UTILIZATION OF COST SHARING FUNDS AND ITS ASSOCIATED FACTORS IN PROCUREMENT OF MEDICINES AND SUPPLIES IN PUBLIC PRIMARY HEALTH FACILITIES IN KYELA DISTRICT COUNCIL.

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By

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A dissertation Submitted in Partial Fulfilment of the Requirements for the Degree of Master of Public Health (MPH) of the Muhimbili University of Health and Allied Sciences

Muhimbili University of Health and Allied Sciences

October, 2013

CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance of a dissertation titled **'Utilization of cost sharing funds and its associated factors in procurement of medicines and supplies in public primary health facilities in Kyela District Council',** in partial fulfilment of the requirements of the Master of Public Health Degree of the Muhimbili University of Health and Allied Sciences.

_____

Dr. Mughwira Mwangu.

(Supervisor)

_____

Date

DECLARATION

AND

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I **Dugange Festo John** declare that except for the references of other people's investigations which have been duly acknowledge, 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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DEDICATION

This dissertation is dedicated to my lovely parents (Mr. John Dugange and Mrs. Marcelina Mgeni) and my lovely wife, daughters and son.

ABSTRACT

Background.

Shortage of essential medicines and supplies in most of public primary health facilities is among of the main challenges facing the health system in Tanzania. Shortages are mainly caused by limited budgets for health financing.

In order to reduce budget gaps (Govt tax, donors), cost sharing schemes are used. Tanzania introduced cost sharing in 1993, aiming at generating revenues to complement government budget. In 1997, the Ministry of Health developed a cost sharing guideline which guides facilities on how to manage the funds. It requires facilities to spend at least 67% of funds for procuring medicines and supplies.

Despite of guideline requirements, most public facilities have persistent shortage of medicines at an average of 40%. This has compromised the quality of health services provided to the community

Objective.

Broadly, the objective of this study was to determine the extent of utilization of cost sharing fund and its associated factors in procurement of medicines and supplies in Kyela District, Tanzania**.**

Materials and Methods:

A facility based cross-sectional study using close-ended questionnaire was conducted in Kyela district in June 2013. The study involved 25 primary health facilities (24 dispensaries, one health centre) and seven CHMT members. Main respondent at the facility level was the facility in charge. The study obtained information on extent facilities utilized cost sharing fund for procuring medicines and other non-medical supplies. Challenges that were mainly encountered were explored. Results obtained were analysed by SPSS version 16 software. Cross-tabulations of results were done to obtain P values using Fischer's exact test.

Results: A total of 32 respondents were included in the study. According to the 25 in charges, it was found that, most of health facilities 23 (92%) utilized the fund for various activities, while 2 facilities (8%) did not utilize the fund for any activity in the past 12

months prior to this study. On the other hand, 17 (68%) of the facilities used cost sharing fund to procure medicines and supplies while 8 (32%) did not procure medicines and supplies regardless of the shortages they experienced. In general, most of facilities 14 (56%) spent less than 40% of cost sharing fund for procuring medicines, none spent cost sharing according to the guideline minimum requirement (67%) for medicines.

Conclusion.

This study found that, in general most of public primary health facilities have cost sharing bank accounts, however utilization of funds poorly adhere to Cost Sharing Guideline. The main challenges reported to affect utilization of funds according to the guideline included: Inadequate financial management capacities at facility level (48%), long distance from health facility to the bank (24%), beaurocratic public procurement procedures (20%) and inadequate technical support from the council (8%).

Recommendations

From findings of this study, it recommends that, with the current persistent shortage of medicines and supplies in most public primary health facilities, the Ministry of Health and Social Welfare should re- examine the impact of cost sharing fund in procurement of medicines and consider more effective alternative options.

Key words: Cost sharing guideline, Cost sharing fund, utilization, shortage of medicines, knowledge of in charges, fund management, Kyela District Council.

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LIST OF ABBREVIATIONS

ALU	Artemether Lummefentrine
CCHP	Comprehensive Council Health Plan
CHF	Community Health Fund
CHMT	Council Health management Team
CHPT	Council Health Planning Team
CHSB	Council Health Service Board
D by D	Decentralization by Devolution
DED	District Executive Director
DMO	District Medical Officer
DP	District Pharmacist
DRF	Drug Revolving Fund
GDP	Gross Domestic Product
GTZ	Gesellschaft fuer Technische Zusammenarbeit
HC	Health Center
HF	Health Facility
HFGC	Health facility Governing Committee
HSSP	Health Sector Strategic Plan
HWs	Health workers
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MoH&SW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MUHAS	Muhimbili University of Health & Allied Sciences
NBS	National Bureau of Statistics
NHIF	National Health Insurance Fund
OPD	Out Patient Department
PHC	Primary Health Care

RAS	Regional Administrative Secretary
TBA	Traditional Birth Attendant
TGPSH	Tanzania German Program Support to Health
U5MR	Under Fiver Mortality Rate
WHO	World Health Organization.

DEFINITION OF KEY WORDS

Cost sharing fund –Is the fund resource that originates from a program or project costs not borne by a sponsoring agency. It is the fund that is contributed by health service beneficiaries (WHO 2001).

Medicines –Are any natural or artificial chemicals used as a drug to treat a disease condition (WHO 1997).

Hospital supplies: These are any materials other than medicines used in providing care specifically in the hospital that covers a wide range from furnaces to surgical dressings (WHO 1997).

Health facility in charge: Are the health workers given the authority to lead all day to day activities of the health facilities. (MOH & SW 1993).

Public primary health facilities: These are the government owned dispensaries and health centres that provide essential health care based on practical, scientifically sound and socially acceptable and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination (Alma Ata Declaration 1978).

Cost sharing fund guideline: Is the directive provided by the Ministry of health, guiding health facilities on how cost sharing funds should be managed in day to day bases at the facility and council level

Availability: The presence and ready to use of different medicines and supplies in a given health facility.

Accessibility: The extent to which the location of supply is in lines with location of clients

CHAPTER ONE

1.0. Introduction

1.1 Background information on cost sharing fund.

Health financing is among of the top priorities in the social services sector worldwide. In the developed world countries, such as United States of America (USA), Germany, France and United Kingdom (UK), health financing is not a big challenge as it is in the developing world such as Asian and African countries. Most of African countries are poor; hence have remarkable budget constraints for health care services (Family & January 2009). On the other hand, most of the developed countries have strong health insurance schemes covering a big proportion of population as opposed to developing countries where health insurance scheme covers a small proportion of the population (Mills et al. 2012).

The majority African countries' budgets for health care financing are obtained from government tax resources and assistance from various development partners. Though helpful, these sources are still not adequate to address health care service problems.

In order to reduce this financial resource gap, most of African countries such as South Africa, Ghana, Zimbabwe, Kenya and Tanzania have introduced cost sharing schemes to complement budget shortage, especially for procurement of medicines, medical equipments and supplies (Akazili et al. 2012).

In Tanzania, the cost sharing scheme was introduced in public health facilities in 1993. It aimed at generating revenues to supplement the government budget for providing quality health care services and ensuring adequate supplies of medicines

Tanzania is following a mixed type of system for health care financing. It largely uses tax financing which dominates and assistance from developing partners (Mtei et al. 2012). In the financial year 2012/2013, it allocated 10% of total public expenditure which includes taxation and development partner funding on health care financing (Anon 2013). Regardless of efforts of the government to increase the budget of health to 10 % of the

Gross Domestic Product (GDP), a gap of 24% exists. This gap needs to be partly complemented by cost sharing funds in health facilities (HSSP III)

The vision of the Ministry of Health and Social Welfare is 'To improve the health and well being of all Tanzanians, with a focus on those at risk, and encourage the health system to be more responsive to needs of the people (MOH & SW 2008 a, Tanzanian et al. 2004).

This vision will only be achieved if the health system is improved, including health financing. Strengthening other sources of revenues such as cost sharing will enhance the capacity of public primary health facilities to collect more funds and use them to address issues like shortage of medicines and supplies (Tanzanian et al 2004).

The Ministry of Health introduced a cost sharing guideline in 1997, which guides use of funds. Apart from other activities, cost sharing fund is mainly meant for complementing government budgets in procuring medicines and supplies to reduce the incidences of 'out-of-stock' of medicines. It requires health facilities to spend at least 67% of cost sharing revenues for procurement of complementary medicines and supplies. Therefore, a big proportion of cost sharing fund should be utilized to improve availability of medicines in a Drug Revolving Fund (DRF) system (MoH & SW 2008a).

Among other major focuses of health sector reforms, financial reforms through enhancement of complementary health financing are insisted. It aims at strengthening the cost sharing funds (Community Health Fund-CHF, National Health Insurance Fund – NHIF, and user fees-Out of pocket).

Under this system, the health facilities are required to collect cost sharing funds (CHF, NHIF and User fees), bank in their respective accounts and use for addressing facility problem (HSSP III).

1.2. Statement of the Problem

The extent and capacity of utilization of cost sharing funds for procurement of medicines/supplies in public primary health facilities is questionable (Mulligan 2007). Regardless of its introduction, there have been little evidence of its use in improving availability of medicines/supplies (Sacca 2000). In Tanzania, for cost sharing fund to be effectively used as per guideline, at least 67% of revenues should be spent in procurement of medicines/supplies (MoH 1997). Properly managed cost sharing funds is therefore expected to reduce incidences of shortages of medicines and supplies in public primary health facilities.

However, most of rural public primary health facilities have persistent shortage of medicines and supplies. The shortages are at an average of 40% and involve very essential medicines (TGPSH 2011). These are the facilities serving the majority Tanzanians (80%) who are mostly rural poor (MoH &SW 2008a).Shortages in rural facilities have more serious impact as accessibility to alternative private medical stores/pharmacies is limited. For most of Tanzanians, the availability of medicines and medical equipments is the major indicator of quality of health care (Mtei et al. 2012).

Various studies show that when cost sharing funds are properly utilized, they do improve quality of services. They improve availability of medicines, increase worker's morale and clients' satisfaction (MoH &SW 2009, Alba et al 2010 and Macha .J.et al 2012). Therefore, if cost sharing funds are well managed and prioritized in procurement of medicines/supplies, the problem of shortages of medicines and supplies may be reduced to a big extent.

So far, information on approaches to improve collection of funds and how to best utilize them are well in place. Revenues generated through these sources are gradually improving (HSSP III). The pattern of expenditure of cost sharing fund is unclear, requiring a study to examine the sources that are collected and spent for medicines and supplies. (Mtei et. al 2012).

On the other hand, there is limited knowledge on the extent health facilities properly utilize these funds. As day to day management are done by facility in charges, their capacities of properly utilizing these funds at facility and council levels and the associated factors are not well known (Mulligan 2007). The extent to which funds are used in procuring medicines/supplies to reduce shortages is not clear (TGPSH, 2011, Mtei et al 2012).

1.3. Rationale of the study.

This study aimed at obtaining information on the extent cost sharing funds is utilized for procuring medicines in public primary health facilities. It also derived information on the capacities of facility in charges in managing these funds according to the 1997 Cost Sharing Guideline. Factors associated with utilization were determined. Findings obtained in this study will add knowledge and help decision makers at local levels make evidence based interventions to improve quality of health services.

1.4. Research questions.

1.4.1. Main research question.

To what extent do public primary health facilities utilize cost sharing fund to procure medicines and supplies and what are the main challenges?

1.4.2. Specific research questions.

1. What is the extent of use of cost sharing fund in procuring medicines and supplies in public primary health facilities?
2. To what extent is cost sharing fund spent for activities other than procuring medicines and supplies?
3. To what extent are health facilities in charges knowledgeable on the cost sharing guideline requirements in public primary health facilities?
4. What is the extent of supervision and mentoring of facility in charges on proper utilization of cost sharing fund in public primary health facilities?
5. What are the main challenges facing public primary health facilities in procurement of medicines and supplies using cost sharing funds?
6. Are there any associations between utilization of cost sharing fund and knowledge of in charge, supervision and frequency of shortages of medicines in health facilities.

1.0. Study Objectives.

1.5.1. Main Objective

To determine the extent of use and main challenges affecting utilization of cost sharing funds in procuring medicines and supplies in public Primary Health facilities in Kyela District Council.

1.5.2. Specific Objectives.

1. To determine the extent of use of cost sharing fund in procuring medicines and supplies in public PHC facilities in the past 12 months in Kyela District Council.
2. To determine the proportion of cost sharing fund spent for activities other than procurement of medicines and supplies in public PHC facilities in the past 12 months in Kyela District council.
3. To determine the extent public primary health facility in charges are knowledgeable on the cost sharing fund guideline and its requirements in Kyela District Council.
4. To determine the extent to which facility In charges have been supervised and mentored on utilization of cost sharing funds for procuring medicines and supplies in the past 12 months in Kyela district.
5. To explore the main challenges facing public primary health facilities in procurement of medicines through cost sharing funds in Kyela District Council.
6. To determine the association between utilization of cost sharing fund and knowledge of in charge, supervision and frequency of shortages of medicines in the past 12 months in Kyela district.

1.5.3. The Conceptual Framework

This study was guided by the conceptual framework presented in figure 1.

In this framework, the availability of medicines in health facilities (**Outcome)** is determined by proper utilization of funds to procure medicines as required by the Cost Sharing Guideline. When these funds are not utilized accordingly, the end result is shortages of medicines and supplies in most of public primary health facilities. Utilization of these funds depends on availability of **resources**, such as funds, cost sharing and procurement guidelines that enhances staff capacity. When these resources are not accessible, the efficiency of utilization of funds becomes low.

On the other hand, **staff competence** enables proper fund utilization and **adherence to guidelines** on utilization of funds, planning for procurement of medicines etc. When health workers are not competent on proper utilization of cost sharing funds as required by the guideline, the risk of facilities facing shortages of medicines and supplies becomes high. Therefore, improving staff competence on fund management, improves the availability of medicines and supplies.

