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Potential Areas for Strengthening Collaboration between the Government and Faith-Based Health Facilities through PPPs: A Case Study of Holy Family Mission Hospital Nangina, Busia County

Achieng Maureen, Manya W. Stephen and Omoga Charles
Alupe University, Kenya

Corresponding author email Address: *machieng040@gmail.com

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Abstract

Public–private partnerships (PPPs) provide opportunities for strengthening healthcare delivery through resource sharing, coordinated decision-making and collaboration between government agencies and faith-based health facilities. However, the effectiveness of these partnerships depends on functional coordination mechanisms, stakeholder engagement, appropriate regulatory arrangements and adequate resource allocation. This study examined opportunities for strengthening government–faith-based health partnerships at Holy Family Mission Hospital Nangina in Busia County, Kenya. Guided by Public–Private Partnership Theory and Collaborative Governance Theory, the study adopted a descriptive case study design using a mixed-methods approach. The target population comprised 50 stakeholders, including hospital managers and administrators, county and sub-county health officials, department heads, clinical staff, and senior nursing and support personnel. Quantitative data were collected using structured questionnaires from 40 staff members, while qualitative data were obtained through semi-structured interviews with 10 purposively selected key informants. Quantitative data were analysed using descriptive statistics and Pearson's product-moment correlation, while qualitative data were analysed thematically. The findings indicated that respondents rated healthcare provision relatively highly (M = 3.82, SD = 0.62), while collaboration mechanisms also received a high rating (M = 3.68, SD = 0.74). Correlation analysis revealed a positive,

statistically significant association between collaboration mechanisms and perceived healthcare provision (r = .642, p < .001). Qualitative findings highlighted existing collaboration in public health campaigns, vaccination programmes and disease surveillance, alongside opportunities to strengthen formal joint planning, accountability, resource allocation, reimbursement coordination, staffing support and technical assistance. The study concludes that stronger collaboration mechanisms are associated with better-rated healthcare provision at the hospital. It recommends regular joint planning and performance-review forums, clearer institutional responsibilities and improved coordination of financial, human and material resources.

Keywords: Public–Private Partnerships, Faith-Based Health Facilities, Collaborative Governance, Healthcare Provision, Stakeholder Engagement, Busia County

Introduction

Public–private partnerships (PPPs) have become an important institutional approach for mobilising resources, coordinating expertise and sharing responsibilities between governments and non-state organisations in the delivery of public services. In healthcare, partnerships with faith-based organisations (FBOs) are particularly relevant because these organisations operate health facilities that complement government provision, including in communities where access to public services may be limited. Their contribution extends beyond the provision of clinical services to include maternal and child healthcare, HIV/AIDS programmes and other essential health interventions. A review by Olivier et al. (2015) demonstrated the substantial role of faith-based health providers in healthcare delivery across sub-Saharan Africa, while Lipsky (2011) highlighted their potential comparative advantages, including community relationships and moral legitimacy. However, the contribution of these providers depends partly on how effectively they are integrated into national health systems and supported through sustainable institutional arrangements.

Effective government–faith-based partnerships require more than the recognition of faith-based facilities as healthcare providers. They depend on clear governance structures, predictable financing, appropriate allocation of human and material resources, stakeholder participation and mechanisms for accountability. Where these arrangements are weak or inconsistent, facilities may experience difficulties sustaining services, coordinating referrals, accessing essential commodities or aligning their activities with government health priorities. Green and Shaw (2002) examined changing relationships between governments and church health services in sub-Saharan Africa and demonstrated the importance of understanding these relationships within broader health-sector reforms. Similarly, Yeboah and Buckle (2017) explored the evolving partnership between the

Government of Ghana and faith-based health providers, highlighting the importance of leadership and institutional relationships in sustaining collaboration. These studies suggest that partnership effectiveness should be examined not simply in terms of whether collaboration exists, but also in terms of how it is organised, implemented and supported.

