PUBLIC-PRIVATE PARTNERSHIP AND HEALTH SERVICE DELIVERY IN TANZANIA

A CASE STUDY OF ARUSHA LUTHERAN MEDICAL CENTER (ALMC), ARUSHA

BY

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A RESEARCH DISSERTATION SUBMITTED TO THE FACULTY OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR'S DEGREE IN PUBLIC ADMINISTRATION OF KAMPALA INTERNATIONAL UNIVERSITY

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DECLARATION

I, Rose M. Marwa declare that this research dissertation on "Public-private partnership and health service delivery in Tanzania: a case study of Arusha Lutheran Medical Center (ALMC), Arusha" is my original work and to the best of my knowledge, has not been submitted for any award at any academic institution.

Signed: .....

Rose M. Marwa

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Date: 14-09-2016

APPROVAL

This is to confirm that this research dissertation on "Public-private partnership and health service delivery in Tanzania: a case study of Arusha Lutheran Medical Center (ALMC), Arusha" is under my supervision and is now ready for submission to the College of Humanities and Social Sciences.

Signature: .....

SUPERVISOR: Mr. Ubale Haruna

Date: 14-09-2016

DEDICATION

I dedicate this piece of work to my beloved mum Happiness Daniel and my dear father Betset Mseti for their endless support both financially and morally without forgetting my dear sisters Gloria Mwita and Beatrice Betseti, my dear uncle Mr. C.D, my lovely son Fabrice Godfrey and Godfrey Mwakasitu (My son's father) for his care and support. I do dedicate this report to my best friends Keneema Immaculate, Ayebare Anthony and Ndamze Nicholas. May the Almighty God bless you abundantly.

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I thank the Almighty God for strength and good health which has enabled me to come this way and achieve the long dream of accomplishment of the degree.

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ABSTRACT

he study focused on Public-private partnership and health service delivery in Tanzania: a case udy of Arusha Lutheran Medical Center (ALMC), Arusha. The study objectives were; to assess ıe role played by public private partnership on health service delivery, to establish the hallenges encountered in administering Public-Private Sector Partnership in Arusha and to etermine the efficiency of health service delivery in Arusha Local Government. A cross ectional survey was used in the course of the study. Both qualitative and quantitative data was athered in order to establish the relationship between Public-private partnership and health ervice delivery. The study targeted the 133 respondents from Arusha Lutheran Medical Center ALMC) and other Local government stakeholders. These included top authorities of ALMC, ıedical staff of ALMC, District health officers, officials from Ministry of Health, Arusha and ther local peasants. Purposive sampling was also used to select only respondents for the esearcher to attain the purpose of the study. Data was collected from primary and secondary ources using questionnaires and interviews. After collecting data, the researcher organized well- ınswered questionnaire, data was edited and sorted for the next stage. The data was presented in abular form, pie charts and bar graphs with frequencies and percentages. The study findings evealed that the sample constituted of 50 respondents of which 35% were females and the 65% emaining were males. This implies that men are the always the majority involved in Arusha Lutheran Medical Center (ALMC) due to societal beliefs that they are more hardworking and capable of managing such institution in relation to health service delivery. The study concludes hat infrastructure created through PPP can improve the quality and quantity of basic nfrastructure such as the provision of water and its treatment, energy supply and transportation. In addition the process can be widely applied to a variety of public services such as hospitals, schools, prisons and government accommodation. There should be macro-prudential review such that the totality of a government's PPP obligations, including contingent liabilities and ripple effects through public lenders, are visible. This should be carried out by the ministry of finance (or similar), as is done with traditional public borrowing and debt limits. At the level of the ministry of health, current year spending and long term liabilities for PPP contracts should also be included in the total health programme spending limits. PPPs should be on the public balance sheet and accounts, except for those variants with a very substantial risk transfer (probably including demand risk).

CHAPTER ONE

.0 Introduction

'his chapter focused on the background of the study, statement of the problem, purpose, bjectives, research questions, hypothesis, significance of study, scope, conceptual framework nd operational definitions of key terms.

.1 Background of the Study

Globally, Public-Private Partnership is an arrangement between government (the public sector), oth local and central, and other organizations (e.g. private sector) for the purpose of providing ublic infrastructure, community facilities and related services. Such partnerships are haracterized by the sharing of investment, risk, responsibility and reward between the partners Chengo, 2011). The reasons for establishing such partnerships vary but generally involve the inancing, design, construction, operation and maintenance of public infrastructure and services.

n Africa, the partnership projects between the public and private sectors as well as the financing of the projects have a long history. For example in the Roman Antiquity, the harbor equipment, he plazas and the thermal establishments were exploited through concession granting. Le Digeste highlights the fact that those who worked in the public sector and who performed public ctivities/work was protected (Duncan, 2011). Beginning with the 17th and 18th centuries, in France concession was used for building bridges and canals and the 19th century was considered he Golden Age of the concessions as well, the railways and the urban utilities(water, drainage, transport, light) being built in this way. Similar forms of partnerships we find in the U.S.A in the second half of 19th century in the construction of railways (Biswas & Paul, 2010). Partnership has significant potentialities for achieving efficient and effective high quality health services. It aims to establish a functional integration and sustained operation of a pluralistic health care delivery system by optimizing the equitable use of the available resources and investing in comparative advantages of the partners. It ensures the utilization of the potentials of both the public and private sectors (Barakat, 2003). The need to provide and improve the health system delivery has been gaining attention worldwide (Jamison et al, 2006). Many countries have introduced reforms with the goal of making health care more effective (Mattke et al, 2006).

n Tanzania, the PPP approach has been successful because by bringing together all stakeholders oth private and public, it ensures ownership of the project by everyone, and makes ustainability of health services possible (Fartaag, 2014). While the focus of PPP has been on rban systems, there have been steps being taken to expand the system to rural areas of the ountry. The international community has also an important role to play. It has to learn from the ast experience in Tanzania and abroad to identify and support successful interventions to be nultiplied so as to gather momentum and optimize the use of scarce resources. It has in articular to assist relevant authorities, private operators and community representatives to fully nderstand and fulfill their role and commitment in order to achieve the maximum impact Warsame, 2008).

The Public-Private Partnership in Health (PPPH) was initiated in 1997 by the Ministry of Health n Tanzania with the support of a parliamentary resolution implementation in July 2000. In Tanzania, the private sector can be broadly categorized into Private- for- Profit (PFP) and Private-not-for-Profit (PNFP) providers. The PFP group contains both formal and informal providers. Informal providers mainly include general merchandise, shops and traditional healers. There are also new non Tanzanian systems of care such as the Indian and Chinese medical systems. Involvement of the private sector is, in part, linked to the wider belief that public sector bureaucracies are inefficient and unresponsive and that market mechanisms will promote efficiency and ensure cost effective, good quality services (WHO, 2000). Another perspective on this debate is linked to the notion that the public sector must reorient its dual role of financing and provision of services because of its increasing inability on both fronts (Mitchell J., 2001). Under partnerships, public and private sectors can play innovative roles in financing and providing health care services.