At council level, supportive supervision, mentoring and training are planned, organised and implemented by the Council Health Management Team (CHMT).For all these factors to function properly, **administrative** and **organizational** issues effected by the CHMT to facilities are mandatory. They will ensure effective supportive supervisions, mentoring and training to facilities that will improve staff competence at facility level. In this study, all these factors were studied and challenges affecting utilization of funds to procure medicines were as well explored.

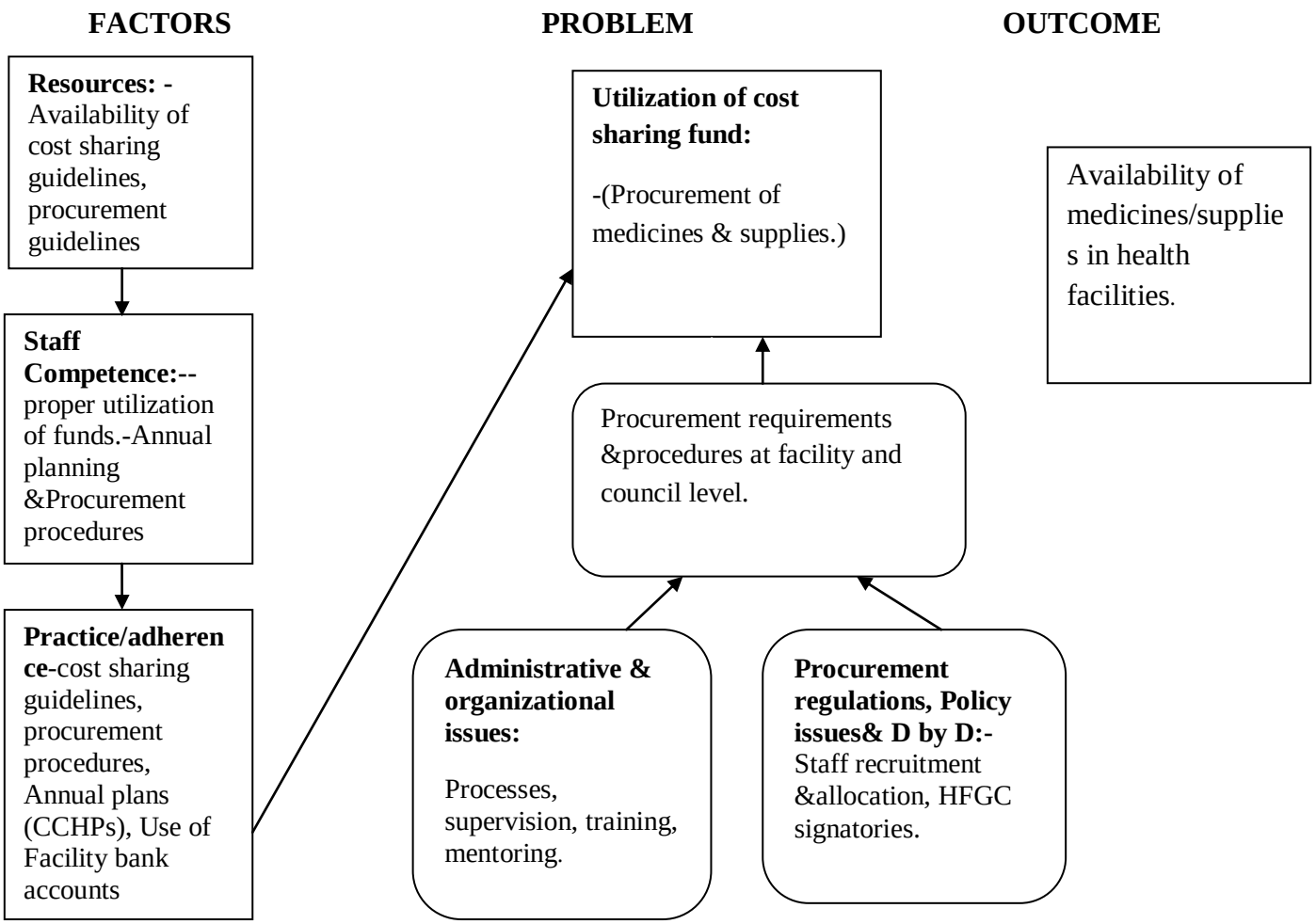


Figure 1. The Conceptual framework.

Source: Researcher 2013.

CHAPTER TWO

2.0. Literature review

2.1. An overview

The effectiveness of health service delivery at any level of care depends on many factors, but importantly on resources available for it to operate optimally. For an optimum delivery of health care services, the way resources are organized and managed is mandatory (Chee & Smith 2002, G. M. Ã et al. 2005)

Worldwide, cost sharing funds are utilized as one of sources for health financing. In German, France and Switzerland, cost sharing has shown to improve quality of services. It improves availability of medicines and motivates health workers. Cost sharing funds can also be used (Family & January 2009).

2.2. Role of cost sharing fund in improving quality of health services.

Worldwide and in Africa, there are evidences of the role of cost sharing fund in improving the quality and accessibility of health services.

Studies done in South –East Asia found that, cost sharing is a drug financing programme that is sustainable as it is affected with contributions from both the public as well as the private sector. It revealed that, when funds are properly utilized, cost sharing fund can lead to achieving the goal of better, efficient and equity in drug supply (Health& Strategic 2008a).

Financing the shortages of medicines and supplies for primary health care facilities in many developing countries was recommended by the World Bank in 1987. It stipulated for some mechanism for mechanism for cost sharing be introduced in order to reduce shortages of essential medicines and supplies in facilities (Health& Strategic 2008a).

Various studies have shown that, user charges in public health facilities are aimed at improving efficiency and quality of health care services. However, in Africa, evidence of

their effect on patient care and community health seeking behaviour is mixed (G. M. Ã et al. 2005).

A study was done in Tanzania on the effect of cost sharing fund collection in improving quality and peoples' health seeking behaviour. It found that, shortages of medicines and supplies lowered community confidence on the role of cost sharing fund. On the other hand, when facilities had adequate supplies of essential medicines and supplies, communities were more positive with cost sharing fund. This improved the quality of services as well as clients' satisfaction. The study concluded that, despite of the potential of cost sharing for revenue mobilization and reducing shortages of essential medicines and supplies, problems with their administration lowers public confidence on its role. When funds are well managed, there is a significant improvement in quality and accessibility of services to the majority poor (G. M. Ã et al. 2005)

Not only that, but also a study done in Tanzania on equity in health care financing and benefit distribution revealed that, the majority poor Tanzanians segment of the population receives a lower share of health care benefits relative to their share of need. This was found to be due to most of rural primary health facilities (70%) running short of medicines and supplies, despite of existence of cost sharing fund system (Mtei et al. 2012). It was therefore insisted that, facilities should improve availability of medicines and supplies to reduce shortages.

Another study was done in Tanzania on the policy on health care fee waivers and exemptions revealed that, the introduction of cost sharing fund was accepted by communities with lots of fears. However, with its proper utilization in procuring medicines and supplies to reduce shortages, resulted to increasing community confidence over its positive impact for improving services (Tanzanian et al. 2004).

On the other hand, the HSSP III clearly stipulated its strategy for financing the health sector. It insisted on the importance of innovating and improving ways of raising funds from Government, Development Partners and from private sector in order to fill the health budget gap of 24% that will exist during the implementation period of the strategic plan. Such improvements are needed in areas of collection and utilization of cost sharing funds. It concluded that, when cost sharing funds are properly utilized in a drug revolving fund

system, shortages of medicines and supplies in health facilities will be remarkably reduced (Health & Strategic 2008).

Therefore, cost sharing fund is one of the most reliable and sustainable source of health financing in both the developed as well as the developing World.

It has impact on health across socio-economic groups (Akazili et al. 2012) and the most at risk groups (Ataguba & McIntyre 2012).Most of the literatures revealed that cost sharing fund needs to be well managed for provision of quality medical care services in all health care levels. Well managed cost sharing funds improves availability of medicines/supplies, and health facility infrastructures. It can also be used as an incentive to improve health workers motivation status (Sacca 2000, Family & January 2009, Khalafalla & Ali 2009). However, various studies revealed that there are some weaknesses in cost sharing fund management and information systems, especially in the operation at the facility level. An important question is whether facility staffs who are often left with the day to day management of the funds are capable of handling fund in addition to delivering services to patients (Mulligan 2007). Lack of knowledge/capacity and experience in community mobilization and financial management is among the factors that have hindered the quality of services (Chee et al 2002, MOH 2006). Some studies recognized incompetence of facility and district staff in utilization of funds (Laterveer et al 2004).

2.3. The 1997 Cost Sharing Guideline

In the cost sharing fund guideline of 1997 (MOH 1997), every public health facility is required to have an active bank account. The accounts are to be used in banking all cost sharing funds as they are collected and utilized for procurement of medicines/supplies and other facility items.

The HSSP III recommends that, as councils are increasing their own sources (cost sharing funds), it is important to use these funds for procurement of medicines and supplies from alternative suppliers when MSD is out of stock.

The extent of health care service needs is related to socio-economic status of the community. Poorest households have the highest need compared to least poor. Distribution of the under five morbidity and mortality rate for example, is along socio-economic groups, the poor being more affected (NBS & ORC Marco 2010). For that matter, programs targeting improving primary health care at lower facilities will benefit the poorest who are majority.

2.4. Shortage of essential medicines in rural primary health facilities.

In Tanzania, rural public health facilities are poorly staffed with persistent shortages of medicines, supplies and medical equipments as compared to urban and private facilities. This result into paying out-of-pocket at health facilities for costly outpatient and inpatient services which again often has out of stock of medicines/supplies. Therefore, cost sharing funds need to be properly utilized for procuring medicines and supplies in order to complement government budget. This will reduce many, among other challenges affecting provision of quality health services in developing countries such as, shortage of medicines, medical equipments and supplies (Macha et al 2012).

The majority of health facilities in Tanzania (70%) are government owned (MOH&SW 2008a). Most of public health facilities often run short of medicines and supplies, situations being worse in rural facilities. As most of councils are rural, majority of Tanzanians (80%) live in rural areas. They get health services from rural facilities that often suffer from stock outs of medicines and other essential supplies. The Tanzania government established a Medical Stores Department (MSD) in the year 1993 by an act of the parliament. The purpose was to enhance supply of essential medicines, medical equipments and supplies to public health facilities. It also established an Integrated Logistic System (ILS), Request and Report (R&R) for public primary health care facilities to order medicines according to local needs. However, the Medical stores Department (MSD) supply gap (gap between what was ordered to what was delivered) is usually big (20-46.4%) and often constant (TGPSH 2011). Apart from the supply gap, delivery of medicines from MSD is usually irregular and late due to overload, a condition which worsens the out of stock conditions.

Shortages involve essential medicines such as antimalarials (ALU, SP), diagnostics like Malaria Rapid Diagnostic Tests (mRDT), Uterotonics such as Oxytocin, Ergometrine, antibiotics etc. The Tanzania German Programme to Support Health (TGPSH) conducted a study to assess availability of medicines and supplies in public health facilities. The study was conducted in four regions of Tanzania, namely; Lindi, Mtwara, Tanga and Mbeya. Assessments done in 2011 to 87 Health facilities in these four regions of Tanzania (Mtwara, Lindi, Mbeya and Tanga) revealed severe stock-outs of essential medicines, supplies and medical equipments. Malaria diagnostic supplies like mRDT has a stock out rate of 75%, oxytocin and ergometrine 50-70%.It was also found that, the MSD fulfilment rate was as high as 65% in average. (TGPSH 2011).

During the study in the four regions, Districts in Mtwara region had a variance in availability of medicines. Tandahimba district had a stock out rate of 62.3%, Masasi 58.4% and Nanyumbu 43.3%. The MSD supply gap observed in Tanga region ranged between 20-73%.MSD fulfilment rates in Mbeya region was between 54.6% to 76.6%. The study recommended having an alternative procurement system to overcome the MSD supply gap. It was also found that, most of public health facilities do not use cost sharing fund as an alternative source to procure medicines when they are out of stock. It was found that, on average, only 15% of facilities had used cost sharing fund to serve the purpose. (TGPSH 2011).

The gap of supply requires an alternative source in order to reduce its severity. Cost sharing is among of important resources to complement medicine shortages at facility level. However, the pattern of utilization is unclear, requiring a study to examine the sources that are collected and spent for medicines and supplies. (Mtei et al 2012)

As a result, patients are obliged to pay at private medical stores/pharmacies or seek more expensive services elsewhere. This situation results into patient dissatisfaction to quality of health services provided in most of public health facilities (Mtei et al 2012).

2.5. Community perception on quality of health services.

For most of Tanzanians, the quality of health care services is indicated by availability of medicine and medical supplies/equipments (Alba et Al 2010). Therefore, lack/shortage of essential medicines and supplies in health facilities is a major obstacle for populations to access quality health care services (MOH& SW 2009, Alba et Al 2012).So far, shortages of supplies and medicines is a persistent problem in most of public health facilities. It results into communities obtaining health services in those areas receive services below quality. As a result, some community members opt to diverge from seeking services to facilities. They do depend on traditional healers for most of services, including maternal and child health services. Maternal and under five mortality rate has not been reduced to planned targets. This trend has compromised efforts to achieve the Millennium Development Goals (MDG) number four and number five.

Not only that, but also, frequent shortages of medicines and supplies in most of public health facilities has affected the National policy of universal coverage of health insurance .Most of community members who are being sensitized to join various insurance schemes, such as Community Health Fund (CHF), TIBA KWA KADI (TIKA), etc are not well responding. In a study conducted in Hanang district on community health fund status, it was revealed that, the most common reason given for not joining the scheme was shortages of medicines and supplies in most of health facilities. Communities were not confident on the role of these insurances while most of facilities do not have adequate supply of medicines. For the community, health services in public facilities are not reliable, therefore joining voluntary health insurances schemes does not have any impact to them(Chee & Smith 2002).