Recent evidence further emphasises the relevance of these arrangements to universal health coverage (UHC). In a scoping review of state–church partnerships in sub-Saharan Africa, Amankwah et al. (2026) identified partnerships as a potential strategy for strengthening healthcare delivery, while highlighting the need to address challenges relating to financing, service quality and integration into national health policies. The review reinforces the importance of sustainable funding, formalised policy arrangements and coordination between governments and faith-based providers. In Kenya, the Ministry of Health (2024a) reaffirmed the government's commitment to collaboration with FBOs as part of efforts to improve healthcare access and advance UHC. The Ministry also documented discussions concerning financial obligations and operational challenges affecting health facilities during the transition to the Social Health Authority, illustrating the practical significance of financing and coordination in sustaining healthcare services (Ministry of Health, 2024b). These policy developments establish a basis for examining whether government–faith-based collaboration is supported by practical arrangements that address facilities' operational and service-delivery needs.

Kenyan evidence provides a more direct basis for investigating the potential areas for strengthening these partnerships. Ringera et al. (2021) examined government–faith-based partnerships in Kisii County and found statistically significant associations between health-system strengthening and partnership components involving material support, human resources for health, leadership and management, and implementation guidelines. Their findings indicate that collaboration can be operationalised through specific administrative and resource-sharing mechanisms rather than through general policy commitments alone. Nevertheless, evidence from one county cannot automatically establish the priorities or experiences of facilities in other settings. Differences in institutional capacity, local health needs, resource availability and government coordination make facility-level investigation important for identifying which partnership arrangements require strengthening in a particular context.

Holy Family Mission Hospital Nangina in Busia County provides a relevant case for examining these issues. The hospital is a faith-based healthcare facility, and the Kenyan Ministry of Health has documented government engagement with it (Ministry of Health, 2023). This engagement provides a basis for investigating how existing relationships between public authorities and a faith-based provider might be strengthened. Relevant areas include joint planning and decision-making, stakeholder engagement, regulatory coordination, financing, human-resource

support, access to medical supplies and mechanisms for monitoring partnership implementation. Examining these dimensions is important because the existence of government engagement does not, by itself, establish whether current arrangements are sufficiently coordinated, predictable or responsive to the hospital's needs.

Despite the broader evidence on the contribution of faith-based healthcare providers and the documented importance of government collaboration, a facility-specific empirical gap remains concerning the relative importance of different mechanisms for strengthening these partnerships at Holy Family Mission Hospital Nangina. In particular, there is a need to examine how collaboration mechanisms, stakeholder engagement, regulatory arrangements and resource allocation relate to perceived healthcare provision within this institutional context. Addressing this gap can help distinguish general policy aspirations from practical opportunities for improving partnership implementation. It can also provide hospital managers and government health officials with context-specific evidence to guide joint planning, clarify institutional responsibilities and identify priorities for more coordinated resource allocation.

Accordingly, this study examined potential areas for strengthening collaboration between the government and faith-based health facilities through PPPs, focusing on Holy Family Mission Hospital Nangina in Busia County, Kenya.

Theoretical Review

Public–Private Partnership Theory provides a basis for explaining how public institutions and non-state organisations can combine resources, expertise and institutional capabilities to deliver services that may be difficult for either party to provide independently. Hodge and Greve (2007) argue that PPPs encompass diverse governance and contractual arrangements and that their effectiveness should be assessed critically rather than assumed from the existence of a partnership. This perspective is relevant to healthcare because government agencies and faith-based health facilities may have complementary responsibilities in financing, staffing, medical supplies, infrastructure and service delivery. In the context of Holy Family Mission Hospital Nangina, the theory helps explain how formal agreements, resource-sharing arrangements, clear institutional responsibilities and performance-monitoring mechanisms could strengthen government–hospital collaboration. However, PPP arrangements are not automatically effective; their outcomes depend on appropriate governance, accountability, resource commitments and implementation. A limitation of this perspective is that conventional PPP discussions often emphasise contracts, financing and risk allocation, potentially giving insufficient attention to trust, community relationships and the participation of frontline health workers. The present study therefore applies PPP Theory alongside Collaborative Governance Theory to examine both

the institutional arrangements and the relationships required to sustain collaboration.

