IMPLEMENTATION OF THE NATIONAL AGEING POLICY IN TANZANIA: WHAT DO STREET LEVEL BUREAUCRATS AND CLIENTS SAY ABOUT ACCESS TO FREE HEALTH SERVICES BY THE ELDERLY POPULATION IN MOROGORO MUNICIPALITY?

By

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A Dissertation Submitted to the Faculty of Public Administration and Management in Fulfillment of the Requirements for the Degree of Master of Research and Public Policy (MRPP) of Mzumbe University

2016

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommended for acceptance by the Mzumbe University, a dissertation entitled, Access to Free Health Services by the Elderly Population at Morogoro Municipality in Tanzania; An Account from the Street-Level Bureaucrats and the Clients on the Implementation of the National Ageing, in partial fulfillment of the requirements for award of the degree of Master of Research and Public Policy (MRPP) of Mzumbe University.

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DECLARATION

I, Musa Amon Malalika, 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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Date.....

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DEDICATION

This work is dedicated to my parents Mwl. Amon Malalika and Mwl. Saida Chipara for exposing me to education. What they invested on my education is highly valued. It is also dedicated to my lovely wife Maria Felician and our daughters Esperanza and Eviana.

ACKNOWLEDGEMENTS

This research is not a work from a single source product but the output of intensive hard work, bravery and blessings from several sources. My first sincere appreciation goes to God the Almighty for uncountable blessings all the way through the undertaken of this study. Plentiful cheers to my supervisor Dr. Orest Masue for his diligence in directing and managing me at different stages of the study. Special thanks should go to my lovely wife Maria Felician, my parents, brothers and sisters for their continual love, generosity, inspiration, fiscal and moral support specifically in the critical time of need. I am impressively indebted to my lovely daughters Esperanza and Eviana. I appreciate the patience they showed me even with missing my love, devotion and care as a father during my studies. This study could have been difficult to accomplish without assistance that I received from former Morogoro and Kinondoni district Executive Director Mr. Ndunguru, Morogoro Elderly People's Organization director (MOREPEO) Mr. Msemembo, Morogoro District Medical officer, Doctors, nurses and the respondents to this study for the valuable information to enrich the findings of the study. Although it is not easy to mention all people who contributed to this work, I deeply express my thanks to all of them who either directly or indirectly contributed to the accomplishment of this work. God bless them all.

ABSTRACT

The goal of this study was to assess the accessibility of Free Health Services by the elderly people in public health facilities account from the street-level bureaucrats and the clients in the implementation of National Ageing Policy in Morogoro Municipality. Three wards of kilakala, Bigwa and Sabasaba were selected to be the study area. The target population was elderly people public health providers and people working with elderly in the municipality. Mixed methods of research designs were used namely qualitative and quantitative methods. The researcher used interview method, questionnaires and documents reviews as the tools for data collections. Sixty three respondents were used as a sample of the study, to which male respondents were 30 and female 33 respectively. The selection of respondents was based on both purposive and random sampling techniques. In this study cross sectional study design was employed. The study findings revealed that National Ageing Policy is not well implemented in the implementation process, as there is a gap between what the policy advocates and its practices on the ground. 38% of respondents had low understanding on the concept, process and procedures when it comes to the free health services implementation. And that 59% of respondents showed their dissatisfaction on the services provided by free health services providers. Also, the findings show that 79% of respondents view that lack of Act and by-laws to support National Ageing Policy on free health services hinders their access to the health services. The study further observes that waiting time for Free Health Service affects their access to the services. 92% of them mentioned drugs shortage specifically drugs relating to age-related diseases affects negatively their access to the free health service.

The researcher recommends for a government to ensure sufficient drugs are available at health facilities and are accessed by the elderly in all public health facilities. Also, special window for elderly at health facilities should be introduced and be used to reduce waiting time by the elderly when seeking the services. Local authority is advised to ensure elderly have health identity cards for easily identification and documentations when seeking the services. Moreover, health providers should work with other stakeholders to disseminate information regarding provision of free health services to the elderly people.

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ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
DED	-	District Executive Director
DMO	-	District Medical Officer
FHS	-	Free Health Services
HIV	-	Human Immunodeficiency Virus
LGA	-	Local Government Authority
LMC	-	Low- and middle-income countries
LMIC	-	Low and Middle Income Country
MDG	-	Millennium Development Goals
MRPP	-	Master of Research and Public Policy
NAP	-	National Ageing Policy
NGO	-	Non-Governmental Organisation
NSGRP	-	National Strategy for Growth and Reduction of Poverty
URT	-	United Republic of Tanzania
WEO	-	Ward Executive Officer
WHO	-	World Health Organisation

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CHAPTER ONE

INTRODUCTION TO THE STUDY

Introduction

This chapter is an exposition of issues on Access to Free Health Services by the Elderly Population an Account from Street Level Bureaucrats and the Clients on the Implementations of National Ageing Policy in Morogoro Municipality in Tanzania. It consists of eight sections, section one is about background of the problem, section two is statement of the problem, section three is objective of the study, section four is about the research questions, section five is significance of the study, section six is the scope of the study, section seven is of definition of the key terms and last section is about the organisation of this thesis.

1.1 Background to the Study

In recent years, the provision of adequate, cost-effective care and free health services for the rapidly increasing number of ageing people in societies has received enhanced attention from national and international organisations, as well as the general public globally. The United Nation Report (1999) shows that number of elderly people has increased in the world which brought about miserly to the elderly's health, nutrition, safety and other basic services needed to support their living particularly in developing countries which had a weak economy to cater for important needs to the elderly. The report further estimates that people who are aged sixty years and above by 2050 globally will be two billions and those above 80 years will be 800 million. Due to diversity in economic development and standards of livings among continents, 80 percent of those estimated will be living in low and middle income counties. In Africa sub Saharan region it was estimated that 8.3% of total population will be of people aged sixty years and above while in Europe it is estimated to be 33.6% by 2050 (WHO, 2014). It is obvious that as time goes on elderly decrease their ability to perform normal activity and hence unable to produce and doing work by their own which later on affects their income to the extent that

some depends on the governments, NGOs and relatives to take care of their needs particularly their accessibility to health services for their survive.

These statistics do not comply with plans and programmes designed to suit and address the needs of elderly people. Global economic changes, expansions of towns, and advancement of science and technology in both rural and towns, followed by the fall-out of old-fashioned ways of supporting family, and the devastating effects of the AIDS-pandemic and chronic poverty influences the hardship for the ageing to access the health services. As a results the majority of elderly people continues to live at risk in the face of abject poverty and limits their accessibility to health services

Research conducted by Poverty and Human Development Report (2007) observes that only 10 percent of elderly receives free health services to the public health facilities according to NAP and other health directives from the government. Due to shortage of drugs and health attendants specialized for elderly concerns at dispensaries and health centers, many elderly turns to the private health facilities for their treatment and some of them are referred to the district hospitals where drugs and more professional health attendants are likely to be, hence they incur transport costs and other costs for their staying.

As being observed by WHO Perth Framework for Age-Friendly Community-Based Health Care (2002) the primary goal of any health care services is to ensure the wellbeing of clients are attained by providing the highest quality standard of health services that will influence better active ageing among people and to continue living their life in dignity. For this to be achieved, health care services must be bounded with six interrelated essential criteria named; efficiency; accessibility; quality; non-discriminations; availability; comprehensiveness; and aged-friendship relationship. For the aspect of non- discrimination should be adhered so that equality in distributions and treatment as well as the prevention of abusive as one thinks of economic, social psychological and physical deficit of an elderly person.

In Tanzania it hard to access health services particularly to ageing people as observed by Pastory (2003) that (70%) of his respondents who were interviewed mentioned that provision of health services their quality and treatment among public health

facilities were determined by patient's age as the results most elderly were failed to get quality and on-timed health services from health attendants as being advocated by NAP services. It was observed by his study also that, some elders reported being neglected by the health services providers either due to their states of illness or because they are being treated free of charge, which is against NAP, NSGRP, National Health policy, and against the guidelines to preparation of medium term plans and budget framework to which all of them advocated the provision of free health services to people who are above sixty years and above without discrimination or prejudices.

One of the core values of NSGRP is break-up all barriers which limits the sustainable developments and the developments of citizens so that they can nourished for their full potential. It also focused on setting foundation to which elderly people and other vulnerable groups in the country to access free health services Benedict (2013) however, the deliverance of the above strategies are not yet effectively implemented to ensure the free health services are being granted to ageing people on the ground. For example, Morogoro Municipality have approximately 10,661 elderly people (Morogoro Municipal Council [MMC], 2011). Of these elderly people, more than 39 per cent take care of orphans and vulnerable children in the municipality still the magnitude of insecurity, vulnerability and their access to free health services of the elderly people in the Municipality are not well taking care off.

It is obvious that many studies on elderly people were done but mostly were conducted long time ago and being conducted in western countries which had favorable conditions to elderly compared to the third world countries. And many of these studies conducted concerned elderly focused on assessing knowledge possessed by elderly, their challenges in accessing services, and assessing elderly people about elderly life expectancy. No current studies which have done on access to free health services by looking the role of street level bureaucrats and clients on the implementation of National Ageing Policy.

For example in Tanzania most of the study on elderly people focused on investigating as to why they are having red eyes and killings due to local believes (which crafts). This influenced a researcher to conduct the study on elderly people's access to free health services as the present study is set to bridge this gap by investigating the understanding of the concept of free health services, the perception on the satisfaction of the programme and the challenges facing elderly people in accessing free health services in public health facilities.

1.2 Statement to the Problem

Frequent and prolonged diseases are the notable characteristics among many facing elderly which needs special attention and professional care. With gradual improvement in health care delivery services, life expectance will be increasing thus preserving of elderly population. The introduction of user fee among public health facilities by the government in the early 1990 brought new changes and challenges in health sector within the country. As far as the ageing people are concerned as one of a vulnerable group in a society, the government through National Ageing Policy (URT, 2003) recognises the importance of elderly people in the Tanzanian society that are the key contributors to the political, economic, cultural and social spheres of development of the country. For that reasons, allocation of resources for older people's free health services has become one of the major concerns of the policy.

HelpAge International ranks Tanzania 90th globally in the welfare of the elderly population-the lowest in the Africa region. As the results of economic and social changes among many societies brought by science and technology, elderly population found themselves behind experienced unfavourable condition in almost all aspects of life including health services. Among many problems facing them illness due to ageing is common facing the elderly. It was revealed by many writers that despite having policies and other directives that gives directions and lay foundation on how to deal with elderly particularly relating to their heath, still these policy prescriptions remained largely rhetorical, and not effectively targeted the needy. Among many barriers for accessing free health services by the elderly, poor information dissemination on the benefits available in the safety-net institutions and

poor communication to both the targeted beneficiaries and the downstream service providers (TAKNET Policy Brief Series No. 09 – 2010).

Despite the clear direction of the Tanzania's National Ageing Policy, NSPR, and Health Policy towards ensuring that ageing people access health services free of charge, empirical evidence shows that the policy intention has not been implemented as intended. An elderly person still faces lot of problems especially when it comes to accessibility to health services. As being observed by Makene (2007) that, there is no good healthcare system to take care of the ageing population. And primary health care are really not age-friendly. Older patients continue to be refused treatment because they are too old and too poor to afford the costs. A survey across 32 countries revealed that 63 per cent of old people faced difficulties in accessing health care services. The study indicated that in Tanzania 40 per cent of old people reported use of inappropriate language by medical staff in health facilities.

It was estimated and planned by the government that by 2010 all elderly population in the country has hundred percent accesses to free health services to all public health facilities and 40% of them be covered by social security measures. But on the ground, this is big mountain to climb by the government. A voice of the people report (2007) found 35% of the elderly population paid cash for them in order to be treated at public health facilities, and 65% of ageing population had health problems, 27% of them, family and caregivers assisted them to pay for their treatment, and only 15% received free treatment, as being advocated by health policy and NAP. An interesting thing is that about 48% were not aware of being entitled to free health services in public government facilities (The economic and social science research-TAKNET, 2010).

This is a clear indication that the implementation of the National Ageing Policy particularly with regard to ensuring that elderly people in the country do have access to a free healthcare services has not been sufficiently implemented. The study examine the implementation of National Ageing Policy with regard to access the availability of free health services to ageing people, with particular focus on Morogoro Municipality as the case of interest.

1.3 Objectives of the Study

1.3.1 General Objective

The general objective is to examine the perception of street level bureaucrats and clients on the implementation of national ageing policy with regards to access to free health services to ageing people.

1.3.2 Specific Objectives

i) To find out how ageing people are identified and documented to facilitate their access to free medical services;
ii) To examine the perceptions of street level bureaucrats and clients on implementation of NAP during identification, verification and handling of specific matters related to health services delivery to ageing people.
iii) To examine the challenges that street level bureaucrats and clients face in the implementation of the free health services to the ageing people and their coping strategies.

1.4 Research Questions

The question at the core of this study is to assess whether ageing population is practically accessed to free health services. In an attempt to tackle the research problem, the following research questions guided the study;

i) How does the process of identification and documentation of the elderly people for free health services go?
ii) Does the process capture all elderly people regardless to their variation in levels of socio-economic status?
iii) How do street-level bureaucrats perceive NAP implementation to elderly particularly on free health service delivery?
iv) How do the local health service providers perceive the philosophy of access to free health service among elderly?
v) How effective is the whole process of identification and documentation of elderly people for free health services?

vi) What is the implementation status of the free health services to elderly people in Morogoro municipality?

1.5 Significance of the Study

There have been few studies conducted focusing on assessing provision of free health services to ageing people as a vulnerable group in Tanzania. Most researchers concentrate on investigating elderly's life expectancy; why elderly people are killed due to local beliefs (termed as witch craft due to their red eyes) and burden lessened to them by society due to HIV/AID and so on. The study I conducted attempts to bridge the knowledge gap by examining whether the opportunity given by the government to the elderly on free health services are fully utilised as supposed to be. For doing this, the findings are useful for policy makers since it tells what is behind the behaviour of elderly and street level bureaucrats toward the access to Free Health Services to elderly people. It is also the truth that there are little emphases on the implementations or practicability of most policies in country. The findings of this study will expose the best ways to which the policy will be smoothly implemented to alter the desired policy goals.

The study is useful as long as the findings add details in the context of service delivery particularly on public health sector or rather it provides an alternative explanation on access to free health services. In addition, the findings of this study might stimulate more research in the area at different demographical, economic and social setting.

1.6 Scope of the Study

This study was conducted at Morogoro municipality, where the units of analysis were Morogoro District Executive Director (DED), District Social Welfare Officers, health attendants (Chief Doctor and Chief Nurse) representatives of NGOs who are dealing with ageing people, caregivers (guardians of an ageing person), Ward Executive Officers of the respective ward, Hamlets, ageing people who are not subjected to formal retirees benefits and community members will be both randomly and purposively selected. Three wards namely Kilakala, Bigwa and Mafiga were the

area where data were collected within Morogoro Municipality. This study also covers the findings of the perception of street level bureaucrats and clients on the implementation of NAP during identification, verification and handling of various matters pertaining free health services delivery to the ageing people and their challenges.