CHAPTER THREE

3.0. Methodology.

3.1. Study area.

The study was conducted in Kyela District Council, Mbeya region. The district was selected because it is a rural, peripheral district.

Kyela District is bordered by Ileje District to the south west, Rungwe District to the North, Makete and Ludewa to the East. Lake Nyasa lies in the South-East and the Republic of Malawi to the South-West, marked by Songwe River. It is divided into 2 divisions namely Unyakyusa with 12 wards and Ntebela with 13 wards making a total of 25 wards. The number of registered villages up to 31.12.2012 was 97.

Socio Demographic characteristics of the study population.

Kyela District is one of the nine councils of Mbeya region. It has two divisions and 25 wards. It has a total of 38 health facilities whereby two are hospitals (Kyela district hospital and Matema Lutheran Hospital), one health centre and 35 dispensaries. Of these, 26 are government owned, four Faith Based Organisations (FBO) owned and eight private. These facilities serve a population of 221,630 of the district (NBS census 2012). Generally, 90% of this population gets health services within 5 kilometres from their settlements.

The map in Figure 1 below shows the geographical distribution of health facilities in Kyela by level of care.

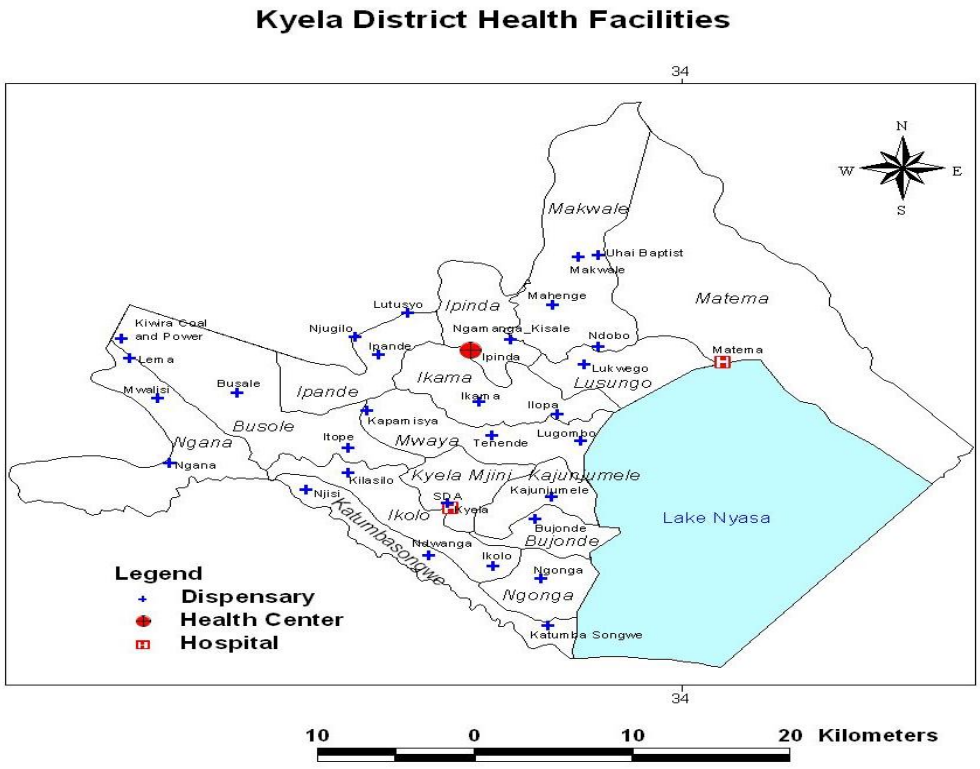


Figure 2: Kyela District Council map with distribution of health facilities.

3.2. Study design.

This study was an explorative cross-sectional study. . It was conducted from May to June 2013, inquiring information on cost sharing fund utilization and its associated factors for the period of 12 months (May 2012 to June 2013) prior to the study. It was conducted in Kyela district council, Mbeya region. The choice of this design was based on it being suitable for exploratory studies, of which this study belonged to that category.

3.2.1. Target population.

There were two study units in this study. The first was all public primary health care facilities and the second was the CHMT members in Kyela district council.

3.2.2. Study population.

There were two study units; public primary health facilities and a part of CHMT members, (7). The public primary health care facilities unit included 25 public Dispensaries and one Health Centre. Health facilities in charges were the main respondents of the facility interview. In the CHMTs unit, there were two key informants, the District Medical Officer (DMO) and the District Pharmacist who were purposively selected. The other five members were randomly selected through a simple random sampling technique.

3.3. Selection of Participants.

3.3.1. Inclusion criteria:

Registered public primary health facilities that actively provide services.

3.3.2. Exclusion criteria:

Health facilities recently registered less than the last 12 months.

Facility in charge who has stayed less than 12 months in the facility

3.4. Sampling Methods and Sample size.

3.4.1. Sample size:

The sample size for the study was 25 public primary health facilities (24 dispensaries, one health centre) and 7 CHMT members. The minimum sample size to be included in this study was calculated by Statcalc using EPI TABLE calculator of Epi Info version 6 of 2012 for calculating sample size of simple random study.

- Size of population –in this study it was the number of all public primary health facilities in Kyela District Council.
- Expected prevalence-in this study it was the percentage of primary facilities shown to adhere to cost sharing guideline.
- Desired precision/worst acceptable value

In a study done by Tanzania German Programme to Support Health in 2011, it showed in average, 15% of public primary health facilities utilized cost sharing funds for procuring medicines/supplies (TGPSH 2011).

Then Inputs of the EPITABLE calculator were:

- Size of the population is 26 (2012/13 Kyela DC CCHP).
- Expected prevalence 'P' is 15%.
- Desired precision 6%.

After substituting the inputs in EPITABLE calculator (Epi Info version 6 of 2012), it gave the minimum number of facilities to be include in the study is 18 (69%).
However, in this study, a total of 25 public primary facilities (24 Dispensaries, 1Health Centre) were included in the study.

This sample size is congruent with the protocols for rapid data analysis which requires covering at least 30-50% of health institutions to get a geographical representation and subsequent generalization (WHO 2005).

3.4.2. Sampling technique.

A simple random sampling was done. A list (sampling frame) of all public dispensaries was prepared. 24 out of 25 dispensaries were drawn by using a table of random numbers. There is only one Health centre in Kyela District. Therefore, the health centre was purposively selected to make a sample size of 25 primary facilities .The health centre was included in this study as a public primary health facility like the dispensaries. This is because; the cost sharing management structure is the same in all primary health care facilities including the health centre.

The CHMT sample size of 7 members was purposively selected. The selected members were those who closely deal with issues of handling and/or facilitating health facilities in day to day management of cost sharing funds. They were therefore purposively selected as key informants at the council level. The District Medical Officer and District Pharmacist were the main respondents in the CHMT group. They were also purposively selected because of being the key figures responsible with supervision, monitoring and control of utilization of facility funds for procurement of medicines and other items in the district.

3.5. Data Collection techniques and tools:

3.5.1. Recruitment and Training.

This study used one research assistant who had some knowledge on public primary health care cost sharing management. This assistant had a health research background and he was involved in data collection. Prior to start of data collection he was oriented and made competent with research questionnaire, ethical issues etc. The research assistant was given a per diem and transport allowance for 14 days he worked with me in the field to collect data.

3.5.2. Data collection and Technique.

In this study, tools which were used include:

i. Structured questionnaire (close ended questions) was used to interview public primary health facility in charges and CHMT members. Questionnaires for CHMT were different from those of facility in charges. Both Swahili and English version questionnaires were prepared, but only Swahili version was used for data collection.

ii. Secondary data: A document review of medicines and supplies registers, Health Management Information System (HMIS), dispensing registers, CCHP books and cost sharing expenditure were done. The reviews were done by checking records in respective registers in order to ascertain the trend of availability of medicines and extent of adherence to guidelines. Document reviews were done in order to verify the information obtained through interviews. They also provided information on the status of availability of medicines in health facilities in the past 12 months, extent the facilities were supervised/mentored and the extent health facilities utilized cost sharing fund to procure medicines/supplies and non-medical items.

3.5.3. Data Collection Procedures.

Research data were collected by principal investigator and one research assistant. Thorough explanation of research objectives and what the study is in general was given to each participant. After a thorough understanding, each participant was asked to give his/her consent to be interviewed. Interview responses were recorded on the questionnaire by the principal investigator or research assistant.

3.6. Study Variables.

3.6.1. Dependent variables

- Availability of essential medicines and supplies.

  Ideally, health facilities are required to have all the essential medicines available all the time for them to perform to clients' expectations. However, this is not the case for most of facilities. Shortages of essential medicines are very common, resulting to clients' dissatisfaction to services.

  In this study, this variable assessed the extent essential medicines and supplies were available and ready for patient consumption at the health facility. It was measured as a proportion of medicines and supplies that were actually available compared to the required amount as per essential medicines list.

- Utilization of cost sharing fund.

  Health facilities are required to utilized most of the cost sharing fund (67%) to procure medicines and supplies. This aims at complementing the government budget in order to reduce the magnitude of shortages. This variable assessed the level to which health facilities utilize cost sharing fund to procure medicines and supplies in order to reduce incidences of shortages in health facilities. It was measured as a proportion of the amount of fund utilized to procure medicines / supplies out of the total cost sharing revenues collected.

- Shortage of medicines and supplies.

  Most of public primary health facilities experience frequent shortages of medicines and supplies. The shortage is the discrepancy between the ideal requirements as per essential medicines list as compared to the actual amount of the available medicines.

  In this study, the variable determined the magnitude and frequency of shortages of medicines and supplies in health facilities in the past 12 months prior this study.

The variable was measured as a proportion of extent medicines and supplies were out of stock as compared to the actual requirement.

- Type of medicines that are out of stock.

  Usually, health facilities have the most common medicines/supplies that are highly consumed compared to others. These are called 'fast moving medicines/supplies'. These items are those used to manage common diseases such as malaria, pneumonia, diarrhoea, etc. As their consumption rates are high, they face the greatest risk of being out of stock more frequently than the others.

  This variable determined the type of medicines that are commonly out of stock in health facilities. It was measured as a proportion of incidences of which certain type of medicines experienced shortages in the past 12 months prior to this study.

- Presence of cost sharing bank account.

  The 1997 guideline requires all public primary health facilities to have an active cost sharing bank account. This account is supposed to be used to bank and utilize all cost sharing revenues in a particular facility.

  The variable determined the number of health facilities that adhered to the 1997 Cost Sharing Guideline by having cost sharing bank accounts. It was measured as a proportion of health facilities that had cost sharing bank accounts.

- Knowledge of facility in charges on cost sharing guideline.

  For cost sharing fund to be utilized according to the guideline requirement, knowledge of the facility in charges is mandatory.

  Health facilities in charges that were conversant on the 1997 Cost Sharing Guideline were determined through this variable. Their capacities on general fund management were also explored. It was measured as a proportion of facility in charges who were aware on requirements of the guideline on how cost sharing fund should be utilized.

3.6.2. Independent variables

- Availability of cost sharing guidelines.

- The Ministry of Health and Social Welfare produced Cost Sharing Guidelines to be used as a reference material in health facilities. Access to the guidelines is expected to improve capacities of facilities to adhere to the requirements of the guideline during fund utilization.

  This variable evaluated the extent Cost Sharing Guidelines as reference materials were accessible to health facility in charges. It aimed at determining the proportion of in charges who had these guidelines at the facility level as a reference material. It was measured as a proportion of health facilities that had a copy of cost sharing guideline for self reference.

- Supportive supervision visits

The 1999 National supportive supervision guideline requires health facilities be supervised and workers mentored at least once per quarter. When supervisions are conducted effectively, the knowledge and performance of health workers improves. This results into in charges being competent on fund management as per guideline, among other areas. The variable determined the extent health facilities were actually supervised and the extent the supervisions checked for status of availability of medicines and supplies at health facilities. It also determined the level of mentoring activities conducted to in charges on proper cost sharing fund management. It was measured as a proportion of supervision visits conducted as compared to the actual visits planned in the supervision matrix in the year.

- Public procurement procedures.

  The 2004 Local Government Financial Memorandum (LGFM) stipulates a procedure to be followed during ant public procurement procedure. This regulation has many beurocratic stages to be followed before the commodities are procured for use. It requires the in charges to identify the required medicines/supplies, write a request letter to the District Medical Officer (DMO). The request is then forwarded to the District Executive Director (DED), if approved, are then

forwarded to the Council procurement officer for tendering process. At the end, procurement takes long time, two or more months before the medicines are brought to health facility for use. However, most of facility in charges is not aware on these procedures, leading to failure of most of their orders.

In this study, the variable explored the extent facility in charges were knowledgeable on the public procurement regulations on procurement of medicines and supplies at facility level. It was measured as a proportion of facility in charges who were aware of procurement procedures.

- Distance from bank facilities-

  As most of public primary health facilities are located in rural areas, most of them are far from bank facilities. During procuring of medicines, the distance may have an effect due to the fact that, there is a limited transport and poor infrastructures in most of rural facilities. This variable therefore determined the effect of distance between the health facility and the bank on the extent health facilities utilized funds to procure medicines. It was measured as a proportion of facilities affected by their distance from bank during utilization of cost sharing funds for procuring medicines and supplies.