Collaborative Governance Theory explains how public agencies and non-governmental stakeholders work collectively through structured processes of dialogue, negotiation, shared decision-making and joint action. Ansell and Gash (2008), drawing on a synthesis of 137 collaborative governance cases, identify factors such as the history of cooperation or conflict, incentives for participation, power and resource imbalances, facilitative leadership and institutional design as important influences on collaborative processes. Emerson et al. (2012) further conceptualise collaborative governance as an evolving system shaped by principled engagement, shared motivation and capacity for joint action. Applied to Holy Family Mission Hospital Nangina, this theory highlights the importance of regular consultation between hospital management and government health officials, meaningful stakeholder engagement, coordinated planning, information sharing and joint monitoring of agreed activities. It also draws attention to potential barriers, including unequal decision-making power, unclear responsibilities, limited communication and inadequate resources for implementing joint commitments. Nevertheless, collaboration alone does not guarantee improved healthcare provision; its effectiveness depends on whether joint decisions translate into adequately funded, coordinated and accountable action. The theory therefore provides a framework for examining the relational and procedural dimensions of partnership strengthening, complementing PPP Theory's emphasis on institutional and resource arrangements.

Integration of the theories and relevance to the study. The two theories are complementary but address different dimensions of government–faith-based health partnerships. PPP Theory explains the institutional and operational arrangements through which government and a faith-based facility can share resources, responsibilities and risks, whereas Collaborative Governance Theory explains how participating institutions establish trust, engage stakeholders, make joint decisions and coordinate implementation. Integrating the theories provides a broader analytical framework for examining collaboration mechanisms, stakeholder engagement, regulatory coordination and resource allocation at Holy Family Mission Hospital Nangina. Specifically, collaboration mechanisms and regulatory coordination reflect the formal structures and responsibilities emphasised by PPP Theory; stakeholder engagement reflects the participatory processes central to Collaborative Governance Theory; and resource allocation involves both institutional commitments and the capacity of partners to agree on and implement joint priorities. Together, the theories suggest that partnership strengthening requires both workable institutional arrangements and effective inter-organisational relationships. Their application to this study is analytical rather than proof of causation: they guide the interpretation of respondents' perceptions and

reported experiences but do not establish that any single partnership dimension independently causes better healthcare provision. This combined framework also addresses a limitation of relying on either theory alone by linking formal partnership arrangements with the practical processes through which collaboration is implemented and sustained.

Empirical Review

Public–private partnerships in healthcare have been investigated as mechanisms for addressing resource constraints, improving coordination and extending the reach of health services. However, empirical evidence indicates that the existence of a partnership does not necessarily guarantee effective implementation. In Tanzania, Nuhu et al. (2020) used a qualitative case study approach involving interviews with public- and private-sector stakeholders and document reviews to investigate challenges affecting healthcare PPPs in Kinondoni Municipality, Dar es Salaam. The study identified inadequate resources, ineffective monitoring and evaluation, insufficient consultation between partners, and weaknesses in the implementation of institutional arrangements. These findings highlight the importance of clearly defined responsibilities, regular communication, adequate resources and accountability mechanisms. Although the study provides useful evidence on healthcare PPP implementation in an African context, it examined public–private partnerships more broadly rather than focusing specifically on government collaboration with a faith-based hospital. Its findings therefore provide a comparative foundation rather than direct evidence of the partnership priorities at Holy Family Mission Hospital Nangina.

Evidence from other African health systems further demonstrates the importance of financing and regulatory coordination. Akweongo et al. (2021) investigated how claims submission and reimbursement arrangements under Ghana's National Health Insurance Scheme affected service delivery, drawing on the perspectives of healthcare providers and insurance managers. Their study highlighted the operational significance of claims processing and reimbursement arrangements for relationships between healthcare providers and the institutions responsible for financing care. Similarly, Osei Afriyie et al. (2023), examining purchasing for quality healthcare under Zambia's National Health Insurance Scheme, explored how purchasing arrangements and institutional factors relate to the delivery of quality care. Although these studies concern health insurance and provider purchasing rather than the full range of government–faith-based partnerships, they demonstrate why financial predictability, transparent payment procedures and effective oversight should be considered when assessing partnership sustainability. Their relevance to the present study lies in the need to investigate whether financing arrangements and regulatory coordination adequately support service provision at facility level.

