CHALLENGES FACING PRIVATE HEALTH SERVICE PROVIDERS IN TANZANIA: A CASE OF ACCREDITED DRUG DISPENSING OUTLETS IN TABORA MUNICIPAL COUNCIL

CHALLENGES FACING PRIVATE HEALTH SERVICE PROVIDERS IN TANZANIA: A CASE OF ACCREDITED DRUG DISPENSING OUTLETS IN TABORA MUNICIPAL COUNCIL

By

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A Dissertation Submitted to Institute of Development Studies in Partial Fulfillment of the Requirements for Award of the Degree of Master of Science in Development Policy (Msc. DP) of Mzumbe University

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation titled **Challenges Facing Private Health Service Providers in Tanzania: A Case of Accredited Drug Dispensing Outlets (ADDO) in Tabora Municipal Council,** in partial fulfillment of the requirements for award of the degree of Master of Science in Development Policy of Mzumbe University.

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Major Supervisor

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Internal Examiner

Accepted for the Board of Institute of Development Studies

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DIRECTOR, INSTITUTE OF DEVELOPMENT STUDIES

DECLARATION

I, Abiud James Kulwijira, declare that this Dissertation 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.

Signature _____

Date_____

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ACKNOWLEDGEMENT

There are significant numbers of people who tirelessly contributed morally and physically to ensure that research report is fully developed and successfully produced. Since it is very difficult to mention all of them by their names, I have to extend my esteemed appreciations to all who in one way or another assisted me to produce this report.

So far, cordial appreciations should go to my supervisor Mr. Yona Matekere for his tireless effort and encouragement and leading me all the way long towards development and finally producing this dissertation. Indeed, his directives and advice have been invaluable to the success of my work.

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DEDICATION

To my wife; Beatrice James Kulwijira and Our daughters; Juliana Abiud James and Rebecca Abiud James

LIST OF ABBREVIATIONS

AIS-LAC	-	Action International's Coordinating Office for Latin America and the Caribbean
ADDO	-	Accredited Drug Dispensing Outlets
APHFTA	-	Association of Private Health Facilities in Tanzania
BAKWATA	-	Baraza Kuu la Waislamu Tanzania (National Muslim Council of Tanzania)
CHMT	-	Council Health Management Team
CMS	-	Central Medical Store
CSSC	-	Christian Social Services Commission
FBOs	-	Faith Based Organizations
HAI	-	Health Action International
HSSP	-	Health Sector Strategic Plan
MEO	-	Municipal Environmental Officer
MHC	-	Municipal Health Secretary
MHISO	-	Municipal Health Management and Information System Officer
MHO	-	Municipal Health Officer
MLT	-	Municipal Laboratory Technician
MIVC	-	Municipal Immunization and Vaccine Coordinator
MMAM	-	Mpango wa Maendeleo wa Afya ya Msingi
MoF	-	Ministry of Finance
MoH	-	Municipal Officer of Health
MoHSW	-	Ministry of Health and Social Welfare
MoSTHE	-	Ministry of Science, Technology, and Higher Education
NDP	-	National Drug Policy
NEDLIT	-	National Essential Drug List for Tanzania
PFP	-	Private For Profit
PHC	-	Primary Health Care

PMO-RALG	-	Prime Minister's Office- Regional Administration and Local Government
PNFP	-	Private Non For Profit
PPP	-	Public Private Partnership
REPOA	-	Research on Poverty Alleviation
SPSS	-	Statistical Package for Social Sciences
STG	-	Standard Treatment Guidelines
TFDA	-	Tanzania Food and Drugs Authority
URT	-	United Republic of Tanzania
WHO	-	World Health Organization

ABSTRACT

The study aimed at examining the Challenges facing private health service providers in Tanzania. Specifically the study focused at examining the Performance of private Accredited Drug Dispensing Outlets (ADDO), the challenges facing private Accredited Drug Dispensing Outlets in the provision of heath services, the causes of the challenges facing the private Accredited Drug Dispensing Outlets in the provision of services and measures in improving the performance of private Accredited Drug Dispensing Outlets in provision of service in Tabora Municipality.

This study applied a case study design, which targeted ADDO owners in Tabora Municipal Council as the private health service providers. A sample size of 100 respondents was drawn by using purposive and simple random sampling techniques. Questionnaire, Interview and Observation methods were applied in collection of primary data, whereas documentary review method was adopted for collecting secondary data. The collected data were analyzed by using the Statistical Package for Social Sciences (SPSS), Excel Software and Content Analysis then presented in tables, figures and texts.

The findings from the study revealed that; Unavailability of qualified staff, Poor storage facilities, shortage of required drugs, Low purchasing power, difficult drug policy, poor Government support, selling expired drugs and high training costs reported by respondents are the challenges facing ADDO.

To overcome the challenges facing ADDO, the study suggests; adherence to the Government medical policies, Proper Dispensing of required drugs, effective and efficiency drug planning, improving drug storage and dispensing enough of the required drug.

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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Introduction

This chapter includes an Introduction of the study, background to the study, statement of the problem, objectives of the study, research questions, significance of the study, scope of the study, limitations of the study and ethical issues.

1.2 Background information

Since independence the government of Tanzania has made efforts to improve access to quality essential medicine and pharmaceutical services to its citizens. Currently all pharmaceutical services are under Food, Drug and Cosmetics Act of 2003. The Act gives power to Tanzania Food and Drug Authority (TFDA) to regulate the quality, safety and effectiveness of medicine, food, cosmetics and medical devices. Furthermore, this Act is in line with National health Policy which emphasizes availability of quality health services to all Tanzanians (TFDA, 2010).

The private Accredited Drug Dispensing Outlets (ADDO) popularly known in Swahili as “Duka la Dawa Muhimu” (DLDM), is the drug outlet registered by TFDA to store and sell medicine that do not need prescription and some essential medicine that needs prescription.

The ADDO program was initiated in Ruvuma region in 2003, and as of April 2007, the program scaled up in Morogoro,(funded by US Agency for International Development [USAID]), as well as Rukwa and Mtwara (funded by the Government of Tanzania). Based upon the success of the pilot program, the Government of Tanzania initiated plans in 2005 to expand the ADDO program to all other regions in the country. By 2013, the status of ADDO in Tanzania were as shown in table 1.1

Table 1.1: ADDO Programme status

AS PER DECEMBER 2013	
Regions scaled up	21
Total no. of drug shops	9,226
Shops accredited (ADDO)	5,542
Shops in application process	3,684
Trained dispensers	13,625
Trained district inspectors	262

Source: Berman and Hanson, 2013

Table 1.1 shows that by 2013, ADDOs had spread to all regions (21) in Tanzania Mainland with a total of 9,926 drug shops whereby 5,542 were accredited shops and 3,684 were in a process to be accredited. Also there were 13,625 trained dispensers and 262 trained inspectors.

The medicine outlets for human beings and livestock have been established to resolve the problems encountered in the Part II Poison shops popularly known as *duka la dawa baridi* (DLDB). The problems encountered in the DLDBs included the following:-

- Drug sellers with no qualifications dispense medicines that were not permitted under the Guideline for Operating Part II Poison Shops, 1998.
- Most DLDBs were located in the urban area instead of rural areas, and this is not in line with the aim of establishing them.
- Most DLDBs (72 percent) found to stock and sell both prescription and nonprescription medicines. This was a threat to the safety of general public's health. According to the Act, DLDBs were supposed to stock and sell non-prescription medicines only.
- Medicine quality was not assured because most DLDBs found to sell expired and/or unregistered medicines.
- Some of the DLDBs sold medicines stolen from public health facilities and from other health-related projects.

- The premises of DLDBs were not maintained adequately for proper storage of medicines.

  This in turn lowered the quality of medicines available in these shops.
- Livestock medicines sold in the open market.
- Medicines sold without following proper guidelines for good dispensing practices.
- The range of medicines authorized to be sold in the DLDBs did not meet the health demand of the customers.

So as to solve these problems, the Ministry of Health and Social Welfare (MoHSW) through the TFDA made some essential amendments to DLDBs operations. These amendments were targeting the knowledge and the skills of the dispensers, supportive supervision of these outlets, the quantity and type of medicines that are allowed to be stocked in the outlet, improvement of the quality of the premises, and conditions for keeping and storing medicines. The objective of these changes was to improve the services rendered by DLDBs through accrediting and upgrading them to become ADDO (Duka la Dawa Muhimu) after meeting criteria as established by ADDO regulations.

To assist individuals who wanted to establish an ADDO, and also to help program implementers to understand the procedures for establishing and operating these outlets, TFDA prepared a Guideline for Establishing and Operating ADDO. This guideline, which covers both people and livestock ADDO, identifies areas that the owners and the dispensers need to abide by.

The owners, dispensers, and overseers of the Act should use always this guideline as a reference book when establishing and operating or when supervising and inspecting these outlets. All partners dealing with the ADDO are encouraged to understand the Food, Drugs and Cosmetics Act, 2003; the ADDO regulations of 2004, and its 2008 amendments.

Although Private sector has been so much encouraged by the government in health services provision, its implementation has not been uniform across the country. There are areas where private health service has proved to be a success while in

others the progress has been slow. In Tabora for example, such health service which includes health centers, dispensaries and private medical shops have not been performing well which is an indicator of challenges existence.

Tanzania German Programme to support Health (2011) conducted an assessment on availability and management of medicines and medical supplies. The assessment aimed to assess the availability of essential medicines (i.e. the extent of the problem) as well as to identify bottlenecks that lead to unavailability of medicines.
Major bottlenecks were twofold: Incomplete supply by Medical Store Department of medicines requests from health facilities and Health facilities' lack of capacity to order medicines correctly including predicting medicine needs and to manage stock keeping.

Medicines Access and Use in Districts Served by private Accredited Drug Dispensing Outlets in Tanzania (2012) is an assessment conducted by Harvard Medical School Department of Population Medicine at Harvard Pilgrim Health Care Institute and Sustainable Drug Seller Initiatives Program. The goal of this assessment was to conduct a holistic assessment of health care seeking behaviour, medicines availability, medicines use, and stakeholder perceptions in communities served by private ADDO in Tanzania. Private sector delivery of health care in Tanzania is another study conducted by Munishi, (1995). The purpose of this study was to provide baseline information and analysis that the Ministry of Health and Social Welfare (MOHSW) can use to further elaborate policies to enhance public-private partnerships in order to expand coverage, strengthen quality and efficiency of health services, and improve health status in Tanzania. Specifically, the study aimed at: (i) Describing the size and scope of the private sector in health care delivery in Tanzania and assess the actual and potential role of the private sector in promoting the public health agenda;
(ii) Describing the current linkages between the public and private sectors in health care and identify areas where collaboration has the potential to improve health services delivery; and

(iii) Identifying factors that affect development of the private sector in Tanzania, especially legal, regulatory, tax, and financial matters.

A health study of Improving the use and management of information in health districts was conducted by Mukama (2003). The main goal of this study was to gain knowledge and understanding of the health information systems at local levels in developing countries using Tanzania and Mozambique as case studies, in order to explore the procedures, tools and problems related to primary health care data collection, storage, use and information flows and to offer ideas and suggestions on how to improve the systems of routine data collection, storage, analysis and use of information and more generally to improve the flows of information and health care information systems. However, the focus of the studies were not on challenges facing private medical shops in a Tanzanian context, and Tabora in particular.

Increasingly, decision-makers in developing countries are taking notice of the role of Private Sector Providers (PSPs) in health care provision. This is because PSPs are important providers of care and health care costs are a major drain on people's resources, particularly the poor. Managing PSPs is among the most complex stewardship tasks facing policy-makers; for this they require better information and tools (Smith *et al* 2001).

In most of developing countries, the historical approach to public sector medicines supply has been the use of the Central Medical Store (CMS) and public health service provider. It was typically owned by the government, organized as part of the civil service—often as a division of the Ministry of Health (MoH)—and financed from the government budget. The CMS normally distributed medicines free of charge to health facilities (Lockefeller Foundation 2008).

As observed in many state-run services around the world, CMSs were characterized by inefficiency and poor performance. There is indisputable evidence that centralized CMSs in developing Countries have experienced serious problems with procurement, financial and logistics management, security, and storage. As other public institutions, CMSs in developing Countries has failed to adapt to the increasing complexity of the global pharmaceutical market. Shortages of trained staff have been

exacerbated by bureaucratic rigidity and poor incentives. In addition, there are evidences of corruption, lack of transparency, leakage, and rent-seeking in the system, which is frequently politically influenced. This was the same to the public health service provision (Ibd).

In the 1980s and 1990s, many governments began experiment with various forms of marketizing in the health sector (Preker and Harding 2003). By far the most popular type of CMS reform was the granting of increased financial and managerial autonomy. Guided by new public management principles similar to those motivating greater autonomy for public hospitals, governments introduced private sector management features into their public sector medicines supply chains (PPP). In developing countries, these changes were often part of wider public sector reforms involving decentralization, privatization, and cost recovery, driven by pressure for fiscal consolidation. This is the time when the private sector medical stores came into operation.

In many developing countries, when people seek treatment for an illness they visit a PSP first. This is the case for many types of illnesses, including those that contribute most to dominant diseases affecting population such as malaria, sexually transmitted infections (STIs), tuberculosis (TB), diarrhea diseases and acute respiratory infections (ARIs). This is due to the fact that private health care can sometimes be more efficient than public sector health provision. Private sector operators may be more innovative in many areas due to profit motive and they can also be more productive. Some authors argue that private health care need to be more careful regulated to ensure that it achieves standards set by the government (Smith et al, 2001). Most of private medical stores staff are not fully qualified (Berman, 2000).

In India, an estimated of 60 to 85 percent of TB cases people seek treatment initially from PSPs (Uplekar *et al*, 1998). About two-thirds of people with TB cases stay with PSPs, rather than changing to public sector providers. Similarly, 80 percent of consultations for childhood diarrhea in India are with PSPs.

Personal ambulatory (Outpatient) care has the potential to address 75 to 80 percent of the global burden of disease. In Egypt – one of the few countries where country-level data are available – more than half of this care is obtained from private physicians (Berman 2000).

PSPs are also often the first choice for women seeking to control their fertility. Excluding India and China, one third of women in the developing world rely on private sources for family planning (Rosen and Conly, 1999). This is particularly the case for temporary methods.

PSPs are active and successful competitors in most health care markets, often more popular than public sector services. Reforms such as the introduction of user charges have driven people with, for example, STIs away from the public sector (Moses et al, 1992). This can have serious implications for population coverage, equity and quality of care (Benjarattanaporn *et al*, 1997).