In Arusha, since 1997, there have been efforts directed at aligning the private sector along with the government of Tanzania, several successful experiences of public-private partnerships for providing services in the major towns of the same zones (Warsame, 2008). Meanwhile, the rural operations have repeatedly requested rehabilitations and further periodic support for even minor repair or replacement of facilities being used in providing the services. For instance, it was identified by UNICEF as a failure of community management to maintain water facilities, caused by a lack of availability of spare parts and insufficient training, worsened by the increasing rural-

rban divide where many of the trained people leave the villages for better economic prospects ı the larger towns (Abdallah, 2009).

ıfter a very slow start-up during 2007 and 2008 PPP initiatives in Arusha Local Government, ıe target communities were assessed and selected, and the PPP options were established Mohamud, 2012). It then became clear that the initial concept of having urban utilities taking ver the operation of formerly community managed systems was confronting the reluctance of ural communities. The implementation of the project was then re-orientated, from providing upport to urban utilities for extension to creating smaller local private companies in each ommunity. From the initial objective of covering 10 locations in each zone, the project logframe vas revised to target only 7 communities in Arusha and 8 in Dar-es-Salaam. Later on, in 2010, he number of target locations was further reduced to 2 in Arusha to allow for concentration of fforts (community mobilization, rehabilitation works) to complete the PPP establishment.

A key advantage which Public-Private Partnership (PPP) has brought to Arusha having the ɔrivate sector provide public services (i.e., private participation) is that it has allowed public ıdministrators to concentrate on planning, policy and regulation (Ministry of State, 2011). The ɔrivate sector, in turn, has been empowered to do what it does best, and in particular improve the efficiency and quality of service.

n partnership with government, Arusha Lutheran Medical Center (ALMC) receives government support from three main sources: Primary Health Care Conditional Grant (PHC CG), Essential Drugs and Personnel through secondment of medical staff (Arusha Lutheran Medical Center (ALMC), 2007). Human resource remains the central gist that determines the overall effects of the reforms (Rigoli, 2003). Arusha Lutheran Medical Center (ALMC) has been a beneficiary of the PPP since 1996/7. Like any other PNFP hospital in Tanzania, the level of financial and human resource support and the extent to which such support has impacted on Arusha Lutheran Medical Center (ALMC)'s efficiency in delivery of health services to the community remains not well understood. This study was conducted to assess the effect of the financial and human resources support through PPP on delivery of health services in Tanzania using Arusha Lutheran Medical Center (ALMC) as a case study.

.2 Statement of the Problem

ike other Private –Not- For- Profit hospitals in Tanzania, Arusha Lutheran Medical Center ALMC) faced financial and human resource challenges resulting from increased cost of drugs, taffing, and budget. In 1997, the hospital adopted the Public Private Partnership (PPP) in Health vith the aim of improving hospital efficiency in health services delivery to the general opulation. In spite of the government financial and human resources support through the Public 'rivate Partnership strategy, Arusha Lutheran Medical Center (ALMC) management is not ertain if the institution has gained substantial improvement in hospital efficiency with regard to ervice delivery especially hospital outputs such as admissions, outpatient department ttendance, antenatal care, immunization and deliveries.

3esides, the Standard Unit of Output (SUO) for Arusha Lutheran Medical Center (ALMC) and ts relationship to human resource, cost of medicines, total costs and user fees is not known. Whether Arusha Lutheran Medical Center (ALMC) has gained efficiency in delivery of health ervices is a critical knowledge gap that needs to be addressed. Failure to appreciate positive ffects of PPP on hospital efficiency may jeopardize future government support to the private - ıot -for -profit institutions and thus negating the aims for which the partnership was established. Thus, this study therefore sought to investigate the effects of public-private partnership on the ıealth service delivery at Arusha Lutheran Medical Center (ALMC) in Arusha Local Government.

.3 Research Objectives

.3.1 General Objective

The general objective of the study was to investigate the significance of the public-private sector partnership in the provision of health services at Arusha Lutheran Medical Center (ALMC) in Arusha Local Government.

3.2 Specific Objective

i. To assess the role played by public private partnership on health service delivery

ii. To establish the challenges encountered in administering Public-Private Sector Partnership in Arusha

ii. To determine the efficiency of health service delivery in Arusha Local Government

.4 Research Questions

i. What is the role played by public private partnership on health service delivery?

ii. What are the challenges encountered in administering Public-Private Sector Partnership in Arusha?

iii. What is the efficiency of health service delivery in Arusha Local government?

.5 Scope of the Study

.5.1 Geographical Scope

The area where this study was conducted at Arusha Lutheran Medical Center (ALMC) in Arusha Local Government, Tanzania, ALMC is situated on Makao Mapya Rd, Arusha, Tanzania.

1.5.2 Content Scope

This study was intended to investigate the role played by public private partnership on health service delivery, the challenges encountered in administering Public-Private Sector Partnership in Arusha and the efficiency of health service delivery in Arusha Local Government

1.5.3 Time Scope

The study took 8 months to completion which starts from January to August 2016. This period included all activities from proposal drafting to submission of final report.

1.6 Significance of the study

The study may be significant to various parties who are stakeholder in the private sector of are interested in health services delivery.

rivate Sector Entrepreneurs: These will be educated on the best ways they can serve the ›ciety. Giving back to society is an act of corporate responsibility which should help them gain .ore acceptances from the public.

.rusha Residents: These stakeholders are bound to receive better services from the public and rivate sectors. These may be in the form of better education, health and security.

;overnment Agencies: the government agencies responsible for the various health services elivery will receive much help from the intervention by the public and private sectors.

'he researcher: The researcher will benefit from the award of Bachelor's degree in Public ıdministration. It is university policy that a student completes an original dissertation as a ›rerequisite for graduation.

.7 Conceptual Framework

'he diagram below presents the conceptual framework for the study.

