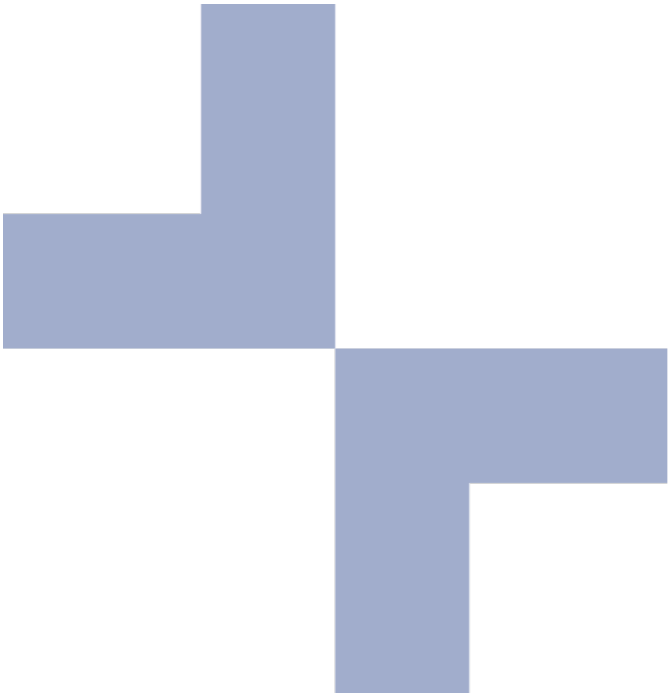
SHOPS PLUS

Access to Finance for Women-Owned Health Care Facilities:

Global Lessons from Tanzania



USAID
FROM THE AMERICAN PEOPLE

Recommended Citation: SHOPS Plus Project. 2021. *Access to Finance for Women-Owned Health Care Facilities: Global Lessons from Tanzania*. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates Inc.

Cooperative Agreement: AID-OAA-A-15-00067

About SHOPS Plus: Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is USAID's flagship initiative in private sector health. The project seeks to harness the full potential of the private sector and catalyze public-private engagement to improve health outcomes in family planning, HIV/AIDS, maternal and child health, and other health areas. SHOPS Plus supports the achievement of US government priorities, including ending preventable child and maternal deaths, an AIDS-free generation, and FP2020. The project improves the equity and quality of the total health system, accelerating progress toward universal health coverage.

Abt Associates Inc.
6130 Executive Boulevard
Rockville, MD 20852 USA
Tel: 301.347.5000 Fax: 301.913.9061
abtassociates.com

American College of Nurse-Midwives | Avenir Health | Broad Branch Associates
Banyan Global | Insight Health Advisors | Iris Group | Population Services International
William Davidson Institute at the University of Michigan

Access to Finance for Women-Owned Health Care Facilities:

Global Lessons from Tanzania

Contents

Abbreviations ii
Introduction 1
Activity scope 2
Findings—Gender Research 2
Access to Finance Solutions 4
Business and financial management 4
Financial product targeting women-owned health facilities 6
Invoice finance loan for ADDOs 6
Annex A. Summary of Gender Assessment Findings 9
Annex B. Business and Financial Management Learnings and Recommendations 25

Abbreviations

ADDO	Accredited Drug Dispensing Outlets
APHFTA	Association of Private Health Facilities in Tanzania
BDS	Business development support
CRS	Credit Reference System
CSSC	Christian Social Services Commission
DCA	Development Credit Authority
DMO	District Medical Officer
FGD	Focus group discussions
FSS	Financial services
ICT	Information communications and technology
ILO	International Labour Organization
MEFI	Medicines, Equipment, Facilities Infrastructure
MSME	Micro, small, and medium enterprises
PST	Pharmaceutical Society of Tanzania
SACCO	Savings and Credit Cooperative Organization
SACCOS	Saving and Credit Cooperative Society
SHOPS	Sustaining Health Outcomes through the Private Sector
TWCC	Tanzanian Women's Chamber of Commerce
WBO	Women business owner
WOB	Women-owned businesses
WOPHSF	Women owners of private health sector facilities

Introduction

The private health sector plays a critical role in meeting the health needs of women and the broader population. In fact, in many countries the private sector is a key provider of family planning, reproductive health, and maternal, newborn and child health. Recent data from an analysis of 36 countries show that on average, more than one out of every three modern method users rely on private sector sources (34 percent).[1]

Reliance on the private health sector continues to grow and as a result, there is an increased need for investment—investments to meet demands in terms of capacity, availability of health services and quality. The challenge the private health sector faces, and in particularly small- and medium-sized facilities, is difficulty in securing access to loans for these investments. While this constraint is universal for all small and medium enterprises, regardless of gender, it tends to disproportionately affect women-businesses.

Financial institutions, which are the primary source of financing, are hesitant to lend to the sector as they have concerns with lack of market information, credit risk, reputational risk and the poor quality of loan applications which are related to the lack of business training many of facility owners lack. As a result, the available financing for required investments is limited hence the sector faces and will continue to face significant challenges in meeting demand of the populations they aim to serve.

The Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project conducted a study of women franchisees which analyzed how women owners of private health sector facilities (WOPHSF) are empowered by the increased opportunities social franchising provides. The study noted that support such as training and access to finance improves the ability of women franchisees to deliver high quality health services, mentor younger women, make household spending decisions, and expand their businesses. The study also found that social franchises and the private health sector as a whole could take a more intentional approach to improving women's empowerment outcomes. Specifically, the study noted the importance of considering a women-specific business training and coaching program that targets gender barriers, such as risk-aversion related to credit and external factors such as family and community. Furthermore, it suggested evaluating potential ways to work with lending institutions or organizations to facilitate access to finance for franchise owners.

Given findings from the study and coupled with SHOPS Plus access to finance (A2F) activities in Tanzania, SHOPS Plus proposed building on the study. The overarching goal of the follow-on activity is to develop tailored A2F solutions for WOPHSF that encompass both business and financial management training and access to finance (bank loans). Expectations are that implementation of A2F solution will result in improved women empowerment outcomes and improved health outcomes.

[1] Bradley, S. and T. Shiras. 2020. *Sources for Family Planning in 36 Countries: Where Women Go and Why It Matters*. Brief. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

Activity scope

Gender analysis

A gender analysis aimed at identifying the barriers and opportunities that WOPHSF face in successfully running their businesses was conducted. The analysis considered relevant normative, policy, and regulatory frameworks, as well as access to markets, finance, assets, technology, and human capital, in the context of cross-cutting themes such as gender, cultural, and social norms. The analysis was guided by four research questions: (1) What is the overall landscape of WOPHSF in Tanzania, including the profile of the female business owners? (2) What barriers and opportunities affect these WOPHSF, in the context of: relevant normative, policy, and strategic frameworks; private health sector facility regulatory systems; and areas including assets, finance and credit, markets, and human capital and agency? (3) How do cultural, social, and gender norms impact WOPHSF and their ability to enjoy equality and access economic-empowerment opportunities? (4) What GBV—including sexual harassment—do WOPHSF face, and how does this impact their ability to enjoy equality and access economic-empowerment opportunities?

The analysis design and methods were modeled on the Women's Economic Empowerment and Equality (WE3) Technical Guide developed for USAID. This included literature review of secondary data related to the private health sector and female entrepreneurship in Tanzania, 17 semi-structured interviews with a range of stakeholders, and focus group discussions (FGDs).

Access to finance solutions

Based on barriers and opportunities identified through the gender analysis, SHOPS Plus evaluated potential to address barriers though development of A2F solutions. Specifically, the project adapted its approach in:

- Business and financial management training program tailored to women-owned health facilities.
- Financial product targeting women-owned health facilities that addressed challenges identified through the gender research.

Findings—Gender Research

The desk-based literature review and the primary research yielded a set of 36 key findings, organized by key research questions. The research team drew 14 broad recommendations that could be taken forward by several development actors in Tanzania, that could include the SHOPS Plus project, USAID and other donors, other development partners, and the Government of Tanzania. Annex A provides a summary of all findings.

SHOPS Plus A2F team analyzed findings and recommendations and determined to focus efforts in addressing seven of the findings through tailored business training and loan bank

product development activities. These seven findings that SHOPS Plus considered are summarized below:

1. Profile

   WOPHSF tend to be Accredited Drug Dispensing Outlets (ADDOs)[2] and maternity/nursing homes operating in rural and peri-urban regions with varying levels of registration/formalization.

