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# Walden University

College of Health Sciences

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Hawa Yatera Mshana

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Review Committee

Dr. Cheryl Cullen, Committee Chairperson, Public Health Faculty

Dr. Magdeline Aagard, Committee Member, Public Health Faculty

Dr. Patrick Tschida, University Reviewer, Public Health Faculty

Chief Academic Officer

Eric Riedel, Ph.D.

Abstract

Community Public-Private Partnership Leadership Synergy in Tanzania

By

Hawa Yatera Mshana

MPH, Sheffield Hallam University, 2006

Dissertation Submitted in Partial Fulfilment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health, Community Education

Walden University

January 2018

## Abstract

Although the public private partnership (PPP) concept in health and social health has been politically accepted as a best pathway to improving health outcomes in many developing nations, implementation lacks leadership synergy. Lack of awareness and engagement of community leaders about PPP interventions and their benefits affect accountability and ownership of health and social care interventions. The purpose of this study was to better understand factors that could promote partnership leadership synergy to enhance ownership and accountability for community health and social welfare initiatives in Tanzania. A qualitative empirical case study design was used; diffusion of innovation and the public private integrated partnership module constituted the theoretical framework. A purposeful sample of 26 participants responded to in-depth, 1-on-1 interviews; they were guided with semi-structured questions; related document were reviewed. NVivo software was used to facilitated data management and content analysis. The key findings indicated that integrated supportive supervision, teamwork, and strategic communications promote partnership leadership synergy. Also, findings show that a lack of clear roles and responsibilities, poor quality data, a lack of understanding the benefits of PPP in health at the community level hinder ownership and accountability in the implementation of PPP health interventions. The results of this study yield insight into the national PPP technical and leadership team that could support the priorities in the implementation of the partnership projects. These results may contribute to social change through an increase in awareness and understanding of PPP at the community level and, in turn, promote ownership and accountability.

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## Dedication

I dedicate this doctorial study to my parents Mr and Mrs Yatera Mmbaga, for your unconditional love, support and guidance, and mostly I am grateful for your belief in value and strength of education, your prayers and encouragement has laid the foundation of the woman and mother that I am today.  Although all you have passed on I know that you are so proud of my accomplishment. Mummy and Daddy, I will always be missing you…you are beneath my wings may Lord rest your soul in peace with all of my love. I also like to dedicate this doctorial achievement to my children, Zena, Kija, and Ibra: Thank you for your enormous encouragement, support and sacrificing the social time without mum, in deed your support and understanding my busy schedule fuel my soul with motivation and courage to complete my study.

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Further, I value and appreciate strategic advice received from my academic adviser Joseph Stevens, and my dissertation editor Timothy Mclndoo for his scrutiny audit on my dissertation. I want also to give special thanks to Dr. Salmon at Sheffield NHS Community Foundation Trust who ignited my interest in research, which motivated my doctorial journey.

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Chapter 1: Introduction to the study

## Introduction

Public-private partnership (PPP) leadership synergy concept in health and social care is essential for promoting accountability to improve health outcomes in developing countries. In Tanzania, the idea of PPP has been adopted to foster collaboration and accountability to deliver continuity of health services, to improve the quality of health, and access to health care (Kikuli & Mbando, 2011; Whites et al., 2013). Because of a synergistic effort, the partnership could prevent early mortality, disabilities, and improve health outcomes for the Tanzanian population. Leadership synergy is the joining coalition force between public and private partners to influence accountability through active communication, shared values and collaboration for the delivery of health and social care services initiatives (Jones & Barry, 2011).

Preventable health conditions associated with child and maternal mortality, HIV, tuberculosis, malnutrition, malaria, and poverty remain major public health concerns in Tanzania (Kikuli & Mbando, 2011). Leadership synergy is vital to promote accountability, particularly in service delivery and data management, to provide insight into quality decision-making on health issues (Cramm, Phaff, & Nieboer, 2012). The literature suggests that most health and social problems are preventable (Kikuli & Mbando, 2011; White, et al., 2013). The consequence of poor healthcare leadership contributes to a range of adverse health outcomes and inequality (White et al., 2013: Wilkinson & Pickett, 2010). Similarly, evidence points to the relationship between the social determinants of health, poor health conditions, and the increased health inequality

in a marginalized poor population (Centers for Disease Control and Prevention, 2010; Wilkinson & Pickett, 2010). Fostering partnership leadership synergy may contribute to promoting accountability in delivering health and social intervention between the public and the private sector.

Leaders represent the voice and needs of citizens. They are accountable for the delivery of health and social care services (Weiss, Taber, Breslau, Lillie & Li, 2010). The Tanzanian government strives to improve the nation's economy. However, the country remains under pressure to ameliorate and mitigate preventable health and social problems because of socioeconomic strain (White et al., 2013). Evidence highlights the fact that a large area in the rural setting and marginalized communities struggle to access quality health care and social services that are publicly provided for the population (Mboya, 2012; Kikuli & Mbando, 2011). A lack of adequate information on health care service delivery and monitoring from the PPP limit decisions and verities of health improvement and coverage on the core health services (White et al., 2013). Enhancing the PPPs leadership synergy and engagement of the community in monitoring the delivery of the health care services and social welfare interventions is essential to promote accountability for the delivery and monitoring of the health care and social welfare interventions (Whites et al., 2013; Kikuli & Mbando, 2011).

## Background

The United Republic of Tanzania is composed of the mainland, Tanzania, and the Island, Zanzibar, with a total population of 49.6 and 1.5 million respectively (World Health Organization, 2012) of which 75% live in rural areas (Tanzania Global Health,

2011). The country faces economic and social development problems that contribute to an increased burden of socially determined conditions, which include diabetes, cardiovascular diseases, mental health issues, sexually transmitted diseases, and injustice gender inequity (Tanzania Global Health, 2011). These behavioral conditions are preventable and have the potential for control with cost-effective interventions (Tanzania Global Health, 2011). Social and behavioral conditions cost the lives of many in vulnerable populations and subject a large portion of the population to poverty due to long-term illness (Whites et al., 2013). Evidence shows that enhancing Public-Private Partnership Leadership (PPPL) could improve mutual accountability, be cost efficient, and increase the potential opportunity for public health integrated initiatives (Koh, 2008; Morse, 2010).

The literature suggests that improving community public health leadership competencies would significantly improve not only program efficiency, but also promote ownership and enhance collaboration that influence mutual accountability (Forrer et al., 2010; Sekhri et al., 2011). Considering factors that affect social determinants of health (SDH), such as places where people are born, live, go to school, work, the social structure and policies promoting ownership is essential for long-term health accountability (Center for Disease Control, 2010; Wilkinson & Pickett, 2010).

In Tanzania, the private health sector plays a vital role in promoting the health and well-being of the population. However, lack of evidence and shared best practices on PPPs limit innovative implementation of primary health care to support leadership synergy (Itika, 2012; White et al., 2013). Evidence found in the literature suggests that

engaging community, increasing awareness, and collaborative action on the social determinants of health to advocate for social change is vital in improving population health (Kikuli & Mbando, 2011; Kwesigabo, Mwangu, Kakoko, & Kilewo, 2012; White et al., 2013). For example, partnership initiatives between comprehensive community - based rehabilitation Tanzania (CCBRT) and the local municipal council provide comprehensive community-based maternal and child health, malaria, HIV/AIDS, health awareness and disability care (Itika, 2012). Similarly, the malaria project has shown significant value for money and improved population health (Itika, 2012).

Despite the major interest in PPP initiatives in promoting Tanzanian health, limited understandings of the social determinants of health concept exist and significant gaps in partnership leadership coordination on PPPs health and social care initiatives (GIZ, 2013; Itika, 2012; Kwesigabo et al., 2012). Leaders perceive that PPPs in the health sector are not a viable practice in addressing and managing health and social care (Kikuli & Mbando, 2011). With the lack of qualitative empirical evidence, leaders and managers have limited insight into best practice PPP concepts (Kikuli & Mbando, 2011; Itika et al., 2013).

The evidence supports the idea that the health outcomes of an increased proportion of disability, mortality rate, and poverty are linked to the social determinants of health (Wilkinson & Pickett, 2010; World health organization, 2010). In Tanzania, there is evidence of limited in-depth understanding, a lack of community collaborative leadership action and engagement, as well as a lack of monitoring strategies for shared best practice (Kwesigabo et al., 2012). Understanding leaders' perceptions of PPP

leadership synergy is important to provide insight into the design and monitoring of health and social interventions in a partnership setting.

Perceptions define personal reality or opinions about the situation, which can be objective or subjective. For example, Levitt (2013) highlighted the implications of public policy in relation to individual perceptions. The differences in perceptions between leaders and managers of the public and private sectors may have a significant influence on how the PPP interventions are designed and implemented (Ansari, 2012). Leader perception may have an impact on the accountability in monitoring and achieving the desired PPP goals (Ansari, 2012; Itika, Mashindano, & Kessy, 2011; Sekhri, Feachem & Ni, 2011). These individual perceptions may have a relative influence on the failure or success of PPPs in health and social care services delivery (Itika, et al., 2011; Montagu & Harding, 2012). A clear understanding of what leaders and managers of PPPs think of partnership leadership synergy may provide data on how to manage the health and social care interventions in a partnership setting.

Improving community health and the well-being of the Tanzanians has been a multifaceted effort, in contrast to the challenges that exist in health and social conditions of the population (Kwesigabo et al., 2012; Whites et al., 2013). Previous research provided evidence that there is a lack of accountability in monitoring and evaluating PPP interventions, limited engagement, and that synergy between the public and private sector is needed to improve health and social issues (Ansari, 2012; Cramm, 2012; Forrer, Kee, Newcomer, & Boyer, 2010; Itika, et al., 2011; Kwesigabo et al., 2013; White et al., 2013). The gap in the literature is limited awareness and engagement of community

leaders on PPPs interventions and their benefits (Itika et al., 2011). Fostering leadership synergy for improving community engagement, accountability and partnership working within these PPPs is essential (Ansari, 2012; Kikuli & Mbando, 2011: Kwesigabo et al., 2012). Addressing social issues requires strong collaboration among different sectors (Ansari, 2012; Feng, Fan & Ma, 2010). Promoting partnership leadership synergy between public and private sectors would influence accountability in the delivery of health and social care initiatives and improve population health (Cramm et al., 2012).

Limited awareness and engagement of community leaders on PPPs interventions and their benefits inhibit collaborative innovation and integrated effort between public and private sectors (Itika et al., 2011). Lack of coalition leadership strategies, and lack of accountability in monitoring and evaluating PPP interventions limit collaborative measures to improve PPP implementation (Ansari, 2012; Cramm, 2012; Forrer, Kee, Newcomer, & Boyer, 2010; Itika, et al., 2011; Kwesigabo et al., 2013; White et al., 2013). This study's literature review provided little or no literature on in-depth understanding of the perceptions of public and private leaders toward leadership synergy to improve PPP interventions.

Literature on the association between partnership functioning synergy and sustainability of innovative programs highlight an increased gap between partnership synergy and their viability (Cramm, et al., 2012). The leadership gap in the community care setting affects the implementation of the long-term health and well-being of the population (Cramm et al., 2012). Further research was needed to provide evidence about leadership synergy in community health–related innovative programs to promote

accountability (Gramm et al., 2012). The result of this study was expected to contribute to filling the gap in the literature of partnership leadership synergy with a view to promoting accountability in the public health leadership field.

## Problem Statements

Although the PPP concept in health and social welfare has been adapted and acknowledged as the best pathway to improving health outcomes in developing countries, its implementation lacks leadership synergy. The partnership leadership synergy gap contributes due to a lack of effective collaboration and reduced accountability on monitoring the delivery of health and on monitoring the social determinants of health interventions, both contribute to the best practice deficits and data to guide public health management decisions in Tanzania (Itika, Mashindano & Kessy, 2011; Mboya, 2010). PPP in health and social welfare is an agreement between government, the public sector, and a non government agency (the private sector) to implement health and social service initiatives (United Republic of Tanzania, Ministry of Social Welfare, 2013). The public sector includes all government agencies, departments, local authorities, and municipals councils; the private sectors involves stakeholders, which constitute international and local nongovernmental organizations (NGO), faith-based organizations (FBO), for-profit and not-for-profit organizations and community-based organizations (United Republic of Tanzania Ministry of Health and Social Welfare, 2013).

There is evidence of existing limited leadership coordination between public and private partnerships, which contribute to the lack of accountability for the delivery of healthcare and social service initiatives (Whites et al., 2013; Itika et al., 2011). The

problem is a lack of leadership synergy on health initiatives, which decreases the level of ownership phenomena that would promote coordination, quality, and positive health outcomes. Further, limited published empirical data hinder shared best practices to address partnership leadership synergy between public and private sector on monitoring the implementation of health and social welfare initiatives in Tanzania (Itika et al., 2012; White et al., 2013). Evidence suggests that the lack of a comprehensive policy and the lack of institutional accountability regarding data quality and management contribute to inefficiency and liability for diseases (Kwesigabo, Mwangu, Kakoko & Kilewo, 2012; White et al., 2013).

## Purpose of the Study

The purpose of this empirical, qualitative case study was to explore the perceptions of project leaders and managers of public and private sectors toward partnership leadership synergy to understand the factors that could promote this synergy and enhance ownership and accountability for community health and social welfare initiatives in Tanzania.

## Research Questions

This study explored the perceptions of public and private community leaders to understand factors that could foster leadership synergy and promote ownership and accountability in the delivery of health and social care interventions within the partnership setting in Tanzania. The following three questions aligned with the study design and served as a guide for this study. To answer the research questions, seven open-ended questions were adapted from a previous similar study (Curry et al. (2012);

see Appendix B. These questions were used to facilitate the one-on-one, in-depth interview with leaders, coordinators, and managers of public and private organizations.

RQ1. What are the perceptions of public and private community health leaders in Tanzanian toward public-private partnership leadership synergy?

RQ2. What are the perceptions of leaders of public and private sector to facilitate leadership synergy for PPP in health and social care interventions in a community setting?

RQ3. How do managers and leaders of the public sector and private sector facilitate synergy for action health and social care interventions implementation in partnership setting?

## Theoretical Framework

This study employed the diffusion of innovation (DoI) theory. The theory has been applied to various environments, such as agriculture, healthcare, social care, and education, and has been successful in communicating new initiatives (Glanz, Rimer & Viswanath, 2008; Resnick & Siegel, 2013; Sharma & Kanekar, 2008). DoI theory was developed by Everest Roger in 1962 the theory originated from communication and provides evidence to explain how an idea can quickly spread and be implemented by the majority and change person/society practice (Resnick & Siegel, 2013; Roger, 2003). Additionally, the Public Private Integrated Partnership (PPIP) model was employed. The literature suggested that the PPIP model facilitated integration initiatives; the design, build, finance and operate (DBFO) construct of the model gives more authority for the private partners to be extra responsible for the delivering of either clinical services or

primary health services (Llumpo, Montangu, Brashest, Foong, Abuzaineli, & Feachem, 2015).

## Nature of the Study

This qualitative design aligned with the qualitative traditions that employ an inductive theoretical approach, and that focus on understanding the description of the phenomena in question (Creswell, 2014). In this case, the empirical case study approach was selected to provide in-depth insight into the perceptions of the project managers and the leaders of the study population toward the public-private partnership leadership synergy in health and social care interventions. Given the limitation of in-depth data on the phenomena in question, an empirical case qualitative study was recommended to provide a descriptive explanation of the complex issues in public-private partnership leadership practice in the population under study (Creswell, 2014; Kohlbacher, 2006). Evidence suggested that an empirical case study has been used to understand complex leadership phenomena in a natural setting with valid results (Creswell, 2007; Nelly, 2012; Kohlbacher, 2006: World Health, 2010).

Purposeful sampling involved a small sample size that was practical and allowed a qualitative researcher to produce thick and descriptive data (Patton, 2014). Purposeful sampling was an interactive process that involved data manipulation during research process (Creswell, 2014; Miles, Huberman & Saldana, 2014). With purposeful sampling, the researcher was able to exhaust required information from the relevant participants and data sources and provided the in-depth understanding of the partnership leadership synergy. With purposeful sampling, the researcher selected six organizations to form a

unit of analysis (Trochim, 2006) and recruited 30 participants who meet the criterion according to research protocol (Appendix A).

Saturation level was reached with 26 volunteers. With the sample size of 26, the researcher derived rich information from different types of experienced project leaders, some with various characteristics, coordinators, and managers from the public and private partnership organizations. Saturation in a qualitative study is a gold standard tool that enables a researcher to use a personal lens to ensure that adequate and quality data are collected to support the study (Fusch & Ness, 2015; Walker, 2012). Equally, the use of the saturation technique increases the validity of the study (Walker, 2012). The reason for the small sample in this qualitative study was to meet the practicability and cost-effectiveness factors in line with time and finance on generating and analyzing descriptive, rich information that was (Creswell, 2014; Miles et al., 2014; Patton, 2015; Trochim, 2006). In many cases, a small purposeful random sampling is used to attain credibility and manageability of the study without trying to be representative of the entire population (Patton, 2015)

For this study, content analysis was considered with the support of Computer Aided Qualitative Research Data Analysis (CAQRDA). The NVivo computer software used to help in the data management and analysis (Miles et al., 2014). The use of the NVivo computer software facilitated the quality and trustworthiness of this study. In many cases, a qualitative researcher used the content analysis approach to review primarily collected data, and link with the research questions to measure and analyze the text (Yin, 2011; Miles et al., 2014). The use of content analysis assisted in reviewing the

transcript. The focus was on the responses, which reflected participants' perceptions of partnership leadership synergy. The transcripts were derived from the open-ended questions obtained from the one-on-one interview with the project leaders and managers of public and private organizations.

In this empirical, qualitative case study, the researcher was an essential instrument, collected data, examined the documents, and interviewed the subjects (Yin, 2011). The triangulation approach was used to ensure the quality and reliability of the study (Patton, 2015). The researcher adapted interview guided discussion questions that were used previously in this area by Curry, Taylor, Chi-Chen, & Bradley (2012): see Appendix B. These questions answered all three-research questions as illustrated in this chapter above.

The researcher conducted interactive face-to-face interviews using open-ended questions with leaders and managers of public and private organizations. All interviews were recorded with an iPhone app, which made it easier for the researcher to play back the interviews for the participants to listen and offer comments while in the field. The researcher transcribed the interviews and uses an analytical lens to manage, analyze, and report the research findings (Creswell, 2014; Patton, 2015). To ensure quality and trustworthiness of study findings triangulation strategy, peer review, thick description, and a reflective journal were used (Patton, 2015). The use of a variety of research tools and approaches increased study rigor (Creswell, 2007).

Before conducting this study, University Research Review (URR) member, then the Walden University Institutional Review Board (IRB) examined the quality of study

proposal and granted the permission number 01-23-17-0103065 to proceed with the study. After Walden University approval, an application for local IRB was performed to meet the Tanzanian government requirements and ethical certificate number NIMR/HQ/R.8a/VOl.1X2423 obtained. Ethical considerations were paramount in this study. As such, the issue of privacy, confidentiality, and voluntary participation was clearly elaborated in research protocol (Appendix A) (Rudestam & Newton, 2015; Walden university, n.d). Participants signed the consent form before proceeding to the interview.

**Types and Sources of Data**

In-depth interviews and document reviews were the main sources of data for this study. Purposeful sampling strategy was employed, and n = 26 participants were interviewed basing on the research protocol and saturation technique (Walker, 2012). The researcher accessed a list of private and public organization that work in a partnership in delivering primary health and social care initiatives from the Tanzania Private Health Sector Assessment document (SHOPS), (2013). Because the PPP registry was not found, the SHOPS and PPP policy documents provided a descriptive profile of private organizations and public-sector profile in the provisions of primary health and social initiatives at the community level (Ministry of Health and Social Welfare, 2011; Ministry of Health and social Welfare, 2013; SHOPS, 2013). Using government documents ensured the reliability and validity of the criteria as a sampling strategy, which increased the quality of this study. The purposeful sampling criteria focused on

- The number of years that the organization has worked in a community health setting (minimum of 3 years)
- The level of the health services that the organizations deliver to the community; this was based on the social determinant of health as described in the definition of the SDH and primary health services in this study.
- The organization should operate within the community setting
- Six organizations were select; three in the private sectors and three in the public sectors. The researcher purposeful sampled 30 participants project leaders, coordinators, and managers and conducted face-to-face in-depth interviews. The quantification of participants focused on the leadership or managerial role that the participants hold at the time of the interview, this is illustrated in the study protocol (Appendix A).

Further, document review of the health and social care interventions were conducted. The documents included the government policy and guidelines on PPP design, implementation, and evaluation, private sector assessment and integrative supervision strategies. In the public sector, the researcher found integrated supervision, malaria, HIV, tuberculosis, leprosy, and maternal health documents, which were reviewed. In the private sector, researcher found the PPP strategy plan for the two organizations and could not access any documents in one of private sector organization. These documents helped the researcher to compare the content and themes, which were reflected in the conceptual framework in this study. Often the qualitative research framework facilitates each step in

the process of gathering and analyzing data (Simon, 2010), which increases quality and rigor of the study result (Creswell, 2014; Simon, 2010).

To gather descriptive information from leaders, coordinators, and managers a set of seven previously used, open-ended, semi-structured questions (see Appendix B) was adapted from Curry et al. (2012). The open-ended questions were used in a relatively similar situation and provided descriptive data (Curry et al., 2012). The researcher recorded the interviews and transcribed each of them. Also, the reflective journal and field notes on the analysis were included. The data focused on the research questions as illustrated above, aligned with the suggested PPIP conceptual framework, and the suggested DoI constructs. This approach of adapting previously tested tools for data collection ensured quality and trust, and supported the interpretation of the research findings (Creswell, 2014; Walden University, 2014).

The analysis focused on the six selected public and private organizations as a primary entity. Public and private organizations were defined as a unit of analysis in this study, and the content analysis process was used systematically for data analysis (Miles et al., 2013). Further, the researcher conducted thematic coding concentrated on the predetermined DoI conceptual framework in each interview transcripts. By using systematic manual and NVivo computer software, themes, patterns and categories were revealed (Miles et al., 2014). And examined for similarities within the conceptual framework; this formed a foundation for data management and analysis (Creswell, 2014; Miles et al., 2014; Yin, 2011). As such, the data management and analysis process was assisted by the use NVivo qualitative computer software program (Creswell, 2014;

Creswell, 2007; Miles et al., 2014). The program was user friendly, and other qualitative researchers have used it to increase the quality and the rigor of the study (Miles et al., 2014). The report included text to illustrate the case, tables and charts that show comparisons and relationship between the theme and the sector.

## Definitions

*Social Determinants of Health*: These are the social factors that are influenced by places where people are born, live, go to school, work including policies and the health infrastructures, and the leadership within the community (WHO, 2010)

*Public - private partnership*: Is a collaborative effort between public and private entities in the implementation of the health and social care initiatives within the targeted community (Montagu & Harding, 2012; White et al., 2013).