1.7 Definitions of Key Terms and Concepts

The study is about access to free health services to the ageing population. However some words have a special meaning when referred to this study. The terms are defined below as being used in Tanzanian context by Eriksen et al (2006).
Dispensary is the first formal health unit of level-one health services, offering outpatient's services including reproductive and child health service as well diagnostic services. It caters for 5,000 people by providing basic curative care.

Health center is the second level health facilities which have simple laboratory facilities and can usually admit patients. It offers outpatient and in-patient services, maternity care and has ability to cater up to 50,000 people and supervise all the dispensaries in the division.

A Hospital is a third level health facility provides outpatients and in-patient care, and act as referral for primary health centers in the district or catchment area and perform general surgical and obstetric operations.

A Ward means a subdivision of a municipal council. This \administrative division of a division or district has a representative in a municipal council.

Council means area over which a municipal council is established under Tanzania local government Act of 1982.

A Municipal council means a council established under Tanzania Local government Act of 1982. It is local governing body of the municipal corporation and the custodian of its powers, both legislative and administrative (ibid).

1.8 Organisation 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, delimitations of the study and the conceptual framework, definitions of terms and the organisation of this thesis. 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 thesis.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The chapter is about literature review and consists of three sections namely; theoretical framework, empirical literature review and summarisation of the chapter. Literature review facilitated understanding what others have done in respect of the problem so as to come up with a research gap and the conceptual framework for guiding the conduct of the study.

2.1 Theoretical Literature Review

2.2 Policy Implementation Literature

Naredra (2009) viewed implementation as a sequential process which put into practice the authoritative decisions and actions planned and approved by government, with purposes of achieving timely and satisfaction in performance during implementation of a planned tasks bounded by a specified rules and guideline. Implementation can also be defined in terms of product of a certain programme or output, whether the planned goals of a programme had been achieved. Finally, at highest level of construct, policy implementation can be defined by the presence of quantified changes in implementation output from a larger problem that was addressed by the policy or public law. Thus, policy implementation generally can be understood as the instruments, means, and networking that connects policies to programme action.

Elmore as quoted by Naledra (2009) mentioned four basic components for effective implementation: first there should be a well-defined objectives and tasks with clearly reflection on the intention of a policy; secondly there should be a strategic management plan that shows how each tasks should be performed at all level of units within an organisation; thirdly there should be the set objectives that will be used to measure performance of subunits within an organisation; and lastly there should be a management system that will control the entire process to ensure checks and

balances so that to make all policy implementers accountable to the task assigned to them.

There are various ways that can lead to the failure to effective policy implementation. It can be sourced from the definition of policy itself, poor planning, poor designing and control. For the successful and effective implementation of any policy two important factors should be bared into minds by the implementers; firstly, is local capacity. Those policy implementers at lower levels should have a capacity in terms of good understandings of the people to which the policy is directed to, skills on how to deals with all impedes that will appears during the process of implementations, accurate information and financial ability so as to execute the objectives of the implemented policy.

The second factor is the will to perform the tasks assigned to them. The issue of motivations and commitments provides a picture of the implementer's on how they value the policy or strategies employed for the implementations. Motivation or will among policy implementers are triggered largely by aspects that operates outside policy environment itself. Issues such as struggle for authority and power, conflicts of interest, priorities or pressures and other socio-political and economic factors greatly can affect an implementer's willingness. This is to say motivation of an individual and conditions within an institution has brought about external policy features which have limited effect on the policy output specifically at the grass root of an institution (Matland, 1995).

2.2.1 Top down Approach of Policy Implementation

Public policy often involves a political process initiated at ministerial level where policy goal and objectives are set, and then transferred to lower level within a state bureaucracy downstream where practical, managerial and administrative tasks are to be executed. Binary approaches of policy implementation are often considered by many implementers; the top-down perspective and bottom up approaches to policy implementations. Top-down perspectives view the implementation of policy as merely a rigid and robotic process which is absolutely independents from policy formulation circle. And ignore the views that policy implementation is rigorous

procedure that can be pre-planned and get supervised by those who formulates the policy. For policy implementation to be effectively achieved, various conditions are needed to be generalised in the manner that these conditions will elicit smoothly undertaken of policy implementation on the ground (Lars Tummers and Victor Bekkers, 2012).

The top down approach briefly presents theoretical orientations which views implementation as a process of interpreting policy objectives, mission and vision, thinking broadly what to do and providing actual physical services to the programme or policy to the policy beneficiaries at different situation and in different environment within a specified organisational setting by the street level bureaucrats.

Sabatier and Mazmanian (1980) developed the model of framework of top-down which they believed that for effective implementation of any public policy one must identify possible variables that may affects implementers during the process and come with counter measures for smoothly implementation. To them these variables can be categorised into three main types, namely nature variables, organisational variables and circumstantial variables. In 1980 (Edwards, 1980) developed an new top-down model for policy implementation .To him there are four factors that may impact policy implementation (Edwards, 1980, p. 148): these are communication; there should be a frequently flow of information between and among all stakeholders involved, in the implementation of policy. This will reduce misinterpretation of policy objectives and influencing cooperation among all who are involved in the process. Resources, in term of human and fiscal resources, as well as enforcement trends to check the progressiveness of the implementation process and bureaucratic structure.

The best of top-down approach to policy implementation is that it seeks to collects and formulates the sound policy advices and reliable recognizable patterns of behaviours within various policy arenas. However, the approach is being criticised as only compelling to legal language as preliminary point without considering the importance and effects witnessed during previous actions. One can say that the approach ignores the roles of political aspects in implementation as well as leaving

behind local implementers during implementation and put much focuses on implementation as the administrative process (Cerna, 2013).

There are abundant worries when comes to the effectiveness of the top-down approach. First, those at higher level bureaucracy (directors, ministers' secretaries etc.) have the tendency to own the whole process and unintentionally sometimes found themselves in authority leakage by allowing less control as you move down the hierarchy of implementation. In this situation, the local officials may feel inferior and thought of being isolated by higher authority leading them to have no passion and willing to implement the policy. Another distress within the top-down approach is shirking. The top implementers sometimes failed to control those who are working under their supervision their non-productive behaviours, which in turn provide rooms for individual to acts and performs their duty outside their job descriptions and hence unattainability of organisational or policy goals. Furthermore, when it happened that implementer is not a stakeholder to the policy being practiced, may develop a counter behaviour that will benefit him/herself rather than serving the policy goals which may resulting to policy goal displacement and automatically its failure.

At the end, what the implementers learn may pamper effectiveness of top-down implementation, as they are unaware of what they supposed to stand for to the extent they are sympathetically to those under their command and fail to stand for regulations and rules established for successful implementation. Thus, the implementers become obedient to the subordinates whose are supposed to be monitor or control. As the way to lessen these problems, often top down implementers integrates on-going monitor and evaluations throughout of programme life" (Elder, Lecture, 2011).

Sometimes it happens that top-downer implementers may successful implement policy with high standards that the common people do not apprehend which may also bypass their normal favorites (DeLeon, 2001), as this happens, policy analysts termed top-down approach to policy implementation as being "tactics" and not a best strategy for policy implementation. The top-down perspective hypothesized that policy objectives can be identified by policymakers and that implementation can be

carried out successfully by setting up certain mechanisms (Palumbo and Calista, 1990, p13).This perspective is 'policy-centered' and represents the policymaker's views. Important point is that only the policy makers is supposed to have capability to control over the environments and situation to which the policy is being implemented and the ability to control the implementers at all levels. It provides theoretical orientations conceiving implementation as the interpreting policy goals and objectives process, thinking loudly what to do and delivering concrete services to the programme or policy to the beneficiaries in different locality and environment by street level bureaucrats within different organisational setting.

The major advantage of top down approach to policy implementations is to create an inclusive policy recommendation and provide consistent notable designs in behaviour across different policy areas (Matland 1995) the approach proud itself for having best structure and hierarchy, which are designed to provide a platform for maintaining ample accountability within any established organisational setting. However, other scholars criticised the design as having weak evaluation strategies which will enable the evaluators to more readily outline the failure or the success of the policy. Also, the top down model take the legal language as their starting point resulting to lacks of put into considerations the significant actions examined prior to the policy-making process. As noted by Winter (1985 and 1986) most difficulties in the policy-making process are found at the initial stage of policy process, it is necessary to understanding vividly each stages for smoothly and effectively implementation of a programme or policy marginalise.

Secondly, top-down approach to policy implementation has been blamed for embracing implementation as administrative tasks away from political aspects. It try to put emphasise on clarity of job done, rule endorsement, and making counter-checks as they based on weberian bureaucrat of making decisions relaying on quality technical criteria observed away from political influences. They have been accused of seeing implementation as a purely administrative process and either ignoring the political aspects or trying to eliminate them. The top-down emphasis on clarity, rule promulgation, and monitoring brings to mind the Weberian bureaucrat making independent decisions based on merit and technical criteria, free from political

influence. However, it is almost impossible to separate politics from administration, though an attempt to separate a matter relating to politics from politics does not automatically lead to a political action. They obvious may lead to a policy failure.

Finally, top-down approach has been critiqued for more relaying on the statute framers as key actors. The notion to this emanated from two major reasons. First they argued that there are people who are expertise and knowledgeable who understand the problems better and are working with local service delivers. Hence, they are in better position to implement a policy successfully. However, top-down implementers' views local actors as the barriers to successful implementation, representatives with dodging behaviour needs to be controlled. The second reason comes from a positive angle that discretion for street-level bureaucrats is unavoidable so abundant that it is merely impractical to expect policy designers to be able to control the actions of these agents. That service deliverers eventually determine policy is a major precept of bottom-up models (Matland, 1995).

2.2.2 Bottom-Up Approach

During policy implementation, bottom-up approach view individuals at subordinate levels as having some optional power to redesign policy objectives and possibly finds other ways as its fit for implementation to be smoothly undertaken. This approach also see policy implementation as a collaborative process involving those who makes up policy, implementers from different levels of government as well as other actors interested to the programme undertaken. As policy can be changed during its implementation, bottom-up approach to policy implementation credited policy actors at the grassroots room to participate in making decisions, setting their priorities to be taken into aboard and best strategies to be used in their local area.

Bottom-up theorists emphasise beneficiaries and service deliverers, arguing that policy is made at the local level (Matland, 1995: 146), and criticize top-down theorists as being egoistic for taking only advices and concerns of only central decision-makers and neglecting the local and marginalized actors. The bottom-up approach, developed by Hanf, Hjern and Porter (1978), were developed in the way

that it identified the networks of various actors from one or more local areas who were involved in service delivery after being asked about their goals, strategies, activities and contacts. Then these contacts established are used to develop networking techniques to actors from different levels of government (local, regional and national actors) who are involved in the designing, funding and implementation of important governmental or non-governmental programmes. For doing so, local actors and decision makers are transformed from merely local actors to the top policy makers in both public and private sectors (Sabatier, 2005: 23).

One of the strength of the bottom-up approach is that it concentrated much on centrally located actors who formulates and implement government programmes hence adhered to the contextual factors at the time of actual policy implementation. It is important during policy implementation to have better understanding of the actors and their goals, their strategies as well as on how they are undertake daily activities for effective implementation of a programme. However, the approach do not provides a dogmatic advice, but rather it gives description factors that may prompt or hindering the attainment of the stated goals. It is important that strategies employed to be flexible so that can support local contextual factors and fits to local difficulties.

Nevertheless, bottom-up approach suffers from two major critiques. One is that the actors who should execute policy control are supposed to be those who's their power stems from their answerability to self-determine voters through their elected representatives, however the authority of street-level bureaucrats does not derive from this. Secondly the bottom-up approach inclines to overemphasize the level of local self-rule (Matland, 1995).

It has been revealed by experiences that bottom-up approach should not be well-thought-out as substitute or divergent to top-down approach from any level of policy implementation authorities, but rather as two approaches that connect and interrelate with them to reach better overall results. The top-down implementation approach is a precise way of command and control from the government to the programme which involves the people.

2.2.3 Andersen Behavioral Theory Approach to Study Access

Andersen (1995) use behavioral theory approach to describe four major scopes of accessibility as one focuses on the fundamental nature of access. These dimensions are as follows. Potential access; this includes resources that are required to enable effective use of health services. Realise access; which implies definite acceptance of the services offered; impartial access; which occurs when demographics and need influence the differences in the acceptance of the services and lastly is prejudiced access; which happens when utilisation of services is judged by social structures, individuals' health beliefs and income.

To him access may be understood over the lens of the complex connection between service providers and clients. This connection governs the routine in which health services are used. Access is therefore, centered on the processes that influence entry into the health care system. Therefore, access is centered within the processes that stimulate entry into health care system. However, it is not exceptional for the concept of access used within the environment of "having access" and "gaining access". Guilliford et al. (2001): 81 (1) to have access to a service implies that the service need exists, is obtainable, and that there are systems in place that would allow service utilisation following a contact with the health care service.

Attainment of access refers to the definite process of entrance into the courses of utilising the service. Here, when one receives a service implies that there is utilisation of a particular service in the named health facility. Health providers and services need to be obtainable at the working areas and where people live. Then, people must have the means and know-how to get to those services and make use of them. Earnings, health insurance, a regular source of care, and travel and waiting times are some measures that can be important (Andersen, 1995). Thus access to free health services to the ageing population was viewed as Dependent variable that are being influenced by Independent variables named as ageing people characteristics, (Self-perceived health status, ageing people satisfaction on free health service and Social cultural practices prior to their illness); Street level bureaucrats' performance (ability to control non-productive behaviour, care and respect to ageing people and

managerial supervision) as well as Organisational characteristics (waiting time for free medical service, availability of drugs and personnel (Doctors and nurses) and availability of health personnel and facilities.) can influence accessibility of ageing people on provision of free medical services.

2.3 Availability, Accessibility, Acceptability and Quality Health Model (AAAQ)

This model was originated by Dr.Hellen Potts during the Declaration of the Alma Ata in September 1978. She tried to formulate a model that can measure accountability and to achieve the right of the healthily clients to attain highest heath standard services. The declaration declares that health is the basic human right and that promotion and safety of the health of the people is vital to sustainable and economic and social development and to better quality of life and the word peace. It also declares that governments have the obligation for the health of their people which can be fulfilled only by provision of adequate health and social measures. The model assumes that for the effective attainment of standard health services four inseparable and important elements should be observed. These are availability; accessibility; acceptability and quality (Potts, H 2002 as quoted by Kagaruki, 2013).
The AAAQ concept operationalizes the right to health in terms of availability, accessibility, acceptability and quality of care. It emphasises that to achieve the right to health, AAAQ must be ensured at all levels of care. Adequate health infrastructure and services must be available within a geographical area, accessible physically and economically, acceptable culturally and ethically, and be of adequate medical quality.

2.3.1Availability

Availability implies the presence of physical Health facilities such as whether there is enough number building to carter the needs of health service provisions and whether there is a sufficient number of health workers, attendants proportionality to the needs of the clients within a specified geographical locality (village, streets, wards, divisions, district or region). Availability of means whether there is the presence of goods and service provisions in a sufficient quantity for smoothly run-off the health facilities within a specified area (Kagaruki, 2013).