Amankwah et al. (2026) conducted a scoping review of state–church partnerships in sub-Saharan Africa to examine their contribution to healthcare delivery and universal health coverage. The review identified the role of faith-based organisations in providing essential health services, including maternal and child healthcare, HIV/AIDS services and workforce training. It also identified challenges relating to funding, variation in service quality and the integration of faith-based providers into national health policies. The authors emphasised sustainable financing, formal partnership frameworks, community engagement and quality assurance as important areas for strengthening these arrangements. The review provides a useful regional synthesis, but its findings draw on evidence from multiple countries and do not determine which partnership dimensions are most strongly associated with perceived healthcare provision in an individual Kenyan hospital. This distinction supports the need for context-specific investigation of collaboration mechanisms, stakeholder engagement, regulatory coordination and resource allocation.

In Kenya, Ringera et al. (2021) examined the role of PPPs in strengthening faith-based health systems in Kisii County. Using a cross-sectional descriptive design, the researchers collected data from officials in faith-based health facilities and the Ministry of Health. The study investigated material support, leadership and management, human resources for health, and guidelines for implementing PPPs. The findings indicated statistically significant associations between these partnership components and health-system strengthening. The study provides direct empirical support for examining resource allocation, institutional leadership, workforce support and formal implementation arrangements as potential areas for improving government–faith-based collaboration. Nevertheless, its geographical focus on Kisii County leaves uncertainty about how these dimensions operate in other counties and individual mission hospitals. In addition, evidence of an association between partnership components and health-system strengthening does not establish that the same components will have equivalent relationships with perceived healthcare provision at Holy Family Mission Hospital Nangina.

Policy and programme evidence from Kenya also illustrates the importance of financing and coordination. The Kenya Yearbook Editorial Board (2022) documented public–private collaboration in healthcare, including the Linda Mama programme, through which maternity services were supported across participating health facilities. Its discussion highlighted reimbursement delays and operational constraints that affected the implementation of publicly supported maternity services. Although this is a policy account rather than a peer-reviewed facility-level study, it illustrates how payment arrangements, administrative coordination and the availability of operational resources can influence the participation of non-state providers in public health programmes. The evidence is relevant to faith-based facilities because their ability to maintain services may depend partly on predictable

financing and effective coordination with government institutions. However, programme-level evidence does not establish the adequacy of arrangements at Nangina or identify the relative importance of financing compared with stakeholder engagement, regulation and other partnership mechanisms.

Research Gap and Hypothesis Development

The reviewed literature establishes that healthcare PPPs can support health-system strengthening but also face implementation challenges involving resources, institutional coordination, monitoring, reimbursement and regulatory arrangements. International and regional evidence provides a broad understanding of these issues, while the Kenyan study by Ringera et al. (2021) offers direct evidence of the relevance of material support, leadership, human resources and implementation guidelines to faith-based health systems. Nevertheless, three limitations remain. First, much of the available evidence examines healthcare PPPs or health-insurance arrangements generally rather than the specific relationship between government agencies and individual faith-based hospitals. Second, studies conducted in other African countries or Kenyan counties may not fully reflect the institutional circumstances of Holy Family Mission Hospital Nangina. Third, the literature does not adequately establish how existing collaboration mechanisms relate to perceived healthcare provision at this facility. The present study addresses this contextual gap by examining government–hospital collaboration at Nangina and considering opportunities to strengthen stakeholder engagement, regulatory coordination and resource allocation alongside the mechanisms used to coordinate partnership activities. Hence the following hypothesis was proposed;

H_{01}: *There is no statistically significant relationship between collaboration mechanisms and perceived healthcare provision at Holy Family Mission Hospital Nangina in Busia County, Kenya.*

Methodology

The study was conducted at Holy Family Mission Hospital Nangina, a faith-based healthcare facility managed by the Catholic Diocese of Bungoma in Busia County, Kenya. The hospital provides inpatient, outpatient, maternal and child healthcare, and HIV/AIDS services. It was purposively selected because of its role in healthcare delivery and engagement with government health programmes, providing an appropriate setting for examining opportunities to strengthen collaboration in governance, stakeholder engagement, regulatory coordination and resource allocation. The study sought to generate context-specific insights rather than statistically generalisable findings for all faith-based health facilities in Kenya.