2. Private health sector regulatory systems

   Long, expensive, and convoluted registration processes pose significant obstacles to initial business registration and there is limited evidence of administrative efforts to ensure that women are informed about business registration regulations and procedures or to assist them with complying.

3. Assets

   WOPHSF frequently lack sufficient business capital to operate their businesses, low levels of capital present a major obstacle to maintaining sufficient inventory their shops and to purchase equipment required to offer full quality services.

   WOPHSF often lack full control over household assets, notably land and real estate, resulting in insufficient collateral for loans.

   WOPHSF often lack authority over the allocation of household assets and may face more social pressure to share resources, which hinders their willingness and ability to invest in their businesses.

   WOPHSF' use of technology is largely limited to mobile phones used for basic business communication. According to one survey, 97 percent of female respondents in Tanzania are using their mobile phones to conduct business.

4. Finance

   WOPHSF mainly rely on personal savings, loans from family and friends, and other non-formal sources to finance their businesses, because of perceived high interest rates, collateral requirements, and high levels of stress related to managing formal debt. At the same time, WOPHSF are interested in formal credit with terms that meet their needs, and specifically that reduce their stress and fear related to interest rates and collateral.

   There is a perception that loan officers/financial institutions have low confidence towards WBOs in general, across sectors; at the same time, they have limited knowledge and experience with the private health sector.

   Women of retirement age, who make up significant number of WOPHSF (both current and potential), face compounded discrimination because of age and gender.

5. Markets

   Women-owned ADDOs typically face challenges in accessing financing to ensure their shops are stocked with high quality medications in adequate supply. ADDO owners stated that they often lack sufficient supplies to meet demand in their shop.

[2] 75 percent of Tanzania ADDOs are estimated to be owned by women.

6. Human capital and agency

   WOPHSF are aware of the need for business-related training but most have never participated in any type of business training; their training focus has largely been on clinical topics and not on business.

   Limited mentorship programs exist for female entrepreneurs, both in general and in the private health sector, despite evidence of their importance to business success.

   KIs note that they often lack self-confidence, especially related to their role as businesswomen versus their role as medical professionals.

7. Cultural, social, and gender norms

   Women business owner (WBO) FGD participants shared that they were burdened with more care work at home than their husbands.

   WOPHSF face male discouragement based on deeply rooted social and gender norms related to roles and responsibilities, expected behaviors, attitudes of superiority of men towards women, and GBV.

Access to Finance Solutions

With regards to the business and financial management, the SHOPS Plus team identified partners with which to develop a sustainable training program in an effort to ensure continuity and expansion. The training program was developed in partnership with local partners that will continue to offer program to its members, it leverages technology to reduce costs, and it is tailored to address broad (traditional and non-traditional business topics) findings from the gender analysis.

With regards to the financing challenge, the team built on existing partnerships with two local financial institutions. It's understood that in order to serve women owners of micro, small, and medium enterprises (MSME), financial institutions need to consider customized offerings which require an understanding of the market, research, and documentation of their needs for financial and support services. The SHOPS Plus team approached partner banks with both, a business case for developing customized offering to women owners of MSME, and proposals on loan products design.

Business and financial management

With the completion of the gender analysis, SHOPS Plus began the process of developing in business and financial management solution by initiating a conversation with a local sustainability partner. A social franchise was selected due to the organization's existing relationship with the project, and the belief that they had a substantial network of private sector health businesses, including women-owned health businesses, and resources to continue providing the training.

Concurrent to discussions with the social franchise, SHOPS Plus conducted a desk review of peer-reviewed and grey literature, gaining practical guidance on developing and adapting trainings using WhatsApp. The resulting brief presented the benefits of using WhatsApp as a

medium for capacity strengthening activities, best practices, potential challenges, and specific recommendations for designing and adapting trainings for WhatsApp in the health sector.

WhatsApp is a widely available and easy-to-use channel to deliver training. It can foster peer-to-peer learning in a safe and convenient environment, including in rural areas. Remote access to participants around the country or globe is particularly useful during the COVID-19 pandemic, during which travel, and gatherings are restricted in affected areas. Delivering training via WhatsApp is also cost-effective compared to traditional in-person trainings, which involve costs of venue rental, food, travel, and lodging. This pilot training aimed to test the feasibility and acceptability of delivering a capacity strengthening training via WhatsApp. The training was also designed to create a venue for participants to ask questions, share experiences, and exchange advice and support.

Module 12
Dear group member;
This week we will prepare a personal work plan that addresses the vision and goals of your business.
An action plan is a list of steps or tasks you need to complete to achieve your goals.....

Next, SHOPS Plus developed a training curriculum drawing subject matter content from the gender analysis, peer-reviewed and grey literature, and the design team's own expertise and research. The training was split into three modules:

- The **enabling environment** around women-owned private health sector businesses which explores relevant laws, policies, and strategic frameworks, formal and informal financing and credit, and mobile savings platforms and digital credit;
- **Interpersonal** factors that influence women-owned private health sector businesses success which explores gender and age discrimination in the financial sector and spousal dynamics and gender-based violence;
- **Individual agency** in strengthening WOPHSF performance, including the role of professional associations, networking, and action planning.

In addition to introductory and wrap up sessions, each module was split into four (4) sessions, totaling 14 sessions. Sessions were delivered through text messages, static images with content or links for additional study, and audio messages. The training curriculum presented an overview of the curriculum plan, including proposed dates for content delivery. It also provided a detailed description of each session, which outlined the purpose, time required for moderators, learning objectives, content/materials shared, procedure/methods for instruction, and other notes.

The training was delivered weekly over a three-month period. For sessions intended to share information, content was delivered at the beginning of the week, with related questions posed throughout the rest of the week to allow participants to engage when most convenient for them. The training curriculum offered fully developed text so that the lead moderator could simply cut and paste into WhatsApp, thus reserving time for facilitating conversation and answering questions. However, moderators were encouraged to adjust language and questions as needed.

Overall, the results of the pilot were positive. All participants provided a high score for methodology and content. Interestingly, 60 percent of participants indicated preference for training via WhatsApp to in-person trainings. The pilot also generated some important learnings that are being considered in the next iteration of the training. The pilot found that WhatsApp is a promising medium for delivering training, with some recommendations for future iterations, such

as: ensure there is sufficient time to co-create with the local partner; focus on learning objectives that are a good fit for the medium, such as the use of tools and processes; consider blended approach using WhatsApp in conjunction with more conventional training approaches; and ensure there is an adequate number of participants to produce robust conversation and sharing of insights.

SHOPS Plus is currently designing a follow-on WhatsApp training that will target clinics thought the Private Nurses and Midwives Association of Tanzania (PRINMAT).

Financial product targeting women-owned health facilities

While the business and financial management training pilot was fully implemented, the development and structuring of a financial product has been a lengthier activity. It is now in partial implementation with results available from a small pilot. Partly, this has been a result of challenges in gaining financial institutions management approvals on proposed products. In addition, financial institutions' focus has been on portfolio management (not growth) given economic situation, and travel restrictions resulting from the pandemic further delayed activities. Nonetheless, SHOPS Plus continues efforts of addressing findings through two different approaches.

1. Developing and implementing an invoicing finance loan product for ADDOs
2. Strengthening PRINMAT Savings and Credit Cooperative Organization (SACCO)

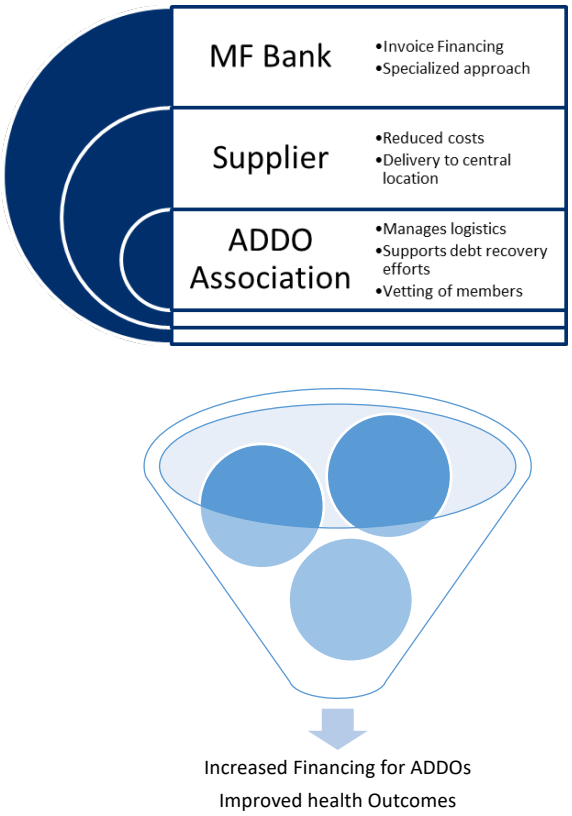
In addition, and in response to the focus groups participating in the gender analysis perception of gender discrimination in the financial sector, SHOPS Plus is in discussions with CRDB Bank[3] to design a “gender-friendly” sales model. The pilot would identify a bank female relationship manager that would be responsible for managing a pipeline of women-owned health facilities that have indicated interest in financing. The bank has indicated interest and the proposal is in discussion phase and given time remaining in project, there are questions as to time to implement.