2.3.2 Accessibility

The concept of accessibility implies not only those health facilities are available for clients to utilise only but also they (clients) must be able to access smoothly without discriminations or prejudices whenever needed especially to the vulnerable groups as elderly. For health facilities to be accessible must be present in area that clients can reach easily as well as they can afford to pay or reached in a cost that can be affordable to them in both physical and in economic bases. For instance a client may not be able to access hospital services even though the hospital is just a nearby his/her residents due to the prolonged procedures and unnecessary formalities at the health facilities. That affects clients' behaviours to go there even if they are entitled to free services offered there. Or sometimes language barrier as the health attendants speaks more professional language to the clients or may not speak the same language as the clients attending for free health services. In such scenario, health facility is not accessible though physical buildings are available.

Accessibility may also means that clients have right to receive accurate information from health attendants, seeks information about his/her ill-related problems as well as to contribute information on health to the health facilities officials. These are prerequisite elements for accountability. For health facilities to be accessible among many things, it also means that its physical infrastructures be user friendly in sense that all clients who seeks for the services are accommodated according to their needs. For instance, infrastructures should be designed in the way that those with physical impairment can easily access the services. If infrastructures were not designed to carter client's diversity it is likely for them not to access FHS though are available at the identified health facilities.

2.3.3 Acceptability

Health facilities and health providers must be respectful of medical and professional ethics, culturally appropriate and gender sensitive. For instance, health attendants should provide their services to the clients in the way that it respects the culture, environments and in a level of understanding of the clients (they should see things as

professionals in the client's eyes). For example, in the cultures that are little bit not gender sensitive, to make the services acceptable by people of a named culture, there is a need to provide services basing the demands of the culture. For instance, male clients should be checked and be attended my male health providers and not by the opposite gender. Doing this the clients will not only access the services offered at that health center, but also will accept the advices and services been provided by those health expertise.

2.3.4 Quality

Hospital, health centers and dispensaries must be run and operated in most scientific and professional manners with high standard of quality. The quality should not be only observed on health attendants' personnel and their services to but also be seen on the tools, consultations and environments in general. For example education on prevention to particular endemic or pandemic diseases should be provided in appropriate and good manner to the extents that the clients would like once more to get the similar education when needed be. One feature of right to health is to ensure full participation of the population in all health-related decision making at local, national and international levels. People have the right to participate in whole process of policy making relating to their health at all levels. Thus, the quality of a good health policy can be measured among many things with the extents to which the population are involved during its formulation and implementations and the quality of their contribution to the successfulness of such policy. For the effective participation to take-off special mechanism should be developed which relaying on clients' right to seek accurate health information, right to receive health-related information and right of clients to contribute to health-related information. This encourages full participation of, women and men, as well as the views of disadvantaged people. These mechanisms are the blue prints for the provision of quality health services at any health facilities (ibid).

In relation to the study availability of health centers/hospitals/ dispensaries and trained health workers to serve older people is essential in rural and urban areas so as to enable older people to acquire health services and there should be no discrimination, elderly people should be treated with special attention putting into consideration that they have got special needs concerning to their age. Health services are not accessible to majority older people as the result their light to health is deprived so the user free charges to special groups like older people is inevitable and older people have to be informed about their rights stated in different policies, strategies and laws. Medical ethics, cultural appropriate and gender sensitivity. Older people are bounded in norms, values and traditional beliefs, health service providers should be aware of acceptability on services they are about to deriver. Older people should be sensitised before health services are provided to them. Moreover quality of health services provided to older people should be considered, for example drugs given to older people should be in good Oder and not provide them expiry drugs because they are old.

2.4 Empirical Literature Review

2.4.1 Health Services Reforms in Tanzania since and after Independence

The term “health services reform” in Tanzania has a historical background running from colonial era to present days. From 1961 soon after independence to 1967 can be referred to as a period in which the health sector in the country tried to wipe out problems which were created by colonialists whereas the health system as to other sector were founded under segregation and divided racial and economic classes. Health facilities were grouped in favoured of colonial masters where first class health services were for white colonialists, second class for Indians and Arabs and last class for the Africans. However, Africans elites who were employed in formal colonial system were given a chance to be treated, though there were no special categorizations for patients with different vulnerability. All were given the same treatment (Maghimbi et al., 1998).

Soon after Arusha Declaration in 1967 the government nationalized all major social and economic sectors so as to pave the room for equality to prevail and to do away with segregation. In relation to health sector the declaration was to ensure universal access to social services to all Tanzanians regardless to their social, economic or political grounds prevails. This was done because the majority Tanzanians were poor and in conformity to the nation's ideology of socialism and self-reliance. Then the Arusha Declaration was followed by the Decentralization Act of 1972. This was aimed, among other objectives, at building regional, district and village capacity to effectively participate in decision making, planning and implementing activities for their own development, and health in particular.

By 1977 Tanzania continued to finance and provide health services free of charge to all citizens who were seeking care from government health facilities. Meanwhile mission health facilities continued to operate as private not-for-profit organisations by charging their patient clients as they had been doing even before independence. According to the Ministry of Health (MOH 1997), Due to poor performance in economy, dramatic increase in cost for running public health care provision, emergences of HIV/AIDS pandemic disease and change in global economy advocated by Word Bank and International Monetary Fund (IMF) the ability of the governments to continue providing universal health services to all citizens were jeopardized. Therefore the establishment of other resource bases for financing health services was viewed as a means of improving the availability and quality of health care delivered in the country.

Due to the above challenges July 1993 the government introduced a cost-sharing policy in referral, regional and district hospital. According to the government's health sector reform policy agenda, cost-sharing was planned to be extended to health center and dispensary levels so that communities would participate in financing their health care needs through formal and informal risk pooling mechanisms, whereas CHF was primarily intended to benefit the majority of the informal sector (e.g., the self-employed), (MOH 1994, 1996). Knowing that most ageing people are poor and living in vulnerable environment and that they cannot afford to pay cost for health service, the government in 2003 formulates and

implements NAP that exempted ageing people from contributing to their access to health services.

2.4.2 Tanzanian Policy, Laws and Regulations Related to Social Care and Protection of Elderly People

The National Ageing Policy was enacted in year 2003, in Tanzania aiming to put elderly into the development agenda of the nation due various difficulties facing elderly such as poverty , poor health services, pension and absence of participation in important decisions affect national development. The drastic changes in traditional ways of taking care of elderly in family level has a greatly affect to the lives of the majority of elderly (URT, 2003a) this brought the government through NAP to recognizes their right as stipulated in the 1977 Tanzanian constitution. The policy also rooted from 1991 United Nation Declaration No. 67 which recognize elderly people rights, freedom, participation, care and respect, self-fulfillment and dignity.

As being observed by Mathias (2013) it is thirteen years National Ageing Policy was formulated and implemented in the country, but still there are no policy instruments such as an Act and regulations to back up the implementation of this policy. District and Municipal council were given room by the policy to set the framework which will enforce the implementation of the policy. However, due to stiff competition within the most council in the country on setting priorities many councils finds themselves behinds on setting infrastructures which will facilitate the implementation of the policy so as free health services to elderly be provided in accurate and sensible manners. The implementers of the policy are normally not taken to tasks soon after the approval of the policy because the guidelines against which the cause of action can be assessed are unavailable. Thus, many health attendants are implementing the policy as if the free health services granted to elderly are the privileges and not legal right to them. Also, the absence of the policy guidelines the assessment and evaluation of the development policy could be more difficult as the result the whole procedures of policy formulation become meaningless.

2.4.3 Accessibility of Free Health Services to Older People in Tanzania

The health of elderly people may be affected largely by the difficulties they encounter when trying to find means for living and inadequate sufficient support from both household level and at the national level at another hand. The environment in term of services, process and verification of elderly at public health facilities are problematic to extent that some of them decides not to look for free health services when they feel sick. To some elderly who can afford to pay for health services the accessibility to free health services is limited as Access to free health services is limited as exemption mechanisms for health care services do exist, but their effectiveness is also limited (URT 2011).

Kagaruki (2013) conducted a study on access to free health services and observed that 48% of the respondents indicated that they have to pay for their medical treatment despites as being entitled by NAP to access health services free of charge for any person who is sixty years and above. This resulted in a few number of elderly to afford the charges when they fall sick. Paying money for the services which is basically entirely free for elderly people create another problems to them as they cannot access the health service whenever their health deteriorate. The study also indicated that many older people live in abject poverty to the extent that they cannot afford the transport cost to and from the health facilities when they fall sick. They cannot even get a little money so that they can use to pay as a transport cost to and from their residence to the health facility. And some of them are physically incapable to visit clinics due to their illness on their own and poorer to the point that they cannot afford to have a balanced diet everyday which makes them weaker.

The study also shows that age limit complications are another obstacle. Many older people are left unattended because they cannot proves to the health attendants that are elderly enough to benefit from free health services 960 years and above) which is the acceptable age limit that entitles them for free health care in Tanzania. The same study identifies that while number of problems associated with lack of access to health facilities in rural study site have been documented, accessibility to medical services in the urban context ought to be better due to the coverage of government

hospitals and dispensaries in Temeke municipality though it is very difficult when it comes to practical steps in achieving proper health care. It was reported that the only service which old people can get for free were consultation from the doctor and the prescription of the required medicine whilst the only drug given without charge are cheap pain killers like panadol (ibid).

2.4.4 The concept of Street Level Bureaucracy in policy implementation

On his book titled "Street-Level Bureaucrats" Michael Lipsky (1980) provides in-depth explanations about public administration and public policy. He further identified street-level bureaucrats as those public officials who are working directly with citizens when implementing government policies or programmes while possessing discretion when performing their duties (Soren, 2012). They are working directly with those affected by the policy and being identified as people employed by the government to practice the government policy during their daily routine, also having power to execute and make decisions at their working areas. And that their job done have major effects on those whose policy is directed to (Lipsky, 1980).

To Nalendra (2002) a street-level Bureaucrat is a public employee who is abided by three conditions that characterised his/her work. Firstly, his daily works are characterised by constantly and frequently interact with citizens. In other words his works are connected directly with the public. Secondly, despite working within a formal bureaucratic structure following a chain of command, still he has a fairly chance to do a work in his own independence. One element of this independence in him is to make decision in a discretion manner but this free will in performing a job is not limited to discretion. The personality, attitudes and behaviours of street level bureaucrats towards his clients may affect his client significantly. These considerations are broader than the term discretion suggests. The potential impact on citizens with whom he deals is fairly extensive.

Most of them have the beliefs that their work can be operated technically from the realms of politics. However, for the effective implementation of a policy or any programme street-level bureaucrats as the most crucial and important actors should not be wiped aside because they are the one whose are working directly with those policy or programmes is designed to. Any policy is nothing but an abstract dreams of the government until the street-level bureaucrats has executed it in the manner that the citizens are in a position and can practiced the policy as intended be. As noted earlier, SLB has got some substantial discretion that guide doing their jobs, this sometimes limits the clients room to receive, seek or contribute accurate information on the smoothly implementation of any public policy. It is obvious that many citizens do not makes thoroughly reading and understanding of a policy or policy instruments which back-up the policy hence solely relaying on information given by the SLB. They often learn the way SLB behave and find themselves be conformed to the behaviour of the SLB and later on the goal and objectives of an implemented public policy be distorted during its implementation (Lipsky, 1980).

2.4.5 Factors for Successful Policy Implementation

There are different ways of looking policy implementation across different field of study and across countries, involving other actors, agencies and contexts. And that the effectiveness of a government is not only mirrored in its ability to formulate policy, but also in its ability to execute such policies effectively. As Francis Sullivan, adviser on the environment to HSBC, a UK-based global banking firm said in late 2005 "Formulating policy is the easiest thing to do; the hardest thing is to get the governance and structure right from day one." Government policies need to be delivered on time, on budget and to expectations. Given the complexity, ambiguity and contestability of the environment in which public administration is delivered, that's no easy task. It requires leadership. And leadership requires support.

There are various factors that may influence policy implementation, some of these are such as the content of the policy itself, the nature of the policy process, the actors involved in the process, and the context in which the policy is designed and implemented.

Implementation is a continuous process of decision-making by key actors working in complicated policy and institutional contexts to which implementers get pressures from those who support as well as those who oppose the policy. As such, the motivation, flow of information, and balance of power and resources among stakeholders influences policy implementation processes. Sometimes it happens to various stakeholders having different perceptions on what constitutes fruitful policy implementation. For instance top-downers to policy implementation stresses on the accuracy with which implementation adhere to the policymakers' intentions. On the other hand, bottom-up implementers maintain the adaption of policy strategies by local implementers to meet local needs and concerns. These dual perspectives can result in very different strategies and outcomes (Anita et al, 2010).

Successfulness of the policy whether has been effectively implemented or not can be judged by those factors whose presence or absence influences the implementation of ageing policy. They can be drivers or enablers. Their nonappearance may lead to policy failure and their existence may lead to policy success. Drivers are the factors that boost or strengthen the successful implementation of ageing policy. Some of these are; Vision and strategy, Government support, External pressure and donor support, rising consumer expectations, Technological change, modernisation, and globalisation. Enablers are the active elements present in society, which help overcome the potential barriers. Some of these are effective project, coordination and change management and Good practice.

Good governance is a prerequisite for successful policy implementation. It is based on two major requirements for public sector entities: First, is performance—governance arrangements and practices that are designed and operate to shape the entity's overall results, including the successful delivery of government programmes and services, and accountability—governance arrangements and practices that are designed and operate to provide accountability for results, decisions and actions to the entity's leadership, the Government, Parliament and the community.

To be successfully implemented, many policies require a range of enabling services and resources. These can include: well-established stakeholder engagement and communication channels, legal and financial services, risk management services, internal audit, fraud and compliance mechanisms, project management, information, communications and technology (ICT) and resource management services forms, system and process design services, feedback and complaints-handling mechanisms, and review and evaluation teams. The Australia National Audit (2014).

Sabatier and Mazmanian (1979: 484-485) presents five conditions beneficial for effective implementation. These include:

Firstly, the programme should be designed to utter the desired changes in target group behaviour. This implies that public policy implementation should be implemented in the environment where theory of cause and effects prevailed. This situation sets the foundation of the requirements on what to be implemented, focusing on proper activities and results which would appear to be a reasonable precondition. The validity of the policy objectives to be attained should be on both technical and compliancy basis (Sabatier and Mazmanian, 1979 p 486). It is often that the target group will be frustrated if there will be no essential cooperation of a target groups even if a program was well designed (Kendal,2006). Similarly the program is likely to fail during its implementation if it is not sound technically but well designed in term of compliancy of a target group. To Sabatier and Mazmanian a successfulness of a program or policy occurs when the target groups' compliance is the sole policy objectives (Sabatier and Mazmanian, 1979. pg487). Under such environment as the result of removing of any attempt that associate the target group behavior to subsequent ends this condition would not apply.

Secondly, policy decisions have to contain unambiguous policy directives and structure the implementation process in a way that increases the chances of good performance of target groups. This condition has got similarities to condition one above as it concentrates on some traits necessary for the implementation of the program or policy implemented. To Sabatier and Mazmanian this condition is solely relaying mostly under the influence of policy formulators as legislators. The

objectives of the policy should be clearly defined and hierarchical to both internally in relation to the accurate statute and externally to the whole program of the public agencies involves in the implementation of such program or policy (Sabatier and Mazmanian, 1979 p 487). This condition makes clear the relevance need for objectives to be clearly understandable to the implementers and clearly to hierarchical both in a goal aspects of the program as well as the whole goals of the implementing organization. The evaluation of both internally and externally discrepancies between agencies outputs and those objectives can be permitted by ensuring clear objectives which in turn facilitate an environment and mechanism of accountability (Kendal, 2006).