*Public health sector:* These are government units that provide health goods for the population. In this study, public health sector includes social welfare services as described by Tanzania Ministry of Health and social welfare (2011). In this study public sector unit includes the Ministry of Health and social welfare, the municipal councils, the local government health and community services.

*Private health sector*: These defined organizations that are voluntary and not for profit, which complement the government effort on the delivering of the health and social services to the community. These organizations are non-governmental organizations (NGO, which include international and the local organizations, the community-based organizations, faith based organization and the charity organization (Tanzania Ministry of Health and social welfare, 2011).

*Partnership leadership synergy***:** Is the facilitative agreement coalition practical and specified role and the responsibilities of public and private organizational leadership with the focus on promoting accountability for the designing, implementing and evaluating of the health and social welfare initiatives (Cramm et al., 2012).

*Social change***:** Social change defined as a significant positive influence and modification of human standards of practice within the established system or social relationship (Laureate Education, 2015g).

*Primary health care***:** These are the core health services and initiatives that are provided at the population level to prevent major health conditions, which includes health awareness and promotions, HIV interventions, Tuberculosis and leprosy interventions, vaccinations, mother and child healthcare services, reproductive and family planning interventions, Malaria control program, diabetes and nutrition awareness and interventions (The United Republic of Tanzania Ministry of Health and Social Welfare, 2013).

## Assumptions

In qualitative research, the role of a researcher is vital in data collection, data management and analysis (Creswell, 2007; Janesick, 2011). Given the fact that Swahili language dominated the communication between the subjects for this study, researcher was confident not only in speaking Swahili language fluently but also in understanding Swahili idioms.

In this study, researcher assumed that leaders and managers in public and private partnership initiatives were resilient, skilled and knowledgeable about public – private

partnership initiatives in health and social care and their benefit to the community that they serve.

## Scope and Delimitations

This study was limited to yielding the information that explained the perceptions of project leaders and managers of the public and private organizations who provided health and social care interventions in the Dar es Salaam Municipal councils. The organizations should be implementing primary health interventions and are not for profit. The intent of this empirical case study was to explore the perceptions of the leaders and managers about partnership leadership synergy to facilitate ownership and accountability in the delivery of health and social welfare interventions in the partnership setting. Given the DoI theory and public PPP model constructs and the CAQRDA software, the NVivo the strategy supported the data collection, management, analysis, and provided guidance on reporting the result of this study.

## Limitations

Limitations of the study were

- Language barriers: the language barrier contributed on to the increased number of the days used to conducting and analyzing this study. This was a barrier because the researcher had to translate the protocol and questions into Swahili language to meet the Tanzania ethical clearance requirement before the study was granted. Although the researcher was confident with Swahili language speaking, understanding and writing, but the process of translation would have resulted into bias if the researcher had done all of the translation. Therefore, to overcome the

bias limitation, researcher had asked for a neutral consultant who is also fluent in both languages to translate the English version protocol, questionnaires into Swahili language.

- Asked for neutral eye to countercheck the interviews against the audio-recorded interview can be expensive. Looking at the cost and time for the translation would pause a degree of delays to progress to data collection.
- Access to the Internet, and transport was problematic, in particular getting transport rom one organization to the other within the country. The problem caused extra spending money in using Internet. So I bought a portable Wi-Fi device to ease Internet access problem issues.

Plan to overcome these limitations were as follows; researcher assessed the situation daily and overcome the problems as they come along. For example, I bought mobile Wi-Fi Internet bundles from three providers: Hallotel, Airtell, and Vodafone to supplement the mobile phone that was used to record the interviews when the normal service went low or off. Researcher consulted a translator soon after URR approved the study and connected to the Uber local services, which was a reliable transport this ensure punctuality to the study location. The researcher was adjustable and flexible to meet the time of the participants in all interview appointments

## Significance

### Significance for Social Change

Social change defined as a significant positive influence and modification of human standards of practice within the established system or social relationship (Laureate

Education, 2015g). The implications for social change in this study could be demonstrated through increased awareness of the perception of PPP leadership synergy within the organizations. This awareness could contribution on influencing and leveraging the collaboration and engagement of the community leaders in monitoring PPP initiatives (Johannessen, Rosemarin, Thomalla, Swartling, Stenstrom, & Vulturius, 2014). Equally, the awareness of PPP benefits would influence changes in PPP policy especially on the designing and the implementation of the health and social welfare interventions, which may leverage inclusion of leadership synergy roles for health projects in the partnership setting.

**Significance to Practice**

The influence of leadership synergy practice may increase understanding and awareness of the benefit of PPP, which may contribute to improving community action for the delivery of the health and social welfare interventions. Further, the process of conducting this study could promote an innovative environment for the public and private sector leaders (Itika, 2013). And may enable mutual leaders working together to enhance accountability, increase awareness, collaboration and integration of services (Ansari, 2012).

The practice in this partisanship the design, monitoring and implementation of health and social care initiatives have synergetic capacity. This capacity could facilitate community engagement and ownership, could also promote accountability in the delivery of health and social services initiatives (Ansari, 2012), which in turn would enhance continuity of primary health care and preventions of poor health conditions.

**Significance to Theoretical Framework:**

In this study, the DoI theoretical framework was utilized to facilitate the data collection process, and analysis. Also, the DoI construct provided a frame for the structuring of the study question and guiding on the analysis on how the communication works at the different level of the leadership in the public and private organisation and at the community level. Evidence suggest that applying DoI theory in communicating new ideas within the society is cost efficient and produces best outcomes (Rogers, 2003). The use of DoI and PPIP constructs, increase quality and trustworthiness of this study, which provide a way to replicate the study findings to a similar setting.

## Summary

The concept of public-private partnership has been adopted to facilitate the delivery of health and social welfare services (Montagu & Harding, 2012; United Republic of Tanzania Ministry of Health & Social Welfare, 2013). The public-private partnership is the agreement between the government (public sector) and private sector to deliver services for the public use. Promoting the accountability of the delivery of health and social care services between these partnerships is vital to ensure access, quality of care, continuity and value for money (Ansari, 2012; Forrer et al., 2010; Sekhri et al., 2010). Partnership Leadership synergy is joint agreement to deliver primary health services with a focus on increasing ownership and accountability within PPP health interventions.

Given the synergetic capacity in the design, monitoring and implementing of health and social services initiatives within this partnership may facilitate community

engagement, ownership and promote accountability of the delivering of primary health and social initiatives (Ansari, 2012). The negative perception toward public-private partnership leaders is a challenge (Cramm et al., 2012). Limited data on partnership leadership contributes to the lack of understanding, limited shared best practice, and limited awareness of the benefits of PPP leadership synergy (Itika et al., 2011). A lack of qualitative data on partnership leadership synergy in developing nations limits the community engagement and effective decisions on the designing and monitoring process, which impinge on the accountability of the delivery of the health and social welfare initiatives (Cramm et al., 2012; Itika et al., 2011)

In Chapter 2, the researcher discuss the literature on the public, private partnership, partnership leadership, social determinants of health, and partnership leadership synergy in response to the study problems, questions, methodology, and practice in different levels of application of the PPP concept. The study aligned with the proposed theory and conceptual frame, which are elaborated in chapter 3.

In summary, Chapter 3 discussed the purposeful criterion and selection of research organizations and participants. The researcher discussed the saturation level that constituted the participants in this study. Moreover, the content analysis was used and the NVivo computer assisted qualitative data analysis was used. In chapter 4 & 5, the researcher provided an in-depth explanation of the study findings. Gave a breadth explanation of all three research questions, aligned the research purpose, and the theoretical framework.

# Chapter 2: Literature Review

## Introduction

This study explored the perceptions of leaders and managers toward leadership synergy of public-private partnership in health and social services. The purpose of this empirical qualitative case study was to explore the perceptions of project leaders and managers in the public and private sectors toward the synergy of partnership leadership and to understand both the factors that could promote this synergy. Such understanding would enhance ownership and accountability of community health and social welfare initiatives in Tanzania.

The research questions were aligned with the purpose of this study and the literature review organized on the topics of public-private partnership, partnership leadership synergy, and social determinants of health. These topics constituted the outline that guided the search strategy (Straus, Tetron & Graham, 2011). The discussion focused on the current debate on public-private partnership and social determinants of health while identifying a gap in the literature on partnership leadership synergy in health and social services. The synergetic gap found on this study provides a big picture to authenticate this study. The following table facilitates transparency in retrieving the literature; it also helps show the validity of the study, which could increase its utility (Straus et al., 2011; Tricco et al., 2010).

Tables 1 and 2 below show the process I used to gather literature using more than one database.

Table 1

*Multidisciplinary database*

| Search topic | Keywords | Results | Comments |
|---|---|---|---|
| Public private partnership | Public Private Partnership Qualitative Subjects: public private sector cooperation, public health, public administration, government support, health and welfare funds Interpersonal relationship, interviewing, health, physical health, obesity, theoretical, | Result in 7 articles **5 articles met criteria** | Among the seven articles five articles met the criteria set illegibility for my study. |
| Public private partnership leadership synergy | Public private partnership leadership qualitative | Result in 1 article **None selected** | Not met the criteria. |
| Social determinants of health | Social Determinate AND health AND Qualitative Subjects-health promotion, public health, health, social status, medical personnel, interviewing, theory of knowledge, malaria, HIV, attitudes, behaviors, maternal health, health facilities, women health, finance, mental health, poverty | 156 articles found then advanced search with limiters: full text, scholarly peer reviewed article, published date 2011 to 2016, core services, developing countries performed and ten articles found. **10 articles selected** | All ten articles that found with advanced search met the literature review criteria for this study |

Note: Key words public private partnership qualitative, partnership leadership, and social determinant of health

Table 2

*ProQuest central social science*

| Search topic | Key word | Results | Comments |
|---|---|---|---|
| Partnership leadership | Collaborative, public private partnership, public health, public private partnership leadership, public sector, leadership, public health, leadership, private sector leadership, collaboration, infrastructure, public private partnership and colleges and universities, public private partnership and economic development, public health and foundation, leadership behaviors, leadership characteristics, partnership collaboration, team work, multidisciplinary organization collaboration | 1,988 articles found,<br><br>Narrowed down to African articles, collaboration, health care delivery, public health, and leadership development – 60 results.<br><br>**Criteria applied and 28 articles selected** | Advanced search engine applied full text, peer reviewed scholarly articles, qualitative case study. |
| Community partnership leadership in health | Collaborative public private coalition, participation, engagement, community leadership, health care system, health care development, organization innovation. Health care infrastructure, multidisciplinary ream, professional, team work, community leadership, leaders | Results 3664 articles, narrowed down – Africa, peer reviewed scholarly articles results 156 articles- Relevance criteria applied and **18 articles met criteria**. | Search engine with advanced search and limiters were applied and relevance criteria |

Note: Key words Partnership Leadership Qualitative; community partnership leadership

In summary, the public-private partnership, partnership leadership, community leadership, qualitative and social determinants of health themes were used as keywords to conduct a broad literature search. The researcher reviewed university electronic database and Google Scholar, in which a total of 70 articles mixed methods, case studies and few qualitative empirical studies were found to be relevant to this study. Unavailability of

evidence for qualitative catalogue has been pointed out, and researchers are encouraged to engage with librarians to search evidence for qualitative research (Tricco et al., 2011). Given the advice from Walden University librarian, the researcher located relevant empirical qualitative articles for this study.

A variety of electronic search engines employed to explore the articles in each topic, which include multidisciplinary database and ProQuest Central Science Direct, and Google Scholar. First, I checked for full text, scholar peer reviewed journals with limited years from 2010 to 2016 and applied advanced search with limiters and selected articles that are directly related to the study topic. Secondly, I imputed selected articles into the Microsoft matrices table; this process facilitates the management and synthesis of literature (Galvan, 2010).

Chapter 2 is organized by topics, which are public-private partnership, social determinants of heath and partnership leadership synergy and theoretical framework. These topics provide a background for discussing current literature, and also provide an overview of argument on this study.

## Public Private Partnership

PPP is a concept that enables contractual agreement opportunity between government, the public sector and private sector in which the private sector assumes a full obligation to provide publicly consumed goods and/or services (Cappellaro & Longo, 2011; Montagu & Harding, 2012; The United Republic of Tanzania, 2009). Further, PPP is defined as government services that involves a contract between one or more private sector and the public authority whereby the private sector provides a public service or

project and undertakes responsibility and risk for financial, technical and operational (Kharizam, Roshare & Hadi, 2012).

PPP is a legal partnership aimed to improve and/or expand public services through the use of the private sector to deliver infrastructure and some services to the public (Kaplan, Kyle, & Shugart, 2012; Meessen, Hercot, Tibouti, Tashobya & Gilson, 2011; Roehrich, Lewis, & George, 2014). The public sector defines the government authority that provides services to the public, and the private sector represents all other non-governmental organizations that are also contribute to the government economy (Kharizam et al., 2012). Although the literature shows variations on PPP definitions, the purpose of PPP in health and social health care delivery services focuses on partnership working to supplement government efforts in delivering healthcare access to the large population (World Bank, 2011; World Health Organizations, 2010).

Since the evolution of PPP, the concept has received not only a variety of definitions, but also differs in its application across countries (Montagu and Harding, 2012). The determinant of PPP definition and application depends on the level of political will and policy with which each country embraces PPP concept (Dewulf, Blanken & Buit-Spiering, 2011). Literature suggests the variation on the PPP application has created confusion on the universal PPP definition between practitioners and service providers globally (Dewulf, Blanken & Buit-Spiering, 2011; Montagu & Harding, 2012). For example, how PPP is institutionalized in developed countries differs significantly to developing countries. In Canada, the infrastructure of delivering PPP focuses on building better services and infrastructure for the Canadian future (Roehrich et al. 2014) In the

United Kingdom, some PPP contracts focus on integrated investments, and community engagement, and promotion of private finance initiatives (Tomlinson, Hewitt & Blackshaw, 2013). In the United States, the PPP is implemented by the federal government as a catalyst for the inner-city infrastructure and regional development via private investments (Global Health Group, 2013; Pina, Cohen, Larsen, Mario, & Sill et al., 2015). In many developing nations, the PPP concept is linked to economic development, and thus the definition and the structure for PPP in health and social care delivery varies significantly (Global Health Group, 2013; Sekhri, Feachem & Ni, 2011; Pina et al., 2015; World Bank, 2011; Zachary, Peter & Chris, 2012).

Although PPP is a new concept in many developing nations it has captured positive political will and its implementation has proliferated fast in many countries that are involved (Global Health Group, 2013; World Bank, 2011). Many developing countries demonstrate involvement in PPP implementation through either policy development or the existing policy reflects on design, build, organize and deliver the PPP concept in a partnership setting (Keown, Parston, Patel, Rennie, Saoud et al., 2014; Pina et al., 2015; Sturchio & Cohen, 2012; World Bank, 2011). For example, in India, the PPP concepts policy promote private investors in all sectors, and in South Africa the PPP aimed to support the government to cope with budget deficiencies and development of the infrastructure (Ayesha, Frederick & Nicola, 2013). The Tanzanian PPP policy focuses on engaging the private sector to deliver public services and utilities under government monitoring and authority (Itika, Mashindano & Kessy, 2011).

In many developing nations, the PPP in health holds a common characteristic, which focuses on supplementing the government effort in the provision of quality health care delivery and promoting access to health for vulnerable populations (DeVone & Champion, 2011; Ejaz, Shaikh & Rizvi, 2011; Sturchio & Cohen, 2012). Many factors may contribute to the variations in the designing, delivery and implementation of the PPP concept in health and social care. Literature suggests clarity to strengthen partnership leadership and to increase the value of PPP interventions, promoting best practices, monitoring, and accountability is crucial (Forrer, Kee, Newcomer & Boyer, 2010; Montagu & Harding, 2012; Roehrich et al., 2014).

The general goals for PPP are to off shoulder government from finance borrowing, improving public service and infrastructure, and improving access to health and social services for underserved population (Global Health Groups, 2013; World Bank, 2011). With PPP strategy, the public sector would be able to accommodate private sectors' expertise and efficiencies into the delivery of some of the public services that were normally procured and delivered by the public sector such us public and health services, education, community services, insurance services to mention few (Dewulf et al., 2011; Global Health Group, 2013; World Bank, 2011). The public sector provides government services to the public, and the private sector consists of different non-governmental organizations that are voluntary, and for profit (business) contributes to the government economy (Kharizam et al., 2012). In many developing nations, the private sector involves stakeholders that are not part of the governments, but supplement government effort in delivering health services such as charitable organization,

community services and faith organization (Itika et al., 2011: World Bank, 2011). The marriage between the public sector and private sector create a partnership value that holds the contractual agreement (Jones & Barry, 2011)

The gap in health outcomes and the financial barrier were the catalyst for PPP in health initiatives, which influenced the dialogue in the late 1990's on maximization and involvement of industries to develop safe and effective pharmaceutical products to support preventions of communicable health conditions such as malaria, HIV prevention, and vaccinations for developing nations (Global Health Group, 2013; World Bank, 2011; World Health, 2010). PPP for health initiatives is the building blocks on the partnership between the global health and pharmaceutical industries that were initiated to develop cost effective and efficient product such as vaccinations, medication, and some treatments for underserved populations (Dewulf et al., 2011; Global Health Group, 2013). Engagement of international not for profit organizations, which care for human health, united interested public and private sector to the partnership continuum contract to deliver the PPP mission (Dewulf et al., 2011; Kharizam et al., 2012). In many developing nations, the PPP concept is a motivational drive that attracts government to a new source of finance for funding public service needs and infrastructure.

With PPP concept, public and private organizations work together to provide access to quality health and social needs for better health outcomes. The rapid increase of PPP innovations should reflect on strengthening government efforts, increasing the viability of PPP, promote best practice, and foster collaborative strategy in overcoming gaps in delivering public health and social service for a large population (Global Health

Group, 2013; World Bank, 2013; World Health Organisation, 2010). Currently, many developed and developing nations continue to invest on PPPs integrative initiatives in various ways (Forrer, Kee, Newcomer & Boyer, 2010; Morse, 2010; Sekhri et al., 2012). On the other hand, developing nations lagged behind in accelerating the implementation of the PPPs concept (Ansari, 2012; Zou, Kumaraswamy, Chung & Wong, 2014). Many factors may contribute to the slow movement in PPPs adaptation in developing nations (Ansari, 2012; Hofstede, 2010; Jones & Barry, 2011).

The influence on partnership in health reflected in the global landscape, national and local governance between interested private and public sector focus on joining forces to implement government health initiatives (Paul, Stephen & Neil, 2013; world Bank, 2011). Evidence in the literature shows partnership promise to improve the quality of care, access and efficiency in the healthcare system (Giulia & Francesco, 2011; Iram, Bakari & Narjis, 2011; Sekhri et al., 2011). However, literature still suffers detailed insight to inform best practice on how to effectively lead the PPP to action health and social care initiatives particularly, in developing nations (Barnes, Curtis, Downey, Moonesignhe, 2012; Montagu & Harding, 2012; Sekhri et al., 2011).

Given the contractual agreement between government and private sector whereby the public sector (the government) engages private sector companies. The private organization shares resources, risk, benefit and expertise in delivering goods and health services for the public consumption (Center for Disease Control and Prevention [CDC], 2014). In many cases, the implementation of PPP policy in health and social care services should incorporate guidelines and procedures for local community engagement, and

indicate how PPP interventions should be operationalize in the community setting (Barnes et al., 2012; Mashindano et al., 2011). Accountability for the delivering and monitoring of the PPP interventions requires effective leadership, trust, and transparency between the service providers (Ansari, 2012; Whites et al., 2013). The methodology of ensuring value for money, quality, safety, accessibility, efficiency and availability of data for the service provision in a partnership setting is imperative especially in an integrative health initiative (Accreditation Canada, 2015; Bulk & Gregory, 2012).

Developed countries such as Canada and United Kingdom demonstrate not only a significant achievement, but also value for money on the design and implementation of the PPP concept (Accreditations Canada, 2015; Bulk & Gregory, 2012). These countries involve an independent non-governmental organization that works in collaboration with the government to monitor, assess and evaluate public and private health services providers against national standards, share evidence-based research and provide accreditation for the organization (Accreditation Canada, 2015; Bulk & Gregory, 2012). The use of independent nongovernmental organizations increases accountability and contributes not only to improving the quality of the health services, but also promoting transparency in communication, risk assessment, capacity building, and shape the policy, procedure, and practices (Accreditation Canada, 2015; Bulk & Gregory, 2012). A developing country such as Tanzania, engages with PPP technical working groups at the national level. Also, the Tanzanian PPP policy is a top-down approach, and the implementation strategy lacks a standardized framework (Whites et al., 2013). A standardized framework ensures quality, safety and efficiency of PPP interventions, and

provides a significant monitoring strategy in integrated partnership interventions (The United Republic of Tanzania, 2009: Whites et al., 2013).

The United Republic of Tanzania National Health Policy (URTNHP) (2007) encourages the implementation of the PPP concept in the health sector, which is illustrated in strategic plan III (2009-2015) (The URTNHP, 2007). This national health policy engages leaders from the public and private sector in a process of formulating guidelines and framework for implementation of PPP, which foster the cooperation between the public and the private health and social services providers (Mashindano et al., 2011; The United Republic of Tanzania, 2009; Whites et al., 2013). However, the policy focuses on the national level and lacks a comprehensive strategy for engaging community health providers (Whites et al., 2013). Improving performance of PPP at local health community is vital to promote the utility of health and social services. In many cases, operationalizing the PPP health interventions needs to focus downstream, to improve community capacity, trust and monitoring strategy to stimulate accountability and continuity of care (Mashindano et al., 2011; Montagu & Herding, 2012). Although PPP holds vital organizational strategy, management, and financial implications, limited evidence exists on how to effectively lead PPPs, measure the success of the quality of health and social services interventions, and monitor the costs of partnership implementation (Montangu & Harding, 2012).

The existing deficiency of descriptive empirical literature on PPP delivery inhibits clear understanding of how to facilitate the integration between the public and private partnership, particularly in undeveloped nations (DeVone & Champion, 2011; Giulia &

Francesco, 2011; Keown et al., 2014; Roehrich et al., 2014; Julia, Dennis & Navindra, 2014; Montagu & Harding, 2012). Moreover, various perceptions and limited understanding of how to lead PPP in a partnership setting hinders leaders and managers to exercise an evidence-based decision-making approach on monitoring the delivery of partnership interventions (Forrer et al., 2010; Osei-Kyei & Chan, 2015).

In the case of Tanzania, the government acknowledges the benefit of leveraging PPP capacity and resources to address social determinants of health through the PPP mission (The United Republic of Tanzania Ministry of Health & Social Welfare, 2013; Ministry of Health and Social Welfare, 2011). The adoption of PPP implementation in Tanzania is significant and politically accepted, and it is demonstrated in the Tanzanian national strategy for growth and poverty reduction (NSGRP/MKUKUTA). The strategy aims to promote PPP through enhancing space for local stakeholders including citizens, communities, civil societies, private sectors, and public-private-NGO partnership to improve the access and quality of health and social services (Ministry of Health and Social Welfare, 2011).

