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**Examining Private Sector Engagement in Provision of Public Health Services Towards
Universal Health Coverage: A Case Study of Kisii County**

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MBA-HCM 93527

**Research Thesis submitted in partial fulfillment of the requirements for the degree of
Master of Business Administration Healthcare Management at Strathmore University**



Strathmore University Business School

Nairobi, Kenya

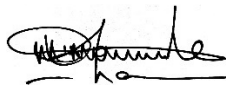
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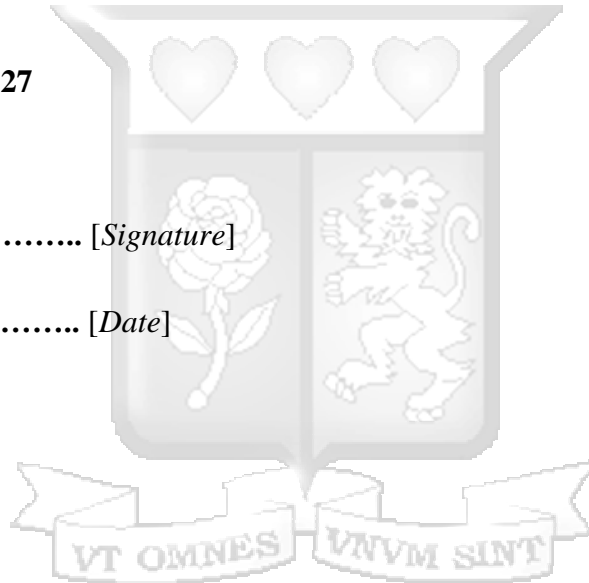
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Abstract

For Kenya to achieve universal health coverage (UHC) by year 2022, the national and county governments must strengthen engagement with the private sector. Yet there is lack of clarity on private sector engagement across counties. This study sought to describe engagement and impact in Kisii County. Specifically, the study sought to describe the private sector engagement models in Kisii, examine achievements and challenges of engaging the sector in meeting public healthcare goals, and explore management views on the perceived impact of private sector engagement. A multiple methods approach was taken, with data collected from 62 employees of the Kisii county health department and the private sector. The quantitative component entailed collecting survey data from 52 participants (21 public, 31 private). The qualitative component entailed 10 in-depth interviews (five each for public and private). Findings indicated that whereas a myriad of private sector engagement models were employed, the public-private partnership model was most preferred. Engagement achievements included public sector getting human resources from the private sector; technical and capacity building support; and technological and financing support from the private sector. Engagement challenges included difficulty in regulating and holding the private actors accountable under the partnership arrangements; difficulty in engaging the private sector in non-profit initiatives; and county government inability to sustain programmes initiated by the private sector. Overall, private sector engagement was perceived to have had a positive impact on progress towards UHC in Kisii across all six-health system building blocks, namely, governance, health work force, financing, service delivery, healthcare technology and access to medicines. Among others, the study recommends that county governments should have a central role to play in targeting and identifying households for National Hospital Insurance Fund (NHIF) enrolment and that national governments ought to avail financial resources to facilitate increased population coverage through the NHIF in keeping with universal health coverage. The study also recommends that the Kenyan government should increase public financing of the health sector at the county level. By dedicating 15% of the national budget towards healthcare for instance, there will be an uplift in the healthcare system enough to realize the Universal Healthcare Coverage as per the Abuja declaration of 2001 to which Kenya is a signatory.

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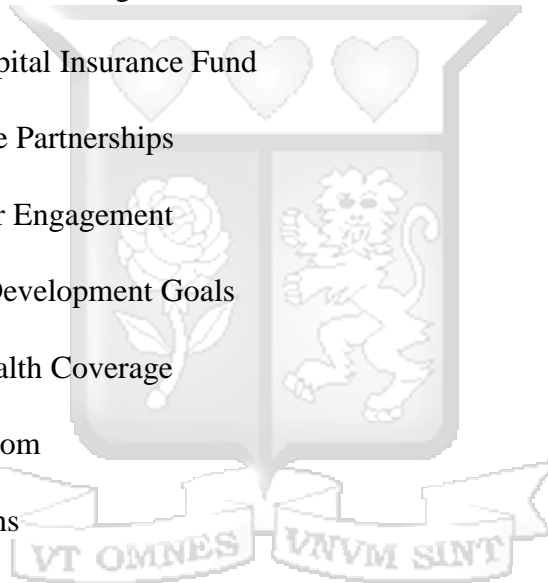
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List of Abbreviations

CBO	Community Based Organization
HICs	High-Income Countries
KSHS	Kenya Shillings
LMICs	Low- and Middle-Income Countries
MoH	Ministry of Health
MoU	Memorandum of Understanding
NGOs	Non-Governmental Organizations
NHIF	National Hospital Insurance Fund
PPPs	Public-Private Partnerships
PSE	Private Sector Engagement
SDG	Sustainable Development Goals
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
WHO	World Health Organization
YRS	Years



Chapter 1 Introduction to the Study

1.1 Introduction

This section builds the case for the study by providing background information, defining the problem, outlining the study objectives and discussing the significance of the study.

1.2 Background to the study

Globally, countries are striving towards achieving Universal Health Coverage (UHC). UHC refers to a system that allows all members in a society to access essential health services without direct financial barriers. The definition embodies three related objectives: equity in access to health services based on need rather than ability to pay; that the quality of health services is good enough to improve overall health; and that there are financial risk protection mechanisms to ensure that persons are not impoverished due to seeking healthcare (World Health Organization, 2013).

Based on international human rights laws, countries are free to choose any mix of public and private involvement in the health sector (World Health Organization, 2013). The private health sector includes a wide range of actors offering a variety of services. Private actors include commercial (for-profit) providers and Non-Governmental Organizations (NGOs), all ranging from multinational corporations to small private practitioners operating clinics, pharmacies and labs. The World Bank defines the private health sector to include all actors outside of government such as for-profit, not-for-profit, formal and informal entities (Preker & Harding, 2003).

Private healthcare service provision is a substantial and growing sector that is capturing an increasing share of the health market across the world, playing a major role in both High-Income Countries (HICs) and Low- and Middle-Income Countries (LMICs) (Hahn, 2014; Reading, 2018). In the United Kingdom (UK), for instance, the National Health Service, a state-funded universal health care system, has a sizeable private sector engagement component, and is increasingly opening services up to competition to improve efficiency (Hahn, 2014). In India for instance, 70% of healthcare services are provided by the private sector (Reading, 2018).

The roles and activities of private sector actors in healthcare include the provision of healthcare services, management of health institutions, production of health products and technologies and financing. In HICs, private provision usually entails care by well-trained professionals in settings with sophisticated equipment (Palmer, 2002). These roles and activities may also be carried out within a publicly run health care system for example, case in the United Kingdom, where private actors have a role in nursing homes for persons with disabilities under the National Health Service.

According to the World Bank, the private sector delivers roughly half of Africa's health products and services (World Bank Group, 2017). Reasons for its popularity include perceived inefficiency and lack of quality in the provision of public health care, increased costs and reduced budgets for health care due to the financial crisis, and encouragement by international financial institutions to rely on private actors to decrease the burden on national budgets (World Bank, 2017). Accordingly, there has been an increase in private sector engagement across governments globally, which is defined as the systematic and deliberate collaboration of the private sector and the government to advance national health priorities forward, beyond individual programs and interventions (World Bank Group, 2017). Governments employ various models in their private sector engagement, including Public Private Partnerships (PPPs), social marketing, dual practice regulation, sector-wide approach, voucher programs, contracting-out, public-private mix approach and financing (Whyle & Olivier, 2016).

Under sustainable development, United Nations (UN) member states committed to working towards achieving universal health coverage by 2030 (Partnership & Annual, 2019). As a result, Kenya adopted UHC as one of the priority projects, targeting to have all Kenyans covered by year 2022. Both the country's Constitution and Vision 2030 emphasize the right to healthcare (The Government of Kenya, 2010). Under Vision 2030 (GOK, 2007), Kenya's development blueprint, UHC is concerned with ensuring access to quality healthcare by increasing structural and resource capacity to handle the growing population. With health tourism being one of the flagship Vision 2030 projects, Kenya is expected to position itself as a destination for specialized health and medical services. With only 22% of Kenyans having health insurance, private sector involvement would supplement and reinforce the services of the public sector. This would help the Kenyan government achieve its goal of 100% coverage by 2022 (Ministry of Health, 2016). For Kenya to

achieve UHC, strategic initiatives have to be put in place. According to a 2019 report by Informa Markets, the private sector will be key in Kenya's achievement of UHC. Through its financial and innovative capability, the private sector can play a crosscutting role in expanding the UHC and improving the quality of care.

Country reports show that the main factors underlying the expansion of the private health sector include the perception of low quality at public facilities, higher private sector focus on customer satisfaction, absence of public health facilities in underserved areas, large rural-to-urban migration lowering the public sector's ability to offer services effectively. And, low government spending on health contributing to high out-of-pocket spending (Stallworthy, Boahene, Ohiri, Pamba, & Knezovich, 2014).

While most obligations identified in international human rights law fall on States, there are clear obligations for non-state actors in health. However, given that such actors do not have formal legal obligations, an exploration of how the private-sector engagements may be aligned to advance UHC is necessary in order to realize synchrony in the tripartite relationship between the right to health, private sector involvement, and the public sector hence the present study.

1.3 Problem Statement

The private sector plays an important role, especially in the financing and services delivery functions, as well as supplying essential products and technologies (Blumenthal & Hsiao, 2015). Studies suggest a strong preference for private health providers in LMICs for various reasons, including the perception of good quality care, focus on customer satisfaction, absence of public health facilities in some underserved areas, high rural-to-urban migration lowering the public sector's ability to offer services effectively, and, low government spending on health contributing to high out-of-pocket spending (Stallworthy et al., 2014).

In Kenya, despite increased private sector engagement activity, worries persist over their role and impact, including concerns over poor information sharing, weak government capacity to lead engagement with private actors, lack of financing, mismatched organizational styles and differing priorities, lack of clear private sector engagement strategy and corruption (Jane, 2014). This is

made worse by an overall lack of trust between the two sectors, poor coordination, and limited interaction between public and private sector players (Okech & Lelegwe, 2015).

To address the challenges, the SDG Partnership Platform was established in Kenya to promote interaction, coordination and communication across sectors. This has helped to formalize policy arrangements, allowing private actors to be involved in policy design. Despite the efforts, there are concerns that communication and engagement remains poor, particularly at sub-national level. There is also lack of clarity on the role that the private sector is playing across counties, and the extent of their involvement in health services and UHC broadly (United Nations Development Programme, 2019).

The Kisii County through its health department strategic plan 2018/23 identifies healthy lives and promotion of well-being for all at all ages as the ultimate goal which anchors the pillars of UHC. Despite the robust strategies put in place by the county government to improve health services, the review of the previous strategic plan brings forth outstanding challenges among which are increased demand due to increasing population surpassing the current supply, weak PPP and partner engagement framework among others (Kisii County Intergrated Plan, 2018).

Coupled with scanty pertinent empirical literature, it is the foregoing reported challenges in private sector engagement towards UHC in Kenya in general and Kisii County in particular, that warranted the present study. The study particularly set out to examine the role of private sector engagement in provision of public health services towards universal health coverage with reference to Kisii County. Findings in this regard would inform recommendations towards addressing the identified challenges for an effective private sector engagement towards universal health coverage in Kisii County, and its generalization to Kenya.

1.4 Research Objectives

1.4.1 Overall Objective

To examine private sector engagement in provision of public health services towards universal health coverage in Kisii County.

1.4.2 Specific Objectives

- i. To describe the private sector engagement models used in Kisii County
- ii. To examine achievements and challenges with private sector engagement in Kisii County
- iii. To explore in-depth the health system managers' perceptions on the impact that private sector engagement has had (if any) on promoting UHC in Kisii County

1.5 Research Questions

- i. What models are used for private sector engagement in Kisii County?
- ii. Are there any achievements or challenges experienced in engaging the private sector to meet public health goals in Kisii County?
- iii. How do health systems manager perceive the impact of private sector engagement in promoting progress towards UHC in Kisii County?

1.6 Scope of the Study

The study was limited to private sector engagement in the provision of public health services in Kisii County. The study was conducted within Kisii County, and used county managers and private healthcare partners as respondents. The geographical scope of the study included the entire Kisii County. This entailed both the central business district where the county government is located, from which county managers were drawn for participation, and the nine (9) sub-counties from which respondent private healthcare partners were sampled. The nine sub-counties include South Mugirango, Bomachoge Chache, Bomachoge Borabu, Bobasi, Kitutu Chache south, Kitutu Chache North, Nyaribari Masaba, Nyaribari Chache and Bonchari. The study was conducted between March and April 2020.

1.7 Significance of the Study

Study findings contribute to the existing body of knowledge on universal health coverage in Kenya and act as a reference point for research looking at the role of the private sector in UHC. Findings also inform the Kisii County government on the achievements and challenges encountered in trying to include the private sector in meeting UHC, a public goal.

Policy makers both at the national MoH and the County governments may also find the study helpful in thinking through and designing policy solutions that seek to take a whole market approach, particularly those that are focused on achieving UHC.



Chapter 2 Literature Review

2.1 Introduction

This chapter discusses the theoretical foundation, empirical literature and the conceptual framework to guide the study.

2.2 Theoretical Foundation

Various theories underpin the relationship between private sector engagement and provision of public services. Prominent among these theories and of particular relevance to this study are the Principal-Agent Theory (Agency Theory) and the Contract Theory.

2.1.1 Agency Theory

The Agency Theory was first proposed by (Coase, 1937), whose concern was understanding why firms exist and the nature of relationships between actors with varying levels of information. The concept was further developed in respect to property rights and the theory of the firm (Alchian & Demsetz, 1972). The theory addresses the relationship between the ‘principal’, normally the shareholders or owner of an organization or the responsibility holder for the strategic roles of an institution, and the agent, normally the management of an organization tasked with delivering the organization’s mandates in the best interest of the principal. The theory is concerned with resolving problems that exist where there is information asymmetry (Jensen & Meckling, 1976). Principle-agent arrangements are inherently problematic because of diverse interests and levels of knowledge across actors.

