There was also joint diagnose and treatment of diseases. The government provided reagents while the private hospital conducted laboratory tests under subsidised rates. The patient paid an average of Tshs. 300 instead of Tshs. 500 market rate. However, the faith based service providers were offering cheaper services ranging from Tshs. 200 to 300 for malaria test. It was the opinion that the government

should make more contributions to the partnership in services like electricity bills and office space and maintenance. Sometimes, private hospitals provide emergency services including accidents and treatment of cholera in the anticipation that patients would pay or the private doctor would be compensated. This area of collaboration was vital for the improvement of emergency services.

Basket Funding: It is government policy that all private hospitals providing health services in areas where there are no district hospitals; such hospitals should be categorized as “Designated District Hospital (DDH)” and receives support through basket funding arrangement. In one incidence, it was found that a hospital categorised as DDH was allocated Tshs 15,262,816 for the 2004/2005 financial year. However, there were complaints that this figure was not revealed to the hospital officials. The sum was paid to a company that supplied a number of goods most of which were neither asked for nor required by the hospital.

The effects of ineffective participation of the private service providers in health planning at the council level noted earlier has also led to negative consequences including lack of commitment and accountability. This state of affairs if go unchecked can lead to wastage of resources at the expense of the poor people who are the tax payers and supposedly the main targeted beneficiaries.

Supply of Drugs and Other Essentials: Public Private Partnerships could be noted with pharmacies in the form of supplies of drugs whenever there were shortages and the MSD could not meet the needs on time. However, this could happen as a “last resort” because of the belief that drugs and other essentials were more expensive in private pharmacies than in MSD. Another concern was noted on the quality of drugs from pharmacies. However, this concern was true in some few cases, but in indeed, drug supplies from private pharmacies were more efficient, better quality and of lower price. Experiences from Bugando Medical Centre and Sekou Toure Regional Hospital in Mwanza show that in most cases the private pharmacies supplied better quality drugs, more efficiently and at lower costs when compared with MSD.

Mduba (2010) conducted a study on the challenges that face health professionals, in her study she argue that; Public district hospitals fulfill a vital role in the state's healthcare system. Without them many people would be unable to receive healthcare in their own communities. District hospitals are authorized not only to operate a hospital, but to deliver any service to help people stay healthy—physically, socially, and mentally. Because they operate to render health services to the community, district hospitals have to align their services to the unique needs of their respective communities.

The study came out with the following challenges that face the health system; lack of human resource management, no staffing, increased turnover rate, and poor retention strategy, human resource policies and implementation are poor, performance management system is poor, there is no human resource development, lack of motivation, and financial constraints.

In the light of these problems, Mduba recommended remedial actions as follows;

The department should conduct an employee satisfaction survey which would allow them to dig deeper into what the problems are and what causes them; The survey must be conducted with a view to the implementation of its findings and not merely to know what the problems are; Infrastructure and resources (human and financial) supply must be reviewed and essential equipment necessary for the attainment of hospitals' objectives provided; The department's attraction and retention strategy must be structured such that it takes into account the rural nature of the area being studied – this must look at incentivizing acceptance of employment in these areas; Accommodation meant for Health Professionals must be improved to ensure the comfort and consequently the settlement of these professionals who are in short supply; Such support functions as human resource management must be improved as they have the capacity to make staff generally unhappy; and Targeted customer care training must be provided to support personnel to improve how they treat and deal with their internal customers.

Masuma and Bangser (2004) conducted a study on poor people's experiences of health services in Tanzania. The results of the study show that, a constant supply of essential drugs is a prerequisite to the credibility of health services and to the quality of health care provided.

Findings from the study indicate that for a large majority, a constant supply of drugs and medical supplies is very important to improved health care. The study reported that, at lower level health facilities in Mbeya rural district that did not charge official fees, most complaints focused on lack of drugs and supplies, and not on the informal fees people were required to pay.

The issue however is not only the inadequate supply of drugs, but as observed in Kondoa district, also of unfair and inefficient distribution of these drugs once they arrive at the dispensaries. Even some essential medicines that are supposed to be free are officially unavailable.

2.9 Knowledge gap

The earlier studies have focused on the problems that government, the private sector and the citizen face in health service delivery, as the research conducted by Itika *et al* (2011) only examine generally the success and constraints for strengthening PPP in health sector and that of Mduba (2010) only focus on the challenges that face the health professionals. Masuma and Bangser (2004) did not explain why there is lack, inefficient and unfair in distribution of drugs. These studies do not give an in depth study in identifying constraints and opportunities in drugs supply. Therefore this study will aim to identify constraints and opportunities in Medical provisioning particularly in the availability of drugs at KCMC in Moshi municipality particularly it will focus to investigate if the government health policies achieve the national health goals in respect to medical provisioning, it will identify the challenges that lead to poor availability of drugs and finally it will identify the opportunities in medical provisioning that are the result of PPP in health.

2.10 Conceptual Framework

Conceptual framework is used to outline possible courses of action or to present a preferred approach to an idea or thought. It acts like a map to give coherence to empirical enquiry (Singh and Bajpai, 2008). The central argument in our conceptual framework is the quality health services in medical provisioning in private hospitals through PPP. The argument that medical provisioning can be effective or ineffective

depends on the collaboration that exists between the government and the private hospitals (PPP).

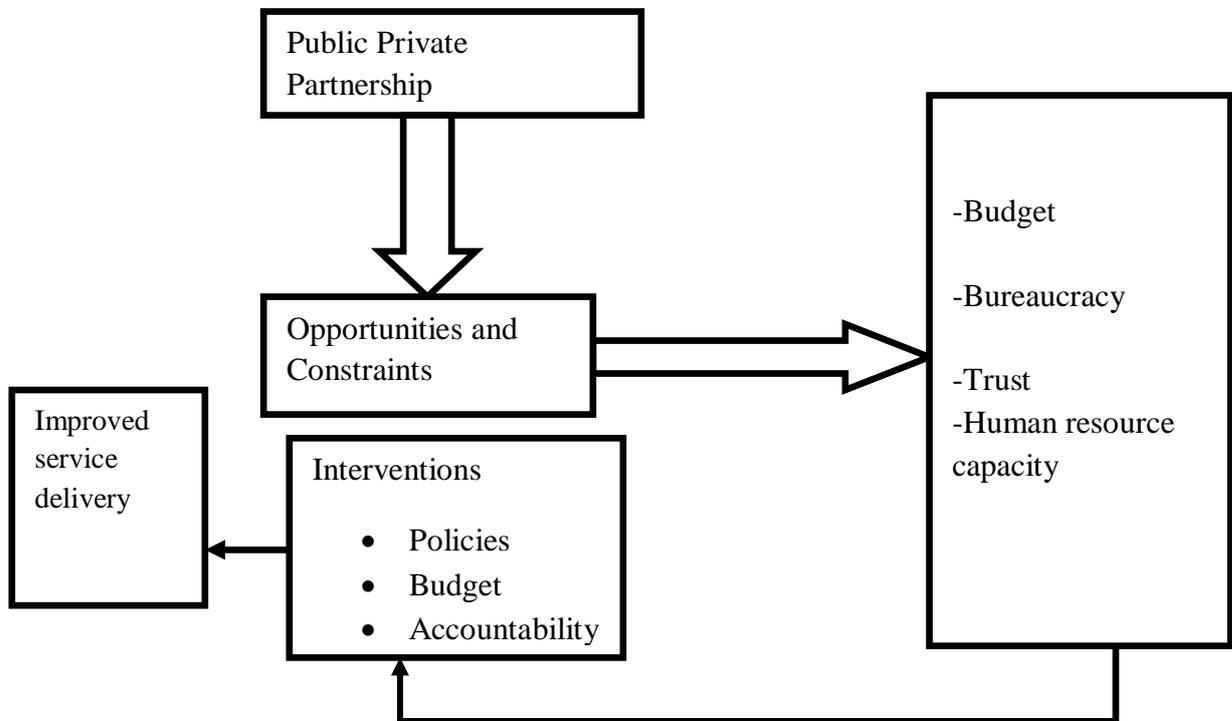
Effective public private partnership allows government to be effective in social service delivery (medical provisioning in our case). The variables that we mostly consider here in our conceptual framework are three, the Independent variable which is the PPP itself, the Dependent variable is the Opportunities and Constraints, and the Intervening variables are the Policies and guidelines in health service delivery, budget, bureaucracy, Trust, and Human resource capacity.

Intervening variables can enhance effective delivery of health service (medical provisioning). Therefore, they should be observed in order to ensure that citizens benefit from this collaboration that exists. For effective PPP the state should ensure that intervening factors are in maximum favourable environment, so that opportunities can be obtained and constraints can be overcome. Actors should be left freely under the legal-regulatory framework for PPP activity; actors in PPP are the state itself, private sectors and the community.

Any PPP is initiated for the aim that success will be obtained depending on the objectives of the partnership, but in opportunities, constraints are there, therefore it is the task of both sides that the public and the private that are in partnership to have mechanism that will reduce the constraints that will be existing, as this study will aim to identify the opportunity and constraints that exist in medical provisioning, and to give the possible solutions to the constraints that will be observed in order to reduce them, and how to increase the opportunities.

Opportunities and constraints in PPP will depend on the type of PPP formulated and how strong the PPP is. Although on the other hand the intervening variables contribute a lot on the success (opportunity) of PPP and the failure (constraints) of that PPP.

Figure 2.1 Conceptual framework



Source: Modified from Itika *et al.* (2011)

PPP framework depends on the budgetary allocation, in order for opportunities to be obtained in medical provisioning, the budget should be allocated in such a way that the MSD will be able to procure the essential drugs, so that they will be available to the community through this collaboration hence improving health service delivery. But if the budget is a constraint, challenges will arise in medical provisioning.

Too much bureaucracy lead to delay of decisions in many public sectors, the availability of drugs in our case study is the task of the government (MSD). The KCMC will issue the requirement of drugs when there is a scarcity to the MSD. Bureaucracy can be a factor for constraints if it is too large that it can lead to delay in medical supplies to KCMC, and it can be of opportunity if accountability will intervein.

Workers Trust have a big impact in availability of drugs; some of the hospital workers for example nurses have tendencies of stealing drugs from hospitals and selling them in their private hospitals.

Most of the partnerships in Tanzania that focus on health services, the government is responsible to provide health packages in hospitals. Through MSD the government is responsible for medical provisioning. Access to essential medical supplies will be successful if trust is strongly built between actors, and good regulatory framework.