For the case of Tanzania the evolution of private sector heath service development was streamlined in development policies and strategies for improving health services. It was after serious deterioration of health care services in the 1980s caused by government failure to meet the costs that led to the re-thinking about the role of the private sector. The importance of the private sector in health service delivery moved the country towards market-based socio-economic reforms to the establishment of the Private Hospitals Regulation Amendment Act of 1991, which facilitated the re-establishment of private medical and dental services. Since then Tanzania has different typologies of private health sector providers. These include Nonprofit (Voluntary Agency) Health Providers, Employer-Based Providers and For-Profit Providers.

Non-profit (Voluntary Agency) Health Providers

The first category is comprised of providers owned, financed, and managed by a legally "approved organization," generally religious and other nonprofit registered entities (hospitals, dispensaries and other health facilities owned by Churches, Moslem Council of Tanzania [Bakwata], Red Cross, Bahai, and Cooperative Unions).

Employer-Based Providers

The second category includes health facilities owned by public-private parastatals and by private companies expressly to treat their own employees and their dependents. These units also sometimes treat nonemployees on a fee-for-service basis. Many large companies in Tanzania, most of which are parastatal (quasi-private) organizations, provide health services for employees and their dependents.

For-Profit Providers

This is the third group which includes independently hospitals, clinics, maternities, dispensaries, Dentists, Traditional Birth Attendants, Herbalists Pharmacies and Retail medical shops. This study is based on retailed shops i.e. private Accredited Drug Dispensing Outlets.

1.3 Statement of the Problem

Despite the government efforts to involve private sector in health service provision to its citizens, evidences from the studies by Tanzania German Programme to support Health (2011), Medicines Access and Use in Districts Served by private Accredited Drug Dispensing Outlets in Tanzania (2012), Private sector delivery of health care in Tanzania by Munishi (1995) and Improving the use and management of information in health districts conducted by Mukama (2003) show that the study on challenges facing private Accredited Drug Dispensing Outlets has not been done. This means that there are no or limited studies on challenges facing private health service providers in service provision specifically ADDO in Tabora Municipality.

This study intends to fill the gap by examining the Challenges facing private health service providers in Tanzania using a case of private Accredited Drug Dispensing Outlets in Tabora Municipality. The study is guided by Policy statement that aims at ensuring the availability of drugs, reagents and medical supplies and infrastructures.

1.4. Study Objectives

1.4.1. General objective

The main objective of this study was to examine the Challenges facing private health service providers in Tanzania using a case of private Accredited Drug Dispensing Outlets in Tabora Municipality as part of the public-private partnership initiative in Tanzania.

1.4.2. Specific Objectives

In order to accomplish the above general objective the study focused on the following specific objectives;

1. To document the Performance of private Accredited Drug Dispensing Outlets in Tabora Municipality.
2. To identify the challenges facing private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.
3. To explore the causes of the challenges facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.
4. To suggest the measures of improving the performance of private Accredited Drug Dispensing Outlets in provision of service in Tabora Municipality

1.5. Research Questions

The following are the research questions guiding the study;

1. What is the performance rate of private Accredited Drug Dispensing Outlets in Tabora Municipality?
2. What are the challenges facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality?
3. What are the causes of the challenges facing private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality?

4. What measures can be used to overcoming the challenges in provision of health services by private Accredited Drug Dispensing Outlets in Tabora Municipality?

1.6. Significance of Study

This study specifically focused on the people of Tabora Municipality, particularly the urban community with the aim of studying the challenges facing private Accredited Drug Dispensing Outlets. The study is important because it assists different development actors within and outside the district, to apply the findings and their proposed solutions in the formulation and reviewing development policies in their respective occupations particularly in the health services and other safety nets programmes designed to improve the livelihood of vulnerable and low-income groups.

The findings of this study will be relevant to all stakeholders including Tabora Municipal Council in searching mitigation to various social economic problems facing the local society. Moreover, this study will help other researchers to conduct other researches.

1.7. Scope of the Study

This is thematic area of the study.The study focused on examining the challenges of private Accredited Drug Dispensing Outlets in provision of health services in Tabora Municipal Council. Although the sector may be faced by a number of challenges, the study focused on challenges associated with sales, preservation, technical skills and measures taken to ensure smooth provision of expected health services. These are deemed to be the key aspects which will result into identification of challenges in the study area.

1.8 Study Limitations

The study was faced with a number of constraints and properly addressed during data collection as follows: Shortage of fund which allocated to support field activities of the study. The researcher solved this problem by using his pocket money to afford

the transport costs, accommodations and costs for stationeries during field activities. Some respondents were reluctant to answer the questionnaires due to security fear. The researcher overcame this problem by using Ward Executive Officers and Ward Health Officers who assured them that it was simply an academic study which is not related to their home affairs.

CHAPTER TWO

LITERTURE REVIEW

2.1. Introduction

This section focused on defining concepts and terms of policy, drug policy, policy implementation, and the accessibility of drugs.

This section also presents a review of literature related to the topic under investigation. The chapter presents theories and empirical studies with a critical analysis of each. The theoretical analyses on how the private Accredited Drug Dispensing Outlets are linked to the contribution of medical service provision as per various scholars are presented first. The chapter also presents a conceptual framework which indicates the relationship between independent variables and the dependent variable. Empirical literature focuses on studies related to the study area.

2.2. Theoretical Literature Review

2.2.1. Definitions of key terms

The terms that are to be defined include: Health Promotion, Accredited Drug Dispensing Outlet (ADDO), Policy, drug policy, accessibility of drugs and policy implementation. These terms are key to this study that enable clear understanding of what is intended as far as this study is concerned.

2.2.1.1 Health Promotion

Health promotion is a discipline that seeks to improve the health of individuals and communities through education, behavioral change and environmental improvement. Health promotion draws from a number of complementary disciplines, such as psychology, sociology, the biological and clinical sciences, and business (marketing and management) to help individuals and communities change their behaviors and improve their environments. In short, health promotion is “the process of enabling

people to increase control over and to improve their health." (Ottawa Charter, First International Conference of Health Promotion, 1986)

2.2.1.2. Private Accredited Drug Dispensing Outlet (ADDO)

The private Accredited Drug Dispensing Outlets (ADDO) popularly known in Swahili as "Duka la Dawa Muhimu" (DLDM), is the drug outlet registered by TFDA to store and sell medicine that do not need prescription and some essential medicine that needs prescription. The ADDO program solicits the support and expertise of stakeholders including health professionals from the public and private sector as well as commercial associations. The program develops the standards and requirements to regulate the ADDO and to build stewardship and governance capacity within the public sector.

2.2.1.3 Policy

Policy is a set of interrelated decisions concerning the selection of goals and the means of achieving them (Jenkins, 1978).

According to Hill(1993) 'policy' is defined as the product of political influence, determining and setting limits to what the state does. For further clarification, when a government takes a decision or chooses a course of action in order to solve a social problem and adopts a specific strategy for its planning and implementation, it is known as public policy (Anderson, 1975).

2.2.1.4. Policy implementation

According to Ottoson and Green (1987) suggest that **"Policy implementation"** is an iterative process in which ideas, expressed as policy, are transformed into behavior, expressed as social action". The social action transformed from the policy is typically aimed at social betterment and most frequently manifests as programs, procedures, regulations, or practices for bringing social betterment.

2.2.1.5. Accessibility of drugs

In this study accessibility means the quantity of drugs delivered and used by the public. Accessibility influences treatment and therefore public health, distance and time used but also reliability and potentially cost (Bartram, 2003). The Tanzania Food and Drugs Authority (TFDA) is responsible for the regulation of medicines and conduct inspections of the public and private drugs dispensing outlets in Tanzania.

2.2.2. The Primary Health Care

Primary Health Care means: Community involvement and the use of local and physical resources to provide a range of curative and preventive services and health promotion measures that are both accessible and affordable to the local population (WHO, 2000). While the national health policy has given broad guidelines on the health services delivery system in Tanzania, the PHC strategy has outlined how the policy is to be implemented.

The Government adopted the PHC as a rational and equitable way of improving the health and well being of the whole population. This means that the PHC is relevant and applicable, whether the population is rural or urban based. It is therefore incorrect to equate PHC to either rural populations or inferior health care (WHO, 2000).

2.2.3. Health Sector in Developing Countries

Increasingly, decision-makers in developing countries are taking notice of the role of Private Sector Providers (PSPs) in health care provision. This is because PSPs are important providers of care and health care costs are a major drain on people's resources, particularly the poor. Managing PSPs is among the most complex stewardship tasks facing policy-makers; for this they require better information and tools.

In many developing countries, when people seek treatment for an illness they visit a PSP first. This is the case for many types of illnesses, including those that contribute most to the population disease burden such as malaria, sexually transmitted

infections (STIs), tuberculosis (TB), diarrhea diseases and acute respiratory infections (ARIs).

In many countries most treatment of malaria (McCombie, 1996) and STIs (Brugha and Zwi, 1999) takes place outside the public sector, through visits to PSPs or direct over-the- counter purchase of drugs, often from untrained shop staff, for self-treatment.

In India, an estimated 60 to 85 percent of TB cases seek treatment initially from PSPs (Uplekar et al, 1998). About two-thirds of these cases stay with PSPs, rather than changing to public sector providers. Similarly, 80 percent of consultations for childhood diarrhea in India are with PSPs, most of whom are not fully qualified (Berman, 2000). Personal ambulatory (outpatient) care has the potential to address 75 to 80 percent of the global burden of disease. In Egypt – one of the few countries where country-level data are available – more than half of this care is obtained from private physicians (Berman, 2000).

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Private healthcare system in Kenya has grown tremendously over the last two decades due to various reasons, among them lack of adequate and quality public healthcare services and introduction of user fees. This growth can also be associated with the health sector reforms undertaken in the 1980s and 1990s when the government relaxed the licensing and regulation of private healthcare providers and also relaxed the prohibition of public sector personnel from working in private practice (Hursh-Cesar et al, 1994). The reform measures implemented by the government called for greater involvement of the private sector in the economy.

These reforms were a result of fiscal constraints that compelled the government to reduce overall expenditure, including budgetary allocations to the health sector, and therefore the need to encourage private healthcare providers to expand and play a greater role in healthcare provision.

Although the relaxation of government policies, regulations, and licensing procedures in the health sector seems to have encouraged growth in private healthcare provision, most of these providers are concentrated in urban areas (Hursh-Cesar et al, 1994). Also, the laws and regulations in private healthcare provision tend to be weakly enforced and show large gaps in application. Nevertheless, the non-restrictive policy environment towards private provision of healthcare services has, among other factors, contributed to the rapid expansion of the Kenyan health system. According to the Health Management Information Systems (Government of Kenya, 2001a),non-governmental organizations, private, and mission organizations account for 47 percent of all health facilities in Kenya. Private clinics, pharmacies, nursing homes and traditional practitioners have mushroomed in most urban and rural areas. However, these private facilities thrive in an unregulated environment.

2.2.4. Health Sector in Tanzania

The leading sector in the Tanzanian health system is the public sector, with stakeholders in the executive and legislative branches of government – PMO-RALG and Parliament – as well as various line agencies and ministries. The primary actor in the public sector is the MOHSW, with support from other government agencies such as the Ministry of Finance and Economic Affairs (MOF) and the Ministry of Science, Technology, and Higher Education (MOSTHE).

Although demand for health services in public facilities has increased as planned, an unintended result has been the migration of medical staff from the private sector to the public sector. This has created healthy competition between the public and private sectors (particularly Private For Profit facilities), but has also exacerbated human resource shortages in the private health sector. Despite the public sector‘s

dominant position within the health sector, there is room for strategic and systematic engagement with the private sector – both PFP and PNFP (MOHSW-2012)

The private health sector is diverse and complex, comprising a wide range of actors and stakeholder groups, and engaged in a wide range of health activities. Historically, the Tanzanian private health sector (particularly Faith Based Organizations- FBOs) have played a significant role in expanding service delivery and providing supportive functions such as pharmaceutical dispensing and laboratory diagnostics. Private health sector involvement in the Tanzanian health system has grown relatively quickly over the past 20 years, in part responding to government policy changes (such as removing the ban on private practice in 1991). Until recently, however, the government has not actively involved the Private For Profit (PFP) sector in policy and planning or engaged them directly in expanding service delivery (MOHSW-2012).

Private Service providers cover one-third of all health care services in Tanzania, whereby about 18 percent of health infrastructure is owned by non-for-profit, mainly faith based organizations (FBOs). While FBOs are prominently located in marginalized rural areas, private self-sustaining health service providers, particularly hospitals and pharmacies, are more common in the urban areas. There are efforts on-going to improve access to medicines by the private Accredited Drug Dispensing Outlets (ADDOs) Programme which established high numbers of well operated and staffed drugs dispensing outlets at all levels.

At institutional level the private-for-profit health service providers are organized and represented in the Association of Private Health Facilities Tanzania (APHFTA) and the FBOs in the Christian Social Services Commission (CSSC) and the National Muslim Council of Tanzania (BAKAWATA). Furthermore, there are 32 associations for health professionals who have come together as a federation of professionals'association as well as training institutions. The landscape of civil society organizations engaging in the health sector is still divers and scattered.

Other smaller and informal groups of private and public key health leaders had been in place over a couple of years, most prominently the National Public- Private Partnerships (PPP) Steering Committee which has been recently reconstructed to a wider forum with wider range of representation from public and private actors namely Public Private Health Forum in Tanzania. At the implementation level, efforts have been made in enhancing the cooperation between private and public health services providers by contracting out services, mainly in rural areas. Particularly many FBOs have entered into Health Service Agreements with Local Government Authorities which reimburse defined primary health services offered to vulnerable populations groups as children under five and pregnant women.

ADDO Program Roles

The ADDO program solicits the support and expertise of stakeholders including health professionals from the public and private sector as well as commercial associations. The program develops the standards and requirements to regulate the ADDO and to build stewardship and governance capacity within the public sector.

ADDO program is also working to build private sector capacity i.e. strengthening the business skills of the drug shop owners; developing dispensing, record-keep and communication skills of shop dispensers; and facilitating the formation of drug shop associations to support owners and dispensers. The program provides incentives to shop owners through an expanded range of medicines that ADDO can legally sell, improved business and dispensing skills, development of marketing strategies to increase shop visibility and access to micro financing institutions for business loans.

2.2.4.1 Availability of Essential Drugs

Studies have shown that from the patients' perspective, a constant supply of essential drugs is a prerequisite to the credibility of health services and to the quality of health care provided. For example, study by Tanzania Development Research Group (TADREG) indicate that for a large majority (87%), a constant supply of drugs and medical supplies is very important to improved health care (TADREG 1998 cited in

WDP 2003). The study reported that at lower level health facilities in Mbeya Rural District that did not change official fees, most complaints focused on lack of drugs and supplies (an issue of quality), and not on the informal fees people were required to pay.