Invoice finance loan for ADDOs

It is estimated that there are over 11,000 ADDOs in Tanzania, which represents an interesting business opportunity for financial institutions. These ADDOs tend to be women owner (estimated at 75 percent) and dispensers are mostly women (estimated at 90 percent). SHOPS Plus relied on information of size of market to make the business case to financial institutions and to get their buy-in.

[3] U.S. International Development Finance Corporation (DFC) partner bank.

SHOPS Plus and the bank structured an invoice financing mechanism that would address a number of barriers faced by women, including collateral requirements, difficult loan process, cost, gender discrimination, and profile.[4] Partners under the invoice financing mechanism included the financial institution, a pharmaceutical supplier, the local ADDO association, and ADDOs interested in accessing working capital loan for purchase of commodities. The microfinance bank relaxed its collateral policies and its loan application process. The ADDO association provides support in developing pipeline of borrowers, and support collecting any loans that are not paid as agreed. And the commodity supplier agreed to reduce prices for participants under the scheme and provide bank with invoices against which loan funds would be disbursed.



During the initial pilot phase, 30 ADDOs requested and were approved for loans. Approximately 15 percent of loan funds were used to increase inventories of family planning products, and 34 percent indicated expanding products offering. SHOPS Plus will be following up with borrowers to enquire as to their experience under the mechanism.

Implementation of activities has been slowed as a result of COVID restrictions, but expectations are for the product to be scaled in the pilot region and to be replicated in at least two additional regions in FY21. SHOPS Plus will leverage field funds to continue support.

Strengthening PRINMAT SACCO

PRINMAT clinics have a high percentage of women ownership and assessments conducted by SHOPS Plus have shown they have significant potential to expand service and product offered. However, the assessment found that, as did the gender assessment, access to finance is a significant barrier to growth and expansion of these clinics. In discussions with PRINMAT, SHOPS Plus learned that the association had a SACCO that had been establishment in 2009 to provide financing to its members. However, the SACCO had been poorly managed and as a result has not been active.

The SACCO is the ideal entity to meet the working capital needs of its member clinics. SHOPS Plus conducted a detailed review and evaluation of the SACCO and based on findings, developed a plan to strengthen the entity. The plan includes the establishment of a new active board, and new management team. The loan portfolio is now being actively managed, membership is growing, and new loans are starting to be disbursed. There are significant concerns to be addressed, including funding that will be required by the SACCO to grow its

[4] Invoice financing product is not restricted to ADDOs owned by women.

portfolio. Discussions are taking place and there are early indications are that the SACCO will be able to access a loan from a local financial institution.

It is still early to measure impact of the financial products developed to support Tanzanian women-owned health facilities. Indications from the women that own ADDOs and borrowed under the invoice finance scheme have been positive, and the bank has indicated its interest in scaling the product. The SACCO is in a difficult financial situation, but should it continue to strengthen operations and grow, it will be an ideal financing source for PRINMAT clinics. And efforts continue with CRDB Bank to develop sales model targeting women owners of health facilities.

Annex A. Summary of Gender Assessment Findings

1. Landscape of women-owned businesses (WOBs) in the private health sector of Tanzania, and profile of the business owners?

   Official sex-disaggregated data on private health sector facility ownership is not consistently available for all types of facilities; anecdotal and statistical data suggests that most WOPHSF tend to be ADDOs or maternity/nursing homes at the village level, while most higher-level facilities—dispensaries, health centers, and hospitals—are predominately male-owned. Only the

   The sex segregation of ownership by facility can likely be explained by traditional gender norms associated with courses of study in the medical field, in the context of regulatory requirements about the medical qualification required to oversee each type of facility. Although more than twice as many women as men graduated in the overall Health and Welfare field in 2018, according to the key informant from PRINMAT, doctors are predominately male while nurses and midwives are predominately female. The same representative emphasized that the predominately male doctors often hold gender-discriminatory attitudes of superiority and authority towards the predominately female nurses and midwives. Indeed, the professional training of FGD participants (i.e., WBOs of ADDOs, maternity/nursing homes, and dispensaries) was typically limited to ADDO dispenser/owner, nursing, and/or midwifery training. For higher-level facilities, regulatory requirements require oversight of operations by a medical doctor; thus, because sex segregation continues in the healthcare field—doctors tend to be male and nurses/midwives tend to be female—most higher-level facilities are presumably owned and managed by men, while ADDOs and maternity/nursing homes are predominately owned by women (with only ADDO dispenser/owner or nursing/midwifery certification).

   Defining a “women-owned business” in the private health sector is often difficult when assets are jointly owned by husband and wife, or when assets are officially owned by the husband even though the wife runs the business as her own. One key informant at CRDB Bank (which has a USAID Development Credit Authority [DCA] guarantee for the private health sector overall and WOBs specifically) noted that the bank had to open up the definition of WOBs to include businesses that are only partially owned by women.

   WOBs in the private health sector, notably maternity/nursing homes and ADDOs, have varying levels of registration/formalization.

   ADDOs and maternity/nursing homes—which are predominately women-owned—meet the health care needs for the most vulnerable and underserved in Tanzania. According to SHOPS Plus estimates, predominately women-owned ADDOs provide the first entry point into the health system for 75 percent of the country’s (predominately poor) rural and semi-urban population. Furthermore, maternity/nursing homeowners FGD participants explained that they provide a number of free maternal and child health programs and low-cost deliveries for women who are unable to afford health insurance or who live too far from public health facilities.

   WBOs of ADDOs tend to be “younger” (under age 50), while maternity/nursing home and dispensary owners tend to be “older” (above age 50) and often are retired from public

service; the WBOs are typically married and typically have completed at least a primary-level education (with most having obtained some secondary-level education) as well as some form of vocational/technical or university-level medical training. 4.1.2 What barriers and opportunities confront women business owners in the private health sector?

2. Normative, policy, and strategic frameworks

Some normative and policy frameworks in Tanzania that support economic development and empowerment do integrate gender, but none address the specific situation of WOPHSF. Likewise, policies that guide the private health sector do not address the gendered aspects of business ownership in the sector. Examples of relevant economic-empowerment laws and policies include: the Land Act and Village Act, guaranteeing the right to own property; the Prevention and Combating Corruption Act, addressing sexual harassment in public spaces related to operating a business; and the Microfinance Act and Policy, seeking to protect vulnerable groups—including women—from predatory practices of microfinance lending institutions. Other relevant policy and strategic frameworks include: the Small and Medium Enterprise Development Policy, that outlines how the government will facilitate disadvantaged groups, including women, in the development of their businesses; the National Financial Inclusion Framework 2018–2022, that outlines specific ways the financial sector will ensure full inclusion of women business owners; and the National Strategy for Gender Development, that sets specific guidelines for economic empowerment of women. However, none of the reviewed laws and policies addressed the specific situation of WOBs in the private health sector.

The Health Sector Strategic Plan (HSSP) IV provides strategic direction to the entire health sector, both public and private. However, it contains only one major reference to the private health sector development—a strategic objective that focuses on health sector financing (including public-private partnership) and the overall growth of the private health sector. The plan includes stipulations for gender mainstreaming in general and in the health sector, but it provides no specific stipulations for WOPHSF.

3. Private health sector regulatory systems

Long, expensive, and convoluted registration processes pose significant obstacles to initial business registration of WOPHSF, despite lobbying efforts by relevant professional associations (notably, PRINMAT, for maternity/nursing homes). According to an International Financial Corporation study, the overall business regulatory system in Tanzania is characterized by bureaucratic and corrupt licensing and registration for businesses, as well as cumbersome tax codes and high tax rates. An International Labour Organization (ILO) study found that women entrepreneurs report difficulties in dealing with corrupt officials who may seek bribes or sexually harass them, and often feel they have no recourse when faced with this type of corruption and abuse. The study also found limited evidence of administrative efforts to ensure that women are informed about business registration regulations and procedures or to assist them with complying.