Thirdly, managerial and political skills as well as the commitment to the policy objectives and goals are required to be well possessed by the leaders who are implementing the policy. It is important to ensure financial resources are available and accessed to implementers for the daily run-off of the program so that they could hire staff, conducting technical analysis needed for the improvement and development of rules and regulation and to monitor services delivery program (Sabatier and Mazmanian, 1979 p 488 - 489). This condition stresses on the importance of allocating enough fiscal resources for the effective implementation of the program although to define what constitute enough fiscal resources presents enormous difficulties in practice (Sabatier and Mazmanian, 1979 p 489). The situation is necessary as the finance bring positive consequence at the beginning of the program if well monitored hence be any possibility of achieving statutory objectives and the level; of funding above this threshold is up to some saturation point for the program (Sabatier and Mazmanian, 1979 p 489).

It is crucial important to assign implementation process to the implementing agencies that concurs to the statutory objectives and to which a higher priority are given to such new program. It is very important therefore that the responsibilities of implementing a new program be assigned to the implementing agencies whose policy is consistent with the statute and will accord to a new program (Kendal, 2006). As the result the creation of a new agency may be assigned to an established present

institution that views a program well-matched with its traditional doing practically. The decision to choose implementing agency and official for a program implementation is highly guarded. Sabatier and Mazmanian once noted that there is a slightly alternatives to assign program implementation to present/traditional agencies that may well be hostile or whose staff may be preoccupied with the existing programs (Sabatier and Mazmanian, 1979 p 490). Professional civil servants may also be viewed as the hindrance when refusing to accept and implement new priorities and the advancement of new assignments. Often this can be viewed as core reason for failure of success in implementing (Sabatier and Mazmanian, 1979 p 490). The legal status or statute or any other basic policy decision gives considerable hierarchical integration and among implementers by reducing number of veto points and giving program supporters incentives and authorization enough to ensure agreements amongst those with potential veto(Sabatier and Mazmanian, 1979 p 490) it is obvious that implementation system which is loose and integrated will promote differences among implementation officials and target groups as each group will respond differently to the resources or incentives to modify a program within their local setting. A high degree of cooperation is thus necessary if the implementation is to be successful in most case.

Any decision ruled by implementers should therefore be supportive of statutory (Sabatier and Mazmanian, 1979 p 492). Statutes often stipulate the decision rules of an agency so that final decisions are fully reliable with legislative intent. When it happens that decision by the agency does not relate with the statute of the program, often the decision ruled may prohibit or contradict the original intent. Thus supportive decision rules are a necessary condition of successful implementation.

The statute or any other basic policy decision open doors for different interest groups of stakeholders be involved in in the implementation process though, for instance substantial rules of standing in agency and judicial proceedings and requirements of timed evaluation of performance of implementing agencies and target groups(Sabatier and Mazmanian, 1979 p 492). To Sabatier and Mazmanian officials who are involving in the implementation of a program cannot be trusted to

act in the way that fits statutory or policy objectives even though every chances and incentives not obstruct the implementation process. The oversight body should be there and sometimes the intervention from supportive constituency groups or legislative or executive are needed (Sabatier and Mazmanian, 1979 p 493). To enable this development, statutes or other basic policy decisions can be designed to facilitate such intervention. For example there can and should be necessities for public contribution at many steps in the verdict processes of implementing agencies (Sabatier and Mazmanian, 1979 p 493).

Forth, the programme also needs to be supported by policy instruments, organised constituency groups and few key legislators throughout the process. By considering the importance of top policy implementing officials in term leadership and their influence over the allocation of resources, their role permits being considered as a different condition (Sabatier and Mazmanian, 1979 pp 494 - 495). Political and managerial skill is also vital. Political skill contains the ability to develop effective working arrangements, to convince opponents and target groups they are being treated fairly, to mobilize support to present the agency's case through the mass media etc (Sabatier and Mazmanian, 1979 p 495). Managerial skill involves the development and maintenance of efficiency, maintaining morale and managing internal dissent (Sabatier and Mazmanian, 1979 p 495).

Fifth, the priority of objectives should not undermine over time by conflicting public policies or changes in socio-economic conditions (Cerna, 2013). It is essential for the long-term success of implementation that the active political support of constituency groups and key legislators or chief executives be maintained. This is not constantly accomplished. Firstly the consideration of whole public and constituency groups may diminish over time despite the uncertainties of any target groups or other concerning the program. This may result to change of awareness and focuses on general public frequently is then reflected by be advancement of lack of concerns by legislative members as a whole and committees in the relevant sub-system. The necessary political support can be achieved given the presence of a fixer or fixers and organised supportive constituent groups. The second necessary

condition is the existence of an organised supportive constituency group that is able to monitor closely the implementation of a program, to intervene as necessary, to appeal (if necessary) adverse agency decisions to the courts and legislatures etc. as the view of Sabatier and Mazmanian if the helpful constituency is existing, correctors can usually be found and nurtured (Sabatier and Mazmanian, 1979 p 497). Inter-governmental relationships can pose distinct problems for the maintenance of political support and consequently the implementation of a program. Regularly the programs of inter-governmental supporters such as local or state governments are subject to revision by higher levels of government. As time passes many of the original circumstances and conditions which emerged when a program or a policy originated could have transformed. For instance, the development of challenging and conflicting programs can extremely weaken the policy or program. The social circumstances the program or policy was intended to affect may be transformed over time thus work into question the continued relevance of the approach. Changes in political belief can also weaken a policy or program. Therefore these variables should be included as a separate condition (Sabatier and Mazmanian, 1979 pg. 499 - 500).

Sabatier and Mazmanian state that if all these conditions are met then any statute will be effectively implemented. The only exception to the need for these five conditions to be met is where modest changes only are required or when little effort needs to be expended to obtain the co-operation of target groups (Kendal, 2006).

2.4.6 Challenges and Coping Mechanism used by Street Level Bureaucrats to Ensure Successive Implementation of a Policy

According to Lipsky, as quoted by Winter (2002) street level bureaucrats often faces problem of limited resources and different demands to be fulfilled which made them to use special coping mechanism when they experienced difficulties in fulfilling their services. These mechanisms sometimes can acts as the barriers during policy implementation process and that prohibit the achievements of the policy objectives. Such coping behaviours are being founded at any working field and at any public

policy setting whether applied by doctors, social workers, teachers, policemen, etc. The similar behaviour is caused by similarities in the structure and conditions of the

Often street-level bureaucrats have a beliefs that the resources entitled to them for the implementation of a particular task or programme are insufficient to the point that they can use them to achieves the demands that are placed to them. To combat this situation they employ known and unknown coping strategies as the way to achieve the demands placed to them. For example, some may try do reduce the demands for their services by not providing accurate and informative message about the services they do offer, letting clients wait for long times without reasons, making access difficulty and sometimes they impose psychological costs on clients as the way to make them tired to the services granted to them (Weatherley and Lipsky, 1977).

Another coping strategy employed by street level bureaucrats is to plan lots jobs to be done within a specific limited time while had a limited time to execute all planned tasks. This forces them to select and concentrate to the limited number of clients to be attended, few cases to deals with and find simple solutions to some of the issues presented before them. They prefers to performs and giving priority to the simple task compared to the complex tasks, to do tasks that are not in their programme (whether daily, monthly programme) and tasks that may consume little or more time depending on the SLB's preferences and simplicity. And often they treat individual client who seeks for their services on an individual basis and normalise their daily routine by setting priorities guidelines among clients. They do so by separating those who seek services into few irregular standard groups and using rules-of-thumb for the extra treatment of each group. A same coping behaviour is "creaming", a concept implying that "street-level bureaucrats often choose (or skim off the top) those clients who seem most likely to succeed in terms of bureaucratic success criteria" (Lipsky, 1980), but who might not be the most needy ones.

Other coping behaviours are controlling clients so as to make their cases simple to the process, slowly increasing more pessimistic views of those seeking the services and transforming project objectives making simple to achieve. Whereas coping may be practical in making fieldwork handy, according to Lipsky, coping is dysfunctional

in systematically distorting and hampering policy implementation and goal achievement (Soren, 2012).

2.4.7 Challenges that Face Street-Level Bureaucrats during Implementation of a Policy

Lipsky (1969) identified three challenges that face street-level bureaucrats during implementation of a policy that may lead to policy failure. One of the challenges is lack of enough resources to support the implementation process. Adequate resources are necessary for policy implementation to function adequately. Lipsky mentioned these resources as organisational resources, and personal resources. One notable organisational resource in this regards is the man power/client ratio. There must be a sufficient numbers of other people working at the same job to provide services to the clients with a relatively low degree of stress, consistence with expectation of service profession.

Street level bureaucrats need sufficient time to make decision and act upon them. Also, they need ample time to access and use information regarding the implementation process. Failure to witness these variable at the field, they may experiencing challenges during implementation of particular policy ending up with the total failure of the policy or partial success to meet the policy objectives or goals.

Another challenge that faces street-level bureaucrats is threat and challenges to authority (Lipsky, 1969). Often the top authority or management in any established organisational setting have the desire to meet the objectives planned by the organisation at given time frame. This led them to work in situation that forces street level bureaucrats to perform their duties in different physical and psychological threat that affects their performance. The reciprocal of threat for Street-level Bureaucrats is personal or role authority. The more pressure imposes to them to perform their task from the top management the more the threat to accomplish the task given and vice versa. One might assume that the greater the threat, the less bureaucrats feel that authority is respected, and the more they feel the need to invoke it.

Expectation about job performance is another challenge that street-level bureaucrats' face. Expectations may involve an unachievable goal dimension. The unattainability of same goal orientations in part is related to the lack of control over the client's background and performance. Street-level Bureaucrats also are not free to determine who their clienteles will be indeed, in this sense Street-level Bureaucrats may be said to be Non-voluntary servants in the same way that their clients are non-voluntary. To the extent that Street-level Bureaucrats consider themselves professionals (and they do to a significant and increasing degree), they are likely to develop frustrations with the institutional framework inhibiting them from doing their jobs "professionally," and with clients "whose uncooperativeness or unmalleability may be used against them.

2.5 Synthesis

In synthesizing the above implementation approaches, top down approach will be used as a blueprint in assessing the implementation of national ageing policy in the country, and Availability, Accessibility, Acceptability and Quality Health Model are also to be adhered by this study. This is the most fruitful approach to synthesis for both theoreticians and practitioners as most policies in Tanzania are being implemented in top down way. Three explained (independent) variables are ageing people characteristics, street level bureaucratic characteristics and organizational characteristics. However, implementation studies have tended to present long lists of variables that may affect implementation. Synthesis that merely combines three variables considered by the top-downers with exploring the theoretical relationship between them is likely to exacerbate the problem. I have chosen, therefore, to concentrate on a more limited set of variables and to explore their theoretical implications more fully.

2.6 Conceptual Framework

According to Schuster et al. (1998: 518), good healthcare quality means "providing patients with appropriate services in a technically competent manner, with good communication, shared decision making and cultural sensitivity". Leebov and

colleagues (2003) believe that quality in healthcare means "doing the right things right and making continuous improvements, obtaining the best possible clinical outcome, satisfying all customers, retaining talented staff and maintaining sound financial performance"

Basing on the Theoretical framework and empirical literature review, this study will use and modify Andersen's (1995) A framework for the Study of Access to Medical care model to guide the presentation of conceptual ideas where they have been contextualized as follows. This study hypothesized that the analysis of accessibility of free health services to aged people can be proceeding from National Ageing/Health Policy through the characteristics of health care system and characteristics of population at risk (inputs).

Basically three types of variables are to be observed here; One outcome/dependent variable and two independent variable which are policy variables. These variables can be or have been extracted from the policy itself. One of which is considered to be mutable in the sense that the researcher is aware of that but not interested to it, and another one is a control variables to which the researcher is interested to and can affects the outcome/dependent variable but are immutable in the sense that they cannot be changed by public policy. These independent variables are characteristics of health care system and characteristics of population at risk, while the outcome or outputs are the dependents variables. The explanatory variables under characteristics of health care delivery system which are the resources, embedded labor and capital devoted to health care. Includes structure in which health care and education are provided as well as equipment and materials used in providing health services.

Organisation variable under characteristic of health care system describes what the system does with its resources. It is the manner in which the medical personnel and facilities are coordinated and controlled in the process of providing medical services. Entry refers to the process of gaining entrance in the medical system (Variables as travel times, waiting time for medical services etc.) all that happened to elderly people after being enrolled to the system when seeking for free health services for example whom he see, and how is being treated can be referred to the structure.

For population at risk, these are explanatory variables characteristics of older people that influence the outcomes variables of consumer satisfaction and utilisation of health services. These includes; age, sex religion and values concerning health and illness, incomes, insurance coverage, and the attributes of the community in which older people lives.(rural urban character ,region and the need for care as either perceived by individual older people or that evaluated by the delivery system.(ibid)

Dependent variables are all variables relating to utilisation of health care system and consumer satisfaction. For example, the place where the care was received (site), the kind of services received and who provide it (the type of utilisation) and the purpose of a visit which means whether it was for preventive, illness related or custodial care. The custodial care provides for the personal needs of the patients but makes no effort to treat his underlying illness. This kind of care is mainly provided in nursing homes and homes for aged.

Consumer satisfactions are dependent variables related to the attitudes towards the medical care system of those who have experienced a contact with it. For example satisfaction with the convenience of care, its coordination and costs, the courtesy shown by the providers, information given to the patient about dealing with his illness and older people's judgments as the quality of care he received. By considering the role of Street Level Bureaucracy and the Ageing people (clients) as the core of understanding the access to free medical services by the ageing population, as being advocated by National Ageing Policy (2003), the study hypothesised a model to guide the presentation of the theoretical idea in which this study lean on the explanations of the phenomenon. Under this hypothesised model, the theoretical idea is that.