It was also revealed from the study that even when the poor are able to find money for basic care, and even when essential drugs are available, their inability to purchase these medicines makes treatment actually impossible. Drugs are often found to be more affordable at government facilities but they run out quickly; they are more available at private and mission facilities but people generally cannot afford to buy them there (WDP, 2003)

2.2.4.2 Regulatory Framework and Policies

The National Health Policy (2007) emphasizes the importance of Public Private Partnership (PPP) in health service provision in Tanzania. The Health Sector Strategic Plan III (HSSP III, 2009-15) which was jointly developed by private and public health leaders, transfers this important role of the private sector into three strategic focal areas at a more operational level, e. g. ensures effective implementation of health PPPs. In this context, within the Sector Wide Approach programme in 2009 a Public Private Partnership Working Group was established in order to coordinate and steer respective activities in this area as for example the development of PPP Policy Guidelines in the Health and Social Welfare Sector.

In the Ministry of Health and Social Welfare a PPP Unit was established and staffed. There is the Private Hospital Regulation Act (1991) which is the guiding regulation for all private health facilities in the country. Applications for establishment of private hospitals must be approved by the Minister of Health and Social Welfare (MoHSW), and a list is maintained by the Registrar of Private Hospitals. The MoHSW is able to regulate price, entry and exit to the market, pay scale of salaries and inspect quality.

The 2003 Food, Drugs and Cosmetics Act, overseen by the Tanzanian Food and Drugs Authority (TFDA) covers the qualification and registration of pharmacists and regulation of manufacture, importation, labeling, identification, storage and sale of pharmaceuticals. The regulation of the private health sector is not yet optimized as for example national standards for accreditation and quality assurance are not in place, and 'inefficient and costly facility licensing processes makes operations cumbersome- (White et al, 2013).

2.2.4.3 Health Sector Reforms

National Health Sector Reforms have been defined as a sustained process of fundamental change in national policy and institutional arrangements, which are evidence based, spearheaded by Government, designed to improve the functioning and performance of the Health Sector and ultimately the health status of the population (WHO, 2000).

The Government is at the forefront of the reforms to ensure that they acquire the needed credibility and sustainability. The ultimate purpose of health reforms is to have a functionally improved health sector leading to the achievement of a better health status of the population (URT,1999).

Any reforms that will not lead to the achievement of this noble goal are not worth undertaking.

There are considerable risks involved in any change process. Therefore, the decision to undertake reforms should not be for the sake of "fashion" (because everybody else is" reforming"). Rather, reforms should be undertaken after careful study, necessary preparations and out of the necessity to improve on the deficiencies identified (WHO, 2000).

The other important aspect to realize and take into account is that there is no "standard blueprint" for implementing health reforms. Every country has its own features, problems and peculiarities when it comes to the health sector. All these have to be taken into account when introducing reforms.

The form and pace of the reforms in any country should be designed and implemented according to the needs and capabilities. Advice on the ways and means to implement reforms from within and outside the country should be carefully analyzed for their relevance and feasibility.

Development partners from within and outside the country need to accept these realities, so as to foster real partnerships. In reforms, these partnerships should be based on respect for each other, mutual trust and learning to responding to the needs and aspirations of the host country, rather than prescribing solutions which in the past have not worked (MoHSW, 1998).

2.2.4.4. Rationale for Health Sector Reforms

Tanzania experienced rapid development in the health sector between 1972–1980. The emphasis was on rural development and expansion of public services in education, health, water and other social services in rural areas. During this period, the Government had an elaborated programme to increase the network of health facilities and train health workers across the country. The Government efforts were on extending access to health services and care to all Tanzanians.

However, in the 1980's the country found itself in an economic slump, exacerbated by Structural adjustment Policies, as was the case in many other African countries and the Government could not meet many of the demands of an expanded health sector. The country experienced shortages of drugs, medical supplies, staff and other essential items, and structures dilapidated, resulting in inadequate services. The need to revisit the strategies became apparent. The Government embarked upon reform whilst still continuing to uphold the basic principles of equity (MOHSW, 1998).

The Government decided to reform the health sector as part of the ongoing economic, administrative and financial reforms. The Government of Tanzania is still committed, through its health policy, to continue to provide quality health services to all Tanzanians, especially the most disadvantaged, to reduce morbidity and mortality and to contribute, as a sector, to the overall national efforts to raise life expectancy.

The challenges facing the health sector are both economic and managerial. In the economic area, since the reforms of the health sector were initiated, an important achievement has been the steady increase in funding to the health sector. This has been in the form of both Government and donor funding, reflected in increased allocations to districts to implement their plans.

Regarding management of health services, one challenge, for instance, is that the District Medical Officer had dual responsibilities and accountability lines to both the Central Government and Local Government Authority, creating many problems. This is continually being improved by MOHSW and PMORALG to remove conflicts and ambiguities (MOHSW -1998).

2.2.4.5 Areas of Health Sector Reform in Tanzania

The following areas of the Health Sector Reform influence district health systems. It is important for Council Health Management Team (CHMT) members to understand them well, as they will always affect the way they will operate.

- Decentralization: power of decision-making is given to the councils, and funds are allocated to, and managed by, the council.
- Management Improvement and Improvement of Quality of Care.
- Efficient Collaboration of Public, Private and Faith-based Providers - a health district can only succeed if everyone works together for the benefit of the people.
- Strengthen the financial situation of the sector through the introduction of user fees and CHF as part of cost-sharing.

2.2.4.6 The Public Health Sector

The leading sector in the Tanzanian health system is the public sector, with stakeholders in the executive and legislative branches of government – PMO-RALG and Parliament – as well as various line agencies and ministries. The primary actor in the public sector is the MOHSW, with support from other government agencies such as the Ministry of Finance and Economic Affairs (MOF) and the Ministry of Science, Technology, and Higher Education (MOSTHE).

In 2007, the MOHSW initiated the Mpango wa Maendeleo wa Afya ya Msingi (MMAM) program to expand delivery of primary health care services for all by 2010. Subsequently, the MOHSW invested to expand, rehabilitate, staff, and equip many facilities (upwards of 8,100 in 62 districts). Moreover, the MOHSW has increased Ministry staff salaries to be more competitive in the labor market. Although demand for health services in public facilities has increased as planned, an unintended result has been the migration of medical staff from the private sector to the public sector. This has created healthy competition between the public and private sectors (particularly Private For Profit facilities), but has also exacerbated human resource shortages in the private health sector. Despite the public sector‘s dominant position within the health sector, there is room for strategic and systematic engagement with the private sector – both PFP and PNFP (MOHSW,2012)

2.2.4.7 The Private Health Sector

The private health sector is diverse and complex, comprising a wide range of actors and stakeholder groups, and engaged in a wide range of health activities. Historically, the Tanzanian private health sector (particularly Faith Based Organizations- FBOs) have played a significant role in expanding service delivery and providing supportive functions such as pharmaceutical dispensing and laboratory diagnostics. Private health sector involvement in the Tanzanian health system has grown relatively quickly over the past 20 years, in part responding to government policy changes (such as removing the ban on private practice in 1991). Until recently, however, the government has not actively involved the Private For Profit (PFP) sector in policy and planning or engaged them directly in expanding service delivery (MOHSW, 2012)

2.3 Theoretical perspective of the study

The mandate of most health education, public health, and chronic disease management programmes are to help people maintain and improve their health, reduce disease risks, and manage chronic illness. Ultimately the goal is to improve

the well-being and self-sufficiency of individuals, families, organizations, and communities.

Often this will require health behaviour change at every level. Each year vast resources are spent trying to modify human behaviour in health education, public health, and chronic disease management programmes. While some intervention strategies are successful, many fall short of their goals. Research shows that those interventions "most likely to achieve desired outcomes are based on a clear understanding of targeted health behaviours, and the environmental context in which they occur". For help with developing, managing and evaluating these interventions, health education practitioners can turn to several strategic planning models that are based on health behaviour theories.

A health behaviour theory offers a number of benefits and can be seen:

• As a toolbox for moving beyond intuition to designing and evaluating health education interventions that are based on an understanding of why people engage in certain health behavior which affect their health;

• As a foundation for programme planning and development that is consistent with the current emphasis on using evidence-based interventions on health;

• As a road map for studying problems, developing appropriate interventions, identifying indicators and evaluating impacts on health;

• as a guide to help explain the processes for changing health behaviour and the influences of the many forces that affect it, including social and physical environments;

• As a compass to help health planners identify the most suitable target audiences, methods for fostering change and outcomes for evaluation.

There are many models and theories that attempt to predict or explain the nature and intensity of intervening variables on human health behaviour. But out of the vast body of literature on health behaviour, three general themes emerge: those that focus on individual capacity – intrapersonal; those that focus on interpersonal relationships and supports; and those that examine environmental supports and contexts. The last sphere of influence is further divided into institutional or organizational factors,

community factors, and public policy factors. Health education's greatest focus is concentrated on the first and second themes– intrapersonal and interpersonal – and to a lesser extent on the third theme – environmental supports – which is more within the broader realm of health promotion.

This study will be guided by "**The health behaviour rational model**". **T**his model falls on interpersonal relationships and supports in which education strategies target individuals and groups and strive to encourage positive and prevent negative health behaviour choices. This is done by presenting relatively unbiased information. This model, also known as the knowledge, attitudes, practices model (KAP), is based on the premise that increasing a person's knowledge will prompt a positive heath behaviour change.

It assumes that the only obstacle to acting "responsibly" and rationally is ignorance, and that information alone can influence behaviour by "correcting" this lack of knowledge (ignorance): change in knowledge leads to change in attitudes/beliefs and eventually change in behavior.

This study reveals challenges facing private health service providers and suggests measures to be taken in order to solve these challenges. However, implementing these measures so as to ensure public health promotion is not enough.

On the other hand people need to be educated in order to change their negative health behavior. Efforts to encourage people to adopt health practices rely heavily on persuasive communications in health education campaigns. In such health campaigns, people are alarmed to take care of diseases and these communications are often used as motivators. Recommended preventive measures are provided as guides for action. People need enough knowledge of potential dangers to warrant action, but they do not have to be frightened out of their wits to act. Rather, what people need is sound information on how disease is transmitted, guidance on how to regulate their negative behavior, and firm belief in their personal life styles to turn concerns into effective preventive actions. Responding to these needs requires a shift in emphasis from trying to scare people into healthy behavior to empowering them with the tools for exercising personal control over their bad health habits.

2.4. Empirical Literature

Minzi and Haule (2008) carried out a study on malaria treatment guidelines among drug dispensers in private pharmacies in Tanzania. The study aimed to assess the knowledge of dispensers in private pharmacies on new malaria treatment guidelines. Data collection was done using structured questionnaire. The study revealed that none of the participants had been involved in the preparation of the treatment guidelines, nor had they undertaken any training on their implementation.

Minzi and Haule's study was on private medical provision. However, although their focus was on assessing knowledge of the dispensers, which is also targeted by this study, the fact that they did not specifically focus on challenges calls for a separate study to be carried out in Tabora. Evidence on whether policy implementation was assessed is also limited from Minzi and Haule's study. Therefore, this calls for a separate study to be carried out in order to find out not only challenges on knowledge of dispensers but also those affecting other key sectors of the scheme.

In 2006 Health Action International's Coordinating Office for Latin America and the Caribbean (AIS-LAC) undertook a survey measuring medicine prices, availability, affordability and component costs in Peru, using the World Health Organization and Health Action International (WHO/HAI) price measurement methodology. The purpose of the study was to measure the price people pay for medicines, and their availability, in various sectors and regions of the country as well as the government procurement price, the affordability of standard treatments for patients on low wages, and all the costs in the supply chain from the manufacturer to the patient (taxes, mark-ups etc). The findings indicated that in private pharmacies prices were very higher than expected. However, the study carried out in Peru took place in a context that is different from that of Tabora in which policy implementation is involved. Besides, the study did not focus on the challenges facing the private Accredited Drug Dispensing Outlets. This therefore raises the need for this study.

Itika *et al*. (2011) carried out a study on successes and constraints for improving public private partnership in health services delivery in Tanzania. Key successes

were noted including increasing number and demand for PPP interventions. However, in the health sector, there were many constraints on coordination, stakeholders' trust and accountability. However, the fact that Tabora was not part of the study, and that it mainly focused on PPP, leaves the challenges encountered by private medical stores in Tabora unravelled, hence the necessity for this study.

A study by Govindaraj and Herbst (2010) in West Africa focused on market mechanisms in Central Medical Stores. This was a follow up study after the reforms of the medical shops in Burkina Faso, Cameroon and Senagal. A study conducted by Mzumbe University Morogoro and VU University Amsterdam in 2011 aimed at improving the understanding in the healthcare sector in Tanzania. The goal of this research was to get a better understanding of the performance of health facilities in Tanzania.

To reach this goal, three sub-goals were formulated i.e. to understand how performance indicators can influence the performance of health care facilities, to make a comparison of the Dutch and Tanzanian view on health facilities in order to get insights in cultural differences and analysis so as to improve the quality and efficiency of future research.

Studies have shown that from the patients' perspective, a constant supply of essential drugs is a prerequisite to the credibility of health services and to the quality of health care provided. For example, study by Tanzania Development Research Group (TADREG) indicate that for a large majority (87%), a constant supply of drugs and medical supplies is very important to improved health care (TADREG, 1998 as cited in WDP, 2003). The study reported that at lower level health facilities in Mbeya Rural District that did not change official fees, most complaints focused on lack of drugs and supplies (an issue of quality), and not on the informal fees people were required to pay.