The experience of WOPHSF is largely similar to that documented in the study of WBOs in Tanzania, although the FGD participants said they had found clear and accessible information about the relevant registration processes for private health sector facilities. WBOs of ADDOs, maternity/nursing homes, and dispensaries spoke extensively in the FGDs about the challenges of registering their businesses initially at start-up and annually thereafter. Regardless of the type of facility or specific regulatory body (e.g., TNMC, PHAB, or Pharmacy Council), the feedback was that the initial registration process was (1) lengthy, taking at least six months for initial registration (or longer for dispensaries, which have many

additional requirements); (2) expensive, requiring expenditures for licenses and taxes, as well as travel to Dar es Salaam or Dodoma for follow-up, if necessary, with relevant national authorities; (3) complex, entailing approvals at four different levels—typically starting at the village level, to ensure the facility is needed by the community, and going to the district, regional, and finally national level.

FGD participants, when asked, mentioned only minimal corruption. When asked if they had experienced or heard of people experiencing requests for sexual favors by authorities, none of the FGD participants could provide an example.

Participating maternity/nursing homeowners explained that, in their experience, one cause of these registration challenges was insufficient human resources and financial capacity at all the levels where approvals are required, and especially at the district level, where the Council Health Management Team and the District Medical Officer (DMO) are responsible for all health services in the district. There are simply too many facilities for the DMO to oversee to speed up the process. One woman shared an experience of needing to travel to Dar es Salaam three separate times during the initial registration process, which required a direct visit to the TNMC (which, though now based in Dodoma, was previously in Dar es Salaam). Although annual registration is not as cumbersome as the initial registration, it still requires significant time and money for the annual registration fees, taxes, and license renewals.

The interviewed PRINMAT representative also mentioned how complicated the registration process continues to be for maternity/nursing homes. However, she emphasized important improvements that were achieved through her organization's lobbying efforts. She also mentioned the important role that PRINMAT plays as a resource and support to facilitate the registration process.

Despite challenges, the benefits of registration outweigh the disadvantages, as the private health sector is highly regulated, as appropriate for the health care field. A facility that chose not to register would soon face closure.

Closures of ADDOs and maternity/nursing homes for minor problems are common entailing a long, bureaucratic process to reopen. ADDO FGD participants shared their and others' experiences with facility closures based on minor problems in interpretation of regulations; these lengthy closures caused significant financial loss because of lost income from clients. The key informant from PRINMAT explained that the biggest issue is not so much about potential infractions, but rather that the automatic response is immediate closure of the facility. This response creates serious gaps in health care coverage, especially when the closure is a maternity/nursing home, since in many regions the maternity/nursing home is the only resource for reproductive health in its geographic area.

4. Assets

Like their female peers in the rest of sub-Saharan Africa, WOPHSF frequently lack sufficient business capital to operate their businesses. A 2019 World Bank publication found that female entrepreneurs in sub-Saharan Africa have systematically lower levels of business capital—including equipment, inventory and property—relative to their male peers, as well as lower levels of labor employed in their businesses. This is also generally an obstacle for WOPHSF in Tanzania. According to ADDO FGD participants, low levels of capital present a major obstacle to maintaining sufficient inventory their shops. Similarly, maternity/nursing homeowners mentioned that they lack such up-to-date equipment as ultrasounds and microscopes, needed to attract new customers, because the cost of the equipment was too

high; they had neither sufficient cash reserves nor available credit to obtain the equipment. Maternity/nursing homeowners mentioned that they keep a very small staff, because they are expected to pay higher than government wages, without delay every month. They mentioned that this was not always possible because of low revenue in a given month. See Findings 12, 14, 17-19, 22, and 23 for further discussion of barriers to profitability and access to credit.

Similar to WBOs in general in Tanzania, WOPHSF often lack full control over household assets, notably land and real estate, resulting in insufficient collateral for loans. In Tanzania, 37 percent of women own a house, while 34 percent own land, either alone or jointly; the comparable figures for men are about 10 percent higher, at 41 percent and 37 percent. However, men are far more likely to have sole ownership: 33 percent of men own a house alone, and 30 percent of men own land alone, as compared to 8 percent and 9 percent of women, respectively. Moreover, over 75 percent of homeowners (women and men) have no title or deed to the house; and among those who have a title or deed, women are less likely to have their names on the deed. In this context, WBOs often face the challenge of having no legal rights to assets, notably land and real estate property, because all assets are in the husband's name.

The KIs from CRDB Bank—which provides funding for the private health sector in Tanzania—confirmed that WOPHSF often face complication with collateral requirements. Women typically sought loans for their businesses using their personal/family property as collateral, most of which is co-owned with spouses; the spouse's signature is required on the loan documents, which presents another barrier when the husband is unwilling to sign. Furthermore, household assets are typically not accepted as collateral by financial institutions —and (according to the PRINMAT representative interviewed) these are the most common type of assets that women have. Therefore, PRINMAT offers a Saving and Credit Cooperative Society (SACCOS) savings and loan fund for its members that accepts personal assets as collateral. See Section

Like Tanzanian women in general, WOPHSF often lack authority over the allocation of household assets and may face more social pressure to share resources, which hinders their willingness and ability to invest in their businesses. According to the 2015–16 DHS survey, only 46 percent of women in Tanzania participate in decisions related to major household purchases, indicating a lack of authority over allocation of household resources. Research shows that female entrepreneurs struggle to direct capital to their business because of competing demands on business profit, including household expenses and demands for money from family or friends. In other words, women business owners are often compelled to share their resources. One ADDO FGD participant shared her experience: family members began asking her for money, once they learned she was making some money with her business; this in turn angered her husband, who said she shouldn't be sharing her income with them. Therefore, she felt she had to give money to her family in secret. However, the most common situation reported in FGD was that the husband expected to receive a portion of profits, or he stopped contributing to household expenses, once the wife's business began making money. See Section 4.1.3 for further related discussion on the impact of gender, social, and gender norms on WOBs.

Like other WBOs in Tanzania, because of lack of training and challenges with reliable energy, WOPHSF' use of technology is largely limited to mobile phones used for basic business communication (with the exception of dispensary owners). According to one survey, 97 percent of female respondents in Tanzania are using their mobile phones to conduct business. Furthermore, most business activities, such as finding new customers

and communicating with existing customers, are much more likely to be done using mobile phones than other forms of information communications and technology (ICT). However, opportunities exist for using mobile phone technology to access market information. Currently, women lag behind men in use of mobile phones for Internet connection (23 percent of women versus 36 percent of men). Only 11 percent of women in Tanzania have websites for their business, and 16 percent are selling their products online.

When asked about their use of technology to conduct business, none of the maternity/nursing home or ADDO FGD participants reported using any form of ICT, other than using a mobile phone to make calls. They all use manual record keeping for accounting, inventory control, client database, etc. The maternity/nursing home FGD participants mentioned that three maternity/nursing homes in the PRINMAT network were participating in pilot program using a digital record keeping. The main challenge cited were lack of training on how to make use of technology. All three dispensary FGD participants used digital record keeping for their businesses. However, they mentioned challenges with access to reliable energy to maintain Internet recordkeeping, which is essential for insurance billing.

5. Finance

ADDOs and maternity/nursing homes must charge low prices because of relevant government policies and because the population they principally serve is low-income and paying out-of-pocket. Maternity/nursing home FGD participants explained they must provide their services either for free because of government mandates (Finding 7) or at a very low price because they typically serve the poorest Tanzanian communities, lacking financial access to health insurance or geographic access to public health services.

ADDO FGD participants also mentioned they needed to charge low prices for medicine and medical commodities because of government controls on pricing regulated products, and also to compete with public drug dispensing entities that dispense medicine and commodities for free or nearly free. According to the 2017 SHOPS Plus ADDO study, customers pay out-of-pocket, and because they often are unable to pay for medicine and goods at the time of purchase, ADDOs may offer credit to their customers. The study found this practice to result in loss for the ADDOs, as they neither properly record accounts receivable nor consistently collect them.

