EFFECTIVENESS OF PUBLIC PRIVATE PARTNERSHIP ON HEALTH DELIVERY SERVICES IN TANZANIA:

A CASE OF MINISTRY OF HEALTH AND SOCIAL WELFARE AND CCBRT HOSPITAL.

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By:

Erasto Edward

A Dissertation submitted to Mzumbe University Dar es Salaam Campus College in partial fulfillment for the requirements for the award of the Degree of Masters of Public Administration (MPA)

of Mzumbe University

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CERTIFICATION

We, the undersigned, hereby certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation titled the **effectiveness of public private partnerships in the delivery of health services in Tanzania: a reflection of the public private partnership between the ministry of health and social welfare and CCBRT,** in partial fulfillment of the requirements for the award of the degree of masters of public administration of Mzumbe University.

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I**, ERASTO EDWARD,** declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award whatsoever.

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ACKNOWLEDGEMENT

Conducting a research is neither a one day activity nor an ordinary simple task. Indeed it requires commitment, inspiration, guidance, patience and above all determination and absolute trust in God. Likewise, it is very hard to undertake such a study independently without the assistance and support from different people. Therefore I find duly obliged to extend intimate thanks and acknowledge the support given to me by some people, though I find it hard to mention all of them but their contribution will always remain at heart.

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DEDICATION

This piece of work is dedicated to my beloved wife Judith Alexander Kamikazi Minzi, My beloved son Gian Erasto Mhavi and my beloved Mother and Father and the whole family.

LIST OF ABRREVIATIONS

CCBRT	-	Comprehensive Community Based Rehabilitation in Tanzania
MoH	-	Ministry of Health and Social Welfare
PPPs	-	Public Private Partnership

ABSTRACT

The government of Tanzania recognized that it has the role to facilitate the private sector and other economic agents to actively and effectively invest in productive and commercial activities in order to accelerate economic growth and development and this would be achieved through putting favorable policies in place, provision of a conducive environment for local and foreign investment, promotion of institutional changes conducive to the development of the private sector and this trend has seen the emergency of public private partnerships in Tanzania. The general objective of the study was to examine the barriers to effective public private partnerships in the Delivery of health services in Tanzania with a reflection of a public private partnership that exist between the Ministry of Health and Social Welfare with CCBRT Hospital.

The findings of the study have indicated that Public Private Partnerships have an impact in the delivery of health services and this is equivalent to 66.7% and that the partnerships are adopted and implemented through management contracts up to 10.0%, the Public Partnership policy of 2009 guides on the adoption and implementation of public private partnerships to 29.2% and the private partnerships promote reliable source of financing for public health service delivery to 10.0%, Partnerships bring creativity and innovativeness in health service delivery and this is equivalent to 8.3%, partnerships influence satisfaction of customer needs and expectations and this is equivalent to 7.5% and that partnerships influence development of new investment opportunities and this is equivalent to 15.0% they influence maintenance of skilled manpower and this is equivalent to 12.5%.

Therefore in order that the Public private partnerships influence improved delivery of health services, the public and private entities operating or implementing a Public Private Partnership in the delivery of health services should undertake effective training and development of personnel who will have the skills of negotiating the partnerships and who will understand the technical frameworks of the partnerships. Consequently the barrier of weak professionalism will relatively be addressed and the implementation of the partnership frameworks will attain its set goals and objective.

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INTRODUCTION

1.1 Introduction

This chapter provides the background of the problem, the statement of the problem, the general and specific research objectives and the general and specific research questions as well. Further, the chapter gives the rationale of the study, the scope of the study and the limitation of the study.

1.2 Background of the Problem

In today's world of complexity and rapid pace it is almost impossible to do anything alone. This is especially true in health where constantly rising prices, changing disease patterns, and increasing use of sophisticated technology for diagnosis and treatment have made it virtually impossible to imagine any single organization providing services without some type of institutional partnership.

These partnerships may take many forms, ranging from global partnerships between multinational companies and multilateral donors to local partnerships between private physicians and government clinics (Mitchell, 2009). The partners, too, may vary from private for profit companies, not for profit organizations, governments, donor organizations, to community groups. Partnerships may vary in terms of financing from millions of dollars to the sharing of non-financial resources. However, all partnerships have one thing in common: they have come about because both partners believe they have something to gain from the partnership agreement (World Health Organization, 2000)

On part of Tanzania which became a centrally planned economy in 1967 and the government controlled everything. Between the country's independence in 1961 and 1996, the government had created 425 parastatal enterprises (Ngowi, 2010). However, overtime the economy deteriorated; the revenue was low and the production was almost

nil. This situation was particularly notable in 1980s and the vulnerability of parastatal sector became evident. The government had to subsidize heavily the parastatals to keep them operating (Ngowi, 2010). In the fiscal year 1986/87, the government priority was on financial reform for public service delivery since there was very little capital formation and the government needed to create favorable environment and encourage foreign investors to come in Tanzania (Mutahaba and Kiragu, 2002).

The Government of Tanzania had to redefine the role of the state to that of policy making, maintenance of law and order, provider of basic social and economic infrastructure and facilitator of economic growth (Mutahaba and Kiragu, 2002). The government of Tanzania recognized that it has the role to facilitate the private sector and other economic agents to actively and effectively invest in productive and commercial activities in order to accelerate economic growth and development and this would be achieved through putting favorable policies in place, provision of a conducive environment for local and foreign investment, promotion of institutional changes conducive to the development of the private sector (Mutahaba and Kiragu, 2002).

In recognition of this important role towards creating an enabling environment for private sector development, the government of Tanzania has been implementing wide ranging institutional and policy reforms. It has liberalized the economy, amended and enacted a number of investment-related laws and policies, undertaken financial reforms, liberalized its trading regime and this social-economic move saw Tanzania becoming become one of the most liberal investment regimes in Africa.

Additionally, since the public sector has been the main actor in the development process of most countries in Africa and beyond until the mid 1980s. The sector was the main actor in production and distribution of goods and services in most economies, especially those that embraced centrally planned economic policies, like Tanzania (Mushi, 2000). The commanding heights of these economies were directly owned and managed by the

public sector (Mushi, 2000). From the mid 1980s, however, following the winds of change in the form of many and far-reaching social, a political and economic reform, the role of the public sector in the development process has substantially changed in many countries (Mutahaba and Kiragu, 2002). Its role now is mainly that of a facilitator for the private sector-led economic development and growth. The role of the private sector in bringing about sustainable development in most economies has increasingly been recognized and acknowledged given the changing roles of the public and private sectors in the bid to bring about sustainable development in most countries, it is no longer sustainable for the public sector to continue to own, manage and operate the commanding heights of the economy (Mushi, 2000).

Therefore, this trend of having a private sector led economy towards efficient and effective production and distribution of goods and services has influenced the adoption of an arrangement within which the public sector engages the private sector in the delivery of public services and this has been operationalized through the adoption and implementation of the public- private partnerships in Tanzania. This study will therefore examine the effectiveness of public private partnerships in the delivery of health services with a reflection of public Private Partnership that exists between the Ministry of Health and Social Welfare with CCBRT hospital.

1.3 Statement of the Problem

After independence in 1961, Tanzania adopted a nationalistic approach and nationalized all the major means of the economy were nationalized and this was just a notable reform which was taken by the new independent state (Ngowi, 2010). Since the Arusha declaration of 1967 up to the late 1980's, Tanzania experienced a dramatic expansion in the role of the state in all areas of the economy. State enterprises, whether newly created or expropriated from the private sector, were heralded as the driving force of economic growth. Wealth generated by these enterprises was intended to finance better service delivery, which would provide free health care, education and other public services to create a well educated and a healthy socialist utopia (Ngowi, 2010).

However due to massive failures in the nationalization that were undertaken by the government, there was need to redefine the role of the state to that of policy making, maintenance of law and order, provider of basic social and economic infrastructure and facilitator of economic growth (Ngowi, 2010). The government of Tanzania recognized that it has the role to facilitate the private sector and other economic agents to actively and effectively invest in productive and commercial activities in order to accelerate economic growth and development and this would be achieved through putting favorable policies in place, provision of a conducive environment for local and foreign investment, promotion of institutional changes conducive to the development of the private sector and this trend has seen the emergency of public private partnerships in Tanzania (Ngowi, 2010).

Never the less, the mechanisms of improving public health service delivery in Tanzania at the national and municipal levels have not produced substantial outcomes despite the adoption of new public service mechanism including the public private partnership (Nkya, 2000). Therefore this study intends to examine the effectiveness of public private partnerships in relation to public health service delivery in Tanzania with a reflection of a public Private Partnership that exists between the Ministry of Health and Social Welfare with CCBRT hospital through an examination of the role of the Partnerships in the delivery of health services, the barriers faced and the mechanisms of addressing the barriers towards effective implementation of the partnerships and delivery of improved health services in Tanzania.

1.4 Objectives of the study

1.4.1 General Objectives

The general objective of the study was to examine the effectiveness of public private partnerships in the delivery of health services in Tanzania.

1.4.2 Specific Objectives of the study

The study was based on the following specific objectives.

i) To examine the role of public private partnership arrangements in the delivery of health services in Tanzania.

ii) To determine and identify the barriers faced in the effective implementation of the Public Private Partnerships in the delivery of health services in Tanzania.

iii) To examine possible mechanisms to address the barriers faced in the implementation of public private partnership arrangements in the delivery of health services in Tanzania.

1.5 Research Questions

1.5.1 General Research Question

The general research question of the study what is the effectiveness of public private partnerships in the delivery of health services in Tanzania.

1.5.2 Specific Research Questions

i) The specific research questions of the study were as below;-

What is the role of public private partnership arrangements in the delivery of health services in Tanzania?

ii) What barriers affect the effective implementation of the Public Private Partnerships in the delivery of health services in Tanzania?

iii) What possible mechanisms can address the barriers faced in the implementation of public private partnership arrangements in the delivery of health services in Tanzania?

1.6 Significance of the study

At the organizational level, the study has demonstrated how the public private partnerships can be best operationalzed by the Public and Private entities operating a Public Private Partnership in the delivery of health services in Tanzania. Additionally the study has helped the principal actors of public private partnerships in giving them

key insights on how to assist to make proper decisions on partnerships and determine which proper public partnership model is suitable for Public service delivery.

The study has also increased the knowledge of the researcher through understanding at wide the effectiveness of public private partnerships in enduring qualitative services at the CCBRT. Consequently the study has indicated and suggested the best alternatives within which CCBRT and the Ministry of Health and Social Welfare can maximize benefits from the public private partnerships in relation to widening the scope of health service provision and meet the service expectation of their customers.

The study has also helped other researchers to identify viable areas for further study since the study is used as an additional reference in examining the effectiveness of public partnerships in the delivery of health services.

The study also serves as a partial fulfillment of the requirements for the Award of the Masters degree of Public Administration of Mzumbe University.

1.7 Scope of the study

The study mainly focused on the effectiveness of Public Private Partnerships in the delivery of health services in Tanzania with a reflection of reflection of the a reflection of public Private Partnership that exists between the Ministry of Health and Social Welfare with CCBRT hospital. The study findings of the study can as well be substantially generalized in drawing impact on the effectiveness of the public private partnerships in improving public health service delivery in other public and private hospital under partnership arrangement. Tanzania. Geographically, the study was conducted in Kinondoni District of Dar es Salaam since the researcher resides in Dar es Salaam and he is familiar with the operations of the CCBRT and there was a high possibility of accessing the relevant information from the two institutions.