It was also revealed from the study that even when the poor are able to find money for basic care, and even when essential drugs are available, their inability to purchase these medicines makes treatment actually impossible. Drugs are often found to be more affordable at government facilities but they run out quickly; they are more

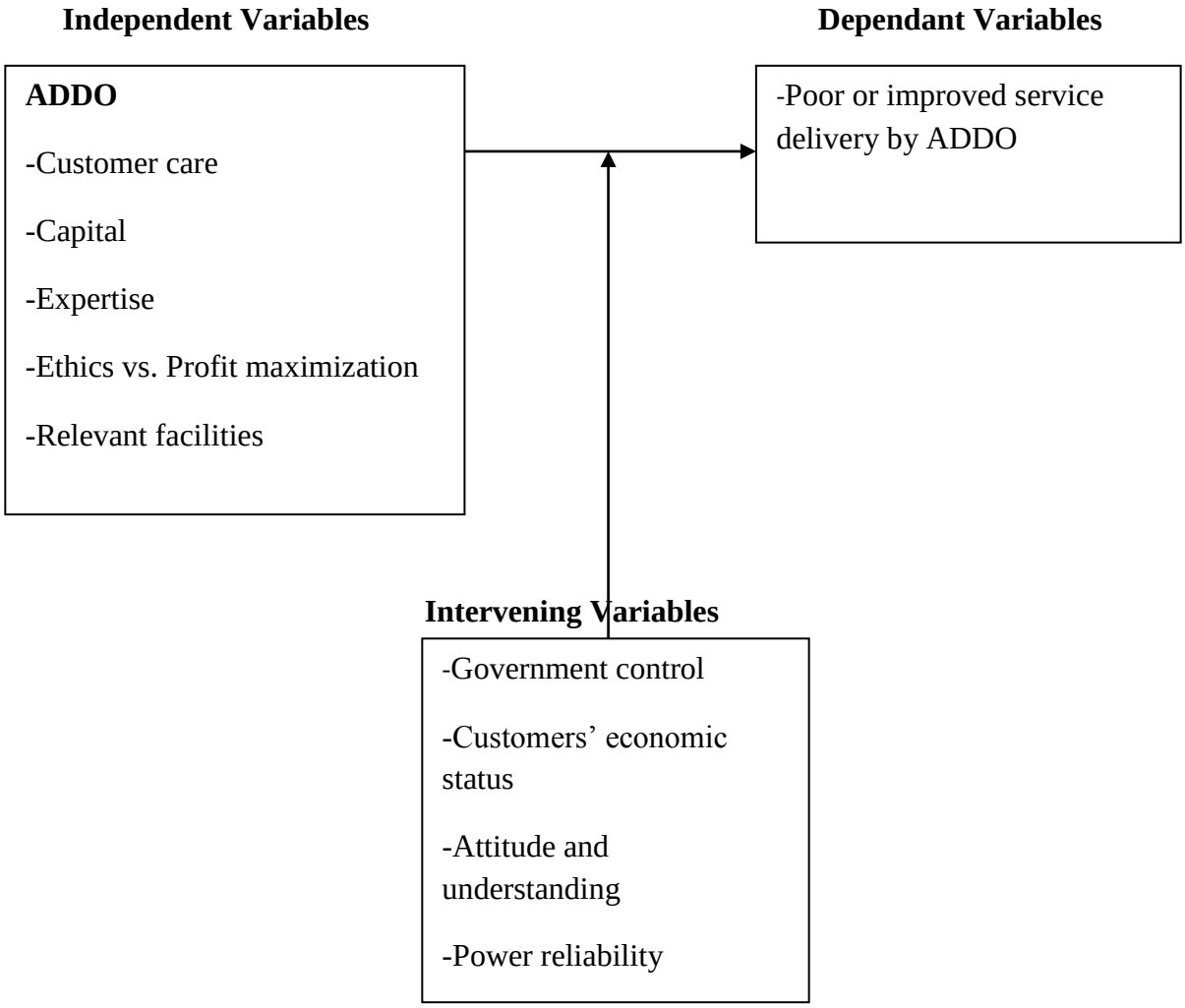
available at private and mission facilities but people generally cannot afford to buy them there (WDP 2003).

The main goal of this study was to gain knowledge and understanding of the health information systems at local levels in developing countries using Tanzania and Mozambique as case studies, in order to explore the procedures, tools and problems related to primary health care data collection, storage, use and information flows and to offer ideas and suggestions on how to improve the systems of routine data collection, storage, analysis and use of information and more generally to improve the flows of information and health care information systems.

2.3. Conceptual Framework

Elliott, (2005) defined conceptual frame work as an abstract idea indicating the relationship between the study topic with other variables for the study; it can be descriptively or graphically represented. In this study the researcher conceptualizes that provision of services by private medical shops is a dependent variable. Its success lies on several independent variables which include Customer care, Capital, expertise, Ethics vs. Profit maximization and relevant facilities. Other key independent variables which also have an influence on the provision of services are Government control, Customers' economic status and Attitude and understanding in ensuring smooth operation of the shops. Challenges at each stage are considered to have direct influence on the provision of medical services by the sector.

The framework for this study can be expressed below as follows:



Source: Author's own construct, 2015

Figure 1.1: Conceptual Framework

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research approach, study area, the sample, techniques used for data collection and their administration. This chapter is divided into the following: Research Philosophy, Area of the study, Research approach, population of study, sample and sampling techniques, data collection methods, and instrumentation, and data analysis procedures.

3.2 Study Area

3.2.1 Location and It's Justification

Tabora Municipality is located at the centre of Tabora Region in the western part of Tanzania. It lies between latitudes 4º52' and 5 º 09' South, and between Longitudes 32 º 39' and 33 º 00' East. Also it is located about 800 kms west of Dar es Salaam and about 320 kms East of Kigoma port on the shores of Lake Tanganyika.

Area:

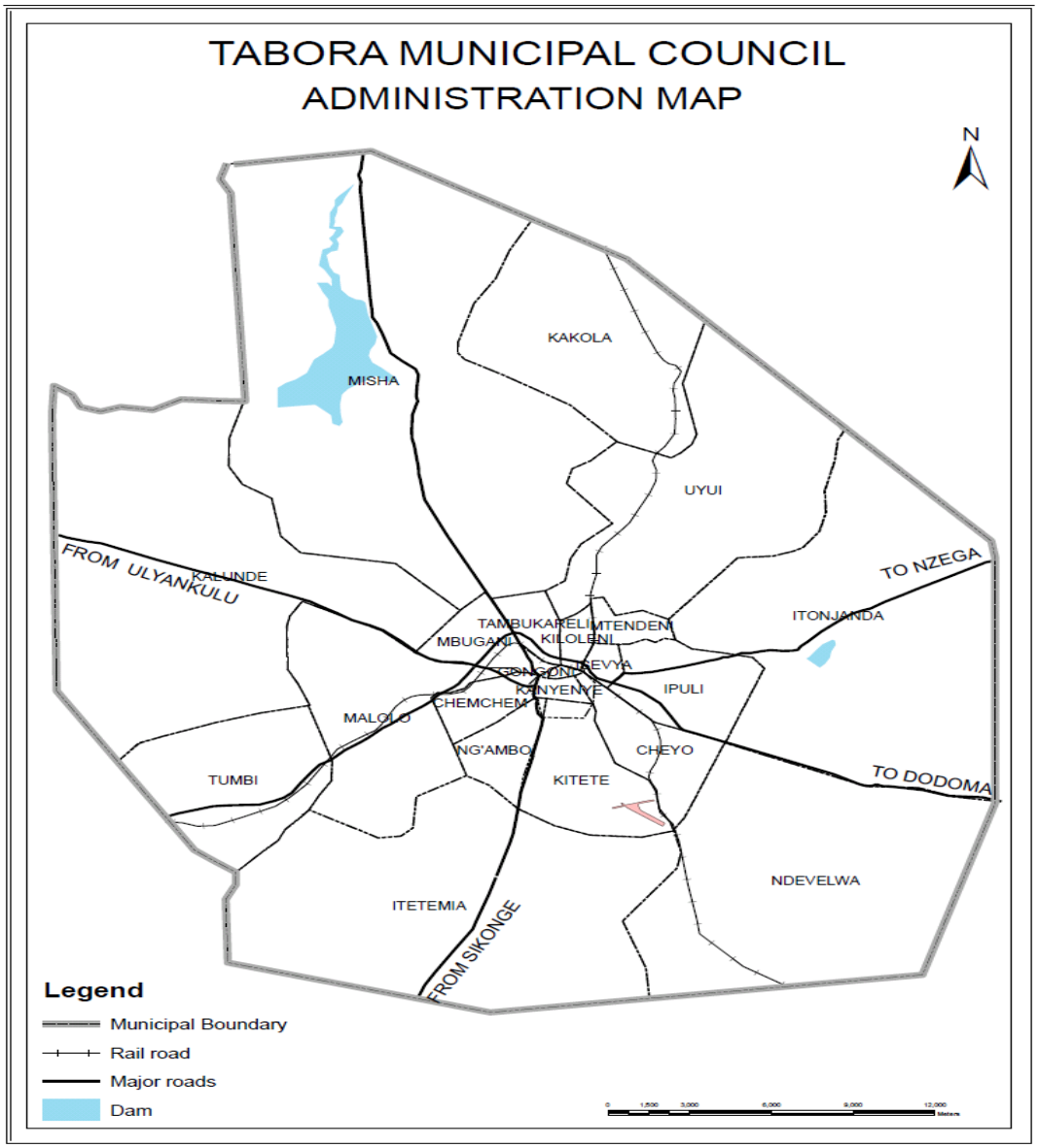
The Municipal is the headquarter of Tabora Region with an area of 1092.26 km2 (109.225 hectares) at a radius of about 18.64 km from the town centre with a reference point at Old Boma.

Administrative Boundaries:

Tabora Municipal borders Tabora District Council (Uyui) in the East, North, West and South. Tabora Municipal was established as a Town Council in 1958. On the re-establishment of the Local Government Authorities in July, 1978, the boundary of Tabora Town Council was re- defined. A ministerial order declaring the boundary was published in the official Gazette as Government Notice No.97 of 30th June, 1978. In July 1988, Tabora Town Council (TTC) was raised to a Municipal status. Hence, Tabora Municipal Town Council continued to Administer 13 wards until 8th

November, 1991 when the Government Notice No.484 declared new boundaries to include 8 wards within its jurisdiction.

Figure 3.1 Map of Tabora Municipal Council



Source: Adopted from Tabora Municipal Council Profile (2013)

At present, Tabora Municipal Council (TMC) consists of 25 wards, 31 villages and 116 hamlets which are within the jurisdiction area covering 1092.26 square kilometers.

Climate:

The climate of the Municipality is highly influenced by its altitude and distance from the sea in the East. It lies between 100m and 1300m above sea level. The prevailing winds blow from East and Northeast. Temperatures range between 22ºC and 26ºC. Peak temperatures occur during September/October prior to the onset of the rain season.

Rainfall:

Tabora Municipal lies within high rainfall zone. It receives an average rainfall of 800mm per annum. The heavy rains fall between November and April, Rainfall patterns are extremely variable and unpredictable. Showers are often much localized, and there is the risk of long dry spells at any time during the rainy season. From the beginning of the rain season normally in November, the rainfall peak in December is followed by a slight lull in January or February. A second lower peak occurs in February or March, and the rains then tails off in April. The mean monthly rainfall does not exceed potential evaporation at any time during the rainy season.

Temperature:

The mean temperature is between 22 º C-26 º C. Highest temperature occurs in October just before the start of the rainy season and falls gradually in December and remains relatively constant until May. Between May and August temperatures are at their lowest levels.

Vegetation:

Much of the natural vegetation in Tabora Municipal has been degraded resulting to low production capacity. This is partially due to the fact that the area has been settled for many years without environmental conservation. Also the disappearance of natural vegetation is attributed to population increase in the areas around Tabora town due to increasing demand for agricultural land, grazing, fuel wood and building materials.

Currently natural vegetation can only be seen in protected areas such as Igombe dam, Urumwa and Ntalikwa forest reserves. Also they occur in areas abandoned by cultivators where the regeneration is taking place. In other parts of the municipality natural vegetation occurs as isolated natural trees or shrubs.

3.3 Research Design

According to Kothari (2004), research design is an economic procedure, for the preparation of the data collection and analysis, in an efficient manner. Research design is a special system that is applied in the research process (Creswell, 2012).

Based on time and the focus of this study, the type of research design adopted was Case study design. According to Yin (2009), Case study design deals with individual, groups, institutions, or even community. Case study design was a crucial selection for this study because; it helped to provide the details on these studied variables. Also, studying contemporary variables in the community, case study design is appropriate choice, thus why, this study selected this design.

Moreover, in this study both approaches (Quantitative and Qualitative approaches) were employed. With regard to Kothari (2004), Quantitative approach is a creation of numerical data, whereas Qualitative approach is about the subjective appraisal of the data, in a non-numerical form. It involves the assessment of opinions, perceptions, attitudes, and behavior.

This study engaged both approaches because; they granted best understanding of the issue being studied. Bearing in mind that both approaches have shortcomings, the limitation of one approach can be used to neutralize the biases of another (Creswell, 2003). Hence, in this study, one approach has been nested into another or compliments the other.

Quantitative approach is also useful to be adopted so as to measure the variables in terms of percentages, numbers, scales, and incidences.

The proposed informants selected in this study were; service users (community members), ADDO owners, ADDO service providers and Council health staff.

3.4 Study Population

Yogesh,(2006) defines study population or universe as a whole mass which is involved in the study and observations. It is the parent group from which a sample is obtained or formed. The target populations involved in this study were; service users (community members), ADDO owners, ADDO dispensers and Council health staff.

3.5 Sample Size and Sampling Techniques

3.5.1 Sample Size

Kamuzora and Adam (2008) say sample size as the actual number of items picked from a study population to form a sample.

In this study, the sample constituted 100 respondents from Tabora Municipality. The sample was desired for two reasons; first, it was a true representation of the finite population. Secondly, sample was large enough to provide a true picture and insight of the intended investigation. In this regard, non-probability sampling technique in which purposive sampling was used to get a sample of respondents who are owners of Accredited Drug Dispensing Outlets for at least six months. This is because owners of these Accredited Drug Dispensing Outlets are aware of challenges facing the field.Table 3.1 shows the distribution of respondents.

Table 3.1 Respondents' Profile

NATURE OF RESPONDETS	NUMBER OF RESPONDENTS
ADDO owners	20
Service Providers	20
Medical Doctors	5
Nurses	5
Pharmacists	2
Ward Leaders	10
Public health Staff	8
Community Members	30
Total	**100**

Source: Survey Data, 2014

3.5.2 Sampling Techniques

It refers to as the technique or the procedure the researcher used in picking items for the sample (Kothari, 2004).The kind of sampling techniques which were adopted in this study included purposive and simple random techniques.

3.5.2.1 Purposive Sampling

Kothari (2004) says a purposive sampling technique facilitates the researcher to select the respondents based on the facts, that the respondents have a suitable character and variables pertaining to the issue being studied. A total of 20 respondents were selected among ADDO owners, 20 respondents among ADDO service providers and 2 pharmacists. The reason for their selection based on their positions, experiences and knowledge concerning the ADDO.

3.5.2.2 Simple Random Technique

It is the type of sampling technique that provides an equal opportunity in selecting the elements for the study population (Kothari, 2004).This technique was used to avoid biasness and ensure the collected data represents the actual conditions of the

Council. Simple Random Sampling Technique employed to select 30 respondents to represent members of the entire community(service users). These respondents were chosen from thirteen (13) sampled wards out of twenty five wards that form the urban and rural set up of the Council (thirteen wards came from urban setting while twelve were from rural). This study was directed to urban area where most of private Accredited Drug Dispensing Outlets are found.

3.6 Data Collection

The study engaged both primary and secondary sources of data. Primary data was collected through questionnaire, interview and observation, while Secondary data were collected through documentary review.

3.6.1 Secondary Data Collection

Documentary review was used in this study as a secondary data collection method; Information from the documentary sources helped to generate knowledge on the study and assisted in disclosing the missing facts about the study during data collection.

3.6.1.1 Documentary Review

It is the systematic examination of documents or records, which are used as sources of data. In documentary examination, the following documents were examined in this study, as sources of secondary data. These were: journals, pamphlets, research papers, project report, records, statistical data, and text books.