Agency theorists often contend that private sector engagement in the provision of for public health services exacerbate the principal-agent problem, where diverse interests and varying levels of information can result in the agent serving less of the principal’s (and by extension, the society’s) purposes, and more of its own purposes (Berezin, Sergi, & Gorodnova, 2018). For this reason, contractual arrangements must ensure proper alignment of interests of the principal and the agent, usually through a variety of ways, most notably, minimizing the information barrier (which means the principal must have ways of monitoring the agent, and ensuring whatever they engage in serves the greater societal good).

The Agency theory has been criticized by a number of scholars on various grounds, including Perrow (1986) who observed that the theory is not concerned about the principals, who exploit, shirk and deceive the agents. According to Perrow (1986), some principals act opportunistically by pulling naïve agents into work with dangerous working environments and without any scope for infringement. Further, Pepper and Gore (2012) criticized the agency theory by arguing that the standard agency theory only lays emphasis on agency cost, the agent and principal theory and parties' interests' realignment with a view to minimize the agency problem. According to Pepper and Gore (2012), the main constituent of the principal–agent association are the agents and that their performance depends mostly upon their motivation and ability.

In this study, the public sector, tasked with delivering UHC, can be considered the principal, whereas the private sector, often rich with information, resources and technological capacity, can be considered the agent chosen to help the principal achieve its mandate. Agency theory thus underpinned the contractual relationship between the private sector and the public sector. The theory was particularly instrumental in the understanding of whether or not the interests inherent among both private sector and public sector actors are aligned and whether this alignment is manifested in the achievements of private sector engagement. The theory was also used to elucidate whether or not the diversity of interests thereof results in agency problems and whether or not the problems are manifested in the challenges of private sector engagement.

2.2.1 Contract Theory

Contract Theory provides further developments on the Agency Theory concepts by modelling the details of the relationship of contracts between parties (Athias, 2007). Contract Theory holds that ownership, specifically the assignment of residual rights, influences the incentives of the engagement parties and will stimulate productive levels of investment. In other words, a properly empowered agent will act in the interests of the principal (Hart, 2003). In economics, Contract Theory studies how economic actors can and do construct contractual arrangements, generally in the presence of information asymmetry.

In a costless world where transaction costs are zero and parties can write complete contracts, contracts would not need to be modified or updated since everything would be anticipated and

planned for in advance, or there would be no cost for engagement of a third party to resolve problems (Hart, 2003). In reality, however, transaction costs are pervasive and substantial, so long-term contracts are always incomplete. Hart defined an incomplete contract briefly as one that “contains gaps or missing provisions”. For an incomplete contract, events will occur that make it desirable for the parties to depart from what was specified in the contract: they may want to revise the contract; they may disagree about the meaning of the contract; and lastly, disputes may occur so parties will need to bring in a third party to determine a solution (Athias, 2007).

Contract Theory also employs the concept of a complete contract, which is conceptualized as a contract that stipulates the legal ramifications of every possible state of affairs (Athias, 2007). When unexpected eventualities arise, the contracting parties must bargain over the best course of action. In such instances, asset owners possess greater bargaining power, which stimulates them to invest. As such, the asset ought to be possessed by the party with the most important investment. Accordingly, Hart (2003) observed that giving one party bargaining power is more effectual compared to spreading bargaining power across several parties.

In criticizing the Contract Theory, Coase (1993) opined that the society is not costless, arguing that the so-called transaction costs may be costs of finding the adequate prices; costs of signing and the negating the contract; costs of searching the transaction partners; information costs emanating from stopping the lack of information during interactions; decision costs emanating from the different parties’ aims for instance, time delay; bargaining costs, for instance, costs of negotiations costs of arranging the transactions; costs of adjusting to the varying conditions; and costs of expired payments and fulfilments. As such, the Contract Theory is built on the grounds being criticized and completed by Coase, who advanced alternative theories often called post-Coasian theories (Kapas, 1999).

Against this background, Contract Theory was employed to understand how private sector engagement stimulates various levels of investment among private actors towards delivering UHC, through the assignment of roles and contractual arrangements in PPPs, contracting-out, public-private mix approach, dual practice regulation and Sector-Wide Approach (SWAs).

2.3 Potential Application of Theory in Understanding Private Sector Engagement

Both theories are pertinent in understanding the association between the various models of private sector engagement and realization of UHC goals in Kisii county. Parties may for instance encounter agency problems anticipated in contractual relationships underpinned by the Contract Theory. The models are expected to bring forth agency problems whereby private sector organizations may be tasked or obligated by the public sector to deliver certain public health services either for free or at subsidized rates, which the private sector may be reluctant to deliver owing to their business model. In anticipation of the foregoing agency problems, the parties may seek to enter into formal contractual agreements in line with Contract Theory.

2.4 Public Health Service in Kenya

The Kenyan health system defines six levels of the hierarchy, as follows: level 1, community services; level 2, dispensaries and clinics; level 3, health centres and maternity and nursing homes; level 4, sub-county hospitals and medium-sized private hospitals; level 5, county referral hospitals and large private hospitals; and level 6, national referral hospitals and large private teaching hospitals. PHC services are primarily provided at levels 1 to 3 (World Health Organization, 2017). Public PHC facilities are governed by health facility committees, which include the facility in-charge and community representatives. For private PHC facilities, government oversight is provided through regulation, implemented through eight regulatory agencies (IFC and World Bank, 2019).

According to the Kenya Health Policy (2014–2030), the 10 leading causes of death in Kenya are HIV-related ailments (29%), perinatal conditions (9%), lower respiratory tract infections (8%), tuberculosis (6%), diarrhoeal diseases (6%), malaria (5%), cerebrovascular diseases (3%), ischaemic heart disease (3%), road traffic accidents (2%) and violence (2%). The country has made remarkable progress in improving key health indicators over recent years. The government's health goal is attainment of universal health care coverage for key services, including maternal, neonatal and child health services. Public primary health facilities have been reported to be pro-poor, particularly across rural locations (World Health Organization, 2017).

In the public sector, the 47 county governments deal with service provision at the local level, while the national level is concerned with policy and the referral hospitals. Taking all the healthcare systems in Kenya together, the fundamental shortcoming is the mismatch between needs and the available care, in particular specialist care and the workforce including doctors and technicians, needed to run it. The Kenya Medical Supplies Authority (KEMSA) is the public agency for medicines, supplying commodities based on orders received from counties. At county level, the county pharmacist is responsible for pooling orders from individual health care facilities, aggregating these, and making orders directly to KEMSA (Kamau, Mukui, & Kimato, 2020).

2.5 Private Health Service in Kenya

Kenya's private sector is one of the most developed and dynamic in Sub-Saharan Africa. In the health sector, where the leading causes of death are HIV/AIDS, acute respiratory infection (ARI), diarrheal diseases, and malaria (WHO, 2019), the private commercial (for-profit) sector and the not-for-profit sector play critical roles in preventing and treating disease. Kenya's healthcare system is made up of several systems: public, private and faith-based or NGO. About 48% are public and operate under the Ministry of Health, 41% are in the private sector, 8% are faith-based health services, and 3% are run by NGOs. Whereas healthcare in public hospitals is free for some services, such as maternity care, and for those with national health insurance, in-patient treatment, healthcare provided by private hospitals, faith-based institutions or NGOs usually comes at a cost and charges will vary (The United States Agency for International Development (USAID), 2019).

The private health sector is increasingly viewed as critical to meeting the growing demand for financing and delivery of health care services, including HIV, in Kenya. Approximately 37 percent of all health spending occurs in private facilities (WHO, 2019). The private health market has dramatically grown over the last two decades and is an important source for care across various segments of the population. For example, 47 percent of poor Kenyans use a private facility when a child is sick and a third (1/3) of couples obtain their family planning methods from the private commercial sector. Further, 10 percent of health care spending goes to NGOs or faith-based facilities for family planning, while a quarter (1/4) of people living with HIV and AIDS access treatment from the commercial private sector (IFC and World Bank, 2019).

Kenya has many legal and regulatory components in place to facilitate growth of the private health sector. There are effective regulatory schemes for health professionals, and the concept of continuing professional education is well established. Moreover, all of the Boards of Registration have procedures in place to withdraw the practice licenses of the health professionals they supervise (Kamau et al., 2020). But there are still areas that need to be strengthened to improve the quality of services, including lack of enforcement by the professional boards result in a highly unregulated private health sector; unqualified health professionals continue to practice privately in the country, despite some well publicized crackdowns; responsibility for licensing of private health facilities is spread across too many regulatory bodies, leading to inefficiencies and gaps in monitoring quality of care; and there is no non-governmental accreditation or certification for facilities and laboratories (USAID, 2019).

2.6 Universal Healthcare Coverage

According to Universal Healthcare Coverage means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course (WHO, 2021). Currently, at least half of the people in the world do not receive the health services they need. About 100 million people are pushed into extreme poverty each year because of out-of-pocket spending on health. UHC strategies enable everyone to access the services that address the most significant causes of disease and death and ensures that the quality of those services is good enough to improve the health of the people who receive them (WHO, 2021).

In Kenya, Universal Health Coverage is one of the “Big Four” strategic pillars declared by the President of Kenya which will see major policy and administrative reforms in the medical sector, to ensure everyone has access to quality and affordable medical coverage by 2022. The country is in the process of defining a Health Financing Strategy which will give impetus to Kenya’s journey towards universal health coverage (International Trade Administration, 2018). Opportunities here are for Public Private Partnerships (PPP’s) with the National Health Insurance Fund financing solutions will be required to meet the demands of the growing population and cater for the underserved regions. The government is also in the process of setting up Cancer Centers of

Excellence (CoE) in two national hospitals to provide affordable, quality cancer treatment in a bid to reduce the high number of patients seeking specialized treatment in other countries. This will also boost the country's large medical tourism market in the East African region (Kariuki, 2020).

Some impediments however, towards the realization of universal healthcare in the country. For instance, there are extreme regional differences in the quality and distribution of care, with the best facilities located in Kenya's capital Nairobi, while the most underdeveloped facilities are in the North-Eastern Province and parts of the coastal region (Oraro & Wyss, 2020). Primary care facilities in rural areas often suffer from shortages of staff, essential drugs, and basic medical equipment. Some patients choose not to seek care due to the distance that they would have to travel to reach the nearest health facility. Only 30% of the rural population has access to health facilities within 4km of their home, compared with 70% of the urban population (Kariuki, 2020).

2.7 Empirical review

2.7.1 Models Used for Private Sector Engagement

Various models of private sector engagement in the provision of public services that have been identified in the literature include: PPPs, social marketing, dual practice regulation, sector-wide approach, Voucher programs, contracting-out, public-private mix approach and financing (Whyle & Olivier, 2016).

2.7.1.1 Public Private Partnership Model

PPPs is defined as: "arrangements where the public and private sectors both bring their complementary skills to a project, with varying levels of involvement and responsibility, for the purpose of providing public services or goods" (The World Bank, Asian Development Bank, & Inter-American Development Bank, 2009). The rise of PPPs worldwide is arguably evidence that traditional methods of infrastructure development are inadequate (Garvin & Bosso, 2008).

PPP model is characterized by high level of engagement, risk transferring/ sharing between the parties, long-term contractual obligations ranging to up to 30 years and highly capital intensive (Hackworth, 2019). This model include: concession contracts, joint ventures, Rehabilitate Operate

Transfer (ROT) contracts and Build Operate Transfer (BOT) type contracts among others (Gaffney, Pollock, Price, & Shaoul, 1999).

2.7.1.2 Social Marketing Model

Private sector utilizes their marketing and communication prowess in the public sector context with the aim of achieving behavior change through sale of products/services of high social or public health impact. Channels of distribution include: CBOs, NGOs, Public facilities like hospitals or schools. The private sector looks for external funding for such programs and complimented with government subsidies on the products/services offered.

Social marketing can be used both downstream (as shown earlier) or upstream to influence behavior change among the policy formulators with the aim of influencing them to draft policies and regulation whose impact results in the intended behavior change (Firestone, Rowe, Modi, & Sievers, 2017).

2.7.1.3 Dual Practice Regulation Model

This model involves bilateral engagement in formulating and enforcement of regulations aimed at controlling public sector health care providers offering services in the private sector and/or stopping the brain drain from public sector to private. Strategies employed in execution of this model include sanctions or incentives; the ultimate goal being rationalization of HRH across sectors but more importantly in the public sector (Whyle & Olivier, 2016).

2.7.1.4 Sector-Wide Approach (SWAps)

Under the SWAps model, the government leads joint negotiations with the private sector, with the aim of pooling resources together for the common good of society. The process should always be steered by the government. The model entails private sector involvement in the planning, budgeting and expenditure processes. Ultimately, the government's aim is to mobilize resources that are sufficient to serve specific goals.

SWAps were introduced in early 90s following widespread dissatisfaction with the prevailing government – donor relationships. Over the years, SWAps gained popularity across countries.

They have been reported to have contributed to aligning, harmonizing and enhancing accountability between governments and donors (Peters, Paina, & Schleimann, 2013).

A fifteen-year implementation of SWAp model in Bangladesh by the ministry of health and family welfare (Ahsan et al., 2016) saw government priorities getting both technical and funding support thus improving program designs and implementation strategies accelerating improvement of health outcomes.

2.7.1.5 Voucher Programs

The voucher program model entails incorporating subsidies on the demand side of the healthcare equation, thus transferring the power to purchase from the providers to the service users, thereby overcoming barriers to uptake of services (Whyle & Olivier, 2016). Causes of low uptake of services include socio-cultural and socio-economic factors. Study on the community level impact of this model on utilization of reproductive services in Kenya showed increased uptake of facility based deliveries by poor women (Obare et al., 2013). Government therefore highlights areas where support is needed and the private sector selects few products/ goods which will now be based on the voucher program.

