

**EFFECTS OF PUBLIC-PRIVATE PARTNERSHIPS IN STRENGTHENING
HEALTH SYSTEMS IN FAITH-BASED HEALTH SERVICES IN KISII
COUNTY**

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other University.

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DEDICATION

This thesis work is dedicated to my family; Naomi, Gavin and Nana, who have been a constant source of support and encouragement. They really encouraged me to complete my graduate studies after many years in graduate school.

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ABSTRACT

Public-Private Partnerships (PPPs) are important in enhancement of efficiency and effectiveness in different agencies. This is a concept that has been borrowed and applied in various sectors. It is noted that within governments, ministries of health concentrates on the public sector often overlooking the enormous private sector provision of health care. This study assessed implementation of PPPs as a strategy for strengthening health systems in Faith-Based Organization (FBO) in Kisii County, especially in the context of key public health services (HIV/AIDS, maternal, neonatal and child health). This study was guided by the following specific objectives: to examine influence of PPPs in leadership and management on health systems strengthening (HSS), to determine the influence of PPPs in material sharing on HSS, to examine influence of PPPs in human resources for health (HRH) on HSS, and to examine the influence of processes guiding the PPP on HSS. To realize these goals, a cross-sectional descriptive study was conducted targeting 78 FBO facilities' Officials from Tabaka, Christianmarian and Nyanchwa hospitals; and Officials from the County Ministry of Health. Data was gathered using structured questionnaires and interview schedules. Collected data was analysed using Statistical Package for Social Sciences and Ms Excel. Analysed data is presented using tables, bars and charts. The study found the relationship between leadership and management support and HSS had a Pearson's Chi-square (X^2) =25.316, $P<0.05$. On material support, the study found the relationship between material support and HSS had a Pearson's Chi-square (X^2) =77.3 $P<0.05$. Concerning HRH, the study found the relationship between HRH enhancement and HSS had a Pearson's Chi-square (X^2) =72.00 $P<0.05$. Finally, the study found the relationship between processes guiding PPP implementation and HSS had a Pearson's Chi-square (X^2) =57.037 $P<0.05$. After fitting the data on the regression model, the study found enhancement of PPP implementation process as the most critical factor in enhancement of HSS. The study concludes that PPPs targeting material support, leadership and management, provision of guidelines to guide the PPP process, and HRH strengthened health systems in support of provision of quality public health services in FBO facilities. From the viewpoint of Kisii County Government, FBO facilities are able to effectively complement the work of government in the provision of public health services and should be supported through the PPP. The respondents from the FBO facilities also appreciated the government's inputs and support in the provision of public health services that the community is not keen to pay for within their facilities. Implementation of this kind of PPP may compliment one of the big 4 agendas of the government of Kenya, that is Universal Health Coverage. The study recommends government and private sector actors to keep on improving and reviewing terms of engagements and processes to further improve and sustain the momentum of this PPP. The study also recommends the government to extend scope in provision of infrastructure and financing to the FBO facilities to partner in the provision of necessary public health interventions such as HIV/AIDS; maternal, neonatal and child health services amongst others.

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LIST OF ABBREVIATIONS

CHAK	Christian Health Association of Kenya
FBHS	Faith-Based Health Services
FBOs	Faith-based Organizations
GDP	Gross Domestic Product
GHWA	Global Health Workforce Alliance
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Syndrome/Acquired Immunodeficiency Syndrome
HMT	Hospital Management Team
HRM	Human Resource Management
HSS	Health Systems Strengthening
HSS	Health Systems Strengthening
ICT	Information and Communication Technology
KCCB	Kenya Conference of Catholic Bishops
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
KHPF	Kenya Health Policy Framework
KNBS	Kenya National Bureau of Statistics
MDGs	Millennium Development Goals
MOH	Ministry of Health
MoU	Memorandum of Understanding
NACOSTI	National Commission for Science, Technology and Innovation

NGO	Non-governmental Organization
NHIF	National Hospital Insurance Fund
NHSSP	First National Health Strategic Plan (2000-2005)
OECD	Organisation for Economic Co-operation and Development
OOPs	Out of Pocket service
PEPFAR	President's Emergency Plan for AIDS Relief
PFI	Private Finance Initiative
PPPs	Public-private partnerships
SDGs	Sustainable Development Goals
SUPKEM	Supreme Council of Kenya Muslims
SWAPs	Sector-wide Approaches
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Care
UN	United Nations
UNAIDS	United Nations Agency for HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

1.1 Background of the Study

The World Health Organization (WHO) defines a health system as all organizations, institutions and resources that produce actions whose primary purpose is to improve health (World Health Organization [WHO], 2000). The World health report 2000 defined overall health system outcomes or goals as: improving health and health equity, in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources. The main building blocks of health systems comprise of good health services, a well-performing health workforce, a well-functioning health information system, access to essential medical products, vaccines and technologies; and leadership/governance. The World Health Organizations further states that health outcomes are unacceptably low across many of the developing countries. The persistence of deep inequities in health status is a challenge from which no country in the world is exempt. At the centre of this human crisis is a failure of health systems. There is a common understanding that only through building and strengthening health systems will it be possible to provide better health outcomes. One of the opportunities of strengthening health systems is through public private partnerships (PPPs) (WHO, 2009).

Public private partnerships has different meanings to different actors and depends on context. Globally, the United Nations Organization (UN) has defined it as follows: an intentional and supportive contract bidding one or two parties, where all parties reach a decision to work as a team to realize a common agenda or to perform a given task sharing risks, responsibilities, resources, skills and benefits (Frenk & Moon, 2013). Buse et al. (2012) describe a PPP in the health sector as a cooperation that

crosses national borders. It includes at least three groups, among them a trade union (and/or industrial organization) and a governmental organization. According to Frenk & Moon (2013) its purpose is to achieve joint health care provision goal on the basis of mutual understanding).

Public private partnerships cover a wide range of arrangements, varying with respect to stakeholder participation, legal status, administration, prioritizing of goals, partner contributions and functional roles (WHO, 2009). They range from small, one-product partnerships with the industry to large institutions developed by UN agencies or private Non-Governmental Organizations (NGOs) (WHO, 2009). Patrinos et al. (2009) view PPPs as follows: contracting-out, service contracts, concessions, private financing initiatives, and divestiture. They also note that the nature of the PPP at any time depends on the supervisory framework, which needs to be used to facilitate new cooperation (World Bank, 2009). From these arguments, there is a general agreement that a PPP takes place when the public or the state actors decide to work together for common interests with the private or the non-state actors. The latter including the for-profit and the largely not-for-profit voluntary sector where Faith-Based Organizations belong (FBOs). The context can be at the local, national or even the international levels.

Public-private partnerships serve different functions. One of the most important purposes is to mobilize private funds for public causes. Many governments in the world are unable to provide health services as needed by their citizens due to resource constraints. Even in the Western countries, many governments are grappling with high costs of health care. In the United States for example, one of the top domestic agendas for any government is health reforms, especially to reduce the cost

of health care, which has become unsustainable in the country. Coupled with the prevailing global economic uncertainties, many governments are forced to look elsewhere for health care financing. Developing countries may not have a choice but to explore the window of opportunity provided by PPPs. Indeed, the Abuja declaration where African countries pledged to commit 15% of their gross domestic products (GDPs) to the health care sector has not been achieved in many countries including Kenya, due to funding challenges (WHO, 2011)

In Kenya, the importance of the private sector cannot be underestimated. The private sector has continued to grow over the last two decades. The total number of health facilities grew more than twice from 4,294 in 1999 to 9,448 in 2013 where private sector accounted for a higher proportion of the facilities. Private ownership of facilities in that period rose from 48% to 53% (The Oxford Group, 2013). The private sector in Kenya commands about 52% of the health infrastructure, with the government owning the other 48% (Ministry of Health [MoH], 2020). Within the private sector, FBO health services remain a major contributor. Some of these health facilities are located in the remotest parts of the country where the government cannot reach. They are mainly represented by 3 institutions namely; the Kenya Conference of Catholic Bishops (KCCB), Supreme Council of Kenya Muslims (SUPKEM) and the Christian Health Association of Kenya (Christian Health Association of Kenya [CHAK], 2016; MOH, 2020).

Kisii County is among the 47 Kenyan Counties formed following the proclamation of Kenya's new constitution in 2010. This formed a new system of administration, in the former province of Nyanza. Kisii County boundaries Nyamira County in the North East, Narok County in the south, and Homabay and Migori Counties in the West.

The County covers an area of 1,332.7 km and is sub-divided into nine Sub Counties including; Kitutu Chache North, Kitutu Chache South, Nyaribari Masaba, Nyaribari Chache, Bomachoge Borabu, Bomachoge Chache, Bobasi, South Mugirango and Bonchari. The population of the County was 1,226,860 people in 2019. This represents 586,062 and 640,081 men and women respectively.

This study is a situational analysis on the extent to which FBO health systems have been strengthened through PPPs in Kisii County.

1.2. Problem Statement

Both the public as well as the private sectors have strong and weak areas. Hence, no sector can independently tackle the entire health requirements of a population and fulfil all the functions of the health system. This is especially true for the publicly-funded mandates like HIV, maternal, neonatal and child health services. Furthermore, these expensive public health services with high social benefits are often provided at public facilities. They are not widely available to informal settlements and other disadvantaged communities. The private not for profit sector and particularly the Kenyan FBO facilities fills this void by ‘going where the government cannot reach’.

Despite this, funding of FBOs has continued to dwindle over the years, making provision of quality services difficult. Kenya continues to rely on donor funds for public health interventions (e.g. PEPFAR and Global Fund). There is a need for deliberate engagements between the FBOs and the larger private sector together with the government. This is in order to ensure that a large part of the population does not suffer in case the donors withdraw, after the country was classified a middle-income country by the World Bank (World Bank, 2014).

Looking at performance reports over the last decade, it is evident that donor funding has not translated into health outcomes, especially in the areas targeted by international investments. Prevalence of HIV stands at 6.1% compared to 4.9 % for Kenya (MOH, 2020). The following indicators are also not doing as well in Kisii: underweight children (8.4%), stunted children (25.5%), immunization coverage (78.1%), and skilled care delivery (69.3%) amongst others (Kenya Demographic and Health Survey, 2014). These indicators are worse off if narrowed down to the FBO health services in the County (MOH, 2017).

1.3. Purpose of the study

The broad objective was to assess the effect of public-private partnerships on health systems strengthening (HSS) in FBO health services in Kisii County.

1.4. Specific Objectives

- i. To examine the influence of PPPs in leadership and management on health systems strengthening in FBO health services in Kisii County.
- ii. To determine the influence of PPPs in material sharing on health systems strengthening in FBO health services in Kisii County.
- iii. To determine the effect of PPPs in human resources for health (HRH) on health systems strengthening in FBO health services in Kisii County.
- iv. To examine the influence of processes employed in managing the PPP on health systems strengthening in the FBO health services in Kisii County.

1.5. Research Questions

- i. How does leadership and management PPP influence strengthening of health systems in FBO health services in Kisii County?

- ii. How does material sharing PPP influence strengthening of health systems in FBO health services in Kisii County?
- iii. What is the effect of HRH enhancement partnership on strengthening of health systems in FBO health services in Kisii County?
- iv. How have the processes employed in managing the PPP influenced health systems strengthening in FBO health services in Kisii County?

1.6. Justification

Despite these challenges, no study has been conducted to examine the effect of PPPs in strengthening of health systems in FBO health services in Kenya. A few general studies focusing on the health sector have been done around PPPs in Kenya that may not address the unique situation in the sector. These studies are also different in terms of objectives, variables being examined and methodologies employed from this study. Historically, FBO health providers in Kenya have enjoyed support from several sources. Empowering them to offer high quality, affordable and accessible services to meet the health care requirements of the poor and needy groups. Such support comprised financial and philanthropic contributions from sister FBO overseas, with foreigners making up the bulk of senior staff like doctors in FBO health facilities. Further support came from the government grants at the national treasury, donated drugs, medical supplies and equipment as well. Support from overseas has dwindled, government grants were stopped in 1996, and as a result, volumes of patients seeking care in FBO facilities have reduced, further weakening the revenue streams (CHAK, 2006).

This study focussed on the Kenya government and the FBO partnership in providing health services in FBO facilities in Kisii County from which the findings can be generalised to other areas of the country.

1.7. Limitation of the study

The study did not broadly cover all areas in health systems strengthening (HSS). The study was limited to HSS outcomes in the high impact public health interventions, which would not succeed without the government working closely with the FBO facilities. These include maternal, neonatal and child health; and HIV/AIDS services. This is because HSS outcomes are broad and would include all Kenya Essential Package for Health (KEPH) outcomes and thus more resources and time would be needed to effectively address it. The study targeted FBO services because they have clearer and better working structures, as well as well-defined leadership and management bodies. Since this study was about PPPs between government and the FBOs in Kisii County, it would be difficult to generalize how a PPP would perform in the for-profit health sector. More research is therefore necessary in this area. Concerning the study design, this was a descriptive study.

1.8 Delimitation of the study

The study covered all aspects of leadership and management support, material sharing, processes guiding implementation of the PPP, and HRH in relation to the PPP arrangement. The study focused on three hospitals that account for approximately 80% of FBO health services provision in the County.

1.9. Assumptions of the Study

The study assumed that all the identified respondents would fill in the designed research instruments with integrity and honesty and within a short period of time to facilitate reliable data collection.

1.10. Significance of the Study

Understanding effectiveness of PPPs as a strategy for strengthening health systems in the FBO health services in Kisii County is be crucial in many ways. The Ministry of Health can use the findings to develop a working partnership framework with the FBO sector elsewhere in the country, to improve provision of public health services. Through such mechanisms, the government can sub contract certain services to the FBOs in areas that it cannot reach. In areas that PPPs are already in place, the government can use the findings to further strengthen the partnership. The government can therefore ensure that services are accessible to those who need them as per the mandate of the Kenyan Constitution 2010. The private sector and specifically the FBOs can use this partnership for resource mobilization and accountability. Hence, remaining relevant according to their mandate even when they lose international funding. Further, the results of the study would contribute to filling gaps in literature on PPPs in the health sector and particularly within the FBOs.

1.11. Operational Definition of Terms

Human resources for health: Secondment of government staff to FBO facility, and training opportunities for FBO staff by the government.

Leadership and management: It refers to the presence of key processes and documents to guide health services provision like policy, MOUs, Contracts, etc.

Material support: This refers to health care financing support, infrastructure, medical products and technologies.

Strengthened health system: The WHO defines the goals/outcomes of a strengthened health system as financial protection, improved efficiency, population coverage and responsiveness. In this study, this was measured through proxy indicators of uptake and coverage of HIV/AIDS services, maternal health, neonatal and child health services. This study adopts the definition according to WHO.

PPP implementation process: This refers to the activities that governs and/or used in monitoring and evaluating the performance of a PPP contract. This study focused on policy for PPP, laws guiding the PPP, standards and quality assurance manuals, robust monitoring and evaluation framework, meetings to guide implementation and audit of financial and non-financial resources within the FBOs.

Health services: A service that provides curative, preventive, promotive and rehabilitative medical care to an individual and the public.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature related to public-private partnerships as a strategy for strengthening health systems in the Kenyan FBO health services. Literature is reviewed from books, journals, magazines, GOK and FBO documents, internet and from periodicals.

2.2. Concept of Public Private Partnership

Regan (2012) describes private-public partnerships as procurement planning, franchises and related engagements with the private practitioners, where the private partners have a contract to offer products and services as a representative of the state. Likewise, Andrews and Entwistle (2010) argue that essentially, private organizations become long-term service providers, while governments become labour consumers. Private public partnerships programs are entrusted on the capacity/ability of each party to meet the needs of the community. These are clearly defined by the suitable provision of resources, costs, and benefits (Quium, 2011). Similarly, Keers and Fenema (2018) describe PPPs as some form of resilience between public and private actors. Where together they are taking the risk and cost associated with development of products and services using institutional lens to serve the public. This definition has several aspects. First, it emphasizes a certain degree of co-operation, where co-operation is not limited to temporary contracts. Secondly, it emphasizes risk allocation as an integral part. Together at the same time, both parties identified the risk components involved. Lastly, the parties pull resources to make product or service and, possibly, both benefit from the outcomes of the greater effort.

Sharma and Bindal (2014) defines PPP as a contractual arrangement between a state and a private firm aimed at funding, planning, operating and utilizing products and services, which is conventionally delivered by the state. This project minimizes the allocation of risk completely between organizations while achieving development objectives. Therefore, the project should be designed in a manner that the private investors have the right amount in its investment.