Human resource availability (pharmacist) is the task of the government concerned, the government is responsible for building the capacity of the human resources that is to train them and to recruit them, together with paying them good salaries. The opportunities that PPP expects will also depend on the availability of well trained human resource (pharmacist). Policy should be structured in such a way that they provide a room for human resource training.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the methodological procedures that were used to collect data in order to address the objectives of the study. This chapter particularly focuses on research design, research area and organization to study, population of the study, sampling procedure and sample size, data collection method and data analysis method.

3.1 Research design

Research design is a detailed plan of work to be done to achieve the research objectives. It is a detailed plan that guides the researcher in the whole process of collecting, organizing, analyzing and interpreting the data. Research design establishes the practicalities of the research. It provides the conceptual framework within which the research is moved from simply an expression of interest into series of issues that lend themselves to being investigated in concrete terms (Cohen *et al.*, 2000).

De Vaus (2001) also argues, a research design is not just a work plan. A work plan details what has to be done to complete the project but the work plan will flow from the project's research design. The function of a research design is to ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible. Obtaining relevant evidence entails specifying the type of evidence needed to answer the research question, to test a theory, to evaluate a programme or to accurately describe some phenomenon.

Case study is an intensive study of a single unit for the purpose of understanding a larger class of (similar) units as defined by Gerring (2004). In conducting this study a case study design was applied which is meant at identifying the constraints and opportunities in medical provisioning at KCMC in Moshi municipality. There were number of reasons for adopting a case study design, but the main drive for adopting this research design was due to its fairly exhaustiveness which enabled the researcher to study intensively and systematically different aspect of a single situation in the study.

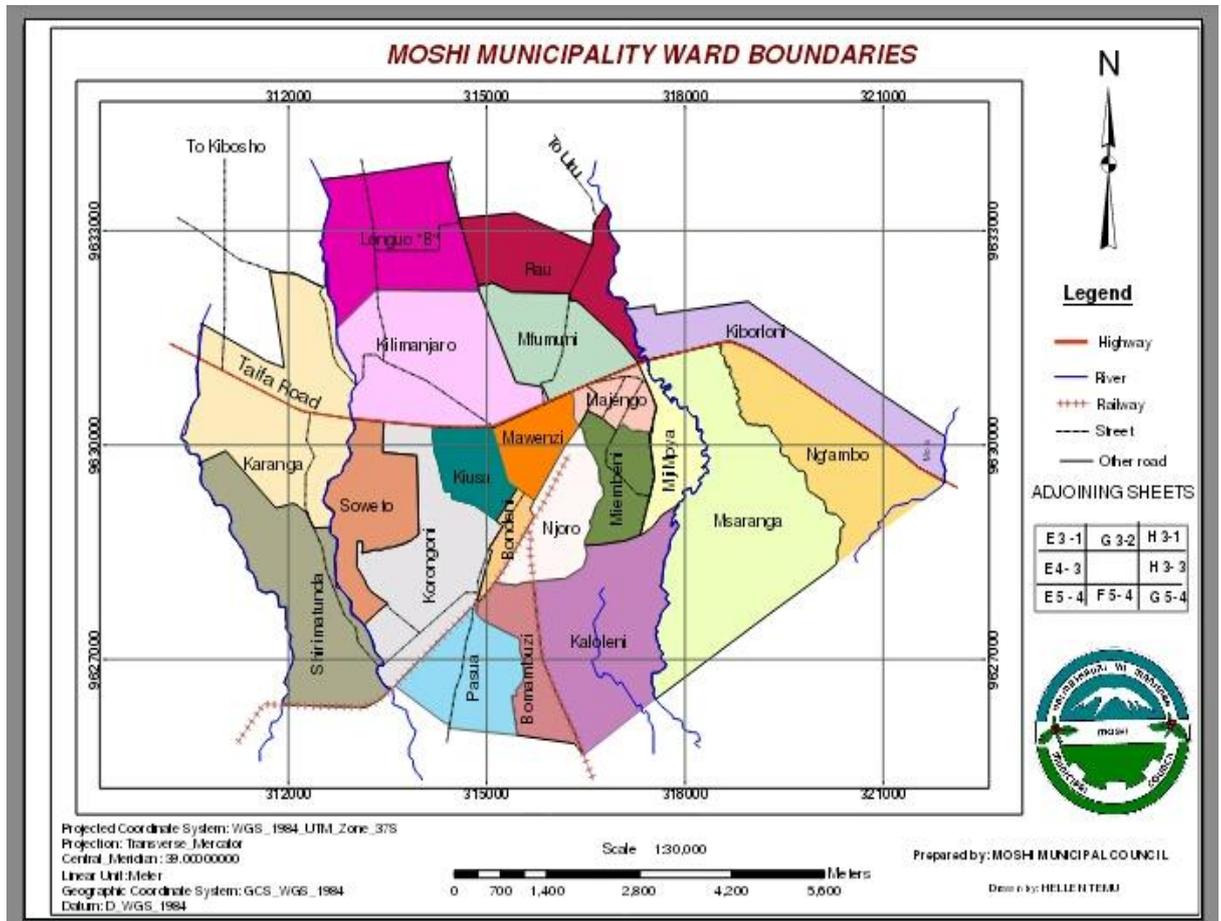
3.2 Area of the Study

The study was conducted at Moshi Municipality in Kilimanjaro region; the study was specifically conducted at KCMC which is situated in Longuo ward. It was possible to gather data from KCMC management, other employees and the patients that are benefiting the health services provided by the hospital, the study also included MSD zonal office at Moshi, where the management and its employees was included in order to obtain useful data

Kilimanjaro Region is located to the North East of the country, it is bordered by Kenya to the North and East, Arusha region to the West, Tanga Region to the East and Manyara Region to the South. The region lies on the southern foothills of Mt. Kilimanjaro. Kilimanjaro Region is divided into six administrative districts Moshi, Hai, Siha, Rombo, Mwanga and Same.

Moshi Municipality is located on the fertile southern slopes of Mt. Kilimanjaro at an altitude of 950 meters above sea level in the North to 700 meters above sea level in the South. The area of Moshi Municipality is 58sq.km. The Municipality is divided into 15 smaller administrative wards of Bondeni, Kaloleni, Karanga, Kiboroloni, Kilimanjaro, Kiusa, Korongoni, Longuo, Majengo, Mawenzi, Mji Mpya, Msaranga, Njoro, Pasua and Rau (Moshi municipality, 2008).

Figure 3.1 : Map of a study area



Source: Moshi municipality, (2008).

3.3 Population of the study

Singh and Bajpai (2008) define population as any group of individuals that have one or more characteristics in common that are of interest to the researcher. Population is used by the researchers to generalize the results of a study derived from a sample drawn from that population.

The population of this study included MSD Zonal manager, director of health services at KCMC, Head department of procurement, Head pharmacy department at KCMC, pharmacist at KCMC, nurses at KCMC, and patients at KCMC.

MSD Zonal manager: The manager was involved in the study because he is in charge of the availability of drugs and medical supplies. By virtue of his position the manager have an impact on the study, as he provided information about the requirements of drugs at KCMC, why there is deficit of drugs and medical supplies and the related information.

MSD employees: By virtue of their positions at MSD, this population was included in the study as they provided the information about the availability of drugs at their stores. This population included accountants, sales officers, procurer officers etc.

Director of health services: The director ensures the appropriateness and quality of health services are available, this include the assurance of the availability of drugs and medical supplies in the hospital. The director of health services provided the information that will be useful to assess the policies and guidelines in health service provisioning, as one among the functions of the director of health services is to participate in administrative decision making and recommends and approves policies and procedures.

Head Procurement Department: Through his or her functions the procurer office was included in the study because he provided the useful information, he is the one who maintains records of receiving and delivery of medical supplies and equipments, he arranges the delivery and distribution of medical supplies and equipments to the pharmacies, he informs the director of health services about the deficit and requirements of drugs and medical supplies, and the expire date of the existing stock.

Pharmacists: Pharmacists distribute prescription drugs to individuals. The study included this group as they are the one who know the drugs requirements of patients. The population provided the information on why deficient of drugs in pharmacies occur. This enabled researcher to analyze data properly.

Nurses: Study included those nurses which were providing medication to the patients in the wards. They were useful to the study as they provide the information on drugs availability, because they are concerned with providing drugs to the patients in the wards.

Patients: Patients in this study were categorized into two groups, the first one were those who were in wards and the second one were those who were coming for medication and leave the hospital. This was an important population in providing the useful information about the study. They are the one that are affected by the availability and unavailability of the drugs. The information that will be provided by these patients will be useful in assessing health service agreements.

3.4 Sample and sampling procedure

3.4.1 Sample of the study

The sample comprised 84 respondents. The sample was considered as an appropriate one because the study required in-depth information on the problem under investigation rather than generalization of the findings. The key respondents of this study were MSD zonal manager, Director of health services at KCMC, Head procurement department, Head pharmacy department , ten pharmacist, ten MSD employees, twenty nurses, and forty patients.

3.4.2 Sampling procedure

The researcher employed two sampling techniques in the study, namely; purposive sampling and simple random sampling. These sampling techniques were used to obtain the sample that provided useful information for the study.

Purposive sampling was used to obtain the elements that have experience and expertise in the field under investigation. These elements selected purposively were; MSD zonal manager, director of health services, head procurement unit, Head pharmacy department, pharmacist, nurses and in-patients. Patients was selected basing on the duration of staying in the wards, the minimum days was 7(seven) days. The assumption was that, those who stay longer for medication will have an experience on the constraints and opportunities in medical provisioning particularly in the availability of the drugs.

Accidental sampling was used to capture patients that was coming for medication in the hospital and then leaves the hospital (out-patients). Twenty patients was selected accidentally to provide the information that was used by the researcher in the study.

Table 3.1 the sample and sampling procedures and size

Occupation	Sampling procedures		
	Purposive sampling	Accidental sampling	Total
MSD zonal manager	1	-	1
Director of Health services	1	-	1
Head department of Procurement (KCMC)	1	-	1
Head Pharmacy department	1	-	1
Nurses	20	-	20
Patients	20	20	40
Pharmacist	10	-	10
MSD employees	10	-	10
Total	64	20	84

3.5 Methods of Data collection

Data collection process was an essential phase in every research. The data collected were useful for the researcher to get in-depth information about the topic under investigation. Before collecting the data from the respondents the researcher seek permission to the MSD Zonal manager and the KCMC Executive director, the permission made the data collection process to be easier, as the researcher was introduced to the population and get familiar with them.