2.7.1.6 Contracting-out Model

This model entails a government entering into a contract with a private entity to provide services or goods on behalf of the government. The private entity gets a fee in exchange. The contract terms govern execution of this model including the duration, terms of payment and termination. This simply therefore means the government purchases private sector services for the public to consume thus bringing along the process efficiencies experienced in the private sector.

2.7.1.7 Public-Private Mix Approach Model

Private sector players meet under the umbrella of the government to devise strategies of combating particular issues, for instance, a disease outbreak. Outbreak of Coronavirus in China has led to concerted effort by governments and the private sector in laying down strategies of managing this disease which world health organization has declared a worldwide emergency.

2.7.1.8 Financing Model

This model, usually no- contractual, experiences transfer of funds from the public sector to the private sector in exchange of service provision. This can be through direct grants or public insurance body like NHIF covering private sector services.

2.7.2 Achievements and Challenges of Private Sector Engagement

Governments are increasingly challenged to provide sufficient funding for public infrastructure as a result of growing populations, urbanization, necessary network expansion and aging infrastructure assets (World Health Organization, 2013). In addition, the public sector often has to provide significant subsidies for healthcare however, it always operates under a deficit. Therefore, if structured correctly, private sector engagement can relieve this burden by activating priory untapped sources of funding from the national or international private sector.

Significant positives have been registered across the world with PSE. This includes: Increased service utilization, improved service quality, enhanced access to services by the disadvantaged in society and reduced out-of-pocket costs for beneficiaries (Jacobs & Price , 2006; Meuwissen, Gorter & Knottnerus., 2006). In addition, there is increased coordination and alignment efforts in policy and programme design and implementation in countries adopting SWAp (Vaillancourt 2009; Negin & Martiniuk, 2012).

PSE's success especially SWAp depend heavily on the capacity and political will of the country's government. As a result, great plans may not be effectively implemented due to competing priorities in LMIC. Marginalization of private sector in policy discussions and consideration of the expenditure and institutional frameworks has been on the rise complicating further the primary goal of the private sector engagement (Hill, 2002; Sundewall, Forsberg , & Tomson, 2006; Vaillancourt, 2009).

Therefore, PSE achievements and challenges in LMIC will revolve around the following key thematic area: health sector plan, government ownership of processes, increased and streamlined funding availability/expenditure and long-term commitment by both parties, institutional capacity and good governance (Ahsan et al., 2016).

2.7.3 Impact of Private Sector Engagement on achieving UHC

The overarching goal of the private sector engagement is to bring about a long-lasting positive impact on every parameter of the six health building blocks which are: effective governance, adequate financing, quality services, modern ICT, adequate supply of commodities and pharmaceutical products and adequate human resource for health.

Governments can thus benefit from the expertise and technological knowhow, as well as the innovation capabilities of the private sector (The World Bank et al., 2009) in achieving UHC. The private sector is heavily dependent on correct cost estimates and revenue forecasts in order to minimize risk and to best predict financial returns. These non-governmental parties, which are driven by their experience and strong profit-driven nature, usually follow higher levels of quality assurance, when compared to the public sector.

Further, the participation of private sector entities in the tendering process for instance, can lead to two advantages for governments according to (Garvin & Bosso, 2008): It can function as a filter for the public sector to detect and abandon white elephant infrastructure projects upfront, as they often simply do not attract private lenders and investors, who have carried out their own project analysis. It can also result in suggestions of innovative ideas by the private sector. If governments show flexibility in finding infrastructure solutions as well as accept unrequested proposals, the private sector can suggest innovative solutions to meet infrastructure challenges.

A private lender or investor undertakes private sector engagement with the clear target to maximize profits and often does so by introducing measures, which can possibly enhance efficiency and effectiveness of the project, in order to optimize both revenues and costs (Iossa & Martimort, 2015). Governments can profit from this mindset of the private sector, by utilizing available scarce resources more efficiently and effectively.

Additionally, these streamlined processes increase the likelihood that these services are provided in an economically sustainable manner and at affordable cost for the user, while still satisfying profit targets (Clarke, 2011). Moreover, private sector engagement allows governments to transfer operational roles to the private sector, while placing their focus on core public sector responsibilities such as regulation and monitoring.

2.8 Summary of Literature Gaps

The foregoing review details empirical studies pertinent to private sector engagement and the provision of public health services in the context of the provision of universal health coverage. The reviewed literature attempt to link the various concepts explored in the present study, including the private sector engagement models, achievements and challenges. It however remains unexplored, the extent to which the private sector is involved in the provision of public health services towards universal health coverage in the Kenyan context, particularly the private sector engagement models, achievements and challenges thereof. Further, extant empirical literature is deficient in exploring the link between the anchoring theories and private sector role in the provision of universal health coverage in the country, hence the present study.



2.9 Conceptual Framework

As illustrated in the conceptual framework (Figure 2.1), the model of PSE adopted define the contractual relationship between the public and private sector actors towards the realization of Universal Health Coverage as anticipated by both the Agency theory and Contract Theory. In tandem with Agency theory, the alignment of interests between the public and private sector actors was anticipated to result in achievements towards the realization of Universal Health Coverage while diversity and conflict of interests would result in challenges affecting the overarching Universal Health Coverage realization. Also, in accordance with Contract Theory, the various incentives in the models, or their lack thereof, would determine the private sector's level of investment and involvement towards the realization of Universal Health Coverage.

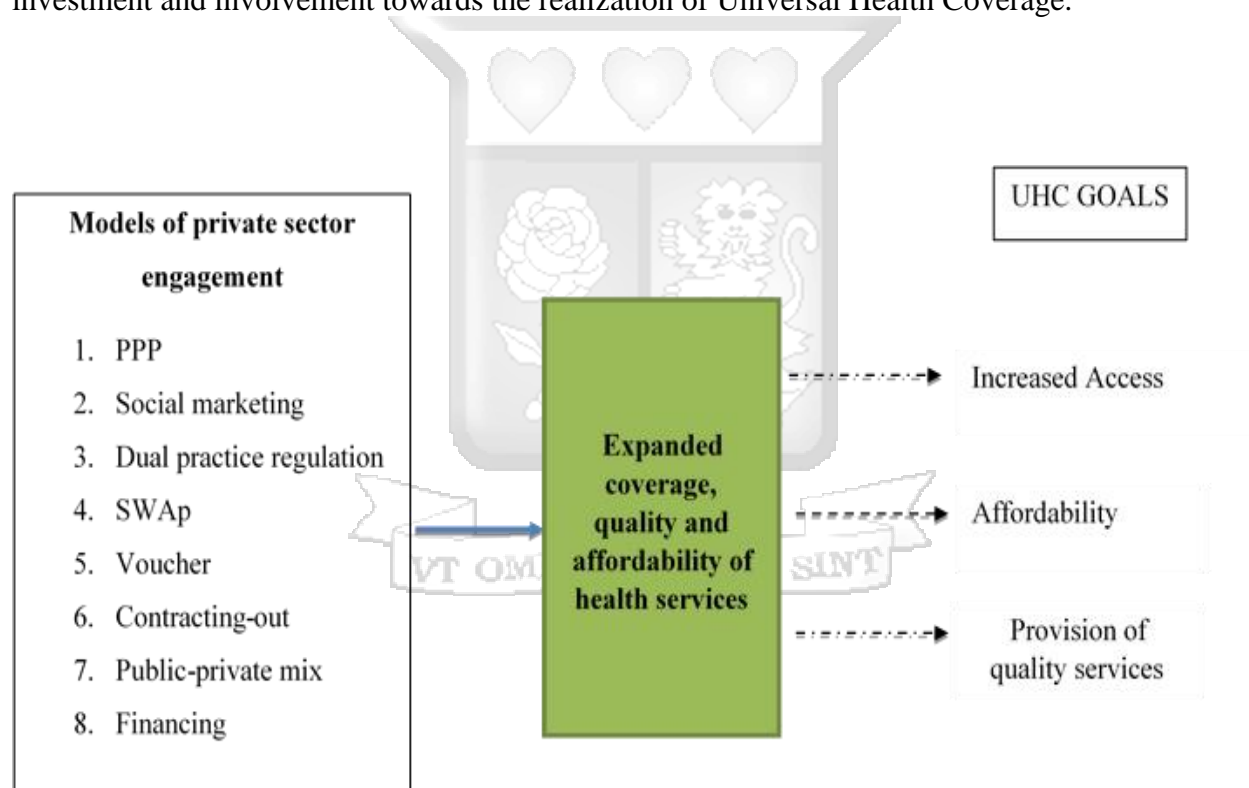


Figure 2.1 Conceptual Framework

Chapter 3 Research Methodology

3.1 Introduction

This chapter discusses the study methodology, specifically looking at the study design, sampling, research quality, data collection methods, data analysis methods and ethical concerns.

3.2 Research Design

The study employed a mixed method approach, combining a questionnaire survey with in-depth qualitative interviews carried out with public and private sector actors. Mixed method approach was deemed adequate in the present study in order to complement quantitative data obtained from the questionnaire with qualitative information obtained from the in-depth interviews as well as for triangulation purposes.

3.3 Population and Sampling

The target population for the study was administrative staff at the Kisii County Government Health Department distributed across three cadres including senior, middle and lower management and private partners engaged in Kisii County as tabulated below.

Table 3.1 Target Population

Category	Population
County Government	
Senior Management	7
Middle Management (CHMT)	10
Lower Management (SHMT)	9
Private Sector Facilities (Focus Areas)	
HIV/AIDS/ TB/ Malaria/ RMNCAH	27
NCD	2
Emergency Response	1
Private insurance (Britam)	1
Adolescent and child health	3
Health systems Management	1
Community Strategy	1
Total	62

{Source: Office of County Director of Health, Kisii County}

3.3.1 Sampling

3.3.1.1 Sampling in the qualitative study

To determine a sample size in a qualitative part of the study, purposive sampling method was used, based on the respondents' conversance or proficiency in the subject matter. Purposive sampling is a form of non-probability sampling whereby the researcher relies on their own judgment when selecting members of the target population to take part in their study. In this case therefore, Moser and Korstjens (2018) recommends 10 interviews to be sufficient. For the purposes of this study, and in consideration of saturation point, five interviews were considered drawn from public and similar numbers drawn from the private sector.

3.3.1.2 Sampling in the quantitative study

The remaining 52 individuals from the population of 62 formed in its entirety the sample size for the quantitative part of the study participation. These included a census of 21 county government health department officials and 31 private sector partners engaged by the Office of County Director of Health, Kisii County. Distribution of the sample size was as shown in Table 3.2.

Table 3.2 **Sample size distribution**

Category	Sample size
County Government	
Senior Management	6
Middle Management (CHMT)	8
Lower Management (SHMT)	7
Private Sector Facilities (Focus Areas)	
HIV/AIDS/ TB/ Malaria/ RMNCAH	22
NCD	2
Emergency Response	1
Private Insurance (Britam)	1
Adolescent and child health	3
Health systems Management	1
Community Strategy	1
Total	52

3.4 Data Collection Methods

3.4.1 Quantitative method

To address study objective 1, data was collected using the 52 semi-structured questionnaires administered to the respondents directly. The questionnaire had two sections. Section A which covered respondents' demographic information while section B contained both open and closed ended questions addressing objective 1 of the study. Questions sought to understand engagement models used by different actors in Kisii County. Questionnaire development was adapted as based on the reviewed literature.

3.4.2 Qualitative method

In-depth interview guides were used to address issues around achievements and challenges of PSE and perceived impact of PSE thus addressing study objective number 2 and 3 respectively. For the purposes of this study, the 10 interviews were conducted in the respondent's office.

Interview guide had three parts where part A contained introduction to the interview, part B and C contained questions addressing the second and third objectives of the study, respectively. Part D of the interview guide collected data on the existence of any private sector engagement framework document(s).

3.5 Data Analysis

The study adopted both descriptive and thematic content analysis techniques. The rationale for the adoption of these techniques was to descriptively articulate the role and extent of involvement of the private sector in provision of public health services towards universal health coverage in Kisii County. This included a description of the private sector engagement models employed, the achievements and challenges thereof as well as the health system managers' perceptions on how effective private sector engagement has been in promoting universal health coverage in Kisii County. While descriptive analysis was employed on quantitative data in presentation of hard facts, thematic content analysis was conducted on qualitative data to enrich and complement the quantitative findings.

3.5.1 Quantitative data

Data collected through the semi-structured questionnaires was analyzed using descriptive analysis which involved the use of frequencies in their absolute and relative forms (percentage) as well as means and standard deviations to measure central tendencies and dispersion respectively using Statistical Package for Social Sciences, version 25.

3.5.2 Qualitative Data

Qualitative data collected through in-depth interview guides and review of existing engagement framework documents were edited for completeness, accuracy and consistency then coded to generate themes, patterns and relationships which are linked up with the study objectives using NVivo software, version 12.

3.6 Research Quality – Validity, Reliability and Objectivity of the Research

3.6.1 Validity

Validity is the extent to which differences found with a measuring tool reflect true differences among respondents being tested (Ayodele, 2012) It can estimate the extent to which the data obtained accurately reflects the theoretical or conceptual concepts; that is if the measurements are consistent with the expectations. External validity was established by asking a series of questions, and often corroborated the answers in the research of others such as supervisors, statisticians and colleagues. Internal validity was ensured by focusing the questionnaires and interviews to the study objectives

3.6.2 Reliability

Reliability refers to the accuracy and precision of a measurement procedure (Ayodele, 2012); measures the degree to which a research instrument gives consistent results. Reliability is concerned with estimates of the degree to which a measurement is free of random or unstable error (Ayodele, 2012).

3.6.3 Objectivity

Objectivity in the study was assured through self-administration of the data collection instruments which were administered on a drop and pick method. Respondents were also directed before the data collection exercise to respond as honestly as possible to the best of their knowledge.