'he conceptual framework diagrammatically shows the relationship between the different variables ı the study. The independent variable was perceived as the public private partnership and dependent ariable was health service delivery

Independent variable

'ublic private partnership

Dependent Variable

Health service delivery

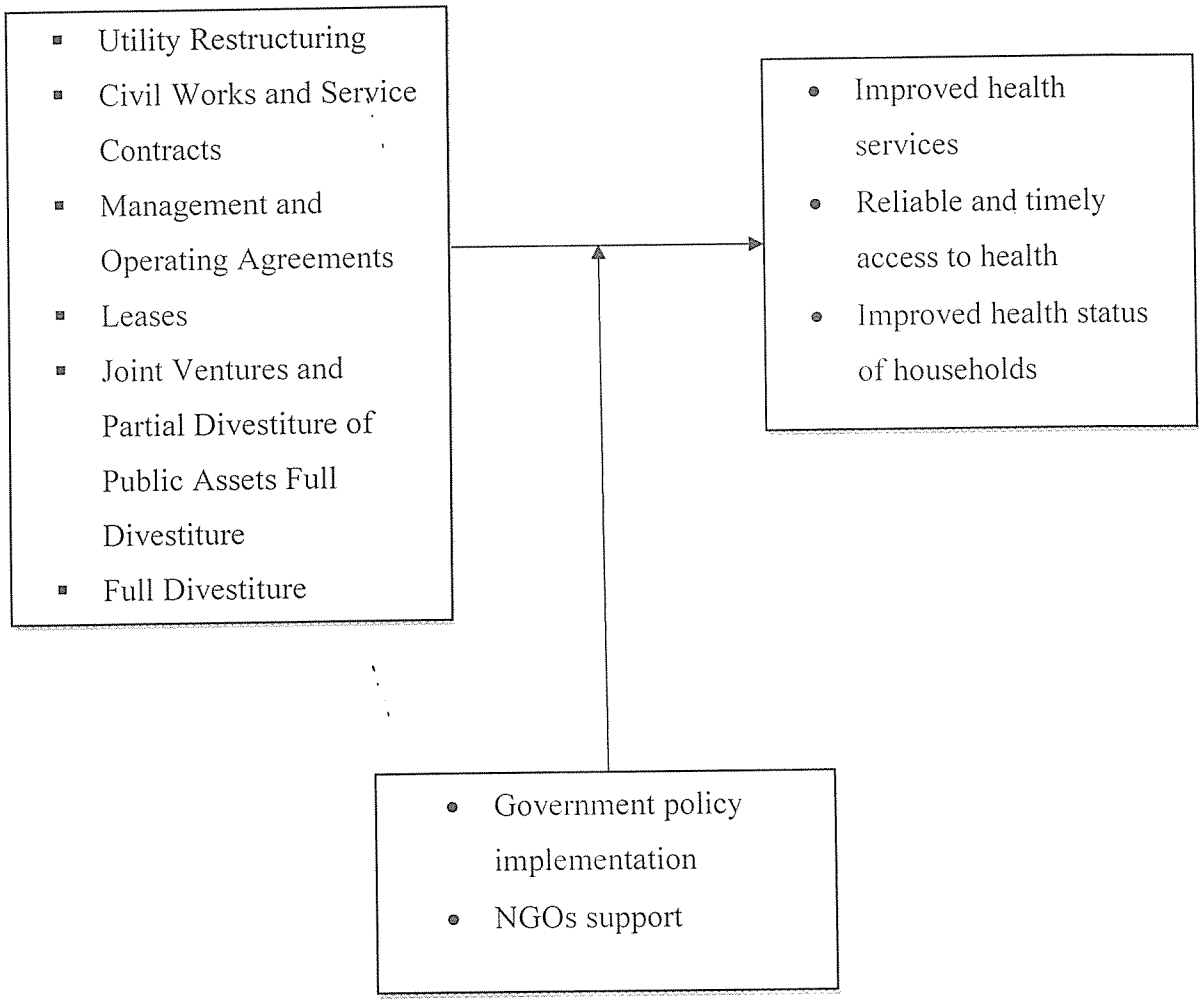

Figure1.1: Conceptual Framework

The independent variable was perceived as the public private partnership whereas the dependent variable was health service delivery. The independent variable concerns utility restructuring, civil

/orks and service contracts, management and operating agreements, leases, joint ventures and artial divestiture of public assets full divestiture and full divestiture. The dependent variable focuses n improved health services, reliable and timely access to health and improved health status of ouseholds. However this is intervened by the government policy implementation and NGOs upport.

.8 Operational Definitions of Key Terms

'ublic-Private Partnership: A contractual framework, or structure, where the public and rivate sector come together to deliver a project/service that is traditionally provided by the ublic sector, by means of risk transference.

Iealth services: These are the essential health services offered to the public in order to ensure heir lives are comfortable or assist them in achieving secondary objectives

Iealth service delivery : This is a term which refers to the state of an entity fulfilling its esponsibility in providing health services and or health to the public whether for a fee or for free

CHAPTER TWO

LITERATURE REVIEW

.1 Introduction

'his chapter dealt with review of literature which is pertinent to the study context, reference is onsistently made to data sources throughout this section which the researcher reviewed. This hapter was written with respect to the study objectives.

.1 The role played by public private partnership on health service delivery

JNECE (2008) articulates that infrastructure created through PPP can improve the quality and uantity of basic infrastructure such as the provision of water and its treatment, energy supply nd transportation. In addition the process can be widely applied to a variety of public services uch as hospitals, schools, prisons and government accommodation.

Construction is being completed to plan and to budget; repairs and maintenance are planned at he outset and in consequence assets and services are maintained at a pre-determined standard ›ver the full length of the concession. Klijn, E.-H. and Teisman, G.R. (2003) mentions that early lelivery of good quality premises and services is delivering wide social benefits.

According to Linder, S.H. (1999), PPPs are helping the public sector develop a more disciplined ınd commercial approach to infrastructure development whilst allowing them to retain strategic ›ontrol of the overall project and service.

n PPP structures the risk of performance is transferred to the private sector. The private sector ›nly realises its investment if the asset performs according to the contractual obligations. As the ›rivate sector will not receive payment until the facility is available for use, the PPP structure ›ncourages efficient completion, on budget without defects. (Peter Farlam, 2005).

There is evidence of better quality in design and construction than under traditional procurement. PPP focuses on the whole life cost of the project not simply on its initial construction cost, it dentifies the long term cost and assesses the sustainability of the project.

tarr, P. (1988) argues that the use of private finance enables the public to have access to nprove services now, not years away when an governments spending programme permits. And ıe expertise and experience of the private sector encourages innovation, resulting in shorter elivery times and improvements in the construction and facility management processes.)eveloping these processes leads to best practice and adds value.

'he process helps to reduce government debt and to free up public capital to spend on other ;overnment services, the tax payer benefits by avoiding paying higher taxes to finance nfrastructure investment development. PPP projects can also deliver better value for money ompared with that of an equivalent asset procured conventionally.