Some limited private health sector-specific financing for WOBs exists, but it consists largely of credit on traditional terms (e.g., with stringent collateral requirements and high interest rates). The Association of Private Health Facilities in Tanzania (APHFTA) has developed a loan product for businesses are designed to improve access to first-line health services. APHFTA launched a subsidiary social enterprise called Afya Microfinance Company Limited, in partnership with the MoHCDGEC, Management Sciences for Health, and the associations of ADDOs. Afya Microfinance Company Limited has a special program that specifically targets WOPHSF. Additionally, USAID signed a five-year DCA Guarantee with CRDB Bank designed to increase access to finance for private health facilities, with 50 percent targeted to women-owned or operated facilities. Covenant Bank for Women's special credit program—targeting excluded populations, especially WBOs have provided only a limited number of loans to WOPHSF, and the bank indicated interest in learning more about the sector. (Tanzania Central Bank has since revoked its license, and the bank is no longer operating.) The SHOPS Plus project recently facilitated the creation of an innovative financial product targeting ADDOs for inventory financing: the ADDOs receive a low-interest, no-collateral loan, principally in the form of inventory for their shops. It is based on a

partnership among FINCA Microfinance Bank, the medical suppliers, and the self-organized ADDO association in the Pwani region.

In addition to these resources, there are other small financial institutions like Pride and Access Bank for MSME, as well as larger banks, like Bank of Africa and National Microfinance Bank that lend to the private health sector in a limited way. Three leasing companies (Equity for Tanzania, Ltd., Selfina, and Vaell) have provided credit for purchase of medical equipment to male and female owners of private health sector businesses; they do not have collateral requirements but impose higher interest rates. The Government of Tanzania, through the National Health Insurance Fund, has a lending window called MEFI (Medicines, Equipment, Facilities Infrastructure) that provides loans to accredited health facilities for equipment purchase and facilities renovation at a highly subsidized rate of 10 percent. A multi-donor initiative called Medical Credit Fund provides a cash guarantee to the bank, by depositing 50 percent of the loan amount disbursed to the borrower into the lender's account, as a guarantee. These funding sources are all targeted to private health sector businesses, whether women- or men-owned.

None of the FGD participants had heard about or accessed the women-specific private health sector formal funding options. This finding aligns with the larger trend among female entrepreneurs in Tanzania, who report that information about financing sources is not widely available.

WOPHSF mainly rely on (and prefer) to tap personal savings, loans from family and friends, and other funding sources to finance their businesses, because of high interest rates, collateral requirements, and high levels of stress related to managing formal debt; in their experience, formal credit was detrimental to the viability of their business. According to available data on WBOs in Tanzania overall, savings are by far the most common method when starting up a business (85.38 percent), followed by loans from family and friends (36.32 percent). A 2019 analysis of evidence from four African countries including Tanzania, conducted by researchers from Savings at the Frontier program found that, despite increased access to formal financial services (FSS) to access credit, the use of informal savings mechanisms (ISMs)—including village-based savings and loan initiatives, such as Village Community Banking (VICOBA)—continues to grow significantly. According to that analysis, ISMs provide flexibility as well as desirable non-financial benefits (e.g., social connections/networks, education/training, etc.) that FSS cannot offer. Similarly, ADDO, maternity/nursing home, and dispensary FGD participants confirmed their preference for using these less formal mechanisms. FGD participants were familiar with a number of savings schemes: in addition to VICOBA, they mentioned SACCOS—peer-group savings and loan plans, typically organized by an organization, especially PRINMAT. Other options mentioned included: Upatu, a group arrangement to contribute a small amount every day, until on a rotating basis each participant has received the "pot"; family contributions; retirement pensions; income from formal employment; and such money-making endeavors as raising pigs, chickens, or produce for sale, to invest in the private health sector business. The participants also preferred to reinvest profits back into their business, rather than seek credit from financial institutions.

Research on Tanzanian WBOs in general finds that high interest rates, high collateral requirements, and the need for a personal guarantee are among the major reasons that WBOs do not take out formal credit. Another important reason is geography: most formal financial products are available only to urban areas, leaving rural women with very limited banking options (village community banks).

WOPHSF gave similar reasons for avoiding formal credit options. The majority of FGD participants shared how formal credit and debt has caused them high levels of stress and fear. Several women explained that the stress is caused by the husband's expectation to take a portion of the loan for his personal use, as well as needing to use some of the loan for other uses that will not go towards growing their businesses. Since their businesses already have low profit margin, on-time payment is often difficult, prompting fear of losing their assets in case of default.

A few FGD participants shared how they learned, through the experience of taking out a formal loan and paying it back, that formal loans do not make financial sense for small businesses like theirs. One dispensary owner explained that all her revenue (not just profit) went to pay back the loan; it never generated enough new income to have justified taking the loan.

WOPHSF use alternative funding sources (e.g., pensions, other employment salaries, and profits from other enterprises) mainly to keep their businesses solvent rather than to make capital investments that would grow their businesses. When FGD participants mentioned alternative funding sources for their business, they mentioned that these sources were needed to keep the business running on a daily basis and not to make capital investments. Without these other sources of income, they couldn't keep their private health sector businesses open. As one dispensary owner explained,

I have a pork production business and also cultivate fruits and garden vegetables to sell, along with a kiosk in my village. If I didn't have these other enterprises that provide me a flow of cash, I wouldn't be able to keep my dispensary open. All the money that I make from those enterprises contributes to the operating costs of my dispensary.

WOPHSF are interested in formal credit with terms that meet their needs, and specifically that reduce their stress and fear related to interest rates and collateral. Despite relatively low levels of formal loan usage of FGD participants, and their fear and stress related to formal credit, many see the potential for business growth that could come from a business loan. For example, the few women who have managed a formal loan would take another, under the right conditions. Similarly, those who had not taken a formal loan would consider one that could meet their needs better than current financial products. The desired conditions included longer repayment periods, lower interest rates, and alternatives to collateral requirements. Alternatives to collateral might include: increasing interest rates for missed payments; or partnerships between the financial institution and the regulatory bodies, such that the facility's licensing and registration serves as a guarantee. A key informant from the Tanzanian Women's Chamber of Commerce (TWCC) mentioned that another alternative to traditional collateral could be signed service contracts, in the case of established businesses; she clarified, however, that this is not standard practice to date.

The current Credit Reference System (CRS) and related training for financial institutions provided by the Bank of Tanzania Training Institute is not gender responsive, providing little value to WBOs (including those in the private health sector) to secure formal credit. A reliable credit registry has been identified as a way to help increase women's access to credit in Tanzania. According to the interviewed representative from the Secretariat for Financial Inclusion at the Bank of Tanzania, the CRS helps men more than women, who tend to lack a formal credit history. One initiative of the Women's Committee of the National Financial Inclusion Framework is to use "big data collateral." This would enable women to borrow from the bank on a group basis—e.g., through a VICOBA group, or another group formally registered with the relevant entity in Tanzania. The bank would rely on the "big data" knowledge that members have of one another as a form of guarantee. Women who

may lack a formal credit history nevertheless have knowledge of the character and activities of other members; this knowledge is the collateral. The Committee is currently proposing this as a legal and formal option for banks to use in lieu of collateral and traditional CRS ratings. The proposal is still being reviewed by the Bank of Tanzania, and the Committee is working with colleagues from other countries to gather evidence and models on which to base the initiative.

Mobile savings platforms and digital credit are alternatives to traditional loans for many female entrepreneurs in Tanzania, especially if paired with business training; however, these virtual options present challenges for WOPHSF. In Tanzania, approximately 10 percent of female adults have only a regular financial institution bank account, 10 percent have both a regular bank account and a mobile money account, and 25 percent have only a mobile money account. (The comparable figures for men are 7 percent, 15 percent, and 30 percent, respectively.) An example of a mobile money platform is M-Pawa from Vodacom, implemented through TechnoServe's Business Women Connect initiative; besides being a mobile savings mechanism, it provides digital credit for female entrepreneurs, as an alternative to taking out traditional loans. According to a 2018 study on digital credit in Kenya and Tanzania, women in Tanzania are more likely to use loans for business purposes, medical needs, and school fees, while men are more likely to borrow to pay for ordinary household needs, airtime, and to pay bills. However, the same study showed that digital borrowers typically tend to be young urban men. Digital credit has challenges in implementation, including: poor transparency, such as unexpected fees; unexpected withdrawal by lender; or consumers' lack of understanding of the costs or terms of a loan. A 2019 World Bank study found that providing business training to women microentrepreneurs resulted in higher levels of savings using mobile money platforms, more digital loans secured through the platform, and greater use of advanced business practices as compared to women entrepreneurs who did not receive the training.