3.7 Ethical Consideration

Prior to data collection, a clearance letter from the Strathmore University Ethical Review Committee and a research permit from the National Commission of Science, Technology and Innovation (NACOSTI) were obtained. These were then presented to the County Government during the introduction for permission to collect data.

The researcher ensured only participants giving voluntary consent participated in the study. Informed consent was based on the information regarding: the purpose of the research study, identification of the researcher, any benefits that may be received. The researcher communicated this to the respondents before the start of the study. To avoid plagiarism, all works borrowed from other scholars are fully acknowledged.



Chapter 4 Results

4.1 Introduction

This chapter presents findings from both the quantitative and qualitative data, their interpretation and discussions in relation to previous related empirical studies. The main analytical operations employed herein include the preliminary screening of data, descriptive analyses and thematic content analysis.

4.2 Response Rate

The study achieved a 100.0% response rate with all the 52 participants targeted for questionnaires and 10 for interviews, reached. This is considered excellent by (Creswell, 2013) who postulates that a response rate of 50% is adequate for analysis and reporting; a rate of 60% is good and a response rate of 70% and over is excellent. The response rate can be attributed to the researcher-administered mode of data collection, as opposed to self-administration. The researcher would book a sit-down session with a respondent at their convenience, read the questions out to them and fill the responses in the questionnaire. It can also be attributed to follow-up phone calls made to interview respondents with a view to secure ample time for interviews in view of busy work schedules.

4.3 Respondent Demographic Characteristics

This section describes the study participants' demographic characteristics including respondent gender, respondent age, highest levels of education, level of management, as well as the nature of organizations respondents work for (Table 4.1).

Table 4.1 Distribution of Respondents by Gender

Category	Frequency (n)	Percentage (%)
Male	31	59.6
Female	21	40.4

Source: Survey Data, 2020

Age categories were also deemed a key factor in determining the age distribution among professionals in provision of public health services towards universal health coverage. The study established in this regard, as presented in Table 4.2, that a majority of study participants 53.8% were between the ages of 40-49 years while the least 1.9% was above 50 years. The finding implies that a majority of health professionals in provision of public health services towards universal health coverage in the study are middle aged.

Table 4.2 Distribution of Respondents by Age

Category	Frequency (n)	Percentage (%)
30-39 years	23	44.2
40-49 years	28	53.8
> 50 years	1	1.9

Source: Survey Data, 2020

The study further deemed respondents' level of education a key indicator of the academic qualification among practitioners (Table 4.3). Most participants (67.3%) had attained undergraduate degrees, while 14 (26.9%) had a post-graduate degree. The least of the participants 3 (5.8%) were diploma holders. The finding is of the implication that a majority of professionals in the provision of public health services towards universal health coverage in the study area had relatively high academic qualifications, with most having at least an undergraduate degree.

Table 4.3 Distribution of Respondents by Education Level

Category	Frequency (n)	Percentage (%)
Diploma	3	5.8
Basic degree	35	67.3
Post-graduate	14	26.9

Source: Survey Data, 2020

The study also deemed respondents' level of management imperative in the administration of health systems and institutions charged with delivering universal health coverage in the country. Reaching participants at different levels of management was also aimed at assuring representativeness and diversity of experiential perspective with respect to administration of public health services towards universal health coverage. Table 4.4 indicates that out of 52 participants 55.8% of the respondents were middle level managers, 42.3% were senior managers

and 1.9% was a lower manager in the various positions in their respective organizations. It can be deduced that the study findings are representative of diverse managerial perspectives pertinent to administration of public health services towards universal health coverage.

Table 4.4 Distribution of Respondents by Level of Management

Category	Frequency (n)	Percent (%)
Senior	22	42.3
Middle	29	55.8
Lower	1	1.9
Total	52	100.0

Source: Survey Data, 2020

Respondents were further asked to indicate whether they worked for government or private organizations. This was aimed at ensuring respondents from both the public and private sector entities pertinent to the provision of public health services towards universal health coverage are reached and represented. As tabulated in Table 4.5, a majority of respondents (59.6%) were proportionately drawn from private sector organizations while the remaining 40.4% were drawn from government institutions. It can thus be deduced that institutions from both the private and public sectors were reached.

Table 4.5 Distribution of Respondents by Organization

Category	Frequency (n)	Percent (%)
Government	21	40.4
Private	31	59.6
Total	52	100.0

Source: Survey Data, 2020

4.4 Form of Private Sector Engagement with the County Government

The study sought to determine the private sector engagement models used in Kisii County. To this end, respondents were asked to indicate the form of engagement existing between the county government and their respective organizations. As portrayed in Table 4.5, the majority of respondents (98.1%) affirmed to engaging with the county government through signing of memorandum of understanding while only 1.9% affirmed to signing contracts.

Table 4.6 Form of Private Sector Engagement with the County Government

Category	Frequency (n)	Percent (%)
MOU	51	98.1
Contracts	1	1.9
Total	52	100.0

Source: Survey Data, 2020

The study further sought to establish the respective pillars that best describes the private sector engagement in relation to realizing universal health coverage. Options to this end included governance, human resource for health, financing, service delivery, health information systems and access to essential drugs and non-drug commodities. Table 4.7 presents findings in relation to governance pillar in the private sector engagement. From the table, only 28.8% of the respondents agreed that governance was the best pillar that describes private sector engagement while 71.2% dissented. Further, 94.2% agreed that service delivery best describes the pillar of private sector engagement while 5.8% disagreed.

With regard to access to drugs and non-drugs as the best pillar to describe private sector engagement, a majority of the respondents (71.2%) dissented while only 28.8% agreed. A majority (51.9%) further disagreed that human resource pillar to describe private sector and county government engagement while 48.1% affirmed. A majority of respondents (53.8%) also dissented that health information pillar best described their private sector engagement while 46.2% affirmed. A majority (73.1%) however affirmed that health financing was the best pillar to describe the private sector engagement while 26.9% dissented.

Table 4.7 Pillars of Private Sector Engagement

Pillar	Yes		No	
	n	%	n	%
Governance	15	28.8	37	71.2
Service delivery	49	94.2	3	5.8
Access to drugs and non-drug commodities	15	28.8	37	71.2
Human resource	25	48.1	27	51.9
Health information system	24	46.2	28	53.8
Health financing	38	73.1	14	26.9

Source: Survey Data, 2020

Respondents were further asked to specify the private sector/government roles in the engagement. This was aimed at establishing the various stakeholder roles in the provision of public health services towards universal health coverage. It was established in this regard that the county government's roles include provision of technical oversight to pertinent intervention projects and programmes; financial and human resource mobilization as per the MOUs and contracts; regulation of the private sector; provision of human resources; data review and provision of essential commodities and service delivery; assignment of roles; information dissemination; NHIF accreditation; administration and auditing; coordination and monitoring of activities; as well as training of staff and capacity building.

The study further sought to determine the private sector engagement models entered between the private sector and the county government. As illustrated in Figure 4.1, a majority of respondents (96.2%) affirmed to Public-private partnership as best describing their private sector engagement models. This was distantly followed by 13.5% of respondents affirming to public-private mix and 11.5% either to financing or social marketing as best describing their private sector engagement models. Only 5.8% of respondents associated their model of engagement with either sector-wide approach or contracting out.

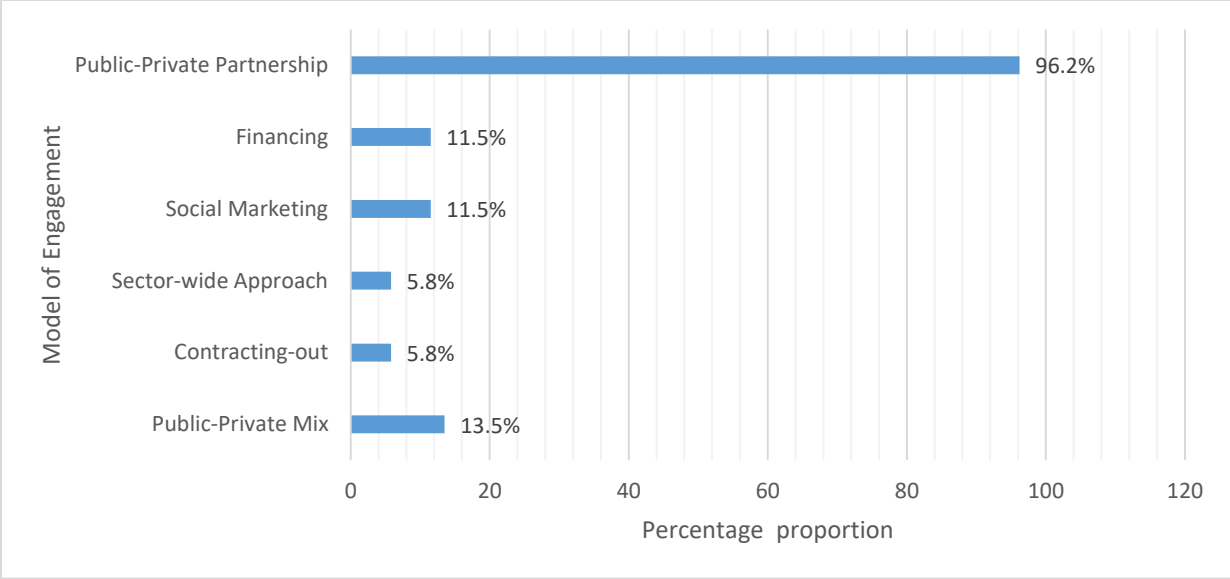


Figure 4.1 Private Sector Engagement Models

Source: Survey Data, 2020

Respondents were also asked to indicate the length of the private sector engagement with a view to determine the sustainability of the engagement models thereof as well as the length of experience with the respective models. As presented in Table 4.7, a majority of the respondents 40 (76.9%) have been in the private sector engagement for 3-5 years period while 12 (23.1%) of the respondent had 0-3 years private sector engagement experienced.

Table 4.8 Length of Private Sector Engagement

	Frequency (n)	Percent (%)
0-3 yrs	12	23.1
3-5 yrs	40	76.9
Total	52	100.0

Source: Survey Data, 2020

The study further sought to establish the legal framework anchoring the private sector engagement in order to find out the legislative framework underpinning private and public sector engagement in the provision of public health services towards universal health coverage. As illustrated in Figure 4.2, a majority of respondents (96.2%) strongly opted for Public-private partnership Act, 2013 as the ideal legal frame work that anchors private sector engagement with the county

government of Kisii, while 13.5% opted for NGO Act, 2012 and 11.5% were of the opinion of public procurement & disposal Act, 2015 respectively.

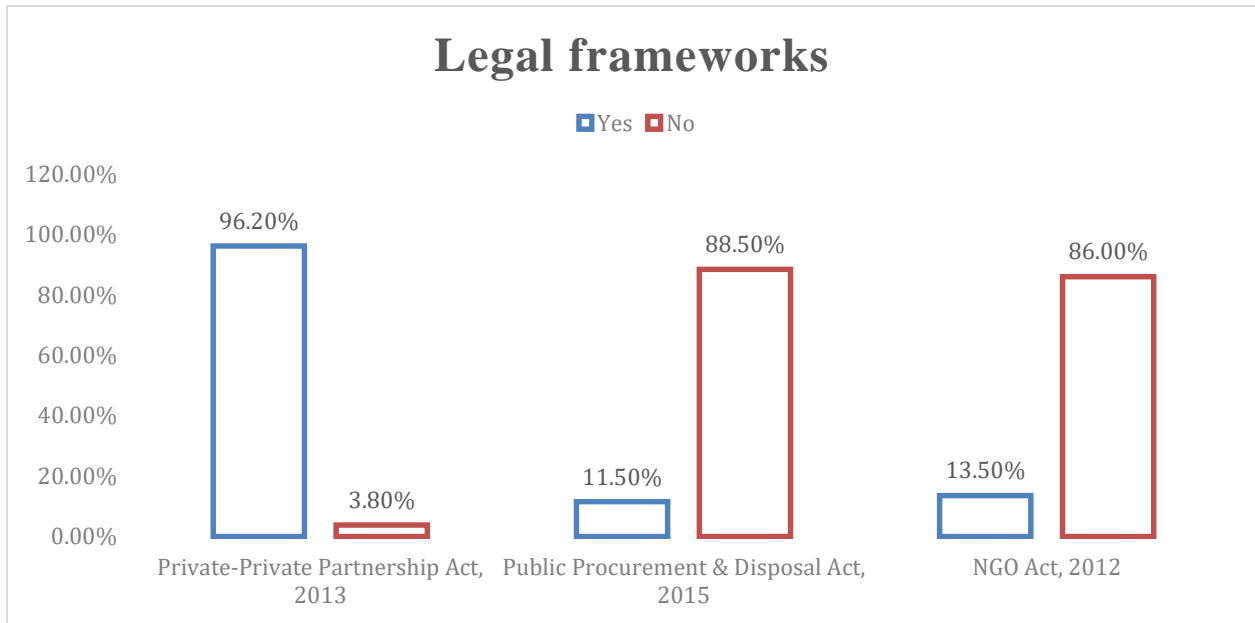


Figure 4.2 Legal Framework for Private and Public Sector Engagement

Source: Survey Data, 2020

Respondents were further asked to indicate the frequency at which the Public-Private dialogue pertinent to the provision of public health services towards universal health coverage were held. As illustrated in Figure 4.3, a majority of the respondents (86.5%) held dialogue meetings on a quarterly basis, while 57.7% affirmed doing so bi-annually. A further 51.9% affirmed to annual dialogue while 48.1% affirmed to holding dialogue on a monthly basis.