Given the positive environment and political will for the implementation of PPP initiatives in many developing nations, the increased positive impact on population health, health care infrastructure maintenance, and improved access to quality care through community health fund (World Bank, 2012). This improvement is demonstrated in some local health centers in Kenya, and on-going capacity building for staff in country such as Liberia, Uganda and Lesotho (World Bank, 2012). Despite the positive outcome of PPP implementation, evidence suggests that strengthening the capacity of a partnership

between government and non-governmental organizations to increase knowledge of PPP procedures would improve the quality of decision-making and promote the PPP strategy (Ejaz et al., 2011).

Developed and developing countries demonstrate that the partnership between the public and private sector has a potential benefit of increasing access to quality, primary care initiatives at the population level (Duc, Sabin, Cuong, Tuien & Feeley III, 2012: Roehrich, 2014). Greater integration on the uptake and diffusion of PPP innovation to address both health and social care is necessary for health improvement (Keown et al., 2014). Maximizing the use of public private integrated partnership (PPIP) model to incorporate wider aspect of health and social care services has a significant positive impact on value for money and access to health services (Sekhiri et al., 2011). Leveraging the benefit of PPP contracts in addressing the wider health and social services demonstrates achievements in health care improvement and bridging the health inequity gap in health access (Kaplan et al., 2012). The literature suggests that the current focus of PPP in many developing nations is on contracts and legal agreements with little attention on operations at the community level (Cappellaro & Longo, 2011). Evidence suggests that a lack of monitoring and accountability of interventions in the Tanzanian PPP policy, demonstrates an insufficient framework and lack of private sector engagement (The United Republic of Tanzania, 2009).

Public private integrated partnership (PPIP) for health and social care interventions, clarity on integration, monitoring, evaluation and accountability need to be established (Forrer et al., 2010; Montagu et al., 2012). There is a broad range of

variations in PPIP model, which determine the form of involvements and risk associated with a contract (Llumpo, Montagu, Brashes, Abuzaineli & Feachem, 2015). Despite the benefit that comes out of PPIP, the literature reveals implementation confusion in the health sector, and a significant lack of conceptualized structure for monitoring the partnership interventions (Llumpo et al., 2015; Montagu & Harding, 2012).

Evidence suggests that in a developing nation, the adoption of PPIP integration approach for public health infrastructure and service delivery remains limited (Keown et al., 2014; Ingram, Douglas & Costich, 2015; World Bank, 2011). In many cases tackling wider social determinants of health, and investing on a comprehensive integration is crucial to ensure the holistic improvement of health outcomes. PPP interventions need to integrate social determinants of health as a lens in improving community health outcomes (Chapman, 2013). Literature highlights potential opportunity in a diffusion of PPP innovations and engaging other sectors in to promote and action social conditions at the community level (Choudne & Culkin, 2012).

## Social Determinants of Health

Social determinants of health (SDH) are conditions that affect a broad range of peoples' health, functioning, quality of life, and have a major impact on health outcomes (Center for Disease Control and Prevention, 2011; World Health Organization, 2010b). Factors that are associated with SDH conditions are places where people are born, live, go to school, work, play, worship, age and the influence on the health system, social behaviors, community, and environmental (Healthy People, 2020; World Health Organization, 2010; Wilkinson & Pickett, 2010). Given the interaction between

individuals and the environment that they live in plays a major role in individual's health and these actions are responsible for health inequality and inequity (Center for Disease and Prevention, 2011; World Health Organization, 2008). Most of the SDH are shaped by social policies, economic and politics (Ray, Garmick & Schinut, 2010). The need to provoke action on inclusive policy on awareness of SDH and health inequity in developing nations is crucial to improving the health outcome of the population (Ray et al., 2010).

Although many developing countries spend a large amount of money on health, people remain ill and die early because of an increased gap in health inequity (World Health Organization, 2010). Evidence suggests that increased percentages of disability, mortality rate, and poverty around the world are linked to the social determinants of health (Wilkinson & Pickett, 2010; World health organization, 2010). For example, in developing nations conditions such as diabetes and obesity, sexually transmitted diseases, HIV and AIDs, teenage pregnancy, alcohol and drugs, domestics abuse, malaria, tuberculosis are preventable conditions yet account for health outcomes of the population (Commission on Social Determinant of Health, 2008).

Integrated health programs such as comprehensive community-based rehabilitating in Tanzania (CCBRT), and faith-based organizations (FBO), provide access to community care and demonstrate value for money in improving the quality of life for people in remote localities through partnership (Whites et al., 2013). In particular core services such as maternal and child health, HIV/AIDS, tuberculosis, nutrition, and malaria program and health awareness are vital for community development

(Commission on Social Determinant of Health, 2008; Soeung, Grundy, Sokhom, Blanc & Thor, 2012).

While the current focus for public-private partnership concentrate on improving hospital care access, there is no methodology to ensure monitoring process of quality of care within the PPP interventions (Montagu & Harding, 2012). Improving medical care access alone cannot heal social health (Braveman, Egerter & Williams, 2011) and thus emphasis on improving the knowledge gap, heath policies and promoting multidimensional interventions to action SDH is essential (Tomlinson et al., 2013). Evidence demonstrates inefficiency in integrating SDH in a PPP concept especially in developing nations (Mtenga, Masanja & Mamdani, 2016; Mumtaz, Salway, Bhatti, Shanner, Zaman, Laing & Ellison, 2014). Inequity in health and social care such us lack of access to quality child health care, maternal health, health education and promotion, health illiteracy, poor health system infrastructure, neglect to mention few are SDH, and have adverse effect on individuals' health, and are responsible for early mortality and morbidity (Brassolotto, Raphael & Baldeo, 2014; Che-Chi, Bulage, Urdai, & Sundby, 2015; Eflekhari, Forouzan, Mirabzedeh, Sajid, Dejman, Raflee, & Golmakan, 2014; Kadir, Marais, & Desmond, 2013; Meessen et al., 2011; Mtenga, et al., 2016; Sturchio & Cohen, 2012; World Health Organization, 2012; World health organization, 2016). Many social factors can lead to morbidity, which may fuel poverty and shorten life expectancy (World health Organization, 2012).

According to Health Gapminder (2015), life expectancy in most of Sub-Sahara African is below the average of 70 years. For example, expected life varies from 57, 60,

62, and 65, for Zambian, Uganda, Tanzanian and Kenya respectively; while in developed nation the average of life expectancy is above 80 years. A country such as Japan (83), Canada (82), UK (81) and the US (79), which is almost ten years difference in expected years of life between developing and developed nations. The literature consistently indicates factors that influence negative social health are preventable, and thus increased SDH awareness and strengthening the partnership between organizations would improve and sustain community health (Braveman et al., 2011; World Health Organization, 2016). Current public health debates acknowledge the social factors that influence health outcomes and encourage both public and private partnership to develop ways to address SDH. However, a literature gap exists, on how to effectively handle partnerships interventions for better health outcomes (Forrer et al., 2010; Jones & Barry, 2011; Kinney Kerber, Blank, Cohen, Nkurumah, Coovadia, Nampala, & Lawn, 2010)

Myriads of effort in addressing the social determinants of health have been demonstrated focusing on closing health gap, and promoting good health for the population (Kinney, et al., 2010; National Partnership for Action HHS, 2011). The literature provides minimal evidence regarding community engagement, monitoring, and evaluating partnership programs to facilitate ownership in health interventions (Chapman, 2013; Richard, 2016; Kee & Forrer, 2012). Employing social determinants of health as a lens within the public-private partnership could draw attention to many organizations and catalyze synergetic action (Ichoku, Mooney & Ataguba, 2013) The question remains unanswered on how to strengthen partnership collaboration to action SDH in the same vein of PPIP initiatives.

The literature suggests that in Tanzania, an increased awareness to better understand SDH across sectors and practices is necessary to strengthen the public health system, and to promote action to identify health inequity needs of the population (Mtenga et al., 2016). Health inequity is identified as a pathway to poverty, yet it is influenced by poor planning, weak government infrastructure, gender inequality, unrealistic health and social policies and inefficient (Blas & Sivasankara, 2010). As a result of lack of attentions to health inequities and SDH such as lack of access to quality health and social welfare services, access to quality education and health literacy, access to safe water and sanitation, and also lack of data for better decision making can hamper health of individuals especially those in a remote location (Itika et al., 2011; Mtenga et al., 2013). With the deficiency of information, integrating SDH in public-private partnership initiatives is a challenge especially when the country lack SDH portfolio (Mtenga et al., 2016).

A lack of empirical descriptive literature undermines the decision-making process by leaders and managers at all level of PPP especially on how to join forces to action the SDH (Chapman, 2013; Richard, 2016). For example, the case of lack of access to health services, literature on policy process analysis in six Sub-Sahara African countries (Burkina Faso, Burundi, Ghana, Liberia, Senegal, and Uganda) found leaders can make critical decisions in reducing the inequity gap that exists (Meessen et al., 2011). However, the existing insufficient policies poor health services design, weak health system, and lack of consultation hinder the progress of achieving positive heath outcome goals (Meessen et al., 2011). Unnecessary delay on action SDH and process on closing

the gap in health inequality is the consequences of week public health structure and less attention to priorities (Meessen et al., 2011; Mtenga et al., 2016). The results on health and social system limitations from the six countries underpin the findings from Tanzania SDH implementation deficiency (Mtenga et al., 2016).

Given a right to health needs, it is vital for the PPP to pay attention to health inequity and action to SDH to improve health outcome (Chapman, 2013). The literature supports a need to strengthen health systems, increasing knowledge of SDH across sectors, promoting collaborative action, ensuring availability of data for better decision making, strengthening partnership between public and private and within organizations (Ichoku, Mooney & Ataguba, 2013; Meessen et al., 2011; Mtenga et al., 2016). A literature gap exists on how to foster community partnership interventions to promote ownership in health and social health. In Kenya for example, evidence shows that engaging community to lead community health and social intervention proves to be effective and efficient, promote ownership, and advocate for social change (Waweru, Goodman, Kedenge, Tsofa & Molyneux, 2016). In the case of Tanzania, the private health sector plays a vital role in promoting the health and well-being of the population. The country lacks evidence and shared best practice on operationalizing the PPP concept in health and social services that could promote action for SDH (Whites et al., 2013). Lack of evidence limits the innovative support for facilitative leadership in a partnership setting (Mtenga et al., 2016; Whites et al., 2013).

Evidence suggests that fostering community partnership, increased awareness of integrated health and social health, and collaborative action on the social determinants of

health could advocate for social change in developing nations (GIZ, 2013; Kikuli & Mbando, 2011; Kwesigabo et al., 2012; White et al., 2013). Tanzanian government has demonstrated goodwill on implementing the opportunities that PPPs offer (Tanzania Global Health Initiatives, 2011). Significant requirements for strengthening leadership actions in a partnership setting remain evident (Ansari, 2012; Mtenga, 2016).

## Partnership Leadership Synergy

Partnership Leadership Synergy is the extent that the engagement and contribution of both partners empower each other and promote team innovative ability and accountability in a holistic attitude (Barner, Curtis, Downey & Ford, 2013). Leadership synergy may address the priorities to the stakeholders' needs in the partnership, which may increase support from community and ownership of health initiatives (Barner et al., 2013). Leadership is the art whereby an individual influences a group of individuals to accomplish a common set of goals (Jones & Barry, 2011; Melvyn Hamstra, Yperen, & Sassenberg, 2011). The literature suggests that effective leadership is the ability to motivate the team to enact change (Curry, Taylor, Chi-Chen, & Bradley, 2011; Silvia & McGuire, 2010).

Although leaders hold a degree of authority and power, in the public health arena, effective leadership goes beyond leadership character to the ability to meet the needs of the people and the organization that a leader serves (Crosby & Bryson, 2010; Koh, 2009; Morse, 2010). Effective leadership fosters teamwork, promotes positive relationships and effective communication, and also facilitates a structured collaborative process (Northhouse, 2010; Morse, 2010; Weiss, Taber, Breslau, Lillie & Li, 2010).

Understanding factors that would enhance leadership synergy within the partnership setting is essential in fostering community leadership accountability in monitoring health interventions (Cramm, 2012; Hofstede, 2010)

Behavior and style approaches to leadership play a significant role in effective leadership especially in a complex organization structure (Bucker & Poutsman, 2010; Chreim, Williams, Janz, & Dastmal, 2010; Choi, Holmberg, Lowstedt & Sundby, 2015). Leaders who have effective communication, promote stewardship, team innovation, and engagement, effectively facilitate a positive partnership function and organizational success (Ansari, 2012; Hofstede, 2010; Jones & Barry, 2011; Melvyn et al., 2011). When protecting and promoting public health needs of the population, leaders should consider not only an innovative approach, but also collaborative and integrative ways of working with their team (Koh, 2009; Weiss et al., 2010).

To achieve effective patient outcomes in a collaborative and coalition leadership, the literature suggests the application of public health leadership competency in a complex organizational culture (Ansari, 2012; Hofstede, 2010; Koh, 2009). A study on integrative leadership discussed the engagement of multidisciplinary practice and leadership practice within the PPP framework as essential ways to enable organizational to function (Fernandez et al., 2010; Silvia & McGuire, 2010). Given adaptive leadership style in a parallel working relationship with shared authority, effective communication, and clear regulations is vital to effective partnership functioning (Northhouse, 2010; Cappellaro & Longo, 2011). Promoting a clear pathway of diffusion of innovation fosters stakeholders to leverage innovations in all levels of delivery (Hess & Schramm,

2014; Wallace, 2014). In many cases, building a partnership leadership in a partnership setting needs a mechanism that would influence and maintain synergy between and among the organizations.

Cappellaro & Longo (2011) suggest that the contractual dimension of PPP focuses on the legal aspects and ignores the health outcomes aspect of partnerships (Cappellaro & Longo, 2011). Although the application of leadership may differ from leaderships in a single to multiple agencies (Hofstede, 2010), organizational culture varies between and across the sectors (Wallace, 2014). Leadership effectiveness and partnership efficiency produce partnership synergy (Weiss et al. (2002), in Jones & Barry, 2011). Synergy stimulates positive partnership process, which yields a facilitative mutual accountability in monitoring health initiatives in a partnership setting (Cramm, 2012; Silvia & McGuire, 2010).

Given other determinants of partnership synergy such as resources, partners' characteristics, arrangements, and environments, these are factors that are outside the partnership context, which needs to be considered (Jones & Barry, 2011). A strong bond between public and private partnership requires a framework that facilitates early engagement of both partners in leadership process, building capacity on leadership and promoting partnership uniqueness (Barner et al., 2013; Sturchio & Cohen, 2012).

Promoting relationships between partnership synergy and partnership functioning needs to consider factors such as trust, conducive environment, communication and leadership behavior to influence positive collaboration, member's satisfaction and promote teamwork, efficiency and ownership (Jones & Barry, 2011; Weiss et al., 2010).

Building a partnership synergy to achieve agreed goal, leadership structure should be established at a very tender stage between organizations (Sturchio & Cohen, 2012). Leadership synergy would tie partnership culture, build trust, establish common shared value, and hold together partnership teamwork (Sturchio & Cohen, 2012). Synergy is a process and product of a total contribution between two or more organizations that come together to act on common good (Cramm, 2012; Jones & Barry, 2011). The body of evidence in the literature that discusses the influence of leadership synergy in health and social cares initiatives in a partnership setting is lacking (Cramm, 2010).

Understanding factors that promote leadership synergy between public and private partnership in health and social care initiatives may promote better partnership working (Cramm, 2010). Given integrative leadership empowers and enhance forces to tackle public health problems in a shared value (Silver & McGuire, 2010). Coalition leadership increases common understanding of social and political debates around PPP, and promotes shared communication on vision and implementations decision strategy (Silvia & McGuire, 2010). In many cases, synergy defines partnership product, which demonstrates leadership, process, and efficiency (Jones & Barry, 2011). Leadership synergy is an important factor to partnership functioning and accountability (Melvyn et al., 2011). Effective joint leadership influences shared the success of a system through evidence, networking, internal and external communication, provide an innovative plan and foster community engagement (Melvin et al., 2011; Weiss et al., 2010).

Embracing shared leadership in a partnership setting environment is critical to improve PPP integration strategy (Kellam, 2012; Silvia & McGuire, 2010). Synergy may

facilitate shared value and respect on differences that each sector and disciplines bring to the partnership (Kellam, 2012). Collaborative leaders may promote group satisfaction, show the direction, communicate shared strategies, and make jointly decisions on PPP interventions (Gramm, 2012; Kellam, 2012; Weiss, 2010). The synergism would increase leader's realization of the value of others, encourage teamwork, and leverage the innovations to the right people within the partnership setting (Cramm, 2012; Silvia & McGuire, 2010).

Facilitating effective leadership requires continued assessment and evaluation of leadership capacity (Ansari, 2012). Demonstrating a certain degree of competences such as communication and relationship, professionalism, knowledge of health care environment, leadership qualities, knowledge on initiatives and delivery strategies as well as business skills are also essential for leadership synergy in a partnership setting (American Collage of Healthcare Executives (ACHE) (2016). Literature on effective leadership underpins communication and relationship as a key to effective collaboration in a shared environment (Ansari, 2012; Curry et al., 2012; Forrer et al., 2010; Melvyn, 2011; Sturchio & Cohen, 2012; Wallace, 2014). Fostering leadership synergy and communication would increase awareness and stimulates action, and thus descends to professional responsibility and accountability (Choudrie, Culkin, 2013; Forrer et al., 2010; Wallace, 2014).

The emphasis on personal and professional accountability at work is another construct to leadership synergy, which is monitored through adherence to ethical and code of conduct, likewise, a leader should demonstrate skills that would drive the

partnership to engage in the community services and diverse partners, show respect, and contribute knowledge to the team (Ansari, 2012; Curry et al., 2012; Green et al., 2009). The literature suggests a lack of awareness, lack of understanding of core concepts of PPP and SDH, and suggested a shared venue where various skills, knowledge, and best practice are consolidated, communicated and practitioners are empowered to deliver the strategy (Curry et al., 2012; Danforth, Doying, Merceron & Kennedy, 2010; Melvyn et al., 2011). However, in the literature there little or no evidence on the factors that would foster leadership synergy to engineer the process and bring people together, influence them to engage fully and promote public health partnership in health and social care initiatives in a partnership setting.

Public health leadership is behind with limited comprehension of leadership effectiveness in a public health arena (Fernandez et al., 2010; Koh, 2009). Although there is some improvement of health and social care services through the implementation of public-private integrated partnership initiatives (PPIP), a need to strengthen leadership to improve efficiency is imperative (Cramm, 2012; Olstad et al., 2012). The manager's knowledge, beliefs, perceptions, and inter-sectorial linkages are key for adapting and improving community health initiatives (Sekhri et al., 2012). Further, fostering leadership in a partnership setting requires a coordinated synergy (Sturchio & Cohen, 2012; Tomlinson et al., 2013). Leadership synergy would be a force to engaging, improving and sustaining community health and social initiatives in PPP context (Cramm et al., 2012; Tomlinson et al., 2010). Promoting PPP concept, a need to authoritative figure is

essential to ensure effectiveness and efficiency in the implementation and monitoring of the health and social interventions (Fernandez et al., 2010; Tomlinson et al., 2013).

The literature supports leadership strengthening to facilitate effective use of public-private integrated partnership (PPIP) model in the healthcare setting to increase collaborative implementation and monitoring (Llumpo et al., 2015). A broader engagement of leadership at the start of the project is a key to a success of PPIP project implementation (Downs, Montagu, Da Rita, Brashers and Feachem, 2013). Many studies on PPIP implementation focus on the association between partnership functioning synergy and the sustainability, and partnership leadership and accountability (Cramm et al., 2012; Forrer et al., 2010). A gap in the literature that explores community PPP leadership synergy in a community health innovative initiatives to promote monitoring and accountability exists (Cramm et al., 2012).

## Theoretical Foundation

Diffusion of innovation (DoI) theory and public private integrated partnership (PPIP) model was employed in this study to guide the data analysis, interpretation and report. The use of theoretical framework in a qualitative research is acknowledged, and it is scientifically and practically powerful tool because it guides on data analysis and interpretation (Creswell, 2007; Glanz, Rimer & Viswanath, 2008). The construct of the theoretical framework in qualitative inquiry facilitates ways of understanding the phenomena in question and increases study credibility (Creswell, 2014). Evidence suggests that the constructs of the theory represents part of social reality and allows the

researcher to take into consideration the expectation, value, background and the role of the subjects in a study population (Glanz, Rimer & Viswanath, 2008).

**Diffusion of Innovation (DoI) theoretical framework:** DoI is the model that seeks to explain how, why and what rate new ideas spread through the population (Roger, 2003; Robinson, 2009). Diffusion is a process of communicating an innovation using certain channels over time to reach members of the society (Roger, 2002). In this study leadership synergy is an innovation that needs to be defused through to the PPP by public and private leaders. An innovation is an idea or practice that is perceived as new by an individual, community, or organization of adoption (Chigona and Linker, 2008; Kaminski, 2011; Robinson, 2009; Roger, 2003). According to Chigona and Linker (2008), DoI theory provides constructs that explain factors that determined an innovation rate of adoptions, and the influence of the uptake of interventions. For example, construct such as relative advantage explains the degree of perceptions of proposed idea, other stakeholder's perceptions and the existing state of relationship (Chigona & Linker, 2008). Similarly, Robinson (2009) commented that the relative advantage construct gauges the perception of an innovation as to whether is better than the idea it replaces by the adopters. For instant, if the leaders and managers of PPP perceived leadership synergy is beneficial and profitable then may increase the rate of adoption (Chigona & Linker, 2008).

Other DoI constructs are compatibility, this gauge the perceived level of consistence of the idea within the existing values, practice and culture against the needs of the potential adopters (Chigona & Linker, 2008). Simplicity construct measures the

perceived implementation difficulties level of an idea (Robinson, 2009). Equally, the simplicity or complicity construct is the degree to which the innovation is perceived as hard or simple to understand or to use (Chigona & linker, 2008). Triability construct explain the perceived level of experimenting an idea on a natural setting (Robinson, 2009). Also, triability measures the degree to which the idea can be adopted in a phase and how the idea can be influenced by the cultural values (Chigona & Linker, 2008). Last is the observability construct, which is the extent that an innovation is visible and produces positive outcome among the users (Robinson, 2009). As such, the observability measures the degree to which the result and benefit of an idea is visible and can be demonstrated or shared to other stakeholders (Chigona & Licker, 2008)

Historically, DoI was employed to understand how new agricultural technologies were communicated and accepted by the famers and in healthcare field the DoI has been used to study how new service is consumed by the user (Roger, 2003). Evidence in the literature highlights advantages of employing diffusion of innovation framework in understanding factors that could promote effective project dissemination and implementation in a various setting and systems (Chigona & Licker, 2008; Robinson, 2009; Wallace, 2014). A qualitative case study employed DoI theoretical framework to examine and understand the impact of strategies used for collaborative arrangement between small firm enterprises and government funding agency found that the DOI not only provide a clear picture, but also the theory was useful for understanding government collaborative interventions (Choudne & Culkin, 2013).