The study adopted a descriptive case study design incorporating quantitative and qualitative methods. Structured questionnaires were used to assess respondents' perceptions of collaboration mechanisms, stakeholder engagement,

regulatory frameworks, resource allocation and healthcare provision, while semi-structured interviews explored existing partnership arrangements, resource-sharing practices and implementation challenges. The two methods complemented each other by providing measurable patterns and contextual explanations. Integration occurred during interpretation through comparison of quantitative findings and qualitative themes, identifying areas of convergence and divergence. The design enabled the examination of associations and stakeholder experiences but did not establish causal relationships.

The target population comprised 50 stakeholders associated with hospital management, healthcare delivery and government engagement. These included five hospital managers and administrators, five county or sub-county health officials, 20 department heads and clinical staff, and 20 senior nursing and support personnel. A census approach was used to invite all 40 eligible staff members to complete questionnaires, while the 10 hospital managers, administrators and government health officials were purposively selected for key informant interviews based on their institutional responsibilities and knowledge of partnership arrangements.

Table 1. Target Population

Stakeholder category	Population	Planned participants	Sampling technique	Instrument
Hospital management and administrators	5	5	Purposive	Interview guide
County/sub-county health officials	5	5	Purposive	Interview guide
Department heads and clinical staff	20	20	Census	Questionnaire
Senior nursing and support personnel	20	20	Census	Questionnaire
Total	50	50	—	—

Source: Study records.

The questionnaire and interview groups were treated as separate, non-overlapping categories. The planned sample comprised 40 questionnaire participants and 10 interviewees; the final report should specify the actual number of completed questionnaires and interviews.

Primary data were collected using structured questionnaires and semi-structured interview guides. Questionnaire items measured the study constructs using a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The interview guide explored collaboration mechanisms, stakeholder participation, regulatory requirements, financing, staffing, infrastructure, medical

supplies and health information systems. Probing questions were used to obtain detailed explanations of existing arrangements and potential improvements.

Content validity was supported through review of the instruments by university supervisors and public health experts at Alupe University. A pilot study involving five respondents was conducted at St. Mary's Hospital, Mumias, to assess clarity, relevance and comprehensibility. Feedback informed revisions where necessary, and pilot participants were excluded from the main study. Internal consistency was assessed using Cronbach's alpha, with .70 treated as an indicative threshold of acceptable reliability (Tavakol & Dennick, 2011).

Table 2. Reliability Results

Construct	Number of items	Cronbach's alpha
Collaboration mechanisms	5	.812
Healthcare provision	5	.854

Source: Pilot study results.

The reported coefficients indicated acceptable internal consistency for the two constructs. Reliability coefficients for stakeholder engagement, regulatory frameworks and resource allocation should be included only if they were calculated. Qualitative trustworthiness was addressed through systematic organisation and interpretation of interview records. The analysis involved familiarisation with the data, coding relevant statements, grouping related codes and developing themes aligned with the study objective. Credibility, dependability and confirmability were supported through consistent interview procedures, documentation of analytical decisions and grounding interpretations in participants' accounts. A description of the institutional setting and participant characteristics supported assessment of the transferability of the findings. Only procedures actually undertaken should be reported as completed.

Data collection commenced after the required institutional and regulatory approvals had been obtained, including the applicable university authorisation, National Commission for Science, Technology and Innovation (NACOSTI) research licence, county health permissions and hospital authorisation. Questionnaires were administered using a drop-and-pick procedure, while interviews were scheduled at times convenient to the key informants. Participants were informed about the study and provided consent before participating. Interviews were audio-recorded only with permission; otherwise, written notes were used where authorised. Completed questionnaires and interview records were checked and organised for analysis.

The questionnaire response rate was calculated by dividing the number of completed and usable questionnaires by the number administered to eligible staff and multiplying by 100. The interview completion rate was calculated separately

using the number of completed interviews divided by the number of key informants invited, multiplied by 100. Non-responses and missing data were handled according to the actual fieldwork records and documented analytical procedures.

Quantitative data were coded and analysed using descriptive and inferential statistics. Frequencies and percentages summarised categorical characteristics, while means and standard deviations described responses to Likert-scale items and composite measures. Pearson's product–moment correlation coefficient was used to examine the direction, strength and statistical significance of relationships between the four partnership dimensions and perceived healthcare provision. Before analysis, the suitability of the composite scores, linearity and influential outliers were assessed. Statistical significance was evaluated at the 5% level (p=.05), and correlation coefficients were interpreted as evidence of association rather than causation.