3.5.1 Interview

The study deployed structured and unstructured interviews in collecting data. Interview was used because the researcher wants to capture first hand information direct from participants' voices. Kothari (2004) argue that, interview method involves presentation of oral-verbal stimuli and reply in terms of oral-verbal responses.

The method was relevant as it allowed collection of comprehensive data through penetrating of the participants' responses. The interviewed elements were MSD zonal manager, the director of health services (KCMC), Head procurement unit (KCMC) and the Head pharmacy department, the method was applied to these elements because they are potential in the study and they have more information about the study.

Interview method was also employed to in-patients, the method was applied to these elements because they are potential and with regard to their state, they have no ability to respond to the questionnaires.

3.5.2 Questionnaire

A questionnaire is a series of questions printed or typed in a definite order on a form. The questionnaire in this study will comprise a mixture of open and closed questions to make them effective. Goddard and Melville (2007) argue that, effectiveness of the questionnaire requires planning before hand to ensure that data can be objectively analysed afterwards.

Questionnaires in this study were used to obtain the expected information from pharmacist, nurses, patients and the MSD employees.

Questionnaires were used to these groups because it was easy to supply and to capture the required information at a minimum time as compared to interview. Some of the members of these groups have a lot official tasks, therefore interviewing them was difficult, and may lead to unsatisfactory responses. Therefore questionnaire was the best method to these groups.

3.5.3 Documentary review

Data can be also generated from documents and records which are non-human sources made available often at low cost, and being factual (Cohen *et al*, 2000). The obtained data enabled the researcher to cross-check the consistency of the data that was obtained through interview and questionnaire. Mason and Bramble (1997) add that document search, especially in qualitative research, is used by the researcher in order to gain insights into the context and social processes underlying the events.

For the purpose of this study, documentary data was obtained from accountant records and documentations about the OCs (Other Charges) from the government funds. The records and documentation was reviewed also at the zonal medical store department and at the KCMC. Other data was obtained from the government records including policies and reports. Books and journals were used to shape the direction of the research.

Libraries were used to provide the researcher with means of accessing the publications. The researcher carefully checked the quality of ideas and information from this method to ensure that they comply with the purpose of the study.

3.6 Data analysis

Data analysis refers to examining what has been collected in a survey or experiment and making deductions and inferences. It involves uncovering underlying structures; extracting important variables, detecting any anomalies and testing any underlying assumptions. It involves scrutinizing the acquired information and making inferences (Kombo and Tromp, 2006).

Both quantitative and qualitative methods of analysing data were used for different types of data. Quantitative data are shown in the form of numeric values accompanied by charts, graphs and tables. Quantitative methods involve the use of factual and logical interpretation of data where Statistical Package for Social Science (SPSS) software was used mostly to analyse the data collected. The qualitative method employed to describe the information that is not in numeric nature especially interviews.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter analyses and interprets data collected from field. Tabulated data are analyzed and integrated in order to give meaning. The section is divided into demographic characteristics of the respondents and the findings of the following research questions

- Do health service agreements result in the achievement of national health goals, through its policies and guidelines in medical provisioning?
- What are the constraints that lead to unavailability of drugs?
- What are the opportunities in medical provisioning that are the results of agreements in health services?

4.1 Profile of the respondents

The profile of respondents according to Age, Gender, Education and Occupation

Table 4.1: The profile of respondents according to Age

Age	Frequency	Percentage
0-20	10	16.6
21-30	32	53.3
31-40	10	16.6
41-Above	8	13.3
Total	60	100

Source: Findings

Table 4.2: The profile of respondents according to Gender

Gender	Frequency	Percentage
Female	54	64.3
Male	30	35.7
Total	84	100

Source: Findings

Table 4.3: The profile of respondents according to Education

Education	Frequency	Percentage
Tertiary	18	21.4
High school/college	33	39.3
University	28	33.3
Masters and above	5	6
Total	84	100

Source: Findings

Table 4.4: The profile of respondents according to Occupation

Occupation	Frequency	Percentage
Patients	40	48
Nurses	20	24
Pharmacist	10	12
MSD(Sales & Distribution)	3	4
MSD(Procurement)	3	4
MSD(Logistics)	2	2
MSD(Accounts)	2	2
HOD Pharmacy	1	1
HOD Procurement	1	1
Director health sector	1	1
MSD zone manager	1	1
Total	84	100

Source: Findings

4.2 Whether health service agreements result in the achievement of national health goals.

In order for the researcher to investigate the problem he should formulate research questions that will guide him through the study. Different policies underlying the health service provisioning are enacted by the government, for example the D by D, the HSR and the MMAM to mention the few. These policies are formulated in order to favour the service provided by the government and the private organisations to the citizens. Some of these policies achieve their intended goals but some fail. This questionnaire aimed at identifying if these policies have brought achievements of national health goals through PPP.

The research question was tested through interviewing the respondents and supplying questionnaires to them. Some of the facts that are used to validate the findings were also obtained from different documents through documentary review.

In that case the researcher finds the following achievements laid by PPPs on medical provisioning, basing on the responses from respondents through interview, questionnaires and documentary review:

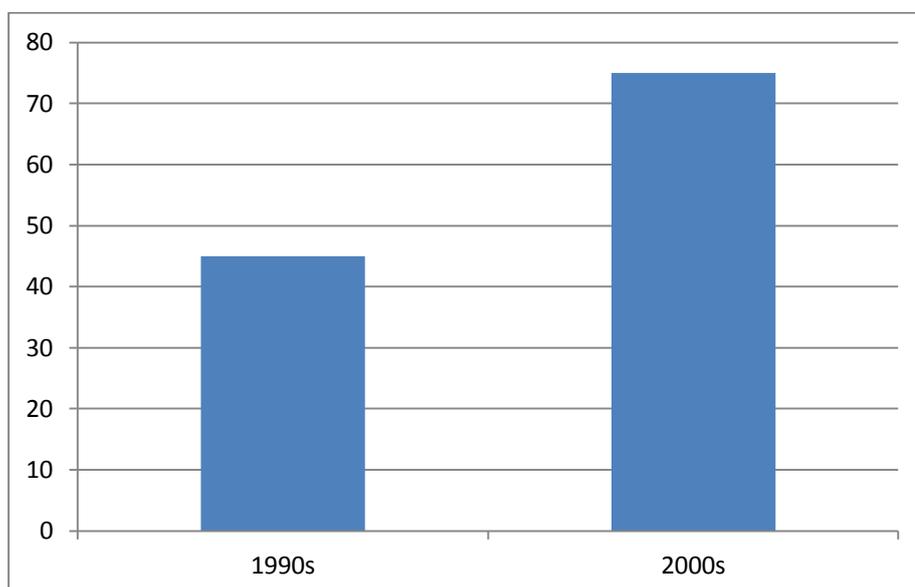
4.2.1 Drugs and equipments

The collaboration between private and public sector as well as the community has contributed to some improvement on medical provisioning especially improving access to drugs as well as facilities for both patients and medical practitioners, in case of KCMC, the citizens through cost sharing contribute some amount of cash which help the hospital in cases of deficit or delay of fund disbursement from the government while private pharmacies have been covering gaps of drugs availability to the hospital by providing credit to the hospital or selling direct to the patients, non –governmental organizations have been so helpful in this partnership by donating some drugs for example anti-malaria drugs and mosquito nets, on the other hand faith based organization have been subsidized to provide health services at the community`s affordance whereas MSD plays a great role of supplying drugs and equipments even giving credit facility to the hospital.

One respondent during interview comment that

“ Sometimes the government through MoHSW delays or disburses inadequate amount of funds. This leads to insufficient availability of drugs and equipments. In such cases we use to apply for credit from MSD and Private pharmacies to cover the deficit, That is not the only way, but also we get donations from NGOs, FBOs, Companies and individuals. All these sources together contribute to improving the situation, contrary to before this partnership when the situation was even worse as access to drugs and equipments was not more than 45% (current it reaches up to 75% depending on the government fiscal year and the economic situation of the country).

Figure 4.1: Achievement of PPPs on improving drugs provision



Source: Findings

Analysis and Interpretation:

Figure 4.1 above illustrates the situation on drug provision before PPPs in 1990s and the improvement attained after the birth of PPPs in 2000s, the figure shows drugs accessibility was 45% in 1990s while after the PPPs come into place, drugs provision has improved by 30% to make total accessibility of 75% in 2000s.

Another respondent adds that

“It is true that the government policies on health have achieved the national health goals that private people are involved in, provision of medical services in the country and taxes levied to hospital equipment and medical drugs have been waived. Government is also giving subsidies to many private hospitals to run the hospital services, technical support is given to private hospitals for free including supervision. Old people (senior citizens), children under five, expectant women, chronic diseases such as people leaving with HIV/AIDS are also being treated for free. The National budget for health is around 10% of the total budget.”

4.2.2 Improved efficacy and effectiveness on service provision

Three-fifths of the respondents through questionnaires recommended on the improvement of service provision in different perspective especially on areas of quality of service, environment of service delivery, human resource capacity, staff payment and health insurance.

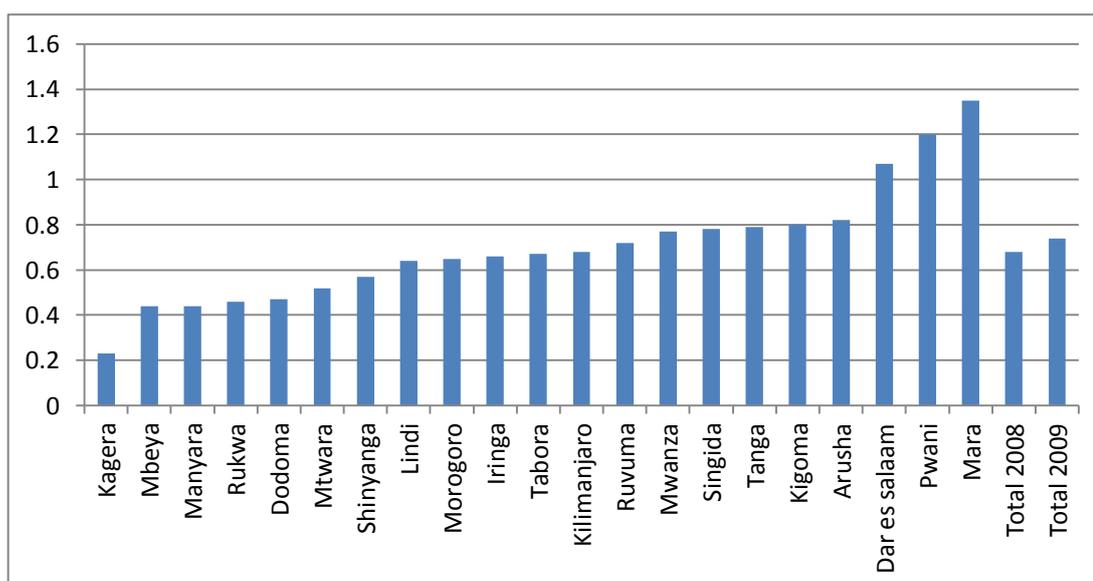
4.2.2.1 Quality of service provision

The efficiency of service provision has been improving since the enacting of PPPs, through joint training number of qualified staffs has increased both in public and private hospitals, especially to referral hospitals.