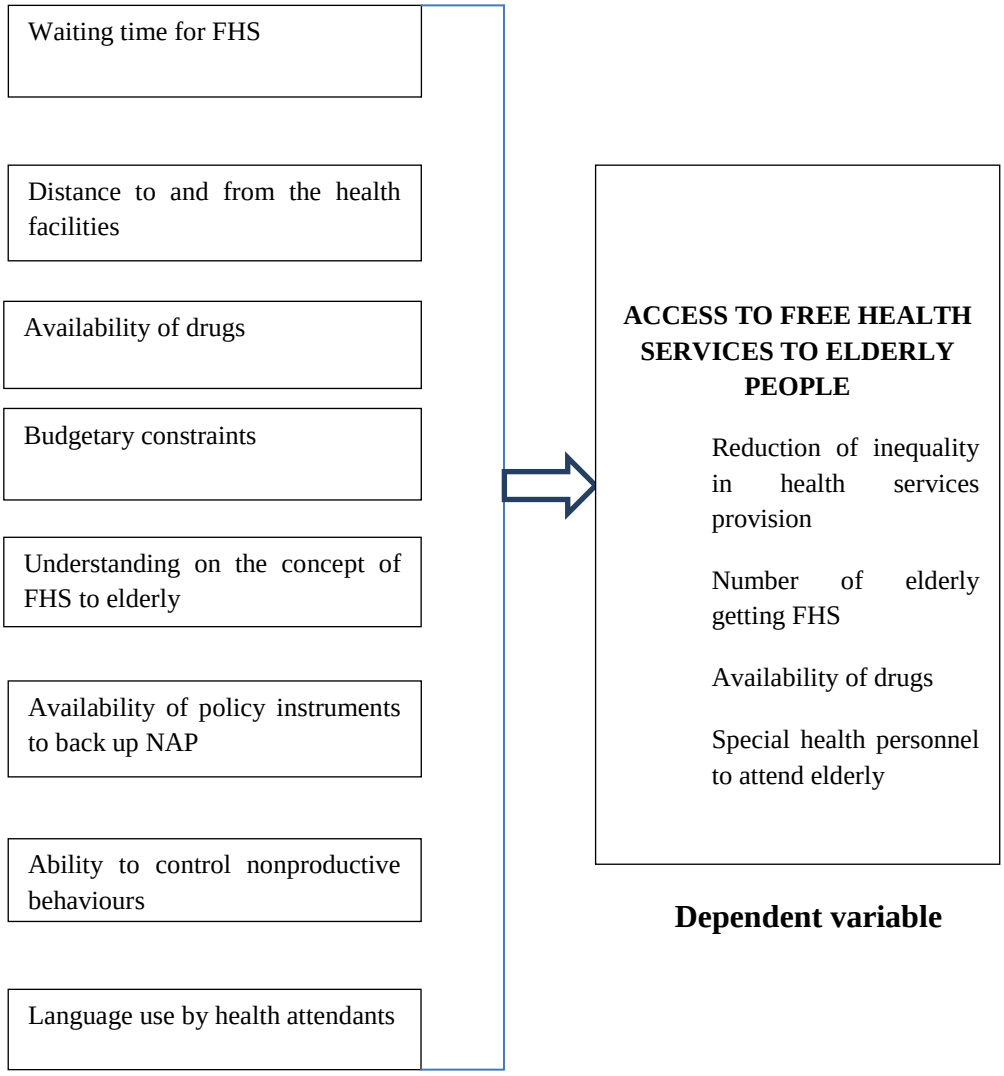
- The access to free health services by the ageing population at Morogoro Municipality in Tanzania is influenced by Street Level Bureaucrats and the clients (ageing people) on the implementation of NAP (2003). This is the functions of three factors;

One: Ageing people characteristics. These are behaviours and characteristics of an elderly that may influence or cause him/her to look for the health services or not to. For example self-perceived health status, satisfaction of free health services provided as well as cultural practices prior to his/her illness, hence influences the outcomes variables of consumer satisfaction and utilisation of health services for example the kind of health services ageing person receives how it is being provided and who provide it.

Secondly: Street level bureaucrats' performance, the behaviour and performance of those who provides health services towards an elderly person. The way the nurses attending an elderly person, how they are being identified and documentation as being eligible to free health services can influence their accessibility to free health services. Ability to control non-productive behaviour, care and respect to ageing people and managerial supervision all together can influence positively or negatively the accessibility of tree medical services by the ageing population.

Three: Organisational characteristics. Waiting time for free medical service, process to be attended, availability of drugs and personnel as well as facilities can influence accessibility of ageing people on provision of free medical services

Figure 2.1 Conceptual Framework



Dependent variable

Independent variable

Source: Research Data, 2016

Table 2.1: Variable and their Measurement on accessibility of free health services on ageing population

Variables	Measurement	Source of data
Access to FHS to elderly people	Whether the available resources (personnel and facilities) influence provision of FHS to ageing people	Doctors, Nurses Ageing people, Caregivers, DED and DMO
Distance to and from health facilities	Whether distance to and from the health facilities influences elderly access to FHS	Elderly, Doctors, nurses and caregivers
Availability of drugs	Whether ageing people receives all drugs and service prescribed at all time.	Doctors, Nurses and elderly people.
Budgetary deficit	Whether sufficiency resources are vested to support FHS to elderly people	DED, DMO, Doctors and WEOs
Awareness on the concept of FHS to elderly	Whether health service provider, local government officials performing their work accordingly to ensure FHS elderly are adhered.	Elderly, caregivers, heads of ageing centers and doctors
Availability of policy instruments to support NAP	Whether there are policies instruments being implemented to ensure FHS are provided to elderly.	WEOs, Doctors and nurses
Ability to control nonproductive behaviours	Whether street level bureaucrats' control their nonproductive behaviours that impede deliverance of FHS to ageing people.	Doctors and Nurses, DED and Head of ageing centers.
Language use by health attendants to clients	Whether health service provider care and respects elderly people's needs	Elderly, doctors, nurses and caregivers
Waiting time for FHS provision	Whether waiting time to ageing people influencing their accessibility to FHS	Ageing people, Caregiver, Doctors and Nurses

CHAPTER THREE

METHODOLOGY

Introduction

This chapter is about the methodology to be employed in this study. The chapter consists six sections. Section one is about research design, section two is area of the study, section three is about population of the study, section four is about sample and sampling procedures, section five is about data collection methods and section six is about data analysis.

3.1 Research Design

Beyman (2008) and Lewis & Lindsay (2000) view research design as a plan represents the structure that guides the execution of research and procedures of data analysis. It is the way research is going to be undertaken. The study employed quantitative data in terms of showing the frequencies, and percentages, tables and figure. While qualitative method which have a large portion of this study is the one seeks to solicit opinions, perceptions and different views from respondents Kothari (2004).This was being done so as to minimize subjectivity of judgments.

This study is a cross-sectional design. The design was employed due to the fact that it provides a model where relevant evidence could be collected with minimal time, human efforts, materials and money. It is also very cost effective as the researcher used survey methods for data collection.

The cross sectional study design also allows number of variables in the one study be observed as for the nature of this study of access to free health services to ageing population. However, the information gathered from the sample of the entire population enable results to be generalised to the whole group. Data can also be collected on individual characteristics, including exposure to risk factors, alongside information about the outcome. In this way cross-sectional studies provide a 'snapshot' of the outcome and the characteristics associated with it, at a specific point in time thus, the researcher decided to use cross-sectional to fulfill that requirements.

3.2 Area of Study

The study was conducted in Morogoro Municipal council in Morogoro Region Tanzania. The district was selected because it has a good number (10,661) of elderly people (MMC, 2011). And has got two ageing center. On top of that the researcher is familiar with the area as he resides in the district. Morogoro Municipality covers an area of 531 km2 (MMC, 2012). The municipality headquarters is located at latitude 6o 49'S and longitude 37o 40' E, approximately 195km west of Dar es Salaam. Morogoro experiences average daily temperature of 30oC with a daily range of about 5oC. The minimum temperature is during June to August period when the temperatures go down to about 16oC. The mean relative humidity is about 66% and drops down to as far as 37%. The total average annual rainfall ranges between 821mm and 1,505mm. Major economic activities include industries of primary and secondary level, subsistence and commercial farming, small scale enterprises and commercial retail as well as wholesale.

Administratively, Morogoro Municipality has one division, 29 Wards and 272 streets popularly known as Mitaa with a population estimate of 387, 945 (MMC, 2012). This study was carried out in randomly selected three wards which are Bigwa, Kilakaka and Sabasaba with the aim of exploring the access of free health service to the ageing population; an account to street level bureaucrats on the implementation of National Ageing Policy.

3.3 Population of the Study

Population for this study was elderly people attending the health facilities in Morogoro Municipality, other elderly people were from elders' camp (FungaFunga and Mgolole), and the rest elderly people were visited at their homes, health workers, and stakeholder (NGOs) who are working with elderly. The sample unit was the ageing population which was 13,627 observed from three selected wards of Bigwa, Kilakala and Sabasaba which then narrowed to 532 populations so as to delimitate some of the possible errors of the study. Thus 532 people proportionally selected

from three wards were considered to be the population of this study and thus used to determine the sample size of this study.

Table 3.1 Morogoro Municipal Council Total Population by Age and Sex

Age group	Male	Female	Total
60-64	2684	2476	5160
65-69	1494	1347	2841
70-74	1181	1197	2378
75-79	622	708	1330
80+	782	1136	1918
TOTAL	6763	6864	**13,627**

Source: National Bureau of Statistics (2013)

3.4 Sample size and Sample Technique

3.4.1 Sample Size

The study population consisted of all people aged sixty years and above resides in the three named wards of Bigwa, Kilakala and Sabasaba as well as some selected Doctors, Nurses, District social worker, WEO/Hamlets and community members whose total sum up to 315,806. A sample size of 63 respondents, which account for 11.8% of the 532 target population, was prepared. Small sample was selected as the researcher believes that it can fulfill the requirement of efficiency, responsiveness, reliability and flexibility as observed by Krishnaswami (2002:146) by sampling it reduces the time and cost of research studies because it has become possible to undertake even a national or global studies at a reasonable cost and time.

3.4.2 Sample Technique

This study used random sampling technique and purposive sampling technique to obtain the study sample. Random sampling technique were used to obtain 15 ageing people care givers and 03 community members accounts for this technique to obtain 18 sample. The approach was used because it provides estimates, which are essentially unbiased, have measurable precision and also it does not depends upon the existence of detailed information about the population for its effectiveness as observed by Milanzi (2009).

Purposive sampling technique was used to obtain 45 samples. The selection of elderly from three wards, WEO/Hamlets, the heads of ageing centers and of the organisation that dealing with ageing people as well as DED were obtained by using this technique. The researcher choose this technique because enabled him to select cases which were intended to answer research questions and research objectives as being observed by Sekaran (2003:277) that the methods is used when a researcher needs to select cases which are particularly informative or will bring in fair representative.

Researcher with helps from hamlets identified households with person aged sixty years and above, then the names were written on piece of paper, folded and mixed thoroughly in a container, and then blindly pick one paper until the needed number of respondents met. This gave every client in the population an equal chance of being chosen. This procedure helps to obtain 15 respondents who were aged sixty years and above.

3.5 Methods of Data Collection

3.5.1 Primary Data Collection

This study purposely focused on finding clear understanding on the access to free medical services by the ageing population at Morogoro Municipal Council in Tanzania, an account from the street level bureaucrats and the client on the implementation of National Ageing Policy and hence to take measures to improve its access. Mixing method for data collection was employed to minimize subjectivity of the judgments as this study has a large portion of qualitative nature and little portion for quantitative.

3.5.2 Questionnaire Method

Questionnaires are number of questions printed or typed in a definite order on a form (Kothari, 2004). This method of data collection is commonly used once a research is dealing with large case of inquiries and wishes to collect quantitative data. Questionnaires were of both open-ended and closed ended prepared in English and some were translated in Kiswahili so as to be easily for respondents to decide the

best language of their preference. For close-ended questionnaires, respondents were required to circle the best answer as they view appropriate to the question asked, then answers were coded.

Thirteen questionnaires were developed for 13 respondents with five subsections. Section one provided introduction about the researcher, his name, course pursued and the purpose of questions to be filled by respondents and then background information to be filled by respondents. The third part concerns questions about the effectiveness of free medical services to the ageing population and how policy was being understood by the respondents. The fourth part of the questionnaire was about to access the way policy was being implemented and the perception of ageing people, caregivers and street level bureaucrats on free medical services. The last subsection was about the extent to which free medical services to ageing people was valued.

3.5.3 Interview Method

Interview method was employed to gather qualitative data. Both structured and unstructured interviews were used. The researcher decided to use interview method for data collection based on truth that most of respondents particularly those who are above sixty years old had some problems in reading either due to their age or they did not attends for formal education that might hinder them to be freely able to explain their concerns unlike other methods of data collection.

Results from each individual case's respondent interviews and researches' observation were combined, compared and analysed across all three themes i.e. effectiveness on understanding concept of free medical service, the perception and challenges facing access to free medical services to ageing population. Researcher also compiles interview transcripts according to each respondent's questions. Then themes were categorized using research questions as a framework from which to start.

3.5.4 Secondary Data Collection

Various publications both published and non-published documents were used to support primary data collected to access the free health services to ageing population in this study.

3.5.5 Documentary Review

Documentary review was used as one of method of data collection which helped the researcher to gather necessary information about the researched area. The method helped the researcher to sharpen the conceptualization of the research problem, deepen the understanding of the study area and identification of the research gap. Specifically, textbooks, Journals, Conventions, legislations, reports, published and unpublished research papers related with access to free health services by the ageing population were reviewed.

Table 3.2 Summary of Data Collection for Study

QUESTIONS	DATA COLLECTION STRATEGY
How ageing people are identified to facilitate the access to free health services to ageing population?	Interview, Documentary review
What are the perception of street level bureaucrats and the elderly in the implementation of National Ageing Policy during identification, verification and provision of health services delivery to ageing people?	Interview and Questionnaire
What are the challenges facing the street level bureaucrats and the clients on the implementation of free health services to ageing people particularly during identification and verification of elderly for FHS and health services provision to elderly?	Interview and Documentary review

3.6 Data Analysis

Descriptive statistics trough pie chart, frequency table and percentage and inferential data analyses were used to analyze the collected data. The process involved the analysis of both secondary and primary data being collected, where editing of collected data was done so as to detect and omit some possible errors to ensure accuracy of the data being collected. Then data were coded, tabulated and percentage calculated to facilitate interpretations and for the drawing of conclusion.

3.7 Ethical Considerations

Ethical consideration was on highly concerned during the investigation. The researcher followed all procedures and requirements needed by the government of Tanzania and thus given the permit to collect data within the municipal. The information also included freedom to withdraw at any point without being intimidated for such decision and action. The verbal request and written informed consent was given to the respondents to sign on voluntarily agreeing to participate in the study.

3.7.1 Validity

Validity of the research instrument was ensured through the use of a well-designed questionnaire. A pre-test study was done to check on the accuracy of the questionnaire so that the answers obtained from the study were true and accurate.

3.7.2 Reliability

Questionnaire was designed to ensure that consistent results were achieved. Reliability was also ensured through selection and training of research assistants, engaging them in the pilot study and supervising them during the data collection process. Completed questionnaires were checked daily and errors were corrected.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF FINDINGS

Introduction

This chapter presents the findings, analysis and discussion of the findings that were obtained through interviews, questionnaires, consultations and informal discussion and gives some interpretations of the findings basing on study's objectives, research questions and theoretical framework. The purpose was to understand the access of free medical services to the ageing population at Morogoro municipal council, an account to the street level bureaucrats and clients on the implementation of National Ageing Policy.

The chapter began by presenting demographic and social-economic characteristics of the sample population focusing on age, sex and occupation the aims is to understand respondent's understandings on the process of identification and documentation of elderly people on their access to free medical services, to explore their perception/satisfaction on the implementation of free health services and to revel the challenges that street level bureaucrats and clients do faces on the implementation of free medical service directives and their copying behaviours and last suggest measures for improving access to free medical services to ageing g people in Morogoro Municipal Council.