Ismail (2013) describe a PPP as an arrangement that involves collaboration between state and private institutions. Where a private institution offers state project and experiences significant monetary, practical and project risk. In other cases of PPPs, the expenses incurred in procuring the service are solely the responsibility of the consumer, not the taxpayers. In some forms, especially private finance schemes, the investments made by private companies provide the services agreed upon by a contract with the government. The price of offering service is fully or partially borne by the state. Especially in situations where government inputs to the PPP could possibly be available for the transferral of present assets. For projects/programs whose purpose is generating public goods such as the development projects, the state can offer support through a combination of subsidies, making it good-looking to private players. In certain circumstances, the state can finance the project by offering income support, as well as tax exemptions or by deducting the assured annual fixed amount.

Stakeholders participating in the general PPP include government officials, who are responsible for designing, assisting and managing the PPP contract; the PPP contractor, responsible for project development in the cases specified by the government authorities; financial agencies responsible for providing financial

services; and financial agents, who are responsible for the payment and delivery of revenue streams (Ferris, 2013).

There are usually two basic drivers of PPPs. First, the PPP is said to empower the public sector to gain access to technology and efficiency as the private players may make provision of specific goods/services that are conventionally provided by the state. Second, the PPP is organized in such a way that no public sector wants to invest. Instead, PPP has borrowed private resources to do a specific job. For PPP projects, where the end user incurs utility costs, the PPP is the remaining sheet of funding for the distribution of new or renewed public property, from a public sector perspective. For PPP projects whose intention is to pay compensation to the private sector by paying for public access, as long as the building has been established or rebuilt, the money is in the balance box, at the discretion of the public sector. Nevertheless, the state will always benefit from sufficient cash flows (Iossa & Martimort, 2012).

A successful PPP benefits the involved parties either financially or non-financially. Iossa and Martimort (2012) argue that PPPs provides financial and non-financial benefits to the state. It bridges the financial limitation in provision of resources for development of local public projects, making the local government to concentrate on other development projects in the public sectors. The PPP is empowered by both players to improve effectiveness and execution of projects in community service delivery. More essential PPPs stress the importance of concentrating on lower costs, better risk allocation, faster implementation, better services and potential productivity.

According to Harris (2011), a successful PPP requires a flexible project structure, with clear and effective risk allocation, contract and legal framework tightness, and transparent bidding process. In addition, public authority should have clear objectives and avoid imposing unreasonable expectations on the private sector.

Eschenfelder (2011) also points out benefits of PPPs that include; private investment and professionalism, simplifying the life cycle of project life, customer service and the development of new opportunities. The worst ones include high financial and purchase costs, poor public perception of tolls, and complex contract structures.

2.3. Concept of Service Delivery

In his research entitled Defining Service Delivery, Chan et al. (2013) first brings into attention a general description of service, whose strategy describes as a product or service that meet consumer requirements or used by the consumer. For it to work, services must have the following characteristics: available and on time to the user in time and space, reliable, that is delivered timely with the necessary user definitions.

Emerging definition on service delivery and policymaking involves the association of communication from high policy practice and alteration of communication to attain effective communication. Provision of service is a practice of the entire organisation and should not be left on to the management. However, management should strive to deliver more quality services through engaging other stakeholders that is consumers and the society at large (Loeffler & Bovaird, 2016). The organisation should strive to replace the old ideas concerning services delivery with new and appealing ideas. Private public partnerships approach seeks to advance the service delivery through provision of incentives to the private players to ensure the community receives quality service in an efficient and effective manner.

In a nation, public sector is entrusted with delivery of goods and services to its citizens. Due to increasing demands for quality services, the private sector has undergone an incredible transformation to ensure their activities are centred on improvement of services and goods that is satisfactory to the consumers (Caiden & Puniha, 2011). Due to the growing needs of the population, the public sector always find themselves constrained in rendering the services and hence seek association with the already existing systems such as the private sector to aid in service provision.

Public sector reforms in emerging countries as well as developed nations are a concern of policy makers and particularly in addressing infrastructure growth (Ball & Exley, 2010). On top of this, governments engage in various processes of reforms and programme to enhance provision of services. This effort involves development of concepts, tools and leadership activities in private corporate governance and establishment of fresh relations between state and the citizens or private sector.

Au and Ferrare (2015) in their study say enhancing provision of service was an important approach to realize the Millennium Development Goals. However, this remains unachieved despite lapse of the period set for MDGs five years prior. MDGs advocated for key public health services and outcomes such as a decrease in infant mortality and maternal mortality. Others included the fight against HIV / AIDS, TB and malaria. Private public partnerships ought to improve the service and access to health services. Safeguarding access to health care is one of the primary roles of the health care sector. These services must meet the highest standards. Various terms such as access, use, accessibility and cover are sometimes used to indicate that persons are getting the services they need. A holistic approach requires organized

valuation of physical, monetary and social access to health services (Porter et al., 2013).

World Health Organization (2012) argue that access to service delivery denote practical access of services that are generally acceptable. The latter frequently needs to be clarified in terms of provision of service features such as simple apparatus, drugs and goods, health workers, and treatment procedures. Population distribution data is needed to measure practical access. Accurate measurements of access adopts travelling duration and expense as opposed to distance covered.

Customer service delivery is a function of the customer's capacity to pay for services. Details can be analysed by visiting a site or home chats. The latter may be an extremely correct indication of value paid by the client. It is less expensive for this service to depend on the amount of customer service that makes the rating. Service concessions in particular have larger social and psychological dimensions, which can be better measured in home research. Consumer outings are a discriminatory sample because those who stay away from the institution due to socio-cultural obstacles will be remembered. These components of access are tied to quality (Berman et al., 2011).

2.4. Provision of healthcare services in Kenya

Kenya, a British colony named after Africa's second highest mountain, gained freedom in 1963. It has a population of about 53 million (Kenya National Bureau of Statistics [KNBS], 2019). The general aim of the Kenyan Government's ministry of health is to encourage and advance the quality of life of all its citizens by ensuring efficient, accessible and affordable health care services (MoH, 2005). To solve challenges experienced in the health sector and enhancing the cost and availability of

the services, the state as the leading provider of health care services to every citizen has adopted various policy and strategy documents developed over the years. The first comprehensive health policy was done in 1994, while the Kenya National health Policy 2014-2030 is in operation today. The overall national development policy framework today is Vision 2030. The primary goal of Kenya's Vision 2030 Policy is to transform the country into a competitive and emerging regional player on matters of excellent health care provision. Health care is classified under the social pillar. It further states that its aim is to increase quality of life for the people of Kenya, where the country must provide a comprehensive, unified and superior health care system with international standards. Community and home-based health care are included through accredited health care system and providers. Collaboration with private sector Kenya is one of the key strategies being employed in the vision of becoming a regional leader in specialized health care services. Enhanced access to universal health care is to be provided through a system that promotes provision of quality of health care services for Kenyans. Through PPPs, individuals who were previously excluded from health coverage due to financial challenges or other reasons can be served (Government of Kenya [GOK], 2007). The government is therefore committed to implementing programs aimed at accelerating the implementation of Universal Health Coverage (UHC) in Kenya, in line with the Kenyan Constitution (MOH, 2020), which mandates the state as the guarantor of public health provision for Kenyans.

Despite this, the health sector in Kenya has not been able to rapidly expand to provide satisfactory coverage, accessibility and acceptable quality of healthcare for its people since independence as shown in recent household and population surveys.

A few areas in public health have made great strides like maternal health, neonatal and infant mortality. Neonatal deaths have dropped from 31 deaths per 1,000 in 2008/9 to 22 deaths per 1000 per year in 2014. Deaths among infants have dropped from 74 per 1000 live births in 2008 to 52 cases per 1000 births in 2014 (Kenya Demographic and Health Survey [KDHS], 2014). Kenya's crude death rate was at 5.39 deaths per thousand populations in 2019, down from 5.47 deaths per thousand populations previous year, a decrease of 1.39% (WHO, 2019). Other public health concerns like HIV/AIDS, non-communicable diseases and TB still face significant challenges.

Total spending on health per capita was 169 \$ in 2014 while total spending on health as percentage of GDP was 5.7% in 2014 (WHO, 2016). This was far much below the Abuja recommendation of 15% (MOH, 2005). This is also lower than the high-income Organization for Economic Cooperation and Development (OECD) countries' average of 8.8% and that of the United States at 17.1% for the same period (OECD, 2019). The insufficient funding in the health sector has slowed the effort to offer adequate health care to Kenyan citizens. Thus, delivery of health care services is reliant on private sector and donors in Kenya to a significant level.

As is commonly stated in National Health Accounts reports, direct out of Pocket Expenditure (OOPs) is the primary source of funding for health care services in Kenya. Direct charges are set for health care services in both public health (cost sharing) and private health facilities. Out of pocket expenditure is high and accounted for 27.7% of Total Health Expenses (THE) in 2015/16. These OOPs prevents the populations who are vulnerable from seeking for health interventions when they need them. Approximately 40% of salaries and wages is spent by 6.4% of

Kenyans on non-food health expenditures (MOH, 2020). It follows then that if Kenyans will enjoy the health status that they deserve, all actors have to come together in the provision and financing of care. The Government alone cannot make it, and this has been appreciated since 1994 when the first comprehensive policy was prepared. Most of the Government policy and plans from then have recommended partnerships as a sustainable way of providing services to Kenyans. This is one of the proposed strategies in vision 2030.

The total number of health facilities more than doubled from 4,294 in 1999 to 9,448 in 2013 with much of this growth coming from the private sector. Private ownership of health facilities in that period rose from 48% to 53% (The Oxford Group, 2013). Faith-based health services form very important actors in the private sector in Kenya and in most of the Sub-Saharan Africa countries.

In Kenya, three institutions namely: the Kenya Conference of Catholic Bishops (KCCB), the Christian Health Association of Kenya (CHAK) are the main organizations representing the faith-based organizations. The inspiration for FBOs interests in health services delivery is founded in their respective faiths to participate in healing. For example, Christian Faith-based Organizations participate in health services provision in response to the great commission to go out in to the world to teach, preach and heal the sick. In addition, medical care gives opportunity for spread of the gospel and practicing Christ's love and kindness.

The Catholic system has been in operation since 1957 and re-organized as KCCB. The Commission for Health, one of the KCCB's commissions, administers its health system. The CHAK system, a group of protestant churches has in place from the 1930s and was referred as the Protestant Churches Medical Association up to 1982

when they changed their name. The KCCB and CHAK act as secretariats encouraging the roles of their units, which are autonomous in dispensation of their duties. Both coordinate different types of health care organisations and programs. The KCCB program is larger and is present in many regions of the Country. Collectively, the two bodies operate approximately 20% of health organisations in the country.

2.5. Historical sources of support for The Kenyan FBO health services and emerging challenges

Historically, FBO health providers in Kenya have enjoyed support from several sources. Empowering them to offer high quality, affordable and accessible services to meet the health care requirements of the poor and needy groups. Such support comprises of financial and philanthropic contributions from sister FBOs overseas. Hence, foreigners making up the bulk of senior staff like doctors in FBO health facilities. Further support came from the government grants at the national treasury, donated drugs, medical supplies and equipment as well. Direct consumer fees have been an important source of funding for the FBO providers (CHAK, 2006).

A significant source of funding for FBO health care services include revenue from patient financing approximated at 70% of total expenditure. Contributions are inconsistent and are mainly planned for financial development, equipment or special programs such as HIV and AIDS. The grant was stopped in 1996. Currently, most of the government support is usually in the form of medical supplies, and few seconded staff. This support includes vaccines, TB medications, family planning supplies, anti-malaria drugs, HIV testing and HIV medications (CHAK, 2020).

Financial stability has become a major problem with this situation where the high cost of health care has led to decline in consumption of health care services in FBO facilities. In an effort to stay true to their goal of working for the poor, the FBO health centres have found themselves in a huge debt burden. This problem unfortunately results in a negative cycle of staff resignations from FBOs, which also compromises the quality of service delivery. To survive, FBO health providers in Kenya must play a role in adopting new funding mechanisms for their health services. They should also identify strategies to improve the motivation and retention of employees in order to offer specialised and quality health services. This is because they have a religious obligation and responsibility to continue providing health care services to the poor. This foundation makes FBO health services providers a key partner with the MOH in health care delivery. In order to strengthen the good work done by FBO health facilities and increase their coverage, sustainable funding strategies such as PPPs need to be taken seriously.

2.6. Kenya Government and Faith Based Health Services partnerships: structures and processes

The journey started in 2004 after the Government recruited human resources for health from the FBO facilities in large numbers. There was a crisis in the FBO health facilities and this forced its leadership to visit the Head of state for a solution. A meeting was later arranged between the FBO leadership and the Ministry of Health where the FBOs presented a document on the constraints that they were facing and the way forward on partnership with Government (CHAK, 2006).

The result of this meeting was a formal forum for consistent engagement with the Ministry of Health and a stakeholders' Technical Working Group was formed

(CHAK, 2006). The Technical Working Group was mandated to carry out a study on how this partnership could be improved.

The situational analysis study was conducted over November 2006. The overall objective of this analysis was to describe the distribution and capacity of MOH and faith-based health facilities to offer health services. The results of this study were to inform the development of a partnership framework, which would work towards a harmonized long-term Kenyan health system through a sector-wide approach (CHAK, 2007). A sector wide approach meant that all stakeholders in the health care sector pull resources together in the same basket and also have a common health care services implementation strategy. It identified three main actors and their responsibilities: The Government, which is the lead agency in terms of policy, strategy, standards and regulation; the implementers, where the FBO health services providers belong, and the development partners who fund the health care sector (GOK, 2008).

A Memorandum of Understanding (MoU) was signed to regulate PPPs in 2009 between the Kenyan government and the FBOs in health on behalf the Christian Health Association of Kenya, the Kenya conference of Catholic Bishops and the Supreme Council of Kenya Muslim. The validation of this framework of cooperation signified the end of a long journey to strengthen cooperation between FBOs and the Government involved in the delivery of health care in Kenya (CHAK, 2009). The main thrust of the MOU was that the Government would support the FBOs in terms of human resources, infrastructure, medical equipment and consumables as budgets allow. The faith-based facilities in return would offer quality and affordable health

services and accountability of resources through good governance, management and reporting.

In addition to government engagement with the FBOs, Kenya's Community Engagement Stability Act 2011 and its policy framework unlocked the establishment of private financial services and technology, and created an enabling setting for private sector contribution in public service (GOK, 2011) which is an additional contribution to the sector wide approaches strategy.

2.7. Empirical Review

At the global level, the concept of public private partnerships in the healthcare sector can be traced back in 1993 when the WHO General Assembly advised health organisations to work together. This initiative targeted governments and all other health care partners, non-governmental and privately owned organisations included (Buse & Waxman, 2001). According to WHO, PPPs can be perceived as public-sector initiatives where participation of private organizations takes place (WHO, 2015). The private sector operates within the limits set out by the government. The Government as a partner sets the operating rules, regulations, standards and other conditions which the private partners in the sector can adhere to. The private sector comprises of facilities run for profit purposes, NGOs and/or large multi-stakeholder organizations (Torchia et al., 2015). The World Health Organization further found that PPPs actively assist in provision of high-quality health programs, but only a few have made HSS a major focus. Private public partnerships are substantially applied in vertical programming with a few concentrate in HSS as their principal goal. However, the participation of private agencies in HSS is increasing continuously, as

PPPs have recently adopted emphasis on digital approaches to global health systems (WHO, 2015).

Innovative strategic approaches should be adopted to enhance HSS in the settings where vertical programmes are in place. Nevertheless, the Global Convergence Series acknowledges knowledge gap concerning cons and pros of involving public and private sectors in service delivery and if the PPP can enhance effectiveness, accessibility and quality in health care delivery (Jamison et al., 2013). The scholarly work in this subject is spread with notable literature describing involvement of private sector players in provision of health care services. In other cases, literature exist on multi-stakeholder initiatives attempt to strengthen the human resource for health or accessibility or availability of medical materials. Evidence on the PPP focused in the entire health system is currently limited.

The PPP model has become a viable option for procurement of health services over the years. World governments have tried to address limited resources and diverse challenges associated with procuring the services through various PPP arrangements (World Economic Forum, 2005). Collaboration between governments and the private sector has remained one of the drivers of good health outcomes. This has been due to ability of the private health sector to incorporate advanced technology, effectiveness, and wide health service options and risk management (Goel et al., 2006). Private public partnerships have enhanced the fight against public health challenges like malaria, HIV / AIDS and TB amongst other diseases, in sub Saharan Africa (Drunce et al., 2004; Caines et al., 2003).