Evidence in the literature found DoI theory was useful in exploring the key role that the national leaders played in adopting partnership norms in a participatory global health system (Wallace, 2014). As such, the DoI theoretical framework allows researchers to understand and measure factors that could influence adoption of new idea such as leadership synergy, which is a key in maximizing its adoption rate (Chigona & Licker, 2008; Roger, 2003). The evidence suggests that the DoI theoretical framework provides a structure that assists researchers in understanding the uptake of an innovation between the organization and groups (Chigona & Licker, 2008).

Employing DoI framework facilitates the process of understanding the factors that are potential solutions to quality and cost improvement of public health care delivery (Zhang, Yu, Yan & Amspil, 2015). According to Robinson (2009), DoI provides three significance insights into the process of social change, which are the qualities that make an innovation spread, the importance of peer-peer conversations and networks, and understanding the needs of different user segments. These insights are tested and will provide a facilitative focus in this study.

**Public-private integrated partnership (PPIP):** Public-private partnership is a collaboration effort between public bodies, which are the central government or local authority and private organization to design, build, finance, and perhaps operate or maintain an infrastructure or a project for the delivery of publicly services/interventions (The Global Health Group, 2013; Montagu & Harding, 2012) Evidence suggests that the partnership between public and private bodies brings expertise, management skills and financial awareness to the hub and create a better value for money for the taxpayers (The

Global Health Group, 2012).

In the public health field, the PPP approach can be applied in a wide range of health system needs, which includes community health and social care interventions (The Global Health Group, 2012; Sekhri, Feachem & Ni, 2012). Evidence shows that the PPIP model is commonly used to assign more responsibilities to the private partner for the delivery of either all or part of the clinical services and/or primary health and social care (Sekhri et al., 2012; Sturchio & Goel, 2012). PPIP model is commonly used in integration and the model provides an opportunity for greater access to, management empowerment, and quality of health services in hospital as well as in the community setting (Sekhri et al., 2012; Sturchio & Goel, 2012).

Literature suggested that the PPIP enables the public providers to leverage private sector expertise and investments to provide public services, which are of high quality, affordable, preventative, and curative to meet the population needs (Sekhri et al., 2012). PPIP model provides an opportunity to support patients who have little or no financial resources to obtain health and social health support (Montagu & Harding, 2012).

Research by Sekhri (2012) underpinned the integration of PPIP model in developing countries health services that delivers a significant benefit in PPP interventions. The PPIP model links the preventive, primary, secondary and tertiary care to achieve better outcomes and ensures financial viability in addressing citizen health needs (Salvail, Turchet, Wattling & Zhang, 2015).

## Summary

In summary, Chapter 2 discussed gap in the literature, which focused on three topics the public-private partnership, the social determinants of health, and partnership leadership synergy. Further, the researcher discussed the application of the theoretical frameworks, the DoI construct and PPIP model, which were employed in this study.

In Chapter 3, researcher discusses the research methodology, the application of theoretical framework and the application of study tool. Moreover, in chapter 3, discussed how the study designed, the approach to data collection and the plans for data analysis and reporting of the research findings.

# Chapter 3: Methodology

## Introduction

Promoting the public private partnership (PPP) leadership concept in health and social care is essential to improve monitoring and accountability of health outcomes in developing countries. In Tanzania, the leaders expect PPP to influence engagement, collaboration, accountability, and monitoring the continuity of health initiatives in order to improve the quality of services and access to care to prevent early mortality and disabilities (GIZ, 2013; Kikuli & Mbando, 2011; Sullivan, 2004).

The relationship between preventable health conditions and child and maternal mortality, HIV, tuberculosis, malnutrition, malaria, and poverty remain major public health concerns in Tanzania (Kikuli & Mbando, 2011). These problems are attributable to a range of health outcomes and inequality (Kikuli & Mbando, 2011; White, et al., 2013). Evidence suggests that social determinants of health exacerbate health and increased inequality in marginalized and socioeconomically disadvantaged populations (Centers for Disease Control and Prevention, 2010).

The Tanzanian government strives to improve the nation's economy. However, it remains under pressure to ameliorate and to mitigate preventable health and social problems with its limited capacity (White et al., 2013). Because of the limitation of the public sector, the rural areas, hard to reach populations, and underserved communities receive health services through the private sector (Mboya, 2012; Kikuli & Mbando, 2011). Lack of adequate information from these private and public organizations limit decisions and facts on health improvement and coverage in the core health services.

Therefore, enhancing PPP collaborative leadership and engagement of the community to monitor public and private partnership interventions is essential to promote ownership and accountability of health and social welfare initiatives (GIZ, 2013; Kikuli & Mbando, 2011).

The purpose of this empirical qualitative case study was to explore the perceptions of project leaders and managers in the public and private sectors toward the synergy of partnership leadership and to understand both the factors that could promote this synergy. Such understanding would enhance ownership and accountability of community health and social welfare initiatives in Tanzania.

Leadership, engagement, shared understanding of local data, and promoting ownership improve the quality of PPP interventions (Basy, Andrew, Kishore, Panjabi & Stuckier, 2012; Koh, 2009). However, very few studies have focused on the in-depth understanding of community leaders' perceptions of engagement and collaborative leadership in the PPP context (Hodge & Greve, 2007). Some practitioners argue that the PPPs are unable to convert the unfeasible project to feasible and viable projects, and recommended that a descriptive study should be carried out to provide insight into best practices (Kikuli & Mbando, 2011: Koh, 2009; Mboya, 2012).

This qualitative study used an empirical case study approach. This approach provided a descriptive insight into the perceptions of leaders and managers of semi-urban populations toward PPP ownership and accountability in health and social cares interventions (Creswell, 2015; Curry, et al., 2012). Given the limitation of in-depth data on the phenomena in question, a qualitative empirical case study was recommended to

provide a descriptive explanation of the complex issues in the PPP leadership of the study population (Creswell, 2014; Creswell, 2007). Evidence demonstrates that empirical case studies have been used to understand complex leadership phenomena in a natural setting with valid results (Creswell, 2007; Curry et al., 2012; Nelly, 2012; World Health Organization, 2010).

The diffusion of innovation (DoI) theory (Glanz, Rimer & Viswanath, 2008) employed to guide on data collection and analysis. Previous study indicate that the DoI theoretical framework constructs have successfully been applied to the various environments such as agriculture, healthcare, social care, and education, and had delivered a significant positive outcome (Resnick & Siegel, 2013; Sharma & Kanekar, 2008). The DoI theory was developed by Roger in 1962, and originated from communication, and the theory explains how an idea can quickly spread and be implemented by the majority and change person/society practice (Resnick & Siegel, 2013; Roger, 2003). Furthermore, DoI provides reliable insights into the process of social change (Robinson, 2009). As such, the theory not only considers qualities that make an innovation spread, and the importance of peer-to-peer conversations and networks, but also provides an understanding of the needs of different user segments (Robinson, 2009; Roger, 2003; National Cancer Institute, 2005).

Additionally, the public-private integrated partnership (PPIP) model was employed to facilitate and inform the data collection, analysis, and research report. The PPIP model has been used to deliver clinical and primary health care in PPP context, and commonly used in the integrated interventions in the community setting (Llumpo,

Montagu, Rashes, Foong, Abuzaineli & Feachem, 2015). The use of the DoI and PPIP theoretical framework guide data analysis and interpretation with the focus on the three proposed overarching research questions, which are:

RQ1. What are the perceptions of public and private community health leaders in Tanzanian toward public-private partnership leadership synergy?

RQ2. What are the perceptions of leaders of public and private sector to facilitate leadership synergy for PPP in health and social care interventions in a community setting?

RQ3. How do managers and leaders of the public sector and private sector facilitate synergy for action health and social care interventions implementation in partnership setting?

As such, the selected constructs of DoI theory guided data collection and analysis for the three overarching research questions. In a view of how public and private organizations generate ideas and diffuse them between the leaders of the organizations and then through the population (Rogers, 2006). Table 3 illustrates the DoI constructs and its definition in this study.

Table 3

*Diffusion of innovations constructs*

| Concepts | Definition |
|---|---|
| Relative advantage | Explained perceived degree to which the interventions are seen as better than the current practice. |
| Compatibility | Explained perceived factors on how consistent the intervention is within values, habit, experience and needs of potential adoption |
| Complexity | Explained perceived difficult on the interventions on |

| | |
|---|---|
| | understanding the concept and the implementation of the PPP leadership synergy |
| Triability | Explain the perceived extent to which the intervention can be monitored for decision and accountability |
| Observability | Explained the perceived extent to which the innovation will provide visible or tangible outcomes |

Adapted from National Cancer Institute (2005).

In addition, the PPIP model was employed to guide data analysis for research question three. Previous studies show that the PPIP model not only commonly used in the integrated services, but also, the model is comprehensive and delivers significant benefit in PPP interventions (Llumpo et al., 2015; Sekhri, 2012). Further, the PPIP model link the preventive, primary, secondary and tertiary care to achieve better outcome and ensures financial viability in addressing citizen health needs (Salvail, Turchet, Wattling & Zhang, 2015). Table 4 illustrates the PPIP constructs and its definition in this study.

Table 4

*The application of PPIP constructs*

| Construct | Description |
|---|---|
| Design | The degree to which the interventions are designed and contracted to the private entities, (plan of action). The degree to which the operating policy engage both partners (public and private) |
| Build | The degree of local capacity in contracting the services<br>The degree to which the community in provision of PPP services<br>The degree to which responsibility and accountability for implementation and on-going maintenance and operation of the services is managed.<br>Degree of shared government resources and tools |
| Finance | The degree of shared risk, power and financial accountability<br>The degree of risk transferred, risk allocation and rewards<br>The source of PPP funding<br>The degree of financial accountability<br>The degree of managing associate financial risk |
| Operate | The degree to which clinical standards are followed<br>The degree, to which the on-going implementation of services is |

| | |
|---|---|
| | monitored, shared and maintained.<br>The degree of collaboration and communication |

## Methodology

**Sampling Strategy:** Qualitative empirical case study method was the focus in this study. Therefore, a purposeful sampling strategy used to guide the recruitment of relevant rich case that explored and illuminated information, which answered the research questions (Creswell, 2007; Patton, 2015). In purposeful sampling, the selection of a sample size focus on the purpose of the study, overarching study questions, and data collection strategy (Patton, 2015). The purposeful sampling method allows researcher to recruit participants likely to provide rich information about interested phenomena on the study site (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2013)

The purpose of this study was to improve understanding of the perception of Tanzanian leaders and managers toward the public-private partnership ownership of the community's health and social welfare initiatives to promote ownership and accountability. Organization unity sample size of 6 (3:3) from public and private partnership organizations was used. The decision for organization unit n=6 (3:3) base on a thumb of rule in descriptive inquiry for a qualitative heterogenic case study (Palinkas et al., 2012). Further, the selected unit sample size considered time, resource and financial constrain challenges of the researcher (Creswell, 2007; Palinkas et al., 2012). The selection of an organization for the unit of the study focused on the partnership collaborative initiatives and the provision of primary health and social services in the community settings.

Similarly, the criterion purposeful sampling employed to recruit 24-30 leaders and managers likely to participate in this study (Frank, 2011; Patton, 2015; Palinkas et al., 2012). Criterion purposeful sampling strategy increases credibility to the data, adds quality on the study, and also reduces the potential risk of bias (Creswell, 2007; Patton, 2015; Sandelowski, 2007). As such, the researcher identified and recruited cases that met predetermined criterion of relevance as described in the study protocol (appendix A). The strategy of applying study protocol at each study site mitigated the risk of potential bias.

**Sample Size:** In respect to the nature and complexity of this study, the use of purposeful sampling allowed the narrowing of a significant number of potential organizations (cases) into a manageable sample size (Patton, 2015; Palinkas et al., 2013). As Patton (2015) commented that a small but strong sample size is essential for "credibility and manageability" (p. 286) and not for generalization of the study result. With this principle in mind, criterion sampling used to select 4-5 leaders and managers who meet the predetermined standards as specified in Appendix A. As such, the principle used to recruit participants from public and private partnership organisations that provide collaborative health and social services initiatives in a community setting. A total of n=26 participants interviewed because the researcher reached saturation level at 25 to 26 interviews (Palinkas et al., 2013).

Determining sample size in a qualitative study depends on a researcher's judgment and analytical lens to determine what data and how much data to collect to answer overarching research questions (Sandelowski, 2007). Knowing the challenges on qualitative sampling ensures the quality of the study (Patton, 2015). As such, the

purposeful sampling principles of criterion sample provided a comprehensive understanding of the partnership leadership synergy in this study. Achieving saturation level goal ensured detailed information yielded to cover all aspects of the phenomenon of interest (Palinkas et al., 2013). Similarly, criterion sampling strategy within the case allowed selection of small sample size to study, which illuminated wealthy and descriptive data that answered the research questions. In many cases saturation occurs when there is no new insight from the participants (Latham, 2013).

**Study Site:** The study sites were the semi urban Municipal councils in Dar es Salaam, Tanzania (Temeke, Kinondoni and Ilala). As such, organizations that provide PPP collaborative health and social care initiatives at community level were selected. The registry list of organization was obtained from the Ministry of health and social welfare then a set of criteria as listed in research protocol Appendix A applied to select three private organization as illustrated in appendix E. The eligibility of private organization based on collaborative initiative in partnership with the Municipal councils, which is the public sector in provision of primary health and social services. Therefore, criterion sampling assisted in determining on what organisation met predetermined standards to participate in this study and this prevented all element of bias.

Although, sampling a study sites can be a challenge, the researcher's judgments and negotiations considered time frame for data collection, financial and resources. Equally, the expected time of response from the potential subject, and the reasonable sample size to generate meaningful research data was considered (Creswell, 2007; Patton, 2015; Sandelowski, 2007). Given a purposeful sample size of 6 study sites (cases) for

unity of study, which consist of three public municipal councils (Kinondoni, Ilala and Temeke municipal council) and three private partnership collaborative organizations, which work in partnership with municipal council to provide primary health and social initiatives in the community settings 26 participants were interviewed.

## Data Collection Strategy

Qualitative empirical cases study methodology built in the constructivist paradigm, which allows the researcher to study a complex phenomenon within the natural setting (Creswell, 2007). With this constructivist concept, triangulation is important to ensure the rigor of the study, validity, and quality of the data (Patton, 2015). In most cases, face-to-face in-depth interview and document review data collection strategies recommended for this case study inquiry (Patton, 2015; Creswell, 2007). Given the triangulation strategy, the researcher examined available and relevant document to complement on interview data and provided an insight to answer study questions. The documents that were accessible are the PPP policies guidelines (national and local), PPP supervision and implementation plans, Private sectors PPP policy guidelines, and the PPP strategic plan.

The in-depth interview method with open-ended guide question was the primary data collection tool for this qualitative case study (Creswell, 2007; Janesick, 2011, Patton, 2015). As such, the interviewing technique involves the researcher as a tool to collect the information from research subjects (Janesick, 2011). The subjects for this study were the leaders and managers at each selected organization. The interview process involved asking open-ended questions and getting the response from each participant’s perceptions

and definitions of the situations in a real setting (Janesick, 2011; Patton, 2015). Although interviews can vary according to the situation and the purpose of the study, the researcher conducted a thirty to one-hour face-to-face in-depth interview with selected subject to saturation level of n=26 (Patton, 2015).

The researcher adapted a semi-structured interview questions from the Curry et al (2012) article and the questions were rephrased to align with this study's research questions (Appendix B). The semi-structured questions guide by Curry was tested, and used in a similar context and produced a validly result. Ethical issues, and copyright permission obtained (Janesick, 2011; Maxwell, 2012; Patton, 2015). Further, the researcher used the Swahili language to interview potential subject. In this case, data collection tools, research protocol and consent form translated from English to Swahili language to meet the compliance, culture and values of the Tanzania research ethical clearance procedures for this study. The researcher is fluent in Swahili language speaking and writing.

The researcher physically visited study sites and met with head of the project at each selected site and made an appointment to discuss research purpose and interview plans. Similarly, the approved local institutional review board (IRB) certificate and letter attached with the study protocol to request access to the collaborative health initiatives document. Then, the letters were delivered physically and handed over to the leader or a manager of the public and private organization in each study site. Further, the follow up for the letters were done by the researcher through personal visit in some of the organizations and via telephone calls on the other organizations, this variation based on

the possibilities and availability of the potential participants or the lead person within the organization involved.

The document review and in-depth interviews with participants facilitate the exploration of information to inform the factors that would enhance partnership leadership synergy. As such, the in depth and document review in this study enabled the understanding and convergence of the data to illuminate the case (Creswell, 2007; Lathan, 2013; Milles et al., 2013). Given the process of data collection, the researcher conducted reflective notes manual recording, audiotape recording, transcribed, translated and computerized the information collected daily. In many cases, the use of various tools on the collection of data such us the audiotapes, interview transcripts, the interview notes, taking field notes, and the use of piloted semi-structured questions, keeping a daily journal, and reflection notes improves quality and validity of the qualitative data (Janesick, 2011; Miles et al., 2013; Patton, 2015).

Further, research protocol in Appendix A illustrated research procedures, participants' information illustrated on the consent form, and Appendixes B illustrate the semi-structured interview questions guides. Patton (2015) stated that the detailed open-ended questions lead qualitative research traditions. These open-ended questions guided the process of harvesting data and provided in-depth understanding of the perceptions of the leaders and managers toward public-private partnership leadership synergy without imposing any pressure to the response (Janesick, 2011; Patton, 2015). Participants' right to participate in this study was genuinely expressed, and clearly informed to the subjects before commencing of data collection procedures. Moreover, the adherence of subjects'

right demonstrated through informed voluntary participation acceptance and consent form, which each participant signed.

To ensure the data is safely secured and stored in a logical manner, the access password used and the Excel computer program employed to help with the storage and monitoring of raw data, monitoring partially processed data, grouping or coding data, and also storing memos and reflective notes (Miles et al. 2013). The use of computer program helped to visualize, follow up, and control the overflow of the data with the focus on the chosen frameworks and research questions (Creswell, 2007; Miles et al., 2013). Similarly, the researcher developed a manual codebook to ensure comparison of collected data and allow maximum organization and documentation of data processing was under control (Creswell, 2007; Janesick, 2011: Miles et al, 2012). The manual codebook should serve for external reliability assessment trial audit and data analysis procedures (Creswell, 2007; Miles et al., 2013).

**Researcher's Role**

In a qualitative study, the researcher is analytic, uses an analytic lens to employ coding processes and to organize data by either bracketing, highlighting, or capitalizing on the text to provide codes that represent categories or themes (Creswell, 2007; Miles et al., 2013). The data texts are the transcripts, field observation and reflective notes, and the documents that are relevant to this study. The researcher used a code or a theme to represent a word or a short phrase. These codes or themes were assigned to give a meaning or a primary summary that explain the summary of transcripts, reflective notes, field notes or the documents review notes. The process of assigning code to the data

allows condensed data for a vigorous analysis (Miles et al., 2013). Because pre-coding structured for data analysis in a qualitative study is plausible, the procedure for data analysis focused on the selected conceptual framework (Miles et al., 2013).

Beyond that, the researcher performed a pre-coding procedure to provide a transition and link between chunks of raw data from the transcripts, field notes, and reflective notes to a code or a theme (Miles et al., 2013). This relationship supported a linkage of data to an idea to facilitate the data analysis process in this study (Creswell, 2007; Maxwell, 2005; Miles et al., 2013). As such, researcher's roles included data collection, perform precoding and provided an idea or a preliminary theme for consideration in line with the codes on the transcripts and the documents reviewed (Creswell, 2007; Miles et al., 2013).

Additionally, the pre-coding exercise facilitates the transformation of data into a clear and understandable form for computer software processing (Miles et al., 2013). The pre-coding process helps to classify information into further steps for computer processing and analysis procedures (Maxwell, 2005; Miles et al., 2013). Then the researcher performed a sorting and organized data to provide a big picture. The process of sorting and organizing data provide a summary, which synthesize what happened in the data (Miles et al., 2013). Similarly, primary data organization help researcher to form a link between data collection, interpretation, and coding, which was used as a foundation for data analysis  (Maxwell, 2005; Miles et al., 2013).

## Data Analysis Plan

Qualitative data analysis is comprehensive; as such it includes data collection, data display, coding, data verification, making conclusions, and data condensing to meaningful essence (Miles et al., 2013). Therefore, knowing the parameters as an analytic in this study, the analysis focus on the directed qualitative content analysis and interpretation strategy (Miles et al., 2012; Patton, 2015). In many cases, the directed content analysis strategy starts with theoretical framework as a guide to initial coding process (Creswell, 2007). Further, the researcher delineates analysis procedure to common perceptions of leaders and managers of the study sites by thematically tracking and coding using Computer Assisted qualitative data analysis software (CAQDAS) (Creswell, 2007; Miles et al., 2013).

Although there are controversial opinions on the use of CAQDAS in qualitative study (Creswell, 2007), its use depends on the nature of the study paradigm (Miles et al. 2013). As such, CAQDAS was employed to help with managing the data systematically, and thus improve the quality, validity, and trustworthiness of the study (Janesick, 2011; Miles et al., 2013). Further, with the aid of DoI and PPIP conceptual framework, and CAQDAS, data was automatically generated and stored on a daily basis (Miles et al., 2013).

Furthermore, the content analysis technique facilitates the interpretation of meaning from the coded content of text data such us transcripts of open-ended interviews and documents review notes with adherence to the naturalistic paradigm (Patton, 2015). The use of initiation coding scheme, such us theoretical framework increases

trustworthiness and validity of the study (Creswell, 2007; Miles et al., 2013). The qualitative content analysis not only focusing on the content meaning of the text, but also allows examination of the content for categorization and comparison for similar meaning or themes (Miles et al., 2013). The process of attaching meaning or codes to the text provides a base for knowledge and understanding of the phenomenon in question (Miles et al., 2013).

Similarly, the use of DoI and PPIP theoretical framework helped the researcher to focus, and provide predictions about the themes of interest and the relationship among the themes. Given the primary collected data through open ended questions interviews transcripts and documents the coding strategy started with the view of research questions, theoretical framework and the purpose of the study (Saldana, 2008). The text code highlighted in the text passage use the pre-determined code (Miles et al., 2013). Then, the researcher performed a comparison across the data on practices, competences and perceptions, experiences of the leaders and managers of PPP to explore possible explanations and answers for the study questions.

In addition, NVivo computer software program for qualitative research analysis employed. The NVivo software was selected to facilitate the organization, coding, and managing data for this study. Bazeley (2007) recommended NVivo software because the software supports qualitative data analysis, and it is user-friendly. The software assists with rich text, and also use of a variety of data sources, to provide a sound level of data analysis while managing either small or large volumes of data (Bazeley, 2007; QSR International, 2015). Although there are many qualitative software that one can choose

from, each software utility depends on the research questions and methodology, so the NVivo program was a fit for this study.