3.6.2 Primary Data Collection

Interview schedule, questionnaire and observation, were the primary data collection methods employed in this study.

3.6.2.1 Interview

Referring to Mishler, (1991) an interview is a face-to-face oral interchange, through which a person, the interviewer, tries to achieve information or expressions of opinions or belief from another person or people. Kahn, (1957) defined interview as a specific pattern of verbal interchange, initiated for a certain purposes, and deals on some specific content or issue.

Semi-structure interview schedules were used in data collection where eight Municipal health staff, five doctors, twenty private ADDO owners, twenty service providers were interviewed in order to get their experiences and feelings about health service delivery, its impact on service users as well as constraints in health service delivery.

Interviews allowed flexibility in data collection since the researcher was able to modify hard questions for more clarification and even probe some more questions for further understanding. Semi structured interview were designed for the purpose of getting intended information in a more systematic way.

The unstructured questionnaire (interview guide) were applied to private ADDO owners (Appendix 3). Application of this type of questionnaire here was very important because of the nature of respondents that most of them were knowledgeable enough to fill the questionnaire themselves. In addition, the nature of the information needed by the study, deep probing was necessary for the exercise of data collection to be successful.

3.6.2.2 Questionnaire

According to Yogesh (2006) questionnaire is a form which is designed and disseminated for the purpose of securing responses. This study used both close and open-ended questionnaires. Questionnaires were designed, pre-tested, and some questions were omitted after review, then questionnares were admimistered to a total number of 100 respondents including private ADDO owners,service providers,Service users and Council staff. Both close and open-ended questionnaires used according to the prevailed situation of the respondents. The structured questionnaires were used to collect data from twenty (20) private ADDO owners,twenty (20) Service providers,thirty (30) Service users and thirty (30) Municipal Council staff. They were provided with questionnaires and requested to fill and return to researcher within a specified period of time (Appendices: 1,4,5 and 6). However, some two health providers and three Council staff delayed returning the questionnaires until several follow up were made by researcher through calling on mobile phones and finally by physical revisiting. It took almost six weeks for researcher to collect all questionnaires from these respondents. Another burden observed from these self administered questionnaires was that, some questionnaires were returned back incomplete and thus necessitated a researcher to go back again in the field for completion.

The questionnaire method was applied due to their flexibility in studying respondents' perception and opinions, and possesses a peculiar advantage over other tools in obtaining both, qualitative and quantitative information (Yogesh, 2006).

Neema's Medical Shop was among Accredited Drug Dispensing Outlets of which Questionnaires were administered

Figure 3.2 Medical Shop (ADDO)

Source: Survey Data, 2014

3.6.2.3 Observation

Observation is a systematic viewing of a specific phenomenon, in its appropriate site for the purpose of collecting data, for a particular study (Kothari, 2004).

Observation was applied in this study using the pre-determined set of schedules to be observed. This method was crucial, due to its independency from subjects' willingness to respond. Therefore, unlike other data collection tools, this method (observation) was also adopted in order to respond to respondents' spoken clarification, or information according to their own thoughts.

Major observed areas were ADDO establishment Guideline, Environmental Cleanliness, Staff qualifications(Certificates), Business licence, Uniform, Clean preservation shelves, Essential Drugs list, Adequate preservation shelves, Proper drugs arrangement, Service providers training manual, Expired drugs shown in shelves, Invoices and Receipts, Ledger Books, Daily cash sales Analysis book, Patient drugs register, Stores Ledger and Bin Cards.

3.7 Data Processing, Analysis, and Presentation

3.7.1 Data Processing

Data processing entails the process of data coding, data editing, data classification and data tabulation so that, they are agreeable during data analysis (Kothari, 2004).This study involved the following data processing;

3.7.1.1 Data Coding Process

Data coding implies the process of assigning numbers, or symbols to responses so that answers can be grouped into a limited number of categories or classes. Coded data were efficiently analysed and answers were squeezed together to a small number of classes. The researcher also assigned numbers in the questionnaires and interview schedule for smooth analysis of information.

3.7.1.2 Data Editing Process

Editing of data is a method of inspecting the collected raw data, aimed at identifying errors, omissions and to make the appropriate measures when feasible. In this study, editing encompassed a careful examination of the completed questionnaires and interview schedules. This technique was done to confirm whether, if the data were correct, and reliable.

3.7.1.3 Data Classification Process

In data classification (categorization), the large volume of untreated data were obtained and then reduced into related homogenous groups so as to get meaningful relationships. Categorization process was employed to secure data having the same

characteristics, in which the same data were placed in one class, and the whole data were separated into a number of classes.

3.7.1.4 Data Tabulation Process

It is a process of briefing the unrefined data and presenting in a dense form (i.e. presenting in a statistical form of tables) for more analysis. In this way data were arranged in columns and rows. Tabulation was applied to conserve space to a lowest level.

3.7.2 Data Analysis

Data analysis refers to the scrutinising of what has been collected in a survey or experiment and making deductions and inferences (Kothari, 2004). It involves investigating the attained information and creating inferences. For the intention of this study, the quantitative data were analysed with the help of Statistical Package for Social Science (SPSS), in which the data and frequencies were computed, the Excel program was employed to draw tables and charts.

Content analysis was also used to analyse the qualitative data in which the words, sentences, phrases and ideas with the same nature were placed in one category and those with different nature were kept into another category. Each category was analysed according to their contents or themes to get a major theme from each category. Each major theme was then discussed and classified according to the relative specific research questions and objectives of the study.

3.7.3 Data Presentation

The analysed data presented in the form of text, tables, bars, pie charts and simple frequency counts. The successful presentation of data has led to appropriate data interpretations, which finally aided much in the conclusion and recommendations part of the study.

CHAPTER FOUR

RESULTS, PRESENTATION AND DISCUSSION

4.1 Introduction

This chapter presents the findings and discussion of the results obtained from the study, which intended to assess the challenges facing the Accredited Drug Dispensing Outlets in Tabora. The chapter comprises of five sections. Section one is about general information of the respondents, which provides personal information. Section two presents the performance of ADDO, section three points out the challenges facing the private Accredited Drug Dispensing Outlets. Section four explores the causes of the challenges and section five provides measures to overcome the challenges. Data were analysed with the help of the SPSS, a Statistical Package for social Sciences.

4.2 Demographic Characteristics of Respondents

By definition demography is the study dealing with the human populations in relation to distribution, compositions, size, and the way in which they change with regard their areas. Demography is important in recognizing social as well as economic issues and suggests solutions on how to solve those problems. Demographic characteristics considered in this study include Sex, Age and Education.

4.2.1 Sex of the Respondents

Sex is the state of being male or female. Sex can have significant contribution on public health promotion. The sex category was considered in this study in order to see the awareness of both, males and females in challenges facing ADDO in health service delivery. The respondents were required to tell their sex. Table 4.1 contains the summarized data on sex of respondents.

Table 4. 1: Sex of the Respondents (N = 87)

Sex	Number	Percent
Male	34	39.1
Female	53	60.9
Total	**87**	**100.0**

Source: Field Data (2015)

Table 4.1 shows that 53 (60.9%) were females and 34 (39.1%) were males. This implies that there was a gender consideration of the respondents, which make our study to have the opinions of both male and female.

4.2.2 Age of the Respondents

Referring to Demographic and Health Survey (DHS), age is an important demographic parameter which is the primary basis for demographic classification in surveys. It is also very important variable in the study of health parameters (DHS, 2010). Matured enough respondents are in good position to give accurate answers as far as the study is concerned.

In order to know their ages, the respondents were asked to fill their ages in the questionnaire given to them. Findings on age of the respondents were presented as appears on figure 4.2.

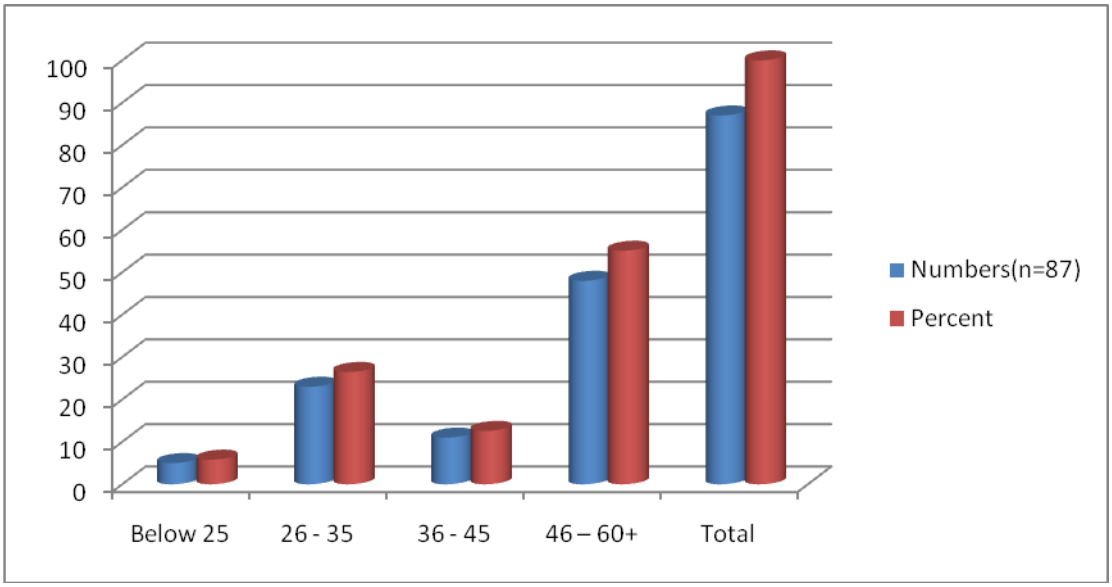


Figure 4. 2: Age of the Respondents (N = 87)

Source: Field Data (2015)

Figure 4.2 shows that 5 (5.8%) respondents were aged below 25, twenty three respondents 26.5 percent were aged between 25 and 35 years, eleven respondents (12.6%) were aged between 36 and 45 where forty eight (55.1%) respondents were aged between 46 and 60 years. This implies that majority of the respondents were matured enough and therefore are in a better position to understand the challenges facing the Private Accredited Drug Dispensing Outlets.

A cross tabulation in Table 4.2 of sex versus age shows that there were 2 males aged below 25 years, while females were 3, in the same way 8 males and 15 females aged between 26 – 35 years. 21 males aged and 27 females aged between 36 and 45 years. Three males and 8 females aged between 46 and 60+ years. This further implies that there are more females respondents than males respondents in this study.

Table 4. 2: Sex Age Cross Tabulation (N = 87)

		Age				**Total**
		Below 25	26 – 35	36 - 45	46 – 60+	
Sex	Male	2	8	21	3	34
	Female	3	15	27	8	53
Total		**5**	**23**	**48**	**11**	**87**

Source: Field Data, (2015)

4.2.3 Education Level of the Respondents

In this study education level was taken into account as it determines someone's capacity in decision making towards achieving his or her development goals. From theory, it could be stated that the health promotion increases with level of education.

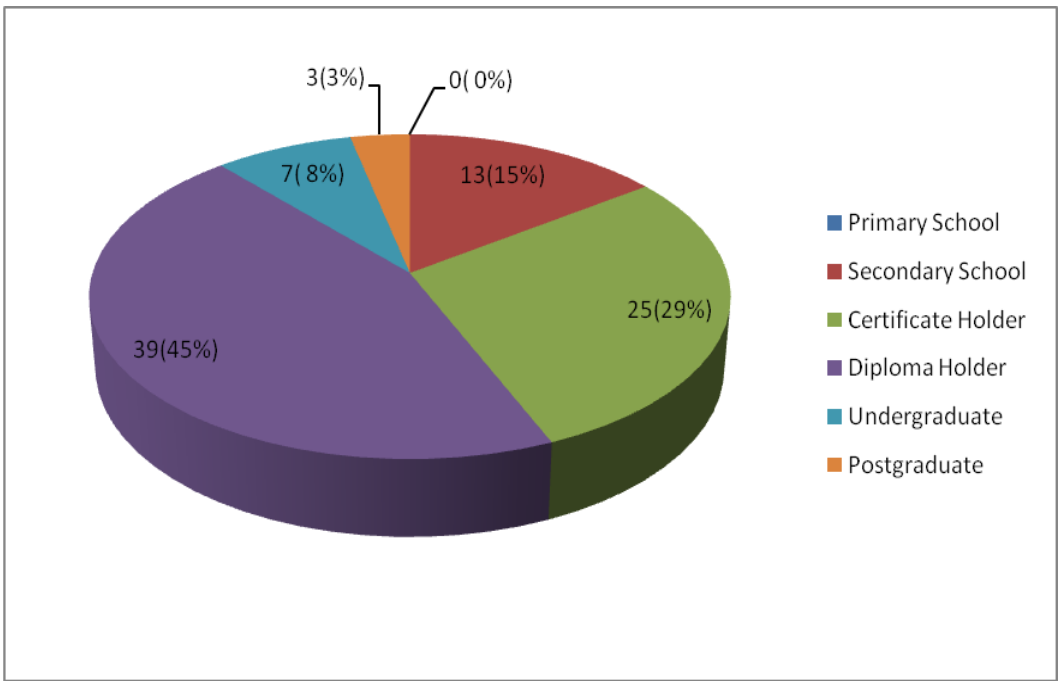


Figure 4. 3: Educational level of the Respondents (N = 87)

Source: Field Data, 2015

Figure 4.3 shows that 0 respondents (00%) were primary school leavers. Thirteen respondents (14.94%) were secondary school leavers. Twenty five ADDO owners (27.73%) were certificate holders. Thirty nine ADDO owners (44.83%) were diploma holders. The findings also show that seven respondents (8.04%) were undergraduate degree holders and 3(3.45%) respondents were postgraduate holders. This implies that respondents had sufficient academic qualifications to read and understand the questionnaire properly and therefore the researcher believe that, they responded to the questions posted to them correctly.

4.2.3 Respondents' Experience

The analysis of the respondents' experience table 4.3 was made and the findings reveals that 0 respondents had a working experience of less than one year, three (15%) had an experience of 1-3 years, sixty (75%) respondents had an experience of 4 - 6 years while five (25%) respondents had an experience of more than 7 years. This signifies that out of 20 ADDO owners surveyed, majority had worked in the sector for more than four years, which implies that ADDO owners who responded to the imposed questions had an experience in operating the Drug Dispensing Outlets and therefore they were in a better position to tell us their experiences concerning challenges facing the Accredited Drug Dispensing Outlets in Tanzania, in the case of Tabora Municipal Council.