4.2.2.1.1 Outpatient attendance

Other indicators used to measure level and quality of service provision like out-patient department (OPD) per capital, ranks Kilimanjaro region in the middle position with 0.72, below Mara and Pwani regions above Kagera, Mbeya and Rukwa while at the national level the situation has improved from 0.68 in 2008 up to 0.74 in 2009. (MoHSW,2010).

Figure 4.2: OPD attendance per capital



Source: MoHSW (2010).

Analysis and interpretation:

One among indicators of quality improvement on service provision in health sector is OPD attendance, by using the experience from KCMC and Kilimanjaro region performance as shown in the figure 4.2, service provision has shown recommendable achievement on quality progress.

4.2.2.1.2 Measles Vaccination

This indicator measures the percentage of the total number of children below one year of age vaccinated against measles in a given population. It enables monitoring of immunization of children against the preventable diseases. The indicator value in 2009 is 91% which has increased from 88% in 2008. (MoHSW,2010)

4.2.2.1.3 Citizens trust to health services facility

Citizens trust to health facilities has improved as can be traced through the proportion of birth attended in health facilities, referring to the reproductive and child health data, 54% of deliveries were attended in health facilities. The 2009 data implies that health facility deliveries increased from 51% and 52% in 2007 and 2008, respectively.

4.2.2.1.4 Maternal Fatality rate

The number of deaths due to maternal complications as a proportion of the number of women admitted due to maternal complications. The reported cases have been declining from 34 percent in 2011 to 25 percent in 2012. (KCMC, 2012)

4.2.3 Improved environment of service delivery

Through health sector reforms, strategic and comprehensive health plans as well as health sector development programme, the environment of service provision has been improving from the increment of the number of beds, quality machinery, improved offices and other facilities.

Fifty six percent of the respondents mainly aged from 31- above which constitute 80% of the respondents who had a positive response on the improvement of the environment of service provision compared the current situation to 1990s, while for those aged below

30 years have shown to have less experience enough to make comparison analysis. Through primary source of data as per respondents of questionnaires, females have shown more appreciation by 77% compared to male respondents where only 51% advocate for the progress made on service provision. The analysis made to examine the cause of disparity of response according to age and gender, unveils that, on the disparity pertaining to age, young generation below 30 had shown less experience of the situation background while the current situation makes them more optimistic for better results. In hospital records of previous three years display the attendance of female patients outnumber male patients by 60%, it suggests that female and children are the first beneficiaries of the health services due to their health complications hence female perception on the environment of service provision matters.

4.2.4 Human resource capacity

The proportion of the number of skilled labor service in health sector to that of skilled to unskilled labor raised from 46:64 in 100 staffs in 2004 up to 57:43 in 100 staffs in 2012. (MoHSW, 2010)

4.2.5 Health insurance

The invention of health insurances from both the government agent like NHIF and other private insurance agents like AAR contribute on better access to health services and assurance of treatment to the beneficiaries. KCMC admits average of 452 patients a month who are beneficiaries of the national health insurance fund, while the number of beneficiaries from other private health insurance served in a month have reached an average of 363 patients within a month in a year 2012. In compilation, it makes an average total of 815 patients in a month accessed to health facilities through both public and private health insurance.

4.2.6 Staff payment

Though the economic hardships and raise of inflation up to double digits, staffs remuneration has been escalating due to the growing competitiveness between private and public sector. In one previous decade earnings of staffs in health sector have been

increasing by more than 20%, this contributes to the increment of old age pension and other compensations generated from monthly payments. Some of the staffs in health sector especially in rural areas get a compensation of working under difficult conditions, under the health sector development program, the government under the MoHSW provides housing for staffs of different health centers and hospitals.

4.3 Constrains that lead to unavailability of drugs

The aim of the government is to provide quality services to its citizens. This effort was observed through many years ago. One among the efforts of the government is to enact policies that will guide the government through achievements of its goals. But whenever there are advantages also disadvantages are there. The government did not set the policies or a strategy to earn disadvantages, to earn advantages is the main target of many governments.

There are different factors that may lead to poor achievement of service delivery particularly in medical provisioning in our case. In this study the factors that hinder the achievement are what we call them as the constraints.

The research question aims to identify the factors that act as the hindrance factors in achievement of national health goals, mainly in medical provisioning (Drugs). The findings that follow were obtained through interview, questionnaire and documentary review.

Findings from primary data, show that respondents when asked if medicine are available in adequate quantity in the hospital, 77% of them replied negatively to imply the inadequate availability of drugs in the hospital while 25% were satisfied with the drugs accessibility, on the other hand 2% of all respondents seem to be unaware if medicines are available in the public hospitals.

From 77% of respondents that constitutes majority of the target group of the study, establish the following reasons as the cause for medicine deficit in public and private hospitals.

4.3.1 Poor policy implementation

The government has endorsed different policies to improve the situation in health sector, from the health sector reforms in 1994 that led to health sector reform strategy followed by health sector reform action plan in 1996-1999 (MoH,1998).

Though these policies were being enacted by the government, translation of these policies into expected impact has been laid behind due to lack of political will.

Both state and non state actors failed to materialize visions and objectives of these policies into efficiency of health services and PPPs in health sector.

Responses from questionnaire show that; Implementers of the policies are also the causative of many government policies to fail. For example there is a free health services for old age people, maternal and children under five years, the government provide medical facilities and drugs to implement this policy, but the implementers are not committed to the government policies. From the questionnaires 20% of respondents agree that there are tendencies of some of the hospital employees to sell drugs to this targeted group (old people, maternal and children under five years).

4.3.2 Unethical practices

During interview patients commented that one among the reasons for the unavailability of drugs is the poor commitment (unethical) practices of some of the employees.

“They usually channel the hospital drugs for patients to their private pharmacies, and they force the patients to buy drugs from these pharmacies. It was found that the price of some of the drugs at these private pharmacies is cheap compared to the hospital pharmacies”.

4.3.3 Budgetary constrains

Eighty percent of respondents from MSD and KCMC employees, complained on delay disbursement and inadequate allocation of funds in the basket fund, the average budget deficit has been more than 50%.

One of the respondents during interview argues that;

“Most of the times the government doesn’t disburse adequate amount of funds for drugs and other facilities contrary to the budgetary demands. Even the little amount provided reach hospitals, MSD and health centers very late. In such a situation we apply for credit to MSD and private pharmacies”.

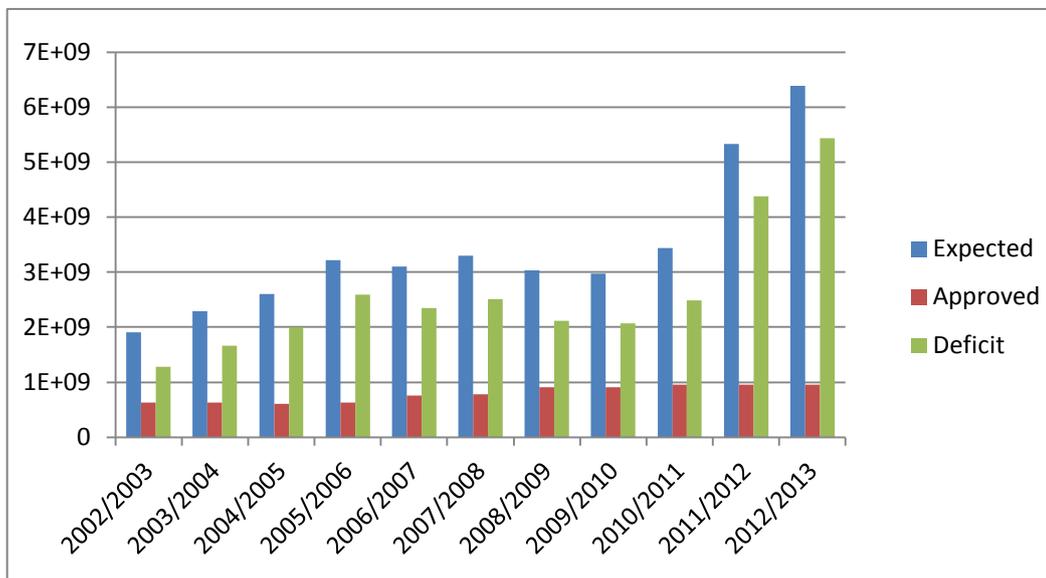
The government allocates the funds to MSD where every hospital in the zone has its account. So what happens is that, the MSD will provide you drugs and other requirements as the government disburse funds to your account. Unfortunately the funds disbursed are not enough compared to the hospital requirements, despite that the funds do not come at the right time.

The respondent in interview adds that,

“we alleviate drugs insufficiency by using other sources of funds, for example funds from donors and cost sharing although they are also not enough because we need not only to buy drugs, but also medical supplies are needed e.g. gloves, reagents etc, food for in-patients, cleanness and other things. Three-fifths of the internal funds collection are used for purchasing drugs, reagents and other medical supplies, and 40 percent for in-patients food, cleanness etc. The government provides us with only about 20 percent of all the OC (Other Charges) we request for. Therefore, in this situation drugs unavailability will continue”.

In addition to that, the MSD policy allows their customers to obtain drugs and other medical facilities before payments. For example KCMC have a credit of 5 million shillings, but the credit is not enough compared to hospital demands, this make the KCMC to borrow drugs form private pharmacies, where they are expensive and they are paying with interest. In this way most of their internal funds are used to pay these private pharmacies. In most cases both the government and the private sector do not have enough resources to finance PPPs.