\ccording to Wikipedia (2003) articulates that the PPP process requires a full analysis of)rojects risks at the outset. This fuller examination of risks by both the government and lenders neans that cost estimates are robust and investment decisions are based on better information.)PPs are creating efficient and productive working relationships between the public and private ;ector.

nternational experience suggests that the quality of service achieved under a PPP is often better han that achieved by traditional procurement. This may reflect the better integration of services vith supporting assets, improved economies of scale, the introduction of innovation in service lelivery, or the performance incentives and penalties typically included within a PPP contract. Stephenson, M.O. Jr. (1991)

2.2 Challenges Faced in Administering Public-Private Partnership

Even though PPP has important roles to play in offering health service delivery to the public, it has some documented challenges which have over time made it hard for it to be properly administered. As Jamie (2011) notes on this, it is due to the relevance of the partnership that these challenges are borne. In other words, he seems to make a claim that something which is beneficial especially on a large scale is sure to have severe challenges of an equal or similar magnitude as the benefits it offers.

First Reinert (2009) argues against public private partnership by stating that this partnership presents funding priorities problems. When parties can't agree on where funding should go this

an sometimes lead to losses in time, resources, and the overall funding for the project. Funding riorities for government bodies looks typically at where the public's funds were spent in elation to the contract made. This then typically is looked at as in how many hours of articipations, forms filled out, meals served. Etc. Neighborhood organizations or small and local ıon-profits saw a broad source of funding during the early years but there has been a shift in unding more recently reducing the overall funding and seeing more of it go to larger agencies ocusing on large grants.

Accountability issues have proved to be a concern for Jamie (2011). She finds that with the rise n public private partnerships there is also a rise in the responsibility that the non-profits tend to ıold. With the government relying on many more of these organizations to provide the public ervices they cannot it is also proving difficult for the government to hold these non-profits esponsible. When responsibilities are not set to the letter, it can cause some in managerial ositions to take the back seat, seeing their counterparts taking the initiative to get tasks done. This leaves an unbalance of work and sometimes those with the most stills are not doing the job. This can also be brought on by under management causing more problems such as a lack of focus for the projects, mismanaged funding, and miscommunication. Too many projects and partnerships can also lead to a lack of accountability. When there are too many tasks they seem to all fall short of the hoped perfection. Some partners may be taking over roles of others because accountability has not been well defined. This can also lead to some taking advantage of others when they note the any weakness. This can cause a distrustful partnership.

Another challenge as noted by Sebagala (2012) is communication or understanding between the two partners. He claims that one of the largest issues that can be discussed, communication can be a huge downfall and can contribute to many of the other risks within partnerships. It can be said that when entering into a cross-sector partnership it is difficult to understand and collaborate due to the diversity and differing languages spoken amongst the sectors. Items like performance measures, goal measurements, government regulations, and the nature of funding can all be interpreted differently thus causing blurred lines of communication.

In another study conducted by Simon (2009), autonomy within the partnership is argued as a fundamental problem when it comes to public private partnership. While working together is important it is somehow better to be able to work on parts of the project alone, take initiative

hen needed, and keep some individualism throughout the process. He finds that this is eginning to happen more with the privatization of public private partnerships where the private rganization may own the partnership itself and the government then keeps full responsibility for . This keeps parts of the partnership separate for focus.

inally, Biswas and Paul (2010) posit that conflicts can arise from various causes, even outside ssues or forces which may bring the partnership to a halt. Even though these partnerships are ntered into with the best of intentions even the most trivial issues can snowball into greater onflict halting a partnership dead in its tracks. They caution that having no understanding and ommunication between parties can cause conflicts with use of language, stereotyping, negative ssumptions, and prejudice about the other organization. These conflicts can be related to erritorialism or protectionism, and a lack of commitment to working within the partnership.

2.3 Efficiency of Health Service Delivery

2.3.1 Immunisation

mmunisation is a method of primary prevention aimed at preventing communicable diseases in order to reduce on morbidity and mortality due to the diseases being targeted. In Tanzania, six childhood immunisable diseases are tuberculosis (T.B), Diphtheria, Whooping cough (Pertusis), Tetanus, poliomyelitis (polio), and measles. Immunisation is one of the government priorities and is well spelt as an approach for primary health care (PHC). It is one of the most important means of mortality and morbidity in children (Jelliffe, 1979), the others being good nutrition and good environmental sanitation.

Each and every year, infants should be fully immunized. The immunization coverage rates are greatly influenced by the socio-economic status of the mothers. An increase in socio-economic status of mothers results in an increase in immunization coverage rates, the level of participation in immunization activities and the number of fully immunized infants while a decrease results in lowered rates(UBOS, 2007). During the period of 1962 to 1970, Tanzania established a comprehensive immunization programme, in which a high degree of vaccination coverage of infants and young children was achieved especially for TB and Polio. By 1973 coverage of TB and Polio was about 70 % for children less than 14 year.

. number of factors do affect immunization service delivery to populations. Some are related to ıe populations themselves while others are related to the health services (Kasule, 1992). In a tudy conducted by Kasule (1992), it was reported that knowledge, attitudes and practices of a ommunity affected coverage rates and that these were linked up with mismanagement. Other actors influencing immunization included: education, status of parents, husbands consent, and eneral health education to the community. In one study done in Hoima by Baguma (1988), it vas found that despite the mothers having good knowledge of immunization centres, the ımmunization coverage was low (18.2 %).

.3.2 Antenatal Care (ANC) attendance

Most women in Sub-Saharan Africa initiate ANC late in pregnancy thereby fail to reach the ecommended 4 visits. Unplanned/mistimed pregnancy is one of the contributing factors to lelayed ANC attendance. Makaweri (2000) on frequency and timing of ANC in Kenya found out hat the first visit occurs in the fifth month of pregnancy on average.

Nyane L (2007) conducted a study on factors associated with Antenatal care drop out among ɔregnant women in Tororo District in Tanzania and found out that the level of education, age, ɔarity (number of children previously had), distance and transport, socio-economic status, clients ɔerception on ANC services, knowledge about ANC, Occupation, decision making, marital ɜtatus, gender dimensions, timing for ANC and unplanned/mistimed pregnancy among others are ɛesponsible for Antenatal Care drop out. A study done in Mberere District in Kenya found out ɪhat mothers living less than 5 km from the health facility utilized ANC services better than the ɪothers who were 5 km from the health facility (Mwaniki & Mbugua, 2002).

2.3.3 Deliveries

Munaaba E. (1995) found out that the distance to a health unit was a major factor in determining whether professional care for delivery was sought or not. The difference in attendance of mothers from within a radius of 3 km from a health unit, as compared to utilization of health units by mothers who came from a distance of greater than 3 Km was found to be highly significant. This finding suggested that the catchment area of a health unit for purposes of maternity care, should be revised to 3 Km.

)ther factors which influence mothers' choice of location of child birth in Tanzania include thnocentricity, position adopted at child birth, staffing at health units, health facility equipment. ,vailability of service is a major factor contributing to choice of location of birth. And the WHO hronicle sums it up thus; As long as they are not sufficient conventional health personnel for)tal population coverage, as long as funds for health care remain mal-distributed and ıadequate, so long will these TBAs continue to be in demand‖ (WHO Chronicle 36 (3) 1982).