According to Bazeley (2007), NVivo program was historically developed in a view of providing detailed analysis and modelling in a qualitative research. With NVivo credentials, mostly academic, government, health and commercial researchers use the software across the diverse range of field, which include social science (Bazeley, 2007; QSR International, 2015). Given the intent of NVivo program, the researcher systematically organized and analyzed structured and unstructured data, allowed classification, sorting and arranging information, to examine the relationship in the data, and combined analysis with linking, shaping and searching for themes (Bazeley, 2007; QSR International, 2015) and provided a base for study report.

Further, the advantage of NVivo tools, which includes significant support on organizing, managing and analyzing information, and, the tools increases flexibility, and improve validity on qualitative study (Creswell, 2007; Miles et al., 2013). Although Patton (2015), argued that the use of software in qualitative study could increase deterministic and rigidity of the process, the researcher understands the limitation. Therefore, the conceptual framework and research questions used to guide the process of data analysis. Similarly, with the focus on the study purpose the use of the software to provide coding system, concentrated on the depth and meaning of the participant's perceptions. As a researcher in this study, the concern raised by Patton (2015) on the use of software in coding process was considered and to eliminate the limitation that might be regarded as a real verification of data, the use of peer review colleague, chair, and

committee member in this process help to verify that the information maintain its depth and meaningful as intended.

## Issues of Trustworthiness

Qualitative data collection and analysis is diverse. Miles et al. (2013) and Patton (2015) highlighted the critical issue in qualitative data quality, credibility, and trustworthiness in research findings. In this study, the researcher considers the following that ensure trustworthiness.

**Internal validity of the study:** The process of ensuring credibility include, triangulation, which allows data collection, analysis and interpretation using variety of sources, and approaches (document review, field notes, reflective notes, in depth interview) and the use of audio-recording provided an opportunity of participants to listen to their comments or read the transcribed notes (Patton, 2015). The researcher also maintained a critical analytical lens to identify and understand the findings as research progress as well as engaging a neutral peer to read and provide constructive advice.

**External validity of the study**: The strategy to ensure transferability include the use of specified criterion for purposeful sampling, careful identified and selected and interview leaders and managers in the study sites. Being critical when ask research question and extract thick descriptive information, and ensure saturation level occur before stop data collection. Thick description allows a base for qualitative research report (Creswell, 2007; Patton, 2015).

**Dependability**: Audit trial and triangulation are strategies that used to ensure dependability in this study. As such, all the interview transcripts, field notes, research

journals and reflective notes are safely stored in a metal box, and portable computer hard drive, for up to three years to serve as evidence when required. Also, an audit trial illustrates all the steps that pertained to the emerged theme, and the guide to the study findings. The researcher described and demonstrated the research process from the beginning to the end, and the chair, committee member, and the university qualitative research quality team assesses the quality of the research analysis and report (Patton, 2015). For triangulation, the use of document review, in depth interviews, transcripts, field notes, NVivo computer software also serve as multiple data source for this study.

**Confirmability:** Strategies to establish confirmability include researcher's account of reflective notes and consideration of participant's point of view, voice, language, feelings and cultural backgrounds as well as being attentive and receptive throughout the process of data collection (Patton, 2015). Further, researcher is an instrument therefore; illustrate potential bias, and the strategies to mitigate them. The process of audit trial confirms the internal coherence of data, findings, interpretations and recommendations (Patton, 2015).

**Reliability:** The strategies to establish reliability include the use of systematic and reliable technique with transparency (Patton, 2015). In this study, researcher employ NVivo computer program to facilitate the process of recording of raw data and documentation of data condensing procedure and analysis. Further, researcher adapted the tool that previous used in a similar situation, this is the semi structured research question guide, served as Appendix B. Furthermore, the focus on documents review procedure based on reliability and accessibility of relevant government and private

organization documents to this study. In the case of translation of protocol and consent form into Swahili language, a consultant who is proficient in both language hired do audit and translate the required documents. Transcripts, audio records, field notes are served for evidence. Further, the use of DoI model and PPIP conceptual framework as explained above provides study precision (Silverman, 2010).

## Ethical Procedures

In this study, researcher is bound to professional code of conduct and ethics, and should adhered to ethical issue in all steps of data collection procedures (Fertman & Allensworth, 2010). Before conducting the research, the Institutional Review Board (IRB) approval from the Walden University and from the local country, the Tanzania NIMR (National Institutional for Medical Research) was acquired. The procedure for obtaining the IRB was done through Internet communication by filling in required IRB application form and sent it to the Walden University. After the approval of IRB by the university, the copy attached together with proposal document to apply for the local IRB in Dar es Salaam NIMR, Tanzania. Further, the researcher had a successful oral defense, which explained step by step on the research purpose, ethical consideration and data collection and analysis procedure.

Researcher should promote the common good principals that emphasize worldwide ethical standard for the human subject (Fertman & Allensworth, 2010). Therefore, special attention and focus should be on the right of the participant's privacy and confidentiality (Patton, 2015). The intended participants in this study are leaders and managers who are over 18 years old, and assumed to be physically and mentally sound. Researcher explains

the health information privacy rule (HHS, 2002) and made it clear to the participants that the rules safeguard their confidentiality.

Further, all participant informed about the purpose of the study and the researcher reiterated and ensured clarity that the participation was voluntary, and also an opportunity for participants and that the participants have a right to prematurely withdraw from participation without any penalty or impact to their job. In the case of publication of the study in research journal, clarity on the issue of anonymity and confidentiality explained and the participants are ensured that the participant's identity is protected. Similarly, researcher respect participant's response and answers and explained to the participants that they're honest and genuinely response to interview questions was expected.

The researcher assumed no adverse event could happened during data collection process, only heavy rain happened during data collection process no adverse event occurred, which flexibility of participants time was considered and were able to continue with research proceedings (Rudestam & Newton, 2015). In the case of data treatment, the researcher used code number to protect the identities of the participants, work site and organizations (Maxwell, 2013). Electronic garget used to store the data for up to five years, and only people who are directly involved in this research such us chair, committee member, URR and the consultant who translated part of the documents to Swahili language (research protocol and consent form) had an access to the data (Maxwell, 2013).

## Summary

In chapter 3, the researcher discussed the general overview of the partnership leadership synergy, the purpose and the study questions, and the theoretical framework for the study.

Further, the chapter described the methodology for qualitative case study, which includes sampling strategy, sample size, strategies for data collection and analysis. According to Creswell (2014), a thick descriptive account of the study methodology provides an opportunity for transferability of study results. Similarly, a descriptive explanation of internal and external threat to validity in the designing of the study insures trustworthiness and quality of the study result (Patton, 2015).

Ethical issues are critical in human research, as such this study demonstrated strategies to manage the right to subject likely to participate in this study in all steps of data collection procedures including the role of the researcher. Acquisition of IRB before data collection process, steps to gain access to participants, informed consent, Privacy and confidentiality were discussed. Chapter 3 provides a bridge to the next step of this study, which is data collection and analysis process. The procedure for data collection and analysis proceeded after the researcher had a successful oral defense.

# Chapter 4: Results

## Introduction

This study explored public and private leader's perceptions of community (PPP) leadership synergy. In Chapter 4, the following topics are covered: setting and demographics of the study, data collection and analysis procedures, evidence of trustworthiness, the theoretical frameworks used to guide the development of the overarching three research questions, and the research findings.

The purpose of this qualitative empirical research was to understand factors that could enhance partnership leadership synergy between the public and private sector to promote ownership and accountability of the health and social care initiatives in Tanzania. The three overarching research questions were as follows:

RQ1. What are the perceptions of public and private community health leaders in Tanzania toward public-private partnership leadership synergy?

RQ2. What are the perceptions of leaders of public and private sector to facilitate leadership synergy for PPP in health and social care interventions in a community setting?

RQ3. How do managers and leaders of the public sector and private sector facilitate synergy for action health and social care interventions implementation in a partnership setting?

Thirty participants were purposefully recruited and one-on-one, in-depth interviews were conducted. The saturation level was reached with 26 volunteers who provided informed consent. The audio-recorded interviews were guided by a set of semi-

structured interview questions, which were adapted from Curry et al. (2012), based on a series of consultations, reviews, and permission. The following set of semi structured interview questions were used to elicit information from the participants:

1. What is your title? (b) What how long have you been in this position? (c) What are you responsible for in a partnership project?
2. I am interested in your experience of leadership synergy
    (a) Think about a problem you were involved in solving in a PPP intervention where your leadership was important to what happened. Tell me about that.
    (b) I am interested in your experience of the synergetic situation: (c) what was the problems/challenges? (d) What was the goal? (e) How did the decision to work on PPP come about? (f) How did you first approach address the leadership challenges in a partnership setting? (g) What did you hope to accomplish? (h) What kind of barriers in the road was there along the way? (I) Who was involved in facilitating the community PPP leadership effort?
    (c) Please describe how the member of the team worked together?
    (d) Did your relationship with any individual (either on the team or outside the team) change as you were working on the project?
    (e) What were the outcomes of the collaborative leadership work?
    (f) What factors do you think made the project successful or led to the project’s failure or slow progress?

3. Was there any sort of turning point where you felt like the right pieces fell into place for the project to be successful?
4. What kind of leadership synergy consequences (positive, negative) occurred? Any surprise?
5. Looking back, is there anything you might have done differently as a manager/leader in this partnership project?
6. I am interested in your experience of being a leader/manager/coordinator in the private/public sector in the community setting?
7. Is there anything else I should have asked to help me understand your experience of working in a partnership setting better?

There were two theoretical frameworks utilized for this research. The first construct, the diffusion of innovation (DoI) theoretical framework: Relative advantage, Compatibility, Reliability, Observability and Triability. The second framework was the four constructs of the public-private integrated partnership (PPIP) model, design, build, finance, and operate (DBFO). These two theories formulated a base for data analysis and findings of this study. The researcher also conducted a document review, which increased the rigor of this study.

The documents that were accessible and reviewed were: The national policy for the public-private partnership for health and social welfare, the strategic plan guideline for private sectors health, and social care initiatives, private sector PPP strategic plan, faith based non-profit integrated strategic plan for health and social initiatives, and the

national tuberculosis, leprosy, supportive supervision guidelines. The procedure for document review is attached as Appendix C.

The transcribed data that was manually recorded include the field notes and a daily researcher reflection summary, added value in the data analysis and findings in this study. Also, no personal, professional experience, or organization influenced the interpretation of the study results.

## Setting

The setting for the data collection was natural and flexible. Initially, the researcher obtained a local research ethical clearance certificate from the National Institute for Medical Research, Tanzania. Then the certificates submitted to the study sites, which are three public and three private organizations to request a letter of cooperation, which was granted before the data collection procedure commenced. The local clearance certificate is reflected in Appendix G and letters for cooperation are in Appendix H.

The researcher was advised to contact the human resource personnel in some private sector organizations and lead research persons in the public-sector organizations to obtain a list of potential participants and their contact information. After getting the email and telephone contact of each potential participant, the researcher telephoned or sent an email for those that were not reachable by telephone. A total of 30 participants were recruited. The researcher provided a consent form and participant leaflet and arranged for a convenient date and time for the one to one interview. Three participants declined to continue with the interview after they had read the consent and participant

leaflet and gave the reason that they were busy with other programs. The researcher thanked those who declined to participate in the study. The researcher sent a reminder email or a text message via mobile phone to remind participants, who volunteered, of the agreed date and time of the interview. A positive reply was received from all participants.

The letters of cooperation and local ethical clearance certificate provided the researcher not only access to recruiting potential participants, but also a privilege of using a participant's office or quiet room to conduct one-to-one interviews. At one organization two interviews were conducted in the car because of the interference of people in the participant's office. As such, the participants suggested the car venue as a private setting to enable free engagement and response to open ended and recorded dialogue.

The consent forms and participants leaflet were written in both the Swahili and English languages, so each participant had options to choose the language that was clearer to them. Before each in-depth, one-to-one interview, each participant was given an opportunity to ask questions and sign the consent form. The average time for the interviews sessions ranged from 30-45 minutes, this variation was based on the individual's responses. Every participant had the freedom to respond to the interview questions, and the environment was conducive, providing no influence on the interpretation of the study.

## Demographics

Six organizations were purposefully selected as research sites. For confidentiality reasons, the researcher gave an identification character to these organization sites. The

three public sector organizations, located in Dar es Salaam City, were labelled DKC, DTC, and DIC. The private sectors, non-profit organizations, located in Dar es Salaam were labelled PRA, PRC, and PRM. The focus in choosing these private organizations was the provision of partnership interventions in a primary health and social care intervention in the community setting. The primary care services are reproductive health, maternal and child healthcare, HIV, tuberculosis, leprosy, malaria, and nutrition interventions. A checklist of primary health care interventions is attached as Appendix E.

Within the six organizations, which are the three-public and three-private, 26 participants responded to this study. Of the total 26 participants, 5 (19.2%) were program directors, 17 (65.4%) were project coordinators, and 4 (15.4%) were program leads managers. In total 11 (42.3%) were female, and 15 (57.7%) were male. Representations from the private and public sectors were 11 (42.3%) and 15 (57.7%), respectively. Most of the participants were medical doctors 15 (57.7 %), nurses 5(19.2%), social workers 4 (15.4%), and health economists 2 (7.7%). Table 5 below shows the percentage of representations between the private sector and the public sector.

Table 5

*Demographic data on participants*

| Organization | Number of Representative | Gender | |
|---|---|---|---|
| | | Female | Male |
| Private | 11 (42.3%) | 5 (45.5%) | 6 (54.5%) |
| Public | 15 (57.7%) | 6 (40.0%) | 9 (60.0%) |
| Total | 26 (100%) | 11 (42.3%) | 15 (57.7%) |

N=26 (100%).

Table 6 below is a description of the programs provided by each public and private organization. The public-sector site DTC provides Human Immune Deficiency Virus (HIV) prevention, Maternal Child Health & Family Planning (MCH/FP), malaria prevention, tuberculosis (TB)/leprosy prevention, and Public Private Partnerships (PPP) health services. Public-sector site DIC provides Malaria prevention, HIV/AIDS, malaria prevention, HIV/AIDs care and prevention, reproductive, MCH/FP, nutrition awareness, and PPP health services. The third public-sector site, DTC, provides malaria prevention, TB/HIV/leprosy awareness, HIV treatment & prevention, MCH program, and PPP health services. The private sector, non-profit site, PRM, provides family planning and reproductive health, integrated malaria services, outreach integrated health services, health promotion & awareness, and MCH services. The second private, non-profit site, PRA, provides PPP technical support, health promotion & education services, and private sector clinical care, integrated private outreach services. The third private, non-profit site, PRC, provides PPP health care, quality assurance, HIV/AIDs prevention & education, PPP technical advice, faith integrated clinical health services, and community health awareness.

Table 6

*Population Sites and Services*

| Population Sites | Organizations | Roles in the Community | Partnership Interventions implementation |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Public Sector | DTC | Public district Health and Social care services | HIV prevention<br>MCH/FP<br>Malaria prevention<br>TB/Leprosy prevention<br>PPP health services |
| | DIC | District Health and social care Services | Malaria prevention<br>HIV/AIDs care & prevention<br>Reproductive, MCH/FP<br>Nutrition awareness<br>PPP health services |
| | DTC | District health and social services | Malaria prevention<br>TB/HIV/Leprosy awareness<br>HIV treatment & prevention<br>Maternal & Child Health<br>PPP health services |
| Private Sector | PRM. | Reproductive community health & outreach services – NGO | Family Planning/Reproductive health<br>Integrated Malaria services<br>Outreach integrated Health services<br>Health Promotion & Awareness<br>Maternal health services |
| | PRA | Private Sector Health organizations PPP- Technical Support Lead | PPP technical support<br>Health Promotion & Education services<br>Private sector clinical care<br>Integrated Private Outreach Services |
| | PRC | Faith Based Integrated clinical and community health and social care services | PPP health care Quality Assurance<br>HIV/AIDs prevention & education<br>PPP technical advice<br>Faith integrated clinical health services<br>Community health awareness |

For confidentiality reason, the participants were given an identification number that corresponds with the site where they work and an additional number for each participant, for example DTC-1. Table 7 below shows a list of participants and their characteristic as responded to this study.

Table 7

*Participants Characteristics*

| No | ID | Title | Years in position | Background Professional/ Roles |
|---|---|---|---|---|
| 1 | DTC-1 | Malaria Project coordinator | 15 years | Social worker |
| 2 | DTC-2 | PPP district coordinator | 6 months | Medical Doctor |
| 3 | DTC-3 | Mother & Child health lead | 5 years | Nurse Officer |
| 4 | DTC-4 | HIV/Leprosy & TB coordinator | 8 years | Medical Doctor |
| 5 | DTC-5 | Director district Health Programs | 1 year | Medical Doctor |
| 6 | DIC-1 | District TB/Leprosy Coordinator | 10 years | Medical Doctor |
| 7 | DIC-2 | MCH/Immunization coordinator | 12 years | Social Worker |
| 8 | DIC-3 | National PPP Trainer & Manager | 6 years | Medical Doctor |
| 9 | DIC-4 | Reproductive & child health | 7 years | Nurse |
| 10 | DIC-5 | HIV community coordinator | 2 years | Nurse |
| 11 | PRC-1 | Director Health Services | 3 years | Medical Doctors |
| 12 | PRC-2 | PPP Technical Advisor | 2 years | Health Economist |
| 13 | PRC-3 | Zone Health Quality coordinator | 1 year | Doctor |
| 14 | PRC-4 | HIV/AIDs Program Coordinator | 3 years | Doctor |
| 15 | DKC-1 | Malaria/IMCI Coordinator | 10 years | Social Worker |
| 16 | DKC-2 | PPP District Coordinator | 6 Month | Medical Doctor |
| 17 | DKC-3 | HIV/TB/Leprosy Lead | 3 years | Medical Doctor |
| 18 | DKC-5 | District Health Manager | 3 years | Doctor |
| 19 | DKC-4 | District HIV coordinator | 6 years | Medical Doctor |
| 20 | PRM-1 | Project Advisor Manager | 2 Years | Health Economist |
| 21 | PRM-2 | Integrated Project Manager | 1 Year | Social Worker |
| 22 | PRM-3 | Reproductive Programs Lead | 3 years | Nurse |
| 23 | PRM-4 | Director Community Health | 1.5 Years | Doctor |
| 24 | PRA-2 | Director PPP Programs | 10 years | Medical Doctor |
| 25 | PRA-3 | Director private sector Projects | 6 years | Medical Doctor |
| 26 | PRA-1 | Community services coordinator | 3 years | Nurse |

## Data collection

Data collection procedures began with the approval of the Walden University IRB and the Tanzania Ethical Research Board. The Walden IRB approval number is 01-23-17-0403065 and the Tanzania ethical clearance certificate reference number is NIMR/HQ/R.8a/Vol.IX/2423, which is attached as appendix G. The researcher also obtained a letter of cooperation from each study site. All six letters can be referred in Appendix H. The researcher visited each of the three public and the three private organizations, made a self-introduction, and explained the purpose of the study. During the visit, the researcher had an opportunity to get the names and contact information of potential participants from the research contact person at the public-sector sites, and the human resources contact person at the private sector organizations. The potential participants were recruited through the study leaflet and the consent form that explains the study purpose, procedures, and the rights of participants who chose to be interviewed. Interviews were scheduled with study participants, who agreed to participate. A text message or email was sent to participants, depending on the chosen contact method, to ensure the scheduled appointment was kept. Three participants opted out of participating in the study.

The researcher spent one to two days in each organization and interviewed four to five participants; the data collection procedure took three weeks. Some interview appointments had to be rescheduled due to the work volume of the participant, but over the three weeks, all interviews were completed. Fifteen interviews were conducted at the participant's office, nine were conducted at a private room within the organization, and

two in the participant's car. All venues were natural and private and provided a freedom of in-depth dialogue between the researcher and the participant.

Data were collected from 26 face-to-face interviews, most of them were conducted in the Swahili language. Before the start of the actual interview, the researcher reiterated the purpose of the study and the informed consent form that was provided, which gave an opportunity for the participant to voluntarily provide verbal consent and sign the consent form. The researcher used a Dictaphone App on iPhone to record the interviews, which was secured with a personal password for privacy for the collected data. Each interview was guided by semi-structured interview questions and lasted from 30-45 minutes. The variation of interview time relied on the individuals' responses.

After each interview, the researcher played back the recorded audio to allow the participant to check their responses and provided some comment, clarifications or explanations to their recorded statements (Rudestam & Newton, 2015). The researcher manually recorded all comments on the field notebook; these comments were needed to support data analysis. Apart from the field notes, the researcher was critically observant for any relevant scene that would support data analysis and jotted down on field notebook and wrote a reflective journal, which was a summary of relevant issues to support data analysis. In many cases, writing personal feelings after each interview helped the researcher to be aware of personal bias (Janesick, 2011: Patton, 2014).

During the data collection time, the country had two bank holidays that interfered with the timeline. Another delay was that it was rain-season in Tanzania, which caused some travel delays for participants, so some of the appointments were rescheduled.

## Data Analysis

In many cases, the analysis of qualitative study focuses on understanding the broad picture by using the collected data to describe not only the phenomena in question but also to provide the explanations and the meaning of the phenomena (Creswell, 2014; Patton, 2014). In this study, the researcher employed content analysis technique that provided a sense of textual data collected and highlighted the significant themes and findings. Content analysis is a systematic procedure that involves constant data assessment in line with the research question and conceptual framework for this study (Milles & Huberman, 2013). The analysis process included the data classification, coding, sorting and synthesizing (Liamputtong & Serry, 2013). The analysis started at the field as the researcher collected data by interviewing, taking field notes, obtaining documents, translating the interview from Swahili to English language and transcribing the interviews.

The researcher collaborated with a colleague who is proficient in both English and Swahili language to counter check the transcripts for any omissions, additions or bias before proceeding to the coding procedure, and this ensured quality and rigor in this study. According to Miles and Huberman (2013), member audit improves the quality of data collected and provides credibility and dependability for this study. Coding is a process of condensing the data by tagging or giving the word to the data without removing the meaning or context of the text (Milles & Huberman; Liamputtong & Serry, 2013). All interview transcripts were translated to the English language, and the researcher manually coded, focused on the preliminary theme to identify relevance of

data collected. The process gave the researcher a critical lens in identifying saturation level and ended the process of data collection. In the process of data collection and analysis, the researcher noted that there was no new information emerged after the 25th to 26th participants and ended the process.

All transcripts were saved individually as PDF files with the participant number in a computer that has a password that is only accessed by the researcher. The researcher used NVivo qualitative computer software and entered the PDF files to manage, organize and to facilitate the coding and analysis process. Creswell (2014) and Patton (2014) argued that using various methods increases the trustworthiness of the study result. The focus on the coding process based on the five constructs of diffusion of innovation conceptual framework: Relative Advantage, Compatibility, Complexity, Practicability, and Triability and the four constructs of community public-private integrated partnership module, which are Design. Build, Finance, and Organize (DBFO) for this study.