1.8 Limitations of the study

In the process of the study, the researcher experienced limitations especially from the respondents during the data collection process. The limitations faced included, lack of cooperation among some respondents who gave interview appointments and they failed to timely meet them and a few respondents failed to return the questionnaires to the researcher. These limitations affected the time schedules of the researcher in collecting data and from involving a relatively bigger number of respondents in the study process. Other limitations faced included financial constraints as well.

CHAPTER TWO
LITREATURE REVIEW

2.1 Introduction

This chapter gives an overview on public private partnerships, describes the functioning of the public private partnership, the management system techniques for public private partnerships, merits and limitations of public private partnerships and the relevant theories to the study. Further, the chapter indicates the opertionalization of Public Private Partnerships in the health sector in the Tanzania context, demonstrates the empirical literature review and the conceptual framework for the study.

2.2 Over view on public private partnerships

The term PPPs has been defined as the cooperation between public-private actors in which they jointly develop products and services and share risks, costs and resources which are connected with these products and services (Bovaird, 2010). Similarly, a public-private partnership (PPP) is a term used to describe a government- sponsored initiative or scheme which involves the use of private finance to facilitate the provision of services to the public and/or the delivery of social infrastructure assets. PPPs have been used to deliver infrastructure assets in the education, transport, and health sectors (Bovaird, 2010).

Some of the fundamental rationales for PPPs is that PPPs enable the public sector to harness the expertise and efficiencies that the private sector can bring to the delivery of certain facilities and services traditionally procured and delivered by the public sector, a PPP is structured so that the public sector body seeking to make a capital investment does not incur any borrowing. Rather, the PPP borrowing is incurred by the private sector vehicle implementing the project and therefore, from the public sector's perspective, a PPP is described as an off-balance sheet" method of financing the delivery of new or refurbished public sector assets and services (Bovaird, 2010).

The Public-Private Partnership (PPP) is collaboration between the public and private sectors, aimed at the implementation of projects or provision of services traditionally provided by the public sector. This cooperation is based on the assumption that each party is able to implement its own tasks that were entrusted thereto, more efficiently than the other party. In this way, the parties complement each other, dealing under PPP, right with that part of the common task they perform best. With the division of tasks, responsibilities and risks, under PPP, the most cost-effective way to create the infrastructure and delivery of public service are achieved (Buse and Walt, 2000).

The origin of PPPs is attributed to the pressure to change the standard model of public procurement which arose initially from concerns about the level of public debt, which grew rapidly during the macroeconomic dislocation of the 1970s and 1980s. Governments sought to encourage private investment in infrastructure, initially on the basis of accounting fallacies arising from the fact that public accounts did not distinguish between recurrent and capital expenditures (Buse and Walt, 2000).

The idea that private provision of infrastructure represented a way of providing infrastructure at no cost to the public has now been generally abandoned; however, interest in alternatives to the standard model of public procurement persisted (Buse and Walt, 2000). In particular, it has been argued that models involving an enhanced role for the private sector, with a single private-sector organization taking responsibility for most aspects of service provisions for a given project, could yield an improved allocation of risk, while maintaining public accountability for essential aspects of service provision. Initially, most public–private partnerships were negotiated individually, as one-off deals, and much of this activity began in the early 1990 (Buse and Walt, 2000).

2.2.1 Functioning of the private public partnerships

A public private partnership being an a contractual arrangement between the Public and the Private sector that targets improving the delivery of services through financing and

reduced operational cost works or operates through the basic fundamentals. The private partnership operational fundamentals include the following;-

The bidding process:- A public sector entity, usually a central government body/local authority like Ministry of Health and Social Welfare identifies the need to deliver a particular project, such as construction and delivery of health services. The public entity will advertise the need for such a project and then run a competitive process under which private sector entities will bid in order to win the right to deliver the project. The winning private sector bidder is then awarded a concession to implement its solution (Grimsey and Lewis, 2004).

The project company;- A private sector entity will contract with the public entity and raise funds from investors and lenders in order to deliver the project company. Usually, a new, separate, private company will be set up to be the project company in order to insulate the private sector sponsors of the project from the risk of insolvency if the project fails. This new company is known as a special purpose vehicle (Grimsey and Lewis, 2004).

The Sponsor; - The activities of the project company will be managed by one or more private sector companies known as the sponsor. Typically, the project company is set up as a direct/indirect subsidiary of the sponsor. The sponsors are usually the equity investment divisions of large construction or facilities management companies who want their construction or facilities management divisions to deliver the project. This arrangement will be documented in a shareholders' agreement (Grimsey and Lewis, 2004).

Documentation; - The project company will enter into a contract with the public sector, called the concession Agreement. This is the key document detailing the terms and conditions of the project.

Contractors; - The project company will enter into contracts to enable it to implement the project as well. There will usually be one entity that is made responsible for the delivery of the facilities management services detailed in the concession agreement and another entity that is made responsible for the provision of the construction works detailed in the concession agreement that is the construction contractor (Grimsey and Lewis, 2004). Certain responsibilities may be sub-contracted to other more specialist entities the sub- contractors

Funding;- The project company will obtain private funding in order to finance the PPP. Usually, funds are made up of a mix of investments by sponsors, usually a small proportion of the overall debt and loans from outside lenders. The lenders will enter into financing agreements" and security agreements with the project company, under which they agree to lend in return for security over the project. There will often also be direct agreements (Grimsey and Lewis, 2004).

The Project finance is provided on the strength of the cash flows of the project company. The payments made by the public sector entity are the sole income stream into the project company so if the concession agreement is terminated, the project company will have no means of repaying its debts (Grimsey and Lewis, 2004). If a project starts to go wrong and the project company's right to deliver the contract is in danger of being terminated by the public sector entity then lenders can rely on direct agreements to prevent the concession agreement from being terminated until the lenders have had a chance to step in to the project company's shoes and attempt to remedy the situation (Grimsey and Lewis, 2004). Therefore the operationalization of a PPP projects reflects the above indicated fundamentals.

2.2.2 The management systems techniques for Public Private Partnerships

The Public -Private Partnership (PPP) is, conceptually collaboration between public and private sector organizations in public service delivery (Sohail, 2003). According to

Gildman et al, (1995), there are four groups of actors in PPPs and these include the government, non-governmental organizations (NGOs). Community Based Organizations (CBOs) and the private sector. Additionally, Gildman et al, (1995) provides various PPPs management systems and techniques and they include the following;-

Contracting Out: - This is the placing of a contract by a public agency to an external private company (Jeffares et all, 2009).

Franchising/Concession: - A private partnership takes over responsibility for operating a service and collecting charges and possibly for funding new investments in fixed assets.

Affermage; - Public authority controls construction and owns the fixed assets but contracts out operations, maintenance and collecting service charges (Jeffares et all, 2009).

Leasing: - Making use of equipment/assets without purchasing but paying a lease.

Privatization:- Public service is entirely sold to a private partner (Jeffares et all, 2009).

Management contract: - Private organization takes over responsibility for managing a service to specified standard by using staff, equipment etc, of public authority.

Build Own and Operate (BOO):- Partnership between public and private sectors whereby the private firm may build, own and operate the asset/service (Jeffares et all, 2009).

Build Operate and Transfer (BOT): -Under here the asset/service will be transferred to the public sector after a period of time (Jeffares et all, 2009).

Management Buyout (MBO):- The management of well run internal functions negotiates the purchase of that function and becomes a private venture.

Co-operatives:- Self governing voluntary organizations designed to serve the interest of their members, working in partnership with public authorities (Jeffares et all, 2009).

2.2.3 Merits and Limitations of Public Private Partnership

Public-private partnership describes a relationship in which public and private resources are blended to achieve a goal or set of goals judged to be mutually beneficial both to the private entity and to the public. The term has gained prominence as its importance has become more significant over time (Peter, 2000). PPPs are associated with some benefits. One of the benefits of PPPs is that the investment decisions under PPP contracts tend to be based on a long-term view rather than short-term concerns, the risk and work are transferred to the party which is best able to manage it at the least cost, achieving best value, PPP projects go through a competitive pricing process, meaning that the cost of public services is benchmarked against market standards, the timings and costing tend to be more certain and therefore deliver better value for money (Peter, 2000).

Similarly, PPPs influence a cross-transfer of public and private sector skills, knowledge and expertise can create innovation and efficiency, the private sector often brings with it greater construction capacity, labour capacity and resources than would be available to the public sector, payments to the private sector in PPP projects are usually linked to how they perform, creating incentives and efficiency and that PPP projects are not subject to political interference and deferred payments for the government (Peter, 2000). However, the PPPs are also associated with some demerits and these include, the number of parties involved and the long-term nature of their relationships often result in complicated contracts and complex negotiations, and therefore high transaction and legal costs (Peter, 2000).

Additionally, PPP projects can take years to complete, There is a risk that the private sector party will become insolvent or make large profits during the course of the project and this can cause political problems for the public entity, the long-term nature of a PPP project means that debt is incurred long before the benefits appear, Sometimes a public sector entity could borrow more cheaply alone than it could via the private sector (Peter, 2000). This has to be balanced against the fact that capital expenditure incurred by a public sector body counts as government expenditure which at certain stages of the economic cycle will score against the various statistical measures of government borrowing (Peter, 2000).

Moreover, there is a significant lack of expertise within governments to design, develop, finance and implement such projects. PPPs are complex to do and require a new set of skills, which typically are found in the private not the public sector. The implications for the private sector of weakness in the public sector include excessive bid costs, increased risks and delays. For the public sector, lack of capacity to procure PPP projects effectively has resulted in ill-conceived projects, termination of projects and eventual public disillusion. Governments can, however, employ better project management skills with the appropriate assistance.

2.3 Relevant theories to the study

2.3.1 Market failure theory

The market failure theory is taken mean a situation when the freely-functioning markets, fail to deliver an efficient allocation of resources. The result is a loss of economic and social welfare and economic inefficiencies in the delivery of social and economic services. Market failure exists when the competitive outcome of markets is not efficient from the point of view of society as a whole (Cowen, 1988). This situation is usually because the benefits that the markets confer through the forces of demand and supply on individuals or businesses carrying out a particular activity diverge from the benefits of the society as a whole**.** The indicators of market failure include, negative externalities,

monopolistic competitions, none provision of public goods and services and high price levels on goods and services (Cowen, 1988).

2.3.2 Government failure

This theory connotes an economic situation where the government through its bureaucratic agencies and institutions fail to efficiently allocate resources in an economy at a given period of time. Government failure is a result of poor planning, under utilization of resources, donor dependence syndrome, failure to protect local industries and bad governance (Akerlof, 1970) The prime indicators that the government has failed include, inflation, high budget deficits, poverty, high levels of un employment, low levels of industrialization, economic regional imbalances and poor social and economic service delivery**.**

2.3.3 The transaction cost theory

It emphasizes that contracts and partnerships should account for both personal and social expenses while reaching a contract and further connotes that the process of contracting could be costly because it includes cost of structuring, bonding, monitoring, negotiation and residual loss due to principal agent problem (Palmer, 2009).

2.3.4 The evolutionary theory

Under this theory, the ideology of partnership in the delivery of public services is all about efficiency and prudent utilization of available resources, which is aims at plummeting replication in the overhead expenses. The exchange and dependency theory, highlight on integrating disjointed policy landscape (Palmer, 2009). Others viewed PPP as a mechanism for management, financial arrangement and development. To others, a PPP framework PPP is just a language gimmick because it is privatization in another way (Palmer, 2009).