4.1 Respondents Characteristics

The researcher was aware of the respondents' personal characteristics and their distribution about them so as to assist him in the understanding the results of the findings. Variables which were taken into consideration were age, sex, district, ward, street and occupation of the respondents. Total number of respondents who were involved in this study was 63 obtained from three selected wards namely Bigwa, Kilakala and Sabasaba found at Morogoro Municipal Council. It comprises of 31 male respondents and 32 female respondents. This implies that 49.2 % of the data collected for all variables used in this study comes from male and female contributions was 50.8% as the table below shows. Researcher aimed to have the

number of female respondents exceeding that of males on the bases that in the country female account large number 23,058933 (51.3%) compared to male 21,869,990 (48.7%) according to National Bureau of Statistics (2013)

Table 4.1 Respondents Characteristics

CHARACTERISTICS	n(%)
1.Area of residence	
Bigwa	23 (**36**%**)**
Kilakala	20 (**32**%)
Sabasaba	20 (**32**%)
Total	**63**
1. Gender	
Male	31 (**49**%)
Female	32 (**51**%)
2. Age Group	
Below 60 years	26 (**41**%)
60-69 years	13 (**21**%)
70-79 years	10 (**16**%)
Above 80 years	14 (**22**%)
3. Occupation	
District social welfare	1 (**2**%)
Doctors	3 (**5**%)
Nurses	3 (**5**%)
Wards Executive officers	3 (**5**%)
NGO CEO	2 (**3**%)
Hamlets	3 (**5**%)
Others	48 (**76**%)

Source: Field Data, 2016

Preference of health worker by gender was associated with access. Respondents who preferred treatment by any gender and those who opted for same sex were less likely to be associated with access when compared with those who liked treatment by opposite sex. This pattern concurred with study conducted by Mutran and Ferraro (1998), who suggested that among elderly persons, the physician's perception of male versus female patients could contribute to differences in hospitalization. Hospitalization may therefore be based not only on biological but also on social factors, as physicians perceive and treat male and female patients differently. This finding however contrasts the report that female doctors are said to be more sensitive to women's problems than male doctors (Bensing et al., 1993) and female physicians are more likely to see female patients (Franks and Bertakis, 2003).

4.1.1 Category of Respondents by Age and Sex

Social scientist and demographers believe that demography can play crucial role in understanding trends and in preparing future development and policies. By understanding demography one can be in a position to provide an analysis on public policies and explaining observed economic and social trends. For example, age structure and sex can be used as an instrument that helps to understand the relationship within the community and the way various activities, policies and programmes are undertaken. Sex has influence on the prioritization of the various services including health services in a society. As such age and sex were taken on this study as variable. Respondents who were included in this study were those who are grown-up and matured enough and some were retired from formal and informal services.

Table 4.2 Demographic of Respondents by Age

SEX	AGE GROUP OF RESPONDENTS				TOTAL
	Below 60	60-69	70-79	Above 80	
Male	11	8	5	7	31
Female	15	5	5	7	32
Total	**26**	**13**	**10**	**14**	**63**

Source: Field Data, 2016

The Table indicates that more respondents were taken from age group below 60 years which were 26 accounts to 41% of the total respondents used in this study. This was that way because most street level bureaucrats involved were still in public services and had so much to share about the implementation of policies and numbers of those who takes care of ageing people at households were on that age group.

The researcher asked the respondents to states their occupation/economic activities, whether they had been employed or were just employed themselves in different activities. This was relevant in the way that it was geared toward understanding whether all people who were above sixty years and above have equal access to free medical service as stipulated by policies. Occupation of the respondent had no significant association with access. However, the respondents who were formerly

had the jobs were more associated with access than those without. This concurs with (Fitzpatrick et al., 2004) which reported that income is a strong predictor of access to health care in the elderly, independent of race.

4.2 Understanding on Free Health Service to Ageing Population

In this study dependent variable was access to free health service to ageing population in Morogoro Municipal Council. To have an understanding on the access of health service, the following quality was observed to determine the extent to which the concept was understood by the respondents.

4.2.1 The Extent the Free Medical Service was Understood

Under this domain, the researcher was eager to know if the clients and FHS providers were aware of the concepts and procedures of identifying ageing person as being prescribed by the National Ageing Policy. This is being measured under the hypothesis that if a person had correct information about the programme being implemented is likely to seek for its access whenever he/she needs. The findings revealed that 30% were very high aware of, 13%were high aware of, 9% had low awareness and 29% had very low understanding of the concepts and process for identification of ageing people and attainment of training and discussion concerning free medical services to ageing people as the table below shows.

Table 4.3 Understanding of the Concept and Process for Free Medical Services to Ageing People

RESPONSE	FREQUENCE	PERCENTAGE
Very High	12	19
High	19	30
Average	08	13
Low	06	9
Very Low	18	29
TOTAL	63	100

Source: Researchers' Field Work, 2016

Having a large number of respondents that is 18 (29%) of respondents who had very low understanding on the concept, process and procedures of free health services to the ageing population implies low accessibility to the services being provided. Most of respondents confuse being aged and being physical disabled or being poor. They believe that free health services are there for any person who is ageing by appearance, poor and not for those who have a good economy or retired from formal activities. Some think that those who are seen as being rich they do not deserve FHS unlikely to the policy directives which was designed to cater all elderly regardless to their financial abilities. Others believe that to be granted for free health services in hospital they must first be given a letter of recognition as being eligible for the services from the WEO or hamlets this prohibit them to access free health services because they do not have a paper from those leaders.

As similar study conducted by Sanga (2003) shows the similar results as it observed that most participants reported the absences of notable procedures that will guide health services providers and the elderly to be attended by the health providers in the manners that will lead to receive proper and accurate health services. It was also observed that there were no clear means that shows how an elderly who is subjected to FHS would do with their catchment area is also not clearly stipulated as to what an elderly should do to benefit from exception plan through their catchment area leaders and getting referral letter when visiting referral hospitals

It was also observed by Human Development Report (2007) that most elderly had poor understanding of the concept of free medical services as it revealed that; "…This is true for many including the elderly. Half of the views of the older people sample over 60's (48%) declared that they did not know that they are entitled to free medical treatment," says part of the Poverty and Human Development Report of 2007.

From the results above, 19% of respondents had very high understanding of the concept and procedures for free health services to ageing people. This happen to be so because of the fact that such statistics comes from group of respondents who are

below sixty years of age and currently in one way or another they are dealing with ageing people and are public workers who are responsible for ageing people.

Likewise, interview with one of the ageing people in Bigwa ward showed that the understanding of the concept and the process to free medical services to them were not clearly understood. The ageing people said

Sisi hapa mtaani barua za kutibiwa bure kwetu wazee ni ngumu sana kupewa, mwenyekiti wa mtaa huwaandika wale wazee walio na urafiki au undugu nao. Ndio maana mimi nikiugua sihangaiki kumtafuta mwenyekiti wa mtaa, najitafutia kahela kangu naenda hospitali*"*

> In our street to have a letter from hamlets to show that we are eligible to be treated free at public health Centre is very hard to get, our leader used to favour only those elderly people who are friends to them and their relatives. That is why whenever I feel sick I am not bothering to look for a recognition letter from our hamlet or street chairperson, I only use a small amount of my savings to go to hospital.

Generally this interview gave a researcher a picture that some ageing people confuse various safety-net programmes undertaken in the society such as that of empowering poor household TASAF and their right entitled by policies. This creates dishonest relationships with their leaders and hindering them to access free medical services.

4.3 Perception of Street Level Bureaucrats, Ageing people and their Caregivers on FMS

This part were used to explore the opinion of street level bureaucrats, ageing people and their caregivers whether they are satisfied with the free health services offering to the ageing population and implementation of policy and directives. Satisfaction of health care services was significantly associated with access. There were four categories for this part. The purpose was to know if they had been satisfied very high, high, low satisfaction or very low satisfaction. Result revealed that the respondents who were very high satisfied were 7 (11%), high satisfied were 18

(29%), low satisfaction was 20 (32%) and very low satisfaction was 18 (29%) as the table shows below.

Table 4.4 Perception on satisfaction on Free Health Services to Ageing People

AREA	VERY HIGH		HIGH		LOW		VERY LOW	
SEX	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
BIGWA	01	00	04	02	05	03	04	04
KILAKALA	00	02	03	04	03	03	02	03
SABASABA	02	02	02	03	03	03	02	03
TOTAL	**03**	**O4**	**09**	**09**	**11**	**09**	**08**	**10**
PERCENTAGE	**11**		**29**		**31**		**29**	

Source: Field Data, 2016

Regarding opinion on perception on satisfaction of street level bureaucrats , ageing people and their caregivers on free medical services, the results shows that 07 respondents with 11% were highly satisfied with the health services offered and 18 respondent 29% were high satisfied. However, a disappointing issue is that 31% were "low" satisfied while 29% were very low satisfied to the services offered. This was due to long waiting time to be attended, abusive languages, and poor information given prior to attend hospital and lack of appropriate drugs particularly those relating to non-communicable diseases which are common illness among the ageing.

The study conducted by Alazri and Neal, (2003) have the similar findings as it agrees with the statement that satisfaction with provider services may impact perceptions of access to health care and clinical outcomes and that an elderly person's perception of the physician's lack of responsiveness was a greater disincentive to seeking care than more tangible barriers. Interpretation of the study finding suggests that the psychological impact of perceptions of about the provider may translate into barriers for seeking future health care.

4.4 Challenges facing Free Health Services Ageing Population

Under this subsection researcher wish to investigate the challenges that facing both the clients and the implementers on making FHS be available and utilised as intended be. The part was examined using the categories of challenges. Challenges facing individual clients to access and utilise free health services; the challenges facing the implementers (street level bureaucrats and other providers) and last challenges were

to observe policy obstacles to free medical services to ageing population. The table below shows briefly the challenges facing the clients and implementers when it comes to the accessibility of free medical services to ageing population.

Table 4.5 Showing Challenges for Access to FHS to Ageing People

Categories of challenges	**Whether the following challenges influences FMS**	**Frequencies**				**Average %both Male & Female**
		M	**%**	**F**	**%**	
Ageing people challenges	Waiting time for services	**20**	64	**17**	53	**59**
	Abusive language from clients to attendants and vice versa	**23**	74	**18**	56	**65**
	Distance to and from the hospital	**16**	52	**20**	62	**57**
	Lack of drugs and health facilities	**29**	93	**30**	94	**94**
Administrative challenges	Care and respect from the clients to the attendants and vice versa	**26**	84	**18**	56	**70**
	Failure to copy with non-productive behaviours	**08**	26	**06**	19	**22**
	Budgets constraints and manpower-clients ration	**08**	26	**11**	34	**30**
	Failure of Municipal council to enact by-law to support FMS	**22**	71	**28**	87	**79**

The results shows that 94 per cent of all 63 respondents believed that lack of drugs particularly those relating to non-communicable disease at health facilities is the major challenge that faces the accessibility free medical services to ageing people. And very few 14 respondents 22% believed that the failure of administrators and health providers to cope with nonproductive behaviours of clients and of the health attendants was the challenges for free medical services. Other results shows that 79% of respondents believe that the failure of municipal council to enact by-law to favour health services to ageing people, 76% views lack of an Act to support NAP and National Health Policy is the major challenges, 70% shows care and respect from the client to health attendants and vice versa, 65% shows 59% shows challenges relating

to waiting time for health services, distance to and from hospital account for 57% and lastly 30% of respondents believe that budgets constraints and human manpower-client ratio as challenges for access to free medical services to the ageing population in Morogoro Municipal Council.

4.4.1 Whether Waiting Time Before Service Provision Affects their Access to FHS

About 58% of respondents from Bigwa, Kilakala and Sabasaba said that the time they spent to wait for health services (to be attended by doctors/nurses) affect negatively their behaviour to access free health services. Furthermore, the results shows this problem inclined more to men than to female as 20 male (64%) and 17 female (53%) viewed it as an obstacle to FHS as one respondent said when interviewed by the researcher;

"Tunatibiwa bure sisi wazee, lakini hospitalini unakuta kuna foleni ndefu sana sasa inakubidi usubiri sana ili kumuona daktari. Wanasema katika maredio kuwe na dirisha la wazee lakini hilo halipo"

> It is true that we receive health services at public health facilities free of charge, but at the hospital often there are long lines of patients who are waiting for services which oblige you to wait for so long in order to be attended by the doctor. They used to say in radio that there should be a special window for elderly people at hospital but such a thing I did not witnessed whenever I was at the hospital.

This result concurred with the study conducted by WHO, (2010) on older population and health system in Botswana, it showed that 47% of respondents of that study indicated that the waiting time before services provision affects negatively ageing people to seek for health services.

4.4.2 Whether Abusive Language Affects Access to FHS

The result showed that 65% of respondents interviewed said that abusive language from health services providers to the clients influences their access to free medical

services. Amongst them men account 74% and female 56%. Most ageing people feel uneasy to attend for free health services as the nurses and doctors use the language that they (clients) feel inappropriate to them. As one respondent said

"Kwa kuwa tunatibiwa bure wanatuchukulia (wauguzi/madaktari) sisi kama watu wakusaidiwa tu, na sio watu tulio na haki ya kutibiwa sawa na wale wenzetu wazee wanao tumia bima za afya."

> "As we are being receiving free health services some nurses and doctors perceive us as people who only need help from others and not as people with right as other elderly people who receive services by using health insurance."

This situation was in line with the study conducted by Kim (2000) who wrote about the interpersonal relationship between the ageing people and health services provider and observed that the relationship between clients and health services providers can influence positively or negatively the access to services. The author noted that "Elderly prefer a service provider who gives warm welcome, acts friendly and polite, shows respect and treats clients as a "human being", is sympathetic, acts fair and does not discriminate (practices 'first-come first serve principle), is humble, communicate well in a language the elders understands, pays attention to the elderly, expresses or demonstrates a commitment to their work, assures elderly of confidentiality" the opposite to that as the using of abusive language can be act as a barrier to free medical services offered to the ageing population.

4.4.3 Whether Distance to and from the hospital influences access to FHS

This subsection researcher intended to know whether the access to FHS By the elderly can be affected by the proximity between the clients' resident and the health center. The results showed that, 57% amongst them 51% male and 62% female agree that the distance to and from the hospital sometimes forces the elderly not to access free medical services offered to public health facilities. Since most of them has problem of walking long distance and due to transport cost, they decide not to attend hospitals hence decided to buy medicine at the nearby pharmacy shop with the little money they had as one respond the question by saying that;

‘Kutoka hapa mpaka kule dispensari ni mbali kutembea kwa hali yangu hii, na hata nikienda naweza nikafika wakaniambia dawa hakuna.Sasa ndio maana nauli ya kwenda kule nikijisikia malaria au kuumwa ni bora nikanunue dawa pale dukani”

> “From here to the public health facilities is far to walk relating to my situation. And if I will reach there still there are no guarantees that I will get medication needed. They may tell me that there are no drugs for my illness. That is why instead of using my money as fare to the health facility I do rather use it to buy medicine at that nearby pharmacy shop.”

This findings concurred with observation made by Lewis (1995)who wrote that Many elderly cannot easily go to the health facility which are often far apart from the area living, even if public transportation is available for the elderly to travel, long distance may make it difficult to some elderly to obtain services.