Table 4. 3 ADDO Owners Experience (N = 20)

Experience	**Number**	**Percent**
Less than 1 year	0	0
1 - 3 years	3	15
4 - 6 years	12	60
More than 7 years	5	25
Total	**20**	**100.0**

Source: Field Data, 2015

4.3 Existence of Challenges in Private Accredited Drug Dispensing Outlets

The aim of this question was to get opinions on the challenges facing private Accredited Dispensing Outlets. Two measures were used to secure the opinions on the challenges facing private Accredited Drug Dispensing Outlets. Respondents were requested to either say "Yes" if they are acknowledging on the existence of challenges or to say "No" if they are not acknowledging on challenges existence. Findings on challenges existence were presented as appears on table 4.4.

Table 4.4: Existence of Challenges in Private Accredited Drug Dispensing Outlet (N = 87)

	Number	**Percent**
Yes	83	95.40
No	4	4.60
Total	**87**	**100.0**

Source: Field Data, 2015

From table 4.4 eighty three (95.40%) respondents acknowledged the existence of challenges in the Private Accredited Drug Dispensing Outlets, meanwhile 4 (4.60%) respondents said that there were no challenges. This implies that the sector is constrained with a number of challenges which need to be solved.

Similarly the same results were observed by Tanzania Food and Drugs Authority (2010). The challenges encountered in the ADDOs include the following:-

Drug sellers with no qualifications dispense medicines that are not permitted under the Guideline for Operating Part II Poison Shops, Most ADDOs are located in the urban area instead of rural areas, and this is not in line with the aim of establishing them, Most ADDOs (72 percent) have been found to stock and sell both prescription and nonprescription medicines, Medicine quality is not assured because most ADDOs have been found to sell expired and/or unregistered medicines, Some of the ADDOs sell medicines stolen from public health facilities and from other health-related projects, the premises of ADDOs are not maintained adequately for proper storage of medicines, livestock medicines have been sold in the open market, and medicines are sold without following proper guidelines for good dispensing practices. The range of medicines authorized to be sold in the ADDOs does not meet the health demand of the customers.

4.4 Performance of private Accredited Drug Dispensing Outlets in Tabora Municipality.

The aim of this question was to determine the performance of private Accredited Dispensing Outlets. 4 measures were used to determine the performance of private Accredited Dispensing Outlets. Respondents were requested to rate each measure by pointing out one appropriate level of performance. The frequencies of their responses were shown in Figure 4.4.

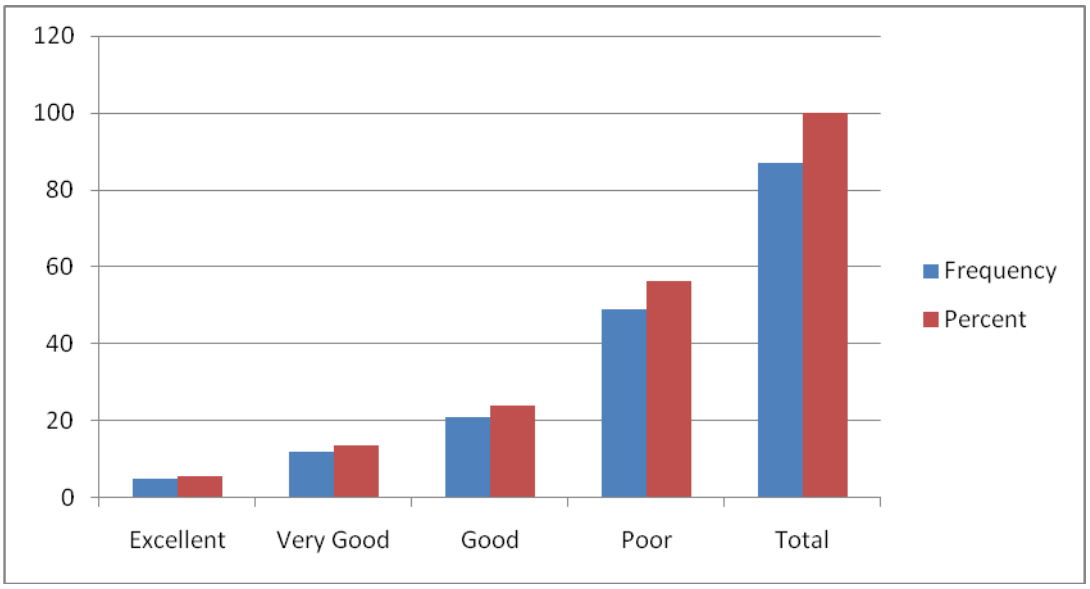


Figure 4.4 The Performance of Private ADDO in Tabora Municipality

Source: Field Data, 2015

Figure 4.4 shows that 49 (56.32%) respondents indicated that there is poor performance of ADDO whereas twenty one (24.14%) respondents indicated that there is good performance of ADDO. Furthermore, 12 (13.79%) respondents indicated that there is very good performance and 5 (5.75) respondents show that there is excellent performance. These findings imply that the Private Accredited Drug Dispensing Outlets are constrained with poor performance and thus a need to explore the challenges facing the private health sector.

The similar result was observed by World Health Organization (2003) through a systematic review of comparative analysis of public and private healthcare systems in low- and middle-income countries. Private sector healthcare systems tended to

lack published data by which to evaluate their performance, had greater risks of low-quality care, and served higher socio-economic groups, the private sector appeared to have lower efficiency than the public sector, resulting from higher drug costs, perverse incentives for unnecessary testing and treatment, greater risks of complications, and weak regulation.

4.5. Challenges Facing the Private Accredited Drug Dispensing Outlets in the provision of Services in Tabora Municipality.

This question aimed at exploring challenges facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.The following scales were used to explore the challenges facing the private Accredited Drug Dispensing Outlets in the provision of services. (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree). The respondents were asked to use the scale in rating a list of nine (9) assumed challenges. The findings were as summarized in table 4.5.

Table 4.5 Challenges Facing the Private ADDOs.

Challenges	**1**		**2**		**3**		**4**		**5**	
	f	**%**	**f**	**%**	**f**	**%**	**F**	**%**	**F**	**%**
Unavailability of professionals.	00	00	00	00	5	5.75	37	42.53	45	51.72
Poor storage facilities	00	00	3	3.45	11	12.64	34	39.08	39	46.43
Shortage of required Drug dispensing	9	10.34	13	14.94	26	29.88	22	25.23	17	19.54
Low purchasing power	00	00	8	9.20	39	44.83	23	26.44	17	19.54
Difficulty policies.	3	3.45	9	10.34	17	19.54	24	27.56	34	39.08
Inadequate preservation	00	00	00	00	7	8.05	38	43.68	42	48.27
Poor Government support	5	5.75	11	12.64	19	21.84	33	37.93	19	21.84
High training costs.	00	00	00	00	5	5.75	37	42.53	45	51.75
Selling Expired drug	9	10.34	13	14.94	26	29.88	22	25.23	17	19.54
High drug price	3	3.45	9	10.34	17	19.54	24	27.56	34	39.08

Source: Field Data, 2015

4.5.1 Unavailability of Professionals.

With regard to unavailability of professionals, table 4.5 shows that, thirty seven 42.53 percent respondents agreed while 45 (51.72%) respondents strongly agreed. In other words 94.25% agreed while only 5.75 percent were neutral due to their low level of understanding. None of respondents either strongly disagree or disagree that Unavailability of professionals is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.

The similar results have also been reported by Jafary, H.L (2014) that unavailability of professionals is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services hence maintaining availability of trained personnel to fill openings in ADDOs.

4.5.2 Poor Storage Facilities

With regard to poor storage facilities, table 4.5 shows that three (3.45%) respondents disagreed that Poor storage facilities is a challenge facing the private Accredited Drug Dispensing Outlets, eleven (12.64%) respondents were neutral due to low level of understanding, meanwhile 34 (39.08%) respondents agreed and 39 (46.43%) respondents strongly agreed. This is equal to say that 85.51 percent agreed that poor storage facilities is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.

The same result was observed by Jafary et al. (2014) through their study that poor medicine storage conditions is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services.

4.5.3 Shortage of Required Drug Dispensing

Regarding to shortage of required Drug dispensing table 4.5 indicates that, nine (10.34%) respondents strongly disagreed while thirteen (14.94%) respondents disagreed that shortage of required Drug dispensed is a challenge facing the private Accredited Drug Dispensing Outlets.In other words 25 percent disagreed and twenty six (29.88%) respondents were neutral. While twenty two (25.23%) agreed and seventeen (19.54%) strongly agreed, this is equal to say 44.8%) agreed.

The same result was observed by Improving Child Health through the ADDO Program: Baseline Survey from 5 Districts in Tanzania, 2006, that shortage of required and unreliable drug dispensing is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services.

4.5.4 Low Purchasing Power

With regard to low purchasing power, table 4.5 reveals that twenty three (26.44%) respondents agreed and seventeen (19.54%) strongly agreed that low purchasing power is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services. In other worlds 46.0 percent respondents agreed that low purchasing power is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality. Only 9.20 percent disagreed and 44.8 percent were neutral.

The same result was observed by Baseline Edmund (2014), that shortage of required and unreliable drug dispensing is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services.

4.5.5 Difficulty Policies

Regarding to difficulty policies, table 4.5 shows that 3.45 percent respondents strongly disagreed while 10.34 percent disagreed. In other worlds 13.79 percent agreed that difficulty policy is a challenge facing the private Accredited Drug Dispensing Outlets. Twenty four (27.56%) respondents were neutral meanwhile 45.98 percent respondents agreed and none of respondents disagreed that difficulty policy is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.

Similar results were also reported by Waters et al. (2014) through their study, that difficult policies is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services.

4.5.6 Inadequate Preservation

As far as inadequate drug preservation is concerned, table 4.5 shows that seven (8.05%) respondents were neutral while thirty eight (43.68%) respondents agreed and forty two (48.27%) strongly agreed. This is to say that 92 percent agreed that

inadequate preservation is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services.

Similar results were also reported by Strategies for Enhancing Access to Medicines Programme Final Report (2008), that inadequate preservation is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services.

4.5.7 Poor Government Support

In accordance with poor government support, table 4.5 reveals that five (5.75%) respondents strongly disagreed while eleven (12.64%) disagreed that poor Government support is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services. Nineteen (21.81%) respondents were neutral. Meanwhile thirty three (37.93%) agreed and nineteen (21.84%) strongly agreed. In other worlds 59.8% agreed that poor Government support is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services.

Similarly,in Bangladesh according to Hossain et al. (2009), poor government support is a challenge to ADDOs. In order for the poor to benefit from poverty alleviation effects of health interventions,the performance of unorganized ADDOs need to be supported by the government.

4.5.8 High Training Costs

With regard to high training cost**s,** table 4.5 indicates that five (5.75%) respondents were neutral while thirty seven (42.53%) respondents agreed while forty five (51.75%) respondents strongly agreed. In other words 94.3 percent of respondents agreed that high training costs is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services.

Similar results were observed by Syed et al. (2009) of which exisiting evidence indicated that high training cost led to the majority of service providers lack the necessary training from the government and capacity to provide basic curative services rationally.

4.5.9 Selling Expired Drug

About selling expired drugs table 4.5 shows that nine (10.34%) respondents strongly disagreed and thirteen (14.94%) respondents disagreed. Twenty six were neutral. Moreover twenty two (25.23%) respondents agreed while seventeen (19.54%) respondents strongly agreed. This is to say that 44.8 percent agreed that selling expired drug is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.

Similar results were also reported by Alliance for Health Policy and Systems Research Flagship Report (2014), that selling expired drugs and unauthorized products is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services.

4.5.10 High Drug Price

Referring to high drug price, table 4.5 indicates that three (3.45%) respondents strongly disagreed and nine (10.34%) respondents disagreed. Seventeen (19.54%) were neutral due to their level of understanding. Also twenty four (27.56%) repondents agreed while thirty four (39.08%) respondents strongly agreed. In other words 66.6 percent agreed that High drug price is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.

Similar results were also reported by Jafary et al. (2014) through their study, that high drug price is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services.

Based on findings relating to challenges the following are the challenges facing the ADDO: Unavailability of Professionals (94.5%), Poor Storage facilities (85.51%), Low Purchasing Power (46.0%), Difficulty Policies (45.98%), Inadequate Preservation (92%), Poor Government Support (59.8%), High Training Costs (94.3%), Selling Expired Drugs (44.8%) and High Drug Price (66.6%).

4.6 Causes of challenges facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.

This section aimed at determining the factors causing the challenges facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality. The following scale was used to determine the factors causing the challenges facing the private Accredited Drug Dispensing Outlets in the provision of services. (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree). The respondents were asked to use the scale in rating a list of ten (10) assumed challenges. The findings were as summarized in table 4.6.

Table 4.6 Factors Causing the Challenges of Private ADDOs

Factors	1		2		3		4		5	
	f	%	f	%	f	%	f	%	f	%
Poor medical infrastructures	00	00	00	00	00	00	35	40.23	52	59.77
Inadequate medical skills.	00	00	00	00	27	31.03	53	60.92	7	8.05
Traditional believes.	7	8.05	11	12.64	34	39.08	35	40.23	00	00
Inadequate capital.	00	00	00	00	5	5.75	52	59.77	30	34.48
Poor Drug planning	00	00	00	00	3	3.45	31	35.63	52	59.77
Inadequate Government support.	12	13.79	19	21.84	37	42.53	19	21.84	00	00
Unethical staff	00	00	00	00	3	3	22	25.29	65	74.71
Poor Drug outlet policy	13	14.94	18	20.69	31	35.63	5	5.75	20	22.99
Inadequate employed qualified staff in the sector	9	10.34	13	14.94	33	37.93	27	31.03	5	5.75
Poor Management	00	00	00	00	19	21.84	35	40.23	33	37.93

Source: Field Data, 2015

4.6.1 Poor Medical Infrastructures

With regard to poor medical infrastructures, table 4.6 shows that thirty five (40.23%) respondents agreed while fifty two (59.77%) respondents strongly agreed. In other words 100 percent of respondents agreed that poor medical infrastructure is a cause for the challenges facing private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality. None were neutral and none of respondents disagreed on the idea that poor medical infrastructure is a factor causing the challenges facing private Accredited Drug Dispensing Outlets in the provision of services.

Similar results were also reported by the Tanzania Assessment of Community Services for Childhood Illness (2012) through their study, that availability of medical infrastructures (weighing scales, vaccine cards and timing device) for assessing service users in health services delivery is very low in private Accredited Drug Dispensing Outlets hence a cause for the challenges.

4.6.2 Inadequate Medical Skills.

In consideration of inadequate medical skills, table 4.6 shows that twenty seven (31.03%) were neutral due to low level of understanding. Again fifty three (60.92%) agreed meanwhile seven (8.08%) strongly agreed. In other words 69 percent agreed that inadequate medical skill is a factor causing the challenges facing private Accredited Drug Dispensing outlets. None were neutral and none disagreed on the idea that poor medical infrastructure is a factor causing the challenges facing private Accredited Drug Dispensing Outlets in the provision of services.