Qualitative data were analysed thematically by coding interview records, grouping related responses and developing themes concerning governance, stakeholder engagement, regulatory coordination, resource allocation and healthcare provision. The themes were reviewed against the interview evidence and compared with the quantitative findings during interpretation. Convergent results were treated as complementary evidence, while divergent findings were examined in relation to participants' roles and experiences. Qualitative findings were used to contextualise statistical associations rather than establish causal effects.

Ethical conduct was maintained throughout the study. The researcher obtained the applicable institutional authorisations, research licence and ethics approval or exemption before data collection. The final manuscript should specify the actual approving institutions, reference numbers and dates. Informed consent was obtained from participants, who were informed of the study's purpose, voluntary nature and applicable withdrawal rights. Confidentiality was protected through the use of respondent codes, secure storage of research records and restricted access to electronic and physical data. Interview quotations were attributed using non-identifying labels where appropriate, and information was handled in accordance with applicable ethical and data protection requirements.

Results and Discussion

Descriptive Statistics of Study Variables

Descriptive statistics were used to summarise respondents' perceptions of collaboration mechanisms and healthcare provision. The results are presented in Table 3. The mean score for healthcare provision was 3.82 (SD = 0.62), indicating a high level of perceived healthcare provision according to the study's interpretation criteria. Collaboration mechanisms also recorded a high mean score of 3.68 (SD = 0.74). Respondents therefore rated both constructs relatively favourably, although

the higher mean for healthcare provision should not be interpreted as evidence that service delivery was objectively better than the quality of collaboration.

Table 3. Descriptive Statistics of Study Variables

Variable	Mean	Standard deviation	Interpretation
Collaboration mechanisms	3.68	0.74	High
Healthcare provision	3.82	0.62	High

Source: Study data.

The findings are broadly consistent with Ringera et al. (2021), whose study highlighted the relevance of partnership-related support and management arrangements in faith-based health systems. Similarly, Getui et al. (2024) reported that collaboration among faith-based groups and health facilities was associated with positive patient-satisfaction experiences in western Kenya. These studies provide contextual support for examining collaboration as part of healthcare delivery, but their outcomes and research settings differ from the perceived healthcare-provision measure used in the present study.

Relationship between Collaboration Mechanisms and Healthcare Provision

Pearson's product–moment correlation was used to assess the relationship between collaboration mechanisms and healthcare provision. The results are presented in Table 4.

Table 4. Correlation between Collaboration Mechanisms and Healthcare Provision

Variables	Correlation coefficient (r)	(p)-value	Interpretation
Collaboration mechanisms and healthcare provision	.642	< .001	Positive, statistically significant association

Source: Study data.

The analysis revealed a positive, statistically significant association between collaboration mechanisms and healthcare provision ($r=.642, p<.001$). This indicates that respondents who rated collaboration mechanisms more favourably also tended to report better healthcare provision. The coefficient represents a relatively strong positive association under commonly used descriptive conventions.

This finding is consistent with Ringera et al. (2021), who reported significant associations between partnership-related factors and the strengthening of faith-based health systems in Kisii County. It also aligns with Getui et al. (2024), whose findings linked collaboration among faith-based groups and health facilities with

positive patient-satisfaction experiences in western Kenya. Collectively, these studies support the relevance of examining institutional collaboration when assessing faith-based healthcare delivery.

Nevertheless, the correlation does not establish that stronger collaboration caused better healthcare provision. The relationship may also reflect other factors, including staffing levels, financial resources, management capacity, service demand or institutional support. Furthermore, the study involved a single hospital and a relatively small stakeholder population. The result should therefore be interpreted as evidence of an association within the study setting rather than a definitive estimate of the effect of PPPs across faith-based health facilities in Kenya.

The study examined the null hypothesis that there was no statistically significant relationship between collaboration mechanisms and healthcare provision at Holy Family Mission Hospital Nangina. The correlation analysis yielded ($r=.642$, $p<.001$). Since the (p)-value was below the .05 significance threshold, the null hypothesis was rejected.