Figure 4.3: Budgetary constrains



Source: KCMC

Figure 4.3 above shows inadequate allocation of funds for drugs and equipments from central government to health sector as a result for poor availability of drugs in KCMC case.

4.3.4 Bureaucracy

Bureaucracy is also seen as one of the factor that lead to unavailability of drugs in hospitals, the interview with respondents shows that the clearing and forwarding process at the Dar Es Salaam port is the main factor for drugs unavailability. Drugs may arrive earl at the port but clearing and forwarding process may take a lot of time causing unavailability of drugs. Other factors from the respondents are, Poor forecast from the health facilities, Drug registration by TFDA, suppliers need to register all types of medicines which they want to trade in Tanzania, therefore, makes difficult for MSD in sourcing drugs which are not registered by TFDA, and Tendering bureaucracy to get required suppliers of medical supplies.

Interviewed respondents argue that

“Disease irruption is unpredictable, they may occur at any time and curing medicine technology is changing very fast, the consumption data of yesterday it might not be the same of the consumption data of tomorrow. We need to have a very responsiveness system of procuring drugs so as to avoid overstocking and less procuring and the system to respond should not have bureaucracy as it is used now in the tender process. The Tender process is good, it takes time to complete the whole process and it reduces multi-practice to some individuals who are not honest and Tender process fetches higher prices than direct buying”.

4.3.4 Shortage of qualified personnel

Shortage of skilled personnel is common phenomena both in private and public hospitals, as health centers and dispensaries. The government has capitalized in seconded doctors while faith based service providers reported to have poor rewards that contributes to their inability to retain potential staffs. Demands of qualified staffs is still very higher and fast growing than the government capacity to supply, the capacity of private service providers to cab this gape is negligible as in most cases private hospitals use qualified doctors and pharmacist from public hospitals in part time agreement, this situation cause divided commitment hence poor performance. Incapacity of state and non-state actors to afford first class doctors and other staffs make these professionals leave the country hence lucky of national expertise to deal with some health issues.

Response from respondent was

“It is a week now since I came for treatment, but it takes me five days to know which disease I am suffering from, the laboratory technicians and doctors are not enough, they are overloaded with the increased number of the patients. Diagnosing ones diseases is not as early as he or she reaches the hospital”.

4.3.5 Mistrust

Absence of mutual trust among partners in PPPs arrangements have been a major challenge, the private service providers blame the government of failing to meet their commitment whenever deny to do so, service agreements are formulated but very few obligations are implemented.

“ Sometimes we are denied a credit of drugs and facilities from private pharmacies, due to our borrowing background since sometimes we fail to deliver our debt payments on time as funds in basket fund lately disbursed by the central government, that situation force us to extend our credits cause for more interest hence inability to settle some dept payments ”

4.3.6 Corruption

The study has found the preference of corruption in health sector is very high, as from nepotism up to the misappropriation of funds.

65% of the interviewed patients complained on the corruption preference whereby patients are denied access to drugs and other service till they pay some amount of money to a staff for them to be well served. 80% of patients perceive that without having enough money when you are ill you may die unattended in a health center or hospital, where by revealed that more than 90% of the cash you are suppose to pay goes to individuals pocket. However that being not only kind of corruption demanded in health care centers and hospitals, patients also reported on the incidences of nepotism, where staffs relatives and friends are given first priority, by being served in first place with better service than ordinary citizens. 30% of staffs complained on misappropriation of drug funds, the amount allocated to purchase drugs sometimes are spent on other less important or vital activities like seminars and refreshments.

4.4 Opportunities in medical provisioning that are the results of PPPs agreements in health services

Citizens expect the best from the government, one of the major tasks of the government is to provide quality and reliable social services to its people. In 1960s the government were the sole provider of social services to the people. The economic crisis of 1980s shift many governments from sole provider to collaboration with private institutions in social service delivery, this is done through PPP. PPP is seen as a relief in many governments as it reduces the government burdens. This questionnaire aims at identifying the advantages/benefits that the citizens get through the collaboration that exist in health service delivery. The findings were obtained through questionnaires, interview and documentary review.

Though there was respondents disparity where by female and youth being more optimist, old male generation seem to be paralyzed by the failed government programs hence see PPPs as just another arrangement for benefit of some few stakeholders, however according to Table 4.1 and table 4.2 shows that youth and female respondents constitutes the majority group of the sample size which implies that majority group is optimist. PPPs in health sector unveil abundant opportunities in medical provision, through this cooperation and collaboration chances for getting more reliable service brought at a close distance.

4.4.1 Access to drugs and equipments

PPP gives a broad access to health packages and significantly reduce costs of health services and price of drugs. In case of shortages in public or private hospital under this arrangement partners can cover one another.

Findings from respondents questionnaire shows that“

Sometimes the government through MoHSW delay or disburse inadequate amount of funds that lead to insufficient availability of drugs and equipments, in such cases we use to apply for credit from MSD and Private pharmacies to cover the deficit, that being not the only way but also we get donations from NGOs, FBOs, Companies and individuals”.

Some patients interviewed have complimented on the role played by private pharmacies and health centers that have been helpful to improve citizens’ access to drugs and other health services. Some pharmacists, doctors and nurses from both public and private sector, testified for the assistants they get from each other on the time they overwhelmed, the assistance have both of materials and expertise of dealing with some outbreaks.

Under PPPs, public or private health service providers can apply for credit or assistance to cover gaps of drugs or facilities. Patients will spend less time on health services and mortality rate will be reduced.

4.4.2 Sustainable and reliable market

With PPPs private pharmacies are assured of market of their medicine, equipments and services to public health centers, hospitals and dispensaries.

Records shows patients preference of service from private hospitals, pharmacies and health centers is higher than 59% in cases of ordinary diseases. Public trust to private hospitals, pharmacies and health center in a period of twenty years has been growing very fast with exceptional to referral issues where public hospital seem to be the champion.

From observation, the experience shows that private hospitals, pharmacies and health centers can sustain their operations and retain enough reserve even without external assistance though in making their services affordable even to ordinary citizen. The implication drawn from that reality is the growing trust that private health sector has invested in that contributes into attracting market from both state actors, non state actors and individual citizens.

4.4.3 Sharing of expertise and resources

This partnership establishes conducive environment for partners to share experience, expertise and resources. As cited from MoHSW (2010), some NGOs and FBOs provides to government hospitals and health centers, malaria drugs in curative measures and mosquito nets in preventive measures of malaria while some private service providers allocate a room for local government staffs to provide mother and child services.

Some of respondents, through the questionnaire commented that;

“The government on its side has been facilitating trainings to both public and private service providers. It also subsidizes some operations of private service providers and conducts tax exemptions to all health facilities that proved for nonprofit use. Also, some qualified doctors from public hospitals offer consultation services and other expertise to private hospitals where by some of them go an extra mile working by part time to private service providers”.

Through health sector reforms, the decentralized system supports coordination of services between non-governmental actors. Local governments can select faith-based hospitals to act as designated district hospitals in areas where there is no government-run hospital. Within this method, FBO facilities can benefit from block grants. These hospitals receive about 35% of basket funds to take on this role (Maluka *et al.*, 2010)

4.4.4 Wide cooperation

Officials can cooperate on service delivery, this occurs especially during emergencies and shortage, for example during the outbreaks of cholera both public and private health facilities collaborate to rescue and give relief to the situation.

Health sector becomes more elastic and responsive during disaster situations and in cases of the outbreaks through the cooperation between private and public health agents. This was supported by one of the respondents during interview, as he argue that;

“During the occurrence of same land slide incidence is the time when we experienced massive advantages of PPPs on improvement of our response capacity, Kilimanjaro region has seen rescue teams from all sectors coming together, when some NGOs provided some relief services to families, FBOs came to provide humanitarian services while some private hospitals offered their staffs and ambulances to rush injuries to hospital. All sectors during this time came together teaming up to restore the humanity, as red cross provided first aid restoring family rinks, the government through prime minister’s office , the ministry of defense, the ministry of internal affairs and MoHSW were all there to collaborate in rectifying the situation”

In Tanzania, the efforts of FBOs can be seen as complementary to public efforts as indicated by their government subsidization. Dambisya and Ichoku (2012) note the significance of FBOs in rural, hard-to-reach areas. Lipsky (2011) identifies the comparative advantages of FBOs in health delivery as having greater flexibility than the government and understanding local context, which ultimately leads to improved responsiveness to local needs. She also identifies their capacity to build social capital through volunteerism and community mobilization as an advantage.

She follows that since “governments are unable to provide everything to their citizens [they] therefore, must seek partnership with other entities to provide some of those services and access necessary resources” (Lipsky, 2011).

4.4.5 Fair ground of operation

Legal and policy arrangements in PPPs creates a fair competitive ground of operation for both public institutions and private institutions, as in some areas even private entities are entitled with some subsidies and tax exemption from the government to reduce their operation costs. Through health policy the government set rules and regulations for PPP operations.(Malangalila,2013)

In 2003, the Tanzanian government updated the 1990 National Health Policy. The 2003 draft of the Health Policy acknowledges the private sector contribution to health including private sector and sets the tone for partnerships. The draft states PPPs are —complementary not confrontational

The 2003 Policy explicitly states:

“The MOHSW anticipates that a mutually beneficial cooperation of public private partnerships shall exist among, public, faith based organizations, NGO, private and informal and civil society sectors in the identification and prioritization of health needs of the population through a joint for a (sic.) The partnership will jointly and transparently mobilize and share resources for development and efficient delivery of well regulated health services while ensuring accountability to the public they serve”. (URT, 2003)

Moreover, the Health Policy defines several principles guiding the collaboration and relationship between the public and private sectors including: mutually beneficial cooperation; jointly and transparently mobilizing and sharing resources; continuing communication, cooperation, coordination and collaboration; jointly regulating health facilities in both sectors; and promoting health services by private sector organizations. The Health Policy acknowledges that the private health sector has a role in policy and planning as well as in monitoring quality (Malangalila, 2013).

4.4.6 Growth/progress

PPPs creates conducive environment for development of health sector through policies and frameworks. The cooperation and collaboration of public and private efforts, shared experience and expertise gear up improvements in health sector.

“Through PPP we will build a healthier society, where they can work and raise the national economic status. These people will build trust to the hospital and the government if health services will be provided properly” (Respondents).

Since 1960s, there have been clear improvements in both life expectancy and infant mortality rates. Additionally, the positive trends in women’s health (contraceptive use and antenatal visits) and decline of HIV prevalence since the 1990s demonstrate overall improvements in the health status of Tanzanians. Short of increases in external funding, public policy and health trends demonstrate that Tanzania is on a positive path towards increasing primary health care for all.