The non-profit organization, 'FHI 360' led the technical aid of the Andhra Pradesh Health Sector Reform Program, which provides government guidance on the best

forms of public and private partnerships for rural emergency travel services and health care lines. Several PPPs already existed, including between the Health Management and Research Institute of India and the non-profit information body. They were created by the Andhra Pradesh government to provide emergency services. In partnership with government, these partnerships help citizens, especially in rural and interior areas, reach out to qualified doctors and get relevant information on health problems through a toll-free line. To ensure commitment and strengthen relationships between partners, FHI 360 developed a monitoring framework and a systematic randomized audit (FHI 360, 2012).

Kumar and Brock (2012), conducted a survey on developing loyalty in Public and Private Partnerships. The study revealed that the number of health insurance uptake kept increasing in India and China at an average rate of 34% in India and 43% in China. The study further noted public and private insurance had critical roles in delivering health care to people who are different in the two countries. The paper presented details of health insurance indicators as a funding mechanism. It proposes a comprehensive policy framework to harmonization and consolidation of powers that would permit for different development of public health insurance.

Tan and Lee (2019) analysed the financial burden of health services using the case of PPP in Singapore. At first glance, effective health care restructurings that stress government's commitment have been adopted on an equitable basis. At a closer look, the Soviets themselves did not seem to care about the equal visibility of the program. Certainly, they seem satisfied to pay share of their medical expenditures, as well as other payments if they wanted a greater services. Actually, access to the necessary care for the poor was assured. Measures were also available to protect individual

from the financial harm caused by a catastrophic illness. The Singapore experience provides a fascinating study of public and private partnerships, which shows how a complex health policy approach can achieve national goals while balancing efficiency and caring for equity.

Mwaengo (2012) conducted research on the Kenyan coast and pointed out that it is clear that short-term cooperation produces better results as opposed to long-term contracts. Despite the benefits associated with the PPP, the execution of PPP contract faced many challenge; lack of technology, regulations; inappropriate agreement, fraud, political meddling, unforeseen events, conflicts between partners and adverse consequences. The study recommended that successfully implementing the expertise, guidance and policies, transparency and integrity of parties, careful consideration and monitoring contract and engaging stakeholders in the procedure are necessary. The study also recommended other studies be conducted in other public bodies to compare results.

Cui et al. (2018) analysed infrastructure projects implemented using the PPP model. The study acknowledged the key features and categorised them into good investment location, economic performance, expertise, sound monetary and dependable contractual engagements. Domingues and Zlatkovic (2015) argue that effective communication; transparency, active organization, feedback and supervision are important attributes of a success. Other publications such one by Zwikael and Smyrk (2015) address trust and guarantee, mutual arrangement, effective management, rewards, agreement style, work rate and financial resources. Other aspects comprise association among participants, reputation trust and inspiration of private sector, good public approval of PPP projects.

2.7.1. Influence of PPPs in leadership and management on health systems strengthening

According to the WHO model of health systems, leadership and governance involve supporting the existence of policy frameworks combined with effective oversight, coalition building, regulation, attention to system design and accountability (WHO, 2000). Such a responsive leadership regime would support PPPs to give the vision and guide its implementation. Some of the specific actions to be undertaken by health care leaders especially from government would include supportive supervision, building alliances and targeted communication to mobilise and encourage all the actors to participate in PPPs (Hawa et al., 2018). They further noted that when communication is uncoordinated, and mandates for various actors are not defined, then ownership and accountability in PPPs is hindered. They propose that if leadership could take up the role of promoting participation of community actors in Tanzania, then access to quality health services could be enhanced for the community.

Governments should make sure that PPPs are implemented in a timely manner to ensure that private sector participation accrues the intended benefits (Al-Hanawi et al., 2020). They further state that a stable legal and regulatory framework must be established that is properly and easily implemented to avoid confusing different actors with too many changes. Ensuring that openness and accountability procedures are improved is also an important undertaking by the government.

This is because questions can arise as to whether PPPs are effective, efficient and convenient, a question which actors outside government could be concerned with

(Mariateresa et al., 2015). They proposed that research could be done in future to answer this question.

Continuous engagements amongst all actors in PPPs can yield better results if done well. Some opportunities for such a process include physical meetings, structured feedback, and joint work planning (Lauren et al., 2018). They found out that such a process led to a good relationship that also gave small private providers more voice in the health care system. They recommend that to sustain this collaboration, formalized protocols for working together should be drawn, as well as less formal open channels of communication. Approaches for bringing small private providers on the table and delivering them to government health care plans have potential to facilitate PPPs as well. However, little evidence existed on how this could be implemented in developing countries.

Abednego and Ogunlana, (2019) examined the contribution of project managers for the success of the PPP project. The study found project management significantly influence project performance. Issues associated with project success on short term include, customer satisfaction, stock flow and organizational problems. Effective management promotes accurate allocation of risk resulting to improved project performance. The processes required to attain decent project management include clarity, uniformity and efficiency.

According to Liu et al. (2015), effective management in planning PPP projects is a difficult task. Public sector players a critical role in supporting the private sector and hence increase the cost of procurement of PPPs. This requires adjusting to power management arrangements to lower the cost of management of PPPs. Understanding the perceptions of effective governance, accountability, openness, involvement,

decisiveness, complaints resolution and reporting of performance is an important concept in success of PPP. Effective governance consists of the following six processes: contribution, cohesion, openness, accountability, impartiality and efficiency (Jørgensen & Sørensen, 2012; Fourie, 2012).

Brinkerhoff and Brinkerhoff (2011) argue that effective leadership provide a positive atmosphere for best performance of the team. The involvement of top management in making decision affects alignment of the team to the realization of the project collaboratively and fosters trust in cooperative organizations. Supporting top project leaderships is very critical to the achievement of PPP projects. Appropriate administrative tasks such as hiring staff according to proper operating procedures to promote the skilled and fruitful project teams should be enhanced to continue sustenance of high productivity.

Minjire (2015) researched the factors that influence the use of PPP in Kenya's health care system. The study sought to explain how co-management and control affect PPP performance in health care projects. A research-based approach was used with sample of 46 participants comprising technical officials and heads of units with prior knowledge on PPP programs. The research findings on collaborative governance, the supervisory atmosphere, and limited funding are amongst the key problems influencing PPP programmes with MoH. In PPP management, respondents felt that the ministry has strict control of programs. The majority of respondents also felt that ministry was devoted to the objectives of the PPP.

Porter et al. (2010) conducted a study of PPP and the question of transparency. This study examined accountability and its impact on public and private facilities involved in PPPs. An analytical framework used to analyse the efficiency of PPP in achieving

the public sector goal. These include; risk, cost and paybacks, political and common benefits, technology, teamwork, and performance indicators were included in the model that helps public managers improve community cooperation.

2.7.2. Influence of PPPs in material sharing on health systems strengthening

According to the WHO, a well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, with scientifically sound and cost-effective use. Further, a good health financing system raises adequate funds for health, in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them (WHO, 2000).

In a study on availability of sexual and reproductive health commodities in Kenya, Uganda, Tanzania and Zambia, Ooms et al. (2020), found that availability of these commodities was low at less than 50% in all sectors, with highest average availability found in Kenyan government health facilities (46.6%). Unavailability of the commodities was common where average number of stock-out days per month ranged from 3 days in Kenya's private and private not-for-profit sectors, to 12 days in Zambia's government facilities. The researchers propose health systems strengthening as a strategy for ensuring reduced stock outs of such critical commodities in public health.

In contrast, Jeffrey and Gary (2012), examined key public-private partnerships that grew out of PEPFAR to identify aspects that made them effective in the fight against HIV/AIDS in Sub Saharan Africa. For example, PEPFAR's Supply Chain Management System took advantage of private industry's best practices in logistics, and a partnership with the medical technology company BD (Becton, Dickinson and

Company) improved laboratory systems. Setting up of ambitious objectives, working with both global and local partners, supporting a culture of partnerships, excellent planning, continuous monitoring and evaluation, and measuring results led to the most effective programs.

Wright et al. (2019) argue that the PPP may allow government and government agencies to undertake costly projects in the form of short-term budget involvement, but against traditional medium purchases. It will not be possible however because of budget constraints, financial regulations or restrictions. In such a case, the amount of money is not the only thing that a government or government agency should consider when deciding whether to take the PPP approach.

In a study conducted by Barlow and Köberle-Gaiser (2013) on Private Financing Initiatives (PFI), it showed that PFI that normally enters into a funding agreement is a different currency in the health sector through spending on a service enhanced by independent partners. In the PFI of the United Kingdom, perhaps the best-known example, long-term private contracts with the government for funding, building, and, often, managing new projects such as the Consortium can build health facilities. Government partners are appointed to ensure effective service delivery. PFIs have been the topic of on-going benefit debate on their use and implementation needs to be carefully evaluated as a matter of policy and in specific contexts, for example, by assessing the overall project requirements.

An article by Barlow et al. (2013), suggests that European governments continue to collaborate with private sector to record the cost of building and working public facilities service delivery centres. In PPP, Public sector avoid the use of salaries and

the use of skills in the private sector while private sector on the other hand, participants aim to give back.

Momanyi et al. (2018) showed how the Kenya National Insurance Fund could partner with health micro-insurances to improve coverage of insurance and improving access to care especially in the rural areas of Kenya. The paper did not however examine how the government can work with other stakeholders in formulating PPPs for public health provision. The paper also concentrated with only one aspect of PPPs that is financing.

Nanda (2010) has shown how FHI 360, in partnership with the department of health reduced the burden on established public hospitals. They have launched the Gold Star Network as an independent provider of HIV/AIDS and family planning services and programs. The network sponsored treatment at private facilities and aided referrals to public facilities for people who could not afford medical costs. Private providers in the network receive training in services and standards of care and gain access to the public management system. Gold Star Network served 116,636 customers in 2010. The report did not indicate whether there was a regulatory body to oversee this merger and did not indicate any results for commissioned customers.

2.7.3. Effect of PPPs in human resources for health (HRH) on health systems strengthening

A well-performing health workforce is one that works in responsive ways, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (WHO, 2000). Labour issues of the health sector especially challenges in service delivery is a global issues. The severe and serious shortage of personnel is documented in reports and in-depth papers on key figures in the world of health

development, such as WHO, GHWA, and representatives of many global organizations, think tanks, institutions, and society. Therefore, staff shortages have continued to limit delivery of health services (Rowe et al., 2018).

A review by Barlow et al. (2013) shows growing interest in a model where a government official works with private companies to plan, construct and run a hospital as a whole. Borrowing from the experiences of developed countries, Barlow et al. (2013) reviewed the involvement with a variety of models. Though practice is still very narrow and complex testing is declining, rate, quality, flexibility and complication are the arising issues. Generally, new amenities, requires a lot of capital to build as opposed to procuring them using traditional approaches. Contrasting traditional approaches and current approaches, the current facilities are more susceptible to time and cost efficiency, nonetheless this appears to be often undermined. The need to reduce risk in groups means that it is very difficult to find structures that “provide proof of the future” in a world that changes so fast. In the end, such developments are exceptionally complex, and a time solid, complex. Though it is not yet time to say whether the perceived problems are related to the basic model or its implementation, it seems that government partnerships with additional companies are reinforcing the already difficult work of building and operating the hospital.

Sirili et al. (2019) conducted an analysing on the vaccination process and observed the effects of PPP on physician training in the health sector in the 1990s. The study found literature reviews and interviews with key informants for information on training centres and umbrella institutions that train and hire health works to both sector. The study also found PPP in training had a significant impact on the increase

in the number of graduate health workers. In the meantime, undermining the independence of learning institution and the large enrolment of students in the medical field had adverse effect on the quality of health staff. However, the success of the PPP has increased the number of graduate doctors, unemployment and lack of data on training needs and graduation skills subjects the public to lack of health care, poor distribution, and lack of service delivery due to health problems. The study recommended a comprehensive program to address training issues within the PPP framework by including all participants in the training and transfer to the planning of the number of medical students while calculating the quality of the training.

To change the labour system driven by demand, the US Department of Labour has taken a number of steps. The author of this paper highlights three major initiatives which include the Workforce Innovation in High Growth Job Training Initiative, the Community Job Training Grants, and the Regional Economic Development Initiative in which strong public-private partnerships was an essential element of all these initiatives (Sutkowski et al., 2010)

2.7.4. Influence of processes employed in managing the PPP on health systems strengthening

In describing implementation of PPPs in Sub-Saharan Africa through a case study in Lesotho, Hellowell (2017) notes that Government, have budget-related incentives to promote the use of PPPs—even in cases in which they may threaten financial sustainability in the long term. To address this, he proposes for PPPs need to be exposed to more effective scrutiny and challenge, taking into account the government's capacity to manage and compensate for contracted services.

Khetrpal (2016) studying PPPs focused on the health sector targeting selected cases of PPPs initiated by several national governments in India. The analysis of these programs showed the inadequacy of appropriate institutional processes for executing independent implementation policies effectively. It was noted need to address the question of PPP in the health sector, the extent of PPP, the role of sponsorships and incentives to promote this partnership while addressing the issue of protecting the public sector from any budget cuts. The study recommended clear, transparent and adequate mechanisms that ensure the involvement of all parties in the process. The study also recommended coordination of various government departments and various implementation agencies to ensure access to resources such as proper HRH, effective monitoring and management systems, adequate information provision for all stakeholders, the establishment of appropriate regulatory agencies to manage new activities and strengthen public programs.

Hwang et al. (2013) conducted a study to examine change in healthcare in Singapore using PPPs. The study identified sound health care regulations that promote health involvement in providing care in Singapore and the opportunity to respond to change with the persistent difficult of growing to health centre attractive to foreigners and safeguarding entrance to inexpensive health care. A three-factor model, connecting not only state and suppliers but also powerful users is essential. The study recommended the state to detach itself from the role of providers as providers continue to contend and engage in more expensive health care systems than their counterparts engage.

Sinisammal et al. (2016) examined the understanding of PPP among entrepreneurs in healthcare and social services. The study was conducted in Finland rural targeting 13

entrepreneurs. The entrepreneurs' perceptions on the specifications of the interaction between the public and private sectors were measured using a questionnaire. The study identified three classes of causes that contribute to the achievement of relationships. These include type of partnerships, business structures and stakeholders. Key issues comprise the reorganization of social and health care procedures and PPPs in service delivery.

Anyaehe et al. (2014) conducted a survey of the challenges and potential of PPP in provision of health care to the developing economy. The aim of this study was to offer an insight on the planning the execution of PPP in Enugu State health system via multi-sectorial identification of problems, limitations and projections. The study concluded that the PPP in health care delivery involved great awareness where participant involvement and well-planned policy was in place prior to the execution. The biggest challenge in planning and execution of PPP would be to ensure that the public sector partners agree to take over and support the private sector participation.

Osei-Kyei and Chan (2015) reviewed studies on key elements of the success of PPP projects from 1990 to 2013. This review identified key elements of the PPP's success. The study focused on Critical Success Factors studies on the use of PPP from other selected top academic journals from 1990 to 2013. The review reflects the growing interest in research to identify key aspects of PPP success since 1990. Critical success factors are prioritized for risk-sharing, resilient private organization, state backing, community support and transparency. It was also noted that to the South Australia, to the West the United Kingdom and to the east China and Hong Kong were the emphasised areas for study.