2.4 Public Private Partnerships in the Health sector: Tanzania Perspective

In the Tanzania context, Public Private Partnership (PPP) as a catchy phenomenon has been used differently by different scholars and gained momentum in the 1990s. Scholars share a common understanding of PPP as collaboration between the public and private sector organizations where there is pooling together of resources such as financial, human and technical resources including sharing information from public and private sources to achieve a commonly agreed social goal. However, the formality or informality of partnerships is not considered as important as the end in itself. For the purposes of simplicity, the term is used to signify collaboration, participation, and partnership interchangeably with the aim of delivering public services. For instance, the former president of the Republic of Tanzania had this to say on partnerships;-

"...My Government is determined to create such effective and efficient public service that will be relevant to the changing needs and times. To succeed, we call for the full cooperation and support of all stakeholders in a spirit of genuine partnership between Government and the Private sector to promote competitive growth, job creation and enhancement of national wealth..."(Mkapa, 2000).

In the past 20 years, the notion of public service provision has undergone a radical revision, ultimately strengthened by a shift towards the view of the state as a regulator and purchaser rather than purely a provider of services. Various provision forms have been adopted: in-house production; outsourcing to other public administrations; contracting out of peripheral, intermediate, or final services to private providers; public-private partnerships (PPPs) and full privatization. It is now common in Tanzanian knowledge that, the private sector, the government and the community can all gain from PPP if there are genuine concerted efforts to work together (Itika, 2007).

Citizens as part of the key stakeholders under PPPs have a genuine stake in making health services accessible, affordable, and reliable and of good quality. The government

may gain through enhanced capacity to deliver health services to citizens while NGOs will also improve capacity to deliver and achieve value for money. The private sector will improve capacity if it assumes that there are skills and resources that will benefit from public sector services, such as commercial incentive increased efficiency, and focus on customer requirements. The demand for PPP calls for innovative approaches and provision of regulatory frameworks that have direct links with the private sector.

In 2000, the Ministry of Health (MoH, 2000) developed key performance indicators and outputs for assessing public private partnership in health service delivery in the country. The indicators are the degree of collaboration among partners in terms of numbers, the contribution of the private and public sector in partnerships and client satisfaction rate. The performance of PPPs was expected to be in the form of implementation strategies and timeframes. Policy and legal review was to be completed by 2001; mechanisms for promoting PPP discipline were to be in place by 2002. Guidelines to private providers to enable them qualify for government support, and mechanisms for joint inspection of health facilities and employees was to be in place by 2002 (MoH, 2000).

Therefore, the position that PPP is the best policy, strategy and a collaborative mechanism for the improvement of health service delivery in Tanzania is no longer an area of controversy. The current debate is how to make PPPs work for maximum benefits of all stakeholders. The most comprehensive study on PPP in health service delivery, commissioned by the Ministry of Health and Presidents' Office Regional Administration and Local Government (MoH/PORALG, 2005), and Tanzania Joint Annual Review (MoH, 2005), observed that despite the good intention of key stakeholders to strengthen PPPs in the health sector, there were still strong dissatisfactions in many areas. These include regulatory framework, coordination, financial support, stakeholders' commitment, human resource capacity and utilization, access to essential drugs, tax relief and adherence to professionalism.

2.5 Over view of the National Private partnership Policy (2009)

The National Public Private Partnership Policy, endorsed in November 2009, confirms the Government's commitment to collaborate with private stakeholders by setting out a regulatory and institutional framework conducive for the policy's implementation. It focuses on putting in place a collaborative mechanism to ensure implementation through win-win strategies for the public and private sectors and other stakeholders involved in PPP.

It addresses constraints and challenges that have prevented the beneficial use of public-private health sector collaboration in terms of financial, human, and technological resources to deliver health and social welfare services. The National PPP Policy identifies PPP as a viable means to effectively address constraints of financing, managing and maintaining public goods and services. Additionally, it acknowledges that PPPs can enable the government to fulfill its responsibility of ensuring the efficient delivery of socio-economic goods and services; by ensuring efficiency, effectiveness, accountability, quality and the outreach of services.

Most PPPs implemented in Tanzania so far have been concessional arrangements for running existing enterprises, with limited provisions for rehabilitation and new investments. Notably, such PPPs have been successfully implemented by Faith-Based Organizations (FBOs) in the education, health and water sectors for many years. The National PPP Policy advances that the participation in PPPs may take place in both productive and socio-economic service sectors including, but not limited to: Agriculture, Infrastructure, Manufacturing, Education, Health, Natural Resources, Tourism, Energy, Mining, Water, Land development, Environment and Solid Waste Management, appropriate Defence Infrastructure, Sports, Communication, Information and Communication Technology (ICT), Trade, Entertainment and Recreation and Irrigation.

The Government, in collaboration with other stakeholders, will develop an Implementation Framework that will includes and provides for the enactment of the new legislation, review of related legislation, and adoption of appropriate regulations and operational guidelines. The scope of the implementation framework will include five key components:

An implementation strategy which defines and gives details on activities to be implemented over a time-frame of an initial five year period, functions and responsibilities of implementing institutions and resource requirements.

An institutional framework for implementation including the PPP Coordination Unit under the Ministry responsible for investment and private sector development, PPP Finance Unit under the Ministry responsible for finance and PPP Managers in implementing Ministries, Departments and Agencies (MDAs). Clear linkages amongst the PPP Units, Project Managers in the implementing Ministries and appropriate bodies at the Local Government will be observed.

Legislation to be reviewed and enacted to support implementation of PPPs and the provision for specific regulations and operational guidelines including:

i) Formulation, Appraisal, Approval and Negotiation of PPPs
ii) Enabling Environment for PPPs
iii) PPP technical committees such as transaction advisors
iv) Sources of finance for PPPs
v) Tendering procedures for both solicited and unsolicited bids
vi) Risk management;
vii) Monitoring and Evaluation of PPPs
viii) Public Accountability and Reporting requirements and
ix) PPPs Investors' guide

The Communication Strategy for sensitization and raising awareness of the general public, beneficiaries and other stakeholders. And regarding the identification of potential PPPs, the National PPP Policy mentions that PPPs can be initiated by Government MDAs, the private sector, individuals and non-state actors.

Additionally, the regulatory framework as exemplified by the Public Private Partnership Act No. 18 of 2010 and the accompanying Public Private Partnership Regulations of 2011 will encourage review of existing legislations as well as adoption of regulations and operational guidelines. These legal documents provide for the institutional framework for the implementation of public private partnership agreements between public sector and private sector entities. They also set out rules, guidelines and procedures governing public private partnership development, procurement, implementation, and other related matters.

2.6 National policies and Programs in support of Health Public Private Partnership Arrangements in Tanzania

The Government has a number of enabling policies and strategies to strengthen health and social welfare services in Tanzania. These policies and strategies target both national and international commitments, such as the Millennium Development Goals. Summary of main health and social welfare related policy and strategies as follows;

i) The National Development Vision 2025: this policy influences supporting and stimulating various actors participating in economic growth by encouraging the private sector to undertake investments in socio-economic goods and services. One of its objectives is the achievement of high quality livelihood for all Tanzanians through public health interventions and primary health services.

ii) National Strategy for Growth and Poverty Reduction (MKUKUTA) **2010:** The strategy recognizes the health sector as a key factor in economic development, with the ultimate goal being improved quality of life and social well being.

iii) The National Health Policy 2007: the Policy aims at implementing national and international commitments and seeks to facilitate the provision of basic health services, which are proportional, equitable, of good quality, affordable, sustainable and gender sensitive. It goes further to suggest that, public private partnership projects are to be promoted for the delivery of reliable and affordable socio-economic services.

iv) The Health Sector Reform Program: The program aims at improving the health sector in terms of provision of quality health services through strategies including PPP.

v) The Health Sector Strategic Plan 2009-2015 (HSSP III): The plan focuses on "Partnership for delivering the Millennium Development Goals". As a key guiding reference document for the health and social welfare sector, it mentions that its overall focus will be on partnership. The sixth of its eleven specific strategies, is 'to continue mainstreaming Public Private Partnerships at all levels' and proposes three key strategies, that is; ensuring conducive policy and legal environment for management of PPPs and ensuring effective operationalization of PPPs and; 3) enhancing PPPs in the provision of health and social welfare services. The HSSP III mentions that PPP is key to achieving increased accessibility and quality of health and social welfare services. The HSSP III states that PPP framework will be installed at national, regional and district levels, and that service agreements will be used in all Local Government Authorities to contract private providers for service delivery. Private training institutions will also be increasingly involved in production of human resources for health (HRH), based on their specific competencies.

2.7 Empirical Literature Review

With the review of the relevant theories, most of the literature reviewed has demonstrated on the benefits of the public private partnerships in the social development context, on challenges in the assessment of public private partnerships, in terms of improving governance at the local levels of municipalities and the implications of public private partnerships in the delivery of health services in Tanzania. A study conducted

Boardman, (2010), by assessing the economic worth of Public private Partnerships in the social development discourse.

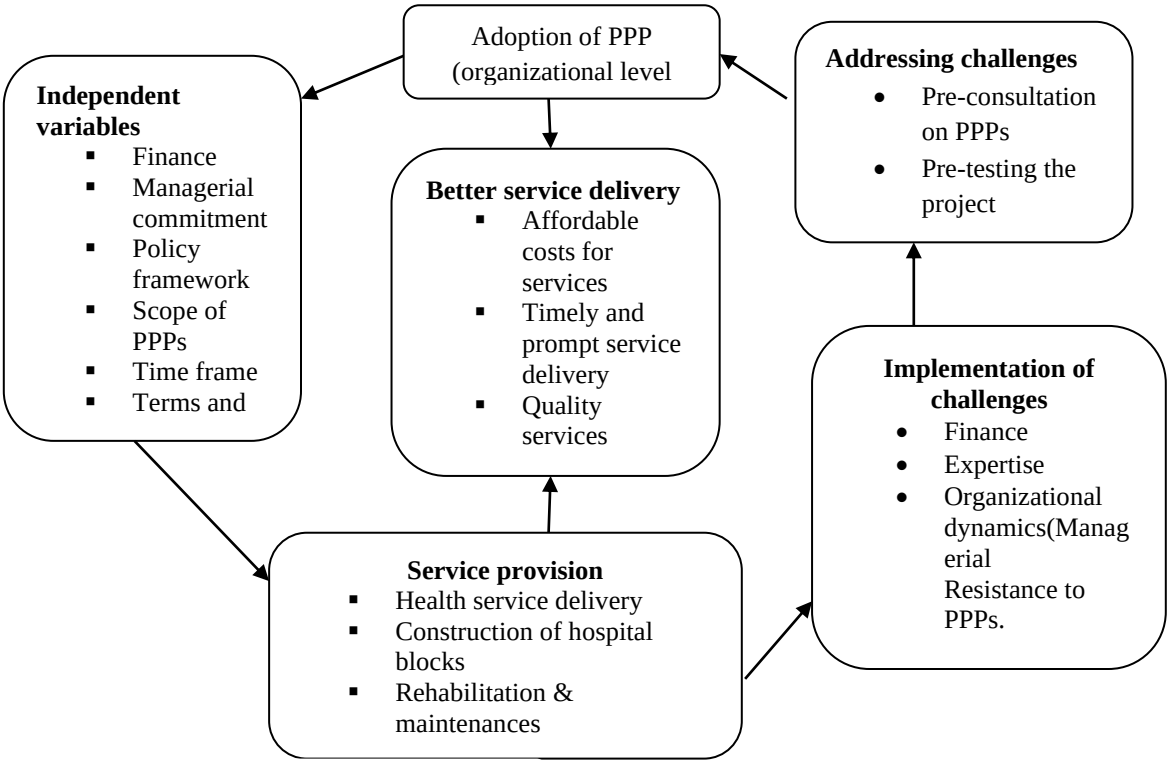
The findings of the study indicated that the PPPs in the modern world have produced a substantive change in the delivery of social public services and this is largely influenced by raising capital and finance between the partnership actors the delivery a specified social service. Additionally a study conducted by Tony, (2009) on the Challenge of evaluating the performance(s) of Public-Private Partnerships, the findings indicated that in some projects under taken under PPPs, there are many limitations to the effect that the intended PPP projects are not achieved this is largely due to financial constraints and commitment from both parties though sometimes it a result of a decline in the interests under the project.