Among the ADDO FGD participants, only three had mobile money accounts. None of the three women had ever taken a digital loan because (1) the amounts are too small to be useful; (2) repayment periods are too short for an ADDO business; (3) owners fear of all forms of debt. One ADDO participant explained that she has never accessed the same-day loan to procure supplies for her ADDO business because of her prior experience with borrowing. She took a three-week loan for personal expenses from another cell phone mobile money platform. She had successfully reached a level of qualifying for 1 million Tanzanian shillings, but one time she delayed repayment and had to pay a penalty of 10 percent for each day she delayed. That was a painful experience for her, and she struggled to pay it off. After that she stopped accepting such offers—especially because, following a single delayed repayment, and even after paying the loan in full, the borrower must start over from the lowest loan level.

Of the four dispensary FGD participants, none use mobile banking of any type, because there is a government regulation that requires using paper checks for all financial transactions that include staff payments, tax payments, etc., to be shown to inspectors as the physical proof of such payments. Therefore, they only use traditional bank accounts.

Loan officers/financial institutions have low confidence towards WBOs in general, across sectors; at the same time, they have limited knowledge and experience with the private health sector. According to key informant interviews conducted as part of the 2014 ILO study, loan officers reported low levels of confidence in WOBs based on the generally informal nature of WOBs, as the bulk of women-owned enterprises are not registered. Another study found that 42 percent of female entrepreneur respondents believe that "loan

officers don't take women seriously," resulting in prolonged or incomplete loan processing. At the same time, financial institutions typically have limited knowledge of the private health care sector overall, with little if any direct marketing of financial services to this sector. Lenders have limited experiencing of dealing with entrepreneurs whose strength is their medical knowledge and experience rather than their business background, and who manage complex health-related businesses, with complicated revenue streams and layered payments including user fees as well as claims reimbursements.

Nevertheless, key informant interviews with financial institutions report better loan repayment performance among women than men and consider women business owners (in all sectors) to be important potential clients. They all mentioned as well that private health sector is a largely untapped sector in their portfolios. These KIs also mentioned that WOPHSF would benefit from additional business training and greater self-confidence as business owners, as they are typically stronger in their medical technical fields than business practices. The key informant from the TWCC mentioned, however, that typically banks do not see women as capable businesspeople and are thus less likely to approve a loan.

Women of retirement age, who make up significant number of WBO (both current and potential) in the private health sector, face compounded discrimination because of age and gender. One maternity/nursing home FGD participant related that she had gone through the entire loan application process, meeting all necessary requirements including collateral. She was informed at the end of the process that they would be unable to give her the loan because of her age. As she explained, "they thought I might die before paying back the loan." The interviewed representative from the TWCC said this type of discrimination was common and was a detriment to the private health sector, as many of the most qualified people to open maternity/nursing homes, dispensaries, clinics, and even hospitals are women who have retired as doctors, nurses, and/or midwives from the public sector. The representative cited one case of a retired female doctor who had identified an important need for a hospital and wanted to fill that need. Despite having a vision and a well-documented need for the private health sector facility, as well as the medical technical experience and assets, she was still unable to secure financing. The key informant from the National Council for Financial Inclusion said that she had not personally heard about cases of compounded discrimination based on gender and age in the financial sector but said this was a topic that was currently being addressed internationally through the Alliance for Financial Inclusion.

6. Markets

Like WOBs in general, women-owned ADDOs face supply chain challenges such as counterfeit medicines and drugs, volatile prices, insufficient capital, and limited opportunities for collective procurement. According to the ILO, WOBs in Tanzania generally lack access to reliable and affordable supply chains; there are few mechanisms for collective procurement of goods, despite the efforts of relevant professional associations. The private health sector has faced specific challenges in procurement, which are addressed to some extent by initiatives such as Mission for Essential Medical Supplies: this is a company "limited by guarantee" (i.e., with members rather than shareholders), owned by the Christian Council of Tanzania and Tanzania Episcopal Conference, that acts as a supplementary supply chain system for faith-based health facilities. The Pharmaceutical Society of Tanzania is considering forming a foundation based on member contributions that would lend funds to its members to overcome business challenges, especially in distribution.

Women-owned ADDOs typically face challenges (as noted in the reviewed literature) in accessing financing to ensure their shops are stocked with high quality medications in adequate supply. ADDO FGD participants confirmed these challenges, stating that they often lack sufficient supplies to meet demand in their shop; they have insufficient capital to purchase medicines and medical commodities even to minimally supply their ADDO—let alone to purchase in bulk, to lower the price per unit. To date, none of ADDO FGD participants have participated in collective procurement in order to access wholesale prices. An interviewed representative from the Pharmaceutical Society of Tanzania (PST) also noted quality challenges, such as counterfeit, unregistered, and expired medicines or medical supplies, which impact all ADDOs, including women-owned ones. He mentioned that ADDOs are more at risk than retail pharmacies, because of lower levels of pharmaceutical education. This key informant interviews also mentioned that the prices of medical commodities in Tanzania are often volatile because they are not regulated as in neighboring countries, making consistent and accurate pricing of goods sold at ADDOs (and pharmacies) a challenge.

Marketing challenges for WOPHSF include: market saturation for ADDOs; lack of access to medical insurance holders for maternity/nursing homes, ADDOs, and even some dispensaries that lack current information. ADDO FGD participants were aware of a regulation allowing only one ADDO for a specific distance (that differs for urban and rural regions). However, because of lack of enforcement, an ADDO can illegally set up shop close to a registered ADDO, causing market saturation for these (often struggling) businesses and suppressing prices through price competition.

As noted under Finding 6, maternity/nursing homeowners are by law barred from accessing medical insurance. Dispensary FGD participants had a similar restriction, until a recent change in the regulations—but many dispensary owners are not aware of this administrative rule change. According to the 2017 SHOPS Plus study, there are no ADDOs that have been accredited by the National Health Insurance Fund to accept insurance payments, and there are no known initiatives in this regard.

7. Human capital and agency

WOPHSF are aware of the need for business-related training—e.g., in financial management and marketing—but most have never participated in any type of business training; their training focus has largely been on clinical topics and not on business. Studies previously conducted on WBOs in Tanzania found that the most important business training needs include marketing, management, and accounting training and competency. Specific challenges identified by women entrepreneurs included lack of knowledge of new markets, lack of IT skills, lack of knowledge on business in general, and insufficient information about business regulations. They identified several other areas requiring business development support (BDS): developing business plans, financial management issues, packaging and labelling products, customer care, and how to use various ICT facilities. Women business owners reported a preference for tailor-made, women-only training to allow them to voice their needs and opinions more openly.

Financial management is likely the most important gap in business training. When asked how they calculate profits, ADDO FGD participants responded that they just use records from their bookkeeping ledger each day. When asked if they feel their records provide an accurate picture, they said they never know whether sales and revenue are registered correctly, and they do not take into account their own salaries. According to the SHOPS Plus study on ADDOs, of the 40 interviewed ADDOs, only two calculated net profit at the end of the month. For maternity/nursing homeowners, the major issue with financial

management is costing analysis and service price-setting. They said they do not have the capacity to conduct the complex costing analysis that is needed for a maternity/nursing home: how to determine costs of consumables, and how to charge for these types of supplies in their fees; how to charge their own salaries as owners; depreciation and rents on property they own, etc. In regard to price-setting, they do not know how to accurately charge for services (such as a medical consultation) because they do not have accurate information on the actual costs of providing those services.

Several private health sector-specific BDS services, for women and men-owned businesses, are provided by professional associations and development partners: the SafeCare joint initiative, among APHFTA, Christian Social Services Commission (CSSC), and PRINMAT; and individual programs offered by CSSC, PRINMAT, APHFTA, and Medical Laboratories Scientists Association of Tanzania. However, when asked, most FGD participants responded that they had not participated in a business training. For example, one of the maternity/nursing home FGD participants mentioned that PRINMAT had offered business training five years previously, but it was only attended by a handful of PRINMAT network maternity/nursing homes. The only business training that ADDO FGD participants had participated in was a SHOPS Plus training workshop on financial management and marketing. Of the four dispensary owners, only one had participated in business training—the joint training on financial control/business management offered by SHOPS Plus and PSI. Overall, FGD participants identified focusing predominately on the clinical side of their profession and not the business side.

These findings align with research on female entrepreneurs generally in Tanzania. According to the 2014 ILO study on women entrepreneurs, few female business owners access BDS services, and few BDS service providers specifically target women as a group, or recognize the specific challenges that are gender-based.