2.8. Theoretical Framework

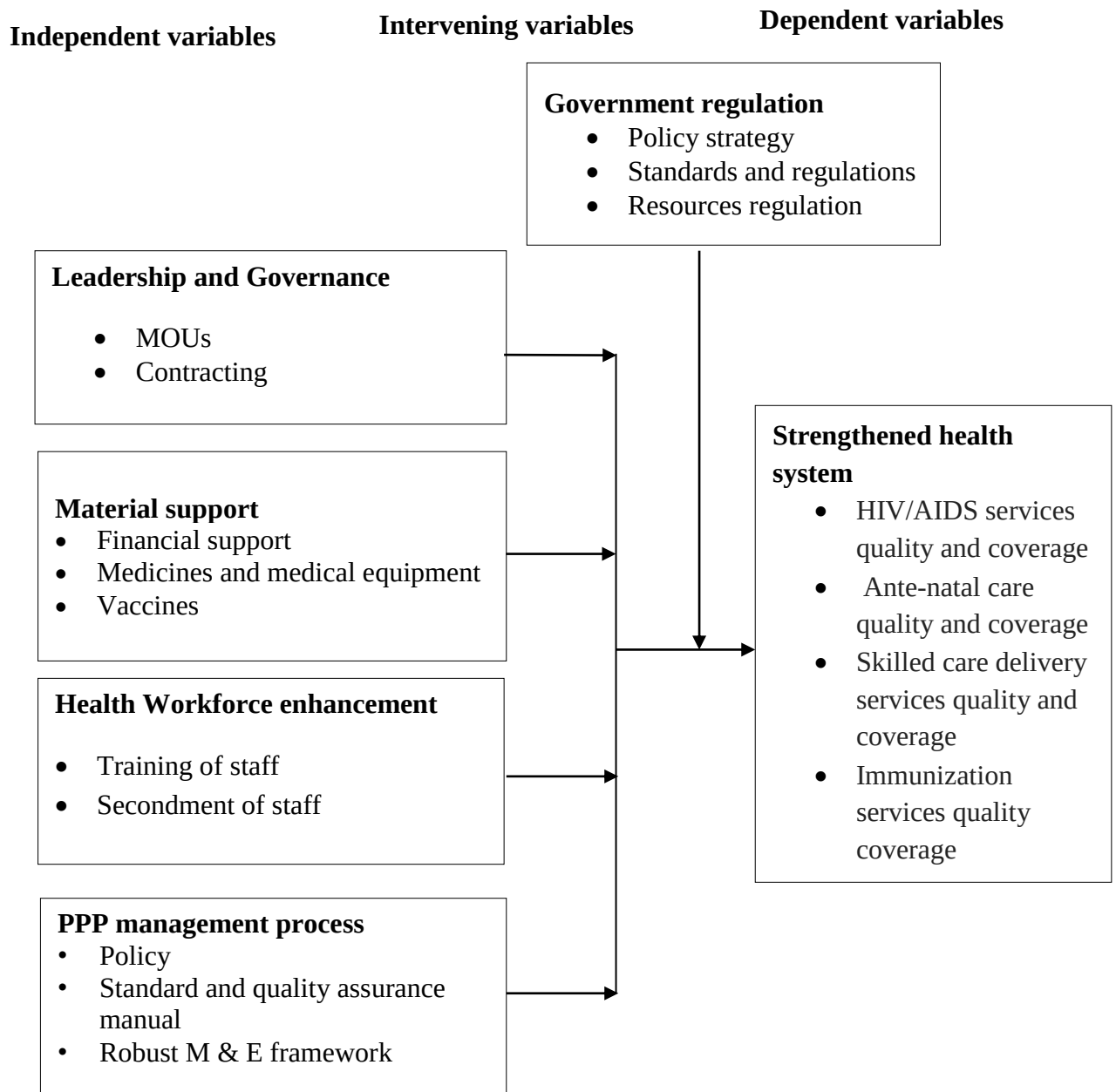
The study used stakeholders' theory; a theory founded by Freeman in 1984. The stakeholders' theory claims that stakeholders group in the health sector includes government, health NGOs and private organisations in the private sector. The other category of stakeholders includes employees, and customers who are the general public. Freeman argues that for stakeholders (institutions) to gain the support of other groups, the institutions should ensure they carefully address the needs of the group involved. According to Jones and Wicks (1999) who are the contributors of stakeholder's theory, the public authorities should assess the needs of all affected parties before rolling out programs. Murdock (2004) and Hwabamungu (2014), argues that successful implementation of PPPs in health sector is dependent on public sector leadership's capability to mobilize the stakeholders. Hwabamungu further emphasises that public health sector should carry out analysis of stakeholders' power, interest and predictability.

This study adopted this theory to examine the relationship between public and private health sectors in Kisii County

2.9. Conceptual Framework

Public private partnership investments in health systems building blocks are the independent variables while what HSS is supposed to achieve (outcomes) forms the dependent variable. Four outcome variables have been purposively chosen.

Figure 2. 1:
Conceptual framework



2.10 Research Gaps

One of the major concerns is that there seems to be no significant breakthroughs in PPPs since 1994 when the KHPF was elaborated by the government while putting PPPs as one of the strategic imperatives of achieving better health for the population. Review of literature has shown that many attempts in supporting the strategy of PPPs have been done in Kenya. The Government and the FBOs health service ‘leadership

have defined the structures, systems and processes to support PPPs. These include the MOH-FBSH-TWG, the MOU, the code of conduct to guide the SWAP strategy, the FBOs Health Services Coordinating Committee, and the joint program of work and funding (CHAK, 2010). This is in addition to the SWAPs (MOH, 2006). The PPP act of the year 2011 as well as the regulations supporting the act provided an avenue where public sector can borrow private capital and professionalism while a conducive environment in which private institutions can take part in delivery of public goods and services (GOK, 2011).

The outputs, outcomes and impacts of these efforts are not clear however. Nobody has done a study to find out if the PPPs are bearing fruits especially in terms of strengthening health systems in the FBO health services.

Manyuru (2013) showed how public private partnerships would be key in the successful devolution of health care services in Kenya, especially in getting rid of counterfeit drugs. He did not however look at the policy and regulatory framework at the County level, and how systems would be strengthened by the PPPs for sustainability.

In a study commissioned by the Embassy of the Kingdom of Netherlands in 2016, a huge opportunity for partnerships in the health care sector in Kenya was demonstrated. The study concentrated on how the Netherlands can conduct private business with Kenya through sale of health products. The study did not look at the public provision of care as this study intends to do

Owino found out that there have been various attempts at crafting systems and structures for PPPs but most of them are not adhered to (Owino, 2005). Wang'ombe (2006) carried out a study to find out the financing woes of health care in Kenya. The

study found out that the FBOs were grossly supported by the government. However, the study did not find out how the partnerships were being implemented. This study seeks to fill this apparent gap. In addition, Munish found out that, PPPs in developed countries were poorly implemented and that the systems in place needed review to make sure that FBO health services live up to their mission. He recommended the same type of study to be replicated in developing nations. This study seeks to do exactly that with reference to Kenya as a developing nation (Munish, 2002).

The WHO found out that although PPPs have a very big potential of improving health care in developing countries, most governments were not paying attention with regard to strengthening this partnerships. The WHO study recommended a situational analysis in PPPs in an African setting to identifying what actually goes wrong when it comes to implementation of PPPs. This study seeks to fill this apparent gap in literature (WHO, 2009). Consequently, previous literature has mainly focused on PPP without going into details on the role played by various investments such as leadership and management, human resources for health enhancement, material support and processes employed in managing the PPP and their effects on strengthening of health systems by producing expected health actions.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methodology which was adopted in execution of the study. These includes study design, the target population, sample size, sampling procedure, pre-test, reliability and validity tests, organisation and data analysis, and ethical considerations.

3.2. Research Design

The study adopted a cross-sectional descriptive research design. The design was adopted since the research sought to describe the subjects on basis of specific variables. According to Babbie and Mouton (2007), cross sectional descriptive study design provides the appropriate model for capturing data to describe a large population. Kerlinger and Lee (2000) also argue that the design is ideal in systematic collection of facts at given period to provide a description regarding a particular phenomenon. A descriptive research design was adopted in order to assess effects of the private public partnership as a strategy for strengthening health systems in the FBO health services in Kisii County. The independent variable was public private partnership while the dependent variable is health systems strengthening in FBO health services in Kisii County. The proxy indicators for health systems strengthening were HIV/AIDS quality and coverage, maternal health services quality and coverage; and neonatal/child health quality and coverage.

3.3. Target Population

The study targeted FBO hospitals in Kisii County, where 78 respondents from selected hospitals were sampled (management teams of Tabaka Mission Hospital,

Christian Marian Mission Hospital, and Nyanchwa Mission Hospital). The study also collected key informants' responses from top health officials in the County Health Management Team of Kisii County, and Sub County Health Management Teams from Nyaribari Chache and South Mugirango Sub Counties. The study measured the support offered by the government of Kenya to the FBO hospitals in Kisii County through the PPP. In return, the FBO hospitals are supposed to utilise this opportunity for HSS in their facilities and catchment populations in offering quality and accessible health care services to those they serve. Faith-based hospitals' actors were therefore the respondents in this study.

Table 3. 1:

Target population and sample for the study

Institution	Strata	Number
Tabaka Mission Hospital	CEO	1
	Departmental and sub departmental heads	26
Christiamarian Mission hospital	CEO	1
	Departmental and sub departmental heads	23
Nyanchwa Mission hospital	CEO	1
	Departmental and sub departmental heads	26
	Total	78
Key informants		
County Health Management Team	Kisii County	2
Sub County Health Management Team	South Mugirango Sub County	1
Sub County Health Management Team	Nyaribari Chache Sub County	1
Total		4

3.4 Sample determination and sampling procedure

The study employed purposive sampling technique to select FBO hospitals that provided sufficient data for this study. The purposive sampling technique, also called judgment sampling, is the deliberate choice of a participant due to the qualities the participant possesses (Etikan et al., 2016). This was adopted as the targeted hospitals were considered to have the complete information that was required in this study. The 3 hospitals account for 80% FBO health services in the county. Heads of the Kisii County Management Team, South Mugirango Sub County Health Management Team, and Nyaribari Chache Sub County Health Management Team were included in this study. The sub counties mentioned are where the 3 FBO hospitals are based.

3.4.1. Inclusion and exclusion criteria

Establishing inclusion and exclusion criteria for study participants is a standard, required practice when designing high-quality research protocols. Inclusion criteria are defined as the key features of the target population that the investigators use to answer their research question (Patino & Ferreira, 2018). Typical inclusion criteria include demographic, clinical, and geographic characteristics. In contrast, exclusion criteria are defined as features of the potential study participants who meet the inclusion criteria but present with additional characteristics that could interfere with the success of the study or increase their risk for an unfavourable outcome. In this study, only those in management were included in the study. On the other side, all persons who worked as departmental or sub departmental heads in the targeted hospitals were included in the study.

3.5 Data Collection

The study used questionnaire and an interview schedule to capture data used in this study. The following sub sections provide the instruments used, the validity and reliability methods used to ensure the tools captured the reliable data. Authorization to collect study was obtained from Kenya Methodist University and Permit from the National Commission for Science, Technology & Innovation. Consent from the participating hospitals was also sort as well as the County Ministry of Health.

After seeking authorization, the researcher approached the respondents and requested them to fill the questionnaires. The questionnaires were left with the respondents due to their busy schedule and collected after one week. For the Kisii County officials, arrangement was made for interviews which were conducted at a time appropriate for the respondents and the researcher.

3.5.1 Research Instruments

Questionnaire and interview schedules were the two main data collection tools. Structured questionnaires were chosen because they are easy to administer and analyse therefore time saving (Kothari, 2017). The researcher carried out an in-depth literature review to design the questionnaire for the survey.

The use of questionnaires in this research was important in obtaining data from departmental and sub departmental heads who have tight working schedules, as questionnaires are ideal for busy respondents. Orodho and Kombo (2004) explained that questionnaires are efficient because they have the ability to collect a large amount of information within a short period of time and they can also be easily analysed. Questionnaires were preferred because data collection is fast and saves time.

Interview schedules were used for key informants. Paton listed six types of questions in a qualitative interview that were considered. These are behaviour or experience, opinion or belief, feelings, knowledge, sensory experience, and background and demographic information (Pope & Mays 2020).

3.6. Pre-test Study

Mugenda and Mugenda (2012) argue that a pre-test is a study conducted prior to the data collection exercise. This stage is critical in development of study tool since it helps to understand the strengths and the weaknesses of the study tool as well as the statements in the tool that do not make proper meaning or subject to be misinterpreted. A pre-test also helps the researcher to assess how various indicators in the tool would be analysed and interpreted (Orodho, 2009). During the pre-test study, questionnaires were administered twice to the same group at an interval of two weeks. The questionnaire was pre-tested using 8 individuals from a hospital in neighbouring Nyamira County.

3.7. Reliability and validity of research instruments

3.7.1. Reliability of research instruments

The degree of consistency in a study tool is referred to as reliability (Kothari, 2017). Research reliability is the degree to which a research method produces stable and consistent results. A specific measure is considered to be reliable if its application on the same object of measurement a number of times produces the same results. Data from the pre-test study was used among other things to establish the reliability of the questionnaire. The questionnaires were given to the same identified group twice in an interval of two weeks. The data was collected within the interval to assess the consistent in the responses. The data obtained was used to compute the reliability

using Cronbach α which is a popular method of determining reliability of a tool. Cronbach's alpha reliability coefficient ranges between 0 and 1. A cronbach alpha of above 0.7 is acceptable. The following is the formula which was used:

$$\alpha = \frac{k}{k-1} \left(1 - \frac{1}{s_T^2} \sum_{i=1}^k s_i^2 \right)$$

Where:

K = number of questions

s_i^2 = variance associated with item i ,

s_T^2 = variance associated with the sum of all k item scores

This was computed in SPSS.

3.7.2. Validity of the research instrument

Validity is the extent to which a concept, conclusion or measurement is well-founded and likely corresponds accurately to the real world. Mbwesa (2008), describes validity as the extent to which a tool captures accurate information. Validity is an indication that the results obtained from the research mirrors the reality and that the findings are generally broad to reflect the population. To increase the validity of the study, research tools were designed in close collaboration with educational authorities. Additionally, the tools were pre-tested and reviewed prior to the actual data collection.

In addition, this study aimed to measure whether the study instruments provided sufficient support for the research questions by assessing the content validity. Content validity is concerned that the test or measurement instrument represents the

full content of the experiment (Mugenda & Mugenda, 2012). To achieve this, questionnaires were thoroughly inspected to ensure access to all key research areas.

In addition to this content validity, the researcher examined the construct validity of the instrument. According to Orodho (2009), construct validity is the extent to which data obtained from the field represents the theoretical concept in accuracy and meaning. This was tested to assess the specific measure was consistent with other variables in practice.

3.8. Data Organization and Analysis

3.8.1 Data organization

After data collection fieldwork was completed, data was prepared for analysis. Data cleaning was performed to identify the incomplete responses or imprecise data, which was modified or removed from the returned questionnaires. The responses were manipulated and coded using Statistical Package for Social Sciences.

To compute the inferential statistics, the researcher computed five variables: leadership and management; material sharing support; human resource for health enhancement, process for implementation of the PPP, and health systems strengthening at FBO healthcare providers. This was done using the formula below:

$$\text{Computed variable} = (X_1 + X_2 + \dots + X_i) / n$$

Where X are the indicators of each variable i= the ith indicators and n= the number of indicators.

The values were rounded up to the nearest whole number and categorised using 5 likert scale (1=strongly disagree, 2= Disagree, 3= undecided, 4= Agree and 5= strongly agree) to reflect the original variables for all independent variables.

The outcome was grouped into 3 likert scale (i.e. =somewhat improved, 2= Very improved, 3=extremely improved). These values were used to determine the association between PPP on leadership and management, material sharing support; human resource for health enhancement, process for implementation of PPP; and health systems strengthening.

The researcher also used the computed index for both independent and dependent variable to fit the data into a regression model so as to determine the relative and cumulative contribution of PPPs on leadership and management, material support, human resource for health enhancement, process for implementation of PPP, on health systems strengthening for FBOs facilities in Kisii County. The regression model below was used:

The regression model is given by the following equation; $Y = \alpha + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + E$

Where:

Y = is dependent variable y (health systems strengthening)

$b_0 = b_4$ are the sample estimates of the coefficients

X_1 = Material support

X_2 = Process for implementation of PPP

X_3 = Human resource for health

X_4 = Leadership and management

ε = Standard Error

The qualitative data was analysed using thematic approach. Responses were grouped into occurring themes from the 4 interviewed County health officials.

3.8.2 Data analysis

Once verification was complete, the final data was moved to Statistical Package for Social Science (SPSS) for analysis. Before data analysis, data was cleaned; this was done by running frequency distribution to find out cases of outliers that could have occurred during data entry. Data was analyzed using SPSS Version 20 because it is flexible package that permits for manipulation of data into several arrangements. Qualitative data was checked for similarity and inferentially analyzed. It was later presented according to the themes of the study in narration form. Quantitative data was checked for completion, cleaned and inputted in a statistical software for analysis. The researcher computed variables from the responses that were used to generate inferential statistics. The study used Chi-square test to determine the association between the PPP and HSS. The study also fitted data into a regression model so as to determine the relative and cumulative contribution PPP on leadership and management; material support; Human resource for health enhancement, process for implementation of PPP on health system strengthening for FBOs facilities in Kisii County

3.9. Ethical Considerations

The Researcher first obtained an authorization letter to carry out the study from the Kenya Methodist University. This letter was to introduce the researcher and state its purpose. Using the authorization letter from the University, the researcher applied for a research permit from National Council of Science, Technology and Innovation (NACOSTI). This letter authorized the researcher to undertake the stated research within the boundaries of Kenya. The Researcher also obtained an authorization letter from Kisii County government and proceeded to collect the data. The study locale

was Kisii County therefore it was necessary to seek permission to undertake this study there. The intention and nature of the study was explained to all involved parties. After the researcher had explained the nature of the study, they give consent. The researcher also ensured the respondents that data collected would be used be used for academic only and findings would be shared with them.