Another study conducted by Nkya (2004) on public-private partnership in relation to constrained Improvement of Solid Waste Management in Dar es Salaam, the findings indicated that almost 68% of the waste management activities in Dar e salaam are a result of PPPs and this has brought relatively substantial progress in the waste management at the Municipal levels in Dar es Salaam. Further a study conducted by Kessy and Itika, (2011) on Public-Private Partnership in Health Service Delivery indicated that the adoption of PPPs in the health sector have improved the delivery of health services in Tanzania despite of some challenges on policy framework, expertise and implementation mechanisms that are still weak. However, little has been examined on their effectiveness in relation to health services and this establishes a study gap and this is why this study has examined the effectiveness the public private partnerships in relation to the delivery of public health services with a reflection of public Private Partnership that exists between the Ministry of Health and Social Welfare with CCBRT hospital.

2.8 Conceptual framework

The assumption of this conceptual framework is to draw the relationship between the independent variables and the dependent variables. In this study, Public Private Partnerships is the independent variable and the delivery of health services is the dependent variable. The Independent variables upon which the PPPs can be adopted at the organizational level in the study is through a consideration of the financial capacity of the public and the private entity entering into partnership for public service delivery. Other important variables include managerial awareness on PPPs, policy frameworks, time scales and the terms and conditions of the PPP arrangement. In order that these factors drive the PPP arrangement in ensuring that good quality services are provided, the organization has to take into account the problems it faces and accordingly identify the mechanism within which they can be addressed for instance through pre-consultations on which model can yield effective delivery of health services. In case better services are to be provided in terms quality and prompt delivery the challenges faced in the implementation of the PPP model should be addressed.

Figure 2.1The Conceptual mode



Source: Developed by Erasto, (2014)

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter gives a description of how the study was conducted and it describes the research design used, the research variables determined, the location of the study, study population, the sample size and sampling procedures used, the sources of data and the data collection tools or instruments. It also addresses issues of validity and reliability of the instruments of data collection used and the research ethics that guided the researcher when gathering information from respondents. Finally, the chapter indicates how data was analyzed.

3.2 Research Design

A research design as a detailed blue print used to guide a research study towards its objectives. And basing on this definition a research design is a detailed plan of work to be done to achieve the research objectives (Adam and Kamuzora, 2008). A research design according to Kothari, C. R. (2004) is taken to mean a blue print for the collections, measurement and analysis of data.

The exploratory research design was used in the study. This research design involved a study of an unfamiliar problem about which the researcher has little knowledge. The rationale for adopting this research design was the interests of the researcher to generate new ideas, increasing the researcher's familiarity with the problem and to gather information for clarifying key concepts in the study. Additionally, the research design used involved the use of both qualitative and quantitative data which was collected from primary and secondary sources of data. In the course of the study, the data was collected through questionnaires, interviews and documentary review. The collected data was analyzed qualitatively through arrangement into categories and coding of the data as well. The coding scheme defined data themes and segments or sections and this was

done through importing and numbering of data files. The data was further analyzed by making connections to research questions, drawing interpretations based on findings and by using the statistical package for social science research.

3.3 Research Variables

According to Adam & Kamuzora, (2008), a research variable is defined as a factor or a characteristic of interest that a researcher would like to handle, observe, investigate or manipulate in the research process so as to establish relationships between the variables. This study has indicated how the independent variables interact with the dependent variables in showing the effectiveness of the Public private partnerships in Tanzania with a reflection of a partnership arrangement that exists between the Ministry of health and social welfare and CCBRT Hospital. In this study, public Private Partnership is an independent variable while provision or delivery of health services is a dependent variable.

3.4 Location of the Study/Study Area

The location of the study geographically was in kinondoni Municipality, Dar es Salaam region. This was because CCBRT hospital is located within Kinondoni, Dar es Salaam. Further, the researcher leaves in Dar es Salaam and had interest in drawing a sample size mainly from the CCBRT hospital managers, officers and other employees in relation to examining the effectiveness of public private partnerships in the delivery of health services in Tanzania.

3.5 Population of the Study

A study population refers to the totality of all respondents, items or groups from which data is t be collected or items under investigation (Adam & Kamuzora, 2008). The study population, items and entities from which findings were drawn and generalized included the health workers at the Ministry of health and social welfare, the managerial workers at CCBRT and all its subordinate employees. In the study process, the researcher

physically visited the Ministry of Health and social Welfare and CCBRT hospital and conducted interviews with them in relation to the effectiveness of public private partnerships in the delivery of health services in Tanzania.

3.6 Sampling Techniques and Procedures

In the course of the study, the researcher used the non-probability sampling in the sampling process to obtain information or the relevant data from the study population This is justified by the fact that this type of sampling does not provide any basis for estimating on the probability that each item or entity in the study population has a chance of being included in the sample size.

Similarly, in the process of the study, the researcher was guided by the accidental or convenience sampling on the availability and willingness of the respondents in the study population to fully and collaboratively participate in the study.

Further, the researcher used the snowball sampling type (Adam and Kamuzora, 2008), as a supplement in the sampling process and this helped the researcher to allocate and identify respondents who had relevant data through those who have been already identified and interviewed by the researcher in regard to the research problem and the selection criteria considered variables like, knowledge or awareness on public Private Partnerships in the delivery of health services and the credibility of their information and the willingness to cooperate in the study process.

3.6.1 Sampling Frame

A Sampling frame is the complete list of all objects or elements in the population from which the sample is drawn (Adam & Kamuzora, 2008). The sampling frame of the study was mainly drawn from the target population of mainly the health workers at the Ministry of Health and social welfare and those from the CCBRT hospital.

3.6.2 Sample Size

A sampling frame is the exact number of items selected from a population to constitute a sample (Adam & Kamuzora, 2008). In the course of the study, the sample size was drawn as indicated in figure

Table 3.1: MoH, Planning and Policy Department and CCBRT

Sampling frame	Total Number	Sample size	Sample size in %
Health workers(Planning and Policy department, MoH& Social Welfare	35	15	42.9%
Managers/Administrators(CCBRT Hospital)	26	15	57.7%
Health Workers(CCBRT Hospital)	More than 200	90	0.45%

Source: MoH, Planning and Policy Department and CCBRT, Hospital (2012)

The Sample size selected as indicated above indicates that, 15 respondents were selected from the Ministry of Health and Social Welfare Policy and Planning Commission, 15 respondents were selected from the Managers/Administrators of (CCBRT Hospital and only 90 respondents from the Health Workers (CCBRT Hospital). This therefore made the total number of respondents who formed up the sample size of the study to be 120 respondents.

3.7 Data Type and Sources

Sources of data refer to bases or sources from which primary and secondary data is collected (Kumar, 2010). In the course of the study, the researcher used and relied on qualitative and quantitative data in order to examine the role of Public Private Partnerships in the delivery of health services in Tanzania.

As for the primary data, the researcher collected it by using primary data collection tools and as for secondary data; the information collected including raw data, the published/unpublished ones. The key sources for secondary data were literature sources

including, textbooks, research reports/dissertations, journals, annual reports, public policies and laws and secondary data was relevant to the study because it required little time and costs and it broadened the data base from which generalizations were made as it is always permanent.

3.8 Data Collection Methods

In the course of the study, the researcher used the following data collection methods;-

3.8.1 Interviews

An interview refers to a process by which the researcher engages a respondent in oral questioning with aim of gathering information on a problem under study (Adam & Kamuzora, 2008). In the process of data collection, the interview method of data collection was used and the method involved direct contact between the researcher and the respondents and the researcher fully engaged the respondents in oral questioning and discussion and the interview was solely reflecting the research questions and objectives. The researcher largely conduct self-administered interviews because they were flexible, involved a high response rate, and have a wide coverage, control of the interview situation and completeness (Adam and Kamuzora, 2008).

3.8.2 Documentary Review

Documentary review refers to a process by which the researcher reads and reviews the published literatures with the aim of extracting out the literatures relevant to the problem under study (Kumar, 2010). This method of data collection was used and especially in the collection of secondary data. In reflection of the study, the purpose of using this method aimed at reading and analyzing various publications, reports, papers, journals, dissertations, annual reports and policies in relation to the effectiveness of Public Private Partnerships in the delivery of health services in Tanzania. The underlying objective of documentary review was to identify any areas of relevancy to the topic of study in

relation to the implementation of public Private Partnerships and the delivery of health services in Tanzania.

3.9 Data Collection Instruments

In the course of the study, the researcher used the following data collection instruments;-

3.9.1 Questionnaires

A questionnaire is defined as a series of questions, each one providing a number of alternative answers from which the respondents can choose (Adam & Kamuzora, 2008). In the course of the study and in the data collection process, this instrument of data collection was used and it involved an administration of a written set of structured questions and each one providing a number of alternative answers. The researcher administered and distributed questionnaires to the selected respondents and the structured questions in the questionnaires were reflecting the research objectives as well as the research questions. Further, the researcher used some open ended questions in the questionnaires in the collection of primary data and in most cases, the researcher used self-administered questionnaires and in a few instances, mailed questionnaires were used accordingly.

3.10 Validity and Reliability

The data collection methods and tools used in the course of this study and in the data collection process were tested as to both their validity and reliability and this was justified in reflection of the nature of the study and the size of the sample size and the nature of the Respondents. The degree of reliability and validity of the data collection methods and tools helped the researcher to identify issues that were not clarified in the questionnaires. This was clarified in the interview processes in relation to the effectiveness in the implementation of public Private Partnerships and the delivery of health services in Tanzania.

The validity and reliability of the data collection methods used was tested as to whether they were valid and reliable in collecting data on the role of Public Private Partnerships in the delivery of health services, the barriers faced in the implementation of the partnerships in relation to service delivery and assessing the mechanism to address the barriers towards delivery of improved health services. Further depending on the nature of the study, the most anticipated valid and reliable data collection methods were interviews and documentation reviews and questionnaires because of the data collected through them was easily clarified.

3.11 Research Ethics

Research ethics can be taken to refer to standard behaviour and attitudes or a composition of values that a research observes while dealing with or gathering information from the respondents (Kumar, 2010). In the course of the study, the researcher observed research ethics and all the respondents were given the opportunity to know their rights and obligations as respondents and the researcher communicated to them the purpose of the study and why data was being collected from them. In the entire process of the study, important research ethics including but not limited to, confidentiality, anonymity, time management and confidentiality were rightly observed by the researcher.

3.12 Data Analysis

Data analysis refers to the computation of certain measures along with searching for partners of the relationship that exists among data groups (Kothari, 2004). Data analysis also involved cleaning or processing and mining data. In the course of the study and before data analysis, the raw data collected from the fled was processed. The researcher collected both qualitative and quantitative data in the study process.

Qualitative data is concerned with data which describes meaning, rather than with drawing statistical inferences and qualitative methods for instance, what interviews lose

on reliability they gain it in terms of validity since they provide a more depth and rich description. Qualitative data can be arranged into categories that are not numerical. These categories can be physical traits, gender, colors or anything that do not have a number associated to it. Qualitative data is sometimes referred to as categorical data. The qualitative process of data analysis is an inductive one, in which the data was examined from a "bottom-up" approach (Kothari, 2004). The specific data was examined to identify more general themes that were used to understand the meaning of the data. The data to be collected was analyzed through qualitative process of breaking it up, separating, or disassembling of research materials into pieces, parts, elements, or units and the facts broken down into manageable pieces, through;-

Central Editing; - Data editing refers to a process of identifying mistakes, spelling errors, incorrect information and omissions in the raw data collected (Adam and Kamuzora, 2008). The underlying objective of data editing was is to secure quality standard of the data and it entailed making necessary corrections in the interview and questionnaire information. In the course of the study, the researcher edited the information collected from the field through the central data editing process and errors in the data were be accordingly rectified.