3.7. Pre-testing of Questionnaires.

The questionnaires were pre-tested in Mkuranga District Council. Selection of Mkuranga district was based on similarities with the study area. Both are rural councils. At least 20 individuals participated in pre-testing. It was done in order to check if questions were well understood and were logically and sequentially arranged. The pre-testing results determined whether the questions needed to be modified in terms of structure and content. It also gave an average time needed per interview. Modifications were done according to observed needs to suit the study objectives.

3.9. Data Management and Quality Control.

In this study, data collection was done from June to July 2013 by the research assistant and the principal Investigator. During data collection (field work), the principal investigator was responsible for supervising the filling of questionnaires and checking of all interviews to ensure they were correct. Close supervision enabled early detection of any error and corrections were done. Data transport was done using public and private transport in two divided portions to ensure safety.

3.9.1. Data entry and analysis.

Data were entered in the computer daily in the evening after field data collection.

Processing (entry, cleaning and validation) was done by using SPSS software version 16 and were analysed using frequency distribution, proportions and cross-tabulations. Associations between variables were obtained through cross tabulations. A Fischer's exact test was used to determine the P- Value at 95% Confidence Interval.

Presentation of study findings were done through narratives, bar charts and tables.

3.9.2. Ethical Issues.

Prior to the start of this study, an ethical clearance/approval was obtained from the Research and Publication Committee of the Muhimbili University of Health and Allied Sciences (MUHAS). The permission to conduct this study in Kyela District Council was sought from Regional Administrative Secretary of Mbeya Region and the District Executive Director of Kyela through the District Medical Officer.

All the study participants were asked for their consent and told the purpose of the study before they were asked to participate. Participants were also assured on the fact that in no way their names would be used and that information provided by them was used for research purpose only.

3.10. Limitations of the study

This study was conducted in one district. The information obtained may have a general picture of how cost sharing fund is managed at facility level and the challenges facing it. It may most likely serve as a fair estimate of the situation in most of public primary health facilities in Mbeya region as well as in the country. However, its results may not necessarily represent an accurate picture of how the funds are managed countrywide.

On the other hand, this study based mainly on quantitative aspect of research, if part of its objective was taken qualitatively such as perception on how cost sharing funds are utilized, more additional results would have been obtained.

CHAPTER FOUR

4.0. Results

The study population consisted of twenty five (25) public primary health facilities (24 dispensaries and one health centre) and seven members of Council Health Management Team (CHMT). The In charge of the health facility was the main respondent at the facility level. Most of the interviewed in charges 15 (47%) were Clinical Officers while 10 (31%) were Assistant Clinical Officers (ACO).Others were 4 (13%) Nursing officers and 2 (6%)Assistant Medical Officers, (AMO). At the CHMT levels, the District Medical Officer (DMO) and the District Pharmacist (DP) were the main respondents. The distributions of facilities under study by level of care were 24 dispensaries (96%) and one health centre (4%). The sex of respondents was distributed with majority (56%) males. With age, majority (31%) were in the age group of 41-50 years. Majority of interviewees (47%) were clinical officers as Table 1 shows.

Table 1: Socio-demographic characteristics of the study sample.

Socio-demographic information.	**Participants n(%).**
Type of facility	
Dispensary	24 (96)
Health Centre	1(4)
Total	**25 (100)**
Sex of head of unit	
Male	18 (56)
Female	14 (44)
Total	**32 (100)**
Age group of head of unit	
21-30 years	9 (28)
31-40 years	8 (25)
41-50 Ears	10 (31)
>50 years	5 (16)
Total	**32 (100)**
Level of education of head of unit	
Assistant CO	10 (31)
Clinical Officer	15(47)
Assistant MO	2 (6)
Nursing Officer	4 (13)
Assistant DO	1 (3)
Total	**32 (100)**

4.2. Extent of use of cost sharing fund and adherence to cost sharing guideline of 1997 in procuring medicines in public health facilities.

During the study, facilities in charges were asked if they had ever spent cost sharing fund for any activity in the past 12 months (June 2012 to May 2013). In case of expenditure, the In charge was asked if the funds were used partly for procuring medicines and supplies and the proportion used as compared to the minimum guideline requirement of 67% of revenues. For those who did not adhere to the guideline, reasons of not doing so were sought.

Overall, most of health facilities 23 (92%) utilized the fund for various activities, while 2 facilities (8%) did not utilize the fund for any activity in the past 12 months prior to this study. On the other hand, 17 (68%) of the facilities used cost sharing fund to procure medicines and supplies while 8 (32%) did not procure medicines and supplies regardless of the shortages they experienced. When In charges of the 8 facilities that did not use cost sharing fund were asked to provide reasons for not using cost sharing fund to procure medicines and supplies, half of them 4 (50%) said it was due to lack of knowledge on procedures for procuring medicines while the other half 4(50%) said it was due to complicated government procurement procedures. In general, most of facilities 14 (56%) spent less than 40% of cost sharing fund for procuring medicines, none spent cost sharing according to the guideline minimum requirement (67%) for medicines as shown in Table 2.

Table 2: Proportion of health facilities that adhered to the 1997 cost sharing guideline.

ADHERENCE CRITERIA	PERCENT OF FACILITIES REPORTED ADHERENCE. YES n (%)	NO n (%)	TOTAL n(%)
Facility has active bank account.	25 (100)	0 (0)	25 (100)
Utilized funds in any activity.	23 (92)	2 (8)	25 (100)
Utilized fund to procure medicines.	17(68)	8 (32)	25 (100)
Utilized at least 67% of funds for medicines.	0 (0)	25(100)	25 (100)
Utilized fund for activities other than medicines.	15 (60)	10(40)	25 (100)

4.3. Proportion of cost sharing fund spent for activities other than procuring medicines and supplies.

During the study, the extent cost sharing fund was utilized in purchasing commodities other than medicines and supplies were inquired.

It was found that, most facilities 15 (60%) utilized a great proportion (50-89%) of funds for activities others than procuring medicines and supplies. Only 7 (28%) of facilities utilized less than 50% of cost sharing fund for activities other than procuring medicines and supplies as shown in Table 3 below.

Table 3: Proportion of cost sharing fund spent for activities other than procuring medicines and supplies.

Proportion of fund utilized for activities other than medicines.	**Number of facilities n (%)**
50-89%	15 (60)
< 50%	9 (36)
Don't know	1(4)
TOTAL	**25 (100)**

4.4. In charges knowledge and accessibility to cost sharing guideline.

In order to determine the proportion of facility in charges who were aware of cost sharing guideline requirement, inquires particularly on procurement of medicines and supplies were made. They were asked if they are aware of the existence of the 1997 Cost Sharing Guideline. The majority 13 (52%) reported to be aware, while 12 (48%) were not aware. On the aspect of In charges being aware on the minimum guideline requirement for cost

sharing fund procuring medicines, most of them 19 (76%) were not aware, while only 6 (24%) were knowledgeable. However, most of health facilities 21 (84%) did not have a copy of the guideline for self reference as compared to only 4 (16%) who had a copy. See table 4 below.

Table 4: Proportion of Facility in charges who are knowledgeable on cost sharing guideline.

Knowledge and accessibility to guideline.	**Yes**	**No**	**Total**
	n(%)	**n (%)**	**n(%)**
Aware on existence of guideline.	13(52)	12(48)	25 (100)
Aware on minimum expenditure for medicines (67%).	6(24)	19 (76)	25(100)
Facility has a copy of the guideline.	4(16)	21(84)	25(100)

4.5. Extent of Supportive supervision and Mentoring of facility in charges.

The CHMT members and in charges were asked if there were supervision matrices and if supportive supervisions and mentoring to health facility workers was done. The supervision on improving cost sharing fund management and reducing incidences of shortage of medicines and supplies was particularly probed.

Overall, all 7 CHMT members and 25 in charges (100%) reported to have supervision matrix for facilities. This was verified by being shown copies of supervision matrix from the interviewees. According to facility in charges, during supervision visits in 25 facilities (as verified in HMIS book 12 which is also used for documenting supervision visits), the majority 13 (52%) of supervised facilities were not checked for medicines status, while only 8 (32%) were checked. The others 4 (16%) did not remember. The study needed to understand the steps that were taken to solve shortages of medicines encountered in health facilities during supportive supervision. The majority of CHMT members respondents 5 (71%) reported to solve the problem of shortages by supplying medicines from other nearby facilities, while only 2 (29%) reported to advice In charges to initiate procurement procedures using cost sharing fund as shown in Table 5 below.

Table 5: Percentage of supportive supervision that checked for drug status in facilities in the past 12 months.

Adherence criteria.	**Percent of facilities reported adherence.**		
	Yes	**NO**	**Total**
	n (%).	**n (%)**	**n (%)**
Supervision matrix in place	25 **(100**)	0 **(0)**	25(100)
Supervision conducted as scheduled.	10 (40)	15**(60)**	25(100)
Facility In charges mentored on cost fund management.	0(0)	25(100)	25(100)
Supervision checked drug status.	13 (52)	12 (48)	25(100)
Medicines procured.	2 (29)	23 (71)	25(100)

4.6. Presence of facility cost sharing bank account.

During the study, health facility in charges and the CHMT members were asked if the facilities had active cost sharing bank accounts. This is a requirement by the Ministry of Health and Social Welfare cost sharing guideline of 1997.

Overall, 25 (100%) of interviewed in charges reported to have active facility bank accounts for cost sharing fund with all signatories as required by cost sharing guideline of 1997. Likewise, 100% of the interviewed CHMT members reported all facilities having active cost sharing fund bank accounts. On ascertaining duration of the functional bank accounts, most of health facilities 17 (72%) had functioning account for more than 4 years, while the minority 8 (28%) has it for a period of between two to four years. There was no facility with a bank account that was not functioning.

4.7. Status of availability of medicines and supplies in health Facilities.

In order to understand the extent of availability of essential medicines and supplies in public primary health facilities, in charges were asked on any experience of incidences of shortages, its frequency and the common medicines that often faced shortages in the past 12 months (June 2012 to May 2013). Overall, majority of facilities 19 (76%) out of 25 experienced shortages of medicines in the past 12months. Only 6 (24%) facilities did not face shortages.

4.7.1. Frequency of shortage of medicines and supplies.

Most of the facilities 13 (68.4%) had experienced shortages once to twice a year. Facilities that had shortages 2-3 times a year were few 5 (26.3%), while only one (5.3%) facility had shortages more than 4 times a year. This information were obtained from in charges and then verified through checking in MSD medicines delivery registers that are used to document all medicines and supplies being supplied from MSD. These registers were available at the health facility. In general, the frequency of shortages was as shown in figure 2 below.

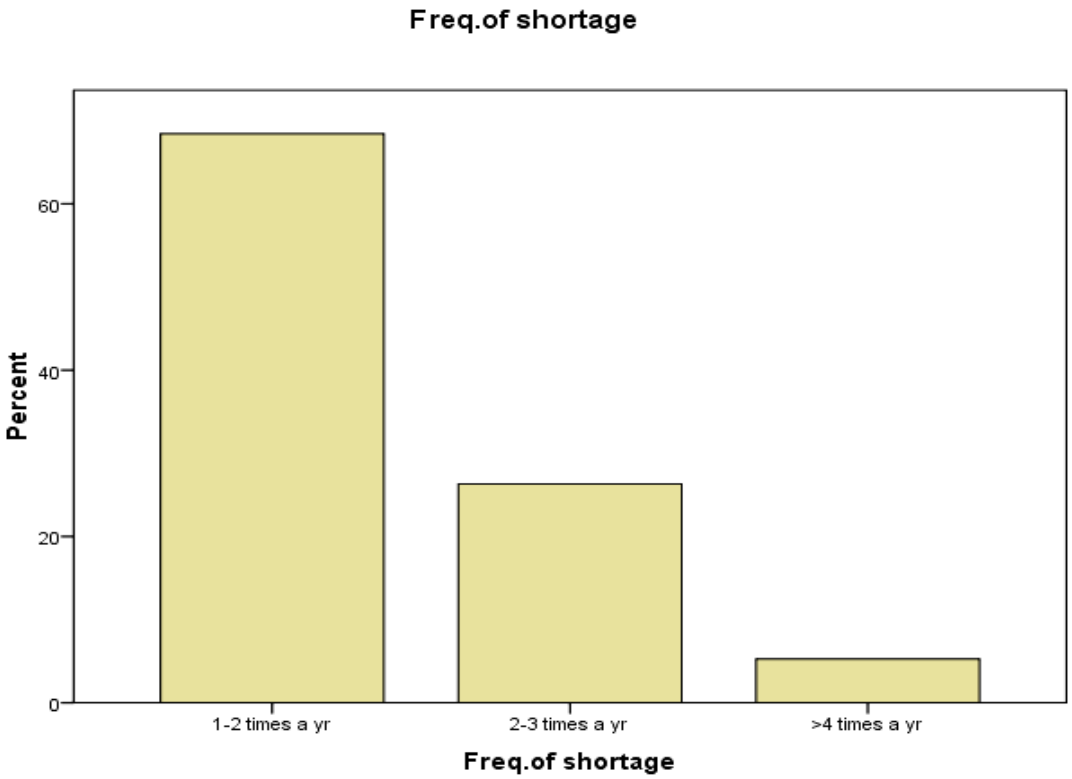


Figure 3: Proportion of facilities and their frequency of shortage of medicines and supplies in the year 2012, Kyela District council.

The CHMT members' responses on incidences of shortages of medicines in facilities were slightly higher than those reported by in charges. Out of the 7 interviewees, the majority 4 (57%) perceived shortages at an average of more than 4 times a year, while 3 (43%) perceived it to be at a range of 1-2 times a year.

On the type of medicines that facilities frequently experienced shortages, out of 19 facilities, most of them 13 (68.4%) reported that antibiotics were commonly out of stock, while 5 (26.3%) said it was antimalarials. On the other hand, only one facility (5.3%) said it was the pain killers. The interview responses were verified through checking into facility dispensing registers, where in case medicines are out of stock, records are kept. These findings are summarized in table 6 below.