Also Sanga (2003) observed the similar thing, that there is a long procedure from the time an elder arrive to the hospital up to when he or she receive treatment which seems a challenge. Even of more disturbances is the walk to and fro in the hospital and sometimes they take a long time waiting the service provider to start providing service.

Distance to health was significantly associated with access as being observed by Waikiro (2009) that in a qualitative study titled condition affecting the elderly primary health care in urban health care centers of Iran reported limitation of distance to health as a barrier of utilising health care centers by the elderly. Alone as a barrier, however, distance does not fully explain accessibility. Several reasons exist why distance to health facility has been identified as a contributing factor; transportation and mobility factors such as poor weather conditions and lack of wheel chair accessible.

4.4.4 Lack of Drugs and Health Facilities

Under this domain the findings shows that lack of appropriate drugs as being prescribed by doctors was the major challenge facing the elderly when comes to access to FHS. 29 Male respondents account for 93% of male involved in this study

and 30 female respondents (94%) said that lack of drugs affects them negatively when it comes to access to FHS. This implies that most respondents were aware of FHS however the unavailability of drugs as being prescribed by doctors at hospital forces them to see no needs to look for free services as were not going to get better services as intended.

As Sanga (2003) observed that not all medications are unavailable although most of them were reported out of stock in the hospital, in such cases participants [elderly] are to get them from pharmacies (outside health facility) where their exception does not apply anymore.

Some respondents during interview reported the shortage of drugs in all government facilities particularly those relating to non-communicable diseases that are common to ageing people. Instead they buy from their own pocket. One respondent argued;

"Madawa yakutusaidia sisi hasa katika magonjwa yanayoambatana na mtu kuwa mzee hayapo. Unapewa panaldo na dawa za malaria tu, wakati mwingine tunaambiwa hakuna dawa za wazee bali za wale wa bima tu"

> "There are no drugs particularly drugs relating to diseases that are common to a person who becomes aged. We often given Panadol and malaria tabs only, sometimes we are being told there are no drugs for us except for those elderly who are using health insurance (NHIF) or Community Heath Fund (CHF)"

Another respondent said that most of the medications which were supposed to be provided to the elderly people freely are told to be bought by themselves where they don't afford to buy them.

From the findings above, it can be concluded that those elderly who are aware of FHS and wish to access the services, are facing with difficulty to be given drugs as prescribed by doctors. The best way to make FHS accessible appropriate medicine should be supplied in all level of hospital to make them available to elderly people.

Availability equipment in health facility was statistical significant to access. As Sanga (2003) had a similar with the observation of this findings as he observe that participants reported that most of the prescribed medication was not available in the hospital which means they have to buy them from pharmacies elsewhere. It should be noted that in such pharmacies exception letter do not apply. This is the same as found in the qualitative part of this study whereby practitioners indicated that some of the prescribed medication were not readily available in the hospital.

Also Waikiro 92009) viewed that unsuitable physical environment and lack of necessary facilities affected elderly primary care and health care access. Normally, equipment is apparatus necessary for diagnosis. There was statistical significance on availability of drugs to access. These findings are supported by a study that reported attitudes toward the health care system, stocked facilities, familiarity with the health-care system, and confidence in the health-care system influence access and utilisation

4.4.5 Care and Respect from the Clients to the Attendants and Vice Versa

Under this domain researcher want to know to what extent care and respect from the clients to the attendants and vice versa can affect the access to FHS. The result shows that 70% of respondents failed to access FHS due to this reason. However, Male respondent shows more affected than female respondents. 84 per cent of male agree that they did not wish to go to hospitals when they get sick because nurses and some doctors does not care and respect them as elderly. Five per cent of female respondents have the same reasons. This comes from both clients and health provider as one elderly said;

"Hospitalini tunatibiwa na vijana wadogo sawa na wa juu zetu, baadhi wanatusema vibaya, hawatujali. Tanapokuwa tunasubiri huduma anaweza kukuita uingie chumba cha mganga au ukachukue dawa, usipoitika maramoja anakugombeza kama mtoto wake"

> "In hospital we are being examined by young doctors and nurses who are likely our grandson/daughters, some of them treat us very harsh and in inappropriate manner. They don't care for us as he/she might call you once or twice if you lately replay he/she will utter bad words to you as if he/she is talking to his/her child".

Even the nurses and doctors experienced the same from the elderly people as one nurses said;

"Nikweli wazee wanatibiwa bure, lakini wengi wao ni wakali mno hasa unapowapa maelezo ya kufata ili tuwape huduma bora. Wanataka wakifika tu wao ndio wawe wa kwanza kutibiwa hata kama kuna mgonjwa anayehitaji huduma ya haraka zaidi."

> "It is true that elderly receives free health services here but some of them are extremely furious when you give them procedures to be followed for their better treatment. They only want to be first to be attended even if there are other patients who need immediate care than them."

From the findings above, it can be concluded that elderly people can be easily utilised and access FHS if they will feel to be cared and respected from the health providers as an observation made by Whittaker as quoted by Sanga 2003) that Elders feel more comfortable if providers respect their privacy during counseling sessions, examinations and procedures. Elders particularly who obtain services in secret, report higher satisfaction with providers who keep their needs and personal information confidential.

4.4.6 Failure to Copy with Non-Productive Behavior

Failure to copy with non-productive behaviours among services providers was raised more by the public street level bureaucrats whose response constitute 21% of 63 respondents. It was also observed that male respondents 26% views this as more challenge compared to 19% of female. The findings also shows that more respondents who were not street level bureaucrats seemed to be less concerned about this challenge as an obstacles to their access to FHS.

This findings is supported by Weatherley and Lipsky,(1977) who viewed that often street-level bureaucrats have a beliefs that the resources entitled to them for the implementation of a particular task or program are insufficient to the point that they can use them to achieves the demands that are placed to them. To combat this situation they employ known and unknown coping strategies as the way to achieve the demands placed to them. For example, some may try do reduce the demands for their services by not providing accurate and informative message about the services they do offer, letting clients wait for long times without reasons, making access difficulty and sometimes they impose psychological costs on clients as the way to make them tired to the services granted to them. If disciplined measures are not taken by the higher authority for the above situations the access to free health services to elderly population will be not achieved as intended by the ageing policy.

4.4.7 Budget Constraints and Manpower-Client Ratio

Under this part researcher want to find whether there was budget constraints and fewer health attendants that may affect negatively the access to free health services to elderly people. About 19 (34%) of respondent said yes there are budget constraints and fewer attendants prohibit their access to FHS. As of the respondents said;

> "Very little money has been injected from central government for ageing people services, and municipality from its own sources has little to contribute for the elderly people concerns. Scarce resources in municipal limit allocation of funds to the ageing people."

It was also noted that to the health centers visited by researcher, doctors revealed that number of patients who attended was not large to the extent to affect their work. One doctor when interviewed said;

"Idadi ya wagonjwa wanaokuja hapa kwa siku si kubwa kiasi kwamba inaweza kuathiri utendaji wangu.Sana sana kufikia saa sita wagonjwa wanakuja mmoja mmoja, hasa watoto na wajawazito."

> "There is no large number of patients who visit here to the point that can it affect negatively my competence in my work. It is normal here that by noon only fewer and fewer patients arrive and most of them are children and pregnant women**."**

This finding is supported by Gasto (1997:46) who argues that lack of finance led to the failure of improving and expanding the services in a local authority which were already in existence especially the administrative educational and medical services. Gasto further states that this was attributed to the unrealistic budgeting and financial juggling that lead local authority (Municipal) to restrict their activities and concentrate their effort upon certain limited objectives,

4.4.8 Lack of Act to Support Policy

Forty eight (76%) of respondents out of 63 believe that lack of Act to support National Ageing Policy since 2003 jeopardized the implementation of FHS to ageing population. Since the service has not yet been backed by Law, its implementation is viewed by many as favor to ageing people rather than seen as their legal right. On respondents said that;

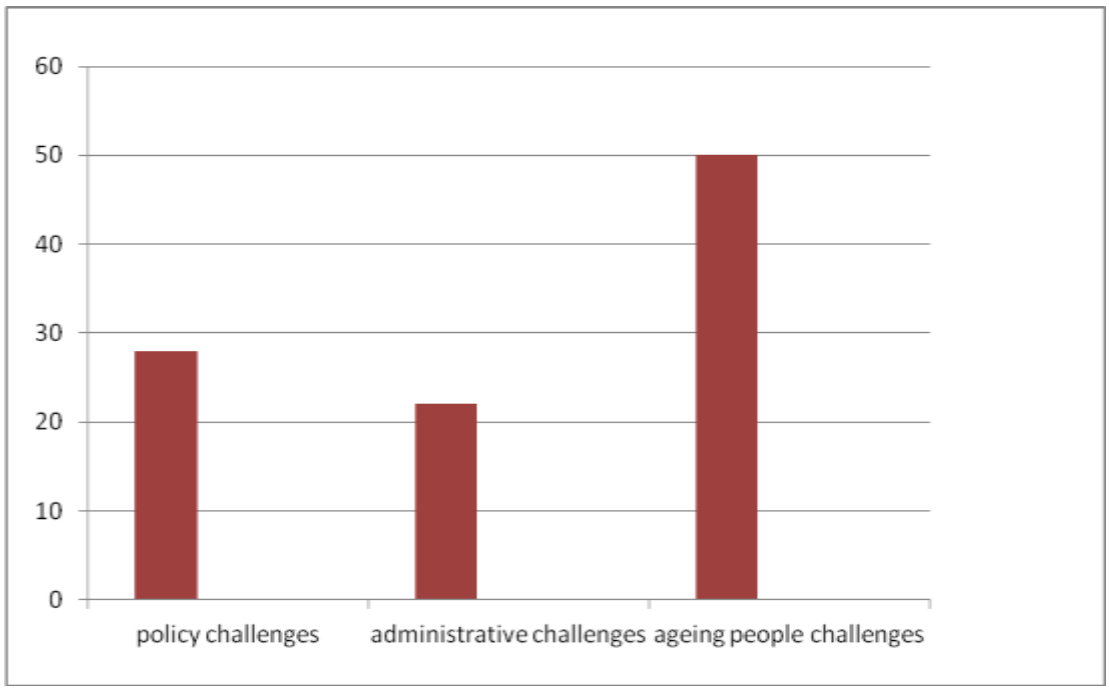
> "Most nurses view an aged person as being provided favour when it comes to FHS rather than being their legal right, thus the service seemed to be as a punishment for being aged forcing some of them not to access the opportunity when they feel sick"

This findings concurs with the study findings conducted by Julia Tobias and Francis Omondi (2014) who observe that central government in Tanzania has made several commitments to protect elderly people's right in the country by ensuring their access to free health services are adhered, but in practice the implementation of these national and international agreements has been slowly and incomplete. This demonstrates significant policy incoherent. For example the passing of National Ageing Policy has not been accompanied by a supportive legal framework to enforce its implementation and hold government accountable for protecting elderly people's right.

Although the National Ageing Policy requires the formation of Older Person Forum (OPF) at the community level to serve the function of bringing elderly people's issues to the attention of local government, in practice these forums have not been functioning in most areas. Similarly, implementation of the policy of free health services and the provision of resources to support it, have been inconsistent. This is part of general trend in the country where the delivery and implementation of legislative frameworks have been weak, indicating that policy formulation does not always lead to policy action (Julia Tobias and Francis Omondi, 2014: pg. 5)

Challenges facing Access to free Health services to Elderly at Morogoro Municipality

Figure 4.1 Lack of Act to support policies



Source: Field Source, 2016.

CHAPTER FIVE

SUMMARY, CONCLUSION AND POLICY IMPLICATIONS

Introduction

This chapter presents the summary, conclusion and Policy implications of the study. The summary shows key study findings. The conclusion shows what the study findings suggest and recommendations show what needs to be done to address the problem.

5.1 Summary of the Study

The aim of this study was to investigate the access of free health services to the ageing population an account to street level bureaucrats and the clients on the implementation of National Ageing Policy in Morogoro Municipal. Cross-sectional study design was employed so that relevant evidence could be collected with minimal time, human effort, materials and money. The design was favoured by researcher also because it provides a snapshot of the outcomes and characteristics associated with it at specific point in time.

Sixty-three respondents were used selected randomly and purposefully from three selected wards in Morogoro Municipal Council. Interviews and questionnaires methods for data collection were employed to collect primary data. For secondary data documentary review were used. Then the data was analysed by using computer software SPSS version 14.0 on data collected by questionnaires. Data collected using interview method was analysed manually through ordering and listing of all answers, and then connected them with the purpose of this study.

It was observed by this study that the extent to which an ageing people are being identified and documented for free medical services, the understanding was below 49% (those with very high understanding account for 19% and those with high understanding 30%) This finding concurs with an observation by Mfumowa Usimamizi MKUKUTA (2007) which observed that almost half of elderly people (48%) who are above sixty years they are not aware of being entitled right to free

health services to public hospitals. Since they are not aware of their right to free medical services to public health facilities, their passion to look for the services whenever needed be is questionable. This result may be attributed to several factors such as education level of clients and politicizing health issues by street level bureaucrats.

Process of identification and documentation of elderly for free health services should be revised to ensure all elderly are easily accessible to the services. For example all elderly should have national health identity to be used in all public health facilities and the private facilities that receive subside from the government. Frequently in-services trainings should be provided and emphasised to health staffs particularly on those dealing with elderly and for geatreac professionals. However allocation of enough funds will solve the issues of inadequate medicine, laboratory facilities and the like. To achieve the mentioned step, The Ministry of Health and Social Welfare in collaboration with NGOs, District Medical Officers, District Council and other stakeholders should ensure that budget for medical facilities are sufficient so as to improve health services provision to elderly people.

On understanding the perceptions of street level bureaucrats and the clients on the implementation of free health services to the ageing people, this study shows that almost fifty per cent of respondent are being satisfied with free health services granted to elderly. This implies that among the elderly who seek health services whether in public hospital, dispensary or health Centre reported their satisfaction of the services and medication from the health attendants. However there are some numbers of elderly and health workers who were not satisfied. They mentions things like shortage of drugs, waiting time, abusive language and lack of an act and by laws leads their dissatisfaction on the whole process of ensuring elderly people receives not only better services but also at a time when they need it.

Objective three of this study was to examine the challenges that street level bureaucrats and the elderly faces in the implementation of National Ageing Policy and their coping behaviour particularly focusing on the provision of free health

services to ageing people. The result of this study shows that challenges relating to ageing people account for about 69 per cent of all challenges that hinder effectives implementation of free health services. Issues such as waiting time to be attended by expert, distance to and from heath facilities, inappropriate language used by health attendants, and lack of drugs were reported by many respondents as the barriers for them to access free medical services.

Another challenge reported by respondents was relating to administration at the health facilities. This account twenty-two percent of all challenges reported. Inadequate funding due to competition for scarce resources which usually target children, adolescents, and women of reproductive age; Lack of care and respect to clients when seeking services, failure of administrators to copy with nonproductive behaviours of their subordinates, and doctor/nurse-patient ratio as well as lack of specific training of doctors and nurses in geriatric care, leading to the inappropriate labeling of all illnesses among older people as due to old age; was observed as barriers to effective provision of free medical services to elderly in Morogoro Municipal Council. It was also reported by this study that challenge relating to policy itself accounts about forty-one per cent.