Many modern facilities charge a fee (user fee) which fees are in monetary terms and on a cash elivery _basis'. The expectant mother may opt for the traditional sector where payment in real erms may be less, mode of payment flexible (that is, cash or kind), and allowing for credit acilities. In Kenya it was estimated that 75 % of all births in areas where the research was onducted occur under the supervision of Traditional Birth Attendants (Nyamawe, 1984)

A survey on utilization of Home and hospital deliveries in Botswana revealed that 77.1% of ırban women chose to deliver from hospital or clinic and only 45.2% of the rural women chose ıospital or clinic. The proportion of home deliveries was highest in the most remote villages low availability of modern service) and lowest in low-cost sites in the urban area (Anderson, .986).

2.3.4 Inpatients

Access and use of hospital in-patient care services can be influenced by several factors. In leveloping countries, Tanzania inclusive, two main aspects of quality that have been locumented to influence service utilization significantly are availability of skilled personnel and essential drugs (Hutchinson, 1999; Barnum and Kutzin, 1993). In the government hospital more patients were likely to be admitted due to the _free services' rendered. However, due to higher tendency of stock outs of drugs and poor quality services, patients are either discharged earlier or seek for referral or may out right leave the government hospital, implying low costs of provision of inpatient care. On the other hand, the PNFP hospital which charges a fee for service may have fewer admissions, more IPDs and longer stays mainly due to good quality services. This may contribute to the high costs of provision of inpatient care and higher unit costs and hence an impression of poor efficiency (Ongom M, 2006).

CHAPTER THREE

RESEARCH METHODOLOGY

.1 Introduction

'his chapter discussed how data regarding to the study was collected. It describes the research esign, the variables under study, and their measures, the area of study, the sources of nformation, sampling design, procedure and a sample size. Data collection and processing are hen discussed later, and lastly the researcher comments on the expected limitations of the study.

;.2 Research Design

'he researcher used descriptive survey study research design where data was collected from a ;ross the population of study. This design was cheap, less time consuming and easy data ;ollection and analysis (Amin, 2005). Both qualitative and quantitative data collected was used luring the data collection.

;.3 Study population

The study targeted the 133 respondents from Arusha Lutheran Medical Center (ALMC) and ;ther Local government stakeholders. These included top authorities of ALMC, medical staff of ALMC, District health officers, officials from Ministry of Health, Arusha and other local ;easants. These were decided to be part of the study since they could have been having a good potential of effectively responding to the questions in the study.

Table 1: Showing Target Population and Sample Size

Type of respondent	Population target	Sample Size
ALMC Top Authorities	10	6
ALMC Medical staff	25	18
District Health officers	20	14
MOH officials, Arusha	15	12
Local peasants	63	50
Total	**133**	**100**

Primary Data (2016)

.4 Sample Size and Sample Techniques

he minimum sample size was computed using the Slovene's formula, which states that for any iven population the required sample size given by;

$$n = \frac{N}{1 + N(e)^2}$$

Equation 3. 1: Slovene's Formula

Vhere; n the required sample size;

J = the known population size; and

= the level of significance, which is = 0.05.

Therefore given a total population of 133 respondents (in the given categories) in the various offices where the study encompassed.

$$1 = \frac{N}{1+Ne^2} = n = \frac{133}{1+133(0.05)^2} = \mathbf{100\ respondents}$$

3.5 Sample Techniques

The sample was purposively and randomly selected.

3.5.1 Purposive sampling

Different stakeholders such as ALMC top authorities and ALMC medical staff were purposely selected because they headed different sections of people and thus had knowledge about public private partnership and impact on health service delivery in ALMC, Arusha Local government. All respondents were assumed to have vital information on the impact of public private partnership and public service delivery on socio-economic development. Respondents who were willing to participate were approached.

.5.2 Random Sampling

'he officials from Ministry of Health, Arusha and other local peasants were randomly selected in rder to provide them with each opportunity of being chosen for equal representation of the espondents.

.6 Sources of data

'he researcher collected data from secondary and primary data sources.

.6.1 Secondary data

Secondary data helped the researcher to establish what other researchers found out previously. This enabled the current researcher to fill some gaps that were left behind. In this respect, extbooks, journals, newspapers and other relevant records were used hand in hand with primary lata.

3.6.2 Primary data

Primary data revealed concrete information about the target population investigated on which basic conclusions were drawn. Both secondary and primary data supplemented each other to enable the researcher analyse information.

3.7 Data collection instruments

The researcher used two major data collection techniques during the gathering of information in the field. There was extensive use of questionnaires, which are self-administered and conducted face to face followed by conducting formal interviews following an interview guide to obtain first-hand information from the respondents.

3.7.1 Questionnaires

Questionnaires were developed and designed in the most understandable way for the respondents with simple language, simple questions that could easily be answered without consuming the time of the respondents. These were used mainly to gather primary data where respondents were expected to react usually in writing and return them filled with answers for

nalysis by the researcher. They were designed in a way that makes them look easy and nderstandable not to consume most of the respondents time.

.7.2 Interviews

he interview method were used to collect key information about private sectors and health ervice delivery from special of respondents that would not have time of filling questionnaires or example the minister and UNDP managers.

.8 Data processing and analysis

he study used both quantitative and qualitative style of data analysis; the qualitative analysis vas through use of results gathered from questionnaires for completeness and accuracy. After ollection of the data, various methods and computer programs such as Microsoft Excel, was ised to process and analyse it. This included editing of the data given by different respondents nd coding and tabulation.

Qualitative data and interpretation was done through the use of interview guide as offered in the appendix. This involved analysis of descriptive information as the respondents responded from the questions. Direct quotations were offered according to the context of analysis.

3.9 Data Analysis

The study explained, described and presented the findings basing on the specific objectives of the study and research questions, where data analysis initially was done through sketchy and generalized summaries of the findings from observation and conclusions in the process of data collection. Data analysis was done using simple statistical percentages and frequencies and thereafter was presented in charts.

3.10 Ethical Consideration

The researcher carried out the study with full knowledge and authorisation of the administration of Arusha Lutheran Medical Center (ALMC), Arusha, Tanzania. The researcher first of all would acquire an introductory letter from the University which she would use to eliminate suspcion.

The researcher thereafter went ahead to select respondents, and arrange for dates upon which she would deliver questionnaires as well as pick them in addition to making appointments for interviews

CHAPTER FOUR

PRESENTATIONS, INTEPRETATIONS AND ANALYSIS OF DATA

.0 Introduction

'his chapter covers the presentation of the findings according to the themes of the study which vere; to assess the role played by public private partnership on health service delivery, to stablish the challenges encountered in administering Public-Private Sector Partnership in Arusha and to determine the efficiency of health service delivery in Arusha Local Government.