CHAPTER 4

RESULTS AND DISCUSSION

4.1 Introduction

In this chapter, the findings from collected data is presented using both descriptive and inferential statistics. The chapter is arranged according to the study objectives. The first section provides preliminary information, response rates, reliability of the study instruments and social economic information.

4.2 Response rate

The sample size of this study was 78 officials working in FBO hospitals and 4 senior officials of the Kisii County Government Department of Health. The response rate of 73.1% was considered sufficient to make decision in this study (Kothari, 2017).

4.3. Reliability results

The study used Cronbach's alpha in examining the reliability of the questionnaire and an alpha value of 0.778 was obtained, indicating high internal consistency. The Cronbach's alpha values obtained for respective variables were found to be consistent, therefore concluding that the tool was reliable in assessing the influence of the PPP in strengthening health systems as shown in the table below:

Table 4. 1

Reliability of study variables

	Factor	Cronbach's alpha
1	Leadership and management support	0.823
2	Provision of material support	0.876
3	Human resources for health enhancement	0.792
4	Processes guiding PPP implementation	0.827
5	Health systems strengthening	0.768

4.4. Social demographic information

The Researcher examined the respondent's gender, age, highest level of education attained at the time of the study and the work experience in years. This information serves to provide the basic understanding of the respondents who took part in the study from which collected responses could be further analysed.

Table 4. 2

Social demographic information

		n	%
Age	Below 25	2	3.5
	25-34 years	15	26.3
	35-44 Years	32	56.1
	45-54 Years	6	10.5
	55 years and above	2	3.5
Gender	Male	31	55.4
	Female	25	44.6
	Total	56	100.0
Education	Certificate	4	7.0
	Diploma	38	66.7
	Bachelor's degree	11	19.3
	Master's degree	4	7.0

The study found majority of the respondents were male 31 (55%), while females were 25 (45%), of the total respondents. This implies that fewer women were represented at managerial levels of Government and FBO hospitals in Kisii County as compared to men. Though gender is not related to provision of services, it helps in describing a key characteristic of the respondents in a study.

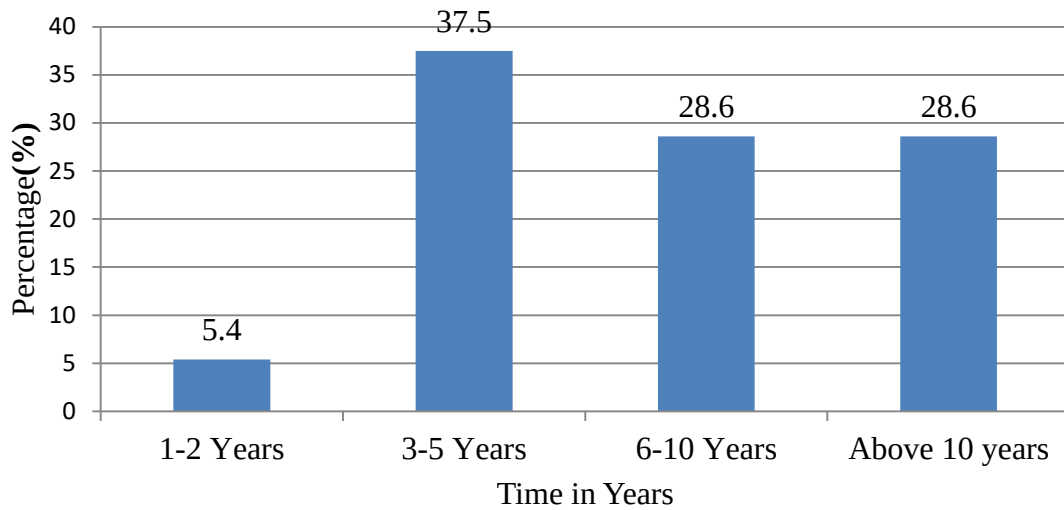
Results showed that majority of the respondents were in the 35-44 years' age bracket and represented 32 (56.1%), followed by the 25-34 years' age bracket at 15 (26.3%).

Those aged below 25 years' age bracket and above 55 years age group were the lowest representing 2 (3.5%) of the respondents each.

Majority of the respondents 38 (66.7%) had attained a diploma as the highest level of education, while 11 (19.3%) of the respondents had bachelors' degree. Four respondents, (7%) said they had attained master's degree while 7 had certificate level qualifications. Education, though a descriptive factor has influence on how we perceive issues in day-to-day life. Education level is critical in any perception-based study. The higher the level of education, the higher the reliability of individual's judgement. The education levels represented were considered sufficient in this study. The study further assessed the duration that the respondents had worked in the position held during the study period. Experience is a factor that may influence one attitudes and effectiveness in executing various programs in life, in this case provision of health services in the FBO facilities and being reliable respondents. The study found that most of the respondents, 21 (37.5%), had been practising at the position held during the study period for about 3-5 years, while 16 (28.6%) had been in the position for 6-10 years. Those who had been promoted to new positions (1-2 years) accounted for 3 (5.4%) of the respondents as shown in figure 4.1. The respondents' duration of work in their current positions was considered sufficient to effectively respond to the questions in the study.

Figure 4. 1:

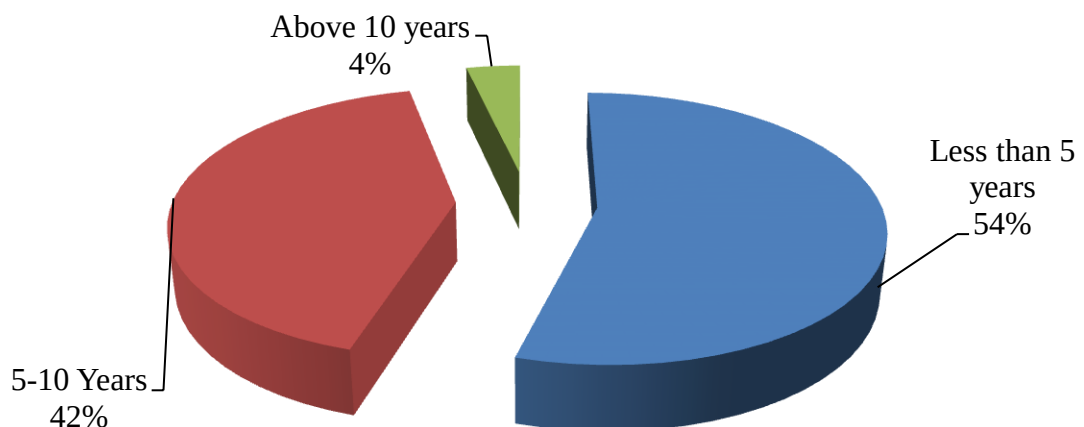
Duration worked in current position



The study further sought to assess the work experience that respondents had attained in their entire career journey. These findings were analysed and presented in figure 4.2 below.

Figure 4. 2:

Work experience



The study found that most respondents had a work experience of below 5 years accounting for 30 (54%) while the second largest proportion of the team had served

for 5-10 years accounting for 23 (42%) of the respondents. Only 2 (4%) had work experience of above 10 years. This might have been explained by the nature of medical career progression where the most experienced health workers prefer to either work with government facilities or end up in FBO hospitals. However, for the purposes of obtaining credible responses in the study, this work experience was also considered sufficient.

4.5. Strengthened health systems within the FBO facilities in Kisii County

The study assessed strengthened health systems using various set of indicators. These were used as proxy indicators to measure health systems strengthening outputs in this study. These key indicators relate to the following key health services and their characteristics: HIV/AIDS services quality and coverage, ante-natal care services quality and coverage, skilled care delivery services quality and coverage; and immunization services quality and coverage.

As a result of the PPP, the respondents were required to rate their level of agreement with various statements relating to prevalence of HIV/AIDS; the cases of new HIV infections; the retention of HIV clients accessing services in the hospital in the cascade of HIV care with viral suppression; the reduction of mother to child transmission of HIV; the increased access and utilization of family planning services within the hospital and region, reduction in maternal death; and increased number of skilled care delivery in the hospital and region. Additionally, increased immunization rates for children in the hospital and region; and reduction in child mortality in the hospital and region were also assessed. The variables were measured using 5-likert scale (1= strongly disagree, 2= Disagree, 3= undecided, 4= agree and 5= strongly agree).

The study found that there was a reduction in the prevalence of HIV/AIDS in the region 38 (70.4%) agreed and 9 (16.7 %) strongly agreed. For reduction in cases of new HIV infections, 34 (64.2%) agreed and 9 (17.0%) strongly agreed. The study further found that HIV/AIDS clients accessing services in the hospitals were retained in the cascade of HIV care and had attained viral suppression (30 (58.8%) = agreed and 14 (27.5%) = strongly agreed). The study further noted that HIV transmission from mother to child had reduced in the hospital as a result of the PPP (28 (51.9%) = agreed and 22 (40.7%) = strongly agreed). Utilization of antenatal care services had increased in the hospital and region (27 (50.9%) = agreed and 22 (41.5 %) = strongly agreed). It was also noted that there was an increase in access and utilization of family planning services within the hospital and region (18 (34.0%) = agreed and 12 (22.6 %) = strongly agreed). Maternal deaths had also reduced in the hospital and the region (29 (54.7%) = agreed and 18 (34.0 %) = strongly agreed). The study further observed increased number of skilled care delivery in the hospitals (20 (37.7%) = agreed and 25(47.2 %) = strongly agreed) and region as well as high immunization rates for children (25 (46.3%) = agreed and 26(48.1%) = strongly agreed) which explains the reduction of child mortality within the region (28(51.9%) = agreed and 19(35.2 %) = strongly agreed).

Table 4. 3:***Strengthened health systems***

	Strongly disagree		disagree		Undecided		Agree		Strongly Agree			
Statement	N	%	N	%	N	%	N	%	N	%		
There has been a reduction in prevalence of HIV/AIDs within the hospital and region as a result of the PPP	2	3.7	1	1.9	4	7.4	38	70.4	9	16.7	3.737	1.188
Cases of new infections with HIV/AIDs have reduced within the hospital and region as a result of the PPP	2	3.8	2	3.8	6	11.3	34	64.2	9	17.0	3.597	1.307
HIV patients are retained in the cascade of HIV care and have attained viral suppression within the hospital and region as a result of the PPP	0	0.0	2	3.9	5	9.8	30	58.8	14	27.5	3.667	1.443
HIV transmission from mother to child has reduced within the hospital and region as a result of the PPP	0	0.0	1	1.9	3	5.6	28	51.9	22	40.7	4.088	1.169
Utilization of antenatal care services has increased in the hospital and region as a result of the PPP	0	0.0	0	0.0	4	7.5	27	50.9	22	41.5	4.035	1.267
There is increased access and utilization of family planning services within the hospital and region as a result of the PPP	13	24.5	4	7.5	6	11.3	18	34.0	12	22.6	3.000	1.680
Maternal deaths have reduced in the hospital and region	0	0.0	3	5.7	3	5.7	29	54.7	18	34.0	3.877	1.310
There has been an increase in the number skilled care delivery in the hospital and region	0	0.0	3	5.7	5	9.4	20	37.7	25	47.2	3.965	1.375
Immunization rates for children have increased in the hospital and region	0	0.0	1	1.9	2	3.7	25	46.3	26	48.1	4.175	1.182
Child deaths have reduced in the hospital and in the region	1	1.9	1	1.9	5	9.3	28	51.9	19	35.2	3.947	1.231

The study found that key public health services had improved in the recent years in the FBO facilities in Kisii County. The services under study (HIV/AIDS, maternal, neonatal and child health services), cannot succeed if the government does not collaborate with the private sector, including the not-for profit providers. Such expensive services are public health goods which most communities especially the vulnerable would not afford to pay for, therefore limiting access. This is consistent with Mohamad et al. (2018) who found that PPPs helped improve service delivery in Malaysia. Even in the developed world, Torchia et al. (2015) found out that PPPs had remarkable contribution on effectiveness in service delivery in Germany. Further, Main et al. (2018) found that PPPs aided in reducing maternal deaths in California. From the findings of this study, coupled with health services outcome data from the District Health Information System 2 (DHIS 2) (MOH, 2020), it can be demonstrated that a PPP can work if certain inputs and processes are managed. Majority of the respondents noted that most services had improved in terms of coverage, uptake and quality. Hossain et al. (2020) found that collaboration between public and private health providers was critical in ensuring successful delivery of services in underserved communities particularly in the area of maternal health in rural Bangladesh. Further, public private partnerships can be seen as approaches adapted by the private sector to obtain optimal and consistent performance in the provision of health care services (MDG Africa Steering Group, 2008). This is true for FBOs who may not have sufficient revenue streams. Currently, PPPs are perceived as social experiments that provide a platform to complement the efforts of public health facilities and governments through the involvement of the private sector. The aim of PPPs is to address challenges of the private sector in the effort to provide health

services through cooperation with the public sector. Shrivastava et al. (2019) notes improvements in laboratory services in support for HIV services in Africa through PPPs. On the hand, Parker et al. (2019) argues that there is still a lack of sound evidence supporting the effectiveness of PPPs in health promotion, and the evidence base is skewed by non-independent evaluations. He further says that public health actors should abstain from engaging in agreements with industries whose business interests have a high potential for competition with the health promotion activity undertaken. On the contrary, this study presents evidence that PPPs can improve public health services if implemented well. They contend that further research is required, for example, to determine how far the artificial emphasis on choice offered within healthcare delivery PPPs weakens the public sector, further diverting public funds to subsidize private providers. This study did not note any complaints especially from the respondents leading the ministry of health in kisii county government that PPPs affected health services in government hospitals, as a result of the PPP. Additionally, the FBO sector is not driven by profits, but service to humanity.

4.6. Leadership and management partnership and strengthening of health systems in FBO facilities in Kisii County

The first study objective assessed the effects of leadership and management PPP on health systems strengthening. To achieve this, the study rated respondents' views on a number of statements. These statements include: existence of PPP between the government and the hospital; availability of governance and management processes to guide the PPP (MOU, contracts); availability of an engagement mechanism in the PPP (Board meetings, County/Sub County level meetings; and support supervision

by the government, etc.). Others included availability of a thorough accountability system to guide the PPP (e.g. regular audits, program specific supportive supervision); government's commitment to the PPP; the relationship between government and the hospital, ability of the PPP to meet the hospital's expectations; contribution to timely provision of health services; and provision of training to the hospital board and management on the PPP. The variables were measured using a 5-likert scale (1= strongly disagree, 2= Disagree, 3= undecided, 4= agree and 5= strongly agree)

The study found that there existed a PPP between hospitals and the government as implied by 81.2% of the respondents who agreed. It was also noted that governance and management processes to guide the PPP were in place (29 (51.8%) = agreed and 9(16.1%) = strongly agreed). Concerning engagement mechanisms, most respondents (27 (48.2%) = agreed and 18 (32.1%) = strongly agreed). These included board meetings, County/Sub County level meetings, and support supervision by government, etc. Most respondents also said that the government had a thorough accountability system to guide the PPP (27 (48.2%) = agreed and 14 (25.0%) = strongly agreed). The study further noted a positive response concerning government commitment to the PPP (30 (57.7%) = agreed). The relationship between the government and hospitals could be termed as conducive enough to provide a fertile ground for the success of PPP as observed by 42 (77.8%) of the respondents. It was observed that the PPP had met expectations of the hospitals and communities by ensuring timely provision of health services and training of hospitals board and managers on the PPP.