Lack of Act to support National Ageing Policy makes the services providers to see FMS to elderly as favour she/he may or may not be given to an ageing people and not a legal right to the elderly. Basically it was observed that free health and medical services was seen by elderly as being too theoretical as all people in the society including the elderly are being emphasised by the government to contribute to health services particularly through Community Health Fund (CHF) and through National Health Insurance Funds (NHIF).

5.2 Conclusion

Elderly people's access to free health services delivery is still a big mount to climb by the Morogoro Municipal Council and Tanzania in general. Their failure to access free medical services prohibits ageing people's opportunity to involve in production as they find themselves victims of health problems. This study discovered that half of ageing people are unaware of being entitled to free health service to public health

facilities. And half of them, who are aware of are not satisfied with the services offered. However, it was an observation of this study that the challenges relating to policy such as lack of Act to support National Ageing Policy and the failure of the municipal council to enact by-law to ensure elderly access free medical service limit elderly to grasp their opportunity to free health service. Also the study discover that most of respondents take long time waiting service delivery in health facilities which discourage even to attend health services. Moreover lack of important drugs was also a challenge as they back home without medications, and lack transport to the health facilities became as barrier to them.

5.3 Limitation of the Study and Suggestions for Further Research

This study suffers from three limitations which paved ways for further researcher to conduct research into. First the study employed a qualitative research method which provides explanations from the realm of individual consciousness and subjectivity, thus the findings of this study cannot be generalised to all street level bureaucrats and elderly in the municipality.

Secondly, the study was a single case conducted in one municipality covering only three wards out of 29 that made up Morogoro municipal council this means that information were gathered from small geographical areas that cannot be generalised as the ideas of all resents of the municipality. It appeared to the researcher that it is worthwhile for other researchers to use other designs as survey study design to conduct research that will cover large areas and uses many respondents for the generalisation of the findings. Also, similar study can be done in rural areas to see if the same challenges appear to elderly people as it is reported in Municipality.

Thirdly, the findings of this study was obtained only after examining the process, perceptions and challenges pertaining street level bureaucrats and clients on free health services as being advocated by the National Ageing Policy. It is known that through that policy all elderly who are above sixty years of age should receive free health services regardless whether they had health insurance or not. This study did not investigate to know whether all elderly receives equal treatment on FHS delivery. I suggest comparative study can be conducted to find out whether there is a similarity

in services delivery between those elderly who uses health insurance and those have not. It is also an observation of this study that this disadvantaged group of elderly suffers so many challenges despites of being given priority by the states to ensure their wellbeing. Further study can be done on the same topic but can be based on other disadvantaged groups like women, children and the socially displaced populations.

5.5 Theoretical Implications

This study shows that half of elderly involved in this study are unaware of the process for identification of elderly people for FHS unlikely to more than half of street level bureaucrats who are aware of. It was noted also by this study that half of street level bureaucrats and elderly who were aware of and use FHS perceived satisfaction on the implementation of NAP regarding to free health services to elderly. The study findings also show the challenges that likely facing the access to free medical services by elderly. It was founded by this study that there are three kinds of challenges. One is challenges associated to elderly on access to free health services. These include waiting time for services, abusive languages and elderly people health status prior to their illness can influence them to access FHS or not.
The second challenge observed was administrative challenges such as care and respect to the clients, ability of bureaucratic to copy with nonproductive behaviours, and budgetary constraints. The third challenge was associated to the policy itself. Lack of policy instruments as by laws and acts to support NAP may influence negatively elderly access to FHS.

Based on Availability, Accessibility, Acceptability and Quality Health Model (AAAQ) as being used to guide this study, the finding shows that in a case of availability, health facilities were available enough to carter the needs of elderly. For example it was founded by this study presence of sufficiency number of health attendants in all researched areas, but there were no special doctors specifically to take care of the elderly compared to other vulnerable groups such as women and children. It is important for the government to ensure each health facilities has got a

special doctors to handle the elderly problems as the way to implement the concept of FHS Valid.

In case of accessibility, the findings shows that services to elderly are easily accessible to most patients, but there is a need to simplify the process of identifying and attending an elderly person. For example a special window for elderly should be there at all health facilities. However, disseminations of information about FHS and procedures for elderly to be attended to the hospital should be more provided to the elderly population and the community at large.

For acceptability of FHS, the findings show that most elderly who fall sick viewed hospital as their best destination to visit for treatment rather than going to traditional healers. However inappropriate language used by some health attendants toward elderly patients lead them not seek for free health services. Thus frequently and progressive in-services training to health attendants should be given as the way to remind them their moral and professional ethics to their jobs.

The findings also show that there is a scientific and professional services offered to the clients on the visited researched area. Quality services prevailed. To maintain these sufficient budgets should be given as intended in a due time.

It is obvious that the NAP is not well implemented as it was intended, there is a deficit in the implementation process as there is a gap between what the policy advocates, and the practices at the ground. Some of street level bureaucratic set their own standard and practices differently from what the policy said. This is being done because there are no policy instruments like policy directives that set the grounds to ensure FHS are provided in the manner that reflects the NAP objectives. Thus health staff must be given frequently training on how to handle the elderly when in need of health care and health services.

5.6 Policy Implications

Based on the findings of this study, there seems to be some weaknesses in the policy to capture the needs of elderly particularly on health services delivery. Budget deficits, shortage of drugs, absences of elderly identity cards for FHS, poor dissemination of information concerns FHS and failure of health providers to copy with their nonproductive behaviours are some indications to the failure of NAP implementation. The idea is good, but must be followed by a functional system that will ensure the implementation of policy to have a check and balances system. It also known that very little money is injected from central government for elderly people services at local authority which affects the provision of FHS. Thus there is a need to revise the process of identification of ageing people who deserve FHS. It was an observation of this study that half of the respondents were not satisfied with the services provided when seeking for FHS. This was due to the lack of policy instruments that form a ground to ensure effective implementation of NAP and inadequacy of drugs just to mention the few. The followings are some policy recommendations based on the findings of this study;

There is a need to design a health care programme specifically meant to elderly population and it should be entirely free or heavy subsidized. Also there is a need for strengthens the staffing by employing more and diverse professionals for relevant units working under elderly people.

There are indications that the government is trying to satisfy its citizens. Formulation and implementation of NAP and National Health Policy is an example of a good will of the government. However, the government has limited resources to carter all the demands to satisfy every vulnerable groups in the country, it is over ambitious towards them. There is a need for the government to set priorities according to the resources in hands and, not to talk of free health services to the elderly while in practical ground there is no environment to support smooth run-off of free health services to elderly. Provision of health insurance cards is vital to simplify the identification and verification of elderly when seeking FHS as well as to make the concept of free health services practical as advocated by the policy.

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APPENDICES

A QUESTIONNAIRE ON THE STUDY ON IMPLEMENTATION OF THE NATIONAL AGEING POLICY IN TANZANIA: WHAT DO STREET LEVEL BUREAUCRATICS AND CLIENTS SAY ABOUT ACCESS TO FREE HEALTH SERVICES BY THE ELDERLY POPULATION IN MOROGORO MUNICIPALITY?

Introduction

My name is **Malalika, Musa Amon** a graduate student from Mzumbe University, Main Campus. I am currently pursuing the **Master of Research and Public Policy (MRPP)** degree. One of the requirements in the programme is to carry out the study particularly the field work and write the dissertation/thesis during the third semester of the study in partial fulfillment for the requirement to attain the degree. I have identified you as one of the key respondents in my study. This is the questionnaire which you are humbly requested to respond to the question on the Accessibility to Free Medical Services by the Ageing Population at Morogoro Municipality in Tanzania; An Account from the Street-Level Bureaucrats and the Clients on the Implementation of National Ageing Policy in Tanzania.

Instructions

i) Place a cross (x) against the answer which you feel explains the best choice

ii) Write your answer in the open spaces provided in the open ended question

iii) You can write additional pieces of information on a fresh piece of paper and then attach it to this questionnaire

I: INFORMATION ABOUT LOCATION

1.1 Region_____

1.2 District _____

1.3 Ward_____

1.4 Street"_____

1.5 Name of health facility or Centre_____

BACKGROUND INFORMATION

1. Age…….Sex; M…….F……..
2. What is your occupation among the following? Tick appropriate

a. District social worker……. ( )

b. Health staff (Doctor, Nurse or Paramedical)……. ( )

c. Service user (ageing person)…….. ( )

d. WEO, Hamlet, District counselor, Ageing people care giver…… ( )

Other (specify)…… ( )

B1. How often do you attend to hospital for treatment?

1. Never
2. Occasionally
3. Fairly frequently ( )
4. Very frequently

B2. I get free health services in all aspects of health services in public health services

1. Strongly disagree
2. Disagree
3. Somewhat disagree
4. Somewhat agree
5. Agree
6. Strong agree **( )**

B3. In public health facilities, have you seen ageing people being exempted for the services and supplies?

1. Very often
2. Often
3. Less often
4. Never **( )**

B2d. Have you ever seen an eligible person being rejected for free medical services?

1. Very often
2. Often ( )
3. Less often
4. Never

B3. To what extent are the following deserving groups excepted in health medical services?

1. Deserve more
2. Deserves
3. Deserves little
4. Don't deserves

- Pregnant and delivering mothers ( )
- Children under five years ( )
- Older people (>60 years) ( )
- People unable to pay ( )
- Family planning and immunization services **( )**

C. POLICY BEING UNDERSTOOD

C.1 Please can you tell me the extent you know about free health services?

1. Very low
2. Low
3. Somewhat low
4. High
5. Very high

C3. Do you know the processes that are involved in identification and documentation of ageing people to facilitate their accessibility to free to free medical services?

I know;

1. Very high
2. High
3. Average
4. Low
5. Very low

C4. Did you attend any training or discussion concerning free medical services on ageing people? ( )

1. Very often
2. Often

3. Less often
4. Never

C5. Do you know the procedure for free medical services as described in NAP and guidelines?

1. Very high
2. High
3. Average
4. Low
5. Very low (**)**

D. THE WAY POLICY IS IMPLEMENTED

D1. How is an exemption efficiently implemented as stipulated as stipulated in NAP, guidelines and directives?

1. Best
2. Good
3. Average ( )
4. Low
5. Very low

D2. Process of exemption in implementation of NAP is continuing (sustainable) process

1. Strong agree
2. Agree
3. Disagree
4. Strong disagree **( )**

F. PERCEPTION OF AGEING PEOPLE AND CAREGIVERS ON FREE HEALTH SERVICES

F1. To what extent do elderly people satisfied with free health services procedures?

1. Very high
2. High
3. Average ( )
4. Low
5. Very low

F2. To what extent is ageing people really benefiting?

1. Very much
2. Somewhat
3. Low
4. Very low **( )**

G. THE EXTENT TO WHICH FREE MEDICAL SERVICES IS VALUED.

G.1 How do you understand the term "ageing people" based on National Ageing Policy?.....

G.2 Based on those paying user fees and exempted categories, are ageing people treated equally in terms of customer care?

1. Strong agree
2. Agree
3. Disagree
4. Strong disagree

G3 Are there satisfaction of health services to ageing people?

1. Strong agree 2. Agree 3. Disagree 4. Strong disagree ( )

G.4. Are there any complainants about staff, management, National ageing policy, and procedure and implementation process on free health service?

1. Very often
2. Often
3. Less often
4. Never

G.4. To what extent the procedure of user fee exemptions is known?

1. Very high
2. High ( )
3. Low
4. Very low

H. STREET LEVEL BUREAUCRATS MOTIVES

H.1 Is free medical services to ageing people main concerns to your objectives?

1Very concern

2 Little concern ( )

3 Less concern

4 Not concerns

H.3 For your view how a politics and economy influencing free health services to ageing people?

1. Very much

2 Somewhat

3. Not at all **( )**

H.4 Is there serious and frequently managerial supervision for free health services process?

1. Strong agree

2. Agree

3. Disagree

4. Strong agree **( )**

H.5 Does the management in health facilities support exempted of user fee?

1. Strong agree

2. Agree

3. Disagree

4. Strong disagree **( )**

J. CLARITY OF POLICY AND PROCEDURES

J.2 There are available transparent policy, guidelines and advertisement to the public about free health services to ageing people?

1. Strong disagree

2. Disagree

3. Agree

4. Strong agree

J.4. To what extent the procedure of user fee exemptions is known?

1. Very high

2. High ( )

3. Low

4. Very low

INTERVIEW GUIDE

UNSTRUCTURED QUESTIONNAIRES AND INTERVIEWS GUIDE

C.1a. Have you ever heard of National Ageing Policy?

1. YES 2. NO ( )

C.1. If YES, what does it say on accessibility of health services to ageing people?.....

.....

B2d. Have you ever seen an eligible person being rejected for free medical services?

B2e. If YES, what was the basic ground?

.....……

C3. Do you know the processes that are involved in identification and documentation of ageing people to facilitate their accessibility to free to free medical services?

C4. What are the eligible conditions for an exemption? List at least three

……

……

G.1 How do you understand the term "ageing people" based on National Ageing Policy?.....

G.4. Are there any complainants about staff, management, National ageing policy, and procedure and implementation process on free health service?

G.5 If YES, what kind of complains are often occur?

.....

.....

C1a. Have you ever heard of National Ageing Policy? 1. YES 2. NO ( )

C1b. If YES, what does it say on accessibility of health services to ageing people?

.....

.....

C4. What are the eligible conditions for an exemption? List at least three

……

……

G.1 How do you understand the term “ageing people” based on National Ageing Policy?

G.2. Are there any complainants about staff, management, National ageing policy and procedure and implementation process on free health service?

G.5 If YES, what kind of complains are often occur?

.....

.....

G3. What are the administrative arrangements do you have in place to ensure smooth provision of free health services to older people? Please mention _____

_____

G4. What should be done to ensure smooth free health services provision to elderly people? Please give your opinion_____

_____

_____

_____

G.5 What are the challenges or problems for management towards free medical services to ageing people?

1……

2……

3……

4……

5……

G.6 How do you know a person that he/she deserves free health services according to the National Ageing Policy?

(State)……

INTERVIEW GUIDE

1 What is your understanding about free medical service?

2 How ageing people are identified as being eligible for free medical service**?**

3 What is your opinion on the way street level bureaucrats implement free medical services to ageing people?

4 For your understanding what are the challenges facing the street level bureaucratic on the implementation of free health services to ageing people?

1Do older people access free health services at your hospitals/health centers/ dispensary?

Yes [ ] No [ ]

2. Which services are accessed freely? Please mention _____

_____

_____

3 Which services area not freely accessed? Please mention_____

_____

_____

4 Which diseases mostly affect older people? Please mention_____

_____

_____

5Are the mentioned diseases treated freely at your hospital/health center/dispensary?

Yes [ ] No [ ]

6. If "NO" which ones are treated freely and which ones are not treated freely? Please mention_____

_____

7. Is there any cost that sick older people are required to incur for medical treatment?

Yes [ ] No [ ]

13. If "Yes" do older people afford to pay the required cost for medical treatment?

_____

_____

Thank you for your time to fill this document.