1.1 Demographic characteristics of respondents

Jnder this section, the researcher was interested in finding out the demographic characteristics of he respondents. They are presented as follows:

1.1.1 Gender of Respondents

The researcher wanted to know the gender or sex distribution of the respondents and this is shown in the following table and illustration. This section indicates the both sexes with the community.

Table 2: presenting the gender distribution of the respondents who participated in the study

Gender	Frequency	Percentage (%)
Females	24	35
Males	26	65
Total	**50**	**100**

Source: Primary Data, (2016)

In the above table 1, the study findings revealed that the sample constituted of 50 respondents of which 35% were females and the 65% remaining were males. This implies that men are the always the majority involved in Arusha Lutheran Medical Center (ALMC) due to societal beliefs

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hat they are more hardworking and capable of managing such institution in relation to health ervice delivery.

.1.2 Age of the respondents

he study went on to establish the different age groups of the respondents and the findings were s presented in table 2. The study also involved all respondents who are responsible and with nature understanding. For example all the respondents were 20 years and above.

able 3 showing age distribution of the respondents

\ge	**Frequency**	**Percentage (%)**
0 -25	8	8
6-35	4	4
6-45	12	12
6-55	40	40
6+	36	36
otal	100	100

ource: Primary Data (2016)

he study revealed that the majority of the respondents fell in the age category 36 - 45 with a 2% representation. Age category 46-55 had a total response of 40%, while 26-45 age group was epresented by 4% the 20 -25 category had a total representation of 8% while the remaining ategory was that of the 56+ with a representation of 36%. This implies that most of the espondents were middle aged adults since it was believed that these tend to have a mature and etter understanding of Public-private partnership and health service delivery in Tanzania.

.1.3 Marital Status of the Respondents

The study further went on to establish the marital status of the respondent and the findings were s represented in table 3. The researcher was also interested in finding out the marital status of espondents.

Table 4 showing marital status of the respondents

Marital Status	Frequency	Percentage
Single	8	8
Married	10	10
Divorced	46	46
Widowed	36	36
Total	**100**	**100**

Source: Primary Data (2016)

The study established that the majority of the respondents were widowed (36%). The divorced comprised of 46%, the married were 10% whereas the single were only 8%. Study findings established that, the majority were widowed and that due to their statuses, had children to take care of and yet resources were not readily available. This implies that these people would involve themselves in Public-private partnership activities in order to improve on the health service delivery hence be able to earn a living and sustain their families.

4.1.4 Education Levels of the Respondents

The study also sought about the educational levels of the respondents and the findings were as represented in table 4. Under this section, the researcher was interested in finding out the education status of all respondents involved in the study. This was partly essential in order to enrich the findings of the study since education level had a significant relationship with level the knowledge about the relationship between Public-private partnership and health service delivery in Tanzania.

Table 5: Educational Level of the respondents

Education level	Frequency	Percentage
Primary	10	10
Secondary level	14	14
Tertiary	26	26
University	50	50
Total	**100**	**100**

Source: Primary Data (2016)

Study findings in table 4 revealed that the least represented level of education was the primary level group which comprised of 10%, followed by secondary level group (14%), while Tertiary level was represented by 26% and the most represented group was that of university level which comprised of 50%. This implies that most respondents in the study were mainly literate, thus with high levels of education. And this further indicated that the majority were relatively educated hence had proper understanding about Public-private partnership and health service delivery in Tanzania especially at Arusha Lutheran Medical Center (ALMC).

.2 FINDINGS ON THE PUBLIC-PRIVATE PARTNERSHIP AND HEALTH SERVICE)ELIVERY

Table 6: Roles played by public private partnership on health service delivery

Responses		Frequency	Percent
	Improve the quality and quantity of basic infrastructure	15	15
	Early delivery of good quality premises and services	35	35
	Better quality in design and construction	25	25
	Access to improved services	15	15
	Helps to reduce government debt	10	10
	Total	100	100

Source: Primary Data (2016)

The table above shows that 15% of the respondents that agreed that public private partnership helps to improve the quality and quantity of basic infrastructure, 35% noted that it helps to ensure early delivery of good quality premises and services, 25% revealed that public private partnership helps to ensure better quality in design and construction, 15% of the respondents were of the view that it also helps to access to improved services and the remaining 10% noted that public private partnership helps to reduce government debt.

This implies that public private partnership plays a vital role in improve on the health service delivery in Tanzania especially at Arusha Lutheran Medical Center (ALMC), Arusha

'able 7: The extent to which public private partnership has played a beneficial role in ealth service delivery

Responses		Frequency	Percentage
	Very High	25	25
	High	30	30
	Not sure	21	21
	Low	11	11
	Very low	13	13
	Total	100	100

ource: Primary Data (2016)

'he findings in the above table revealed that 25% of the respondents suggested that extent to /hich public private partnership has played a beneficial role in health service delivery is very igh, 30% of the respondents noted high extent, 21% were not sure of the extent, 11% revealed)w extent and the remaining 13% of the respondents noted very low extent. This implies that ublic private partnership plays a vital role in improve on the quality of health services delivered t Arusha Lutheran Medical Center (ALMC), Arusha

Table 8: Challenges Faced in Administering Public-Private Partnership

Responses		Frequency	Percent
	Funding priorities problems	25	25
	Poor accountability issues	38	38
	Poor communication	16	16
	Lack of autonomy within the partnership	21	21
	Total	100	100

ource: Primary Data (2016)

Results in table above indicate that 25% of the respondents agreed that funding priorities problems is one of the major challenges facing in administering Public-Private Partnership in Tanzania, 38% of the respondents noted Poor accountability issues, 16% suggested Poor communication and the remaining 21% noted that lack of autonomy within the partnership. This further implies that there is a multitude of challenges facing the process of administering Public-Private Partnership in Tanzania. This further indicates that there is still a lot that the government of Tanzania and its stakeholders need to do to address these issues so as to improve on the health service delivery to the people.

Table 9: The extent to which administering Public-Private Partnership faces challenges in Arusha, Tanzania

Responses	Frequency	Percentage
Very High	25	25
High	30	30
Not sure	21	21
Low	11	11
Very low	13	13
Total	100	100

Source: Primary Data (2016)

The findings in the above table revealed that 25% of the respondents suggested that extent to which administering Public-Private Partnership faces challenges in Arusha, Tanzania is very high, 30% of the respondents noted high extent, 21% were not sure of the extent, 11% revealed low extent and the remaining 13% of the respondents noted very low extent. This shows that there are a lot of hindrances to the process of administering Public-Private Partnership in Tanzania.