Figure 4.4

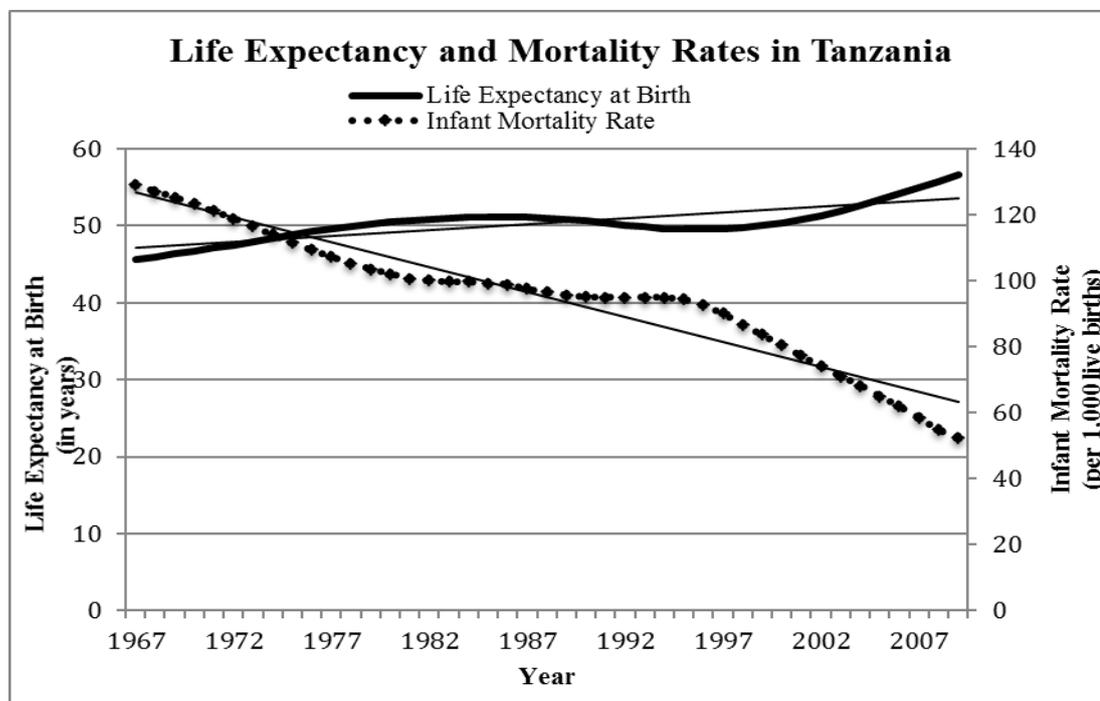


Figure4.4: Life Expectancy and Mortality Rates in Tanzania

Source: World Development Indicators (WDI), Health Systems 2010 Database (USAID).

As shown in Figure 4.5, life expectancy saw some stagnation in the 1990s, but has shown improvement since 2002. Infant mortality has also seen positive gains, decreasing from 147 deaths/1,000 live births in 1999 to 112 deaths/1,000 live births in 2005. Under-five mortality (not shown) also decreased between 1978 and 2002, from 231 to 162 per 1,000 live births.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

In this chapter the conclusion and recommendations are drawn from the findings from the field. This chapter makes a specific conclusion and recommendations to answers of each research question.

5.1 Conclusion

The national health goals have been achieved by the government through PPP. More than 50 percent of the total respondents argue positively about the introduction of PPP and its contribution in achievement of national health goals.

The national drug policy of 1991 for example has shown some improvements in health services after the introduction of PPP. Accessibility to drugs has been improved from 45 percent before PPP in 1990s to 75 percent after PPP in 2000s.

The government disburses funds to private hospitals (referral and designated hospitals) to ensure that health services are accessible to citizens at affordable costs. Sharing of experts is improved through PPP, where specialist doctors offer consultations in private hospitals. Training to both public and private hospital employees is conducted under the government expenses through PPP.

Health insurance was made accessible to citizens in public and private hospitals, and even private pharmacies e.g. NHIF. This has improved the out-patient attendance in private hospitals. The exemption of taxes in drugs, reagents and hospital equipments, and the opening of MSD all together improved the health service delivery.

Though respondents differences as shown in table 4.1,4.2,4.3 and 4.4, in most cases with optimum awareness of PPPs, they reached consensus on constrains and opportunities bought by PPPs. By using different milestones as established through questionnaires, interviews, observation along with secondary sources and tools. This study identified constrains and opportunities of PPPs on medical provisioning in health sector.

PPPs has shown to be a very important policy option for development of health sector in the country, since so far managed to improve service delivery. Through this collaboration patients have better access to drugs and treatments, hospitals are assured with supply of drugs and equipments from MSD, donors and private sector. With trainings human capital has been more equipped with skills and expertise while community trust to health facilities rises.

The goals and visions of PPPs have been hampered by poor commitment and political will to implement PPPs complementing policies, programs and frameworks. Poor planning and implementation of fiscal policies by the government lead to budgetary constraints and deficit due to delays or inadequate disbursement of funds, deprived mechanisms of drugs supply and institutional incapacity of MSD is another hindrance towards better provision of medical services.

Health sector in the country is facing serious shortage of qualified medical personnel both in private and public institutions. Putting more efforts on implementing PPP policy and regulatory frameworks will ray down more opportunities like better access to drugs and equipments, sustainable market and competitive ground between private and public sector hence creates a clear way for growth of health sector.

The public and private partnership contributed to some improvement on medical provisioning especially improving access to drugs as well as facilities for both patients and medical practitioners. The PPPs have been doing recommendable job so far of taking health service to the community. Refer to figure 4.1

Lucky of commitment and political will to implement PPPs towards realizing its goals and objectives has been pulling factor of PPPs progress. Budgetary deficit as the government and other donors delays or disburse in adequate amount of cash contrary to demands, shortage of qualified personnel plus poor capacity of MSD act as constraints for PPPs full translation.

PPPs give a broad access to health packages and significantly reduce costs of health services and price of drugs. In case of shortages in public or private hospital under this arrangement partners can cover one another. Under PPPs public or private health service

provider can apply for credit or assistance to cover gaps of drugs or facilities. It creates conducive environment for development of health sector through policies and frameworks. The cooperation and collaboration of public and private efforts, shared experience and expertise gear up improvements in health sector.

Despite the strong dissatisfactions with the performance of PPPs in the health service, given the long history of the private sector as well as the increasing number of PPPs in the service delivery, poor capacity and mistrust between the government and the private sector. Public-private partnerships are the best policy option for improving health service delivery in the co

5.2 Recommendations

Public and private partnership should be cemented by clear plans and strategies by every part of the partnership, with a focused goal and harmonized policies. The government should avoid bureaucracy and practice full decentralization of PPPs to local government with authority to reach agreement with the partners in provision of medical facilities.

It's recommended that, For PPPs to materialize stakeholders should honor their commitments towards this partnership to create trust and strengthening cooperation in a very transparent way. Continuous trainings shall be conducted to capacitate human personnel on delivering their daily duties . It is important that local authorities develop strategies for reducing donor dependency by setting budget allocation from their own revenues special for supporting public- private sector partnerships.

With centralized PPP programs makes difficult for local government to perform promptly, so it is high time for the central government to give full mandate to local authorities to negotiate and establish contractual relationships with development partners who will directly support the local authorities instead of through the current top-down programmes.

The government should ensure that enough budgets is allocated in order to implement its policies, for example free health services to maternal, children and old people, fail because of the unavailability of facilities to provide this free health service. E.g. drugs availability.

The government should put more emphasis to its policies until they are achieving the targeted goals first, there is a tendency of enacting new policies before accomplishing the existing one, and this is a big weakness in our government. We always have good policies but we fail to accomplish the because of enacting many policies as compared to our budget availability.

The government should stand on its strictly by laws, unethical practices by employees should be eradicated, this can be done through labeling all the medical facilities that are the government properties including the drugs, so that if they are found in private pharmacies can be caught as stolen.

5.3 Policy implications

From the findings that this study tried to obtain there were some lesson learnt that the policy and policy implementers should adhere in order to improve health services, and these include;

There is a need of conducting national public information campaign to make people aware of the collaboration that exists between the government and FBOs in some hospitals. People should be aware how the government (MSD) operates in relation to medical facilities and drugs availability.

The acceptability of health care is an important factor influencing its utilization and quality resulting from health care. Encouraging more and more appropriate use of government health services depends on understanding more fully of the collaboration that exists. Some drugs are provided freely by the government but people are not aware, they usually tend to buy drugs that are not for sell, the policy developers and implementers need to make people aware of that, this can be done by public announcement of the drugs that a freely available to the citizens.

The partnership that exist in health sector and that was supported by the PPP policy and other health policies, only focuses on one aspect of service provisioning. There is a need of engaging in collaboration with the FBOs in order to build an environment that will be conducive for them to start industries that will produce drugs and medical facilities in our country. This will reduce the procuring cost and shipping cost hence will improve health service delivery.

5.4 Need for farther researches and policy implication

An effective implementation of Public Private Partnerships requires a strategy to give discretionary power to local governments and strengthen their ability to make agreements and frame works with private institutions around its operational dimension. Such a strategy prescribes certain actions on the political, administrative and fiscal dimensions of decentralization. We observe that in our case studies the implementation of PPPs fail due to bureaucracy and poor commitment of partners including the government into sealing its pledges. We optimize on more fiscal and administrative authority to local government to shorten decision making process, strengthen responsive ability and raise government commitment into PPPs. Since data support that PPP is the right policy option for improving health service delivery, it is important for the local authorities to work closely with the partners to establish guides and frame works to manage various forms of PPPs in the health sector. This will reduce many problems which arise due to lack of clarity, responsibility and accountability in PPP arrangements. Local authorities should establish PPP units that will be responsible for identifying suitable areas for partnerships, conducting feasibility studies, facilitating monitoring and evaluating their establishment. Such units will coordinate PPP initiatives with support from the national level unit.

This also implies that a political economy analysis of the country, preceding the articulation, review and implementation of policies, regulations and frameworks complimenting the PPPs, will encourage the formulation of effective strategy by indentifying the hurdles in the commitment towards batter results. This political economy analysis should comprise the understanding of the configuration of current power-holders, relationship between different actors in the polity and the distribution of

economic and political power. Understanding political environment is not only imperative to encourage comprehensive decentralization reforms in a country but also to bridge the gap between de jure and de facto by helping us to understand how the prescribed rules are expected to be implemented.