According to Miles and Huberman (2013), previous social scientists identified various code types that produced practical relevance for public health research. With the three research questions in mind and printed out in a paper, the researcher frequently read the transcripts and reflected on the data analysis. Similarly, to avoid the risk of bias, the researcher highlighted her-own bias and tackled the coding objectively.

This study is an exploratory qualitative study focused on understanding the factors that would promote the partnership leadership synergy in Tanzania. According to Saldana (2013), the researcher needs to choose a relevant coding approach to align with the research questions. Bearing in mind that epistemological study seeks to understand

the phenomena in question, the coding approach based on theming coding (Saldana, 2013). The theming coding procedure provided an opportunity to select a phrase or a sentence that described and captured the meaning of an aspect of the data based on the predetermined theme (Miles et al., 2013). After the coding process, the researcher grouped the information according to the conceptual framework, and then linked the data, identified the relationship between the codes, the frequency and the underlying description on each theme/construct.

With the NVivo program, the researcher created a unit of analysis as program and case classification as the private sector and the public sector, then a list of nodes, these are the five DoI conceptual framework constructs; Relative Advantage, Observability, Compatibility, Complexity and Triability. A node is a category that contains references to themes in the study (NVivo 11 QSR international, 2013). Then the researcher identified the prominent theme by coding references and the aggregation of the theme in each organization. Also, the frequently highlighted themes by the participants were noted to assist in data analysis and recommendations. Then the researcher used a critical analytical lens to mirror the essence of the meaning between the themes. The themes were grouped according to the underlying descriptive lens in the notes, which consist of themes and categories to answer the research questions.

With the NVivo program, the researcher could manage data, code all transcripts, explore, visualize the relationship not only between the themes, but also between the organizations, and compare the diagrams and table on each theme by coding participant's references. Also, the themes and the participants coding references were compared by the

organizations, this provided a visual comparison diagram. Further, the researcher coded for themes to understand the themes that had more coding references and identified the prominent theme. The researcher compared themes to explore patterns and to find a connection between public and private organizations. In the process of synthesizing data, the researcher ran the category queries to identify common patterns that were referred to by the participants. The researcher ensured all the participant's responses were coded and reflected in the themes.

Given the process of comparing the relationship between the theme by participant's references and research notes, the researcher could explain the findings of this study in the results section. As such, the researcher used a critical lens to review the data repeatedly, and back and forth to ensure all response information is recorded appropriately and in a relevant theme. According to Parton (2014), reviewing data several times provides not only extensive coding but also inclusive of all applicable information to each theme, which adds to the quality of this study.

Themes that were frequently highlighted by both cases were as follows: teamwork, lack of data linkage for planning, integrated supervision, strategic communication, limited understanding of PPP benefit, and lack of clear roles and responsibility. These themes were highlighted because they provide an insight that provided a lens to better understand leader's opinion on leadership synergy in a partnership setting. For example, table 4 below indicates that 23 (88.5%) of respondents mentioned integrative supervision and meetings as one of the elements that promote leader's engagement on auctioning PPP primary health care interventions in a partnership

setting. On the other hand, 6 (23.1%) of respondents indicated lack of roles and responsibility contribute to the negative impact of the implementation of PPP in primary health at the community.

Table 8

*Common Emerged Themes*

| Theme/categories | Number emerged | Specific sector |
|---|---|---|
| Integrated supportive supervision & Meetings | 23 (88.5%) | 18 times in the Public (78.3%)<br>5 times in the private (19.2%) |
| Teamwork | 19 (73.1%) | 11 times in the Public (42.3%)<br>8 times in the Private (30.8%) |
| Lack of data quality and linkages | 11(42.3%) | 6 times in the public (23.1%)<br>5 times in the Private (19.2%) |
| Strategic communication between partners | 6 (23.1%) | 3 times in the Public (11.5%)<br>3 times in the Private (11.5%) |
| Lack of clear Roles and Responsibility in PPP health interventions | 12 (46.2%) | 7 times in the Public (26.9%)<br>5 times in the Private (19.3%) |
| Limited understanding of PPP benefits | 12 (46.2%) | 6 times in the Public (23.1%)<br>6 times in the Private (23.1%) |

The findings of this study employed DoI conceptual framework and PPIP constructs to facilitate the analysis and address three overarching research questions. Given the conceptual framework constructs, the researcher used the NVivo qualitative data analysis program to code the data appropriately. For example, each construct was coded against each interview transcripts, and then compared the relationship and the frequencies of participants' references. Further, the information was synthesized, and the documents were reviewed to provide an explanation that is not only descriptive but also aligned to the researcher questions, which provided insight that explains the results of this

study. For example, Table 9 below compares the response of private sector and the public-sector perceptions toward leadership synergy facilitation. The result shows that observable outcomes are more prominent by 23 (88.5%). Of which 13 (50.0%) has been referred by the public sector and 10 (38.5%) by the private sector. The construct of complexity is less prominent by an overall of 11 (42.3%) with 5 (19.2%) from the private sector and 6 (23.1%) from the public sector.

Table 9

*Perceptions of Leadership Synergy Facilitation*

| Theme/ Constructs | Number of coding references | Public Sector | Private Sector | Total % of each theme |
|---|---|---|---|---|
| Complexity | 11 | 5 (19.2%) | 6 (23.1%) | 42.3% |
| Relative Advantage | 19 | 7 (26.9%) | 12 (46.2%) | 73.1% |
| Observability | 23 | 13 (50.0%) | 10 (38.5%) | 88.5% |
| Compatibility | 16 | 8 (30.8%) | 8 (30.8%) | 61.6% |
| Triability | 21 | 11 (42.3%) | 10 (38.5%) | 80.8% |

Table 10 below illustrates the analysis of PPIP constructs. The table shows a summary of aggregated theme coding reference, which shows that operationalizing, 22 (45%), PPIP interventions is the most prominent construct, followed by build, 16 (33%), finance 7 (14%), then finally design 4 (8%).

Table 10

*Engagement in the PPP Implementation*

| PPIP Concepts | Participants References | Documents Reviewed | | Private sector | Public Sector |
|---|---|---|---|---|---|
| | | Public | Private | | |
| Design | 4 (8.0%) | 1 | 0 | 3 | 1 |
| Build | 16 (33.0%) | 3 | 0 | 9 | 7 |
| Finance | 7(14.0%) | 0 | 0 | 3 | 4 |
| Operate | 22 (45.0%) | 6 | 2 | 11 | 11 |

**Discrepant Cases:** the purpose of this study was to explore leaders and manager's perceptions on partnership leadership synergy with a view of understanding the factors that would enhance ownership and accountability of health and social care interventions. The researcher revealed no sign of discrepant or non- conforming data.

## Evidence of Trustworthiness

**Credibility:** The researcher used a variety of data sources, which included one-to-one participant interviews, document review, field notes, and daily reflection notes. The use of different data source approach is called triangulation (Creswell, 2014; Patton, 2015) that provides an incredible and valid data source to support study analysis and interpretation. The researcher manually entered all interview transcript files and texts notes to the NVivo program that facilitated the process of data analysis as explained in data analysis procedure in this study. The process of using computer software data

analysis provided the analytical focus that not only increases the value of the data interpretation and results of this study, also provided a visual lens that enabled the researcher to explore the themes, compare the relationships, and identify the prominent themes and categories. The analysis process used to provide the conclusions of this study.

The researcher recorded all interviews using a Dictaphone voice recorder, which allowed the researcher to play back the interview for the participant to listen to their comments and make corrections. All comments from participants were manually noted in a field note, and the researcher counter checked with the participants to ensure that the comments reflected what participant said and that each participant agreed on their response documented information: this was done for each participant and all participants (100%) agreed to their documented response information.

In this study, the researcher followed the study protocol, as detailed in Appendix A, and used a criterion purposeful sampling to select the private organizations listed in Appendix C. The private organizations were selected according to a working status that was to provide primary health and social services at the community level within study population area. Then the researcher recruited potential participants who voluntarily were informed and signed the consent form before the interview. The researcher engaged a neutral colleague to review all the transcripts (the Swahili version and the English version) to ensure that all information has been translated without any bias, omission or addition. The researcher not only maintained personal critical analytical lens to identify the saturation level before stopped data collection procedure but also, understood the findings as the research progressed.

**Transferability: T**he researcher **e**mploying triangulation methodology and member check procedure confirmed that the results of this study are valid, which would provide a base for transferability. Although the results express the perceptions of selected participant responses there is a possibility that the methodology can be transferred to understand similar phenomena in partnership leadership synergy for health and social care interventions. The values remain at the unit level; in this case, the results inform public and private sector in the provision of primary health and social services interventions in the Dar es Salaam city.

**Dependability**: The dependability or the reliability of this study was ensured using peer check, 100% participants' confirmation, and the use of triangulation strategies. As such, all interview transcripts are kept safely in a password protected computer drive, and the field notes, research journals and reflective notes are stored safely in a locked box, which can be accessed up to five years as evidence when required.

According to Janesick (2012), member checking journal and field note kept during and after interviews provide insight during data analysis. The researcher repetitively checked the data, used a critical lens to ensure saturation level was reached before stopped data collection procedure and ensured that information that was observed during the interview and data obtained from all sources were considered during data analysis. Further, the researcher used NVivo computer program to facilitate the procedure of data recording, condensation and analysis. As such, the systematic and reliable techniques with transparency (Patton, 2015) that the researcher used confirm study reliability.

For example, the researcher kept observing themes, that were constantly repeated by the participant "team work" "integrated supportive supervision" "Working together as a team is a good thing" integrated meeting" after the interview. With journaling and memoing technique (Janesick, 2012), the researcher could track the themes that facilitated the process of data interpretation and conclusion of this study. The researcher demonstrated the research process from the beginning to the end through acquiring ethical clearance from the university, the local ethical clearance certificate, and the letters of cooperation, which are all attached to this study report as Appendix E. Moreover, the research committee team and the university qualitative research quality team assess the quality of the research analysis and report.

**Confirmability:** Being an instrument in this study**,** the researcher kept a daily reflective note while observing personal biases. The reflective practice allowed the researcher to critically consider participant's point of view, voice, language, feelings and cultural backgrounds. For example, during playing back the recorded audio for participants to listen, confirm that the views of participants were considered. Patton (2015) mentioned that being attentive and receptive throughout the process of data collection gives the researcher an opportunity to reflect on the own potential bias, and the strategies to mitigate them.

## Results

The result of this study based on in-depth one-on-one interviews with participants n=26, who were from the private sector n= 11(42.3%) and the public sector- n= 15 (57.7%). The participants were leaders, managers and coordinator of public and private

partnership interventions in Dar es Salaam, Tanzania and at the time of this study were the leaders of some of the primary health interventions within their organisation and in a partnership environment. As noted previously, the professional characteristic of the participants ranged significantly from medical doctors, social workers, health economist, and nurses, and among them, 19.2% were project directors, 65.4% were project coordinators, and 42.3% were project led managers.

This study was an explanatory empirical qualitative case study that focused on understanding the factors that would enhance partnership leadership synergy in public-private partnership health and social care interventions. The researcher used diffusion of innovation theoretical framework and community public-private integrated partnership module (DBFO) to guide data collected and analyzed for this study. The three overarching research questions formulated the basis for reporting the results of this study. Each question was addressed separately, and data were presented to support each finding, table and figures were provided to illustrate results. Table 11 below illustrates a summary of data analysis framework and six emerged themes, which are the outcome of this study.

Table 11

Result Framework Summary

| **Data Source** | **Unit of Analysis** | **Three Research Questions** | **Conceptual Framework** | **Six Emerged Themes** |
|---|---|---|---|---|
| Interview Transcripts<br><br>Document Review | **Organization** | What are the perceptions of public and private community health leaders in Tanzania toward public-private | **DoI Constructs** Relative Advantage, Compatibility, Triability, Observability, and | Integrated Supervision<br><br>Team work<br><br>Strategic |

| | | | | |
|---|---|---|---|---|
| Field Notes<br><br>Reflective Journal | | partnership leadership synergy? | Complexity. | communication between partners |
| | **Three Private Sector organizations**<br><br>PRM<br>PRC<br>PRA | What are the perceptions of leaders of public and private sector to facilitate leadership synergy for PPP in health and social care interventions in a community setting | | Lack of clear roles and responsibilities<br><br>Limited understanding of PPP in health at community level<br><br>Lack of data quality |
| | **Three Public Sector Organizations**<br><br>DTC<br>DIC<br>DKC | How do managers and leaders of the public and private sector facilitate synergy for action health and social care interventions implementation in partnership setting? | **PPIP Module**<br>Design, Build, Finance and Operate | |

Given the summary of analysis and the results of this study; the following are the responses from the participants, which are organized by the three overarching research questions. RQ1: What are the perceptions of public and private community health leaders in Tanzania toward public-private partnership leadership synergy? RQ2: What are the perceptions of leaders of public and private sector to facilitate leadership synergy for PPP in health and social care interventions? and RQ3: How do managers and leaders of the public sector and private sector facilitate synergy for action health and social care intervention implementation in partnership setting?

**RQ1: What are the perceptions of leaders in Tanzania toward leadership synergy?**

In RQ1, Researcher was interested in understanding the perceptions of leaders in the study area about leadership synergy in implementing PPP in health interventions. The followings are the responses from the participants:

"I think the integration of services and PPP leadership is good…because we share plan and implement the result in a harmonized setting" (DIC-3)

"It's really good because…together we can identify the gap, and mutually we increase our cooperation…You know it may improve efficiency" (PRM-3)

"I think it is a challenge you know…however the leaders and coordinators of both sector, I mean the private and the public may think that community PPP partnership leadership can be shared you know I think is a good practice but may need advocacy" (PRA-2)

"I don't know because the government has the responsibility of the implementation of the PPP it can be kind of challenge you know…and another thing is in the community no much awareness of the PPP benefit" (DTC-4)

"Although it is hard you know…but with integrated activities we are actually communicating very well with the private sector now…we can see things together at the community and correct with limited conflict…but the council management team should be the coordinator I think" (DKC-3).

" I think the engagement of private sector in our supportive supervision it's a good idea because it has increased the trust in the services implementers. Both coordinators visit the centre and if there any problem both sides see the problem you know and that kind of

bias from one side is avoided you know and now private sector feel that there is fairness" (DTC-2)

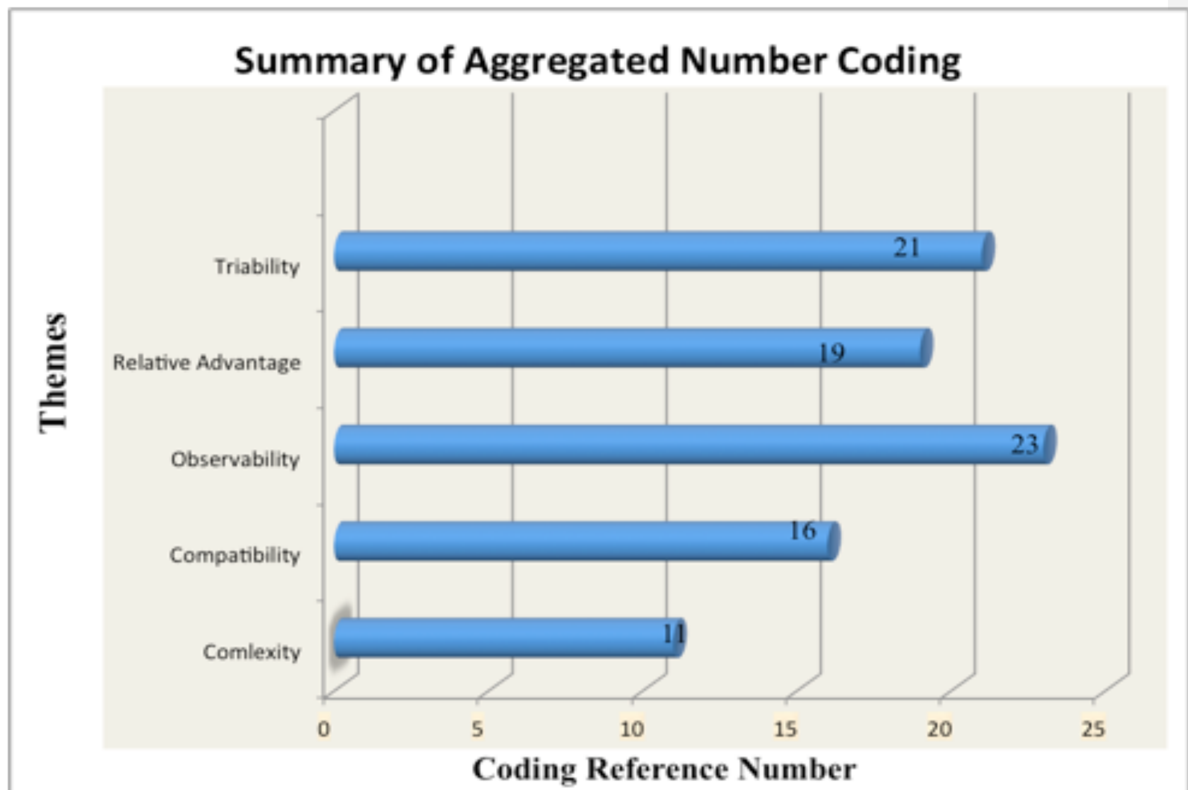
" Well … Joint relationship with partners is good in managing PPP health interventions…But this should be two ways traffic, and I think on the side of public sector we need to open doors and engage more of private sector leaders and work together this should start at the local government you know… I think we need to involve private much more**"** (DIC-3).

"It can be a challenge you know the way government work is different sometimes they have lots of bureaucracy…most in private side, we focus on achieving our goals…you know, but in PPP I think at the national level it is okay and can be possible, but in the community, I think the PPP collective leadership can be a challenge you know may need promotion" (PRC-3).

**RQ2: What are the perceptions of leaders about leadership synergy for PPP?**

In RQ2, the researcher was interested in understanding the perceptions of leaders in facilitating leadership synergy in a community setting. Figure 1 below illustrate a summary of results that answer RQ2, which shows that observability and triability are more prominent than other themes by 88.5% (23) and 80.8% (21) respectively. The coding references reflect both private and public sector. On the other hand, the overall frequency on the complexity shows less remarkable by 42.3% (11) compare to the other themes and Table 8 below provides evidence of the participant's responses in each theme/construct.

*Figure 1: Leaders' Perceptions on Leadership Synergy facilitation*




**RQ2 Evidence from The Participants' Responses**

**Relative Advantage:** Relative Advantage explains the perceived degree to which the partnership leadership synergy will be better than the current practice. The evidence from the participants indicate the following response:

"I think It really helps to avoid duplication of activities in the outreach" (PRM-3) "You know besides the challenges, but in this integrated leadership, we work as a team in a PPP. Also, we have network group which in case we have a client who wants long term method we just put in a group and specialist who is free pick up and go to meet the patient instantly you know we don't have to make an appointment …it is good practice I

tell you" (DIC-4). "In my case, I think the integration has increased trust among the implementers as both private and public supervisors can see things together limit bias" (PRA-3)

“ I think it has increased a good relationship with partners you see (PRC-2) “…it is good and need to be two ways traffic. Also, I think on the side of public sector we need to open doors and engage more of private sector leaders and work together this should start from the municipal level I think we need to involve private much more and the private need this will promote transparency (DIC-3)

**Compatibility:** Compatibility explains perceived factors on how consistent the intervention is within values, habit, experience and needs of the Public and private organizations**.**

Evidence from the Participants Responses

“I think we all use similar national PPP guidelines and when we do supportive supervision we look how the government standards are adhered by the private sector ” (DTC-2)

“ At the national level the technical term comprised of the private and public sector, so I think we all serve the same population we should work toward similar values in the PPP…I think" (PRC-1) “…for example in the PPP project we have introduced the issue of task sharing and shifting. Because of the shortage of staff, the strategy has built community trust on the staffing issue in private facility that we support (DKC-5). "Also the forum that we have established in each local government should work together and monitored against the PPP interventions and a set indicators" (PRC-2). "Historically the

private sector has a tracking footage of complementing government health care effort…I think we embrace similar values (PRA-2).

**Observability:** Observability explain the perceived extent to which the partnership leadership synergy will provide visible or tangible outcome

Evidence from the participants

"Since I establish integrated team work in my unit I can see that we have increased access and the work is so easier" (DIC-2) "…the task sharing and task shifting motivate staff, of course, they earn extra income you know…" (PRC-2)

" I used to see some leaders used a lot of effort...you know...sometimes unnecessary to engage with other partners in this collaborations. Because initially, it was so hard to engage with the public sector, but after the PPP initiatives the private sectors can engage with, collaborate, and even plan together now you see...(PRM-1). "…where we see there is some duplications or shortage in the public centers the private partners take over to share the shortage and move to other community to minimize duplication" PRM-3) "…I think the idea has proved a vivid achievement because we have increased the reach to the community I mean the coverage you know especially the involvement at planning stage is very good and my observation is that the partnership working has promoted ownership, and also our management team has received a good feedback of promoting ownership at the community level" (DKC-5) "…team work has improved, and now we can see a bit of data linkages need action to improve"(PRA-3).

**Triability:** Triability explains the perceived extent to which the partnership

leadership can be monitored for accountability.

Evidence from the participants

“Although we encounter various challenges but in general the integrated meeting solve many issues in a harmonious way” (PRC-3) “…we do have a council management team, which is multidisciplinary although it entails public sector health coordinators and leaders only but the team work together with private sector to conduct supervision in all of the outreach facility within the council" (DIC-1). "at national level we think we are fully engaged in planning and our zone coordinators attend PPP community meetings and work together with other partners on training and outreach services (PRM-4) “I think during integrated meeting with partners gives opportunity to share and plan together which minimize duplication” (PRM-2). " In real practice we share transport, and when doing integrated supervision every team has own goals and targets, so other partners have short checklist than ours, so they finish sooner than us, so sometimes I have to go back to finish on my own” (DIC-4). “Although we benefit on transport in working together with private sector but sometimes I think the integrated supervision result into very shallow supervision” (DIC-4). “we don’t include private sector in our supervision because many are business health provider anyway so we supervise them and provide them with government order” (DTC-2). “in our council, we have PPP service with one private hospital we engage the management in our planning and our annual budget, and together we monitor the delivery of services we have a set of indicators” (DTC-5). " I think the PPP forum are only functional at the national level as I heal at the community level are not functioning…is just public-sector bureaucracy and not prioritizing things I think"

(PRA-1). **“**As far as I am aware of everyone works independently may be following government guidelines we only work together if there is training we do together private and public, and also we collaborated in immunization week…I think there is no much engagement really” (DIC-5). “Each stakeholder has own influence from the top level, but what we do here is that we hold a meeting so that we can identify them stakeholders who work within our municipal with ministry of health agreement, and this is the time we got to know where they are and what they do” (DKC-2).