Table 10: Efficiency of Health Service Delivery

sponses	Frequency	Percent
Quality of Immunization	35	35
Antenatal Care (ANC) attendance	18	18
Deliveries	20	20
Inpatients	27	27
Total	100	100

Source: Primary Data (2016)

The table above shows that the majority of the respondents 35% noted that quality of mmunization is one of the indicators of the efficiency of health service delivery, 18% of the espondents suggested Antenatal Care (ANC) attendance, 20% noted deliveries and the emaining 27% of the respondents suggested inpatients. This implies that there is a multitude of ndicators that can be used to determine the efficiency of health service delivery in Arusha Lutheran Medical Center (ALMC), Arusha.

Table 11: The extent to which is Health Service Delivery efficient in Arusha Lutheran Medical Center (ALMC), Arusha

Responses	Frequency	Percentage
Very High	25	25
High	30	30
Not sure	21	21
Low	11	11
Very low	13	13
Total	100	100

Source: Primary Data (2016)

The findings in the above table revealed that 25% of the respondents suggested that the extent to which measures to overcome the challenges faced by gender participation applied in Somalia is very high, 30% of the respondents noted high extent, 21% were not sure of the extent, 11% revealed low extent and the remaining 13% of the respondents noted very low extent. This shows that there is still less that has been done in Somalia to address the hindrances facing gender participation.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter summarizes, concludes and recommends reflecting on the study findings presented in the previous chapter.

5.1 Summary of the Findings

The study findings revealed that the sample constituted of 50 respondents of which 35% were females and the 65% remaining were males. This implies that men are the always the majority involved in Arusha Lutheran Medical Center (ALMC) due to societal beliefs that they are more hardworking and capable of managing such institution in relation to health service delivery.

The study revealed that the majority of the respondents fell in the age category 36 - 45 with a 2% representation. Age category 46-55 had a total response of 40%, while 26-45 age group was represented by 4% the 20 -25 category had a total representation of 8% while the remaining category was that of the 56+ with a representation of 36%. This implies that most of the respondents were middle aged adults since it was believed that these tend to have a mature and better understanding of Public-private partnership and health service delivery in Tanzania.

The study established that the majority of the respondents were widowed (36%). The divorced comprised of 46%, the married were 10% whereas the single were only 8%. Study findings established that, the majority were widowed and that due to their statuses, had children to take care of and yet resources were not readily available. This implies that these people would involve themselves in Public-private partnership activities in order to improve on the health service delivery hence be able to earn a living and sustain their families.

Study findings revealed that the least represented level of education was the primary level group which comprised of 10%, followed by secondary level group (14%), while Tertiary level was represented by 26% and the most represented group was that of university level which comprised of 50%. This implies that most respondents in the study were mainly literate, thus with high levels of education. And this further indicated that the majority were relatively educated hence

had proper understanding about Public-private partnership and health service delivery in Tanzania especially at Arusha Lutheran Medical Center (ALMC).

It was found out that 15% of the respondents that agreed that public private partnership helps to improve the quality and quantity of basic infrastructure, 35% noted that it helps to ensure early delivery of good quality premises and services, 25% revealed that public private partnership helps to ensure better quality in design and construction, 15% of the respondents were of the view that it also helps to access to improved services and the remaining 10% noted that public private partnership helps to reduce government debt. This implies that public private partnership plays a vital role in improve on the health service delivery in Tanzania especially at Arusha Lutheran Medical Center (ALMC), Arusha

The findings revealed that 25% of the respondents suggested that extent to which public private partnership has played a beneficial role in health service delivery is very high, 30% of the respondents noted high extent, 21% were not sure of the extent, 11% revealed low extent and the remaining 13% of the respondents noted very low extent. This implies that public private partnership plays a vital role in improve on the quality of health services delivered at Arusha Lutheran Medical Center (ALMC), Arusha

It was discovered that 25% of the respondents agreed that funding priorities problems is one of the major challenges facing in administering Public-Private Partnership in Tanzania, 38% of the respondents noted Poor accountability issues, 16% suggested Poor communication and the remaining 21% noted that lack of autonomy within the partnership. This further implies that there is a multitude of challenges facing the process of administering Public-Private Partnership in Tanzania. This further indicates that there is still a lot that the government of Tanzania and its stakeholders need to do to address these issues so as to improve on the health service delivery to the people.

The findings revealed that 25% of the respondents suggested that extent to which administering Public-Private Partnership faces challenges in Arusha, Tanzania is very high, 30% of the respondents noted high extent, 21% were not sure of the extent, 11% revealed low extent and the remaining 13% of the respondents noted very low extent. This shows that there are a lot of hindrances to the process of administering Public-Private Partnership in Tanzania.

t was also found out that the majority of the respondents 35% noted that quality of mmunization is one of the indicators of the efficiency of health service delivery, 18% of the espondents suggested Antenatal Care (ANC) attendance, 20% noted deliveries and the emaining 27% of the respondents suggested inpatients. This implies that there is a multitude of ndicators that can be used to determine the efficiency of health service delivery in Arusha Lutheran Medical Center (ALMC), Arusha.

The findings revealed that 25% of the respondents suggested that the extent to which measures to overcome the challenges faced by gender participation applied in Somalia is very high, 30% of the respondents noted high extent, 21% were not sure of the extent, 11% revealed low extent and the remaining 13% of the respondents noted very low extent. This shows that there is still less that has been done in Somalia to address the hindrances facing gender participation.

5.2 Conclusion of the Findings

The study concludes that infrastructure created through PPP can improve the quality and quantity of basic infrastructure such as the provision of water and its treatment, energy supply and transportation. In addition the process can be widely applied to a variety of public services such as hospitals, schools, prisons and government accommodation.

It also concludes that construction is being completed to plan and to budget; repairs and maintenance are planned at the outset and in consequence assets and services are maintained at a pre-determined standard over the full length of the concession.

The study further concludes that PPPs are helping the public sector develop a more disciplined and commercial approach to infrastructure development whilst allowing them to retain strategic control of the overall project and service.

In PPP structures the risk of performance is transferred to the private sector. The private sector only realises its investment if the asset performs according to the contractual obligations. As the private sector will not receive payment until the facility is available for use, the PPP structure encourages efficient completion, on budget without defects.

t also concludes that even though PPP has important roles to play in offering health service lelivery to the public, it has some documented challenges which have over time made it hard for t to be properly administered.