Table 6: Type of medicines reported to be frequently out of stock in health facilities.

Type of drug in shortages.	**n (%)**
Malaria medicines	5 (26.3)
Antibiotics	13(68.4)
Pain killers	1(5.3)
Total	**19 (100)**

4.7.2. Timely supply of 'ILS' medicines to health facilities.

As far as medicines and supplies is concerned, all public primary health facilities are enrolled in an 'Integrated Logistic System' for a timed (usually once quarterly) supply of medicines from the Medical Stores Department (MSD). The CHMT members were asked on timely supply of medicines and supplies to facilities. Overall, the majority 6 (86%) reported to have medicines rarely supplied on time, while only 1 (14%) reported timely supply. On the other hand, most of the health facility respondents 22 (88%) reported that medicines were always supplied late from MSD to their facilities. The other 3 (12%) reported to have medicines rarely supplied on time. This information was then verified by checking medicine and supplies registers and delivery invoices from MSD to the DMOs office. The registers showed the date, amount of medicines/supplies ordered, amount actually delivered and the time it was to be supplied compared to the time that the order has actually been delivered.

4.8. Reasons for under-utilization of funds for procuring medicines and supplies.

According to responses of in charges, 15 (60%) of facilities used more than 50% of funds for activities other than procuring medicines. Various reasons were given that led to utilizing cost sharing fund for medicines below the guideline requirement. Majority of In charges 13 (52%) gave a reason of not being aware on government procurement procedures, while 9 (36%) said it was due to bureaucratic government procurement procedures. The other 3 (12%) reported to have all the essential medicines most of the time. The CHMT members were also asked on the reasons that lead to facilities spending funds less than the guideline requirements. Overall, 4 (57%) said it was due to inadequate funds management capacity at facility level as table 6 shows below.

Table 7: Reasons given for non-adherence to guideline.

Reason for non-adherence.	**Number of health facilities**		
	Yes	**No**	**Total**
	n (%)	**n (%)**	**n (%).**
All essential medicines were available.	3 (12)	22 (88)	25 (100)
Not aware on procurement procedures.	13 (52)	12 (48)	25 (100)
Beurocratic procurement procedures	9 (36)	16 (64)	25 (100)

4.9. Main challenges facing utilization of cost sharing fund to procure medicines.

The in charges and CHMT members were asked on what were the main challenges affecting management of cost sharing fund for procuring medicines and supplies as per 1997 guideline.

Overall, 12 (48%) in charges said it was due to inadequate knowledge on general cost sharing fund management at facility level. Some 6 (24%) said it was due to long distances from facilities to bank, 5 (20%) said it was due to beurocratic government procurement procedures while 2 (8%) said it was due to inadequate technical support at council level. See Table 9 below.

Table 8: Main challenges affecting proper utilization of cost sharing funds in health facilities.

Main challenge faced.	**Number of facilities** **Responded Yes** **n (%)**
Inadequate knowledge	12 (48)
Long distance to bank	6 (24)
Beaurocratic procurement procedures	5 (20)
Inadequate technical council support.	2 (8)
Total	**25 (100)**

4.9.1 Lack of proper Annual plans for procurement of medicines and supplies.

According to the Comprehensive Council Health Plan (CCHP) guideline of 2012, all health facilities' individual procurement plans must be prepared at the facility level. The plans are then submitted to the council level before the planning sessions to be integrated in the council plan. However, during the study, some CHMT members and in charges reported to face some challenges during implementation. These challenges were mainly due to in charges failing to plan and submitting their plans late. The other challenge was lack of enough copies of the CCHPs for in charges to make reference of their activities that have been incorporated. This situation results into CCHPs being prepared without including activities of some facilities while some in charges remain uninformed.

Therefore, facilities in charges were asked if their facilities had planned for procurement of medicines and supplies in the financial year 2012. Overall, majority of in charges 19 (76%) reported not having the plan for using cost sharing funds to procure medicines, while only 2 (8%) reported to have the plan and 4 (16%) did not know if their plans were incorporated in the CCHP or not (as shown in Table 9). Similarly, majority of CHMT members 5 (71.4%) reported that more than 50% of facilities did not have a plan for medicines and supplies in the 2012/2013 CCHP. Not only that, but also, none of the few facilities that had an annual plan for medicines and supplies actually implemented as planned. These information were verified through checking activities of each facility in the 2012/13 CCHP.

Table 9: Proportion of health facilities that had annual plans for procurement of medicines and supplies as reported by facility in charges.

Presence of annual plan for medicines.	**Number of facilities' Responses n (%)**
Yes	2 (8)
No	19 (76)
Don't know	4 (16)
Total	**25 (100)**

4.9.3. Association between Extent of utilization of cost sharing fund and other factors.

In this study, there were various variables that were likely to have associations. In order to ascertain the associations between the extent of utilization of cost sharing fund and other variables, cross-tabulation was done. The results were determined on their statistical significance at 95% Confidence Interval. In this study, the Fischer's exact test was used in all cross tabulation tables that had some of values less than five. The following tables show the associations between variables.

Table 10: Association between Knowledge of facility in charge and the extent of cost sharing fund used for medicines.

Knowledge of In charge	**Fund utilization for medicines.**		
	Yes	**No**	**Total**
	n (%)	**n (%)**	**n (%)**
Knowledgeable on guideline	11 (85)	2 (15)	13 (100)
Not knowledgeable on guideline	3 (27)	9 (73)	12 (100)

Fischer's exact test, P =0.018 at 95% Confidence Interval.

Table 10 shows that, health facilities led by in charges who were knowledgeable on the guideline utilized a bigger proportion (85%) of cost sharing fund to procure medicines and supplies compared to only 27% spent by facilities led by In charges not knowledgeable on the guideline. This difference in proportion of number of facilities that utilized cost sharing fund to procure medicines between the facilities with knowledgeable and those not knowledgeable is statistically significant (P <0.05).

Table 11: Association between utilization of cost sharing fund to procure medicines and frequency of shortage of medicines.

Utilization of fund for medicines. (%)	**Frequency of shortages /year**
Utilized 40-66 %	1-2 times/ year **(67)**
Utilized < 40%	3-4 times/ year (**75)**
None	> 4 times/year **(85)**

Fischer's exact test, P= 0.04 at 95% Confidence Interval.

The table above shows that, health facilities that did not use cost sharing fund for procuring medicines had the highest frequency (> 4 times/ year) and highest proportion (85%) of facilities experiencing shortages of medicines and supplies. Those facilities that had the highest proportion (40-66%) of fund utilized for procurement of medicines have the lowest frequency (1-2 times a year) and proportion of facilities (67%) experiencing shortages of medicines.

This difference is statistically significant (P< 0.05) at 95% Confidence Interval.

Table 12: Association between awareness on the guideline and extent of facility utilizing cost sharing fund for procuring medicines.

Awareness on guideline	**Number of facilities utilized the fund.**		
	Yes	**No**	**Total**
	n (%)	**n (%)**	**n (%)**
Aware on guideline	9 (69)	4 (31)	13 (100)
Not aware on guideline	8 (66)	4 (34)	12 (100)

Fischer's exact test, P= 0.89 at 95% Confidence Interval.

The table above shows that, a slight majority (69%) of facilities with charges who had knowledge on cost sharing guideline used cost sharing fund for procuring medicines compared to those whose in charges were not aware on guideline requirement. However, the difference is slight and statistically not significant, P > 0.05.

Table 13: Association between awareness of guideline requirements and frequency of shortage of medicines.

Awareness on guideline	**Frequency of shortages**			
	1-2times/year.	2-3 times/year.	> 4 times/year.	Total
	n (%)	n (%)	n (%)	n (%)
Aware on guideline	7 (64)	4 (36)	0 (0)	11(100)
Not aware on guideline	1(12.5)	6(75)	1 (12.5)	8 (100)

Fischer's exact value, P = 0.029 at 95% Confidence Interval.

As depicted by the table above majority (64%) of facilities led by in charges that were aware of cost sharing guideline requirements had shortage frequencies of 1-2 times a year. Few facilities (36%) had shortage at an average of 2-3 times a year. On the other hand, most of facilities (75%) of those led by in charges that were not aware on guideline had more severe frequencies of shortages of medicines. Shortages were at an average of 2-3 times a year, with one having shortages more than four times in a year. This difference is statistically significant, $P < 0.05$.

Table 14: Association between supportive supervision and in charges knowledge on fund management at facility level.

Frequency of supervision	**Knowledge on fund management.**		
	Yes	**No**	**Total**
	n (%)	**n (%)**	**n (%)**
Not supervised	4 (40)	6 (60)	10 (100)
1-3 times per year	7 (58)	5 (42)	12 (100)
4 times or more per year	2 (67)	1 (33)	3 (100)

Fischer's exact test, P = 0.58 at 95% Confidence Interval.

The table shows that, facilities that were supervised four times or more per year had the highest proportion (67%) of knowledgeable in charges in management of cost sharing fund as compared to facilities that were not supervised which had the lowest proportion (40%) of knowledgeable in charges. It was seen that, supervised facilities are two times more likely to be competent on fund management than the unsupervised facilities. However, this difference was not statistically significant, p> 0.05.

Table 15: Association between adherence criteria and stock out of medicines.

Adherence criteria	**Stock out in a facility/year n (%)**			**Total n (%)**
	1-2	3-4	>4	
Utilized < 67%	2 **(8)**	3 **(12)**	12 **(48)**	17 **(100)**
Utilized at least 67%	6 (**24)**	1 **(4)**	1 **(4)**	8 **(100)**

Fischer's exact test, P = 0. 03 at 95% Confidence Interval.

Table 15 shows that, among health facilities that did not adhere to utilization of the minimum proportion of cost sharing fund to procure medicines and supplies, most of them 12 **(48%)** had the highest frequency of stock outs (> 4 times / year). On the other hand, most of health facilities 6 **(24%)** that adhered to utilization of funds as per guideline had the lowest frequency of stock outs (1-2 times/ year).

This difference was statistically significant, P< 0.05 .

CHAPTER FIVE

5.0. Discussion.

5.1. Introduction

The Ministry of Health and Social Welfare introduced a Cost Sharing Guideline in 1997 in order to guide and ensure cost sharing funds are properly utilized.

The guideline requires health facilities to spend at least 67% of funds for procuring medicines and supplies to supplement shortages.

Despite of the existence of the guideline requirements, most of public primary health facilities have persistent shortages of medicines and supplies at an average of 40% (TGPSH 2011).

5.2. Presence of health facility cost sharing bank account

This study has showed that, some of cost sharing fund guideline requirements were fulfilled, while most of others were not being adhered to. During the study, it was found that, all public primary health facilities 25 (100%) included in the study had active cost sharing bank accounts with all signatories as required .Therefore, from these findings, it can be seen that, presence of cost sharing bank account does not necessarily mean that facilities adhere to cost sharing guideline. These facilities had funds that were not effectively used to procure medicines and supplies .Other studies have shown similar findings that, presence of cost sharing fund did not determine the extent funds were utilized to procure medicines and supplies. Other factors such as knowledge of in charges, simplified public procurement procedures etc were mandatory for an effective fund utilization (TGPSH 2011, Family & January 2009, Khalafalla & Ali 2009).

5.3. Extent of utilization of cost sharing fund for procurement of medicines and supplies.

In this study, it has been shown that, health facilities utilized very low amount of cost sharing fund to procure medicines and supplies. Most of funds were utilized for activities other than procuring medicines and supplies. For example, majority of facilities (92%) utilized the funds for various activities in the past 12 months (June 2012 to May 2013). A good proportion of facilities (68%) utilized the funds for procuring medicines and supplies. However, all the facilities that utilized cost sharing fund for medicines and supplies, they utilized less than 40% of funds for medicines and supplies. On the other hand, 32% of health facilities did not utilize cost sharing at all for procuring medicines and supplies.

This is contrary to the 1997 guideline that requires facilities to spend at least 67% of funds for medicines and supplies. This may be one of contributory factors to the serious shortages of medicines and supplies in most of facilities.

The quality of health services depends on many factors, among of them is the availability of resources that are well organized and managed (Smith 2002, G.M A et al 2005).

Cost sharing fund is used worldwide in the health system to serve various purposes, particularly to improve availability of medicines and supplies (Family & January 2009).

In German and Switzerland, cost sharing fund is mainly used to procure medicines, medical equipments and supplies (Family & January 2009). As well, In Africa, particularly Sudan and Ghana, cost sharing fund is mainly used to procure medicines and supplies. It has played a big role in reducing incidences of shortage of medicines in most of health facilities. This has improved the quality and accessibility of health services (Azakili et al 2012).

In Sudan, at least 70% of costs sharing fund revenues need to be utilized to procure medicines and supplies. However, in a study in done in Khartoum state (Sudan) in 2012 showed that, most of public facilities under-utilized cost sharing fund for procurement of medicines. Most facilities that were studied 15 (75%) utilized funds below the minimum proportion (70%) required for medicines. Various reasons were given, mainly being inadequate knowledge of the facility managers and ineffective supervision to facilities (Khalafalla & Ali 2009). These findings are similar to those found in this study.

In Tanzania, there is a Local Government Financial Memorandum (LGFM) 2004, which stipulates that, public funds need to be utilized according to plans. The Cost Sharing Guideline also requires facilities utilize collected funds to solve facility problems, including shortages of medicines and supplies.

Shortages of essential medicines and supplies in public health facilities pose a big challenge for populations to access quality health services (MoH &SW 2009, Alba et Al 2012).

As these shortages include essential medicines such as antibiotics (68.4%), antimalarials (26.3%) and pain killers (5.3%), it poses a major obstacle for populations to access quality health services.