The study found an overwhelming consensus amongst the respondents that there exists a PPP between the hospitals and the government with 91.2% of the respondents agreeing, with well-defined structures and processes. A study conducted in Tanzania by Kamugunya and Olivier (2016) proposes a need for new social contracts that would support integrative collaboration at the local level and bring all non-state actors to the centre of the district health system, for PPPs to be effective. From the study, this is what Kisii County and the FBO sector have done. The findings were further consistent with Rothballer and Kim (2013) who found PPPs improved performance of health systems through capacity building. Sadeghi et al. (2016) found out 4 main themes and 20 subthemes in terms of strategies to develop and promote PPPs in the provision of hospital services in Iran, including changes in policies and laws, socio-cultural changes, improvement of mechanisms and current processes, and financial and capital capacity building. The study found out that the respondents were aware of the national PPP policies and laws, mechanisms and processes are in place, and both parties were keen to see the PPP succeed.

Table 4.4***Leadership and management partnership on the strengthening of health systems***

Statement	Strongly Disagree		disagree		Undecided		Agree		Strongly Agree		Mean	S_SD
	N	%	N	%	N	%	N	%	N	%		
a). There exists a PPP between the Hospital and the Government	0	0.0	2	3.5	3	5.3	34	59.6	18	31.6	4.193	0.092
b). A governance and management process to guide the PPP is in place (MOU, Contracts)	1	1.8	3	5.4	14	25.0	29	51.8	9	16.1	3.684	.985
c). There is in place an engagement mechanism in the PPP (Board meetings, county/sub county level meetings, support supervision by government, etc.)	2	3.6	1	1.8	8	14.3	27	48.2	18	32.1	3.965	1.068
d). The government has a thorough accountability system to guide the PPP (e.g. regular audits, program specific supportive supervision)	1	1.8	4	7.1	10	17.9	27	48.2	14	25.0	3.807	1.060
f). The government is committed to the PPP.	2	3.8	2	3.8	13	25.0	30	57.7	5	9.6	3.333	1.327
g). The relationship between the hospital and the government is conducive enough for the PPP to succeed.	1	1.9	6	11.1	5	9.3	32	59.3	10	18.5	3.614	1.250
h). The PPP has met hospital expectations	3	5.7	10	18.9	17	32.1	22	41.5	1	1.9	2.930	1.223
i). The PPP has contributed to timely provision of health services	1	2.0	5	10.0	11	22.0	29	58.0	4	8.0	3.158	1.437
j). The PPP has met the expectations of the community e.g., quality and access of care	1	1.8	5	8.9	13	23.2	27	48.2	10	17.9	3.649	1.045
k).The government trains the hospital board and managers on the PPP	7	12.7	6	10.9	16	29.1	26	47.3	0	0.0	3.000	1.180

Globally, health partnerships have made significant inputs to boost the health performance as well as the management of global public health. However, the global health landscape is complex and resources to address health challenges are limited demanding continuous enhancement and application of every knowledge to promote health partnership performance. Leadership and management were found to be a key determinant of the successful implementation of the PPP in this study, a finding that was found to be consistent with Buse and Tanaka (2011). The study also supports the findings of Asante and Zwi (2007) which found a strong leadership to be responsible for the global successful implementation of PPPs in the health sector.

4.7. Influence of material sharing on the strengthening of health systems

The second objective of this study assessed effects of material sharing support on strengthening of health systems. To achieve this, the study rated the agreement on a number of statements by the respondents. The study assessed the benefits in terms of financial resources, vaccines and cold chain (vaccine commodities, fridges, documentation and tools), improvement in pharmaceutical and non-pharmaceutical supply, transportation and logistics, benefits from medical equipment and infrastructure. The variables were measured using 5-likert scale (1= strongly disagree, 2= Disagree, 3= undecided, 4= agree and 5= strongly agree).

The study noted that the hospitals had benefitted from vaccines and cold chain (vaccine commodities, fridges, documentation and tools) (46.4%= agreed and 46.4%= strongly agreed). The PPP was also associated with hospitals' improvement in pharmaceutical and non-pharmaceutical supply (47.2%= agreed and 22.6%= strongly agreed), transport facilities/logistics 25 (46.3%) who agreed and medical equipment (24 (44.4%) = agreed and 5(9.3%) = strongly agreed). However, they

disagreed that the PPP had contributed to growth of hospitals in terms of infrastructure (13 (24.1%) = strongly disagreed and 16.7%= disagreed) as shown in the table below. Most respondents also said that the hospitals had not benefited from financial support.

Table 4. 5

Effects of material sharing on the strengthening of health systems

Statement	Strongly Disagree		disagree		Undecided		Agree		Strongly Agree		Mean	S_Dev
	n	%	n	%	N	%	N	%	n	%		
a). The hospital has benefited from PPPs in terms of financial resources	6	10.9	14	25.5	13	23.6	18	32.7	4	7.3	2.89	1.263
b). The hospital has benefited from PPPs in terms of vaccines and cold chain (vaccine commodities, fridges, documentation and tools)	0	0.0	1	1.8	3	5.4	26	46.4	26	46.4	4.298	.885
c). PPPs have enabled our hospital to improve on pharmaceutical and non-pharmaceutical supply	1	1.9	5	9.4	10	18.9	25	47.2	12	22.6	3.526	1.351
d).The hospital has benefited from PPPs in terms of transport facilities/logistics	10	18.5	9	16.7	9	16.7	25	46.3	1	1.9	2.807	1.355
e).The hospital has benefited from PPPs in terms of medical equipment	10	18.5	7	13.0	8	14.8	24	44.4	5	9.3	2.965	1.451
f).The hospital has benefited from PPPs in terms of infrastructure	13	24.1	9	16.7	16	29.6	12	22.2	4	7.4	2.579	1.375

It was observed that nearly all respondents 52 (92.8%) agreed that the hospitals had benefited from PPPs in terms of vaccines and medical equipment. Similarly, a majority agreed that pharmaceutical/non-pharmaceutical supply support had improved. This is similar to what Wiedenmayer et al. (2019) found in Tanzania that tracer medicines availability increased from 69% in 2014 to 94% in 2018 after PPP implementation. This is also consistent with Walwyn and Nkolele (2018), who notes that the principal benefit of the PPP has been the uninterrupted supply of vaccines and the ability to respond quickly to vaccine shortages while evaluating South Africa's PPP for the localization of vaccine research. Baliga et al. (2016) in India and Swanson et al. (2010) in USA and UK found material sharing as an important input in success of PPPs in the health sector. However, most respondents 33 (60.0%) disagreed that hospitals had benefited in terms of financial resources and a majority 38 (70.4%) also disagreed that the hospitals had benefited in terms of infrastructural resources. Further research is needed to study why there seems to be no significant investments in the areas of financing and infrastructure in FBO facilities by the Government of Kisii County. According to Okie (2006), the outstanding growth of global health structures was the generous financing provided by a number of foundations. Okie associated the growth to provision of materials, the findings which was found consistent with this study. Table 4.5 shows the frequency at which antenatal care and maternity supplies, vaccines, family planning commodities, HIV/AIDS drugs and test kits and medical equipment to the hospital.

Table 4. 6:***Frequency of material support***

	Quite frequently (quarterly)		Frequently (once in a year)		Rare (sometimes like after 5 years)		Hardly (Not discussed at all)		Mean	S_Dev
	n	%	n	%	n	%	n	%		
Antenatal care and maternity supplies	23	44.2	7	13.5	12	23.1	10	19.2	1.983	1.302
Vaccines	31	55.4	5	8.9	6	10.7	14	25.0	1.965	1.295
Family planning commodities	12	22.2	5	9.3	3	5.6	34	63.0	2.930	1.425
HIV/AIDS drugs and test kits	29	52.7	7	12.7	2	3.6	17	30.9	2.053	1.381
The hospital has benefited from PPPs in terms of medical equipment	7	13.5	8	15.4	18	34.6	19	36.5	2.684	1.298

The study found most hospitals had frequently received antenatal care and maternity supplies (44.2%), vaccines (55.4%), HIV/AIDS drugs and test kits (52.7%) and rarely benefited from PPPs in terms of medical equipment hospital and hardly received family planning commodities (63.0%).

4.8. Human resources for health enhancement and health systems strengthening

The third objective of this study assessed influence of HRH enhancement on strengthening of health systems through the PPP. To achieve this, the study rated the agreement on a number of statements by the respondents. These include: seconding of health workers to hospitals; ability of hospitals to handle the workload in patient care because of the seconded staff; integration of seconded workers with other

hospital workers in patient care; management of the seconded workers, salary scales for the seconded workers compared to hospital workers; and finally the working relationship between seconded workers and the hospital staff. The variables were measured using 5-likert scale (1= strongly disagree, 2= Disagree, 3= undecided, 4= agree and 5= strongly agree).

Table 4.5 presents the findings. The study found that the PPP had enhanced on-going training of health workers in FBO hospitals (25 (45.5%) = agreed and 5(9.1%) = strongly agreed), provision of seconded workers to FBO hospitals by government resulting to effective management of workload by the hospitals 18 (35.3%) = agreed and 8(15.1%) = strongly agreed). The study found to some extent seconded workers had been integrated with other hospital workers in patient care (26(48.1%) = agreed and 5(9.3%) = strongly agreed). In many cases, hospitals managed seconded workers on day to day basis (26 (46.3%) = agreed and 11.1%= strongly agreed). However, the study found the salary scales of seconded workers differed with the salary scale of FBO staff (28 (50.9%) = strongly disagreed and 5 (9.1%) = strongly agreed) though the management reported that workers were happy working with seconded staff (24 (43.6%) = agreed and 12 (21.8 %) = strongly agreed).

Table 4.7:

Human resources for health enhancement on strengthening of health systems

	Strongly disagree		disagree		Undecided		Agree		Strongly Agree			
Statement	n	%	n	%	n	%	n	%	N	%		
a) The PPP program has enhanced on-going training of health workers in the hospital	8	14.5	8	14.5	9	16.4	25	45.5	5	9.1	4.298	1.133
b). The government seconded health care workers to our hospital	5	9.4	7	13.2	6	11.3	27	50.9	8	15.1	4.052	.894
c). The hospital is able to handle the workload in patient care because of the seconded staff	7	13.7	8	15.7	10	19.6	18	35.3	8	15.7	4.122	.888
d).The seconded staff are integrated with other hospital staff in patient care	8	14.8	6	11.1	9	16.7	26	48.1	5	9.3	2.649	1.329
e). The hospital fully manages the seconded workers on a day to day basis	9	16.7	5	9.3	9	16.7	25	46.3	6	11.1	3.859	.972
f). The salary scale and other benefits are the same between the government seconded staff and hospital staff	28	50.9	5	9.1	16	29.1	3	5.5	3	5.5	3.965	1.085
g). The hospital staff are happy working together with the seconded staff	5	9.1	7	12.7	7	12.7	24	43.6	12	21.8	3.702	.944

To provide acceptable quality health services, a competent, qualified health

workforce and good working conditions are essential. Most nations suffer from

inadequate staffing requirements due to inadequate training of health care workers, migration of the workforce, inferior combination of qualifications and demographic factors (Szabo, et al, 2020). Due to financial challenges, most private hospitals have been found to engage low qualified staff whose skills can be enhanced through a PPP (Ganle et al., 2016). In most cases, health care workers move from rural to urban settings and thereafter to developed countries in search of better salaries, conducive working conditions and career opportunities as well as effective management support (WHO, 2006). This poses a challenge to the hospitals in developing countries, especially the FBOs which many times are located in the rural and hard to reach areas. According to United States Agency for International Development [USAID] (2009), collaborative sharing of competences amongst different actors and across various cadres can significantly influences health systems in a positive way. Over the years, the FBO facilities have suffered labour migration to the government posing a challenge in the provision of quality health care services to those who need them most, due to better pay in government (CHAK, 2008). Secondment of health care workers from the ministry of health to FBO facilities is therefore very paramount. Continuous and ongoing capacity building of health care workers can respond to some of these challenges (Olojede et al., 2020). They further argue that workforce training improves implementation of PPPs and therefore strengthening of health systems. The study found out that the PPP had supported training of health workers and seconding of health workers to FBO hospitals by Government, resulting in effective management of workload and therefore improved quality of health services. Hossain et al. (2020) noted such benefits of PPPs in building human resources capacity in low income countries.

4.9. Processes guiding the PPP implementation and health systems strengthening

The fourth objective of the study sought to assess the processes employed in guiding PPP implementation and its effects on health systems strengthening. To achieve this, the study rated the agreement on a number of statements by the respondents. These included: making the hospital aware of the existence of the PPP, availing of standards and quality assurance manuals or expectations to hospitals from government, having a robust monitoring and evaluation framework for the PPP, having meetings to guide the implementation and availability of audit for financial and non-financial resources availed by the government. The variables were measured using 5-likert scale (1= strongly disagree, 2= Disagree, 3= undecided, 4= agree and 5= strongly agree). Regulatory frameworks are a vital component in attaining a good PPP (Sustainable programme for accelerated infrastructure development [SPAID], 2007). The study found key processes for guiding PPP implementation were made in an attempt at strengthening the health systems. A good number of respondents reported that the government had made hospitals aware of the PPP laws to guide its implementation (21 (40.4%) = agreed and 3 (5.8 %) = strongly agreed). The study also noted that most hospitals had standards and quality assurance manuals or expectations from the government (26 (52.0%) = agreed and 12 (24.0 %) = strongly agreed). The study further observed that a robust monitoring and evaluation framework for the PPP was in place (26(52.0%)= agreed and 5(9.6 %)= strongly agreed) as well as the plan to audit financial (25(48.1%)= agreed and 5(9.6 %)= strongly agreed) and non-financial resources availed by the government, and

meetings initiated to guide implementation of the PPP scheduled accordingly (13(25.0%)= agreed and 13(25.0 %) = strongly agreed).

Table 4.8

Processes for guiding PPP implementation in an attempt at strengthening health systems

	Strongly disagree		disagree		Undecided		Agree		Strongly Agree			
Statement	n	%	n	%	n	%	N	%	n	%	Mean	S_Dev
The hospital has been made aware of the PPP law to guide its implementation	5	9.6	8	15.4	15	28.8	21	40.4	3	5.8	2.895	1.372
The hospital has a standards and quality assurance manual or expectations from government	3	6.0	2	4.0	7	14.0	26	52.0	12	24.0	3.368	1.599
There is a robust monitoring and evaluation framework for the PPP	3	5.8	6	11.5	12	23.1	26	50.0	5	9.6	3.158	1.386
Meetings to guide implementation of the PPP are scheduled	3	5.8	7	13.5	12	23.1	25	48.1	5	9.6	3.123	1.390
There is a plan to audit financial and non-financial resources donated by government	4	7.7	4	7.7	18	34.6	13	25.0	13	25.0	3.2105	1.509
In the development and execution of any PPP, there are various government guidelines, which the parties involved, must take into considerations. This ensures												

that all the PPPs are inclined to the development goals of the nation. It also supports coordinated achievements between the several parties involved (PPP Knowledge Lab, 2017). Processes guiding PPPs must be clear for them to be effective and sustainable (F et al., 2017). The study found that there was a clear process guiding implementation of the PPP in Kisii County. The other very important aspect of a PPP is how it is measured. The study found that a monitoring plan is in place to measure its implementation. Liu et al. (2014) points out that a good measurement plan must be ongoing rather than happening at the end of a project's life. This would ensure that any concerns raised by different actors are dealt with in a timely manner.

4. 10. Assessment of the PPP by the Ministry of Health

Faith-Based hospitals were reported as significant partners in the provision of public health care services like HIV/AIDS, maternal, neonatal and child health services. The community in the region preferred some of these facilities like Tabaka more than public facilities. This is because it is a referral facility, the other one being the County Referral Hospital, for the entire County. The FBO hospitals also targeted disadvantaged populations especially in areas where government facilities are situated far from them. The respondents said;

“The faith-based based hospitals are people centred and are found in places far removed from the presence of government facilities and serve the vulnerable communities. For instance, Tabaka hospital is one of its kind in the region”

Though FBOs and the government facilities provided similar services, FBOs were found to be less affected by bureaucracies and industrial actions and are therefore able to continuously offer quality services. In responding to this, the respondents said:

“the decision making in the private facilities is fast because of less bureaucracies and are able to restock medicines without long procedures compared to government facilities making them more proactive to people’s health needs”

The Ministry had adopted various strategies to improve the PPP strategy with the FBOs to strengthen health systems and improve performance. These included provision of materials and supplies such as drugs and vaccines; leadership and management collaboration, quality assurance and support supervision; and seconding of staff to those hospitals. Concerning material sharing, the respondents said:

“the ministry of health gives material supports such as antiretrovirals, family planning commodities, and vaccines among others. The Ministry of Health also collaborates with FBOs by seconding of staff”

To ensure effectiveness of the PPP, the Ministry collaborated with FBOs through sharing of health services data, regular performance review meetings and support supervision amongst others.