Limited mentorship programs exist for female entrepreneurs, both in general and in the private health sector, despite evidence of their importance to business success. However, WOPHSF are informally creating mentorships among themselves. A review of literature conducted for a World Bank study on supporting growth-oriented women entrepreneurs found that mentorship and coaching provide “invaluable market information to female entrepreneurs, facilitate access to finance, and provide intangible benefits in terms of support and increased confidence…and [can] be critical in motivating women entrepreneurs to lead crossover enterprises, that is, firms operating in more productive, male-dominated sectors.” Despite this, an online search revealed only a limited number of mentorship programs for female entrepreneurs in Tanzania. Examples are TechnoServe’s Women Business Connect and one that serves all of sub-Saharan Africa, called MicroMentor. A 2016 study made a recommendation to include mentorship as a core component of the SHOPS Plus training program.

When asked about mentorship programs, only one among all the ADDO, maternity/nursing home, and dispensary FGD participants responded that she had participated in a formal, organization-sponsored mentorship program. However, she was unable to remember the details of the program. On the other hand, each group mentioned examples of informal, WBO-initiated mentoring. In fact, in each of the FGD groups, there was at least one older, more experienced WBO who had been or continued to be a mentor to another FGD participant. Such informal mentoring involved providing insight and experiences about the entire business development process (registration, procurement, etc.) and assisting with problem-solving related to operating the business.

Adding coaching to professional development programs for WBOs (and other business owners) is desired by business owners and is more beneficial than training alone. In an informal conversation with the PSI representative who helped coordinate the FGD with the dispensary owners, he mentioned to the research team how much the participants of the joint SHOPS Plus/PSI business training had benefited from that training; he also emphasized that the participants were requesting follow-up and more hands-on coaching, to put into practice what they had learned in the training. Findings from the SHOPS Plus study on ADDOs also showed the need for more hands-on coaching: even though all ADDO owners had received business training as part of the certification process to become an ADDO owner—training which included a module on profit-and-loss calculation—only two of the 40 interviewed ADDOs actually completed a profit/loss calculation each month.

Research confirms the benefits of training accompanied by coaching versus training alone. For example, one program targeting female entrepreneurs in Tanzania illustrated how impacts can vary according to the entrepreneur's experience level. One group of firms were offered basic business training, while another group received the training plus individual specific consulting sessions and coaching. In line with other studies, the basic business training was found not to result in improved business performance. The enhanced support did improve business practices—but only the more experienced participants improved their earnings; and the impact was greater with every additional year of experience. This finding suggests that experience may increase the ability to translate the training program's lessons into improved business practices, or perhaps that more experienced entrepreneurs may not be as affected by other barriers hindering business growth.

WOPHSF participate actively in formal professional associations and self-organized associations principally in order to access benefits that include training, credit, and potential opportunities for collective procurement, rather than as an avenue for intensive networking. Research shows that belonging to a network is a key strategy for businesses to acquire role models, increase business contacts, access market opportunities and further develop their product or service. Despite these benefits, only 23 percent of women surveyed as part of the 2014 ILO study on female entrepreneurship were members of women's business associations.

WOPHSF participate at a much higher rate in professional associations than their peers in other sectors, according to feedback from FGD participants. For example, all the maternity/nursing home FGD participants are PRINMAT members. The representative from PRINMAT also confirmed that nearly all maternity/nursing homeowners in Tanzania (predominately though not exclusively women) are members of PRINMAT. The representative further explained that PRINMAT provides a large range of support to members, such as: lobbying and advocacy efforts that have improved the regulatory processes; a SACCOS savings and loan program; training; and networking opportunities, including their annual conference. According to the PRINMAT representative (who is also a female maternity/nursing homeowner), female maternity/nursing homeowners are very interested in being board members and taking on regional leadership roles. Among the maternity/nursing home FGD participants, one has taken on a leadership role in the organization.

Currently, there is not a national professional association that represents ADDO owners. Although the PST and Tanzanian Association of Women Pharmacists represent the pharmaceutical sector, ADDO owners and/or dispensers are not members, despite their critical role in providing essential medicines and medical commodities. However, according

to FGD participants, ADDO owners are currently organizing themselves into regional associations as a means to access credit, training, and possibly collective procurement.

All dispensary owner FGD participants mentioned being members of the APHFTA. The four FGD participants said that their participation included receiving facility registration support as well as training on quality control. However, according to the APHFTA website, the association also provides additional services to members: advocacy, knowledge sharing, networking of private health sector facilities, and private health sector facilities staff training.

None of the FGD participants who are ADDO, maternity/nursing home, or dispensary owners mentioned using their membership as a networking tool to grow their businesses.

Recent research on WBOs in all sub-Saharan Africa shows that women often do not have the same access as men to large, diverse social networks that can support the growth and competitiveness of their business. A 2019 report by World Bank on women business owners in sub-Saharan Africa noted important differences between the way women and men experience networking.

- Women's networks have fewer resources than men's and are more likely to be family or kin relationships.
- Female entrepreneurs' business networks are mostly comprised of other women.
- Men have larger business networks than women.
- Women rely on their networks when starting a business and for financial support, but men more intensively use their business networks to share information, equipment, and supplies.
- The relationship between networks and business performance is likely not straightforward and depends on aspects such as the depth of the relationships and their influence on various areas of business development.

Although motivations of WOPHSF include economic push factors (such as economic necessity) similar to WBOs overall in Tanzania, pull factors—especially love of their vocation and helping others—were most often cited as motivation. A 2018 study that surveyed approximately 400 female entrepreneurs in Tanzania found that their primary motivation for starting their own business was economic necessity. Pull factors were not identified by respondents (e.g., the attraction of a specific field of work). The study postulates that motivation rooted in push factors, notably economic necessity, may be a reason for the limited growth of WOBs. According to FGD participants, economic necessity is only part of their motivation. Several maternity/nursing homeowners mentioned their love of midwifery, saving lives, and reproductive health care overall. Another maternity/nursing homeowner mentioned the desire to be self-employed, which provides more respect. Likewise, a few ADDO FGD participants mentioned the desire for self-employment, including one woman who had a negative experience working for another ADDO that terminated her contract when she became pregnant. Another ADDO participant wanted to have retirement income. None of the FGD participants emphasized the pull of having their own business per se.

Self-reporting of confidence among WOPHSF is high, especially as medical professionals; however, other KIs note that they often lack self-confidence, especially related to their role as businesswomen versus their role as medical professionals. A 2019 WB study finds that in sub-Saharan Africa, women's lack of confidence relative to men may keep them from taking the risks that lead to high returns that could lead to business growth. This also makes them less likely to compete for (and possibly win) opportunities that could grow their businesses. When asked to rate their self-confidence, the second group of maternity/nursing homeowners all rated their level as "high," citing predominately their confidence as medical

professionals. However, KIs noted that WOPHSF often lack the needed self-confidence needed to grow their business because they do not see themselves as leaders, able to access appropriate credit and to report corruption.

8. How do cultural, social, and gender norms impact WOPHSF?

Like all women in Tanzania, WOPHSF are significantly burdened with unpaid domestic and care work because of persistent social norms that assign women to this traditional role, leaving them with reduced time and energy to dedicate to their business. Women are more burdened with unpaid domestic and care work in Tanzania than men: as of 2014, women dedicate on average 3.95 hours per day on unpaid domestic and care work, versus only 1.02 hours a day for men. Women are unable to effectively redistribute this care to men, to community/government support services, or to other paid services because of several factors, including: persistent gender norms that assign women to the traditional care-taking role; lack of essential public services (e.g., good sanitation, roads, and health facilities); and the overall low incomes of both women and men in Tanzania. This double burden prevents them from expanding their business and acts as major deterrent to continued operations when they must take maternity leave.

When questioned about their roles and responsibilities in the household, WBO FGD participants shared that they were burdened with more care work at home than their husbands. One maternity/nursing home FGD participant talked about how tired they all are, because of domestic responsibility that falls primarily to them as women and because of the nature of medical services that require extended hours of operation, since medical needs must be met 24 hours per day. One maternity/nursing homeowner shared that her husband was angry with her for relinquishing her household responsibilities—notably, for cooking his meals—when she started her business (see below, under Finding 34). A dispensary owner shared how the burden of work—between household responsibilities, her dispensary, and the various other money-making enterprises needed to keep her dispensary running—has had a negative impact on her health.