**Complexity:** Complexity explains perceived difficulty on understanding the PPP concept and the implementation of leadership synergy**.**

Evidence from the participants

“You know in our municipal council health management team we don’t have any member of the private sector because it should be government authority isn’t it I think it would be a bit of challenge to engage business providers” (DTC-1).

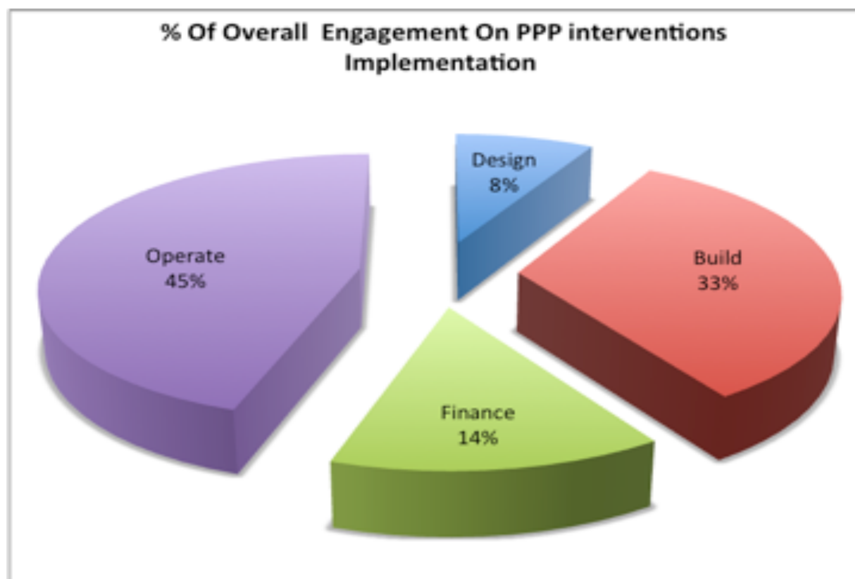
“Although at the national I mean at the ministry the PPP awareness in health has increased but with changes in leadership and on the other hand, if you like some leaders are against private sector as they judge them as money makers …we still need a lot of advocacy I think (PRA-2) "It is a bit of challenge due to share the leadership due to bureaucracy at the public, and I think they don't have priority …" (PRM-1). " I think the roles and responsibility within this PPP aren't clear" (DTC-3). “I think priority differs so it the partnership leadership may need a framework you know" (PRC-4). To me, I found that the lack of understanding the PPP concept especially with community leaders you know and no commitment you know it demotivates another partner” (PRM-3)

"…actually there are no data linkages we talk in a preamble it's hard to plan together… I don't know (PRA-3).

**RQ3: How do manager facilitate synergy for action health intervention**

In RQ3, the researcher was interested in understanding the facilitation of leadership synergy for action PPP in a partnership setting. Figure 2 below illustrate a summary of leadership engagement on PPP implementation, which indicate that 45% of public and private sector leaders come together to operationalize the PPP interventions in a partnership setting. Also, the figure indicate that the design process of the PPP health interventions is less engaging leaders compared to build, finance and operate by 8% in both public and private sector.

***Figure 2: Partnership Leadership Engagement on PPP implementation.***




**A summary of participants quotes in response to RQ3**

"I am getting support from the ministry of health and social welfare; I use ministry's PPP guideline. In actually another issue is having a PPP policy, which can be one of the

factors that have made it possible to resolve challenges it has become lighter in cooperating PPP interventions with public partners" (PRC-1).

" You know as private sector working with the ministry to describe PPP nationwide has slowly increased an awareness of PPP in health issues because some leaders they were against private sector as they were saying how can we work with the private agency while them they make money…this I found was an issue of lack of understanding the PPP concept…actually after education and awareness raising I think things start to come together and we plan together now" (PRA-2).

"I believe without teamwork our services that we give to people both from private and public sector would make people experience different things you know…in fact, we all serve the same population, so we really need to work as a team" (DKC-1)

"So, I think working together with private sector in all level is important especially at the level of designing this intervention so that we don't duplicate our resources" (PRC-4)

"Being a leader, you need other leaders you know…because without engaging stakeholder it's difficult to get things done you know and if you don't engage stakeholder you will get a very weak result" (DKC-5)

"my experience is you know when I plan for a team work supervision we do together with private sector coordinators so we do have integrated team work per week in a month so we can reach all centres this includes public and private sector" (DIC-4)

"We work together with partners on capacity building and supervisions, this has improved the trust to the community that we serve, and also we get commodities supply from the council you know…at least this compensates a little bit you know" (PRM-3).

"We always engage with the facilities leaders during supervision … we have synergy meetings in this meeting we discuss challenges and this the time we plan together and if there is any kind of guidelines you know…I mean the organisation or government guideline we share and update all stakeholders and our partners…This is how we actually plan together on how to implement national PPP policies and guidelines" (PRA-3).

## Summary

The purpose of this study was to understand factors that would enhance partnership leadership synergy on public-private partnership health and social care interventions in Tanzania. The result presented in this chapter is the descriptive account of in-depth interviews that were coded, sorted and synthesized in line with the conceptual framework themes to address the overarching research questions. The semi-structured interview questions provided answers to research questions one, two and three. However, in response to research question three the PPIP themes were aligned to provide data. The researcher reviewed the following document; National PPP policy guidelines, APHFTA PPP strategic planning, and faith based PPP strategic document, and in the case of the international private health sector organization, the researcher was unable to obtain any document on the PPP implementation.

**In response to RQ1:** What are the perceptions of public and private community health leaders in Tanzania toward public-private partnership leadership synergy? The results from the analysis of data collected from leaders, coordinators and managers responses' highlighted the following factors: PLS engages private implementers and

minimizes bias; the integration increases trust to the PPP implementers; public sector not fully engaging community leaders of the private sector; private health centres have no capacity and are for business; primary health care is free services, not often provided through the private sector; public sector leaders have bureaucracy, and private sector leaders are not transparent.

**In response to RQ1**: What are the perceptions of leaders of public and private sector to facilitate leadership synergy for PPP in health and social care interventions. The common phrases that leaders, coordinators and managers from both private and public sector voiced were as follows: Teamwork has increased coverage: Integrated Supportive supervision involved both the private and public sectors in the provision of reproductive health harmonize relationship and minimize duplication, and on the other hand, these integrated supportive supervisions lack fully engagement of community health leaders at the municipal level: Strategic communication among leaders improves collaboration and iron out misunderstanding among partners: Although council health management team involves only public health sector entities, but engage the private sector in the integrated planning meetings.

**In response RQ3:** How do managers and leaders of the public sector and private sector facilitate synergy for action health and social care intervention implementation in partnership setting? In this question, the researcher was interested in understanding how leaders, managers and coordinators facilitate joint actions for health and social care intervention implementation in a partnership setting. Looking at the participants' responses from both public and private sectors the findings show that there limited

understanding of how PPP in primary health care are designed, build and finance at the community level. There is a lack of clear roles and responsibilities of leaders at the implementation ground; the local government, and community in action PPP interventions. Both private and public sector review the national policy and guideline for PPP but community health leaders are not fully involved. Leaders encounter ineffective planning problems due to unclear data linkages and poor data quality. PPP training programs are functional in one district council, Ilala where there is a stability in PPP leadership, while the other two councils experienced frequency reshuffle of leaders and health management staff and no strategy for handover of PPP in health implementation plan.

Reviewed documents show that PPP in health and social welfare is well mainstreamed from National to ward level as illustrated in table 7 below. As such, the reviewed national PPP policy, private sector strategic planning documents and the faith based PPP implementation plan illustrate pathways to engage partners in health interventions. According to MoHSW (2013), the municipal PPP health forum is responsible for synergizing PPP leadership activities at all levels. However, respondents in this study stated that it is unfortunate the community PPP forums are not functional at the regional level and the community (PRA-2; PRC-1; PRC-2; DIC-3). On the other hand, respondents mentioned that the financial constraint challenges the leadership of the PPP integration strategies, as highlighted by the participant: “ Oh yes you know sometimes we don't have the budget for the PPP forum…and sometimes it depends on council priorities" (DKC-3). Also, the limited knowledge on the PPP benefits hinders the

leadership synergy as explained by the participant: " to be honest with you I don't know how this PPP forum operate…anyway, I will have my PPP training soon” (DTC-2). On the other hand, the national policy guideline highlights the lack of clear understanding of the benefit of PPP in health at the community (MoHSW, 2013).

In Chapter 5, the researcher discussed a summary of the research findings and interpretation. The conceptual framework of diffusion of innovation was used to guide the discussion, and the researcher provided the meaning of the construct and showed the relationship of the construct with the study findings and previous studies. Further, the limitations and the implications of the study are discussed, and lastly, the key insights and recommendations are provided in a conclusion section of this study.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

The PPP in health has been embraced as a pathway to improving health outcomes of the population. Previous studies indicated that public health leadership is vital to promote ownership and accountability in the implementation of public health and social care interventions (Cramm, Phaff, & Nieboer, 2012). This study found that the PPP in health takes various routes to implement primary health interventions in a partnership setting. This study explored public and private project leaders and managers perceptions of partnership leadership synergy (PLS) in the implementation of primary health interventions in the community. The primary health interventions at the community level are HIV, tuberculosis, leprosy, maternal health, child health, reproductive health, malaria prevention and treatment, nutrition and quality health promotion (APHFTA; 2015; CSSC, 2015; MoHSW, 2013a; 2013b; & 2013c). The strategies for engaging the private and public sector to implement the primary determinant of community health are revealed in the government PPP policy guidelines (MoHSW, 2013a).

The purpose of this study was to understand the factors that would foster ownership and accountability of primary health interventions by the PPP leaders to improve the quality of life. The researcher used an empirical qualitative case study to understand sensitive practices that require explanatory inquiry in a natural setting (Creswell, 2014). Therefore, this discussion focused on the in-depth interview with purposefully selected leaders and managers of the six organizations, three public and

three private, non-profit health sites in the Dar es Salaam, of Tanzania. The key findings were organized in five themes that were reflected in the diffusion of innovation conceptual framework and the four concepts of PPIP. Table 12 below provides a summary of the organizational framework for the PPP health and social welfare sector in Tanzania.

Table 12

*Tanzania Organizational Framework for the PPP Health and Social Welfare Sector*

| Finance Unity (Ministry of Finance) | | | |
|---|---|---|---|
| | Private Sector | Health and Social Welfare Sector | Public Sector |
| National | Representative of Faith Based Organizations, Professional Association, Private Health Insurance, Private Health Companies, NGO, Civil Society Organization and all others | Public-Private Health Forum<br>Social Welfare/PPP Technical Working Group | MoHSW PPP office<br>Prime Ministers Office-Regional Administration and Local Government PPP office.<br>Health Insurance Funds |
| | Representative of Private | Council Health Forum | PPP Regional authority |
| Council | Representative of Private | Council PPP Health Forum | PPP Local Government Authority |
| Ward/ Village | Community/NGO All other Private | Community PPP Health Forum | PPP Ward/Village Authority |

Note: The table provide a layout of PPP from the national level to the community/ village authority. Adapted from the MoHSW (2013).

## Summary of Key Findings

In this study, the researcher found six factors that would contribute to a body of knowledge and provide insight on enhancing the promotion of partnership leadership synergy for a PPP in primary health care and social welfare partnerships. The first is that promoting full engagement on integrative, supportive supervision to meet the PPP in primary health care and social welfare. Secondly, fostering partner leadership and teamwork is essential. Third, leaders much ensure quality data is linked to PPP in primary health care at all levels. Forth, strategic communication between partners is essential to ensure everyone is moving toward the same intervention goals. The fifth goal is for leaders to ensure clear delineation of roles and responsibilities of all levels of employees and at the establish PPP primary care interventions. The sixth factor is the necessity to ensure an understanding of PPP benefits, goals, and quality of care to improve the primary care of the population.

## Discussion

**Relative advantage:** Relative Advantage explains the perceived degree to which the partnership leadership synergy (PLS) idea will be better than the current practice in the implementation of PPP in primary health intervention in the community setting (Robinson, 2009: Roger, 2003). The study findings show that 19 (73.1%) of the total participants perceived that synergetic leadership promotes engagement, which provides a positive environment for the effectiveness of their activities. Looking at the public sector

where 23 (88.5%) of the participants mentioned that integrative supervision and meetings had improved the level of engagement between the two partners, the private and public sector

Roger (2003), mentioned that the existing level of relationship would influence adoption of the new idea. Because of teamwork and integrative leadership in supervision, and meetings leaders, coordinators and managers within the PPP built an environment of sharing and correcting each other. Further, the integrative meeting reduced the duplication of activities and improved trust with community health providers and users (DIC-4: PRM-3)

The teamwork when two partners provide a working platform that coordinates outreach services through an electronic application network has contributed not only to increase service access but also to promote service uptake on the use of long-term family planning services (Personal communication: DIC-4 & DIC-5). Taking a relative advantage of the existing teamwork and integrated supervision practices, the PLS concept would effectively facilitate and advocate policy guidelines. A previous study showed that collaboration and integrative ways of working not only promoted positive partnership, but also increased ownership and effectiveness of public health innovations (Ansari, 2012; Fernandez et al., 2010).

On the other hand, 11 (42.3%) of respondents highlighted complexity would be a challenge in the promotion of PLS implementation because of bureaucracy in the public sector (PRC-1: PRM-2: PRM-3) and that the private sector is defined as business organizations, which are not transparent on their business (DTC-2; DKC-2). The

literature suggests that leaders behaviour contribute significantly to the effectiveness of the leadership in a complex organizational framework (Bucker & Poutsman, 2010; Choi et al., 2015). Therefore, strategic communication promotes not only team innovation and engagement, but also a positive partnership functioning (Ansari, 2012; Cramm et al., 2012; Jones & Barry, 2011).

To achieve a positive health outcome of the population in a collaborative and coalition leadership, the literature suggests that engagement of multidisciplinary and leadership practice within the PPP framework is essential to enable the organization to function (Fernandez et al., 2010; Silvia & McGuire, 2010). Although teamwork, strategic communication and integrated supervision and meetings practices are highlighted to be the relative advantage for enhancing Partnership leadership synergy, Jones & Barry (2011) argued that the framework for integration needs to be considered and understood by both partners.

Looking at the Tanzania Ministry of Health and Social Welfare PPP policy (MoHSW, 2013), the policy document concentrates on top down leadership practice and lacks partnership leadership directives for the PPP at the municipal and community level. The document provides evidence on emphasis to supportive supervision and integrative meetings, which aim to improve the quality of services clearly documented in the national supervision guideline (MoHSW, 2008). However, the level of engagement of private sector and community PPP implementers is not clear.

The PPP national policy is explicit on task sharing, and this could provide a relative advantage for the partnership leadership synergy for the community leaders in the

community setting. The private sector coordinating hub, the APHFTA association, assumes the representation of the private sector leadership, which is a relative advantage strategy-incorporating private sector, for profit organizations to provide primary health interventions. The APHFTA (n.d) private sector strategic plan document 2016-2020, highlights the strategies for the private sector integration project plan in a PPP intervention and emphasizes on the provision of quality primary health services. However, the APHFTA strategic plan for PPP did not specify the level of inclusion of community private leadership in the delivery of PPP interventions in a partnership environment. The CSSC comprehensive PPP plan has illustrated the level of mainstreaming PPP health and social welfare interventions within the faith based not for profit agencies in the country (CSSC, n.d). The leadership strategic PPP plan document for the local and international NGO that provides primary health care in Tanzania was not found.

This study found 6 (23.1%) and 5 (19.2%) of the public and private sector respondents respectively mentioned that lack of data linkages and poor-quality data contribute to ineffective health and social care interventions coverage plan. Further, 12 (46.2%) of the respondents, both private and public sector stated that limited community leader’s engagement, lack of ownership and accountability contribute to poor quality data production. On the other hand, 7 (26.9%) of public sector respondents highlighted that lack of capacity and understanding of the roles and responsibilities of PPP leadership at the community level also contributes to the lack of data reliability and linkages. The PPP policy underpinned the findings of poor quality data and stated that limited capacity and

health related data hinder the design and service agreement implementation and output (MoHSW, 2013a). Equally, limited awareness on the benefit of PPP plays a role in the lack of ownership and accountability (MoHSW, 2013a).

Further, the HIV and Tuberculosis strategic guideline (2013) exemplify the benefit of PPP in the provision of primary health outreach services, of which 19 (73.0%) of the respondents noted that team work in a PPP setting enabled the comprehensive coverage and increased access to services in the remote area. Also, public sector participants 11 (42.3%) acknowledged the contribution of the private sector that it is eminent in the provision of health and social care particularly in the community and remote areas. This study found that promoting integrated supportive leadership supervision; enhancing integrative leadership teamwork and fostering strategic leadership communication are some of the factors that would foster ownership and accountability in the implementation of PPP in health interventions in a partnership setting.

**Compatibility:** The compatibility theme explained perceived factors on how consistent the PLS is within values, habits, experiences and needs of potential adoption of PLS practice within the PPP in health framework (Robinson, 2009). The finding in this study shows that 8 (30.8%) of private sector leaders and 8 (30.8%) of public sector leaders perceived that they could exist together successfully. For example, the faith based health organization has historical background on complementing government efforts on the provision of health and social care services in the remote area (CSSC, n.d; MoHSW, 2013). On the other hand, the APHFTA association represents the private sector facilities, which advocates not only for the inclusive policy, adherence and legal framework, but

also the financial capacity for the implementation of primary health care (APHFTA, n.d). Local and international NGOs for primary health would require a PPP working plan to promote accountability and minimize duplication of activities.

For example, private participants commented, “I am getting support from the ministry of health and social welfare” (PRM-1; PRC-3). “I use ministry’s PPP guideline” (PRA-2; PRC-4). “…actually, another issue has a national PPP in health policy you know…this is one of the factors that has made it possible to resolve partnership challenges …the process has become lighter in cooperating PPP interventions” (PRA-2). On the other hand, the public-private participants also added “…initially it was so hard to engage with partners, but after the PPP initiatives private sector can engage, collaborate, and even plan together” (DIC-3; DKC-5). “and where we see there is some duplications or shortage in the public centers the private partners take over to serve the shortage” (DIC-4; DKC-5). “…In fact, the idea has proved a vivid achievement you know…we have increased the reach to the community coverage” (DIC-1; DIC-2; DKC-1; DTC-5). “So, I think the involvement of community health leaders at the planning stage is very good and my observation is that the partnership working has promoted ownership"(DKC-5).

A previous study indicated that enhancing clear pathway of diffusion of innovation foster the stakeholders to leverage the idea at all levels (Wallace, 2014). In this study, 46.2% (12) participants stated clear roles and responsibilities among leaders of PPP at community level would facilitate the awareness of the benefit of PPP and promote ownership. Historically, the government of Tanzania had open ground for both private

sector and public sector working to meet the health and social needs of the population (CSSC, n.d; MoHSW, 2013). With strategic communication, the existing values and experience of working together between public and private sector, in health interventions bring an integral effort of sharing leadership to deliver a universal value (Silver & McGuire, 2010; Sturchio & Cohen, 2012). The literature also suggested that synergy is a contribution of efforts between two or more organizations that come together to act for the common good (Cramm, 2012). As illustrated in MoHSW (2014), the integrated meetings bring partners together and provide a fair ground on planning, which increases coverage of health interventions. With shared values, Silver & McGuire (2010) promotes empowerment in a partnership environment.

**Triability:** Triability explains the perceived extent to which the partnership in health interventions can be monitored for decision and accountability (Robinson, 2009; Rodger, 2003). The findings in this study showed 21 (80.8%) prominent on triability of which 10 (38.5%) in private sector participants and 11 (42.3%) in public sector participants perceived that the leadership in PPP could be evaluated for its decisions and accountability through meetings and supervisions. This was reflected in participants comments such as "We always engage with the facilities during supervision" (DTC-2). "we have synergy meetings you know, and in this meeting, we discuss challenges and this the time we plan together and if there is any kind of guidelines here I mean the organization or government guideline we share and update all stakeholders and our partners" (PRA-3; PRC-3; PRM-1; DKC-5). "So, we plan together on how to implement national policies and guidelines" (PRA-1). On the other hand, the national PPP

implementation assessment magnifies the intensity of private sector, and the advantages of PPP promote effective integration between a private and public sector (Whites et al., 2013).

The study done by Hayers et al. (2015) shows that having an opportunity for the organization to experiment or try addressing challenges together predict change and minimize the risk of perceived risk. With integrated meetings and supportive supervision participants in this study observed an increased coverage in a primary health care services (DIC-2: DKC-5) and noticeable reduction of duplication of outreach services (PRM-3). Further, employing strategic communication between partners promoted understanding between partners and harmonized engagement (DIC-3; PRC-1; PRM-2). Leaders exercising integration in PPP interventions supervisions and planning meetings (MoHSW, 2014) provide an observable prediction for promoting synergy in a partnership setting for implementing PPP primary health care interventions.

**Observability:** The Observability concept explains the perceived extent to which the innovation will provide visible or tangible outcomes (Robinson, 2009; Hayers et al., 2015). According to the result of this study, 23 (88.5%) of the participants perceived that the coalition partnership leadership in PPP is not the only strategic idea, but also would provide value for money. Equally, study shows triability provides observable outcomes that would facilitate the adoption of the synergetic leadership (Hayers et al., 2015). Six (23.1%) of the participants mentioned strategic communication in the partnership produced visible results such as harmonized teamwork and mutual relationship in the integrated supportive supervision. On the other hand, 12 (46.2%) highlighted a limited

understanding of partnership leadership and the PPP in health concept deprives ownership and accountability of PPP interventions. The result on observability underpin the study done by Curry et al., (2012) & Danforth et al., (2010) on shared values where various skills, knowledge and best practice are consolidated and communicated that empower leaders in the partnership environment.

**Complexity**: Complexity explains the perceived difficulties in understanding the PPP concept and the implementation of the Leadership Synergy in a partnership setting (Robinson, 2009). This study revealed a controversial insight on the perceived complexity of the implementation of to PPP in primary health care in a partnership setting. Findings show that 11 (42.3%) of the respondents revealed that stigma exists in engaging PPP especially for profit (PRA-2). Also, the results indicate a lack of clear roles and responsibilities within the PPP in health at the community level, which would also affect the increase of awareness on the benefit of PPP in health at the population.

Given the reviewed documents, the lack of awareness and limited understanding of leaders on the benefit of PPP in health is highlighted as a challenge in the implementation of PPP strategies (MoHSW, 2013; MoHSW, 2014; Whites et al., 2012). On the other hand, participants mentioned that changes in politics focus and priorities of the new government provide uncertainty of PPP design and implementation (PRA-2; DIC-3). Also, findings in this study show that bureaucracy and lack of transparency including instability of leadership at the local government pose complexity issues on promoting ownership and accountability of PPP health interventions.