The findings of this study are similar to those found in Sudan. However, in Tanzania, all (100%) of facilities utilized fund below the guideline minimum requirement (67%). Furthermore, more than half (56%) of facilities utilized less than 40% of fund for medicines. Reasons given were similar to those found in Sudan. The reasons for under utilization were inadequate knowledge (52%), beurocratic procurement procedures (28%) and long distance to bank (20%). However, there were differences in the proportion of facilities that did not adhere to guideline requirements in Tanzania (100%) compared to 75% of the Khartoum state. These differences might be due to more simplified special public procurement procedures for hospital supplies in Sudan compared to Tanzania. Also, all of facilities studied in Khartoum state are located in urban areas where access to bank facilities is better than facilities in this study which all of them are located in rural areas.

The results are also similar to findings in a study done by Tanzania German Programme to Support Health (TGPSH) 2011. It was done to four regions (Mtwara, Lindi, Mbeya and Tanga). The study revealed that, most of health facilities do not utilize cost sharing fund to procure medicines that are out of stock as it is required by the guideline (TGPSH 2011).

However, although the findings of these two studies came up with the similar findings, there is a difference in the magnitude of facilities that use the funds for procuring medicines. In this study, the proportion of facilities that utilized cost sharing fund for medicines is higher (68%) compared to that found in the TGPSH study in the four regions (15%). This difference might be due to the fact that, this study was done in only one

district hence having a limited sample size which cannot be generalized to represent regions as done in the four regions.

5.4. Extent of use of cost sharing fund for activities other than medicines and supplies.

Most of public health facilities were found to utilize most of cost sharing fund mainly for activities other than procuring medicines and supplies. Some of facilities did not utilize it for medicines and supplies at all in the period of 12 months prior to the study.

This study has shown that, (60%) of facilities utilized about 50-89% of fund for activities other than medicines and supplies. The proportion of fund utilized for procurement of medicines was less than 40% for most of facilities.

On the other hand, the study found most of facilities (76%) had experienced shortages of essential medicines at least once to more than four times within the past 12 months. It was therefore anticipated the gap would have been filled up by procuring medicines using cost sharing fund.

However, the findings of this study shows that, the priority for procuring medicines in public health facilities lie low in their list, hence aggravating the situation of out of stock of medicines.

This hinders provision of quality health services to the community. Consequently, community satisfaction with quality of services is compromised.

As most of facilities experience frequent shortage of medicines and supplies without setting down effective procurement mechanisms, the capacities of in charges need to be improved. Various studies have shown that, most of facilities in charges do not have the required financial management capacities, leading into ineffective and improper utilization of cost sharing funds (Mtei et al 2012). Findings of the study have revealed similar findings, as most of in charges (76%) were not competent on guideline requirements and cost sharing fund management in general. This contributed to under-utilization of cost sharing fund for procuring of medicines and supplies.

5.5. Extent Facility In charges are knowledgeable on cost sharing guideline.

The study has revealed that, most facility in charges were not knowledgeable on the guideline and cost sharing fund management in general. It showed that, some of in charges (52%) were aware of the mere existence of the cost sharing guideline.

However, most of them (76%) were not aware on the guideline requirements, including the minimum proportion of cost sharing fund revenues that should be utilized for procuring medicines and supplies.

Not only that, but also, most of in charges (84%) did not have a copy of the guideline for self reference.

This means that, most of funds collected are not utilized for procuring medicines as required by the guideline, worsening the frequencies of shortages of medicines in facilities. For a proper and effective implementation of the cost sharing guideline, health facility in charges and other health workers need to be competent on the guideline. An important question is whether facility staffs who are often left with the day to day management of the funds are capable of handling fund in addition to delivering services to patients (Mulligan 2007). Lack of knowledge/capacity and experience in community mobilization and financial management is among the factors that have hindered the quality of services (Chee et al 2002, MOH 2006). Some studies recognized incompetence of facility and district staff in utilization of funds (Laterveer et al 2004).

5.6. Extent in charges are supervised and mentored on utilization of cost sharing fund.

This study has shown that, all the interviewed CHMT members (100%) and most of facility in charges (92%) had a copy of supervision matrix and showed it for verification. However, minority (40%) of supervisions were conducted as scheduled (as was shown in supervision reports and HMIS book 12). More than half (60%) of planned supervisions were not conducted.

Furthermore, the study has shown that, there were no any mentoring activities done to in charges for the past 12 months (June 2012 to May 2013). This fact reflects that, regardless

of inadequate knowledge on fund management among most of in charges, there are weak, if any deliberate efforts to improve their capacities.

It is therefore important for the CHMT members to strengthen supervision and mentoring activities to health facilities. Conducting supervisions and mentoring activities to facilities as scheduled in the matrix will improve fund management capacities at facility level.

As most of facilities (76%) reported experiencing incidences of shortage of medicines, supportive supervisions need to emphasize on checking drug status of facilities.

This study showed that, in the period of 12 months, only 52% of supervised facilities were checked for drug status. A good proportion (48%) of supervised facilities was not checked for drug status. This is a serious gap that needs to be addressed.

When supervisions check drug status, they do help facilities identify shortages or pending shortages on time. This enables facilities to have a prior planning and initiate procurement procedures on time.

Failure to do so leads into more frequent shortages affecting the quality of services. In this study, it was also found that, very few health facilities (29%) were advised to procure medicines using cost sharing funds in case of shortages. Most of CHMT members (71%) solved the problem of shortage of medicines encountered in one facility by supplying medicines from a nearby health facility. However, this was like shifting shortages from one facility to the other. Therefore, regardless of high incidences of shortage of medicines in facilities, supervision visits have shown little emphasis on advising in charges to procure medicines using cost sharing fund. This leads into facilities operating without adequate supply of medicines and supplies while they have funds dormant in their accounts. The funds that are collected are mostly utilized for procuring non-medical materials contrary to the guideline.

Supportive supervision and mentoring are activities of paramount importance in improving fund management capacity of in charges. In Ghana, well supervised facility in charges led to improved collection and expenditure of cost sharing funds. For example, in the year 2005/6, cost sharing fund accounted for 45% of health financing budget in Ghana. This was achieved through an effective supervision and mentoring of facility in charges and other health workers. It eventually enabled managers at facility level improve quality of health services that benefits all people across socio-economic classes (Ataguba & McIntyre 2012).

In Tanzania, supportive supervision is among the strategies to improve facility performances. According to the 1999 National supervision guideline, supervisions need to be planned and matrix prepared and communicated prior to conducting them in facilities (MOH&SW 2008a)

5.7. Challenges affecting procurement of medicines using cost sharing fund.

. This study explored the main challenges facing public primary health facilities in procurement of medicines and supplies through cost sharing funds.

It was found that, there were several challenges including the following:

5.7.1. Inadequate fund management capacity at facility level.

It was found that, most of facility in charges were not competent on cost sharing fund budgeting, collection, expenditure and reporting. A good proportion of in charges (48%) were not aware on their responsibilities in managing cost sharing funds. When CHMT members were asked on capacities of in charges in fund management, most of them (57%) reported that, the main challenge was in charges being incompetent. During the interview, it was noticed that some in charges were not capable of creating good atmosphere for improving cost sharing fund collection. When funds were collected, expenditures were not done, including not procuring medicines while facilities had shortages.

Some in charges reported that they were not aware of their authority to initiate procurement of medicines using cost sharing fund. This led into some facilities having accumulations of unspent funds for years in banks while their facilities are experiencing persistent shortage of medicines.

According to the cost sharing guideline, the facilities in charges are responsible with general management (Planning, collection, expenditure and reporting) of funds at facility level. When these workers are not capacitated to manage the funds, incidences of shortages of medicines and supplies will persist.

5.7.2. Long distance from Facilities to bank.

It was seen that, distance between health facilities and bank facilities had a role in extent of fund utilization. Most of facilities were affected by long distances, unreliable transport and poor infrastructures during processing procurement of medicines.

In this study, 24% of in charges reported long distance from their facilities to bank with poor infrastructures and transport system as one of the main challenges affecting utilization of fund for procuring medicines. They reported that, sometimes the process to reach the bank can take more than a month due to limited transport as they wait for council teams visit for supervisions or distribution in order to have transport to town.

Most of public primary health facilities are operating in rural areas, some being located in 'hard to reach' areas. Such facilities face remarkable challenges due to poor infrastructures such as roads, reliable transport and long distances to district head quarters where most of bank facilities are located. This situation poses a challenge on timely utilization of cost sharing funds for procuring medicines and supplies in case of shortages.

Findings of this study are different from those found in the Khartoum state. In the Khartoum study, long distance was not among the main challenges that affected utilization of cost sharing fund. This difference might be due to the fact that, the Khartoum state study was done in an urban setting where transport is not a problem as compared to this study which was done in a rural setting.

5.7.3. Complicated (bureaucratic) public procurement procedures.

Findings of this study showed that, complicated public procurement procedures had a significant role in reducing the extent facilities utilized funds to procure medicines and supplies. During this study, 20% of interviewed in charges and 43% of CHMT members reported complicated public procurement procedures as one of the main challenges affecting proper utilization of cost sharing fund for procuring medicines and supplies. This has led into most of facilities utilizing a small proportion of cost sharing fund to procure medicines and supplies. As a result, the availability of essential medicines and supplies have been highly jeopardized.

The government has set several procedures to which any public procurement process should adhere to. According to Local Government Financial Memorandum (LGFM) of

2004, all procurement transactions in councils are done by a procurement unit which is responsible to the District Executive Director. Facilities therefore need to identify their procurement needs and send their written requests to the Director. The Director authorizes the procurement unit to proceed with other processes, including advertising for tendering. When tenders are invited, the tender board conducts a meeting, scheduled once monthly or quarterly for awarding tenders ready for procurement. This process is long and beurocratic as it may take up to three months until it is affected. For issues concerning medicines and supplies, it is usually too late when procurements are affected.

Findings of this study are different from those of the Khartoum state study. In Khartoum state, it was revealed that, the delay of procurement of medical supplies was remarkably reduced after setting a special procurement system. In Tanzania, all procurements including procurement of medicines and supplies follow more or less the same procedures.

5.7.4. Lack of annual plans (CCHP) for procurement of medicines in facilities.

This study revealed that, most of health facilities (71.4%) did not have annual plans for procuring medicines. Among facilities which had an annual plan for procuring medicines, more than half of them (57%) partially implemented their plans as planned. The remaining facilities (43%) implemented less than 50% of planned activities. For facilities to conduct procurement activities effectively, emphasis should be put to proper planning of annual procurement plans.

This situation hampers facilities from effecting procurement of medicines and supplies as the transactions are not encoded in the government EPICOR accounting system. With the EPICOR system, all public budgets are entered in a computer server which is centralized. Therefore, no any procurement that will be done in case its information is not entered at the central server. It is therefore a role of facilities and CHMT members to ensure all plans are entered.

For government procurement to be effected, all procurement activities must be planned and indicated in the annual procurement plan. In case procurement activities (including those of procuring medicines) are not included in the annual plan (CCHP) and procurement plan, it will be difficult to implement them.

The Ministry of Health and Social Welfare has set strategies to improve quality of services provided in all health facilities. Among other prime priorities of the Health Sector Strategic

Plan (HSSP) III, is improving availability of essential medicines and supplies in facilities. This target will be reached through improving budget allocation for medicines and supplies as well as ensuring effective utilization of other revenues such as cost sharing fund for procuring medicines and supplies from alternative supplies in case of shortages through Integrated Logistic System.

CHAPTER SIX

Conclusions and Recommendations.

Conclusions

From this study, the following can be concluded;

- All of public primary health facilities have cost sharing bank accounts, however utilization of funds poorly adhere to Cost Sharing Guideline.
- Utilization of cost sharing fund for procurement of medicines and supplies in public primary health facilities as required by the 1997 Cost Sharing Guideline is very poor despite persistent shortages of medicines.
- Most of cost sharing fund in public primary health facilities is utilized for activities other than procurement of medicines and supplies.
- Due to better utilization of cost sharing fund for procuring medicines, health facilities led by in charges who are knowledgeable on cost sharing fund management have a better supply of medicines and supplies.
- Inadequate financial management capacity of in charges, beurocratic public procurement procedures and long distances from health facilities to bank are the main challenges affecting utilization of cost sharing fund for procurement of medicines and supplies.

Recommendations

- With the current persistent shortage of medicines and supplies in most public primary health facilities, the Ministry of Health and Social Welfare should re- examine the impact of cost sharing fund in procurement of medicines and consider more effective alternative options. These options should include: setting a special, simplified public procurement regulation specific for medicines, medical equipments and supplies.
- As routine supervisions in public facilities often overlook checking drug status, the current supervision checklists and HMIS books should be enriched with drug status information to be regularly checked during supervisions.
- The MSD system of supply of medicines in public facilities should be reviewed and strengthened to come up with an effective drug supply mechanism. Increasing the government budget to MSD, Human Resource and reliable transport for drug distribution may be useful in improving timely and adequate supply of medicines and supplies to health facilities.
- Cost sharing fund management capacities of health facility in charges should be strengthened. This may be done through including cost sharing fund management entity in the curriculum of health professionals and strengthening supportive supervision and mentoring activities in facilities.
- As preparations of facility annual and procurement plans is a big challenge at facility level, CHMT members should strengthen capacity development to in charges on planning to enhance their performance. This may be done by conducting special training programmes on guideline requirement and proper fund management to facility in charges. This activity should be continuous in every financial year, as most workers keep changing with time.
- The Ministry of Health and Social Welfare should ensure there is adequate distribution and availability of cost sharing guidelines to all public health facilities. This will enhance knowledge of health workers on proper fund management through self reference.

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APPENDICES

Appendix 1: Informed Consent Form

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS, MUHAS

ID-NO. ☐☐

Consent to participate in study

Greetings,

My name Dugange Festo John, Working for School of Public Health and Social Sciences at Muhimbili University of Health and Allied Sciences in Dar es Salaam.