Like WBOs in general in Tanzania, WOPHSF face male discouragement and even harassment based on deeply rooted social and gender norms related to roles and responsibilities, expected behaviors, attitudes of superiority of men towards women, and GBV. Research in Tanzania has found a general lack of support by husbands for their wives' starting a business; moreover, they often refuse to help with family responsibilities once their wife's business begins to have success, and they may complain that they are not receiving money from the profits of the business. One study finds that family support wanes as a woman's business grows, as this typically means she is spending less time on household activities. Parents-in-law also often discourage women from using their own property as collateral, for fear they will not be able to repay the loan and will lose the assets.

FGD participants shared similar experiences, with many noting that husbands were most unsupportive at business start-up. The lack of support manifests itself through a number of deeply rooted social and gender norms related to gendered roles and responsibilities, expected gendered behaviors, and GBV.

For example, one maternity/nursing homeowner described her experience:

At the beginning of the business start-up, it was not easy since I was also working another job at the time. I did not have time to be at home. So, my husband did not like it. Sometimes he was furious. He would say "Did I marry you to look for money or for you to cook for me? Did I marry the house girl since she is the one always cooking for me?" At that time when I

opened the clinic, my husband had no money. My clinic started to work well, and I was making the household income. Progressively he was happy about it. At that time, he also was making money again and [he] even bought me a car, because I was having a hard time walking back and forth to the clinic [maternity/nursing home]. Since then, there was harmony.

This vignette illustrates a number of cultural norms that impact WBOs. It shows the traditional expectation that women are expected be care providers (e.g., cooking) at the expense of their business. It illustrates that men, especially, when they are not financially providing for the family, may feel threatened by their wives' success.

A couple of ADDO FGD participants explained that once the woman is making money (not necessary profit, but some revenue), the husband relinquishes his financial responsibility to the family, leaving all household expenses to the wife, while his income goes to his own personal expenses. One ADDO participant shared her experience that other family members begin to ask for money—something her husband does not like, requiring her give to her family in secret. Another ADDO participant shared how she sometimes needed to ask for money to support her business from her husband, who works far from home. She explained that his reaction is always one of mistrust that she is trying to deceive him; he wants to know why she needs money for the business if she is selling things. He finds it hard to believe her when she explains that the profits are so low. Another ADDO participant mentioned how she had to stay out late at night to run her shop, because those late hours are typically when people need medical attention; her husband doesn't like her to be out at night. One of the dispensary owners shared that she co-owns her dispensary and health center with her husband, who is also a doctor. Although they both are doctors and owners of the business, her husband often does not take her business opinions and ideas seriously. Another ADDO FGD participant noted that husbands are often jealous when their wives are making more money with their businesses. Her experience is that the jealousy manifests itself in abusive language and yelling. See Section 4.1.4 for further discussion, in the context of GBV.

Society in general considers (predominately female) nurses and midwives inferior to (predominately male) doctors; at the same time, a "culture of support" exists for nurses and midwives that "exempts" them from women's traditional domestic roles. The key informant from PRINMAT explained that gender discrimination continues to be a major challenge faced by nurses and midwives, because they are considered inferior to doctors, who are predominately male. (See Finding 7 for discussion of the relationship between gender discrimination and private health sector policies that disproportionately impact women-owned maternity/nursing homes.) Dispensary FGD participants also shared that men in many cases do not want to receive care from a woman's dispensary—even when their life is in jeopardy. They want a man to attend to them because they think the care will be better. They cited the case of a man who died because he didn't want to go to the women-owned dispensary.

However, maternity/nursing home FGD participants shared their experience of what they call a culture of supporting nurses and midwives in the community. This "culture of support" entails "exempting" them from some cultural and social roles, including household responsibilities, if they are practicing their vocation as a nurse/midwife.

9. What GBV—including sexual harassment—do women business owners in the private health sector face, and how does this impact them?

Like WBOs overall in Tanzania, many WOPHSF experience GBV typically from their spouses in relationship to their entrepreneurial activities. However, WOPHSF do not identify their experiences as (spousal) GBV. GBV in Tanzania takes multiple forms: 40 percent of women age 15–49 have ever experienced physical violence, with the rate higher among ever-married women and particularly formerly married women. Almost 75 percent of ever-married women experienced some form of physical control in Tanzania. Half of all ever-married women have experienced spousal violence: 39 percent experience physical violence, 36 percent emotional violence, and 14 percent sexual violence. According to World Bank's 2019 study on WOBs in Africa, GBV is one of nine key constraints to the performance of African WOBs. The study concludes that, "GBV likely has complex consequences on women's mental health, which may hinder their managerial capacities and lead to losses in productivity and revenues."

Tanzania-specific data cited as part of the WB study shows that 11 percent of female entrepreneurs say they have received a request for sex in exchange for support for their business in the past 12 months. Asked the same question in terms of other women— "out of ten women, how many do you think have received requests for sex in exchange for help with their business in the past 12 months?"—the proportion reaches 40 percent. As the WB researchers explain, the latter question is important, since women are typically hesitant to discuss their own experience with GBV versus the experience of others, making this question likely more accurate.

When FGD participants were asked about whether they or anyone they knew had ever experienced GBV, as business owners, they did not have any information to share; they noted they had not heard of any cases of GBV related to their or others' experience as a business owner. When asked about reported cases of corruption in the form of requests for sexual favors by regulatory officials, they stated that they had not heard of such cases, but that those types of things were typically "private" by nature.

Based on the U.S. government's definition of GBV, however, and in the context of various unsupportive behaviors of spouses described in Finding 34, the gender analysis identified a number of instances of GBV that were not described by FGD participants as GBV.

Annex B. Business and Financial Management Learnings and Recommendations

The SHOPS Plus WhatsApp training for women owners and managers of private health sector businesses in Tanzania offered a multitude of lessons and recommendations for how best to adapt the training moving forward. Key recommendations for teams looking to implement WhatsApp-based capacity strengthening are as follows:

- **Consider use of WhatsApp for training and capacity building**. Our experience supports the use of WhatsApp for training. Our sustainability partner was excited by the low cost, flexibility, and far reach of the training platform. Participants were encouraged by being able to learn continuously at a pace that was convenient for them, and they felt strongly that they gained knowledge and skills as a result of the training. We were also able to solve many of the technical and structural challenges uncovered and moderators were able to test out a variety of approaches to engage participants.
- **Plan for sufficient time to co-create the training with the local partner**. Using a platform like WhatsApp offers substantial advantages over traditional classroom trainings in terms of cost-effectiveness. Whereas handing over classroom trainings to local partners is often unsuccessful because the partners lack the funds to consider financing these trainings, a WhatsApp training can be continued at a very low cost. However, the training still must match the mission of the partner, and the partners should have (or have access to) the necessary human resources to continue the moderation. Sufficient investment in co-creation before launching the training increases the likelihood that the partner will be able to continue to offer the training after the end of project funding.
- **Match the training content to the medium**. The focus on gender and women's empowerment had some inherent challenges for discussion on WhatsApp. Gender empowerment is needed, but not necessarily demanded by the participants; they were more immediately concerned about more directly applicable instruction related to the running of their businesses, and this may have affected participation. Additionally, participants expressed concerns that sensitive messages around spousal dynamics, discrimination, or gender-based violence might be seen by husbands or shared by other participants to a broader audience. Restricting participation to women to create a safe space to discuss these shared experiences limited the overall group size, which impacted participation. A training on business or clinical skills might be better suited to WhatsApp, since the content would be less personal and more applicable.
- **Consider a blended approach**. An approach that combines traditional training with digital engagement, or multiple forms of digital engagement, may be the best approach, depending on the content and the audience. WhatsApp training is particularly useful for a large group of participants with low bandwidth. With higher bandwidth, a WhatsApp training can be paired with an interactive platform (e.g., Zoom). In other cases, WhatsApp as a complement to in-person trainings might be best. In general, the training content can be fit to a blended media.
- **Ensure an adequate group size**. The small group size impacted participation. With a larger group of participants, the likelihood of having a variety of active participants, engaging with the material, stimulating conversation, and learning from a wide range of experiences and insights would go up significantly. We found that participants were regularly reading content

even when they were not actively commenting, so having more active participants would benefit the whole group. We did not want to test this small group size model. The marginal cost of an additional participant to a WhatsApp training is effectively zero, meaning we could have accommodated tens or hundreds of participants. We recommend engaging 40 or 50 participants per training. Ensuring the ability to deliver an adequate group size should be an important factor in local partner selection.