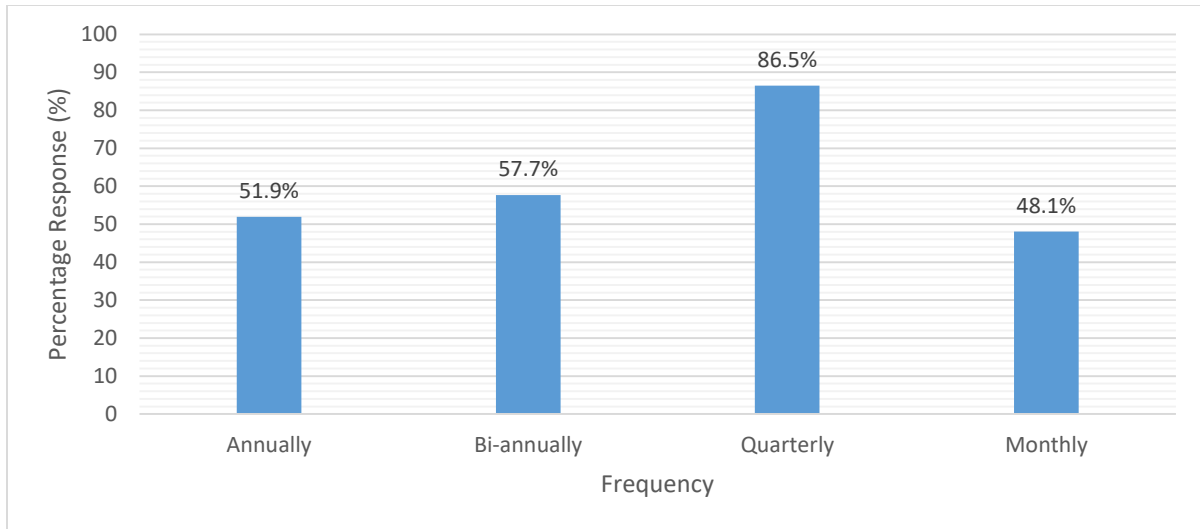


Figure 4.3 Frequency of Public-Private Sector Dialogue

Source: Survey Data, 2020

The study further sought to determine the purpose of the dialogue held with a view to determine the various areas of engagement. As Figure 4.4 illustrates, a majority of the respondents engaged the with the county government of Kisii during the planning (82.7%) and performance review (92.2%) periods, while 76.9% engaged the county during budgeting periods and the least being during policy issues.

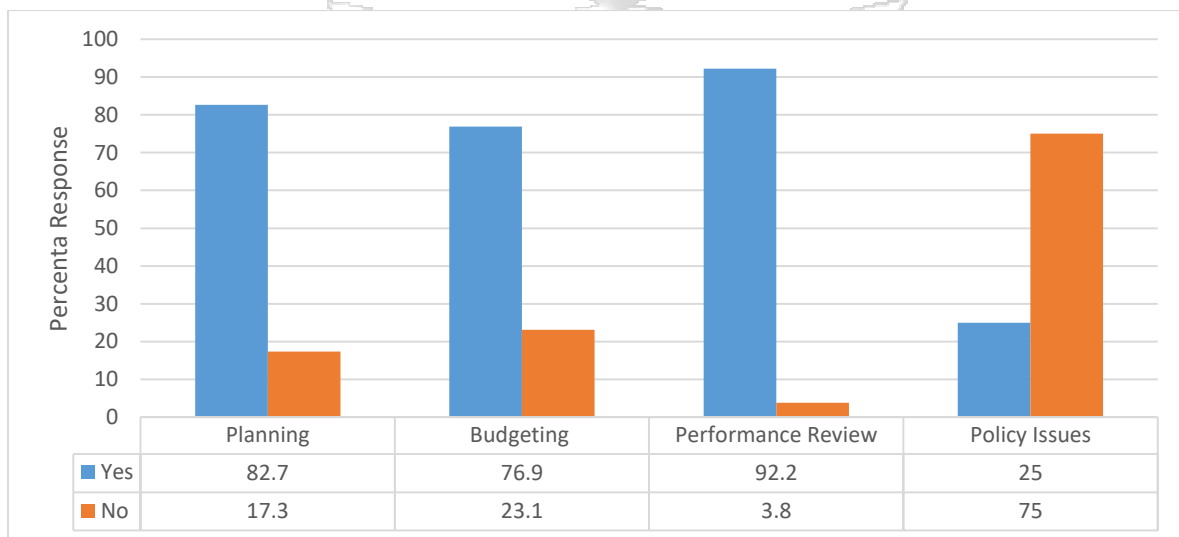


Figure 4.4 Areas of Engagement in Public-Private Sector Dialogue

Source: Survey Data, 2020

4.5 Perceived achievements and Challenges in Engaging the Private Sector

The study sought to explore the achievements and challenges the Kisii County government faces in engaging the private sector. To this end, interview respondents were first asked to describe the private sector engagement's contribution in realizing universal health care in Kisii County.

Overall, majority of respondents observed that private sector engagement had contributed towards the realization of UHC in their respective areas.

Engagement achievements mentioned included the private sector provision of human resource to supplement the understaffed public health facilities; technical and capacity building support, provision of commodity supplies; training of community health volunteers; technological support through digitalization of otherwise paper based data collection and reporting; financial support through payment of stipends to community health volunteers and financing of projects and/or programme activities aimed at UHC. The other achievement mentioned was provision of healthcare services through private facilities.

“.....The private sector has contributed in many aspects towards realizing universal health coverage in Kisii county for instance, technical and financial support. They also supplement the staff that are employed by Kisii county by providing human resource which is a critical arm in achieving universal health coverage”

Public Sector Provider II

“...We have been able to support some of the interventions by the county government at the community level. We have built capacity of community health volunteers to enable them diagnose and manage basic healthcare conditions at the community level and refer cases that they are not able to manage.... We have empowered the community health volunteers with smartphones for access to data and information sharing...”

Private Sector Provider I

The study also sought to understand challenges faced by the county government in public private engagement. A key challenge identified was difficulty in regulating and holding accountable the

private sector, as they had leeway to choose activities to engage in. Other challenges mentioned included difficulty engaging the private sector in less profitable initiatives such as HIV prevention campaigns; inability of the county to sustain programmes initiated by the private sector; supply chain gaps, mainly touching on commodities; insufficient financing of health services and activities; and non-disclosure of data to enable the county government develop and improve its indicators. Interview informants for instance intimated that:

“.....Private sector is very difficult to regulate. though they support our activities, we don't regulate. most of the activities they do are per their own activities.....”

Public Sector Provider II

“.....We also have commodity issues. when these community health volunteers are capacity built, they are supposed to management common ailment but they are not able to due to intermittent supply of commodities, there is a supply chain gap in that at times when they are required to be supplied on a quarterly basis, it happens semi-annually and therefore they go a full quarter with no sufficient amounts of essential commodities to support at the level..... Finances are also a challenge..... At least 15% is supposed to be allocated for health which is not adhered so there is a lot of underfunding of activities aimed at realizing universal health coverage.....”

Public Sector Provider VI

Respondents were further asked how the challenges could be addressed. Majority proposed increasing public health financing at both the national and county government level. Another proposal was for the county government to lead the process of developing joint plans with the private sector that include UHC priority activities, thereby making better use of private sector resources and support.

Interviewees advised that robust capacity building of healthcare workers was needed to make the engagement activities more sustainable and with higher impact. It was further suggested that in order to address the supply chain challenges, particularly delays in supply of commodities, the

county government should be given the mandate by the national government to procure and supply commodities. A feedback from the interview respondents is as displayed below:

“.....As a county, we should be able to have some control over some of the private sector actors because at times you have all of them supporting one area. We should be able as a county to consider our areas of interest, and propose areas of support for the private sector to chip in.....”

Public Sector Provider VI

4.6 Manager Perceptions on the Impact of Private Sector Engagement

The study sought to explore health system managers’ perceptions on the impact of private sector engagement in promoting progress towards UHC in Kisii County. To this end, respondents were asked to indicate how the healthcare system in Kisii County benefit from private sector engagement along six key thematic areas, including system governance, improved health work force, health financing, access to quality health services and health seeking behaviors, improved technology and access to quality drugs.

4.6.1 System Governance

The study sought to find out whether or not in respondents’ opinion, system governance had benefited from private sector engagement. A majority of respondents observed that engagement had improved health system governance. More specifically, existing memoranda of understanding had resulted in improved alignment of purpose by catering for the interest of both the public and private sectors, clearly stipulating the terms of engagement, accountability structures and transparency measures. Further, the private sector was engaged in quarterly stakeholder meetings for purposes of planning, performance reviews, and budgeting which has led to strengthening of governance systems. Resource mobilization had also improved with the engagement of the private sector as they contribute both human and financial resources to programmes and activities towards universal health coverage. An interview informant noted that:

“.....System governance is much better off now with the engagement of the private sector. We had been experiencing improved financial resource allocation from the donors because of more transparency and accountability in monies which were channeled through the private sector. As opposed to early 2000s when donor funds dwindled due to lack of accountability, with engagement with the private sector, the accountability has improved as it is now more of a resource-based funding whereby money is given as need arises instead of giving money first and they accounting later.....”

Public Sector Provider II

4.6.2 Improved Health Work Force

Similarly, interviewees recognized the role of engagement in strengthening health workforce. It was noted that the private sector had contributed by recruiting staff at the county government and community levels but are remunerated by the private sector, which significantly bridges the human resource gaps at the county government as a result of attrition and low employment rates. The private sector also contributes by training of staff, capacity building and by boosting staff capacity of nurses and clinical officers, as well as by provision of lay workers, for instance mentor mothers, PIA navigators and adherence counselors who run various key the programs such as HIV/AIDS campaigns, contact tracing, appointment bookings among others.

“...Private sector employs a good number of healthcare providers for the public sector under their payroll. They contribute to paying stipends to community health volunteers which is the primary health level for the sub county...”

Public Sector Provider III

“.....We recruit, retain and build capacity of staff at the community level to bridge the gap by the county government in various interventions. We also empower the staff at community level by giving them mobile technology for clerking of clients and referrals”

4.6.3 Health Financing

The study further established that the private sector has significantly improved health financing, bridging the inadequate budgetary allocation for health at the county government, through financing of various activities and programmes aimed at realizing the universal health coverage, recruitment and payment of staff. A few challenges were however noted in health financing, including non-allocation of funds to pertinent areas in the realization of universal health coverage, such as community sensitization and development of relevant robust community initiatives. Some of the response are as follows:

“.....The budget from the government for health is not adequate. The private sector helps bridge the gap, for instance, payment of the staff they recruit, easing public facilities.....”

Public Sector Provider IV

4.6.3.1 Access to Quality Health Services and Health Seeking Behaviors

The study further established that private sector engagement has greatly improved access to quality health services and health seeking behaviors, through among other ways, recruiting, training and empowering community health volunteers to be able to diagnose, treat and refer cases, as well sensitize the communities on the importance of seeking health services and in good time. Some have specialized in special groups, such as adolescents, people living with HIV/AIDS and expectant mothers, empowering them on how to, when and where to seek health services. A response is as presented below:

“.....Most of the mothers now are able to deliver in maternity hospitals due to sensitization on the part of the private sector ... They have also helped in training healthcare providers with a view to improve the quality of services.....”

Public Sector Provider VI

4.6.5 Improved Technology

It was also established that the private sector has led to improvements in technology through the development of health management information systems, which has enhanced the decision-making process at the county government as well as efficiency of operations through digitization of various administrative services, data collection, data aggregation, computation and information sharing hence improved service delivery. The private sector has also developed community-based applications which have helped community health volunteers improve healthcare at the lowest level in the long run through providing real time data for effective and timely decision making. Health facilities also use electronic medical records which run on systems developed by and supported by the private sector. Some of the responses to this effect are hereunder provided:

“.....The private sector has revolutionized has we used to delivery healthcare services..... Back then, it used to be heavily paper based but now we have systems installed and computers which has improved service delivery. Living Goods for instance have an app that community health volunteers use and for contact and defaulter tracing and reporting.....”

Public Sector Provider II

“....We have supported the county in improved technology in terms of attending to patients, systems of follow ups referrals, access to quality data. Initially, data at the community level was paper based but we have been able to digitize reporting tools making it easier for anyone to access data at any point in time. This has reduced the turnaround time in terms of reporting at the community level since whoever is supposed to collate does not have to wait for hardcopy data..... We have a dashboard that can be accessed by everybody including supervisors who are able to monitor the information for prioritized supervision...”

Private Sector Provider III

4.6.6 Access to Quality Drugs

Private sector engagement has further led to the improvement in access to quality drugs through standardizing the quality of drugs and availing donor funded drugs such as for Tuberculosis, Malaria, cancer treatment drugs and Antiretroviral for HIV treatment which are scarcely available in government facilities. Further, the private sector has been instrumental in supplementing commodity stock outs and supplying community health volunteers with quality drugs which has led to reduction in mortality and morbidities previously experienced. An interviewee for instance offered that:

“.....We have been able to ensure the drugs offered at the community level are standardized by taking them through the normal standardization test that is checking their effectiveness and efficiency based on the disease conditions they are supposed to be treating and so we have been able to get certification on a yearly basis. Additionally, we are only able to procure commodities from outlets identified and approved by the government.....”

Public Sector Provider VII

4.7 Existence of Engagement Framework

The study finally sought to establish whether there existed a legal and/or strategic framework that guided recruitment of private sector players into the system. It was established in this regard that the main legislative documents underpinning the county government’s engagement with the private sector included the Public Private Partnership Act, a Partner Coordination Framework and memoranda of understanding with individual private sector partners outlining the various parties’ individual and joint responsibilities. This was echoed by all interview respondents:

“..... We have an MOU that includes resource sharing resources for example finances and human resources.....”

Public Sector Provider V

“.....We have an MOU that guides the implementation of interventions between us and the county. It has several guidelines in terms of areas of improvement, roles and responsibilities of different parties.....”

Private Sector Provider IV



Chapter 5 Discussion

5.1 Introduction

This chapter presents a summary of key findings and draws conclusions based on the research findings. Recommendations are further provided for practice and policy, as well as suggestions for future studies informed by the present study limitations.