Purpose and Description of the Study

Dear respondent I would like to inform you that this is a research study titled "Utilization of cost sharing fund and its associated factors in procurement of medicines/supplies in public primary health facilities in Kyela District Council'. I would like to give you information about your participation in the study.

This study is aiming at explore the extent of use of cost sharing funds for procuring medicines/ supplies in public primary health facilities and its associated factors. Kindly be honest and true for betterment of the results that could lead to better intervention and recommendations in future.

Confidentiality

We will protect and treat the information you will be providing with high confidentiality to the best of our knowledge. We will not write your name on the questionnaire or in any report/documents that might let someone identifies you. Your name will not be linked with the research information in any way. The investigators will take care of the data. And information collected. However, the final results after the analysis will be shared with national stakeholders and I will submit the manuscript for publication in scientific journals.

Right and withdrawal alternatives

Your participation is voluntary. You may decline from participation to the study at anytime during interview even if you have consented to participate. Your decision to participate or not will not be associated with your right to work in the facility. There is no penalty for refusing to participate on the study. You will not experience any loss if you refuse to participate in this study.

Benefits

The information you provide will help to increase our understanding and give a clear picture on the extent to which cost sharing fund is utilized in procurement of medicines/ supplies and the main challenges affecting its implementation. This can therefore help in providing useful information and contribute to future health care policy formulation and strategic planning.

If any damage will occur

It is not expected that there will be any damage for your participation as the respondent to this study.

Risks

There is no harm for participating in the study. However, you are free to stop participation at any time during this discussion in the event you feel uncomfortable.

Who to Contact

If you ever have questions about this study, you should contact the **Principal Investigator**, Dr. DUGANGE Festo John (0754-725458) of Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam.

If you ever have questions about your rights as a participant, you may call **Prof. M. Moshi, Chairman (Research and Publications Committee, MUHAS. P.O.Box 65001,** Dar es Salaam – Tanzania, Tel **+2552150302-6**); and **Dr. M. Mwangu** who is the supervisor of this study (Tel. **0713-253513**)

Signature:

Do you agree?

Participant agrees …….. Participant does NOT agree …….....……

I ……. have read the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of participant ……

Signature of Research Assistant ……..

Date of signed consent ……

DECLARATION

The above document describing utilization of cost sharing funds and its associated factors in procurement of medicines and supplies in public primary health facilities in Kyela DC has been read and explained to me and I have agreed to participate. I certify that the nature and purpose, the potential benefits and possible risks associated with participating in this study have been explained to me.

Signature or Right Thumb stamp of the respondent.....DATE.....

Signature of Research Assistant.....……..... DATE.....

Appendix 2: Informed Consent Form, Kiswahili version

CHUO KIKUU CHA SAYANSI ZA AFYA MUHIMBILI

KURUGENZI YA TAFITI NA UCHAPISHAJI

FOMU YA RIDHAA

Namba ya utambulisho ☐☐

Ridhaa ya kushiriki kwenye utafiti

Hujambo! Ninaitwa ……, nashughulika kwenye utafiti huu wenye lengo la kutathmini matumizi ya fedha za uchangiaji huduma za afya na changamoto zake katika ununuzi wa madawa kwenye vituo vya serikali wilayani Kyela.

Madhumuni ya Utafiti

Utafiti huu unafanyika katika kutimiza sehemu ya matakwa ya shahada ya uzamili ya afya ya jamii ya Chuo Kikuu cha Afya na Sayansi ya Tiba Muhimbili. Utafiti unalenga kuchunguza matumizi ya fedha za uchangiaji huduma za afya katika kununua madawa pindi vituo vinapoishiwa baadhi ya madawa hayo. Tafadhali kuwa mkweli na muwazi kwa vile matokeo ya utafiti huu yanaweza yakatoa maamuzi na mapendekezo ya baadaye.

Nini kinahitajika ili kushiriki

Ukikubali kushiriki katika utafiti huu, utasailiwa ili kuweza kujibu maswali toka kwenye dodoso lililoandaliwa kwa ajili ya utafiti huu.

Usiri

Taarifa zote zitakazokusanywa kupitia dodoso zitaingizwa kwenye ngamizi kwa kutumia namba za utambulisho.Kutakuwa na usiri na hakuna mtu yeyote asiyehusika atakayepata taarifa zilizokusanywa.

Hatari

Hatutegemei madhara yoyote kukutokea kwa kushiriki kwako kwenye kwenye utafiti huu.

Haki ya kujitoa au vinginevyo

Ushiriki katika utafiti huu ni wa hiari. Unaweza kuacha kushiriki katika utafiti huu muda wowote hata kama ulikwishatoa idhini yako. Kukataa kushiriki au kujitoa kutoka kwenye utafiti hakutahusisha adhabu yoyote.

Faida

Kama utakubali kushiriki kwenye utafiti huu taarifa utakazotoa zitatuwezesha kutupa mwanga zaidi juu ya mtazamo za wafanyakazi wa afya kwenye matumizi ya fedha za uchangiaji kununua madawa katika vituo vya serikali. Matokeo ya utafiti huu yanaweza kutoa taarifa ambazo zinaweza kusaidia katika kuboresha sera ya huduma ya afya na mipango.

Endapo utapata madhara

Hutegemewi kupata madhara yoyote kutokana na ushiriki wako katika utafiti huu.

Nani wa kuwasiliana naye

Kama una maswali kuhusiana na utafiti huu, wasiliana na Mtafiti mkuu wa utafiti huu, **Dr.DUGANGE Festo John (Tell. +255 754 72 54 58)** wa Chuo Kikuu cha Afya na Sayansi ya Tiba Muhimbili, S. L. P. 65001, Dar es Salaam.

Kama una swali kuhusu stahili zako kama mshiriki unaweza kumpigia simu kwa **Mwenyekiti wa baraza la Utafiti na machapisho Prof. M. Moshi, 65001, Dar –es Salaam. (Simu: 2150302-6)** au msimamizi wa utafiti huu **Dr. M.Mwangu** (0754 271 171).

Sahihi: .....

Je umekubali?

Mshiriki amekubali ……..... Mshiriki hajakubali …….....

Mimi ..... nimesoma maelezo ya fomu hii.

Maswali yangu yamejibiwa.Nakubali kushiriki katika utafiti huu.

Sahihi ya mshiriki……

Sahihi ya mtafiti msaidizi……

Tarehe ya kutia sahihi ya idhini ya kushiriki……..

Appendix 3: Questionnaire for Health Facility in Charges.

Utilization of cost sharing funds and its associated factors in procurement of medicines in public primary healthcare facilities in Kyela district council.

QUESTIONNAIRE 1: HEALTH FACILITY QUESTIONNAIRE.

(To be administered to the in charge of the health facility).

General instructions.

1. Any information collected will be strictly confidential.
2. Do not write names of interviewee or of health facility on the questionnaire
3. Circle or tick the number of the answer corresponding to the response

PART I: Background information.

1. Questionnaire number ……..
2. Name of interviewer ……..
3. Date of interview …….
4. Facility code …….

PART II: Basic Facility information.

Type of health facility.

1. Dispensary ☐
2. Health centre

PART III: Presence of Facility active bank accounts.

1. Do this health facility have a bank account for cost sharing fund?

1. =Yes ☐

2. = No

3. Don’t know

If No/don't know go to Qtn 2, If Yes go to Qtn 3.

2. What are the reasons for this facility operating without a bank account?

1. = Lack of accessibility to a bank

2. = Lack of knowledge on its importance

3. = Opening processes are ongoing.

3. How long the facility is having the bank account since it was opened?

1. = 1 year

2. = 2-4 years

3. =More than 4 years.

4. Do the health facility bank account have signatories as per guidelines?

1. =Yes

2. = No

3. = Don't know

PART. IV. Health facility status of medicines/supplies in the past 12 months.

5. Has your health facility at sometime experienced incidences of shortage of medicines in the past 12 months?
   1. = Yes
   2. = No
   3. = Don't know
6. How many times this facility experienced shortage of medicines/supplies in the past 12 months?
   1. =1-2 times
   2. = 3 – 4 times
   3. =More than 4 times

7. What are the commonest essential medicines that often run out of stock in your facility?
   1. =Antimalarials
   2. =Antibiotics
   3. Analgesics

PART V: Utilization of Cost sharing fund as per 1997 guideline.

8. Has your facility utilized cost sharing fund in any activity in the past 12 months?
   1. = Yes.
   2. =No.
   3. Don't know

9 .Have the facility spent cost sharing fund for procuring medicines/supplies in the past 12 months?

   1. =Yes
   2. = No
   3. =Don't know

   If No go to Qtn 10, if yes go to Qtn 11.

10. What were the reasons of the facility not using cost sharing fund to procurement of medicines/supplies in the past 12 months?
    1. =There was no shortage of any medicines/supplies.
    2. =Not aware on procedures for procuring medicines
    3. = Complicated government procurement procedures.

11. What is the proportion of cost sharing fund spent for procuring complementary medicines/supplies in the past 12 months? (Calculate the percentage of amount spent for medicines in cost sharing files/Total fund spent in 12 months)

1. = ≥ 67%

2. = 40-66%

3. = Less than 40%.

If the answer is 2 or 3 above, go to Qtn 12 If answer is 1, go to Qtn 13.

12. What were the reasons that led into utilizing less than 67% of cost sharing fund in procuring medicines?

1. = All essential medicines were always available
2. =Not aware on medicine procuring procedures
3. = Complicated procurement procedures
4. = Others, (explain) …….

13. What is the proportion of cost sharing fund spent for activities other than procuring medicines in the past 12 months? (Calculate the percentage of amount spent for activities other than medicines in cost sharing files/Total fund spent in 12 months)

1. = ≥ 90%
2. = 50-89 %
3. < 50 %.

PART VI : In charges Knowledge and use of Cost sharing guideline requirements.

14. Are you aware of the existence of the 1997 Cost sharing guideline of the Ministry of Health?

1. = Yes

2. = No

15. Do your health facility have a copy of the cost sharing guideline of the Ministry of Health for self reference? (If yes, please show the copy).

1. =Yes

2. =No

3. =Don't know

16. According to the cost sharing guideline, what is the minimum percentage of funds required to be spent for procurement of medicines/supplies?

1. = 55%
2. = 67% ☐
3. = 90%

17. What challenges do you generally face during implementing cost sharing guideline on collection, banking and expenditure of cost sharing funds?

1. = Inadequate knowledge on general cost sharing management
2. =Inadequate council support on collection and expenditure as per guideline.
3. = Long distances to bank.
4. = Others, (explain)……

18. In the last (2012/2013) financial year did this facility have annual budget plan for procurement of medicines/supplies?

1. = Yes ☐
2. = No.
3. = Don't remember

19. In the past 12 months, how many times was your health facility supervised/ mentored on cost sharing fund management? (Please verify supervision notes in HMIS book 2).

1. = None
2. = 1-3 times ☐
3. = 4 times and more.

If answer is 2or 3 go to Qtn 20.

20. During supervisions, did the supervisors check the drug status of the facility and advice to use cost sharing fund to procure medicines that were out of stock?

1. =Yes
2. = No ☐
3. =Don't remember

Appendix 4: Questionnaire for Facility in Charges (Swahili version)

DODOSO I: ZAHANATI NA VITUO VYA AFYA.

(Litumike kwa waganga wafawidhi wa vituo.)

SEHEMU I: TAARIFA ZA AWALI.

1. **Namba ya dodoso……..**
2. **Jina la msaili…….**
3. **Tarehe ya usaili ……**
4. **Namba ya kituo……..**

SEHEMU II: TAARIFA ZA MSINGI ZA KITUO.

Aina ya kituo

1. Zahanati
2. Kituo cha afya

SEHEMU YA III: UWEPO WA AKAUNTI YA BENKI KATIKA KITUO.

1. Je, kituo hiki kinayo akaunti ya benki kwa ajili ya kutunza fedha za uchangiaji huduma?

1. =Ndiyo
2. =Hapana
3. =Sijui

Kama ni Hapana nenda swali la 2, kama ndiyo/sijui nenda swali la 3.

2. Ni sababu zipi zilizofanya kituo hiki kukosa akaunti ya benki?

1.= Benki kuwa mbali na kituo
2. =Kutokuwa na ufahamu kuhusu umuhimu wake.
3. =Tratibu za kufungua zinaendelea

3. Ni kwa kipindi gani sasa kituo hiki kina akaunti ya benki tangu imefunguliwa?

1. = Mwaka 1.
2. =Miaka 2-4
3. = Zaidi ya miaka 4.

4. Akaunti hiyo ya kituo inawaweka saini kadri ya miongozo?

1. =Ndiyo
2. =Hapana
3. =Sijui

SEHEMU YA IV: Hali ya upatikanaji wa madawa /vifaa kituoni kwa kipindi cha miezi 12 iliyopita.

5.Kuna kipindi chochote katika miezi 12 iliyopita kituo chako kilipungukiwa dawa?

1. =Ndiyo
2. =Hapana
3. =Sijui

Kama jibu ni ndiyo nenda swali 6, kama Hapana/sijui nenda swali la 7.

6.Ni mara ngapi kituo kilipata upungufu wa madawa/vifaa tiba katika kipindi cha miezi 12 iliyopita.

1. = Mara 1-2.
2. = Mara 2-3.
3. = Zaidi ya mara 4.

7.Ni madawa gani muhimu ambayo mara nyingi kituo kimekuwa kikiishiwa?

1. =Dawa za malaria
2. =Antibiotic
3. Dawa za maumivu.

SEHEMU VI: Matumizi ya fedha za uchangiaji huduma za afya kadri ya mwongozo wa 1997.