The previous study shows that not only leaders or managers perceptions affect the diffusion of the interventions, but also evidence of data and the linkages between them can have an impact on planning health and social care interventions (Curry et al., 2012; Hess & Schramm, 2014; Wallace, 2014). As such, strengthening the public- private integrated partnership in health interventions clear roles and responsibilities for the leaders are vital for increasing ownership and accountability (Ansari, 2012; Cappellaro & Longo, 2011; Cramm et al., 2012). The national framework for operationalizing PPP in health and social welfare shows a top down plan that concentrates on the national PPP implementation (MoHSW, 2013), which in one way or another contributes to deprive leaders of the community in the provision of PPP in primary health care.

According to Global Health Group (2012), the partnership between the government and private sector would bring the expertise, management skills and financial awareness to the unit and produce a better value for money. In this study, findings show no evidence of a plan of action that engages both private and public leaders, 8% of the design is noted at the national strategic plan (MoHSW, 2014). Fourteen per cent of shared risk, power and financial accountability, 33% of shared government resources and tools, but no evidence on the management and implementation of PPP in primary health care. Further, findings show that 45% of leaders are aware of the operation, collaboration and communication of the PPP services. The integrated PPP model focuses on the provision of greater access to management empowerment, and quality of services in the community setting (Sekhri et al., 2012; Sturchio & Goel, 2012). The policy documents reviewed lack

coherence on the integration of PPP in primary health interventions in a partnership setting (MoHSW, 2013; MoHSW, 2014).

## Limitations

The English language barriers posed an issue of longer time spent on translating the interviews from the Swahili recorded dialogue to English. Maintaining the originality and the meaning of the perceptions of the participants was a key to this study. Because the researcher was fluent in both languages, she produced the first draft of transcripts that were in Swahili. Considering the limitations of electronic application that convert the Swahili language dialogue and retain similar meaning in English, the researcher transcribed the entire interview in Swahili version first and converted all the transcripts in the English version for computer analysis. As such, the process of manual transcription could introduce a certain degree of researcher bias that may affect the analysis of this study.

Creswell (2014) and Janesick (2012) argued that engaging another person in checking and proofreading against the interview transcripts promote retention of the original message. With member checking approach, the researcher consulted a colleague who was a neutral person knowledgeable of both the Swahili and English language to go through all the Swahili interview transcription against the recorded audio interviews. Also reviewed the Swahili version transcripts against English version to ensure that the meaning of the participant's response was retained before proceeding to the analysis.

The process of maintaining the original response of the participants while transcribing and translating the interview took six weeks. Although the process was

costly regarding time and money for proofreading, the procedure increased the trustworthiness of this study. As such, the process of member counter check of participants' transcripts, proofreading and advice before analysis limited researcher bias and ensured the originality of participant's response was analyzed. Therefore, this limitation was overcome, and the process was ethically accepted.

## Recommendations

This study was carried out to understand factors that would foster partnership leadership synergy (PLS) to promote ownership and accountability in the implementation of primary health interventions in the community. Therefore, the findings of this study reflected on the perceptions of leaders and managers of public and private, not for profit sector that provides an integrated PPP in primary health interventions to increase access and promote quality of care. Considering the previous studies that indicated the significant impact of various perceptions of leadership on the implementation of the PPP in health projects, understanding leader's opinion is vital to promote ownership and accountability (Ansari, 2012, Itika, et al., 2011). The results of this study highlight factors that foster or limit the use of PLS between public and private not for profit organizations in the provision of primary health interventions at the community level. Therefore, the researcher recommends that a similar methodology is replicated to explore the perceptions of private for-profit organizations toward PLS in implementing primary health interventions in a partnership setting.

Because the findings of this study are not transferable or generalizable to the other PPP in the health environment, the researcher recommends a mixed methodology study

that would allow generalization to gain generic insight to better understand factors that promote ownership and accountability in PPP interventions in Tanzania.

## Implications

**Significance to Social Change:** Because of this study, social change may be significant in various stages. First, the managers and leaders of the PPP projects at the study sites could influence factors that would promote PLS, which could motivate leaders of both sides to engage in a partnership setting and enhance ownership and accountability of PPP in primary health interventions. In the similar vein, these leaders could advocate for leadership synergy policy in the implementation of PPP in social health at the community level. At the community level, the leaders would be engaged in monitoring of the primary care programs to improve accountability and promote ownership.

Second, the insight that this study provides could increase the knowledge to the private and public PPP implementers, on integrating and leading primary health interventions in a partnership setting and may advocate for the improvement of access and quality of primary health that they provided at the community level. Third, because of this study, individual leaders and managers could influence, and some may start to observe their perceptions during planning and advocacy for PPP in primary health interventions. The leader’s awareness of their attitudes could improve the level of engagement in design, build, financing, and implementation of the PPP in health strategy at the community level.

Lastly, a previous study indicated that leadership synergy contributed to influence and leverage engagement of the community leaders in monitoring PPP initiatives

(Johannessen et al., 2014). This study found that awareness of partnership leadership synergy within the public and the private sector in the implementation of PPP health interventions promote ownership, and motivate the access of data linkages that would better data quality for health planning.

**Significance to Practice:** The municipal council leaders and managers are accountable for the delivery of PPP in primary care interventions. The increased understanding of PLS could enhance advocacy on community leaders engagement, which may facilitate active communication, ownership and accountability of social determinant of health. Further, the synergetic process may promote an innovative environment for the public and private sector leaders (Itika, 2013), which would enable mutual leaders working together to enhance accountability, increase access, ownership and integration of primary health services (Ansari, 2012).

**Significance to Theoretical Framework:** The DoI construct provided a foundation for the structure of the analysis of this study. The theory (DoI) facilitates effective communication and adaptation of the innovation at different levels (Rogers, 2003). As such, the result of this study could influence the use of diffusion of innovation theory in increasing awareness on the PLS practices and the implementing the PPP in primary health interventions in the community setting. Evidence suggests that applying DoI theory in communicating new ideas within the society is cost efficient and produces best outcomes (Rogers, 2003).

## Summary

The concept of public-private partnership has been adopted to facilitate the delivery of health and social welfare services (The United Republic of Tanzania Ministry of Health & Social Welfare, 2013: Montagu & Harding, 2012). The public-private partnership is the agreement between the government, public sector, and private, sector to deliver services for the public use. Promoting the accountability of the delivery of health and social services between these partnerships is vital to ensure access, quality of care, continuity and value for money (Ansari, 2012; Forrer et al., 10; Sekhri et al., 2010).

The synergetic capacity in the design, monitoring and implementing of health and social services initiatives within this partnership may facilitate community engagement, ownership, and promote accountability of the delivering of these health and social initiatives (Ansari, 2012). The stigma and detrimental perception toward public-private partnership leaders is a challenge (Cramm et al., 2012). Limited data on partnership leadership contributes to the lack of understanding, limited shared best practice, and limited awareness of the benefits of PPP leadership synergy (Itika et al., 2011). A lack of qualitative and quantitative literature on partnership leadership synergy in developing nations limits the evidence on community engagement and effective decisions. Given the challenges of the designing and monitoring process of PPP projects, it impinges on the ownership and accountability of the delivery of the primary health and social welfare initiatives (Cramm et al., 2012; Itika et al., 2011).

## Conclusions

The PPP leadership synergy is the coalition between leaders of the public and private organizations to implement health and social care interventions in a partnership setting. To the varying extent, the local government, public partner, assumes the overall leadership role of all health and social interventions within the municipality, the local government. This study found that the private sector provides a broad range of health services, reaching remote area populations with limited community leadership engagement at the municipal level. Provision of primary health care, which defined as publicly free consumed health interventions, requires not only integrated supervision leadership activity, but also, role specification to promote accountability and ownership in a partnership setting.

This study employed a diffusion of innovation conceptual framework that explained relative opportunity for synergism between the private and public leadership in the delivery of primary health interventions in a partnership setting. Given leader's perception, which influences the decisions on how the health and social interventions are planned, implemented and evaluated. This study found a limited understanding of the shared leader's roles in the implementation of primary health intervention within a PPP. Also, the result indicates unclear roles and responsibility between local government and community leaders on the delivery of primary care in a partnership setting. Further, the frequency relocation of health executive leader' position within the local government has a negative impact on the continuity of PPP in health awareness, and a lack of leadership roles upon the private partners in PPP health interventions.

The results of this study indicate significant evidence of promoting accountability and ownership through enhancing leadership synergy between public and private or private and private partnerships in the implementation of primary health care interventions in a partnership setting. Further research should explore the perceptions of the public-private sector for profit in the implementation of primary health care intervention in a partnership setting at the community level. This study would also contribute to the body of literature on the field of public-private partnership in health and social care and public health leadership in the implementation of primary health care at the community level.

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Appendix A: Interview Research Protocol

**Information for the participants**

This is a qualitative study, which employs empirical case study to explore the perceptions of the project leaders and managers of the public and private sector toward partnership leadership synergy. The purpose of this study is to understand factors that could promote leadership synergy between public and private partnership community health initiatives to enhance monitoring and accountability for health and social interventions in Dar es salaam, Tanzania.

The researcher aim to answer the following three main research questions: (1) what are the perceptions of public and private community health leaders in Tanzanian toward public-private partnership leadership synergy? (2) What are the perceptions of leaders of public and private sector to facilitate leadership synergy for PPP in health and social care interventions in community setting? And (3) how do managers and leaders of public sector and private sector facilitate synergy for action health and social care interventions implementation in partnership setting?

In this study, criterion purposeful sampling employed to select and interview a maximum of 30 leaders and managers from six public and private sector organisation. The sample size of n=30 intended to reach saturation level, that means the researcher would have collected relevant information to answer research questions and no new information will come out after interviewing 24-30 subject. A list of public and private interventions and organisation that work in partnership would be obtained from the Ministry of health and social welfare. Three Municipals councils Ilala, Kinondoni and

Temeke are purposeful selected, because they are governed by government authority and accountable for community publicly health and social services. The selection of private organisations that would be eligible to participate in this study focus on criterion purposeful sampling, and three organisations would be selected from the public-private collaboration organisation list. The eligibility criteria, which will be applied, include, organisations that deliver core healthcare and social care service in a community level and work in partnership with public sector, here refers to Municipal council.

The core health and social services includes: maternal and child health, malaria prevention, reproductive and family planning health, HIV and AIDs, nutrition, tuberculosis and diabetes care. Further, all project leaders are the subject for this study, in this case, the criteria for selecting the leaders and managers to participate in the study based on the following characteristics: (1) should be a male or a female person who is 18 years and above (2) a leader or a manager who has lead the projects for the last six month and above, (3) a leader or a manager who have influence in project decision making, (4) a leaders or a manager who attend or attended PPP collaborative meetings (5) a leader or a manager who is involved in monitoring PPP community health and social care initiatives and (6) a leader or a manager who manage and report PPP project activities (7) a leader or a manager who oversee community health and social care initiatives project activities in Tanzania.

The researcher would make an appointment through telephone call to meet with director of the projects and physically visit the organisations and Municipal council to deliver the flyer and meet up with potential subjects. Then, researcher make an

arrangement for a meeting with potential participants and explain the intent of the study, invite them for informed voluntary consent and for face-to-face open-ended interview. The total time for one to one interview is one hour (sixty minutes), for each leaders or a manage of public and private sector, and each one will be encouraged to sign the consent form before the actual interview. Moreover, the researcher would provide a bottled of juice, or bottled of water, a pack of fresh fruits or biscuits or a pack of simple lunch as a thank you to the participants.

The researcher will use similar set of guided discussion questions for each interview and all selected subjects. These structures open-ended questions are intended to produce descriptive information that answer research questions. The interview would be recorded, using audio recorder, and also the researcher may take some notice, to help on comparing the notice as this ensure no missing out of any important discussed information. Similarly, the researcher may call back for further information if need be, so please bear in mind if this happen. The researcher informs the participants through telephone or physically pays a visit to the research site for further clarity or information. The interview would be transcribed, analyze and report will be produces in reflection of the research findings. Equally, the report will be share with the participants through dissemination of report or presentation. Further, confidentiality issues are clearly narrated on the consent form, and the Walden University Institution Review board (IRB) granted the permission for this study after verification of quality and benefit of this study to the area of study. Further, the researcher has been granted permission to conduct this study in

the study sites (Kinondoni, Ilala and Temeke) by the Tanzania research review board. This study courses no potential harm.

In summary, each participant is required to voluntarily participate in this study, and all potential participants have a right to terminate the participation if one feels so. However, your participation is really appreciated and highly valued. In fact, participants are actually contributing to the knowledge that would enhance better understanding of the PPP projects. Participants information will be treated privately and confidential, that means no individual names will appear in any writing of this study and even the selected organizations' names will only appear in a list of organisation that have participated in this study. Please proceed to consent form information and if you are eligible to participate in this study, and you are willingly to participate say YES and the researcher will contact you.

**Background Information**

The population of Tanzania is 49.6 millions, of which 75% live in rural are (Tanzania Global Health, 2011). The country is facing economic and social development challenges that contribute to an increased burden of socially determined conditions. In particular, the influence of social determinants of health, which associated with child and maternal mortality, HIV, tuberculosis, malnutrition, malaria and poverty including chronic illness such us diabetic are preventable and have potential for control with cost effective initiatives. Limited awareness and engagement of community leaders and managers in public private partnership initiatives and their benefit may have influence on lack of accountability and ownership of health and social health initiatives.

The purpose of this study is to explore the perceptions of project leaders and managers of public and private sector toward partnership leadership to understand the factors that could promote partnership leadership synergy to enhance accountability for community health and social welfare initiatives in Tanzania. Although public-private partnership in health and social care initiatives has been adapted as a best pathway to improving healthcare access, continuity of care, equity in social health, quality of care, and promoting positive health outcomes in the population, lack of awareness and engagement of community leaders on PPP interventions and their benefit affect accountability and ownership of health and social care interventions. Limited data and understanding of PPP concept and its benefit also contribute to lack of community engagement, shared best practice and quality decision making on health and social initiatives. Further, evidence shows managers and leaders hold various perceptions on PPP implementations and thus suggest improving synergetic capacity in PPP design, monitoring and implementation may facilitate community engagement in PPP, improve accountability and ownership of social health initiatives. The positive social impact for this study will be demonstrated through increased awareness of the benefit of PPP and community engagement and ownership on health and social welfare interventions. The result of this study contributes to the body of literature in public health leadership initiatives.

**Procedures**

After the agreement to voluntarily participate in this study, participants were explained the procedure, which include:

- To read the research protocol.

- To sign the consent form
- To take part/respond to the seven-guided open-ended questions. That the interview is interactive, face-to-face and audio taped, and take 45 minutes to one hour to finish for each participant.
- To repeat their response or make clear by elaborating answers further. Also, explained that the researcher may follow up for more clarity in case needed after the initial interview. And that if the follow up would be needed, he researcher would either give a phone call to arrange for the time to visit personally.
- Participants were advised to keep all conversation regarding this study interview confidential.
- Participants were offered a soft drink and biscuits after the interview as appreciation from the researcher. The researcher appreciated for time and contribution of each participant after each interview.

Here are some sample questions:

1. What is your title at work and how long have you been in this position?
2. What are you responsible for in a partnership project?
3. We are interested in your experience of leadership synergy.
    a. Think about a problem you were involved in solving in a PPP intervention where your leadership was important to what happened. Tell me about that.
    b. We are interested in the details and your experience of the synergistic situation.
    c. What was the problem?
    d. What was the goal?
    e. How did the decision to work on PPP come about?
    f. How did you first approach addressing the leadership challenge in a partnership setting
    g. What did you hope to accomplish?
    h. What kinds of bumps in the road were there along the way?
    i. Who was involved in facilitating the community PPP leadership effort?
    j. Please describe how the members of the team worked together?
    k. Did your relationship with any individuals (either on the team or outside of the team) change as you were working on PPP project?
    l. What were outcomes of the collaborative leadership work?

**Voluntary Nature of the Study**

This study was voluntary. Participants were explained that everyone’s decision would be respect regardless of whether or not they choose to be in the study. Further, explained that no one from the public or private sector collaborative partnership in health initiatives would treat participants differently if they decide not to be in the study. The decision to

join was flexible and thus if one decided to change mind after would be allowed to do so at any time. Participants are informed that the volunteers who would take part in this study were purposefully selected to illuminate information that would answer the research questions. Therefore, the researcher contacted volunteers directly via their telephone, and also physically visits them on their work site

**Risks and Benefits of Being in the Study**

This study protocol explained that, being in this study would not pose any risk to safety or well-being. Participation in this study would help understanding of factors that would help to foster accountability and promote ownership of PPP interventions in a partnership setting. Further, this protocol explained that understanding the perceptions and experiences of PPP interventions would provide insight for decision makers on designing and implementing health and social health initiatives**.**

**Payment**

There was no tangible gift or money for the volunteering in this study, but, the researcher provided a soft drink and biscuits as an appreciation to the participants at the end of interview.

**Privacy**

Participants were informed that any information that they provide is kept confidential. The researcher should not use personal information for any purposes outside of this research project. Also, the researcher would not include participants name or anything else that could identify participants in the study reports. Data is kept secure by using data security measures, which include password protection, data encryption, use of codes in place of names, and omit names as necessary, all personal identity not used in this study and the information that would identify a person would be protected and pseudonyms are used instead of real names. Further, data is kept for a period of at least 5 years, as required by the university.

**Contacts and Questions**

Participants were given contact details for any enquiry they may have. These were as follows: Researcher's telephone number +447727677648. And for any private matters about rights as a participant, they could call Dr. Leilani Endicott. Who is the Walden University representative, her phone number is 612-312-1210. Walden University's approval number for this study was **IRB 01-23-17-0403065** and it expires on **January 22,2018.** All participants signed the consent form and were given a copy of the research protocol.

Appendix B: Semi-Structured Research Discussion Questions

1. What is your title at work and how long have you been in this position? What are you responsible for in a partnership project?
2. I am interested in your experience of leadership synergy.
   m. Think about a problem you were involved in solving in a PPP intervention where your leadership was important to what happened. Tell me about that.
   n. I am interested in the details and your experience of the synergistic situation.
   o. What was the problem?
   p. What was the goal?
   q. How did the decision to work on PPP come about?
   r. How did you first approach addressing the leadership challenge in a partnership setting
   s. What did you hope to accomplish?
   t. What kinds of bumps in the road were there along the way?
   u. Who was involved in facilitating the community PPP leadership effort?

   v. Please describe how the members of the team worked together?
   w. Did your relationship with any individuals (either on the team or outside of the team) change as you were working on PPP project?
   x. What were outcomes of the collaborative leadership work?
   y. What factors do you think made the PPP project successful (or led to its failure or slow progress)?
4. Was there any sort of turning point where you felt like the right pieces fell into place in order for the PPP project to be successful?
5. What kinds of unintended leadership synergy consequences (either positive or negative) occurred? Any surprises?
6. Looking back, is there anything you might have done differently as a manger/leader in this community public and private partnership project?
7. I am interested in your experience of being a leader/manager in the private health sector/ public health sector in community setting. Is there anything else we should have asked to help us understand your experience of working in a partnership setting better?

Adapted from Curry et al. (2012).

## Appendix C: Documents Review Procedure

The purpose of document review in this study is to triangulate. Triangulating data provide a source of evidence, which increases credibility of the research (Bowel, 2009; Patton, 2014). The researcher will examine information collected through different methods and collaborate the findings across data set; this method will reduce the impact of potential biases that can exist through only one method and also may uncover important insight to the research problems (Patton, 2014). In this study, documents review include public-private partnership policies, PPP collaborative and engagement guidelines and policies, PPP meetings report, project reports, training reports, PPP design, implementation and monitoring guidelines, and any relevant, accessible document to the study.

Procedure

- The researcher will seek permission from the organizations; will present the local IRB permit for the study including signed confidentiality letter for documents review.
- In each organization, researcher will give the consent to documents access to be allowed to review available documents
- The researcher will skim the documents content for the relevance focus on the categories related to the central questions of the research.
- The researcher should determine the authenticity, credibility, accuracy and representation of the documents and consider its relevance to the study.
- The researcher will photocopy, and or scan the relevant text from the document or copy the document for reference.
- The researcher will critically examine the selected data and perform coding and categories based on the research questions to uncover themes pertinent to phenomena in question.
- Researcher will input selected or harvested data into Microsoft Excel program for analysis
- The researcher will then use the codes employed in the in-depth interview to compare, analyze and interpret the findings.

Appendix D: Dissertation Study Budget Plan

| Item | Description | Cost | Total cost |
|---|---|---|---|
| Research registration fee | Local research registration charges | =$150.00 | $150.00 |
| Transport | 3 weeks (15 days)<br>$ 48 X 15 days | =$720.00 | $720.00 |
| Stationary | Photocopy<br>30 people X $2.00<br>Printings X $ 28.00 | =$30.00<br>=$28.00 | $58.00 |
| Biscuits & Soft drinks for participants | 30 people X $ 5. 00 | =$150.00 | $150.00 |
| Documents Translation | Protocol 2 pages $500.00<br>Consent form 4 pages $ 1000.00<br>Research tools 2 pages $ 500.00 | =$500.00<br>=$500.00<br>= $500.00 | $1000.00<br>$ 500.00 |
| | | Total | $2,578.00 |
| | | Miscellaneously | $200.00 |
| | | Grand Total | $2,778.00 |

* The grand total budget does not include the translation of interview transcripts.

Appendix E: Tanzania Public and Private Sector Organisations

| Government Sector (Public Sector) | Private Not For Private Sector |
|---|---|
| Community Health Fund (CHF) | National Muslim Council of Tanzania (BAKWATA) |
| Local Government Authorities (LGAs) | Christian Social Services Commission (CSSC) |
| Ministry of Science, Technology and Higher Education (MOSTHE) | Association of Private Health Facilities Tanzania (APHFTA) |
| Ministry of Finance & Economic Affairs (MOF) | Medical Association of Tanganyika (MAT) |
| Prime Minister Office (PMO) | Marie Stopes/Tanzania MS/T) |
| Prime Ministers Office-Regional Administration and Local Government (PMO-RALG) | Private Medical Training Institute (PMTI) |
| Regional Health Management team (RHMT) | Private Nurses and Midwives Association of Tanzania (PRINMAT) |
| Tanzania Investments Centre (TIC) | Tanzania Association of NGOs (TANGO) |
| Ministry of Health and social Welfare (MOHSW) | Tanzania Public Health Association (TPA) |

| International Donors | Private For Profit Sector |
|---|---|
| Danish Technical Cooperation (DANIDA) | Accredited Drug Dispensing Outlet (ADDOs) |
| Global Fund for TB, AIDS and Malaria (GFTAM) | Corporate Social Responsibility (CSR) |
| German Technical Cooperation (GIZ) | **Civil Society** |
| President’s Emergency Plan for AIDS Relief (PEPFAR) | Tanzanian NGO for youth and Youth Action Volunteers (SIKIKA) |
| United States Government (USG) | “We can Make it happen” Citizens Initiatives (TWAWEZA) |
| United States Agency for International Development (USAID) | Pastoral Activities and Services for People with AIDS Dar es Salam Archdiocese (PASADA) |

Adapted from Whites et al. (2013).

Appendix F: Study Area Map, Dar es Salaam City