5.2 Summary of Key Findings

The study sought to determine the private sector engagement models used in Kisii County. A majority of respondents (98.1%) affirmed to engaging with the county government through signing of memorandum of understanding while only 1.9% affirmed to signing contracts. The study also sought to establish the respective pillars that best describes the private sector engagement in relation to realizing universal health coverage. A majority of respondents affirmed that service delivery (94.2%) and health financing (73.1%) were the pillars that best describe their private sector engagement.

The study further sought to determine the private sector engagement models entered between the private sector and the county government. It was found that a majority of respondents (96.2%) affirm to public-private partnership as best describing their private sector engagement models. A majority of respondents (96.2%) further strongly opted for Public-private partnership Act, 2013 as the ideal legal framework that anchors private sector engagement with the county government of Kisii,

The study also sought to explore the achievements and challenges the Kisii County government faces in engaging the private sector using the identified models. It was established that among the achievements include the private sector provision of human resource to supplement the understaffed public sector particularly in public health facilities; technical and capacity building support; technological support; and financial support. Among the main challenges identified with private sector engagement include difficulty in regulating and holding accountable the private sector.

The study further sought to explore health system managers' perceptions on the impact of private sector engagement in promoting progress towards UHC in Kisii County. A majority of

respondents affirmed that system governance has improved with the engagement of the private sector through mission alignment between the public and private sector. It was particularly noted that the private sector has contributed by recruiting staff at the county government and community levels but are remunerated by the private sector, which significantly bridges the human resource gaps at the county government.

5.3 Discussion of Results

It can be deduced from the foregoing findings that there exist formal arrangements between public and private sector actors in provision of public health services towards universal health coverage, and that a majority of private sector actors adopt MOUs as opposed to contracts in their engagements with the county government. This is tandem with Maluka et al. (2018) who observe that in the context of universal health coverage, formal engagement with private sector providers is an imperative strategy in a majority of middle—and-low-income countries for extending coverage of publicly financed health services. This is also in agreement with Grieve and Olivier (2018) who assert that formal engagement between private and public sector organizations in the provision of public health services is beneficial since upon availing public funds to the private sector formally, it reduces the private sector's need to attempt to raise funds through high user fees. Further, such formal arrangements help establish quality standards for private sector health services and increasing accountability thereof.

It can also be deduced from the findings that service delivery and health financing best describe the pillar of private sector engagement. This is in line with (Blumenthal & Hsiao, 2015) who observe that service delivery is a direct output of the health system inputs including financing, the health workforce, supplies and procurement, and that increasing inputs would directly translate into enhanced access to services and improved service delivery. The service delivery pillar secures access to and ensures availability of public health services meeting a minimum quality standard which are major health systems' functions. The finding is also in agreement with (Stallworthy et al., 2014) who argued that health financing is critical in health systems' ability to improve and maintain human welfare. Without the requisite finances at the extreme, medicines would not be available, health workers would not be employed, and health prevention or promotion would not take place.

The findings are further of the implication that the role of the county government in their engagement with the private sector towards realizing universal health coverage is largely supervisory, resource mobilization, administration, monitoring and coordination as well as service delivery. The finding is consistent with Achoki, Miller-Petrie, Glenn, Kalra, Lesego and Gathecha (2019) who found that the county governments have a central role to play in targeting and identifying households for NHIF enrolment and that national governments ought to avail financial resources to facilitate increased population coverage through the NHIF in keeping with universal health coverage.

It is also implied from the findings that whereas a myriad of private sector engagement models is employed in the study area, Public-private partnership is the most popular. Accordingly, (Garvin & Bosso, 2008) and (Hackworth, 2019) attribute the rise of PPPs worldwide to its characteristic high level of engagement, risk transferring/ sharing between the parties, long-term contractual obligations ranging to up to 30 years and highly capital intensive. Gaffney, Pollock, Price, & Shaoul (1999) are in agreement that PPPs owe their popularity to their operational diversity which include concession contracts, joint ventures, Rehabilitate Operate Transfer (ROT) contracts and Build Operate Transfer (BOT) type contracts among others.

The findings agree with (Nabyonga-Orem, Nabukalu, & Okuonzi, 2019) who studied partnership with private for-profit sector for universal health coverage in sub-Saharan Africa with a focus on opportunities and caveats. Results from the study showed that public-private partnership in health exist in several forms including strategic partnerships bound by a memorandum of understanding (MOU) between the different parties. The study also showed that in some countries, contractual arrangements bound by a legal contract have been attempted although the capacity to negotiate and monitor contracts in LIC is weak.

Similarly, Whyte and Olivier (2016) reported in their systematic review of models of public-private engagement for health services delivery and financing in Southern Africa, that 52 individual public-private partnership in health initiatives in Southern Africa. These initiatives represent eight distinct public-private partnership in health models, including social marketing, sector-wide approach, contracting out, voucher programmes, public-private mix approach, regulation, financing and public-private partnership.

The results however contrast Hung, Klinton and Eldridge (2020) whose study assessed the level of private health sector engagement in 18 low- and middle-income countries (LMICs) with highest overall utilization of private health providers in six WHO regions. Findings from the study indicated a general recognition of private health sector's role in achieving population health goals, but specific policies on private sector engagement remained uncommon.

The study further deduces from the findings, that public and private sector engagement towards realizing universal health coverage have been in place for over 3 years, indicate sustainability in the short term, and therefore a prospect for the long term. Accordingly, Jamison, Summers, Alleyne, Arrow, Berkley and Binagwaho (2013) argued that governments with the resolve, ambition and vision to invest in firming up their health systems towards realizing universal health coverage will reap the social, economic and health benefits in the long and short term.

It is established from the findings that the main legal framework underpinning private and public sector engagement in the provision of public health services towards universal health coverage include the Public-Private Partnership Act, 2013, Public Procurement & Disposal Act, 2015 and the NGO Act of 2012. According to Ministry of Health of Kenya (2014), Kenya's 2010 constitution provides an all-encompassing legislative framework for a rights-based approach to health service provision and governance and successive national health strategies have channeled investment on health services provision from this foundation across five health system levels and attempted to ensure geographical nearness to services among patients across the country.

It is also notable that both the private and public sector actors hold dialogue pertinent to the provision of public health services towards universal health coverage on a regular basis, mostly quarterly. This is in line with (Ahsan et al., 2016) who argues that a majority of low and middle income countries have engaged in multi-stakeholder dialogue or structured debate concerning the role of UHC and the private sector. There is as a result, consensus among stakeholders domestically, including civil society groups and health systems users regarding the private sector's role in the provision of public health services towards universal health coverage. The main points of engagement between the private and the public sector pertinent to the provision of public health services towards universal health coverage include performance review, planning, and budgeting. According to (Okech & Lelegwe, 2015), planning, budgeting and performance reviews provide a

strong imperative among public and private sector actors to engage in dialogue towards realizing public health targets and goals including universal health coverage.

The study findings validate the Contract Theory as proposed by Hart (2003). It is particularly found that among other interventions, the elaborate legal framework establishing the contractual modes of engagement between the public and the private sector including the Public-Private Partnership Act, 2013, Public Procurement & Disposal Act, 2015 and the NGO Act of 2012, the engagement of the private sector in pertinent dialogue on a regular basis as well as the benefit of visibility serve as incentives to the private sector for productive levels of investment. Commendable levels of investment were accordingly recorded among private actors towards delivering UHC, through the assignment of roles and contractual arrangements in PPPs, contracting-out, public-private mix approach, dual practice regulation and Sector-Wide Approach (SWAs).

The study sought to explore the achievements and challenges the Kisii County government faces in engaging the private sector using the identified models. It can be deduced from the foregoing findings that among the achievements attained through engaging the private sector include the private sector provision of human resource, technical and capacity building support, technological support and financial support. Among the main challenges identified with private sector engagement include difficulty in regulating and holding accountable the private sector; difficulty in engaging the private sector in non-profit initiatives; as well as inability of the county government to sustain programmes initiated by the private sector.

Similarly, Hung, Klinton and Eldridge (2020) found in their study on the level of private health sector engagement in 18 low- and middle-income countries, that about a third of the countries also have regulation on pricing of medical services and/or medications. Despite the existence of regulation however, enforcement appears to be a challenge in most countries. The findings also agree with WHO (2018) who found in a survey on private sector engagement for advancing universal health coverage, that among the challenges faced in UHC include private care providers' reluctance to invest in preventive care or in remote or deprived areas. Non-existent or weak regulatory systems and weak mechanisms for monitoring the quality of health services offered by private health providers were also identified as major challenges.

The findings are further in agreement with Clarke, Doerr, Hunter, Schmets, Soucat and Paviza (2019), in whose study on the private sector and universal health coverage found that governments in low- and middle-income countries face major challenges with the private sector because their existing governance and regulatory arrangements are not designed to effectively manage and coordinate mixed health systems. One of the challenges relates to the for-profit private sector. In many countries, this sector has not been properly managed or regulated, resulting in behaviours that threaten the UHC objectives of equity and quality. Such behaviours include monopolistic behaviour and predatory pricing, unresolved conflicts of interest and regulatory capture.

The study findings validate the Agency theory as proposed by (Coase, 1937). It is particularly inferred from the findings, in the course of their engagement, the public sector runs into problems with the private sector, which can be attributed to the individual parties' interests, resulting in agency problems. Whereas achievements were recorded in instances where the interests inherent among both private sector and public sector actors were aligned, challenges were reported where there was conflict of interest. The public sector particularly complained of difficulty in engaging the private sector in non-profit initiatives owing to their business orientation and difficulty in regulating and holding accountable the private sector; as well as inability of the county government to sustain programmes initiated by the private sector.

The study sought to explore health system managers' perceptions on the impact of private sector engagement in promoting progress towards UHC in Kisii County. It is implied from the findings that private sector engagement has had a significant impact on the promotion of progress towards universal health coverage in Kisii County, across all six key thematic areas including system governance, improved health work force, health financing, access to quality health services and health seeking behaviors, improved technology and access to quality drugs. System governance has particularly been strengthened through existing memoranda of understanding which guide stakeholder relations between the public and private sector by stipulating the terms of engagement, the mission, accountability structures, modes of resource mobilization and transparency measures.

The study established that private sector engagement has been instrumental in improving the health work force through recruitment, remuneration, training and capacity building of staff at the county government and community levels significantly bridging human resource gaps. The private

sector has also significantly improved health financing, bridging the inadequate budgetary allocation for health at the county government, through financing of various activities and programmes aimed at realizing the universal health coverage, recruitment and payment of staff. Further, the private sector has greatly improved access to quality health services and health seeking behaviors, through among other ways, recruiting, training and empowering community health volunteers to be able to diagnose, treat and refer cases, as well sensitize the communities on the importance of seeking health services and in good time.

Improvements in technology have also been recorded as a result of private sector engagement through the development of health management information systems, which has enhanced the decision-making process at the county government as well as efficiency of operations through digitization of various administrative services, data collection, data aggregation, computation and information sharing hence improved service delivery. Private sector engagement has further led to the improvement in access to quality drugs through standardizing the quality of drugs and availing donor funded drugs such as for Tuberculosis, Malaria, cancer treatment drugs and Antiretroviral for HIV treatment which are scarcely available in government facilities. The main legislative documents underpinning the county government's engagement with the private sector included the Public Private Partnership Act, a Partner Coordination Framework and memoranda of understanding with individual private sector partners outlining the various parties' individual and joint responsibilities.

The findings are consistent with Stroman (2019) who assessed the importance of the private sector in achieving universal health coverage and identified the variety of private actors who could play a role in realizing the vision of universal health coverage. According to the study, professional networks and associations can serve as formal or informal partners to tackle specific objectives, provide technical assistance, training, and on-the-ground expertise while financiers: Financial institutions and payers can provide resources via a variety of mechanisms and channels. Program implementers including NGOs can on the other hand support on-the-ground program implementation, in many cases increasing capacity at the point of care as academic institutions and partners train the next generation of health care workers to address shortages, as well as provide platforms for identifying and sharing best practices across countries. Corporations in life

sciences and other medical product companies can further invest/co-invest in LMIC markets—and private logistics companies can help manage supply chains and distribution in these markets.

The findings are also in tandem with Gautham, Balasubramaniam, Bloom, Lakew and Forsberg (2019) who study how the private sector can contribute to UHC. In the study, Gautham, et al. (2019) argue that as governments continue to embrace UHC, they will need to invite the private sector to join key conversations, to build trust and ensure that partnerships, innovations and initiatives provide evidence-based support for long-term health system goals and are also responsive to private sector interests. The study further argues that private sector can be an advocate and partner to the global UHC movement, and should be encouraged to put the SDGs at the core of their mission. Both for-profit and not-for-profit private providers bring a unique set of skills and resources that can complement the public sector to improve access and outcomes particularly for vulnerable, poor and rural communities.

5.4 Study Limitations

The main limitation faced in the study was generalizability of the study findings to all counties in the country, as the study was only conducted in one county, that is Kisii. As every county could have factors unique to their respective healthcare systems the study was unable to generalize findings to all counties in the country. To address this limitation, the study only made recommendations specific to Kisii County based on the established in study findings.

Another limitation of the study was in the limited sample size, that is 52. The sample size was relatively too small to be adequately reflective of the entire population of administrative stakeholders of universal health coverage in the country. To address this limitation, the study also only made recommendations specific to Kisii County based on the established in study findings.

The study was conducted between March and April 2020, which coincided with the first time at which the first Coronavirus (COVID-19) case was reported in the country. In line with the Ministry of Health guidelines which encouraged non-essential workers to stay at home. This made it difficult to book and have sit-down sessions with some respondents for fear of possible infection, posing a non-response challenge. To address this, the researcher conducted telephone interviews with some respondents and adhered to the Ministry's guidelines of wearing a face mask, keeping a 1.5-meter social distance and carrying a hand sanitizer during physical data collection.