Qualitative Findings

The thematic analysis generated three themes: governance and strategic collaboration; resource allocation and financial sustainability; and institutional alignment, staffing and capacity building. Together, these themes highlighted existing areas of government–hospital collaboration, operational constraints and opportunities for strengthening public–private partnerships (PPPs) at Holy Family Mission Hospital Nangina.

Governance and Strategic Collaboration

The findings indicated that collaboration between government agencies and the hospital occurred through public health campaigns, vaccination programmes and disease surveillance. However, participants identified opportunities to strengthen formal joint planning, communication, monitoring and accountability. This suggests that collaboration in specific health programmes did not necessarily translate into comprehensive strategic coordination.

One hospital administrator explained:

> *"We frequently collaborate on public health campaigns, like child immunization and disease surveillance. However, when it comes to long-term strategic joint governance and policy co-design, the formal framework is either lacking or poorly operationalized at the county level."* (Key Informant 02, Hospital Administration)

This account suggests a distinction between operational collaboration and institutionalised partnership. Although programme-level cooperation was evident, weaknesses in formal planning and accountability could limit continuity and coordination. Ringera et al. (2021) similarly identified leadership, management and

implementation guidelines as important factors associated with strengthening faith-based health systems in Kisii County, Kenya.

Resource Allocation and Financial Sustainability

The second theme concerned financial resources, reimbursement arrangements, medical supplies and staffing support. Participants described delayed reimbursements and limitations in material and human resources as challenges to hospital operations. Resource sharing, staff secondment and technical assistance were identified as potential areas for collaboration.

A county health representative observed:

> "*Holy Family Nangina absorbs a massive outpatient and maternal health load. Yet, financial reimbursements under national insurance health schemes and county medical supply support often suffer severe bureaucratic lags, creating acute cash-flow strains.*" (Key Informant 05, County Health Directorate)

The account highlights the importance of predictable financing and coordinated resource allocation. Delayed payments may complicate procurement, staffing and operational planning, even where reimbursement arrangements are formally established. In a Kenyan study involving public, private and faith-based providers, Obadha et al. (2019) found that delayed payments and concerns about the adequacy and predictability of reimbursement affected providers' operations. This provides a relevant comparison for interpreting the present findings, although the specific reimbursement experiences reported at Nangina require verification against hospital financial and administrative records.

Institutional Alignment, Staffing and Capacity Building

The third theme concerned coordination of institutional responsibilities, human resources and technical capacity. Participants identified staff secondment, technical assistance and coordinated planning as potential mechanisms for strengthening collaboration. These findings suggest that effective partnerships require clear institutional mandates and practical arrangements for mobilising and managing personnel and technical resources.

The findings are consistent with Ringera et al. (2021), who reported significant associations between faith-based health-system strengthening and partnership-related factors, including human resources for health, material support, leadership and management, and implementation guidelines

Conclusion

The findings indicate that collaboration mechanisms were positively and significantly associated with perceived healthcare provision at Holy Family Mission

Hospital Nangina. The qualitative evidence highlighted existing cooperation in public health activities while identifying opportunities to strengthen formal governance, resource coordination, financial predictability and institutional capacity. These findings suggest that government–faith-based partnerships may benefit from clearer responsibilities, regular joint planning, transparent resource commitments and systematic performance monitoring.

The conclusions should be interpreted in light of the study's limitations. The research focused on one hospital, relied partly on stakeholder perceptions and used a cross-sectional design. Consequently, the results cannot establish causation or be generalised statistically to all faith-based health facilities. Future research involving multiple facilities, objective service indicators and longitudinal data could establish whether improvements in collaboration are followed by measurable changes in healthcare delivery.

Recommendations

Busia County health authorities and Holy Family Mission Hospital Nangina should establish or strengthen a formal coordination mechanism for joint planning, service priorities, resource allocation and performance review. Written partnership agreements should clarify institutional responsibilities, expected contributions, reporting requirements and procedures for resolving disputes. Relevant agencies should also improve communication regarding reimbursement and supply arrangements and explore feasible approaches to staff development and technical assistance.

The hospital and its government partners should introduce a joint monitoring framework with clearly defined indicators, responsibilities and review intervals. Future studies should examine the individual contributions of governance, stakeholder engagement, regulatory coordination and resource allocation using verified dimension-specific data and, where possible, objective measures of service availability, continuity and quality.

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