Coding: The initial coding of data involved representing and noticing new things in the collected data and this meant that the researcher read the original data files many times and it involved creation of a coding scheme and then coding the data. This further involved creating a coding scheme that best defined the themes that were identified and provided a way to break up the data for further analysis. The codes were used to identify the specific sections for instance, of the interview data that represented the category. The data coding process lead to revisions in the coding scheme and the data was analyzed by noticing new things in the data through importing and numbering data files, coding data files and searching for coded segments in the data (Dooley, 2003).

Making Connections to the Research Questions; this technique involved describing and further developing the themes from the data to answer the major research questions. The themes identified were revisited with the major research questions as the lens for analysis of data and this was applied to each research question and the data collected on it.

Interpreting Findings; Once the data was collected and it was coded, the data was then divided into themes. This was done by cutting up the interview data "blocks" and sorting them into each of the codes. This involved making multiple copies of the transcripts to limit data being placed into more than one category and it is important to keep the original information in its entirety. The data was then reviewed within the themes or categories, and an understanding of each theme will be reached.

As for quantitative data analysis which entails the development of certain indices from the raw data and processing of generalization by running various tests of significance for testing research objectives in order to draw inferences.(Adam and Kamuzora, 2008). The inferences drawn from the collected data become bases for drawing conclusions after analysis of the quantitative data. The Quantitative data collected was analyzed mainly by using the statistical package for social sciences (SPSS).

Therefore, this chapter has indicated the research design used the type of data collected, the data collection methods and instruments, the sample side adopted and how the data collected was analyzed in relation to the research questions and objectives.

CHAPTER FOUR
PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents the study findings, their analysis and their discussion. The chapter is composed of four major sections; the first section presents on demographics or characteristics of the respondents. The second section presents findings and discussion on the role of public private partnerships in the delivery of health services in Tanzania, the third section presents findings and discussion on the barriers that affect the effective implementation of public private partnerships in the delivery of health services in Tanzania and the fourth section presents findings on the mechanisms and strategies for which the barriers can be addressed towards effective implementation of public private partnerships in the delivery of health services in Tanzania.

The general objective of the study was to examine the barriers to effective public private partnerships in the Delivery of health services in Tanzania with a reflection of a public private partnership that exist between the Ministry of Health and Social Welfare with CCBRT Hospital. Further, the study was carried out basing on research questions which included determining, what role do public private partnerships play in the delivery of health services in Tanzania, what barriers are faced in the effective implementation of public private partnerships in delivering health services in Tanzania and the determining and what mechanisms or strategies can be used in addressing the barriers faced in the delivery of health services in Tanzania. The presentation and findings and there discussion in this chapter reflects the research objectives and the research questions as well.

4.2 Demographics of Respondents

In the process of obtaining data from the respondents and describing them, the researcher had interests in knowing the age range of the sampled respondents and their level of education. The following table indicates the demographic variables that the

researcher used in obtaining data and describing the respondents 4who participated in the study.

Table 4.1 Age Cohorts for the Sampled Respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	25-35 years	45	37.5	37.5	37.5
	35-45 years	39	32.5	32.5	70.0
	45-55 years	25	20.8	20.8	90.8
	55-65 years	11	9.2	9.2	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings in table 4.1 indicate that 45 out of the 120 respondents were between the age of 25-35 years and this is equivalent to 37.5%, 39 out of the 120 respondents were between the age of 35-45 years and this is equivalent to 32.5% while 25 out of the 120 respondents were between the age of 45-55 years of age and this is equivalent to 20.8% as opposed to 11 out of the 120 respondents who were between the age of 55-65 years and this is equivalent to 9.2%.

The above findings reflect that many of the sampled respondents are still within the working age periods and this implies that there is a small retirement gap and the available labour force within the Ministry of Health and social welfare and the employees at the CCBRT can transform the way public private partnerships can enhance improved delivery of health services in Tanzania and this is attributed to the opportunity that the respondent can understand at wide the operationalization of the partnership between the Ministry of Health and Social welfare and the Management of CCBRT hospital.

Additionally, the researcher had interest in knowing the education levels of the 120 respondents who participated in the study and the table below indicates the levels of education for the sampled respondents.

Table 4.2: Respondents Levels of Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary Education	2	1.7	1.7	1.7
	Secondary Education	5	4.2	4.2	5.8
	Certificate level of Education	29	24.2	24.2	30.0
	Diploma level of Education	32	26.7	26.7	56.7
	Degree level of education	40	33.3	33.3	90.0
	Masters Level of Education	9	7.5	7.5	97.5
	Phd Level of Education	3	2.5	2.5	100.0
	Total	120	100.0	100.0	

Source: Field Data, (2014)

The findings in table 4.2 indicate that 2 out of the 120 respondents had attained only primary Level of education and this is equivalent to 1.7%, 5 out of the 120 respondents had attained the secondary level of education and this is equivalent to 4.2% while 29 out of the 120 respondents had attained to the certificate level of education and this is equivalent to 24.2%. Additionally, 32 out of the 120 respondents had attained the diploma level of education and this is equivalent to 26.7% as opposed to 40 out of the 120 respondents who had attained the degree level of education and this is equivalent to 33.3%. Further, 9 out of the 120 samples respondents had attained the masters Level of Education and this is equivalent to 7.5% while only 3 out of the 120 respondents had attained PhDs and this is equivalent to 2.3%.

These findings reflect and imply that the majority of the respondents who participated in the study have the capacity the capacity of understanding the role of public private partnerships in the delivery of health services in Tanzania. However this can be attained only when they are effectively engaged in identifying the key areas that should be covered by the partnerships and this should not be undertaken by the key stakeholders.

Additionally the respondents can as well read and write and this implies a relative possibility that they can at least understand the language that is used in the partnerships.

4.3 Role of Public Private Partnerships in the Delivery of Health Services in Tanzania

In determining this objective, the respondents were first asked on whether they were aware of any Public Private Partnerships in the delivery of health services and the table below indicates the responses of the respondents and the study findings.

Table 4.3 Awareness of Respondents on Public Private Partnerships in health service delivery

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	25	20.8	20.8	20.8
	No	72	60.0	60.0	80.8
	I don't Know	23	19.2	19.2	100.0
	Total	120	100.0	100.0	

Source: Field data (2014)

The findings from 4.3 indicate that 25 out of the 120 respondents said yes implying that they were aware of the public private partnerships in the delivery of health services in Tanzania and this is equivalent to 20.8% and 72 out of the 120 respondents said No and this implies that they were not specifically aware of the Public Private Partnerships in the delivery of Health services in Tanzania and this is equivalent 60.0% while 23 out of the 120 respondents could not tell whether they were aware of the Public Private partnerships in the delivery of health services in Tanzania.

The findings above reflect and imply that the 25 respondents who were aware of the partnerships have had an opportunity to effectively participate in them and they could as well make references to some clauses in the partnerships. However majority of the samples respondents have never participated in the negotiations or even coming across

the said partnerships and this is why they were not aware of them and some could not even understand their operationalization in the delivery of health services in Tanzania.
The respondents were further asked on whether the Public private partnerships have any impact on to the delivery of health services in Tanzania and the table below indicates their responses and findings as well**.**

Table 4.4 Respondents Perceived Impact of Public Private Partnerships in the delivery of health services in Tanzania

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	80	66.7	66.7	66.7
	No	26	21.7	21.7	88.3
	I dont Know	14	11.7	11.7	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings from table 4.4 indicate that 80 out of the 120 respondents said yes implying that the Public Private Partnerships have an impact in the delivery of health services and this is equivalent to 66.7% and 26 out of the 120 respondents said No, implying that they could not see any impact of the partnerships in the delivery of health services in Tanzania and this is equivalent to 21.7% while 14 out of the 120 respondents could not identify any impact of the partnerships in relation to the delivery of health services in Tanzania.

The above findings reflect that the perceived impact of the partnerships is attributed to certain outcomes that are beneficial to the service recipients of the health service delivery frameworks including improved service delivery, stability in financing the services and perceived cost effectiveness. However at the same time the partnership frameworks are not understood by many health workers and the beneficiaries as well and knowing their impact on health delivery services is appears to be passive considering the status and quality of serviced being delivered in public hospitals like CCBRT.

The respondents were further asked on their perception as to whether the Public Private partnerships are effective in the delivery of health services in Tanzania and the table below indicates their responses and study findings as well.

Table 4.5 Respondents perceptions on the effectiveness of Public Private Partnerships in the delivery of health services in Tanzania

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	28	23.3	23.3	23.3
	No	72	60.0	60.0	83.3
	I dont Know	20	16.7	16.7	100.0
	Total	120	100.0	100.0	

Source: field data, (2014)

The findings from table 4.5 indicate that 28 out of the 120 respondents said that the Public private partnerships are effective in the delivery of health services and this is equivalent to 23.3% and 72 out of the 120 respondents said they are not effective and this is equivalent to 60.0% while 20 out of the 120 respondents could not understand whether they are effective or not and this is equivalent to 16.7%. These findings imply that many of the respondents are not aware on the effectiveness of the Public private partnerships and this is largely attributed to the poor health services that are not yet satisfactory that are being provided in spite of the partnerships that are being concluded for instance by the Ministry of Health and social welfare at the CCBRT hospital.

The respondents were further asked on the extent to which the Public private partnerships are effective in the delivery of health services in Tanzania and the table below indicates their responses and study findings as well.

Table 4.6 Extent of effectiveness of Public Private Partnerships in the delivery of health services in Tanzania

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-25%	22	18.3	18.3	18.3
	25-45%	76	63.3	63.3	81.7
	45-75%	10	8.3	8.3	90.0
	75-100	12	10.0	10.0	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings from table 4.6 indicate that 22 out of the 120 respondents said that the Public Private partnerships are effective within the range of 1-25% and this is equivalent to 18.2%, 76 out of the 120 respondents said that they are effective between 25-45% and this is equivalent to 63.3% while 10 out of the 120 respondents said that the Public Private Partnerships are effective between 45-75% and this is equivalent to 8.3% as opposed to 12 out of the 120 respondents who said that the partnerships in the delivery of health services are effective between the range of 75-100%.

The divergences in the perceptions as to the extent of effectiveness of the public private partnerships in the delivery of health services is attributed to the degree to which the respondents agree and differ or perceive the quality of health services being accessed and delivered after the adoption of the partnerships. The existence and implementation of the partnerships has changed little on the quality of health services being delivered and this is why their effectiveness is still minimal and their outcomes still has not satisfied the expectations of many respondents.

The respondents were further asked whether the public private partnerships are important in the delivery of health services in Tanzania and the table below indicates the study findings and the respondents' responses on perceived importance's of the public private partnerships.

Table 4.7: Respondents perceptions on the importance of Public Private Partnerships in the delivery of health services in Tanzania

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	79	65.8	65.8	65.8
	No	32	26.7	26.7	92.5
	I dont Know	9	7.5	7.5	100.0
	Total	120	100.0	100.0	

Source: field data, (2014)

The findings from table 4.7 indicate that 79 out of the 120 respondents said that the Public Private partnerships are important in the delivery of health services and this is equivalent to 65.8% and 32 out of the 120 respondents said that they are not important and this is equivalent to 26.7% while 9 out of the 120 respondents could not tell whether they are important or not in the delivery of health services in Tanzania.