Despite the above limitations, the quality of the study was not compromised. The researcher contends that the challenges presented did not affect the results the research design, output and subsequent development of the research thesis.

5.5 Conclusion

The study concludes based on the findings presented that whereas a myriad of private sector engagement models is employed in the study area, Public-private partnership is the most popular. It is also deduced that there exist formal arrangements between public and private sector actors in provision of public health services towards universal health coverage, and that a majority of private sector actors adopt MOUs as opposed to contracts in their engagements with the county government. The study further deduces that service delivery and health financing best describe the pillars of private sector engagement in Kisii County.

The study further concludes that among the achievements attained through engaging the private sector include the private sector provision of human resource, technical and capacity building support, technological support and financial support. Among the main challenges identified with private sector engagement include difficulty in regulating and holding accountable the private sector; difficulty in engaging the private sector in non-profit initiatives; as well as inability of the county government to sustain programmes initiated by the private sector.

It is further concluded that private sector engagement has had a notable impact on the promotion of progress towards universal health coverage in Kisii County, across all six key thematic areas including system governance, improved health work force, health financing, access to quality health services and health seeking behaviors, improved technology and access to quality drugs. System governance has particularly been strengthened through existing memoranda of understanding which guide stakeholder relations between the public and private sector by stipulating the terms of engagement, the mission, accountability structures, modes of resource mobilization and transparency measures.

With the engagement of the private sector, health work force has also been improved through recruitment, remuneration, training and capacity building of staff at the county government and community levels significantly bridging human resource gaps. The private sector has also significantly improved health financing, bridging the inadequate budgetary allocation for health at

the county government, through financing of various activities and programmes aimed at realizing the universal health coverage, recruitment and payment of staff. Further, the private sector has greatly improved access to quality health services and health seeking behaviors, through among other ways, recruiting, training and empowering community health volunteers to be able to diagnose, treat and refer cases, as well sensitize the communities on the importance of seeking health services and in good time.

The Kisii county government has further recorded improvements in technology with the engagement of the private sector through the development of health management information systems, which has enhanced the decision-making process at the county government as well as efficiency of operations through digitization of various administrative services, data collection, data aggregation, computation and information sharing hence improved service delivery. Private sector engagement has further led to the improvement in access to quality drugs through standardizing the quality of drugs and availing donor funded drugs such as for Tuberculosis, Malaria, cancer treatment drugs and Antiretroviral for HIV treatment which are scarcely available in government facilities.

5.6 Recommendations

5.6.1 Policy Recommendations

Based on the foregoing findings, the study recommends that a clear policy action is required from national government and county governments in order to develop a logical and consistent approach towards UHC in Kenya. The study particularly recommends that county governments should have a central role to play in targeting and identifying households for NHIF enrolment and that national governments ought to avail financial resources to facilitate increased population coverage through the NHIF in keeping with universal health coverage.

The study also recommends a universal, budget-funded entitlement for the entire county population and a complimentary benefit based on contributory entitlement. In this regard, the space for private financing to be mainly outside of this publicly defined service package, apart from possible co-payments for complimentary benefits for those who do not have complimentary insurance coverage.

The study also recommends that the Kenyan government should increase public financing of the health sector at the county level. By dedicating 15% of the national budget towards healthcare for instance, there will be an uplift in the healthcare system enough to realize the Universal Healthcare Coverage as per the Abuja declaration of 2001 to which Kenya is a signatory.

The study further recommends the empowerment of county departments of health in their evolving healthcare service provision role. This may include identifying unique sub-national health systems priorities; developing representative county operational and implementation health plans; and aligning county health plans with national health policy. These activities will be central towards assisting county governments in developing effective health budget allocation and annual planning mechanisms in order to optimize healthcare service delivery.

5.6.2 Management Recommendations

The study recommends that the county government channels resources towards the empowerment of community health volunteers by absorbing them into the county government on long-term bases in order to assure sustainability of the health services they provided at the grassroots with a view to further promote sensitization of the communities and improved health seeking behaviour hence furthering progress towards the realization of universal health coverage in the county.

Further, counties should be enabled to develop tailored solutions to their particular UHC implementation challenges. There is need for instance, for an institutional setup at county level that is resourced and staffed to analyze and tailor service delivery arrangements that adapt to local needs while still ensuring adherence to national standards and performance criteria.

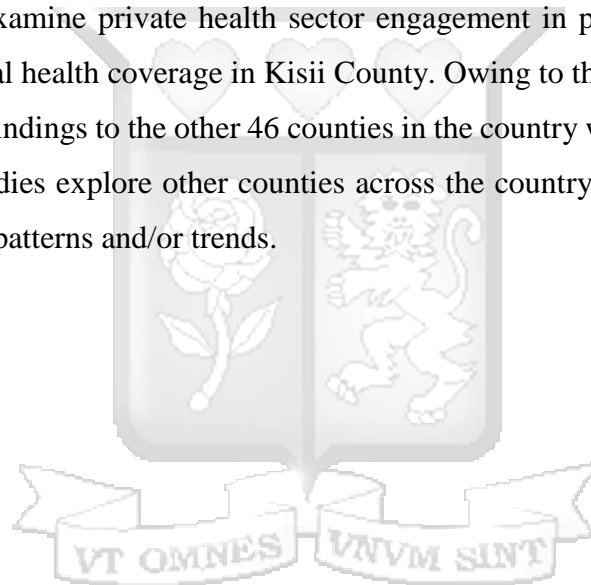
Further, given that the Kenyan Constitution explicitly lays the purview of health system governance on the national government, the responsibility for encouraging and influencing the actions of all actors within the sector ultimately falls to its Ministry of Health. There is need for the ministry to build a robust environment for intra-sectoral collaboration to allow all health stakeholders to contribute towards UHC agenda-setting and spearhead clear communication channels for intra- and intersectoral collaboration to optimize UHC policy adaptation and implementation, as well as resource mobilization for health.

In order to address the supply chain gap particularly delays in supply of commodities, the county government, through the Ministry of Health, should be given the mandate by the national government to procure and supply the commodities to health facilities within the county. The government of Kenya should also move away from passive purchasing, and adopt strategic purchasing practices to enhance the equity, efficiency and quality of healthcare service delivery

The study also recommends that to address the inability of the county government to regulate the private sector, there is need to jointly develop common plans and objectives in order to have concerted efforts pertinent to the realization of universal health coverage.

5.7 Suggestions for Further Studies

The present set out to examine private health sector engagement in provision of public health services towards universal health coverage in Kisii County. Owing to the case study nature of the study, generalization of findings to the other 46 counties in the country was not possible. It is thus suggested that future studies explore other counties across the country in order to establish any similarities, differences, patterns and/or trends.



References

- Achoki, T., Miller-Petrie, M. K., Glenn, S. D., Kalra, N., Lesego, A., & Gathecha, G. K. (2019). Health disparities across the counties of Kenya and implications for policy makers, 1990–2016: a systematic analysis for the global burden of disease study 2016. *Lancet Glob Health*, 81-95.
- Ahsan, K. Z., Streatfield, P. K., Rashi da-E-Ijdi, Escudero, G. M., Khan, A. W., & Reza, M. M. (2016). Fifteen years of sector-wide approach (SWAp) in Bangladesh health sector: An assessment of progress. *Health Policy and Planning*, 31(5), 612–623.
- Alameddine, m., Bou Karroum, K., & Hijazi, M. A. (2019). Upscaling the pharmacy profession in Lebanon: workforce distribution and key improvement opportunities. *Hum Resour Health*, 47-67.
- Alchian, A. A., & Demsetz, H. (1972). Linked references are available on JSTOR for this article : Production , Information Costs , and Economic Organization. *The American Economic Review*, 62(5), 777–795.
- Athias, L. (2007). Uncertainty, Renegotiation and Incentives in Public Private Partnerships: An Economic Analysis of Worldwide Toll Road Concessions.
- Awoonor-Williams, J. K., Tindana, P., Dalinjong, P. A., Nartey, H., & Akazili, J. (2016). Does the operations of the National Health Insurance Scheme (NHIS) in Ghana align with the goals of primary health care? Perspectives of key stakeholders in northern Ghana. *BMC Int Health Hum Rights*, 178-201.
- Ayodele, J. (2012). Validity and Reliability Issues in Educational Research. *Journal of Educational and Social Research*, 2(2).
- Badr, E., Mohamed, N. A., Afzal, M. M., & Bile, K. M. (2018). Strengthening human resources for health through information, coordination and accountability mechanisms: the case of the Sudan. *Bull World Health Organ*, 868-873.
- Berezin, A., Sergi, B. S., & Gorodnova, N. (2018). Efficiency assessment of public-private partnership (PPP) projects: The case of Russia. *Sustainability (Switzerland)*, 10(10), 1–18.

- Blumenthal, D., & Hsiao, W. (2015). Lessons from the East - China's rapidly evolving health care system. *New England Journal of Medicine*, 372(14), 1281–1285.
- Clarke, L. (2011). Responsibility of International Organizations under International Law for the Acts of Global Health Public-Private Partnerships. *Chicago Journal of International Law*, 12(1), 55–84.
- Coase, R. H. (1937). The Nature of the Firm. *Economica*, 4(16), 386–405.
- Coase, R. (1993). *A vállalat természete, in: A vállalat és működése*. Budapest: AULA Kiadó.
- Creswell, J. (2013). *Qualitative Inquiry and Research Design: Choosing Among the Five Approaches (3e)*. Los Angeles: Sage.
- Creswell, J., & Piao Clark, V. (2007). Introducing a mixed method design. *Designing and Conducting Mixed Methods Research*, 58–89. Retrieved from
- Dalinjong, P. A., Welaga, P., Akazili, J., Kwarteng, A., Bangha, M., & Oduro, A. (2017). The association between health insurance status and utilization of health services in rural Northern Ghana: evidence from the introduction of the National Health Insurance Scheme. *J Health Popul Nutr*, 144-169.
- Dussault, G., Kwarar, R., Castro Lopes, S., & Campbell, J. (2018). *Building the primary health care workforce of the 21st century*. Geneva: World Health Organization.
- Fieno, J. V., Dambisya, Y. M., George, G., & Benson, K. A. (2016). A political economy analysis of human resources for health (HRH) in Africa. *Hum Resour Health*, 44-61.
- Firestone, R., Rowe, C. J., Modi, S. N., & Sievers, D. (2017). The effectiveness of social marketing in global health: A systematic review. *Health Policy and Planning*, 32(1), 110–124.
- Gaffney, D., Pollock, A. M., Price, D., & Shaoul, J. (1999). PFI in the NHS—is there an economic case? *Bmj*, 319(7202), 116–119.
- Garvin, M. J., & Bosso, D. (2008). Assessing the Effectiveness of Infrastructure Public—Private Partnership Programs and Projects. *Public Works Management & Policy*, 13(2), 162–178.

- GOK. (2007). The Kenya Vision 2030. *Government of the Republic of Kenya*, 32.
- Grieve, A., & Olivier, J. (2018). Towards universal health coverage: a mixed-method study mapping the development of the faith-based non-profit sector in the Ghanaian health system. *Int J Equity Health*, 97-117.
- Hackworth, J. (2019). 4. The Public-Private Partnership. *The Neoliberal City*, 27(27), 61–76.
- Hahn, B. (2014). The History of Healthcare Quality: The First 100 Years 1860-1960. *International Journal of Africa Nursing Sciences*, 1(1), 18–22.
- Hart, O. (2003). Incomplete Contracts and Public Ownership: Remarks, and an Application to Public-Private Partnerships. In *Source: The Economic Journal* (Vol. 113).
- Hill, P. (2002). The rhetoric of sector-wide approaches for health development. *Social Science Medicine*, 1725–37.
- Hogan, D. R., Stevens, G. A., Hosseinpoor, A. R., & Boerma, T. (2018). Monitoring universal health coverage within the Sustainable Development Goals: development and baseline data for an index of essential health services. *Lancet Glob Health*, 152-168.
- Hung, Y., Klinton, J., & Eldridge, C. (2020). *Private health sector engagement in the journey towards Universal Health Coverage: Landscape Analysis*. Geneva: World Health Organization
- International Trade Administration. (2018, June 2). *Kenya - Universal Healthcare Coverage*. Retrieved from www.trade.gov: <https://www.trade.gov/market-intelligence/kenya-universal-healthcare-coverage>
- Jacobs, B., & Price, N. (2006). Improving access for the poorest to public sector health services: insights from Kirivong Operational Health District in Cambodia. *Health Policy and Planning*, 27–39.
- Kamau, R., Mukui, J. T., & Kimato, M. (2020). *Towards a strategic framework for reforming the pharmaceutical sector in Kenya (draft report)*. Nairobi: MOH
- Kapás, J. (1999). Szükséges-e többdimenziós vállalatelmélet? Az evolúciós vállalatelmélet.