Effective PPP requires that each partner has plan for sustained strengths, including financial, technical and human resources, to fulfill the agreed obligations and be ready to account for whatever happens. The research findings show that local authorities run health service partnerships by depending on resources from the central government and donors through top- down health programmes. It is important that local authorities develop strategies for reducing donor dependency by setting budget allocation from their own revenues special for supporting public- private sector partnerships.

The apparent gap of literature on identifying of constraints and opportunities of PPPs in Medical Provisioning, there is a big gap on capacity analysis of the actors in partnership especially in health sector in ensuring effective performance of PPPs. So further research are needed to make a deep analysis on the constrains and opportunities of PPPs especially on the capacity of the actors of PPPs to eliminate constrains and promote achievements and opportunities.

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APPENDICES

Appendix i

Research questionnaire for KCMC employees

These questionnaires are prepared to gather information about the opportunities and constraints in medical provisioning at KCMC. You are kindly welcomed to give your response to the questions so that the study can have a significant benefit to MSD (the government), KCMC, the community, and other stakeholders that depend on KCMC for quality health service delivery. (*NOTE: the information you provide will be confidential*)

“Put a tick (v) in appropriate bracket”.

Date.....

A. Personal Details:

1. Designation.....
2. Age of respondent;
 - (a) 0-20 []
 - (b) 21-30 []
 - (c) 31-40 []
 - (d) 41 above []
3. Gender:
 - (a) Male []
 - (b) Female []
4. Education level of respondent:
 - (a) Informal education []
 - (b) Primary education []
 - (c) Secondary education []
 - (d) College []
 - (e) University []
5. Department which you are working.....
6. Length of service within the organization.....
7. Length of service in current position.....

B. Questions;

1. How many pharmacies are there in your hospital?
2. Are they enough?
 - (a) Yes []
 - (b) No []
3. Do you think the pharmacist are enough compared to the load?
 - (a) Yes []
 - (b) No []
4. If they are enough do they arrive at a right time at work?
 - (c) Yes []
 - (d) No []
5. Are they available to the pharmacies all the time?
 - (a) Yes []
 - (b) No []
6. a. If the answer is “No” to the above question what do you think are the reasons?.....
.....
.....
.....
.....
- b. What should be done to improve Human Resource (Pharmacist) capacity?
.....
.....
.....
.....
7. Are the medicine enough in your pharmacies?
 - (a) Very adequate []
 - (b) Adequate []
 - (c) Inadequate []
 - (d) Very in adequate []

8. After what time you receive the medicine, when the stock starts to decline?
- (a) Immediately after you provide the information []
 - (b) After one week []
 - (c) After one month []
 - (d) There is no specific time []
9. The medicines that you receive in your stock are they relevant as what you have requested in terms of quality and quantity?
- (a) Yes []
 - (b) No []
10. Are you aware of the collaboration that exists between KCMC and MSD?
- (a) Yes []
 - (b) No []
11. How do you range the type of co-operation?
- (a) Close co-operation []
 - (b) Loose co-operation []
 - (c) Others (please specify).....
-
-
12. Do you think this collaboration improve efficiency and effectiveness in the health service delivery particularly in medical provisioning?
- (a) Yes []
 - (b) No []
13. If 'Yes or No' to the above question please explain.....
-
-
-
14. Do you think there is any political interference exists in that co-operation?
- (a) Yes []
 - (b) No []

15. If the answer is 'Yes' to the above question, does it have any impact? Explain.

.....
.....
.....

16. a. Do you think bureaucracy on acquiring medicine at KCMC is one of the factors that lead to unavailability of drugs?

(a) Yes []

(b) No []

b. What are other factors which lead to unavailability of medicines at KCMC?

.....
.....
.....
.....

17. Do you think the government policies on health have resulted in the achievement of national health goals?

(a) Yes []

(b) No []

18. Basing on the government policies on health, what do you think should be done to improve the availability of drugs in hospitals?.....

.....
.....

19. What challenges you face when there is medicine deficit or in medicine department?

.....
.....
.....

20. What do you think are the factor (constraints) that led to unavailability of drugs in your hospital?.....

.....
.....

21. Are there any advantages that you think are the result of availability of drugs? If yes list them.....

.....
.....

22. Comment on the government commitment in medical provisioning.

.....
.....
.....

22. Please comment on the performance of MSD as one of the government institution that facilitate the provision of quality health service in your hospital and what should be done to improve medical services in hospitals

.....
.....
.....
.....

Thank you for your willingness to participate in this questionnaire.

Appendix ii

Questionnaire for Employees at MSD

These questionnaires are prepared to gather information about the opportunities and constraints in medical provisioning at KCMC. You are kindly welcomed to give your response to the questions so that the study can have a significant benefit to MSD (the government), KCMC, the community, and other stakeholders that depend on KCMC for quality health service delivery. *(NOTE: the information you provide will be confidential)*

“Put a tick (v) in appropriate bracket”.

Date.....

A: Personal Details.

1. Designation.....
2. Age of respondent;
 - (e) 0-20 []
 - (f) 21-30 []
 - (g) 31-40 []
 - (h) 41 above []
3. Gender:
 - (c) Male []
 - (d) Female []
4. Education level of respondent:
 - (f) Informal education []
 - (g) Primary education []
 - (h) Secondary education []
 - (i) College []
 - (j) University []
5. Department which you are working.....
6. Length of service within the organization.....
7. Length of service in current position.....

B: Questions:

1. Do you have enough funds to purchase and supply medicine at a right time?
 - a. Yes []
 - b. No []
2. Do you receive request of medicine from KCMC?
 - a. Yes []
 - b. No []
3. Do you supply the medicines according to their requirements and funds available into their account?
 - a. Yes []
 - b. No []
4. If the answer is 'No' to the above question, explain why.....
.....
.....
5. Do you think PPP policy is effective in medical provisioning?
 - a. Yes []
 - b. No []
6. What challenges do you get in your partnership (PPP) with KCMC?
.....
.....
.....
7. Is budget a hindrance factor for the availability of drugs in your stores?
 - a. Yes []
 - b. No []
8. What measures you take when there is deficit of medicines in your store?
.....
.....
.....

9. a. Do you think bureaucracy on acquiring medicine and medical supplies through tendering at Medical Store Department (MSD) is one of the factors that lead to unavailability of drugs in MSD?

a. Yes []

b. No []

b. What are the factors which lead to unavailability of medicines at MSD?.....
.....
.....

10. Do you think the government policies on health have achieved the national health goals?

a. Yes []

b. No []

11. Basing on the government policies on health, what do you think should be done to improve the availability of drugs in hospitals?.....
.....
.....

12. What do you think are the factor (constraints) that led to unavailability of drugs in hospitals?.....

13. Are there any advantages that you think are the result of availability of drugs in hospitals? If yes list them.....
.....
.....

14. Do you think the government is committed to provide health services to the community through MSD?.....

Comment.....
.....
.....

15. Is there any political interference that exist and act as a hindrance factor in medical provisioning?.....

Comment.....
.....
.....

16. Please comment on the performance of KCMC as one of the hospital that collaborate with the government to facilitate the provision of quality health services in Tanzania and what should be done to improve medical services to Tanzanian hospitals.....

.....
.....

Thank you for your willingness to participate in this questionnaire.

Appendix iii

Dodoso kwa ajili ya wagonjwa wa KCMC

Dodoso hii imeandaliwa ili kukusanya taarifa kuhusiana na changamoto na faida ambazo zinapatikana katika huduma za madawa katika hospital ya KCMC. Unakaribishwa kutoa ushirikiano katika kujibu maswali yaliyolizwa, kwani ushirikiano wako ndio utakao saidia */kutoa taarifa kwa serikali (MSD) na hospitali ya (KCMC) na jamii kwa ujumla. Taarifa hii itaisaidia serikali (MSD) pamoja na KCMC katika kuboresha huduma ya afya. (*Angalizo: taarifa utakayo toa ni siri kati yako na mtafiti*).
“Weka alama ya tiki (v) katika mabano husika”.

Tarehe.....

A. Taarifa binafsi:

1. Jinsi.

(a) ME []

(b) KE []

2. Umri wako.

(a) 0-20 []

(b) 21-30 []

(c) 31-40 []

(d) zaidi ya 41 []

3. Ajira

(a) Serikali []

(b) Mashirika binafsi []

(c) Mkulima []

(d) Mfanya biashara []

(e) Nyinginezo []

4. Kiwango cha elimu

(a) Elimu ya msingi []

(b) Elimu ya sekondari []

(c) Chuo/ Chuo kikuu []

(d) Nyingine []

B. Maswali:

1. Ni maduka mangapi ya dawa yapo ndani ya hospitali ya KCMC (yanayomilikiwa na hospitali).....
2. Je maduka hayo yanatosheleza kwa huduma za dawa hospitalini hapo?
 - (a) Ndio []
 - (b) Hapana []
3. Je umekwisha wahi andikiwa dawa na ukaambiwa haipo katika maduka hayo ya dawa?
 - (a) Ndio []
 - (b) Hapana []
4. Kama jibu ni ndio katika swali la 3 hapo juu. Je ni mara ngapi umekutana na hali ya upungufu wa dawa katika maduka hayo ya dawa?
5. Je dawa unazopatiwa katika maduka hayo unafikiri zina ubora unaofaa?
 - (a) Ndio []
 - (b) Hapana []
6. Kama jibu hapana katika swali la 5 hapo juu, Eleza (kama kuna tatizo ulipata kutokana na kutumia dawa hizo,eleza na taja aina ya dawa kama unaikumbuka)
.....
.....
.....
7. Je umewahi sikia au unafahamu kitengo cha bohari kuu ya dawa Tanzania (Medical Store Department-MSD)?
 - (a) Ndio []
 - (b) Hapana []
8. Je unatambua kuwa kitengo hicho kina ushirikiano na hospitali ya KCMC katika kutoa huduma ya afya, hasa upande wa madawa?
 - (a) Ndio []
 - (b) Hapana []
9. Unalinganisha vipi uhusiano huo na upatikanaji wa dawa katika hospitali hiyo?
 - (a) Mzuri []
 - (b) Hafifu []
 - (c) Hafifu zaidi []

10. Unafikiri sera ya ushirika (PPP) kati ya serikali na hospitali binafsi imetatua tatizo la upatikanaji wa dawa katika mahospitali?