4.11. Inferential statistics

The study adopted chi-square statistic to study the association between leadership/management, material support, human resources for health, processes of implementation of the PPP and strengthening of health systems. The variables leadership/management, material support, human resource for health, processes of implementation of PPP and the strengthening of health services were computed by getting an average of the indicators of each variable and then rounded up to the nearest whole number. The resulting values were assigned labels using Likert scale for both independent and dependent variables. Regression analysis was conducted using index computed from leadership/management, material support, human

resource, processes of implementation of the PPP; and strengthening of health systems.

4.11.1. Association between leadership and management support and strengthening of health systems in Kisii County

Table 4.8 below presents cross tabulation of leadership/management and the Health system strengthening

Table 4. 9:

Association between leadership/management and health systems strengthening

<i>Health systems strengthening * leadership/management</i>					
HSS	Strongly Disagree	disagree	Undecided	Agree	Strongly Agree
Somewhat improved	0 0.0%	1 16.7%	2 33.3%	3 50.0%	0 0.0%
Very improved	1 2.8%	1 2.8%	13 36.1%	20 55.6%	1 2.8%
Extremely improved	0 0.0%	0 0.0%	2 16.7%	10 83.3%	0 0.0%

The study found that most respondents (83.3%) who reported that the health system had extremely improved also agreed that the leadership/management had influence on health system strengthening. This number was slight smaller than those who felt health system was very improved because of leadership/management support (55.6%).

Leadership and management are crucial components any health system (Vriesendorp et al., 2010). Leadership and management are linked to government's role in health care provision and setting standards for other actors involved in the provision of health care services. This includes supervision and directing the entire health system to defend the interests of the public (WHO, 2007).

The study found the relationship between leadership/management support and health systems strengthening had a Pearson's Chi-square (X^2) =25.316 (table 4.9). While examining the strength of the relationship between leadership and management support and health systems performance, it was found that the relationship was significant at $\alpha=0.05$.

Table 4. 10:

Association between leadership and health systems strengthening

Chi-Square Tests			
	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	25.316 ^a	6	.000
Likelihood Ratio	27.747	6	.000
Linear-by-Linear Association	19.256	1	.000
N of Valid Cases	54		

a. 9 cells (75.0%) have expected count less than 5. The minimum expected count is .11.

The study also assessed the strength of association between leadership and health systems strengthening. The study found a positive Pearson correlation of 0.603 between leadership/management support and health systems strengthening (Table 4.10). This implies that for every unit increase in leadership/management, health systems strengthening will increase by 0.603 units.

Table 4. 11:***Correlation between leadership and health systems strengthening***

		Symmetric Measures			
		Value	Asymp. Std. Error ^a	Approx. T ^b	Approx. Sig. ^c
Interval by Interval	Pearson's R	.603	.060	5.447	.000 ^c
Ordinal by Ordinal	Spearman Correlation	.584	.063	5.182	.000 ^c
N of Valid Cases		54			

a. Without H_0 assumption.

b. Using the asymptotic standard error while assuming H_0

c. while taking normal approximation into consideration.

In the conclusions of the digital health hub of the Transform Africa Summit, Tran Ngoc et al. (2018) puts a strong case for a robust government leadership and public-private-partnerships agenda as key minimum deliverables for a sustainable scale up of digital health in Africa. Abednego and Ogunlana (2006) reported that good project management is a function of leadership. Good leadership promotes product success in both short term and long-term basis. Leadership also ensures smooth flow of work, customer satisfaction among other organisation-based activities. Effective leadership also provides proper risk management and promote desired outcomes (World Economic Forum, 2005). From the findings of the study, it can be observed that the Kisii County Government officials have taken this steering role in leadership of the PPP with the FBO facilities.

4.11.2. Association between material support and strengthening of health systems in Kisii County

The study assessed the relationship between material support and health systems strengthening using cross tabulation (Table 4.11). The study found most of the respondents who agreed that material support influenced health systems

strengthening also felt that health systems strengthening had extremely improved (58.3%). It was also observed that 42.9% of those who agreed that that material support influenced health systems strengthening also felt that health systems strengthening.

Table 4. 12:

Association between material support and Health systems strengthening

HSS	<i>Health systems strengthening *material</i>				
	Strongly Disagree	disagree	Undecided	Agree	Strongly Agree
Somewhat improved	1 16.7%	1 16.7%	2 33.3%	1 16.7%	1 16.7%
Very improved	1 2.9%	5 14.3%	13 37.1%	15 42.9%	1 2.9%
Extremely improved	0 0.0%	1 8.3%	2 16.7%	7 58.3%	2 16.7%

The study found the relationship between material support and health systems strengthening had a Pearson's Chi-square (X^2) =77.3 (table 4.11). While examining the strength of relationship between material sharing and health systems strengthening, it was found that the relationship was significant at $\alpha=0.05$.

Table 4. 13:

Association between material sharing and health systems strengthening

Chi-square tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	77.300 ^a	6	.000
Likelihood Ratio	71.314	6	.000
Linear-by-Linear Association	38.319	1	.000
N of Valid Cases	54		

a. 8 cells (66.7%) have expected count less than 5. The minimum expected count is 1.11.

The study found a positive Pearson correlation of 0.850 between material support and health systems strengthening (Table 4.13). This implies that for every unit increase in material sharing, health systems strengthening will increase by 0.850 units.

Table 4. 14:

Correlation between material support and health systems strengthening

		Symmetric Measures			
		Value	Asymp. Std. Error ^a	Approx. T ^b	Approx. Sig.
Interval by Interval	Pearson's R	.850	.038	11.650	.000 ^c
Ordinal by Ordinal	Spearman Correlation	.832	.049	10.826	.000 ^c
N of Valid Cases		54			

a. Without H_0 assumption.

b. Using the asymptotic standard error while assuming H_0

c. while taking normal approximation into consideration.

4.11.3. Association between human resources for health and health systems strengthening in Kisii County

The study assessed the relationship between human resource for health and health systems strengthening using cross tabulation (Table 4.14).

Table 4. 15:

Association between human resources for health and health systems strengthening

Performance * workforce Cross tabulation					
HSS	Strongly Disagree	disagree	Undecided	Agree	Strongly Agree
Somewhat improved	1 16.7%	1 16.7%	2 33.3%	2 33.3%	0 0.0%
Very improved	5 14.3%	3 8.6%	17 48.6%	9 25.7%	1 2.9%
Extremely improved	1 8.3%	1 8.3%	1 8.3%	7 58.3%	2 16.7%

The study found most of the respondents who agreed that human resource for health influenced health systems strengthening also felt that health systems strengthening had extremely improved (58.3%). However, 48.6% of those who felt that health systems strengthening were very improved reported that they were not sure if the improvement was as a result of human resource for health.

The study found the relationship between HRH enhancement and health systems strengthening had a Pearson's Chi-square (X^2) =72.00 (table 4.15). While examining the strength of the relationship between HRH and health systems strengthening, it was found that the relationship was significant at $\alpha=0.05$.

Table 4. 16:

Association between HRH enhancement and performance of health systems

Chi-Square Tests			
	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	72.000 ^a	8	.000
Likelihood Ratio	60.963	8	.000
Linear-by-Linear Association	34.678	1	.000
N of Valid Cases	54		

a. 13 cells (86.7%) have expected count less than 5. The minimum expected count is .33.

The study had a strong and positive Pearson correlation of 0.809 between HRH and health systems strengthening. This implies that for every unit increase in HRH, the HSS will increase by 0.809 units.

Table 4. 17:***Correlation between HRH and health systems strengthening***

		Symmetric Measures			
		Value	Asymp. Std. Error ^a	Approx. T ^b	Approx. Sig.
Interval by Interval	Pearson's R	.809	.047	9.921	.000 ^c
Ordinal by Ordinal	Spearman Correlation	.776	.056	8.873	.000 ^c
N of Valid Cases		54			

a. Without H_0 assumption.

b. Using the asymptotic standard error while assuming H_0

c. while taking normal approximation into consideration.

The findings in the study are consistent with Ganle et al. (2016) which considered inadequate staffing of health facilities as main challenges weakening the health system. Regarding HRH in PPPs, Gawanas and Sharp (2008) argues that workforce training improves implementation of PPPs and strengthening of health systems. The study found out that the PPP had supported training of health workers and seconding of health workers to FBO hospitals by government, resulting in effective management of workload and therefore improved quality of health services. Vian et al. (2007) noted such benefits of PPPs in building human capacity in low-income countries. It was also noted to some extent seconded workers had been integrated with other hospital workers in patient care and were being managed by hospitals on day-to-day basis. However, the salary scale of seconded workers differed with the salary scale of FBO hospital workers though this did not influence them negatively as workers from FBO hospitals were happy working with seconded staff. However, the PPP helped to bridge HRH related challenge in provision of health services. However, further research needs to be conducted to determine how terms of service

for health care workers from different agencies working in the same institution can be harmonized. These findings are consistent with Chandrasekar (2011) who found that relationships at the work place had effects on performance of the health sector.

4.11.4. Association between processes guiding PPP implementation and health systems strengthening

The study assessed the relationship between PPP implementation process and health systems strengthening using cross tabulation (Table 4.17).

Table 4. 18:

Association between guiding PPP implementation and strengthening health systems

HSS	Strongly Disagree	disagree	Undecided	Agree	Strongly Agree
Somewhat improved	0 0.0%	0 0.0%	1 20.0%	3 60.0%	1 20.0%
Very improved	2 5.7%	3 8.6%	3 8.6%	13 37.1%	14 40.0%
Extremely improved	0 0.0%	0 0.0%	0 0.0%	1 8.3%	11 91.7%

The study found most of the respondents who strongly agreed that PPP implementation process influenced health systems strengthening also felt that health systems strengthening had extremely improved (91.7%). It was also observed that 40.0% of those who agreed that that PPP implementation process influenced health systems strengthening was very improved. The study found the relationship between process guiding PPP implementation and health systems performance had a Pearson's Chi-square (X^2) =57.037 (Table 4.18). While examining the strength of relationship between the process guiding PPP implementation and health systems performance, it was found that the relationship was significant at $\alpha=0.05$.

Table 4.19:

Association between the process guiding PPP implementation and health systems strengthening

Chi-Square Tests			
	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	57.037 ^a	8	.000
Likelihood Ratio	42.479	8	.000
Linear-by-Linear Association	24.893	1	.000
N of Valid Cases	52		

a. 12 cells (80.0%) have expected count less than 5. The minimum expected count is .15.

There was a strong and positive Pearson correlation of 0.699 between process guiding PPP implementation and performance of health systems (Table 4.19). This implies that for every unit increase in guiding PPP implementation, the HSS will increase by 0.699 units.

Table 4.20:

Correlation between guiding PPP implementation and health systems strengthening

Symmetric Measures					
		Value	Asymp. Std. Error ^a	Approx. T ^b	Approx. Sig.
Interval by Interval	Pearson's R	.699	.071	6.905	.000 ^c
Ordinal by Ordinal	Spearman Correlation	.649	.073	6.039	.000 ^c
N of Valid Cases		52			

a. Without H_0 assumption.

b. Using the asymptotic standard error while assuming H_0

c. while taking normal approximation into consideration.

These findings are consistent with SPAID (2007) and Thai (2001) who emphasizes on the importance of clear guiding processes in the implementation of PPPs. According to Thai, it should be a legal enforced process.

4.11.5. Regression analysis

Regression model is a mathematical procedure of fitting predictive variable and predicted variables assess the relationship. The R square is an output that indicates how well the values fit the data. Statistical analysis is an analysis that shows how the variability in one variable predicts the difference in the other.

Table 4.20 shows that PPPs on material sharing support, leadership and management support, human resource for health enhancement and processes guiding implementation of the PPP accounted for 47.9% on strengthening of health systems for the FBOs in Kisii County (table 4.20).

Table 4. 21

Effects of PPP on strengthening of health systems

Model	R	Model Summary		
		R Square	Adjusted R Square	Std. Error of the Estimate
1	.718 ^a	.516	.479	.48762

a. Predictors: (Constant), leadership, process, material, workforce

The value of $F(4, 52) = 13.867$, $P\text{-value} < 0.05$ shows that PPP on health systems significantly predicts strengthening of health systems in FBO facilities in Kisii County.

Table 4. 22***Predictability of health systems strengthening using PPP in FBO facilities***

		ANOVA ^a			F	Sig.
Model		Sum of Squares	df	Mean Square		
1	Regression	13.189	4	3.297	13.867	.000 ^b
	Residual	12.364	52	.238		
	Total	25.554	56			

a. Dependent Variable: performance

b. Predictors: (Constant), leadership, process, material, workforce

The study used a multiple regression model to fit the data so as to assess the how material support, leadership and management support, human resource for health enhancement and guide on implementation of PPP to the performance of service delivery in FBOs health facilities influence health systems in Kisii County. The findings show that PPP had significant effect on health systems strengthening in FBO health facilities at $\alpha=0.05$. The findings of the study are consistent with Mohamad, Ismail and Said (2018) who found that the PPPs helped improve the service delivery and helped satisfy needs of more persons attending public health facilities in Malaysia. The study also supports Torchia et al. (2015) who found that PPPs had remarkable contribution on effectiveness in service delivery.

Table 4. 23***Effect of PPP on health system strengthening of FBOs services in Kisii County***

	Coefficients^a			t	Sig.
	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta		
(Constant)	2.488	.325		7.654	.000
Material support	.049	.090	.072	.543	.005
Process for implementation of PPP	.248	.052	.614	4.741	.000
Human resource for health	.024	.089	.036	.265	.002
Leadership and management	.060	.134	.062	.448	.007

a. Dependent Variable: performance

The regression model is given by the following equation; $Y = \alpha + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 +$

$\beta_4 X_4 + E$

Performance = 2.488+ 0.049(material support) + 0.248 (process for implementation of the PPP) + .024 (human resource for health) +0.060 (leadership and management).

These findings imply that the health systems strengthening would increase by 2.488 units when the leadership/management, material support, HRH enhancement and process for implementation of PPP were zero. Adherence to implementation process of the PPP was found to be the highest contributor to the health systems strengthening in FBOs in Kisii County followed by leadership/management, material support and finally human resource for health in that order. This implies that health systems strengthening could improve more if they put more efforts at adherence processes guiding implementation of the PPP. An increase of one unit in material support would increase health systems strengthening by 0.49 units while an increase of one unit in process for implementation of PPP would increase HSS by 0.248 units

while an increase of one unit in human resource for health would increase HSS by 0.024 units. The findings also imply that a change of leadership/management by one unit would increase the HSS of FBOs by 0.060 units.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1. Introduction

A cross-sectional descriptive study was conducted targeting 78 FBO facilities' Officials from Tabaka, Christianmarian and Nyanchwa hospitals; and officials from the Ministry of Health in Kisii County. The study used self-administered questionnaires that were distributed to the respondents and collected after one week. Key informants interviews carried out with top officials in the health sector at County level were used to reinforce the findings of this study. This chapter presents the summary of the findings from the field data, conclusion and the recommendations of the study.

5.2. Summary of the findings

The summary is organized based on the objectives of the study. The study response rate was 73.1%, which was considered sufficient (Kothari, 2017). Majority of the respondents were male 31 (55%), those aged 35-44 years 32 (56.1%). Thirty-eight respondents (66.7%) had attained a diploma as the highest level of education. Respondents who had worked 3-5 years were the most at 21 (37.5%). It was further observed that most respondents had work experience of below 5 years accounting for 30 (54%). The demographic and social economic profiles of the respondents was considered reliable in being to respond to the questions effectively.

Health systems strengthening in Faith-Based health services in Kisii County

The study observed that key public health services that were used as proxy indicators for health systems strengthening had improved. These included HIV/AIDs services, maternal, neonatal, child health services. It was noted that the prevalence and incidence of HIV/AIDS had reduced in the region. People living with HIV/AIDS

accessing services in the hospitals were retained in the cascade of HIV care and had attained viral suppression. HIV transmission from mother to child had reduced in the hospital and the region. Respondents also recorded that utilization of antenatal care services had increased in the hospitals and region as well as increased access and utilization of family planning services. Skilled care delivery, maternal deaths, immunization rates for children and child mortality had all recorded good numbers.

Effects of leadership and management on health systems strengthening

The study found that there existed a PPP between hospitals and the government as implied by 52 (91.2%) of the respondents who agreed with the statement. Most of the respondents 45 (80.3%) agreed that there was an engagement mechanism for the PPP with the FBO hospitals. This implies that leadership and management enhancement influenced health systems strengthening as perceived by respondents. A Chi-square test of association between leadership and management support and performance of faith-based healthcare facilities in Kisii County was done. The results show that there was a positive and scientifically significant association between leadership and management support and performance at $\alpha=0.05$.