The study concludes that accountability issues have proved to be a concern. With the government relying on many more of these organizations to provide the public services they cannot it is also proving difficult for the government to hold these non-profits responsible. When esponsibilities are not set to the letter, it can cause some in managerial positions to take the back seat, seeing their counterparts taking the initiative to get tasks done. This leaves an unbalance of work and sometimes those with the most stills are not doing the job.

t also concludes that another challenge is communication or understanding between the two partners. One of the largest issues that can be discussed, communication can be a huge downfall and can contribute to many of the other risks within partnerships. It can be said that when entering into a cross-sector partnership it is difficult to understand and collaborate due to the diversity and differing languages spoken amongst the sectors.

5.3 Recommendations

There should be macro-prudential review such that the totality of a government's PPP obligations, including contingent liabilities and ripple effects through public lenders, are visible. This should be carried out by the ministry of finance (or similar), as is done with traditional public borrowing and debt limits. At the level of the ministry of health, current year spending and long term liabilities for PPP contracts should also be included in the total health programme spending limits. PPPs should be on the public balance sheet and accounts, except for those variants with a very substantial risk transfer (probably including demand risk).

A health care project should be checked thoroughly for robustness and relevance on clinical, economic, environmental and social grounds before the procurement method (including PPP) is chosen. Notably, an appropriate care service model is critically important.

A robust and believable PSC/VfM calculation should always be undertaken. It should be updated and maintained throughout the whole negotiation period;

PPP development should include full stakeholder negotiation, but particularly including the clinicians, especially if clinical services are involved, as clinical staff can assist or resist the implementation of a PPP, especially if PPP implementation affects their work practices and staff management rules;

Full-service PPPs (infrastructure and clinical) should be subject to the same rules on patient access and tariff and inadmissibility of out of pocket payments as hospitals controlled by other public, private or social sector sponsors, to the extent that the patient experience should not differ significantly.

When there is high political discontent and a lack of competition, monitoring capability and citizen engagement, turning towards PPPs might prove to be a costly choice. Central to this debate is the issue of whether or not services need to be bundled or whether it is economically beneficial to unbundle urban services and award them as separate contracts. In order to ensure that the right decisions are taken, it is important that PPPs become a policy option and are not the 'only game in town'. Capacity to take such decisions should be built.

Accommodation-only (PFI) should be used only in special cases (when the public sector needs to construct infrastructure, has no money for investment in the budget but is able to make annual payments).

5,4 Areas for further research

More research needs to be done of the following;

- Privation and health service delivery.
- Public Private Partnership and education service delivery
- Public Private Partnership and local government performance

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Office of the Head of Department

September 2, 2016

Dear Sir/Madam,

RE: INTRODUCTION LETTER FOR MS. ROSE M.MARWA,
REG. NO. BPA/41186/133/DF

The above mentioned candidate is a bonafide student of Kampala International University pursuing a Bachelors Degree in Public Administration.

She is currently conducting a field research for her dissertation entitled, **Public –Private Partnership and Health Service Delivery in Tanzania. A case study of Arusha Lutheran Medical Center. (AIMC).**

Your organisation has been identified as a valuable source of information pertaining to her research project. The purpose of this letter then is to request you to accept and avail her with the pertinent information she may need.

Any data shared with her will be used for academic purposes only and shall be kept with utmost confidentiality.

Any assistance rendered to her will be highly appreciated.

Yours truly,

Gerald Muzaare,
HOD-Administrative and political studies

APPENDICES

APPENDIX I: QUESTIONNAIRE

Dear Respondent

My name is **ROSE M. MARWA, BPA/41186/133/DF,** a student from Kampala International University, carrying out a study on **Public-Private Partnership and Health Service Delivery in Tanzania: a Case Study of Arusha Lutheran Medical Center (ALMC), Arusha.** I am very glad that you are my respondent for this study. The purpose of this questionnaire was to obtain your opinion/views to be included among others in the study. This research is one of the requirements leading to the award of Bachelor's degree in Public Administration of Kampala International University. It is hence an academic research and will not be used for any other purpose other than academic.

Your co-operation and answers to these questions heartily and honestly will be significant to this study to gather the data needed and will be handled confidentially. Thank you in advance for your cooperation

SECTION A: BACKGROUND INFORMATION

1. Gender

Male ☐

Female ☐

2. Marital Status

Single ☐

Married ☐

Divorced ☐

Widowed ☐

3. Highest Educational level

Primary ☐
Secondary ☐
Tertiary ☐
University ☐

4. Age.

20 -25 ☐
26-35 ☐
36-45 ☐
46-55 ☐
56+ ☐

SECTION B: PUBLIC-PRIVATE PARTNERSHIP AND HEALTH SERVICE DELIVERY

What are the roles played by public private partnership on health service delivery?

a) Improve the quality and quantity of basic infrastructure
b) Early delivery of good quality premises and services
c) Better quality in design and construction
d) Access to improved services
e) Helps to reduce government debt

To what extent has public private partnership played a beneficial role in health service delivery?

a) Very high ☐
b) High ☐
c) Not sure ☐
d) Low ☐
e) Very low ☐

What are challenges Faced in Administering Public-Private Partnership?

a) Funding priorities problems ☐
b) Poor accountability issues ☐
c) Poor communication ☐
d) Lack of autonomy within the partnership ☐

To what extent is administering Public-Private Partnership facing challenges in Arusha, Tanzania?

a) Very high ☐
b) High ☐
c) Not sure ☐
d) Low ☐
e) Very low ☐

What is the efficiency of Health Service Delivery?

a) Immunisation ☐
b) Antenatal Care (ANC) attendance ☐
c) Deliveries ☐
d) Inpatients ☐

To what extent is Health Service Delivery efficient in Arusha Lutheran Medical Center (ALMC), Arusha?

a) Very high ☐
b) High ☐
c) Not sure ☐
d) Low ☐
e) Very low ☐

Thanks for your responses

End

APPENDIX II

INTERVIEW GUIDE

What are the roles played by public private partnership on health service delivery?

To what extent has public private partnership played a beneficial role in health service delivery?

What are challenges Faced in Administering Public-Private Partnership?

To what extent is administering Public-Private Partnership facing challenges in Arusha, Tanzania?

What is the efficiency of Health Service Delivery?

To what extent is Health Service Delivery efficient in Arusha Lutheran Medical Center (ALMC), Arusha?

APPENDIX III :

TIME FRAME

Activity	J	F	M	A	M	J	J	A
Topic selection and problem identification								
Data collection of literature review								
Meeting with supervisor								
Final proposal submission								
Data collection								
Data analysis and report writing								
Report writing supervisor meeting								
Submission for approval								

APPENDIX IV:

BUDGET ESTIMATES

ITEM	QUANTITY PIECES/UNITS	UNIT PRICE UGX	TOTAL PRICE UGX
Papers	2	15000	30000
Files	2	5000	10000
.Umbrella	1	7000	7000
Clip boards	2	4500	9000
Pens	6	500	3000
Rulers	2	1000	2000
Transport			100000
Others			80000
Total			**241000**