(a) Ndio []

(b) Hapana []

11. Unafikiri kuna nguvu yeyote ya kisiasa ambayo inaathiri upatikanaji wa dawa katika hospitali ya KCMC?

(a) Ndio []

(b) Hapana []

12. Kama jibu ni ndio katika swali la 11, eleza.....

.....

13. Je umeshawahi kuandikiwa dawa na muuza madawa akakuambia ukanunue duka la dawa lililopo karibu na hospitali?

(a) Ndio []

(b) Hapana []

14. Kama jibu ni Ndiyo katika swali la 13 hapo juu. Unafikiri nini ni sababu ya kuambiwa ukanune dawa nje ya hospitali?.....

.....

15. Je unafikiri kuna usawa katika ugawaji wa madawa hapo hospitalini?

(a) Ndio []

(b) Hapana []

17. Kama jibu ni “Hapana” katika swali la 15, unafikiri nini ni sababu za kutokuwepo kwa usawa katika ugawaji na upatikanaji wa madawa?.....

.....

17. Umeshawahi kutoa rushwa ili upate dawa unazozihitaji?

(a) Ndio []

(b) Hapana []

18. Je wauza madawa katika maduka ya madawa hapa hospitalini wanapatikana madukani?

(a) Ndio []

(b) Hapana []

19. Je unafikiri kuna haja ya kuongeza wauzaji wa maduka ya madawa hospitalini hapa?

(a) Ndio []

(b) Hapana []

20. Je wauzaji wa madawa wanatoa huduma vizuri kwa wateja?

(a) Ndio []

(b) Hapana []

20. Je unafikiri sera za serikali katika kuboresha huduma za afya, zinakidhi matakwa au malengo ya wananchi, hasa katika upatikanaji wa madawa?

(a) Ndio []

(b) Hapana []

21. Kama jibu ni 'Ndio au Hapana' katika swali la 21 hapo juu, Eleza.....

.....
.....

23. Ni changamota gani unazipata upande wa maduka ya dawa ya hospitali hiyo?

.....
.....

24. Unafikiri ni changamoto zipi zinapelekea kutokupatikana kwa madawa katika hospitali?

Eleza.....
.....
.....

25. Je ni faida gani unazipata kama huduma za madawa zinapatikana kwa uhakika?.....

.....
.....

26. Tafadhali eleza kama ushirikiano kati ya MSD na KCMC upande wa madawa unaleta tija katika huduma hiyo, toa maoni yako na mapendekezo nini kifanyike kuboresha huduma ya madawa mahospitalini.

.....
.....

Nashukuru kwa ushirikiano wako katika kujibu maswali haya.

Appendix iv

Usahili kwa ajili ya wagonjwa waliopo KCMC

Usahili huu imeandaliwa ili kukusanya taarifa kuhusiana na changamoto na faida ambazo zinapatikana katika huduma za madawa katika hospital ya KCMC. Unakaribishwa kutoa ushirikiano katika kujibu maswali yaliyoulizwa, kwani ushirikiano wako ndio utakao saidia kutoa taarifa kwa serikali (MSD) na hospitali ya (KCMC) na jamii kwa ujumla. Taarifa hii itaisaidia serikali (MSD) pamoja na KCMC katika kuboresha huduma ya afya. (*Angalizo: taarifa utakayo toa ni siri kati yako na mtafiti*).

A: Taarifa binafsi.

1. Jina (sio lazima).....
2. Jinsi (ME au KE).....
3. Mahali unapoishi.....

B: Maswali.

1. Ni kwa muda gani umeanza kuumwa?.....
2. Je umekwisha wahi andikiwa dawa, na ukaambiwa haipatikani katika maduka ya dawa ya hospitali?.....
3. Je umeshawahi kuandikiwa dawa na muuza madawa akakuambia ukanunue duka la dawa lililopo karibu na hospitali?.....
4. Kama jibu ni Ndiyo katika swali la 3 hapo juu. Unafikiri nini ni sababu ya kuambiwa ukanune dawa nje ya hospitali?.....
.....
.....
5. Je umekutana na hali ya upungufu wa dawa katika maduka ya dawa ya hospitali mara ngapi?.....
6. Je umeshawahi kusikia kuhusu kitengo cha bohari kuu ya madawa (MSD)?
.....
7. Je unajua kama kuna ushirikiano kati ya bohari kuu ya madawa na hospitali ya KCMC?.....
8. Unafikiri uhusiano huu una faida au hasara katika uboreshaji wa huduma ya afya hospitalini hapa, hasa upande wa madawa?.....

9. Kama jibu ni ‘Ndio’ au ‘Hapana’ kwa swali hapo juu. Eleza.....

10. Je unafikiri kuna usawa katika ugawaji wa madawa hapo hospitalini?.....

11. Kama jibu ni “Hapana” katika swali hapo juu, unafikiri nini ni sababu za kutokuwepo kwa usawa katika ugawaji na upatikanaji wa madawa?.....

12. Umeshawahi kutoa rushwa ili upate dawa unazozihitaji?.....

13. Unafikiri sera za serikali katika kuboresha huduma za afya zinakidhi matakwa na matarajio ya wananchi hasa katika upatikanaji wa madawa?.....
 Eleza.....

14. Unafikiri nini kifanyike ili kuboresha huduma ya afya hasa upande wa madawa?.....

15. Unafikiri ni changamoto gani zinapelekea kuwa na uhaba wa madawa hospitalini?.....

16. Unafikiri ni faida zipi unazipata kama upatikanaji wa madawa katika mahospitali unakua ni wa uhakika?.....

Nashukuru kwa ushirikiano wako, ugua pole.

Appendix v

Zonal Manager Interview guideline at MSD.

These questions are prepared to gather information about the opportunities and constraints in medical provisioning at KCMC. You are kindly welcomed to give your response to the questions so that the study can have a significant benefit to MSD (the government), KCMC, the community, and other stakeholders that depend on KCMC for quality health service delivery. (*NOTE: the information you provide will be confidential*)

Date.....

A. Personal Details:

1. Designation.....
2. Age of respondent.....
3. Gender.....
4. Designation.....
5. Department which you are working.....
6. Length of service within the organization.....
7. Length of service in current position.....

B. Questions;

1. Do you have enough funds to purchase and supply medicine at a right time?
2. Do you receive request of medicine from KCMC?
3. Do you supply the medicines according to their requirements and funds available into their account?
4. If the answer is 'No' to the above question, explain why.
5. Do you think PPP policy is effective in medical provisioning?
6. What challenges do you get in your partnership (PPP) with KCMC?
7. Is budget a hindrance factor for the availability of drugs in your stores?
8. What measures you take when there is deficit of medicines in your store?

9. (a). Do you think bureaucracy on acquiring medicine and medical supplies through tendering at Medical Store Department (MSD) is one of the factors that lead to unavailability of drugs in MSD?
 (b). Comment on bureaucracy.
 (c). What are the factors which lead to unavailability of medicines at MSD?
10. (a). Are there enough Human Resource capacity to deliver services to your customers?
 (b). What should be done to improve Human Resource capacity?
11. Do you think the government policies on health have achieved the national health goals?
12. Basing on the government policies on health, what do you think should be done to improve the availability of drugs in hospitals?
13. What do you think are the factor (constraints) that led to unavailability of drugs at KCMC?
14. Are there any advantages that you think are the result of availability of drugs in hospitals? Can you explain them?
15. Do you think the government is committed to provide health services to the community through MSD? Comment
16. Is there any political interference that exists and act as a hindrance factor in medical provisioning? Comment.
17. Do you agree that trust in the government sectors and the FBOs like KCMC can be a factor to improve medical availability in hospitals? Comment.
18. Please comment on the performance of KCMC as one of the hospital that collaborate with the government to facilitate the provision of quality health services in Tanzania and what should be done to improve medical services to Tanzanian hospitals

Thank you for your willingness to participate in this interview.

Appendix vi

Interview guideline for Executive Director at KCMC

These questions are prepared to gather information about the opportunities and constraints in medical provisioning at KCMC. You are kindly welcomed to give your response to the questions so that the study can have a significant benefit to MSD (the government), KCMC, the community, and other stakeholders that depend on KCMC for quality health service delivery. (*NOTE: the information you provide will be confidential*)

Date.....

A. Personal Details:

1. Designation.....
2. Age of respondent.....
3. Gender.....
4. Designation.....
5. Department which you are working.....
6. Length of service within the organization.....
7. Length of service in current position.....

B. Questions;

1. How many pharmacies are there in your hospital?
2. Are they enough?
3. Are the medicine enough in your pharmacies?
4. (a). Do you forecast the medical demands at a right time, when the stock starts to decline?
 - (b). What are the factors that lead to delay in forecasting of the medicines?
5. (a) MSD supply you the medicines at a right time after requesting?
 - (b) What do you think are the factors that lead to delay in medical provisioning from MSD?
6. The medicines that you receive in your stock are they relevant as what you have requested in terms of quality and quantity? Explain why?

7. Do you have enough pharmacists to deliver services to your customers? What is your suggestion to increase the workforce?
8. Do you receive any complaints from your customers about unfair practices in drugs distribution? Who are the causes of unfair distributions?
9. How do you range the co-operation that exists between the hospital and government (MSD)?
10. Do you think there is any political interference exists in that co-operation that leads to unavailability of drugs? Comment.
11. Do you think this collaboration improve efficiency and effectiveness in health service delivery? How?
12. (a) Do you think the PPP policy is effective with the availability of drugs? What should be done?
13. Do you think the government policies on health have resulted in the achievement of national health goals? Can you say something on that?
14. Do you think bureaucracy is one among the factor that lead to unavailability of drugs in hospitals? Can you explain how bureaucracy hinders the availability of drugs?
15. What challenges you face when there is medical deficit at the hospital?
16. How do you overcome the problem of drugs deficit in your institution?
17. (a) Do the government allocate enough funds for you to purchase drugs?
(b) What are your other sources of funds that you depend on if the government budget is not enough?
18. If you have all those sources of funds, what then is the factor that causes drugs unavailability?
19. What are the advantages of availability of drugs in hospitals and to the community and the government?
20. What are the factors that lead to unavailability of drugs in hospitals?
21. Is the government committed to provide quality services to the community through your collaboration? Comment.
22. Please comment on the performance of MSD as one of the government institution that facilitate the provision of quality health service in hospitals and what should be done to improve medical services in hospitals

Thank you for your willingness to participate in this interview.

Pictures during data collection