The above findings reflect that public private partnerships are important in the delivery of health services and this is attributed to the accrued benefits that can be realized after adoption and negotiation of partnerships with the aim of improving health service delivery. Additionally their implementation fills up the financial and human resource gaps that are required for the delivery of satisfactory, timely and quality services in public hospitals. However, some respondents still undermine their significance and this is because of the service conditions under which the health services are provided. For instance, a mere laboratory checkup can take almost 4-6 hours and therefore services make the partnerships meaningless.

The respondents were also asked to identify the forms or methodologies of how the public private partnerships are contracted in the delivery of health services and the table below indicates the responses of the respondents and the study findings as well.

Table 4.8: Methodologies for contracting partnerships in the delivery of health services in Tanzania

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Through build-Operate and Transfer	15	12.5	12.5	12.5
	Through design-Build-finance and Operate	29	24.2	24.2	36.7
	Through Concession Contracts	19	15.8	15.8	52.5
	Through Management Contracts	12	10.0	10.0	62.5
	Through Lease Contracts	3	2.5	2.5	65.0
	Through Joint Ventures	2	1.7	1.7	66.7
	Through Collaborative Partnerships	21	17.5	17.5	84.2
	Through affermage Contracts	19	15.8	15.8	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings in table 4.8 indicate that 15 out of the 120 respondents said that one of the methodologies through which public private partnerships are contracted with the aim of provision of health services is through the build-operate and transfer methodology and this is equivalent to 12.5%, and 29 out of the 120 respondents said that it is through design- Build-finance and Operate and this is equivalent to 24.4% while 19 out of the 120 respondents said that it is through the concession contracts and this is equivalent to 15.8%. Further, 12 out of the 120 respondents said that the partnerships are adopted and implemented through management contracts and this is equivalent to 10.0% while 3 out of the 120 respondents said that the partnerships are contracted through lease agreements and this is equivalent to 2.5% as opposed to 2 out of the 120 respondents who said that they are contracted through joint venture and this is equivalent to 1.7% while 21out of the 120 respondents said that the partnerships are contracted through collaborative partnerships and this is equivalent 17.5% as compared to 19 out of the 120 respondents who said that the partnerships are contracted through affirmage contracts and this is equivalent to 15.8%.

The above findings reflect that, the adoption of a specific methodology for which a methodology of a partnership be contracted depends on the interests of the stakeholders and the time frame and nature of the services to be provided. For instance the use of the build-operate and transfer methodology involves a situation the private sector in this type of contract is responsible and in charge of all the stages of a given project for the provision of health services. While the concession contracts imply a situation where the private sector is responsible for financing, constructing new opportunities or modernizing an existing facility and operates such a facility for a given period and the public sector takes over the project or the facility after expiration of the set time period. Therefore, the methodology for contracting of partnerships is part of the negotiations and its adoption can as well reflect the interests of the stakeholders.

The respondents were further asked to identify and mention policies, regulations and programs that have been initiated by the government in support of the Public Private partnerships in the delivery of health services and the table below indicates the study findings and the policies identified by the respondents being initiated in support of the Public private arrangements.

Table 4.9: Identified policies initiated by the government in support of the Public Private partnerships in delivering health services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	The National Public Private Partnerships Policy, 2009	35	29.2	29.2	29.2
	The Public Private Partnership Regulations, 2011	12	10.0	10.0	39.2
	The National Health Policy,2007	32	26.7	26.7	65.8
	The National Development Vision, 2025	15	12.5	12.5	78.3
	The National strategy for economic growth and poverty reduction,2010	9	7.5	7.5	85.8
	The Health sector Reform Programme	7	5.8	5.8	91.7
	The Health sector Strategic Plan, 2009	10	8.3	8.3	100.0
	Total	120	100.0	100.0	

Source: field data, (2014).

The findings from table 4.9 indicate that 35 out of the 120 respondents said that the government has initiated the Public Partnership policy of 2009 to guide on the adoption and implementation of public private partnerships and this is equivalent to 29.2%, 12 out of the 120 respondents said that there is the public Private Regulations of 2011 which also guide and support the adoption and implementation of Public Private partnerships and this is equivalent to 10.0% while 32 out of the 120 respondents said it is the national health policy of 2007 and this is equivalent to 26.7%. Additionally 15 out of the 120 respondents said that the National development Vision 2025 has a reflection of which the partnerships are implemented or adopted in the delivery of health services and this is equivalent to 12.5% as opposed to only 9 out of the 120 respondents who said that the National strategy for economic growth and reduction of poverty is also a policy that bares a framework for the adoption of the partnerships in the delivery of health services and this is equivalent to 7.5%.

Further, 7 out of the 120 respondents said that the health sector reform program has also influenced the adoption of public private partnerships in the delivery of health services and this is equivalent to 5.8% as opposed to 10 out of the 120 respondents who said that even the health sector strategic Plan, 2009 also guides and has influenced the adoption and usage of public private partnerships in the delivery of health services in Tanzania. These findings imply that the objects or goals for which the partnerships are formed and adopted between the public entity and the private hospital must reflect the set forth objectives in the national health policy, 2007, the National development vision 2025 and the National strategy for economic growth and reduction of poverty, 2010 and all other policies and programs. This is because all the identified policies and programs address health issues which are crucial for the successful implementation of any public private partnership in the delivery of health services.

The respondents were also asked to state and identify the role of public private partnerships in the delivery of health services in Tanzania and the table below indicates the roles identified by the respondents on Public private partnerships in enhancing health service delivery.

Table 4.10 Roles of Public Private Partnerships in delivery of health services in Tanzania

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Reliable Source of financing for public health service delivery	12	10.0	10.0	10.0
	Creativity and Innovativeness in Health service Delivery	10	8.3	8.3	18.3
	Effective Utilization of Resources	15	12.5	12.5	30.8
	Builds health service delivery capacities for public hospitals	9	7.5	7.5	38.3
	Influences the use of Technology in public health service delivery	12	10.0	10.0	48.3
	Fosters better customer needs satisfaction	9	7.5	7.5	55.8
	Developing of new Investment opportunities for health service delivery	18	15.0	15.0	70.8
	Access and Maintenance of Health expertise	15	12.5	12.5	83.3
	Facilitates Financial Injections in the Health sector and Reduces public debt	20	16.7	16.7	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings from table 4.10 indicate that 12 out of the 120 respondents said that the Public private partnerships promote reliable source of financing for public health service delivery and this is equivalent to 10.0%, 10 out of the 120 respondents said that the Partnerships bring creativity and innovativeness in health service delivery and this is equivalent to 8.3% as opposed to 15 out of the 120 respondents who said that partnerships brings effective utilization of resources for public service delivery and this is equivalent to 12.5% as compared to 9 out of the 120 respondents who said that the partnerships build the health service delivery capabilities for public hospitals and this is equivalent to 7.5%. Further, 12 out of the 120 respondents said that the partnerships influence the use of technology in the delivery of health services and this is equivalent to 10.0% while 9 out of the 120 respondents said that the partnerships influence satisfaction of customer needs and expectations and this is equivalent to 7.5%.

Additionally, 18 out of the 120 respondents said that the partnerships influence development of new investment opportunities and this is equivalent to 15.0% while 15 out of the 120 respondents said that partnerships influence maintenance of skilled manpower and this is equivalent to 12.5% compared with 20 out of 120 respondents who said that the partnerships facilitate the financial injections in the health sector through the public date can be reduced and this is equivalent to 16.7%.

The above findings reflect that the adopted and implemented public partnerships in the delivery of health services ensure the attaining of many benefits for instance the sources of finance for the services is sustainable since there is a contribution for the public and the private entity and consequently improved, timely and quality health services are delivered.

4.4 Barriers to effective Implementation of Public Private Partnerships in the Delivery of Health services in Tanzania

In determining this objective, the 120 respondents were asked on the existence of barriers to the effective implementation of the Public Private partnerships and the table below indicates the study findings on the respondents' perceptions on existence of barriers in the implementation of Partnerships in delivery of health services.

Table 4.11: Respondents perceptions on the barriers to effective Implementation of Public Private Partnerships in the delivery of Health services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	89	74.2	74.2	74.2
	No	15	12.5	12.5	86.7
	I don't Know	16	13.3	13.3	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings in table 4.11 indicate that 89 out of the 120 respondents said that yes implying that there are barriers that affect the effective implementation of public private partnerships in the delivery of health services and this is equivalent to 74.2% and 15 out

of the 120 respondents who said that there are no barriers to the effective implementation of public private partnerships in the delivery of health services and this is equivalent to 12.5% while 16 out of the 120 respondents could not tell whether there are barriers or not and this is equivalent to 13.3%. The findings reflect that even though the partnerships have been adopted and implemented by both the public and the private entities towards the delivery of health services, the implementation process is not effective and this is attributed to barriers that affect it. Additionally the latter implies that if the existing parries to the implementation of partnerships are not addressed, the adoption of te partnerships to enhance better health service delivery will remain meaningless and the set objectives or the goals within the partnerships themselves will not be attained.

The respondents were further asked on the extent to which the barriers affect the effective implementation of the of the partnerships in the delivery of health services and the table below indicates the extent to which the barriers affect the effective implementation of the public private partnerships and the table below indicates the levels of effectiveness as responded to by the respondents.

Table 4.12 Level at which the barriers affect the effective implementation of the Public Private Partnerships in the delivery of health services.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-25%	13	10.8	10.8	10.8
	25-45%	12	10.0	10.0	20.8
	45-75%	67	55.8	55.8	76.7
	75-100%	28	23.3	23.3	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings in table 4.12 indicate that 13 out of the 120 respondents said that the barriers have affected the effective implementation of the partnerships in the delivery of health services between the range of 1-25% and cumulatively this is equivalent to 10.8% and 12 out of the 120 respondents said that the barriers affect the partnership

implementation between 25-45% and cumulatively this is equivalent to 10.0% while 67 out of the 120 respondents agreed that the barriers affect the effective implementation of partnerships and cumulatively this is equivalent to 55.8% compared to 28 out of the 120 respondents who said that the partnerships are affected by barriers between 75-100% and cumulatively this is equivalent to 23.3%.

The above findings reflect that the effective implementation of pubic private partnerships in the delivery of improved health services in public and private hospital entities require concurrent monitoring and establishment of controls which will be able to identify the barriers that affect the effectiveness of the partnerships in implementation process. The occurrence or existence of barriers affect the attainment of the benefits of partnerships in the delivery of health services and these include poor quality of health services, poor financing schemes for the health services, inadequate infrastructures and all these are consequences that the entities under a health service provision partnership will encounter.

The respondents were also asked to identify the nature of the barriers that affect the effective implementation of the partnerships in the delivery of health services and the table below indicates the barriers as identified by the respondents that affect the partnerships.

Table 4.13: Nature of barriers that affect the effective Implementation of public Private Partnerships in the delivery of health services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Financial Oriented	26	21.7	21.7	21.7
	Political Barriers	19	15.8	15.8	37.5
	Technical Barriers	7	5.8	5.8	43.3
	Policy Oriented Barriers	27	22.5	22.5	65.8
	Managerial Oriented Barriers	29	24.2	24.2	90.0
	Technological oriented Barriers	12	10.0	10.0	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings from table 4.13 indicate that 26 out 120 respondents said that the nature of the barriers that affect the implementation of public private partnerships are financial oriented and this is equivalent to 21.7%, 19 out of the 120 respondents said that the barriers to the effective implementation of the partnerships in the delivery of health services are political in nature and this is equivalent to 15.8% while 7 out of the 120 respondents said that the barriers are technical in nature and this is equivalent to 5.8% as compared to 27 out of the 120 respondents who said that the barriers are policy oriented and this is equivalent to 22.5%. Further 29 out of the 120 respondents said that the barriers affecting the implementation of the partnerships are managerial oriented and this is equivalent to 24.2% while 12 out of the 120 respondents said that the barriers are technological in nature and this is equivalent to 10.0%.