8.Katika kipindi cha miezi 12 iliyopita, kuna fedha za uchangiaji zilizotumika katika shughuli zozote?

1. =Ndiyo
2. =Hapana
3. =Sijui

Kama Ndiyo,nenda swali la 9, kama Hapana nenda swali 10.

9. Katika kipindi cha miezi 12 iliyopita,kuna fedha zozote za uchangiaji huduma zilizotumika kununua madawa/vifaa tiba?

1. =Ndiyo
2. =Hapana
3. =Sijui

☐

10.Sababu zipi zilifanya kituo kisitumie fedha za uchangiaji kununua madawa katika kipindi cha miezi 12 iliyopita?

1. =Hakukuwa na upungufu wa madawa
2. =Kutokuwa na ufahamu wa taratibu za manunuzi ya dawa.
3. =Ukiritimba wa taratibu za manunuzi ya serikali.

☐

11.Katika jumla ya matumizi ya fedha za uchangiaji iliyotumika katika miezi 12 iliyopita, ni sehemu gani ilitumika kununua madawa?(Kokotoa asilimia ya fedha za madawa/Jumla ya fedha zilizotumika.)

1. = ≥ 67%
2. =40-66%
3. =Chini ya 40%

☐

Kama jibu ni 2 au 3 nenda swali la 12,kama jibu ni 1 nenda swali 13.

12.Unafikiri ni sababu gani zilifanya kituo kitumie chini ya 67% ya fedha za uchangiaji kununua madawa?

1. =Madawa yote muhimu yalikuwepo
2. =Kutokuwa na ufahamu wa taratibu za manunuzi
3. =Taratibu ngumu za manunuzi.
4. = Mengineyo (taja)…….

13. Ni sehemu gani ya fedha zilitumika kununua vitu mbali na madawa kwa kipindi cha miezi 12 iliyopita? (Kokotoa asilimia ya fedha zilizotumika kwa bidhaa zisizo za madawa/Jumla ya matumizi.)

1. = ≥ 90%.
2. = 50-89%.
3. = < 50%

SEHEMU VI: Ufahamu wa wafawidhi wa vituo juu ya muongozo wa fedha za uchangiaji.

14.Unafahamu kuwa kuna mwongozo wa wizara ya afya juu ya namna ya matumizi ya fedha za uchangiaji huduma?

1. =Ndiyo
2. =Hapana

15. Kituo hiki kinayo nakala yoyote ya mwongozo wa matumizi ya fedha za uchangiaji huduma kwa rejea? (Kama ipo, tafadhali onesha nakala hiyo).

1. =Ndiyo
2. =Hapana
3. =Sijui

16.Kwa mujibu wa mwongozo wa Wizara ya afya wa matumizi ya fedha za uchangiaji, ni sehemu gani ya fedha inatakiwa angalau itumike kununa madawa na vifaa tiba?

1. = 55% ☐
2. = 67%
3. = 90%.

17. Ni changamoto zipi unazipata wakati wa ukusanyaji, utunzaji na utumiaji fedha za uchangiaji huduma?

1. =Kutokuwa na ufahamu wa namna ya kutumia fedha kwa kununua dawa.
2. Msaada hafifu ngazi ya wilaya juu ya mahitaji ya mwongozo.
3. =Umbali mrefu kwenda benki. ☐
4. Mengineyo (taja)……..

18.Katika mpango kabambe wa afya wa mwaka uliopita (CCHP 2012/13),Kituo hiki kiliweka bajeti ya kununua madawa kwa fedha za uchangiaji?

1. = Ndiyo
2. =Hapana ☐
3. =Sikumbuki

19. Katika miezi 12 iliyopita, ni mara ngapi kituo hiki kilifanyiwa usimamizi saidizi juu ya matumizi bora ya fedha za uchangiaji?

1. = Hakuna
2. = Mara 1-3 ☐
3. = Zaidi ya mara 4.

20.Wakati wa usimamizi huo, hali ya madawa iliangaliwa na kituo kushauriwa kutumia fedha za uchangiaji kununua madawa yaliyokuwa yamekwisha?

1. =Ndiyo
2. =Hapana ☐
3. =Sikumbuki

Asante kwa ushirikiano.

Appendix 5: Questionnaire - CHMTs (English version).

COUNCIL HEALTH MANAGEMENT TEAM (CHMTs) QUESTIONNAIRE:

To be admitted to five (5) CHMT Members. (DMO, DPH, & 3 others)

General instructions.

1. Any information collected will be strictly confidential.
2. Do not write names of interviewee on the questionnaire
3. Circle or tick the number of the answer corresponding to the response

PART I: Background information.

1. Questionnaire number ……..
2. Name of interviewer ……..
3. Date of interview …….
4. CHMTs code …….

PART II: Adherence to 1997 cost sharing guideline.

1.In this district, what is the proportion of primary health facilities with bank accounts?

1. = Less than 50%
2. More than 50 %
3. 100%

If answer is 1 or 2 go to Q2 if answer is 3 go to Q 3.

2. What are the reasons for some of facilities operating without bank accounts as required by the guideline?

1. =Lack of HFGC signatories
2. =Beurocratic procedures to open a facility bank account
3. =Poor funds collection

3. In the past 12 months, what is the proportion of health facilities that spent at least 67% of cost sharing fund for procuring medicines/supplies? (Verify by calculating the percentage through facility cost sharing expenditure files-Those spent over 67%/ total No. of facilities X 100)

1. = Less than 50%

2. More than 50% ☐

3. =100%

If answer is 1 or 2 go to Q 4, If answer is 3 go to Q 5.

4. What do you think are the reasons for spending less than guideline requirement in procurement of medicines/supplies?

1. = Inadequate In charge capacities on use of funds. ☐

2. = Beurocratic procurement procedures

3. =Inadequate concentration on facility medicines needs.

PART IV: Status of medicines/ supplies in public primary health facilities in the past 12 months.

5. According to facility group in the 'Integrated Logistic System' (ILS) do all health facilities receive timely supply of medicines and supplies at least once in three months from MSD?

1. = Yes.
2. =Rarely. ☐
3. =No.

6.In average in the past 12 months, how many times did health facilities face shortages of essential medicines/supplies

1. = 1-2 times
2. =3-4 times ☐
3. = More than 4 times.

7. In case of shortage of medicines/supplies, how many health facilities used cost sharing fund to procure complementary medicines in the past 12 months? (Check in the cost sharing files)

1. = 1-5

2. = 5-12 ☐

3. = More than 18.

8. What are the main challenges affecting use of cost sharing funds in procurement of medicines for facilities?

1. = Inadequate capacity of In charges ☐

2. =Beurocratic procurement procedures

3. =Inadequate funds at facility level

4. =Others, (explain) ……..

PART V: Supportive supervision/mentoring of facility In charges.

9. Does the department have a regular supportive supervision schedule/matrix? (Show supervision matrix)

1. = Yes

2. = No ☐

3. =Don't know

10. During supportive supervision visits done in the past 12 months, how many facilities were checked for drug status? (Verify, Check in HMIS book 2 supervision information).

1. = Less than 9

2. = 9- 18 ☐

3. More than 18 facilities.

11. In case of shortages of medicines in health facilities, what do you normally do to solve the problem?

1. =supply medicines from other facilities

2. =advice in charges to initiate procurement through cost sharing funds.

3. =Wait MSD supply round

4. = Others (specify)……..

12. During supportive supervision, are there any mentoring activities to In charges on proper utilization of funds as per guideline?

1. =Yes

2. = No

3. = Don't remember

PART VI: Annual plans for procurement of medicines.

13.In the last financial year annual plan (2012/13 CCHP) how many facilities included annual budgets for procurement of medicines/supplies using cost sharing fund?(Check in the 2012/13 CCHP Plan)

1. = Less than 9

2. = More than 9

3. = All 18 facilities.

14. During implementation of the CCHP, how many facilities implemented as planned?.

1. =Less than 9

2. =More than 9

3. = All 18 facilities

15. In general, what do you think are the main challenges facing the department during procurement of medicines through cost sharing funds?

1. =Incompetent In charges to initiate processes
2. = Beurocratic procurement processes
3. =Inadequate CHMT support to facilities.
4. = Others (explain)……..

Thank You.

Appendix 6: CHMT Questionnaire (Swahili version).

DODOSO II: KAMATI YA USIMAMIZI WA HUDUMA ZA AFYA (CHMT).

(Kwa ajili ya usaili wa wajumbe watano (5) wa CHMT.)

Maelezo ya Ujumla.

1. Taarifa zote zitakazokusanywa ni siri.
2. Usiandike jina la unayemsaili.
3. Weka alama ya vema katika kiboksi au zungushia namba ya jibu.

SEHEMU I: Taarifa za awali.

1. Namba ya dodoso…….
2. Jina la msaili……..
3. Tarehe ya usaili…….
4. Namba ya Msailiwa (CHMT)…….

SEHEMU II: Utekelezaji wa muongozo wa uchangiaji huduma za afya wa 1997.

1. Katika Wilaya, ni sehemu/asilimia gani ya vituo vina akaunti za benki?
    1. = Chini ya 50%
    2. = Zaidi ya 50% ☐
    3. = 100%

Kama majibu ni 1 au 2 nenda swali la 2, kama jibu ni 3 nenda swali 3.

2. Ni sababu zipi zilizofanya baadhi ya vituo kukosa akaunti za benki za fedha za uchangiaji huduma za afya?
    1. =Ukosefu wa waweka saini kutoka kundi la wajumbe wa kamati ya usimamizi wa kituo (HFGC).
    2. Ukiritimba katika utaratibu wa kufungua akaunti za vituo ☐
    3. Vituo kukusanya mapato hafifu

3. Katika kipindi cha miezi 12 iliyopita, ni sehemu gani ya vituo vilitumia angalau 67% ya fedha za uchangiaji kununua madawa? (Kokotoa asilimia ya vituo vilivyotumia angalau 67%/ Jumla ya vituo vyote X 100)

1. = Chini ya 50%. ☐

2= Zaidi ya 50%.

3.= 100%.

Kama jibu ni 1 au 2nenda swali 4, kama jibu ni 3 nenda swali la 5.

4.Unafikiri ni sababu zipi zinapelekea fedha za uchangiaji kutumika chini ya 67% kununua madawa kinyume na mwongozo?

1. =Uwezo mdogo wa wafawidhi katika matumizi ya fedha hizo.
2. =Ukiritimba katika manunuzi
3. =Umakini mdogo katika suala la madawa vituoni ☐

SEHEMU IV: Hali ya madawa katika vituo vya serikali katika kipindi cha miezi 12 iliyopita.

5.Kutokana na kundi la kituo katika mfumo wa 'ILS' wa MSD, ni vituo vyote hupokea mgao wa madawa kwa wakati kila baada ya miezi mitatu?

1. =Ndiyo ☐

2. = Mara chache sana

3. = Hapana

6. Kwa wastani, ni mara ngapi vituo vilipata upungufu wa dawa kwa kipindi cha miezi 12 iliyopita?

1. = Mara 1-2
2. =Mara 3-4 ☐
3. =Zaidi ya mara 4.

7. Ikitokea baadhi ya vituo vimeishiwa baadhi ya madawa, ni vituo vingapi vilitumia fedha za uchangiaji kununua dawa hizo katika kipindi cha miezi 12 iliyopita?

1. = Chini ya 9.
2. = 9-18.
3. = Zaidi ya 18.

8. Ni changamoto zipi kwa kiasi kikubwa zinaathiri manunuzi ya madawa kupitia fedha za uchangiaji?

1. =Uwezo mdogo wa wafawidhi
2. =Ukiritimba katika manunuzi
3. =Fedha kidogo vituoni
4. = Mengineyo (taja)……

9. Idara ya afya inautaratibu maalum wa kuwa na mpango maalum wa usimamizi saidizi (supportive supervision matrix) wa vituo?

1. =Ndiyo
2. =Hapana
3. =Sijui

10. Wakati wa ziara za usimamizi saidizi, kwa kipindi cha miezi 12 iliyopita, vituo vingapi viliangaliwa hali ya dawa?

1. = Chini ya 9
2. = 9-18
3. = Zaidi ya 18

11. Ikibainika kuna upungufu wa dawa kituoni,hatua zipi huchukuliwa?

1. =Dawa huchukuliwa kutoka kituo kingine na kupelekwa katika kituo chenye upungufu.
2. =Huwashauri wafawidhi kununua dawa kwa kutumia fedha za uchangiaji.
3. =Husubiri MSD walete dawa zamu ikifika.

12. Wakati wa ziara za usimamizi saidizi, kuna mafunzo yoyote (mentoring) ambayo hutolewa kwa wafawidhi juu ya mwongozo wa Wizara?

1. =Ndiyo
2. =Hapana
3. =Sikumbuki

SEHEMU IV: Mipango ya mwaka ya ununuzi wa madawa vituoni.

13. Katika mpango kabambe wa afya wa mwaka uliopita (CCHP) 2012/13, ni vituo vingapi vilitenga bajeti ya fedha za uchangiaji kwa ajili ya kununua madawa?

1. = Chini ya 9
2. = 9-18
3. =Zaidi ya 18.

14. Katika utekelezaji mpango kabambe wa afya wa mwaka (CCHP) 2012/13, ni vituo vingapi vilitekeleza ununuzi kama ulivyopangwa?

1. = Chini ya 9
2. = Zaidi ya 9
3. = Zaidi ya 18.

15. Kwa ujumla, unafikiri ni changamoto zipi kubwa zinaikabili idara wakati wa ununuzi wa madawa kupitia fedha za uchangiaji vituoni?

1. =Uwezo mdogo wa wafawidhi
2. =Ukiritimba katika taratibu za manunuzi ya serikali
3. =Msaada mdogo wa CHMT kwenye vituo
4. = Mengineyo (taja)……

ASANTE