- Kariuki, M. (2020, December 2). *Ensuring Healthy Lives and Well-being for All*. Retrieved from <http://kmco.co.ke/>: <http://kmco.co.ke/wp-content/uploads/2020/12/Ensuring-Healthy-Lives-and-Wellbeing-for-All-Kenyans-Kariuki-Muigua-December-2020.pdf>
- Kisii County Government. (2018). *Intergrated Development Plan*. Kisii: Kisii County Government.
- Kisii County Government County Intergrated Development Plan, 2018.
- Iossa, E., & Martimort, D. (2015). The simple microeconomics of public-private partnerships. *Journal of Public Economic Theory*, 17(1), 4–48.
- Jamison, D. T., Summers, L. H., Alleyne, G., Arrow, K. J., Berkley, S., & Binagwaho, A. (2013). Global health 2035: a world converging within a generation. *Lancet*, 898-923.
- Jane Wanjiru, K., & of Nairobi, university. (2014). challenges in provision of universal health care by the national hospital insurance fund, kenya karanja jane wanjiru a research project submitted in partial fulfilment of the requirement for the award of degree of master of business administration, school of business, university of nairobi.
- Jensen, M. C., & Meckling, W. H. (1976). Also published in Foundations of Organizational Strategy. In *Journal of Financial Economics*.
- Kieny, M. P., Bekedam, H., Dovlo, D., Fitzgerald, J., Habicht, J., & Harrison, G. (2017). Strengthening health systems for universal health coverage and sustainable development. *Bull World Health Organ*, 537-559.
- Kenya National Bureau of Statistics. (2019). 2019 Kenya Population and Housing Census Volume 1: Population by County and Sub-County. In *2019 Kenya Population and Housing Census*.
- Maluka, S., Chitama, D., Dungumaro, E., Masawe, C., Rao, K., & Shroff, Z. (2018). Contracting out primary health care services in Tanzania towards UHC: how policy processes and context influence policy design and implementation. *Int J Equity Health*, 118-135.
- McPake, B., & Hanson, K. (2016). Managing the public-private mix to achieve universal health

- coverage. *Lancet*, 622-630.
- Meuwissen, L., Gorter, A., & Knottnerus, A. J. (2006). Impact of accessible sexual and reproductive health care on poor and underserved adolescents in Managua, Nicaragua: a quasi-experimental intervention study. *Journal of Adolescent Health*, 56.e1–56.e9.
- Ministry of Health of Kenya. (2014). *Kenya Health Policy 2014-2030*. Nairobi: Government Printer.
- Ministry of Health. of Kenya (2016). *Refocusing on quality of care and increasing demand for services; Essential elements in attaining universal health coverage in Kenya*. Nairobi: MOH Policy Brief.
- Moser, A., & Korstjens, I. (2018, January 1). Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *European Journal of General Practice*, Vol. 24, pp. 9–18.
- Nabyonga-Orem, J., Nabukalu, J., & Okuonzi, S. (2019). Partnership with private for-profit sector for universal health coverage in sub-Saharan Africa: opportunities and caveats. *BMJ Global Health*, 4(9), 116-142.
- Negin, J., & Martiniuk, A. (2012). Sector wide approaches for health in small island states: lessons learned from the Solomon Islands. *Global Public Health*, 137–48
- Obare, F., Warren, C., Njuki, R., Abuya, T., Sunday, J., Askew, I., & Bellows, B. (2013). Community-level impact of the reproductive health vouchers programme on service utilization in Kenya. *Health Policy and Planning*, 28(2), 165–175.
- Okech, T. C., & Lelegwe, S. L. (2015). Analysis of Universal Health Coverage and Equity on Health Care in Kenya. *Global Journal of Health Science*, 8(7), 218–227.
- Oraro, T., & Wyss, K. (2020). Policy levers and priority-setting in universal health coverage: a qualitative analysis of healthcare financing agenda setting in Kenya. *BMC Health Serv Res*, 182.
- Palmer, E. (2002). Should Public Health be a Private Concern? Developing a Public Service Paradigm in English Law. *Oxford Journal of Legal Studies*, 22(4), 663–686.

- Pandey, R., & Verma, M. R. (2008). Samples Allocation in Different Strata for Impact. *Rev. Bras. Biom*, 26(4), 103–112. Retrieved from
- Partnership, S. D. G., & Annual, P. (2019). *Office of the United Nations Resident Coordinator in Kenya May 2019* <http://ke.one.un.org>. (May).
- Pepper, A., & Gore, J. (2012). Behavioral agency theory new foundations for theorizing about executive compensation. *Journal of Management*, 41(4), 1045–1068.
- Perrow, C. (1986). *Complex organizations*. New York, NY: Random House.
- Peters, D. H., Paina, L., & Schleimann, F. (2013). Sector-wide approaches (SWAs) in health: What have we learned? *Health Policy and Planning*, 28(8), 884–890.
- Preker, A. S., & Harding, A. L. (2003). Private Participation in Health Services: Health, Nutrition, and Population. In *Human Development Network: Health, Nutrition, and Population Series*.
- Reading, J. P. (2018). Who’s responsible for this? The globalization of healthcare in developing countries. *Indiana Journal of Global Legal Studies*, 17(2), 386.
- SDG Partnership Platform. (2019). *A New Approach to Partnerships for*. New York: Multidisciplinary Digital Publishing Institute.
- Stallworthy, G., Boahene, K., Ohiri, K., Pamba, A., & Knezovich, J. (2014). Roundtable discussion: what is the future role of the private sector in health? *Globalization and Health*, 10(1), 55.
- Stroman, T. (2019, September 23). *The Importance of the Private Sector in Achieving Universal Health Coverage*. Retrieved from www.linkedin.com: <https://www.linkedin.com/pulse/importance-private-sector-achieving-universal-health-coverage-trish>
- Sundewall, J., Forsberg, B. C., & Tomson, G. (2006). Theory and practice: a case study of coordination and ownership in the Bangladesh health SWAp. *Health Research Policy System*, 5-34.
- Taber, K. S. (2018). The Use of Cronbach’s Alpha When Developing and Reporting Research Instruments in Science Education. *Research in Science Education*, 48(6), 1273–1296.

- The Government of Kenya. (2010). The Constitution of Kenya, 2010. *Kenya Law Reports*, (February), 31.
- The World Bank, Asian Development Bank, & Inter-American Development Bank. (2009). *Public-Private Partnerships Reference Guide 2.0*. 231.
- United Nations Development Programme. (2019). *Kenya SDG Partnership Platform 2018 Annual Report*. Nairobi: SDGPP PHC Window Steering Committee.
- USAID. (2019). *Kenya Private Health Sector Assessment*. Nairobi: Abt Associates Inc.
- Vaillancourt, D. (2009). *Do Health Sector-wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries*. Washington, DC: The World Bank.
- Wagenaar, C., Marwa, H., & Irrgang, E. (2016). *How a public-private partnership can help make healthcare work in Northern Tanzania*. Amsterdam: PharmAccess.
- WHO. (2013). Arguing for Universal Health Coverage.
- WHO. (2013). Arguing for Universal Health Coverage.
- WHO. (2014). Universal Health Coverage: . *Fact Sheet* , 395.
- WHO. (2021, April 5). *Universal Health Coverage*. Retrieved from who.int: https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
- WHO. (2021, April 1). *Universal health coverage (UHC)*. Retrieved from WHO: [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))
- Whyte, E. B., & Olivier, J. (2016). Models of public-private engagement for health services delivery and financing in Southern Africa: A systematic review. *Health Policy and Planning*, 31(10), 1515–1529.
- World Bank Group. (2017). *Improving Emerging Markets Healthcare*. (February).
- World Bank (2019). *Doing business 2019; Country profile for Kenya*. . Washington, DC: The World Bank.
- World Health Organization. (2013). Arguing for Universal Health Coverage. *World Health Organization*, 39.
- World Health Organization, W. H. (2017). *Primary Health Care Systems: Case study from Kenya*.

Geneva: WHO publications



Appendices

Appendix 1: Letter of Introduction

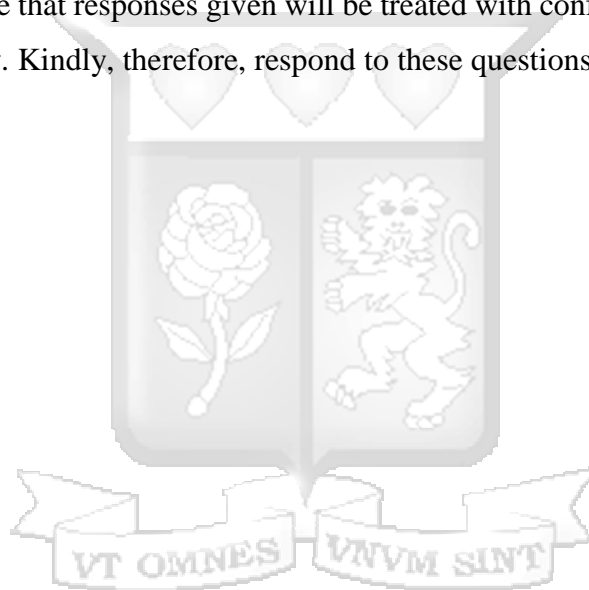
Dear Participant,

Ref: Participation in the research study

My name is **Mounde Mokaya Isaiah**, currently a final year MBA-HCM student at Strathmore Business School. I am conducting a research on “*Examination of Private Sector Engagement for Public Health Services Towards Universal Health Coverage: A Case Study of Kisii County*”. This Thesis will be used purely for academic purposes and for the partial fulfillment of a post graduate degree course. Please note that responses given will be treated with confidentiality and strictly for the purposes of this study. Kindly, therefore, respond to these questions as honestly and precisely as possible.

Thank you for your time

Mounde Mokaya Isaiah



10. Which of the following best describes the private sector engagement model entered with the county? *(Tick all that apply)*

- Public-Private Partnership Social Marketing
- Dual Practice regulation Sector-wide Approach
- Voucher Program Contracting-out Public-Private Mix
- Financing Other. Specify.....

11. What is the length of the private sector engagement? *(Tick as appropriate)*

- 0-3 years 3-5 years

12. Which legal framework anchors the private sector engagement? *(Tick that applies)*

- Public –Private Partnership Act, 2013
- Public Procurement and Disposal Act, 2015
- Other. Specify.....

13. How often is the Public Private dialogue? *(Tick the most appropriate)*

- Monthly Quarterly Bi-annually Annually
- Other. Specify.....

14. What is the nature of the dialogue?

- Planning Budgeting Performance Review Policy Issues
- Other. Specify.....

Thank you for your participation.

Appendix III: Interview Guide

Part A: Introductions

I want to thank you for taking the time to meet with me today.

My name is **Mounde Mokaya** a student pursuing a master of Business Administration in Healthcare Management degree at Strathmore University Business School. I'm conducting a research study on examining private sector engagement in provision of public health services towards universal health coverage in Kisii County and would like to talk to you about your experiences on the subject matter especially on the achievements, challenges and impact of private sector engagement in UHC realization.

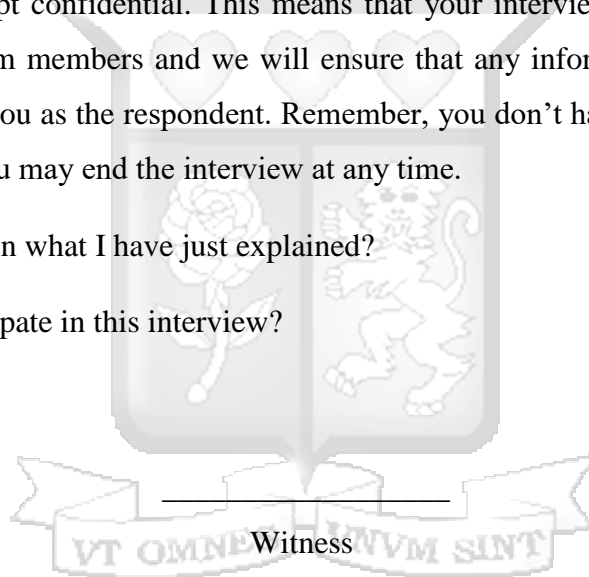
The interview should take less than 25 minutes. To ensure that I don't miss out on any of your valuable comments, I will be recording this session though admixed with short episodes of notes taking.

All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in the report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Are there any questions on what I have just explained?

Are you willing to participate in this interview?

Interviewee



Witness

Date

Part B: Achievements and challenges of engaging the private sector in meeting public health goals in Kisii County

1. What is your highest level of education?
2. What is your level of management?
3. How would you describe the PSE contribution in realizing UHC in Kisii County?
4. What challenges are you experiencing or experienced in these engagements with the private sector?

5. In your opinion how would you propose the challenges mentioned above can be overcome?

Part C: Manager Perceptions on the impact of private sector engagement

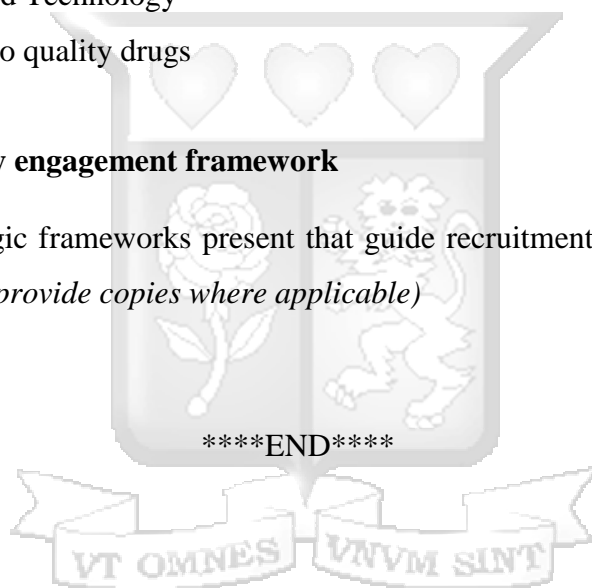
How is the healthcare system in Kisii County benefiting from PSE? Are they better off than before PSE? Please explain your answer.

Key Themes

1. System governance
2. Improved health work force
3. Health financing
4. Access to quality health services and health seeking behaviors
5. Improved Technology
6. Access to quality drugs

Part D: Existence of any engagement framework

What legal and/or strategic frameworks present that guide recruitment of private sector players into the system? *(Kindly provide copies where applicable)*



Appendix IV: Budget

Item	Unit	Rate	Total (Ksh)
1. Personnel Recruitment costs			
a. Data collector	2	10,000	20,000
b. Data analyst	1	15,000	15,000
c. Statistician	1	15,000	15,000
2. Training	unit	5,000	5,000

3. Printing (data collection tools)	Unit	5,000	5,000
4. Transport	10 days	500	5000
5. Equipment hiring			
a. Recorder	2	3,000	6,000
b. Laptop computer	1	4,000	4,000
6. Communication			
a. Airtime	unit	1,000	1,000
b. Internet	unit	2,000	2,000
7. Report preparation and Manuscript publication	unit	25,000	25,000
8. Contingencies			10,000
Total			<u>113,000</u>