The same result was observed by Strategies for Enhancing Access to Medicines (2011) assessment report on Populations access to essential medicines, that Dispensers lacked basic skills and qualifications.

5.6.3 Inadequate Capital

With referrance to Inadequate Capital, table 4.6 indicates that fifty two (59.77%) repondents agreed and thirty (38.48%) respondents strongly agreed. In other words 98.3 percent agreed that inadequate capital is a cause of challenges facing private Accredited Drug Dispensing outlets. None of respondents disagreed that inadequate capital is a factor causing the challenges to private Accredited Drug Dispensing Outlets in the provision of services. Five (5.75%) respondets were neutral due to their low level of understanding.

The same result was observed through the study conducted by World Development Program (2003) that inadequate capital is a factor causing the challenges to private Accredited Drug Dispensing Outlets. Even when the poor are able to find money for basic care, and even when essential drugs are available, their inability to purchase these medicines makes treatment actually impossible. Drugs are often found to be more affordable at government facilities but they run out quickly; they are more available at private and mission facilities but people generally cannot afford to buy them.

5.6.4 Poor Drug Planning

Regarding poor drug planning, table 4.6 shows that, thirty one (35.63%) respondents agreed while fifty two (59.77%) respondents strongly agreed. In other words 95.4 percent of respondents agreed that poor drug planning is a cause of challenges facing private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality. Three (3.45%) were neutral and none of respondents disagreed that inadequate capital is a cause of challenges facing private Accredited Drug Dispensing Outlets in the provision of services.

Similar results were reported by Tanzania Development Research Group (1998), that inadequate capital is a cause of challenges facing private Accredited Drug Dispensing Outlets in the provision of services. Constant supply of drugs and medical supplies is very important to improved health care. The study reported that at lower level health facilities in Mbeya Rural District that did not charge official fees, most complaints focused on lack of drugs and supplies (an issue of quality), and not on the informal fees people were required to pay.

5.6.6 Unethical Staff

Referring to unethical staff, table 4.6 indicates that twenty two (25.29%) repondents agreed and sixty five (74.71%) respondents strongly agreed. In other words 97 percent agreed that unethical staff is a cause of challenges facing private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality. Three (3%) respondets were neutral due to their low level of understanding. None of respondents disagreed that unethical staff is a cause of challenges facing private Accredited Drug Dispensing Outlets in the provision of services.

Similar results were also reported by Tanzania Food and Drugs Authority (TFDA) (2009) through their study, that unethical staff is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services. Some of the ADDOs sell medicines stolen from public health facilities and from other health-related projects.

5.6.7 Poor Drug Dispensing Outlets Policy

In consideration of Poor Drug Dispensing Outlets policy, table 4.6 shows that thirteen (14.94%) respondents strongly disagreed while eighteen (20.69%) respondents disagreed. In other words 35.63 percent disagreed. Thirty one (35.63%) respondents were neutral. Moreover, five (5.75%) respondents agreed meanwhile twenty (22.99%) strongly agreed. In other words 28.74 percent agreed that Poor Drug Dispensing outlets policy is a factor causing the challenges facing private Accredited Drug Dispensing outlets.

The same result was observed by Minzi and Haule (2008), that none of the ADDO service providers had been involved in the preparation of the treatment guidelines, nor had they undertaken any training on their implementation.

5.6.8 Inadequate Employed Qualified Staff

With regard to inadequate employed qualified staff, table 4.6 reveals that nine (10.34%) respondents strongly disagreed and thirteen (14.94%) disagreed. In other words 25.28 percent disagreed. Thirty three (37.93%) respondents were neutral while twenty seven (31.03%) respondents agreed and five (5.75%) strongly agreed. In other words 36.78% respondents agreed that inadequate employed qualified staff is a factor causing the challenges facing private Accredited Drug Dispensing outlets.

Similar results were also reported by Accrediting retail drug shops to strengthen Tanzania's public health system survey (2015), that inadequate qualified staff is a challenge facing the private Accredited Drug Dispensing Outlets in the provision of health services.

5.6.9 Poor Management

With regard to Poor management, table 4.6 reveals that thirty five (40.23%) respondents agreed and thirty three (37.93%) respondents strongly agreed. In other words 78.16 percent agreed that the Poor management is a cause of challenges facing private Accredited Drug Dispensing Outlets in the provision of services.

Nineteen (21.84%) respondents were neutral and none of respondents disagreed that Poor management is a cause of challenges facing private Accredited Drug Dispensing Outlets.

Similar results were also reported by Richard, et al. (2011) through their study, that poor management is a cause of challenges facing the private Accredited Drug Dispensing Outlets in the provision of health services. Medicines are sold without following proper guidelines for good dispensing practices.

Based on the findings relating to factors causing the challenges facing the ADDOs the following are the causes: Poor Medical Infrastructures (1005%), Traditional Believes (40.23%), Inadequate Medical Skills (69.0%), Poor Drug Planning (95.4%), Inadequate Capital (98.5%), Unethical Staff (97%), Inadequate employed qualified Staff (36.78%) and Poor Management (78.16%).

These findings imply that the employed public Health staff and Owners of Accredited Drug Dispensing Outlets are knowledgeable and aware of the causes of the challenges facing private Accredited Drug Dispensing outlets.

4.7 Measures to overcoming the challenges in provision of health services by private Accredited Drug Dispensing Outlets in Tabora Municipality

This section aimed at suggesting measures of improving the performance of the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality. The following scale was used to suggesting measures of improving the performance of the private Accredited Drug Dispensing Outlets in the provision of services. (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree). The respondents were required to use the scale in rating a list of ten (8) assumed measures. The findings were as summarized in table 4.7.

Table 4.7 Measures to Overcome Challenges Facing the Private ADDO

Measures	1		2		3		4		5	
	f	%	f	%	f	%	f	%	f	%
Employment of medical professionals	00	00	00	00	00	00	35	40.23	52	59.77
Training to the owners and service providers.	00	00	00	00	27	31.03	53	60.92	7	8.05
Adhere to the Government medical policies.	7	8.05	11	12.64	34	39.08	35	40.23	00	00
Proper Dispensing of required drugs	00	00	00	00	5	5.75	52	59.77	30	34.48
Effective and Efficiency drug planning	00	00	00	00	3	3.45	31	35.63	52	59.77
Improve drug storage	00	00	00	00	9	10.34	29	33.33	49	56.32
Dispensing enough and required drug	00	00	00	00	00	00	22	25.29	65	74.71
Provide public support	13	14.94	18	20.69	31	35.63	5	5.75	00	00

Source: Field Data, 2015

4.7.1 Employment of Medical Professionals

With regard to employment of medical professionals, table 4.7 reveals that thirty five (40.23%) respondents agreed and fifty two (59.77%) respondents strongly agreed. In other words 100 percent respondents agreed that employment of medical professionals is a measure of improving the performance of the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality.

None of respondents were neutral and none disagreed that employment of medical professionals is a measure of improving the performance of the private Accredited Drug Dispensing Outlets.

Similar results have been reported by AHPSR Flagship Report (2014). The grade levels of ADDO dispensers to be employed including nurses, nurse-midwives, clinical officers, assistant medical officers, pharmaceutical assistants, and pharmaceutical technicians as a measure to overcoming challenges facing ADDOs. The most common qualification of ADDO dispensers prior to ADDO training is nurse assistant.

4.7.2 Training to ADDO owners and service providers

Consideration of training to ADDO owners and Service Providers, table 4.7 shows that fifty three (60.92%) respondents agreed while seven (8.05%) respondents strongly agreed. In other words 68.97 percent agreed that training to the ADDO owners and service providers is a measure to overcome challenges facing the private Accredited Drug Dispensing Outlets. Twenty seven (31.03%) respondents were neutral and none of respondents disagreed.

Similar results have been reported by Mwakawelesya (2012), that ADDO owners and dispensers training curriculum should be reviewed so as to become more comprehensive hence solving challenges facing ADDOs. Tools such as Drug dispensing register, a list of ADDO recommended medicines and ADR forms should be available and easily accessible by ADDO owners.

4.7.3 Adhere to the Government Medical Policy

With regard to adherence to the Government medical policy, table 4.7 reveals that seven (8.05%) respondents strongly disagreed and eleven (12.64%) respondents disagreed. In other words 20.69 percent respondents disagreed that adhere to the Government medical policy is a measure to overcome challenges facing the private Accredited Drug Dispensing Outlets. Thirty four (39.08%) respondents were neutral due to their low level of understanding. Thirty five (40.23%) respondents agreed, this is to say that 40.23 percent agreed that adhere to the Government medical policy is a measure to overcome challenges facing the private Accredited Drug Dispensing Outlets.

The same results were reported by WHO (2011), that National Medicines Policy should be adhered for it provides a framework to ensure the supply of good quality affordable and appropriate medicines in the private sector as well as the public sector while preventing the import and distribution of dangerous and sub-standard products.

4.7.4 Proper Dispensing of Required Drugs

With regard to proper dispensing of required drugs, table 4.7 indicates that fifty two (59.77%) repondents agreed and thirty (34.48%) respondents strongly agreed. In other words 94.25 percent agreed that proper dispensing of required drugs is a measure to overcome challenges facing the private Accredited Drug Dispensing Outlets. Five (5.75%) respondets were neutral due to their low level of understanding. None of respondents disagreed that proper dispensing of required drugs is a measure to overcome challenges facing the private Accredited Drug Dispensing Outlets.

Similar results were also reported by Valimba (2011), that proper dispensing of required drugs by dispensing staff through training, education, and supervision is a measure to overcome challenges facing the private Accredited Drug Dispensing Outlets.

4.7.5 Effective and Efficiency Drug Planning

In consideration of effective and efficiency of drug planning, table 4.7 shows that thirty one (35.63%) respondents agreed while fifty two (59.77%) respondents strongly agreed. In other words 95.4 percent agreed that proper dispensing of required drugs is a measure to overcome challenges facing the private Accredited Drug Dispensing Outlets. None were neutral due to their low level of understanding and none disagreed.

The same results were reported by WHO (2011), that selection of medicines for procurement by ADDO owners should be based on the national *essential medicines list*, but the quantity to order depends on how much is being used. The use of *standard treatment guidelines* based on the standard list is the best way to ensure access to appropriate treatment.

4.7.6 Improving Drug Storage

With regard to improving drug storage, table 4.7 reveals that Twenty nine (33.33%) respondents agreed and forty nine (56.32%) respondents strongly agreed. In other words 89.65 percent respondents agreed that improving drug storage is a measure to overcome the challenges facing the private Accredited Drug Dispensing Outlets. Nine (10.34%) respondents were neutral due to their low level of understanding. None of respondents disagreed that improving drug storage is a measure to overcome challenges facing the private Accredited Drug Dispensing Outlets.

Similar results have been reported by Blasco, et al. (2011), the premises of ADDOs should be maintained adequately for proper storage of medicines. This in turn improves the quality of medicines available in these shops.

4.7.7 Dispensing Enough and Required Drugs

In consideration of dispensing enough and required drugs, table 4.7 shows that twenty two (25.29%) respondents strongly agreed while sixty five (74.71%) respondents agreed. In other words 100 percent agreed that dispensing enough and required drugs is a measure to overcome challenges facing the private Accredited Drug Dispensing Outlets. None of respondents disagreed. None were neutral and none disagreed.

The same results have been reported by Martha, *et al*. (2003) through their study, that the range of medicines authorized to be sold in the ADDOs does not meet the health demand of the customers.

According to the findings in relation to measures, the following are the measures to be taken: Employment of Medical Professionals (100%), Training to the owners and service providers (68.97%), Adhering to Government medical policies (40.23%), Proper Dispensing of required drugs (94.25), Effective and Efficiency drug planning (95.4%) and Improve drug storage (89.65%).

These findings implies that despite of existence of good measures available for curbing the challenges facing the sector, there is partial application of the measures to overcome the challenges facing the private Accredited Drug Dispensing Outlets.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The main objective of this study was to examine the Challenges facing private health service providers in Tanzania using a case of Accredited Drug Dispensing Outlets in Tabora Municipality as part of the public-private partnership initiative in Tanzania. Specifically the study aimed at examining the Performance of private Accredited Drug Dispensing Outlets in Tabora Municipality, find out the challenges facing private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality, explore the causes of the challenges facing the private Accredited Drug Dispensing Outlets in the provision of services in Tabora Municipality and suggest the measures of improving the performance of private Accredited Drug Dispensing Outlets in provision of service in Tabora Municipality

5.1 Summary of Findings

The findings show that; Majority of respondents (95.40%) indicated the private Accredited Drug Dispensing Outlets to be constrained with the number of challenges (table 4.4); 4 measures were used to determine the performance of private Accredited Drug Dispensing Outlets. Generally poor performance was reported by the majority of respondents as shown in Table 4.4

The study also shows the challenges facing Private ADDO; some of them were; Unavailability of professionals reported by 94.25 percent of respondents, Poor storage facilities reported by 85.51 percent of respondents, Low purchasing power (46.0%), difficult drug policy reported by 45.98 percent of respondents, poor Government support reported by 59.8 percent, selling expired drugs reported by 44.8 percent of respondents and high training costs reported by 94.3 percent of respondents and high drug price reported by 66.6 percent (see table 4.5).

Causes of the ADDO challenges were pointed by the respondents to be poor medical infrastructures (100%), Traditional believes (40.23%), Inadequate capital (98.3%), Inadequate medical skills (69%), poor drug planning (95.4%), Unethical staff (97%), inadequate employed staff (36.78%) and Poor Management (78.16%).

To overcome the challenges facing ADDO, a number of measures were suggested by the respondents, these include; employment of medical professionals (100%), Training to ADDO owners and dispensers (68.97%),Adhering to Government medical Policy (40.23%),Proper Dispensing of required drugs (94.25%), effective and efficiency drug planning (94.5%) and improving drug storage (89.65%).

5.2 Conclusion

This chapter has summarized the findings of the study objectives. The findings from the study revealed that; Majority of respondents indicated private accredited dispensing outlets to be constrained with the number of challenges, various measures were used to determine the degree of performance of private Accredited Dispensing Outlets and generally poor degree of performance was reported by the majority of respondents.

The study exposed the challenges facing Private ADDO; Unavailability of professionals, Poor storage facilities, shortage of required drugs, Low purchasing power, difficult drug policy, poor Government support, selling expired drugs and high training costs reported by respondents to be the major challenges facing the Private Accredited Drug Dispensing Outlets.

Causes of the ADDO challenges were pointed by the respondents to be poor medical infrastructures, Traditional believes, Inadequate capital, Inadequate medical skills, poor drug planning, Inadequate government support, Unethical staffs, poor drug dispensing outlet policy, inadequate employed staff and poor Management.

To overcome the challenges facing ADDO, a number of measures were suggested by the respondents, these include; adherence to the Government medical policies,

Proper Dispensing of required drugs, effective and efficiency drug planning, improving drug storage and dispensing enough and required drug.