Effects of material support on health systems strengthening

On material support, hospitals had benefited in terms vaccines and cold chain (vaccine commodities, fridges, documentation and tools). The PPP also improved pharmaceutical and non-pharmaceutical supply, transport facilities/logistics and medical equipment. However, the PPP had no noticeable contribution to growth of hospitals' infrastructure and finances. The study found the relationship between material support and health systems strengthening had a Pearson's Chi-square (X^2) =0.273. While examining the strength of relationship between material sharing and

health systems strengthening, it was found that the relationship was significant at $\alpha=0.05$.

Effects of human resources on health systems strengthening

The PPP was found to have enhanced on-going training of health workers in FBO hospitals, provision of seconded staff by government resulting in effective management of workload. It was also noted that seconded staff had been integrated with other hospital workers in patient care and were being managed by hospitals on day-to-day basis. However, the salary scale of seconded workers differed with the salary scale of FBO hospital workers though this did not influence them negatively as workers from FBO hospitals were happy working with seconded staff. The study found the relationship between HRH enhancement and health systems strengthening had a Pearson's Chi-square (X^2) =0.256. While examining the strength of relationship between HRH and health systems strengthening, it was found that the relationship was significant at $\alpha=0.05$.

Effects of processes guiding PPP implementation on health systems strengthening

On the processes guiding PPP implementation, a good number of respondents reported that the government had made hospitals aware of the PPP law to guide its implementation. Hospitals on the other hand had standards and quality assurance manuals or expectations from the government. Consequently, the study observed that a robust monitoring and evaluation framework for the PPP was in place as well as the plan to audit financial and non-financial resources availed by government and meetings initiated to guide implementation of the PPP scheduled accordingly. The study found the relationship between processes guiding PPP implementation and

health systems strengthening had a Pearson's Chi-square (X^2) =0.316. While examining the strength of relationship between process guiding PPP implementation and health systems strengthening, it was found that the relationship was significant at $\alpha=0.05$.

Assessment of the PPP by the County Ministry of Health

From the view point of the Kisii County Government, Faith-Based hospitals were significant partners in the provision of public health services like HIV/AIDs, maternal, neonatal and child health services. The FBO hospitals also targeted disadvantaged populations especially in areas where government facilities are situated far from them. Though FBOs and the government facilities provided similar services, FBOs were found to be less affected by bureaucracies and industrial actions and are therefore able to continuously offer quality services. The Ministry had adopted various strategies to improve the PPP strategy with the FBOs to strengthen health systems and improve performance. These included provision of materials and supplies such as drugs and vaccines; leadership and management collaboration, quality assurance and support supervision; and seconding of staff to those hospitals. To ensure effectiveness of the PPP, the Ministry collaborated with FBOs through sharing of health services data, regular performance review meetings and support supervision amongst others.

5.3. Conclusion

The study concludes that PPPs targeting material support, leadership and management, provision of guidelines to guide the PPP process, and HRH strengthened health systems in support of provision of quality public health services in FBO facilities. From the view point of the Kisii County Government officials, it

can be concluded that the PPP is yielding fruits in the government effort to strengthen delivery of health services in the County. Further, FBO facilities are able to effectively complement the work of government in public health services and should be supported through the PPP. The respondents from the FBO facilities also appreciated the government inputs and support in the provision of public health services that the community is not keen to pay for. Implementation of this kind of PPP may compliment one of the big 4 agendas of the government of Kenya, that is Universal Health Coverage.

5.4. Recommendations

From the findings, the study recommends:

- i. That the scope of services offered at no cost to the community under KEPH in FBO facilities should be defined clearly to guide further support from the government in Kisii. This will ensure coverage and quality of services while ensuring that FBO facilities do not suffer significant financial risks.
- ii. That government and private sector actors to keep on improving and reviewing terms of engagements and processes to further improve and sustain the momentum of this PPP, in Kisii County and elsewhere.
- iii. Policy makers need to relook at areas of financing and infrastructure support to FBO facilities especially in regards to budgeting processes in Kisii, and other the County Executives and assemblies, since health care is devolved in Kenya.
- iv. Concerning HRH, the study recommends harmonization of remuneration for all staff working in FBO facilities to boost morale, create harmony and therefore lead to more outputs. Seconding staff to FBO facilities especially to support critical public health services should be sustained and enhanced

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APPENDICES

APPENDIX I – QUESTIONNAIRE FOR THE HOSPITALS

This questionnaire is to collect data for purely academic purposes. The study seeks to investigate public-private partnerships as a strategy for strengthening health systems in the faith-based health services in Kisii County. All information will be treated with strict confidence. Do not put any name or identification on this questionnaire.

Answer all questions as indicated by either filling in the blank or ticking the option that applies.

Section A: General Information of Respondent

Please indicate

1. Your age a). Below 25 ☐ b). 25-34 Years ☐ c)35-44 Years ☐
d). 45-54 Years ☐ e). 55 years and
above ☐
2. Your gender? Please tick. Male ☐ Female ☐
3. Marital status? Single Married ☐ Divorced ☐ Widowed
☐
4. Highest level of Education and training attained?
Certificate ☐ Diploma ☐ Bachelor's Degree ☐ Master's Degree
☐
5. Work experience in years. a). 1-2 Years ☐ b). 3-5 Years
☐
c). 6-10 Years ☐ d) above 10
Years ☐
- Position currently held.....
6. Number of years in your current position?

Less than 5 years [] 5-10 years [] above 10 years []

SECTION B: LEADERSHIP AND MANAGEMENT PARTNERSHIP ON THE STRENGTHENING OF HEALTH SYSTEMS

7. The following items seek to find out any partnership in leadership and management activities in your hospital. Please tick the statement that you agree with.

1= strongly disagree, 2= Disagree, 3=Undecided, 4 =Agree, 5=strongly agree

a		1	2	3	4	5
b	There exists a PPP between the hospital and the Government					
c	A governance and management processes to guide the PPP is in place (MOU, Contracts)					
d	There is in place an engagement mechanism in the PPP (Board meetings, county/sub county level meetings, support supervision by government, etc.)					
e	The government has a thorough accountability system to guide the PPP (e.g. regular audits, program specific supportive supervision)					
f	The government is committed to the PPP.					
g	The relationship between the hospital and the government is conducive enough for the PPP to succeed.					
h	The PPP has met hospital expectations					
i	The PPP has contributed to timely provision of health services					
j	The PPP has met the expectations of the community e.g., quality of care					
k	The government trains the hospital board and managers on the PPP					

SECTION C: MATERIAL SHARING ON THE STRENGTHENING OF HEALTH SYSTEMS

7. The following items seek to find out any material sharing partnership in your hospital. Please tick the statement that you agree with.

1= strongly disagree, 2= Disagree, 3=Undecided, 4 =Agree, 5=strongly agree

	STATEMENT	1	2	3	4	5
a	The hospital has benefited from PPPs in terms of financial resources					
b	The hospital has benefited from PPPs in terms of vaccines and cold chain (vaccine commodities, fridges, documentation and tools)					
c	PPPs have enabled our hospital to improve on pharmaceutical and non-pharmaceutical supply					
d	The hospital has benefited from PPPs in terms of transport facilities/logistics					
e	The hospital has benefited from PPPs in terms of medical equipment					
f	The hospital has benefited from PPPs in terms of infrastructure					

Kindly rate the provision of the following material support through PPP programme

1= quite frequently (quarterly). 2= frequently (Once in a year), 3= Rarely (Sometimes once after every 5yrs) , 4= Hardly (Not discussed at all)

	STATEMENT	1	2	3	4
a	Antenatal care and maternity supplies				
b	Vaccines				
c	Family planning commodities				
d	HIV/AIDS drugs and test kits				
e	The hospital has benefited from PPPs in terms of medical equipment				

SECTION D: HUMAN RESOURCES FOR HEALTH ENHANCEMENT ON STRENGTHENING OF HEALTH SYSTEMS

7. The following items seek to find out any partnership on human resources in your hospital. Please tick the statement that you agree with.

1= strongly disagree, 2= Disagree, 3=Undecided, 4 =Agree, 5=strongly agree

		1	2	3	4	5
a	The PPP program has enhanced ongoing training of health workers in the hospital					
b	The government seconds health care workers to our hospital					
c	The hospital is able to handle the workload in patient care because the seconded staff					
d	The seconded workers are integrated with other hospital workers in patient care					
e	The hospital fully manages the seconded workers on a day to day basis					
f	The salary scale and other benefits are the same between the government seconded and hospital staff					
h	The hospital staffs are happy working together with the seconded staff					

SECTION E: PROCESSES FOR GUIDING PPP IMPLEMENTATION IN AN ATTEMPT AT STRENGTHENING HEALTH SYSTEMS

7. The following items seek to find out whether any processes to guide implementation of the PPP are in place in your hospital. Please tick the statement that you agree with.

1= strongly disagree, 2= Disagree, 3=Undecided, 4 =Agree, 5=strongly agree

		1	2	3	4	5
a	A policy to guide PPP implementation is in place in the hospital					
b	The hospital has been made aware of the PPP law to guide its implementation					
c	The hospital has a standards and quality assurance manual or expectations from government					
d	There is a robust monitoring and evaluation framework for the PPP					
e	Meetings to guide implementation of the PPP are scheduled					
f	There is a plan to audit financial and non-financial resources donated by government					

SECTION F: PERFORMANCE OF HEALTH SYSTEMS

7. The following items seek to find out any outcome realised from the PPP in your hospital. Please tick the statement that you agree with.

1= strongly disagree, 2= Disagree, 3=Undecided, 4 =Agree, 5=strongly agree

		1	2	3	4	5
a	There has been reduction on prevalence of HIV/AIDs within the region					
b	Cases of new infections with HIV/AIDs have reduced in the region					
c	HIV patients accessing services in the hospital are retained in the cascade of HIV care and have attained viral suppression					
d	HIV transmission from mother to child has reduced in the hospital as a result of the PPP					
e	Utilization of antenatal care services has increased in the hospital and region					
f	There is increased access and utilization of family planning services within the hospital and region					
g	Maternal deaths have reduced in the hospital and region					
h	There has been an increase in number skilled care delivery in the hospital and region					
i	Immunization rates for children have increased in the hospital and region					
j	Child deaths have reduced in the hospital and in the region					

Thank you for participation

Thank you very much for taking your time to fill this questionnaire

APPENDIX II - INTERVIEW GUIDES FOR MOH OFFICIALS

Please be free and honest to provide the information required according to accompanying instructions.

1. Do the FBO hospitals contribute significantly to health systems strengthening in your County/Sub County? Explain

2. What are the in their process of strengthening health systems in the county/sub county?

3. What strategies can be adopted to improve the PPP strategy in the FBO hospitals in their process of strengthening health systems in the county/sub county?

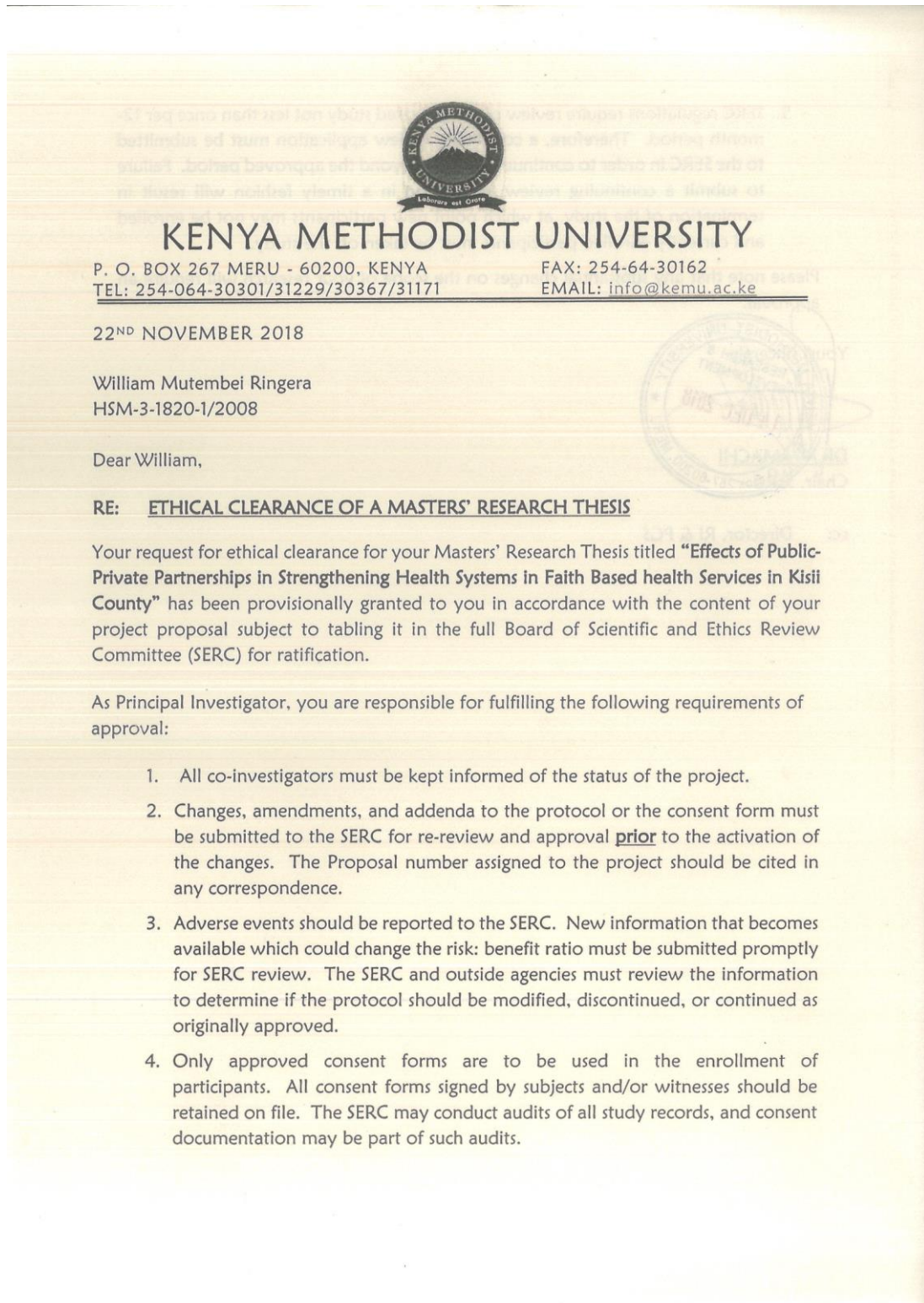
4. What is your ministry doing with regard to ensuring effectiveness of PPP in strengthening health systems in the FBO hospitals?

5. How can systems, structures and processes related to PPPs as a strategy of strengthening health systems in the faith-based health services is improved?

END OF QUESTIONNAIRE

Thank you very much for taking your time to fill this questionnaire

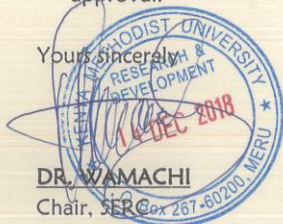
APPENDIX III: KEMU APPROVAL LETTER



5. SERC regulations require review of an approved study not less than once per 12-month period. **Therefore, a continuing review application must be submitted to the SERC in order to continue the study beyond the approved period.** Failure to submit a continuing review application in a timely fashion will result in termination of the study, at which point new participants may not be enrolled and currently enrolled participants must be taken off the study.

Please note that any substantial changes on the scope of your research will require an approval.

Yours sincerely,



cc: Director, RI & PGS

APPENDIX IV: NACOSTI LICENSE



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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2241349, 3310571, 2219420
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When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref. No. **NACOSTI/P/19/44404/28018**

Date: **12th June, 2019**

William Mutembei Ringera
Kenya Methodist University
P.O. Box 267- 60200
MERU.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on *“Effects of public-private partnerships in strengthening health systems in faith-based health services in Kisii County”* I am pleased to inform you that you have been authorized to undertake research in **Kisii County** for the period ending **12th June, 2020**.

You are advised to report to **the County Commissioner and the County Director of Education, Kisii County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

DR. MOSES RUGUTT, PHD, OGW
DIRECTOR GENERAL/CEO

Copy to:

The County Commissioner
Kisii County.

The County Director of Education
Kisii County.

National Commission for Science, Technology and Innovation is ISO9001:2008 Certified