These findings imply that there are barriers of a different nature and they all affect the way the public private partnerships are implemented in the provision of health services. The financial and managerial oriented barriers include inadequate finance that can threaten or pose difficulties in the pooling of resources for delivery of health services and the managerial barriers include absence of managerial commitments at the hospital levels to use and utilize and transform the partnership opportunities in terms of service delivery or the failure by the hospital managements to have long term plans or action plans of improving the deliverance of health services through the set standards in the partnerships.

Additionally on part of the technical barriers that may include weak professionalism and technicalities in the language used by the stakeholders that create a minimum opportunity for the beneficiaries not to fully understand the operationalization of the partnerships. On part of the policy, the partnership policy and regulations themselves are not comprehensive and this leaves a wider room for the partnerships not to effectively work as they are backed by a weak policy framework and this means that it is very hard to attaining the partnership goals which is delivery of improved health services. The

Political barriers in most cases depict the political interests of the one stakeholder, that is the government and this may end up causing political differences between the public and the private entity. Never the less, the implementation of partnerships requires technology especially its installation with a private entity where public health services are being offered through a partnership.

The respondents were also asked to identify the barriers that affect the effective implementation of public private partnerships in the delivery of health services and the table below indicates the barriers identified by the respondents.

Table 4.14: Identified barriers that affect the effective implementation of public private partnerships in the delivery of health services in Tanzania

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Existence of substantial differences among the Stakeholders	14	11.7	11.7	11.7
	Usage of Technical Languages in PPP policy Frameworks	17	14.2	14.2	25.8
	Inadequate engagement of PPP beneficiaries	9	7.5	7.5	33.3
	Poor Management of PPP frameworks	12	10.0	10.0	43.3
	Poor Monitoring and Evaluation Frameworks for PPPs	16	13.3	13.3	56.7
	Weak Professionalism/Lack of Expertise in the PPPs field	20	16.7	16.7	73.3
	Poor Implementation Frameworks for PPPs	16	13.3	13.3	86.7
	Poor Procurement Frameworks for PPPs	16	13.3	13.3	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings in table 4.14 indicate that 14 out of the 120 respondents identified existence of substantial differences in the interests of the stakeholders and this is equivalent to 11.7% and 17 out of the 120 respondents identified the use of technical language in the public partnerships or agreements and this is equivalent to 14.2% while 9 out of the 120 respondents identified inadequate engagement of the people of the beneficiaries in the preparation and negotiation of partnership agreements and this is equivalent to 7.9% as compared to 12 out of the 120 respondents who identified the poor management of Public Private partnerships towards effective delivery of services and this is equivalent to 10.0%.

Further 16 out of the 120 respondents identified poor monitoring and evaluation frameworks for the Public Private partnerships and this is equivalent to 13.3% while 20 out of the 120 respondents identified inadequate expertise or weak professionalism in operationalizing the partnership terms and goals to service delivery and this is equivalent 16.7% to as opposed to 16 out of the 120 respondents who identified poor implementation frameworks in the delivery of health services through Public Private Partnerships and this is equivalent to 13.3% and 16 out of the 120 respondents who said that poor procurement frameworks for Public Private Partnerships pose a threat to the effective implementation of the Public Private partnerships to the delivery of health services at a satisfactory level and this is equivalent to 13.3%.

These findings reflect that the conclusion and adoption of public private partnerships as a means of improving the delivery of health services requires frameworks within which the barriers can be identified. The latter implies that partnerships can set forth realistic goals and they can as well put achievable standards but the barriers are probe to making the implementation exercise very difficult and eventually the key goal of a partnership which is delivery of improved health services cannot be attained. The effective implementation of partnerships requires monitoring and evaluation since this helps the implementers to measure the success and failure of the partnerships but this is also

dependent on professionalism that can understand the operationalization of the partnership framework and can understand the technical language or wording of the partnerships. Similarly, the higher the existence of the barriers the greater the partnerships will fail to achieve the desired improved health service delivery.

4.5 Mechanisms of addressing the Barriers to effective Implementation of Public Private Partnerships in the delivery of Health services in Tanzania

In determining this objective, the respondents were asked to give their perceptions on the mechanisms through which the barriers affect the effective implementation of the public private partnerships in the delivery of improved health services and the table below indicates the respondents perceived perceptions the mechanism to address the barriers affecting the implementation of the partnerships.

Table 4.15 Perceptions of respondents on the mechanism for addressing barriers affecting the implementation of the Partnerships in the delivery of health services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	32	26.7	26.7	26.7
	No	69	57.5	57.5	84.2
	I dont Know	19	15.8	15.8	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings from table 4.15 indicate that 32 out of the 120 respondents said yes implying that there are mechanisms that can be put on board by the stakeholders in addressing the barriers faced in the implementation of the public private partnerships in the delivery of improved health services and this is equivalent to 26.7% while 69 out of the 120 respondents said No implying that there are no mechanisms to them that can address the barriers faced and this is equivalent to 57.5% f compared with 19 out of the 120 respondents who could not tell whether there are any strategies or not through which the barriers can be addressed and this is equivalent to 15.8%.

These findings imply that those who said yes were aware of the Public Private partnerships that are concluded by the private and the public entity for instance that of the Ministry of Health and social welfare and CCBRT in the provision of improved health services and at the same time they knew the barriers that affect the effective implementation of the partnerships and that is why they were able to suggest and identify the possible mechanisms through which the barriers can be addressed. Additionally those who said (No) and those who could not tell whether there are any strategies or not were not familiar the implementation of the partnerships and that is why they failed to identify any strategy that can be put on board by the key stakeholders addressing the barriers.

The respondents were further asked to the existence of any extra role to be played y the stakeholders in making the partnerships effective in the delivery of improved health services and the table below indicates their perceptional responses on the stakeholders extra role.

Table 4.16: Respondents perceptions on the extra role to be played by the partnerships stakeholders in the delivery of improved health services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	78	65.0	65.0	65.0
	No	13	10.8	10.8	75.8
	I dont Know	29	24.2	24.2	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings from table 4.16 indicate that 78 out of the 120 respondents said that there is an extra role to be played by the stakeholders in addressing the barriers faced in the implementation of Public private Partnerships towards the delivery of improved health services and this is equivalent to 65.0% while 13 out of the 120 respondents said (No) implying that an extra role is not needed since there are certain barriers that have posed a threat to the effective implementation of partnerships in the delivery of health services

and this is equivalent to 10.8% as opposed to 29 out of 120 respondents who could not understand an extra to be played by the stakeholders in delivery of improved health services through public private partnerships and this is equivalent to 24.2%.

These findings reflect that the existence of barriers to the effective implementation of public private partnerships towards the delivery of health services require an extra role to be undertaken by the stakeholders in ensuring that the partnership agreements concluded for the provision of health services are attained through extra roles and this can be done through effective collaboration of key actors, effective sharing of resources in the provision of services, agreement of standards for the delivery of the services and more and transparent engagement of the beneficiaries in the negotiation of the partnerships and increasing finance for the delivery of services as well.

The respondents were further asked to identify the mechanisms that can be used by the stakeholders in addressing the barriers to effective implementation of the Public Private Partnerships towards delivery of improved health services and the table below indicates the mechanisms identified by the respondents in addressing the faced barriers.

Table 4.17: Identified mechanisms which can address the barriers to effective implementation of Public Private Partnerships in delivery of health services.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Through transparent formulation and Negotiation of PPPs	21	17.5	17.5	17.5
	Undertaking Effective cost-benefit analysis for PPPs Frameworks	16	13.3	13.3	30.8
	Developing of Monitoring and Evaluation Frameworks for PPPs	14	11.7	11.7	42.5
	Designing Risk Management Frameworks for PPPs	9	7.5	7.5	50.0
	Training and Development of Expertise	17	14.2	14.2	64.2
	Improving Central Health systems	19	15.8	15.8	80.0
	Developing of Financial capacities for the Local Government Authorities	6	5.0	5.0	85.0
	Strengthening of the Health sector Regulatory Framework	8	6.7	6.7	91.7
	Use of Resource Sharing Approaches by Key Stakeholders	10	8.3	8.3	100.0
	Total	120	100.0	100.0	

Source: Field data, (2014)

The findings from table 4.17 indicate that 21 out of the 120 respondents said that the barriers can be addressed through transparent formulation and negotiation of Partnerships and this is equivalent to 17.5%, 16 out of the 120 respondents identified that undertaking of effective cost benefit analysis for the Partnerships frameworks and this is equivalent to 13.3% while 14 out of the 120 respondents identified developing of monitoring and evaluation frameworks and this is equivalent 11.7 as compared to 9 out of the 120 respondents who identified designing risk management frameworks for

addressing the barriers to the effective implementation of the partnerships in the delivery of health services and this is equivalent to 7.5%.

Further 17 out of the 120 respondents who identified training and development of experts who will operationalize the partnerships towards delivery of health services and this is equivalent to 14.2% and 19 out of the 120 respondents who identified improving of the central health systems and this is equivalent to 15. 8% while 6 out of the 120 respondents who identified developing financial capacities of the local government authorities and this is equivalent to 5.0% compared to 8 out of the 120 respondents who identified strengthening of the health sector regulatory framework for effective implementation of the partnerships towards effective delivery of health services and this is equivalent to 6.7% while 10 out of the 120 respondents who identified use of sharing approaches among key stakeholders in the implementation of partnerships in the delivery of improved health services.

The above findings reflect that the barriers faced in the implementation of the public private partnerships towards the effective delivery of improved health services can be addressed through the suggested mechanisms and the frameworks. However more importantly the designing of monitoring and evaluation frameworks that will concurrently identify symptoms in the implementation of partnerships, improving the central heath systems and undertaking training and development of experts who will be able to understand at wide the technical languages used in the partnerships and make effective attempts in operationalizing the partnerships towards effective delivery of improved health services at private entities like at CCBRT.

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter four has sections and the first section provides a summary of the study by pointing out the objectives and the summary of findings of the study. The second section provides conclusions of the study in relation to the research objectives and the research questions and the third section provides recommendation and the fourth section gives suggestions made for further studies.

5.2 Summary of study Findings

The general objective of the study was to examine the barriers to effective public private partnerships in the delivery of health services in Tanzania with a reflection of a public private partnership that exist between the Ministry of Health and Social Welfare with CCBRT Hospital. Further, the study was carried out basing on research questions which included determining what role do public private partnerships play in the delivery of health services in Tanzania, what barriers are faced in the effective implementation of public private partnerships in delivering health services in Tanzania and the determining what mechanisms or strategies can be used in addressing the barriers faced in the delivery of health services in Tanzania.

The findings of the study have indicated that Public Private Partnerships have an impact in the delivery of health services and this is equivalent to 66.7% and that the partnerships are adopted and implemented through management contracts up to 10.0%, the Public Partnership policy of 2009 guides on the adoption and implementation of public private partnerships to 29.2% and the private partnerships promote reliable source of financing for public health service delivery to 10.0%, Partnerships bring creativity and innovativeness in health service delivery and this is equivalent to 8.3%, partnerships influence satisfaction of customer needs and expectations and this is equivalent to 7.5% and that partnerships influence development of new investment

opportunities and this is equivalent to 15.0% they influence maintenance of skilled manpower and this is equivalent to 12.5%.