5.3 Recommendations and policy implication

5.3.1 Recommendations

Despite that the study was carried out in the selected area, the researcher has some general recommendations with respect to the improvement of private health service provision.

First of all, policy makers from Tabora Municipality in collaboration with Ministry of Health should review the policy in improving public health management and private Accredited Drug Dispensing Outlets.

Government should provide short courses of three months to ADDO owners and their service providers after two years on principles guiding the public health and the negative impacts of poor provision of health services in the public.

Secondly, the available Private Accredited Drug Dispensing Outlets should be furnished with good shelves, fixtures and frigerators for drug preservation and if possible new and modern storage facilities should be provided by the government to the ADDO owners.

Good ethical conduct is needed to all public officials in performing public health activities so as adhered with public health policy which calls for client confidentiality.

Thirdly, the issue of poor performance and management in the public health sector should be tackled through strengthening the capacity to control ADDO as part of public health provision through re-orientation programmes.

Fourthly, drug regulations and principles should not only exist on paper but must be operational.

Fifthly, Government should ensure that there is enabling environment for the ADDO owners, service providers and public health employees to perform their health responsibilities; this will be achieved by providing good health infrastructures and motivation to the best ADDO service providers.

5.3.2 Policy Implication

This study was about examining the Challenges facing private health service providers in Tanzania using a case of Accredited Drug Dispensing Outlets in Tabora Municipality as part of the public-private partnership initiative in Tanzania.

The study found that drugs availability and dispensing is under National health Policy which emphasizes availability of quality health services to all Tanzanians. But the study found the following weaknesses as far as drugs availability and dispensing is concerned. These includes Unavailability of qualified staff, Poor storage facilities, shortage of required drugs, difficult drug policy, poor Government support, selling expired drugs and high training costs.

Therefore the government should effectively supervise the implementation of the existing National health policy so as to address these challenges.

5.4 Areas for further research

The study focused on examining the Challenges facing private health service providers in Tanzania using a case of Accredited Drug Dispensing Outlets in Tabora Municipality as part of the public-private partnership initiative in Tanzania. Only 13 wards from urban area out of 25 wards were considered. In this manner, the findings of the study cannot be claimed to be representative of the whole region and the nation at large. Thus, in order to investigate the extent of the problem, it is recommended that other related studies be undertaken in other Municipalities and Districts Councils specifically those areas with ADDO which are experiencing challenges like in urban area of Tabora Municipality where this study was carried out.

The researcher also recommends another study to be conducted on Impacts of selling freely all types of drugs by private Drug Dispensing Outlets in Tanzania: a case of Accredited Drug Dispensing Outlets. This proposed study is aiming at identifying the impacts of selling freely all types of drugs by private sector. This is because most of ADDO owners claimed as to why they are not allowed to dispense some of the essential drugs.

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APPENDICES

APPENDIX 1

QUESTIONNAIRE FOR ACCREDITED DRUG DISPENSING OUTLETS SERVICE PROVIDERS

Dear respondent,

I am a student at Mzumbe University, pursuing a Masters degree in Development Policy. Currently I am carrying out a study on challenges facing private medical shops in Tabora Municipality. You together with other respondents are requested to provide some information for this study. Please be assured that the information you provide will be used for academic purposes only. Thanking you for your cooperation.

Abiud James

Instructions

Please tick in the brackets provided and fill in the space provided.

Section A: Demographic information

1. Sex Male [ ] Female [ ]
2. Age .....
3. Nationality.....
4. Eduction level

Primary [ ]

Secondary [ ]

Tertiary [ ]

5. Marital status

Single [ ]

Married [ ]

Divorced [ ]

Separated [ ]

Widowed [ ]

6. Occupation

Farmer [ ]

Business [ ]

Government employee [ ]

Domestic activities [ ]

Student [ ]

Retired [ ]

Unemployed [ ]

Section B: Accredited Drug Dispensing Outlets Performance

7.Do you have regular medicine customers?

Yes for all types of medicine [ ]

Yes but for some types of medicine [ ]

No, there are no regular customers [ ]

8. If no give reasons

No purchasing power [ ]

Unavailability of medicines [ ]

9. Do you always sell all the medicine before they expire?

Yes [ ]

No [ ]

If No, please explain what you do with the medicine which are not bought on time

…..…….....

……

10. How often do you get complaints from your customers that you sold them ineffective medicine?

Always [ ]

Some time [ ]

Not at all [ ]

11. What other performance do you experience?

i).....

ii).....

iii).....

Section C: Challenges facing Accredited Drug Dispensing Outlets

12.Please use the scale below to rank the challenge where appropriete

(1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree)

Factors	**1**		**2**		**3**		**4**		**5**	
	f	**%**	**f**	**%**	**f**	**%**	**f**	**%**	**f**	**%**
Poor medical infrastructures										
Inadequate medical skills.										
Traditional believes.										
Inadequate capital.										
Poor Drug planning										
Inadequate Government support.										
Unethical staff										
Poor Drug outlet policy										
Inadequate employed qualified staff in the sector										
Poor Management										

Other (please specify) ……..

……..

……..

Section D: Factors causing the challenges

Please use the scale below to rank the factors causing the challenges where appropriete

(1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree)

Factors	**1**		**2**		**3**		**4**		**5**	
	f	**%**	**f**	**%**	**f**	**%**	**f**	**%**	**f**	**%**
Poor medical infrastructures										
Inadequate medical skills.										
Traditional believes.										
Inadequate capital.										
Poor Drug planning										
Inadequate Government support.										
Unethical staff										
Poor Drug outlet policy										
Inadequate employed qualified staff in the sector										
Poor Management										

13. Which two major challenges do you mainly face as a medicine service provider?

……

Section E: Measures on overcoming the challenges

14. Please use the scale below to rank the challenge where appropriete

(1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree)

Measures	**1**		**2**		**3**		**4**		**5**	
	f	**%**	**f**	**%**	**f**	**%**	**f**	**%**	**f**	**%**
Employment of medical professionals										
Training to the owners and service providers.										
Adhere to the Government medical policies.										
Proper Dispensing of required drugs										
Effective and Efficiency drug planning										
Improve drug storage										
Dispensing enough and required drug										
Provide public support										

Thank you for your cooperation

APPENDIX 2: OBSERVATION GUIDE

Item	**In Place**	**Not in Place**	**Remark(In use or not in use)**
ADDO establishment Guideline			
Building			
Environmental Cleanliness			
Staff qualifications(Certificates)			
Business licence			
Uniform			
Clean preservation shelves			
Adequate preservation shelves			
Essential Drugs list			
Proper drugs arrangement			
Expired drugs shown in shelves			
Service providers training manual			
Invoices and Receipts			
Ledger Books			
Daily cash sales			
Analysis book			
Patient drugs register			
Stores Ledger			
Bin Card			

APPENDIX 3

INTERVIEW GUIDE FOR ACCREDITED DRUG DISPENSING OUTLETS OWNERS

1. Which sale-related challenges do you experience in your service provision? ……

……

……...(probe)

2. Please explain preservation-related challenges encountered by private Accredited Drug Dispensing Outlets in Tabora ……(probe)

3. Which technical-know-how related challenges affect your provision of medical services?.....……

……(probe)

4. a) What measures have you taken as an individual to improve the provision of health services? .....

……

b) To what extent have the strategies contributed to smooth provision of medical services?

……

……

……. (Probe)

APPENDIX 4

QUESTIONNAIRE FOR ACCREDITED DRUG DISPENSING OUTLETS SERVICE USERS

Dear respondent,

I am a student at Mzumbe University, pursuing a Masters degree in Development Policy. Currently I am carrying out a study on challenges facing private medical shops in Tabora Municipality. You together with other respondents are requested to provide some information for this study. Please be assured that the information you provide will be used for academic purposes only.Thanking you for your cooperation.

Abiud James

Instructions

Please tick in the brackets provided and fill in the space provided.

Section A: Demographic information

1.Sex Male [ ] Female [ ]

2.Age .....

3.Nationality.....

4.Eduction level

Primary [ ]

Secondary [ ]

Tertiary [ ]

5.Marital status

Single [ ]

Married [ ]

Divorced [ ]

Separated [ ]

Widowed [ ]

6.Occupation

Farmer [ ]

Business [ ]

Government employee [ ]

Domestic activities [ ]

Student [ ]

Retired [ ]

Unemployed [ ]

Private Sector [ ]

Section B: Purchases-related challenges

7. Do you purchase medicines from medical shops regularly?

Yes for all types of medicines [ ]

Yes but for some types of medicines[ ]

No, there is no regular purchase [ ]

8. Do you always buy the medicines before they expire?

Yes [ ]

No [ ]

If Yes, please explain what actions do you take to address this problem

……

……

……

……

9. How often do you buy expired medicines from medical stores?

Always [ ]

Some time [ ]

Not at all [ ]

10.What challenges do you face in drugs availability from private Accredited Drug Dispensing Outlets?

Buying expired drugs[ ]

Buying fake drugs [ ]

High drugs price [ ]

Unavailability of some drugs [ ]

11. What steps do you take to overcome this challenge?

Going to witch doctors [ ]

Recovering without treatment [ ]

Assistance from good samaritans [ ]

12. What other purchases-related challenges do you face?

.....

.....

.....

.....

.....

.....

13. Which two major challenges do you mainly face as a medicine service user?

Buying expired drugs[ ]

Buying fake drugs [ ]

High drugs price [ ]

Unavailability of some drugs [ ]

Section C: Measures taken to ensure smooth provision

14. Please use the scale below to rank the challenge where appropriete

(1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree)

Measures	**1**		**2**		**3**		**4**		**5**	
	f	**%**	**f**	**%**	**f**	**%**	**f**	**%**	**f**	**%**
Employment of medical professionals										
Training to the owners and service providers.										
Adhere to the Government medical policies.										
Proper Dispensing of required drugs										
Effective and Efficiency drug planning										
Improve drug storage										
Dispensing enough and required drug										
Provide public support										

Thank you for your cooperation

APPENDIX 5

QUESTIONNAIRE FOR HEALTH STAFF

Dear respondent,

I am a student at Mzumbe University, pursuing a Masters degree in Development Policy. Currently I am carrying out a study on challenges facing private medical shops in Tabora Municipality. You together with other respondents are requested to provide some information for this study. Please be assured that the information you provide will be used for academic purposes only. Thanking you for your cooperation.

Abiud James

Instructions

Please tick in the brackets provided and fill in the space provided.

Section A: Demographic information

1.Sex Male [ ] Female [ ]

2.Age .....

3.Nationality.....

4.Eduction level

Primary [ ]

Secondary [ ]

Tertiary [ ]

1.Marital status

Single [ ]

Married [ ]

Divorced [ ]

Separated [ ]

Widowed [ ]

6.Occupation

Farmer [ ]

Business [ ]

Government employee [ ]

Domestic activities [ ]

Student [ ]

Retired [ ]

Unemployed [ ]

Section B: Purchases-related challenges

7. From your experience are private medical shops customers purchase medicines from medical stores regularly?

Yes for all types of medicines [ ]

Yes but for some types of medicines[ ]

No, there is no regular purchase [ ]

8. Do customers always buy the medicines before they expire?

Yes [ ]

No [ ]

If Yes, please explain what actions do you take to address this problem

……

……

……

……

9. How often customers buy expired medicines from Accredited Drug Dispensing Outlet?

Always [ ]

Some time [ ]

Not at all [ ]

10.What challenges do private Accredited Drug Dispensing Outlets owners face in service provision?

I) Bureaucratic stifling

ii) Selling expired drug

iii) Unskilled labor

iv) Poor infrastructure

11. What measures do they take to overcome these challenges? Mention

i).....

ii).....

iii).....

iv).....

vi).....

12. What other challenges do private Accredited Drug Dispensing Outlets owners face?

i).....

ii).....

iii).....

iv).....

Section C: Measures taken to ensure smooth provision

13. Please use the scale below to rank the challenge where appropriete

(1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree)

Measures	**1**		**2**		**3**		**4**		**5**	
	f	**%**	**f**	**%**	**f**	**%**	**f**	**%**	**f**	**%**
Employment of medical professionals										
Training to the owners and service providers.										
Adhere to the Government medical policies.										
Proper Dispensing of required drugs										
Effective and Efficiency drug planning										
Improve drug storage										
Dispensing enough and required drug										
Provide public support										

Thank you for your cooperation

APPENDIX 6

QUESTIONNAIRE FOR WEOs

Dear respondent,

I am a student at Mzumbe University, pursuing a Masters degree in Development Policy. Currently I am carrying out a study on challenges facing private medical shops in Tabora Municipality. You together with other respondents are requested to provide some information for this study. Please be assured that the information you provide will be used for academic purposes only. Thanking you for your cooperation.

Abiud James

Instructions

Please tick in the brackets provided and fill in the space provided.

Section A: Demographic information

1.Sex Male [ ] Female [ ]

2.Age .....

3.Nationality.....

4.Eduction level

Primary [ ]

Secondary [ ]

Tertiary [ ]

5.Marital status

Single [ ]

Married [ ]

Divorced [ ]

Separated [ ]

Widowed [ ]

6.Occupation

Farmer [ ]

Business [ ]

Government employee [ ]

Domestic activities [ ]

Student [ ]

Retired [ ]

Unemployed [ ]

Section B: Purchases-related challenges

7. Do you purchase medicines from medical shops regularly?

Yes for all types of medicines [ ]

Yes but for some types of medicines[ ]

No, there is no regular purchase [ ]

8. Do you always buy the medicines before they expire?

Yes [ ]

No [ ]

If Yes, please explain what actions do you take to address this problem ……..……

……...…

……...

9. How often do you buy expired medicines from Accredited Drug Dispensing Outlets?

Always [ ]

Some time [ ]

Not at all [ ]

10.What challenges do private Accredited Drug Dispensing Outlets owners face in their business operations?

i) Bureaucratic stifling

ii) Selling expired drug

iii) Unskilled labor

iv) Poor infrastructure

11. What measures do they take to overcome these challenges? mention

i).....

ii).....

iii).....

iv).....

vi).....

12. What other challenges do private Accredited Drug Dispensing Outlets owners face?

i).....

ii).....

iii).....

iv).....

v).....

Section C: Measures taken to ensure smooth provision

13.Please use the scale below to rank the measures where appropriete

(1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree)

Measures	**1**		**2**		**3**		**4**		**5**	
	f	**%**	**f**	**%**	**f**	**%**	**f**	**%**	**f**	**%**
Employment of medical professionals										
Training to the owners and service providers.										
Adhere to the Government medical policies.										
Proper Dispensing of required drugs										
Effective and Efficiency drug planning										
Improve drug storage										
Dispensing enough and required drug										
Provide public support										

Thank you for your cooperation