Further, the study indicated that there are barriers that affect the effective implementation of public private partnerships in the delivery of health services and this is equivalent to 74.2% and the barriers to the private partnerships are financial oriented and this is equivalent to 21.7% and at the same time barriers are technical in nature and this is equivalent to 5.8% as compared to the barriers are policy oriented and this is equivalent to 22.5%. Additionally the key barriers identified by the respondents include existence of substantial differences in the interests of the stakeholders and this is equivalent to 11.7% and the use of technical language in the public partnerships or agreements and this is equivalent to 14.2% compared to the inadequate engagement of the people of the beneficiaries in the preparation and negotiation of partnership agreements and this is equivalent to 7.9%.

On part of the mechanisms for addressing the barriers that affect the implementation of the partnerships in delivering improved health services, the findings have indicated that transparent formulation and negotiation of Partnerships is a mechanism for addressing barriers and this is equivalent to 17.5%, designing risk management frameworks which is equivalent to 7.5%, training and development of experts who will operationalize the partnerships towards delivery of health services and this is equivalent to 14.2% and strengthening of the health sector regulatory framework for effective implementation of the partnerships towards effective delivery of health services which is equivalent to 6.7%.

5.3 Conclusion

The Public private Partnerships play significant roles in the effective delivery of health services and these include influencing reliable sources of financing for public health service delivery, creativity and innovativeness in Health service Delivery, promote reliable source of financing for public health service delivery, effective utilization of resources, they build health service delivery capacities for public hospitals, influences

the use of technology in public health service delivery and the partnerships influence the developing of new investment opportunities for health service delivery.

On part of the role of public partnership in the delivery of health services, the PPP's promote reliable source of financing for public health service delivery to 10.0%, Partnerships bring creativity and innovativeness in health service delivery to 8.3%, partnerships brings effective utilization of resources for public service delivery, the partnerships build the health service delivery capabilities for public hospitals to 7.5%. Further, partnerships influence the use of technology in the delivery of health services to 10.0% and they satisfaction of customer needs and expectations to 7.5%. Partnerships influence development of new investment opportunities to 15.0% and the partnerships influence maintenance of skilled manpower in the delivery of health services to 12.5%.

On part of the barriers, the partnerships in the delivery of health services are affected by existence of substantial differences in the interests of the stakeholders to 11.7%, the use of technical language in the public partnerships or agreements to 14.2%, inadequate engagement of the people or the beneficiaries in the preparation and negotiation of partnership agreements to 7.9% the poor management of Public Private partnerships towards effective delivery of services to 10.0%. Poor monitoring and evaluation frameworks for the Public Private Partnerships, inadequate expertise or weak professionalism in operationalizing the partnership terms and goals to service delivery.

However, the above barriers that affect the effective implementation of Public Private Partnerships can be addressed through transparent formulation and negotiation of Partnerships to 17.5%, undertaking of effective cost benefit analysis for the Partnerships frameworks to 13.3%, developing of monitoring and evaluation frameworks to 11.7, designing risk management frameworks for addressing the barriers to the effective implementation of the partnerships in the delivery of health services to 7.5%. The barriers also identified training and development of experts who will operationalize the

partnerships towards delivery of health services, improving of the central health systems, developing financial capacities of the local government authorities to 5.0%, strengthening of the health sector regulatory framework for effective implementation of the partnerships towards effective delivery of health services and use of sharing approaches among key stakeholders in the implementation of partnerships in the delivery of improved health services.

5.4 Recommendations

Basing on the findings and the views given by the different respondents involved the study; the following recommendations can objectively enhance, strategically strengthen and improve the effectiveness of implementing the way Public Private Partnerships towards the delivery of improved health services in Tanzania.

The Public and private entities operating or implementing a Public Private Partnership in the delivery of health services should undertake effective training and development of personnel who will have the skills of negotiating the partnerships and who will understand the technical frameworks of the partnerships. Consequently the barrier of weak professionalism will relatively be addressed and the implementation of the partnership frameworks will attain its set goals and objectives.

The Public and private entities operating or implementing a Public Private Partnership in the delivery of health services should design effective monitoring and evaluation frameworks. These frameworks will help the implementers to identify symptoms and divergences in the implementation process and corrective actions will thereby be put in place. Additionally the evaluation and monitoring mechanism will be methodologies for assessing outcomes of the partnerships in relation to the delivery of improved health services.

The Public and private entities operating or implementing a Public Private Partnership in the delivery of health services should call upon the government to strengthen the partnership regulatory frameworks and this implies that the Partnership policy and its

regulations requires to be strengthened in order that it comprehensively guides stakeholders in the partnership arrangement and the policy should set up a mechanism of resolving partnership disputes which may end up affecting the delivery of the intended service.

The Public and private entities operating or implementing a Public Private Partnership in the delivery of health services should design strategic plans for developing and strengthening their financial capacities since finance or resources is a key success variable for any public private partnership contracted with the aim of delivering public health services.

5.5 Suggestion for further study

In reflection of the study objectives and the findings, I suggest that a study be conducted on the effectiveness of the Public Private Partnership Policy in the implementation of Public Private Partnerships in Tanzania.

REFERENCES

Adam, J., & Kamuzora, F. (2008). Research Methods for Business and Social Studies, Mzumbe Book Project, Mzumbe, Tanzania

Akerlof. G., (1970), "The market for Lemons", quarterly journal of economics. Vol.336.

Boardman, A.E. and Vining, A.R. (2010). Assessing the Economic Worth of Public–Private Partnerships', in Hodge, Graeme, Greve, Carsten & Boardman, Anthony. (Eds). International Handbook on Public-Private Partnerships. Cheltenham: Edward Elgar

Bovaird, T. (2010). A Brief Intellectual History of the Public-Private Partnership Movement' in Hodge, Graeme, Greve, Carsten & Boardman, Anthony. (Eds). 2010. International Handbook on Public-Private Partnerships. Cheltenham: Edward Elgar.

Peter, K (2000). The Need for Public Private Partnerships. Rout ledge. New York.

Buse, K and Walt, G. (2000b). The World Health Organization and Global Public Private Partnerships. In Search of Good Global Health Governance. WHO

Commonwealth (2003). "Public – Private Partnerships: A Review with Special Reference to Local Government" in Commonwealth Local Government Handbook. KPL. Rochester

Grimsey, D. and Lewis, M. (2004). Public-Private Partnerships: The Worldwide Revolution in Infrastructure Provision and Project Finance. Cheltenham: Edward Elgar.

Itika, J (2003) "Public-Private Partnership in Health Service Delivery: Does it make a Difference to the Public"**.** Research Report. Mzumbe University.

Itika, J. S., Mashindano, O., and Kessy, F. (2011). Successes and Constraints for Improving Public Private Partnership in Health Services Delivery in Tanzania.

Jeffares, Stephen; Sullivan, Helen & Boivard, Tony (2009. 'Beyond the Contract. The Challenge of Evaluating the Performance(s) of Public-Private Partnerships. Paper for the 13th IRSPM conference, April, Copenhagen, Denmark.

Itika, J. S., Mashindano, O., and Kessy, F. (2011). Successes and Constraints for Improving Public Private Partnership in Health Services Delivery in Tanzania.

Kironde, J.M.L, (1999). Urban Waste and Governance in Africa: A Case of Dar es Salaam, Tanzania. Inm Onibokun, A.G (Editor) Managing the Monster. International Development Research Centre, Ottawa, Canada.

Ministry of health and Social Welfare.(2000). Annual Report, Dar es Salaam Tanzania.

Mutahaba, G. and Kiragu, K. (2002). Lessons of international and African Perspectives on Public service reform: Examples from Five African Countries. African Development. Vol. XXVII.

Mushi, S. S. (2000). Privatization and the fate of the public sector in Tanzania. Occasional paper, University of Dar es Salaam.

Nkya, E. (2004). Public-Private Partnership and Institutional Arrangements: Constrained Improvement of Solid Waste Management in Dar Es Salaam. In Uongozi Journal of Management Development, Vol. 16. Mzumbe Book Project.

Nkya, E .(2000) "Public-Private Sector Partnership and Institutional Framework at Local Level: The Case of Solid Waste Management at the City of Dar es Salaam, Tanzania." Mzumbe, Published Report.

Ngowi, H. P. (2010) Public-Private Partnership (PPPs) in the Management of Municipalities in Tanzania – Issues and Lessons of Experience Economics Department, Mzumbe University.

APPENDECES

Appendix I

Questionnaire Used for Data Collection

Sampling: accidental sampling

Data Collection Technique: Self administered questionnaire.

Instructions:

a) The objective of this study is was to examine the effectiveness of Public Private Partnerships in the delivery of health services in Tanzania.
b) The answers in this questionnaire should be kindly written in the space provided.
c) Kindly answer the questions clearly and honestly and the researcher hereby guarantees that the information given shall be solely used for the study and the information shall be treated with high confidentiality.

1. Personal Information:

a) Name of the Respondent: (Optional) ……
b) Place of work: ……..
c) Department: ……
d) Position held: ……..

2. Demographics

1. Sex: Male ( ) Female ( )

2. Age: Below 18 years ( )
18—25 ( )
25---35 ( )
35---45 ( )
45---55 ( )
55----65( )

3. Level of education

Primary School ( ) Secondary school ( ) Certificate ( )

Diploma Degree ( ) Masters ( ) Doctorate (PhD) ( )

4. General Information about Public Private Partnerships

a) Are you aware of any Public Private Partnerships in the delivery of health services?

Yes ( )

No ( )

I don't know ( )

b) Do you think Public Private Partnerships have any Impact to the delivery of health services in Tanzania?

Yes ( )

No ( )

I don't know ( )

c) Do you think Public Private Partnerships are effective in the delivery of health services in Tanzania?

Yes ( )

No ( )

I don't know ( )

d) To what extent are they effective

1-25 %( )

25-45 %( )

45-75 %( )

75-100% ( )

5. (Objective one). Role of Public Private Partnerships in the delivery of health services in Tanzania

a) Do you think Public Private Partnerships are important in the delivery of health services in Tanzania?

Yes ( )

No ( )

I don't know ( )

b) Briefly state the methodologies within which the partnerships are contracted.

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c) Kindly Mention the policies, regulations and programs initiated by the government in support of delivery of health services through public Private Partnerships.

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d) Kindly mention the role of Public Private Partnerships in the delivery of health services in Tanzania.

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6. (Objective two). Information on the barriers affecting the effective Implementation of Public Private Partnerships in the delivery of health services in Tanzania.

a) Do you think there are barriers to the effective implementation of Public Private Partnerships in the Delivery of Health services in Tanzania?

Yes ( )

No ( )

I don't know ( )

b) To what extent do these barriers affect the effective implementation of Public Private Partnerships in the Delivery of Health services in Tanzania?

1-25 %( )

25-45 %( )

45-75 %( )

75-100% ( )

c) In your Opinion what is the nature of the barriers?

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d) Kindly mention the barriers that affect effective implementation of Public Private Partnerships in the Delivery of Health services in Tanzania?

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7. (Objective Three). Information on the mechanism to be used in addressing the barriers faced in the implementation of Public Private Partnerships

a) Are there any mechanisms to be used in addressing the barriers faced in the implementation of Public Private Partnerships

Yes ( )

No ( )

I don't know ( )

a) Is there any extra role to be played by the key stakeholders in addressing the barriers faced in the implementation of public Private Partnerships in the delivery of Health services in Tanzania?

Yes ( )

No ( )

I don't know ( )

If yes, briefly state the extra role to be played

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b) Accordingly, mention the strategies that can be put on board in addressing the barriers faced in the implementation of public Private Partnerships in the delivery of Health services in Tanzania?

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Thank you for sharing with me your knowledge and experience